THE STATE KNOWS BEST: A COMPARISON AND ANALYSIS OF THE DIFFERING TREATMENT OF ORGAN DONORS AND PREGNANT WOMEN

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INTRODUCTION

IN 2000, A COURT ORDERED THE FORCED SEPARATION OF CONJOINED INFANT twins, Mary and Jodie.[1] Mary, the weaker twin, was sapping all of Jodie's energy, and without such an operation, doctors speculated that both twins would die within the year.[2] But with the operation, doctors hypothesized that Mary would surely die but that Jodie had an excellent survival chance.[3] Despite the twins' parents' objections, the court ordered the separation anyway.[4] Mary died within a few days; Jodie, within six months.[5]

This happened in Britain, an ocean away, and we would like to think that this would not happen in America because our society does not require one person to rescue another[6]—even when the rescuing does not threaten the rescuer's life.[7] After all, when a child is a perfect donor match for her ailing brother (and offers him the only known hope of survival), courts will not compel a donation against the parents' wishes.[8] And even where the parents do not object, the courts generally will not allow the donation unless the donor receives some psy-

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1 Charles I. Lugosi, *Conforming to the Rule of Law: When Persons and Human Beings Finally Mean the Same Thing in Fourteenth Amendment Jurisprudence*, 22 ISSUES IN L. & MED. 119, 268 (Fall 2006/Spring 2007).

2 *Id.*

3 *Id.*

4 *Id*.

5 Lugosi, *supra* note 1, at 268 (arguing that "[u]tilitarian values trumped over Mary's civil liberties").

6 *E.g.*, McFall v. Shimp, 10 Pa. D. & C.3d 90, 91 (1978) (discussing how a person is not obligated to save or rescue another person).

7 *See* discussion *infra* Part II.

8 *See* discussion *infra* Part II.

chological benefit from the donation.[9] The assumption underlying and influencing this standard is that the right to bodily autonomy is inviolate.[10]

But this is not always the case with pregnant women: for many courts, the pregnant woman's right to bodily autonomy crumbles when the unborn fetus is in medical peril.[11] These courts have compelled medical treatment of a pregnant woman to save her unborn fetus, even though the woman has objected, and even though the science behind the fetus's prognosis may be uncertain.[12] Several valid explanations exist for compelling medical treatment of pregnant women to save their unborn fetuses, especially in contrast with donor cases; nonetheless, the analysis that courts use in these two situations differs, arguably to an improper extent.[13]

This paper explores the different treatment of two groups of individuals—pregnant women and donors—when they share a similar situation: the necessity of *their* medical treatment to save the life of *another*. Part I presents a brief overview of the framework under which the courts analyze the right to refuse medical treatment.[14] Part II discusses relevant case law about compelling medical treatment of donors to save another's life.[15] Part III discusses relevant case law about compelling medical treatment of pregnant women to save a fetus's life.[16] Part IV sorts through the possible arguments for the different standard used for donors and pregnant women and offers responses to these arguments.[17]

I. The Right to Bodily Autonomy and the General Framework for Compelling Medical Treatment

The right to bodily autonomy has a strong history in the United States: "[n]o right is held more sacred, or is more carefully guarded by the common law, than the right of every individual to the possession and control of his own person, free from all restraint or interference of others, unless by clear and unquestionable authority of law."[18]

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9 *See* discussion *infra* Part II.A.4.

10 *See* discussion *infra* Part II.A.2.

11 *See* discussion *infra* Part III.A.2.

12 *See* discussion *infra* Parts III.A.2, III.A.3.b.

13 *See* discussion *infra* Part IV.

14 *See* discussion *infra* Part I.

15 *See* discussion *infra* Part II.

16 *See* discussion *infra* Part III.

17 *See* discussion *infra* Part IV.

18 Union Pacific Ry. Co. v. Botsford, 141 U.S. 250, 251 (1891); *accord* JOHN STUART MILL, ON LIBERTY 13 (Currin V. Shields ed., The Liberal Arts Press 1956) (1869). Mill might have approached the right to refuse medical treatment from a self-determination point of view:

This principle is not absolute, and at times yields to the state's interests.[19] To determine whether the state's interests or the individual's right will prevail, courts generally balance the patient's right to refuse medical treatment and the patient's right to bodily autonomy against four state interests: (1) the preservation of life; (2) the prevention of suicide; (3) the protection of third party interests; and (4) maintaining the ethical integrity of the medical profession.[20]

Courts deciding donor cases do not use this four-part interest; rather, they use the "best interests" or the "substituted judgment" test because the minors or incompetents involved cannot speak for themselves.[21] What is interesting is that courts deciding pregnancy cases, on the other hand, either put the four-part interest on the state's side of the balance[22] *or* disregard it entirely and put the state's compelling interest in the fetus's potential life on the state's side of the balance.[23]

II. Case Law Involving Donors

For donors, the courts protect as inviolate the donor's right to bodily integrity or right to be free from unwanted medical treatment. This section discusses the relevant case law about organ donors, with a focus on the minor and incompetent sibling organ, bone marrow, or tissue donors because those cases occur most frequently.

A. The Typical Scenario

The typical scenario with a petition for the court to compel organ donation occurs when a minor or incompetent is the only known match for a sibling who needs an organ or bone marrow. The potential donor is often too young to understand the situation, or mentally incompetent, so the potential donor's parent or legal guardian asks the court to compel the donation because the hospital where the potential donee is being treated, presumably to protect itself from a battery claim, will not perform the transplant without a court order.

> [T]he only purpose for which power can be rightfully exercised over any member of a civilized community, against his will, is to prevent harm to others. His own good, either physical or moral, is not a sufficient warrant. He cannot rightfully be compelled to do or forbear because it will be better for him to do so, because it will make him happier, because, in the opinion of others, to do so would be wise, or even right.

JOHN STUART MILL, ON LIBERTY 13 (Currin V. Shields ed., The Liberal Arts Press 1956) (1869).

19 *E.g.*, *In re* E.G., 549 N.E.2d 322, 328 (Ill. 1989).

20 *Id.*

21 *See* discussion *infra* Part II.A.3.

22 *See* discussion *infra* Part III.A.1.

23 *See* discussion *infra* Part III.A.2.

1. Requirements for the Court to Hear a Compelled Organ Donor Petition

Before a court will even hear a compelled organ donor petition, at least one parent or the legal guardian must give consent for the transplant.[24] Indeed, where there is no consent from at least one parent or guardian, lower courts have refused to hear the petition or have sustained lower courts' decisions not to hear the petition because a minor or incompetent cannot legally consent to a medical procedure.[25] In *In re Pescinski*, for instance, an appellate court sustained the trial court's refusal to hear a petition for a kidney transplant of an incompetent ward of the state for his dying sister because "no consent ha[d] been given by the incompetent or his guardian ad litem."[26] And without consent from the patient, the parent (if the patient is a minor), or the guardian (if the patient is incompetent), the court has no power to authorize the operation where the *donor*'s own life is not in danger or there is no benefit to the donor.[27] Of course, parents are not entirely free to decide how to raise their children; the state often steps in to compel vaccinations, blood transfusions, and other life-saving procedures.[28] But with organ or bone marrow transplant cases, the court will not override the parent sua sponte, and where the operation already occurred but without parental consent, the courts have suggested that a battery occurred because of the lack of parental consent.[29]

2. Foundational Basis for Donor Cases

Most of the courts that hear donor cases start with the premise that the right to bodily autonomy is a precious right—that "one human being is under no legal

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24 In 1941, before several of the donor cases came before the courts, one court noted that "[i]n the great majority of the states, this question seems never to have arisen[;] . . . [h]owever, the general rule is that the consent of the parent is necessary for an operation on a child." Bonner v. Moran, 126 F.2d 121, 122 (D.C. Cir. 1941); *accord* Hart v. Brown, 289 A.2d 386, 390 (Conn. 1972) ("[N]ontherapeutic operations can be legally permitted on a minor as long as the parents or other guardians consent to the procedure.") (internal citation omitted). The exceptions to the rule are when an emergency arises, the parents cannot be reached in time to give consent, or where the child has been emancipated. *Bonner*, 126 F.2d at 122.

25 *In re* Guardianship of Richard Pescinski, 226 N.W.2d 180, 181 (Wis. 1975).

26 *Id.* at 180.

27 *Id.* at 181.

28 The Supreme Court's holding in *Prince v. Massachusetts,* that parents are not free "to make martyrs of their children," Prince v. Massachusetts, 321 U.S. 158, 170 (1944), has been used to compel minor children to undergo medical procedures like vaccinations, Matter of Christine M., 595 N.Y.S.2d 606 (N.Y. 1992), blood transfusions, Matter of McCauley, 565 N.E.2d 411 (Mass. 1991), chemotherapy, Custody of a Minor, 379 N.E.2d 1053 (Mass. 1978), and even tonsillectomies, *In re* Karwath, 199 N.W.2d 147 (Iowa 1972), against their parents' wishes.

29 *Bonner*, 126 F.2d at 123.

compulsion to give aid or to take action to save another human being or to rescue."[30] And "[f]or our law to *compel* [another] to submit to an intrusion of his body would change every concept and principle upon which our society is founded[,] . . . defeat[ing] the sanctity of the individual" and "impos[ing] a rule which would know no limits, and one could not imagine where the line would be drawn."[31]

3. The Best Interests Standard and the Doctrine of Substituted Judgment

Once the court has determined that it will hear the petition, it generally applies a best interests standard for minors; for incompetents, the court applies the best interests standard or the substituted judgment standard.[32]

Courts will use the doctrine of substituted judgment for once competent persons who are now incompetent, with the goal of getting as close to the person's likely preferences as possible.[33] Thus, a hierarchy emerges: the first source to consult with is the person himself; the next best is the substituted judgment; the third best is the best interests standard. The doctrine of substituted judgment "requires clear and convincing proof of the incompetent person's intent before a court may authorize a surrogate to substitute his or her judgment for that of the incompetent" because, otherwise, "[a]ny lesser standard would 'undermine the foundation of self-determination and inviolability of the person upon which the right to refuse medical treatment stands."[34]

Courts use the best interests standard when it would be impossible to determine what a minor or incompetent would want because of his or her age or lifelong mental impairment.[35] For instance, in *Bosze v. Curran*, one parent wanted a guardian to impose substituted judgment for three-and-a-half year twins about whether they would donate marrow.[36] The court refused to apply the doctrine of substituted judgment because "it is not possible to discover that which does not exist, specifically, whether the three-and-a-half-year-old twins would consent or refuse to consent to the proposed bone marrow harvesting procedure if they were competent . . . ."[37] The court noted that because of the twins' age, "[i]t is not possible to discover the child's [treatment preferences] by examining the child's 'philosophical, religious and moral views, life goals, values

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30 McFall v. Shimp, 10 Pa. D. & C.3d 90, 91 (1978).

31 *Id.*

32 *In re* A.C. 573 A.2d 1235, 1252 (1990).

33 Bosze v. Curran, 566 N.E.2d 1319, 1325 (Ill. 1990) (internal quotation omitted).

34 *Id.* at 1326 (internal quotation omitted).

35 *E.g.*, *id.* at 1326.

36 *Id.* at 1322.

37 *Id.* at 1326.

about the purpose of life and the way it should be lived, and attitudes towards sickness, medical procedures, suffering and death.'"[38] The court thus used the best interests standard.[39]

4. Psychological Benefit Required

No matter which test the court uses, most interestingly, the court will only require the donation where the *donor* will likely receive a demonstrable psychological benefit.[40] This is even the case where the court uses the substituted judgment standard, even though the substituted judgment standard involves looking not at what would be in the person's best interests, but what the person would decide, were he competent.[41] Because "the key inquiry [is] the presence or absence of a benefit to the potential donor,"[42] where the donor will not receive a psychological benefit from the donation, or where the physical or psychological risks to the donor would outweigh the psychological benefit to the donor, the court will not compel the donation.[43]

Thus, in *Strunk v. Strunk*, the court allowed an incompetent twenty-seven-year-old's kidney to be removed and donated to his twenty-eight-year-old brother who was dying from kidney disease even though the incompetent could not then express how he would obtain a psychological benefit from the donation.[44] The court allowed the donation not only because it would be beneficial to the dying brother but also because it would be "beneficial to [the incompetent] because [he] was greatly dependent upon [his brother], emotionally and psychologically, and . . . [the incompetent's] well-being would be jeopardized more severely by the loss of his brother than by the removal of a kidney."[45]

In *Madsen v. Harrison*, the court similarly focused on the emotional impact of losing a sibling to support the idea that donation would benefit the donor.[46] There, the court authorized a transplant between nineteen-year-old twins.[47] Not only had the donor and his mother consented to the transplant, but a psychiatr-

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38 Bosze v. Curran, 566 N.E.2d 1319, 1336 (Ill. 1990) (internal quotation omitted).

39 *Id.* at 1331.

40 *E.g.*, Little v. Little, 576 S.W.2d 493, 498-99 (Tex. Civ. App. 1979); Hart v. Brown, 289 A.2d 386, 391 (Conn. 1972); Strunk v. Strunk, 445 S.W.2d 145, 146 (Ky. Ct. App. 1969).

41 *Little*, 576 S.W.2d at 498.

42 *Bosze*, 566 N.E.2d at 1331.

43 *E.g.*, *id.* at 1344. As one of the expert doctors in *Bosze* explained, "the way we think about it in medicine is basically a risk-benefit ratio" that compares the "likely psychological benefits" with the "psychological risks." *Id. at 1336.*

44 *Strunk*, 445 S.W.2d at 146.

45 *Id.*

46 Madsen v. Harrison, No. 68651 Eq. (Mass. June 12, 1957).

47 *Id.*

ist testified about the "grave emotional impact" that the donor would suffer if his brother died.[48] Thus, the court, in authorizing the transplant, focused both on the donor's consent and the emotional pain that he would suffer if his brother were to die from not receiving the transplant.[49]

In *Little v. Little*, to support its compelling of a kidney transplant by an incompetent minor, the court pointed to extensive evidence of the close relationship between the siblings.[50] It noted the following:

> [T]he testimony in this case conclusively establishes the existence of a close relationship between [the donor] and [the donee], a genuine concern by each for the welfare of the other and, at the very least, an awareness by [the donor] of the nature of [the donee's] plight and an awareness of the fact that she is in a position to ameliorate [the donee's] burden. . . . [T]here is ample evidence to the effect that [the donor] understands the concept of absence and that she is unhappy on the occasions when [the donee] must leave home for hours when he journeys . . . for dialysis.[51]

On the other hand, courts will not compel a donation where the psychological benefit to the donee is absent or unclear. In *In re Pescinski*, where the potential donor lived in an assisted-living facility and had the mental capacity of a twelve-year-old and could not appreciate the bond he might have shared with his sister, the court refused to compel him to donate his kidney to his sister because no evidence existed of what benefit he would receive from donating his kidney.[52]

And at least for one court, "[o]nly where there is an existing relationship between a healthy child and his or her ill sister or brother may a psychological benefit to the child from donating [tissue or an organ] realistically be found to exist."[53] The court went on to explain that "the existing sibling relationship, as well as the potential for a continuing relationship, . . . forms the context in which it may be determined that it will be in the best interests of the child to undergo a . . . procedure for a sibling."[54]

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48 *Id.*

49 *Id.*

50 Little v. Little, 576 S.W.2d 493, 498 (Tex. Civ. App. 1979).

51 *Id.* The *Little* court even stretched the definition of psychological benefit beyond the benefit to the donee herself, noting that "[s]tudies of persons who have donated kidneys reveal resulting positive benefits such as heightened self-esteem, enhanced status in the family, renewed meaning in life, and other positive feelings including transcendental or peak experiences flowing from their gift of life." *Id.* at 499. The court did note that there was evidence that the donee, even though she was incompetent, was "capable of experiencing such an increase in personal welfare from donating her kidney." *Id.*

52 *In re* Guardianship of Richard Pescinski, 226 N.W.2d 180, 180 (Wis. 1975).

53 Bosze v. Curran, 566 N.E.2d 1319, 1344 (Ill. 1990).

54 *Id.*

5. Full Support Network Needed

Though at least one parent must consent to the procedure for the court even to hear the petition,[55] the court is not likely to grant the petition where the custodial parent opposes the procedure. The idea behind this is that it cannot be in a child's best interests to undergo a procedure "without the constant reassurance and support by a familiar adult known and trusted by the child."[56] Thus, in *Bosze*, where the non-custodial father wanted his three-and-a-half-year-old twins to undergo a bone marrow transplant for their half brother, the court was adamant that the twins "would need the emotional support of their primary caregiver if they were to donate bone marrow" and that the twins' mother's refusal to consent—combined with the lack of a close relationship between the potential donors and donee—weighed against compelling donation.[57]

In fact, in other cases where donation *has* been compelled, the courts have been sure to point out that everybody is on the same page about donation and *wants* donation,[58] indicating that everybody involved needs to want the medical procedure to occur. Or, in other words, the courts will not substitute their judgment or a guardian's judgment for the family's judgment.

III. CASE LAW INVOLVING PREGNANT WOMEN

If one followed the best interests or the substituted judgment test that the courts use for compelling organ donation, one would assume that a pregnant woman also could not be required to submit to a medical procedure against her will for the sake of her unborn fetus unless the mother receives a tangible psychological benefit.

But the pregnant women in these cases usually can speak for themselves, unlike the minor or incompetent organ donors. Where the women do not consent to a procedure, though, the courts do not consider whether she will receive a psychological benefit. Instead, the outcomes vary based on how the court frames the question:[59] is this about the restrictions on reproductive freedom,[60] or is this

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55 *Id. See* discussion *supra* Part II.A.1.

56 Bosze v. Curran, 566 N.E.2d 1319, 1344 (Ill. 1990).

57 *Id.*

58 *E.g.*, Little v. Little, 576 S.W.2d 493, 498-99 (Tex. Civ. App. 1979); Hart v. Brown, 289 A.2d 386, 390 (Conn. 1972); Strunk v. Strunk, 445 S.W.2d 145, 147 (Ky. Ct. App. 1969).

59 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, 120-21 (2005) (arguing that *Jefferson* and *Pemberton* "focused on reproductive rights since they did not attempt to distinguish the C-section case from other refusal of medical treatment cases," whereas *In re Baby Boy Doe* and *In re A.C.* focused on the right to refuse medical treatment and the right not to save another's life without getting into a discussion of how *Roe* might give the state a compelling interest in a viable fetus).

about the right to bodily autonomy or the right to be free from unwanted medical treatment?[61]

A. The Typical Scenario

The cases that seem to come before the courts most typically involve a woman in her third trimester who comes to the hospital either for a routine check-up or because she is having unusual symptoms. Once at the hospital, her doctor or doctors determine that a blood transfusion or a cesarean section is medically necessary to save her fetus's life. The woman refuses the blood transfusion or the cesarean section, often on religious grounds, but sometimes just because she does not wish to have an invasive medical procedure, or wants nature to take its course.[62]

1. Courts that See the Right to Bodily Integrity or the Right to Refuse Medical Treatment as Inviolate

Some courts conclude that a medical treatment cannot be compelled against one's wishes, no matter what life-saving benefits that it may have for another. The courts that come to this conclusion focus on the right to bodily autonomy or the right to refuse medical treatment and dismiss or ignore the reproductive cases.

In *In re A.C.*, a woman twenty-five weeks into her pregnancy came for a regular check-up complaining of a cough.[63] She had been in cancer remission for fourteen years, but the doctors discovered an inoperable lung tumor and speculated that she would have only days to live.[64] Wanting to save the life of her viable fetus as soon as possible, the doctors advised her to have a cesarean section, but the woman was ambivalent about consent.[65] She wanted to live for another two weeks, if possible; as for her fetus, she at first said "I don't know; I think

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60 *E.g.*, Pemberton v. Tallahassee Mem'l Reg'l Hosp., 66 F. Supp. 2d 1247 (N.D. Fla. 1999), *In re* Jamaica Hosp., 491 N.Y.S.2d 898 (Sup. Ct. 1985), Raleigh Fitkin-Paul Morgan Mem'l Hosp. v. Anderson, 201 A.2d 537 (N.J. 1964) (cases that focus on the limitations on reproductive freedom).

61 *E.g.*, *In re* Baby Boy Doe, 632 N.E.2d 326 (Ill. App. Ct. 1994), *In re* A.C., 573 A.2d 1235 (D.C. 1990), Taft v. Taft, 446 N.E.2d 395 (Mass. 1983) (cases that focus on the right to bodily autonomy or the right to refuse medical treatment).

62 JAMES R. SCOTT ET AL., DANFORTH'S OBSTETRICS & GYNECOLOGY 455 (9th ed. 2003); *see also* Levy, *supra* note 59, at 99 ("Cesareans can lead to a variety of postpartum complications, including wound infection, hemorrhage, severe complications from anesthesia, and even death. The pregnancy related mortality rate . . . is about 35.9 deaths per 100,000 while the mortality rate among women with vaginal delivery with a live birth outcome is about 9.2 per 100,000.").

63 *In re* A.C., 573 A.2d at 1238.

64 *Id.*

65 *Id.* at 1239.

so,"[66] then later said "I don't want [the cesarean section] done."[67] The hospital petitioned the court to compel the cesarean section.[68] After a three-hour hearing at the hospital, the court compelled the cesarean section.[69] The infant died two-and-a-half hours later; the mother, two days later.[70]

Based on the equivocal consent and then revoked consent to the cesarean section, the appellate court set aside the trial court's order of the cesarean section.[71] The court noted that the trial court:

> [D]id not go on, as it should have done, to make a finding as to what [the pregnant woman] would have chosen to do if she were competent. Instead, the court undertook to balance the state's and [the fetus's] interests in surgical intervention against [the pregnant woman's] perceived interests in not having the caesarean performed.[72]

The court further pointed out that if a patient is "capable of making an informed decision about the course of her medical treatment," and if she "makes such a decision, her wishes will control in virtually all cases."[73] The court stated that it would "not quite foreclose the possibility that a conflicting state interest may be so compelling that the patient's wishes must yield, but . . . that such cases will be extremely rare and truly exceptional" for fetal rights to win over maternal rights.[74] Though the court declined to decide when the state's interests could prevail, it emphasized "that it would be an extraordinary case indeed in which a court might ever be justified in overriding the patient's wishes and authorizing a major surgical procedure such as a cesarean section."[75]

The court came to the same conclusion about the inappropriateness of balancing the pregnant woman's rights with the fetus's rights in *In re Baby Boy Doe*.[76] In that case, a doctor speculated that the fetus of a woman in her thirty-

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66 *Id.* at 1239.

67 *Id.* at 1241.

68 *Id.* at 1252.

69 *In re* A.C., 573 A.2d 1235, 1238 (D.C. 1990).

70 *Id.* at 1252.

71 *Id.* The court noted that a case like this, where the mother and fetus had already died, would normally be moot, but that because other cases in the D.C. area would surely arise in the future, it wanted to set the law straight on maternal-fetal conflict. *Id.* at 1242.

72 *Id.* at 1252.

73 *Id.*

74 *Id.* The court did not wish to foreclose *every* possibility not because it could imagine such a scenario right then, but because it did not wish to limit courts in the future in case a rare circumstance arose. It noted that "[a]bsolutes like 'never' should generally be avoided because 'the future may bring scenarios which prudence counsels our not resolving anticipatorily.'" *Id.* at 1252 n.22 (internal quotation omitted).

75 *In re* A.C., 573 A.2d 1235, 1252 (D.C. 1990).

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

fifth week of pregnancy was not receiving enough oxygen.[77] The doctor suggested "immediate delivery by cesarean section"; he and other doctors hypothesized that "failure to provide an immediate delivery by cesarean section . . . could result in the child being born dead or severely retarded."[78] The woman refused the procedure and "chose to await natural childbirth" based on her "abiding faith in God's healing powers."[79]

The court denied the state's petition to compel the cesarean section.[80] Though the court recognized that the doctors had testified that the fetus's chance of surviving vaginal childbirth was "close to zero" and that, even if the fetus did survive, he would likely be brain dead, the court also pointed out that a cesarean section was a major surgery that would occur against the woman's religious beliefs and that there are neither Illinois cases "nor . . . any cases from the U.S. Supreme Court which mandate balancing tests by which a court balances . . . the right to life of a viable person versus the right of the mother to choose a medical procedure which may cause death or other injury."[81]

The appellate court agreed with the circuit court's denial of the cesarean section petition for similar reasons, noting that "Illinois courts should not engage in such a balancing, and that a woman's competent choice in refusing medical treatment as invasive as a cesarean section during her pregnancy must be honored, even in circumstances where the choice may be harmful to her fetus."[82] But the court pointed out that no matter how invasive or non-invasive a procedure was, "the right to refuse treatment does not depend upon whether the treatment is perceived as risky or beneficial to the individual."[83]

The court even looked to donor cases and suggested that a court would not "compel minors to undergo even a blood test for the purpose of determining whether they would be compatible donors"; therefore:

> If a sibling cannot be forced to donate bone marrow to save a sibling's life, if an incompetent brother cannot be forced to donate a kidney to save the life of his dying sister, then surely a mother cannot be forced to undergo a cesarean section to benefit her viable fetus.[84]

Finally, the court rejected the state's argument that *Roe v. Wade* "impl[ies] that a viable fetus does have some rights."[85] It flatly responded that "*Roe* . . .

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77 *Id.* at 327.

78 *Id.*

79 *Id.*

80 *Id.* at 329.

81 *Id.* at 328-29.

82 *Id.* at 330.

83 *In re* Baby Boy Doe, 632 N.E.2d 326, 330 (Ill. App. Ct. 1994).

84 *Id.* at 333-34 (internal quotations omitted).

85 *Id.* at 334.

merely stated that, in the context of abortion, the state's interest in the potential life of the fetus becomes compelling at the point of viability, and therefore the state is permitted to prohibit post-viability abortion . . . ."[86] It went on to note that "[t]he fact that the state may prohibit post-viability pregnancy terminations does not translate into the proposition that the state may intrude upon the woman's right to remain free from unwanted physical invasion of her person when she chooses to carry her pregnancy to term."[87]

Instead of using *Roe* to justify compelling treatment, and therefore putting the state's compelling interest in the fetus on the state's side of the balance, the *In re Baby Boy Doe* court put the state's traditional four interests on the state's side of the balance: the preservation of life, the prevention of suicide, the protection of third parties, and the ethical integrity of the medical profession.[88] The court quickly concluded that the preservation of life and the prevention of suicide were "simply irrelevant here" because the fetus should not be considered part of the 'preservation of life' prong: instead, "courts have traditionally examined the refusal of treatment as it impacts upon the preservation of the life of the maker of the decision."[89] And in this case, the "proposed cesarean section was never suggested as necessary, or even useful, to the preservation of [the pregnant woman's] life or health," but "[t]o the contrary, it would pose greater risk to her."[90] As for the protection of third parties, the court also found this irrelevant because "[t]he 'third parties' referred to in this context are the family members, particularly the children, of the person refusing treatment."[91] As for the fourth factor, the ethical integrity of the medical profession, the court also found that this weighed in the pregnant woman's favor.[92] It stated that "the medical profession strongly supports upholding the pregnant woman's autonomy in medical decision-making" and that where she "rejects the doctor's recommendation, the appropriate response is not to attempt to force the recommended procedure upon her . . . ."[93]

Even where the surgery is less invasive than the cesarean sections in *In re A.C.* and *In re Baby Boy Doe*, a court may not necessarily compel it. For instance, in *Taft v. Taft*, a probate court ordered a "purse-string" operation (which holds the woman's cervix together) on a four-months' pregnant born-again Christian

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86 *Id.*

87 *Id.*

88 *Id.*

89 *In re* Baby Boy Doe, 632 N.E.2d 326, 334 (Ill. App. Ct. 1994).

90 *Id.* at 334. The court also noted that "even in cases where the rejected treatment is clearly necessary to sustain life, these factors alone are not sufficiently compelling to outweigh an individual's right to refuse treatment." *Id.*

91 *Id.*

92 *Id.*

93 *Id.* at 335 (internal citation omitted).

woman in her fifth pregnancy because she had the same purse-string operation in her three successful previous pregnancies, and her fourth pregnancy, the only pregnancy that did not involve the purse-string operation, had ended in a miscarriage.[94] Though the risks of the operation were allegedly "very minor,"[95] the court upheld the lower court's vacation of the probate court's order because the fetus was not yet viable and because the record had "no findings, based on expert testimony, describing the operative procedure, stating the nature of any risks to the wife and to the unborn child, or setting forth whether the operation is merely desirable or is believed to be necessary as a life-saving procedure," and that there was "no showing of the degree of likelihood that the pregnancy will be carried to term without the operation."[96]

2. Courts that Favor the Fetus's Potential Life over the Pregnant Woman's Choice

In contrast, other courts focus on the restrictions of reproductive freedom in deciding to compel a procedure against the woman's wishes and brush aside the right to be free from an unwanted medical procedure or the right of bodily autonomy. These courts do not put the traditional four factors on the state's side of the balance; rather, they use *Roe v. Wade* to justify putting the state's compelling interest in the fetus on the state's side of balance.

In *Jefferson v. Griffin Spalding County Hospital Authority*, a woman in her thirty-ninth week of pregnancy came to the hospital for prenatal care.[97] The doctor who saw her diagnosed her with complete placenta previa[98] and opined that there was almost a one-hundred percent chance that the fetus would die without a cesarean section and that the woman had a fifty-percent chance of dying.[99] The woman refused the cesarean section because of her religious beliefs, believing that "the Lord has healed her body and that whatever happens to the child will be the Lord's will."[100] The hospital's petition to the court for a court-ordered cesarean section, however, was successful: the court reasoned that intervention was appropriate because "the life of [the] defendant and of the unborn child are, at the moment, inseparable," so the court may "infringe upon the wishes of the mother to the extent it is necessary to give the child an opportunity

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94 Taft v. Taft, 446 N.E.2d 395, 396 (Mass. 1983).

95 *Id.*

96 *Id.* at 397.

97 Jefferson v. Griffin Spalding County Hosp. Auth., 274 S.E.2d 457, 458 (Ga. 1981).

98 Placenta previa occurs when the "placenta has grown abnormally low in the uterus, partly or completely covering the cervix." AMERICAN MEDICAL ASSOCIATION, COMPLETE MEDICAL ENCYCLOPEDIA 990 (2003).

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

100 *Id.* at 458-59.

to live."[101] The Georgia Supreme Court upheld the lower court's decision, explaining that "[w]e weighed the right of the mother to practice her religion and to refuse surgery on herself, against her unborn child's right to live," and, in doing so, "found in favor of her child's right to live."[102] To support putting the fetus on the state's side of the balance, the court pointed to *Roe v. Wade* and stated that *Roe* stands for the proposition that "the state's compelling interest in preserving the life of this fetus is beyond dispute."[103]

Like in *Jefferson*, the court in *Pemberton v. Tallahassee Memorial Regional Hospital* employed a balancing test with the fetus on the state's side of the balance and determined that the state's interest in a potential life outweighed the woman's right to refuse unwanted medical treatment.[104] The woman in *Pemberton* had previously had a child via a cesarean section, but the type of cesarean section (a vertical incision type) "presented a greater risk of uterine rupture during any subsequent vaginal delivery than would be the case with a [horizontal incision] cesarean section."[105] But because the woman wanted to have a vaginal delivery for her second child, she decided to have a homebirth with a midwife because the various doctors she consulted refused to deliver the baby vaginally.[106] A day into the labor, when she became dehydrated, she went to Tallahassee Memorial Regional's emergency room.[107] Upon examining the woman, the attending physician told her that she needed a cesarean section, but the woman refused; the doctor then notified hospital officials, who "institute[d] [a] court proceeding . . . to compel [this] medical procedure without [the] patient's consent."[108] The judge granted the order—but by this point, the woman had left the hospital against the hospital's wishes and had returned home, so a police officer went to the woman's house and had an ambulance bring her back to the hospital against her will.[109] In upholding the judge's granting of the order, the court used *Roe v. Wade* to point out that "[t]he balance tips far more strongly in favor of the state . . . because here the full-term baby's birth was imminent, and more importantly, here the mother sought only to avoid a particular procedure for giving birth, not to avoid giving birth altogether."[110] The court then explained that "[b]earing an unwanted child is surely a greater intrusion on the mother's consti-

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101 *Id.* at 460.

102 *Id.*

103 *Id.* at 461.

104 Pemberton v. Tallahassee Mem'l Reg'l Med. Ctr., 66 F. Supp. 2d 1247, 1251-52 (N.D. Fla. 1999).

105 *Id.* at 1249.

106 *Id.*

107 *Id.*

108 *Id.* at 1249-50.

109 *Id.* at 1250.

110 Pemberton v. Tallahassee Mem'l Reg'l Med. Ctr., 66 F. Supp. 2d 1247, 1251 (N.D. Fla. 1999).

tutional interests than undergoing a caesarean section to deliver a child that the mother affirmatively desires to deliver," so therefore, "the state's interest here was greater, and the mother's interest less, than during the third trimester situation addressed in *Roe*."[111]

For court-ordered blood transfusions, the balancing test looks the same as for cesarean sections. In *In re Jamaica Hospital*, the court authorized a blood transfusion of a woman who was eighteen-weeks' pregnant because her hemoglobin and hematocrit levels were "far below normal" and her doctor feared that, without a blood transfusion, "she was in danger of dying."[112] The woman had refused because she was a Jehovah's Witness.[113] In authorizing the blood transfusion over the woman's wishes, the court offered little explanation beyond the fact that "[t]he state has a highly significant interest in protecting the life of a mid-term fetus, which outweighs the patient's right to refuse a blood transfusion on religious grounds."[114]

The Supreme Court of New Jersey similarly offered a terse explanation for reversing the lower court's judgment and ordering a blood transfusion against a thirty-two-weeks' pregnant woman's wishes in *Raleigh Fitkin-Paul Morgan Memorial Hospital v. Anderson*.[115] The hospital treating the Jehovah's Witness woman sought authority to compel blood transfusions in the future should they become necessary, based on evidence "establish[ing] a probability that at some point in the pregnancy [the woman] [would] hemorrhage severely and that both she and the unborn child [would] die unless a blood transfusion [were] administered."[116] The court stated that the pregnant woman and the fetus "are so intertwined and inseparable that it would be impracticable to attempt to distinguish between them"; as a result, "blood transfusions (including transfusions made necessary by the delivery) may be administered if necessary to save her life or her child, as the physician in charge at the time may determine."[117] The court did not discuss what the evidence of risk to the fetus was, only vaguely stating that "[t]he evidence establishes a probability that at some point in the pregnancy [the woman] will hemorrhage severely and that both she and the unborn child will die unless a blood transfusion is administered."[118]

Thus, all of the cases that allow the procedure despite the pregnant woman's objections start from the proposition that *Roe v. Wade* gives the state a compelling interest in the fetus's life. Then, when balancing the state's compelling in-

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111 *Id.* at 1251-52.

112 *In re* Jamaica Hosp., 491 N.Y.S.2d 898, 899 (Sup. Ct. 1985).

113 *Id.*

114 *Id.* at 900.

115 Raleigh Fitkin-Paul Morgan Mem'l Hosp. v. Anderson, 201 A.2d 537 (N.J. 1964).

116 *Id.* at 537-38.

117 *Id.* at 538.

118 *Id.*

terest in the fetus's life with the (comparatively minor) intrusion into the pregnant woman's body from a cesarean section or blood transfusion, these courts easily conclude that the balance tips in favor of the fetus.

3. Problems with Focusing on Roe's Limitations on Reproductive Freedom Instead of Focusing on the Woman's Right to Be Free from Unwanted Medical Treatment or the Right to Bodily Autonomy

When such a balance is done, the fetus will always win. But several problems exist when a court puts the state's compelling interest in the fetus's potential life on one side of the balance instead of the traditional four-part state's interest.

i. The Risk to the Fetus Does Not Have to Be Great

The first problem with the court's balancing of the 'small' risk to the woman compared with the state's "compelling" interest in the fetus's potential life is that the risk of death to the fetus does not have to be high for the court to order the treatment. In *Pemberton*, for instance, the doctor testified at the hearing that there was a "substantial and unacceptable risk of death," but "not that death was a certainty."[119] The court then quickly dismissed the pregnant woman's assertion that "she could and would have delivered her baby vaginally without harming him in any way":

> The medical evidence belies [her] bravado. . . . [I]t is possible for a woman to deliver vaginally [after having a previous horizontal incision cesarean section] without uterine rupture or other complications. Nonetheless, there is a very substantial risk of uterine rupture and resulting death of the baby . . . . In anything other than an extraordinary and overwhelming case, the right to decide would surely rest with the mother, not with the state. But based on the evidence disclosed by this record, this was an extraordinary and overwhelming case . . . .[120]

The court's language of "a very substantial risk" and the "extraordinary and overwhelming" evidence of risk implies an ominously high risk. But the court very plainly goes on to explain what "a very substantial risk of . . . [the] resulting death of the baby" means: "four to six percent."[121] The court pointed out that "[w]hen the consequence is almost certain death, this is a very substantial risk," and posited that "if an airline told prospective passengers there was a four to six percent chance of a fatal crash, *nobody* would board the plane."[122] This arguably improperly overstates the risk to the fetus so that the balance always comes out

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119 Pemberton v. Tallahassee Mem'l Reg'l Med. Ctr., 66 F. Supp. 2d 1247, 1250 (N.D. Fla. 1999).

120 *Id.* at 1252-54.

121 *Id.* at 1253.

122 *Id.*

to favor the fetus.[123] This line of logic also ignores that birthing a child already presents a risk of death,[124] and that birth by cesarean section—the method the court granted in this case—presents an even greater risk.[125]

ii. Doctors Can Misdiagnose a Situation

It is also not always clear what the risk of death to the fetus is, because doctors can be wrong.[126] The doctors in *Jefferson* quoted a higher probability of risk[127] (almost one-hundred percent) than the doctors in *Pemberton*, but, interestingly, the placenta previa in *Jefferson* corrected itself.[128] But because it would be rare—if not impossible—for placenta previa to shift, the original diagnosis was likely wrong in the first place.[129] Another incorrect diagnosis occurred in *In re Baby Boy Doe*, where doctors told the woman that a cesarean section was necessary for her fetus either to live or to be born without severe brain damage.[130] The expert doctors testified that the fetus had a "close to zero" chance of surviving a

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123 As one commentator describes, "[t]his tendency has been referred to as the 'maximin strategy': doctors choose a treatment alternative that minimizes the risk of the worst possible outcome, regardless of how unlikely that outcome may be" in order to "prevent[] the . . . 'worst case scenario,' rather than . . . optimizing care in the normal majority of cases." Charity Scott, *Resisting the Temptation to Turn Medical Recommendations into Judicial Orders: A Reconsideration of Court-Ordered Surgery for Pregnant Women*, 10 GA. ST. U. L. REV. 615, 665-66 (1994) (quoting Howard Brody & James R. Thompson, *The Maximin Strategy in Modern Obstetrics*, 12 J. FAM. PRAC. 977, 983 (1981)). She argues that this approach "reflects a confidence in modern medical technology's ability to avoid medical disasters and a bias towards judging success in terms of physiological rather than emotional factors." *Id.* at 666 (citation omitted).

124 The most recent United States data shows that the maternal death ratio is 15.1 per every 100,000 births. Ina May Gaskin, *Maternal Death in the United States: A Problem Solved or a Problem Ignored?*, J. OF PERINATAL EDUC., Mar. 4, 2008, *available at* http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2409165/. Of course, this rate is lower than the four to six percent risk of fetal death from *Pemberton*, but nonetheless shows that childbirth itself, like many life activities, presents a risk of death to the pregnant woman.

125 The maternal death rate is two to ten times higher for cesarean sections births compared to vaginal births. Lorna McBarnette, *Women and Poverty: The Effects on Reproductive Status*, 12 WOMEN & HEALTH 55, 72 (1988). This figure does not, however, differentiate between normal and high-risk pregnancies, and many high-risk pregnancies conclude in cesarean sections.

126 One study reports that in six out of twenty-one cases where the pregnant woman had a medical procedure to save her fetus's life, the prediction of fetal harm was incorrect. Veronika E.B. Kolder et al., *Court-Ordered Obstetrical Interventions*, 316 NEW ENG. J. MED. 1192, 1195 (1987). Yet the courts compelled treatment in all but three of these cases. *Id.*

127 Jefferson v. Griffin Spalding County Hosp. Auth., 274 S.E.2d 457, 458 (Ga. 1981).

128 Robert N. Berg, *Georgia Supreme Court Orders Cesarean Section—Mother Nature Reverses on Appeal,* 70 J. MED. ASSOC. OF GA. 451 (1981).

129 James J. Nocon, *Physicians and Maternal-Fetal Conflicts: Duties, Rights and Responsibilities*, 5 J.L. & HEALTH 1, 24 (1990-1991) ("[P]lacentas do not shift . . . . Clearly, the diagnosis was entirely erroneous.").

130 Don Terry, *Illinois Is Seeking to Force Woman to Have Cesarean*, N.Y. TIMES, Dec. 14, 1993, at A11.

vaginal birth.[131] After the court refused to compel the cesarean section, the woman successfully delivered a baby vaginally who had no brain damage whatsoever.[132]

Thus, when courts examine the risk to the fetus on one side of the balance, there is complete deference to the medical doctors' judgments. Doctors are the ones most competent to make these judgments, but doctors, like anybody else, can give an incorrect diagnosis. This is an ominous path down which some courts tread, because the possibility of incorrect diagnoses "creates the danger that court orders based on these judgments will expose pregnant women to unnecessary surgery, and hence to unnecessary risks to their own health."[133] And even if the doctors give a correct diagnosis, there is still the issue discussed in the previous section of the "substantial risk" of harm actually meaning a fairly low risk (such as the four to six percent risk from *Pemberton*).

iii. Undervaluing of the Woman's Convictions

Unlike their deference to medical judgments, the courts that put the fetus on the state's side of the balance generally do not defer to the woman's pain or fear threshold or her religious beliefs.[134] For Jehovah's Witnesses—who are often the ones attempting to refuse medical treatment in these cases—taking of another's blood is a sin that damns the woman to an eternity in hell[135] and ostracizes her from her religious community. If these courts took seriously the woman's religious belief, these same courts might figure in the risk to the mother more greatly in the balance. Similarly, as some argue—and even as the Supreme Court in *Casey v. Planned Parenthood* intimated—the mother's *psychological* health should figure into the equation.[136]

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131 *In re* Baby Boy Doe, 632 N.E.2d 326, 328 (Ill. App. Ct. 1994).

132 *Id.*

133 Scott, *supra* note 123, at 661.

134 The Illinois Appellate Court is a notable exception for accepting the woman's *subjective* belief about the proposed medical procedure instead of imposing its own (or the medical community's) *objective* belief. *In re* Fetus Brown, 689 N.E.2d 397, 405 (Ill. App. Ct. 1997). There, the court stated that a blood transfusion is "an invasive medical procedure that interrupts a competent adult's bodily integrity" and that it disagreed with the court's determination in *In re Baby Doe* that a blood transfusion, as compared to a cesarean section, was a "relatively noninvasive and risk-free procedure." *Id.* at 405 (quoting *In re* Baby Boy Doe, 632 N.E.2d 326, 333 (Ill. App. Ct. 1994)).

135 Jehovah's Witnesses find biblical support in a few different verses. *E.g.*, Leviticus 17:11, 12 ("No soul of you must eat blood"); Acts 15:28, 29 ("Abstain from blood").

136 Planned Parenthood of Se. Pa. v. Casey, 505 U.S. 833, 882 (1992) ("It cannot be questioned that psychological well-being is a facet of health."); Lawrence J. Nelson, *Of Persons and Prenatal Humans: Why the Constitution Is Not Silent on Abortion*, 13 LEWIS & CLARK L. REV. 155, 168 (2009) (arguing for courts to consider more seriously the psychological implications on the pregnant woman when medical treatment is done against her will for the fetus's sake).

iv. Broken Trust

Court-ordered medical treatments also have the potential to "erode the element of trust that permits a pregnant woman to communicate to her physician—without fear of reprisal—all information relevant to her proper diagnosis and treatment."[137] The American College of Obstetrics and Gynecology even cautions against doctors' seeking court orders, noting the "destructive effect of court orders on the pregnant woman's autonomy and on the physician-patient relationship," and that, therefore, "[r]esort to the courts is almost never justified."[138] Without such trust, pregnant women "at high risk of complications during pregnancy and childbirth" might escape "out of the health care system to avoid coerced treatment."[139]

v. Lack of Concern for the Soon-to-Be-Infant's Quality of Life

The fetus's ensuing quality of life is irrelevant. In fact, none of the cases that favor the fetus discusses the birth defects that the infant may still suffer from after a successful cesarean section. Instead, the focus seems to center on the preservation of *a* life, without any regard to *what* kind of life that means.

The case of Sidney Miller in Texas offers a particularly egregious example of this.[140] Though the case did not involve a conflict between a pregnant woman and a fetus, and instead involved a disabled infant, it nonetheless shows that the law favors life instead of a certain quality of life.

Sidney Miller was born four months' prematurely, weighing 629 grams (1.39 pounds).[141] Twelve hours before Sidney's birth, her parents and their doctor agreed that "no heroic measures" would be taken to resuscitate Sidney, and this was indicated in Sidney's medical chart.[142] But when a nurse later saw the order

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137 *In re* A.C., 573 A.2d 1235, 1248 (D.C. 1990) (referring to an *amicus curiae* brief from the American Public Health Association opposing court-ordered cesarean sections).

138 ACOG Cmte. on Ethics, *Patient Choice: Maternal-Fetal Conflict*, CMTE. OPINION (American College of Obstetrics & Gynecology, Washington, D.C. 1987).

139 *Id.* (referring to an *amicus curiae* brief from the American Public Health Association opposing court-ordered cesarean sections). The court in *In re A.C.* then cited two cases for illustrative purposes:

> In at least one case, a woman whose objection to a cesarean delivery had been overridden by a court went into hiding and gave birth to her child vaginally. In another case, a 16-year-old pregnant girl in Wisconsin has been held in secure detention for the sake of her fetus because she tended to be on the run and to lack motivation or ability to seek prenatal care.

In re A.C., 573 A.2d at 1248 n.16 (citation and quotation omitted).

140 HCA v. Miller, 36 S.W.3d 187 (Tex. App. 2000); Miller v. HCA, 118 S.W.3d 758 (Tex. 2003).

141 *HCA*, 36 S.W.3d at 190.

142 *Id.*

not to perform any heroic measures, she worried and contacted the hospital administration,[143] an emergency meeting was called, and the hospital decided, without telling Sidney's parents, that Sidney would be resuscitated when born.[144] The hospital had a policy of resuscitating any infant who weighed more than 500 grams (1.10 pounds),[145] and Texas's state statute requires resuscitation when a disabled infant is not terminally ill.[146] The appellate court and the state Supreme Court held that the hospital should not be liable, and the Millers were left with zero dollars to care for Sidney.[147] Sidney now is twenty years old but has the mental capacity of an infant and cannot feed, bathe, or clothe herself.[148] She wears diapers.[149]

The hospital, like any other hospital in a similar situation, could not consider Sidney's quality of life because the federal law that prompted the state statute simply requires resuscitation based on more objective stances than a quality of life determination, such as whether the infant has an irreversible condition and whether, in the physician's reasonable medical judgment, treatment will "ameliorat[e] or correct[]" the infant's life-threatening condition.[150] Indeed, even the Supreme Court has given its blessing for the state to favor life without regard to the quality of life.[151] In the pregnancy context, this presents a problem because a

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143 Miller v. HCA, 118 S.W.3d 758, 762 (Tex. 2003).

144 *Id.*

145 *Id.*

146 25 TEX. ADMIN. CODE §§ 405.51-405.63 (1996). Texas's statute responds to the federal Child Abuse Prevention and Treatment Act (CAPTA), which withholds funds from federally funded institutions if they deny medical treatment to handicapped infants solely on the basis of the handicap. Pub. L. No. 98-457, 98 Stat. 1749 (codified as amended at 42 U.S.C. §§ 5101-5106i (2006) and implemented in relevant part by 45 C.F.R. § 1340.15 (2008)). Under CAPTA, a state receiving federal funds for child welfare programs must delineate how medical professionals will respond to potential medical neglect of infants. *Id.*

147 HCA v. Miller, 36 S.W.3d 187 (Tex. App. 2000); Miller v. HCA, 118 S.W.3d 758 (Tex. 2003).

148 *Miller*, 118 S.W.3d at 764.

149 *Id.*

150 Pub. L. 98-457, 98 Stat. 1749 (codified as amended at 42 U.S.C. §§ 5101-5106i (2006) and implemented in relevant part by 45 C.F.R. § 1340.15 (2008)). In fact, one study showed that sixty percent of physicians (approximately 300 physicians in this study) believed that the CAPTA rules do "not allow for adequate consideration of the infant's physical condition," such as the infant's "pain and suffering." Loretta M. Kopelman, Arthur E. Kopelman, & Thomas G. Irons, *Neonatologists Judge the 'Baby Doe' Regulations*, 318 NEW ENG. J. MED. 677, 679 (1988). More than 250 of the 500 respondents "agreed that critically ill infants were overtreated when their chances for their survival were very poor . . . ." *Id.* Finally, an absolute majority of the survey group "thought [that] the [CAPTA rules] affected parental rights to consent to or refuse treatment [based] on what they thought was in the infant's best interests." *Id.* at 680.

151 Cruzan v. Dir., Mo. Dep't of Health, 497 U.S. 261, 282 (1990) ("[W]e think a State may properly decline to make judgments about the 'quality' of life that a particular individual may enjoy, and simply assert an unqualified interest in the preservation of human life . . . .").

doctor, perhaps to avoid malpractice liability, is more likely to try *too hard* to rescue a fetus instead of not trying *hard enough*.[152]

IV. RECONCILING THE DIFFERENCES BETWEEN THE CASES INVOLVING PREGNANT WOMEN THAT PUT THE FETUS'S RIGHTS ON THE STATE'S SIDE OF THE BALANCE AND THE DONOR CASES THAT HOLD THE RIGHT TO BODILY AUTONOMY AS INVIOLATE

The doctor who is trying to avoid liability might therefore bring a petition to the court to compel treatment in a pregnancy case or have the court's blessing for donation in a donor case. But why can the outcomes vary so greatly? Medical interventions with pregnant women and potential donors both involve the right to control one's medical care and bodily autonomy and the potential to safe another's life. But even though both situations share important similarities—and therefore, arguably, could lend themselves to an identical standard—only some courts analyze pregnancy cases using the traditional four interests on the state's side.[153] Other courts balance the fetus's potential *death* with a comparatively minor bodily intrusion on the pregnant woman's body and end up compelling the medical treatment against the woman's wishes.[154] If this kind of balancing test were used with organ donation cases, the courts would all easily conclude that the donation should be compelled because the effects of removing a kidney and living with one less kidney, however strong, will likely never be as strong as the effects of the donee's death.

There are several reasons validating some courts' use of a different standard for pregnant women than for potential donors, and this section acknowledges some of the potential justifications for affording would-be donors more rights than pregnant women and offers responses to those arguments.

A. The Mother Is the Only One Who Can Save the Fetus

Perhaps the most significant and persuasive justification for putting the fetus's interests instead of the traditional four factors on the state's side of the balance is that a pregnant woman offers the only possibility for the fetus's success.

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152 A medical malpractice claim requires the standard negligence claim elements of duty, breach, causation, and damages. If an obstetrician 'over-treats' a fetus by performing all treatments she believes necessary to bring the fetus to term (and the injury is wrongful life, not an incidental injury caused from the over-treatment), and if the jurisdiction even recognizes a wrongful life cause of action, the plaintiff probably will have a difficult time proving that the obstetrician breached her duty to birth the child. *See also, e.g.*, Lisa L. Chalidze, *Misinformed Consent: Non-Medical Bases for American Birth Recommendations As a Human Rights Issue*, 54 N.Y.L. SCH. L. REV. 59, 100 (2009-2010) ("Ob-gyns are . . . trained to fear the devil they know: malpractice lawsuits.").

153 *See* discussion *supra* Part III.A.1.

154 *See* discussion *supra* Part III.A.2.

She is connected to the child through the umbilical cord until after birth, and each pregnancy case deals with a medical condition that can *only* be cured by the mother.[155] In contrast, a potential donor sibling does not necessarily offer the only prospect of saving the donee sibling.[156] Though the sibling donor petitions often arise because the potential donor sibling is the only compatible match who has been identified until that point, his being a match does not mean that he is the *only* match—there could be other matches in the world who have not yet been identified. So although the healthy sibling offers the sick sibling the only chance of survival known until that point, a pregnant woman's actions or inactions directly affect the fetus's survival.

But this argument about the fetus's complete dependency on the pregnant woman can also swing the other way. This is what the Illinois Supreme Court pointed out in a 1998 case rejecting a tort action by the child against his mother for prenatal injuries:[157]

> No other plaintiff depends exclusively on any other defendant for everything necessary for life itself. No other defendant must go through biological changes of the most profound type, possibly at the risk of her own life, in order to bring

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155 As the dissenting judge in *In re A.C.* explained, a pregnant woman's relationship to her fetus is "unique" because of "the singular nature of the dependency of the unborn child upon the mother." *In re* A.C., 573 A.2d 1235, 1256 (D.C. 1990) (Belson, J., dissenting).

156 *E.g.*, *id.* (Belson, J., dissenting). The dissenting judge in that case argued for putting the fetus on the state's side of the balance instead of treating them the same as organ donors:

> A woman carrying a viable unborn child is not in the same category as a relative, friend, or stranger called upon to donate bone marrow or an organ for transplant. Rather, the expectant mother has placed herself in a special class of persons who are bringing another person into existence, and upon whom that other person's life is totally dependent. Also, uniquely, the viable unborn child is literally captive within the mother's body. No other potential beneficiary of a surgical procedure on another is in that position.

Id. (Belson, J., dissenting). Interestingly, the dissenting judge's view about the fetus's being "literally captive within the mother's body" is the exact same reason some argue that a fetus is *not* a third party deserving of protection in the state's traditional four interests. Harvard Law Review Association, *State Intervention During Pregnancy*, 103 HARV. L. REV. 1556, 1569-70 ("[T]he complete dependence of the fetus upon its mother for life renders it implausible to view the fetus as a third party, separate and distinct from its mother. The fetus's interests are inextricably bound up with its mother's, and the state may not use the supposedly third-party interests of the fetus as a predicate for violating the privacy rights and bodily integrity of the human being of which it is a part."). Similarly, a philosopher analogized a woman's pregnancy to a donor situation to point out how anyone would consider it "outrageous" to be forced to serve as a vessel for another for nine months. JUDITH JARVIS THOMPSON, A DEFENSE OF ABORTION (1971), *reprinted in* INTERVENTION AND REFLECTION: BASIC ISSUES IN MEDICAL ETHICS 69-80 (5th ed. Ronald Munson ed., Wadsworth 1996). Though Thompson used this analogy in the context of abortion to support her pro-choice position, the comparison nonetheless highlights the similar positions of organ donors and pregnant women and the unjustness of encroaching on a woman's right to bodily autonomy when doing so would be considered "outrageous" in the donor context. Some also use the Court's comment in *Roe v. Wade* to point out that a fetus is not a person deserving of Fourteenth Amendment protection. Roe v. Wade, 410 U.S. 113, 158 (1973) ("[T]he word 'person,' as used in the Fourteenth Amendment, does not include the unborn.").

157 Stallman v. Youngquist, 531 N.E.2d 355 (Ill. 1988).

> forth an adversary into the world. It is, after all, the whole life of the pregnant woman which impacts on the development of the fetus . . . . That this is so is not a pregnant woman's fault: it is a fact of life.[158]

Thus, it is arguable that it is precisely because "it is a fact of life" that the pregnant woman and her fetus are inextricably linked that a pregnant woman should not be compelled to undergo treatment to save her fetus.

B. The Pregnant Woman Waived Her Right to Decide What to Do with Her Body After Not Aborting in the First Trimester

Another significant reason for the differing treatment is that it may be that the pregnant woman has knowingly and voluntarily assumed the responsibility of doing whatever is necessary to bring her fetus to viability. Cesarean sections and blood transfusions may just be part of the territory for a pregnant woman, and the courts may be relying on this idea in overriding a pregnant woman's bodily autonomy. In fact, many scholars and courts use this argument to bolster the compelling of medical treatment of pregnant women, relying on *Roe v. Wade*, where the woman has a choice during the first trimester to abort a fetus for any reason she wishes.[159] When the woman's choice diminishes as her pregnancy progresses, these scholars and courts assert that a woman 'assumes the risk,' so to speak, of carrying her fetus to a successful, healthy birth.[160] Supporters of this argument use a similar tagline: "[o]nce she decides to forgo abortion and the state chooses to protect the fetus, the woman loses the liberty to act in ways that would adversely affect the fetus"[161] and that her choice not to abort equals her indication that she "has chosen to lend her body to bring [a] child into the world."[162] The same cannot be said of being a sibling to a sick child, of course.[163]

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158 *Id.* at 360.

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

160 The Supreme Court in dictum stated that "it might be said that a woman who fails to act before viability has consented to the State's intervention on behalf of the developing child." Planned Parenthood of Se. Pa. v. Casey, 505 U.S. 833, 870 (1992). This may have just been intended in the context of abortion, however.

161 John A. Robertson, *Procreative Liberty and the Control of Conception, Pregnancy, and Childbirth*, 69 VA. L. REV. 405, 437 (1983).

162 *Id.* at 456; *accord In re* A.C., 573 A.2d 1235, 1256 (D.C. 1990) (Belson, J., dissenting) (arguing that it is "not . . . unreasonable" to classify a pregnant woman differently from a potential donor because she is in a "unique category of persons" because she has "undertaken to bear another human being, and has carried an unborn child to viability"). A closely related argument is that if a state can proscribe abortion, certainly the state can take *less* extreme measures than proscribing abortion. For instance, the Court in *Roe v. Wade* stated that "[i]f the State is interested in protecting fetal life after viability, *it may go so far as to proscribe abortion*." Roe v. Wade, 410 U.S. 113, 164 (1973) (emphasis added). The *Pemberton* court used this reasoning to support the forced cesarean section, noting that "[b]earing an unwanted child is surely a greater intrusion on the mother's constitutional interests

This argument—that a woman becomes a vessel, duty-bound to do whatever it takes to ensure maximal health for her fetus just because she did not abort the fetus earlier—is misguided because *Roe* allowed states to proscribe abortion; its holding did not extend to physical intrusions into the pregnant woman's body against her consent.[164] Further, abortion is a positive action, whereas refusing treatment is a passive action or inaction and, unlike abortion, could center on the pregnant woman's decision to let nature take its course. Indeed, "[i]n most Cesarean refusal cases, the potential mother does not intend to *abort* the pregnancy. She does, however, refuse to undergo an intrusive surgery in order to deliver the baby"; in abortion cases, in contrast, "it is the intent of the woman to end the pregnancy and not deliver the fetus."[165]

The number of physical intrusions also may continue to increase because medical technology will keep increasing,[166] perhaps to the point of being able to detect every possible birth defect. But some women wish to experience a natural pregnancy, both in the pregnancy itself and the actual childbirth, especially with the rise of what some call the "medicalization"[167] of childbirth:

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than undergoing a caesarian section to deliver a child that the mother affirmatively desires to deliver." Pemberton v. Tallahassee Mem'l Reg'l Hosp., 66 F. Supp. 2d 1247, 1251 (N.D. Fla. 1999).

163 *E.g.*, 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, 110 (2005) ("[T]he difference [between organ donation and maternal-fetal compelled treatment] is that the woman has become pregnant and chosen not to abort the pregnancy.").

164 *Roe*, 410 U.S. at 154. The Court in *Roe* stated that "[a]t some point in pregnancy, these respective interests become sufficiently compelling to sustain regulation *of the factors that govern the abortion decision*." *Id.* (emphasis added); *accord* Scott, *supra* note 123, at 652 (arguing that "*Roe* did not purport to recognize the state's authority to protect [the state's] interest in any way other than by proscribing post-viability abortions"). *See also generally* April L. Cherry, *Roe's Legacy: The Nonconsensual Medical Treatment of Pregnant Women and Implications for Female Citizenship*, 6 U. PA. J. CONST. 723 (2004). Also, the Court in *Casey v. Planned Parenthood* said the following:

> [I]f *Roe* is seen as stating a rule of personal autonomy and bodily integrity, akin to cases recognizing limits on governmental power to mandate medical treatment or to bar its rejection, this Court's post-*Roe* decisions accord with *Roe*'s view that a State's interest in the protection of life falls short of justifying any plenary override of individual liberty claims.

Planned Parenthood of Se. Pa. v. Casey, 505 U.S. 833, 857 (1992) (citing Cruzan v. Dir., Mo. Dep't of Health, 497 U.S. 261, 278 (1990)).

165 Levy, *supra* note 59, at 103 (arguing that *Roe v. Wade* and its progeny should not govern these cases and that, instead, cesarean section refusal should be analyzed under the right to refuse medical treatment).

166 *E.g.*, Mark R. Mercurio, *The Aftermath of Baby Doe and the Evolution of Newborn Intensive Care*, 25 GA. ST. U. L. REV. 801, 845 (2009) (describing the "dramatic increase in the effectiveness of, and use of, techniques for prenatal diagnosis" in the past twenty-five years and that prenatal ultrasound, which can detect congenital heart disease, intestinal and tracheoesophageal atresias, and sometimes even Down Syndrome, today has a "near universal use in pregnancy in the United States").

167 *E.g.*, Chalidze, *supra* note 152, at 67 (describing how "[i]n the latter half of the nineteenth century, American medicine started to become professionalized, as practitioners seeking financial

> [N]inety-five percent of American births occur in hospitals. Although hospital-based birth has great advantages for the child and the mother in high-risk or difficult births, it has no particular advantages in normal births—in fact, it may even have disadvantages. Hospital births often take place in a depersonalized setting, and giving birth in a hospital may increase the risk of iatrogenic infections and unnecessary cesarean sections. Hospitals often limit the number of people who attend the birth, subject the mother to unpleasant 'standard procedures' such as intravenous lines, enemas, and shaving, and prevent close contact between mother and infant. Childbirth at home is more intimate and more subject to the mother's control. As a result, some women prefer to give birth at home.[168]

Some women also might not want to know what possible diseases or ailments their fetuses are facing—not to mention the fact that these diagnoses might be incorrect, as discussed above with the misdiagnosed placenta previa in *Jefferson v. Griffin Spalding County Hospital Authority*.[169]

C. The Pregnancy Cases Often Involve an Immediate Threat to Life—No Time to Corral the Pregnant Woman's Experts, but the Doctors Have Science on Their Side

Another potential reason for the differing treatment is that most of the cases involving pregnant women and their fetuses necessitate immediate or near-immediate treatment to save the fetus's life. Cases involving sibling donors, on the other hand, often involve the sick sibling's chronic disease. This immediacy, combined with the difference in the *types* of petitions, may compound the problem. In the pregnancy cases, the doctors or the hospital bring the petition to the court to compel treatment, or they seek to make a hospital administrator the fetus's legal guardian;[170] in the donor cases, on the other hand, the minor's or incompetent's guardian is the one who brings the petition. Both types of petitioners use expert opinions to bolster their petitions to compel treatment (either

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reward gladly incorporated burgeoning technology of the nineteenth-century spirit of innovation into their practices").

168 Robertson, *supra* note 161, at 453.

169 *See* discussion *supra* Part III.A.3.b.

170 Underlying a doctor's or a hospital's reason for pursuing a court-ordered petition to compel treatment may be a concern for malpractice liability. In turn, courts often give particular deference to medical judgments because they feel they are incompetent to question the professional judgment of medical doctors. *E.g.*, Roe v. Wade, 410 U.S. 113, 164-65 (1973) (allowing "medical judgment" to govern "the abortion decision and its effectuation" in the first trimester, and "appropriate medical judgment" to govern when the state is prevented from acting in the third trimester because of a danger to the mother's health or life). This deference "becomes particularly problematic when the doctor has financial, legal, or ideological interests at stake in the determination." Randy Beck, *Gonzales, Casey, and the Viability Rule*, 103 NW. U. L. REV. 249, 260 (Winter 2009) (citing Moore v. Regents of Univ. of Cal., 793 P.2d 479, 485 (Cal. 1990) (recognizing that a doctor's "personal interests . . . may affect his medical judgment")).

the organ donation or the medical procedure on the pregnant woman). But the petitioners in the pregnancy cases have the advantage of a short time-frame. Because the petitions in pregnancy cases often are emergency petitions, the petitioners come equipped with an expert witness: the doctor herself. The pregnant women, on the other hand, often do not have this luxury. Instead:

> [A]ny judicial proceeding in a case such as this will ordinarily take place . . . under time constraints so pressing that it is difficult or impossible for the mother to communicate adequately with counsel, or for counsel to organize an effective factual and legal presentation in defense of her liberty and privacy interests and bodily integrity.[171]

In one case involving an emergency petition, the woman's court-appointed attorney could not meet with her before the hearing, and when her case was heard, her medical condition "did not allow her to be present, nor was it reasonably possible for the judge to hear from her directly."[172] Also, her "medical records were not before the court" during the hearing, and "the physician who had been treating [her] for many years . . . was not even contacted and hence did not testify."[173] In another case also involving an emergency petition, the pregnant woman's doctor was the state's sole witness; the only testimony offered in the pregnant woman's support came from the pregnant woman herself, who expressed her concerns about the cesarean section.[174] In yet another emergency petition case, the judge ordered a hearing at the pregnant woman's bedside where the pregnant woman was the only person to offer testimony against a blood transfusion.[175] The state, however, presented testimony from the pregnant woman's internist, and a note from the pregnant woman's obstetrician predicting the danger to both her and her fetus's life was read into evidence.[176] With the deck stacked against the pregnant woman—the bevy of doctors who can testify as expert witnesses, the pregnant woman's having no experts on her behalf, and the pregnant woman's sometimes debilitated state—the difference in the outcome of pregnancy cases compared with donor cases is logical.

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171 *In re* A.C., 573 A.2d 1235, 1248 (D.C. 1990). The court in *In re A.C.* cautioned:

> Any intrusion implicating such basic values ought not to be lightly undertaken when the mother not only is precluded from conducting pre-trial discovery (to which she would be entitled as a matter of course in any controversy over even a modest amount of money) but also is in no position to prepare meaningfully for trial.

Id.

172 *Id.*

173 *Id.*

174 *In re* Baby Boy Doe, 632 N.E.2d 326, 328 (Ill. App. Ct. 1994).

175 *In re* Jamaica Hosp., 491 N.Y.S.2d 898, 899 (Sup. Ct. 1985).

176 *Id.*

Supporters of fetal rights might concede that fewer procedural safeguards exist in this context because of the time-sensitive nature of these cases. In contrast to donor cases, where a child's illness is often chronic, the maternal-fetal cases often must involve quick decisions if there is any hope of saving the fetus's life. One judge justified the lack of procedural due process by explaining that because "[t]he baby's birth was imminent[,] convening a full adversary hearing with greater advance notice would have been impossible."[177] Another judge similarly justified the lack of procedural due process by pointing out the imminency of the situation: "I felt that the usual formalities of the assignment of counsel, notice to her family and testimony in a courtroom setting with stenographic record must be dispensed with because of the danger of imminent death."[178] The judge in that case ultimately decided to conduct a quick hearing and order a blood transfusion even though the fetus was not yet viable.[179]

But although the cases involving pregnant women often are immediately life threatening[180]—especially in comparison to the chronic illnesses in sibling donor cases—it is unclear that this should override a woman's rights. Precisely because these cases often involve an invasive medical treatment that the woman finds repugnant, and precisely because of the deficient procedural safeguards, the courts should perhaps tread more cautiously; after all, "courts dealing with other kinds of medical decision-making conflicts have insisted both upon much more rigorous procedural standards and upon significantly more information."[181] Without such caution:

> The procedural shortcomings rampant in these cases . . . undermine the authority of the decisions themselves, posing serious questions as to whether judges can, in the absence of genuine notice, adequate representation, explicit standards of proof, and right of appeal, realistically frame principled and useful legal responses to the dilemmas with which they are being confronted.[182]

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177 Pemberton v. Tallahassee Mem'l Reg'l Hosp., 66 F. Supp. 2d 1247, 1254 (N.D. Fla. 1999).

178 *In re* Jamaica Hosp., 491 N.Y.S.2d 898, 899 (Sup. Ct. 1985).

179 *Id.* at 900 ("While I recognize that the fetus in this case is not yet viable, and that the state's interest in protecting its life would be less than 'compelling' in the context of abortion cases, this is not such a case. In this case, the state has a highly significant interest in protecting the life of a mid-term fetus, which outweighs the patient's right to refuse a blood transfusion on religious grounds.").

180 It would probably be a mistake to assume that *all* of these cases are immediately life-threatening. As discussed above, doctors sometimes mistakenly think that a situation involving a fetus is imminently life-threatening when it is actually not, and the courts give great deference to the medical judgment that a situation is life-threatening. *See* discussion *supra* Part III.A.3.b.

181 Janet Gallagher, *Prenatal Invasions and Interventions: What's Wrong with Fetal Rights*, 10 HARV. WOMEN'S L.J. 9, 49 (1987).

182 *Id.* at 49; *accord* Joelyn Knopf Levy, *Jehovah's Witnesses, Pregnancy, and Blood Transfusions: A Paradigm for the Autonomy Rights of All Pregnant Women*, 27 J.L., MED. & ETHICS 171, 177 (Summer 1999) ("[T]he necessity of rendering a speedy decision in obstetrical cases . . . leaves judges, already ignorant of the necessary medical information, ill equipped to render an informed opinion.").

And for the pregnant woman, she becomes "ill equipped to mount a defense of her autonomy, given the lack of notice she has to prepare and the difficulty of seeking appropriate counsel due to her physical condition."[183]

D. Organ, Tissue, or Bone Marrow Donation Are More Intrusive Because They Always Involve the Removal of a Body Part

The courts examining compelled donor petitions are candid about the tragedies that usually surround these petitions, and they sympathize with the fact that the potential donee will most likely die without the donation. Nonetheless, these courts are adamant about drawing the line for donations, only allowing donations where the donee *and* the donor will benefit:[184] a win-win situation. Otherwise, as one court noted in rejecting a donor petition, "one could not imagine where the line would be drawn."[185] The court continued:

> 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. Forceable extraction of living body tissue causes revulsion to the judicial mind. Such would raise the spectre of the swastika and the Inquisition, reminiscent of the horrors this portends.[186]

The difference with a donor case and a pregnancy case, then, could be about the very extraction of organs—the extraction of one's *property* for the sake of another. With pregnant women on the other hand, their property is not being removed for their fetuses; instead, if they and their fetuses are seen as *one* entity, any medical procedure could simply be seen as a procedure that benefits that singular entity.

Of course, the problem with this thinking is two-fold. First, it is dangerous to look at the degree of intrusion on a person objectively. For many of the pregnant women wishing to refuse certain medical treatments for their fetuses, what they consider a damnable intrusion is not what every person would consider a damnable intrusion.

Second, the same concern that some courts in donor cases discuss about where the line would be drawn also exist for pregnancy cases. If a court can compel a pregnant woman who carries a viable fetus to submit to a massively invasive surgery like a cesarean section, what else can a court make her do? As a concurring judge pointed out in *Whitner v. State*, a South Carolina case upholding the conviction of a woman for drug use during pregnancy, "[i]s a pregnant

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183 Levy, *supra* note 182, at 177.

184 *See* discussion *supra* Part II.

185 McFall v. Shimp, 10 Pa. D. & C.3d 90, 91 (1978).

186 *Id.* at 92.

woman's failure to obtain prenatal care unlawful? Failure to quit smoking or drinking?"[187] He went on to warn that "the impact of today's decision is to render a pregnant woman potentially criminally liable for myriad acts which the legislature has not seen fit to criminalize."[188]

CONCLUSION

The concurring judge's concern in *Whitner* may not be all that farfetched. Examples abound of pregnant women who are jailed or convicted of felony child abuse because of substance abuse (sometimes abuse of legal substances, like alcohol). In Wyoming, for instance, a pregnant woman was jailed for felony child abuse based on her alcohol use until the charges were dropped.[189] In Wisconsin, officials detained a pregnant teenager based on her tendency to "be on the run" and "lack of motivation or ability to seek prenatal care."[190] A Wisconsin statute allows a judge to place a pregnant woman into custody based on a "satisfactory" showing that there is a "substantial risk" that her alcohol use will harm her unborn child;[191] the same statute allows a law enforcement official to place a pregnant woman into custody upon the same suspicion.[192] This can occur even though alcohol use by itself is lawful, and even though there is no conclusive evidence that alcohol use causes harm to a fetus.[193]

Indeed, conclusive evidence is not necessary to compel treatment in pregnancy cases; instead, for some courts, it is enough for just one doctor to speculate that the fetus faces a "substantial risk" of harm.[194] Thus, when a pregnant woman's rights are balanced against the potential harm to her fetus's life, the balance will always favor the fetus—and the pregnant woman becomes no more than a vessel to carry her fetus to term in the healthiest way possible.[195]

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187 Whitner v. State, 492 S.E.2d 777, 788 (S.C. 1997) (Moore, J., concurring).

188 *Id.*

189 Charles Levendosky, *Turning Women into Two-Legged Petri Dishes*, STAR TRIBUNE (MINN.), Jan. 21, 1990, at A8.

190 Veronika E.B. Kolder et al., *Court-Ordered Obstetrical Interventions*, 316 NEW ENG. J. MED. 1192, 1195 (1987).

191 WIS. STAT. ANN. § 48.193(1)(c) (2005).

192 *Id.* § (d)(2).

193 Doctors disagree about the effects of alcohol. Some say that any amount of alcohol during pregnancy is unsafe. *E.g.*, The American Pregnancy Association, *Foods to Avoid During Pregnancy*, *available at* http://www.americanpregnancy.org/pregnancyhealth/foodstoavoid.html (last visited October 10, 2010). Others say that a moderate amount, even four drinks per week, will not harm a fetus. *E.g.*, Royal College of Obstetricians and Gynecologists, *Alcohol and Pregnancy: Information for You* (Nov. 2006), *available at* http://www.rcog.org.uk/womens-health/clinical-guidance/alcohol-and-pregnancy-information-you (last visited October 10, 2010).

194 *See* discussion *supra* Part III.A.3.a.

195 *See* discussion *supra* Part IV.A-B.

But this framework, which inappropriately stretches *Roe v. Wade*, ignores the woman's right to be free from bodily intrusion, and improperly relies on medical professionals' speculations about the potential harms to the fetus. Especially when compared with the near-complete deference to the individual in donor cases, the treatment of pregnant women suggests that some courts believe that the state knows what is best for the mother and child.