Toward Guidelines for Compelling Cesarean Surgery: Of Rights, Responsibility, and Decisional Authenticity

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INTRODUCTION

When, if ever, may a pregnant woman be compelled to undergo a cesarean section\(^1\) to save the life of a viable, verge-of-birth fetus?\(^2\) Courts and scholars have increasingly addressed

1. Throughout this piece I discuss cesarean sections necessary to prevent death or serious harm to the viable fetus. Thus, I am not at all suggesting that as many, or more, cesarean surgeries be performed as at present. I am of course aware of the controversy over the number of unnecessary cesarean sections performed in this country. See, e.g., MORTIMER ROSEN & LILLIAN THOMAS, THE CESAREAN MYTH: CHOOSING THE BEST WAY TO HAVE YOUR BABY (1989). For a host of reasons, including legal defensiveness, an excessive commitment to technological solutions, the seeking of higher profits by physicians and hospitals, and misunderstandings about the true need for cesarean sections, there are many unnecessary cesarean procedures performed in this country. Twenty-seven percent of births are performed by cesarean, more than in almost any other country. Jane E. Brody, Personal Health, N.Y. TIMES, July 27, 1989, at B5. Since cesarean surgeries present greater risks than vaginal deliveries and require a period of recuperation, the number of these operations should be reduced.

the constitutional and ethical problems presented when a woman about to give birth requires a cesarean section to prevent the death of or severe harm to her fetus, and the woman refuses to have the surgery. Nationally, over a five year period, courts have heard twenty-one cases in which a court-ordered cesarean was being sought. Under what circumstances, if any, is it legally and ethically appropriate to compel a woman to undergo such surgery in order to save the life or essential health of the fetus, and perhaps the mother's own life as well?

There are three basic obstetrical scenarios: first, where the cesarean is essential for the life or health of the mother and the fetus; second, where the cesarean is only minimally risky to the life or health of the mother but is necessary to save the life or health of the fetus; and third, where the cesarean would substantially jeopardize the health of the mother, but is necessary to protect the life or health of the fetus.

The solutions this Article proposes are based, in part, on certain qualities of the mother's decision, as well as the net gain or loss in terms of human life. The solutions also take into account the mother's bodily integrity, decisional autonomy, and privacy rights.

In the first scenario, where the life of the mother and the fetus are both in jeopardy absent a cesarean, and a cesarean substantially reduces the risks to both parties, this Article proposes that the surgery be performed despite the mother's competent, authentic, voluntary, and informed refusal. In the second scenario, where the fetus would die without a cesarean, but a cesarean would present only the usual risks to the mother, her refusal must be honored unless there is strong evidence that she is incompetent, acting involuntarily, or asserting


a decision manifestly contrary to her authentic position. Finally, in the third scenario, where a cesarean would jeopardize a mother's life or health, the court should respect her decision to forego the surgery.

Commentators have focused on the comparative rights and interests of the mother and the fetus, frequently concluding that the maternal interest in bodily integrity, autonomy, and privacy trumps any right a fetus, or a state acting on behalf of a fetus, might have to compel a woman to undergo major surgery. Commentators have paid scant attention to the situation where both the mother and the fetus would probably die or be severely harmed absent a cesarean, or to the question of the authenticity of a woman's refusal to submit to cesarean surgery.

Recently, the District of Columbia Court of Appeals considered the legality of nonconsensual cesarean section in In re A.C. Commentators have greeted the A.C. decision as a laudable recognition of a person's right to refuse treatment and to be immune from nonconsensual invasive medical procedures. Even before A.C., many scholars had expressed similar views.


5. The decision was met with substantial approval by writers, scholars, and spokespersons for various interest groups in the field. See, e.g., George J. Annas, Foreclosing the Use of Force: A.C. Reversed, HASTINGS CENTER REP., July-Aug. 1990, at 27; Curran, supra note 3, at 490; Barton Gellman, Mother’s Right Upheld Over Fetus’s: D.C. Court Rules in Case of Cesarean Section for Dying Woman, WASH. POST, Apr. 27, 1990, at Al; Linda Greenhouse, Court in Capital Bars Forced Surgery to Save Fetus, N.Y. TIMES, Apr. 27, 1990, § A, at 1.


6. Probably the two leading articles written on behalf of the mother's right to refuse a cesarean are those by Rhoden (legal perspective) and Nelson and Milliken (medical perspective). See Rhoden, supra note 2, at 1982-84 ("[i]n no other situation are rescues that risk life and limb mandated by law."); Nelson & Milliken, supra note 2, at 1060 (discussing patient autonomy and the distinction between fetus and born child); see also Nelson et al., supra note 2, at 703.

A distinguished scholar who finds a maternal duty to submit to a cesarean section is Professor John A. Robertson. See John A. Robertson, The Right to Procreate and In Utero Fetal Therapy, 259 J. LEGAL MED. 333, 357-78 (1982); see also Deborah Mathieu, Respecting Liberty and Preventing Harm: Limits of State Intervention in Prenatal Choice, 8 HARV. J.L. & PUB. POL’Y 19 (1985).

6. See, e.g., Annas, The Most Unkindest Cut, supra note 2, at 16;
This Article argues that the issue of whether to compel a cesarean section is much closer than the A.C. court recognized. There is a case to be made for protecting the values of bodily integrity and autonomy in these situations. There is, however, a much stronger case than courts and commentators have acknowledged for requiring submission to cesarean surgery under certain circumstances.

Part I of this Article discusses the developing law in the area of compelled cesarean sections. Part II presents an argument for compelled cesarean sections in general, as far as the law, logic, and medicine reasonably take it, and Part III discusses the countervailing arguments for the right to refuse an unwanted cesarean section. Part IV describes the medical conditions for which cesareans are indicated, and discusses associated surgical mortality and morbidity risks. Finally, Part V presents the Article's main thesis and details the factors which are, or should be, met before maternal autonomy may be overcome. Part VI concludes by stressing the need for dialogue between doctor and patient.

I. COMPPELLING CESAREANS: CONFLICTING LEGAL AUTHORITIES

A. THE A.C. CASE

In the A.C. case, a twenty-seven year old woman who had suffered from bone cancer for fourteen years became pregnant with her first child. During her twenty-fifth week of pregnancy her condition became terminal. Told by doctors that her life might be extended to the twenty-eighth week and that the baby could be delivered by cesarean section, the woman, who was heavily sedated and barely able to communicate her views, gave inconclusive responses about her willingness to undergo the surgery. A neonatologist, in a hearing at the hospital, offered the opinion that the woman's fetus had a fifty percent to sixty percent chance of survival if delivered immediately. Another physician testified that further delay would reduce the fetus's chances of survival.

Mahowald, supra note 2, at 111-12; Nelson & Milliken, supra note 2, at 1060; Nelson et al., supra note 2, at 708; Rhoden, supra note 2, at 1951.


8. Id. at 1239.

9. Id.

10. Id.
The judge, finding that the mother's wishes could not be ascertained, ordered doctors to perform a cesarean. The D.C. Court of Appeals denied a stay. The baby died two-and-one-half hours after its birth; the mother died two days later.

Thereafter, the full court of appeals, sitting en banc, heard the case despite its mootness. The court held that "in virtually all cases the question of what is to be done is to be decided by the patient—the pregnant woman—on behalf of herself and the fetus." If a woman is incompetent, the court continued, her views on the matter should be ascertained by the substituted judgment process. The substituted judgment process explores the woman's statements, preferences, and values to determine what her expressed wishes would have been were she sufficiently competent or conscious to declare them.

The court concluded that a medical procedure could not be performed on a conscious, competent person without that person's informed consent, that one person could not be required to submit to bodily intrusion for the benefit of another's health, and that a fetus cannot have rights "superior to those of a person who has already been born." According to the court, "the right to accept or forego medical treatment is of constitutional magnitude." The court also stated that a risk of coerced surgery would drive women with high-risk pregnancies out of the health care system and that judicial proceedings in these kinds of cases involve insufficiently protective procedural standards, inadequate information, and inadequate preparation time for any counsel appointed for the patient.

The court left an indeterminate, but small, opening for

11. Id. at 1240 (describing trial court opinion).
13. 573 A.2d at 1238. Although the birth certificate listed the cesarean as a contributing cause of the death, there is some controversy over that question. See Barbara Mishkin, But She's Not an "Inanimate Container . . .", HASTINGS CENTER REP., June-July 1988, at 40, 41.
14. 573 A.2d at 1237.
15. Id. at 1249.
16. The court should hear from the patient, family, friends, and healthcare professionals. It should look for evidence of previously expressed wishes of the patient and "previous decisions of the patient concerning medical treatment, especially when there may be a discernibly consistent pattern of conduct or of thought" regarding the patient's values or goals. Id. at 1247, 1249-50.
17. Id. at 1243-44.
18. Id. at 1244.
19. Id.
20. Id. at 1248.
"overriding the patient's wishes." In the court's words, "we do not quite foreclose the possibility that a conflicting state interest may be so compelling that the patient's wishes must yield... but we anticipate that such cases will be extremely rare and truly exceptional." Significantly, in a footnote, the A.C. court seemed to resuscitate the case for compulsion by refusing to disapprove of an earlier District of Columbia case that ordered a cesarean against the mother's will where it was necessary to protect the health of both the mother and the full term fetus.

B. THE JEFFERSON CASE

In the only other appellate opinion addressing this question, the Georgia Supreme Court took a view contrary to the subsequent A.C. court's stance. In Jefferson v. Griffin Spalding County Hospital Authority, the physicians concluded that the mother, in her thirty-ninth week of pregnancy (the last...
week of normal pregnancy) was experiencing complete placentia previa. Consequentially, the doctors stated they were ninety-nine percent certain that the fetus could not survive vaginal childbirth, and that the chances of the mother surviving such a birth were "no better than 50%." The physicians believed that a cesarean would provide almost a one hundred percent chance of saving both the mother and the fetus. The mother, however, refused to submit to cesarean surgery because of her religious opposition to receiving a blood transfusion and because she did not believe that she needed surgical removal of the fetus.

The trial court ordered the mother to submit to a sonogram, to be followed by a cesarean section if the placenta previa still blocked vaginal childbirth. Finding that the fetus was not receiving proper care, the trial court gave child protection agencies the authority to consent to surgical delivery. The court found that "the intrusion . . . into the life of Jessie Mae Jefferson and her husband . . . is outweighed by the duty of the State to protect a living, unborn human being from meeting his or her death before being given the opportunity to live."

The Georgia Supreme Court, in a per curiam opinion, refused to grant the parents’ motion for a stay. Citing Roe v. Wade, a concurring judge declared that "[t]he Supreme Court has recognized that the state has an interest in protecting the lives of unborn, viable children." A second concurrence, evaluating the mother’s religious claims, found that the state had no less restrictive alternative for carrying its compelling interest in preserving the life of the viable fetus.

25. For a description of this condition, see infra note 215.
26. 274 S.E.2d at 458.
27. Id. at 459.
28. The mother believed that "the Lord ha[d] healed her body and that whatever happen[ed] to the child [would] be the Lord's will." Id.
29. Id. at 459-60 (quoting the trial court opinion).
30. Id. at 459 (quoting the trial court opinion).
31. Id. at 460 (quoting the trial court opinion).
32. Id.
34. 274 S.E.2d at 460 (Hill, Presiding J., concurring).
35. Id. at 461 (Smith, J., concurring).
II. MATERNAL-FETAL CONFLICTS DURING LATE STAGES OF PREGNANCY

A. THE LEGAL STATUS OF A VIABLE FETUS

Historically, a fetus became a person in the law when it was born alive. As early as 1946, however, a court awarded damages to a child for injuries it had sustained as a fetus. In *Bonbrest v. Kotz*, a federal district court rejected the argument that a fetus is only a “part” of its mother and therefore not entitled to an independent legal claim. Professor Patricia King has observed that by 1967 every state had followed *Bonbrest*’s lead and permitted recovery for fetal injury if the fetus was subsequently born alive. In one case, a child recovered from its mother for injuries it suffered as a fetus.

The fetus has enjoyed juridical recognition for many years, especially in property law. At common law, a fetus, from the time of conception, could be named an heir to a decedent’s estate. The unborn child’s property rights, however, vested only upon live birth. Intestate succession statutes have recognized the rights of posthumous children.

In addition, courts have deemed a viable fetus to be a “person” in the context of civil actions for personal injury. A few

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38. Id. at 140.
39. King, supra note 36, at 1660.
41. For example, an Ohio statute treats a child in gestation who is subsequently born alive as a life in being for purposes of the rule against perpetuities. See Ohio Rev. Code Ann. § 2131.08(A) (Anderson 1990) (adopting the common law rule against perpetuities).
42. See Tomlin v. Laws, 134 N.E. 24 (Ill. 1922).
states have enacted statutes that make the culpable killing of a fetus a form of homicide.46

That the culpably caused stillbirth of a viable fetus justifies recovery for lost consortium or wrongful death in at least thirty-three states47 indicates that the negligently caused death of a viable fetus is not treated as the loss of a chattel or of an organ of the mother, but as the loss of an independent person with human qualities and human potential.48 Some courts calculate damages for these losses as damages for the loss of a


46. Most courts have not extended common law crimes, such as manslaughter or homicide, to the killing of a fetus. See, e.g., Keeler v. Superior Court, 470 P.2d 617, 624 (Cal. 1970) (en banc); State v. Green, 781 P.2d 678, 682 (Kan. 1989). But see Commonwealth v. Lawrence, 536 N.E.2d 571, 575-76 (Mass. 1989) (holding that a viable fetus is a "person" for the purposes of the Massachusetts common law crime of murder); Commonwealth v. Cass, 467 N.E.2d 1324, 1325 (Mass. 1984) (holding prospectively that a viable fetus is a "person" for the purposes of a vehicular homicide statute); State v. Horne, 319 S.E.2d 703, 704 (S.C. 1984) (holding prospectively that it is a crime to murder a viable fetus).

Several states have enacted statutes treating the killing of a fetus as a form of homicide. See People v. Shum, 512 N.E.2d 1183, 1198 (Ill. 1987); Perigo v. State, 541 N.E.2d 936 (Ind. 1989).

The common law held that one who fatally injures a fetus which is later born alive and dies, has committed homicide. See State v. Cornelius, 448 N.W.2d 434, 437 & n.4 (Wis. Ct. App. 1989).

47. Summerfield v. Superior Court, 698 P.2d 712, 721 n.5 (Ariz. 1985) (en banc) (collecting cases). Evidently only nine states have explicitly rejected the claim of a wrongful death action based on the culpably caused stillbirth of a viable fetus. Id. at 722 n.6. The Summerfield court observed that "[t]he majority [of courts] . . . 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.'" Id. at 722.

The following observation of the Ohio Supreme Court is also pertinent:

"Suppose, for example, viable unborn twins suffered simultaneously the same prenatal injury of which one died before and the other after birth. Shall there be a cause of action for the death of one and not for that of the other? Surely logic requires recognition of causes of action for the deaths of both or for neither."


child. Moreover, in states that have survivorship statutes, a stillborn fetus may have a separate estate to which damages may flow. Thus, the fetus is treated as if it were a born child in many circumstances.

Of course the fetus is not a "person" for purposes of constitutional standing, but the cases strongly suggest that what happens to a viable fetus is a legally cognizable concern. Beyond private litigation, the state has a compelling interest in the potential life of the fetus at least from the time it is viable and, perhaps, even earlier. In addition to the existing legally cognizable interests, viable fetuses may enjoy some emerging rights against the mother.

B. FETAL versus MATERNAL RIGHTS

Courts have heard about twenty-one cases where a court-ordered cesarean section was being sought. In Jefferson, doctors determined that the risk to both the fetus and the mother would be significantly greater if delivery were vaginal than if delivery occurred by cesarean section. The court subordinated the mother's autonomy and bodily integrity to the welfare of the fetus.

49. See, e.g., Williams, 482 A.2d at 398 ("Evidentiary problems of causation and pecuniary loss are not demonstrably more difficult when the decedent is a viable fetus than when the decedent is a child or newborn infant."); Werling, 476 N.E.2d at 1054; Amadio, 501 A.2d at 1088. Contra DiDonato, 358 S.E.2d at 493-94 (denying possibility of recovery of damages for lost income and services on grounds that damages would be too speculative).

50. See, e.g., Williams, 482 A.2d at 397-98 (holding that cause of action in favor of estate of fetus survives its stillbirth); Amadio, 501 A.2d at 1088 (same).

51. See, e.g., Amadio, 501 A.2d at 1088.


53. Id. at 163-64.


55. See supra note 3 and accompanying text.


57. But see Taft v. Taft, 446 N.E.2d 395 (Mass. 1983), in which the court found that a woman could not be ordered to submit to an operation designed to assure that her cervix would remain competent throughout her pregnancy. Id. at 397. The woman, a born-again Christian, based her refusal to have the minor surgery on her religious beliefs. Id. at 396. Among other things, the court pointed out that the fetus was not viable and that it had found no case ordering submission "to a surgical procedure to assist in carrying a child not then viable to term." Id. at 397 n.4. Moreover, there was no showing in this
That numerous actions, both criminal and otherwise, have been brought, sometimes successfully, against mothers who have injured or endangered their fetuses through drug or alcohol use bespeaks at least the evolving mores of our age. Courts have applied child neglect laws to take custody of children from their mothers on the basis of prenatal conduct. In one case, a court held a mother liable for the damages a new-case of the likelihood that the pregnancy would be carried to term without the surgical procedure. Id. at 397.

Although the court found that the woman's constitutional right to privacy prevailed under the facts before it, it observed:

*We do not decide whether, in some situations, there would be justification for ordering a wife to submit to medical treatment in order to assist in carrying a child to term. Perhaps the State's interest, in some circumstances, might be sufficiently compelling . . . to justify such a restriction on a person's constitutional right of privacy.*

Id. Thus, had the fetus been viable and in jeopardy, the result may have been different. But cf: In re Milton, 505 N.E.2d 255, 260 (Ohio) (upholding the right of a patient to refuse to undergo surgery for cervical cancer for religious and other reasons), cert. denied, 484 U.S. 820 (1987).

58. "[T]here have been about 35 cases, involving a wide range of novel legal theories, in which women have faced criminal charges for using drugs or alcohol while pregnant. In most the charges were ultimately dismissed or dropped, sometimes before indictment." Tamar Lewin, *Drug Use in Pregnancy: New Issue for the Courts*, N.Y. Times, Feb. 5, 1990, at A14.


60. See, e.g., In re Ruiz, 500 N.E.2d 935, 939 (Ohio Com. Pl. 1986) (holding that, because a mother's drug use created a substantial risk to the health of her fetus, the child, who was born addicted to heroin, was an abused child).

In In re Baby X, 293 N.W.2d 736 (Mich. App. 1980), the state petitioned to take temporary custody of a child who exhibited signs of drug withdrawal 24 hours after birth. The court discussed whether a mother's prenatal behavior is relevant in determining if a newly-born child has been neglected. It concluded that since a child "has a legal right to begin life with a sound mind and body . . . it is within [the] best interest [of the child] to examine all prenatal conduct bearing on that right." Id. at 739. The court held that a newborn suffering withdrawal symptoms as a consequence of prenatal maternal drug addiction was a neglected child for the purposes of probate court jurisdiction. Id.

In In re Smith, 492 N.Y.S.2d 331 (Fam. Ct. 1985), the court determined that a mother's alcohol abuse and her failure to seek proper medical care for her unborn child were "sufficient to establish an 'imminent danger' of impairment of physical condition, including the possibility of fetal alcohol syndrome." Id. at 334. Therefore, the court held that the child, who had been born, was neglected. Id. It must be noted that the court relied on a legal presumption that the child of a person who repeatedly uses alcohol to the extent of impairment of judgment is a neglected child. Id. The presumption may be rebutted by enrollment in a recognized rehabilitative program. Id.

"The important state interests in preservation of life, the potentiality of life, and child welfare lend resolute support to the argument that child abuse and neglect statutes should include unborn children. In reality, this is the
born suffered from a prescription drug the mother took during pregnancy.  

Courts have also ordered pregnant women to undergo blood transfusions against their religious beliefs for the sake of a fetus. In Raleigh Fitkin-Paul Morgan Hospital v. Anderson, the court decreed that, if necessary to save the life of a pregnant Jehovah’s Witness or the life of her fetus, the hospital would be ordered to give the woman a blood transfusion against her will and religious convictions. The pregnancy was beyond the thirty-second week.  

In In re Jamaica Hospital, a mother, eighteen weeks pregnant and in critical condition, had refused a transfusion on religious grounds. The court appointed a physician as the special guardian of the unborn child and ordered the doctor “to exercise his discretion to do all that in his medical judgment was necessary to save its life, including the transfusion of blood into the mother.” The transfusion was needed to stabilize the woman and to protect the life of her midterm fetus. The court said that the fetus could be regarded “as a human being, to whom the court stands in parens patriae, and whom the court has an obligation to protect.”  

In Crouse Irving Memorial Hospital, Inc. v. Paddock, a New York court ordered a transfusion, despite the mother's religious objection, to save the mother and the fetus she was to deliver prematurely.  

These cases suggest that a viable fetus should be treated as only way to give meaningful effect to those interests." John Myers, Abuse and Neglect of the Unborn: Can the State Intervene?, 23 DUQ. L. REV. 1, 29 (1984).  
64. Id. at 538.  
65. Id. at 537.  
67. Id. at 899.  
68. Id. at 900.  
69. Id. at 900.  
70. Id. at 900.  
72. Id. at 443-44.
a child worthy of legal protection. In these cases the state has impinged on the autonomy and bodily integrity of mothers, but has done so to serve a traditional state value, the prevention of harm to third parties.

Courts have also ordered medical treatment of a sibling to allow another sibling to live. In *Strunk v. Strunk*, the court approved transplantation of a kidney from an incompetent child to a sibling in order to save the recipient’s life. It is not clear whether parental consent was critical to the judicial authorizations. One author finds that *Strunk* suggests "a rather stringent duty to prevent or remove harm, or both, to a member of one’s immediate family, a duty that involves significant risk to oneself and is shared even by members of the family who are incompetent to shoulder other types of obligations."

C. **THE SIGNIFICANCE OF FETAL VIABILITY**

The Supreme Court's language in *Roe v. Wade* regarding the juridical status of the viable (normally third trimester) fetus cannot be ignored. In essence, the Court held that a third trimester fetus, because it is presumptively viable, may consti-

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73. See Watson A. Bowes & Brad Selgestad, *Fetal Versus Maternal Rights: Medical and Legal Perspectives*, 58 OBSTETRICS & GYNECOLOGY 209, 212-13 (1981) (arguing that a full term viable fetus clearly has rights deserving of protection).


75. *Hart v. Brown*, 289 A.2d 386, 391 (Conn. Super. Ct. 1972); *Strunk v. Strunk*, 445 S.W.2d 145, 149 (Ky. 1969). But cf. *Curran v. Bosze*, 566 N.E.2d 1319, 1343-45 (Ill. 1990) (holding that three-year-old twins could not be compelled, against their mother’s wishes, to be tested as potential donors of bone marrow to their half-brother, who was dying of leukemia, where the twins had almost no contact with the half-brother (who lived in a separate household) and the prospect of benefit to the patient was poor).

76. 445 S.W.2d at 148-49. *Contra* *Lausier v. Pescinski*, 226 N.W.2d 180, 182 (Wis. 1975) (declining to follow *Strunk* and holding that it lacked the power to permit the removal of a kidney from an incompetent child to save the life of his brother, notwithstanding only slight risk of harm to the incompetent sibling).

77. Mathieu, *supra* note 5, at 43-44. Mathieu states that in *Strunk* the costs to the donor were not given much weight and that the "consensus among informed and competent people was that the donation should be made, even though the donor could not understand what was being asked of him," and that the court would allow an incompetent person to donate a kidney to a sibling. Id. at 43. Cf. James F. Childress, *Analogical Reasoning: Organ/Tissue Donation and Cesarean Sections*, 2 BioLaw (University Publications of America) Special Section, at S:443 (June, 1990) (discussing ethical considerations in imposing a duty to provide an organ or undergo a cesarean).
tutionally be protected by the state from all but therapeutic abortions.\(^7\) It said that in the third trimester the state's compelling interest may outweigh the mother's interest in an abortion, unless an abortion is essential to the preservation of the mother's health or life.\(^8\) Thus, a state's interest in the potential life of a viable fetus may prevail over a mother's procreative rights, absent a threat to the preservation of a mother's health or life.\(^9\)

Viability means that the fetus's condition is such that it can survive after birth with help from neonatal intensive care resources.\(^10\) According to the Supreme Court in Roe, "viability is usually placed at about seven months (28 weeks) but may occur earlier, even at 24 weeks."\(^11\) Since the 1973 decision, improvements in health care have made survival more likely at a gestational age of between twenty-four and twenty-eight weeks.\(^12\)

Most women in their seventh month expect to be mothers.\(^13\) With that expectancy comes the assumption of responsibilities. Moreover, tradition in child bearing strongly suggests that the expectant mother has obligations to the fetus. Moral-medical injunctions to the expectant mother regarding prenatal care are not new or radical, except to the extent that medicine has recently become aware of the importance of such care to a healthy outcome for the eventual baby.\(^14\) A viable fetus is in one sense a part of the mother, but in another sense a charge of the mother, who protects it from the elements, shock, trauma, excessive temperatures, and poisonous substances. As


\(^9\) "For the stage subsequent to viability, the State in promoting its interest in the potentiality of human life may, if it chooses, regulate, and even proscribe, abortion except where it is necessary, in appropriate medical judgment, for the preservation of the life or health of the mother." Id. at 164-65.

\(^80\) The question whether the risks from cesarean surgery bring this exception to bear will be explored in this Article. It does not necessarily follow, however, that a nonconsensual cesarean section is mandated if an abortion is prohibited.

\(^81\) Mahowald, supra note 2, at 110.

\(^82\) 410 U.S. at 160.


\(^84\) This Article takes no position, express or implied, on the question of abortion of a previable fetus.

\(^85\) See Paul H. Wise et al., Infant Mortality Increase Despite High Access to Tertiary Care: An Evolving Relationship Among Infant Mortality, Health Care, and Socioeconomic Change, 81 PEDIATRICS 542, 546 ("Although the precise mechanisms of action require further delineation, the importance of prenatal care services to optimal birth outcome seems well established.").
Professor Nancy K. Rhoden observed, "[t]he vast majority of women will accept significant risk, pain, and inconvenience to give their babies the best chance possible. One obstetrician who performs innovative fetal surgery stated that most of the women he sees 'would cut off their heads to save their babies.'"86

Moreover, a mother holds the child, in part, for the equitable benefit of the father. Although a father does not have a right to prevent the mother from aborting a non-viable fetus, the father has a strong interest in the emerging child,87 although it cannot take precedence over a woman's autonomy. The paternal interest strengthens as the fetus nears term and fatherhood is just at hand.

Although delivering a fetus at a point earlier than viability would not be likely to produce a new member of the species for a normal life span, delivering it after viability would have that consequence. Under certain circumstances, the person most threatening to the life of the fetus is the mother. It begs the main question to assert that, while the state should be able to enforce the interests of a fetus, it should not be able to do so against the mother.88 If a viable fetus is a child-in-waiting, i.e., a verge-of-birth fetus,90 then analogical inferences may be drawn from the law governing parental obligations to children.

How does one go about answering the question whether the fetus, particularly the verge-of-birth fetus, is a separate juridical being, in certain significant senses, from the woman who carries it? Many physicians consider the viable fetus to be a

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86. Rhoden, supra note 2, at 1959.
87. Planned Parenthood of Central Mo. v. Danforth, 428 U.S. 52, 69 (1976); id. at 93 (White, J., concurring in part and dissenting in part) ("A father's interest in having a child—perhaps his only child—may be unmatched by any other interest in his life.").
89. The viability criterion "represents a societal commitment to bestowing rights on those likely to contribute to its advancement. It naturally follows the societal instinct for self-preservation." King, supra note 36, at 1677.
90. By verge-of-birth I am being only somewhat tautological. I do not mean to suggest that cesareans are performed mostly on women at term, for many cesareans are performed because it would be dangerous for the woman and/or the fetus to go to term. These fetuses, although viable, are premature. Nevertheless, in a study of court ordered cesareans, 13% were sought at 31 to 33 weeks gestation, 33% were sought at 34 to 36 weeks gestation, and the remainder at or beyond term. None were borderline viability cases. See Kolder et al., supra note 2, at 1193.
second patient. One of the leading obstetrical textbooks states in the preface to a recent edition:

Happily, we have entered an era in which the fetus can be rightfully considered and treated as our second patient. In this edition, we have sought to do just that. Fetal diagnosis and therapy have now emerged as legitimate tools the obstetrician must possess. . . . We are of the view that it is the most exciting of times to be an obstetrician. Who would have dreamed—even a few years ago—that we could serve the fetus as physician? A leading study of cesarean sections echoes that view:

In the case of cesarean delivery there are almost always at least two patients involved—only one of which (the mother) may be able to speak for herself. Indeed this is the main feature that makes decision-making in cesarean birth unique ethically. The other patient (fetus or fetuses) will always require that someone else make the decision for (him)(her)(them). Usually, but not necessarily, the mother will be assumed to be the surrogate who has the fetus(es)' best interest at heart.

Indeed, a whole field of medicine, perinatal medicine, has been developed to care for and treat the fetus. Professor King observed that birth has traditionally been “the point at which the fetus was entitled to full legal protection of its interests because birth was once synonymous with viability. . . . Today viability precedes birth, and . . . is preferable to birth [as the point of entitlement] because . . . there is no relevant difference between a viable fetus and a newborn.” Professor King concluded that “viable fetuses merit all protection currently given the newborn.”

The state, in asserting the interests of a viable fetus, has at least an arguable case for requiring maternal submission to a cesarean under certain circumstances. Almost by definition, when doctors consider a cesarean section, the fetus is beyond the point of viability. The discussions about the significance of viability, while relevant, ignore the actual stage of gestation in-

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91. For an amusing and enlightening brief history of the treatment of fetus as patient, see Michael R. Harrison, Unborn: Historical perspective of the fetus as patient, PHAROS, Winter 1982, at 19. “Although he cannot make an appointment and seldom even complains, this patient will at times need a physician.” Id. at 23-24.
94. See Lenow, supra note 43, at 15-17.
95. King, supra note 36, at 1663, 1676 (emphasis deleted).
96. Id. at 1687.
volved in typical decisions about whether to have a cesarean.97 A cesarean normally becomes an option only at the point where the fetus, with the mother’s cooperation, is about to be born and begin its infancy;98 in other words, long after the point at which the fetus merely had a chance of surviving outside the womb. The fetus at the verge of birth may well deserve greater state protection than the fetus who could merely survive outside the womb. A verge-of-birth fetus is no different than a newborn, except for the fact that it is still in utero.99 The state’s right to require life-saving, handicap-preventing treatment is no less than the newborn’s right to have such treatment. The medical profession places no greater emphasis on the health of a newborn than it does on the healthy birth of a fetus.

D. DUTIES TO RESCUE: DOCTRINAL ANALOGIES

One of the first doctrines that most students of criminal law learn is that parents have a duty to come to the aid of their children in perilous situations. Although the cases are few and far between, the authoritative declarations are unambiguous. Thus, as noted criminal law experts Professors LaFave and Scott explain in their treatise on criminal law:

The common law imposes affirmative duties upon persons standing in certain personal relationships to other persons—upon parents to aid their small children, upon husbands to aid their wives ... Thus a parent may be guilty of criminal homicide for failure to call a doctor for his sick child, a mother for failure to prevent the fatal beating of her baby by her lover, a husband for failure to aid his imperiled wife, a ship captain for failure to pick up a seaman or passenger fallen overboard, and an employer for failure to aid his endangered employee. Action may be required to thwart the threatened perils of nature, (e.g., to combat sickness, to ward off starvation or the elements)

97. See supra note 90 (discussing points in gestation for court-ordered cesareans).
98. See F. GARY CUNNINGHAM ET AL., WILLIAMS OBSTETRICS 441 (18th ed. 1986) (stating that a cesarean section is warranted whenever “further delay in delivery would severely compromise the fetus, the mother, or both, yet vaginal delivery is unlikely to be accomplished safely”).
99. Nasciturus pro jam nato habetur: “Those who are about to be born shall be considered already born.” DAVID M. WALKER, THE OXFORD COMPANION TO LAW 133 (1980). Since temporal proximity to birth has always been one of the criteria used to determine the status of a fetus, it is not question-begging to point out that fetuses involved in the cesarean birth controversy, being as close to birth as possible, arguably deserve the greatest protection.
Parents may have a legal duty to rescue their drowning children. States may require parents to save their child by obtaining medical attention for the child even if their religion counsels otherwise. Parents may be required to rescue or obtain help for their child when someone is assaulting the child. The more problematic query is determining what risks parents must take to protect their children from harm. Although the actual cases have not yet involved the breadth of the situations set down by the leading commentators, the cases have prescribed the same general bounds of parental duty.

A North Carolina case, State v. Walden, elaborates at considerable length on the parental duty to rescue a child in peril. Walden involved a parent's duty to rescue a child from an assault. The court stated:

[We believe that to require a parent as a matter of law to take affirmative action to prevent harm to his or her child or be held criminally liable imposes a reasonable duty upon the parent. Further, we believe this duty is and has always been inherent in the duty of parents to provide for the safety and welfare of their children, which duty has long been recognized by the common law and by statute. This is not to say that parents have the legal duty to place themselves in danger.

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101. See LAFAVE & SCOTT, supra note 100, at 204 n.15 (citing Rex v. Russell, [1933] V.R. 59 (while wife drowned the small children, father stood by without attempting to rescue them and was held guilty of manslaughter)).


103. See LAFAVE & SCOTT, supra note 100, at 204 & n.15; see also State v. Walden, 293 S.E.2d 780, 782 (N.C. 1982) (mother may be found guilty of assault on aiding and abetting theory because she was present while her child was assaulted and she failed to take reasonable steps to prevent the assault); State v. Williquette, 385 N.W.2d 145 (Wis. 1986) (parent who knew her spouse had repeatedly abused her children, and who took no action to stop the abuse, could be tried for child abuse).

104. 293 S.E.2d 780 (N.C. 1982).
of death or great bodily harm in coming to the aid of their children. To require such would require every parent to exhibit courage and heroism which, although commendable in the extreme, cannot realistically be expected or required of all people. But parents do have the duty to take every step reasonably possible under the circumstances of a given situation to prevent harm to their children.

In some cases, depending upon the size and vitality of the parties involved, it might be reasonable to expect a parent to physically intervene and restrain the person attempting to injure the child.105

The parent-child relationship is not the only source of a pregnant woman's duty to rescue her viable, verge-of-birth fetus from potential death. The law of mandatory rescue also holds that: one who causes a person to be in peril has a duty to rescue that person,106 and one who, by beginning to care for or rescue a person, makes rescue by others impossible or unlikely, has a duty to complete the rescue.107 The Restatement (Second) of Torts imposes a duty on one "who voluntarily takes the custody of another under circumstances such as to deprive the other of his normal opportunities for protection."108 Thus, there is a duty to rescue one's child from peril, a duty to rescue a person whom one has innocently or culpably placed in peril, and a duty to rescue another whose care one has voluntarily assumed and, in so doing, prevented others from rendering

105. Id. at 786 (citations omitted). This Article contends that the degree of risk of given levels of danger, rather than the mere existence of any danger, should be the controlling factor. To expect mothers at or very near term to undergo cesareans when only the normal and usual risks are involved is hardly to call for an act of courage or heroism.

Parents are obligated in accordance with their means to support and maintain their children—i.e., to furnish adequate food, clothing, shelter, medical attention and education. A parent's failure to observe minimum standards of care in performing these duties entails both remedial sanctions, such as the forfeiture of custody, and criminal sanctions. Parents are also obligated to provide proper guidance and guardianship of their children and are vulnerable to legal sanction for failure to meet minimum standards of care, for example, by the excessive infliction of corporal punishment, by the excessive use of drugs or alcohol, or by directing or authorizing a child under 16 to engage in an occupation involving substantial risk of danger to his life or health. Parents are also obligated to supervise their children.


106. See LAFAVE & SCOTT, supra note 100, at 206. If one has culpably caused the predicament there is even a stronger case for a duty to rescue.

107. Jones v. United States, 308 F.2d 307, 310 (D.C. Cir. 1962); LAFAVE & SCOTT, supra note 100, at 205-06.


109. There may be a legal difference, however, between culpably placing another in a position of danger, and innocently creating the danger. Cf. LAFAVE & SCOTT, supra note 100, at 206.
The law imposes, in addition, a duty not to prevent others from rendering aid whether or not one has caused the predicament.

Several bases support an obligation to rescue, as well as a duty to allow others to rescue, in the case of a pregnant woman whose fetus is at or beyond the point of viability. She is the mother of the being. She is responsible for placing the being's life in jeopardy by conceiving it and perhaps also by allowing it to reach this stage without aborting it as a previable fetus. She has enabled it to reach the stage at which it is doomed unless she delivers it.

Once the time for a lawful abortion has passed, the mother implicitly undertakes to take care of her fetus and bring it to life in as healthy a condition as she can without shouldering an unreasonable burden. Although such an undertaking cannot be said to be a contractual undertaking, as there is no agreement and no consideration, the imposition of quasi-contractual duties—contractual duties by virtue of public policy—seems reasonable. One who assumes a duty by contract, such as a firefighter or bomb-squad member, may be required to take a higher risk than one who has a duty by virtue of relationship only. So it might be argued that the mother has agreed to take, not whatever risks are reasonable in the abstract, but whatever risks are reasonable to bring about the birth of a healthy child. Courts may interpret the term “reasonable” in this sense as the normal risk that the one million women who voluntarily agree to undergo cesarean sections undertake each year.

There are also statutory and contractually undertaken duties to rescue.

She would be responsible (certainly not “culpable”) for conceiving it unless she was the victim of rape, incest, failed contraception, or deception as to the use of a condom by her partner.


Compare this argument with that made in Rhoden, supra note 2, at 1975-82, which also presented the rescue theory. Rhoden raises and rejects the analogy of rescue doctrine on the grounds that the strength of an obligation to rescue does not affect the degree of risk the rescuer is obliged to undertake. Id. I respectfully take issue with that conclusion, particularly in light of the fact that the traditional analysis of duty to others in our legal system is in terms of criminal penalties for failure to comply with one’s legal duty. The analysis and proposal involved herein do not contemplate criminal penalties, except as a possible sanction for contempt of court. Furthermore, in the only situation in which this Article’s proposal unequivocally requires a cesarean, there is a benefit, not a risk, to the mother from such surgery. See infra part V.

Joel J. Alpert, Primary Care: The Future for Pediatric Education, 86
Commentators have asserted by way of analogy, however, that a person has no duty to compromise her bodily integrity by donating an organ or tissue to another, even if such donation is necessary to save the life of the other. The court in In re A.C. discussed at length a Pennsylvania trial court opinion, McFall v. Shimp, in which the court refused to compel the cousin of a terminally ill patient to undergo additional testing for tissue compatibility and to “donate” bone marrow for transplantation if sufficiently compatible. This procedure, involving only a slight risk of harm to the donor, could have offered the donee a real hope of survival. The court did not require the cousin to render assistance, stating that the proposed order “would change every concept and principle upon which our society is founded.”

In expressing concern about the possible effects of establishing a duty to undergo invasion of one’s body for the benefit of another, the Shimp court said that 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.”

Notwithstanding the hyperbolic language of Shimp, the mother who refuses a cesarean is distinguishable from a cousin who refuses a bone marrow transplant to save his dying relative. The mother’s physiological processes would bring about the death of the fetus if she did not permit a cesarean. In addition, the mother usually bears a responsibility for the creation of the life within her. It is her son or daughter that is strug-
gling to be born, not a distant relative. As such, the causal connection between the death of the fetus and the mother is much closer than the connection between the death of the dying cousin and the refusing cousin. Indeed, the physical connection between fetus and mother, the physiological interdependence, and the drawing of sustenance from the mother's blood stream, suggest that nondelivery of the infant would be more akin to terminating life support or failing to refill the feeding tube of a comatose patient. 119 Furthermore, in some situations, vaginal delivery would threaten the life of the mother as well as the fetus. Under those circumstances, and unlike the situation with the donor of bodily organs, the mother's health is substantially benefitted by a cesarean. 120

Another pertinent consideration not mentioned in the literature on this subject is a virtually universal clause in living will statutes: that the will provisions discussing cessation of treatment do not apply if the patient is pregnant. 121 This im-

119. Professor Rhoden observed:
The Cesarean cases unquestionably feel different from cases or hypotheticals involving forced intrusions on parents to save children. For one thing, the woman is going to give birth anyway, and if she does it surgically instead of vaginally the baby will probably be fine. . . . Moreover, it seems to some that women who choose not to abort thereby assume certain obligations to their fetuses, a by no means unreasonable suggestion. Generally, pregnancy is a unique situation. A dying relative, even a child, is a separate, independent person.


Rhoden goes on to say, however, that what a court does when it compels a cesarean is no different from what it does when it compels an organ donation. Id. This writer disagrees with the premise that compelled donation of a kidney from a parent to a child is legally impermissible, and agrees that even if it were, the compelled cesarean is different in both “feel” and legal justification.

Philosopher Peter Singer posits that the moral duty of beneficence comes into play “if it is in our power to prevent something bad from happening, without thereby sacrificing anything of comparable moral importance.” Peter Singer, Famine, Affluence and Morality, 1 PHIL. & PUB. AFFAIRS 229, 231 (1972).

On the other hand, philosopher Michael Sloate says that “one has an obligation to prevent serious evil or harm when one can do so without seriously interfering with one’s life plans or style and without doing any wrongs of commission.” Michael Sloate, The Morality of Wealth, in WORLD HUNGER AND MORAL OBLIGATION 125-27 (William Aiken & Hugh La Follette eds., 1977).


121. E.g., MD. HEALTH-GEN. CODE ANN. § 5-605 (1990); WYO. STAT. § 35-22-102(b) (1987). To the same effect, see the Ohio Durable Power of Attorney for Health Purposes, OHIO REV. CODE ANN. § 1337.13(D) (Anderson 1990). A Georgia statute states: “If I am female and I have been diagnosed as pregnant,
plies that a pregnant woman has no right to refuse life-saving treatment if the refusal will harm the fetus. Although the restrictions on living wills are meant to apply to life-extending treatment,\textsuperscript{122} life-extending treatment may be at least as intrusive as a cesarean. The reason the mother may not refuse treatment is to assure the well-being of the fetus and birth of the child before the mother dies.

Courts have also held that failure to provide medical attention to one's children constitutes neglect.\textsuperscript{123} Even a good faith religious objection will not override parents' obligations to provide for the medical needs of their children.\textsuperscript{124} In a recent Ohio case, the court held that the parents' refusal to allow further medical treatment of their sick child was sufficient to support a finding that the child was a dependent child.\textsuperscript{125} The court stated that the parents' religious faith did not permit them to expose their child to progressive ill health and death.\textsuperscript{126}

E. JUSTIFICATION

Under the law of justification, a person is entitled to injure or kill an aggressor to save her own life. Some scholars argue that self-defense is justified even against an "innocent" aggressor who threatens the life of the subject.\textsuperscript{127} If a child has

\begin{itemize}
\item this living will shall have no force and effect during the course of my pregnancy." GA. CODE ANN. § 31-32-3 (Michie 1989). An Idaho statute states: "If I have been diagnosed as pregnant and that diagnosis is known to any interested person, the directive shall have no force during the course of my pregnancy." IDAHO CODE § 39-4504 (1989).
\item Certain situations calling for cesarean sections do further the health and life interests of the mother; with respect to these, the analogy to living wills legislation is even closer.
\item See O.G. v. Baum, 790 S.W.2d 839 (Tex. Ct. App. 1990) (holding that appointment of a temporary conservator for a 16-year-old Jehovah's Witness who, along with his parents, refused a blood transfusion, was not an abuse of discretion); cf. Mercy Hospital v. Jackson, 489 A.2d 1130 (Md. Ct. Spec. App. 1984) (mother could not be compelled to have a cesarean requiring a blood transfusion when it was not necessary for the well-being of the fetus; the court implied that a contrary ruling would have been issued if the fetus's well-being was at stake), vacated as moot, 510 A.2d 562 (Md. 1986). But see In re Green, 307 A.2d 279, 280 (Pa. 1973) (holding that a mature, competent, 17-year-old Jehovah's Witness, who did not desire elective surgery and whose mother refused to consent to blood transfusions which would be required for the surgery, was not a "neglected child" within the meaning of the law), enforcing In re Green, 292 A.2d 387 (Pa. 1972).
\item See O.G., 790 S.W.2d at 840.
\item In re Willman, 493 N.E.2d 1380 (Ohio Ct. App. 1986).
\item Id. at 1382.
\item R. Kent Greenawalt, Violence: Legal Justification and Moral Appraisal, 32 EMORY L. J. 437, 463-64 nn. 52-53.
\end{itemize}
picked up a gun and is shooting wildly, if an insane person is swinging a club, or if a person having an epileptic seizure is strangling another, the victim may use whatever force is necessary to extricate herself from the situation. Under prevailing law, a third party may intervene and use force to the same extent as the victim. In the cesarean scenario, the fetus is the subject-victim, and the mother refusing a cesarean is threatening the life of the fetus. In this scenario, the state, acting on behalf of the fetus, should have the right to use reasonable force, by compelling a cesarean, to avoid the application of deadly force against the fetus.

The relationship between a verge-of-birth fetus and a mother refusing a cesarean may also be analyzed in terms of the tort of false imprisonment. The tort of false imprisonment involves constraint of a person. The tort occurs whether or not the person is conscious of the constraint or harmed by it, whether or not the constraint was committed where the confinement took place, and whether or not the means of escape were unknown or unreasonably dangerous to the person. The tort is committed whether the tortfeasor imposed physical barriers or failed to provide a means of egress. The legal duty to furnish a means of escape is imposed where there is a special relationship between the parties. Thus, a mother, having created a special duty toward her fetus by declining to have a first or second trimester abortion, could conceivably be liable for falsely imprisoning her fetus by refusing to release it through a cesarean.

F. CONSTITUTIONALLY PERMISSIBLE INFRINGEMENTS OF BODILY INTEGRITY

In Winston v. Lee, the Supreme Court held that a state could not compel a shooting suspect to undergo surgery, requiring a general anesthetic, to remove a bullet embedded in his body. The Court found that because the state had other evi-
dence of the suspect's involvement in the crime, and because of the risks that this particular surgery entailed, including those associated with general anesthesia, the state could not subject the suspect to the operation.\footnote{Id. at 764-66.} Although the Court was not very receptive to the idea of compulsory surgery, it did not preclude compulsory surgery under all conditions and in all situations. Indeed, the Court established the following test:

The Fourth Amendment neither forbids nor permits all such intrusions; rather, the Amendment’s “proper function is to constrain, not against all intrusions as such, but against intrusions which are not justified in the circumstances, or which are made in an improper manner.” The reasonableness of surgical intrusions beneath the skin depends on a case-by-case approach, in which the individual’s interests in privacy and security are weighed against society’s interests in conducting the procedure. In a given case, the question whether the community’s need for evidence outweighs the substantial privacy interests at stake is a delicate one admitting of few categorical answers.\footnote{Id. at 760 (quoting Schmerber v. California, 384 U.S. 757, 768 (1966)).}

The Court found that the state had substantial evidence of the crime without the bullet.\footnote{Id. at 765.} Thus, the Court’s opinion did not address the question at hand: Is the state prohibited from compelling surgery as the only means to save the life of a verge-of-birth fetus, given that such surgery is voluntarily entered into by nearly a million women per year,\footnote{In 1988, 967,000 cesareans were performed in the United States. Myers & Gleicher, supra note 114, at 200 tbl. 1.} and involves little more than minimal risk of death or serious complications?\footnote{For a discussion of risks, see infra part IV.B.}

\textit{Winston} did, however, make one thing clear: Compulsory surgery is not per se forbidden; it is instead an invasion of personal interests that must never be performed without substantial justification and an analysis of all relevant factors.\footnote{Winston, 470 U.S. at 760.}

In a sense, the \textit{Winston} balancing test merely codifies the considerations courts have weighed when facing similar questions. For example, the nation may compel military service.\footnote{Lichter v. United States, 334 U.S. 742 (1948).} In order to prevent contagion to third parties, a person may be
quarantined,\textsuperscript{139} treated against his or her will,\textsuperscript{140} or compelled to submit to vaccination.\textsuperscript{141} A state may compel a person to submit to the taking of blood samples\textsuperscript{142} or urine samples\textsuperscript{143} to enforce laws against driving while intoxicated,\textsuperscript{144} or to determine, for safety purposes, any recent use of drugs or alcohol.\textsuperscript{145} The state may conduct strip searches\textsuperscript{146} or body cavity searches\textsuperscript{147} (both visual and digital probes) at the nation's borders to keep out illegal substances,\textsuperscript{148} and in jails or prisons to keep lock-ups free from weapons or contraband.\textsuperscript{149} Courts have placed substantial limits on the liberty rights of a person with active tuberculosis. Courts have also required subjects to be treated with powerful drugs against their wills in order to prevent infliction of violence on third parties.\textsuperscript{150} In addition, the

\textsuperscript{139} Moore v. Armstrong, 149 So. 2d 36 (Fla. 1963); Varholy v. Sweat, 15 So. 2d 267 (Fla. 1943); In re Holland, 356 So. 2d 1311 (Fla. Dist. Ct. App. 1978).

\textsuperscript{140} State v. Snow, 324 S.W.2d 532 (Ark. 1959).

\textsuperscript{141} Jacobson v. Massachusetts, 197 U.S. 11 (1905).


\textsuperscript{143} National Treasury Employees Union v. von Raab, 489 U.S. 656 (1989).

\textsuperscript{144} Schmerber v. California, 384 U.S. 757, 767-68 (1966).

\textsuperscript{145} von Raab, 489 U.S. at 615.

\textsuperscript{146} See Bell v. Wolfish, 441 U.S. 520 (1979) (holding that inmates, following a visit from friends and relatives, could be both strip and body-cavity searched). \textit{But see} Stewart v. Lubbock County, Tex., 787 F.2d 153 (5th Cir. 1983) (county's policy of permitting any arrested individual, including minor offenders, to be strip searched was an unconstitutional violation of Fourth Amendment rights), \textit{cert. denied}, 475 U.S. 1066 (1986); Giles v. Ackerman, 746 F.2d 614 (9th Cir. 1984) (a person arrested for a minor offense may be subjected to a strip search only if officials have a reasonable suspicion that he is carrying contraband), \textit{cert. denied}, 471 U.S. 1053 (1985); Mary Beth G. v. City of Chicago, 723 F.2d 1263 (7th Cir. 1983) (strip search of misdemeanor offenders who posed no danger was unreasonable under the Fourth Amendment).

The Ninth Circuit has rejected due process challenges to highly intrusive searches for contraband hidden in body cavities and to forced physical treatment to recover swallowed contraband in contexts where these actions were undertaken without coercion, violence, or brutality to the person. Blefare v. United States, 362 F.2d 870 (9th Cir. 1966) (rejecting "outrageous conduct" challenge to insertion of tube into defendant's stomach to force him to vomit swallowed drug capsules when pain was limited and procedure was performed by licensed physician).

\textsuperscript{147} Some courts have upheld intrusive body cavity searches, particularly at the border and within prisons. United States v. Handy, 788 F.2d 1419 (9th Cir. 1986); \textit{see also} United States v. Rodriguez, 592 F.2d 553, 556 (9th Cir. 1979) (discussing the three standards for border searches: no suspicion for questioning and luggage searches; real suspicion for strip searches; clear indication for body cavity searches).

\textsuperscript{148} Rodriguez, 592 F.2d at 556.

\textsuperscript{149} See Bell v. Wolfish, 441 U.S. 520 (1979).

\textsuperscript{150} See Rennie v. Klein, 720 F.2d 266 (3d Cir. 1983) (notwithstanding the right to refuse psychotropic medication, these drugs may be given to an invol-
state may administer powerful drugs to prisoners against their wills to maintain prison discipline and order.\textsuperscript{151} Moreover, the state may compel a criminal defendant who is incompetent to stand trial to take drugs solely for the purpose of rendering her competent.\textsuperscript{152} Courts have also held, notwithstanding the classic case of \textit{Rochin v. California},\textsuperscript{153} that federal authorities may subject a person to a stomach-pump type of procedure, or require him to ingest emetics, in order to bring about regurgitation of evidence.\textsuperscript{154} The state will not release from a mental hospital a person who refuses to take medication if there is a risk that the person will behave dangerously without the drugs.\textsuperscript{155} Lastly, courts have denied parental rights to a parent who has refused to take prescribed medication.\textsuperscript{156}

untarily committed patient whenever, "in the exercise of professional judgment, such an action is deemed necessary to prevent the patient from endangering himself or others"); see also \textit{In re Guardianship of Roe}, 421 N.E.2d 40 (Mass. 1981); Rivers v. Katz, 495 N.E.2d 337 (N.Y. 1986) (dangerous or potentially disruptive mental patients may be given psychoactive drugs against their wills).

In many cases, psychiatric inmates who have a theoretical right to refuse treatment find this right inapplicable if they would be dangerous to others without treatment. The drugs used in treatment may cause serious and extremely distressing movement and neurological disorders as side effects, and may also cause a very serious long term disorder, tardive dyskinesia, in 20\% to 50\% of patients. See Jessica Litman, \textit{A Common Law Remedy for Forcible Medication of the Institutionalized Mentally Ill}, 82 COLUM. L. REV. 1720, 1726 (1982). Many patients also consider the overall feeling and effect of these drugs extremely unpleasant.

In Rogers v. Commissioner, 458 N.E.2d 308, 311 (Mass. 1983), the court held that, although a patient has the right to refuse treatment, this right may be overridden in an emergency. The court found that a patient could be treated against his will if treatment would avoid "immediate, substantial, and irreversible deterioration of a serious mental illness." \textit{Id.} (quoting MASS. GEN. L. ch. 123, § 21 (1986)).

151. Washington v. Harper, 494 U.S. 210, 243 (1990) (Stevens, J., joined by Brennan, J., & Marshall, J., dissenting in part) (disagreeing with the majority's opinion that the prison policy at issue allowed forced administration of psychotropic drugs only if administration of those drugs would benefit the inmate's medical condition).


153. 342 U.S. 165 (1952) (forcible extraction of evidence from a suspect with a stomach pump violates due process).

154. \textit{See} Blefare v. United States, 362 F.2d 870 (9th Cir. 1966).


G. RELEVANCE OF MATERNAL HEALTH RISKS

Opponents of compelled cesarean sections, noting the medical risks which accompany the procedure, point to the Supreme Court's holding in Thornburgh v. American College of Obstetricians and Gynecologists.\textsuperscript{157} Thornburgh struck down a regulation which required that "‘[t]he abortion technique employed shall be that which would provide the best opportunity for the unborn child to be born alive unless... that technique ‘would present a significantly greater medical risk to the life or health of the pregnant woman.’"\textsuperscript{158} The Court found the language invalid because it would require a pregnant woman to bear a greater medical risk to save the life of the viable fetus.\textsuperscript{159} Ostensibly relying on an earlier decision, Colautti v. Franklin, it discussed the "undesirability of any ‘trade-off’ between the woman’s health and additional points of fetal survival."\textsuperscript{160}

This discussion was in the abortion context, and abortion, as of this writing, is a highly protected constitutional right. Abortion can be denied only in exceptional circumstances. In the third trimester, however, the state may prohibit abortion after the point of fetal viability except if an abortion is necessary to preserve the life or health of the mother.\textsuperscript{161} Those who oppose court ordered cesareans argue that they pose a risk to

\textsuperscript{157} 476 U.S. 747 (1986) (5-4 decision).
\textsuperscript{158} Id. at 788 (citations omitted).
\textsuperscript{159} Id. at 788-89.
\textsuperscript{160} Id. at 789 (citing Colautti v. Franklin, 439 U.S. 379, 400 (1979), which declared, but did not hold, that a trade-off would create "serious ethical and constitutional difficulties").
\textsuperscript{161} Roe v. Wade, 410 U.S. 113, 164-65 (1973). This is not to say that the state's right to prohibit an abortion in the third trimester necessarily implies the right to require cesarean surgery. What Roe does say is that the state's in-
the mother's health. The health argument takes a concept used in one very unique and distinctive area of the law—abortion rights—and applies it to a situation not contemplated by the Court. An abortion requires consultation between the patient and her physician, as well as concurrence of the physician in the decision to terminate a pregnancy. An abortion is usually done because the mother does not want a child. With respect to legal abortions, the law is unconcerned with preserving the life or health of the fetus. When a woman chooses to have a cesarean, however, she has usually done so to save her child.

In any event, Webster v. Reproductive Health Services cast great doubt on the continued vitality of Roe as well as the Thornburgh interpretation. A plurality of the Webster Court upheld the constitutionality of a portion of the statute at issue, which it construed as requiring a physician to use reasonable professional judgment in determining fetal viability if the fetus was suspected to be at or beyond twenty weeks gestation. The statute created what is essentially a rebuttable presumption of viability at twenty weeks, which the physician is required to rebut with tests—including, if feasible, those for gestational age, fetal weight, and lung capacity—indicating that the fetus is not viable. In upholding the statute, the plurality construed it to require physicians to adhere to professional standards of care in determining when and whether to conduct the tests for viability.

Webster seems to overrule Colautti by disapproving of Roe's "rigid" trimester tests and by its willingness to tolerate regulations concerning viability and protection of the fetus.

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162. See, e.g., Nelson & Miliken, supra note 2, at 1064-65.
163. Roe stated that the state could prohibit a third trimester abortion "except where it is necessary, in appropriate medical judgment, for the preservation of the life or health of the mother." 410 U.S. at 165. So, whether the fetus-destroying behavior, an abortion or a non-cesarean, is necessary for the health or life of the mother is a matter of "appropriate medical judgment." When a cesarean poses only the normal and usual risks, a doctor can appropriately, i.e. non-negligently, conclude that a cesarean would not significantly endanger the life or health of the mother.
164. But see infra note 204 (discussing women who refused cesarean surgery evidently in order to avoid having "inconvenient" children).
166. Id. at 513-20 (plurality opinion).
167. Id. at 500-01.
168. Id. at 512-14.
Although protection of maternal health was not emphasized in *Webster*, the case permits viability testing *even though some tests could endanger the mother*. This means that the protection of fetal well-being could be considered to outweigh the interest in maternal health if a physician believes tests are needed. In *Webster* there was evidence that some of the medical tests at or around twenty weeks might harm the woman's health.\textsuperscript{169} *Webster*, then, demonstrated the Supreme Court's willingness to uphold legislation that created some risk to the mother's health for the sake of the fetus. As construed by the plurality, a physician is free to balance maternal health risks against risks to the fetus in accord with the physician's professional judgment.

In light of both *Webster* and the retirement of Justices Brennan and Marshall, it is appropriate to recall the minority view of the issue in *Thornburgh*. As Justice White noted in dissent: "I find the majority's unwillingness to tolerate the imposition of any nonnegligible risk of injury to a pregnant woman in order to protect the life of her viable fetus in the course of an abortion baffling."\textsuperscript{170}

Finally, even if *Thornburgh*’s "no trade-off" language controls and applies in a non-abortion situation, it would not prohibit a compelled cesarean where such surgery *advances* the mother's health interests as well as the state's interest in the live birth of a fetus. As will be discussed below, both the health of the mother and her fetus are endangered absent cesarean surgery in several obstetrical scenarios.\textsuperscript{171}

It has also been argued that, in order to invade the bodily integrity of a woman for the sake of the fetus, the state must

\textsuperscript{169} The lower court in *Webster* found that "amniocentesis imposes additional significant health risks for . . . the pregnant woman." Reproductive Health Servs. v. Webster, 662 F. Supp. 407, 422 (W.D. Mo. 1987), aff'd in part and rev'd in part, 851 F.2d 1071 (8th Cir. 1988), rev'd, 492 U.S. 490 (1989). The Supreme Court plurality read the statute as requiring that a physician use his or her professional skill and judgment in determining whether to test for viability at the 20th week, even though some of the tests might increase the risk to the mother's health, and even though some of those tests might in fact be performed on a non-viable fetus. There were four votes for overruling *Roe*. Justice O'Connor would apply an "undue burden" test to determine whether a given regulation was an undue burden on the right to an abortion, and she invited new state regulations to be brought to the Court for consideration. 492 U.S. at 530-32 (O'Connor, J., concurring).


\textsuperscript{171} See, e.g., Chervenak & McCullough, *supra* note 120, at 13 (discussing complete placenta previa).
demonstrate a compelling interest and must implement the law in the least intrusive manner possible.\textsuperscript{172} This Article argues that in situations where vaginal childbirth would seriously endanger the fetus,\textsuperscript{173} a cesarean is the least intrusive and most narrowly tailored means that will accomplish the compelling objective of saving the life of the viable, verge-of-birth fetus.

\section*{III. BALANCING THE RIGHT TO REFUSE CESAREAN SURGERY}

In some circumstances fetuses, especially viable fetuses, have legal rights.\textsuperscript{174} Further, because a cesarean involves a verge-of-birth fetus, one can reasonably argue that this fetus should have the rights of a born person under the duty to rescue, the duty not to prevent rescue, and the medical neglect and justification doctrines.\textsuperscript{175}

Although there is, then, a substantial case to be made for a maternal duty to undergo a cesarean if necessary to save the life of the verge-of-birth fetus, the argument is admittedly somewhat less than compelling. The relevant case law leaves us short of a doctrine that all women must take the risks of a cesarean in order to save the life of a fetus. There are legitimate ways of distinguishing and reading less broadly the precedential lines I have discussed. For example, although there is a duty to rescue in some situations, courts have not determined how great a risk one must take to satisfy that duty. And although there are many legitimate invasions of bodily integrity, the Supreme Court's tone, if not holding, in \textit{Winston v. Lee} surely disapproved of compulsory surgery barring unusual circumstances.\textsuperscript{176} Although the Supreme Court has held that the state may have a compelling interest in the life of a viable fetus, it has also held that a state could not prohibit a third trimester abortion if doing so would endanger the life or health of the mother.\textsuperscript{177} Moreover, the generally permissible prohibition of a third trimester abortion is not the equivalent of the mandating of cesarean childbirth. While some cases recognize

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\textsuperscript{172} See Johnsen, \textit{supra} note 88, at 619.
\textsuperscript{173} See Nelson et al., \textit{supra} note 2, at 707 n.12, 707-08 n.16, 708 n.21 (indicating some of the conditions as to which there is high rate of fetal mortality absent a cesarean).
\textsuperscript{174} See \textit{supra} part II.A.
\textsuperscript{175} See \textit{supra} parts II.D. and II.E.
\textsuperscript{176} 470 U.S. 753 (1985).
\textsuperscript{177} The early cases interpreting health were very broad indeed. See, e.g., Doe v. Bolton, 410 U.S. 179 (1973); United States v. Vuitch, 402 U.S. 62 (1971).
\end{flushleft}
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e's against its mother, they are few and far between. They may show that a mother has legal duties to her fetus, but they do not answer the question of how far such duties extend. While some state trial courts have upheld criminal and civil actions which amount to a charge of fetal abuse, there have been only a handful of inconsistent appellate holdings on the subject. That a state may not apply the terms of a living will to a pregnant woman, in short, that she may not refuse life-extending treatment, does not necessarily imply that she must submit to a cesarean against her wishes. Finally, the medical neglect cases, other than the transfusion cases, do not involve bodily invasions of parents, or protection of fetuses.

The basic argument against compelling a pregnant woman to submit to cesarean surgery to save a fetus may be summarized as follows:

A woman has a right to privacy and/or a liberty interest which includes the right to refuse treatment. To overcome this right, the state must have a compelling interest. The right to privacy includes the right to personal autonomy, particularly regarding decisions over what may be done to one's own body. The state may not coerce a person into sacrificing bodily integrity either to benefit society at


179. See supra notes 45-49, 58-61 and accompanying text for a general discussion.

180. E.g., Johnson v. Florida, 578 So. 2d 419 (Fla. Dist. Ct. App. 1991) (upholding a woman's conviction for delivery of a controlled substance to a minor because she ingested cocaine during her pregnancy); People v. Hardy, 469 N.W.2d 50, 53 (Mich. Ct. App. 1991) (holding that an indictment charging the defendant with delivering a controlled substance to a minor should be quashed on the grounds that the legislature did not enact the statute to prosecute mothers for the transfer of cocaine metabolites from them to their infants via the umbilical cord), appeal denied, 471 N.W.2d 619 (Mich. 1991); In re Stefanel Tyesha C., 556 N.Y.S.2d 280, 282 (App. Div. 1990) (holding that allegations that a child tested positive for cocaine at birth, that his mother admitted using drugs during her pregnancy, and that the mother was not enrolled in a drug rehabilitation program are sufficient to state a cause of action for neglect), appeal dismissed as moot sub nom. In re Sebastian M., 565 N.E.2d 1267 (N.Y. 1990); In re Fathima Ashanti K.J., 558 N.Y.S.2d 447 (Fam. Ct. 1990) (birth of child with positive toxicology for cocaine, symptoms of drug withdrawal, and low birth weight, to drug abusing parent established neglect); State v. Gray, No. L-89-239, 1990 WL 125695, at *4 (Ohio Ct. App. 1990) (dismissing an indictment for child endangerment brought against a woman who used cocaine during her pregnancy, and stating that “to commit the offense of child endangering, the offender must be a person having custody or control of a child, 'which presupposes the existence of a living child susceptible' to custody or control”).

181. See generally Gallagher, supra note 2, at 18-21 (discussing the woman's right to self determination and bodily integrity).
large or any individual. The state may not abrogate the privacy right to benefit a fetus since it may not invade the right to benefit a born person. 182 A person is entitled to make decisions regarding reproduction based on her own judgment and values. 183 It is inappropriate for the state or the judiciary to balance the rights of, or state's interest in, a fetus against the rights of the mother. The fetus does not have rights that can trump the right of the mother to be immune from invasions of bodily integrity. Whatever the ultimate outcome of the abortion debate, this particular decision does not implicate any affirmative right of a mother to abort a fetus; rather, it addresses the right of a person to be free from compelled medical treatment.

The Supreme Court has looked with disfavor on compulsory surgery. With the exception of cesarean sections, no court has required a person to undergo major surgery for the sake of a third party. The state may not prohibit even third trimester abortions if the prohibition jeopardizes maternal health or life. 184 Cesarean surgery jeopardizes maternal health and life. Indeed, the Supreme Court has held that a state may not allow a “trade-off” between state interests in the life of a fetus and degrees of risk to maternal health. 185 In other words, any risks to maternal health constitutionally outweigh any dangers to a fetus. 186 The duty to respect bodily integrity not only protects against risks to one's health, but against dignitary injuries by embarrassing, humiliating, or invasive intrusions.

When a pregnant woman is not conscious, the substituted judgment test is the appropriate means of determining whether she would choose to have the cesarean. What is inappropriate is to balance the right of the fetus, or the state's interest in the fetus, against the rights or interests of the mother. 187

Having considered the strengths and weaknesses of these arguments, and of my own submissions, I reiterate that although each component of my argument may be “distinguishable,” the whole is greater than the sum of its parts. A number of factors weigh in favor of compulsion, including the increasing likelihood that Roe v. Wade will be altered; the fact that Roe did find a compelling, albeit conditionally compelling, state interest in the potential life of a viable fetus; the trend toward wrongful birth actions and survivorship actions against tortfeasors causing stillbirth; the treatment of late stage fetuses as patients by the medical profession; the arguable identity of the

182. See id. at 23-26 (discussing the well rooted judicial refusal to “physically subordinate one individual to another”).
183. See id. at 28-31 (discussing the right to privacy and its importance to a pregnant woman).
184. See Rhoden, supra note 2, at 1989-94.
186. See Rhoden, supra note 2, at 1989-94.
187. See Nelson et al., supra note 2, at 749-63.
rights of late-stage, verge-of-birth fetuses with the rights of born infants; the persuasive parallels to justification theories; the multiple sources of duties to rescue, as well as a general duty not to prevent rescue of an individual in peril; the permissible invasions of bodily integrity in a wide variety of circumstances; the clear import of the treatment of pregnancy in living will legislation; the close analogy of the blood transfusion cases in light of the relatively low risks involved in the ordinary cesarean section; and the fact that the alternative to compulsion in many cases is the death or lifetime debilitation of a virtually born human being.

However, a slippery slope argument makes me hesitate. If we exercise compulsory jurisdiction over women in this situation, where will the process stop? Pregnancy itself might become quasi-suspect, and pregnant women could be subjected to an array of regulations and sanctions to protect their fetuses from abusive behaviors. A pregnant woman could become a sort of second-class citizen, unable to drink or smoke, or take even prescription drugs without the "pregnancy police" one or two steps behind her with some sort of legally coercive "remedy" at hand. Even a specific diet and moderate exercise could be made mandatory. Would we move ever closer to the kind of society Margaret Atwood bitingly satirized in The Handmaid's Tale?\textsuperscript{188} Pregnancy is not a social disease or a medically or legally suspect category.\textsuperscript{189} Yet were all pregnant women denied the right to refuse a cesarean, it would be a small step to give the well-being of fetuses priority over their mothers' rights in a variety of situations.\textsuperscript{190} Placing burdens on a woman who is

\textsuperscript{188} MARGARET ATWOOD, THE HANDMAID'S TALE (1985).

\textsuperscript{189} On the other hand, I cannot agree with the sexist implications in the assertion that giving legal recognition, in some situations, to fetal rights (or interests or welfare) over the rights of the mother is to treat the mother as no more than a "fetal container." \textit{Contra} George J. Annas, \textit{Pregnant Women as Fetal Containers}, HASTINGS CENTER REP., December 1986, at 13-14. For the purposes of the welfare of the fetus she may indeed be treated as a holder of the fetus, but in all other respects, and at the same time, she is treated as a person in her own right. We all have different roles to play at different times and in different circumstances, yet we are entitled to more respect than is summed up by an inflammatory phrase describing our specific duties under these circumstances.

\textsuperscript{190} The Supreme Court, in International Union v. Johnson Controls, Inc., 111 S. Ct. 1196 (1991), held that where a company barred fertile women from jobs involving actual or potential exposure to lead levels that might endanger fetuses, it violated the Pregnancy Discrimination Act of 1978, 42 U.S.C. \textsection 2000e(k) (1988), 111 S. Ct. at 1200, 1203, 1210. The Court found that there was disparate treatment through explicit facial discrimination. \textit{Id.} at 1203.
carrying a verge-of-birth fetus, however, does not necessarily imply that any burdens may be placed on a pregnant woman at an earlier stage of gestation.

Based on the above precedents and considerations, I conclude that there is a right to refuse cesarean surgery, but that it is a circumscribed right. The state has an interest in the birth of the viable fetus, but it is not always controlling. A mother may refuse a cesarean section except in instances where the life or vital health interests of the fetus are at stake and: I) the cesarean promotes the woman's health or life, or II) there are no unusual risks to the mother191 but she asserts her refusal without what I will call decisional maturity192 or for reasons other than her bodily integrity. Of course, if the cesarean is especially risky to the mother she may refuse the procedure no matter what effect that decision has on the fetus.

IV. CESAREAN SECTIONS

An understanding of the nature of a cesarean section, its

The Court said that the company's policy was not neutral because it did not apply to male employees in the same way it applied to female employees despite evidence that male exposure to lead affects the male reproductive system. Id. Neither the business necessity defense nor the defense of bona fide occupational qualification were applicable; nor was the safety exception to the failure to meet the latter requirement. Id. at 1204-07.

This case has little bearing on the issue at hand. For one thing, the Pregnancy Discrimination Act applies only to employment situations. For another, the Equal Protection clause does not forbid classification on the basis of pregnancy, since those who are not pregnant are not "similarly-situated." Pregnancy discrimination has not been recognized as sex discrimination under the Fourteenth Amendment. Geduldig v. Aiello, 417 U.S. 484 (1974). Finally, in Johnson Controls any pre-birth protection afforded by the company's policies was not limited to conceived fetuses, or viable fetuses, let alone verge-of-birth fetuses.

Were pregnancy found to be a suspect category for equal protection purposes, as is gender, the state would meet the test necessary to validate the discriminatory action. See Mississippi Univ. for Women et al. v. Hogan, 458 U.S. 718 (1982). Hogan provided that to uphold discriminatory action it must be shown that "the classification serves 'important governmental objectives and that the discriminatory means employed' are 'substantially related to the achievement of those objectives.'" Id. at 724 (quoting Wengler v. Druggists Ins. Co., 446 U.S. 142, 150 (1980)).

191. The Supreme Court has held that whatever the medical label placed on a surgical procedure, the issue is one of law. Winston v. Lee, 470 U.S. 753, 763 (1985). It would follow that the realities of the procedure, as more or less intrusive and dangerous, would supersede the medical labels, e.g., "major surgery," attached to the procedure. Id. at 764 n.8.

192. A mature refusal is one that is actually informed; voluntary; authentic, i.e. congruent with the person's values and preferences; and based on a concern for bodily integrity. See infra part V.C.2.
indications, and its morbidity and mortality rates, is a necessary prerequisite to the development of a legally, medically, and ethically sound model for intervention.

A. CESAREAN SURGERIES

Cesarean surgery is an alternative to vaginal childbirth. In general, doctors perform a cesarean "whenever it is believed that further delay in delivery would seriously compromise the fetus, the mother, or both, yet vaginal delivery is unlikely to be accomplished safely." The surgery involves making incisions in the abdominal and uterine walls and then removing the infant. During cesarean surgery the mother is under general, spinal, or epidural anesthesia.

There has been considerable concern and controversy over whether the number of cesareans performed in this country is excessive. In 1970, only 5.5% of births occurred by cesarean; in 1989 the percentage had jumped to 23.8%, almost one million cesarean sections per year. The rate of cesarean sections in the United States is one of the highest in the western world. Some evidence suggests that obstetricians perform an indeterminate number of cesareans because they fear malpractice suits that may involve huge damages for devastating injuries. Obstetricians' biggest concern with malpractice suits for cesarean

193. CUNNINGHAM ET AL., supra note 98, at 441.
194. Id.
195. See ROSEN & THOMAS, supra note 1, at ix-xiii; Brody, supra note 1, at B5. Commentators have urged that fewer cesareans be performed. See Norma I. Gavin et al., Cesarean Section in North Carolina: The Need for Review, 51 N.C. MED. J. 81 (1990) (study of cesarean section rates).

In January, 1989, after making an extensive compilation of cesarean statistics, the Washington-based Public Citizen Health Research Group concluded that the optimal rate of cesareans should be 12% of all births, approximately half of the current rate. Linda R. Monroe, Affluent Women Twice as Likely as Poor to Have Cesarean Births, L.A. TIMES, July 27, 1989, § 1, at 3.

The indications for cesareans that are most controversial are previous cesarean surgery, dystocia, and breech position. See CUNNINGHAM ET AL., supra note 98, at 441-42.


197. In 1983, the rate of 20.3 cesareans per 100 births was the highest of the 19 industrialized countries. This rate increased over the next few years, but has since leveled off. The rate of primary cesarean sections in 1988, 17.5%, was essentially the same as it had been for the two previous years. Taffel et al., supra note 196, at 200.

198. See Brody, supra note 1, at B5.
sections are the “suit[s] brought for failure to perform a cesarean delivery which the patient argues was necessary and, if performed, would have prevented the injury suffered [by the infant].” Critics charge that doctors perform unnecessary cesareans to increase profits because “[d]octors usually earn 20 to 40 percent more and hospitals may double their revenue with a Cesarean birth.”

Women who refuse cesareans base their decisions on religious beliefs, fear of stigmatization, fear of surgery, fear of dying, disbelief of the medical diagnosis, and their desire not to have the baby. Women may also refuse because of the undesirability of an abdominal scar, because of a pathological denial of pregnancy (especially teenagers), or because of depression or other mental disability. There have been several cases where, subsequent to the court order, the mother delivered vaginally, with neither mother nor child suffering untoward effects.

B. Maternal Mortality and Morbidity

The risks from cesarean sections are not considered to be high; indeed, cesarean sections are now considered to be among

199. Cesarean Childbirth, supra note 93, at 484.
200. Brody, supra note 1, at B5.
202. See, e.g., Bowes & Selgestad, supra note 73, at 209.
203. See, e.g., Lieberman et al., supra note 2, at 516.
204. See Jurow & Paul, supra note 2, at 596. Jurow and Paul discuss a mother who did not want the cesarean because she did not want the baby. She said having no baby would solve her already complicated personal life. Id. at 597. Standing by and supporting her was a male friend with whom she had been living, but who was not the father of the fetus. Id. Since she presented at term, the woman, in effect, was asking for an illegal abortion. (The surgery was performed without court ordered intervention and despite her refusal; no force was necessary. Id.). See also Lieberman et al., supra note 2, at 516 (patient said that death of the fetus would solve her complicated personal problems).
206. See Rhoden, supra note 2, at 1959-60.
the safest major operations performed in this country.\(^{207}\) Rosen and Thomas, who have argued that too many cesareans are performed in this country, nevertheless conclude that “cesareans have become far less risky over the years and now pose a very low mortality risk for mothers.”\(^{208}\) The risk of death attributable to cesareans is not easily determined because of the difficulty in separating the risks associated with the underlying condition from those of the cesarean itself.\(^{209}\) Studies of the mortality rate associated with cesarean sections have produced widely varied results. Reports reveal maternal mortality rates from zero to 277 deaths per 100,000 sections.\(^{210}\) A relatively recent summary of studies on maternal mortality rates states that “[t]he absolute risk from cesarean delivery alone was thought to be 6 per 100,000 procedures.”\(^{211}\)

The most common causes of post-operative morbidity are infection, hemorrhage, and urinary tract injury.\(^{212}\) Not surprisingly, the complication rate is higher among women who undergo cesareans in emergency situations.\(^{213}\)

C. WHEN CESAREANS ARE INDICATED

The four most common situations in which doctors perform cesareans are dystocia, breech, fetal distress, and repeat cesareans.\(^{214}\) There are a number of additional medical situations


\(^{208}\) ROSEN & THOMAS, supra note 1, at 9.


\(^{210}\) See Miller, supra note 209, at 629.

\(^{211}\) Id. “The [maternal] death rate directly related to surgery was 5.8 per 100,000 cesarean sections between the years 1954 and 1985, a figure to be compared with a death rate of 10.8 per 100,000 patients delivered vaginally. The main causes of death appear to be sepsis and pulmonary embolism.” Rogers, supra note 207, at 673.

\(^{212}\) CUNNINGHAM ET AL., supra note 98, at 444.

\(^{213}\) “A prospective study of cesarean sections indicates that the risk of surgical complications is 11.6%, but there are differences according to the indications: the surgical complication rate for emergency operations is 18.9% and that for elective operations, 4.2%.” Rogers, supra note 207, at 673.

\(^{214}\) CUNNINGHAM ET AL., supra note 98, at 442 tbl. 26-1. Dystocia is a term used for a variety of conditions which cause difficulties in labor that cannot be corrected, making vaginal delivery extremely difficult and dangerous, if not impossible. See DORLAND’S ILLUSTRATED MEDICAL DICTIONARY 415 (26th ed.
where cesareans are indicated. For purposes of my suggested guidelines, this Article will analyze only those circumstances in which vaginal delivery would substantially endanger the life or vital health interests of the fetus and cesarean section would not. In some of these scenarios, the cesarean would benefit the mother by preventing serious harm to her. In others, the cesarean would involve the usual risks of surgery to the mother, without any countervailing advantages to her. In yet other situations, where the cesarean is necessary to preserve the life or vital health interests of the fetus, the operation would involve high risks of mortality or morbidity to the mother. In the next section, this Article will analyze the legal and ethical propriety of compelling cesarean surgery in each of these three situations, stipulating, based on realistic medical scenarios, that absent a cesarean the fetus would die or suffer severe handicaps.

V. SUGGESTED GUIDELINES FOR INTERVENTION

Any proposed solution must reflect the fact that,

1985) [hereinafter DORLAND'S]; WILLSON & CARRINGTON, supra note 209, at 486. A breech presentation is one in which the fetus is malpositioned such that, depending on additional circumstances, cesarean surgery may be safer than vaginal delivery. See DORLAND'S, supra, at 1065; WILLSON & CARRINGTON, supra note 209, at 486.

215. See TAYLOR, supra note 209, at 540 tbl. 41.1, where the following situations are listed as indications for primary cesarean section: cephalopelvic disproportion (21.5%); uterine inertia (13.8%); excessive size of infant (3.5%); pelvic tumor (1.2%); toxemia (10.2%); placenta previa (7.4%); premature separation of placenta (7.2%); malpresentation of the infant (7.1%); diabetes (4.8%); elderly primipara (4.5%); fetal distress (4.0%); prolapse of cord (2.3%); poor obstetrical history (1.2%); previous vaginal plastic surgery (0.9%); miscellaneous (10.4%).

Cephalopelvic disproportion is a condition in which the infant's head is too large for the pelvis of the mother. DORLAND'S, supra note 214, at 397. The term uterine inertia describes sluggish uterine contractions during labor. Id. at 663. Toxemia is a condition of metabolic disturbance, causing pregnant women to suffer high blood pressure, edema, proteinuria (protein in the urine), and sometimes convulsions and coma. Id. at 1063, 1379. Placenta previa is a condition in which the placenta develops in the lower uterine segment, such that it covers or adjoins the internal os (through which the baby must pass during delivery). Id. at 1023.

216. There have been several proposed models or tests. For example, Chervenak and McCullough have proposed guidelines which would permit cesarean surgery when "the risks [of treatment] to the fetus are minimal, the potential benefit to the fetus is substantial, and the risks to the woman are those she should reasonably accept on behalf of the fetus." Frank A. Chervenak & Laurence B. McCullough, Perinatal Ethics: A Practical Analysis of Obligations to Mother and Fetus, 66 OBSTETRICS & GYNECOLOGY 442, 445
whatever the courtroom proceeding involved, it is likely to be ex parte. Although critics of involuntary cesareans have objected to ex parte proceedings, cesarean sections are not the only procedures that courts have ordered on an ex parte basis despite privacy concerns. Indeed, in emergency situations involving danger to the patient or others, courts and legislatures have approved administration of psychotropic drugs without any hearing whatsoever.

(1985). Mathieu has advocated a balancing test in which the relative weights of the conflicting interests vary according to the point in pregnancy at which they arise. Mathieu, supra note 5, at 51-52. Myers would create a presumption against intervention and would require the state to use the least restrictive means when intervention is necessary. Myers, supra note 60, at 68-69; see Peta Hallisey, Comment, The Fetal Patient and the Unwilling Mother: A Standard for Judicial Intervention, 14 PAC. L.J. 1065, 1069 (1983) (advocating guidelines which clearly define the extent of maternal authority in refusing fetal therapy); Note, Constitutional Limitations on State Intervention in Prenatal Care, 67 VA. L. Rev. 1051, 1066-67 (1981) (exploring the constitutional limits on state regulation and intervention in prenatal care).

217. The American Medical Association (AMA) has recently taken a position generally against court ordered cesareans. See Helen M. Cole, Legal Interventions During Pregnancy: Court Ordered Medical Treatments and Legal Penalties for Potentially Harmful Behavior by Pregnant Women, 264 JAMA 2663 (1990) (Board of Trustees Report). Part of the AMA's rationale is its conception of the comparative legal rights and interests of the woman and the fetus. Another part of the rationale is concern over medical liability, and a third part is that ex parte proceedings are unfair to the woman involved. The last point is dealt with herein by the high qualitative and quantitative standards of proof and the requirement that the standards be communicated in writing to the magistrate or judge.

218. See United States v. Couch, 688 F.2d 599 (9th Cir. 1982) (ex parte order for X-ray search of a suspect's digestive tract), cert. denied, 459 U.S. 857 (1982); United States v. Erwin, 625 F.2d 838 (9th Cir. 1980) (ex parte order for a strip and body cavity search); In re Melvin, 546 F.2d 1 (1st Cir. 1976) (ex parte order that a suspect submit to fingerprinting and photographing); In re Rosahn, 551 F. Supp. 505 (S.D.N.Y. 1982) (holding petitioner in contempt for failing to comply with an ex parte court order directing her to provide a grand jury with photographs, fingerprints, handwriting exemplars, and hair samples); In re Anonymous, 549 N.Y.S.2d 308 (App. Div. 1989) (order for a blood test of the defendant for the AIDS virus for possible use by the prosecution in a case charging attempted murder by biting), aff'd, 559 N.E.2d 670 (N.Y. 1990).

219. See People v. Medina, 705 P.2d 961, 963 (Colo. 1985) (medication may be administered to a nonconsenting patient prior to a hearing in an emergency that "poses an immediate and substantial threat to the life or safety of the patient or others"). The fact that violent mental patients may, in emergency situations, receive forced treatment does not suggest that an involuntary cesarean may be performed in an emergency without any court hearing. Unlike a violent mental patient, whose endangerment of others is never justified, a pregnant woman is entitled, under the analysis herein, to endanger her fetus by electing against a cesarean, if she is "decisionally mature."

Where long term, nonconsensual medication or civil commitment of a mental patient is contemplated, courts are increasingly holding that the pa-
Proceeding on the assumption that an ex parte hearing will be possible and necessary, this Article offers guidelines for the quality and quantity of proof at such hearings. When only doctors or hospital officials appear before a judge or magistrate to advocate a compelled cesarean section, they should bear the initial burden of establishing two factors by clear and convincing evidence:220 that the fetus will die or suffer severe lifetime handicaps unless there is surgical intervention,221 and that the mother was warned of all the risks, alternatives, and material attendant circumstances, including the dire risk to the fetus if the surgery is not performed.222

If the judge is satisfied that this burden has been met, she shall hear and rule on additional submissions as follows:

Category I: If the court further finds the existence of a substantial probability that the cesarean will be of significant medical value to the life or health of the mother, it shall order the mother to undergo the cesarean. Category II: If, however, the court does not make such a finding, it shall determine (A) whether a clear and convincing showing has been made that the risks to the mother are no higher than the ordinary and usual risks of a cesarean. If the court finds “A” then it shall inquire further whether (B) there is a compelling basis for concluding that the patient’s decision is inauthentic, the product of external pressures, without adequate understanding and awareness, or being made for reasons other than bodily integrity. If it does not find “B” the court may not order the surgery, as the decision is mature. If it finds “A” and “B” the court shall require proof that (C) no reasonable probability exists that the patient is suffering from pathological levels of anxiety or panic.
such that compelling surgery would be inhumane. If it finds II "A," "B," and "C," the court shall order the mother to undergo the cesarean surgery.223 Category III: If the court finds that the mother's risks are unusual, it shall not order a cesarean. In this situation the surgery may take place only with the mother's informed consent. The petitioning party shall append a copy of these rules to the petition.224

A. CLEAR AND CONVINCING EVIDENCE OF THE NECESSITY FOR A CESAREAN

This evidentiary standard will exclude the numerous situations in which obstetricians may reasonably disagree about whether a cesarean is warranted. Thus, courts must follow the dictates of the mother absent an abiding conviction of the high risk of fetal death or severe impairment.226

This Article's proposal posits a situation in which the fetus will die or suffer serious lifetime handicaps unless delivered by cesarean. Any arguable ambiguity about the necessity of a cesarean to save the fetus removes all justification for performing the cesarean against the mother's will.227 Further, if doctors perform the cesarean without her consent, there must be a very strong reason; a necessary but not sufficient reason is that the fetus's life or vital health interests would be severely jeop-

223. Under Category Two, cesarean surgery may be compelled if gynecological surgery under general anesthesia would be necessary in any event because the fetus would expire in the womb and not be extractable otherwise.

224. Given the rarity of this sort of case, the need for expedited judicial action, and the fact that the patient will, by hypothesis, not be represented at an ex parte proceeding, this requirement seems appropriate.


226. Many breech presentations are subject to debate as to whether a cesarean is necessary. See ROSEN & THOMAS, supra note 1, at 37-38. Fetal distress is also a debatable category in many situations. See id. at 30-31, 34. A previous cesarean is not necessarily an indication for a repeat cesarean. See id. at 40. Dystocia is a problematic diagnosis, and may result in unnecessary cesareans if made unjustifiably. See id. at 30. If justified, however, a cesarean is indicated. Id.

227. There have been at least two situations where physicians expressed the view that vaginal delivery was too dangerous to the mother or the fetus, but the mother nevertheless vaginally delivered a healthy baby with no detrimental effects to herself. See Rhoden, supra note 2, at 1959-60.
ardized without a cesarean. The requirement of clear and convincing evidence is designed to control the well-documented tendency of obstetricians to recommend cesareans in situations where the procedure is not clearly indicated, either because the diagnosis is uncertain or medical authority is not strongly supportive.\textsuperscript{228} It should also limit any tendency to overemphasize cesareans for minority, poor, or non-English-speaking women.

B. \textbf{CATEGORY ONE: PREVENTING SUBSTANTIAL HARM TO MOTHER AND FETUS}

In a Category One situation, where a cesarean section would prevent substantial harm to the mother and prevent death, major deformities, disabilities, or disease of the child, the law is justified in ordering a mother to submit to the surgery. Clinical examples of a Category One situation include: fetal distress with placental abruption, complete placenta previa, and gross cephalopelvic disproportion.\textsuperscript{229}

In these examples, the life or essential health of the fetus and the mother are both at stake; both will be seriously jeopardized absent a cesarean section. The claim to autonomy, already weakened by strong arguments on behalf of a maternal obligation to the verge-of-birth fetus, is substantially lessened here. The refusal to undergo a cesarean under these circumstances appears to be not only harmful to a third party but self-harming as well. In that sense, the decision is irrational.\textsuperscript{230}

Normally even an irrational decision of a competent patient to refuse treatment is not a legal basis for paternalistic in-

\textsuperscript{228} Cf. Chervenak \& McCullough, supra note 120, at 13-16.

Those who plead uncertainty make a fundamental mistake. They hold clinical prognostic judgment to a standard of truth that it can never satisfy, namely, that it never turns out to be false in an individual case. On such a standard of truth, before the outcome actually occurs, all clinical prognostic judgments must be judged possibly false and therefore disabled by uncertainty. In effect, [those who claim that there is inherent uncertainty of diagnosis and that this militates against compulsory cesareans, propose] an impossible epistemological standard, one that bears little relation to a reasonable test of epistemological reliability of clinical prognostic judgments. This test emphasizes the reliability with which such judgments are formed because, prospectively, knowledge of the actual outcome is unavailable.

\textit{Id.} at 13.

\textsuperscript{229} Elkins et al., supra note 2, at 152.

\textsuperscript{230} In using the term irrational, I am utilizing the definition and analysis of Charles M. Culver and Bernard Gert in their work \textit{PHILOSOPHY IN MEDICINE: CONCEPTUAL AND ETHICAL ISSUES IN MEDICINE AND PSYCHIATRY} (1982). The attractiveness of the Culver and Gert thesis is that they do not
Ordinarily, beneficence of a physician may not take precedence over the patient's right of medical self-determination. The patient has a right to decide, and to decide on the basis of information conveyed by her physician, whether or not she will undergo recommended treatment. After all, it is the patient's body that will be subject to the medical procedure. But these are close questions. A patient's right to determine her treatment is balanced against the state's interest in preventing suicide and preserving life.

In this case, however, the patient's right must be weighed against an additional factor: the harm to a viable, verge-of-birth fetus who has acquired many of the rights provided to babies. Thus, because the irrationality will cause harm not only to the patient herself but to a third party as well, this Article asserts that the law is justified in intervening to save the two lives. Since the right to harm oneself is not an absolute posit that one need have a reason to act rationally; they posit that one need have an adequate reason to do harm to oneself. Id. at 29.

An irrational decision is one that is self-harming and not based on a future-oriented, adequate reason. For a reason to be "adequate," a weighing of good and evil must result in a net good to the parties involved. When those tests are not met, we can say that the decision is irrational. Id. at 27-31.

The authors define self-harming as "causing (or not avoiding) some evil for oneself. Evils or harms consist of the following conditions: death; pain (physical or mental); disability (physical, cognitive, or volitional); and the loss of freedom, opportunity, or pleasure." Id. at 27.

Self-harm sought to be justified by present emotions or facts about the past is always irrational according to Culver and Gert. Id. at 29. They do not hold that one need have a reason to act rationally. They contend, however, that self-harming behavior without a reason rooted in the future is to act irrationally. Id.

All this is not to say that Culver and Gert would intervene on a mere showing of irrational conduct. For their definition of justifiable paternalism (requiring as one element that the conduct be irrational) see id. at 143-163.

231. See, e.g., Lane v. Candura, 376 N.E.2d 1232, 1235-36 (Mass. App. Ct. 1978) (holding that the irrational refusal of amputation is not equivalent to incompetence, and thus surgery could not be performed against the patient's will); In re Quakenbush, 383 A.2d 785, 789 (Morris County (N.J.) Ct. 1978) (upholding a patient's privacy right to refuse amputation of gangrenous leg); In re Yetter, 62 Pa. D. & C.2d 619, 623 (Northampton County Ct. 1973) (honoring a 60-year-old patient's refusal of a breast biopsy for reasons that included delusional fear of loss of child-bearing capacity and a chance for a movie career).

232. This would be so even if the mother in Category One met the tests in Category Two, i.e., gave a competent, voluntary, personally authentic reason, rooted in her concern with bodily integrity.

Note also that the concept of "irrationality" as used here has no place in Category Two analysis. Rationality is a difficult concept to define, and I have omitted it from the formulation for Categories Two and Three. The definition I offered above, however, should serve to make it less ambiguous, and the con-
right, it hardly qualifies as a principle worthy of protection no matter what the cost to others.

C. CATEGORY TWO: PREVENTING SUBSTANTIAL HARM TO FETUS WHEN MOTHER’S RISKS ARE NORMAL

In a Category Two situation, where a cesarean section would prevent death or serious injury of the fetus and would present only the usual risks to the mother, the court may be justified in ordering a cesarean if the mother’s decisional maturity is in significant doubt. This category will also apply to cases in which the mother is not conscious and cannot give her informed consent. Clinical examples of a Category Two situation include: ruptured membrane with prolapse of umbilical cord and fetal distress.\(^\text{233}\)

In this category, the first step for determining whether to override a mother’s failure to consent to cesarean surgery is a clear and convincing medical diagnosis that the fetus faces substantial risks of death or serious medical injury. If such a diagnosis is made, then a court may disregard the mother’s failure to consent, or her objections, only after undertaking an additional three-step analysis. It first must determine whether the mother’s failure to consent is rooted in concerns about something other than bodily integrity, and then it must decide if the patient has exhibited decisional maturity. Finally, the court must determine that requiring the mother to undergo the procedure will not set off such intense levels of fear that the surgery would be inhumane.

1. Bodily Integrity Considerations

As long as the refusal is made with decisional maturity, concern about bodily integrity, by itself, is a sufficient basis for a woman to refuse a cesarean, even if the fetus faces substantial risks and the mother faces the normal risks associated with the procedure. Concern about bodily integrity may take many forms. If, for example, the mother expresses fear of the surgery because she is diabetic, her reason is rooted in an aspect of bodily integrity. So is a Jehovah’s Witness’s refusal to have a blood transfusion because she believes the blood will make her body unclean.

\(^{233}\) See Leiberman et al., supra note 2, at 515.
Some reasons do not comport with bodily integrity. If the patient refuses to consent to the procedure because she does not want to have the child, as has occurred in at least two cases, she is not basing her concern on bodily integrity. Instead, she is asking for the equivalent of a third trimester abortion, and doctors should not respect her wishes. Similarly, the court should not view disagreement with the doctor's diagnosis as a bodily integrity reason. The patient's limited autonomy rights do not include the right to deny, at the expense of her fetus, a diagnosis that has been established by clear and convincing evidence.

2. The Requirement of Decisional Maturity

An informed, voluntary, and authentic choice deserves to be heeded. These three decisional qualities, combined with a reason for refusing based on bodily integrity, I refer to as "decisional maturity." A woman as to whom there is no strong evidence of incompetence or inauthenticity, and who refuses for reasons of bodily integrity, has every right to have her refusal honored. Why should decisional maturity suffice to allow a refusal which results in the death of the fetus? A woman who is exhibiting decisional maturity has given the matter some thought, and is in touch with her deepest sense of self, is fully aware of and unpressured by externalities, and rejects the surgery for reasons associated with her bodily integrity. The rejection is a meaningful one, not frivolous or merely a reflection of transient values or external pressures. It is the paradigm of an autonomous choice by a competent person.

a. Voluntariness

The mother's decision to refuse the cesarean must be her own free choice. It must not be based on external duress. For example, the woman has not made a free decision if she is bowing to pressure from her husband, lover, family, or members of her religion. In other words, the situation must be such that she could not say afterwards, having refused the surgery, that she could not have done otherwise under the circumstances. The decision must reflect her true choice, the consequence of the operation of her unweighted internal scales, not the imposed demands, direct or indirect, of other people.

234. See supra note 204.
b. **Authenticity**

By the term "authenticity" I refer to the decisions and actions of the authentic self. These actions should be fundamentally faithful to the values, preferences and principles that the person has held over the long run. The idea of authenticity is an idea of true choice. The present views a patient voices may not be her authentic choice. The court should determine whether there is congruence between her present position and her long run values and preferences. If the patient has vacillated continuously, the fact that the last position she takes before action is necessary to save the child is a position against the surgery should not be conclusive evidence of her desires on the subject. The question is one of authenticity. What is her authentic view? Do the views she previously expressed include the views she expressed since she learned that she was pregnant, the views expressed to her husband or other friends and relatives? Has she taken steps to provide good prenatal care? Has she been in a high risk pregnancy program? Has she asked questions of, or made statements to, her physician or others indicating that she was looking forward to having the child? What feelings has she expressed about surgery in general and cesarean surgery in particular?

For example, if the mother had consistently voiced a desire to have a cesarean if necessary, and was fully informed about what that would entail, but in the excitement or panic of the moment changed her mind, a serious question would arise about whether her change of mind reflected her authentic

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235. The genesis of this concept in the present author's thinking was a television special, *Ethics in America: Does Doctor Know Best?*, which aired on PBS in February, 1989. On this program, Dr. Williard Gaylin, a psychiatrist, ethicist, and then head of the Hastings Center used "authenticity" to mean something like the more familiar "substituted judgment test" employed where a once-competent patient is presently incompetent.


For an additional discussion of "authenticity," see Bruce A. Miller, *Autonomy and the Refusal of Lifesaving Treatment*, HASTINGS CENTER REP., Aug. 1981, at 24 (suggesting a multi-factorial test, which included analysis of conflicts between the factors for determining autonomy, i.e., determining whether a decision is voluntary, intentional, authentic, and the product of knowledgeable and rational deliberation and moral reflection).
A person certainly can change her mind. It is only where there has been a previous well-integrated expression of willingness to have a cesarean that a sudden shift would be suspect. A single past assertion of willingness to have a cesarean does not establish her authentic position. The prior expression should be tested for its repetitive consistency, its depth of expression, its stated rationale, and its proximity to the present.

Although critics might argue that overruling a woman's expressed wishes on the ground that they are not "authentically" hers is paternalistic, it is helpful to consider that a patient's choice may be the result of varying levels of autonomy. For example, because of exigencies such as pain, confusion, drugs, stress, or excitement, a patient who is nonetheless "competent" may be exercising a low level of autonomy when faced with a treatment decision.

It is important to keep in mind that the overwhelming majority of women, when informed that a cesarean section is necessary for the safe delivery of their baby, willingly undergo the surgery. Nor should the reader gather the impression that even those very few women who refuse to undergo an indicated cesarean act out of whimsy. Religious reasons, unfamiliarity with the language, clinical depression, or deep seated fear of surgery are hardly whimsical bases for refusal.

If a patient has previously consistently and forcefully expressed a view contrary to her current view, she is arguably not now being her true self. This is not a paternalistic claim to know better than the patient what is for her own good. Rather, the patient's own history, long-standing value system, behavioral past, and expressed wishes tell us that she is not manifesting her true self at this time. In other words, when the traditional "substituted judgment" test would give a doctor a high degree of confidence that the patient genuinely would favor childbirth by the necessary cesarean section, that doctor, or a court, is justified in overriding her apparent election, at least where there is a strong state and life interest competing with the patient's ostensible choice.

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238. Time permitting, the physician or judge need not rely on what she can discern from the patient alone, but can speak to the patient's husband, lover, relatives, friends, and other physicians the patient may have seen.

239. Cf. Scoccia, supra note 236, at 318 (discussing when it is ethically permissible to interfere with another's irrational choice).
c. Informed Refusal

This "informed refusal" requirement demands a manifestation of awareness and understanding of the critical facts. This portion of the test does not require the woman to inform herself of the risks, options, and consequences, but merely insists that she have an adequate degree of understanding after a physician has made a vigorous, good faith effort to inform her of the circumstances.

Doctors must inform the mother of the risks and benefits to her own medical interests from the cesarean, from an attempt at vaginal delivery, and from doing nothing. Doctors must also inform the mother of the risks to the fetus under all three alternatives. She must fully understand both the diagnosis and the prognosis.

An informed refusal has been required where an incompetent patient's family sought to have her artificial feeding terminated, and where the survivors of a woman claimed that her physician had committed a battery by placing her on a respirator in an emergency. In the latter case the court found that if the woman, while competent, had made an informed refusal to be placed on a respirator, doing so when she became incompetent would be a battery even though an emergency normally provides implied consent to such treatment.

Ordinarily, treatment requires informed consent. The law does not, however, ordinarily hold that to refuse treatment a person must be fully informed. But where the life of a third party would be threatened by non-treatment, a woman whose declination of treatment is to be respected must at least make an informed decision to forego treatment. For in so doing, she will initiate devastating consequences to the fetus.

240. Cruzan v. Harmon, 760 S.W.2d 408, 424 (Mo. 1988) (en banc) (stating that "[a] decision to refuse treatment, when that decision will bring about death, should be as informed as a decision to accept treatment"), aff'd sub nom. Cruzan v. Director, Mo. Health Dep't., 110 S. Ct. 2841 (1990).
241. Estate of Leach v. Shapiro, 469 N.E.2d 1047, 1053 (Ohio Ct. App. 1984) (stating that "[b]efore [the] refusal can controvert the implied consent of a medical emergency . . . it must satisfy the same standards of knowledge and understanding required for informed consent").
242. See id. When a woman is mentally incompetent and facing an emergency situation, and a cesarean presents the usual risks, she should be presumed to want delivery of her baby, even by cesarean if necessary. Such a presumption is warranted by the facts that most women permit delivery of their newborns; the fetus would die or suffer severe handicaps if a cesarean is not performed; and a substituted judgment test is procedurally unrealistic at this stage.
If the patient is suffering from very high levels of anxiety such that it would be inhumane to subject her to involuntary surgery, the law should recede. For in a decent society, the law must never be an instrument of psychic terror.

d. Religious Objection

Should the law honor a religiously based refusal to undergo a cesarean? Religious objections of patients to treatment of themselves usually prevail, but often under circumstances where the liberty right to refuse treatment would prevail in any event. Parents' religious claims do not prevail against the state's claim of medical necessity to preserve the lives of children. Earlier, this Article cited decisions holding that a religious objection to a blood transfusion should not prevail where the mother is pregnant and the transfusion is necessary to save the life of the fetus as well as the mother.

Although religious claims alone do not warrant action or inaction that jeopardizes the life of the child, religious claims may form the basis of a mature refusal. The Jehovah's Witness claim is based on bodily integrity grounds; it is likely to be authentic; it is not involuntary merely because it is based on firm religious views; and it may or may not be sufficiently informed, depending on the circumstances. If the woman appreciates the risks to her fetus from not having the surgery, as well as the nature of the surgery and its risks, she can give an informed refusal.

If a woman claiming a religious objection is being put under duress by outsiders, perhaps threatening her with theological or cult-based sanctions if she has the surgery, she may not be acting voluntarily. This is not to say that courts are free to determine from her beliefs that she is not acting voluntarily. If, however, there is manifest evidence of external pressure on her to refuse the cesarean, her voluntariness may be questioned.

In any event, one may question whether a court must recognize religious claims asserted to avoid general and neutral obligations. In Employment Division v. Smith, the Supreme Court held that the First Amendment did not excuse a religious act from criminal punishment and, perhaps, general regul-

244. See, e.g., In re Willman, 493 N.E.2d 1380 (Ohio Ct. App. 1986).
245. See supra notes 62-72 and accompanying text.
latory laws requiring or forbidding certain conduct. Religious beliefs do not constitutionally require any exemptions from prohibitions or requirements of conduct, unless the action or inaction is supported by some other constitutional provision.\textsuperscript{247} The Court declared that "a neutral, generally applicable regulatory law that compel[s] activity forbidden by an individual's religion" is valid, whether or not the state can show a compelling interest for overriding the religious belief.\textsuperscript{248} "[T]he right of free exercise does not relieve an individual of the obligation to comply with a 'valid and neutral law of general applicability on the ground that the law proscribes (or prescribes) conduct that his religion prescribes (or prescribes),'"\textsuperscript{249}

Nothing in \textsl{Smith} precludes recognition of religiously based claims. Precedent, however, strongly indicates that parents may not interpose their religious beliefs in situations where such beliefs will endanger their children.\textsuperscript{250} Consequently, religious beliefs alone should not be a basis for respecting an otherwise less than fully mature decision to forego a cesarean, thereby facilitating the death or severe lifetime impairment of the virtually born fetus.

D. CATEGORY THREE: PROTECTING THE MOTHER FROM SUBSTANTIAL RISKS

In a Category Three situation, where the cesarean entails a substantial risk to the mother's health, the surgery should be performed only after the mother has given informed consent. Clinical examples of a Category Three situation include: a mother with a severe bleeding disorder, a mother with a family history of unexplained death or paralysis from anesthesia, or a mother who would be rendered sterile by the surgery.\textsuperscript{251} Additional examples include a mother with thrombocytopenia, or a recent myocardial infarction or pulmonary condition that would complicate the administration of general anesthesia, which might be necessary in an emergency.\textsuperscript{252}

The law should not demand that a woman undergo unusu-
ally risky surgery. The fetus, struggling for survival itself, is not entitled to require the mother to take substantial risks of serious harm without her consent. This is because the life of the fetus is not yet equal in value to the life of the mother. It is only a contingent, albeit viable, prospective being. The law may demand that a parent do something to stop an assault on her child, but it does not demand that she grapple with the assailant herself. So the principle of "do no harm"—non-maleficence—toward the patient, the mother, overrides the principle of do no harm to the fetus, especially where the mother is also asserting autonomy and bodily integrity. I would propose a single exception to this rule: namely an exception for the situation in which death of the mother is imminent and the mother is unconscious. In that situation the mother will not live to suffer the complications and adverse consequences of the cesarean surgery. The death itself will precede the projected harms from the surgery. It would be unnecessarily tragic to permit two deaths when one being could have been saved at questionable harm to the other.

VI. IMPORTANCE OF A DIALOGUE

A dialogue about the possibility of a cesarean should begin as soon as it is apparent that the patient is undergoing a high-risk pregnancy. The law should encourage an ongoing dialogue between the patient and the physician designed to avoid the ethical conflict at a time of crisis.

Realistically, this proposal places the burden on physicians and affiliated personnel to consult with their pregnant patients from the earliest time to discuss alternatives, risks, and options. Doctors should particularly initiate this dialogue with a patient who presents with a high risk pregnancy. The physician should make clear the circumstances under which a cesarean might be indicated for the patient's or fetus's benefit. The doctor should

254. It could be argued that an involuntary cesarean on a woman who is about to die deprives her of the right to die with dignity, in peace and quietude. But suppose the dying mother gave birth vaginally? Not much peace and solitude in that. Death would not be comfortable when the mother has within her a viable, verge-of-birth fetus that she knows is about to die with her.
255. See Chervenak and McCullough, supra note 216, at 442; see also Dena S. Davis, Reflections on A.C., 2 BioLaw (University Publications of America) Special Section, at S:448 (June, 1990).
advise the patient of risks and complications. In addition, the
doctor should seek to discern the patient's preferences, both at
the beginning and over the course of the pregnancy. Some
writers suggest that if there is a real risk that a cesarean would
be necessary and the patient balks at that prospect, the doctor
and patient should discuss the subject of an abortion early in
the pregnancy.\textsuperscript{256} The physician should certainly inquire into
the reasons for refusing a cesarean, provide information if ap-
propriate, and continue the discussion until the patient's views
are well settled and quite clear. This should occur earlier in
the process of consultation, but the woman's views might not
become clear until the child approaches viability. What is im-
portant is that there be a dialogue between participants in the
birthing process.\textsuperscript{257}

Chervenak and McCullough offer an excellent model of a
dialogue.\textsuperscript{258} The essential obligation of the physician is to con-
vey, in an understandable manner, the information the patient
needs for making an informed decision.

A number of medical writings urge maximum persuasive
efforts in late-term pregnancy.\textsuperscript{259} As long as neither threats
nor deception are employed, it is ethically acceptable for a phy-
sician "to try to persuade a pregnant woman refusing medically
indicated treatment to change her mind."\textsuperscript{260} Chervenak and

\textsuperscript{256} According to one writer, what justifies the compulsory cesarean is the
fact that the mother had options throughout the pregnancy to terminate it.
Kluge, supra note 112, at 209-10.

\textsuperscript{257} Failure of the physician to have these sorts of conversations with the
patient should be deemed legally culpable neglect.

\textsuperscript{258} Frank A. Chervenak & Lawrence B. McCullough, Clinical Guides to
Preventing Ethical Conflicts Between Pregnant Women and their Physicians,
162 AM. J. OBSTETRICS & GYNECOLOGY 303 (1990). The Chervenak-McCul-
lough model would begin with informed consent, continue with negotiations,
and conclude with respectful persuasion. Beyond the usual subjects that must
be disclosed to the patient, any matter that has a real potential for conflict
should be disclosed. The information "should be disclosed at a level and at a
pace appropriate to the intellectual capacity of the woman to understand it.
We caution against underestimating this capacity in pregnant women. For
non-English-speaking patients a competent translator should be provided at
this and [late]... stages of the informed consent process." Id. at 304. The doc-
tor must convey that "when the pregnancy is going to term the fetus is also a
patient." Id. at 305; see Davis, supra note 255, at S:450. The next step in the
process is negotiation toward consensus.

\textsuperscript{259} See Bowes & Selgestad, supra note 73, at 213; Lieberman et al., supra
note 2, at 517; Thomas L. Shriner, Maternal vs. Fetal Rights-A Clinical Di-

\textsuperscript{260} Nelson & Milliken, supra note 2, at 1061.
McCullough offer a paradigm of "respectful persuasion." They posit the possibility, however, that respectful persuasion will not be effective.

It is my view that as long as the risks and benefits of a cesarean, the comparative risks and benefits of vaginal delivery and of doing nothing, as well as the experience of the hospital and physician with cesarean sections are accurately portrayed to the woman, the physician is entitled to convey to the mother, in an appropriate manner, an opinion about what is in the mother’s best medical interests. Within the time frame allowed, the physician should try to ascertain the patient’s values, preferences and beliefs, and tap into them to contend that they support, if they do, acquiescence in cesarean surgery to prevent the death or lifetime debilitation of the viable fetus. Persuasion must be kept far short of the point of duress, coercion, undue influence, deceit, or manipulation. The physician, in seeking to persuade, must do nothing to undermine the patient’s existing competence, authenticity, and voluntariness.

Although courts once applied the prohibitions of the abortion cases to efforts to persuade a woman to act in favor of the life of the fetus, they may no longer be applicable in view of Webster v. Reproductive Health Services.

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261. Chervenak & McCullough, supra note 258, at 305-06.
262. Id.
263. In Thornburgh v. American College of Obstetricians & Gynecologists, 476 U.S. 747 (1986), the Court held that the state could not mandate delivery of information to a woman contemplating an abortion, where such information was designed "to influence the woman’s informed choice between abortion or childbirth." Id. at 760 (quoting Akron v. Akron Center for Reproductive Health, 462 U.S. 416, 443-44 (1983)). The state had asserted that the statute, "describing the general subject matter relevant to informed consent" and stating "in general terms the information to be disclosed," was valid. Id.

The Thornburgh Court did not agree. It pointed out that one of the seven types of information that had to be conveyed to the woman seeking an abortion within 24 hours before consent is given was that there may be detrimental effects from the abortion. Id. Thornburgh found that the informed consent provisions in Akron were struck down for two reasons. First, “the information required is designed not to inform the woman’s consent but rather to persuade her to withhold it.” Id. at 762 (quoting Akron, 462 U.S. at 444). Second, “a rigid requirement that a specific body of information be given . . . intrudes on the discretion of the pregnant woman’s physician.” Id.

264. 492 U.S. 490 (1989). The Webster plurality opinion suggests that Thornburgh’s invalidation of the informed consent provision of the ordinance might no longer be followed, since it cites with approval Justice White’s dissent in Thornburgh on that point. Id. at 517. “As the dissenters in Thornburgh pointed out, such a statute would have been sustained under any traditional standard of judicial review, or for any other surgical procedure except abortion.” Id. (citations omitted).
CONCLUSION

In balancing between the life of a full term fetus and the mother's right to respect for her bodily integrity and autonomy, courts best resolve this dilemma by respecting the mother's right to refuse a cesarean. Courts should require the mother to submit to a cesarean only in the occasional case where the mother would also suffer serious bodily harm absent a cesarean, or where she lacks decisional maturity or concern regarding bodily integrity and the surgery would entail minimal risks. Even in this last situation, a court should not order surgery when the prospective mother is suffering from pathologically high levels of fear regarding the surgery. This Article envisions resolving the competing interests of mother and fetus at a hearing, albeit necessarily an ex parte hearing. The Article would require the state (acting on behalf of the fetus) to satisfy its evidentiary burden at numerous successive steps before a court could order the performance of a cesarean on an unwilling mother.

In an ideal world, societal education, discussion, and communication would obviate the need for compelled cesareans. However, this Article seeks to resolve the conflicting interests of mother and fetus, and proposes a model that will provide principled standards to guide judicial decision making.