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LIFESAVING MEDICAL TREATMENT FOR THE NONVIABLE
FETUS: LIMITATIONS ON STATE AUTHORITY
UNDER *ROE v. WADE*

INTRODUCTION

Over a decade ago, the Supreme Court established that a woman has a constitutional right to decide whether to conclude or continue her pregnancy.¹ The decision has provoked myriad challenges² testing the parameters of this right. These challenges are grounded, for the most part, on the underlying belief that the unborn child is a "person" who consequently deserves legal protection.³

Advancing medical technology has generated a new concept, held by both medical and legal authorities,⁴ in which the fetus is viewed as a patient.⁵ The implication of this view is that the fetus is ethically, if not

1. *Roe v. Wade*, 410 U.S. 113, 154 (1973).

2. During the 13 years since the Supreme Court decided *Roe v. Wade*, 410 U.S. 113 (1973), and its companion case, *Doe v. Bolton*, 410 U.S. 179 (1973), the Court has heard 15 more cases questioning the constitutionality of city, state and federal legislation regulating abortion. See *Simopoulos v. Virginia*, 462 U.S. 506 (1983); *Planned Parenthood Ass'n v. Ashcroft*, 462 U.S. 476 (1983); *City of Akron v. Akron Center for Reproductive Health, Inc.*, 462 U.S. 416 (1983); *H.L. v. Matheson*, 450 U.S. 398 (1981); *Williams v. Zbaraz*, 448 U.S. 358 (1980); *Harris v. McRae*, 448 U.S. 297 (1980); *Bellotti v. Baird*, 443 U.S. 622 (1979); *Colautti v. Franklin*, 439 U.S. 379 (1979); *Poelker v. Doe*, 432 U.S. 519 (1977) (per curiam); *Maher v. Roe*, 432 U.S. 464 (1977); *Beal v. Doe*, 432 U.S. 438 (1977); *Bellotti v. Baird*, 428 U.S. 132 (1976); *Singleton v. Wulff*, 428 U.S. 106 (1976); *Planned Parenthood v. Danforth*, 428 U.S. 52 (1976); *Connecticut v. Menillo*, 423 U.S. 9 (1975) (per curiam). In addition, two more were argued during the 1985 term and decisions are forthcoming. See *Charles v. Daley*, 749 F.2d 452 (7th Cir. 1984), *prob. juris. noted sub nom.* *Diamond v. Charles*, 105 S. Ct. 2356 (1985); *American College of Obstetricians & Gynecologists v. Thornburgh*, 737 F.2d 283 (3d Cir. 1984), *juris. postponed*, 105 S. Ct. 2015 (1985).

3. The most direct of the federal challenges are the proposed "human life amendments," by which the definition of "person" within the meaning of the fourteenth amendment would be broadened to include the unborn from the moment of conception. See Westfall, *Beyond Abortion: The Potential Reach of a Human Life Amendment*, 8 Am. J.L. & Med. 97, 99 (1982). Some federal legislation already reflects the belief that a fetus is a "person," including the Hyde Amendment, Pub. L. No. 96-123, § 109, 93 Stat. 926 (1979), which limits the use of Medicaid funds for abortions, and the fetal experimentation regulations issued by the Department of Health and Human Services, 45 C.F.R. §§ 46.201-211 (1985), which govern funding for medical research that uses human fetuses. See Friedman, *The Federal Fetal Experimental Regulations: An Establishment Clause Analysis*, 61 Minn. L. Rev. 961, 991-92 (1977); Gold, *Does the Hyde Amendment Violate Religious Freedom? Harris v. McRae and the First Amendment*, 6 Am. J.L. & Med. 361, 363 (1980).

4. See Dillon, Lee, Tronolone, Buckwald & Foote, *Life Support and Maternal Brain Death During Pregnancy*, 248 J. A.M.A. 1089, 1089 (1982); Robertson, *Procreative Liberty and the Control of Conception, Pregnancy, and Childbirth*, 69 Va. L. Rev. 405, 443 (1983) [hereinafter cited as Robertson I]; Shaw, *Conditional Prospective Rights of the Fetus*, 5 J. Leg. Med. 63, 78-81 (1984); Note, *Current Technology Affecting Supreme Court Abortion Jurisprudence*, 27 N.Y.L. Sch. L. Rev. 1221, 1241 (1982) [hereinafter cited as *Current Technology*].

5. See *Hughson v. St. Francis Hosp.*, 92 A.D.2d 131, 136, 459 N.Y.S.2d 814, 817 (1983); Bowes & Selgestad, *Fetal Versus Maternal Rights: Medical and Legal Perspec-*

legally, entitled to medical care.⁶ This perception of the fetus raises a series of legal issues, such as the scope of duty a physician,⁷ other third person,⁸ or the pregnant woman herself⁹ may owe the fetus.

tives, 58 *Obst. & Gyn.* 209, 213 (1981); Fletcher, *The Fetus as Patient: Ethical Issues*, 246 *J. A.M.A.* 772, 772 (1981); King, *The Juridical Status of the Fetus: A Proposal for Legal Protection of the Unborn*, 77 *Mich. L. Rev.* 1647, 1675 & n.134 (1979).

6. See Leiborman, Mazor, Chaim & Cohen, *The Fetal Right to Live*, 53 *Obst. & Gyn.* 515, 517 (1979); Mathieu, *Respecting Liberty and Preventing Harm: Limits of State Intervention in Prenatal Choice*, 8 *Harv. J.L. & Pub. Pol'y* 19, 22-31 (1985); Shaw, *supra* note 4, at 79-83. But see Fletcher, *supra* note 5, at 772 ("it would be unwise now in fetal therapy to close the issue between fetal interests and parental interests in favor of the fetus"); Note, *The Creation of Fetal Rights: Conflicts with Women's Constitutional Rights to Liberty, Privacy, and Equal Protection*, 95 *Yale L.J.* 599, 619-20 (1986) (state coercion of fetal medical treatment constitutes an "intrusion upon basic individual rights that the Constitution prohibits") [hereinafter cited as *Fetal Rights*].

7. Whether a physician owes a duty of care to a fetus is a central issue in "wrongful life" cases, in which the alleged harm to the fetus consists of being born with a nontreatable defect instead of not being born at all. See, e.g., *Curlender v. Bio-Science Laboratories*, 106 *Cal. App. 3d* 811, 828, 165 *Cal. Rptr.* 477, 488 (1980); *Becker v. Schwartz*, 46 *N.Y.2d* 401, 408, 386 *N.E.2d* 807, 810, 413 *N.Y.S.2d* 895, 898 (1978). Wrongful life cases must be distinguished from "wrongful birth" cases in which the physician is liable to the parents of the defective child for his or her negligent prenatal treatment, as well as from "wrongful conception" cases in which the prospective parents institute an action on their own behalf because the prescribed method of contraception failed, resulting in the birth of an unwanted child. See *id.* at 408-10, 386 *N.E.2d* at 810-11, 413 *N.Y.S.2d* at 898-99.

8. Finding a third person liable to the fetus for prenatal injuries is a relatively new development in tort law. Prior to 1946, recovery was generally not allowed. See *W. Keeton, D. Dobbs, R. Keeton & D. Owen, Prosser and Keeton on the Law of Torts* § 55, at 367 (5th ed. 1984). Currently, however, recovery is permitted in all U.S. jurisdictions. See *id.* at 368. More controversial is the related question of whether recovery will lie for wrongful death of the fetus. A majority of the states allow recovery. See *id.* at 369-70.

9. Typically, this issue would arise where the expectant mother has decided to carry the fetus to term, and by virtue either of her conduct, genetic make-up or external circumstances, the health or life of the fetus is jeopardized by risks that can be reduced or eliminated by medical care. The preliminary question is whether she owes the fetus any duty at all to comply with medical recommendations. Some courts, as well as several commentators, have concluded or at least implied that she may owe such a duty. See *Jefferson v. Griffin Spalding County Hosp. Auth.*, 247 *Ga.* 86, 88, 274 *S.E.2d* 457, 459 (1981) (per curiam); *Raleigh Fitkin-Paul Memorial Hosp. v. Anderson*, 42 *N.J.* 421, 423, 201 *A.2d* 537, 538 (per curiam), *cert. denied*, 377 *U.S.* 985 (1964); *In re Jamaica Hosp.*, 128 *Misc. 2d* 1006, 1007-08, 491 *N.Y.S.2d* 898, 899-900 (Sup. Ct. 1985); Mathieu, *supra* note 6, at 54-55; Robertson, *The Right to Procreate and In Utero Fetal Therapy*, 3 *J. Leg. Med.* 333, 352-53 (1982) [hereinafter cited as Robertson II]; Shaw, *supra* note 4, at 104. Cf. *In re Baby X*, 9 *Mich. App.* 111, 116, 293 *N.W.2d* 736, 739 (1980) (a newborn's symptoms of narcotics withdrawal are probative of the mother's prenatal neglect); *Hoener v. Bertinato*, 67 *N.J. Super.* 517, 524-25, 171 *A.2d* 140, 144-45 (*Juv. & Dom. Rel. Ct.* 1961) (parents who refused for religious reasons to consent to a blood transfusion for their unborn child were neglecting to provide proper care); *In re "Male" R.*, 102 *Misc. 2d* 1, 9-10 & n.18, 422 *N.Y.S.2d* 819, 825 & n.18 (*Fam. Ct.* 1979) (whether an adjudication of neglect can be based on prenatal maternal conduct "is a difficult question"). The contrary position is also advocated. See *Reyes v. Superior Court*, 75 *Cal. App. 3d* 214, 216, 141 *Cal. Rptr.* 912, 913 (1977) (mother's prenatal heroin use was not felonious child endangering within meaning of statute because "person" does not include "fetus"); Fletcher, *supra* note 5, at 772 (since the fetus is not separate from the mother, the mother's choice should be respected); *Fetal Rights*, *supra* note 6, at 614-15 ("Vesting

One question in this controversy is whether a pregnant woman may be legally coerced to submit to medical treatment in order to protect the fetus. This situation arises with some regularity in hospitals¹⁰ but is relatively novel in the courts.¹¹ These fetal "medical treatment" cases¹² can

fetuses with rights that are assertable against the women bearing them would create an unprecedented intrusion on women's bodies and personal lives."); Note, *A Maternal Duty to Protect Fetal Health?*, 58 Ind. L.J. 531, 545-46 (1983) (practical considerations dictate that a maternal duty to protect fetal health should not be enforced).

A related question concerns how this duty might be enforced. One commentator suggests a series of possible methods, including enacting criminal statutes that would forbid pregnant women from engaging in conduct likely to be injurious to the fetus, and amending child protection laws to apply to the fetus. Robertson I, *supra* note 4, at 442-43. If such a duty is imposed, an additional question relates to what its reasonable limits should be. For instance, it is one thing to mandate by legislation that expectant mothers undergo diagnostic testing and quite another to insist that they submit to experimental uterine surgery. For a summary of some fetal health risks and developments in medical treatment and technology from a physician's perspective, see Shaw, *supra* note 4, at 66-81.

Finally, there is the prospect, already emerging in the courts, that an infant may have a cause of action in tort against the mother for her negligence in prenatal medical care. See *Grodin v. Grodin*, 102 Mich. App. 396, 400-01, 301 N.W.2d 869, 870-71 (1980); Note, *Parental Liability for Prenatal Injury*, 14 Colum. J.L. & Soc. Prob. 47, 90 (1978).

10. Medical specialists in obstetrics and gynecology periodically encounter the legal dilemma posed by a pregnant woman who refuses or is unable to consent to lifesaving medical treatment. Among the relevant medical cases discussed in the literature are instances where the mother refused to undergo a cesarean section, see Bowes & Selgestad, *supra* note 5, at 209-10; *Fetal Right to Live*, *supra* note 6, at 515-16, or rejected psychiatric treatment, see Soloff, Jewell & Roth, *Civil Commitment and the Rights of the Unborn*, 136 Am. J. Psychiatry 114, 114 (1979), or was technically "brain dead" but could be sustained by life support systems until the infant could be delivered, see *Maternal Brain Death*, *supra* note 4, at 1089. For interesting analyses of the ethical aspects of the dilemma, see generally Fletcher, *supra* note 5, at 772-73; Mathieu, *supra* note 6, at 45-49; Veatch, *Maternal Brain Death: An Ethicist's Thoughts*, 248 J. A.M.A. 1102, 1102-03 (1982).

11. In total, only eight fetal medical treatment cases have been considered by the courts. The earliest and perhaps most widely cited case is *Raleigh Fitkin-Paul Morgan Memorial Hosp. v. Anderson*, 42 N.J. 421, 201 A.2d 537 (per curiam), *cert. denied*, 377 U.S. 985 (1964), in which the New Jersey Supreme Court held that the viable fetus was entitled to the court's protection, and consequently ordered that a blood transfusion be administered should it prove necessary in order to save the fetus' life, despite the mother's objections. See *id.* at 423-24, 201 A.2d at 538. A New York court similarly authorized physicians to give a blood transfusion to an unwilling mother and viable fetus, in part to safeguard the infant's life and health. See *Crouse-Irving Memorial Hosp. v. Paddock*, 127 Misc. 2d 101, 102-03, 485 N.Y.S.2d 443, 444-45 (Sup. Ct. 1985).

In an unreported case, a Colorado juvenile court found that a fetus was a dependent and neglected "child" within the meaning of the state's neglect statute and ordered that a cesarean section be performed on the mother to protect the viable fetus. See Bowes & Selgestad, *supra* note 5, at 209-10 (discussing the case). Facing similar facts, Georgia's highest court affirmed a lower court's order assigning temporary custody of the "neglected" fetus to state authorities and compelling the mother to submit to a cesarean section in order to sustain the viable fetus' life. *Jefferson v. Griffin Spalding County Hosp. Auth.*, 247 Ga. 86, 89, 274 S.E.2d 457, 460 (1981) (per curiam). In an unreported case in Pennsylvania, the Allegheny County Court of Common Pleas, in order to protect a viable fetus, sustained an order of inpatient psychiatric treatment over the mother's objections. See *Civil Commitment*, *supra* note 10, at 114 (discussing the case). A California court on similar facts reversed a lower court detention order, holding that the legislature impliedly excluded fetuses from the state's dependent child statute, and the court

be categorized according to whether the fetal "patient" is viable or non-viable because under *Roe v. Wade*¹³ the legal issues raised in either category will differ in certain significant respects.¹⁴ Judicial cases falling into the nonviable category are rare. Only two have been officially reported.¹⁵ As medical technology in prenatal care advances,¹⁶ however, it is likely that the issue of compulsory medical treatment for the nonviable fetus will receive increasing attention,¹⁷ commanding in turn satisfactory resolution of the maternal/fetal conflicts.

In each reported case addressing care for the nonviable fetus, the woman declined treatment prescribed by her physician to save the fetus' life.¹⁸ In each instance, a third party brought an action requesting the court to issue an order imposing the treatment for the nonviable fetus.¹⁹ One court did so.²⁰ The other did not,²¹ but limited its holding to the facts of the particular case, noting in dictum that should the appropriate circumstances arise in the future, a court order might properly ensue.²²

This Note will consider the primary question raised by these two cases—the constitutional limits on the state's authority to coerce a pregnant woman to accept lifesaving medical treatment to benefit her non-

consequently lacked jurisdiction over the viable fetus. See *In re Steven S.*, 126 Cal. App. 3d 23, 29-30, 178 Cal. Rptr. 525, 527-28 (1981).

Courts have addressed the issues raised by coercive medical treatment to benefit a non-viable fetus in only two reported cases. See *Taft v. Taft*, 388 Mass. 331, 446 N.E.2d 395 (1983); *In re Jamaica Hosp.*, 128 Misc. 2d 1006, 491 N.Y.S.2d 898 (Sup. Ct. 1985). A third court noted in dictum that it was "a difficult question whether an adjudication of neglect can be based . . . upon pre-natal maternal conduct" in a case where the expectant mother throughout her pregnancy was an alcohol and drug user. See *In re "Male" R.*, 102 Misc. 2d 1, 9-10 & n.18, 422 N.Y.S.2d 819, 825 & n.18 (Fam. Ct. 1979) (dictum).

12. For the purposes of this Note, a "medical treatment" case refers to a situation in which a patient refuses medical treatment that his or her physician has prescribed, and a third party, usually but not necessarily a medical authority, has requested a court order compelling the treatment. A fetal medical treatment case is one in which the treatment is prescribed on behalf of the fetus against the mother's objections. In most cases the mother objects on religious grounds, although this need not be, and is not always the case. See *infra* note 26 for a discussion of the various grounds for refusal and their interrelationship.

13. 410 U.S. 113 (1973).

14. See *infra* notes 116-21 and accompanying text.

15. See *Taft v. Taft*, 388 Mass. 331, 446 N.E.2d 395 (1983); *In re Jamaica Hosp.*, 128 Misc. 2d 1006, 491 N.Y.S.2d 898 (Sup. Ct. 1985).

16. See generally *Shaw*, *supra* note 4 (summarizing innovative technologies and increasing knowledge in reproduction and prenatal care); *Current Technology*, *supra* note 4 (survey of advancements in fetal technology since *Roe v. Wade*).

17. See *Fletcher*, *supra* note 5, at 772; *Robertson II*, *supra* note 9, at 342-43; *Shaw*, *supra* note 4, at 115-16; *Fetal Rights*, *supra* note 6, at 605.

18. See *Taft v. Taft*, 388 Mass. at 332-33, 446 N.E.2d at 396; *In re Jamaica Hosp.*, 128 Misc. 2d at 1006, 491 N.Y.S.2d at 898.

19. See *Taft v. Taft*, 388 Mass. at 331, 446 N.E.2d at 395 (petition brought by husband); *In re Jamaica Hosp.*, 128 Misc. 2d at 1006, 491 N.Y.S.2d at 898 (application brought by hospital).

20. See *In re Jamaica Hosp.*, 128 Misc. 2d at 1008, 491 N.Y.S.2d at 900.

21. See *Taft v. Taft*, 388 Mass. at 335; 446 N.E.2d at 397.

22. See *id.* at 334, 446 N.E.2d at 397 (dictum).

viable fetus. It will focus on situations in which coerced treatment is necessary to save the nonviable fetus' life, excluding situations in which treatment is recommended to assure the health of an unborn child carried to term who would otherwise be delivered defective.²³

By balancing the interests of the individual and the state, this Note will show that the individual's fundamental and carefully guarded privacy interest in bodily integrity encompasses the right of a woman in the first two trimesters of pregnancy to refuse lifesaving medical treatment for her fetus. The Note argues that although the women in these and like cases have not exercised their right to have an abortion, the principles of *Roe v. Wade* and the subsequent Supreme Court abortion decisions regarding the extent of a state's power to protect fetal life are nonetheless applicable. In applying by analogy the standards of *Roe v. Wade* to these fetal "medical treatment" cases, this Note concludes that state interference

23. Several commentators have addressed the issues raised by coerced treatment for fetuses who will be carried to term. For a discussion of the legal and ethical issues raised by these cases, see generally Mathieu, *supra* note 6, at 49-54 (moral and conceptual framework for requiring fetal therapy); Robertson II, *supra* note 9, at 342, 352-53 (parents who elect to carry a fetus to term should have a duty to provide medical care to assure the child's health); Shaw, *supra* note 4, at 63, 66 (parents may "incur 'a conditional prospective liability' " to their unborn children); *Fetal Rights*, *supra* note 6, at 599-600 (state expansion of fetal rights threatens women's constitutionally-protected rights to bodily autonomy in reproduction).

Regardless of whether the treatment is needed to save the fetus' life or merely recommended to assure its health, the expectant mother has autonomy and frequently religious interests at stake that may and, it has been argued, should protect her from the state's intrusion into her personal decisions regarding childbearing. See *id.* at 614-20. The freedom protected under *Roe v. Wade* is essentially twofold in nature. See *Roe v. Wade*, 410 U.S. 113, 163 (1973); Tribe, *The Supreme Court, 1972 Term—Forward: Toward a Model of Roles in the Due Process of Life and Law*, 87 Harv. L. Rev. 1, 10-11 (1973). It encompasses the freedom, first, to decide whether or not to terminate a pregnancy. Second, it is the freedom to effectuate that decision and have an abortion. See *Roe*, 410 U.S. at 163. Viewed in this light, the basic freedom involved should include the right of the woman to decide to terminate a pregnancy, to decide to carry it to term, to postpone making a decision and to change her mind. Consequently, it can be argued that the state cannot impose treatment for the fetus prior to viability even in instances when the woman has, at least preliminarily, decided to continue her pregnancy because the right under *Roe* should encompass the freedom to alter that decision.

From the state's perspective, the situation in which a nonviable fetus will die if treatment is not administered may differ ethically from that in which the fetus will survive the pregnancy but will be born in a defective state that could have been medically ameliorated. In the latter case, it may be difficult from an ethical perspective to justify permitting an expectant mother to refuse treatment that will subject the fetus she has decided to bear to a life of unnecessary suffering or limitation. In addition, the state arguably has some interest in assuring the health of a fetus who, if deformed, brain damaged or otherwise defective, might burden the state. It has been argued that with respect to a fetus who will be born the state has a conditional prospective interest in the human being he or she will become at birth. See Shaw, *supra* note 4, at 66.

The ethical and social dilemmas faced by the state are arguably less acute in situations where the lack of treatment will result in a termination of the pregnancy. No prospective "person" must be protected. No costs or burdens would be imposed on the state, and the mother's constitutional right to terminate her pregnancy has been otherwise firmly established under *Roe v. Wade*. See *Roe*, 410 U.S. at 154.

with a woman's freedom of bodily integrity by coercing treatment to save the "potentiality of human life"²⁴ of a nonviable fetus is constitutionally prohibited.

I. FETAL MEDICAL TREATMENT CASES

In a growing number of cases, various kinds of medical treatment have been imposed on pregnant women in the interest of preserving the lives of viable fetuses.²⁵ Less common are cases considering the state's authority to compel a woman to submit to treatment²⁶ to protect a nonviable fetus.²⁷ Presumably because the issue had not been squarely addressed by the courts until recently, it has received only limited attention from commentators as well.²⁸

In the past three years, two courts facing similar factual situations have addressed this issue.²⁹ In the first case, *Taft v. Taft*,³⁰ the Massachusetts Supreme Judicial Court vacated a lower court's judgment ordering a surgical procedure necessary to save the life of a sixteen-week-old

24. *Roe*, 410 U.S. at 162.

25. See *supra* notes 10-11 and accompanying text.

26. Professor Robertson points out that an expectant mother's refusal to consent to medical care for her fetus could stem from a number of sources, including fear of invasive medical procedures such as surgery, idiosyncratic fears or religious objections. See Robertson I, *supra* note 4, at 444 n.120. Although generally in fetal and other medical treatment cases the patient's objection to treatment is based on religious beliefs, this is not always the case. See, e.g., *In re Jamaica Hosp.*, 128 Misc. 2d 1006, 1007, 491 N.Y.S.2d 898, 899 (Sup. Ct. 1985) (expectant mother refused lifesaving blood transfusion on religious grounds); *Civil Commitment*, *supra* note 10, at 114 (discussing an unreported Pennsylvania case in which the expectant mother, who suffered from psychotic delusions, denied her need for treatment). The various reasons for refusing medical care all implicate the mother's constitutionally-protected privacy interest in bodily integrity, even if she fails to assert that interest specifically. See *infra* notes 66 and 105. Consequently, this Note will focus on the bodily integrity basis for refusal, without discussing the mother's first amendment religious interests.

27. See *supra* note 11 for a summary of fetal medical treatment cases.

28. Two law professors, Dr. Margery Shaw and Professor John Robertson, have focused their studies on fetal medical treatment cases. Dr. Shaw extends her analysis back through the early stages of pregnancy and suggests that a duty to provide medical care be imposed on expectant mothers even in the preivable and preconception stages in the interest of the fetus, although she later mentions without discussion that the state cannot intervene prior to viability. See Shaw, *supra* note 4, at 81-88, 115. Professor Robertson is more cautious, limiting most of his argument to viable fetuses but suggesting that therapeutic intervention be imposed during the previability stage where there is clear and convincing evidence that the mother has elected not to abort. See Robertson II, *supra* note 9, at 361; Robertson I, *supra* note 4, at 446-47. An interesting and more philosophical argument regarding the moral status of the fetus throughout gestation and the mother's duty to prevent harm is presented by Dr. Mathieu, see *supra* note 6, at 45-49. Finally, in *Fetal Rights*, *supra* note 6, at 620-25, the author argues that the creation of fetal rights constitutes a politically unacceptable regression of women's rights and violates equal protection safeguards.

29. See *Taft v. Taft*, 388 Mass. 331, 446 N.E.2d 395 (1983); *In re Jamaica Hosp.*, 128 Misc. 2d 1006, 491 N.Y.S.2d 898 (Sup. Ct. 1985).

30. 388 Mass. 331, 446 N.E.2d 395 (1983).

fetus.³¹ The court stated that the woman's privacy and religious interests were "established on the record" and that the "circumstances" of the case were not sufficiently compelling to outweigh her constitutional rights.³² The court cautioned, however, that there might "in some situations . . . be justification for ordering a [woman] to submit to medical treatment in order to assist in carrying a child to term."³³ The court reasoned that an order was not justified on the facts before it because there was no showing of either the medical necessity or risk of the procedure,³⁴ thus suggesting that the state's interest in the life of a nonviable fetus might be sufficient to override a mother's privacy interests if there were such a showing.

In *In re Jamaica Hospital*,³⁵ the New York Supreme Court, using a balancing test similar to the one used in *Taft*, reached the contrary result and ordered a blood transfusion to save the life of the nonviable fetus, despite the woman's religious objections.³⁶ The court based its decision to compel treatment on the doctrine of *parens patriae*.³⁷ Under this doctrine, the state has the power, and indeed the duty, to protect individuals not otherwise able or willing to protect themselves.³⁸ Conceding that the mother's constitutional rights were at stake, the court asserted that if "her life were the only one involved here, the court would not interfere."³⁹ In conclusion, however, the court stated that another life was at risk, and that the state's interest in this life outweighed the mother's rights.⁴⁰

To circumvent the holding of *Roe v. Wade* that the state's interest in

31. *See id.* at 335, 446 N.E.2d at 397.

32. *See id.* at 334-35, 446 N.E.2d at 397.

33. *See id.* at 334, 446 N.E.2d at 397.

34. *See id.* at 335, 446 N.E.2d at 397. The court's position on what state interest might be sufficient to override the mother's rights is ambiguous. It noted that it knew of no case in which a court ordered an expectant mother to submit to medical treatment on behalf of a nonviable fetus. *See id.* at 334 n.4, 446 N.E.2d at 397 n.4. It went on to state that the state's interest in prison administration had been shown to be sufficiently compelling to order a recalcitrant prisoner to submit to treatment. *See id.* at 334, 446 N.E.2d at 397. It concluded by stating that in some circumstances the state's interest might be sufficiently compelling to justify coerced treatment to assist a fetus. *See id.* Thus, it is unclear whether the court is saying that the state interest in protecting the life of a nonviable fetus might justify a restriction on privacy interests, or merely that some other, as yet unidentified, state interest might do so.

35. 128 Misc. 2d 1006, 491 N.Y.S.2d 898 (Sup. Ct. 1985). The Supreme Court of New York is a trial court.

36. *See id.* at 1008, 491 N.Y.S.2d at 899-900. Although the woman objected to the treatment solely on religious grounds, her right to bodily integrity was nonetheless implicated. *See supra* note 26.

37. *See Jamaica Hosp.*, 128 Misc. 2d at 1008, 491 N.Y.S.2d at 900.

38. The state's *parens patriae* power has been defined as "the state's limited paternalistic power to protect or promote the welfare of certain individuals, like young children and mental incompetents, who lack the capacity to act in their own best interests." *Developments in the Law—The Constitution and the Family*, 93 Harv. L. Rev. 1156, 1199 (1980); *see also Hawaii v. Standard Oil Co.*, 405 U.S. 251, 257 (1972).

39. *Jamaica Hosp.*, 128 Misc. 2d at 1007, 491 N.Y.S.2d at 899.

40. *Id.* at 1007-08, 491 N.Y.S.2d at 899.

an unborn child is not compelling until viability,⁴¹ the court reasoned that *Roe* was inapposite because the woman had not affirmatively exercised her constitutional right to have an abortion.⁴² Thus freed from the constraints of *Roe*, the court ordered the transfusion, concluding that the "[nonviable] fetus can be regarded as a human being, to whom the court stands in *parens patriae*, and whom the court has an obligation to protect."⁴³

Neither the *Jamaica Hospital* nor *Taft* court precisely articulated the underlying legal principles needed to support their decisions.⁴⁴ Several commentators, however, have proposed possible solutions to the conflicts inherent in fetal medical treatment cases.⁴⁵ One of these proposals suggests that the fetus be deemed a "child" for purposes of the state child neglect or abuse statutes.⁴⁶ The state, invoking its *parens patriae* power, could appoint a guardian for a medically "neglected" fetus under its relevant child neglect statute.⁴⁷ If an expectant mother rejected medical care, the guardian could then consent to treatment on the fetus' behalf.

41. See *Roe v. Wade*, 410 U.S. 113, 163 (1973). See also *infra* notes 109-21 and accompanying text.

42. See *Jamaica Hosp.*, 128 Misc. 2d at 1007-08, 491 N.Y.S.2d at 899.

43. *Id.* at 1008, 491 N.Y.S.2d at 900.

44. Unfortunately, the courts in *Jamaica Hosp.* and *Taft* reached their decisions without extensive discussion of the issues. Reasons for their lack of discussion are suggested by both courts. In *Jamaica Hosp.*, the judge was called in at the last moment to render a decision in a life and death situation. See *Jamaica Hosp.*, 128 Misc. 2d at 1006, 491 N.Y.S.2d at 898-99. In *Taft* the court makes reference to a "sparse record," devoid of transcripts, testimony and facts, which may account for the limited discussion. See *Taft*, 388 Mass. at 332, 335, 446 N.E.2d at 395, 397.

45. See *infra* notes 46-56, 86-89 and accompanying text.

46. Professor Shaw is the foremost proponent of this theory which, for the purposes of this Note, will be referred to as the "fetal neglect" theory. See Shaw, *supra* note 4, at 98-104. She and several other commentators recommend the extension of state child neglect statutes to include the unborn as a means for the state to intervene in fetal medical treatment decisions. See Robertson II, *supra* note 9, at 352; Robertson I, *supra* note 4, at 443; Note, *Constitutional Limitations on State Intervention in Prenatal Care*, 67 Va. L. Rev. 1051, 1051-53 (1981); see also Note, *The Right of the Fetus to be Born Free of Drug Addiction*, 7 U.C.D. L. Rev. 45, 52-55 (1974) (recommending extension of criminal child abuse statute to include viable fetuses). Furthermore, courts have frequently relied on an expansive reading of the state child protection laws to assert jurisdiction for custody of an unborn child in order to protect its life or health. See *Jefferson v. Griffin Spalding County Hosp. Auth.*, 247 Ga. 86, 87-88, 274 S.E.2d 457, 459-60 (1981) (*per curiam*); *Hoener v. Bertinato*, 67 N.J. Super. 517, 524-25, 171 A.2d 140, 143-45 (Juv. & Dom. Rel. Ct. 1961); *Gloria C. v. William C.*, 124 Misc. 2d 313, 323-25, 476 N.Y.S.2d 991, 997-98 (Fam. Ct. 1984); see also *Bowes & Selgestad*, *supra* note 5, at 210-11 (summarizing an unreported Colorado case). *But see In re Steven S.*, 126 Cal. App. 3d 23, 30-31, 178 Cal. Rptr. 525, 528 (1981); *In re Dittrick Infant*, 80 Mich. App. 219, 223, 263 N.W.2d 37, 39 (1977).

47. It seems well established that courts have inherent power to appoint guardians *ad litem* to protect the interests of the unborn in the field of property law. See *Hatch v. Riggs Nat'l Bank*, 361 F.2d 559, 565-66 (D.C. Cir. 1966). Outside the field of property law, guardians have been appointed where the unborn child is almost certain to be born, see *Wainwright v. Moore*, 374 So. 2d 586, 588 (Fla. Dist. Ct. App. 1979), and in order to administer lifesaving medical treatment to benefit a viable fetus, see *Jefferson v. Griffin Spalding County Hosp. Auth.*, 247 Ga. 86, 88, 274 S.E.2d 457, 459 (1981) (*per curiam*).

According to this "fetal neglect" theory, the state's authority to intervene derives from its power to order medical treatment for children, a power subsumed under the doctrine of *parens patriae*.⁴⁸ Pursuant to this authority, the parents' desires are subordinated to the state's interest when their conduct results, or could result, in serious harm to the child⁴⁹ or the public interest.⁵⁰ The state is then entitled to intervene. The proponents of the "fetal neglect" theory,⁵¹ as well as the court in *Jamaica Hospital*⁵² and possibly that in *Taft*,⁵³ claim a logical extension from the state's well established *parens patriae* power to compel lifesaving treatment for children to a presumed power to protect nonviable fetuses. The proponents conclude that the state should be permitted in the interest of

48. As a general proposition, parents have a constitutional right to family integrity, broadly defined as the right to make decisions regarding the care and upbringing of their children. See *Quilloin v. Walcott*, 434 U.S. 246, 255 (1978); *Carey v. Population Servs. Int'l*, 431 U.S. 678, 685 (1977); *Prince v. Massachusetts*, 321 U.S. 158, 166 (1944). This protected realm of decisionmaking authority includes the right to select the nature of educational training for one's child, see *Pierce v. Society of Sisters*, 268 U.S. 510, 534-35 (1925); *Meyer v. Nebraska*, 262 U.S. 390, 400 (1923), to advise one's immature child regarding her decision to have an abortion, see *H.L. v. Matheson*, 450 U.S. 398, 409-13 (1981); *Bellotti v. Baird*, 443 U.S. 622, 647-48 (1979), and to commit one's child to a mental institution, see *Parham v. J.R.*, 442 U.S. 584, 602-04 (1979). This power, however, is not absolute or beyond review. Invoking the doctrine of *parens patriae*, courts have ordered vaccinations for children, compelled blood transfusions, and ordered other forms of medical intervention. See *Zucht v. King*, 260 U.S. 174, 175-77 (1922) (vaccinations); *Harley v. Oliver*, 404 F. Supp. 450, 457 (W.D. Ark. 1975) (blood transfusions), *aff'd*, 539 F.2d 1143 (8th Cir. 1976); *Jehovah's Witnesses v. King County Hosp.*, 278 F. Supp. 488, 503-05 (W.D. Wash. 1967) (blood transfusions), *aff'd per curiam*, 390 U.S. 598 (1968); *Custody of a Minor*, 375 Mass. 733, 754-56, 379 N.E.2d 1053, 1066-67 (1978) (chemotherapy); *Morrison v. State*, 252 S.W.2d 97, 103 (Mo. App. 1952) (blood transfusions); *State v. Perricone*, 37 N.J. 463, 472-74, 181 A.2d 751, 756-57, (blood transfusions), *cert. denied*, 371 U.S. 890 (1962); *Board of Educ. v. Maas*, 56 N.J. Super. 245, 264, 152 A.2d 394, 404 (App. Div. 1959) (vaccinations), *aff'd per curiam*, 31 N.J. 537, 158 A.2d 330, *cert. denied*, 363 U.S. 843 (1960); *In re Gregory S.*, 85 Misc. 2d 846, 847-48, 380 N.Y.S.2d 620, 621-22 (Fam. Ct. 1976) (hernia, cavities and fractured teeth); *In re Clark*, 21 Ohio Op. 2d 86, 89, 185 N.E.2d 128, 131-32 (1962) (blood transfusions); *In re Jensen*, 54 Or. App. 1, 3, 8, 633 P.2d 1302, 1303, 1306 (1981) (hydrocephalus); *In re Hamilton*, 657 S.W.2d 425, 429 (Tenn. App. 1983) (*per curiam*) (state's interest in protecting child's life outweighed parents' interests). But see *In re Seiferth*, 309 N.Y. 80, 85-86, 127 N.E.2d 820, 823 (1955) (where there is no present emergency, parent's discretion in medical care will be respected).

49. See, e.g., *Harley v. Oliver*, 404 F. Supp. 450, 456 (W.D. Ark. 1975), *aff'd*, 539 F.2d 1143 (8th Cir. 1976); *Jehovah's Witnesses v. King County Hosp.*, 278 F. Supp. 488, 504 (W.D. Wash. 1967), *aff'd per curiam*, 390 U.S. 598 (1968); *State v. Perricone*, 37 N.J. 463, 477-78, 181 A.2d 751, 759, *cert. denied*, 371 U.S. 890 (1962).

50. See, e.g., *Prince v. Massachusetts*, 321 U.S. 158, 166 (1944) (the family may be regulated by the state in the public interest).

51. See *supra* note 46 and accompanying text.

52. See *In re Jamaica Hosp.*, 128 Misc. 2d 1006, 1008, 491 N.Y.S.2d 898, 900 (Sup. Ct. 1985).

53. The court in *Taft* reserved judgment on whether the state might, under certain circumstances, have a sufficiently compelling interest in the life of a nonviable fetus to compel medical treatment. See *supra* notes 32-34 and accompanying text.

its wards to reach past the viability obstacles erected by *Roe v. Wade*⁵⁴ and compel lifesaving treatment for fetuses in the early, previable stages of a woman's pregnancy.

The "fetal neglect" solution to the dilemma raised by fetal medical treatment cases fails to consider one essential factor. Forcing a pregnant woman to provide her fetus with medical care would frequently, if not always, infringe on her right to bodily integrity,⁵⁵ a problem obviously not encountered with a neglected child, who is physically separate from its mother. Depending on the nature of the medical procedure, the severity of this infringement will vary. To meet constitutional standards, the asserted state interests must be balanced against the woman's right to govern her own body.⁵⁶

II. MATERNAL PRIVACY INTERESTS

A. *The Right to Bodily Integrity*

The "freedom to care for one's health and person, [free] from bodily restraint or compulsion"⁵⁷ may be the most basic element of the broader right of privacy.⁵⁸ One noted student of privacy concluded that "the body constitutes the major locus of separation between the individual and the world and is in that sense the first object of each person's freedom."⁵⁹

The Supreme Court accorded fundamental stature to the right to bodily integrity as early as 1891 when it recognized the "sacred" and "carefully guarded" right to exercise control over one's body.⁶⁰ This right has since been invoked in various contexts to protect individuals from unwarranted governmental intrusions. For instance, persons suspected of criminal activity may refuse to have their stomachs pumped.⁶¹ Adult patients or their guardians may refuse blood transfusions,⁶² amputations,⁶³ con-

54. 410 U.S. 113 (1973). For a discussion of the viability standard under *Roe v. Wade*, see *infra* notes 116-21 and accompanying text.

55. For an overview of the right to bodily integrity, see *infra* notes 57-84 and accompanying text.

56. See *infra* notes 75-84 and accompanying text.

57. *Doe v. Bolton*, 410 U.S. 179, 213 (1973) (Douglas, J., concurring).

58. See Gerety, *Redefining Privacy*, 12 Harv. C.R.-C.L. L. Rev. 233, 266 (1977) ("control over the body is the first form of autonomy"); cf. *Schmerber v. California*, 384 U.S. 757, 779 (1966) (Douglas, J., dissenting) (drawing blood involves the clearest invasion of right of privacy); *Union Pac. Ry. v. Botsford*, 141 U.S. 250, 251 (1891) (most sacred right is control over one's person).

59. L. Tribe, *American Constitutional Law* 913 (1978).

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

61. *Rochin v. California*, 342 U.S. 165, 172 (1952). In *Rochin*, the Court concluded that pumping a suspect's stomach for evidence of crime constituted "conduct that shocks the conscience" and violated the due process clause. *Id.* at 172-73. But less intrusive forced bodily invasions for the purpose of obtaining evidence have been upheld. See *Schmerber v. California*, 384 U.S. 757, 771-72 (1966) (blood test of arrestee to determine blood alcohol content); *Breithaupt v. Abram*, 352 U.S. 432, 439 (1957) (blood test to determine blood alcohol content of unconscious arrestee).

62. *St. Mary's Hosp. v. Ramsey*, 465 So. 2d 666, 668 (Fla. Dist. Ct. App. 1985); *In re*

tinued life support intervention⁶⁴ and other medical treatment⁶⁵ on the basis of their protected interest in bodily integrity.⁶⁶ This protected interest is also recognized as part of a woman's right to decide to terminate a pregnancy.⁶⁷

Despite the fundamental nature of this right, not all such intrusions by the state are constitutionally barred.⁶⁸ Courts have upheld certain bodily intrusions where they furthered a compelling state interest.⁶⁹ For instance, regulations establishing mandatory vaccinations against contagious disease in the interest of public health and safety have been upheld,⁷⁰ as have court orders compelling necessary medical treatment for incompetent adult patients⁷¹ as well as competent patients in certain limited circumstances.⁷² The scope of the "right to die," which impli-

Brooks, 32 Ill. 2d 361, 362, 373-74, 205 N.E.2d 435, 436, 442 (1965). *But see In re President & Directors of Georgetown College, Inc.*, 331 F.2d 1000, 1008-09 (D.C. Cir.) (court has power to order transfusion and save patient's life because of overriding state interests), *cert. denied*, 377 U.S. 978 (1964); *In re Storar*, 52 N.Y.2d 363, 380-82, 420 N.E.2d 64, 72-73, 438 N.Y.S.2d 266, 274-75 (guardian may not decline lifesaving blood transfusions on behalf of terminally ill patient incompetent since birth), *cert. denied*, 454 U.S. 858 (1981).

63. *Lane v. Candura*, 6 Mass. App. 377, 378, 376 N.E.2d 1232, 1233 (1978); *In re Quackenbush*, 156 N.J. Super. 282, 290, 383 A.2d 785, 789 (County Ct. 1978); *see also State Dep't of Human Servs. v. Northern*, 563 S.W.2d 197, 207 (Tenn. Ct. App. 1978) (patient would have the right to refuse the amputation if she would affirmatively make that choice).

64. *Satz v. Perlmutter*, 379 So. 2d 359, 360 (Fla. 1980); *In re Torres*, 357 N.W.2d 332, 339 (Minn. 1984) (en banc); *In re Conroy*, 98 N.J. 321, 336, 360, 486 A.2d 1209, 1216, 1229 (1985); *In re Quinlan*, 70 N.J. 10, 55, 355 A.2d 647, 671-72, *cert. denied*, 429 U.S. 922 (1976); *In re Storar*, 52 N.Y.2d 363, 369-72, 420 N.E.2d 64, 66-68, 438 N.Y.S.2d 266, 268-70, *cert. denied*, 454 U.S. 858 (1981); *In re Colyer*, 99 Wash. 2d 114, 120, 660 P.2d 738, 742 (1983) (en banc).

65. *Rogers v. Okin*, 634 F.2d 650, 653 (1st Cir. 1980), *vacated on other grounds sub nom. Mills v. Rogers*, 457 U.S. 291 (1982); Superintendent of Belchertown State School v. Saikewicz, 373 Mass. 728, 759, 370 N.E.2d 417, 435 (1977); *In re Yetter*, 62 Pa. D. & C.2d 619, 623 (C.P. County Ct. 1973).

66. Many patients refuse treatment on the basis of their religious beliefs, without asserting their interests in bodily integrity. Even then, however, their privacy interests are implicated. *See supra* note 26. For a discussion of the right to bodily integrity as a subset of the constitutional right of privacy or the common law right of privacy, *see infra* note 104.

67. *See Roe v. Wade*, 410 U.S. 113, 153 (1973).

68. *See infra* notes 70-74 and accompanying text.

69. *See Osgood v. District of Columbia*, 567 F. Supp. 1026, 1030-31 (D.D.C. 1983) (memorandum opinion); *In re Torres*, 357 N.W.2d 332, 339 (Minn. 1984) (en banc). *See also infra* notes 70-72 and accompanying text.

70. *Zucht v. King*, 260 U.S. 174, 176-77 (1922); *Jacobson v. Massachusetts*, 197 U.S. 11, 37-38 (1905); *Board of Educ. v. Maas*, 56 N.J. Super. 245, 264-67, 152 A.2d 394, 404-05 (App. Div. 1959), *aff'd per curiam*, 31 N.J. 537, 158 A.2d 330, *cert. denied*, 363 U.S. 843 (1960).

71. *Rogers v. Okin*, 634 F.2d 650, 657 (1st Cir. 1980), *vacated on other grounds sub nom. Mills v. Rogers*, 457 U.S. 291 (1982); Opinion of the Justices, 123 N.H. 554, 560-61, 465 A.2d 484, 489 (1983); *In re Storar*, 52 N.Y.2d 363, 381-82, 420 N.E.2d 64, 73, 438 N.Y.S.2d 266, 275-76, *cert. denied*, 454 U.S. 858 (1981); *State Dep't of Human Servs. v. Northern*, 563 S.W.2d 197, 211-12 (Tenn. Ct. App. 1978).

72. *See Commissioner of Correction v. Myers*, 379 Mass. 255, 263-64, 399 N.E.2d

cates bodily integrity in that it involves the final decision regarding one's body,⁷³ may thus be limited by the state.⁷⁴

In determining whether the state can intrude on a person's right to bodily integrity, the courts apply a balancing test, weighing the nature and extent of the intrusion, and thus the infringement of the right of privacy, against the significance of the state's interest.⁷⁵ Included among the goals that the courts have recognized as legitimate, and in some instances compelling, in medical treatment cases are the state's interests in protecting life and health,⁷⁶ preventing suicide,⁷⁷ and preserving the integrity of the medical profession.⁷⁸ The courts also consider such factors as the risk to the patient if the treatment is not given,⁷⁹ the risk and discomfort created by the treatment itself⁸⁰ and the likelihood that treat-

452, 457-58 (1979) (prisoner may be required to accept necessary treatment in interest of prison security); *In re Conroy*, 98 N.J. 321, 353, 486 A.2d 1209, 1225 (1985) (cases denying a patient's right to refuse lifesaving treatment involve innocent third parties or patients incapable of making a rational choice); see also Byrn, *Compulsory Lifesaving Treatment for the Competent Adult*, 44 Fordham L. Rev. 1, 36 (1975) (a competent patient's fundamental right to reject lifesaving medical treatment may be subordinated to the compelling state interests of preventing the spread of disease or protecting minor children).

73. See L. Tribe, *American Constitutional Law* 921 (1978).

74. See *In re President & Directors of Georgetown College, Inc.*, 331 F.2d 1000, 1007, 1009 (D.C. Cir.) (medical treatment authorized by court to save life of patient who asserted right to die because of her "religious scruples" but did not really want to die), *cert. denied*, 377 U.S. 978 (1964); *State Dep't of Human Servs. v. Northern*, 563 S.W.2d 197, 210-12 (Tenn. Ct. App. 1978) (partially incompetent patient who did not comprehend the facts of her condition not permitted to refuse lifesaving medical treatment).

75. See *Rogers v. Okin*, 634 F.2d 650, 656 (1st Cir. 1980), *vacated on other grounds sub nom. Mills v. Rogers*, 457 U.S. 291 (1982); *In re Spring*, 380 Mass. 629, 634, 405 N.E.2d 115, 119 (1980); *In re Quinlan*, 70 N.J. 10, 41, 355 A.2d 647, 664, *cert. denied*, 429 U.S. 922 (1976); *In re Quackenbush*, 156 N.J. Super. 282, 290, 383 A.2d 785, 789 (County Ct. 1978); *In re Colyer*, 99 Wash. 2d 114, 122-23, 660 P.2d 738, 743 (1983) (en banc).

76. See *In re President & Directors of Georgetown College, Inc.*, 331 F.2d 1000, 1009 (D.C. Cir.), *cert. denied*, 377 U.S. 978 (1964); *Superintendent of Belchertown State School v. Saikewicz*, 373 Mass. 728, 740-41, 370 N.E.2d 417, 425 (1977); *In re Quinlan*, 70 N.J. 10, 40-41, 355 A.2d 647, 663-64, *cert. denied*, 429 U.S. 922 (1976).

77. See *Superintendent of Belchertown State School v. Saikewicz*, 373 Mass. 728, 741, 370 N.E.2d 417, 425 (1977); *In re Torres*, 357 N.W.2d 332, 339 (Minn. 1984) (en banc); *In re Conroy*, 98 N.J. 321, 348, 486 A.2d 1209, 1223 (1985); *In re Storar*, 52 N.Y.2d 363, 377-78 n.6, 420 N.E.2d 64, 71 n.6, 438 N.Y.S.2d 266, 273 n.6, *cert. denied*, 454 U.S. 858 (1981); *In re Colyer*, 99 Wash. 2d 114, 122, 660 P.2d 738, 743 (1983) (en banc).

78. See *United States v. George*, 239 F. Supp. 752, 754 (D. Conn. 1965); *In re Torres*, 357 N.W.2d 332, 339 (Minn. 1985) (en banc); *In re Conroy*, 98 N.J. 321, 348-49, 486 A.2d 1209, 1224 (1985); *In re Colyer*, 99 Wash. 2d 114, 122, 660 P.2d 738, 743 (1983) (en banc).

79. *In re President & Directors of Georgetown College, Inc.*, 331 F.2d 1000, 1007 (D.C. Cir.) (court authorized intervention where patient would die without treatment and had better than a 50% chance of surviving with treatment), *cert. denied*, 377 U.S. 978 (1964); *United States v. George*, 239 F. Supp. 752, 753 (D. Conn. 1965) (blood transfusion ordered where death was probable without treatment); *In re Quackenbush*, 156 N.J. Super. 282, 285-86, 383 A.2d 785, 787 (County Ct. 1978) (patient's life would be saved by amputation).

80. *Superintendent of Belchertown State School v. Saikewicz*, 373 Mass. 728, 730.

ment will ameliorate the condition.⁸¹ If the government interest is sufficiently compelling, then even highly invasive state action may be warranted, as with the imposition of major surgery on a patient who lacks capacity to make a rational medical choice⁸² or on a prisoner in the interest of prison security.⁸³ The competent patient, however, is entitled to reject even minimally invasive lifesaving treatment if the government fails to demonstrate a compelling state goal.⁸⁴

B. *The Right to Bodily Integrity in Fetal Medical Treatment Cases*

In fetal medical treatment cases, the woman's right to bodily integrity is inevitably implicated. It is hard to identify any form of treatment for the fetus, no matter how minor, that would not impinge on the woman's body in some way. Even seemingly benign treatment orders, such as those requiring that the pregnant woman refrain from drinking alcohol, ingest prescribed doses of vitamins or submit to prenatal diagnostic testing, limit her right to control her own body.⁸⁵ Where the woman rejects the treatment, the maternal/fetal conflict should be resolved by weighing her freedom to do so against the asserted state interest in ordering the treatment.

To resolve this conflict, a noted commentator in the field of fetal rights has proposed a solution that is based on the bodily integrity balancing test.⁸⁶ According to this "bodily integrity" approach, medical intervention should be permitted provided that the degree of harm and intrusion to the woman is less than the expected benefit to the fetus.⁸⁷ The theory presumes a strong state interest in preserving the life and health of the fetus,⁸⁸ whether or not it is viable.⁸⁹ The obvious question raised by this approach, as well as by the holdings in *Jamaica Hospital* and *Taft*, is

732-35, 370 N.E.2d 417, 419, 421-24 (1977); *In re Quackenbush*, 156 N.J. Super. 282, 286, 383 A.2d 785, 787 (County Ct. 1978); *In re Storar*, 52 N.Y.2d 363, 381, 420 N.E.2d 64, 73, 438 N.Y.S.2d 266, 275, cert. denied, 454 U.S. 858 (1981); L. Tribe, *supra* note 73, 917.

81. *Superintendent of Belchertown State School v. Saikewicz*, 373 Mass. 728, 732-33, 735, 370 N.E.2d 417, 420-21, 422 (1977); *In re Quackenbush*, 156 N.J. Super. 282, 285, 383 A.2d 785, 787 (County Ct. 1978).

82. *See State Dep't of Human Servs. v. Northern*, 563 S.W.2d 197, 211-12 (Tenn. Ct. App. 1978).

83. *Commission of Correction v. Myers*, 379 Mass. 255, 263-65, 399 N.E. 452, 457-58 (1979).

84. *See St. Mary's Hosp. v. Ramsey*, 465 So. 2d 666, 668-69 (Fla. Dist. Ct. App. 1985).

85. For summaries of the spectrum of conceivable forms of intervention on behalf of a fetus, ranging from mandatory noninvasive prenatal genetic testing to force-feeding a pregnant anorexic teenager, and to compelling in utero surgical intervention, see Robertson II, *supra* note 9, at 357-59; Shaw, *supra* note 4, at 71-75, 78-79; *Current Technology*, *supra* note 4, at 1239-42; *Fetal Rights*, *supra* note 6, at 605-09.

86. *See Robertson II*, *supra* note 9, at 353-55, 357.

87. *See id.* at 354-55; *Robertson I*, *supra* note 4, at 445-46.

88. *See Robertson II*, *supra* note 9, at 360.

89. *See supra* note 28 and accompanying text.

whether this asserted state interest in nonviable fetal life may be sufficiently compelling to override the pregnant woman's fundamental interest in her bodily integrity.

III. THE COMPELLING STATE INTEREST TEST AND THE VIABILITY STANDARD

As previously discussed, state action that burdens the exercise of an individual's fundamental right of privacy must be evaluated under the "compelling state interest" test.⁹⁰ The *Taft* court, the *Jamaica Hospital* court, and the proponents of the "bodily integrity" and "fetal neglect" theories have all relied on or suggested the existence of a state interest in preserving prenatal life.⁹¹

The state asserted this same interest in nonviable fetal life to justify intrusion into an expectant mother's right of privacy in the line of Supreme Court abortion decisions beginning with *Roe v. Wade*.⁹² Strict application of the legal principles of the abortion decisions to fetal medical treatment cases, however, has its difficulties. The women in *Taft* and apparently in *Jamaica Hospital* did not affirmatively exercise their right under *Roe v. Wade* to terminate their pregnancies.⁹³ Thus, it is not clear whether the principles of *Roe v. Wade* governing the state interest in fetal life⁹⁴ are relevant to fetal medical treatment cases.

The court in *Jamaica Hospital* addressed this issue but, without offering any rationale, concluded that *Roe v. Wade* was inapposite.⁹⁵ Some

90. See *Carey v. Population Servs. Int'l*, 431 U.S. 678, 685-86 (1977); *Doe v. Bolton*, 410 U.S. 179, 211-13 (1973) (Douglas, J. concurring); Smith, *Constitutional Privacy in Psychotherapy*, 49 *Geo. Wash. L. Rev.* 1, 32-39 (1980).

91. See *Taft v. Taft*, 388 Mass. 331, 333, 446 N.E.2d 395, 397 (1983); *In re Jamaica Hosp.*, 128 Misc. 2d 1006, 1007-08, 491 N.Y.S.2d 898, 899-900 (Sup. Ct. 1985); *Robertson II*, *supra* note 9, at 360-61; *Shaw*, *supra* note 4, at 99-100. See also *supra* notes 33-34 and accompanying text.

92. 410 U.S. 113 (1973). See *infra* notes 116-21 and accompanying text.

93. In *Taft*, the court stated that the mother wanted the unborn child but believed the medical treatment was unnecessary, thus suggesting that she had decided not to have an abortion. See *Taft*, 388 Mass. at 332-33, 446 N.E.2d at 396. It is unclear in *Jamaica Hosp.* whether the mother wanted the child, or would have considered an abortion, but in any event, it is clear that she did not exercise her right to terminate the pregnancy. See *Jamaica Hosp.*, 128 Misc. 2d at 1007-08, 491 N.Y.S.2d at 899-900.

94. In *Roe v. Wade*, the Supreme Court held that the state has an "important and legitimate interest in protecting the potentiality of human life" represented by the fetus throughout the mother's pregnancy. *Roe*, 410 U.S. at 162-63; see *Harris v. McRae*, 448 U.S. 297, 324 (1980) (quoting and reaffirming *Roe v. Wade*); *Maher v. Roe*, 432 U.S. 464, 478 (1977) (*Roe* "explicitly acknowledged the State's strong interest in protecting the potential life of the fetus"). The Court pointed out, however, that this interest is not sufficiently compelling to override the mother's privacy rights until the fetus attains viability. See *Roe*, 410 U.S. at 153-54, 164-65. The perimeters of the state's interest in fetal life are discussed in more detail in *infra* notes 107-21 and accompanying text.

95. The court in *Jamaica Hosp.* concluded that:

While [we] 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 the abortion cases, this is not such a case. In this case, the state has a

commentators in the area of fetal medical care have considered the question of *Roe*'s precedential value, for the most part limiting their focus to the individual rights involved.⁹⁶ Several commentators conclude that the individual's right to decide to terminate a pregnancy differs from the right to terminate a fetus' life either directly, or indirectly by withholding lifesaving medical treatment.⁹⁷ Although this may be so, it does not necessarily follow that the state's interest in nonviable fetal life should be compelling in treatment cases, especially when that same state interest is merely important, and not compelling, in abortion cases.

Examination of the compelling state interest doctrine and the individual interests asserted in each line of cases reveals that the state interest standard applied by the Court in *Roe v. Wade*⁹⁸ should apply equally to fetal medical treatment cases. It is true that the compelling state interest test is relative in its operation. A state interest that is sufficiently compelling in relation to one particular constitutionally-protected interest may be inadequate to tip the scales in the state's favor when weighed against another.⁹⁹ Conceivably, the state's interest in nonviable fetal life could

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.

In re Jamaica Hosp., 128 Misc. 2d 1006, 1008, 491 N.Y.S.2d 898, 899 (Sup. Ct. 1985).

96. See Robertson II, *supra* note 9, at 359. Dr. Mathieu, *supra* note 6, at 37-39, discusses the applicability of the viability standard of *Roe v. Wade* to fetal medical treatment cases. She concludes, essentially, that the standard enunciated in *Roe* applies only when the state interferes with a woman's right to have an abortion. See *id.* Other commentators have argued otherwise. See Fletcher, *supra* note 5, at 772; Note, *Jefferson v. Griffin Spalding County Hospital Authority: Court-Ordered Surgery to Protect the Life of an Unborn Child*, 9 Am. J.L. & Med. 83, 96 (1983).

97. In *Roe v. Wade* and the subsequent abortion decisions, the Supreme Court has not fully defined the contours of the right to decide to terminate a pregnancy. See Robertson II, *supra* note 9, at 334. Thus, the Court has provided little guidance regarding the distinction between terminating a pregnancy and terminating a fetus' life. See *Current Technology*, *supra* note 4, at 1242-43 & n.155 (the Court may not have considered this distinction in the early abortion decisions). With advancements in medical science, it is already possible in some instances to perform an abortion by removing the fetus from the mother's womb without killing the fetus in the process. See *Colautti v. Franklin*, 439 U.S. 379, 399 (1979); *American College of Obstetricians & Gynecologists v. Thornburgh*, 737 F.2d 283, 300 (3d Cir. 1984), *juris. postponed*, 105 S. Ct. 2015 (1985). Furthermore, there is reason to believe that the instances of fetal survival will increase because of continuing medical advances. See *Current Technology*, *supra* note 4, at 1243-44. The right defined under *Roe* to terminate a pregnancy does not necessarily include the right to kill an aborted fetus that survives the procedure, nor to cause the death in utero of a fetus by withholding lifesaving treatment. For an interesting discussion of the possible distinctions between these two rights, see Mathieu, *supra* note 6, at 32-37.

98. *Roe v. Wade*, 410 U.S. 113, 162-64 (1973). See also *supra* notes 118-24 and accompanying text.

99. For instance, the state's interest in obtaining criminal evidence has been recognized as sufficiently compelling to justify the minimal intrusion of bodily integrity involved in drawing blood to determine alcohol content for purposes of a criminal trial. See *Schmerber v. California*, 384 U.S. 757, 770-72 (1966); *Breithaupt v. Abram*, 352 U.S. 432, 439-40 (1957). This interest may be entirely insufficient, however, when weighed against other individual protections, such as the protection accorded privileged communications. See C. McCormick, *McCormick on Evidence* 170-87 (3d ed. 1984). Along the same lines, Professor Tribe points out:

be compelling in the context of medical treatment while merely "protectible"¹⁰⁰ in the context of abortion. But this result implies that the magnitude of the woman's interest in bodily integrity is somehow less than the magnitude of her interest in deciding to terminate a pregnancy. Despite the lack of perfect symmetry between these two interests, they should be considered, at a minimum, roughly equivalent in magnitude. Indeed, one commentator considers it "self-evident" that the right to exercise control over one's body is "the first form of autonomy and the necessary condition . . . of all later forms,"¹⁰¹ suggesting that this right may be even more fundamental to and "implicit in the concept of ordered liberty"¹⁰² than the abortion decision. Since both interests are fundamental¹⁰³ and are recognized as part of the right of privacy,¹⁰⁴ they

The central problem, then, is to decide what makes a purpose illegitimate or insufficient. That in turn depends on the nature of the right being asserted and the way in which it is brought into play Thus a purpose adequate to justify regulating the quality of brake linings might not serve to justify requiring the wearing of seat belts.

L. Tribe, *supra* note 73, at 891; *see also* Smith, *supra* note 90, at 32 (although state has interest in preserving evidence for trial, this interest could not justify compelling a woman to bear a fetus in order to obtain the evidence).

100. Harris v. McRae, 448 U.S. 297, 350 (1980) (Stevens, J., dissenting) ("In *Roe v. Wade*, . . . the Court recognized that the States have a legitimate and protectible interest in potential human life. But the Court explicitly held that prior to fetal viability that interest may not justify any governmental burden on the woman's choice . . .") (citations omitted); *see* *Roe v. Wade*, 410 U.S. 113, 162-63 (1973).

101. Gerety, *supra* note 58, at 266 & n.119.

102. *See* *Roe v. Wade*, 410 U.S. 113, 152 (1973) (quoting *Palko v. Connecticut*, 302 U.S. 319, 325 (1937)).

103. *See* *Roe v. Wade*, 410 U.S. at 152-53; *Rogers v. Okin*, 634 F.2d 650, 653-54, (1st Cir. 1980), *vacated on other grounds*, 457 U.S. 291 (1982); *Guardianship of Roe*, 383 Mass. 415, 433 & n.9, 421 N.E.2d 40, 51 & n.9 (1981); *Superintendent of Belchertown State School v. Saikewicz*, 373 Mass. 728, 740-42, 370 N.E.2d 417, 424-26 (1977); *cf.* *Union Pac. Ry. v. Botsford*, 141 U.S. 250, 251 (1891) (right to bodily control is the most sacred right). *See also* *supra* note 60 and accompanying text.

104. The right to control matters concerning reproduction, including the right to decide to terminate a pregnancy, has been firmly established as one of the autonomy interests subsumed under the fourteenth amendment right of privacy. *See* *Roe v. Wade*, 410 U.S. 113, 153 (1973) (right to terminate a pregnancy); *Griswold v. Connecticut*, 381 U.S. 479, 485-86 (1965) (right to use contraceptives).

Although the Supreme Court has not identified a constitutional source for the right to refuse medical treatment, *see* *Mills v. Rogers*, 457 U.S. 291, 298-300, 305 (1982); *In re Storar*, 52 N.Y.2d 363, 376, 420 N.E.2d 64, 70, 438 N.Y.S.2d 266, 272-73, *cert. denied*, 454 U.S. 858 (1981), most authority that has addressed the question finds its origins within either the fourteenth amendment right of privacy, the common law right of privacy, or as deriving from both privacy rights. *See, e.g.,* *Guardianship of Roe*, 383 Mass. 415, 433 & n.9, 421 N.E.2d 40, 50 & n.9 (1981) (derived from both); *In re Conroy*, 98 N.J. 321, 486 A.2d 1209, 1222-23 (1985) (derived from both); *In re Colyer*, 99 Wash. 2d 114, 119-21, 660 P.2d 738, 741-42 (1983) (en banc) (fourteenth amendment right); *cf.* *Mills v. Rogers*, 457 U.S. 291, 298-300 (1982) (an involuntarily committed mental patient may have a constitutionally-protected interest to refuse medical treatment, but if state law adequately protects these interests, then the liberty interests will be defined by the "broader state protections"); *Rennie v. Klein*, 653 F.2d 836, 844-45 (3d Cir. 1981), *vacated on other grounds*, 458 U.S. 1119 (1982), *on remand*, 720 F.2d 266, 269 (3d Cir. 1983) (en banc) (affirming prior decision in which the right to refuse medical treatment

should be accorded similar protection under the due process clause.¹⁰⁵ It is necessary, therefore, that the state posit against both interests a countervailing interest that rises to a similar minimum level of strength in order to warrant intrusive action. Only in the abortion cases has the Supreme Court addressed this central issue of when, or if, a state's interest in nonviable fetal life rises to the level needed to override privacy rights.¹⁰⁶ The state interest standard enunciated in the abortion decisions can and should be applied to the fetal medical treatment cases to determine the constitutional measure of the state's interest in fetal life when balanced against the fundamental right of privacy.

Satisfactory determination of the constitutional weight to be accorded to the state's interest in fetal life requires a brief examination of *Roe v. Wade*.¹⁰⁷ In *Roe*, the Supreme Court adopted the much criticized "trimester approach"¹⁰⁸ in its effort to balance the competing interests of the individual and the state. The Court recognized the fundamental nature of the woman's privacy interests but held that "this right is not unqualified and must be considered against important state interests."¹⁰⁹ In identifying three important state interests, the Court related each interest to one of three stages of the woman's pregnancy, which in turn corresponded to the age of the fetus.¹¹⁰ During the first stage of approximately three months, the state has merely a "protective interest in fetal life,"¹¹¹ and state action is limited to assuring adherences to minimal standards of medical safety in the abortion procedure itself.¹¹² Through-

was recognized as warranting the protection of the fourteenth amendment). There is, however, some discussion that the fourteenth amendment right of privacy may not completely encompass the right to bodily integrity. See Byrn, *supra* note 72, at 9.

105. It is hornbook law that the constitutional right of privacy entails a zone or shield of protection that the state cannot invade unless it asserts a compelling reason for doing so. See *Roe v. Wade*, 410 U.S. 113, 155 (1973); *Griswold v. Connecticut*, 381 U.S. 479, 497 (1965) (Goldberg, J., concurring). The measure of protection accorded the right to decide to terminate a pregnancy is provided by this compelling state interest doctrine. To the extent that the right to bodily integrity is recognized as a subset of the constitutional right of privacy, bodily integrity would be accorded this same protection. If, on the other hand, the right to refuse medical treatment derives solely from the common law right of privacy, then, too, it has been recognized as a liberty interest warranting the protection of the fourteenth amendment due process clause and may be burdened by the state only if the state asserts a compelling reason for doing so. See *supra* note 104. See also Byrn, *supra* note 72, at 9 ("the traditional right to determine what shall be done with one's body includes the right to refuse lifesaving treatment . . . provided there [is] no . . . compelling state interest in the continuance of the patient's life"). For a succinct review of the compelling state interest doctrine, see Smith, *supra* note 90, at 32-39.

106. See *Roe v. Wade*, 410 U.S. at 154-55.

107. 410 U.S. 113 (1973).

108. See *id.* at 163-65. Critical discussions of the analytic framework adopted by the Court in *Roe* are too numerous to list here. A widely cited criticism is found in Justice O'Connor's dissenting opinion in *City of Akron v. Akron Center for Reproductive Health*, 462 U.S. 416, 452-59 (1983) (O'Connor, J., dissenting).

109. *Roe*, 410 U.S. at 154.

110. See *id.* at 162-64.

111. See *supra* note 100.

112. *Roe*, 410 U.S. at 149-50, 154; see *Planned Parenthood v. Danforth*, 428 U.S. 52,

out the second trimester, extending from roughly the fourth month of pregnancy to the point of fetal viability, usually estimated to occur during the seventh month,¹¹³ the state's "protectible interest" persists, but only its interest in protecting maternal health is considered compelling.¹¹⁴ Toward that end, the state can regulate the abortion procedure even at the cost of burdening the woman's freedom of choice, but is constitutionally precluded from barring the exercise of her privacy rights altogether.¹¹⁵ Only when the fetus attains viability, when it "presumably has the capability of meaningful life outside the mother's womb,"¹¹⁶ does the state have a "compelling" interest in protecting the unborn "potentiality of human life."¹¹⁷ At this stage state action circumscribing the mother's liberty interests is permissible provided the infringing regulation is narrowly tailored to further only the state's interest in protecting viable fetal life.¹¹⁸

In its subsequent decisions, the Supreme Court has repeatedly and consistently reaffirmed the viability standard¹¹⁹ enunciated in *Roe v.*

67-71 & n.11 (1976) (spouse's consent requirement unconstitutional); *Connecticut v. Menillo*, 423 U.S. 9, 10-11 (1975) (per curiam) (requirement that only physicians may perform abortions upheld); *Doe v. Bolton*, 410 U.S. 179, 195 (1973) (state requirement that abortion may only be performed in a hospital too broad).

113. *Roe*, 410 U.S. at 160, 163. The questions of how viability should be defined and at what point in development a fetus achieves viability are recurring themes in the Supreme Court abortion cases. *See, e.g.*, *City of Akron v. Akron Center for Reproductive Health*, 462 U.S. 416, 457-58 (1983) (O'Connor, J., dissenting); *Colautti v. Franklin*, 439 U.S. 379, 393, 395-96 (1979); *Planned Parenthood v. Danforth*, 428 U.S. 52, 63-65 (1976). Furthermore, the inquiry has apparently not abated. *See Charles v. Daley*, 749 F.2d 452, 459 (7th Cir. 1984), *prob. juris. noted sub nom. Diamond v. Charles*, 105 S. Ct. 2356 (1985). Despite the inherent flexibility of the viability standard, *see Colautti*, 439 U.S. at 387; *Danforth*, 428 U.S. at 61, 64, as well as the ongoing criticisms, *see, e.g., Akron*, 462 U.S. at 455-58 (O'Connor, J., dissenting), the Court has steadfastly adhered to its position that the state's interest in fetal life is not compelling prior to fetal viability. *Colautti*, 439 U.S. at 388-89. *See infra* notes 119-21 and accompanying text for additional discussion of the Court's reaffirmance for the viability standard.

114. *Roe*, 410 U.S. at 162-63.

115. *See id.* at 163-64; *see also Planned Parenthood Ass'n v. Ashcroft*, 462 U.S. 476, 481-82 (1983) (requirement that all second trimester abortions be performed in hospital invalidated because it limits accessibility to abortions and is not reasonably designed to further state's interest in maternal health); *City of Akron v. Akron Center for Reproductive Health*, 462 U.S. at 431-34 (second trimester hospital requirement overbroad); *Planned Parenthood v. Danforth*, 428 U.S. at 75-81 (prohibition of saline abortions in second trimester unconstitutional because not reasonably related to maternal health, but recordkeeping requirements upheld because they protect maternal health without affecting the abortion decision).

116. *Roe*, 410 U.S. at 163.

117. *Id.* at 162-64.

118. *Id.* at 155, 163-64.

119. In *Colautti v. Franklin*, 439 U.S. 379 (1979), the Court summarized the decisions in which it addressed the viability standard. *See id.* at 386-89. It began with *Roe v. Wade*, noting that there the Court established that "the State's interest in the potential life of the fetus reaches the compelling point at the stage of viability." *Id.* at 386. The Court then noted its rejection in *Planned Parenthood v. Danforth* of an attempt to move the standard to a pre-viability stage. *Id.* at 388. The Court stated that in these prior decisions it "stressed viability" as the point when the state may bar the exercise of the wo-

Wade. In determining when the state's interest in protecting fetal life is compelling, the Court has emphasized that "[v]iability is the critical point"¹²⁰ and "[h]ence, prior to viability, the State may not seek to further this interest by directly restricting a woman's decision."¹²¹

Treatment orders, such as those considered by the courts in *Jamaica Hospital* and *Taft*, which coerce women to accept lifesaving medical care for a nonviable fetus, are difficult to justify under the *Roe* standard on the basis of the state's interest in protecting a potentiality of life. As a preliminary matter, a competent adult woman has the right to refuse lifesaving medical treatment on the basis of her privacy interests in bodily integrity.¹²² The state can curtail this protected freedom only if it can demonstrate a compelling reason to do so.¹²³ According to *Roe v. Wade*, the state has no compelling interest in the life of the nonviable fetus.¹²⁴ The decisions in *Jamaica Hospital*¹²⁵ and *Taft*¹²⁶ departed from the standard set forth in *Roe v. Wade*. In issuing, or reserving judgment to issue treatment orders on behalf of a nonviable fetus, the courts failed to accord the proper weight to the state's interest in nonviable fetal life, failing as well to provide the constitutional protection due the woman's privacy interests.

man's privacy interest. *Id.* at 388. Indicating that it did not intend to retreat from its prior position, the Court concluded:

We reaffirm these principles. Viability is reached when . . . there is a reasonable likelihood of the fetus' sustained survival outside the womb, with or without artificial support. Because this point may differ with each pregnancy, neither the legislature nor the courts may proclaim one of the elements entering into the ascertainment of viability—be it weeks of gestation or fetal weight or any other single factor—as the determinant of when the State has a compelling interest in the life or health of the fetus. Viability is the critical point. And we have recognized no attempt to stretch the point of viability one way or the other.

Id. at 388-89.

120. *Id.* at 389.

121. *Id.* at 386.

122. See *supra* notes 62-66, 74-85 and accompanying text. In *In re Jamaica Hosp.*, 128 Misc. 2d 1006, 491 N.Y.S.2d 898 (Sup. Ct. 1985), the court conceded that a patient who is not pregnant may refuse lifesaving treatment without court interference. See *id.* at 1007, 491 N.Y.S.2d at 899. Similarly, in *Taft v. Taft*, 388 Mass. 331, 446 N.E.2d 395 (1983), the court noted that where there is no compelling state interest, the court will uphold an individual's right to refuse lifesaving medical treatment. See *id.* at 334, 446 N.E.2d at 397.

123. See *supra* notes 75-84 and accompanying text.

124. *Roe v. Wade*, 410 U.S. 113, 162-63 (1973).

125. *In re Jamaica Hosp.*, 128 Misc. 2d 1006, 1007-08, 491 N.Y.S.2d 898, 899 (Sup. Ct. 1985).

126. *Taft v. Taft*, 388 Mass. 331, 446 N.E.2d 395 (1983). The court in *Taft* did not consider the applicability of the principles of *Roe v. Wade* to the medical treatment case, choosing instead to focus on the "constitutional right" to refuse lifesaving medical treatment. See *id.* at 334, 446 N.E.2d at 397. The court reached its conclusion without fully addressing whether the state has a compelling interest in nonviable fetal life. See *id.* See also *supra* note 34.

CONCLUSION

Courts and commentators have argued that the state's interest in non-viable fetal life is sufficiently compelling in fetal medical treatment cases to override an expectant mother's fundamental interest in bodily integrity. Their position contravenes the mandate of *Roe v. Wade*, which teaches that although the state has an interest throughout a woman's pregnancy in protecting fetal life, this interest is subordinate to her privacy rights, at least until the fetus reaches viability. Until then, the woman has, "as against the Government, the right to be left alone,"¹²⁷ a right that entitles her to refuse medical care and outweighs the government's interest in protecting the nonviable fetus.

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127. *Olmstead v. United States*, 277 U.S. 437, 478 (1928) (Brandeis, J., dissenting).