

**“A SPECIAL CLASS OF PERSONS”:
PREGNANT WOMEN’S RIGHT TO REFUSE MEDICAL
TREATMENT AFTER *GONZALES V. CARHART***

*Margo Kaplan**

*As several scholars have noted, the Supreme Court’s *Gonzales v. Carhart* decision upholding the federal Partial Birth Abortion Ban Act of 2003 (PBABA) represents a major departure from its previous abortion jurisprudence. What has received little attention is the ease with which Carhart’s rationale can be imported into cases involving the medical treatment of women who wish to continue their pregnancies to term. This article analyzes the implications of Carhart in a context that has thus far been overlooked and, in doing so, argues that its reasoning is broader and more troubling than the majority acknowledged or perhaps even intended.*

While common and constitutional law protect the right to refuse medical treatment, courts have compelled the medical treatment of pregnant women on rare occasions, citing the states’ interest in protecting fetal life as recognized in abortion jurisprudence. Until Carhart, abortion jurisprudence provided very limited support for compelled medical treatment of pregnant women more generally. Carhart interprets the state interests in fetal life and maternal health so broadly that it essentially creates new, dubious state interests that, in the context of compelled treatment cases, expand state justifications for requiring medical treatment of pregnant women, even where such treatment would harm women’s health. The expansion of state power to compel medical treatment has disturbing implications for women’s liberty and equality. Carhart paves the way to designating women as a “special class of persons” who have more limited rights to bodily autonomy and informed consent.

* Visiting Assistant Professor of Law, Brooklyn Law School. B.S. 2000, Cornell University; J.D. 2004, New York University School of Law; M.P.A. 2004, Kennedy School of Government, Harvard University. I would like to thank Derrick Bell, Diana Kasdan, Sylvia Law, Andrew Lund, Alison Mehlman, Howard Minkoff, Lynn Paltrow, Jill Siegelbaum, and Kenji Yoshino for their comments and insight, and my husband, Ben, for his love and support.

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I. INTRODUCTION

Despite the majority's protestations to the contrary, the Supreme Court's *Gonzales v. Carhart*¹ decision represents a significant departure from its previous abortion jurisprudence. In *Carhart*, the Supreme Court upheld the federal Partial Birth Abortion Ban Act of 2003 (PBABA), which outlawed a procedure used during abortions.² As the dissent notes, the majority's argument uses new, dubious interpretations of state interests to justify abortion regulation.³ The Court also upheld PBABA despite significant medical evidence that the banned procedure is necessary to preserve women's health in many circumstances, undermining the principle under *Roe v. Wade* and its progeny that women's health must always be paramount in abortion regulation.⁴

Although numerous scholars have noted *Carhart*'s troubling implications for expanding states' ability to regulate abortion,⁵ there has

¹ 550 U.S. 124 (2007).

² *Id.* at 132, 168.

³ *See id.* at 181–87 (Ginsburg, J., dissenting) (noting that “[t]he Court offers flimsy and transparent justifications for upholding a nationwide ban on intact [intact dilation and evacuation procedure] sans any exception to safeguard a women’s health”).

⁴ *See id.* at 161–68 (discussing medical evidence pertaining to the necessity of the banned procedure and concluding that the Act should be upheld despite this evidence).

⁵ *See, e.g.*, Leading Cases, *Abortion Rights—“Partial Birth” Abortion*, 121 HARV. L. REV. 185, 265 (2007) [hereinafter Leading Cases, *Abortion Rights*] (arguing that *Carhart*'s deference to Congress in the face of medical disagreement was “inadequately theorized and swept too broadly”); Michael C. Dorf, *Abortion Rights*, 23 TOURO. L. REV. 815, 822–24 (2008) (criticizing *Carhart*'s reasoning as expanding accepted state justifications for restricting abortion); Matthew Gordon, *State Attempts to Expand Abortion Informed Consent Requirements: New Life After Gonzales v. Carhart?*, 35 J.L. MED. & ETHICS 751, 751, 753 (2007) (arguing that *Carhart* may provide new support to other restrictions on abortion access); Reva B. Siegel, *The Right's Reasons: Constitutional Conflict and the Spread of Woman-Protective Antiabortion Argument*, 57 DUKE L.J. 1641, 1650 (2008) [hereinafter Siegel, *Right's Reasons*] (arguing that *Carhart*'s woman-protective rationale for restricting abortion advances an anti-abortion argument that is gender-paternalistic and unresponsive to the real needs of women); Hannah Stahle, *Fetal Pain Legislation: An Undue Burden*, 10 QUINNIPIAC HEALTH L.J. 251, 274–75 (2007) (arguing that *Carhart* elevated the status of the fetus and diminished the status of a woman by banning an abortion procedure without creating an exception for medical necessity); Ronald Turner, *Gonzales v. Carhart and the Court's “Women's Regret” Rationale*, 43 WAKE FOREST L. REV. 1, 41–42 (2008) (arguing that *Carhart*'s reasoning can be expanded to restrict other abortion procedures).

been little discussion of the ease with which *Carhart's* rationale can be imported into cases involving the medical treatment of women who wish to continue their pregnancies to term. This article argues that, while *Carhart* is objectionable solely based on the abortion issue it squarely addresses, further analysis reveals that its reasoning has troubling implications for women's right to control other medical decisions during pregnancy. Lower courts have considered attempts to compel treatment of pregnant women who intend to carry their pregnancies to term, but who have rejected medical intervention that would, in their physicians' opinion, be optimal or even necessary to preserve the life or health of the fetus. Courts have looked to abortion jurisprudence to determine the parameters of the state's interest in fetal life and whether that interest can justify intervention in pregnant women's medical decisions that place the fetus they carry at risk. Until *Carhart*, abortion jurisprudence provided very limited support for such intervention.

This article analyzes implications of *Carhart* that have thus far been overlooked and argues that its reasoning is broader and more troubling than the majority acknowledged or perhaps even intended. While on its face *Carhart* is limited to abortion procedures, it relies heavily on reasoning that is easily expanded to the compelled treatment of pregnant women. *Carhart* reinterprets the state interests in fetal life and maternal health and recognizes new interests that justify abortion regulation: expressing respect for fetal life and preventing a woman from exercising informed consent where her decision would harm the fetus and might subsequently cause her to feel remorse. The decision also undermines the principle that these state interests may not be pursued at the expense of maternal health. In the context of compelled treatment cases, this reasoning allows the state to compel medical treatment of pregnant women in order to further the dubious interpretations of state interests in showing respect for the fetus and protecting the woman from making medical decisions the state believes she might regret and may even justify compelling such treatment where it would harm the woman's health.

Part II of this article outlines the *Carhart* decision and argues that *Carhart's* reasoning expands the state interests that may be used to regulate abortion. *Carhart* also eroded the primacy of women's health, implying that these interests may be pursued at the expense of women's health in certain circumstances. Part III examines the jurisprudence of compelled medical treatment of pregnant women. While common law and constitutional jurisprudence recognize the right to refuse medical treatment, courts have often viewed pregnancy as a unique circumstance subject to additional state interference.

In doing so, they looked to abortion jurisprudence to allow limited state intervention in pregnant women's medical treatment choices to further the state's interest in fetal life. Part III argues that, until *Carhart*, abortion jurisprudence provided only very limited support for compelled medical treatment of pregnant women.

Part IV argues that a reasonable interpretation of *Carhart's* reasoning expands state power to compel medical treatment of pregnant women who intend to carry their pregnancies to term. While *Carhart* and its predecessor, *Stenberg v. Carhart*,⁶ concerned abortion rights, the crux of the issue in both cases was balancing a patient's right to choose her course of medical treatment against the state's interest in fetal life. *Carhart* recognizes new state interests and allows the state to pursue them at the expense of women's health where there is a modicum of uncertainty about the effect on women's health. It provides new arguments for those seeking to compel the medical treatment of pregnant women for the benefit of the fetus, even where such treatment might be detrimental to the health of the woman. Part IV also demonstrates how this reasoning could be applied to specific medical decisions that arise during pregnancy and childbirth.

Part V argues that the expansion of state intervention into the medical treatment decisions of pregnant women has several disturbing consequences. Doctrinally, it infringes on women's liberty and equality rights, designating pregnant women as a "special class of persons"⁷ who, solely because of their pregnancy, have more limited rights to bodily autonomy and informed consent. It perpetuates the view that pregnant women are less autonomous than other individuals and that the state may commandeer their bodies because of their reproductive capabilities. Because Supreme Court jurisprudence has separated and weakened liberty-based and equality-based arguments that challenge limitations on women's reproductive rights, it often fails to recognize the full implications of compelled medical treatment. Part V presents an approach that views these two interests as intertwined, which more accurately addresses the ramifications of compelled medical treatment and provides fuller protection for pregnant women's rights to refuse medical treatment. Part V also argues that compelled medical treatment has troubling public health implications, damaging the physician-patient relationship, placing physicians in the ethically questionable position of seeking court in-

6 530 U.S. 914 (2000).

7 *In re A.C.*, 573 A.2d 1235, 1256 (D.C. 1990) (Belson, J., concurring in part and dissenting in part).

tervention in more situations, and compromising prenatal medical care.

II. THE *GONZALES V. CARHART* DECISION

A. *Background*

The Supreme Court first recognized the constitutional right to an abortion in *Roe v. Wade*.⁸ In *Roe*, the Court held that the right to an abortion is part of the right to privacy implicit in the Fourteenth Amendment.⁹ It acknowledged the health issues of women needing abortions and held that, while the state has an interest in fetal life that becomes compelling at viability, this interest may not be pursued at the expense of the health or life of the mother.¹⁰ The state may prohibit abortion after viability, but it must allow an exception for the life or health of the mother. The Court's 1992 decision in *Planned Parenthood of Southeastern Pennsylvania v. Casey* held that the state may regulate abortion prior to viability to further its interest in protecting women's health, as long as the regulations do not create an "undue burden" on a woman's ability to obtain an abortion.¹¹ It reaffirmed *Roe*'s holding that the state's interest in fetal life becomes compelling at viability and that the state may regulate and even proscribe abortion after viability as long as it maintains an exception for the life or health of the mother. *Casey* therefore sustained the primacy of the mother's life and health over the state's interest in protecting fetal life.¹²

In *Stenberg v. Carhart*, the Court struck down a Nebraska statute outlawing what it termed "partial birth abortions."¹³ The Court cited

⁸ 410 U.S. 113 (1973).

⁹ *See id.* at 152–54.

This right of privacy, whether it be founded in the Fourteenth Amendment's concept of personal liberty and restrictions upon state action, as we feel it is, or, as the District Court determined, in the Ninth Amendment's reservation of rights to the people, is broad enough to encompass a woman's decision whether or not to terminate her pregnancy.

Id. at 153.

¹⁰ *See id.* at 163–64 ("If the State is interested in protecting fetal life after viability, it may go so far as to proscribe abortion during that period, except when it is necessary to preserve the life or health of the mother.").

¹¹ *See Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 877 (1992) ("A statute with [a purpose of creating an undue burden on a woman's access to an abortion] is invalid because the means chosen by the State to further the interest in potential life must be calculated to inform the woman's free choice, not hinder it.").

¹² *See id.* at 846 (restating and reaffirming the holding of *Roe v. Wade*).

¹³ *See Stenberg v. Carhart*, 530 U.S. 914, 945–46 (2000) ("We must consequently find the statute unconstitutional."); *see also* Leading Cases, *Abortion Rights*, *supra* note 5, at 265

two grounds for its holding: (1) that the Nebraska law contained no health exception, and (2) that the law was unconstitutionally vague, making it impossible for physicians to determine whether several abortion procedures were permissible under the statute.¹⁴ *Stenberg v. Carhart* reiterated the health exception requirement set forth in *Roe* and *Casey*.¹⁵ It rejected the argument that a health exception is not required where there are safe alternatives available because Nebraska failed to demonstrate that the ban would not create significant risks for women.¹⁶ It cited the “significant medical authority” supporting the proposition that “in some circumstances, [the banned procedure] would be the safest procedure.”¹⁷ *Stenberg v. Carhart* affirmed that the mother’s health may not be compromised by abortion regulation, and that this requirement not only prohibits courts from banning post-viability abortion altogether, but also from banning a particular pre-viability or post-viability abortion procedure that is a safer alternative than another procedure that remains available.

The Court also rejected arguments that the health exception is not required because of uncertainty as to whether the procedure would be necessary or affect most women’s health. The Court dis-

(noting that “the Supreme Court struck down on facial challenge Nebraska’s ‘partial-birth’ abortion ban for failing to provide an exception allowing the procedure when necessary to protect the health of the mother”); Dorf, *supra* note 5, at 817–18 (discussing how the Court found Nebraska’s partial-birth abortion ban to be unconstitutional because it violated “the principles of *Casey*”); Turner, *supra* note 5, at 12 (providing information about the Supreme Court’s decision to strike down Nebraska’s “‘partial-birth abortion’ law”); Laura J. Tepich, Note, *Gonzales v. Carhart: The Partial Termination of the Right to Choose*, 63 U. MIAMI L. REV. 339, 365–71 (2008) (discussing the Supreme Court’s rationale for its decision in *Stenberg v. Carhart*). The term “partial birth abortion” was coined by a member of Congress while developing legislation banning certain abortion procedures. It is a political, rather than medical, term and is not recognized in the medical field. See Alex Gordon, *The Partial-Birth Abortion Ban Act of 2003*, 41 HARV. J. ON LEGIS. 501, 502 n.15 (2004) [hereinafter Gordon, *PBABA*].

14 See *Stenberg*, 530 U.S. at 930, 937–38, 942–43 (elaborating on the two grounds for the Supreme Court’s holding); see also Dorf, *supra* note 5, at 817–18 (discussing the two grounds for the Supreme Court’s holding); Tepich, *supra* note 13, at 367–68 (“The Court, after summarizing the medical procedures involved in the Nebraska statute, proceeded quickly to conclude that the statute violated the Constitution for at least two independent reasons.”).

15 See *Stenberg*, 530 U.S. at 930 (noting that the law lacked an exception to preserve the mother’s health).

16 See *id.* at 932 (“The State fails to demonstrate that banning [the dilation and evacuation procedure] without a health exception may not create significant health risks for women”); see also Tepich, *supra* note 13, at 369 (discussing the Court’s conclusion that a substantial number of medical experts believed that the procedure would be safer for some patients).

17 *Stenberg*, 530 U.S. at 932; see also Tepich, *supra* note 13, at 369 (discussing the Supreme Court’s rationale in *Stenberg v. Carhart*).

missed the argument that the health exception was not necessary because the procedure was rarely employed, arguing, “the State cannot prohibit a person from obtaining treatment simply by pointing out that most people do not need it.”¹⁸ The determination that a procedure is necessary for the preservation of the life or health of the mother does not require “an absolute necessity,” “absolute proof,” or “unanimity of medical opinion.”¹⁹

In reaction to the decision, Congress passed the federal Partial-Birth Abortion Ban Act of 2003 (PBABA).²⁰ PBABA is materially identical to the Nebraska statute in all respects except that it contains a different definition of what constitutes a “partial-birth abortion,” a term used to describe a variation of a procedure the medical community refers to as a “dilation and evacuation,” or a “D&E.”²¹ The statute provides anatomical landmarks intended to give greater notice to physicians as to whether a procedure is outlawed than the Nebraska statute.²² It contains a life exception but no health exception, citing congressional findings that a “moral, medical, and ethical consensus exists that the practice of performing a partial-birth abortion . . . is never medically necessary.”²³ PBABA was successfully challenged in the Eighth and Ninth Circuits, which both held that

18 *Stenberg*, 530 U.S. at 934; *see also* Tepich, *supra* note 13, at 369 (“[T]he Court concluded that the infrequency of the [dilation and evacuation] procedure did not justify Nebraska’s lack of a health exception and that the procedure’s relative rarity was ‘not highly relevant.’”).

19 *Stenberg*, 530 U.S. at 937; *see also* Tepich, *supra* note 13, at 369 (discussing how a “significant body of medical opinion” believed that the dilation and evacuation procedure was safer for some patients and noting that the *Carhart* Court felt the procedure should not be banned in light of this belief).

20 18 U.S.C. § 1531 (Supp. III 2003); *Leading Cases, Abortion Rights, supra* note 5, at 266; Dorf, *supra* note 5, at 818–19.

21 *See* Press Release, ACOG Files Amicus Brief in *Gonzales v. Carhart* and *Gonzales v. PPF* (Sept. 22, 2006), http://www.acog.org/from_home/publications/press_releases/nr09-22-06.cfm; *see also* Gordon, *PBABA, supra* note 13, at 502 n.15. The term “partial birth abortion” is not a medical term and was invented for the purposes of legislation. *See id.*

22 *See* 18 U.S.C. § 1531 (b) (1) (A) (Supp. III 2003). The act defines a “partial-birth abortion” to be an abortion in which the individual performing the abortion deliberately and intentionally vaginally delivers a living fetus until, in the case of a head-first presentation, the entire fetal head is outside the body of the mother, or, in the case of breech presentation, any part of the fetal trunk past the navel is outside the body of the mother . . .

See also Dorf, *supra* note 5, at 818–19 (describing how the federal act provided a clearer definition of a partial-birth abortion than the Nebraska law).

23 18 U.S.C. § 1531 (Supp. III 2003); *see also* *Leading Cases, Abortion Rights, supra* note 5, at 266 (noting that Congress adopted factual findings in conflict with those relied upon by the *Stenberg v. Carhart* court in enacting the Partial-Birth Abortion Ban Act of 2003).

PBABA unconstitutionally failed to provide a health exception.²⁴ The Supreme Court granted certiorari and reversed both decisions in *Gonzales v. Carhart*.²⁵

B. *The Majority Opinion*

The majority opinion, authored by Justice Kennedy, cited numerous state interests supporting PBABA. Primary among these was an interest in expressing respect for human life.²⁶ The Court, citing the state interest in protecting fetal life, stated, “[t]he government may use its voice and its regulatory authority to show its profound respect for the life within the woman.”²⁷ The Court argued that the state could further this interest by banning a procedure that would “coarsen society to the humanity of not only newborns, but all vulnerable and innocent human life”²⁸

The Court also cited a related state interest in protecting the integrity and ethics of the medical profession by protecting the respect for fetal life within the medical profession.²⁹ The Court argued that the state’s “legitimate interests in regulating the medical profession in order to promote respect for life, including life of the unborn,” was served by PBABA because the banned procedure “implicates additional ethical and moral concerns” above and beyond other abortion procedures.³⁰ It argued that PBABA also furthered this interest

24 See *Carhart v. Gonzales*, 413 F.3d 791, 792–96 (8th Cir. 2005) (finding the PBABA unconstitutional due to its lack of health exception); see also *Planned Parenthood Fed’n of Am., Inc. v. Gonzales*, 435 F.3d 1163, 1171–73 (9th Cir. 2006) (finding the PBABA unconstitutional on the grounds that it “lacks the constitutionally required health exception”). The Ninth Circuit also held that PBABA was unconstitutionally vague and unconstitutionally restricted the dilation and extraction abortion procedure. See *Planned Parenthood Fed’n*, 435 F.3d at 1171.

25 550 U.S. 124 (2007).

26 See *id.* at 157 (“The Act expresses respect for the dignity of human life.”); see also *Turner*, *supra* note 5, at 15 (citing passages from *Gonzales v. Carhart* which highlight state interests supporting PBABA).

27 *Gonzales v. Carhart*, 550 U.S. at 157; see also *Leading Cases, Abortion Rights*, *supra* note 5, at 268 (discussing governmental interests underlying the ban deemed legitimate by the Court); *Tepich*, *supra* note 13, at 381 (quoting the highlighted passage); *Turner*, *supra* note 5, at 15 (quoting the highlighted passage).

28 *Gonzales v. Carhart*, 550 U.S. at 157; see also *Stahle*, *supra* note 5, at 274–75 (quoting the highlighted passage).

29 See *Gonzales v. Carhart*, 550 U.S. at 157 (“There can be no doubt that the government ‘has an interest in protecting the integrity and ethics of the medical profession.’”); see also *Tepich*, *supra* note 13, at 381 (quoting passages from *Gonzales v. Carhart* suggesting that the public’s perception of a doctor’s appropriate role during the delivery process could be upset by knowledge that doctors assist in partial-birth abortions).

30 *Gonzales v. Carhart*, 550 U.S. at 158; see also *Turner*, *supra* note 5, at 15 (quoting the highlighted passage).

because Congress might reasonably conclude that “partial birth abortion, more than standard D&E, ‘undermines the public’s perception of the appropriate role of a physician during the delivery process, and perverts a process during which life is brought into the world.’”³¹

The Court also described a state interest in protecting a woman from the regret it presumed she would feel if she chose to undergo the banned procedure. In the majority’s words:

Respect for human life finds an ultimate expression in the bond of love the mother has for her child. The Act recognizes this reality as well. Whether to have an abortion requires a difficult and painful moral decision. While we find no reliable data to measure the phenomenon, it seems unexceptionable to conclude some women come to regret their choice to abort the infant life they once created and sustained. Severe depression and loss of esteem can follow.³²

In support of this theory, the Court cited an amicus brief supporting PBABA that argued that “abortion hurts women physically, emotionally, and psychologically,” and that women who have abortions often suffer from “Post-abortion Syndrome.”³³

The Court also tied this concern to the need to protect informed consent among patients:

In a decision so fraught with emotional consequence some doctors may prefer not to disclose precise details of the means that will be used, confining themselves to the required statement of risks the procedure entails. . . . It is, however, precisely this lack of information concerning the way in which the fetus will be killed that is of legitimate concern to the State. The State has an interest in ensuring so grave a choice is well informed. It is self-evident that a mother who comes to regret her choice to abort must struggle with grief more anguished . . . when she learns, only after the event, what she once did not know: that she allowed a doctor to pierce the skull and vacuum the fast-developing brain of her unborn child, a child assuming the human form.³⁴

After finding that PBABA furthers these purported state interests, the Court turned to the question of whether PBABA is unconstitu-

³¹ *Gonzales v. Carhart*, 550 U.S. at 160 (quoting Congressional Findings ¶(14)(K)). *But see* Tepich, *supra* note 13, at 381 (suggesting the public’s perception of physicians might actually be improved by allowing doctors to use safe abortion methods).

³² *Gonzales v. Carhart*, 550 U.S. at 159 (internal citations omitted); *see also* Turner, note 5, at 16–18 (discussing the meager evidence available to support the “regret rationale”).

³³ Brief of Sandra Cano et al. as Amici Curiae in Support of Petitioner at 5, 19, *Gonzales v. Carhart*, 550 U.S. 124 (2007) (No. 05-380); *see also* *Gonzales v. Carhart*, 550 U.S. at 159 (citing the Sandra Cano et al. amicus brief); Turner, *supra* note 5, at 16–17 (highlighting sections of the Sandra Cano et al. amicus brief which suggest that abortion harms women).

³⁴ *Gonzales v. Carhart*, 550 U.S. at 159–60 (internal citation omitted); *see also* Turner, *supra* note 5, at 17–18 (discussing the women’s regret rationale used to support the Court’s decision in *Gonzales v. Carhart*).

tional because it lacks a health exception. The Court determined that PBABA need not contain a health exception because of “documented medical disagreement” over whether the procedure is medically necessary.³⁵ While the Court would not give complete deference to legislative findings—and, indeed, noted inaccuracies in Congress’s findings—it implied that it would defer to legislative findings where “medical uncertainty” exists.³⁶

The Court justified its holding by distinguishing facial attacks from as-applied challenges and by arguing that medical uncertainty about the need for a health exception precluded a holding that PBABA was invalid on its face.³⁷ The respondents had not met the “heavy burden” of a facial attack because they had not demonstrated that PBABA “would be unconstitutional in a large fraction of relevant cases.”³⁸ It further argued that the statute at issue was applicable whenever “the doctor proposes to use the prohibited procedure, not merely those in which the woman suffers from medical complications. It is neither our obligation nor within our traditional institutional role to resolve questions of constitutionality with respect to each potential situation that might develop.”³⁹ The Court concluded that a facial attack could not succeed because the respondents could not show that the banned procedure is medically necessary in a large fraction of the cases in which the procedure is used.⁴⁰

The Court left open the question of whether an as-applied challenge could succeed. It argued that an as-applied challenge, rather than a facial challenge, was the proper means to challenge PBABA “if it can be shown that in discrete and well-defined instances a particular condition has or is likely to occur in which the procedure prohibited by the Act must be used” because “[i]n an as-applied challenge

35 *Gonzales v. Carhart*, 550 U.S. at 162–66; see Leading Cases, *Abortion Rights*, *supra* note 5, at 268 (indicating that despite the “documented medical disagreement” regarding whether the procedure was ever medically necessary, the Court upheld the PBABA).

36 *Gonzales v. Carhart*, 550 U.S. at 164–65; see Leading Cases, *Abortion Rights*, *supra* note 5, at 268 (discussing this section of the *Gonzales v. Carhart* opinion); Dorf, *supra* note 5, at 821 (noting that the Court chose to uphold PBABA despite noting that Congress is “not entitled to any special deference”).

37 See *Gonzales v. Carhart*, 550 U.S. at 166–67 (“The Act is not invalid on its face where there is uncertainty over whether the barred procedure is ever necessary to preserve a woman’s health, given the availability of other abortion procedures that are considered to be safe alternatives.”).

38 *Id.* at 167–68.

39 *Id.* at 168.

40 *Id.* at 167–68.

the nature of the medical risk can be better quantified and balanced than in a facial attack.”⁴¹

C. *The Dissent*

The dissent, authored by Justice Ginsburg and joined by Justices Stevens, Souter, and Breyer, criticized the majority opinion for sacrificing women’s health to further dubious state interests. Echoing the majority opinion in *Stenberg*, the dissent noted that PBABA did not further any of the state interests that *Roe* identified as justifying the regulation of abortion in limited circumstances. It argued that PBABA does not further the state interest in fetal life because no fetal lives were saved; the ban only limits how a fetus will be aborted rather than whether a fetus will be aborted.⁴²

The dissent also rejected the “mother’s regret” rationale as a paternalistic intrusion into the rights of women to make their own medical decisions.⁴³ The dissent noted that there was no evidence supporting the majority’s conclusion that women “regret their choices, and consequently suffer from ‘[s]evere depression and loss of self-esteem.’”⁴⁴ The dissent also argued that, if women’s informed consent were a legitimate concern, the proper state response would be to require physicians to inform women of the different procedures and their risks, rather than “deprive[] women of the right to make an autonomous choice, even at the expense of their safety.”⁴⁵ Ginsburg’s dissent decried the paternalism inherent in the majority decision, cautioning that the majority’s “way of thinking reflects ancient notions about women’s place in the family and under the Constitution—ideas that have long since been discredited.”⁴⁶

⁴¹ *Id.* at 167.

⁴² *See id.* at 181 (Ginsburg, J., dissenting) (“The law saves not a single fetus from destruction, for it targets only a *method* of performing abortion.”); *see also* Leading Cases, *Abortion Rights*, *supra* note 5, at 269 (“Justice Ginsburg argued that the Act furthered no legitimate governmental interests, and in fact did not even further the government’s asserted interest in protecting potential life, due to the availability of alternative late-term abortion procedures.”).

⁴³ *See* *Gonzales v. Carhart*, 550 U.S. at 183–85 (Ginsburg, J., dissenting) (noting that the Court’s paternalistic views of “women’s place in the family and under the Constitution” were long ago “discredited”); *see also* Turner, *supra* note 5, at 18–19 (discussing Justice Ginsburg’s alarm over the majority’s view of the proper role of women).

⁴⁴ *Gonzales v. Carhart*, 550 U.S. at 183 (Ginsburg, J., dissenting) (quoting the majority); *see also* Turner, *supra* note 5, at 18–19 (quoting the highlighted passage).

⁴⁵ *Gonzales v. Carhart*, 550 U.S. at 183–84 (Ginsburg, J., dissenting); *see also* Turner, *supra* note 5, at 19 (quoting the highlighted passage).

⁴⁶ *Gonzales v. Carhart*, 550 U.S. at 185 (Ginsburg, J., dissenting); *see also* Turner, *supra* note 5, at 19 (quoting the highlighted passage). Justice Ginsburg cites, as examples, *Bradwell v.*

The dissent noted that the majority opinion compromised the health exception requirement set forth in *Roe*, *Casey*, and *Stenberg* and for the first time accepted a ban on an abortion procedure without a health exception.⁴⁷ It argued that the majority's conclusion that a facial challenge required a showing that the ban was unconstitutional in "a large fraction of relevant cases" was inconsistent with both precedent and logic. The Court has considered and upheld numerous facial attacks on abortion statutes since *Roe*, including a nearly identical attack in *Stenberg*.⁴⁸ The majority's holding that a successful facial challenge to the ban would need to show medical necessity in a large fraction of relevant cases made little sense given that "[t]he very purpose of a health *exception* is to protect women in the *exceptional* cases."⁴⁹

The dissent also argued that there is, in fact, no real medical uncertainty. Congress's findings were based on a small number of ideologically-driven health care providers and contained numerous errors, in contrast with the substantial medical authority stating that the banned procedure is, in certain circumstances, far safer than the alternatives.⁵⁰ The dissent concluded that the majority opinion conflicted with Supreme Court precedent holding that the state may not

Illinois, 83 U.S. (16 Wall.) 130, 141 (1872) and *Muller v. Oregon*, 208 U.S. 412, 421 (1908), discussed *infra* Section V.A.3.

47 See *Gonzales v. Carhart*, 550 U.S. at 170–71 (Ginsburg, J., dissenting) (“[T]he Court blesses a prohibition with no exception safeguarding a woman’s health.”); see also Dorf, *supra* note 5, at 821–22 (discussing how the Court decided to uphold the PBABA despite the lack of exception to safeguard the health of the mother).

48 See *Gonzales v. Carhart*, 550 U.S. at 187–88 (Ginsburg, J., dissenting) (“This holding is perplexing given that, in materially identical circumstances we held that a statute lacking a health exception was unconstitutional on its face.”); see also Leading Cases, *Abortion Rights*, *supra* note 5, at 269 (“[T]he dissent lamented the Court’s rejection of a facial attack, since such challenges had been approved in similar circumstances . . .”).

49 See *Gonzales v. Carhart*, 550 U.S. at 189 (Ginsburg, J., dissenting). The dissent argued: *Casey* makes clear that, in determining whether any restriction poses an undue burden on a “large fraction” of women, the relevant class is *not* “all women,” nor “all pregnant women,” nor even all women “seeking abortions.” Rather, a provision restricting access to abortion, “must be judged by reference to those [women] for whom it is an actual rather than an irrelevant restriction.” Thus the absence of a health exception burdens *all* women for whom it is relevant—women who, in the judgment of their doctors, require an intact D&E because other procedures would place their health at risk.

Id. at 188 (Ginsburg, J., dissenting) (internal citations omitted).

50 See *id.* at 174–80 (Ginsburg, J., dissenting) (noting that “[t]he congressional findings on which the Partial-Birth Abortion Ban Act rests do not withstand inspection, as the lower courts have determined and this Court is obliged to concede”); see also Dorf, *supra* note 5, at 822 (“Congress could only find a small number of ideologically-driven doctors to say that the procedure is never necessary. And even those doctors did not quite say that.”).

subject women to health risks by forcing women to resort to less safe methods of abortion.⁵¹

D. Reconciling the Two Interpretations: What Does Carhart Really Say?

While *Carhart* does not overrule *Stenberg* and states that *Casey* is controlling, it is a significant departure from past abortion jurisprudence on several grounds. First, it expands the “fetal life” state interest far beyond what *Roe* and its progeny intended, essentially recognizing new state interests in promoting respect for human life and protecting women from medical decisions they might regret. It holds that no health exception is necessary if there is uncertainty regarding health risks in the majority of cases. More disturbing, it allows for such uncertainty to be generated through the use of flimsy evidence. Together, the recognition of new state interests and devaluing of women’s autonomy and health imply that the state may pursue these new state interests even where they significantly compromise the health of women.

While the majority opinion cites *Casey* to argue that it is furthering the state interest in protecting fetal life, what it actually furthers is far more abstract. As the dissent notes, PBABA does not further the state’s interest in protecting fetal life because it saves no fetal lives.⁵² The majority broadly interprets the state’s interest in fetal life to include a symbolic purpose of “express[ing] respect for the dignity of human life.”⁵³ Thus, the majority interprets the state’s interest in protecting fetal life to include the state’s simple, even if ineffectual, expression of moral opposition to abortion even where no fetal lives are saved as a direct result.⁵⁴

⁵¹ *Gonzales v. Carhart*, 550 U.S. at 172–74 (Ginsburg, J., dissenting) (noting that “the Court has consistently required that laws regulating abortion, at any stage of pregnancy and in all cases, safeguard a woman’s health”).

⁵² *Id.* at 181 (Ginsburg, J., dissenting); see *Leading Cases, Abortion Rights*, *supra* note 5, at 269 (describing Ginsburg’s argument as to why PBABA does not further the state interest of protecting life); see also Gordon, *supra* note 5, at 753 (describing how the *Gonzales v. Carhart* majority “accepted as sufficient the rationale that [PBABA] furthered the state’s interest in ‘preserving and promoting fetal life’ even when, as the dissent noted, the law seems unlikely to actually save any fetuses because it merely outlaws a single method of abortion”); Tepich, *supra* note 13, at 381 (highlighting that the statute does not prevent abortions and thus “does not further a state’s interest in the potentiality of human life”).

⁵³ *Gonzales v. Carhart*, 550 U.S. at 157; see also Dorf, *supra* note 5, at 824 (“[I]n banning a procedure that looks uncomfortably like infanticide, Congress aimed to preserve the line between infanticide and abortion.”).

⁵⁴ See Dorf, *supra* note 5, at 823–24 (“[T]he [*Gonzales v. Carhart*] Court expanded the state’s expressive interest in describing its moral opposition to abortion . . .”). While *Casey* did uphold the state’s ability to promote respect for fetal life, it did not recognize this as a dis-

Carhart implies that the state's interest in fetal life justifies state action that is directed at sending a message to society in general about the morality of a particular method of abortion. Concerned about the procedure's effect of "coarsen[ing] society to the humanity of not only newborns, but all vulnerable and innocent human life," the Court allows the state to ban an abortion procedure in order to "promote respect for life, including the life of the unborn."⁵⁵ The intended impact is not on fetal lives, but rather society as a whole.⁵⁶

The decision also recognizes a new state interest in protecting the maternal-fetal relationship and protecting women from the regret the Court assumes they will feel should they harm that relationship. The Court frames this interest in terms of protecting women's health. *Casey* recognized that a state interest in protecting women's health may justify an abortion regulation as long as the regulation does not create an undue burden on women's right to an abortion. *Carhart* reasons that PBABA furthers this interest because: (1) there is a special relationship between women and the children they carry; (2) because of this special relationship, a woman may regret her decision to have an abortion, particularly an abortion that used the banned procedure; and (3) women may suffer psychological harm due to their regret. By banning the procedure, the Court argues, the state is protecting women from making a decision that may harm their psychological health.

While the majority argued that it was somehow protecting informed consent, the majority decision actually eliminated women's ability to make an informed medical decision rather than providing

distinct state interest justifying abortion restrictions. Rather, *Casey* allowed the state to advance its interest in protecting fetal life through "informed consent" requirements meant to impress upon a pregnant woman the state's respect for fetal life, and thereby persuade her not to have an abortion. See *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 878 (1992) (upholding the state's informed consent requirements). *Casey* states that:

To promote the State's profound interest in potential life, throughout pregnancy the State may take measures to ensure that the woman's choice is informed, and measures designed to advance this interest will not be invalidated *as long as their purpose is to persuade the woman to choose childbirth over abortion.*

Id. (emphasis added). Expression of respect for life was therefore permitted only as a means to protect fetal life—the state action must be intended to persuade women considering abortion to forego abortion. In contrast, PBABA saves no fetal lives—the expression of respect for fetal life to society in general is the end in itself.

⁵⁵ *Gonzales v. Carhart*, 550 U.S. at 157–58.

⁵⁶ See Dorf, *supra* note 5, at 824 ("The audience for partial-birth abortion bans, the audience for the expression of Congress's condemnation of this form of abortion, is not just individual women . . . but the population as a whole."); see also John Lawrence Hill, *The Constitutional Status of Morals Legislation*, 98 KY. L.J. 1, 51–52 (2009–2010) (using *Carhart* as an example of the Court's approval of a regulation used to promote moral values, independent of any justification based on harm to life).

them with additional information to make a more informed choice.⁵⁷ It rests its decision on a baseless assumption, lacking credible evidence, about the psychological harm abortion must cause women.⁵⁸ Citing the “bond of love” the Court assumes the mother feels for her unborn child and the profound regret women must feel after abortion, the Court implies that pregnant women do not have the same ability to make informed medical choices as the rest of the population, and that the state is therefore justified in making these decisions for them.⁵⁹ The majority delineates pregnant women as a unique class of persons who cannot make informed decisions, at least with regard to decisions that may harm the unique bond they share with the fetus they carry.

As the dissent argues, this reasoning is acutely paternalistic, reflecting traditional notions about a woman’s place in society as a mother rather than more recent jurisprudence allowing women to choose their own place in society. The dissent compares the majority’s reasoning to cases discussed *infra*, Section 0, in which the Court accepted state mandates that limited women’s ability to pursue employment because such employment might interfere with their roles as mothers and their ability to bear healthy children for the benefit of society.⁶⁰ Kennedy’s insistence that the bond of love between a mother and child can be used to limit women’s access to abortion procedures is in direct conflict with *Casey*, which explicitly rejects the state using a woman’s reproductive capability to “insist . . . upon its own vi-

⁵⁷ See *Gonzales v. Carhart*, 550 U.S. at 183–84 (Ginsburg, J., dissenting) (“[T]he Court deprives women of the right to make an autonomous choice”); see also Dorf, *supra* note 5, at 823 (arguing that, because the state chooses to ban the procedure rather than promote more information about it, the state interest cannot be an interest in informed choice).

⁵⁸ See Turner, *supra* note 5, at 22–28, 40–42 (discussing the importance of the development of, and Court endorsement of, the “women’s regret” rationale); Tepich, *supra* note 13, at 384 (stating that the Court “chooses to criminalize an abortion procedure to protect women from themselves”).

⁵⁹ The reasoning that women do not really understand what they are doing when they have abortions is common rhetoric of the anti-choice movement. See Reva B. Siegel, *The New Politics of Abortion: An Equality Analysis of Woman-Protective Abortion Restrictions*, 2007 U. ILL. L. REV. 991, 1008–10 [hereinafter Siegel, *New Politics*] (discussing women-protective justifications for an abortion ban in South Dakota).

⁶⁰ See *Gonzales v. Carhart*, 550 U.S. at 185 (Ginsburg, J., dissenting) (citing *Muller v. Oregon*, 208 U.S. 412 (1908) and *Bradwell v. Illinois*, 83 U.S. (16 Wall.) 130 (1872)); see also Turner, *supra* note 5, at 19–21 (citing pertinent passages from *Muller v. Oregon*); *infra* Section V.A.3.

sion of the woman's role, however dominant that vision has been in the course of our history and our culture."⁶¹

The decision also undermines the health exception requirement set forth in *Roe* and its progeny. Cases such as *Roe*, *Casey*, and *Stenberg* treat the health exception as a distinct requirement.⁶² *Carhart* treats the health exception as part of the undue burden analysis, concluding that the lack of health exception is acceptable because it does not pose an undue burden.⁶³ Analyzing the health exception under the undue burden analysis makes little sense, given that the health exception is required even after viability, when states may prohibit abortion altogether.

Perhaps more important, *Carhart* does not require a health exception where there is uncertainty about whether the banned procedure may be medically necessary. The Court reasons that, in areas of medical uncertainty, it will accept legislative judgment about what is medically necessary.⁶⁴ This stands in stark contrast to past cases, including *Stenberg*, in which the Court held that medical uncertainty requires that courts find a ban unconstitutional.⁶⁵ It also conflicts with prior decisions, including *Roe*, stating that the decision whether to have an abortion for medical reasons must be left to patients as guided by the professional judgment of physicians.⁶⁶

61 See *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 852 (1992); see also *Turner*, *supra* note 5, at 21 (emphasizing the way in which the *Gonzales v. Carhart* Court's holding contradicts the holding of *Planned Parenthood of Southeastern Pennsylvania v. Casey*).

62 See, e.g., *Stenberg v. Carhart*, 530 U.S. 914, 929–31 (2000) (finding that Nebraska's statute banning partial-birth abortions violates the Constitution, *Roe*, and *Casey*); see also B. Jessie Hill, *The Constitutional Right to Make Medical Treatment Decisions: A Tale of Two Doctrines*, 86 TEX. L. REV. 277, 289–90 (2007) (discussing the *Stenberg* Court's rationale for finding the Nebraska statute banning partial-birth abortions to be unconstitutional).

63 See *Gonzales v. Carhart*, 550 U.S. at 164 (providing passages suggesting that the Court merged the health exception into the undue burden analysis).

64 See *id.* at 163 ("The question becomes whether the Act can stand when this medical uncertainty persists. The Court's precedents instruct that the Act can survive this facial attack."); see also *Dorf*, *supra* note 5, at 822 (arguing that there was actually medical certainty of the necessity of partial-birth abortions because Congress had a difficult time finding an expert to testify that a partial-birth abortion is never medically necessary); *Gordon*, *supra* note 5, at 753 (discussing the dangerous precedent set by the Court in deferring to legislative, rather than medical, judgment in *Gonzales v. Carhart*).

65 See *Stenberg v. Carhart*, 530 U.S. 937–38 (holding that a Nebraska statute banning partial-birth abortion was unconstitutional due to its lack of an exception to safeguard the health of the mother); see also *Gonzalez v. Carhart*, 550 U.S. at 173–74 (Ginsburg, J., dissenting) ("[T]he Court has consistently required that laws regulating abortion, at any stage of pregnancy and in all cases, safeguard a woman's health."); *Dorf*, *supra* note 5, at 822 (discussing how the Court's deference to legislative judgment over medical judgment conflicts with the holding of *Stenberg*).

66 See *Roe v. Wade*, 410 U.S. 113, 163 (1973) (describing how, during the early stages of pregnancy, the decision whether to have an abortion should be made by the physician

The *Carhart* decision also showed a troubling willingness to accept flimsy medical evidence in order to support a finding of “medical uncertainty.” The dissent and the district court opinions cited substantial evidence from numerous recognized physicians and medical authorities detailing how an intact D&E may be medically necessary in various circumstances.⁶⁷ In contrast, Congress’s findings were based on the testimony of physicians with no training in or experience with intact D&E and who performed abortions only on rare occasions.⁶⁸ The majority allowed small amounts of questionable evidence to negate the need for a health exception by deferring to Congress based on the “uncertainty” created by this testimony.⁶⁹

III. COMPELLED MEDICAL TREATMENT OF PREGNANT WOMEN

A. Introduction

Despite common law and, more recently, constitutional law principles recognizing and protecting the right to refuse medical treatment, pregnancy is often viewed as a special case by courts. Courts have intervened in the medical treatment of pregnant women in ways they have not dared with the non-pregnant. Courts have allowed

and his patient); *see also* Dorf, *supra* note 5, at 822 (discussing how precedent suggests that “the decision whether to have a therapeutic abortion should be left to patients as guided by the professional medical judgment of their physicians”).

67 *See* *Gonzales v. Carhart*, 550 U.S. 174–79 (Ginsburg, J., dissenting) (citing evidence from *Planned Parenthood Fed’n of Am. v. Ashcroft*, 320 F. Supp. 2d 957 (N.D. Cal. 2004), and *Carhart v. Ashcroft*, 331 F. Supp. 2d 805 (D. Neb. 2004)).

68 *See* *Gonzales v. Carhart*, 550 U.S. at 180 (Ginsburg, J., dissenting) (discussing how some of the more highly qualified experts who provided the Court with evidence about the D&E procedure suggested that it was the safest available procedure in certain circumstances).

69 The facial/as-applied distinction the majority uses to justify the lack of health exception falls apart on examination. The facial attack has been the primary means of challenging abortion regulation statutes since *Roe*, including a nearly identical attack in *Stenberg*. *Id.* at 187–88; *see also* Leading Cases, *Abortion Rights*, *supra* note 5, at 269 (“[T]he dissent lamented the Court’s rejection of a facial attack, since such challenges had been approved in similar circumstances . . .”). Such facial attacks need not demonstrate that a health exception is needed in a large fraction of cases given that “[t]he very purpose of the health exception is to protect women in *exceptional* cases.” *Gonzales v. Carhart*, 550 U.S. at 189 (Ginsburg, J., dissenting). It is also worth noting that the respondents challenged PBABA both on its face and as-applied to particular doctors. *See* Dorf, *supra* note 5, at 825 (discussing how *Gonzales v. Carhart* was brought as both a facial and an as-applied challenge). If the Court was stating that an as-applied challenge must be brought by particular pregnant women, this is likely to impose significant obstacles on those seeking to challenge PBABA—a plaintiff facing a difficult and personal medical decision must be willing to lay bare her medical history and decision to have an abortion, knowing that the slow pace of litigation will make it all but impossible for her to obtain relief in time to secure the procedure that best serves her health. *See id.* at 825.

state intervention in pregnant women's medical treatment choices on the grounds that the state has an interest in fetal life, as outlined by Supreme Court abortion jurisprudence. Pre-*Carhart* abortion cases provided very limited support for state intervention in the treatment of pregnant women. Intervention could only be contemplated when the fetus's very life was at stake. Even then, the uncertainty with which intervention was needed to save the life weakened the state's interest. Supreme Court jurisprudence also foreclosed the possibility of intervention when it would compromise the health of the mother. Thus, invasive medical procedures that would put the mother's health or life at risk could not be compelled for the sake of furthering the state's interest in fetal life.

B. The Right to Refuse Medical Treatment

Under state common law, the right to refuse medical treatment is grounded in the concept of autonomy. It is closely related to the right to informed consent, with some courts citing additional support in the common law or constitutional right to privacy and bodily integrity.⁷⁰ These rights share the common thread of respect for an individual's right to autonomy.⁷¹ Informed consent promotes patient autonomy by requiring physicians to inform patients of their diagnosis, the alternative treatments and their consequences (including the consequence of no treatment), and their recommendations for treatment so that a patient is able to make a meaningful choice.⁷²

⁷⁰ See *Cruzan v. Dir., Mo. Dep't of Health*, 497 U.S. 261, 271 (1990) (outlining pertinent cases).

⁷¹ See Reva B. Siegel, *Dignity and the Politics of Protection: Abortion Restrictions Under Casey/Carhart*, 117 YALE L.J. 1694, 1754–56 (2008) [hereinafter Siegel, *Dignity*] (discussing how the right to refuse medical treatment and the right to informed consent both relate to principles of autonomous decision making).

⁷² See *id.* at 1754–55 (discussing the importance of informed consent); see also COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS, AM. MED. ASS'N, CODE OF MEDICAL ETHICS OF THE AMERICAN MEDICAL ASSOCIATION: CURRENT OPINIONS WITH ANNOTATIONS 227 (2006–2007) (“The patient’s right of self-decision can be effectively exercised only if the patient possesses enough information to enable an intelligent choice.”); Pamala Harris, Note, *Compelled Medical Treatment of Pregnant Women: The Balancing of Maternal and Fetal Rights*, 49 CLEV. ST. L. REV. 133, 134 (2001) (“The general rule of medical treatment is that doctors may not act without a patient’s informed consent. Informed consent promotes patient autonomy and safeguards the integrity of the physician.”) (footnotes omitted). Tort law recognizes this by holding a health care provider who does not obtain informed consent before treating a patient liable for battery because the provider has intruded on the bodily autonomy of the individual. See *Schloendorff v. Soc’y of N.Y. Hosp.*, 105 N.E. 92, 93 (N.Y. 1914) (“[A] surgeon who performs an operation without his patient’s consent commits an assault, for which he is liable in damages.”); Susan Goldberg, *Medical Choices During Pregnancy: Whose Decision Is It Anyway?*, 41 RUTGERS L. REV. 591, 596 (1989) (“A

The logical corollary of informed consent is the right to exercise autonomy by withholding consent and refusing treatment.⁷³ Similarly, the right to privacy and bodily integrity protects the right to be let alone from government interference, particularly with regard to bodily autonomy.⁷⁴

The common law right to refuse medical treatment is not absolute. Courts have recognized four countervailing state interests that may be used to override a patient's right to refuse treatment: (1) the prevention of suicide; (2) the preservation of life; (3) the protection of third parties; and (4) the preservation of the ethical integrity of the medical profession.⁷⁵ The right to refuse treatment strengthens, and state interest weakens, as the degree of bodily invasion increases and likelihood that the treatment would effectively treat the patient decreases.⁷⁶

While all of these exceptions are limited and rarely employed, it is particularly important to note that the protection of third parties has only been applied in very limited circumstances. In general, it is well accepted that the state cannot compel an individual to undergo medical treatment for the benefit of another, even where doing so would save the life of a third party.⁷⁷ The classic case cited for this proposi-

doctor must obtain consent before treating the patient or the unauthorized contact will be deemed a battery."); *see also* SHEENA MEREDITH, *POLICING PREGNANCY: THE LAW AND ETHICS OF OBSTETRIC CONFLICT* 6–7 (2005) (discussing how the law protects an individual's decision to obtain or refuse medical treatment); Harris, *supra*, at 134 (describing how a doctor may be able to obtain a court order to compel treatment if a pregnant woman refuses).

⁷³ *Cruzan*, 497 U.S. at 270.

⁷⁴ *See* Taft v. Taft, 446 N.E.2d 395, 396–97 (Mass. 1983) (finding that a pregnant woman, entitled to the constitutional right of privacy, is permitted to exercise this right by refusing medical treatment).

⁷⁵ *See Cruzan*, 497 U.S. at 271 (stating the same four state interests); MEREDITH, *supra* note 72, at 46–50 (detailing the four countervailing state interests); Goldberg, *supra* note 72, at 597 (noting the same four countervailing state interests).

⁷⁶ *See In re Quinlan*, 355 A.2d 647, 664 (N.J. 1976) (noting that a state's interest weakens as the degree of bodily invasion grows), *abrogated on other grounds by In re Conroy*, 486 A.2d 1209 (N.J. 1989); *see also* BARRY R. FURROW ET AL., *HEALTH LAW* § 19-4 (2d ed. 2000) (discussing a state's remedies when a fetus is neglected or harmed by the pregnant woman); Janet Gallagher, *Prenatal Invasions & Interventions: What's Wrong with Fetal Rights*, 10 HARV. WOMEN'S L.J. 9, 55–56 (1987) (noting the necessity of judicial inquiry in each case, and the, often, incomplete and conflicting evidence that judges find).

⁷⁷ *See* FURROW ET AL., *supra* note 76, § 19–2 (“The law does not recognize any circumstance when a person must undergo a medical procedure for the benefit of another person.”); *see also* Cheryl E. Amana, *Drugs, AIDS and Reproductive Choice: Maternal-State Conflict Continues into the Millennium*, 28 N.C. CENT. L.J. 32, 57 (2005) (“A woman should not be treated differently based on her pregnancy, but that does not mean that she will not be.”); Gallagher, *supra* note 76, at 23–24 (discussing Judge Flaherty's order in *McFall v. Shimp*, 10 Pa. D. & C.3d 90 (1978), which rested upon the duty to rescue theory in refus-

tion is *McFall v. Shimp*, in which a court declined to order a man to donate bone marrow that would save his cousin's life.⁷⁸ The court held that:

The common law has consistently held to a rule which provides that one human being is under no legal compulsion to give aid or take action to save another human being or to rescue. . . . For our law to *compel* defendant to submit to an intrusion of his body would change every concept and principle upon which our society is founded. To do so would defeat the sanctity of the individual, and would impose a rule which would know no limits⁷⁹

For this reason, the third party exception is somewhat controversial and has only been applied in rare circumstances.⁸⁰

In 1990, the Supreme Court recognized a constitutional dimension to the common law right to refuse medical treatment in *Cruzan*

ing to compel an individual to undergo treatment to benefit another); Michael A. Grizzi, *Compelled Antiviral Treatment of HIV-Positive Pregnant Women*, 5 UCLA WOMEN'S L.J. 473, 488–89 & n.70 (1995) (noting that courts are “wary” of having one individual undergo a medical treatment to benefit the other individual, who is the fetus); Howard Minkoff & Lynn M. Paltrow, *The Rights of “Unborn Children” and the Value of Pregnant Women*, 36 HASTINGS CENTER REP. 26, 27 (2006) [hereinafter Minkoff & Paltrow, *Rights of Unborn Children*] (discussing how worrisome it is that laws have elevated the rights of the fetus to the rights of the pregnant woman); Terri-Ann Samuels et al., *Obstetricians, Health Attorneys, and Court-Ordered Cesarean Sections*, 17 WOMEN'S HEALTH ISSUES 107, 108 (2007) (noting that it is not within the framework of our law to compel one individual to undergo medical treatment to benefit another).

⁷⁸ *McFall v. Shimp*, 10 Pa. D. & C.3d 90, 91 (1978) (noting that a court has no authority to compel one person to undergo treatment to benefit another person); see also FURROW ET AL., *supra* note 76, §19-4 n.5 (citing Prosser and Keeton on the Law of Torts, to state that children born alive can sue their parents); Amana, *supra* note 77, at 57 (“As with *McFall v. Shimp*, it is difficult to change the questionable moral obligation into a legal one.”); Gallagher, *supra* note 76, at 23–24 (citing *McFall*, and Judge Flaherty's refusal to compel one individual to undergo a bone marrow procedure to save his cousin); Grizzi, *supra* note 77, at 488–89 & n.70 (noting the courts refusal to allow one person to undergo medical treatment on behalf of another); Minkoff & Paltrow, *Rights of Unborn Children*, *supra* note 77, at 27 (citing *McFall* as stating that courts have precluded forced surgeries to benefit “born persons”); Samuels et al., *supra* note 77, at 108 (quoting the *McFall* decision).

⁷⁹ *McFall*, 10 Pa. D. & C.3d at 91.

⁸⁰ These circumstances are limited to matters concerning the general public health and dependents who might be abandoned by the patient's death. See MEREDITH, *supra* note 72, at 48 (citing the outcome of a case which held that the state's interest in protecting a patient's children outweighed the patient's right to refuse treatment); Gallagher, *supra* note 76, at 23–26 (explaining that judicial refusal to allow one person to be compelled physically to aid another is based on the common law principle of self-determination); Eric M. Levine, Comment, *The Constitutionality of Court-Ordered Cesarean Surgery: A Threshold Question*, 4 ALB. L.J. SCI. & TECH. 229, 281–82 (1994) (addressing financial and emotional concerns of leaving a child without a parent, and concerns that threaten public health and safety); Robin M. Trindel, Note, *Fetal Interests vs. Maternal Rights: Is the State Going Too Far?*, 24 AKRON L. REV. 743, 749 (1991) (noting the state's interest in the protection of a dependent third party in cases where a pregnant woman's decisions may result in abandonment of a minor child).

*v. Director, Missouri Department of Health.*⁸¹ Recognizing a common law right to refuse medical treatment rooted in the right to informed consent, the Court held that there was a constitutionally protected liberty interest in refusing medical treatment.⁸² The Court cited cases recognizing the right to be let alone from bodily intrusion in the context of searches and seizures involving the body; an unwanted medical examination for the purposes of discovery in a civil action; an unwanted vaccination that would compromise the patient's health; the unwanted administration of antipsychotic drugs; mandatory behavior modification; and unnecessary confinement for medical treatment.⁸³ The Court also cited the four countervailing state interests that it identified in the context of the common law right to refuse medical treatment: (1) the prevention of suicide; (2) the preservation of life; (3) the protection of third parties; and (4) the preservation of the ethical integrity of the medical profession.⁸⁴ Thus, it is likely that the analysis for balancing an individual's right to refuse medical treatment under the Constitution against relevant state interests is similar or identical to that of the common law.

81 497 U.S. 261 (1990).

82 *See id.* at 278–79 (following other cases which support a liberty interest in refusing to receive medical treatment). While the majority opinion recognizes a liberty interest in refusing medical treatment, three Justices dissented, arguing that the Constitution provides a fundamental right to refuse medical treatment. *See id.* at 302–12 (Brennan, J., dissenting).

83 *See id.* at 269, 278–79 (citing *Union Pac. Ry. Co. v. Botsford*, 141 U.S. 250, 251 (1891) (“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.”); *see also* *Washington v. Harper*, 494 U.S. 210, 221–22 (1990) (noting the existence of “a significant liberty interest in avoiding the unwanted administration of antipsychotic drugs under the Due Process Clause of the Fourteenth Amendment”); *Vitek v. Jones*, 445 U.S. 480, 494 (1980) (stating that transport to a medical center along with forcible behavioral treatment was against one’s liberty interest); *Parham v. J.R.*, 442 U.S. 584, 600 (1979) (“[A] child, in common with adults, has a substantial liberty interest in not being confined unnecessarily for medical treatment”); *Breithaupt v. Abram*, 352 U.S. 432, 439 (1957) (“As against the right of an individual that his person be held inviolable . . . must be set the interests of society”); *Jacobson v. Massachusetts*, 197 U.S. 11, 24–30 (1905) (noting that the court balanced a person’s interest in declining a smallpox vaccine versus the State’s interest in public health).

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

C. *The State Interest in Fetal Life as a Legal Justification for Compelled Treatment*

Courts overriding a pregnant woman's refusal of medical treatment⁸⁵ justify their decision by citing a countervailing state interest in fetal life. This can be viewed as either the state interest in protecting life, the state interest in protecting third parties, or a combination of the two.⁸⁶ However, protection of fetal life does not fit neatly into the four countervailing state interests identified in Section III.B. Some courts and commentators have cited it as a separate, fifth state interest, noting that preservation of life refers to the life of the decision maker, and that the third-party exception has been limited to born children and the public health.⁸⁷

The Supreme Court recognized a state interest in protecting fetal life in *Roe v. Wade*. While in *Roe* the Supreme Court made clear that the fetus is not a person under the 14th Amendment,⁸⁸ it also held

85 Courts generally compel medical treatment through a court order, which is often accompanied by an order awarding custody of the fetus, and therefore custody of the mother, to a state agency or hospital. Most compelled treatment cases do not result in reported opinions, making them difficult to track and limiting public scrutiny. See Nancy K. Rhoden, *The Judge in the Delivery Room: The Emergency of Court-Ordered Cesareans*, 74 CALIF. L. REV. 1951, 1951 (1986). A *New England Journal of Medicine* study published over twenty years ago that tracked court-ordered medical treatment of pregnant women found twenty-one cases of court orders being sought for Cesarean surgeries. See Veronika E. B. Kolder et al., *Court-Ordered Obstetrical Interventions*, 316 NEW ENG. J. MED. 1192, 1192 (1987). Orders were obtained in 86% of the cases in which they were sought, spanning eleven states. See *id.* In addition, hospital detentions were obtained in two states. See *id.* However, there are only a handful of reported cases from this period. See *infra* notes 109–112 and accompanying text. The practice of obtaining court ordered medical treatment has continued throughout the last two decades. See, e.g., Lisa Collier Cool, *Could You Be Forced to Have a C-Section?*, BABY TALK, May 20, 2005, at 56, 57; LYNN M. PALTROW, NAT'L ADVOCATES FOR PREGNANT WOMEN, COERCIVE MEDICINE (Mar. 21, 2004), http://advocatesforpregnantwomen.org/file/Coercive_Medicine.pdf (outlining numerous cases and incidents where a court has forced a woman to undergo a C-section even though the woman wished not to do so).

86 See Trindel, *supra* note 80, at 749–50 (noting that a state's interest may be in preserving "life" or protecting the "innocent third party").

87 See *In re Fetus Brown*, 689 N.E.2d 397, 402–04 (Ill. App. Ct. 1997) (discussing the four countervailing state interests but then resting on the "ultimate issue, the State's interest in protecting the viable fetus"); see also Goldberg, *supra* note 72, at 597–99 (stating that "no trade-off between a woman's health and the state's interest in protecting potential life is permissible"); Levine, *supra* note 80, at 278–87 (noting the distinction between the preservation of life and the preservation of potential life, and the State's interest in protecting third parties such as already born, minor children).

88 See *Roe v. Wade*, 410 U.S. 113, 157–58, 162 (1973) (noting that the word "persons" in the Fourteenth Amendment applies only postnatally and does not include the unborn); see also Gallagher, *supra* note 76, at 40 (noting that the United States has never treated the unborn as though they were a "person"); Goldberg, *supra* note 72, at 601 (explaining that, as determined by *Roe*, the Fourteenth Amendment's use of "person" does not in-

that the state has a legitimate interest from the outset of pregnancy in protecting not only the health of the woman, but also the life of the fetus. In *Roe*, the Court identified the state's "important and legitimate interest in potential life," which becomes compelling at viability.⁸⁹ The Court identified viability as a turning point at which "the fetus then presumably has the capability of meaningful life outside the mother's womb."⁹⁰ At that point, the state may regulate and even

clude a fetus). Historically, the U.S. legal system treated the fetus as part of the woman bearing it and afforded it no separate rights. See Harris, *supra* note 72, at 137 (stating that the fetus is legally perceived as part of the woman and thus has no "recognized legal existence"); Trindel, *supra* note 80, at 745 (describing the fetus as one that lacks existence or personality due to its attachment to the mother, making it unable to pursue a legal claim); see also Dawn E. Johnsen, *The Creation of Fetal Rights: Conflicts with Women's Constitutional Rights to Liberty, Privacy and Equal Protection*, 95 YALE L.J. 599, 600–01 (1986) (noting that the law was reluctant to provide a fetus with legal rights since it is not a person in the whole sense). To the extent fetal rights were recognized, they were contingent upon live birth and were available only against third parties and not against the mother. See *id.* at 600–02. For example, fetuses were granted the status of a person for the limited purpose of inheritance, provided the fetus was subsequently born alive, in order to effect parents' wishes to provide for children not yet born at the time of their death. See *id.* at 601. After 1946, tort law in some states began to allow children born alive to recover against third parties for injuries inflicted while they were in the womb. See *Developments in the Law—State Intervention During Pregnancy*, 103 HARV. L. REV. 1519, 1559 (1990) [hereinafter *Developments—State Intervention*]; Goldberg, *supra* note 72, at 600–01 (noting that in some jurisdictions, the requirement that a live birth occur in order for a suit to be brought has been abandoned); Johnsen, *supra*, at 601–02 (explaining that the purpose of tort law—to compensate victims and deter such harmful conduct—is consistent with allowing a child to recover against third parties for conduct inflicted upon the pregnant mother). Criminal law traditionally punished only third-party assaults on a fetus that survived birth. See *Developments—State Intervention*, at 1560.

Over the past few decades, legislatures and courts have eroded the legal distinction between born children and those in utero. In recent years, several states have amended existing murder statutes or enacted specific feticide statutes, imposing criminal sanctions against third parties even if the fetus died before birth. See *id.* at 1559. Similarly, states now recognize wrongful death recovery against third parties for harm to a viable fetus that dies before birth. See *Developments—State Intervention*, at 1559; Harris, *supra* note 72, at 745; see also Johnsen, *supra*, at 602. While by virtue of their exclusion of mothers from liability these statutes do not directly conflict with the rights of mothers, they represent a conceptual move by recognizing fetal rights independent of the pregnant woman. See *id.* at 603–04.

More troubling, however, is the recognition of actions on behalf of the fetus against the pregnant woman for her conduct during pregnancy. States have amended—or courts have interpreted—child abuse statutes to cover not only born children, but also fetuses. See *Developments—State Intervention*, *supra*, at 1574–75; Johnsen, *supra*, at 604–05. Some courts have interpreted criminal statutes protecting fetuses to hold women liable for conduct during pregnancy even where the statutes unambiguously exclude pregnant women from liability. See Minkoff & Paltrow, *Rights of Unborn Children*, *supra* note 77, at 26.

⁸⁹ *Roe*, 410 U.S. at 163; see also Gallagher, *supra* note 76, at 15 (quoting *Roe* regarding the state's interest in potential life).

⁹⁰ *Roe*, 410 U.S. at 163.

proscribe abortion, subject to an exception for the life or health of the mother.⁹¹

Courts have interpreted this state interest as providing legal grounds to override a pregnant woman's right to refuse treatment. For example, in *Pemberton v. Tallahassee Memorial Regional Medical Center, Inc.*, the Northern District of Florida held that a pregnant woman's rights were not violated by a court-ordered Cesarean surgery and blood transfusion.⁹² Citing *Roe* for the proposition that a State possesses an "increasing interest in preserving a fetus as it progresses toward viability," the court concluded that "[w]hatever the scope of Ms. Pemberton's personal constitutional rights in this situation, they clearly did not outweigh the interests of the State of Florida in preserving the life of the unborn child."⁹³ Indeed, every post-*Roe* reported opinion compelling the medical treatment of a pregnant woman for the benefit of the fetus has relied on *Roe* in its argument that the state's interest in fetal life outweighs the mother's right to refuse treatment.⁹⁴

D. Limitations of the State Interest in Fetal Life as a Legal Justification for Compelled Medical Treatment

Until *Carhart*, Supreme Court abortion jurisprudence provided limited support for the assertion that the state's interest in fetal life can override a pregnant woman's right to refuse medical treatment. This is in part because of the inherent limitations in applying abortion jurisprudence to medical treatment cases, as well as the primacy *Roe* and its progeny put on a woman's health.

One of the limitations of applying abortion jurisprudence to compelled treatment is that the state interest in fetal life is not implicated in the same manner in compelled treatment cases. In the con-

⁹¹ See *id.* at 163–64 (noting that a state may proscribe abortion if the fetus is viable and it will not endanger the health of the woman).

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

⁹³ *Id.* at 1251.

⁹⁴ See *id.*; *In re Madyun*, 114 Daily Wash. L. Rptr. 2233, 2239 (D.C. 1986) (citing *Roe* to discuss the state's compelling interest in forcing treatment); *In re Jamaica Hospital*, 491 N.Y.S.2d 898, 899–900 (1985) (noting that the state's interest increases and becomes compelling when the fetus reaches viability); *Jefferson v. Griffin Spalding Cnty. Hosp. Auth.*, 274 S.E.2d 457, 460 (Ga. 1981) (per curiam) (holding that the intrusion involved in the treatment is outweighed by the state's interest in the fetus); see also *In re A.C.*, 533 A.2d 611, 613–15, 617 (App. D.C. 1987) (noting the difference between a woman's right to an abortion and her obligations to the fetus once it becomes viable), *vacated* 573 A.2d 1235 (App. D.C. 1990). A court refusing to compel treatment also recognized the state's interest in fetal rights under *Roe* as the crux of the argument for the parties urging compelled treatment. See *In re Fetus Brown*, 689 N.E.2d 397, 404 (Ill. App. Ct. 1997).

text of abortion, fetal life will certainly be terminated; this is one of the purposes of abortion. However, medical treatment cases do not involve the purposeful termination of fetal life. Instead, they concern differences of opinion in how to achieve a live birth. While abortion involves the certain termination of fetal life, medical treatment cases involve disagreements over risk to fetal life.

Some medical treatment cases involve disagreement over what is an acceptable degree of risk to fetal life. For example, in *Pemberton*, the patient argued that vaginal delivery did not pose an appreciable risk to the fetus.⁹⁵ Five physicians had testified that the risk of uterine rupture, however, was “unacceptably high.”⁹⁶ One physician estimated the risk at 4 to 6%, and another placed the risk at between 2% and 2.2%.⁹⁷ Although the court stated that uterine rupture would result in “almost certain death” to the fetus, the one physician it cited estimated a 50% chance of fetal death if uterine rupture occurred.⁹⁸ The Northern District of Florida held that these odds posed unacceptable risk to the fetus.⁹⁹ However, a medical decision that allows a 1-3% chance of fetal death implicates a far different degree of state interest in fetal life than an abortion.

Physician uncertainty also raises the question of whether statistics themselves can be trusted to provide an accurate assessment of risk and whether a given risk even exists. Medicine is inherently imprecise, and physicians often overestimate the potential harm to the fetus and the need for intervention.¹⁰⁰ In *In re Baby Boy Doe*, a mother delivered a healthy baby vaginally despite her physician’s urging to the court that insufficient oxygen flow to the fetus would result in the baby being born dead or severely retarded unless a Cesarean surgery

95 *Pemberton v. Tallahassee Mem’l Reg’l Med. Ctr.*, 66 F. Supp. 2d 1247, 1252–53 (N.D. Fla. 1999).

96 *Id.* at 1253.

97 *Id.*

98 *Id.*

99 *Id.* (noting the substantial risk of uterine rupture and death to the fetus).

100 See MEREDITH, *supra* note 72, at 6, 65–66 (noting numerous cases where the medical outcome differed from the percentages given by the doctors); Janna C. Merrick, *Caring for the Fetus to Protect the Born Child? Ethical and Legal Dilemmas in Coerced Obstetrical Intervention, in THE POLITICS OF PREGNANCY: POLICY DILEMMAS IN THE MATERNAL-FETAL RELATIONSHIP* 63, 73–75 (Janna C. Merrick & Robert H. Blank eds., 1993) (discussing several cases where medical percentages suggested that vaginal delivery was impossible and yet successful vaginal deliveries occurred); *Developments—State Intervention*, *supra* note 88, at 1583 (“First, medicine is an inherently imprecise science.”); Trindel, *supra* note 80, at 757–58 (stating that doctors cannot make entirely accurate guesses as medical uncertainty usually exists).

was performed.¹⁰¹ In an unreported Colorado case, an order compelling a Cesarean surgery was granted only to discover that the diagnosis of fetal hypoxia prompting surgery was incorrect.¹⁰² A 1987 *New England Journal of Medicine* survey showed that physicians inaccurately predicted harm to the fetus in over twenty-eight percent of the cases in which court orders compelling treatment were sought.¹⁰³

Changing medical knowledge underscores the uncertainty underlying the state's interest in fetal life in medical treatment cases. Thirty years ago, a diabetic pregnant woman's refusal of DES treatment and an x-ray would be considered a danger to her fetus.¹⁰⁴ Physicians now know that these procedures endanger the fetus and would undermine, rather than further, any state interest in fetal life to compel them. While changing medical knowledge may introduce more grounds for medical intervention, it is also likely to undermine the need for several interventions that physicians now feel are optimal or necessary. For example, many experts are beginning to question the efficacy of electronic fetal monitoring (EFM), which is commonly used to determine the need for Cesarean surgery due to fetal distress.¹⁰⁵

Even to the extent that the state's interest in fetal life is indicated in medical treatment cases, the primacy of the mother's health limits the state's ability to compel medical treatment. *Roe* provides that, while the state's compelling interest in fetal life allows it to proscribe abortion in the third trimester, it may not proscribe abortion when doing so would endanger the life or health of the mother.¹⁰⁶ Health

101 See *In re Baby Boy Doe*, 632 N.E.2d 326, 327, 329 (Ill. App. Ct. 1994) (noting that, although a doctor determined that an immediate C-section was necessary, the vaginal birth produced a healthy baby); see also George J. Annas, *Forced Cesareans: The Most Unkindest Cut of All*, 12 HASTINGS CENTER REP. 16 (1982) [hereinafter Annas, *Forced Cesareans*] (showing that a medical diagnosis is not always accurate and arguing that a woman should be able to decide what procedures to have done regarding her fetus).

102 See Annas, *Forced Cesareans*, *supra* note 101, at 16 (quoting the doctor who stated that the case "simply underscores the limitations of continuous fetal heart monitoring as a means of predicting neonatal outcome").

103 See Kolder et al., *supra* note 85, at 1195 (noting that the prediction of harm to the fetus was incorrect in six of twenty-one cases (just over 28%)); Trindel, *supra* note 80, at 757 (noting that doctors incorrectly predicted harm to the fetus in six of twenty-one cases that were reported).

104 See Thomas B. Mackenzie et al., Commentary, *Case Studies: When a Pregnant Woman Endangers Her Fetus*, 16 HASTINGS CENTER REP. 25, 25 (1986) (suggesting a potential problem that may have occurred twenty-five years ago regarding fetal treatment).

105 See *infra* note 210 and accompanying text.

106 See *Roe v. Wade*, 410 U.S. 113, 163-64 (1973) (noting that abortion during viability may be proscribed except when necessary to preserve the health or life of the mother); see also Annas, *Forced Cesareans*, *supra* note 101, at 17 (discussing that the state's compelling interest in preserving the life of the fetus does not outweigh the interest in the life or health of

must be broadly construed, encompassing not only physical well-being, but also psychological and emotional well-being.¹⁰⁷ Even after viability, when a state's interest in fetal life becomes "compelling," states may not pursue this interest at the expense of a woman's health. In subsequent cases, the Court has reaffirmed that the state cannot sacrifice maternal health for the sake of preserving fetal life.¹⁰⁸

The logical corollary to this principle is that, even if the state's interest in fetal life ever allows it to mandate medical treatment of a pregnant woman against her will, the state may not do so if treatment would come at the expense of the woman's health. Courts should be foreclosed from mandating any treatment that would benefit the fetus but would pose health risks to the mother. The requirement that state interests in fetal life may not be pursued at the expense of fetal health is reflected in case law in which courts contemplate intervening to further state interest in fetal life. In general, while some courts, citing *Roe*, have been willing to intervene to mandate medical treatment of pregnant women for the benefit of the fetus, these cases have been limited to situations in which the treatment was arguably

the mother); Goldberg, *supra* note 72, at 619 (explaining that "exemptions from state proscriptions on abortions are available for the health of the mother"); Levine, *supra* note 80, at 258 (stating that the state may not prevent an abortion if doing so endangers the mother's health); Trindel, *supra* note 80, at 750 (noting that no court has held that a woman must jeopardize her own health in order to protect her fetus).

107 See *Doe v. Bolton*, 410 U.S. 179, 192 (1973) (noting that medical well-being extends to physical, emotional, psychological and familial considerations); *United States v. Vuitich*, 402 U.S. 62, 71–72 (1971) (discussing a holding that allowed an abortion for mental health reasons); see also Goldberg, *supra* note 72, at 619 ("Health has been broadly defined."); Levine, *supra* note 80, at 258 (stating that a woman's "health" must be broadly construed to include physical, psychological and emotional well-being).

108 In *Thornburgh v. Am. Coll. of Obstetrics and Gynecologists*, the Court considered a statute that required a physician performing a post-viability abortion to exercise reasonable care to preserve the life and health of the fetus and to perform a technique that would provide a fetus with the best chance to be aborted alive unless it would pose a significantly greater medical risk to maternal life or health. 476 U.S. 747, 768 (1986), *overruled on other grounds*, *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833 (1992). The Court held that the statute was unconstitutional because it required a trade-off between maternal health and fetal life rather than requiring "that maternal health be the physician's paramount consideration." *Thornburgh*, 476 U.S. at 768–69; see also Levine, *supra* note 80, at 259 (noting a court's issue with a Pennsylvania statute that balanced consideration for the fetus's life with consideration for maternal health); Trindel, *supra* note 80, at 750–51 (discussing the *Thornburgh* decision and the unconstitutionality of an act that required a "trade off" between fetal health and maternal health). The Court sustained the primacy of a women's health over the state interest in fetal life in *Planned Parenthood of Southeastern Pennsylvania v. Casey*, reaffirming the health exception requirement. See *Casey*, 505 U.S. at 846, 850–51, 872, 879, 880 (continuing to note the primacy of the woman's health when considering whether an abortion is a necessity).

in the medical interests of both the fetus and the mother.¹⁰⁹ Courts do not always compel treatment where it is in the pregnant woman's

109 With the exception of one case decided prior to *Roe*, every reported case of compelled medical treatment of a pregnant woman that I found occurred in circumstances in which the physicians could argue that treatment would benefit the mother's health as well as the fetus.

In *Jefferson v. Griffin Spalding County Hospital*, a 1981 case, the Supreme Court of Georgia gave the state temporary custody of a fetus and ordered a woman in her thirty-ninth week of pregnancy to submit to a sonogram and Cesarean surgery. 274 S.E.2d 457 (Ga. 1981) (per curiam). The patient had complete placenta previa, and physicians estimated that there was a 99% chance that her child would not survive a vaginal delivery, and a 50% chance that she would not survive a vaginal delivery, as opposed to a near 100% chance that both mother and child would survive a Cesarean surgery. *See id.* at 458-59. The court concluded that the state's interest in fetal life under *Roe* and Georgia law outweighed the infringement on the mother's "wishes." *See id.* at 460.

In *In re Jamaica Hospital*, a New York trial court ordered a woman in her eighteenth week of pregnancy to submit to a blood transfusion to save the life of the fetus. 491 N.Y.S.2d 898, 899 (1985). The court based its intervention solely on the state's interest in preserving the life of the fetus under *Roe*, and acknowledged that it would not intervene if the patient were not pregnant. *See id.* However, the transfusion was recommended to save both the mother and the fetus. *See id.* The case has since been cited by other New York trial courts for the proposition that courts may compel the medical treatment of women in order to protect the health and welfare of a fetus. *See, e.g., In re Guardianship of Baby K*, 727 N.Y.S.2d 283, 286 (N.Y. Surr. Ct. 2001) (noting that the court has the authority to take action to protect the life of a fetus); *see also Foscire v. Nicoleau*, 536 N.Y.S.2d 492, 496 (1989) (citing *In re Jamaica Hospital* for the proposition that protecting health and welfare of a fetus is deemed "paramount" when a mother is refusing medical treatment).

In *In re Madyun*, the District of Columbia Superior Court granted a hospital's petition for an order compelling a pregnant patient at term to undergo a Cesarean surgery. 114 Daily Wash. L. Rep. 2233, 2240 (1986). The court held that, while a competent adult may decline medical treatment for religious reasons, the state could override this decision based on its interest in protecting fetal life delineated in *Roe*. *Id.* While the decision speaks only in terms of risk to the fetus—and even acknowledges that the Cesarean surgery posed "minimal risks to the mother"—, *see id.*, a subsequent decision by the same court states that that the Cesarean surgery in *Madyun* was also recommended in the interest of the mother's health. *See In re A.C.*, 573 A.2d 1235, 1252 n.23 (D.C. 1990) (en banc) (distinguishing *A.C.* from *Madyun*). In this later decision, the same court would vacate a decision that ordered a Cesarean surgery that was not in the medical interests of the mother, and hold that a pregnant woman's refusal of medical treatment should be respected in virtually all cases. *See id.* In doing so, the court distinguished *Madyun* in part because the surgery in *Madyun* was in the interest of the mother. *See id.*

In *Pemberton v. Tallahassee Memorial Regional Medical Center*, 66 F. Supp. 2d 1247 (1999), the Federal District Court for the Northern District of Florida held that an order compelling a woman to submit to a cesarean section did not violate her constitutional rights. *Id.* at 1257. The court relied on *Roe* and its progeny for the principle that, "by the point of viability . . . the state's interest in preserving the life of the fetus outweighs the mother's own constitutional interest in determining whether she will bear a child." *Id.* at 1251. Because "[b]earing an unwanted child is surely a greater intrusion on the mother's constitutional interests than undergoing a [C]esarean surgery to deliver a child that the mother affirmatively desires to deliver," the court concluded that "the state's interest here was greater, and the mother's interest less, than during the third trimester situation ad-

medical interest; for example, the Appellate Court of Illinois has explicitly stated that Illinois law prohibits courts from doing so.¹¹⁰ However, all reported decisions compelling the treatment of a pregnant woman for the sake of the fetus occurred in circumstances in which the physician could argue that the treatment would also benefit the pregnant woman.¹¹¹ In contrast, where treatment would negatively impact the mother's health, courts have either refused to compel treatment or have overturned compelled treatment on appeal.¹¹²

dressed in *Roe*." *Id.* at 1251–52. While the decision provided no discussion of how the Cesarean surgery would impact the patient, the surgery was recommended to avoid uterine rupture, *see id.* at 1257, which would pose serious risks to the health and life of the mother. *See* Kevin S. Toppenberg & William A. Block, Jr., *Uterine Rupture: What Family Physicians Need to Know*, 66 AM. FAM. PHYSICIAN. 823, 823, 826 (2002).

In *Raleigh Fitkin-Paul Morgan Memorial Hospital v. Anderson*, 201 A.2d 537 (N.J. 1964) (per curiam), the New Jersey Supreme Court granted a hospital's appeal seeking a court order to compel a blood transfusion for a woman in the thirty-second week of pregnancy. *Id.* at 538. The court appointed a guardian *ad litem* for the fetus, ordered the guardian "to consent to such blood transfusions as may be required and seek such other relief as may be necessary to preserve the lives of the mother and the child," and directed the trial court to "direct the mother to submit to such blood transfusions." *Id.* It acknowledged that, while it was questionable whether an adult could be compelled to submit to transfusions to save her life, "the welfare of the child and the mother are so intertwined and inseparable that it would be impracticable to attempt to distinguish between them with respect to sundry factual patterns which may develop." *Id.* However, unlike the other cases outlined in this footnote, *Raleigh Fitkin-Paul* was decided prior to *Roe*. Thus, in contrast to the other cases outlined in this subsection, *Raleigh Fitkin-Paul* bases its holding upon the court's perception of the rights of the fetus, rather than the state interest in fetal life. In a subsequent case, *New Jersey Division of Youth and Family Services v. L.V.*, a lower court has since interpreted the New Jersey constitution to protect a pregnant woman's right to refuse medical treatment even if that refusal results in her death or the termination of her pregnancy. 889 A.2d 1153, 1158 (N.J. Super. Ct. Ch. Div. 2005).

110 *See In re Fetus Brown*, 689 N.E.2d 397, 405–06 (Ill. App. Ct. 1997) (noting that Illinois law did not allow a mother to be compelled to undergo medical treatment that would help her viable fetus).

111 *See supra* note 109.

112 In *Taft v. Taft*, the Supreme Judicial Court of Massachusetts refused to order a cervical cerclage, a suturing of the uterus, on a pregnant woman at risk of losing her pregnancy in the fourth month due to an incompetent cervix. 446 N.E.2d 395, 395 (Mass. 1983). The court cited the mother's privacy rights and the fact that there were no findings based on expert testimony that described the risks to the mother or to the fetus or "setting forth whether the operation is merely desirable or is believed to be necessary as a life-saving procedure." *Id.* at 397. The court also cited, in a footnote, the fact that the fetus was not viable, distinguishing the case from *Raleigh Fitkin-Paul* and *Jefferson* on those grounds. *See id.* at 397 n.4. Thus, the *Taft* decision may have left open the question of whether the court would be willing to compel treatment if a fetus is viable and if the operation were shown to be necessary to ensure the pregnancy was carried to term.

In *In re A.C.*, decided two months before the Supreme Court recognized the right to refuse medical treatment, the Court of Appeals of the District of Columbia held that a pregnant woman's rights were violated by an order compelling a Cesarean surgery. 573 A.2d 1235 (D.C. 1990). The Cesarean surgery increased the chances of survival for the twenty-six week fetus but would hasten the mother's death. *See id.* at 1239–40. The pa-

IV. CARHART'S IMPACT ON PREGNANT WOMEN'S RIGHT TO MAKE TREATMENT CHOICES

A. Introduction

As described above, there are limitations in interpreting abortion jurisprudence in the context of medical treatment refusal cases.¹¹³ Abortion is generally about a decision to end a pregnancy, as opposed to choosing or refusing treatment options while carrying a

tient had refused the Cesarean surgery despite difficulties in communicating while on a ventilator; however, the judge had indicated that he was uncertain what her intent was. *See id.*; George J. Annas, *She's Going to Die: The Case of Angela C.*, 18 HASTINGS CENTER REP. 23, 24 (1988) [hereinafter Annas, *Angela C.*]. Her family had also argued she would not have consented to the Cesarean surgery. *See In re A.C.*, 573 A.2d at 1239–40. The trial court ordered the procedure; the nonviable fetus died two hours later, and the mother, now both recovering from major surgery and faced with the knowledge of her child's death, died two days later. *See Annas, Angela C.*, at 24.

The Court of Appeals held that the trial court had erred, citing the right of every patient to informed consent and the right to refuse medical treatment. *See In re A.C.*, 573 A.2d at 1243–45. The court held that, although courts have “in rare cases” judicially overridden a patient's right to refuse medical treatment in the interest of protecting fetal third parties, “a court must determine the patient's wishes by any means available, and must abide by those wishes unless there are truly extraordinary or compelling reasons to override them.” *Id.* at 1246–47. The court spoke harshly against overriding a pregnant woman's refusal of medical treatment, but did not go so far as to overrule its previous holding in *Madyun*. It distinguished *Madyun* and *Jefferson* in part because the treatment ordered in these cases did not conflict with the health interests of the mother. *See id.* at 1252 n.23. The court also distinguished *Madyun* as involving a full-term fetus. *See id.*

In *In re Baby Boy Doe*, the Appellate Court of Illinois held that a woman cannot be compelled to undergo a treatment as invasive as a Cesarean surgery, even if her choice might be harmful to her fetus. 632 N.E.2d 326 (Ill. App. Ct. 1994). Physicians testified that, because of the lack of oxygen the fetus was receiving in the womb, the fetus had almost no chance of surviving the natural child birth the mother had chosen and if he did survive birth he would be mentally disabled. *See id.* at 328. In contrast, the child had a near one-hundred percent chance of surviving a Cesarean surgery. *See id.* In refusing to compel treatment, the *Baby Boy Doe* court explicitly relied upon the health risks to the mother, as well as the language in *Roe* and its progeny prohibiting a trade-off between the woman's health and the life of the fetus. *See id.* at 333. The court noted that the Cesarean surgery increased the risks of death for the mother, would be more painful to the mother, would require additional recuperation, and could lead to additional complications. *See id.* at 328–29. The court cited *Thornburgh* for the principle that “the woman's health is always the paramount consideration; any degree of increased risk to the woman's health is unacceptable.” *Id.* at 333. Because a Cesarean surgery “by its nature, presents some additional risks to the woman's health,” particularly when “recommended solely for the benefit of the fetus,” the court found that “[u]nder *Thornburgh*, then, it appears that a forced [C]esarean section, undertaken for the benefit of the fetus, cannot pass constitutional muster.” *Id.* The court left open, however, the question of whether a court could order a woman to submit to a less invasive treatment, such as a blood transfusion, that would pose no risks to the mother, which it subsequently refused to do in *In re Fetus Brown*, 689 N.E.2d at 405–06.

113 *See supra* Section III.D.

pregnancy to term. Yet the two bodies of law involve similar rights and principles. As *Stenberg* and *Carhart* demonstrate, abortion jurisprudence is often about a patient's right to make medical treatment decisions. While this right was subtext in *Roe* and *Casey*,¹¹⁴ it was the crux of the issue in *Stenberg* and *Carhart*. Both *Stenberg* and *Carhart* concerned women's ability to choose a safer method of abortion procedure rather than whether they could obtain an abortion. What was at issue in both cases was not the right to choose whether to become a parent, but rather the right to choose the medical procedure that would give effect to that right.¹¹⁵

This section argues that the *Carhart* decision has implications not only for abortion jurisprudence but also pregnant women's right to refuse medical treatment. Subsection IV.B argues that *Carhart's* reasoning encourages more state intervention in the medical treatment of pregnant women who seek to carry their pregnancy to term by recognizing new or expanded state interests and abridging the primacy of women's health. Subsection IV.C discusses these implications in the context of specific medical treatment choices, such as Cesarean surgery, the treatment of HIV-positive pregnant women, and fetal surgery.

B. Applying Carhart to Pregnant Women's Right to Refuse Treatment

The *Carhart* decision may influence cases concerning the medical treatment of pregnant women in several ways. The decision expands the state interests that the Court recognizes as justifying intrusion into women's medical treatment decisions during pregnancy. The majority's reasoning also implicitly weakens women's right to informed consent in the context of medical decisions during pregnancy. Finally, the decision undermines the principle that a woman's health cannot be compromised to further the state interest in protecting fetal life.

In the context of a pregnant woman's right to refuse medical treatment, *Carhart's* expansion of the state's interest in fetal life expands the justification for states to compel medical treatment. As discussed above, in medical treatment cases, the state's interest in fetal life is not as compelling as in abortion cases: such treatment cases involve risk to the fetus's life or health, but not the termination of fetal

¹¹⁴ See *supra* note 66 and accompanying text.

¹¹⁵ See Hill, *supra* note 62, at 325 (discussing *Carhart* I and II in the context of reproductive choice).

life at issue in abortion.¹¹⁶ Fetal life is implicated far more in these cases than in *Carhart*, which concerned the method of abortion rather than whether a fetus would be aborted. Courts may determine that, if the state's interest in fetal life justifies state intrusion into women's medical decisions in *Carhart*, it is an even stronger justification for intrusion into the medical treatment decisions in cases where there is evidence that a fetus may live or die depending on a chosen course of medical treatment.

Carhart encourages the argument that intervention in these cases is necessary to further a state interest in demonstrating its respect for fetal life. *Carhart* allowed the state to ban a procedure that the majority opinion found morally reprehensible because it undermined respect for fetal life. This reasoning can be translated to other medical treatment decisions that courts also find abhorrent to the principle of respect for fetal life. The decision to risk a child's death during birth, asphyxiation in utero, a painful and debilitating birth defect, or a chronic and debilitating disease may logically strike a court as raising moral issues at least as serious as the choice of an intact D&E over another method of abortion. The court may also see these decisions as raising ethical issues for physicians at least equal to the concerns the Court expressed over a physician's performance of an intact D&E. Thus, courts may see *Carhart* as allowing, or even compelling, intervention in these cases in order to further the state interest in "promot[ing] respect for life, including life of the unborn."¹¹⁷

Carhart's interpretation of the state's interest in protecting the health of the woman also undermines women's autonomy in the context of medical decisionmaking during pregnancy. *Carhart* implies that, in the context of women's relationships with the children they carry, pregnant women cannot be trusted to exercise informed consent. This has enormous implications for medical treatment cases, where a woman's exercise of informed consent allows her to choose a course of treatment that poses increased risks for the fetus's life or health. *Carhart's* reasoning indicates that the state need not respect women's right to informed consent in the context of medical treatment choices during pregnancy because of the regret she might feel if her decision harms her child.

Indeed, this alleged state interest is arguably implicated even more in the context of compelled treatment cases than in *Carhart*. *Carhart* involved circumstances in which a woman who has decided to

116 See *supra* Section III.C.

117 *Gonzales v. Carhart*, 550 U.S. 124, 158 (2007).

terminate her pregnancy must decide which procedure to use to accomplish those ends. In the context of medical treatment cases, a woman's medical treatment decision may result in death or harm to the fetus she has decided to carry to term. A woman who has decided to carry her pregnancy to term and is faced with the decision of whether or not to have a Cesarean surgery to increase the fetus's chances of survival may already identify as a mother and have a strong bond of love with the child she carries. It stands to reason that the loss of or harm to a child she has decided to carry to term could cause as much, if not more, regret than the choice of which medical procedure to use during an abortion.¹¹⁸

Some scholars argue that while *Carhart* uses language reflecting the argument that abortion can be restricted to protect women from regret, the Court did not adopt this rationale as an independent basis for restricting access to abortion.¹¹⁹ As Reva Siegel notes, *Carhart* relied heavily on *Casey*, which rejected justifications for restricting abortion access that were rooted in gender stereotypes about women.¹²⁰ "Absent dramatic new developments," Siegel writes, "the constitutionality of a ban based on gender-paternalist justifications for restricting abortion would be determined in a doctrinal framework that protects women's autonomy to decide whether to bear a child."¹²¹ Restricting abortion based on paternalistic desires to protect women from the regret they might feel by contradicting their natural roles as mothers would be "in deep tension" with the very precedent that the *Carhart* majority relies upon and purports to uphold.¹²²

While *Carhart* uses the language of *Casey* and its respect for women's dignity to support its decision, it does so in a way that actually undermines these goals. Although *Carhart* does not state that protecting women from their regret is an independent justification for restricting abortion access, it frames this very justification in the form of protecting women's health, which is an independent justification

118 It should be noted that many women who have abortions, including those that use the procedure banned by PBABA, identify as mothers and would prefer to carry their pregnancies to term, yet decide to terminate the pregnancy for reasons including medical necessity. It stands to reason that a medical treatment decision that may cause harm or death to a fetus the woman intends to carry to term would cause as much potential regret, if not more, than the choice of which medical procedure to use during an abortion.

119 See, e.g., Siegel, *Dignity*, *supra* note 71, at 1705, 1767–73 (discussing the court's reasoning for creating the "undue burden" framework).

120 See, e.g., *id.* at 1701–02, 1705, 1767–74 (asserting that *Roe* and *Casey* symbolize the fact that "women are able and entitled to decide their own life course, especially in the matters concerning family roles").

121 *Id.* at 1701.

122 *Id.* at 1701–02, 1767–73.

for restricting abortion that was accepted by *Casey* as consistent with respecting women's autonomy. *Carhart* reinterprets the women's health justification in a way that includes gender-paternalistic assumptions about women's roles and capabilities, taking a justification meant to protect women's dignity and autonomy and reinterpreting it in a way that undermines these principles. This reasoning, imported into compelled-treatment cases, undercuts women's ability to make autonomous medical decisions in the context of refusing treatment when doing so might cause harm or death to the fetus.¹²³

Also troubling is *Carhart's* repudiation of the principle that there can be no trade off between the woman's health and these state interests. *Carhart* allows the state to pursue these interests by intervening in pregnant women's medical treatment decisions at the expense of women's health if the state can show a modicum of uncertainty about the effects of the medical treatment on women. In the past, courts have avoided compelling treatment of pregnant women where doing so would compromise women's health, with one court directly citing *Roe* for the principle that women's health may not be sacrificed to further the state interest in fetal life.¹²⁴ Indeed, an American College of Obstetricians and Gynecologists article published two years prior to the *Carhart* decision that considered whether to seek court intervention when a woman's refusal to undergo a Cesarean surgery poses risk to the fetus relied on *Stenberg* for its conclusion that treatment may not be compelled because doing so would compromise the woman's health.¹²⁵

Carhart calls this conclusion into doubt. For the first time, the Court has allowed the state to ban an abortion procedure without any exception for the life or health of the mother. The majority justifies this by citing the uncertainty about the need for a health exception and maintaining that, where there is uncertainty, courts can defer to

123 Even if *Carhart* does not designate protecting women from decisions they may regret as an independent basis for restricting abortion, it need not do so to influence other cases concerning women's autonomy in medical treatment decisions. In the context of compelled medical treatment, the *Carhart* court discussed numerous factors as justifying its conclusion—the interest in fetal life, expressing respect for fetal life, and the regret women may feel over their decisions. All of these factors may be imported to compelled treatment cases. The Court's consideration of the regret women might feel and the need to protect women from that regret signals that courts may weigh it with these numerous factors and may allow it to influence their conclusion, even if courts may not rely on it as an independent basis for restricting women's decisions.

124 See *supra* notes 109–112 and accompanying text.

125 See Richard L. Berkowitz, *Should Refusal to Undergo a Cesarean Delivery Be a Criminal Offense?*, 104 *OBSTETRICS & GYNECOLOGY* 1220, 1220 (2004) (discussing whether a woman should have the right to refuse a Cesarean delivery).

the state and err on the side of state interests. The Court's willingness to rely on slim and questionable evidence to generate uncertainty implies that very little evidence may be needed to override a woman's health concerns.

One potential way to distinguish *Carhart* from compelled treatment cases is that while *Carhart* was a facial challenge to a statute, compelled treatment cases are more likely to occur on a case-by-case basis. The *Carhart* majority justified their refusal to require a health exception by distinguishing facial and as-applied challenges and stating that a facial challenge required the respondents to demonstrate that the procedure was medically necessary in a large fraction of cases. It left open the possibility that the statute would not survive an as-applied challenge where a particular woman could demonstrate that the procedure was medically necessary for her. Compelled treatment cases will likely not involve a challenge to a statute, but rather case-specific determinations that more closely resemble as-applied challenges.

While this is a valid distinction that prevents *Carhart* from fitting neatly into the framework of compelled medical treatment cases outlined above, *Carhart* still provides troubling precedent for compelled treatment cases by eroding the primacy of women's health. Past Supreme Court cases made no distinction between the unqualified need for a health exception in facial challenges as opposed to as-applied challenges because there was no reason to distinguish these two types of cases. As the dissent argues, the health exception is required to protect the exceptional cases and underscore the fact that *in no circumstance* may women's health be undermined to protect fetal life. The majority, on the contrary, provides a holding that will require women to undergo less safe procedures in numerous circumstances. The majority argued that it could not find that the statute was unconstitutional on its face because the respondents did not demonstrate that the procedure was medically necessary in "a large fraction" of cases.¹²⁶ This implies that the majority willingly accepted a ban on a procedure that is medically necessary in a small fraction of the cases. Perhaps more important, the majority's deference to Congress in the face of medical uncertainty also means that, regardless of the fraction of cases in which the procedure may be medically necessary, any uncertainty allows the procedure to be banned. If any lack of

¹²⁶ *Gonzales v. Carhart*, 550 U.S. 124, 167–68 (2007) (Thomas, J., concurring); *see also* Leading Cases, *Abortion Rights*, *supra* note 5, at 269 (arguing that the court in *Carhart* "upheld an abortion restriction without knowing whether necessary abortions would in fact be barred").

certainty requires complete deference to Congress, then a ban that might prohibit a medically necessary abortion in seventy-five percent of cases would survive constitutional scrutiny as easily as a ban that might prohibit a medically necessary abortion in twenty-five percent of cases.¹²⁷ Thus, *Carhart* allows an intrusion into the medical treatment decisions of women that it implicitly acknowledges will result in compromising women's health.

Carhart's erosion of the primacy of women's health is not necessarily limited to facial challenges. *Carhart* allows manufactured uncertainty to undermine the principle that there can be no circumstance in which women's health can be undermined to further state interests in fetal life (and, in the case of *Carhart*, other dubious state interests). There is no logical reason to hold that uncertainty can undermine this principle in facial challenges as opposed to as-applied challenges. If uncertainty can compromise the primacy of women's health in facial challenges, why can it not be used to compromise women's health in as-applied challenges or in the case of specific women seeking to avoid unwanted medical treatment?

This facial/as-applied distinction does not apply to the expanded state interests described above, which the state could assert in an as-applied challenge or a compelled medical treatment case. Thus, the *Carhart* majority's argument that a state may limit a pregnant woman's medical options in order to promote an interest in fetal life applies in the context of any state action; the state could raise this justification in a facial challenge to a statute, an as-applied challenge to a statute, or an order compelling the treatment of a specific woman. Similarly, *Carhart's* argument that the state may further its interest in women's health by limiting their ability to choose medical procedures they may regret also applies in the context of any state intrusion, whether by statute or through an order compelling treatment.

In sum, the principles set forth in *Carhart* allow states to compel medical treatment in more and more cases, relying on dubious state interests. *Carhart* undermines the principle that these interests may not be pursued at the expense of maternal health. As the following section sets forth, this reasoning supports compelled medical treatment in a variety of contexts in which courts have heretofore been less likely to accept.

¹²⁷ *Abortion Rights*, *supra* note 5, at 270 (considering the implications of a health exception for allowing abortions under certain conditions of risk).

C. *The Impact of Carhart's Reasoning on Specific Treatment Choices*

1. *Surgical Interventions*

The overwhelming majority of Cesarean surgeries are performed for the benefit of the fetus and do not provide any medical benefit to the pregnant woman.¹²⁸ While Cesarean surgery has become a very common procedure, with rates increasing from 5% in the 1970s to 31.1% in 2006,¹²⁹ it is an invasive medical procedure for a woman, involving major abdominal surgery. During the procedure, the patient is anesthetized, an incision is made into her abdominal wall and uterus, and various connective tissue are retracted so that the surgeon can reach in and remove the fetus through the incision.¹³⁰ The surgeon then extracts the placenta and amniotic membranes from the uterine wall, sutures the uterus, and closes the several layers of the abdominal wall.¹³¹ Approximately ten percent of patients will hemorrhage excessively, requiring a blood transfusion.¹³² Afterwards, if the patient received spinal anesthesia, she must remain supine for eight hours. She cannot eat for eight hours following the procedure and may have to take antibiotics to reduce the chance of infection. Cesarean surgery involves a significantly longer recovery time than vaginal birth.

Cesarean surgery also involves additional risks for the mother. The risk to a pregnant woman's life is four to five times greater than vaginal deliveries¹³³ and "maternal morbidity is more frequent and

128 See Berkowitz, *supra* note 125, at 1220 (stating that many women undergo Cesarean sections "for the express purpose of benefiting their fetuses"); see also Telephone Interview with Howard Minkoff, Chairman, Dep't of Obstetrics and Gynecology, Maimonides Hosp., (June 25, 2009). Common indications for Cesarean surgery are "dystocia, fetal distress, repeat cesarean delivery, and breech or malpresentation." Levine, *supra* note 80, at 238 (listing the risks that women who receive Cesarean sections encounter).

129 See Joyce A. Martin et al., *Births: Final Data for 2006*, 57 NAT'L VITAL STATISTICS REP. 1 (2009) (noting that this percentage is an all time high for Cesarean deliveries); see also Levine, *supra* note 80, at 235 (placing the rate for a Cesarean section at over 20%). This drastic increase has been the cause of considerable controversy, as some argue that the increase is due not merely to improvements in medical technology, but also convenience, economics, and fear of malpractice suits. See Levine, *supra* note 80, at 236; see also Gallagher, *supra* note 76, at 50 n.210.

130 See Levine, *supra* note 80, at 237 (discussing the procedure for a Cesarean surgery).

131 See *id.*

132 See *id.*

133 See MEREDITH, *supra* note 72, at 66–67 (asserting that despite the improvements in technology, the risk of maternal fatality with a Cesarean delivery remains higher than the risk posed by a vaginal delivery); Levine, *supra* note 80, at 238 (citing the potential harm that could result to the mother from a Cesarean surgery).

likely to be more severe.”¹³⁴ Short-term risks involve reactions to anesthesia, excessive blood loss, bladder injury, and infection.¹³⁵ Long-term risks involve uterine rupture in subsequent labor and the need for Cesarean surgery in subsequent pregnancies.¹³⁶

Carhart's reasoning changes the analysis in the overwhelming majority of Cesarean surgeries that are performed for the benefit of the fetus and without benefit to the mother. While Cesarean surgeries in general clearly pose additional risks to the mother, it is not difficult to imagine the use of a single study demonstrating that risks were minimal in order to inject “uncertainty” into the court’s mind, just as questionable medical evidence was used to create uncertainty among the *Carhart* majority about whether a health exception was necessary for PBABA.¹³⁷ While in the past the Court had ruled that uncertainty required courts to err on the side of the mother’s health, courts may feel free to err on the side of allowing state interest in the shadow of *Carhart*.

This same reasoning can be expanded to compel medical treatment in the context of fetal surgery. Like the majority of Cesarean surgeries, fetal surgery is surgery that is performed to address fetal health issues, rather than maternal health issues. During fetal surgery, the surgeon makes an incision into the abdomen and uterus, similar to a Cesarean surgery, and exposes the fetus so that the fetus is partially outside the womb.¹³⁸ While fetal surgery is still relatively experimental, it has been established that fetal surgery can provide “unequivocal, life-saving benefit” with regard to at least two congenital anomalies.¹³⁹ Risks of fetal surgery are infection of the incision or lining of the uterus, uterine rupture, premature labor and delivery,

134 Levine, *supra* note 80, at 238.

135 *See id.* at 239 (noting the short term risks of Cesarean delivery).

136 *See id.* (discussing the long term risks of Cesarean delivery).

137 For example, some studies suggest that elective, scheduled Cesarean surgeries might actually improve maternal health outcomes. *See, e.g.*, Howard Minkoff & Frank Chervenak, *Elective Primary Cesarean Delivery*, 348 NEW ENG. J. MED. 946, 946 (2003). While these studies may not apply to the circumstances of a compelled treatment case, they merely demonstrate how selective interpretation of studies can be used to create uncertainty about a particular medical treatment.

138 *See* Lawrence J. Nelson, *Of Persons and Prenatal Humans: Why the Constitution is Not Silent on Abortion*, 13 LEWIS & CLARK L. REV. 155, 184 (2009) (stating the procedure for fetal surgery where the unborn child is medically treated in the womb).

139 *See* Michael W. Bebbington et al., *Open Fetal Surgery*, in *PRENATAL MEDICINE* 493, 497 (John M.G. van Vugt & Lee P. Schulman eds., 2006) (stating that open fetal intervention benefits CCAM (cystic adenomatoid malformation) and SCT (sacroccygeal teratoma)); *see also* Nelson, *supra* note 138, at 184 (suggesting the benefits of open fetal surgery for particular life threatening congenital anomalies).

bleeding, leakage of amniotic fluid, and complications associated with anesthesia.¹⁴⁰

Similarly, *Carhart's* reasoning supports increased intervention in the context of cerclage, a suturing of the cervix that is used to prevent premature labor where a woman's cervix is weak. Cerclage is only likely to be successful where a cervix has been properly diagnosed as incompetent, a diagnosis that is very difficult to make and can often be inaccurate.¹⁴¹ Risks include reaction to anesthesia, cervical infection, cervical laceration, rupture of membranes, premature contractions, and the inability of the cervix to dilate normally in the course of labor.¹⁴² While the Massachusetts Supreme Court overturned the performance of a cerclage in *Taft v. Taft*, the court relied in part on the lack of evidence that the cerclage was necessary and the lack of information provided about the risks it posed.¹⁴³ *Carhart's* reasoning expands state interests beyond the need to save fetal lives, arguably making the necessity of the operation less critical in a compelled treatment case. More importantly, *Carhart's* erosion of the primacy of maternal health also makes the risks posed by the procedure less dispositive where evidence can be presented that those risks are uncertain.

2. Treatment of Pregnant HIV-Positive Women

The medical treatment of HIV-positive pregnant women provides an example of a chronic medical condition that may generate tension between physicians' recommendations and pregnant women's treat-

140 See Bebbington et al., *supra* note 139, at 506 (examining the maternal risks of open maternal-fetal surgery).

141 See, e.g., R.W. Rush et al., *A Randomized Controlled Trial of Cervical Cerclage in Women at High Risk of Spontaneous Preterm Delivery*, 91 BRIT. J. OF OBSTETRICS & GYNAECOLOGY 724, 728 (2005) (discussing the variances and difficulties in making a diagnosis of "cervical incompetence"); Catrin Tudur-Smith et al., *Individual Patient Data Meta-Analysis: Cervical Stitch (Cerclage) for Preventing Pregnancy Loss in Women*, 5 BMC PREGNANCY AND CHILDBIRTH 5, 5 (2005) ("Several observational studies into the efficacy of cervical cerclage have claimed high rates of successful pregnancy outcome in women with a poor obstetric history attributed to cervical incompetence . . . Current data suggests that cervical cerclage is likely to benefit women considered to be "at very high risk" of a second trimester miscarriage due to a cervical factor, however identifying such women remains elusive . . .").

142 See Rush et al., *supra* note 141, at 728-29 (noting the deleterious effects of cerclage on some women).

143 See 446 N.E.2d 395, 397 (Mass. 1983) (The record is devoid of facts that support the judgment ordering the wife to submit to an operation against her consent. We have no findings . . . describing the operative procedure, stating the nature of any risks to the wife . . . or setting forth whether the operation is merely desirable or is believed to be necessary . . .).

ment choices. HIV may be transmitted in utero and during childbirth. While all infants born to mothers living with HIV will test positive for HIV antibodies, this does not necessarily mean these infants will develop HIV. Without medical intervention, the rate of transmission during pregnancy and birth is approximately 25.5%.¹⁴⁴ Prophylactic measures such as antiretroviral therapy (“ARV” therapy) and Cesarean surgery prior to the rupture of membranes reduce the perinatal transmission rate still further, to less than 2%.¹⁴⁵

While they are extremely effective at preventing mother-to-child transmission, ARVs and Cesarean surgery have numerous risks and side effects. The side effects of ARV therapy range from unpleasant to life-threatening, including the following: nausea; vomiting; diarrhea; a painful and potentially debilitating condition called neuropathy that causes pain in the hands and feet; impaired functioning of vital organs such as the liver and the kidneys; bone marrow suppression; damage to the reproductive system; and increased risk of heart disease.¹⁴⁶ Patients taking ARVs may also develop resistance to them, which could reduce a woman’s treatment options when ARV therapy is needed for her own health.¹⁴⁷ Pregnant women who take ARVs for the sake of preventing transmission when their own health does not require ARV therapy may therefore shorten their own life as a result.

144 Joseph P. McGowan & Sanjiv S. Shah, *Prevention of Perinatal HIV Transmission During Pregnancy*, 46 J. ANTIMICROBIAL CHEMOTHERAPY 657, 658 (2000) (finding that perinatal HIV transmission was about 25.5% in a placebo group of pregnant women).

145 Dep’t of Health & Hum. Servs., Ctrs. for Disease Control & Prevention, *Achievements in Public Health: Reduction in Perinatal Transmission of HIV Infection—United States, 1985–2005*, 55 MORBIDITY & MORTALITY WKLY. REP. 592, 592 (2006) (“[R]eduction is attributed to routine HIV screening of pregnant women, use of antiretroviral . . . drugs . . . avoidance of breastfeeding, and use of elective [C]esarean delivery With these interventions, rates of HIV transmission during pregnancy, labor, or delivery from mothers infected with HIV have been reduced to less than 2% . . .”).

146 See Samantha Catherine Halem, Note, *At What Cost?: An Argument Against Mandatory AZT Treatment of HIV-Positive Women*, 32 HARV. C.R.-C.L. L. REV. 491, 494–95 (1997) (“There are significant side effects to taking AZT. Among these are bone marrow suppression, malaise, nausea, headaches, and occasional seizures.”); see also Kimberley M. Mutcherson, *No Way to Treat a Woman: Creating an Appropriate Standard for Resolving Medical Treatment Disputes Involving HIV-Positive Children*, 25 HARV. WOMEN’S L.J. 221, 230–31 (2002) (discussing the “significant drug side effects” that “range from annoying to aesthetically unpleasing to life-threatening”).

147 See Halem, *supra* note 146, at 501–02 (“[O]ne potential concern of pregnant women is the risk of developing an immunity to AZT, thus decreasing their long-term chance of survival.”); Mutcherson, *supra* note 146, at 231 (“A patient may derive benefits from beginning [ARV treatment] while her immune system is relatively strong, but she may later find that she has developed resistance to drugs that she needs more desperately as her disease progresses.”).

Cesarean surgeries come with increased risks to the mother, and these risks may be magnified for women living with HIV.¹⁴⁸

Prior to *Carhart*, courts had little legal justification to mandate ARVs or a Cesarean surgery over the objection of an HIV-positive pregnant woman in order to reduce risks of transmission. While *Roe* recognized a state interest in protecting fetal life, transmission of HIV is not equivalent to death; what is at issue is not death or even risk of death, but rather risk of the transmission of a serious, chronic disease. *Roe* and subsequent cases made clear that treatment could not be compelled where doing so would harm the health of the mother. Compelled treatment would therefore be prohibited in the cases where ARVs could cause debilitating side effects or cause a woman to build up resistance prematurely. This reasoning would also prevent courts from compelling Cesarean surgeries to prevent mother-to-child transmission.

Carhart's reasoning can easily be interpreted to shift the balance of state interests and empower the state to mandate treatment. Courts may use *Carhart's* purported state interests in promoting respect for the fetus and preventing pregnant women from making medical decisions they might regret to justify mandating treatment that will reduce the likelihood that a pregnant woman will transmit HIV to her fetus. Given the large degree of uncertainty about the effects ARVs may have on any given individual, courts may decide to err on the side of compelling treatment under *Carhart*; for the reasons stated in the previous subsection, courts may reach the same conclusion with regard to Cesarean surgeries.¹⁴⁹

3. Other Medical Decisions

In the context of fetal therapy, numerous additional medical decisions can be the source of state intervention, such as treatment for gestational diabetes, fetal drug therapies to prevent premature labor, and even the requirement that women undertake significant dietary changes where, in rare circumstances, diet might otherwise lead to

¹⁴⁸ See *Amana*, *supra* note 77, at 60 (“[S]ome data indicate that the risk of complications [from c-sections] in HIV positive women may be higher than in negative women. . . . [C]esarean delivery . . . is associated with significant morbidity in infected women.”).

¹⁴⁹ While ARV therapy is a long-term treatment plan, rather than a single procedure, courts could order women to undergo treatment and report regularly to ensure their adherence much in the same way courts order and monitor drug rehabilitation. Doing so would force women not only to undergo invasive drug therapy and endure its side effects, but also to undergo constant monitoring to ensure compliance.

severe birth defects.¹⁵⁰ As new fetal therapy techniques are discovered, more occasions for intervening in the medical decisions of pregnant women are likely to arise.

In addition to fetal therapy decisions, more indirect treatment decisions may also raise the ire of the state. For example, physicians and courts may view the decision to undergo a home birth as unacceptably risky to the fetus, particularly in a high-risk pregnancy. In *Pemberton*, the court ordered a woman attempting a home birth to return to a hospital and submit to surgical intervention against her will.¹⁵¹ Similarly, failure to undertake bed rest can, in some cases, lead to premature labor and fetal demise.¹⁵² Indeed, in a recent unreported decision, a Florida county court ordered, at the state's request, that a woman in her twenty-fifth week of pregnancy remain hospitalized and confined to bed rest and submit to any treatment, including Cesarean surgery, that her physicians deemed necessary "to preserve the life and health of [her] unborn child."¹⁵³

V. THE IMPLICATIONS OF COMPELLED MEDICAL TREATMENT OF PREGNANT WOMEN

A. *Doctrinal Implications: Women as a "Special Class of Persons"*

1. *Introduction*

Expanding state power to compel treatment of pregnant women has significant constitutional law implications. Specifically, compelled treatment infringes on both constitutional liberty and equality guarantees by designating pregnant women as a special class of indi-

¹⁵⁰ See, e.g., Berkowitz, *supra* note 125, at 1220 (discussing the many voluntary procedures pregnant women undergo for the health of their babies); John A. Robertson & Joseph D. Schulman, *Pregnancy and Prenatal Harm to Offspring: The Case of Mothers with PKU*, 17 HASTINGS CENTER REP. 23, 23 (1987) ("The need for public policies to prevent avoidable prenatal injuries has arisen in several different contexts: prenatal medical or surgical treatment and [C]esarean section; prenatal abuse of alcohol, heroin, and cocaine; exclusion from workplaces posing prenatal hazards to offspring; and prenatal transmission of herpes and syphilis.").

¹⁵¹ See *Pemberton v. Tallahassee Mem'l Reg'l Med. Ctr.*, 66 F. Supp. 2d 1247, 1249–50 (N.D. Fla. 1999) (holding that the order compelling the pregnant woman to submit to a cesarean section against her will did not violate the woman's substantive constitutional rights and granting summary judgment to the hospital).

¹⁵² See Berkowitz, *supra* note 125, at 1220 (noting that pregnant women may undertake bed rest for preterm contractions).

¹⁵³ *In re Unborn Child of Samantha Burton*, No. 2009 CA 1167 (Fla. Cir. Ct. Mar. 27, 2009); see Brief of ACLU et al. as Amici Curiae in Support of Appellant, *Burton v. Florida* (No. ID09-1958) (Fla. Dist. Ct. App. Jul. 31, 2009). The case is currently pending appeal.

viduals with limited autonomy. The troubling nature of compelled medical treatment can be seen most clearly and addressed most effectively by an approach that recognizes the intertwined nature of its liberty and equality implications.

2. *Compelled Treatment's Implications for Women's Liberty*

Compelling medical treatment of pregnant women deprives women of their right to bodily autonomy. While many may argue that a woman who decides to carry her pregnancy to term assumes a moral duty to her fetus,¹⁵⁴ the law does not impose every moral duty as a legal duty.¹⁵⁵ For example, a parent cannot be legally required to provide a life-saving bone marrow transplant for her child.¹⁵⁶ While a parent may have a moral obligation to undergo the medical treatment, courts may not compel it because doing so would infringe on the parent's right to refuse medical treatment.

Compelled medical treatment of pregnant women excludes pregnant women from the standard medical model of counseling and informed consent.¹⁵⁷ This cannot be justified by the state's interest in

154 See, e.g., Robertson & Schulman, *supra* note 150, at 24–25 (arguing that women who decide to carry a child to term assume moral obligations to undergo medical treatment to ensure the child's health); see also Merrick, *supra* note 100, at 68–69 (“[I]t is morally irresponsible to voluntarily bring an infant into the world but refuse to make reasonable efforts to allow that child to be born healthy.”) (internal quotation marks omitted).

155 See Grizzi, *supra* note 77, at 498 (observing that establishing a duty of a mother to her fetus in certain contexts could only be grounded on “a pronounced extension of duty principles in prior case law”).

156 See MEREDITH, *supra* note 72, at 28–29 (noting that no parent has ever been forced to undergo surgery to save the life of a child); Amana, *supra* note 77, at 56 (“[A] mother is not legally required to donate a kidney if her child needs it; nor would an identical twin be forced to donate bone marrow to a sibling in need.”); Annas, *Forced Cesareans*, *supra* note 101, at 17 (“No mother has ever been legally required to undergo . . . bone marrow . . . transplant[] to save the life of her dying child.”); Howard Minkoff & Lynn M. Paltrow, *Melissa Rowland and the Rights of Pregnant Women*, 104 *OBSTETRICS & GYNECOLOGY* 1234, 1235 (2004) (observing that courts have ruled that relatives cannot be compelled to submit to bone marrow transplants); cf. *McFall v. Shimp*, 10 Pa. D. & C.3d 90, 90–92 (1978) (holding that a terminally ill patient has no right to require a relative to submit to a life-saving transplant).

157 See Goldberg, *supra* note 72, at 620 (“Requiring women to undergo unwanted treatment for the sake of their fetuses would deprive women of the liberty of *choosing* a course of action, which choice is the crux of the informed consent decision.”); Rothman, *supra* note 104, at 25 (“Competent adults in this society have the right to refuse medical treatment, even when it is believed to be life-saving.”); see also Gallagher, *supra* note 76, at 57–58 (“Until a child is brought forth from the woman's body, our relationship with it must be mediated by her.”); cf. Minkoff & Paltrow, *Rights of Unborn Children*, *supra* note 77, at 27 (arguing that the Unborn Child Pain Awareness Act, which requires physicians to provide women seeking abortions with scientifically questionable information about the pain a fetus might feel during the abortion “makes women and abortion providers a unique class,

fetal life, much less by the more amorphous and questionable interest in expressing respect for fetal life identified in *Carhart*. Society's interest in fetal life may be deep-rooted and profound, but, as Sylvia Law has noted, "the sustenance the fetus needs is not society's to give. It can only be provided by a particular pregnant woman."¹⁵⁸ Forcing a woman to undergo a medical treatment to further societal interests allows the state to determine for a woman what risks she must assume for the benefit of the fetus and physically appropriates her body to serve the state's interest in the fetus.¹⁵⁹ Such appropriation is so abhorrent to the concept of individual liberty protected by the Constitution that courts have denied the state's ability to demand similar sacrifices in the context of saving the lives of third parties or furthering a criminal investigation.¹⁶⁰

Carhart gives credence to an additional justification for compelled medical treatment that has gained popularity among anti-choice advocates in recent years: namely, that curtailing women's autonomy in this way benefits women and is necessary to protect their health and well-being.¹⁶¹ This justification posits that a woman will come to regret a decision she makes before birth that results in harm to the child she carries and that this profound regret will cause her physical and psychological harm; denying her this choice is therefore necessary to protect her health.¹⁶²

Such reasoning curtails women's liberty by assuming, and reinforcing, that pregnant women have limited agency. Some proponents of the women-protective rationale argue that a woman cannot

excluded from the standard medical model in which counseling is provided by a physician who uses professional judgment to determine what a reasonable individual would need in order to make an informed choice about a procedure").

158 Sylvia A. Law, *Rethinking Sex and the Constitution*, 132 U. PA. L. REV. 955, 1027 (1984).

159 See Gallagher, *supra* note 76, at 42 ("[F]etal rights may be predicated upon a new set of parental duties . . . [T]he state is virtually required to appropriate the woman's body and life to the affirmative service of the fetus. The pregnant woman, no longer treated as the virtual chattel of her husband, instead becomes the subject of the state . . .").

160 See *Winston v. Lee*, 470 U.S. 753, 766 (1985) (holding that the state cannot compel surgery in order to obtain evidence of a crime without compelling circumstances); *McFall*, 10 Pa. D. & C.3d at 91-92 (refusing to compel a bone marrow transplant to save the life of the potential donor's cousin).

161 For detailed discussions of the women-protective argument, see Siegel, *New Politics*, *supra* note 59, at 992-93 (outlining the spread and use of the woman-protective antiabortion argument); Siegel, *Right's Reasons*, *supra* note 5, at 1641 (discussing the woman-protective rationale for restricting abortion). See generally Turner, *supra* note 5 (discussing the rationale of the majority in *Carhart*).

162 See Siegel, *New Politics*, *supra* note 59, at 1006-29 (discussing the rationale of South Dakota's abortion ban); Siegel, *Right's Reasons*, *supra* note 5, at 1651-56 (providing examples of the women-protective argument in the campaign to ban abortion in South Dakota).

exercise informed consent in a manner that causes harm to the child she carries because it goes against her very nature; thus such decisions must have been the result of coercion, duress, lack of information, or some other interference with the proper exercise of informed consent.¹⁶³ The women-protective argument accepted in *Carhart* deprives her of this decision while simultaneously arguing that it is protecting her right to informed consent; it makes the decision she would have made had she been truly exercising informed consent.¹⁶⁴ It presumes that women are incapable of making informed decisions about their pregnancy that contradict what the state has presumed to be their nature;¹⁶⁵ thus, the state must make these decisions for them.

While all such infringements on women's autonomy are troubling,¹⁶⁶ they are particularly so where the state's decision may come at

163 See Siegel, *New Politics*, *supra* note 59, at 1008–10 (noting that supporters of woman-protective abortion restrictions suggest “that no matter what a clinic tells a [pregnant] client or however great [the client’s] expertise, the abortion procedure *inherently* lacks consent because a pregnant woman cannot make a truly informed decision to give up a relationship with a child until *after* the child is born”).

164 See *id.* (“[W]omen making a decision to abort a pregnancy cannot knowingly consent to the procedure unless they are in the position of women making a decision to give up a child for adoption, and have the opportunity to reconsider their decision *after* the child’s birth.”).

165 See Siegel, *Right’s Reasons*, *supra* note 5, at 1674–75 (observing that the “pro-woman” strategy rests on the idea that “[t]he best interests of the child and the mother are *always* joined—even if the mother does not initially realize it, and even if she needs a tremendous amount of love and help to see it”); see also Joanna Grossman & Linda McClain, *Gonzales v. Carhart: How the Supreme Court’s Validation of the Federal Partial-Birth Abortion Ban Act Affects Women’s Constitutional Liberty and Equality*, FINDLAW (May 7, 2007), http://writ.news.findlaw.com/commentary/20070507_mcclain.html (noting *Carhart*’s focus on “protecting women from ill-considered decisions” and the psychologically harmful effects of the decision to abort). Overriding a pregnant woman’s refusal of medical treatment compels her to conform to what the state defines as her proper role as a mother: to nurture and protect the fetus she carries as best she can. See Ian Vandewalker, Note, *Taking the Baby Before It’s Born: Termination of the Parental Rights of Women Who Use Illegal Drugs While Pregnant*, 32 N.Y.U. REV. L. & SOC. CHANGE 423, 429–32 (2008) (arguing that patriarchal views define motherhood as a woman’s most important role, and “misconduct during pregnancy is taken as proof that the woman fails the model of the ideal mother”); cf. Johnson, *supra* note 88, at 612 (“If the state were to deprive women of their right to choose to have an abortion, it would impose on women a duty to bear unwanted children; by creating fetal rights susceptible to use against pregnant women, the state compels women who desire to bear children to reorganize their lives in accordance with judicially-defined norms of behavior.”). This is also in stark contrast to the language of *Casey*, which warns against the state imposing its moral views on the roles of mothers. See *infra* note 207 and accompanying text.

166 Indeed, the health exception itself highlights the value judgments courts have made about women’s roles as potential mothers. As Reva Siegel argues, “more than any sex-based legislation the Court has reviewed in the modern era, the therapeutic exception [to abortion regulation] graphically defines women as childbearers” because, by allowing the

the expense of the pregnant woman's health. In these circumstances, the state requires a woman not only to sacrifice her autonomy, but also her well-being. She must subordinate her medical needs to the whim of the state and, in some situations, literally allow herself to be cut into, sutured, or injected with medication causing debilitating side effects. She must risk complications, short-term and long-term side effects, and even death. In one case, the court's decision to compel treatment actually hastened a woman's death before a higher court overturned it.¹⁶⁷ *Carhart* potentially expands the state's license to devalue and infringe upon women's autonomy by allowing the state to subordinate women's autonomy to the state's interests—not only in fetal life but also in merely expressing respect for fetal life—even where women's health is compromised.

3. *Compelled Treatment's Implications for Women's Equality*

This infringement on autonomy and the underlying assumptions used to justify it also have significant constitutional implications for women's equality. Compelled treatment cases, like abortion cases, concern burdens that only women must bear, and assumptions about their unique role in society as child bearers. Compelling women to undergo treatment for the sake of the fetus sets them apart as a separate class of individuals with limited autonomy rights. This "unique class" view is perhaps best illustrated by Judge Belson's dissenting opinion in *In re A.C.*¹⁶⁸ In *A.C.*, the District of Columbia Court of Appeals held that a compelled Cesarean surgery that hastened a

state to regulate abortion except where doing so would threaten the life or health of the mother, the state defines the pregnant women's liberty interest in abortion as merely one of "brute physical survival" and ignores many of the social, intellectual, or emotional stakes women may have in avoiding becoming parents. See Reva Siegel, *Reasoning From the Body: A Historical Perspective on Abortion Regulation and Questions of Equal Protection*, 44 STAN. L. REV. 261, 365 (1992) [hereinafter Siegel, *Reasoning*]. In the context of compelled medical treatment, some court's willingness to compel treatment based on the intrusiveness of the treatment or the harm it might do the mother reflects this reasoning and demonstrates a lack of willingness to consider seriously a woman's interests in controlling her bodily autonomy unless she can demonstrate sufficient physical harm will result from compelled treatment.

¹⁶⁷ See *In re A.C.*, 533 A.2d 611, 613–15, 617 (D.C. 1987) ("[The Court] well know[s] that we may have shortened [the pregnant mother's] life span by a few hours."), *vacated* 573 A.2d 1235 (D.C. 1990); Annas, *Angela C.*, *supra* note 112, at 24 ("Mrs. C., now confronted with both recovery from [a Cesarean section] and the knowledge of her child's death, died approximately two days [after the court-ordered Cesarean section].").

¹⁶⁸ 573 A.2d 1235, 1253–56 (1990) (Belson, J., concurring in part and dissenting in part).

woman's death violated her rights.¹⁶⁹ Dissenting in part, Judge Belson argued:

[A]woman who carries a child to viability is in fact a member of a unique category of persons. Her circumstances differ fundamentally from those of other potential patients for medical procedures that will aid another person, for example, a potential donor of bone marrow for transplant. This is so because she has undertaken to bear another human being, and has carried an unborn child to viability. . . . [T]he expectant mother has placed herself in a special class of persons who are bringing another person into existence, and upon whom that other person's life is totally dependent.¹⁷⁰

What Judge Belson refers to as a "special class" is, in reality, second-class citizenship that is unique to women.¹⁷¹ The state, acting on behalf of the fetus or the alleged interests of the woman herself, restricts a woman's ability to control her body in a context that is particular to women: childbearing.¹⁷² While not all women can or will become pregnant, women are unique in their capacity to become pregnant and give birth. This uniqueness comes with significant burdens both biological—such as burdens on a woman's health and mobility—and constructed by society—such as burdens on a woman's independence and ability to earn income.¹⁷³ Thus, reproductive decisions concern both women's autonomy and their ability to participate

169 See *id.* at 1253.

170 See *id.* at 1256.

171 See Mackenzie et al., *supra* note 104, at 25 (mandating medical treatment of pregnant women for the benefit of the fetus raises the "danger of creating of pregnant women a second class of citizen, without basic legal rights of bodily integrity and self-determination").

172 See, e.g., Gallagher, *supra* note 76, at 43 (noting that the "fetal rights theory" would support making a woman subordinate from the early stages of pregnancy); Law, *supra* note 158, at 955–56 ("[A]lthough men may be disadvantaged by their relatively minor role in reproduction, we have constructed a society in which men are advantaged, relative to women, in important material and spiritual ways."); Siegel, *Reasoning*, *supra* note 166, at 269 ("[T]he capacity to gestate distinguishes the sexes *socially*: Judgments about women's capacity to bear children play a key role in social definitions of gender roles and thus in the social logic of 'discrimination based on gender as such.'").

173 See Law, *supra* note 158, at 956 ("Pregnancy and childbirth are . . . burdensome to health, mobility, independence, and sometimes to life itself . . ."); Reva B. Siegel, *Sex Equality Arguments for Reproductive Rights: Their Critical Basis and Evolving Constitutional Expression*, 56 EMORY L.J. 815, 817–20 (2007) [hereinafter Siegel, *Sex Equality Arguments*] (outlining arguments of a "sex equality" approach to reproductive rights, which gives "attention to the social as well as physical aspects of reproductive relations"); see also Siegel, *Reasoning*, *supra* note 166, at 274 (noting that "[b]ecause *Roe* and its progeny treat pregnancy as a physiological problem, they obscure the extent to which the community that would regulate a woman's reproductive choices is in fact implicated in them, responsible for defining motherhood in ways that impose material deprivations and dignitary injuries on those who perform its work").

as full members of society equal to men.¹⁷⁴ Compelling medical treatment of women curtails this significantly by designating women as a class of citizens with limited abilities to make decisions that impact both their own bodies and their place in society.

The designation of women as a special class of citizens because of their reproductive capacity is rooted in and reinforces traditional stereotypes about women's social roles and capacities. Early Supreme Court cases, written before modern equal protection jurisprudence, contain paternalistic language affirming the state's right to regulate women's roles in society because of their ability to have children. In *Bradwell v. State*, an 1873 case in which the Supreme Court upheld a statute prohibiting women from becoming members of the bar, Justice Bradley justified the statute on the grounds that "[t]he natural and proper timidity and delicacy which belongs to the female sex evidently unfits it for many of the occupations of civil life. . . . The paramount destiny and mission of woman are to fulfill the noble and benign offices of wife and mother."¹⁷⁵ In 1908, the Court upheld legislation limiting the number of hours women could work, in part because "healthy mothers are essential to vigorous offspring, the physical well-being of woman becomes an object of public interest and care in order to preserve the strength and vigor of the race."¹⁷⁶

Compelled medical treatment of pregnant women continues this reasoning¹⁷⁷ by reinforcing women's traditional role as nurturers and

174 See Ruth Bader Ginsburg, *Some Thoughts on Autonomy and Equality in Relation to Roe v. Wade*, 63 N.C. L. Rev. 375, 383 (1985) ("Also in the balance [when discussing abortion rights] is a woman's autonomous charge of her full life's course . . . her ability to stand in relation to man, society, and the state as an independent, self-sustaining, equal citizen."); Law, *supra* note 158, at 956 ("Pregnancy and childbirth are also burdensome to health, mobility, independence, and sometimes to life itself, and women are profoundly disadvantaged in that they alone bear these burdens.").

175 83 U.S. (16 Wall.) 130, 141 (1872) (Bradley, J., concurring).

176 *Muller v. Oregon*, 208 U.S. 412, 421 (1908). *Muller* was decided only a few years after the Supreme Court struck down protective labor legislation that applied to male workers, arguing that "limiting the hours in which grown and intelligent men may labor to earn their living" failed to recognize men's constitutional right to freedom of contract. *Lochner v. New York*, 198 U.S. 45, 61–62 (1905); see also Jill Elaine Hasday, *Protecting Them From Themselves: The Persistence of Mutual Benefits Arguments for Sex and Race Inequality*, 84 N.Y.U. L. REV. 1464, 1502–03 (2009) (comparing *Lochner* and *Muller* in the context of women-protective labor laws).

177 While this article focuses on the decisions of competent pregnant women in the context of medical treatment, the state has limited the autonomy of pregnant women based on their pregnancy in numerous other contexts. For example, two-thirds of states either explicitly do not recognize or make it more difficult to enforce an advance directive if the patient is pregnant. Daniel Sperling, *Do Pregnant Women Have (Living) Will?*, 8 J. HEALTH CARE L. & POLY 331, 333–34 (2005) (discussing regulation of pregnancy clauses throughout the United States). Many states also provide harsher penalties for drug use

caregivers, whose first priority must be the well-being of others, particularly their children. Tellingly, courts do not intervene where a mother is seeking to undergo surgery that might compromise her health for the sake of the fetus, even though ostensibly the state has a vested interest in preserving the health and life of the woman in those circumstances just as it has an interest in preserving fetal life. Women's decisions in these situations, however, are not questioned because such a decision comports with stereotypes about women's roles as mothers and their natural inclination to protect their children. The women-protective argument embraced in *Carhart* makes this rationale explicit, referencing the bond of love women are presumed to feel for their children as a unique part of women's nature, and using this to justify imposing restrictions on their autonomy.¹⁷⁸ Such arguments presume women are "impaired in their capacity to make life plans to the extent that their life decisions deviate from role expectations concerning women's obligations as mothers."¹⁷⁹

Modern Supreme Court equal protection jurisprudence rejects traditional notions of women's roles as a basis for state action. While historically federal and state law often discriminated against women and justified such discrimination with traditional notions of differentiated family roles, this reasoning was rejected in a line of cases beginning in the 1970s which redefined sex discrimination jurisprudence and rejected sex-based state action premised on traditional sex roles.¹⁸⁰ Such state action was rejected even where such actions pur-

during pregnancy. See generally, Vandewalker, *supra* note 165, at 423 (noting that several states have "made the use of illegal drugs while pregnant a ground for terminating a mother's parental rights).

178 See *Gonzales v. Carhart*, 550 U.S. 124, 159 (2007) ("Respect for human life finds an ultimate expression in the bond of love the mother has for her child. The [Partial Birth Abortion] Act recognizes this reality as well."); see also Grossman & McClain, *supra* note 165 ("[I]n *Carhart*, Justice Kennedy . . . describes abortion as a 'difficult and a painful moral decision' and declares that the [Partial Birth Abortion Act] recognizes the 'reality' that 'respect for life finds an ultimate expression in the bond of love the mother has for her child.'"); Hasday, *supra* note 176, at 1485–86 ("In *Carhart* . . . the argument that anti-abortion laws protect women from regret has two central premises. The first premise was that women's fundamental nature was maternal."); Siegel, *Dignity*, *supra* note 71, at 1792.

179 Siegel, *New Politics*, *supra* note 59, at 1036.

180 In *Reed v. Reed*, the Court struck down a law in which men were preferred to women for estate administration purposes. 404 U.S. 71, 77 (1971) ("By providing dissimilar treatment for men and women who are . . . similarly situated, the [law] violates the Equal Protection Clause."). Since *Reed*, the Supreme Court has consistently struck down sex-based classifications justified by traditional stereotypes about women's roles as caretakers and men's roles as breadwinners. See Siegel, *New Politics*, *supra* note 59, at 995 ("In a series of equal protection cases . . . in the 1970s, the Court struck down sex-based laws premised on the male breadwinner/female caregiver model."). The Court held that military fringe benefits, social security benefits, welfare assistance, and workers' compensation all must

portedly protect women;¹⁸¹ in *Mississippi University for Women v. Hogan*, for example, the Court held that a policy of excluding males from a state nursing school violated the equal protection clause, stating that:

Care must be taken in ascertaining whether the statutory objective itself reflects archaic and stereotypic notions. Thus, if the statutory objective is to exclude or “protect” members of one gender because they are presumed to suffer from an inherent handicap or to be innately inferior, the objective itself is illegitimate.¹⁸²

Despite this strong language, the Court has tailored equal protection jurisprudence to provide little protection against state actions that enforce these stereotypes in the realm of reproduction and pregnancy. In *Geduldig v. Aiello*, the Court upheld a state operated

be guaranteed to women to the same extent they are guaranteed to men. See *Wengler v. Druggists Mut. Ins. Co.*, 446 U.S. 142 (1980) (striking down Missouri workers’ compensation laws); *Califano v. Westcott*, 443 U.S. 76 (1979) (finding the Aid to Families with Dependent Children Act unconstitutional because it provided benefits only when the father becomes unemployed); *Califano v. Goldfarb*, 430 U.S. 199 (1977) (holding that the Social Security Act’s survivors’ benefits section was unconstitutional because it awarded female workers’ spouses less protection than male workers’ spouses); *Weinberger v. Wiesenfeld*, 420 U.S. 636 (1975) (invalidating a gender-based distinction mandated by a section of the Social Security Act); *Frontiero v. Richardson*, 411 U.S. 677 (1973) (concluding that sections of a statute awarding military fringe benefits violated the Due Process Clause of the Fifth Amendment). Also offensive to the notion of sex equality was a Louisiana law that designated the husband as the head of the household with the unilateral right to dispose of jointly owned property. See *Kirchberg v. Feenstra*, 450 U.S. 455, 456 (1981) (concluding that the Louisiana statute violates the Equal Protection Clause of the Fourteenth Amendment); Reva B. Siegel, *Gender and the United States Constitution: Equal Protection, Privacy, and Federalism*, in *THE GENDER OF CONSTITUTIONAL JURISPRUDENCE* 306, 314–18 (Beverly Baines & Ruth Rubio-Marin eds., 2005) [hereinafter Siegel, *Gender and the Constitution*] (“Modern equal protection law thus views sex distinctions in public law as presumptively unconstitutional. In numerous cases . . . the Court has invalidated a variety of laws that drew distinctions on the basis of sex.”); see also Ginsburg, *supra* note 174, at 377–80 (outlining the 1970s gender discrimination cases).

181 See Siegel, *New Politics*, *supra* note 59, at 995–96 (“The Court has also emphasized that the Constitution’s prohibition on laws enforcing gender-differentiated family roles extends to laws that purport to protect women.”). Striking down an alimony statute that allocated benefits differently based on sex, the Court rejected the state’s ability to make laws with the objective of enforcing a family model “under which the wife plays a dependent role” and held that:

[T]he old notion that generally it is the man’s primary responsibility to provide a home and its essentials, can no longer justify a statute that discriminates on the basis of gender. . . .

. . . .

Legislative classifications which distribute benefits and burdens on the basis of gender carry the inherent risk of reinforcing the stereotypes about the proper place of women and their need for special protection.

Orr v. Orr, 440 U.S. 268, 279–80, 283 (1979) (internal quotation marks and citations omitted).

182 458 U.S. 718, 725 (1982); see also Siegel, *New Politics*, *supra* note 59, at 995–96 (“Since . . . 1971 . . . the Court has never sustained laws having the objective or purpose of preserving or perpetuating gender-differentiated family roles.”).

disability income protection plan that excluded pregnancy, holding that in the context of equal protection, discrimination that is based on biological differences is not sex-based discrimination because the sexes are not “similarly situated” in that context.¹⁸³ The Court reasoned that pregnancy discrimination does not involve “gender as such,” but rather “an objectively identifiable physical condition with unique characteristics.”¹⁸⁴ The Court distinguished pregnancy discrimination from sex-based discrimination on the grounds that, while all pregnant persons are female, the non-pregnant classification contains both males and females.¹⁸⁵ Pregnancy-based classifications were therefore shielded from the heightened equal protection scrutiny reserved for sex-based classifications “[a]bsent a showing that distinctions involving pregnancy are mere pretexts designed to effect an invidious discrimination against the members of one sex or the other.”¹⁸⁶

The Court continued this line of reasoning throughout the 1980s, repeatedly upholding reproductive-based distinctions between men and women on the ground that the sexes are not similarly situated with regard to their ability to become pregnant. In *Michael M. v. Superior Court*, the Court upheld a statutory rape law that penalized only

183 417 U.S. 484, 496–97 n.20 (1974) (“Absent a showing that distinctions involving pregnancy are mere pretexts designed to effect an invidious discrimination against the members of one sex or the other, lawmakers are constitutionally free to include or exclude pregnancy from the coverage of legislation such as this on any reasonable basis, just as with respect to any other physical condition.”); *see also Developments in the Law—Medical Technology and the Law*, 103 HARV. L. REV. 1519, 1581–82 (1990) [hereinafter *Developments in Law—Medical Technology*] (“The Supreme Court . . . has been skeptical of gender discrimination claims based on pregnancy. Because the Court tends to see the disparate treatment as falling between the pregnant and the nonpregnant, rather than between men and women, it is unlikely to find an equal protection violation.”); Johnsen, *supra* note 88, at 620–22 (“Current doctrine . . . offers women no protection against discrimination that is based on real biological differences between women and men, and in fact denies that such discrimination is sex-based.”); Levine, *supra* note 80, at 291–92 (“[T]he Supreme Court has held that because of the unique nature of pregnancy and the biological differences between men and women, pregnant women and men are not similarly situated.”); Siegel, *Reasoning*, *supra* note 166, at 268–69 (characterizing *Geduldig* as holding “that pregnancy classifications are not sex-based”). Congress subsequently abrogated *Geduldig* by passing the Pregnancy Discrimination Act of 1978, which includes pregnancy classifications within the definition of gender discrimination for the purposes of Title VII. Pregnancy discrimination is therefore unlawful in the context of employment. *See* 42 U.S.C. § 2000e(k) (1982) (“The terms ‘because of sex’ or ‘on the basis of sex’ include, but are not limited to, because of or on the basis of pregnancy.”).

184 *Geduldig*, 417 U.S. at 496 n.20.

185 *See id.* (“The California insurance program does not exclude anyone from benefit eligibility because of gender but merely removes one physical condition—pregnancy—from the list of compensable disabilities.”).

186 *See id.*

men, arguing that the statute upheld the state interest in protecting teen pregnancy, and only teenage females are capable of becoming pregnant.¹⁸⁷ The Court also upheld more stringent standards to determine the citizenship status of children born abroad and outside of marriage to American men than those born abroad and outside of marriage to American women because “[f]athers and mothers are not similarly situated with regard to the proof of biological parenthood.”¹⁸⁸ In *Bray v. Alexandria Women’s Health Clinic*, the Court held that abortion protesters obstructing access to a clinic were not targeting women as a class, again distinguishing sex-based classification from pregnancy-based classification.¹⁸⁹

The Supreme Court has also foreclosed the argument that discrimination in the context of reproductive rights violates the equal protection clause because its *impact* is to discriminate against women. The Court has interpreted the equal protection clause to apply only to actions that have discriminatory intent.¹⁹⁰ State action that disparately impacts women because of their ability to become pregnant is only considered sex-based discrimination if it can be shown that the action was taken with the invidious purpose of discriminating against women as a class; otherwise, it is subject only to rational basis scrutiny.¹⁹¹

The development of equal protection jurisprudence in a way that essentially forecloses most equal protection-based challenges in compelled medical treatment cases unduly protects the very type of discrimination the equal protection clause should prohibit. In the context of women it is the ability to bear children that has been the source of state limitations on their autonomy, whether in the context of their employment or their right to choose and refuse medical

187 450 U.S. 464, 471 (1981) (“Of particular concern to the State is that approximately half of all teenage pregnancies end in abortion. . . . Only women may become pregnant.”).

188 Tuan Anh Nguyen v. INS, 533 U.S. 53, 63 (2001).

189 506 U.S. 263, 267–78 (1993) (“[C]laim that petitioners’ opposition to abortion reflects an animus against women in general must be rejected.”).

190 *See* *Washington v. Davis*, 426 U.S. 229, 239 (1976) (“[O]ur cases have not embraced the proposition that a law or other official act, without regard to whether it reflects a racially discriminatory purpose, is unconstitutional *solely* because it has a racially disproportionate impact.”); *see also* *Levine*, *supra* note 80, at 291–92 (“[T]he classification in court-ordered [C]esarean cases is not the result of discriminatory purpose, but rather, discriminatory effect . . . [which], in and of itself, is not sufficient to establish a violation of equal protection.”).

191 Pregnancy discrimination may be challenged in the context of employment under Title VII. *See supra* note 183.

treatment.¹⁹² It is this very historical discrimination that the *Casey* court rejected in the context of abortion¹⁹³ and that Justice Ginsburg warned that the *Carhart* decision reinvigorates.¹⁹⁴ Several scholars have criticized the chasm between reproductive rights jurisprudence and equal protection jurisprudence, and have proposed alternative ways to approach the equal protection doctrine that would account for the equality implications of infringements on women's reproductive rights.¹⁹⁵ For example, Sylvia Law proposes that courts scrutinize laws to ensure that the law has no significant impact in perpetuating "the oppression of women or culturally imposed sex-role constraints on individual freedom."¹⁹⁶ If the law has this impact, Law proposes that it must be "justified as the best means of serving a compelling state purpose."¹⁹⁷

Such an approach to equal protection would more fully address the troubling implications compelled medical treatment of pregnant women has for women's equality and would make it more difficult for courts to compel medical treatment without running afoul of the equal protection clause. Under Law's analysis, compelled medical treatment would be subject to strict scrutiny because it has a significant impact in perpetuating the oppression of women and culturally

192 See *supra* notes 174–179 and accompanying text; see also Johnsen, *supra* note 88, at 623 ("State and social regulations concerning reproductive differences have served to create and reinforce separate and unequal sex-segregated spheres in the United States."); Law, *supra* note 158, at 1009 (noting "how central state regulation of biology has been to the subjugation of women, the normal presumption of constitutionality").

193 See *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 851–52 (1992) ("Though abortion is conduct, it does not follow that the State is entitled to proscribe it in all instances.").

194 See *supra* note 46 and accompanying text.

195 See, e.g., Johnsen, *supra* note 88, at 622 ("By dismissing claims of sex discrimination on the grounds that the sexes are differently situated in matters of reproduction, the Court rationalizes differential treatment of the sexes as legitimate and as merely 'reflecting' the fact of biological difference."); Law, *supra* note 158, at 955 (attempting "to articulate a stronger constitutional concept of sex-based equality than that which currently exists"); Siegel, *Reasoning*, *supra* note 166, at 268–71 (criticizing the Court's decision in *Geduldig* and subsequent decisions based on similar reasoning); Kenji Yoshino, *Covering*, 111 YALE L.J. 769, 913–15 (2002) ("The simple statement [in *Geduldig*] that the Court does not recognize pregnancy discrimination as sex discrimination should be sufficient to demonstrate the troubling narrowness of the Court's definition of sex for the purposes of equal protection. Closer examination of the sex discrimination jurisprudence, however, reveals an even more disturbing tension in the Court's analysis.").

196 See Law, *supra* note 158, at 1008–09; see also *Developments in Law—Medical Technology*, *supra* note 183, at 1582 ("Sylvia Law proposes an alternative approach to equal protection that would eliminate the presumption of constitutionality attached to laws based on real biological differences."); Johnsen, *supra* note 88, at 624 (stating that "[e]qual protection doctrine should incorporate the approach advocated by Professor Sylvia Law").

197 See Law, *supra* note 158, at 1009.

imposed sex-role constraints on their individual freedom. Treatment could only be compelled if it were the best means of serving a compelling state interest. Under current abortion jurisprudence, the state's interest in fetal life becomes compelling after viability; thus, treatment could only be compelled if it could be shown that it was the best means of preserving fetal life after viability.

However, even a more robust equal protection analysis for reproductive rights would be unlikely to provide a complete analysis of the troubling implications of compelled medical treatment. Analyzing compelled treatment as an equal protection violation alone cannot fully realize its infringements on a woman's liberty just as viewing compelled treatment only as an infringement on a woman's liberty fails to fully realize its implications for women's equality.

A complete view of the implications of compelled medical treatment requires acknowledgement of its affect on both the liberty and equality of women. The next subsection discusses how these two interests intertwine to form a hybrid claim based on dignity and how compelled medical treatment violates the dignity of women.

4. *Compelled Treatment and Women's Dignity*

The previous two subsections discussed the liberty and equality implications of compelled medical treatment of pregnant women and how approaches that distinguish and separate these two interests fail to account adequately for the full harm caused by compelled medical treatment. This subsection argues that an approach that recognizes the interdependent nature of these two interests can fully recognize and protect pregnant women's reproductive rights in general and their right to avoid compelled treatment in particular.

Compelled medical treatment of pregnant women distinguishes women as a "special class" with limited autonomy, infringing on both their liberty and equality interests. Compelled medical treatment of pregnant women implicates women's liberty by abridging their ability to control their own bodies; in doing so, it burdens women in ways men are not burdened and both relies upon and reinforces gender stereotypes about women's role as mothers. In this way, liberty and equality interests are inexorably intertwined in what Laurence Tribe has deemed a "double helix."¹⁹⁸ This double helix is, in essence, about protecting the dignity of autonomous decisionmaking and pro-

¹⁹⁸ Laurence H. Tribe, *Lawrence v. Texas: The "Fundamental Right" that Dare not Speak its Name*, 117 HARV. L. REV. 1893, 1898 (2004).

protecting individuals from the subordination of dignity in a way that designates them as second-class citizens.¹⁹⁹

The Supreme Court's decision in *Lawrence v. Texas* demonstrates the double helix approach and provides insight into the troubling implications of compelled medical treatment.²⁰⁰ In *Lawrence*, the Supreme Court held that a Texas statute that outlawed same-sex sodomy was unconstitutional, overturning its previous decision in *Bowers v. Hardwick*.²⁰¹ Justice Kennedy's opinion cited decisions in which the Court recognized the right to privacy in personal relationships, advocating for the right of same-sex couples to the same privacy in intimate relationships: "Persons in a homosexual relationship may seek autonomy for these purposes, just as heterosexual persons do."²⁰² However, the decision did not stop there—it recognized and relied upon the interrelated nature of liberty and equality: "Equality of treatment and the due process right to demand respect for conduct protected by the substantive guarantee of liberty are linked in important respects, and a decision on the latter point advances both interests."²⁰³ *Lawrence* held that the Texas statute was unconstitutional, not because there was a specific fundamental right to same-sex sodomy, but because of the statute's troubling implications for the rights of gay individuals. The statute essentially criminalized same-sex sexual relationships, infringing on the liberty of individuals to choose and pursue intimate relationships; in doing so, the statute stigmatized these relationships and all gay individuals, designating them as second-class citizens.²⁰⁴

The Court's analysis in *Lawrence* allows a more robust approach to liberty and equality that addresses many of the troubling implications of compelled medical treatment of pregnant women. First, *Lawrence*

199 See Siegel, *Dignity*, *supra* note 71, at 1703–04 (discussing the Court's various "dignity" arguments).

200 539 U.S. 558 (2003). For a deeper discussion of Tribe's double helix argument and the *Lawrence* decision, see generally Tribe, *supra* note 198.

201 *Lawrence*, 539 U.S. at 577–79.

202 *Id.* at 574.

203 *Id.* at 575.

204 *Lawrence* notes:

When homosexual conduct is made criminal by the law of the State, that declaration in and of itself is an invitation to subject homosexual persons to discrimination both in the public and in the private spheres. . . . The stigma this criminal statute imposes, moreover, is not trivial. . . . [I]t remains a criminal offense with all that imports for the dignity of the persons charged.

Id.; see also Tribe, *supra* note 198, at 1903–07 ("[T]he social and cultural meaning of any ban on sodomy, gender-neutral or otherwise, particularly given *Bowers*, is that being gay or lesbian means being a *sodomite*, which in turn means being a *criminal*.").

recognizes that it is not necessary to label a specific act at issue as a fundamental right in order to determine that constitutional principles are violated by the prohibition of that act where the prohibition impacts the right of individuals to make private decisions inherent to their dignity.²⁰⁵ While the right to refuse medical treatment has only been given status as a “liberty interest” under the constitution, compelled treatment significantly impacts the right of women to define the borders and contents of deeply personal experiences such as medical treatment and childbearing. It infringes on these rights just as the statute at issue in *Lawrence* infringed on the rights of individuals to define their personal relationships.

Second, the Court’s reasoning implies that a statute need not target a specific class in order to impair that class’s equality. The Court’s reasoning was not grounded in the Texas statute’s application to same-sex sodomy alone; because of the strong cultural association of sodomy with the gay male, a sodomy statute that applied to all individuals would still have furthered the stigmatization of gay individuals, and would have been “in and of itself . . . an invitation to subject homosexual persons to discrimination both in the public and in the private spheres.”²⁰⁶ Thus, under the Court’s reasoning, even a law that applied to all individuals would be unconstitutional. Compelled treatment of pregnant women may not explicitly target women, but its targeting of pregnant individuals infringes on the rights of women just as surely as sodomy laws infringe on the rights of gay individuals.

The *Lawrence* decision exemplifies the way in which infringements on liberty and equality can be inextricably intertwined; the Texas statute infringed on liberty and, in doing so, implicated the equality of all gay individuals. Similarly, compelled medical treatment of pregnant women implicates the double helix of liberty and equality. It limits the autonomy of pregnant women and, in doing so, designates women as a class of persons with limited liberty and thus second-class citizenship. Indeed, in the context of reproductive rights, *Casey*

205 See Tribe, *supra* note 198, at 1900–05 (“[T]he Supreme Court went out of its way to recast the plaintiff’s claim [in *Lawrence*] to substantive protection under the Due Process Clause for his private sexual relationships as an asserted ‘fundamental right to engage in homosexual sodomy.’”).

206 See *Lawrence*, 539 U.S. at 575; see also Tribe, *supra* note 198, at 1907–16 (noting that “cultural conflation of sodomy with ‘homosexual’ sodomy, however out of sync with social reality it may be, means that any law banning sodomy, even if it reaches opposite-sex sodomy” will subject homosexual persons to discrimination). This argument is supported by the Court’s reliance on liberty as opposed to merely equal protection and its overturning of *Bowers*, which concerned a statute that criminalized sodomy between all individuals and not just same-sex sodomy.

hinted at the need for such an approach in order to adequately address the right of women to make reproductive decisions:

These matters, involving the most intimate and personal choices a person may make in a lifetime, choices central to personal dignity and autonomy, are central to the liberty protected by the Fourteenth Amendment. . . . [T]he liberty of the woman is at stake in a sense unique to the human condition and so unique to the law. The mother who carries a child to full term is subject to anxieties, to physical constraints, to pain that only she must bear. That these sacrifices have from the beginning of the human race been endured by woman with a pride that ennobles her in the eyes of others and gives to the infant a bond of love cannot alone be grounds for the State to insist she make the sacrifice. Her suffering is too intimate and personal for the State to insist, without more, upon its own vision of the woman's role, however dominant that vision has been in the course of our history and our culture. The destiny of the woman must be shaped to a large extent on her own conception of her spiritual imperatives and her place in society.²⁰⁷

In *Carhart*, the Court moved away from this reasoning, all but ignoring the dignity of women in its decision. In doing so, it embraced reasoning that may open the door for further curtailment of women's reproductive freedom. The troubling implications of this move in the context of compelled medical treatment demonstrate why a doctrinal approach that acknowledges the full impact of state action on women's liberty and equality is vital to uphold their rights as individuals.

B. Public Health Implications

Compelled medical treatment and expanded state power over women's reproductive choices also has troubling implications for public health. While the previous section focuses on constitutional principles, constitutional concepts of liberty and equality are important both because of their impact on doctrine and because constitutional ideas shape culture.²⁰⁸ By limiting women's liberty and equality, cases allowing compelled medical treatment not only directly impact specific women's health, but also indirectly impact all women's health by shaping the culture of reproductive medicine.

Expanding state power to compel the medical treatment of pregnant women will likely result in cases in which neither maternal nor

²⁰⁷ *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 851–52 (1992); *see also Lawrence*, 539 U.S. at 574 (quoting *Casey*, 505 U.S. at 851–52).

²⁰⁸ *See Law*, *supra* note 158, at 956–57 (“[C]onstitutional concepts of equality are important both because of their concrete impact on legislative power and individual right and because constitutional ideas reflect and shape culture.”).

fetal health is served. Medicine is inherently imprecise, and medical technology and knowledge limits physicians' abilities to accurately predict the outcome of treatment choices.²⁰⁹ For example, Cesarean surgeries are often indicated for "fetal distress" as measured by electronic fetal monitoring (EFM). However, the efficacy of EFM is questionable, leading physicians to overestimate risks to the fetus and perform unnecessary operations in order to avoid liability.²¹⁰ While ordinarily patients are free to weigh these predictions themselves, compelled medical treatment allows the state to weigh the risks for the pregnant woman and determine how much risk is appropriate for her to undergo in order to further state interests. Physicians have sought—and courts have ordered—compelled medical treatment only to find that their concerns were unwarranted.²¹¹ Expanding state justifications for compelled treatment increases the likelihood that more women will be compelled to undergo treatment that serves neither their health nor the health of the child they carry.

Compelled medical treatment also creates confusing and ethically troubling obligations for physicians. In the shadow of *Carhart's* language on women's regret, health care providers may conclude that, as a matter of law, pregnant women are less capable of making autonomous medical decisions, particularly where those decisions may lead to results women might later regret. Hospitals and physicians may fear that, if the mother is not legally capable of exercising informed consent, they will find themselves liable should she later regret her decision. The implication that treatment may now be compelled where there is uncertainty about the consequences for the mother's health increases the circumstances in which physicians and hospitals may feel the need to seek court intervention to avoid potential liability. Where physicians are uncertain about whether a medical treatment is necessary for fetal health, they may err on the side of fetal health, rather than maternal health, and seek court intervention to avoid future liability.²¹²

Coercive care also damages the doctor-patient relationship and discourages women from seeking prenatal care.²¹³ This is particularly

209 See *supra* notes 100–105 and accompanying text.

210 See Sylvia A. Law, *Childbirth: An Opportunity for Choice that Should be Supported*, 32 N.Y.U. REV. L. & SOC. CHANGE 345, 360–62 (2008) (discussing problems with the use of EFM).

211 See *supra* notes 100–103 and accompanying text.

212 See Gallagher, *supra* note 76, at 50–53 (“One of the pressures for court-ordered Caesareans [sic], and probably for the increased number of Caesarean [sic] sections overall, arises from physicians' anxiety about potential malpractice liability.”).

213 See Comm. on Bioethics, Am. Acad. of Pediatrics, *Committee Opinion 321: Maternal Decision Making, Ethics, and the Law*, 106 OBSTETRICS & GYNECOLOGY 1127, 1134 (2005) (“Coercive

troubling in the context of women with high risk pregnancies, who are most in need of prenatal care but will be more likely to avoid it if their high-risk status will encourage physicians to compel treatment. For these reasons, medical organizations caution that compelling medical treatment of pregnant women raises serious ethical concerns for physicians and may damage physicians' ability to provide prenatal care.²¹⁴

For those who do seek medical care, the prospect of compelled treatment creates an adversarial relationship between patient and physician.²¹⁵ It undermines the trust that allows women to communicate with their physicians.²¹⁶ If physicians are able to compel treat-

and punitive policies are potentially counterproductive in that they are likely to discourage prenatal care and successful treatment, adversely affect infant mortality rates, and undermine the physician-patient relationship.”); see also FURROW ET AL., *supra* note 6, at § 19-2 (“[J]udicial balancing of the interests of pregnant women and their fetuses, and the consequent possibility of judicial intervention to require pregnant women to undergo medical treatment against their will, adversely affects the doctor-patient relationship and may discourage some pregnant women from seeking the health care they need.”); Gallagher, *supra* note 76, at 53–54 (“Judicial decisions authorizing forced Caesareans [sic] threaten to distort the medical care of all birthing women . . . [and] introduce an implicit threat of coercion into doctor-patient relationships.”).

214 The American Medical Association (AMA), the American Academy of Pediatrics (AAP), the American College of Obstetrics and Gynecologists (ACOG), and the American Public Health Association (APHA) all discourage physicians from seeking court intervention and state that pregnant women’s medical treatment decisions should be respected. See FURROW ET AL., *supra* note 76, § 19-2 (discussing arguments for and against judicial intervention to protect the interests of the fetus); H.M. Cole, *Legal Interventions During Pregnancy: Court-Ordered Medical Treatments and Legal Penalties for Potentially Harmful Behavior by Pregnant Women*, 264 J. AM. MED. ASS’N 2663, 2663-66 (1990) (“The physician’s duty is to ensure that the pregnant woman makes an informed and thoughtful decision, not to indicate the woman’s decision. Physicians [s]hould [n]ot [h]ave a [l]egal [d]uty to [s]eek [c]ourt-[o]rdered [o]bstetrical [i]nterventions.”); Comm. on Bioethics, Am. Acad. of Pediatrics, *supra* note 213, at 1061 (stating that maternal decisions must be respected, criticizing coercive and punitive measures, and stating that judicial intervention should not be employed absent “extraordinary circumstances, circumstances that, in fact, the Committee on Ethics cannot currently imagine”); Comm. on Bioethics, Am. Acad. of Pediatrics, *Fetal Therapy—Ethical Considerations*, 103 PEDIATRICS 1061, 1061–62 (1999) (stating that physicians should respect maternal choice and assessment of risk and that, under limited circumstances when fetal therapy would prevent irrevocable and substantial fetal harm with negligible risk to the health and well-being of the pregnant woman, physicians should engage in a process of communication and conflict resolution that may require consultation with an ethics committee; judicial review is only to be employed in “rare cases”); see also Harris, *supra* note 72, at 140–42 (outlining the American College of Obstetricians and Gynecologists position on maternal versus fetal rights).

215 See MERRICK, *supra* note 100, at 73 (“Court-ordered intervention may . . . create adversarial relations between the woman and the fetus—and subsequently the born child—if [the woman] feels her own health are welfare are being sacrificed.”).

216 See FURROW ET AL., *supra* note 76, at § 19-2 (“[J]udicial intervention to require pregnant women to undergo medical treatment against their will . . . may discourage some pregnant women from seeking the health care they need.”); Annas, *Forced Cesareans*, *supra*

ment of pregnant women at the expense of their health, pregnant women may be less likely to discuss symptoms of conditions they fear will result in a court order. Physicians, in turn, may be less likely to explain medical options and obtain informed consent if they can threaten with court orders those patients they believe to be irrational or unlikely to agree with their recommended treatment.²¹⁷ These consequences have particularly troubling implications for low-income and minority patients. Low-income women have more difficulty finding a physician, much less the flexibility to choose a physician that will respect their decisions and birthing plans.²¹⁸ A 1987 *New England Journal of Medicine* survey of compelled medical treatment of pregnant women found that 81% of women subject to orders were minorities, and 24% did not speak English as their primary language.²¹⁹

VI. CONCLUSION

The *Carhart* decision gives new life to an outdated view of pregnant women as second-class citizens. Like Judge Branford's opinion in *In re A.C.*, the *Carhart* majority designates pregnant women as a unique category of persons with limited autonomy. It implies that women not only have diminished rights to exercise informed consent, but also that, in the context of medical decisions that could detrimentally impact the child they carry, pregnant women have diminished capacity to exercise informed consent. The decision concludes that the state, armed with the dubious interests of expressing respect for fetal life and protecting women from making medical decisions they might regret, may ban a procedure that may be a woman's safest option where questionable evidence creates any degree of uncertainty about women's medical needs.

note 101, at 45 (arguing that forced Cesarean sections "encourage[] an adversarial relationship between the obstetrician and the patient"); Comm. on Bioethics, Am. Acad. of Pediatrics, *supra* note 213, at 1134 ("Various studies have suggested that attempts to criminalize pregnant women's behavior discourage women from seeking prenatal care.")

217 See Annas, *Forced Cesareans*, *supra* note 101, at 45 ("[The ability to seek court-ordered operations] gives the obstetrician a weapon to bully women he views as irrational into submission."); Gallagher, *supra* note 76, at 52 ("Courts should make clear that doctors and hospitals will not be under a duty to disregard a competent woman's rights by overriding her informed refusal of a Cesarean [sic] section or other invasive medical treatment.")

218 See Barbara M. Aved et al., *Barriers to Prenatal Care for Low-Income Women*, 158 WEST. J. MED. 493 (1993) (discussing obstacles low-income women face in finding a physician for prenatal care and birth, and the fragile relationship between low-income women and the medical community).

219 See Kolder et al., *supra* note 85, at 1193.

While this Article focuses on the majority opinion's implications for compelled medical treatment, the majority opinion's expansion of state interest and erosion of the primacy of women's health has implications far beyond compelled treatment and abortion. During the course of pregnancy, nearly every action a woman takes is likely to have some impact on the fetus because of the fetus's dependence on the pregnant woman's body. Few of these decisions will create a risk of fetal death such that the state's interest in fetal life recognized in *Roe* is implicated. However, *Carhart* expands the state interest in fetal life and reinterprets the state interest in maternal health to implicate nearly any decision a pregnant woman may make. Pregnant women may also wish to undertake medical treatment that poses additional risks to the fetus, such as elective surgery or medications for pain management or psychological illness. Under *Carhart*, the state may justify intervention in these decisions based on newly recognized interest in promoting respect for human life and preventing pregnant women from making medical decisions they may regret due to their unique relationship with the child they carry. State intervention need not be limited to medical treatment. These newly recognized state interests are also potentially implicated when an obese pregnant woman eats fattening foods, when a woman with a misaligned placenta engages in sexual intercourse, or when a pregnant woman decides to forgo prenatal vitamins. Pregnancy is unique in many ways, both as a medical condition and as a life experience. The exceptional experience of women, however, does not justify their designation as a separate class of individuals deprived of basic rights to bodily autonomy and informed consent. Rather than commandeering the bodies of pregnant women, the most effective way to ensure healthy pregnancies and births is to ensure that every medical decision a pregnant woman makes is fully informed, uncoerced, and supported by her ability to access quality medical care and effect her choice in the safest way possible.