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NOTES

MOTHER V. FETUS—THE CASE OF “DO OR DIE”: IN RE A.C.

“Render therefore unto Caesar the things which are Caesar’s; and unto God the things that are God’s.”

Matthew 22:21

The appellate courts have confronted only recently the issue of involuntarily sacrificing a mother’s rights for the sake of her fetus. In re A.C.1 involved a terminally-ill mother who refused to have a Caesarean operation which potentially would have reduced her life span but would have saved her fetus. The Court of Appeals for the District of Columbia ultimately found that George Washington Hospital could perform a Caesarean section on the mother without her permission.2

Court ordered surgery on a pregnant woman inevitably affects not only the mother, but also her fetus. In In re A.C.,3 the Court of Appeals for the District of Columbia was confronted with a most perplexing issue that not only involved legal, but also moral, medical, religious, philosophical, technological and social considerations.4 While the voluntary murder of one’s

2. Id.
3. Id.
4. Judge Nebeker, contemplating these considerations, suggested that “[i]t would be far better if, by legislation, these bioethical decisions could be made by duly constituted and informed ethical groups within the health care system, and if desired, appellate review as provided in other administrative proceedings.” 533 A.2d at 612. This suggestion leads one to believe that Judge Nebeker believes this to be a case which is not proper for a judge to consider because of the complex medical facts involved and the expediency in which they need to be digested and utilized by the decision-maker. Other courts deciding similar issues as those involved in In re A.C. have recognized the same difficulties. In In re Conroy, 98 N.J. 321, 344, 486 A.3d 1209, 1220 (1985), the court stated that “[n]o one person or profession has all the answers.” Another court stated:

child has not been sanctioned by our society as a protected right, the courts recently have initiated the formation of the parameters of a pregnant woman’s right to die without any involuntary bodily invasion.\(^5\) Since the courts only recently have confronted these cases, there is little juridical discord as to the pregnant woman’s right.\(^6\)

This Note will first examine a similar case, Jefferson v. Griffin Spalding County Hosp. Auth.\(^7\) It will then survey three bodies of law: (1) the right to privacy; (2) the right of a competent adult to refuse medical treatment; and (3) the right of a parent to refuse medical treatment on behalf of his or her offspring.\(^8\) The Note will proceed with an examination of the facts and the court’s analysis in In re A.C., to be followed by a critical analysis of the court’s reasoning and of the ramifications of this decision on future cases. It is important to note that this case involved a very sensitive issue to which the courts would rather not respond\(^9\) and which the legislature has not addressed.\(^10\)

I. RELEVANT LAW

Because Caesarean surgery involves an invasion of a pregnant woman’s person, the courts must consider the constitutional analysis of a woman’s right to bodily integrity and the established law which deals with a competent person’s right to refuse medical treatment. Additionally, because the refusal of treatment by the mother most likely will affect the health and life

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5. The law involved in these types of cases actually dates back to Roe v. Wade, 410 U.S. 113 (1973), concerning the privacy right of the mother and the state’s interest in the viability of the fetus.

6. The more complex and difficult issue for the courts is the one presented in In re A.C.. In this case, the court decided to forego the two days remaining in the mother’s life in order to make an attempt to save the fetus. This Note will use the term “fetus” and not “unborn child.” It is crucial to make the distinction between the two. The word “child” implies legal status under the Constitution. The Supreme Court in Roe, however, did not determine whether the “fetus” had legal status under the Constitution. 410 U.S. 113. “Fetus” is a scientifically correct term for an unborn in the first few months of development. See Note, Family Law-Court-Ordered Surgery for the Protection of a Viable Fetus—Jefferson v. Griffin Spalding Hosp. Auth., 5 W. NEW ENG. L. REV. 125, 126 n.11 (1982) [hereinafter Note, Family Law].


8. See In re A.C., 533 A.2d at 615.

9. See id. at 612.

of the fetus detrimentally, the courts must examine the precedent concerning the mother's right to refuse medical treatment for her child.\footnote{11}

\section*{A. Jefferson v. Griffin Spalding County Hosp. Auth.}

One of the first cases decided by a state's high court addressing a pregnant mother's right to refuse a Caesarean section was \textit{Jefferson v. Griffin Spalding County Hosp. Auth.}\footnote{12} A woman, thirty-nine weeks pregnant, who was an out-patient at Griffin Spalding County Hospital, refused to have blood transfusions and a possible Caesarean section. Her doctor determined that she was suffering from "placenta previa."\footnote{13} Because of this condition, there was a high probability that the child would not survive and that the mother had only a fifty percent chance for survival if the child was born by natural child birth.\footnote{14}

The Georgia Supreme Court found the fetus to be viable and therefore believed that the unborn child had the right under the United States Constitution to have the protection of the state.\footnote{15} The court continued its analysis by finding that the life of the mother and of the unborn child were at that time inseparable. The court deemed it appropriate to infringe upon the rights of the mother to the extent necessary to give the child an opportunity to live.\footnote{16} In making this determination, the court balanced the intrusion into the mother's life against the duty of the state to protect the unborn child from meeting death before being provided the opportunity to live.\footnote{17}

\section*{B. The Privacy Right of a Pregnant Woman}

\textit{Roe v. Wade}\footnote{18} has developed into the paradigm case of a woman's right to privacy\footnote{19} in the context of her decision to terminate her pregnancy. The
Supreme Court in *Roe* concluded that there is a right of privacy, implicit in the liberty secured by the fourteenth amendment, which "is broad enough to encompass a woman's decision whether or not to terminate her pregnancy." The privacy right, although fundamental, is not absolute, and must be considered against "compelling" state interests in the health of the pregnant woman and in the potential life of the fetus. A state interest in the potential life of the fetus reaches a compelling point at the stage of viability. After viability, the state may regulate or prohibit abortion except when necessary, in appropriate medical judgment, to preserve the life or health of the pregnant woman. Moreover, the Supreme Court did not explicitly provide the fetus with legal rights, but merely recognized a state interest in the fetus. Therefore, the Court did not recognize the fetus as a person with legal status and, consequently, the fetus is not afforded the same rights as a newly born child.

While the controversy of a fetus' legal rights continues, the Supreme Court has attempted to clarify when the mother's rights prevail over the state interest in the fetus. In *Colautti v. Franklin*, the Supreme Court opined that a mother's right must prevail when the state attempts to sacrifice the health, well-being, or life of the mother for the sake of the fetus. The Court stated: "These interests are separate and distinct. Each grows in substantiality as the woman approaches term and, at a point during pregnancy, each becomes 'compelling.'" Additionally, the Court noted that viability is usually placed at about twenty-eight weeks, but may occur as early as twenty-four weeks. *Roe*, 410 U.S. at 163.

States Supreme Court concluded, in a plurality decision, that while the right to privacy is not an enumerated right, it does emanate from "zones of privacy" which can be found in the "penumbras" of the Bill of Rights. *Id.* at 484.

20. *Id.* at 153.

21. *Id.* at 162. The Court stated: "These interests are separate and distinct. Each grows in substantiality as the woman approaches term and, at a point during pregnancy, each becomes 'compelling.'" *Id.* at 162-63.

22. The Supreme Court has recognized "viability" to mean "potentially able to live outside the mother's womb, albeit with artificial aid." *Id.* at 160. Additionally, there must be potentiality of "meaningful life," *id.* at 163, and not merely momentary survival. *Colautti v. Franklin*, 439 U.S. 379, 387 (1979) (citing *Roe v. Wade*, 410 U.S. 113, 163 (1973)). Additionally, the Court noted that viability is usually placed at about twenty-eight weeks, but may occur as early as twenty-four weeks. *Roe*, 410 U.S. at 160.


24. *Roe*, 410 U.S 113 (1973); *see also In re A.C.*, 533 A.2d at 616-17.


26. *Colautti*, 439 U.S. at 400. The Court analyzed the statute and determined that it was susceptible to a construction allowing for the mother's health and well being to be subordinate to the fetus' health and life when both conflict. Therefore, the statute was determined to be unconstitutionally vague. *Id.* at 400-01. Section 5 of the statute in controversy read in pertinent part:

(a) Every person who performs or induces an abortion shall prior thereto have made a determination based on his experience, judgment or professional competence
that, in the absence of a more precise statute, a criminal sanction may not be imposed on a physician who performs an abortion when the life and health of the mother conflicts with the life and health of the fetus.27

The Court in a subsequent case, *Thornburgh v. American College of Obstetricians & Gynecologists*,28 confirmed the implications of the *Colautti* language when it stated that "this Court recognized the undesirability of any "trade-off" between the woman's health and additional percentage points of fetal survival."29 The *Thornburgh* court, adopting the Third Circuit's reasoning, held the Pennsylvania statute to be facially invalid because the language of the statute "is not susceptible to a construction that does not require the mother to bear an increased medical risk in order to save her viable fetus."30 The Court disregarded the vagueness argument and instead ruled on its merits. In so doing, the Court developed a standard to utilize in

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27. *Id.* at 400-01.
28. 476 U.S. 747 (1986). The Supreme Court noted that the Third Circuit ruled that a provision in the Pennsylvania statute was unconstitutional because "it required a 'trade-off' between the woman's health and fetal survival, and failed to require that maternal health be the physician's paramount consideration." *Id.* at 768-69 (citation omitted).

The Pennsylvania statute, section 3210(b), read:

> Every person who performs or induces an abortion after an unborn child has been determined to be viable shall exercise that degree of professional skill, care and diligence which such person would be required to exercise in order to preserve the life and health of any unborn child intended to be born and not aborted and the abortion technique employed shall be that which would provide the best opportunity for the unborn child to be aborted alive unless, in good faith judgment of the physician, that method or technique would present a significantly greater medical risk to the life or health of the pregnant woman than would another available method or technique and the physician reports the basis for his judgment. The potential psychological or emotional impact on the mother of the unborn child's survival shall not be deemed a medical risk to the mother. Any person who intentionally, knowingly or recklessly violates the provisions of this subsection commits a felony of the third degree.

*Id.* at 768 n.13 (emphasis added).
29. *Id.* at 769 (quoting *Colautti*, 439 U.S. at 400).
30. *Id.* at 769.
a case where the mother's and fetus' health and life conflict. Instead of retaining the "significantly greater medical risk" standard, which was used in the Pennsylvania statute, the Court adhered to a lower "increased medical risk" standard. Consequently, it implies that a statutorily required sacrifice of health, welfare, or life of the mother for the sake of the fetus is constitutionally unacceptable.31

C. Right to Refuse Medical Treatment32

Absent some important governmental interest, an individual's right to refuse medical treatment has generally been upheld as a basic right to control one's body.33 This right has been based on the right to privacy34, informed consent35 and self-determination.36

31. Justice White, while cognizant of the implication of the majority's holding, remarked: "[I]f the state's interest in preserving the life of a viable fetus is, as Roe purports to recognize, a compelling one, the state is at very least entitled to demand that that interest not be subordinated to a purported maternal health risk that is in fact wholly insubstantial." Id. at 807, (White, J., dissenting).

32. While the refusal of medical treatment may be potentially exercised by a competent or incompetent adult or child, this Note will only speak to the law which deals with the competent adult, since In re A.C. involves only a competent adult. However, it is worth noting that the courts have extended the competent's right to refuse medical treatment to incompetents. In such a case the courts have an additional burden of determining the incompetent's probable intent. See, e.g., In re Conroy 98 N.J. 321, 345, 486 A.2d 1209, 1221 (1985); Superintendent of Belchertown v. Saikewicz, 373 Mass. 728, 370 N.E.2d 417 (1977); In re Colyer, 99 Wash.2d 114, 660 P.2d 738 (1983); John F. Kennedy Memorial Hosp., Inc. v. Bludworth, 452 So.2d 921 (Fla. 1984).

33. This concept dates back in our courts as far as Union Pac. Ry. Co. v. Botsford, 141 U.S. 250, 251 (1891), where the Supreme Court refused to compel a personal injury plaintiff to undergo a pretrial medical examination stating: No right is held more sacred, or is more carefully guarded by the common law, than the right of every individual to the possession and control of his own person, free from all restraint or interference of others, unless by clear and unquestionable authority of law. As well said by Judge Cooley, "the right to one's person may be said to be a right of complete immunity: to be let alone." See also In re Colyer 99 N.J. 321, 346, 486 A.2d 1209, 1221 (1985). See generally In re Melideo, 88 Misc. 2d 974, 390 N.Y.S.2d 523 (1976).

34. See supra notes 18-23 and accompanying text.

35. See, e.g., 98 N.J. at 346, 486 A.2d at 1222, where the court stated: The doctrine of informed consent is a primary means developed in the law to protect this personal interest in the integrity of one's body. 'Under this doctrine, no medical procedure may be performed without a patient's consent, obtained after explanation of the nature of the treatment, substantial risks, and alternative therapies.' (Citation omitted).


While the fundamental principle of individual autonomy is well-established in our legal history, the fact that these principles are not unqualified is just as well implanted in our society. Courts and commentators have commonly identified four state interests that may restrain the person's right to refuse medical treatment: preserving life, preventing suicide, protecting innocent third parties, and maintaining the integrity of the medical profession. 37

Commonly considered the most significant of the four state interests is the preservation of life. 38 In cases that do not involve the protection of an actual or potential life of someone other than the decision-maker, the state's tangential interest in preserving life will usually become subordinate to the more direct or personal interest of the competent person to control his body. “Indeed, insofar as the ‘sanctity of individual free choice and self-determination [are] fundamental constituents of life,’ the value of life may be lessened rather than increased ‘by the failure to allow a competent human-being the right of choice.’” 39

Pursuant to the state's “preservation of life” objective, states have promulgated statutes to prevent suicide or the aiding of a suicide. 40 Some states attempt to categorize the refusal of treatment as suicide. However, it has been noted by many courts that declining life-sustaining medical treatment is not an attempt to commit suicide. 41 Generally, the intent to commit suicide is lacking when the patient declines any medical treatment. The patient declines medical treatment in order to not violate a religious doctrine or for various other reasons, but the patient does not decline the treatment with the intent to commit suicide. Therefore, the person is not considered to be com-

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38. See, e.g., 98 N.J. at 349, 486 A.2d at 1223; 373 Mass. at 740, 370 N.E.2d at 425.

39. 98 N.J. at 350, 486 A.2d at 1223-24 (citation omitted).

40. See, e.g., N.J. STAT. ANN. § 2C:11-6 (West 1982).

mitting suicide.\textsuperscript{42}

Because the general precept of the medical profession is to save lives, the idea of allowing a patient to die contravenes one of the medical profession's most basic principles.\textsuperscript{43} Consequently, the maintenance of the integrity of the medical profession has frequently been asserted as a limitation on a patient's right to refuse medical treatment. However, this interest, like the interest in the prevention of suicide, has had in actuality little effect on the patient's refusal right.\textsuperscript{44} As the court in \textit{In re Conroy} stated:

Medical ethics do not require medical intervention in disease at all costs. As long ago as 1624, Francis Bacon wrote, 'I esteem it the office of a physician not only to restore health, but to mitigate pain and dolours; and not only when such mitigation may conduce to recovery, but when it may serve to make a fair and easy passage.'\textsuperscript{45}

The court continued by explaining that physicians today distinguish between the curable and the dying:

'[T]hey refuse to treat the curable as if they were dying or ought to die, and that they have sometimes refused to treat the hopeless and dying as if they were curable.' Indeed, recent surveys have suggested that a majority of practicing doctors now approve of passive euthanasia and believe that it is being practiced by members of the profession.\textsuperscript{46}

The state interest that seems to have the most limiting effect on the patient's right to refuse medical treatment is the protection of innocent third

\textsuperscript{42} Id.


\textsuperscript{45} 98 N.J. at 352, 486 A.2d at 1224-25 (citation omitted).

\textsuperscript{46} Id. at 352, 486 A.2d at 1225. As the New Jersey Supreme Court similarly expressed, the Massachusetts Supreme Court noted:

[T]he prevailing ethical practice seems to be to recognize that the dying are more often in need of comfort than treatment. Recognition of the right to refuse necessary treatment in appropriate circumstances is consistent with existing medical mores; such a doctrine does not threaten either the integrity of the medical profession, the proper role of hospitals in caring for such patients or the State's interest in protecting the same. It is not necessary to deny a right of self-determination to a patient in order to recognize the interest of doctors, hospitals, and medical personnel in attendance on the patient.

parties. The patient's exercise of his or her free choice will many times become subordinate to the state interest because his or her choice to die will adversely affect the health or life of others. Frequently, while other state interests will not prevail, courts will rule in favor of this state interest even to override religious objections.

When examining the person's right to refuse medical treatment and the state compelling interest, the court must conduct a delicate balancing of the two. In most circumstances, even if the patient's condition is hopeless, the patient's right of privacy outweighs the state interest in preserving life, preventing suicide or safeguarding the integrity of the medical profession. However, the patient's rights can be subordinated when the interest of the state involves the protection of an innocent third party. The balance then will tip usually in favor of the state interest.

D. Parental Rights to Withhold Treatment

Another line of cases which must be considered when confronted with a pregnant woman's refusal of medical treatment concerns the right of parents to withhold treatment from their minor children. As one court noted:

It is well-settled that parents are the 'natural guardians of their children [with] the legal as well as moral obligation to support . . . educate' and care for their children's development and well-being. . . . Indeed, these 'natural rights' of parents have been recognized as encompassing an entire 'private realm of life which must be afforded protection from unwarranted State interference.'

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47. See, e.g., Saikewicz, 373 Mass. at 728, 370 N.E.2d at 425; In re Colyer, 99 Wash. 2d 114, 121, 660 P.2d 738, 743; In re Conroy, 98 N.J. 321, 349, 486 A.2d 1209, 1223; Application of President & Directors of Georgetown College, Inc., 331 F.2d at 1008.


50. See supra notes 33-46 and accompanying text.

51. See supra notes 47-49 and accompanying text.

52. Of course the relevancy of these cases depends on the legal status of the fetus. See supra notes 6, 15-27 and accompanying text.

Parental autonomy, however, is not absolute. The state, through the doctrine of *parens patriae*, has the duty and responsibility to care for and protect those who are unable to care for and protect themselves. The use of this doctrine provides the state a vehicle with which to intervene when a parent refuses to give his or her consent to medical treatment that will substantially benefit the child's health or life. In non-life-threatening circumstances, the courts have upheld the parent's right to refuse medical treatment for his or her child. However, most cases involve a life-threatening situation for the child, and, in such cases, courts will allow the state to intervene to protect the child.

The distinction between the mother's right to refuse medical treatment for herself and the mother's right to refuse medical treatment for her child becomes critical when the health and life of the mother contravenes the health and life of the fetus. The distinction revolves around the legal status given to the fetus. If the fetus is given legal status equal to that of an infant then the cases preventing parents from refusing medical treatment for their children would be controlling. Consequently, the state could successfully prevent the mother from refusing to have a Caesarean section that would benefit the child. However, if the fetus is not given legal status equal to that of an infant, then the cases which allow an individual to refuse medical treatment

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55. *Id.; In re Philip B.*, 92 Cal. App. 3d 796, 801, 156 Cal. Rptr. 48 (1979) (court ordered surgery for a child with congenital heart defect over parent's objections); *Crouse Irving Memorial Hosp., Inc. v. Paddock*, 127 Misc. 2d 101, 102, 485 N.Y.S.2d 443, 445 (Supp. 1985) (court ordered pregnant woman to receive blood transfusions to protect the welfare of a fetus that was to be prematurely delivered); *Jehovah's Witnesses v. King County Hosp.*, 278 F. Supp. 488, 504 (1967) (Washington statute empowering judges to authorize blood transfusions for children against parent's wishes was not constitutionally invalid); *but see Taft v. Taft*, 388 Mass. 331, 332, 446 N.E.2d 395, 397 (1983) (court vacated judgement of lower court ordering a woman, four months pregnant, to undergo a "purse string" operation to prevent miscarriage).

The underlying rationale of *parens patriae* is reflected in the oft quoted statement by the Supreme Court in *Prince v. Massachusetts*, 321 U.S. 158, 170 (1944): "Parents may be free to become martyrs themselves. But it does not follow they are free, in identical circumstances, to make martyrs of their children before they have reached the age of full and legal discretion when they can make that choice for themselves."

for one's self will control. Consequently, the mother would be able to successfully refuse the Caesarean section.

II. FACTUAL BACKGROUND AND COURT'S ANALYSIS OF IN RE A.C.

A. Facts

To fully appreciate this particular case, the reader must understand the sensitive nature of the facts. Angela Carder, in her twenty-fifth week of pregnancy, was admitted to the George Washington University Medical Center after a doctor, in a regularly scheduled prenatal visit, diagnosed her shortness of breath and back pain as a tumor mass in her lung. This was determined to be a metastatic oxygenic carcinoma. The doctor's prognosis was that Carder was terminal.

On June 15, 1987, in her twenty-sixth week of pregnancy, Carder agreed to be treated with experimental chemotherapy in order to relieve her pain and prolong her life for a few more weeks. She assented to this treatment because her doctors believed the fetus' "chances of viability would be greatly increased if it were delivered when it had reached twenty-eight weeks gestational age." The next day, the tumor began to worsen more rapidly than the doctors had expected. However, because the doctors sedated her to enable her to breathe, they were not able to ask her whether she desired delivery by Caesarean section in her twenty-sixth week despite the fact that the baby's chance of survival or being born without defects would be low.

The hospital administration decided it was obligated to seek the guidance of the Superior Court for the District of Columbia. The court heard argu-

58. In re A.C., 533 A.2d at 615. Angela Carder was originally diagnosed with leukemia when she was thirteen years old. Prior to this bout with the disease, she lived through two other episodes of the disease. During these hard times she had one leg amputated and half of her pelvis removed because of cancer. See also Remnick, supra note 10, at 14.
59. In re A.C., 53 A.2d at 615.
60. Id.; see also Remnick, supra note 10, at 18.
61. 533 A.2d at 612.
62. At this time everyone involved understood that Angela Carder was not going to live to the twenty-eighth week which would have given the fetus a greater probability of survival. "Things were starting to happen at a pace that would bewilder everyone for months to come." Lewis Hamner, A.C.'s obstetrician, later remarked, "We didn't realize how quickly she would deteriorate, ... Jefferey Moscow, Angie's oncologist from [National Institute of Health], told Hamner he'd rarely seen such a rapid advance." Remnick, supra note 10, at 19.
63. 533 A.2d at 612-13; Remnick, supra note 10, at 19. However, before Carder was heavily sedated, the doctors discussed with her the possibility of performing an operation in the twenty-eighth week, to which she assented. But, unfortunately, a twenty-sixth week operation was not discussed.
64. The impetus behind the hospital's desire to seek a court ruling was their fear of a possible lawsuit if they did not actively attempt to save the baby and allowed it to die with the mother. 533 A.2d at 617; Remnick, supra note 10, at 15; see, e.g., Greater Southeast Commu-
ments from the lawyers representing the fetus, Angela Carder and the city, as well as testimony from Carder's parents, Carder's husband, and doctors. After hearing the arguments, the Superior Court ordered the Caesarean section.

Shortly after the judge ordered the surgery, Dr. Hamner informed Carder of the court's decision. She agreed to the surgery, aware that she may not survive it. However, one half hour later, Dr. Hamner brought Carder's parents and another doctor to verify her answer. This time she indicated she did not want the surgery performed. The trial court reconsidered in light of Carder's stated intent, but allowed the court's original ruling to stand. Judge Sullivan believed her sudden change of heart was a reflection that her intent still was not clear.

On appeal, a hastily assembled Court of Appeals for the District of Columbia affirmed the decision of the trial court. The Caesarean section was

\[\text{(References and footnotes omitted for brevity.)}\]
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imilar to the one ordered by the court in this case, assists the reader to better understand the extent of the intrusion into Angela Carder's body:

The surgeon takes a scalpel from the nurse and with one strong and definite motion creates a crescent-shaped incision along the woman's pubic hairline. As the skin is cut, the subcutaneous tissue bulges upward as though it had been straining to get through all the time. Within moments this fatty tissue, interconnected by thin transparent fibers, becomes dotted and then covered with blood that oozes out of tiny vessels. With scalpel and forceps—delicate tweezers—the surgeon cuts deeper beneath the subcutaneous tissue, to a thick layer of fibrous tissue that holds the abdominal organs and muscles of the abdominal wall in place. Once reached, this fibrous layer is incised and cut along the lines of the original surface incision while the muscles adhering to this tissue are scraped off and pushed out of the way. The uterus is now visible under the peritoneum, a layer of thin tissue, looking like Saran Wrap, which covers most of the internal organs and which, when inflamed, produces peritonitis. The peritoneum is lifted away from the uterus and an incision is made in it, leaving the uterus and bladder easily accessible. The bladder is peeled away from the uterus, for the baby will be taken out through an incision in the uterus underneath where the bladder usually lies . . . .

The obstetrician extends the initial cut either by putting two index fingers into the small incision and ripping the uterus open or by using blunt-ended scissors and cutting in two directions away from the initial incision. If the membranes are still intact, they are now punctured by toothed forceps, and the fluid spills out onto the table. In the normal position, the baby's head is down and under the incision, so the obstetrician places one hand inside the uterus, under the baby's head, and with the other hand exerts pressure on the upper end of the uterus to push the baby through the abdominal incision. The assistant also uses force now to help push the baby out . . . .

The rest of the surgery is more difficult for the woman. There is more pain and women often vomit and complain of difficult breathing as we handle their organs and repair the damage . . . .

The placenta separates from or is peeled off the inside of the uterus. Then, since the uterine attachments are all at the lower end, near the cervix, the body of the uterus can be brought out of the abdominal cavity rested on the outside of the woman's abdomen, thus adding both visibility and room in which to work.

With large circular needles and thick thread a combination of running and individual stitches is used to sew closed the hole in the uterus. A drug called pitocin is added to the woman's IV to help the uterus contract and to decrease the bleeding. Small sutures are used to tie and retie bleeding blood vessels. The "gutters," spaces in the abdominal cavity, are cleared of blood and fluid. The uterus is then placed back in the abdominal cavity. The bladder is sewn back onto the surface of the uterus, and then finally the peritoneum is closed. Now sponges are counted to be sure none have been left inside the abdominal cavity, and then the closure of the abdominal wall begins.

Muscles overlying the peritoneum are pushed backed in place, and are sometimes sewn with loose stitches. Fascia, the thick fibrous layer, is the most important one, since it holds all the abdominal organs inside and keeps them from coming through the incision, especially if the woman coughs or sneezes. Therefore this layer is closed with heavy thread and many individual stitches so that, even if a thread breaks, the stitches won't all come out. The subcutaneous tissue, most of which is fat, is closed in loose stitches that mainly close any air spaces which might become sites for infec-
performed.\textsuperscript{71}

\textbf{B. Analysis of the Decision on Appeal}

The Court of Appeals found this case to be one of first impression.\textsuperscript{72} In resolving this case, the court examined three modes of analysis: (1) the right to privacy; (2) the right to refuse medical treatment; and (3) the parental right to refuse treatment on behalf of his or her offspring. Additionally, it examined \textit{Jefferson v. Griffin Spalding Hosp. Auth.} which addressed the issue of whether a court should require the performance of a Caesarean section.\textsuperscript{73}

While realizing there is a delicate balance between a woman’s bodily autonomy and a compelling state interest, the court, relying on \textit{Roe v. Wade}, concluded that a compelling state interest existed which authorized the city to intervene.\textsuperscript{74} The court noted that the Supreme Court made it explicit that a state may not always prohibit an abortion, but it may, however, prohibit one when the fetus has any potentiality of living outside the mother’s womb naturally or artificially.\textsuperscript{75} When this potentiality exists, “a balancing of the interests must replace the single interest of the mother, and as in this case, time can be a critical factor.”\textsuperscript{76}

The more traditional rights of a competent adult to refuse treatment and a parent to refuse treatment on behalf of her offspring were also considered in the court’s analysis. The right of privacy, which exists within the penumbras of the Fourteenth and Ninth Amendments of the United States Constitution,
encompasses the right of an individual to bodily integrity.\textsuperscript{77} Furthermore, an individual’s right to bodily integrity encompasses a competent adult's right to refuse treatment.\textsuperscript{78} However, the right to refuse medical treatment must be balanced with the four countervailing state interests of preserving life, preventing suicide, maintaining the integrity of the medical profession, and protecting innocent third parties.\textsuperscript{79} The court was cognizant that “[t]he state's interest in the preservation of life, prevention of suicide, and the integrity of the medical profession, while significant, usually will not overcome the [patient’s] right to bodily integrity.”\textsuperscript{80} Judge Nebeker wrote that the “state's interest in protecting innocent third parties from an adult's decision to refuse medical treatment, however, may override the interest in bodily integrity.”\textsuperscript{81}

The D.C. Court of Appeals recognized a significant difference between the state's interest in authorizing medical treatment of a born child and the state's interest in authorizing medical treatment of a fetus.\textsuperscript{82} The intrusiveness involved in the case of a born child is less substantial than in the case of a fetus. Indeed, when the state authorizes the treatment of the fetus, it necessarily authorizes the invasion of the mother's body. When the state authorizes the treatment of the born child, however, it creates no physical intrusion of the mother's body. Moreover, when the state attempts to protect the fetus' health and life, its interest may run directly counter to the mother's interest in her sacred bodily integrity.\textsuperscript{83}

Finally, the court balanced the mother's right against the state interest. It concluded that although the surgery is intrusive to the mother, “[t]he Caesa-

\textsuperscript{77} See supra notes 18-31 accompanying text.
\textsuperscript{78} 533 A.2d at 615.
\textsuperscript{79} Id. (citations omitted). The court noted that the state's interest in preventing suicide was not relevant, nor was safeguarding the integrity of the medical profession. Id.; see generally supra notes 33-46 and accompanying text.
\textsuperscript{80} 533 A.2d at 616.
\textsuperscript{81} 533 A.2d at 616; see also supra notes 47-51 and accompanying text. The court explained that other courts have used this rationale to hold that parents may not withhold medical treatment from their children when their lives are in danger. Indeed, the D.C. Court of Appeals recognized that some jurisdictions have equally applied this doctrine when an unborn child is the benefactor of the treatment. 533 A.2d at 616.
\textsuperscript{82} 533 A.2d at 616-17; see also Roe, 410 U.S. at 163. The D.C. Court of Appeals, however, recognized that “the state has compelling interests in protecting the life and health of both children and viable unborn children.” 533 A.2d at 616-17.
\textsuperscript{83} The court recognized the argument that the state may infringe upon the mother's right to bodily autonomy to protect the life of the fetus, unless to do so will significantly affect the health of the mother and unless the child does not have a significant chance of being born alive. 533 A.2d at 617. The court noted that “the death rate of women upon whom Caesarean sections have been performed is between 0.1 percent and 1 percent, significantly higher than the death rate of women who have delivered their babies vaginally.” Id. at 617 n.5.
ream section would not significantly affect A.C.'s condition because she had, at best, two days left of sedated life. . . . The child, on the other hand, had a chance of surviving delivery, despite the possibility that it would be born handicapped." Therefore, Carder's right of bodily integrity must be subordinated to the state interest in protecting innocent third parties.

III. A CRITICAL REVIEW OF THE COURT'S ANALYSIS

The Court of Appeals for the District of Columbia found this to be a unique case and, consequently, did not rely on any one particular case or area of law. While Jefferson v. Griffin Spalding County Hosp. Auth. was similar, the Georgia court never delineated any real foundation upon which the court in In re A.C. could build. Because the Jefferson court failed to discuss in depth the underlying rationale and issues, the decision provided little guidance to the District of Columbia court. Consequently, Judge Nebecker in his opinion merely cited Jefferson v. Spalding County Hosp. Auth.

An examination of Roe indicates a pregnant woman has a strong interest in the integrity of her body. However, as the court in In re A.C. recognized, Carder's interest was limited by the compelling state interest in preserving the fetus' life. Two points need to be made about the limitation of a state's compelling interest which the court failed to highlight. First, in two cases subsequent to Roe, Colautti v. Franklin and Thornburgh v. American College of Obstetricians and Gynecologists, the Supreme Court limited the notion of "compelling state interest." The high court opined that the state cannot cause an increased risk to the mother's health, welfare, or life. The court in In re A.C. ignored the rule prescribed in these Supreme Court decisions and reinstated the "significant risk" standard, which would limit the compelling state interest only when it caused a significant risk to the mother. The high court, however, concluded that the "significant risk" standard was constitutionally repugnant.

84. Id. at 617 (emphasis added).
85. Id.
86. 247 Ga. 86, 274 S.E.2d 457 (1981); see supra notes 12-17 and accompanying text.
89. 476 U.S. 747 (1986).
90. See supra notes 25-31 and accompanying text.
91. The D.C. Superior court remarked that a Caesarean section could be ordered as long as the risk to the mother's health, well-being and life is not significant. The court implied that the risk encountered by the mother in such an operation is not significant enough to overcome the probability of the fetus' survival. 533 A.2d at 617. While the Supreme Court has not
However, what constitutes an "increased risk" remains an unanswered question. While the Court has not explained this, one can obviously realize that it does not mean any increased risk. If it was any increased risk it potentially would preclude any state interest in the health and life of the fetus. The better definition of "increased risk" would consider the comparison of the risk involved when the Caesarean section is performed to the risk involved without the Caesarean section. Generally, it would be a comparison between the risk involved without the medical treatment and the risk involved in pursuing the medical treatment. In so doing, this test incorporates the risk which exists in the surgery. For example, in Jefferson, if the pregnant woman were to attempt a vaginal delivery, there was a fifty percent chance that she would not survive the delivery. However, if she has the Caesarean section, there is a ninety-nine percent chance of survival. So if the mother has the surgery, there is a one percent risk, but if she does not have it performed, she has a fifty percent risk. Therefore, the surgery actually decreases the risk to the mother. Since the risk to the mother is lower when the operation is performed, her bodily integrity right becomes subordinate to the state's interest in the fetus' health. This comports with the sanctity given to the mother's right to bodily autonomy, because Jefferson presents a situation where the mother's and fetus' life, health and well-being are parallel, unlike in In re A.C. where the mother's and fetus' life, health and well-being conflict.

Second, if treatment is allowed that would jeopardize the life, well-being, or health of the mother, then Roe, holding that even a viable fetus could be aborted when it endangers the life, well-being or health of the mother, would be contradicted. Therefore, while Roe recognizes a compelling state interest when the fetus is viable, it still qualifies it when the mother's health and life are at stake. Roe's underlying policy concludes that the mother's life, health and well-being are superior to the state's compelling interest in the fetus when the mother's and fetus' life, health and well-being conflict.

In re A.C. presents a problem for the "increased risk" test. Judge Nebeker implied that because the remaining days of Carder's life would be spent sedated, on balance, the potentiality of the fetus being born alive should override the fact that her life may be shortened by the surgery. In so doing, the

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expounded on its "increased risk" test, it seems to imply that an increased risk to the mother for the sake of the fetus' well-being is not acceptable.

92. 247 Ga. 86, 274 S.E.2d 457 (1981); see supra notes 12-17 and accompanying text.
93. 247 Ga. at 86, 274 S.E.2d at 458.
94. 410 U.S. at 163-64.
95. He remarked, "This case does not present facts indicating that A.C.'s good health was being sacrificed to save her child's life . . . ." 533 A.2d at 615 n.4. However, he stated earlier in the opinion that the court should not "opine whether the decision would have or should
court appears to be determining the quality of Carder's life. In this whole analysis, the mother's quality of life should not be considered. In *Brophy v. New England Sinai Hosp.* 96, a Massachusetts court stated: "It is antithetical to our scheme of ordered liberty and to our respect for the autonomy of the individual for the State to make decisions regarding the individual's quality of life." 97 It is not the authority of the court to decide on the quality of the pregnant woman's life. Therefore, the fact that Carder would have been sedated the rest of her remaining days, should be of no consequence in this matter. 98

When balancing the mother's right and the state's interest in the fetus, the Court of Appeals for the District of Columbia emphasized the probability of the fetus being born alive as a factor which required placement on the scale. The D.C. court used a "significant" test again, stating that a state cannot infringe on the mother's bodily integrity "unless the child has a significant chance of being alive." 99 The court seems to use the "significant" test to focus on the fetus' chance for survival rather than the increased harm caused to the woman from the surgery. This analysis does not comport with the analysis of *Roe*. *Roe* determined that if the fetus is viable the state can prevent the abortion, unless there is an increased risk to the mother. The *Roe* analysis focused on the risk to the mother and not the fetus' chances for survival. 100

Indeed, if the courts begin to focus on what is most advantageous for the life, health and well-being of the fetus, the analysis becomes problematic. This can become a slippery slope in which the state may conceivably order all the mother's prenatal care guised as a benefit for the fetus. 101

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98. The decision on medical treatment and the effects on the patient is the patient's alone to judge. The doctors can only provide the facts to the patient, and the patient must make a decision based upon those facts. *In re Conroy*, 98 N.J. at 367, 486 A.2d at 1232-33.
99. 533 A.2d at 617. The court must consider "significant" to be at least somewhere over fifty percent since A.C.'s fetus was given a fifty to sixty percent chance of survival, and the court still ordered the surgery.
100. 410 U.S. at 163-64.
IV. CONCLUSION

While this area of the law is still developing, it is clear that many scenarios could exist. Therefore, the analysis which must be used needs to be flexible enough to cover the myriad of possible factual patterns. The D.C. Court of Appeals’ analysis considered all the areas of law which require accounting, but applied some rules too strictly. With these areas of law now being used as the basis in the balancing test, the court has at least recognized the enormous importance of a woman’s right of bodily integrity.

A court ordered Caesarean section involves numerous controversial issues. For the Court of Appeals for the District of Columbia to resolve these issues, they have developed a delicate balance between the mother’s right to bodily autonomy and the state’s compelling interest in the health, welfare and life of the fetus. However, in its balance, the court failed to give sufficient weight to the increased harm which the woman would be required to endure when undergoing a Caesarean section.

During this process, the court considered the case law regarding the right to privacy generally, which is encompassed in the competent adult’s right to refuse medical treatment and the parent’s right to refuse treatment on behalf of his or her offspring. In all these cases a critical underlying problem is the fetus’ legal status which has not been determined in *Roe* and its progeny. Consequently, this problem requires an explicit solution.

While it is difficult to determine the type of impact *In re A.C.* may have on future decisions, it, in combination with *Jefferson*, has assisted in the establishment of further intrusions into the private life and body of the pregnant woman.

*Douglas B. Snyder*