

Court Ordered Cesarean Sections: Why Courts Should Not Be Allowed to Use a Balancing Test

“MacDuff was from his mother’s womb, Untimely ripped.” ~ MacBeth, Act V, Scene vii

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ABSTRACT

Many women nowadays give birth via cesarean section, and most of the time, both the doctors and the women are in agreement regarding the use of this procedure. Some women, however, refuse to undergo this procedure, and their doctors may try to obtain a court order to perform a cesarean section. This Article advances the argument that courts should not use a balancing test when determining whether a woman should be compelled to undergo a cesarean section. This argument is based on the right to privacy, which arises from abortion cases and informed consent situations, and on the common law idea that a person usually has no duty to rescue another. It analyzes the compelling interests and considerations presented by the state when it seeks court-ordered treatment and considers four cases that have addressed the issue of court-ordered cesarean sections. Although these situations are difficult to resolve and often occur in time-strapped situations, women should be allowed to make their own decisions regarding the delivery of their children. Additionally, discussions regarding various delivery options should occur sooner rather than later in the pregnancy to avoid situations in which the women and their doctors transform from a cooperative team to battling adversaries.

I. INTRODUCTION

A person enters a burning building and must choose between saving a family member or a complete stranger. Most people would likely save the family member due to the familial bond. Doctors, more specifically obstetricians, often find themselves in a similar situation with pregnant patients. Do they treat the woman, the fetus, or both? Pregnancy creates a unique situation for doctors because to treat the fetus, the doctor must treat the woman. Often, women willingly undergo a treatment because doctors believe that the fetus receives the treatment’s benefits. What happens if a woman refuses a treatment that benefits the fetus? Doctors encounter the same quandary as the person in the hypothetical burning building. Should doctors honor the woman’s refusal, or should they seek a court order to compel treatment? If the doctor opts for judicial intervention, then the fetus often prevails over the woman

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because the courts balance the fetus's rights against the woman's rights. Courts, however, should not conduct a balancing test, especially with procedures like cesarean sections. The court-ordered procedure undercuts the woman's constitutional rights and makes her a glorified incubator, which courts may open at their leisure. The balancing test sets women's rights back centuries because courts may unconsciously (or perhaps consciously) make value judgments on the situation. The courts may skew established law because the woman only contests the method of delivery.

II. CESAREAN BACKGROUND

Since ancient times, people have known and used the cesarean section. Myths, legends, and Shakespearean plays have all referred to the surgery.¹ Cesarean sections occurred in Egypt in 3,000 B.C., as well as other countries like Greece, Italy, and Persia.² Unlike today, doctors considered cesarean sections as the final delivery option because the woman was often dead or dying after the completed procedure.³ Until the sixteenth century, doctors performed cesarean sections postmortem, but at the time live women began to undergo the procedure as well.⁴ Women who chose to undergo the procedure had a high risk of death.⁵ Doctors did not opt for this delivery method with a live woman "unless [she] had been in labor for a very long time and was unable to deliver vaginally" because of the high mortality rates from hemorrhaging and infection.⁶ Cesarean sections, however, became routine after the Catholic Church mandated that doctors perform these procedures to save children for the purpose of baptism.⁷

The cesarean section gradually shifted from a final, last resort option to another delivery method between the late nineteenth and early twentieth century.⁸ The procedure's mortality rates dropped with three surgical developments: "adoption of the use of uterine sutures to arrest hemorrhage, the adoption of aseptic technique, and changes in operative technique from the classical to lower-segment operations."⁹ These developments made the cesarean section safer and caused mortality rates to decline. By the mid-twentieth

1. See MORTIMER ROSEN & LILLIAN THOMAS, *THE CESAREAN MYTH* 13 (1989). Some historical figures may have been born via cesarean section: Gorgias of Sicily, Robert II of Scotland, Andrea Doria, the Genovese admiral; Pope Gregory XIV, and Bishop Paulus of Spain. Vern L. Katz & Robert C. Cefalo, *History and Evolution of Cesarean Delivery*, in *CESAREAN DELIVERY* 1, 3 (Jeffrey P. Phelan & Steven L. Clark eds., 1988).

2. See ROSEN & THOMAS, *supra* note 1, at 13.

3. See *id.* at 13-14.

4. See Katz & Cefalo, *supra* note 1, at 4.

5. See *id.* (noting that three women underwent a cesarean section, but only one survived).

6. *Id.* Even in the Renaissance, scholars had heated ethical debates on the use of cesarean sections. *Id.* at 4-5.

7. See *id.* at 5.

8. See *id.*; ROSEN & THOMAS, *supra* note 1, at 15.

9. Katz & Cefalo, *supra* note 1, at 5. Classical operations involve vertical cuts from the belly button to the bikini line, while lower segment operations involve horizontal cuts at the bikini line. ROSEN & THOMAS, *supra* note 1, at 19-20.

century, cesarean sections accounted for “about four percent of all births.”¹⁰ With the decline in maternal mortality during the 1930s and 1940s, doctors created more reasons to perform the cesarean section, like the baby’s safety and a mother’s history of previous cesarean sections.¹¹

In today’s society, people often consider the cesarean section as a frequently performed “low risk procedure,” and doctors have created more cesarean section indicators thanks to fetal technology advances.¹² These indicators include medical and legal reasons, as well as convenience and monetary factors.¹³ Cesarean sections, however, mainly occur if the fetus appears to be in breech, dystocia, or fetal distress.¹⁴ Doctors also have non-medical reasons for performing cesarean sections, like lack of experience with vaginal births, possible lawsuits for not performing a cesarean section,¹⁵ convenience in the delivery schedule, and differences in insurance coverage.¹⁶

While doctors often perform cesarean sections for “legitimate” medical reasons, the procedure is still major surgery. The woman receives a form of anesthesia before the doctor begins the incisions.¹⁷ The doctor cuts through skin, fat, muscle, tissue, the peritoneum, and uterus before cutting the amniotic membrane and removing the baby.¹⁸ The doctor then removes the placenta, closes the incisions, and places about seven sets of stitches into the woman’s body.¹⁹

Even with a “successful delivery,” the woman is not out of danger. The surgery poses mortality risks to the mother and the fetus, which is often four times higher than the vaginal birth.²⁰ In spite of this risk, the cesarean section is one of the most commonly performed medical procedures.²¹ In 2004, 29.1% of all childbirths occurred by cesarean section, which is the highest rate ever

10. ROSEN & THOMAS, *supra* note 1, at 15.

11. Katz & Cefalo, *supra* note 1, at 12-13.

12. ROSEN & THOMAS, *supra* note 1, at 15; *see also* Norbert Gleicher et al., *Methods for Safe Reduction of Cesarean Section Rates*, in CESAREAN SECTION: GUIDELINES FOR APPROPRIATE UTILIZATION 141, 143 (Bruce L. Flamm & Edward J. Quilligan eds., 1995) (stating that the cesarean section is the most frequently performed surgical procedure in the United States).

13. Bruce L. Flamm, *Cesarean Delivery in the United States: A Summary of the Past 20 Years*, in CESAREAN SECTION, *supra* note 12, at 1, 6.

14. *See, e.g.*, ROSEN & THOMAS, *supra* note 1, at 23-39 (explaining the various cesarean section indicators). Other medical factors indicate a cesarean section like postdate pregnancy, premature rupture of the membrane, placenta previa, and various mother-related illnesses. *See id.* at 45.

15. *Id.* at 56.

16. *See* Gleicher et al., *supra* note 12, at 142-43; *see also* Flamm, *supra* note 13, at 6 (listing the doctors’ reasons for performing cesarean sections); ROSEN & THOMAS, *supra* note 1, at 56 (listing the doctors’ reasons for performing cesarean sections with the supporting rationales).

17. ROSEN & THOMAS, *supra* note 1, at 18-19. Women can choose from three types of anesthesia: spinal, epidural, or general. *Id.*

18. *Id.* at 19-20. Prior to cutting the amniotic membrane, the woman has lost about 150 centiliters of blood. *Id.* at 20.

19. *Id.*

20. *Id.* at 63. Women have a mortality rate of “35.9 deaths per 100,000,” and infants have a mortality rate of “9.2 per 100,000.” Daniel R. Levy, *The Maternal-Fetal Conflict: The Right of a Woman to Refuse a Cesarean Section Versus the State’s Interest in Saving the Life of the Fetus*, 108 W. VA. L. REV. 97, 99 (2005).

21. *See* Gleicher et al., *supra* note 12, at 143.

reported in the United States, and shows an increase from 27.5% in 2003.²² The rate of cesarean sections, however, shows no signs of decreasing. First-time cesarean section rates have increased from 19.1% in 2003 to approximately 23.4% in 2007 while vaginal birth after cesarean (VBAC) rates have decreased from 10.6% in 2003 to approximately 8.0% in 2007.²³ The possibility of fetal injury also does not appear to be a deterrent. During a cesarean section, fetuses have a 1.1% chance of injury with the most common injury being skin lacerations.²⁴

Doctors consider all of these factors in their decision about whether a woman needs a cesarean section. While doctors share the goal of “the birth of a perfect baby to a healthy mother,”²⁵ they may have other concerns that affect the decision.²⁶ Women, however, have become more educated about the procedure for their own edification and due to increased media focus on the issue.²⁷ With this information and knowledge, women may refuse the procedure. Thus, a pregnancy power struggle could result in which the doctor wants to perform a procedure that the woman does not want. Unlike a normal doctor-patient relationship, this decision affects an unborn third party. Thus, the courts may be required to resolve the situation, which may cause the woman’s rights to be completely subordinated to the fetus’s rights.

III. CESAREAN CASES

When most people think of the courts and reproductive rights, they automatically conclude that the issue is abortion. Cesarean sections, however, have also created controversy. These controversies rarely proceed past the trial court, and the rulings are often not published. Thus, cases do not consistently reach the appellate level, and many courts may not have addressed the issue. As a result, while these courts reach different conclusions in their cases, the conclusions fall into two camps: pro-women and pro-fetus.

22. Joyce A. Martin, et al., *Preliminary Births for 2004: Infant and Maternal Health*, CTRS. FOR DISEASE CONTROL & PREV., <http://www.cdc.gov/nchs/data/hestat/prelimbirths04/prelimbirths04health.htm> (last visited Oct. 13, 2010) (noting that 29.1% translates into about 1.2 million births); *Fastats – Birth – Method of Delivery*, CTRS. FOR DISEASE CONTROL & PREV., <http://www.cdc.gov/nchs/fastats/delivery.htm> (last visited Oct. 13, 2010).

23. Martin, *supra* note 22; *Fastats – Obstetrical Procedures*, CTRS. FOR DISEASE CONTROL & PREV., <http://www.cdc.gov/nchs/fastats/obgyn.htm> (last visited Oct. 13, 2010); *QuickStats: Total and Primary Cesarean Rate and Vaginal Birth after Previous Cesarean (VBAC) Rate – United States, 1989-2003*, CTRS. FOR DISEASE CONTROL & PREV., <http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5402a5.htm> (last visited Oct. 13, 2010).

24. *Risk Factors for Fetal Injury During C-section Identified*, REUTERS, Oct. 12, 2006.

25. Bruce L. Flamm, *Introduction to CESAREAN SECTION*, *supra* note 13, at xv, xvi.

26. Mary Beth Pfeiffer, *C-section Rates Tick Upward as Doctors Fear Being Sued*, POUGHKEEPSIE JOURNAL, May 9, 2010, <http://www.poughkeepsiejournal.com/article/20100509/NEWS01/5090346/C-section-rates-tick-upward-as-doctors-fear-being-sued> (noting that several factors including previous cesarean sections, liability issues, the birth of multiple children at once, induced labor, misread signs of fetal distress, and convenience have led to more cesarean sections).

27. See Flamm, *supra* note 13, at 3-4.

A. Pro-Women

i. *Illinois v. Mother Doe (In re Baby Boy Doe)*²⁸

The Illinois Appellate Court placed itself staunchly in the pro-women camp. Mother Doe received treatment at a Chicago hospital during her pregnancy.²⁹ During a visit, Dr. Meserow, a board-certified OB/GYN affiliated with the hospital, examined her.³⁰ After some tests, he recommended a cesarean section or induced labor, which she refused on religious grounds.³¹ Even with an examination two weeks later, she still refused the recommended procedures, and the hospital sought appointment as the fetus's custodian.³² After a second medical opinion and a judicial hearing, the court denied the petition.³³

Even though the issue was resolved with the baby's birth, the parties appealed to settle the issue of compelled treatment because the situation could occur again.³⁴ The court did not address the earlier jurisdictional issue and focused on whether the circuit court "should have balanced the rights of the unborn but viable fetus . . . against the right of a competent woman to choose the type of medical care she deemed appropriate" ³⁵ The court rejected a balancing test, holding that a woman's right to refuse invasive medical treatment involving her pregnancy "must be honored, even in circumstances where the choice may be harmful to her fetus."³⁶

The court based its decision on the past precedent of *Stallman v. Youngquist*³⁷ and a person's right to refuse treatment.³⁸ The court also considered the uniqueness of pregnancy for women; even with pregnancy, a woman can refuse lifesaving or invasive treatment as she can without a pregnancy.³⁹ The court did not think that a "woman's rights can be subordinated to fetal rights."⁴⁰ While the court analyzed the four state countervailing interests, these interests did not override a woman's refusal.⁴¹ Thus, the Illinois Appellate Court concluded that courts should honor a woman's choice and not use a balancing test.

28. 632 N.E.2d 326 (Ill. App. Ct. 1994).

29. *Id.* at 326.

30. *Id.* at 326-27.

31. *Id.* at 327.

32. *Id.*

33. *Id.* at 328. A jurisdictional issue created some complications, and the appellate court suggested that the Juvenile Court Act was inapplicable. *Id.* The circuit court agreed, and the state filed an amended version of its petition. *Id.*

34. *Id.* at 329-30. Mother Doe vaginally delivered a healthy baby boy after the court denied the state's petition. *Id.* at 329.

35. *Id.* at 330.

36. *Id.*

37. 531 N.E.2d 355 (Ill. 1988).

38. *Baby Boy Doe*, 632 N.E.2d at 330-31.

39. *Id.* at 332.

40. *Id.* (citing *Stallman*, 531 N.E.2d at 361).

41. *Id.* at 334.

ii. *In re A.C.*⁴²

The District of Columbia Court of Appeals also joined the pro-women camp, but, due to the case's complexity, not as definitively as the Illinois Appellate Court. A.C. was a married, twenty-seven year old woman in remission from cancer.⁴³ During her pregnancy's twenty-fifth week, George Washington University Hospital discovered an inoperable tumor in her lung.⁴⁴ After discussing some options, A.C. had not decided whether she still wanted to give birth, and the hospital requested a declaratory judgment to deliver the fetus.⁴⁵ A dispute arose over whether A.C. consented to a cesarean section before twenty-eight weeks, and after several doctors' testimony, the court ordered a cesarean section.⁴⁶ When A.C. regained consciousness from her heavy sedation, doctors informed her of the order, but she appeared not to consent.⁴⁷ The court reconvened but still ordered the cesarean section.⁴⁸

Like *In re Baby Boy Doe*, this appeal addressed the issue after doctors performed the procedure because the situation could occur again. The court analyzed the issue under two standards. First, the court addressed a person's right to refuse treatment based on bodily integrity.⁴⁹ The court acknowledged that it could not "compel one person to permit a significant intrusion upon his or her bodily integrity for the benefit of another person's health."⁵⁰ The court also dismissed the idea that pregnant women should be held to a different standard due to their pregnancies. The court did not believe that a fetus had rights "superior to those of a person who has already been born."⁵¹ The court acknowledged that the right to refuse treatment did not exist exclusively in the common law and had "constitutional magnitude."⁵² Second, because A.C. appeared incompetent at the time, the court thought that the trial judge should have used substituted judgment to reach a decision.⁵³ To determine A.C.'s decision, the court should have considered her wishes, along with her treatment directions to family or friends.⁵⁴

Thus, the District of Columbia Court of Appeals determined that the trial court should not have used a balancing test to reach its decision.⁵⁵ The court,

42. 573 A.2d 1235 (D.C. Cir. 1990) (en banc).

43. *Id.* at 1238.

44. *Id.*

45. *Id.* at 1239.

46. *Id.* at 1239-40.

47. *Id.* at 1240-41. The hospital department thought that the family's wishes should be honored. *Id.* at 1240.

48. *Id.* at 1240-41. The judge relied on the District of Columbia's only decision on the issue, *In re Madyun*, 114 Daily Wash. L. Rptr. 2233 (D.C. Super. Ct. July 2, 1986). A.C.'s baby died a few hours after the surgery, and A.C. died two days later. *In re A.C.*, 573 A.2d at 1241.

49. *In re A.C.*, 573 A.2d at 1243.

50. *Id.* at 1243-44. The court also examined the four countervailing state interests, but these factors were quickly dismissed. *Id.* at 1245-49.

51. *Id.* at 1244.

52. *Id.*

53. *Id.* at 1249.

54. *Id.* at 1250-51.

55. *Id.* at 1247.

however, did not hold that a woman's refusal was absolute, because a situation involving "truly extraordinary or compelling reasons" might override her decision.⁵⁶

B. Pro-Fetus

i. Pemberton v. Tallahassee Memorial Regional Medical Center, Inc.⁵⁷

The United States District Court of Northern Florida joined the pro-fetus camp in 1999. In her second pregnancy, Ms. Pemberton wanted a vaginal birth.⁵⁸ Because doctors refused to perform a vaginal birth, she decided on a home birth with a midwife.⁵⁹ After more than a day of labor, she went to the hospital for fluids.⁶⁰ Dr. Thompson told Ms. Pemberton that a cesarean section was needed, which she refused.⁶¹ The hospital refused to provide fluids, and Ms. Pemberton left.⁶² The hospital sought a court order to compel treatment, and a hearing occurred at the hospital.⁶³ Additionally, the judge ordered Ms. Pemberton to appear at the hospital, and law enforcement forced her to return against her will.⁶⁴ The hearing resulted in a court ordered cesarean section, which was then performed.⁶⁵ Ms. Pemberton sued the hospital for violating her constitutional rights of bodily integrity, the right to refuse treatment, and the right to make important decisions about bearing children "without undue governmental interference."⁶⁶

The court acknowledged Ms. Pemberton's constitutional rights but determined that the state's interest "in preserving the life of the unborn child" outweighed her rights.⁶⁷ The court based its conclusions on *Roe v. Wade*,⁶⁸ in which the Supreme Court "recognized the state's interest in preserving a fetus as it progresses toward viability."⁶⁹ The *Pemberton* court based the imperativeness of the procedure on two rationales: the fetus's imminent birth and the mother's desire to avoid a specific procedure, not the birth itself.⁷⁰ The

56. *Id.* The court did not overrule *In re Madyun*, in which the court had compelled a cesarean section. The concurrence agreed with this result, but advocated a balancing test because A.C.'s situation was different "from those other potential patients for medical procedures that will aid another person, for example, a potential donor of bone marrow for transplant." *Id.* at 1256 (Belson, J., concurring in part and dissenting in part).

57. 66 F. Supp. 2d 1247 (N.D. Fla. 1999).

58. *Id.* at 1249.

59. *Id.* Ms. Pemberton's first pregnancy resulted in a vertical cesarean section, and vertical incisions are more likely to cause uterine rupture if vaginal delivery is attempted during subsequent pregnancies. *Id.*

60. *Id.*

61. *Id.*

62. *Id.*

63. *Id.* at 1250.

64. *Id.*

65. *Id.*

66. *Id.* at 1251.

67. *Id.*

68. 410 U.S. 113 (1973).

69. *Pemberton*, 66 F. Supp. 2d at 1251.

70. *Id.*

risk of uterine rupture, which could have injured or killed Ms. Pemberton and her fetus, as well as the fact that “medicine is not an exact science,” tipped the balance in favor of a cesarean section.⁷¹

ii. *Jefferson v. Griffin Spalding County Hospital Authority*⁷²

The Georgia Supreme Court first considered the issue of compelled cesarean sections in 1981 and held that a woman could be compelled to have a cesarean section. Ms. Jefferson went to Griffin Spalding County Hospital for prenatal treatment, where the hospital informed her that she had placenta previa.⁷³ The doctor told Ms. Jefferson that a cesarean section was necessary to preserve her life, as well as her fetus.⁷⁴ Ms. Jefferson refused the surgery, as well as blood transfusions, on religious grounds, and the hospital sought to determine whether the fetus “ha[d] any legal right to the protection of the Court.”⁷⁵

The *Jefferson* court also cited *Roe* in its analysis and held that a viable fetus merited state protection based on the Constitution and “statutes prohibiting the arbitrary termination of the life of an unborn fetus.”⁷⁶ A Georgia criminal statute on abortion reinforced this belief, and, as a result, the Georgia Supreme Court found that the state’s duty to protect the fetus outweighed Ms. Jefferson’s refusal.⁷⁷ The court determined that “the life of defendant and of the unborn child are, at the moment, inseparable, . . . [and deemed] it appropriate to infringe upon the wishes of the mother to the extent it [was] necessary to give the child an opportunity to live.”⁷⁸ Thus, the Georgia Supreme Court ordered Ms. Jefferson to undergo a cesarean section.

IV. REASONS SUPPORTING A WOMAN’S RIGHT TO REFUSE

Four courts have addressed the issue of court ordered cesarean sections, but the judicial system has not yet reached a consensus. States often try to obtain authority over the fetus through juvenile laws or child neglect statutes.⁷⁹ These statutes often contain language on parents and their omissions to provide

71. *Id.* at 1253-54. The court, however, noted that if the case had not been “extraordinary and overwhelming,” then Ms. Pemberton, rather than the state, would have had the “right to decide.” *Id.* at 1254.

72. 274 S.E.2d 457 (Ga. 1981) (per curiam).

73. *Id.* at 458. Placenta previa “is an abnormal implantation of the placenta at or near the internal opening of the uterine cervix so that it tends to precede the child at birth usually causing severe maternal hemorrhage.” MEDLINE PLUS, Medical Dictionary, Placenta Previa, MERRIAM WEBSTER, <http://www2.merriam-webster.com/cgi-bin/mwmednlm?book=Medical&va=placenta%20previa> (last visited Oct. 13, 2010).

74. *Jefferson*, 274 S.E.2d at 458.

75. *Id.*

76. *Id.* (citing *Roe v. Wade*, 410 U.S. 113 (1973)).

77. *Id.* at 460.

78. *Id.* at 458. While the concurring judge noted a possible jurisdictional issue involving the juvenile court and concerns about interfering with religious freedom, he believed that the risks merited intervention. *Id.* at 460-62 (Hill, J., concurring).

79. See D.C. CODE § 4-1321.01 (2001); FLA. STAT. ANN. § 827.03(3)(a) (West 2006); GA. CODE ANN., § 49-5-180(5)(b) (2006); MICH. COMP. LAWS ANN. § 722.622(f) (West 2002); TENN. CODE ANN. §§ 39-15-401 to -402 (2003 & Supp. 2010).

medical treatment, and states use this language to argue that women have an obligation to provide medical treatment for their fetuses.⁸⁰ Two courts have found the states' arguments on this topic, in conjunction with other state interests, to prevail when a balancing test is used.⁸¹ Two other courts refused to use a balancing test and did not find these arguments persuasive enough to override the woman's choice.⁸² Two arguments, however, exist for refusing a cesarean section and not using a balancing test to resolve the situation: a right to privacy and no duty to rescue another person.

V. RIGHT TO REFUSE BASED ON A PERSON'S RIGHT TO PRIVACY

A. Based on Abortion Law

While the Constitution "does not explicitly mention any right of privacy,"⁸³ the Supreme Court has found that privacy rights exist in "specific guarantees in the Bill of Rights" by penumbras.⁸⁴ These privacy rights encompass "the refusal of medical treatment, marriage, contraception, procreation, family relationships, and child rearing" and merit protection under various amendments.⁸⁵ The Supreme Court has held that "the right of privacy is a fundamental personal right, emanating 'from the totality of the constitutional scheme under which we live.'"⁸⁶ When judges decide on fundamentality, they "are not left at large to decide cases in light of their personal and private notions. Rather, they must look to the 'traditions and (collective) conscience of our people' to determine whether a principle is 'so rooted (there) . . . as to be ranked as fundamental.'"⁸⁷

The Supreme Court expanded the right to privacy even further with *Roe v. Wade*. The Supreme Court extended the right to a woman's decision surrounding an abortion, though this right was not absolute.⁸⁸ States could limit a woman's rights if a "compelling state interest" existed.⁸⁹ The state's interests encompassed the rights "in safeguarding health, in maintaining medical

80. See OKLA. STAT. ANN. tit. 21 § 852(A) (West 2002 & Supp. 2010) ("[A]ny parent . . . having custody or control of a child . . . who willfully omits, without lawful excuse, to furnish necessary food, clothing, shelter, monetary child support, *medical attendance* . . .") (emphasis added).

81. See *Pemberton v. Tallahassee Mem'l Reg'l Med. Ctr., Inc.*, 66 F. Supp. 2d 1247 (N.D. Fla. 1999); *Jefferson v. Griffin Spalding Cnty. Hosp. Auth.*, 274 S.E.2d 457 (Ga. 1981) (per curiam).

82. See *In re Baby Boy Doe*, 632 N.E.2d 326 (Ill. App. Ct. 1994); *In re A.C.*, 573 A.2d 1235 (D.C. Cir. 1990) (en banc).

83. *Roe v. Wade*, 410 U.S. 113, 152 (1973).

84. *Griswold v. Connecticut*, 381 U.S. 484, 484 (1965).

85. Eric M. Levine, Comment, *The Constitutionality of Court-Ordered Cesarean Surgery: A Threshold Question*, 4 ALB. L.J. SCI. & TECH. 229, 256 (1994).

86. *Griswold*, 381 U.S. at 494 (Goldberg, J., concurring) (quoting *Poe v. Ullman*, 367 U.S. 497, 517 (1965) (Douglas, J., dissenting)).

87. *Id.* at 493 (Goldberg, J., concurring) (quoting *Snyder v. Massachusetts*, 291 U.S. 97, 105 (1934)).

88. *Roe v. Wade*, 410 U.S. 113, 154 (1973). The Supreme Court stated, "The pregnant woman cannot be isolated in her privacy. She carries an embryo and, later, a fetus, if one accepts the medical definitions of the developing young in the human uterus." *Id.* at 159.

89. *Id.* at 156.

standards, and in protecting potential life.”⁹⁰ Thus, states could regulate abortions when their interests became compelling, but not before that time.

In *Colautti v. Franklin*,⁹¹ the Supreme Court limited the state’s regulation when the Court overturned a Pennsylvania statute that required a doctor to use “the abortion technique ‘which would provide the best opportunity for the fetus to be aborted alive so long as a different technique would not be necessary in order to preserve the life or health of the mother.’”⁹² When examining the statute, the Supreme Court focused on the statute’s use of the word necessary in the context of selecting techniques to perform abortions.⁹³ The Court stated that the use of the word necessary implied “that a particular technique must be indispensable to the woman’s life or health—not merely desirable—before it may be adopted” when the doctor used an abortion technique which did not “provide the best opportunity for the fetus to be aborted alive.”⁹⁴ Thus, the doctor might engage in “a trade-off” between fetal survival and a woman’s health, which was undesirable.⁹⁵ The Supreme Court reaffirmed the idea of no trade-offs between a woman’s health and her fetus’s survival in *Thornburgh v. American College of Obstetricians and Gynecologists*.⁹⁶ In this case, the Supreme Court noted that “no individual should be compelled to surrender the freedom to make [reproductive decisions] for herself simply because her ‘value preferences’ are not shared by the majority.”⁹⁷

While these cases expanded on *Roe*, they also called its holding into question, and the Supreme Court re-examined the abortion issue in *Planned Parenthood of Southeastern Pennsylvania v. Casey*.⁹⁸ The Supreme Court’s holding had three parts: a woman enjoyed a right to obtain an abortion without state interference before viability, the state held a right to restrict abortions after viability unless the woman’s health was in danger, and the state possessed legitimate interests in protecting the fetus’s life and the woman’s health.⁹⁹ The Supreme Court, however, couched these rights in relation to a woman’s unique biological situation and reasoned, “the destiny of the woman must be shaped to a large extent on her own conception of her spiritual imperatives and her place in society.”¹⁰⁰ The Supreme Court noted that a state should not insist “upon its own vision of the woman’s role, however dominant that vision has been in the

90. *Id.* at 154. The Supreme Court, however, did not include the fetus in the definition of “person,” within the meaning of the Fourteenth Amendment, and states could not limit abortion when it was “necessary, in appropriate medical judgment, for the preservation of the life or health of the mother.” *Id.* at 158, 164-65.

91. 439 U.S. 379 (1979).

92. *Id.* at 390 (quoting PA. STAT. ANN. § 6605(a) (West 1977), *invalidated by Colautti*, 439 U.S. 379, 401 (1979)).

93. *Id.* at 400.

94. *Id.* at 390.

95. *Id.* at 400-01.

96. 476 U.S. 747, 769 (1986), *overruled by Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833 (1992).

97. *Id.* at 777 (Stevens, J., concurring).

98. 505 U.S. 833 (1992).

99. *Id.* at 846.

100. *Id.* at 852.

course of our history and our culture,” and the right to abortions has allowed women to achieve equality in American society.¹⁰¹ A state, however, can regulate abortions after viability and even provide information to ensure that the woman makes an informed choice.¹⁰² At the same time, the state’s decision to provide information cannot cause an “undue burden” on women.¹⁰³ In spite of this new test, the Supreme Court reaffirmed a woman’s right to have an abortion, and found that a fetus was still not considered a person with a right to life under the Fourteenth Amendment.¹⁰⁴

i. Analysis of Refusal Based on Abortion Law

Under *Roe* and its progeny, women enjoy a right to privacy in their reproductive decisions, though states can limit this right through their compelling interest in protecting potential life. Some courts often use this limitation to compel a “pregnant woman to undergo treatment intended to benefit a viable fetus,” especially cesarean sections.¹⁰⁵ The argument’s rationale depends on women’s reproductive rights not being absolute: because the rights are not absolute, and because the fetus could viably “live outside the womb,” the state invokes its compelling interest in protecting life.¹⁰⁶ Thus, the state must balance the fetus’s viability against the only exception in post-viability abortion law—preservation of the life or health of the woman. If the woman is not endangered, then some courts assert that she must undergo treatment to benefit the fetus and further the state’s compelling interest.

This argument, however, misinterprets *Roe* and its progeny.¹⁰⁷ First, *Roe* allows states to prohibit abortions after viability, but the case does not mention anything about compelling treatment “to promote fetal health.”¹⁰⁸ Second, states cannot compel trade-offs between the woman and her fetus.¹⁰⁹ If states cannot impose trade-offs for post-viability abortions, “then they must be unconstitutional for deliveries as well.”¹¹⁰ Doctors who pursue cesarean sections have “presumably determined that the risks to maternal life or health justify performing the cesarean section over vaginal delivery.”¹¹¹ Thus, the fetus’s chances of survival improve if doctors perform a cesarean section. The

101. *Id.*

102. *Id.* at 872-75.

103. *Id.* at 877. The Supreme Court adopted an “undue burden” test. An undue burden occurs when “a state regulation has the purpose or effect of placing a substantial obstacle in the path of a woman seeking an abortion of a nonviable fetus.” *Id.*

104. *Id.* at 913-14 (Stevens, J., concurring in part and dissenting in part); see *Roe v. Wade*, 410 U.S. 113, 158 (1973).

105. Lawrence J. Nelson & Nancy Milliken, *Compelled Medical Treatment of Pregnant Women: Life, Liberty, and Law in Conflict*, 259 JAMA 1060, 1062 (1988).

106. Levy, *supra* note 20, at 102.

107. See Nelson & Milliken, *supra* note 105, at 1062.

108. *Id.*

109. See *Colautti v. Franklin*, 439 U.S. 379, 400-01 (1979).

110. Nancy K. Rhoden, *The Judge in the Delivery Room: The Emergence of Court-Ordered Cesareans*, 74 CAL. L. REV. 1951, 1992 (1986).

111. Levine, *supra* note 85, at 261; see Rhoden, *supra* note 110, at 1192 (stating that doctors “are unlikely to seek court orders for surgery when there is only *some* indication that surgery would be preferable”).

woman's chances of death or post-surgery complications, however, increase with cesarean sections as opposed to women who give birth vaginally.¹¹² Thus, a trade-off occurs between the woman and the fetus, which violates the constitutional standards established in *Colautti* and reaffirmed in *Thornburgh*.

Additionally, engaging in a trade-offs analysis places a value judgment on women. States "assume that [women] owe this duty as a matter of course. This assumption . . . appears to rest upon a conception of women's role that has triggered the protection of the Equal Protection Clause."¹¹³ This perception of women, however, is "no longer consistent with our understanding of the family, the individual, or the Constitution."¹¹⁴ Times have changed, and women are no longer in the kitchen barefoot and pregnant. A balancing test causes the courts to engage in a trade-off between the woman and the fetus and shows the courts' indifference to an "individual's freedom to make such judgments."¹¹⁵

While most women would willingly make a trade-off for their fetuses, the courts should be "constitutionally barred from forcing [her] to undergo medical treatment for the sake of the fetus if that treatment endangers her life and health in any way."¹¹⁶ States possess a compelling interest in potential life, but this interest does not imply that a trade-off must occur. By engaging in a trade-off, the courts have determined that the woman's risks are less than the fetus's risks.

Thus, based on a right to reproductive privacy, the courts should not apply a balancing test. By making a trade-off between the woman's rights and fetus's rights, the courts violate the constitutional principles established in *Roe* and its progeny.

B. Based on Informed Consent and Bodily Integrity

Courts may honor a refusal of a cesarean section under a right to reproductive privacy, but a stronger justification is the right to refuse medical treatment based on informed consent and bodily integrity. Pregnancy, however, is a conundrum in the legal and medical fields because by refusing treatment, the woman exercises her right of refusal, but the fetus never has an opportunity to refuse. While this challenge does exist, the woman's right to refuse stems from her right to privacy through informed consent, as well as bodily integrity, and outweighs the state's four countervailing interests, which means that courts have no reason to use a balancing test.

Any medical procedure requires the patient's (or guardian's) consent. Without consent, the doctor will commit an assault and a trespass on the patient regardless of the procedure's success or failure.¹¹⁷ Consent is critical because society considers that "no right is more sacred or is more carefully guarded by

112. Rhoden, *supra* note 110, at 1992. Some rare situations exist in which a vaginal delivery has as much risk as a cesarean delivery. *Id.*

113. *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 928 (1992) (Blackmun, J., concurring in part and dissenting in part).

114. *Id.* at 897 (majority opinion).

115. *Id.* at 916 (Stevens, J., concurring in part and dissenting in part).

116. See Nelson & Milliken, *supra* note 105, at 1062.

117. See *Schloendorff v. Soc'y of N.Y. Hosp.*, 105 N.E. 92, 93 (N.Y. 1914), *overruled by* *Bing v. Thunig*, 143 N.E.2d 3 (N.Y. 1957).

the common law than the right of every individual to the possession and control of his own person, free from all restraint or interference of others, unless by clear and unquestionable authority of law.”¹¹⁸ The idea of bodily integrity helped to develop the informed consent doctrine because “every human being of adult years and sound mind has a right to determine what shall be done to her own body.”¹¹⁹ Thus, doctors could only operate with patient consent unless an emergency arose with an unconscious patient that required a necessary operation.¹²⁰ While “general consent” was sufficient early on, courts began to require that doctors inform their patients of surgery’s risks, possible outcomes, and necessary follow-ups if these factors materially affected the patient’s decision.¹²¹ Patients generally lack medical training, and, to make the right decision, they must understand the important issues related to treatment.¹²² Thus, doctors became liable if they did not disclose these issues regarding the impending procedure to their patients.

In the seminal case *Canterbury v. Spence*,¹²³ the United States Court of Appeals in the District of Columbia shaped the informed consent doctrine. In this case, a young man consented to surgery on a ruptured disc.¹²⁴ The surgery appeared uneventful, but the man fell out of bed, which resulted in complications,¹²⁵ and the patient suffered paralysis below the waist.¹²⁶ The operation had a one percent chance of paralysis, which the patient was unaware of prior to surgery.¹²⁷ The patient believed that the doctor should have informed him of this risk because it would have affected his decision.¹²⁸ The court held that the doctor had a duty to inform the patient about the treatment’s risks if they materially affected the patient’s decision.¹²⁹ With this standard, informed consent “has become firmly entrenched in American tort law” and indicates the importance of respect for patient autonomy, even if the doctor considers the decision ridiculous or neurotic.¹³⁰

While informed consent provides patients with information to decide whether to pursue the treatment, a corollary to this right exists. If patients have a choice about consenting to a procedure, then “the patient generally possesses the right to not consent . . . to refuse treatment.”¹³¹ This right to refuse medical treatment has a basis in “a constitutional right of privacy,” which encompasses Fourteenth Amendment issues, and a “common law right to self determination

118. *Union Pac. Ry. Co. v. Botsford*, 141 U.S. 250, 251 (1891).

119. *Schloendorff*, 105 N.E. at 93.

120. *See id.*

121. *Canterbury v. Spence*, 464 F.2d 772, 786-87 (D.C. Cir. 1972).

122. *See Levine, supra* note 85, at 272.

123. 464 F.2d 772 (D.C. Cir. 1972).

124. *Id.* at 777.

125. *Id.*

126. *Id.*

127. *Id.* at 778.

128. *Id.*

129. *Id.* at 787.

130. *Cruzan ex rel. Cruzan v. Dir., Mo. Dep’t of Health*, 497 U.S. 261, 269 (1990); *see Rhoden, supra* note 110, at 1970.

131. *Cruzan*, 497 U.S. at 270.

and informed consent."¹³² Thus, people may refuse medical treatment even if the decision results in their deaths.¹³³ Even if medical technology could restore a person to perfect health, the courts generally abide by the patient's decision.¹³⁴

While the right to refuse medical treatment "has come to be widely recognized and respected by the courts of the nation," this right, like women's abortion rights, is not absolute.¹³⁵ States possess interests that counter the patient's right to refuse treatment: "the preservation of life, the protection of the interests of innocent third parties, the prevention of suicide, and the maintenance of the ethical integrity of the medical profession."¹³⁶ Pregnancy, however, creates a unique quandary with refusal of treatment: can a pregnant woman refuse treatment even if the fetus could suffer harm? Supporters of court ordered cesarean sections argue that the four countervailing state interests outweigh the rights of self-determination, informed consent, and bodily integrity. This argument, however, fails to overcome these long established rights of every free person in the United States.

i. The Four State Factors

1. Preservation of Life

First, the preservation of life is often considered the most important state interest, and the state may "assert an unqualified interest in the preservation of human life."¹³⁷ This interest is very compelling when the person's life "can be saved where the affliction is curable," but the state must acknowledge "an individual's right to avoid circumstances in which the individual . . . would feel that efforts to sustain life demean or degrade [her] humanity."¹³⁸ While courts recognize that the refusal of treatment involves a person's quality of life and should be left to the patient, they often examine other factors like recovery chances, the treatment's invasiveness, and "the patient's desires and experience of pain and enjoyment."¹³⁹ When a person can regain good health through a minimally invasive procedure, like a blood transfusion, the preservation of life interest becomes more compelling.¹⁴⁰ Despite the increased value, courts have upheld a patient's decision to refuse a minimally invasive and possibly life saving treatment.¹⁴¹

132. *Id.* at 272.

133. *Id.* at 273.

134. *See In re Osborne*, 294 A.2d 372, 375 (D.C. 1972) (upholding a Jehovah's Witness's decision to refuse a potentially life-saving blood transfusion).

135. *Brophy v. New Eng. Sinai Hosp., Inc.*, 497 N.E.2d 626, 633 (Mass. 1986); *see Cruzan*, 497 U.S. at 270.

136. *Cruzan*, 497 U.S. at 271.

137. *Id.* at 282.

138. *Brophy*, 497 N.E.2d at 635.

139. *Id.* at 635-36. (stating that the wife of a man in a persistent vegetative state could have her husband's feeding tube removed and discontinue his artificial means of survival).

140. *See Raleigh Fitkin-Paul Morgan Mem'l Hosp. v. Anderson*, 201 A.2d 537, 538 (1964) (per curiam) (holding that hospitals may administer blood transfusions if necessary to save a woman's life or the life of her child).

141. *In re Osborne*, 294 A.2d 372, 375 (D.C. 1972).

If the procedure's invasiveness increases and requires surgery, then the state's interest becomes less compelling as the patient's autonomy is infringed. Courts are less willing to override a patient's decision if "the procedure may threaten the safety or health of the individual."¹⁴² In *Winston v. Lee*,¹⁴³ the Supreme Court refused to compel a surgery to remove a bullet for evidence because of the surgery's risks to the suspect.¹⁴⁴ The concerns over a surgery's risks also occur in pregnancy cases. A Massachusetts court refused to compel a woman to undergo a purse string operation during her pregnancy, which would have required suturing the woman's cervix to ensure that it "[would] hold the pregnancy."¹⁴⁵ The state had not proven whether the operation was necessary, whether the pregnancy could not be carried to term without the procedure, and what the risks of impact on the woman were.¹⁴⁶ These types of concerns affect the court's view of whether an invasive medical procedure helps or hurts the state's preservation of life argument.

a. Analysis of the Preservation of Life

Cesarean sections support the state's preservation of life argument because the outcome generally results in a success for all parties, but success is not enough. Cesarean sections may improve the fetus's chance to be restored to full health, but the procedure, with its increased morbidity and mortality rates, actually places the woman's life at risk.¹⁴⁷ The woman has a greater chance of dying with a cesarean section, which implies that the state is gambling with the woman's life. The state claims a desire to preserve the lives of both parties, but it places the woman, who is likely a productive member of society, at risk for the chance that the fetus will become a productive member of society. The state's logic contains flaws and appears counterintuitive.

Additionally, a cesarean section is incredibly invasive for a woman. The doctor cuts through several layers of tissue and enters her body to remove the fetus.¹⁴⁸ This level of invasiveness surpasses the level that the Supreme Court has considered unacceptable.¹⁴⁹ The invasiveness and number of incisions required in a cesarean section also increase the woman's chances for infection, which places her life at risk again.¹⁵⁰ Thus, the state's interest in preserving life appears unmet by compelling a woman to undergo a cesarean section. While the state may preserve the fetus's life, the woman's life may not be saved, which

142. *Winston v. Lee*, 470 U.S. 753, 761 (1985).

143. 470 U.S. at 753.

144. *Id.* at 764-65. (referring to the Fourth Circuit's refusal to compel the surgery because "the greater intrusion and the larger incisions increase the risks of infection").

145. *Taft v. Taft*, 446 N.E.2d 395, 396-97 (Mass. 1983).

146. *Id.*

147. *See supra* Part II.

148. *See id.*

149. *See Winston*, 470 U.S. at 764 (suggesting that surgery to remove a bullet without the patient's consent was an intrusion of personal privacy and integrity as it would require probing the muscle tissue and could result in damage to the muscles and nerves); *Taft*, 446 N.E.2d at 397 (holding that a purse string operation may unjustifiably restrict a woman's constitutional right to privacy as it would involve surgery to suture her cervix to hold the pregnancy).

150. *See Winston*, 470 U.S. at 764; *supra* Part II.

appears to defeat the state's overall goal. This interest, however, usually involves only one patient, not two, and to address the situation fully, this argument must consider the protection of innocent third parties.

2. Protection of Innocent Third Parties

Second, the state has an interest in the protection of innocent third parties. This interest may not have the most significance in right to refuse cases, but in cesarean sections cases, it acquires pertinence because the woman determines the fetus's fate as well as her own. Courts often cite this factor in overriding a patient's refusal if the patient already has minor children.¹⁵¹ In these situations, the state's main concern involves the child's emotional well-being to have two parents.¹⁵² Additionally, the state has concerns about children becoming a burden to the state.¹⁵³ Courts believe that parents should not be permitted "to abandon a child" and that parents have "a responsibility to the community to care" for their children.¹⁵⁴ If the courts think that extended family and financial planning adequately meet these factors, then they will likely uphold a patient's decision.

a. Analysis of the Protection of Innocent Third Parties

This argument is strong, but it still does not override the woman's right to refuse because it applies to children already born. As stated earlier, courts do not consider fetuses, unlike children already born, to be people under the Fourteenth Amendment.¹⁵⁵ Courts considered situations that involved protecting already born children from abandonment.¹⁵⁶ Fetuses should not receive an unfair expansion of their rights over a grown woman's rights when the fetuses have not merited those protections yet.¹⁵⁷ The fetus may not survive childbirth or may be stillborn, which means that the doctor cut open the woman's body for no reason. Additionally, these cases and courts have focused mainly on whether the child might be abandoned and become a burden to the state.¹⁵⁸ A woman's refusal of a cesarean section, however, may not necessarily result in the fetus becoming a ward of the state. The woman may deliver naturally with no complications.¹⁵⁹ The fetus could die during or prior to childbirth, or because of the compelled procedure the woman and fetus could

151. See *In re President & Dir. of Georgetown Coll., Inc. (In re Georgetown)*, 331 F.2d 1000, 1008 (D.C. Cir. 1964); *In re Osborne*, 294 A.2d 372, 374 (D.C. 1972); *In re Dubreuil*, 629 So. 2d 819, 824-25 (Fla. 1994); *In re Jamaica Hosp.*, 491 N.Y.S.2d 898, 900 (N.Y. Sup. Ct. 1985).

152. See *Dubreuil*, 629 So. 2d at 826.

153. See *Osborne*, 294 A.2d at 374; *Dubreuil*, 629 So. 2d at 827 n.12 (noting that the state's only concern was "that the children would be cared for and would not be a burden on the State" when their mother refused a blood transfusion).

154. *Georgetown*, 331 F.2d at 1008.

155. See *supra* Part V.A.

156. See *Georgetown*, 331 F.2d at 1008; *Jamaica Hosp.*, 491 N.Y.S.2d at 900.

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

158. See *Georgetown*, 331 F.2d at 1008; *Osborne*, 294 A.2d at 374; *Dubreil*, 629 So. 2d 819, 825 (Fla. 1994) (citing *Wons v. Pub. Health Trust*, 500 So. 2d 679, 688 (Fla. Dist. Ct. App. 1987)).

159. See *In re Baby Boy Doe*, 632 N.E.2d 326, 329 (Ill. App. Ct. 1994) (stating that the mother delivered the fetus naturally before the court resolved the proceedings).

die on the operating table. In all of these situations, the fetus does not become a ward of the state. The fetus, however, has a greater chance of becoming a ward of the state because of the cesarean section's increased morbidity and mortality rates to the woman during and after surgery.¹⁶⁰ Thus, the state preserves the fetus's life by a cesarean section, but the state does not protect all of the fetus's interests. The woman could die from the cesarean section, which could cause the fetus to become a ward of the state and deprives the fetus of having two parents. Like the state's preservation of life argument, this argument could still lead, ironically, to the fetus becoming a ward of the state or having one or no parents, which completely defeats the state's overall goal.

3. Prevention of Suicide

Third, the prevention of suicide is a weak argument. By refusing a "life sustaining treatment," courts should not view a patient as "attempt[ing] to commit suicide."¹⁶¹ This rationale works for two reasons. First, even if the refusal results in death, the death would be due to "the underlying disease, and not the result of a self inflicted injury."¹⁶² Second, a person may wish to live but without the specific treatment.¹⁶³ Neither of these reasons fit the concept of suicide. Suicide is defined as "taking one's life," the act is intentionally done, and the person often lacks the will to live.¹⁶⁴ These factors, however, can be misconstrued in a woman's refusal and used as a way to circumvent her refusal.

a. Analysis of Prevention of Suicide

If a woman refuses a cesarean section, she is not trying to commit suicide. She, like a Jehovah's Witness refusing blood, chooses a different path from the one that doctors prefer. This choice may increase her chances of dying, but the situation may unfold with no complications and without the undesired treatment.¹⁶⁵ She is not intentionally killing herself. Additionally, a woman who carries a pregnancy to term seems like an unlikely candidate for suicide. If she were suicidal, why would she go to the hospital? She could stay home and do nothing. Plus, most women would not give birth and abandon the child with their deaths.

Finally, living in the technologically advanced twenty-first century, a woman has more than one delivery option, which itself implies a choice. If she lived during the sixteenth century, then she would have had no other option than to give birth vaginally until the fetus was born, or she died, which would then result in a cesarean section. Now, the woman who refuses a cesarean section merely allows nature to take its course, which is not the same as imposing an intentional, self-inflicted injury. While some might fail to

160. See *supra* Part II.

161. *Brophy v. New Eng. Sinai Hosp. Inc.*, 497 N.E.2d 626, 638 (Mass. 1986).

162. *Id.*

163. See, e.g., *In re Osborne*, 294 A.2d 372, 374 (D.C. 1972) (The patient, a Jehovah's Witness, stated, "I wish to live, but with no blood transfusions.").

164. BLACK'S LAW DICTIONARY 1475 (8th ed. 2004); see *In re Georgetown*, 331 F.2d 1000, 1009 (D.C. Cir. 1964).

165. *In re Baby Boy Doe*, 632 N.E.2d 326, 329 (Ill. App. Ct. 1994) (noting that the mother delivered the fetus naturally before the court could determine if a compelled cesarean section was necessary).

understand her decision or view it as irrational, the decision is hers to make as an autonomous individual. The state's suicide argument is weak because the refusal, while an intentional choice, is not a self-inflicted injury. Also, the woman may not die from her refusal, which obliterates the factor of taking one's life because death is not guaranteed. The state's argument on this interest appears so incredulous because a woman, who likely nurtured and cared for the fetus until delivery, does not mesh with society's vision of a suicidal person.

4. Maintenance of the Ethical Integrity of the Medical Profession

Finally, the maintenance of the ethical integrity of the medical profession does not support the pro-fetus camp. Courts generally do not require doctors or hospitals to violate their moral or ethical principles and do allow them to refuse to withhold "treatment if they believe that it will cause the patient's death."¹⁶⁶ Thus, if the doctors do not want to perform a court ordered cesarean section due to the belief that it will cause the patient's death, they do not have to perform the procedure. This scenario, however, will likely not occur because doctors often seek court approval for the procedure.

Professional societies, however, have taken a stance on the issue and "suggest that doctors accede to the patients' and families' needs and wishes . . ." ¹⁶⁷ In fact, the American College of Obstetricians and Gynecologists (ACOG) and the American Medical Association (AMA) believe that the final decision on cesarean sections belongs to the woman.¹⁶⁸ The ACOG states:

Once a patient has been informed of the material risks and benefits involved with a treatment, test, or procedure, that patient has the right to exercise full autonomy in deciding whether to undergo the treatment, test, or procedure, or whether to make a choice among a variety of treatments, tests or procedures. In the exercise of that autonomy, the informed patient also has the right to refuse to undergo any of these treatments, tests, or procedures. . . . Such a refusal [of consent] may be based on religious beliefs, personal preference, or comfort.¹⁶⁹

Although some doctors disagree with the ACOG's perspective, the ACOG and AMA's statements undermine the state's argument "that professional integrity supports compulsory treatment."¹⁷⁰

a. Analysis of Maintenance of the Ethical Integrity of the Medical Profession

If the woman refuses treatment, the doctor must abide by her decision. Ethically, the patient's decision binds the doctors, which the ACOG's committee opinion supports. Doctors may not agree with the decision ethically or morally, but unless they want to commit a battery or disrespect a patient's wishes by obtaining a court order, they must accept the decision. Additionally, courts

166. *Brophy*, 497 N.E.2d at 632, 639.

167. ROSEN & THOMAS, *supra* note 1, at 88.

168. See LYNN M. PALTROW, NAT'L ADVOCATES FOR PREGNANT WOMEN, COERCIVE MEDICINE (2004), available at http://advocatesforpregnantwomen.org/file/Coercive_Medicine.pdf.

169. *Id.* (quoting AM. COLL. OF OBSTETRICIANS & GYNECOLOGISTS, INFORMED REFUSAL, Op. No. 237 (2000)).

170. Rhoden, *supra* note 110, at 1972.

should realize that by granting a court order, they act counter to the medical community's standards, which were promulgated for the doctors' benefit.¹⁷¹

Courts must consider the ethical implications of compelling the cesarean section due to the doctors' ethical obligation to honor the patient's wishes and to do no harm. By forcing a woman to undergo a cesarean section, the doctors, with court approval, violate this oath. The doctors inflict mental, as well as physical harm, on the woman by disregarding her wishes, cutting her open, and removing her fetus in an undesired manner. Thus, courts must maintain the doctors' ethical integrity by upholding the woman's right to refuse treatment. The ACOG's standards and the Hippocratic Oath derail the state's argument that the profession's integrity supports mandated treatment.

Taking all of these factors together, the state's interests do not outweigh a woman's right to refuse medical treatment. Once a doctor fully informs the woman of the surgery's benefits and the risks of refusal, the doctors and courts should abide by her decision. Courts should not use a balancing test that weighs her privacy rights against the fetus's rights. Her right to privacy based on informed consent and bodily integrity trump the state's countervailing interests.

VI. RIGHT TO REFUSE BASED ON NO DUTY TO RESCUE ANOTHER

Besides a right to refuse based on the right to privacy, women also have an argument involving the common law idea of no duty to rescue another person and equal protection under the law. This argument refutes claims that pregnant women have a duty to rescue their fetuses. Any "rescue obligation" violates the Fourteenth Amendment and perpetuates a paternalistic society.

A persistent idea in American law is that one does not have a duty to rescue another person.¹⁷² While early contemplations of the law considered active and passive roles in the risk separately, the law now considers these roles together.¹⁷³ The overall idea, however, has not changed: "an actor whose conduct has not created a risk of physical harm to another has no duty of care to the other" unless a court determines that an "affirmative" duty exists.¹⁷⁴ Thus, a person has "no duty of care when another is at risk for reasons other than the conduct of the actor, even though the actor may be in a position to help . . ."¹⁷⁵

This idea, however, is qualified by the existence of special relationships, which establish an affirmative duty to act.¹⁷⁶ These relationships range from innkeepers and guests; landlords and tenants; and common carriers and passengers.¹⁷⁷ The exception also encompasses custodians who are "required by law to take custody . . . of the other" and "[have] a superior ability to protect the

171. See PALTROW, *supra* note 168.

172. RESTATEMENT (SECOND) OF TORTS § 314 (1965).

173. See RESTATEMENT (THIRD) OF TORTS HARM § 37 cmt. a (Proposed Final Draft Apr. 6, 2005).

174. *Id.* § 37.

175. *Id.* § 37 cmt. b.

176. *Id.* § 40(a) ("An actor in a special relationship with another owes the other a duty of reasonable care with regard to risks that arise within the scope of the relationship.").

177. See *id.* § 40(b).

other.”¹⁷⁸ Parents and their dependent children belong in the custodian exception.¹⁷⁹ Thus, parents usually have a duty to rescue their children. Without a special relationship, a person generally has no duty to rescue another because this country has a tradition of siding with individual freedom and autonomy.¹⁸⁰

While people do not have a duty to rescue others, they try to compel rescue in certain contexts, like organ donation and bone marrow. In *McFall v. Shimp*,¹⁸¹ Mr. McFall had a bone marrow disease, and without a transplant, he would die.¹⁸² Mr. Shimp matched Mr. McFall as a donor, but he refused to donate.¹⁸³ The Pennsylvania court acknowledged that the common law provided “that one human being is under no legal compulsion to give aid or to take action to save another human being or to rescue.”¹⁸⁴ The court also noted that society respected a person and wanted to prevent an “individual from being invaded and hurt by another.”¹⁸⁵ The court held that Mr. Shimp could not be compelled “to submit to an intrusion of his body” because it “would defeat the sanctity of the individual and would impose a rule which would know no limits”¹⁸⁶ While the court thought that Mr. Shimp’s choice contained moral flaws, it analogized a forced procedure to Nazism and the Inquisition.¹⁸⁷

While that situation involved two adults with no special relationship, the courts have also not compelled a rescue in situations involving siblings or natural fathers. In the case of *In re Richardson*,¹⁸⁸ Roy was a seventeen-year-old mentally disabled boy, and his sister needed a kidney transplant.¹⁸⁹ After the entire family underwent testing, Roy was deemed the best match.¹⁹⁰ The father wanted authorization for the procedure, but the court held that Roy had a “right to be free in his person from bodily intrusion to the extent of loss of an organ unless such loss to be in the best interest of the minor.”¹⁹¹ Thus, he had no obligation to rescue his sister.

While dialysis provided an alternative in *Richardson*, bone marrow situations are trickier, but courts have still upheld a family member’s refusal not

178. See *id.* § 40(b)(7)(a)-(b).

179. See *id.* § 40 cmt. n.

180. See *id.* § 40 cmt. o (noting that the special relationships list is not exclusive, and courts may add exceptions in some situations, especially with other family members).

181. 10 Pa. D. & C.3d 90 (Pa. Com. Pl. 1978).

182. *Id.* at 90.

183. *Id.*

184. *Id.* at 91.

185. *Id.*

186. *Id.*

187. *Id.* at 92. The court used vivid language to reinforce its point: “For a society which respects the rights of one individual, to sink its teeth into the jugular vein or neck of one of its members and suck from it sustenance for *another* member, is revolting to our hard-wrought concepts of jurisprudence.” *Id.*

188. 284 So. 2d 185 (La. Ct. App. 1973).

189. *Id.* at 186.

190. *Id.* at 187.

191. *Id.* The court also noted and considered that the sister could survive with renal dialysis for an indefinite period of time. *Id.* at 186.

to rescue another person. In the case of *In re George*,¹⁹² the son, who had been adopted, suffered from leukemia.¹⁹³ He could stay alive on drugs temporarily, but to survive, he needed a bone marrow transplant.¹⁹⁴ He sought information on his natural father to determine if he was a possible match.¹⁹⁵ Despite the court's attempts to convince the natural father to consent to testing, he refused, regardless of the court's offers of anonymity.¹⁹⁶ The son argued that the trial court abused its discretion, but the Missouri Court of Appeals thought that the son's need, along with the satisfaction of his need and the father's cooperation, merited consideration.¹⁹⁷ The court ruled that his situation did not merit the adoption records to be unsealed, which implied that the natural father had no duty to rescue his son.¹⁹⁸

A. Analysis of No Duty to Rescue

Cesarean sections have similar levels of need and intrusion as organ or bone marrow donations. The doctors and courts, however, rationalize the first procedure differently from the latter procedures. The women want to give birth, but they do not want to undergo the particular delivery procedure, whereas people who refuse to donate an organ or bone marrow want nothing to do with the whole situation.¹⁹⁹ The doctors and courts rationalize that refusing a particular delivery method is not as significant or intrusive as refusing an organ donation. Overriding the decision is only a minor detail for them. This rationalization, however, reeks of paternalism and treats women as if they made a hysterical decision during labor. The people noted in the above cases appear to have more control over their rights in the doctors' and courts' minds on whether to rescue someone than a woman who refuses a cesarean section.

Additionally, many contend that pregnant women have a "special relationship" with their fetuses, which vitiates the no duty to rescue rule. They base this argument on the biological fact that what happens to the woman affects the fetus. They contend that a woman has certain obligations and is compelled to "protect [the fetus] in [her] charge from risks posed by third persons," which in this situation would be herself.²⁰⁰ To reinforce this point, some people argue that women who do not undergo abortions waive their rights to refuse medical procedures, like a cesarean section, that aid the fetus.²⁰¹ Thus, a woman must provide her fetus "with such things as 'necessary medical attendance.'"²⁰²

192. 630 S.W.2d 614 (Mo. Ct. App. 1982).

193. *Id.* at 615.

194. *Id.*

195. *Id.* at 616.

196. *Id.* at 616-17. The "father" claimed that he was not the natural father. *Id.* at 616.

197. *Id.* at 622-23.

198. *Id.* at 623.

199. See Rhoden, *supra* note 110, at 1979.

200. RESTATEMENT (THIRD) OF TORTS, *supra* note 173, § 40 cmt. n.

201. See Rhoden, *supra* note 110, at 1979.

202. George J. Annas, *Pregnant Women as Fetal Containers*, 16 HASTINGS CENTER REP. 13, 13 (1986).

This special relationship argument has some merit, but it does not override a woman's decision. First, women have a "right to bear children," and no waiver of that right ever occurs.²⁰³ Second, comparing the parent and child category to the woman and fetus stretches the Fourteenth Amendment. A child is a person, but under the Fourteenth Amendment, the fetus is not considered a person, which implies that the custodian special relationship does not apply to pregnant women unless courts expand the list.²⁰⁴ Third, while parents have an obligation to act in their children's best interests, these interests do not infringe on their bodily integrity.²⁰⁵ Parents do not have to sacrifice their lives or organs for their children even though they likely would if the situation required it. With a pregnant woman, the doctor must infringe on the woman's bodily integrity to rescue the fetus, which "degrades and dehumanizes the mother and treats her as an inert container."²⁰⁶ Finally, the special relationship applies only to women. Courts do not compel fathers, siblings, or other family members to infringe on their bodily integrity and save family members.²⁰⁷ Courts could extend the special relationship standard beyond parent and child, but the courts have chosen to maintain the standard.²⁰⁸ Thus, courts have created a double standard between men and women involving their bodily integrity rights and aiding their children. Under the Fourteenth Amendment, courts cannot "deny to any person within its jurisdiction the equal protection of the laws."²⁰⁹ Courts do not compel fathers to infringe on their bodily integrity to save their children.²¹⁰ By forcing women to undergo cesarean sections, the courts reinforce stereotypical gender roles, relegating the woman to the kitchen, barefoot and pregnant, and violating her equal protection rights. Until the courts require both parents to surrender their bodily integrity rights to aid their children, women should not be compelled to give up their rights to refuse treatment based on a special relationship argument.

If courts treat women as "mere means" to delivering a fetus based on their special relationship, which fathers do not have, then Margaret Atwood's cautionary tale, *The Handmaid's Tale*, becomes more likely.²¹¹ *The Handmaid's Tale* involves a society in which only some women reproduce, and society considers reproduction as their job.²¹² To avoid this mindset, the "special

203. *Id.* at 14.

204. See *Roe v. Wade*, 410 U.S. 113, 158 (1973); RESTATEMENT (THIRD) OF TORTS, *supra* note 173, § 40 cmt. o.

205. George J. Annas, *She's Going to Die: The Case of Angela C.*, 18 HASTINGS CENTER REP. 23, 24 (1988).

206. *Id.* at 24.

207. William Ruddick & William Wilcox, *Operating on the Fetus*, 12 HASTINGS CENTER REP. 10, 12 (1982); see *In re Richardson*, 284 So. 2d 185, 187 (La. Ct. App. 1973); *In re George*, 630 S.W.2d 614, 623 (Mo. Ct. App. 1982); see also *McFall v. Shimp*, 10 Pa. D. & C.3d 90, 92 (Pa. Com. Pl. 1978).

208. RESTATEMENT (THIRD) OF TORTS, *supra* note 173, § 40 cmt. o.

209. U.S. CONST. amend. XIV § 1.

210. See, e.g., *In re George*, 630 S.W.2d at 622-23 (holding that adoption records that would presumably identify a son's biological father could not be unsealed based solely on the son's medical need).

211. Frank A. Chervenak & Laurence B. McCullough, *Justified Limits on Refusing Intervention*, 21 HASTINGS CENTER REP. 12, 12 (1991); see Annas, *supra* note 202, at 13.

212. Annas, *supra* note 202, at 13.

relationship” exception should not apply to pregnant women because of gender discrimination and violation of the Equal Protection Clause.

VII. ANALYSIS OF THE FOUR CESAREAN CASES

Given all of this information, the Illinois Appellate Court reached the right result with *In re Baby Boy Doe*. The court refused to use a balancing test because the “woman’s competent choice” trumped the state’s rights.²¹³ The court acknowledged her right to refuse treatment, the uniqueness of her situation, and her constitutional rights.²¹⁴ In the case of *In re A.C.*, the District of Columbia Court of Appeals also reached the correct result by honoring a woman’s refusal, but the decision depended on informed consent and bodily integrity.²¹⁵ The court, however, thought that a “truly extraordinary” situation for overriding the woman’s decision could occur. While an extreme, inconceivable situation could arise, the courts should not leave the situation undefined. Without a standard, a slippery slope exists, which could eventually encroach on the woman’s decision and place the court back in the same quandary that existed with *In re A.C.*²¹⁶

The *Jefferson* and *Pemberton* courts, however, employed paternalistic approaches. Both courts used *Roe* and its compelling interests’ concept to support their decisions.²¹⁷ As stated earlier, *Roe* does not pertain to compelling medical treatments for fetuses but to abortions.²¹⁸ Second, these courts required women to endure trade-offs. Women would be forced to undergo an unwanted surgical procedure for their fetuses. The procedure increased their chances of morbidity and mortality, because it benefited the fetus.²¹⁹ Finally, these courts likely engaged in value judgments on the situations. Ms. Jefferson and Ms. Pemberton wanted natural births. The courts may have implicitly or directly considered the idea that “the woman commits herself to obedience and maternal devotion; she agrees to sacrifice any distinct self interest for the sake of her child”²²⁰ Regardless, the *Jefferson* and *Pemberton* courts felt that the state’s interests outweighed the women’s choices, and these decisions were likely based the idea that the state possesses an overwhelming interest to preserve all life. While determining how personal perspectives may affect courts’ decisions is difficult, a balancing analysis could unconsciously cause the courts’ personal views to influence the decision. These courts misinterpreted well-established ideas of informed consent, bodily integrity, abortion, and no duty to rescue by misapplying *Roe* and using a balancing test to order cesarean sections.

213. *In re Baby Boy Doe*, 632 N.E.2d 326, 326 (Ill. App. Ct. 1994).

214. *See generally id.*

215. *In re A.C.*, 573 A.2d 1235, 1242 (D.C. 1990) (en banc).

216. *Id.*

217. *See Pemberton v. Tallahassee Mem’l Reg’l Med. Ctr., Inc.*, 66 F. Supp. 2d 1247, 1251-52 (N.D. Fla. 1999); *Jefferson v. Griffin Spalding Cnty. Hosp. Auth.*, 274 S.E.2d 457, 458 (Ga. 1981) (per curiam).

218. *See Nelson & Milliken*, *supra* note 105, at 1062.

219. *See Thornburgh v. Am. Coll. of Obstetricians & Gynecologists*, 476 U.S. 747, 769 (1986), *overruled by Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833 (1992); *Colautti v. Franklin*, 439 U.S. 379, 400-01 (1979); *Rhoden*, *supra* note 110, at 1992.

220. *Ruddick & Wilcox*, *supra* note 207, at 12.

VIII. SOLUTIONS TO THE COURT ORDERED CESAREAN SECTION

Court ordered cesarean sections come up infrequently in the courts, but when the situation occurs, it occurs in the worst possible way. The decision-making time is often limited and the doctors face a pressing deadline. Parents are unprepared to defend their position and the courts lack the time to analyze the law and issue properly. While the best solution would be for the Supreme Court to address the issue, it is unlikely that the Supreme Court will receive and accept a petition on this issue. The reason that a case may never reach that level of review is because only four recorded cases have reached the appellate level. Thus, unless there is an increase in the number of cases heard in appellate courts and a circuit split develops, the Supreme Court may not see the need to address this issue. In lieu of Supreme Court resolution, the hospitals, patients, and doctors must establish other methods that could prevent judicial intervention.

First, the hospital could accept the woman's refusal and not perform a cesarean section. As long as the women appear competent and fully informed of the risks of refusing treatment, doctors fulfill their ethical duty. This idea, however, might conflict with a doctor's desire to save the fetus, but the decision belongs to the woman.

Second, doctors could receive more training in alternative delivery methods like VBAC, vaginal breech delivery, or delivery by forceps.²²¹ Doctors frequently perform cesarean sections because they learned the procedure in medical school and often lack experience in other methods.²²² At the slightest sign of trouble, doctors usually opt for a cesarean section, which may conflict with the woman's wishes. With training in alternative delivery methods, doctors could deliver the fetus safely and comply with the woman's wishes.

Third, doctors perform cesarean sections to avoid malpractice suits, and by performing a cesarean section, the doctors can prove that they complied with the standard of care.²²³ If malpractice claims were reduced through tort reform, then the number of cesarean sections performed would likely decrease. Even with a woman's consent, doctors might still have liability concerns. If a woman gives informed consent for her cesarean section refusal, then she likely has no legal case against the doctor, and lawsuits brought by the father or child should also fail.²²⁴ Doctors, however, think that compelling a cesarean section will reduce, if not absolve, their possible liability issues.²²⁵ While this rationale is misguided, the legal field needs to address the doctors' liability concerns. With reform, the doctors can focus on the best course of treatment in compliance with the patient's wishes rather than the possibility of a lawsuit.²²⁶

221. Gleicher et al., *supra* note 12, at 143.

222. *See id.*

223. *See generally* ROSEN & THOMAS, *supra* note 1, at 108-09 (stating that doctors often perform cesarean sections as defensive medicine to show that they did everything possible).

224. Nelson & Milliken, *supra* note 105, at 1063.

225. *See id.*

226. In addition to reducing liability, hospitals must equalize the costs of vaginal births and cesarean sections. Cesarean sections are more expensive than vaginal births, and these excess costs are covered by insurance. Unless changes are made, profit-focused doctors will be more likely to use cesarean sections. ROSEN & THOMAS, *supra* note 1, at 53.

Finally, the doctor and patient must discuss these issues earlier in the pregnancy. The doctor needs to know about the woman's views on childbirth because the doctor will need to present her with the available options and risks of each choice. The woman then has time to research these options and ask questions. If they do not discuss their views and options, then a court ordered intervention could result, which destroys the doctor-patient relationship and trust.²²⁷ The relationship will change from a joint venture for the best possible outcome into a hostile relationship.²²⁸ By discussing the issues earlier, the woman can decide whether their views mesh, or whether she needs to search for a new doctor. Additionally, the discussion prevents any last minute chaos and confusion that a birth, especially a problematic one, can create. Discussion prevents the doctor and the woman from becoming enemies during the most important time of the relationship—the delivery.

IX. CONCLUSION

Court ordered cesarean sections happen infrequently, but they can occur. Because of their infrequency, courts have reached different results on the issue. In these situations, however, courts should honor the woman's wishes and not use a balancing test. By using a balancing test, the woman becomes nothing more than a shell protecting the fetus until birth. Women have come a long way since the image of a docile, subservient woman and have the same legal rights as men in this country. A balancing test, however, causes the courts to sweep aside the woman's rights and places her firmly in the Middle Ages, when the cesarean section was a last resort. While doctors face a quandary about who to treat with a pregnant patient, they, as well as the courts, should honor the woman's decision. By acting contrary to her decision, the woman's constitutional rights are violated, and she is placed back in the kitchen, barefoot and pregnant. Courts should not presume to know what is best for the woman. Thus, they should abide by the woman's informed refusal of a cesarean section and not use a balancing test, which could result in a trade off between her rights and the fetus's rights.

227. See Veronika E.B. Kolder, et al., *Court-Ordered Obstetrical Interventions*, 316 NEW ENG. J. MED. 1192, 1195 (1987); Nelson & Milliken, *supra* note 105, at 1065.

228. Nelson & Milliken, *supra* note 105, at 1065.