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Peta Hallisey

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# The Fetal Patient and the Unwilling Mother: A Standard for Judicial Intervention

For centuries the human fetus has been a "medical recluse."<sup>1</sup> Until recently, the advancement of medical knowledge about the fetus was restrained by a limited ability to observe and study fetal growth and development *in utero*.<sup>2</sup> Beginning in the 1960's, however, the fetus slowly emerged from its gestational hiding place with the advent of new technological developments that provided practical methods to examine and analyze fetal characteristics.<sup>3</sup> These new techniques enabled physicians for the first time to make prenatal diagnoses of certain fetal disorders.<sup>4</sup> Once prenatal diagnosis became a standard part of obstetrical care, the potential to treat at least some of these defects also became a possibility.<sup>5</sup>

The first important diagnostic tool to appear was amniocentesis<sup>6</sup>—a procedure that allows identification of some inherited and chromosomal abnormalities prior to birth.<sup>7</sup> This technique was used primarily in conjunction with selective abortion to prevent the birth of defective children.<sup>8</sup> Standing alone amniocentesis did not offer any significant treatment possibilities.<sup>9</sup> The development of ultrasound (so-

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1. See Harrison, Golbus & Filly, *Management of the Fetus with a Correctable Congenital Defect*, 246 J. AM. MED. A. 774, 774 [hereinafter cited as *Management of the Fetus*].

2. See Nadler, *Prenatal Diagnosis*, in MODERN PERINATAL MEDICINE 123-125 (1974).

3. See Friedman, *Legal Implications of Amniocentesis*, 123 U. PA. L. REV. 92, 95 (1974); W. Ruddick & W. Wilcox, *Operating on the Fetus*, 12 HASTINGS CENTER REP., October 1982, at 10, 10. These include amniocentesis, ultrasound, and fetoscopy. See *infra* notes 6-13. See generally D. SIGGERS, *PRENATAL DIAGNOSIS OF GENETIC DISEASE* (1978).

4. Friedman, *supra* note 3, at 94-96.

5. Amniocentesis is now accepted standard of care for medically indicated pregnancies. See *infra* note 193; see also *Call v. Kezirian*, 135 Cal. App. 3d 189, 194, 185 Cal. Rptr. 103, 105 (1982); Damme, *Controlling Genetic Disease Through Law*, 15 U.C. DAVIS L. REV. 801, 834-35 (1982).

6. Amniocentesis, derived from the Greek, means to puncture (*kentesis*) the membrane (*amnion*) that envelops the fetus. See Friedman, *supra* note 3, at 95.

7. *Id.* at 99-102. Amniocentesis, generally performed between the 14th and 16th week of pregnancy, is accomplished by inserting a needle through the mother's abdominal wall and uterus into the amniotic sac to withdraw a sample of amniotic fluid. This sample is then analyzed to detect abnormalities. See J. PRITCHARD & P. MACDONALD, *WILLIAMS OBSTETRICS* 330 (16th ed. 1980) [hereinafter cited as *WILLIAMS OBSTETRICS*]. This process of analysis can require up to one month before results are available. See J. HOBBS & F. WINSBERG, *ULTRASONOGRAPHY IN OBSTETRICS AND GYNECOLOGY* 116 (1977).

8. See Friedman, *supra* note 3, at 94.

9. See Ruddick & Wilcox, *supra* note 3, at 10; Clewell, Johnson & Meier, *A Surgical Approach to the Treatment of Fetal Hydrocephalus*, 306 NEW ENG. J. MED. 1320, 1323 (1982).

nography)<sup>10</sup> for obstetrical use, however, provided the major technological means to transform the fetus into a full-fledged patient by facilitating direct *in utero* visualization of fetal anatomy.<sup>11</sup> Until recently, fetal treatment has been nonsurgical in nature.<sup>12</sup> Advances in microsurgery,<sup>13</sup> however, coupled with the availability of new drugs,<sup>14</sup> have now enabled surgeons to operate on the fetus.<sup>15</sup> Some examples of fetal surgery include an intrauterine procedure to correct congenital hydrocephalus<sup>16</sup> and an extrauterine procedure to alleviate bilateral congenital hydronephrosis.<sup>17</sup>

Although currently an experimental procedure, the use of fetal surgery is likely to increase as new techniques are developed and existing procedures become more established.<sup>18</sup> This probable expansion of the field of fetal surgery has been welcomed by commentators, parents, and physicians alike because it portends an increasing ability to cope with

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10. See generally HOBBS & WINSBERG, *supra* note 7; H. THOMPSON & R. BERNSTINE, *DIAGNOSTIC ULTRASOUND IN CLINICAL OBSTETRICS AND GYNECOLOGY* (1978). Ultrasound is a technique that utilizes high frequency sound waves to transfer an image of the fetus to a television screen. Ultrasound can establish the number, size and position of the fetus(es) and aids in visualization of fetal anatomy so that *in utero* surgery may be performed.

11. See *Management of the Fetus*, *supra* note 1, at 777.

12. For example, medications and nutrients are injected into the amniotic fluid that surrounds the fetus to treat congenital hypothyroidism and goiter, and intrauterine malnutrition. These substances are absorbed by the fetus when it swallows amniotic fluid. Fetal red blood cell deficiency caused by fetal-maternal RH blood type incompatibility can be treated by transfusing red blood cells into the fetal peritoneal cavity. See *id.*, *supra* note 1, at 775-76.

13. Fetoscopy is an example. A fetoscope is an instrument that is inserted through an incision in the maternal abdominal wall and uterus to allow direct visualization of the fetus. The view of the fetus at any instant is limited to 2 to 4 cm. of fetal surface. See WILLIAMS OBSTETRICS at 347; the fetoscope also can be used to obtain fetal blood samples and skin biopsies. See *Management of the Fetus*, *supra* note 1, at 776. For a clinical description of the technique, see I. ROCKER & K. LAURENCE, *FETOSCOPY* 51-64 (1981).

14. Ritodrine is a drug that inhibits uterine contractions which typically cause premature labor when surgical intervention is attempted during pregnancy. See *AMA DRUG EVALUATIONS* 797-99 (4th ed. 1980). Prostaglandin inhibitors (*e.g.*, Indocin) are also used since prostaglandins are thought to play a role in stimulating uterine contractions during normal labor. *Id.* at 798.

15. See, *e.g.*, Harrison, Golbus & Filly, *Fetal Surgery for Congenital Hydronephrosis*, 306 *NEW ENG. J. MED.* 591-93 (1982) [hereinafter cited as *Fetal Surgery*]; Clewell, *supra* note 9, at 1320-25. Very few fetal abnormalities are presently amenable to *in utero* surgical treatment. *Management of the Fetus*, *supra* note 1, at 774, 776. Some problems are best handled postnatally or by manipulating the time of delivery. *Id.* at 774. The abnormalities that are appropriate candidates for *in utero* surgery are those anatomic malformations that interfere with the proper course of prenatal growth and development. *Id.* at 776. Harrison has identified three malformations currently suitable for surgical intervention: bilateral hydronephrosis, obstructive hydrocephalus, and diaphragmatic hernia. *Id.* at 775-76.

16. See Clewell, *supra* note 9. Hydrocephalus is an abnormal accumulation of cerebrospinal fluid on the brain that results in increased intracranial pressure. This condition, if untreated, results in gross cranial and facial abnormalities and profound brain damage. This case involved surgical implantation of a shunting device in the fetal skull to divert excess cerebrospinal fluid. *Id.*

17. See *Fetal Surgery*, *supra* note 15. Congenital hydronephrosis is a condition that results in atrophy of the kidneys as a result of urinary obstruction. This condition ultimately leads to renal failure. See *DORLAND'S ILLUSTRATED MEDICAL DICTIONARY* at 624 (26th ed. 1981); *Fetal Surgery*, *supra* note 15, at 592.

18. See *Management of the Fetus*, *supra* note 1, at 777.

birth defects by a less drastic means than abortion.<sup>19</sup> Despite this positive outlook, the advent of fetal surgery is not without controversy.<sup>20</sup> In addition to the auspicious prospect of preventing birth defects, complex legal, ethical, and moral issues have been raised by the availability of fetal surgery.<sup>21</sup> For example, one moral concern is the impact fetal surgery will have on abortion. Previously, when prenatal diagnosis revealed a congenital or developmental defect the choice was sharply defined: abort or give birth to an impaired or stillborn child.<sup>22</sup> Prenatal surgery that could cure or minimize crippling defects, however, now provides a third alternative that makes the choice less clear.<sup>23</sup> Although a mother has an absolute constitutional right<sup>24</sup> to choose abortion prior to the point of fetal viability,<sup>25</sup> the availability of a therapeutic alternative might make abortion a morally unacceptable choice.<sup>26</sup>

In addition to this moral concern, one legal issue created by these technological advances is whether a mother has the right to refuse recommended fetal surgery.<sup>27</sup> At first it would seem that a mother's refusal to consent to recommended fetal surgery could be resolved in the same manner as a conflict over medical care for a child.<sup>28</sup> The distinction between medical treatment for the child and surgical treatment of the fetus, however, is based upon the fact that mother and fetus form an organic whole; treatment of the fetus requires gynecological intervention, treatment of the child does not.<sup>29</sup> Therefore, since a mother has a right to refuse medical or surgical treatment for herself, her rights stand as a potential barrier to mandating fetal therapy against her

19. See Robertson, *The Right to Procreate and In Utero Fetal Therapy*, 3 J. LEGAL MED. 333, 343 (1982).

20. See *Management of the Fetus*, supra note 1, at 776; Barclay, McCormick, Sidbury, Michejda & Hodgen, *The Ethics of In Utero Surgery*, 246 J. AM. MED. A. 1550, 1550-55 (1981); Fletcher, *The Fetus as Patient: Ethical Issues*, 246 J. AM. MED. A. 772, 772 (1981). But see Friedman, *Technology in Search of a Patient* (Letters to the Editor), 307 NEW ENG. J. MED. 565, 565 (1982).

21. See *id.*

22. See Robertson, supra note 19, at 343; *Management of the Fetus*, supra note 1, at 774.

23. Ruddick & Wilcox, supra note 3, at 11; Barclay, McCormick, Sidbury, Michejda & Hodgen, *The Ethics of In Utero Surgery*, 246 J. AM. MED. A. 1550, 1551 (1981).

24. This right was guaranteed by the United States Supreme Court in its landmark abortion decision. *Roe v. Wade*, 410 U.S. 113 (1973).

25. *Id.* at 165.

26. See Ruddick & Wilcox, supra note 3, at 11.

27. At the present time fetal surgery is strictly an experimental procedure. See *Management of the Fetus*, supra note 1, at 774; Robertson, supra note 19, at 345. This comment will be limited to a consideration of fetal surgeries that will become accepted medical practice. As Robertson points out, neither parents nor physicians are obligated to try an experimental alternative to abortion. *Id.* Since California law prohibits abortion post-viability, except to save the mother's life, this comment will focus on a conflict over fetal therapy recommended after the point of viability has been reached. CAL. HEALTH & SAFETY CODE §§25950-25957.

28. See Robertson, supra note 19, at 365-66.

29. See Ruddick & Wilcox, supra note 3, at 12.

wishes.<sup>30</sup>

To determine the appropriate balance between the rights of the mother and the rights of the fetus, this comment will address the legal problems surrounding a mother's refusal to consent to recommended fetal surgery, including both life-enhancing and life-saving fetal treatments.<sup>31</sup> A consideration of the unique circumstances posed by fetal therapy will demonstrate that in certain situations a mother should be allowed to refuse. In order to define the circumstances in which a mother may refuse fetal therapy, it is first necessary to identify the interests involved in the conflict, including (1) the right of the mother to parental autonomy<sup>32</sup> and bodily integrity,<sup>33</sup> (2) the right of the fetus to independent legal recognition as a patient,<sup>34</sup> and (3) the interest of the state in protecting the health and welfare of unborn children<sup>35</sup> and in promoting responsible private medical care decisions.<sup>36</sup>

Following an identification of these interests, this comment will assert that a definition of the circumstances in which a mother should be authorized to refuse fetal surgery must be embodied in a standard for judicial intervention. Merely determining the circumstances in which a mother may refuse fetal therapy does not resolve the legal issue posed by a conflict over a fetal treatment decision. Adequate protection of the interests of all the parties involved in this conflict requires the adoption of a standard for judicial intervention. The need to provide extra safeguards for the rights of mother, fetus, and state stems from the pervasive uncertainty about the extent of parental authority to make medical care decisions for a child.<sup>37</sup> Once fetal surgery becomes accepted medical practice, the same problem of assessing maternal decisionmaking authority can be anticipated. In part, the uncertainty regarding parental authority is due to the lack of substantive guidelines in the statutes that authorize judicial intervention when recommended medical care for a child is refused.<sup>38</sup> Statutes that authorize intervention seldom provide specific directives to aid judges in determining when intervention is justified.<sup>39</sup> As a result, judicial decisions in these cases tend to be erratic and inconsistent because they frequently are based upon a substitution of the value system of the individual judge for that

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30. See Robertson, *supra* note 19, at 353.

31. This comment will emphasize California law.

32. See *infra* notes 55-63 and accompanying text.

33. See *infra* notes 64-77 and accompanying text.

34. See *infra* notes 81-105 and accompanying text.

35. See *infra* notes 113-119 and accompanying text.

36. See *infra* notes 106-112 and accompanying text.

37. See Ellis, *Letting Defective Babies Die: Who Decides?*, 7 AM. J.L. & MED. 393, 401-13 (1982).

38. See *infra* notes 128-146 and accompanying text.

39. See *infra* note 121.

of the parents.<sup>40</sup> This lack of substantive guidelines, therefore, tends to result in decisions that can vary between too little protection for the interests of the child<sup>41</sup> and too great an interference with parental autonomy.<sup>42</sup>

Accordingly, this comment will demonstrate that development and adoption of a standard for judicial intervention in fetal treatment conflicts will serve to safeguard the interests of mother, fetus, and state by clarifying the situations in which a mother has authority to refuse fetal therapy. Moreover, specific guidelines that clearly define the extent of maternal authority will help to (1) prevent conflicts from arising, (2) reduce the number of inconsistent judicial decisions, (3) define the role of the physician in a fetal treatment conflict, and (4) help to prevent the use of malpractice suits as a method for determining the appropriate standard of care.

Following a discussion of the need for developing a standard for judicial intervention, this comment will balance the interests of mother, fetus, and state to delineate the circumstances that will dictate when the interests of the mother should prevail over those of the fetus. This comment will suggest that the mother should be allowed to refuse fetal therapy in two situations. Specifically, a mother should be allowed to assert her right of parental autonomy to refuse fetal therapy when it is offered not as a cure, but solely to prolong or salvage the life of a seriously impaired fetus. Similarly, a mother should be allowed to assert her right of bodily integrity when the efficacy of the recommended therapy is subject to dispute or the procedure constitutes a significant risk to her life. Finally, based upon the two situations identified above, this comment will propose a standard for judicial intervention. Before addressing the reasons for developing a standard for judicial intervention when a mother refuses recommended fetal therapy, however, it is first necessary to begin with a description of the interests involved in this conflict.

#### INTERESTS INVOLVED IN FETAL SURGERY DECISIONS

A conflict over recommended surgery for the fetus can be analogized to the conflict encountered when parents refuse recommended medical care for their child, but not without a recognition of the important distinctions.<sup>43</sup> In the case of medical care for the child the interests impli-

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40. See Comment, *State Intrusion in Family Affairs: Justifications and Limitations*, 26 STAN. L. REV. 1383, 1387 (1974).

41. *Id.*

42. *Id.*

43. See Robertson, *supra* note 19, at 365. Mothers have already been forced to undergo cesarean sections for the benefit of the fetus. See *infra* notes 208-222 and accompanying text.

cated are those of the parents in controlling the upbringing of their child, including the right to make medical care decisions for the child;<sup>44</sup> the right of the child to be provided with the necessities of life, including medical care;<sup>45</sup> and the interest of the state in safeguarding the health, welfare, and safety of the individual child<sup>46</sup> and in promoting responsible private medical care decisions.<sup>47</sup> Although there are similarities between the refusal of parents to provide recommended medical care for their child and the refusal of a mother to allow fetal surgery, certain significant differences exist.<sup>48</sup> Specifically, medical care for the child involves bodily intrusion on the child only, whereas fetal surgery requires surgical intervention on the mother as well.<sup>49</sup> Moreover, the legal status of the fetus remains unclear following the refusal of the United States Supreme Court to recognize the fetus as a person within the meaning of the United States Constitution.<sup>50</sup> Thus, a fetus may not possess the same right to medical care that the law affords to a child. A consideration of these important differences between ordering surgery for the fetus against the wishes of the mother and ordering medical care for the child over parental objections will affect the weight given the interests involved. To assess whether the rights of the mother in a fetal treatment conflict should be afforded greater weight than the rights of the fetus, the analysis will begin with a discussion of the nature and extent of maternal rights.

#### *A. The Mother's Rights*<sup>51</sup>

Since fetal surgery involves surgery on both fetus and mother, two constitutionally protected maternal rights are implicated.<sup>52</sup> A mother

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44. See Ewald, *Medical Decision Making for Children: An Analysis of Competing Interests*, 25 St. Louis U.L.J. 689, 691 (1982).

45. In California, this right has been codified in Penal Code section 270.

46. See Ewald, *supra* note 44, at 713.

47. See *Carroll v. Skloff*, 202 A.2d 9, 11 (Pa. 1964).

48. See *Ruddick & Wilcox*, *supra* note 3, at 12.

49. There are examples of forced organ transplants from one sibling for the benefit of another sibling. See, e.g., *Strunk v. Strunk*, 445 S.W.2d 145 (Ky. Ct. App. 1969); see also *Ruddick & Wilcox*, *supra* note 3, at 12.

50. 410 U.S. at 158.

51. This comment is limited to a discussion of the rights of the mother. The rights of the father in a fetal treatment conflict are unclear. In the case of *Planned Parenthood v. Danforth*, 428 U.S. 52 (1976), the Court indicated that, since the mother must bear the child, her decision to have an abortion must be preferred. *Id.* at 71. An argument can be made that a mother's decision to refuse prenatal therapy is analogous and should preclude the father's wishes from overriding those of the mother.

52. The right of procreative choice guaranteed by *Roe v. Wade*, 410 U.S. 113 (1973), is not implicated by the conflict that is the focus of this comment. Procreative choice protects a woman's right to choose abortion up to the point of fetal viability. *Id.* at 165. Viability is the point at which the fetus can survive outside the womb. Viability is usually placed at about seven months (28 weeks gestational age) but may occur earlier, even at 24 weeks. *Id.* at 160. This comment will be limited to a consideration of conflicts over fetal surgery recommended after the point of viability has passed. Thus, the right of procreative choice does not directly apply. See *Robertson*, *supra*

possesses the right to parental autonomy in childrearing, including the right to make medical care decisions for minor children.<sup>53</sup> Thus, a mother may be able to assert this right to refuse recommended fetal surgery that she feels is not justified. Additionally, the mother possesses a right of bodily integrity that protects against unwarranted bodily intrusion without her consent.<sup>54</sup> Therefore, a mother also may be able to assert her right to bodily integrity by refusing recommended fetal surgery which requires that she submit to a major surgical procedure. An analysis of the extent of both these rights will help to determine the extent of a mother's authority to refuse fetal surgery.

### 1. Parental Autonomy

Parental autonomy concerns the right of parents to control the care, education and custody of their children and prohibits the state from undue interference with parental decisionmaking, including medical care decisions.<sup>55</sup> This "natural right" of parents to make decisions on behalf of their children was first recognized in a line of cases beginning with *Meyer v. Nebraska*.<sup>56</sup> Ultimately, the United States Supreme Court decision in *Griswold v. Connecticut*<sup>57</sup> embodied this "natural right" of parents in a constitutional right of privacy that provides a shield against state interference into a broad range of family matters.<sup>58</sup> Reinforcing the constitutional right of privacy in family matters is our

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note 19, at 359. The issue involved is not whether to bear a child, but rather, once the decision has been made to carry a pregnancy to full term, whether recommended fetal surgery can be refused. Presumably, a mother has an unqualified right to refuse treatment prior to viability since her right to choose abortion is still protected by the right of privacy defined in *Roe v. Wade*, 410 U.S. at 152-54. Of course, if it could be established that abortion is an option to which she would never agree, fetal treatment required before the point of viability could be included in the issue to be resolved here.

53. See *Parham v. J.R.*, 442 U.S. 584, 602 (1979); *Wisconsin v. Yoder*, 406 U.S. 205, 213 (1971); *Prince v. Massachusetts*, 321 U.S. 158 (1943); Goldstein, *Medical Care for the Child at Risk: On State Supervention of Parental Autonomy*, 86 YALE L.J. 645 (1977).

54. See L. TRIBE, *AMERICAN CONSTITUTIONAL LAW*, 890-91 (1978); Regan, *Rewriting Roe v. Wade*, 77 MICH. L. REV. 1569 (1979); see *supra* notes 64-76 and accompanying text.

55. 442 U.S. at 602-603.

56. 262 U.S. 390, 399-400 (1923); *Pierce v. Society of Sisters*, 268 U.S. 510, 535 (1925); *Wisconsin v. Yoder*, 406 U.S. 205, 213 (1972).

57. 381 U.S. 479 (1965).

58. *Id.* at 482-83, 488. See generally J. NOWAK, R. ROTUNDA & J. YOUNG, *HANDBOOK ON CONSTITUTIONAL LAW*, at 626 (1978). Certain personal rights embodied within the right of privacy have been deemed fundamental rights, 381 U.S. at 494-95, and, therefore, legislation affecting these rights is subject to "strict scrutiny" under the due process clause of the fourteenth amendment. 410 U.S. at 155. Thus, these rights may be interfered with only when necessary to effectuate a compelling state interest. See NOWAK, *supra*, at 524. Protection of human life is an example of a compelling state interest that meets this strict scrutiny test. 410 U.S. at 163. Although the Court has not specifically identified the appropriate standard of review for medical decisionmaking, it appears to consider this a fundamental right. 406 U.S. at 214, 232 and 410 U.S. at 211.



strong societal preference for parental autonomy.<sup>59</sup> This preference emanates from a respect for diverse lifestyles and methods of childrearing,<sup>60</sup> and a legal recognition of the fact that parents tend to act in the best interests of their children.<sup>61</sup> Nonetheless, parents do not have an absolute right to control the lives of their children.<sup>62</sup> Thus, when a parent's refusal to provide recommended medical care for a child places the child's life or health in jeopardy, the state may intervene on behalf of the child.<sup>63</sup> By analogy, the state should be able to assert this same right to intervene on behalf of a fetus whose life or health will be jeopardized by a mother's refusal to consent to fetal surgery. Therefore, a mother has only a limited right to assert parental autonomy as a basis for refusing recommended fetal therapy. The right of parental autonomy, however, is not the only maternal right affected by a conflict over fetal therapy. Since treatment of the fetus requires at least minimal intervention on the mother, her right to bodily integrity also must be considered.

## 2. *The Right of Bodily Integrity*

In various contexts, the United States Supreme Court has recognized a qualified right to be free of unwarranted bodily intrusions.<sup>64</sup> This right guarantees that each individual is entitled to reasonable control over his or her own body, including the right to refuse judicially ordered surgery.<sup>65</sup> In contrast to the right of parental autonomy, which is protected by the due process clause of the fourteenth amendment,<sup>66</sup> the guarantee of bodily integrity originates in the fourth amendment "right of the people to be secure in their persons, houses, papers and effects, against unreasonable searches and seizures . . . ."<sup>67</sup>

The Constitution does not prohibit all bodily intrusions, however,

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59. *See In re Phillip B.*, 92 Cal. App. 3d 796, 801, 156 Cal. Rptr. 48, 51 (1979), *cert. denied*, 445 U.S. 949 (1980).

60. *Id.*

61. *Parham v. J.R.*, 442 U.S. 584, 602 (1979).

62. 406 U.S. at 230; 442 U.S. at 603; 321 U.S. at 166.

63. 92 Cal. App. 3d at 801, 156 Cal. Rptr. at 51.

64. "[T]he 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 Terry v. Ohio*, 392 U.S. 1, 9 (1968) (quoting *Union Pac. Ry. v. Botsford*, 141 U.S. 250, 251 (1891)).

65. *See Bowden v. State*, 510 S.W.2d 879, 881 (Ark. 1974); *People v. Smith*, 362 N.Y.S.2d 909, 914 (Sup. Ct. Queens County 1974); Comment, *In Search of Evidence Against a Criminal Defendant: The Constitutionality of Judicially Ordered Surgery*, 22 CATH. LAWYER 315, 327 (1976).

66. *See supra* note 58 and accompanying text.

67. U.S. CONST. amend. IV; *see Schmerber v. California*, 384 U.S. 757, 767 (1966). In *Schmerber* the Court developed a three part test to be applied in determining the reasonableness of the proposed bodily intrusion: (1) there must be a clear indication that evidence will be found; (2) the test itself must be reasonable; and (3) the test must be performed in a reasonable manner. *Id.* at 766-72.

only those that are unreasonable.<sup>68</sup> For example, compulsory vaccinations have been upheld for the protection of public health.<sup>69</sup> Additionally, courts have permitted bodily intrusions to gain evidence for use against criminal defendants, including forced blood samples<sup>70</sup> and body cavity searches.<sup>71</sup> The few cases that have mandated surgery to obtain evidence, however, have made a distinction between minor and major surgical procedures.<sup>72</sup> Major surgery requiring more than local anesthesia has been prohibited.<sup>73</sup> Consequently, surgical removal of evidence will be allowed only when the risks of surgery are minimal and only when the need for evidence is important enough to justify the intrusion.<sup>74</sup>

Based upon these precedents from the area of criminal law, it would appear that a mother could assert her right to bodily integrity to refuse a major surgical procedure required to perform surgery on the fetus. Her right to refuse fetal treatment requiring only minor surgery, however, would seem to be restricted to "unreasonable" procedures. Nevertheless, *any* forced surgical treatment on the body of one person for the benefit of another is held in disregard in our society.<sup>75</sup> A high value has been placed on individual freedom. Courts, therefore, are reluctant to allow violations of this liberty.<sup>76</sup> Despite this high regard for personal liberty, however, courts have continued to order life-saving blood transfusions for Jehovah's Witnesses when the welfare of their minor children was dependent upon the parents' continued survival.<sup>77</sup> Thus, the cases dealing with bodily intrusions stand for the proposition that a mother only has a qualified right to refuse recommended fetal surgery.

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68. See, e.g., *Carroll v. United States*, 267 U.S. 132, 147 (1925); *Ker v. California*, 374 U.S. 23, 33 (1963).

69. See *Jacobson v. Massachusetts*, 197 U.S. 11, 31 (1905).

70. 384 U.S. at 768-72; *Breithaupt v. Abram*, 352 U.S. 432, 433 (1957).

71. See, e.g., *Rivas v. United States*, 368 F.2d 703, 712 (9th Cir. 1966), *cert. denied*, 386 U.S. 945 (1967).

72. Compare *United States v. Crowder*, 543 F.2d 312, 315-16 (D.C. Cir. 1976) with 510 S.W.2d at 881 and 362 N.Y.S.2d at 911.

73. 510 S.W.2d at 881; 362 N.Y.S.2d at 911.

74. *Id.*

75. See *Regan, Rewriting Roe v. Wade*, 77 MICH. L. REV. 1569, 1583-89 (1979).

76. 384 U.S. at 772. In fact, this high esteem for personal liberty has resulted in a "right to die" movement, created in the wake of the *Karen Quinlan* case. See *In re Quinlan*, 355 A.2d 647 (N.J. 1976). California provides this right by statute. CAL. HEALTH & SAFETY CODE §7186.

77. See Application of the President of Georgetown College, 331 F.2d 1000 (D.C. Cir.), *cert. denied*, 377 U.S. 978 (1964) (Court prohibited Jehovah's Witness from refusing life-saving treatment for herself because she was the mother of a seven month old child). These cases have involved a relatively minor bodily intrusion, such as a blood transfusion. More major intrusions, including organ donations from a parent to save a child's life, have not been ordered and appear less likely. *Ruddick & Wilcox, supra* note 3, at 12. Moreover, it has been argued that until organ donations become mandatory, forcing a mother to submit to surgery for the benefit of the fetus is prejudicial to women since fathers are not bound by the same requirement. *Id.* Nevertheless, forced surgery on the mother to save the life of the fetus has already been ordered. See *infra* notes 208-22 and accompanying text.

Accordingly, the right of a mother to refuse fetal surgery will depend upon balancing the degree of maternal risk against the fetal need for the recommended procedure.

To balance maternal risk against fetal need, however, it is first necessary to determine whether a fetal right to medical care exists. If the fetus has no independent right to medical care, the right of a mother to refuse fetal surgery might be absolute. On the other hand, if the California statutes and case law establish the fetus as an independent patient, the right of a mother to refuse fetal therapy may be foreclosed. The question of whether the fetus has legal rights as a patient has not been resolved;<sup>78</sup> in fact, the controversy over what rights the fetus should possess has not abated since the United States Supreme Court declared a decade ago that the fetus is not a "person" within the meaning of the United States Constitution.<sup>79</sup> Despite this refusal to consider the fetus a person, technology has transformed the fetus into a patient.<sup>80</sup> Therefore, a determination of the legal rights of the fetal patient is now required. An analysis of the California case law and statutes will follow to determine whether an independent fetal right to medical treatment exists.

### B. *The Fetal Patient—A New Fetal Right*

Prior to the last century, the fetus was accorded few rights. At common law, a child *en ventre sa mere*<sup>81</sup> was viewed as simply a part of its mother with no separate existence of its own.<sup>82</sup> The fetal rights that were given legal recognition were for the purposes of inheritance and property law and became effective only in the event of the fetus' subsequent birth.<sup>83</sup>

Modernly, however, fetal rights have been expanded well beyond the few rights that existed at common law.<sup>84</sup> For example, California statutes and case law provide the fetus a cause of action for prenatal injuries,<sup>85</sup> a right to support from its parents,<sup>86</sup> and a limited right to

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78. For an overview of fetal rights, see generally Doudera, *Fetal Rights? It depends*, 18 TRIAL April 1982, at 18; Shaw & Damme, *Legal Status of the Fetus*, in GENETICS AND THE LAW 3 (A. Milunsky & G. Annas, eds. 1976).

79. 410 U.S. at 158.

80. See Ruddick & Wilcox, *supra* note 3, at 11.

81. BLACK'S LAW DICTIONARY (5th ed. 1979) (a French phrase meaning "in its mother's womb").

82. See Comment, *Recovery for Prenatal Injuries: The Right of a Child Against its Mother*, X SUFFOLK U.L. REV. 582, 584-85 (1976).

83. See W. BLACKSTONE COMMENTARIES \*130 (1762); Scott v. McPheeters, 33 Cal. App. 2d 629, 92 P.2d 678, *hearing denied*, 93 P.2d 562, 33 Cal. App. 2d 629 (1939).

84. See *supra* note 78.

85. CAL. CIV. CODE §29.

86. CAL. PENAL CODE §270; CAL. CIV. CODE §186.

recover for its wrongful birth.<sup>87</sup> Notwithstanding this expansion, the legal and moral status of the fetus remains unclear.<sup>88</sup> Although the fetus has not gained constitutional recognition as a person,<sup>89</sup> medical technology has allowed the fetus to become an independent patient.<sup>90</sup> Therefore, the law also must respond to the pressure of technological change by affording legal recognition of the fetal patient. In fact, an analysis of existing California statutes, particularly Civil Code section 29<sup>91</sup> and Penal Code section 270,<sup>92</sup> reveals an argument that may be offered as support for the proposition that the fetus already possesses legal rights as a patient. Specifically, Civil Code section 29 provides that "a child conceived, but not yet born, is to be deemed an existing person, so far as may be necessary for its interests in the event of its subsequent birth."<sup>93</sup> Section 29 is a statutory change from the common-law view that rejected a fetal cause of action for prenatal injuries.<sup>94</sup> The common-law rationale for rejecting a fetal right to recover for prenatal injuries included a lack of precedent,<sup>95</sup> absence of a duty to the fetus since it had no separate existence from its mother,<sup>96</sup> a fear of fraudulent claims,<sup>97</sup> and fear of encouraging suits against the mother for her conduct during pregnancy.<sup>98</sup> Increasing dissatisfaction with the common-law view ultimately lead to a rejection of this position in the case of *Bonbrest v. Katz*.<sup>99</sup> The *Bonbrest* decision, which established a fetal right to recover for injuries suffered prior to birth, was eventually codified in Civil Code section 29.<sup>100</sup> Section 29 places a duty on tortfeasors to act reasonably in order to avoid injuring the fetus.<sup>101</sup> Moreover, since the statute recognizes the fetus as a life in being from the time of conception, it acknowledges the independent legal existence of the fetus.<sup>102</sup>

87. See *Turpin v. Sortini*, 31 Cal. 3d 220, 239, 643 P.2d 954, 966, 182 Cal. Rptr. 337, 349 (1982).

88. See Robertson, *supra* note 19, at 360.

89. 410 U.S. at 158.

90. See Robertson, *supra* note 19, at 360. The argument is made that once the fetus has passed the point of viability, the mother has abrogated her right not to procreate by foregoing abortion. Hence, the moral worth of the fetus is stronger and less controversial than pre-viability. *Id.*

91. CAL. CIV. CODE §29.

92. CAL. PENAL CODE §270.

93. CAL. CIV. CODE §29.

94. *Id.* §29. *Norman v. Murphy*, 124 Cal. App. 2d 95, 98, 268 P.2d 178, 180 (1954); *Kyne v. Kyne*, 38 Cal. App. 2d 122, 127, 100 P.2d 806, 809 (1940); 33 Cal. App. 2d 632-33, 92 P.2d 680-81.

95. See, e.g., *Allaire v. St. Luke's Hosp.*, 56 N.E. 638, 640 (Ill. 1900).

96. 33 Cal. App. 2d at 632, 92 P.2d at 680.

97. See, e.g., *Stanford v. St. Louis—San Francisco Ry.*, 108 So. 566, 566 (Ala. Sup. Ct. 1926).

98. 56 N.E. at 640.

99. 65 F. Supp. 138 (1946).

100. See CAL. CIV. CODE §29.

101. See *supra* note 94.

102. 4 B. WITKIN, SUMMARY OF CALIFORNIA LAW *Torts* §379 (8th ed. 1973). Thus, California has avoided the problem of determining whether the fetus is a person as a prerequisite to recovery.

Despite the broad scope of section 29, it does not specifically guarantee a fetal right to necessary medical care.<sup>103</sup> Penal Code section 270, however, holds a parent criminally liable for failing to provide the necessities of life, including medical care, to his or her unborn child.<sup>104</sup> Although Penal Code section 270 grants a fetal right to necessary medical care, it does not grant a cause of action in the fetus to enforce that right. Accordingly, in order to establish a fetal right to recognition as a patient independent of its mother, Civil Code section 29 must be read in conjunction with Penal Code section 270. Penal Code section 270 supplies the specific fetal right to medical care, and Civil Code section 29 provides the civil action by which the fetus can enforce that right. Therefore, since Penal Code section 270 places a duty upon parents to provide their unborn child with the necessities of life including medical care, and Civil Code section 29 provides a cause of action to the fetus for anything beneficial to its interests, statutory authority already exists to afford legal recognition of the fetal patient.<sup>105</sup>

A statutory authorization of a fetal right to patient status is not sufficient to ensure the protection of this right. Since the fetus is unable to assert its own interests, the state may be required to intervene to protect

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The only requirement is that the fetus be born alive and not be claiming recovery under a purely statutory right. *See, e.g.,* CAL. CIV. PROC. CODE §377 (wrongful death statute). *Bayer v. Suttle*, 23 Cal. App. 3d 361, 364-65, 100 Cal. Rptr. 212, 214-15 (1972) (the court denied recovery for the wrongful death of the fetus). This appears to be a minority position. 23 Cal. App. 3d at 363, 100 Cal. Rptr. at 213.

103. This section has been construed to guarantee protection of whatever is "profitable or beneficial" to the unborn child in the event of its subsequent birth. 38 Cal. App. 2d at 127, 100 P.2d at 809; 33 Cal. App. 2d at 631, 92 P.2d at 680. Although the scope of the statute is potentially limitless, courts have refused to extend the protection of section 29 to criminal statutes that fail to include the fetus specifically. In the case of *Keeler v. Superior Court*, 2 Cal. 3d 619, 470 P.2d 617, 87 Cal. Rptr. 481 (1970), the California Supreme Court refused to find the fetus to be a person within the meaning of the homicide statute. The legislature responded to this decision by amending the statute to include the fetus. *See* CAL. PENAL CODE §187. In *Reyes v. the Superior Court, Etc.*, 75 Cal. App. 3d 214, 141 Cal. Rptr. 912 (1977), the court refused to apply the felony child endangering statute to a heroin addict for using heroin during her pregnancy and for failing to obtain prenatal care. *Id.* at 219, 141 Cal. Rptr. at 914. The mother subsequently gave birth to twins who were addicted to heroin and suffered withdrawal. *Id.* at 217, 141 Cal. Rptr. at 913. The court held that the legislature intended to exclude unborn children from the statutory designation "child." The reluctance of courts to extend section 29 to the criminal law is based upon a policy of narrowly construing criminal liability, rather than a reluctance to expand fetal rights. 75 Cal. App. 3d at 914, 141 Cal. Rptr. at 219.

104. CAL. PENAL CODE §270, provides in pertinent part:

If a parent of a minor child wilfully omits, without lawful excuse, to furnish necessary clothing, food, shelter or medical attendance, or other remedial care for his or her child, he or she is guilty of a misdemeanor. . . . A child conceived but not yet born is to be deemed an existing person insofar as this section is concerned.

Since section 270 specifically includes the fetus, the policy argument for narrowly construing criminal statutes is inapplicable. It could be argued, however, that reliance on section 270 as authority for legal recognition of the fetal patient does expand parental criminal liability. The rights of the fetus as a patient could be interpreted to include a maternal duty not only to employ all appropriate fetal therapy but also to discover whether treatment might be needed. *See infra* notes 187-198 and accompanying text. *See also* Robertson, *supra* note 19, at 352.

105. *See supra* notes 91-104.

fetal patient rights if the mother fails to do so. Thus, the rights and responsibilities of the state in a fetal treatment conflict also must be explored.

### C. *The Duties and Interests of the State*

The state has an interest in the health and welfare of its citizens both collectively and as individuals.<sup>106</sup> Thus, the state has a duty to protect the interests of society when parental conduct poses a threat to the political, social, economic or moral concerns of the general public.<sup>107</sup> The power of the state to regulate parental conduct for public health and welfare reasons derives from its sovereign police power,<sup>108</sup> and includes the right to protect society from a collective financial burden by promoting responsible medical care decisions.<sup>109</sup> Based upon this right to protect the public fisc, the state has an interest in preventing a mother from refusing fetal surgery that would cure a serious fetal defect. Since fetal surgery would not be attempted if the procedure could be postponed until after birth, a mother's refusal to allow the only possible "cure" would be characterized as an irresponsible decision.<sup>110</sup> Thus, allowing a mother to refuse fetal surgery that could cure or prevent a birth defect may result in a significant economic burden on society.<sup>111</sup> Since children born with serious birth defects often require lifetime institutional care, the need for state financial support of these children is an accepted reality.<sup>112</sup>

The state also has an interest in the welfare of the individual child.<sup>113</sup> If a child is deemed neglected or abused, the state is justified to intervene on its behalf.<sup>114</sup> When the state does intervene to protect the interests of a child, the power to do so is based upon the doctrine of *parens patriae*.<sup>115</sup> This doctrine authorizes the state to intervene in family af-

106. See Kleinfeld, *The Balance of Power Among Infants, Their Parents and the State*, 4 FAM. L.Q. 410, 415 (1970).

107. See *Prince v. Massachusetts*, 321 U.S. at 165 (1943); Comment, *State Intrusion into Family Affairs: Justifications and Limitations*, 26 STAN. L. REV. 1383, 1387 (1974). An example of state intervention into family matters on behalf of society is the requirement that all children be vaccinated before entering school. See *Jacobson v. Massachusetts*, 197 U.S. 11, 31 (1905).

108. 197 U.S. at 25.

109. See Comment, *Parental Liability for Prenatal Injury*, 14 COLUM. J.L. & SOC. PROBS. 47, 82 (1978).

110. See Comment, *supra* note 107, at 1390.

111. See Friedman, *supra* note 3, at 111 n.123.

112. See Comment, *supra* note 107, at 1390.

113. See *Meyer v. Nebraska*, 262 U.S. 390, 395 (1922). In California, this power has been codified in Welfare & Institutions Code sections 300 and 727.

114. 92 Cal. App. 3d at 51, 156 Cal. Rptr. at 801.

115. Citing origins in the English common law, J. Cardozo described *parens patriae*:

The chancellor . . . acts as *parens patriae* to do what is best for the interest of the child. He is to put himself in the position of a "wise, affectionate, and careful parent" and make provision for the child accordingly. He "interferes for the protection of infants, qua infants, by virtue of the prerogative which belongs to the Crown as *parens patriae*."

fairs to protect the health, safety, and welfare of children.<sup>116</sup> Similarly, it is appropriate for the state to invoke the doctrine of *parens patriae* in the context of a conflict over recommended fetal surgery. When a mother's refusal to consent to fetal surgery constitutes an unjustifiable threat to the health or safety of an individual fetus, the state should have the power to intervene.<sup>117</sup> Nonetheless, the state must show strong justification for intervening against the wishes of the parents on behalf of the individual child.<sup>118</sup> This justification is required not only because of our societal preference for parental autonomy, but also because the appropriateness of any medical care recommended for the child may be the subject of legitimate disagreement.<sup>119</sup> Accordingly, the situations in which the state is authorized to intervene on behalf of the individual fetus should be clearly defined.

As demonstrated, an analysis of the interests of mother, fetus and state discloses that each has significant interests at stake when a mother refuses recommended fetal therapy. The mother has constitutionally protected rights to parental autonomy and bodily integrity. Neither right, however, provides the mother absolute control over fetal treatment decisions. Likewise, an examination of California case law and statutes identifies existing legal rights for the fetus as a patient. The extent of these rights, however, is uncharted and may be dependent upon the nature of the rights of the mother. Finally, the state has an interest in protecting the health of unborn children and an interest in promoting responsible private medical care decisions affecting the fetus.

To ensure that the rights of the mother, fetus and state will be safeguarded, however, when a mother does refuse fetal surgery, it is necessary to develop a standard for judicial intervention. The adoption of a standard will accomplish several important objectives. Initially, a standard will provide substantive guidelines to resolve a conflict that arises when fetal therapy is refused by clarifying what decisions a mother is authorized to make. A clear understanding of the mother's decision-making authority will help to prevent conflicts from developing and also will help to reduce the number of inconsistent judicial decisions. In addition, substantive guidelines for judicial intervention will forestall the use of medical malpractice suits as a vehicle for determining

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Finlay v. Finlay, 148 N.E. 624, 626 (N.Y. App. 1925) (citations omitted).

116. See Ewald, *supra* note 44, at 713-14.

117. Although the fetus is not specifically identified in California Welfare and Institutions Code sections 300 and 727, the fetal right to patient status authorized by California statutes would enable the state to intervene on behalf of the fetus. See *supra* notes 91-104 and accompanying text.

118. See *In re Phillip B.*, 92 Cal. App. 3d at 801, 156 Cal. Rptr. at 51.

119. See Comment, *supra* note 107, at 1386.

the appropriate standard of care, and will help to clarify the role of the physician when a conflict does arise.

#### JUDICIAL INTERVENTION ON BEHALF OF THE FETUS—A RATIONALE FOR DEVELOPING A STANDARD

The desirability of developing a standard for judicial intervention in conflicts over medical care for the fetus would appear to be obvious: it would provide a consistent method for resolving conflicts and would also aid in preventing some conflicts by delineating the relative rights and responsibilities of the parties involved.<sup>120</sup> Despite the advantages of developing firm guidelines, statutes authorizing state intervention on behalf of abused or neglected children seldom provide substantive guidance.<sup>121</sup> One possible reason for this omission is that developing a standard for resolving medical care conflicts often requires confrontation with difficult moral and ethical issues that many individuals are reluctant to face.<sup>122</sup>

Another reason for a lack of firm guidelines is that technology frequently creates a novel situation that gives rise to an unanticipated conflict.<sup>123</sup> Indeed, the issue presented by fetal surgery, whether the state can require bodily intrusion on the mother to assist the child, has not previously arisen.<sup>124</sup> Resolution of this question, however, will benefit from substantive guidelines for state intervention. Therefore, an analysis of the need for a decisionmaking framework will follow.

Two potential problems are generated by a failure to develop an appropriate framework to deal with a conflict over fetal therapy. First, parents and physicians are often unsure what decisions they are author-

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120. See *infra* notes 168-236 and accompanying text.

121. See, e.g., NEV. REV. STAT. §201.090 (1981) (a neglected child is any person less than 18 years of age who is not provided with the necessities of life by his parents); N.Y. SOC. SERV. LAW §§371, 383b (Commissioner of Social Services may give consent for medical and hospital services for any child found to be neglected. A neglected child is one whose parents have failed to supply adequate medical or surgical care). The number of standards proposed for state intervention in medical decisionmaking for children underscores this lack. See, e.g., J. GOLDSTEIN, A. FREUD & A. SOLNIT, *BEFORE THE BEST INTERESTS OF THE CHILD* (1979); Goldstein, *Medical Care for the Child at Risk: On State Supervention of Parental Autonomy*, 86 YALE L.J. 645 (1977); Sokolosky, *The Sick Child and the Reluctant Parent—A Framework for Judicial Intervention*, 20 J. FAM. L. 69 (1981-82); Comment, *Court Ordered Non-Emergency Medical Care for Infants*, 18 CLEV.-MAR. L. REV. 296 (1969); Comment, *State Intrusion into Family Affairs: Justifications and Limitations*, 26 STAN. L. REV. 1383 (1974).

122. See Duff & Campbell, *Moral and Ethical Dilemmas in the Special-Care Nursery*, 289 NEW ENG. J. MED., October 25, 1973, at 890, 893. Ellis, *Letting Defective Babies Die: Who decides?*, 7 AM. J.L. & MED. 393, 413 (1982). Other than for religious objections, parents rarely refuse to provide their child medical care that is clearly warranted. The difficulty arises in cases where the benefits or results of treatment are ambiguous or where "quality of life" considerations are implicated by the treatment proposed.

123. See Robertson, *supra* note 19, at 353.

124. *Id.*



ized to make without incurring civil or criminal liability.<sup>125</sup> As a result, liability for use or omission of a new therapeutic technique is resolved by two equally unsatisfactory methods: routine judicial intervention prior to treatment<sup>126</sup> or resolution of liability in court "after the fact."<sup>127</sup> Second, a lack of firm guidelines results in erratic and inconsistent judicial decisions that are often the result of substituting the values of the individual judge for those of the parents.<sup>128</sup> Each of these problems will be explored in demonstrating the need for a standard.

### A. Inconsistent Judicial Decisions

Faced with a vague statutory grant of authority to intervene on behalf of children deemed abused or neglected, judges are often left on their own to define an appropriate social policy as a basis for resolving medical care conflicts.<sup>129</sup> For example, California Welfare and Institutions Code section 300(b) provides that a child may be adjudged a dependent of the court if the child is not provided with "the necessities of life."<sup>130</sup> The following cases will illustrate the varying interpretations that can apply to the phrase "necessities of life" or the equivalent phrases used in other jurisdictions.

In the case of *In re Phillip B.*,<sup>131</sup> the court did not consider life-prolonging surgery to be within the ambit of "necessities of life."<sup>132</sup> Instead, the court upheld the right of the parents to refuse cardiac surgery for their 12 year old son who was a victim of Down's Syndrome.<sup>133</sup> Although medical opinion indicated that Phillip's life would be severely shortened without the surgery, the court concluded that there was no clear and convincing evidence that Phillip was not provided with the "necessities of life."<sup>134</sup> In reaching this decision, the court stressed that the state has a "serious burden of justification before abridging parental autonomy by substituting its judgment for that of

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125. See Ellis, *supra* note 122, at 401-13; Duff & Campbell, *supra* note 122, at 894.

126. See Bowes & Selgestad, *Fetal Versus Maternal Rights: Medical and Legal Perspectives*, OBSTETRICS & GYNECOLOGY, August 1981, at 209, 214. Practical reasons also exist to avoid the need for judicial intervention as a routine solution for fetal treatment conflicts. Time is often the enemy of judicial intervention during pregnancy. Especially during labor, the onset of problems can be so sudden and fetal deterioration so rapid that a judicial hearing is impossible. Shriner, *Maternal Versus Fetal Rights: A Clinical Dilemma*, OBSTETRICS AND GYNECOLOGY, April 1979, at 518, 519.

127. See Friedman, *supra* note 3, at 116.

128. See S. KATZ, WHEN PARENTS FAIL 70-79 (1971); Comment, *supra* note 107, at 1392; Sokolosky, *supra* note 121, at 70.

129. See KATZ, *supra* note 128, at 59.

130. CAL. WELF. & INST. CODE §300(b).

131. 92 Cal. App. 3d 796, 156 Cal. Rptr. 48 (1979), cert. denied, 445 U.S. 949 (1980).

132. 92 Cal. App. 3d at 803, 156 Cal. Rptr. at 52.

133. *Id.* at 800, 156 Cal. Rptr. at 50.

134. *Id.* at 802-03, 156 Cal. Rptr. at 51, 52.

the parents.”<sup>135</sup>

By contrast, in the case of *In Re Karwath*,<sup>136</sup> the Iowa court ordered tonsillectomies on three children over the religious objections of their father.<sup>137</sup> The court based its right to intervene on an interpretation of the statutory duty of parents to provide “necessary medical care” to mean a duty to provide “ordinary” medical care even in the absence of immediate risk to life.<sup>138</sup> The Pennsylvania court in the case of *Re Green*,<sup>139</sup> however, refused to uphold a court ordered spinal fusion to ameliorate a polio-induced spinal curvature over the mother’s religious objections absent a finding that the life of the child was endangered.<sup>140</sup> The court’s sole statutory guideline for determining a need to intervene was an assessment of whether Ricky Green was a “neglected child.”<sup>141</sup>

In addition, the medical literature includes case reports of treatment conflicts involving defective newborns that present even more compelling evidence of the inconsistent results that a lack of substantive guidelines engenders.<sup>142</sup> A court in Maryland refused to order surgery for a child afflicted with Down’s Syndrome who was also born with duodenal atresia and intestinal obstruction, a condition that would require surgery to allow the child’s digestive system to function. The court declared that it “would not force the parents or society to bear the burden of such a child.”<sup>143</sup> A court in Maine, however, ordered surgery on a newborn with no left eye, no right ear canal, several unfused vertebrae, and various digestive abnormalities that prevented normal feeding by mouth.<sup>144</sup> The total effect of these birth defects meant that the child would be paralyzed, blind, deaf, unable to communicate, and perhaps unable to stand.<sup>145</sup> Nevertheless, the court declared that parents have no right to withhold treatment and that the basic right enjoyed by every human being is the right to life itself.<sup>146</sup>

As these examples illustrate, vaguely worded statutes leave room for widely differing interpretations. Courts almost invariably consider life-saving medical treatment to be inherent in the meaning of “necessary medical care,” but are divided on whether “necessary medical care” mandates state intervention for anything less than lifesaving medical

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135. *Id.* at 801, 802, 156 Cal. Rptr. at 51.

136. 199 N.W.2d 147 (Iowa 1972).

137. *Id.* at 150.

138. *Id.*

139. 292 A.2d 387 (Pa. 1972).

140. *Id.* at 392.

141. *Id.* at 387.

142. See Gimbel, *Infanticide: Who Makes the Decision?*, 73 WIS. MED. J., May 1974, at 10.

143. *Id.*

144. *Id.*

145. *Id.* at 11.

146. *Id.*

treatment.<sup>147</sup> In the absence of a clearly defined public policy specifying the extent of parental authority to make medical care decisions on behalf of children, judicial decisions may often be only a reflection of the value systems of the individual judge.<sup>148</sup> In cases of child abuse or failure to provide lifesaving medical care for an otherwise healthy child, there is general agreement that state intervention is appropriate.<sup>149</sup> In cases where the recommended treatment would prolong or salvage a life of low quality, however, societal consensus disappears.<sup>150</sup> A quality of life dilemma often will be presented by a conflict over fetal surgery since the fetus requiring surgery will always have some pre-existing genetic or developmental defect.<sup>151</sup> Thus, the appropriateness of lifesaving medical treatments for seriously impaired fetuses will almost always require a quality of life value judgment.<sup>152</sup> Rather than leave this kind of quality of life decision to the discretion of the particular judge, it should be left to the person most affected by the decision—the mother.<sup>153</sup>

Accordingly, a standard that assigns responsibility for quality of life decisions to the mother will significantly reduce the inconsistent judicial decisions that result when a court interposes its own value judgments, because the need for judicial intervention will be greatly reduced. Furthermore, since maternal decisionmaking authority will be more clearly defined, and judicial decisionmaking authority will be limited, adoption of a standard will help to ensure that those decisions requiring judicial intervention will be more consistent. Adoption of this standard will not mean that fetal treatment decisions involving quality of life questions will invariably be handled in the same manner. Instead, it assures that whatever the ultimate decision is, it will be made by those who will bear the day-to-day burden of the social, psychological, and economic costs.

In addition to the problem of inconsistent judicial decisions, failure to define parental decisionmaking authority has an impact on another party involved in medical care conflicts—namely, the physician.<sup>154</sup> Uncertainty about parental authority tends to confuse the appropriate role physicians should play in medical care conflicts.<sup>155</sup> In addition, new technology, such as fetal surgery, tends to raise standards of care

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147. See *supra* notes 131-42 and accompanying text.

148. See KATZ, *supra* note 128, at 59.

149. *Id.* at 11, 23.

150. *Id.* at 11. Goldstein, *supra* note 121, at 54.

151. See *Management of the Fetus*, *supra* note 1, at 775-76.

152. See Gimbel, *supra* note 142, at 11.

153. *Id.*

154. See Ellis, *supra* note 122, at 415.

155. *Id.*

more quickly than the law can respond.<sup>156</sup>

### B. *The Role of the Physician*

Whenever technology outpaces the ability of society to respond in assigning legal responsibility for employing or failing to employ new therapeutic techniques, two possible approaches to malpractice liability result: (1) criminal and civil liability is determined in the courts "after the fact,"<sup>157</sup> or (2) routine judicial intervention is sought.<sup>158</sup> Neither approach is satisfactory for a number of reasons and can be avoided by establishing substantive guidelines for intervention.

In particular, determining liability in court long after the event is especially burdensome on physicians. Although there is no professional liability for failing to recommend experimental procedures,<sup>159</sup> the line that divides an experimental procedure from an established one is never clear.<sup>160</sup> Thus, a standard that clarifies the rights and responsibilities of parents and physicians in fetal treatment conflicts can help to smooth the transition.

In addition, the physician<sup>161</sup> providing health care to a pregnant woman has two patients simultaneously, the mother and the fetus. When the interests of these two patients conflict, the question arises as to whose interest should prevail. The physician who chooses one is left open to a charge of abandonment of the other.<sup>162</sup> This professional dilemma was illustrated in a report of a mother who refused a cesarean section recommended for severe fetal distress during labor.<sup>163</sup> The physicians and the hospital were concerned that a failure to act on behalf of the fetus would result in charges of professional or institutional negligence.<sup>164</sup> On the other hand, the possibility of criminal assault charges existed if surgery were performed against the mother's will.<sup>165</sup> The solution to this dilemma was to request the intervention of the

156. See Professional Liability Newsletter XIV, no. 1, at 2 (Dec. 1982) (copy on file at the Pacific Law Journal).

157. See Bowles & Selgestad, *Fetal Versus Maternal Rights: Medical and Legal Perspectives*, OBSTETRICS & GYNECOLOGY, August 1981, at 209, 214.

158. See Ellis, *supra* note 122, at 401-13; Duff & Campbell, *Moral and Ethical Dilemmas in the Special-Care Nursery*, 289 NEW ENG. J. MED. 890, 894, October 25, 1973.

159. See Robertson, *supra* note 19, at 346.

160. *Id.* at 351 n.85.

161. Because fetal treatments ordinarily require surgical interventions, it is assumed that the health care provider involved in a conflict over the use of any treatment will be a licensed physician.

162. See Ruddick & Wilcox, *supra* note 3, at 12; see also Colautti v. Franklin, 439 U.S. 379, 400 (1979). The Court, in declaring §5a of the Pennsylvania Abortion Control Act void for vagueness, recognized the serious ethical and constitutional difficulties inherent in the question of whether the physician's paramount duty is to mother or fetus. *Id.*

163. Bowles & Selgestad, *supra* note 157, at 209.

164. *Id.* at 211.

165. *Id.*

juvenile court to avoid possible professional liability.<sup>166</sup> In a case like this, a standard for state intervention that clearly indicates the mother's decisionmaking authority frequently would eliminate the need to resort to judicial intervention to prevent potential malpractice liability. Instead, the role of the physician could be limited to providing information on all possible treatment options, including the option of no treatment at all. Then the final decision could be left to the mother in all cases in which she had specific authority to decide.<sup>167</sup>

Thus, a standard for judicial intervention would accomplish several important objectives by providing specific clarification of maternal decisionmaking authority in fetal therapy conflicts. First, the interests of the mother, the fetus and the state would be safeguarded from inconsistent judicial decisions based upon vague statutory authority for state intervention. Furthermore, substantive guidelines for intervention will prevent too great an interference with maternal rights and too little protection of fetal rights. Second, the adoption of a standard will help to confine the physician's role to one of counselling and advising the mother of the available fetal treatment options. Finally, a standard will help to prevent unfair liability for physicians as fetal surgery begins to cross the line from an experimental procedure to a procedure clearly within the standard of care.

As demonstrated, compelling reasons exist for adopting a standard for judicial intervention in fetal treatment conflicts. Formulating a standard, however, requires making a policy decision to allow the interests of one party in the conflict to prevail over those of the other parties. Thus, in order to determine which interests should prevail in a fetal treatment conflict, the interests of the mother, fetus and state must be weighed and balanced.

#### BALANCING THE INTERESTS

In balancing the interests of the mother, the fetus, and the state when recommended fetal surgery is refused, an analysis of whose interest should prevail can begin from one of three points of view.<sup>168</sup> These views are as follows:

(1) *The fetal view*, which would require that all fetal treatment decisions be made in favor of the fetus, except when the mother's life is

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166. *Id.* at 212.

167. See *infra* pp. 67-68 (A Standard for Judicial Intervention in Fetal Treatment Decisions).

168. See Ruddick & Wilcox, *supra* note 3, at 12-13. The authors suggest three "therapeutic contracts" that might serve as a basis for an understanding between a mother and her physician regarding the physician's duty in treating the fetus.

threatened by the procedure.<sup>169</sup>

(2) *The maternal view*, which would allow the mother sole authority for all fetal treatment decisions with no state intervention permitted.<sup>170</sup>

(3) *The qualified maternal view*, which would permit the mother to make most fetal treatment decisions, but would authorize the state to intervene on behalf of the fetus in certain situations.<sup>171</sup> Each of these views will be explored in order to demonstrate that the third option is the only choice that adequately protects the interests of fetus, mother, and state.

#### A. *The Fetal View*

The fetal view would require that the mother submit to all recommended fetal surgery unless the procedure threatened her own life. This view is unacceptable for a number of reasons. Primarily, the fetal view presents an unnecessary interference with the mother's rights of parental autonomy and bodily integrity.<sup>172</sup> Since most mothers are committed to doing whatever is necessary to assure the best possible outcome for their child, the number of treatment refusals is likely to be very small.<sup>173</sup> In fact, an examination of the actual procedures used in fetal surgery reveals two situations in which a mother is most likely to refuse a proposed treatment.<sup>174</sup>

The first situation would be when the recommended treatment required a major surgical procedure, such as a cesarean section, on the mother.<sup>175</sup> The reasons for refusal in this situation might include religious beliefs or fear of surgery.<sup>176</sup> The other situation in which a rejection of recommended fetal therapy might occur would be when the

169. *Id.*

170. *Id.*

171. *Id.*

172. See *supra* notes 55-77.

173. See Robertson, *supra* note 19, at 351 n.86.

174. For example, the procedure to repair bilateral congenital hydronephrosis required a cesarean section on the mother in order to remove the fetus so that the fetal surgery could be performed. The fetus was removed without interrupting fetomaternal circulation. Once the repair was completed, the fetus was returned to the uterus to await cesarean delivery three months later. See *Fetal Surgery*, *supra* note 15, at 591. By contrast, the implantation of the shunting device to correct hydrocephalus required only a small incision in the mother's abdomen. This was followed by insertion of a thirteen-gauge needle through the incision into the fetal skull. The needle then served as a conduit for the introduction of the shunt. See Clewell, *supra* note 15, at 1321. In a case like this one, the level of intervention on the mother is roughly equivalent to that required for amniocentesis. Consequently, refusals are less likely to occur when this type of treatment is recommended since the mother often would have already agreed to an equally intrusive diagnostic test to discover the fetal problem sought to be alleviated. See *Management of the Fetus*, *supra* note 1, at 777. An exception would be a refusal based upon the fear of salvaging a damaged fetus that might not otherwise have survived.

175. See Robertson, *supra* note 19, at 351, n.86, 361.

176. See Leiberman, Mazor, Chaim & Cohen, *The Fetal Right to Live*, *OBSTETRICS & GYNECOLOGY*, April 1979, at 515, 516.

mother felt that the recommended procedure was not in the best interests of the fetus, regardless of the degree of maternal invasion required by the proposed treatment.<sup>177</sup> The reasons for refusal in these circumstances might be religious beliefs, fear of harm to the fetus, or concern over the possibility of salvaging a fetus whose prospects for a life worth living are dismal.<sup>178</sup>

Thus, a mother might refuse recommended fetal surgery for "unjustifiable" reasons, for example, based upon an unreasonable fear of surgery or a rejection of technology regardless of the potential benefit to the fetus; however, her refusal might also be based upon more legitimate grounds, for example, when the benefit of the proposed treatment was uncertain. Therefore, adoption of the fetal view, which essentially eliminates maternal input in fetal treatment decisions, is an unnecessary interference with the mother's right of parental autonomy. Moreover, since the fetal view would require a mother to consent to all recommended fetal procedures, even those of disputed benefit, her right to bodily integrity would be unreasonably burdened.

A second reason to reject the fetal view is that it tacitly approves a "fundamental right to a healthy birth."<sup>179</sup> Many commentators have urged the recognition of a right to be born whole and healthy.<sup>180</sup> In addition, a number of jurisdictions have based their decisions allowing recovery for prenatal injuries on this right.<sup>181</sup> Although a right to be born whole and healthy would seem to substantiate our societal concern for the value and quality of human life, recognition of this right has implications far beyond the goal of providing each child the best possible start in life.<sup>182</sup> The difficulties inherent in a right to a healthy birth have been well stated:

"[S]uch a principle . . . misstates the relative rights and obligations of physicians, parents, and progeny. [T]he principle of a right to a healthy birth is too far-reaching to establish a legal rule. The enforcement of such a rule by the state, through the courts and other agencies of social control, would quickly lead to unprecedented eugenic totalitarianism."<sup>183</sup>

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177. See Ruddick & Wilcox, *supra* note 3, at 11.

178. *Id.*

179. See, e.g., WILLIAMS OBSTETRICS, *supra* note 7, at 9; Ament, *The Right to be Well Born*, J. LEGAL MED., Nov.-Dec. 1974, at 24; *Grodin v. Grodin*, 301 N.W.2d 869, 870 (Mich. App. 1981); Davis, *Ethical and Technical Aspects of Genetic Intervention*, 285 NEW ENG. J. MED. September 30, 1971, at 800.

180. *Id.*

181. See *Smith v. Brennan*, 157 A.2d 497, 503 (N.J. 1960); *Gleitman v. Cosgrove*, 227 A.2d 689, 692 (N.J. 1967).

182. See Capron, *The Continuing Wrong of "Wrongful Life"*, in GENETICS AND THE LAW II 91 (A. Milunsky & G. Annas, eds. 1980).

183. *Id.*

Thus, the problem with a fundamental right to a healthy birth lies in the interpretation of "healthy."<sup>184</sup> If all children must be born "healthy," who is to decide what defects or abnormalities cannot be allowed to exist?<sup>185</sup>

Furthermore, as previously noted, fetal surgery cannot cure all potential defects and abnormalities. Implicit in the notion of a healthy birth is a limit on parental options if the fetus is "defective." The choices mandated by the requirement of a right to a healthy birth would be limited to (1) surgical repair, if appropriate, or (2) abortion, if surgery were not appropriate.<sup>186</sup>

Moreover, since a right to a healthy birth would place a duty upon mothers to employ all recommended fetal therapy,<sup>187</sup> a duty to *discover* any potential defect would also arise.<sup>188</sup> Establishing a duty to discover whether a treatable abnormality exists means nothing less than mandatory prenatal care and mandatory screening of all pregnancies

184. See *Turpin v. Sortini*, 119 Cal. App. 3d 690, 696 n.3, 174 Cal. Rptr. 128, 132 (1981), *rev'd on other grounds*, 31 Cal. 3d 220, 643 P.2d 954, 182 Cal. Rptr. 337 (1982); *Becker v. Schwartz*, 46 N.Y.2d 401, 405, 386 N.E.2d 807, 812; see also Motulsky, *Governmental Responsibilities in Genetic Diseases*, in *GENETICS AND THE LAW II* 237, 237 (A. Milunsky & G. Annas, eds. 1980); Annas, *Righting the Wrong of 'Wrongful Life'*, 11 HASTINGS CENTER REP., 8, 9, February 1981.

185. See *supra* note 184. Another potential problem with legal recognition of a right to be born whole and healthy might be a reliance on civil suits by a child against its mother. If a mother could be sued for her conduct during pregnancy that resulted in harm to the fetus, a mother's refusal to employ fetal surgery could serve as a basis for liability. The possibility of a child suing its mother for her prenatal conduct was suggested by the court in the case of *Curlender v. Bio-Sciences Laboratories*, 106 Cal. App. 3d 811, 816, 165 Cal. Rptr. 477, 481 (1980). In addition, one case has been reported in which a child was allowed to state a cause of action against a mother for her allegedly negligent conduct during pregnancy. See *Grodin v. Grodin*, 301 N.W.2d 869, 871 (Mich. App. 1981) (child's permanent teeth brown and discolored as a result of mother's use of the drug Tetracycline during pregnancy). Although *Grodin* arose in Michigan, the court's suggestion in *Curlender* could serve as authority for a case like *Grodin* in California. This type of suit would not be barred by intrafamilial tort immunity since that doctrine has been abolished in California. See *Gibson v. Gibson*, 3 Cal. 3d 914, 916, 923, 479 P.2d 648, 648, 654, 92 Cal. Rptr. 288, 288, 294 (1971). There is statutory authority, however, that can be cited as prohibiting civil suits by a child against its mother for her prenatal conduct. California Civil Code section 43.6 provides: "no cause of action arises against a parent of a child based upon the claim that the child should not have been conceived, or, if conceived, should not have been allowed to have been born alive." This section has been construed as eliminating any cause of action by a child that would encourage parents to choose abortion rather than risk liability for giving birth to a "less than perfect child." See *Turpin v. Sortini*, 31 Cal. 3d 220, 229, 643 P.2d 954, 959, 182 Cal. Rptr. 337, 345 (1982). The possibility of a civil suit by the child against a mother for failing to employ fetal surgery would definitely tend to encourage abortion as a simpler solution to a conflict over recommended fetal therapy. This would be especially true if the recommended fetal therapy required a highly invasive procedure on the mother. Accordingly, civil suits against the mother for failure to employ fetal therapy should be prohibited under section 43.6.

186. See *supra* note 184.

187. See Robertson, *supra* note 19, at 352; Shaw, *The Potential Plaintiff: Preconception and Prenatal Torts*, in *GENETICS AND THE LAW II* 225, 228 (A. Milunsky & G. Annas, eds. 1980); see generally Comment, *Parental Liability for Prenatal Injury*, 14 COLUM. J.L. SOC. PROBS. 47 (1978); Comment, *Recovery for Prenatal Injuries: The Right of a Child Against its Mother*, X SUFFOLK U.L. REV. 582 (1976).

188. See Robertson, *supra* note 19, at 352-53. One California court and several commentators have suggested that a duty to discover potential fetal problems already exists. 106 Cal. App. 3d 811, 829, 165 Cal. Rptr. 477, 488 (1980). See Shaw, *supra* note 187, at 228-29.



for fetal abnormalities.<sup>189</sup> Although mandatory prenatal care, including screening and treatment of every pregnancy, may be a legitimate goal of society, this is a decision that properly belongs to the legislature as the chosen representative of society.<sup>190</sup> A judicially created duty to discover potential birth defects would probably meet with great resistance. The cost alone would surely lead to massive non-compliance.<sup>191</sup>

Even if the legislature were to enact mandatory prenatal care and screening laws, formidable problems would remain. First, screening all pregnancies using amniocentesis and ultrasound in order to detect possible fetal abnormalities is currently not standard medical practice. The risks of the procedures do not outweigh the benefits to be gained by routinely testing all pregnant women.<sup>192</sup> Second, screening only medically indicated pregnancies<sup>193</sup> would not reveal all treatable defects. Some defects are not amenable to prenatal diagnosis by any technique.<sup>194</sup>

Finally, mandatory prenatal care, as a means of preventing birth defects, would require inordinate state intrusion into the lives of pregnant women, and could lead to a serious deprivation of liberty.<sup>195</sup> Women could be required to take medications to maintain their own health and could be prohibited from using alcohol or other substances that might pose a threat to the developing fetus.<sup>196</sup> State regulation of a mother's life during pregnancy might extend to the nature of her work, her diet,

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189. See Robertson, *supra* note 19, at 360. For an example of a prenatal screening program, see Crandall, Robertson, Lebherz, King & Schroth, *Maternal Serum  $\alpha$ -Fetoprotein Screening for the Detection of Neural Tube Defects—Report of a Pilot Program*, 138 WESTERN J. MED. 524-30 (April 1983).

190. 410 U.S. 113, *Doe v. Bolton*, 410 U.S. 179, 222 (1973) (Rehnquist, J. and White, J., dissenting) "a sensitive area such as this, involving as it does issues over which reasonable men may easily and heatedly differ . . . should be left with the people and to the political processes the people have devised to govern their affairs."

191. See generally Motulsky, *Governmental Responsibilities in Genetic Diseases*, in GENETICS AND THE LAW II 237, 246 (A. Milunsky & G. Annas, eds. 1980).

192. See Friedman, *supra* note 3, at 111. The three major risks of amniocentesis are the following: (1) trauma to the fetus, to the placenta or less often, to the umbilical cord or maternal structures, (2) infection, (3) abortion or premature labor. Risk of fetal loss is placed at between 2.6 – 3.5% as compared to a control of 1.1 – 3.2%. WILLIAMS OBSTETRICS, *supra* note 7, at 330-34.

193. For example, the medical indications for amniocentesis are (1) advanced maternal age (35 or over); (2) previous pregnancy resulted in birth of a child with a chromosomal abnormality; (3) family history of genetic disease. WILLIAMS OBSTETRICS, *supra* note 7, at 338-44.

194. *Id.*

195. See Annas, *Forced Cesareans: The Most Unkindest Cut of All*, 12 HASTINGS CENTER REP. June 1982 at 16, 45; Annas, *Righting the Wrong of 'Wrongful Life'*, 11 HASTINGS CENTER REP., February 1981, at 8, 9.

196. See Annas, *Forced Cesareans*, *supra* note 195, at 45; Robertson, *supra* note 19, at 358. See, e.g., N.Y. TIMES, Apr. 27, 1983, at 11, col. 4. A physician in Baltimore has petitioned the juvenile court in an effort to force a pregnant woman to stop taking drugs. The complaint contends that the mother's drug abuse, described as the use of substantial amounts of Quaalude, Valium, Cocaine, and morphine, has retarded the growth of the 7-month old fetus, and placed both her life and the life of the unborn child in dangerous life-threatening situations.

and even her personal habits.<sup>197</sup> Although these measures might be motivated by a legitimate purpose, the potential for abuse is too great.<sup>198</sup>

As demonstrated, the fetal view would pose an unnecessary burden on a mother's rights of parental autonomy, bodily integrity, and individual liberty. The fetal right to necessary medical care does not require depriving the mother of all authority to make medical care decisions for the fetus. Indeed, the fetal view raises a specter of intrusive state regulation that has been consistently shunned by our society.<sup>199</sup>

If the fetal view represents one extreme position in the matter of fetal treatment conflicts, the maternal view represents the other extreme. The maternal view would be advocated by those who resent any state interference with parental decisions about medical care for children.<sup>200</sup> An analysis of the maternal view, however, will reveal that it does not go far enough in protecting the right of the fetus to medical care or the interest of the state in assuring the protection of that right.

### B. *The Maternal View*

The maternal view of balancing the interests involved in a conflict over fetal treatment would give paramount importance to the mother's rights of bodily integrity and parental autonomy.<sup>201</sup> This approach would allow the mother an absolute right to choose whether or not the fetus should become a patient at all. Fetal treatment would be authorized only with the mother's informed consent.<sup>202</sup> A number of commentators see this approach as the only appropriate option.<sup>203</sup> Allowing the mother complete control, however, is inconsistent with the fetal right to medical care authorized by California law,<sup>204</sup> and would prohibit the state from exercising its duty to protect the health of the unborn.<sup>205</sup> Moreover, judicial precedents already exist that reject an absolute right of choice in the mother.

In particular, the United States Supreme Court has limited a mother's right to choose abortion once the fetus has become viable.<sup>206</sup>

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197. *Id.*

198. See Annas, *Righting the Wrong*, *supra* note 195, at 9.

199. See generally Henkin, *Privacy and Autonomy*, 74 COLUM. L. REV., 1410, 1410-21 (1974).

200. See, e.g., Hubbard, *The Fetus as Patient*, MS. MAGAZINE, October 1982, at 28, 32.

201. Ruddick & Wilcox, *supra* note 3, at 12.

202. *Id.*

203. See Fletcher, *The Fetus as Patient: Ethical Issues*, 246 J. AM. MED. A. 772, 772 (1981); Shriner, *Maternal Versus Fetal Rights—A Clinical Dilemma*; OBSTETRICS & GYNECOLOGY, April 1979, at 518, 519; Annas, *Forced Cesareans*, *supra* note 158, at 45.

204. See *supra* notes 81-105 and accompanying text.

205. See *supra* notes 113-19 and accompanying text.

206. 410 U.S. at 163 (1973).

The Court has declared that the state may prohibit abortion after viability has been reached.<sup>207</sup> Furthermore, several cases have already approved surgical procedures on the mother to save the life of her unborn child.<sup>208</sup>

In the case of *Raleigh Fitkin-Paul Morgan Memorial Hospital v. Anderson*,<sup>209</sup> a Jehovah's Witness refused a blood transfusion recommended to save both her life and the life of the fetus.<sup>210</sup> The woman subsequently left the hospital against medical advice so the question became moot.<sup>211</sup> Nevertheless, the Supreme Court of New Jersey decided that the life of an unborn child is entitled to protection from the state, and declared that the court would order whatever medical relief was necessary to preserve fetal life.<sup>212</sup> The value of this case as reliable precedent is somewhat limited, however, because a blood transfusion is a minimal surgical intervention<sup>213</sup> and the mother never was required to submit to a transfusion.<sup>214</sup>

The same position was taken by another court in a more recent case. In *Jefferson v. Griffin Spaulding County Hospital*,<sup>215</sup> the Supreme Court of Georgia ordered a cesarean section and blood transfusions over the religious objections of the mother who was 39 weeks pregnant.<sup>216</sup> Medical indication for the surgery was based upon a finding of complete placenta previa.<sup>217</sup> The court granted temporary custody of the child to the state of Georgia declaring that interference with the mother's religious beliefs was outweighed by the duty of the state to protect "a living, unborn human being."<sup>218</sup>

Finally, a case was reported in the medical literature concerning a woman who refused a cesarean section recommended for severe fetal distress because she feared the surgery.<sup>219</sup> The mother was an increased surgical risk because of excessive obesity.<sup>220</sup> The court appointed attorneys for both mother and fetus and a hearing was held at

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207. *Id.* at 163, 165.

208. *See infra* notes 209-22.

209. 201 A.2d 537 (1964).

210. *Id.* at 537-38.

211. *Id.* at 538.

212. *Id.*

213. *See Annas, Forced Cesareans, supra* note 195, at 17.

214. *Id.*

215. 274 S.E.2d 457 (Ga. 1981).

216. *Id.* at 458.

217. Placenta previa is a serious but rare complication of pregnancy in which the placenta, or afterbirth, is implanted in the uterus so that it blocks the baby's entrance to the birth canal. Even a simple vaginal exam can cause sudden, massive and even fatal hemorrhage. Cesarean section is the accepted method of delivery in all cases of total placenta previa. *See WILLIAMS OBSTETRICS, supra* note 7, at 508-10, 514.

218. 274 S.E.2d at 460.

219. *See supra* note 157, at 209.

220. *Id.* at 211.

her bedside.<sup>221</sup> The court declared the fetus to be a neglected and dependent child under the Colorado Children's Code, and a cesarean section was ordered to preserve its life.<sup>222</sup>

In the face of these precedents dealing specifically with the unborn child,<sup>223</sup> an absolute maternal right to make all medical decisions on behalf of the fetus cannot be supported legally. Moreover, an absolute maternal right of choice is inconsistent with the fetal right to medical care authorized by California law,<sup>224</sup> as well as the sovereign power of the state to protect the health and welfare of the unborn.<sup>225</sup> Finally, the interest of the state in promoting responsible private medical care decisions would prohibit a strict maternal view as the basis for a standard. Since the fetal view allows unwarranted interference with the mother's rights, and the maternal view falls short in protecting fetal rights, a qualified maternal view offers the only approach that can satisfactorily protect the interests of all the parties involved.

### C. *The Qualified Maternal View*

Under the qualified maternal view, the fetus would be a provisional patient. The mother would be permitted to make most fetal treatment decisions; however, the state would be authorized to intervene, and the fetal right to treatment would prevail, when the recommended treatment would prevent serious irreversible harm to the fetus without posing serious risk to the mother's life. Accordingly, a mother's duty to employ a recommended fetal therapy would not arise until the following three conditions were met: (1) the mother chose to undergo a prenatal diagnostic test that was medically indicated according to current standards of care; (2) the diagnostic test revealed the presence of a treatable birth defect; and (3) the proposed treatment would prevent serious irreversible physical or mental impairment to the fetus, would pose no substantial risk to the mother's life, and offered the only reasonable opportunity to correct the fetal problem.

Thus, the treatment proposed would have to be both a medically accepted procedure and one that offered a clear benefit to the fetus. The "clear benefit" expected from this type of treatment would be similar to

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221. *Id.* at 210. No written opinion was given by the court.

222. *Id.* These precedents compelling lifesaving fetal treatments have all involved normal fetuses whose lives were threatened by external conditions. This must be distinguished from the situation in which a fetal surgery would be recommended. All the conditions identified as amenable to fetal surgery involve fetuses that have either a developmental or genetic abnormality. Consequently, a "quality of life" question often will be implicated in a conflict over fetal surgery.

223. *See supra* notes 209-22.

224. *See supra* notes 81-105 and accompanying text.

225. *See supra* notes 113-19 and accompanying text.

the use of eye drops at birth to prevent blindness<sup>226</sup> or fetal blood transfusion to prevent severe mental retardation secondary to erythroblastosis (RH incompatibility).<sup>227</sup> An example of a fetal surgery that might satisfy the proposed standard would be the implantation of a shunt to alleviate hydrocephalus.<sup>228</sup> The cranial abnormalities and mental retardation caused by this condition are a direct result of the accumulation of cerebrospinal fluid that retards brain growth.<sup>229</sup> Implantation of a shunt prevents pressure on the brain, thereby allowing normal brain development to occur.<sup>230</sup> Once this procedure becomes established, it may offer the type of "clear benefit" encompassed within the qualified maternal view.

Adoption of a standard based upon the qualified maternal view would therefore avert the problems encountered by both the fetal and maternal views previously discussed. In particular, the qualified maternal view would prohibit state interference with a mother's right to parental autonomy unless clearly necessary for the benefit of the fetus. In addition, it would eliminate a duty to discover fetal defects—a duty that would lead to a serious invasion of the liberty of pregnant women. This view also would guarantee that the right of the fetus to necessary medical care would be protected. Finally, the interest of the state in protecting society from unreasonable financial burdens would be satisfied by preventing, when possible, the kinds of fetal conditions that require lifetime institutional care.

Accordingly, under the qualified maternal view, the mother's right to make fetal treatment decisions about any procedure not offering a clear benefit to the fetus would be preserved. Furthermore, no mother would be forced to consent to fetal therapy that would prolong or salvage the life of a fetus whose prospects for a "life worth living" are dismal. Treatments recommended in cases where the results were uncertain or marginal would be performed only with the informed consent of the mother. Since the mother bears the emotional burden of caring for a severely defective child, she should have the authority to make lifesaving treatment decisions that involve a judgment about the quality of life.<sup>231</sup> The California Supreme Court voiced its approval of the right of parents to make quality of life decisions on behalf of the

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226. See ANNIS, *THE CHILD BEFORE BIRTH* 129 (1978).

227. *Id.* at 87-90.

228. See Clewell, *supra* note 15, at 1320.

229. *Id.*

230. *Id.*

231. See Duff & Campbell, *supra* note 122, at 894; PRESIDENT'S COMMISSION FOR THE STUDY OF ETHICAL PROBS. IN MED. AND BIOMEDICAL AND BEHAVIORAL RESEARCH, *DECIDING TO FOREGO LIFE-SUSTAINING TREATMENT; A REPORT ON THE ETHICAL, MEDICAL, AND LEGAL ISSUES IN TREATMENT DECISIONS* 197, 223-27 (March 1983).

fetus in the case of *Turpin v. Sortini*.<sup>232</sup> Citing the California "right to die" statute,<sup>233</sup> the court declared that the public policy of the state does not establish, as a matter of law, a preference for impaired life over nonlife.<sup>234</sup> Moreover, the court indicated that, since the unborn child is unable to make a choice as to the relative value of life, the law generally accords the parents the right to make this decision.<sup>235</sup>

Balancing the rights and interests of mother, fetus, and state, therefore, reveals that the fetus must be considered a provisional patient. The fetal right to independent recognition as a patient must be limited to those treatments that are of clear benefit to the fetus. This limitation on the legal rights of the fetus as a patient will not only circumvent the problems inherent in the right to a healthy birth, but also will prevent unnecessary intrusions on the mother's rights of parental autonomy and bodily integrity.<sup>236</sup> Despite this limitation, however, the duty of the state to protect the health of the unborn and preserve the public fisc will be satisfied. Therefore, the following standard based upon the qualified maternal view should be adopted.

#### JUDICIAL INTERVENTION IN FETAL TREATMENT DECISIONS—A STANDARD

(1) The fetus is a provisional patient. The fetal right to medical treatment will ordinarily arise only by consent of the mother. All fetal treatment decisions will be made by the mother with full disclosure by her physician of all treatment options and expected consequences, including the expected consequences of no treatment at all.

(2) The mother has authority to make all fetal treatment decisions involving procedures that would prolong or salvage a life of low quality.

(3) The court will be authorized to intervene against the wishes of the mother, however, if and only if: (a) the recommended fetal therapy is established, proven, and would be a clear benefit to the fetus, (b) the use of the particular fetal therapy would prevent significant irreversible physical or mental impairment, (c) no less intrusive medical alternative is available to prevent the impairment, and (d) the procedure would not result in serious harm to the mother.

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232. 31 Cal. 3d 220, 643 P.2d 954, 182 Cal. Rptr. 337 (1982).

233. CAL. HEALTH & SAFETY CODE §7186.

234. 31 Cal. 3d at 233, 643 P.2d at 962, 182 Cal. Rptr. at 345 (1982).

235. *Id.*

236. *See supra* notes 55-77.

## CONCLUSION

The advent of fetal surgery has been greeted with enthusiasm because it offers a realistic potential to prevent debilitating birth defects. This enthusiasm has been tempered, however, by a recognition of the moral, ethical, and legal concerns associated with the availability of this new technology. This comment has considered the legal issues surrounding a conflict over recommended fetal therapy, and has concluded that in certain situations a mother should have the right to refuse. In order to define the circumstances in which a mother should be allowed to refuse recommended fetal surgery, this comment has identified the interests implicated when a conflict over fetal therapy arises, including: (1) the right of the mother to make medical care decisions on behalf of the fetus, and her right to avoid unwarranted bodily intrusions; (2) the right of the fetus to legal recognition as a patient; and (3) the dual interests of the state in safeguarding the health of the unborn, and in promoting responsible private medical care decisions.

In order to protect the interests of mother, fetus, and state when a conflict over fetal therapy does arise, this comment has demonstrated that a standard for judicial intervention must be adopted. A standard for judicial intervention that provides substantive guidelines clarifying decisionmaking authority of the mother in fetal treatment conflicts will accomplish several important objectives. These goals include reducing the number of inconsistent judicial decisions and clarifying the role of the physician. Accordingly, this comment has proposed a standard for judicial intervention that characterizes the fetus as a provisional patient. Further, this standard grants the mother specific authority to refuse recommended fetal therapy that would prolong or salvage a life of low quality, or that would provide anything less than a "clear benefit" to the fetus. The adoption of a standard for judicial intervention in fetal treatment conflicts should go a long way toward enhancing the potential benefits offered by fetal surgery.

*Peta Lewis Hallisey*