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Abstract

The patient's name was Angela.

KEYWORDS: harvesting, organ, cesarean

IN RE A.C.: A COURT-ORDERED CESAREAN BECOMES PRECEDENT FOR NONCONSENSUAL ORGAN HARVESTING.[1]

I. INTRODUCTION

The patient's name was Angela.[2] She was twenty-six weeks pregnant and dying of cancer. In a half-hour emergency phone hearing, the court held, over the objections of Angela, her family and her physicians,[3] Angela's right against bodily intrusion must be subordinated to the interests of the fetus and the state. Thus, the court denied a motion for stay of an order to perform a cesarean.[4] The operation was performed, and soon thereafter both Angela and her child died.[5]

The court began its opinion, admittedly written after the fact and thus perhaps "self-justifying,"[6] by stating that the opinion "is to assist others and to test this court's decision with analysis of precedent . . . ."[7] This article is an acceptance of the court's invitation to test its decision and an attempt to show that Angela's right to privacy and bodily integrity was improperly subordinated. After a discussion of the events leading to the court's decision, the court's balancing of the interests of Angela, the fetus and the state will be examined. Finally, an analogy will be drawn between court-ordered caesareans and the involuntary removal of an organ to be transplanted into another person.

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1. *In re* A.C., 533 A.2d 611 (D.C. 1987), *reh'g granted*, 539 A.2d 203 (D.C. 1988).

2. The initials "A.C." were used, perhaps ironically, to protect Angela's privacy. *See, e.g.*, Remnick, *Whose Life Is It, Anyway?*, Washington Post Mag., Feb. 21, 1988, at 14, col.1 [hereinafter Washington Post].

3. *See, e.g.*, Goode, *A Mother's Body, A Fetus's Fate*, Insight Magazine, June 27, 1988, at 54, col. 2 [hereinafter Insight]. Note that Angela's husband (the father of the fetus) was silent throughout the judicial proceedings. *See* Washington Post, *supra* note 2, at 40, col. 1-2.

4. *In re* A.C., 533 A.2d 611, 617 (D.C. 1987).

5. *Id.* at 612.

6. *Id.* at 613.

7. *Id.* at 611.

II. BACKGROUND

A. THE CASE

On June 11, 1987, Angela's physicians discovered a tumor mass in her lung and admitted her to George Washington University Hospital.[8] Twenty-five weeks pregnant, she was told she would die within weeks.[9] It was not the first time in Angela's life that she had been told she had no chance to survive. Angela survived two long bouts with cancer and suffered many operations since age thirteen, including amputation of a leg and half of her pelvis.[10] However, before Angela became pregnant, her cancer had been in remission for three years and she had not undergone chemotherapy for more than a year.[11]

On June 15th, a few days after her admission to the hospital, Angela, then in her twenty-sixth week of pregnancy, was told that she might die within a few days.[12] The physicians further determined that if Angela "died before delivery, the fetus would die as well."[13] Because the fetus had a much better chance to survive at twenty-eight weeks or more of gestation,[14] Angela indicated she would undergo treatment to extend her life, but "she expressed a desire to her physicians to be kept as comfortable as possible . . . and to maintain the quality of her life."[15]

On June 16, Angela's condition rapidly declined, and she was heavily sedated.[16] Angela's wish was only to die and to be free of

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8. *Id.* at 612.

9. Annas, *She's Going to Die: The Case of Angela C*, 18 HASTINGS CENTER REP. 20-28 (1988) [hereinafter Annas, *She's Going to Die*].

10. *See* Washington Post, *supra* note 2, at 14, col. 2.

11. *In re* A.C., 533 A.2d at 612.

12. *See* Insight, *supra* note 3, at 54, col. 1.

13. *In re* A.C., 533 A.2d at 613. *But see* Katz, Dotters & Droegemueller, *Perimortem Cesarean Delivery*, 68 OBSTET. GYNECOL. 571, 572 (1986) (reporting an infant survival rate of 188 out of 269 postmortem cesarean sections performed between 1971 and 1985, including incidences of maternal death caused by malignancy); Arthur, *Postmortem Cesarean Section*, 132 AM. J. OBSTET. GYNECOL. 175-79 (1978).

14. *In re* A.C., 533 A.2d at 612. *Cf.* Mathieu, *Respecting Liberty and Preventing Harm: Limits of State Intervention in Prenatal Choice*, 8 HARV. J.L. & PUB. POL'Y 19, 38 n.47 (1985) [hereinafter Mathieu] (stating that viability determinations are in a constant state of flux and cannot be identified precisely).

15. *In re* A.C., 533 A.2d at 613.

16. *Id.* at 617.

pain.[17] That wish, however, raised concern for the fetus, and the hospital administrators feared liability.[18] The administrators consulted outside counsel, who sought judicial intervention. The trial judge came to the hospital[19] and appointed volunteer counsel for Angela and for her fetus. The District of Columbia was permitted[20] to intervene as *parens patriae* on behalf of the fetus only, implying that Angela was deemed competent.[21]

At the hearing, counsel representing the fetus argued that "the fetus was 'a probably viable fetus, presumptively viable fetus, age twenty-six weeks,' and that the court's task was to 'balance' the interests of the fetus 'with whatever life is left for the fetus's mother . . . . ' "[22] Angela's counsel argued against surgical intervention.[23] However, with apparent disregard for Angela's wishes, hospital counsel simply wanted to know "what medical care, if any, should be performed for the benefit of the fetus . . . . "[24]

Angela's physician testified that Angela would not want the fetus delivered before the twenty-eight week gestation period due to the higher risk of "the pain of having handicaps that are associated with premature delivery."[25] A neonatologist with "no direct involvement with the mother or the family"[26] hypothetically estimated fetal viability at fifty to sixty percent and the likelihood of fetal handicap at less than twenty percent.[27]

After three hours of testimony, "[t]he court ordered the [cesarean] despite uncontested testimony that it would endanger [Angela's] health and life and over the unanimous objections of [Angela],

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17. Annas, *Letters; Reply*, 18 HASTINGS CENTER REP., June-July 1988, at 41, 42 [hereinafter Annas, *Reply*].

18. *See* Washington Post, *supra* note 2, at 15, col. 1. Presumably, the basis of liability would be in the form of 'fetal euthanasia.' *See generally* Murray, *Moral Obligations to the Not Yet Born: The Fetus As Patient*, 14 CLIN. PERINATOL. 329-43 (1987).

19. Annas, *She's Going to Die*, *supra* note 9, at 23.

20. One commentator has suggested the District of Columbia was "invited." *Id.*

21. The doctrine of *parens patriae* is applicable to incompetents as well as minors. *See* 67A C.J.S. *Parens Patriae* 159 (1946) (stating that the doctrine is to provide protection to persons *non sui juris*).

22. Annas, *She's Going to Die*, *supra* note 9, at 23.

23. *Id.*

24. *Id.*

25. *In re* A.C., 533 A.2d 611, 613 (D.C. 1987).

26. Annas, *She's Going to Die*, *supra* note 9, at 23, col. 3.

27. *Id.*

her husband, her parents, all attending physicians, and the entire Department of Obstetrics and Gynecology at the hospital where she was being treated."[28]

Upon hearing of the order, Angela indicated at first that she would comply. However, when her physician later asked Angela whether she wanted the cesarean, Angela said several times, "I don't want it done."[29] Angela's refusal was deemed irrelevant because the judge considered the entire proceeding to be premised on lack of consent.[30] If Angela consented, there would have been no need for a judicial proceeding in the first place. The hospital would have performed the cesarean without seeking a court order.

On appeal, which amounted to a half-hour, three-judge telephonic hearing,[31] the judge refused a motion for stay of the order and doctors performed the cesarean. "[T]he fetus was so far from viability that no extraordinary measures were even attempted on [the baby's] behalf,"[32] and the baby died less than two hours after delivery.[33] Angela died less than two days after the surgery.[34]

On March 17, 1988, the full bench of the District of Columbia Court of Appeals vacated the appellate ruling,[35] and counsel for the District of Columbia, who argued in favor of the cesarean, has since disavowed its own position and joined in the request for a rehearing by the full court.[36]

B. THE MEDICAL PRECEDENT

This was a case of first impression for the District of Columbia Court of Appeals.[37] Indeed, the combination of a court-ordered cesarean for a questionably viable fetus and a terminally ill mother

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28. Petition for Rehearing and Suggestion that Rehearing Be *En Banc* at 2, *In re* A.C. 533 A.2d 611 (D.C. 1987) (No. 87-609) [hereinafter Petition for Rehearing].

29. *In re* A.C., 533 A.2d 611, 613 (D.C. 1987); Annas, *She's Going to Die*, *supra* note 9, at 24, col. 1.

30. Annas, *She's Going to Die*, *supra* note 9, at 24, col. 2.

31. *Id.*

32. *Id.*

33. Washington Post, *supra* note 2, at 15, col. 1.

34. *Id.*

35. *See* Petition for Rehearing, *supra* note 28, at 2 n.5 (stating that even though the cesarean cannot be undone, the case is not moot under the "capable of repetition yet evading review" exception to mootness).

36. Annas, *Reply*, *supra* note 17, at 42.

37. *In re* A.C., 533 A.2d 611, 614 (D.C. 1987).

may well be a case of first impression in any jurisdiction.

Only one prior case regarding a court-ordered cesarean has been officially reported.[38] The District of Columbia Appellate Court distinguished this case, *Jefferson v. Griffin Spalding County Hospital Authority*, because the mother in *Jefferson* was at term.[39] However, the *Jefferson* case is relevant to this article because Mrs. Jefferson's physicians insisted that without a cesarean delivery "it is virtually impossible that [the problem] will correct itself prior to delivery: and that it is a ninety nine percent certainty that the child cannot survive natural childbirth (vaginal delivery). The chances of [the mother] surviving vaginal delivery are no better than fifty percent."[40]

Because of her religious beliefs, Mrs. Jefferson defied the court order to submit to a cesarean and uneventfully delivered a healthy baby vaginally.[41] This case illustrates an essential point: "that physicians *feel certain* that disaster will ensue [without a cesarean] does not mean that it will."[42]

Although many court-ordered obstetrical interventions go completely unreported,[43] the New England Journal of Medicine conducted a national survey investigating and analyzing court-ordered obstetrical procedures in cases in which pregnant women refused to consent to therapy deemed necessary for the fetus.[44] The survey found fifteen court orders for cesarean sections had been sought in eleven states, all but two were obtained, and two of the remaining thirteen were not enforced because the patient eventually complied voluntarily.[45]

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38. *See* Jefferson v. Griffin Spalding County Hosp. Auth., 247 Ga. 86, 274 S.E.2d 457 (1981).

39. *In re* A.C., 533 A.2d at 614.

40. *Jefferson*, 247 Ga. at 86, 274 S.E.2d at 458.

41. *See* Berg, *Georgia Supreme Court Orders Caesarean Section-Mother Nature Reverses on Appeal*, 70 J. MED. ASSOC. GA. 451-53 (1981).

42. Rhoden, *The Judge in the Delivery Room: The Emergence of Court-Ordered Caesareans*, 74 CALIF. L. REV. 1951, 2023, (1986) [hereinafter Rhoden, *Judge*] (emphasis in original); *See also In re* Baby Jeffries, No. 14004, slip op. at 9 (Mich. P. Ct. May 24, 1982) (also ordering a cesarean but resulting in a successful vaginal delivery) (as cited in Rhoden, *Caesareans*, *infra* note 43, at 124 n.2).

43. Rhoden, *Caesareans and Samaritans*, 15 LAW, MED. & HEALTH CARE 118 (1987) [hereinafter Rhoden, *Caesareans*].

44. Kolder, Gallagher & Parsons, *Court-ordered Obstetrical Interventions*, 316 NEW ENGLAND J. MED. 1192 (1987). Note that this survey was published approximately five weeks prior to the ruling in Angela's case.

45. *Id.* at 1193.

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C. THE PROBLEM

The New England Journal of Medicine survey reveals that the prognosis of inevitable harm to the fetuses was inaccurate in six of fifteen cases.[46] The survey confirmed that:

> [H]ospital administrators and lawyers often have little forewarning of impending conflicts. Judges, unfortunately, have even less time for deliberation. In 88 percent of the cases in our survey, court orders were obtained within six hours. In 19 percent, the orders were actually obtained in an hour or less, at times by telephone. The time required to weigh complex relative medical risks and benefits for both mother and fetus and then to balance these against the woman's rights is rarely, if ever, available. Impulsive and inconsistent judicial decisions are undesirable, and the court is unlikely to provide a meaningful review of the medical facts. Furthermore, time pressure makes it unlikely that the pregnant woman will have adequate legal representation.[47]

Judicial intervention ordering an extreme physical intrusion into an unwilling woman without sufficient time for due process and adequate judicial review and which may be based on erroneous medical predictions is a power that should not be used.[48]

The problem is evident in Angela's case. Many facts are still in dispute.[49] The court admitted "[t]here was no time to have the transcript read or to do effective research."[50] The judges had virtually no choice but to rely on the physicians' prognosis.[51] However, the physicians did not anticipate that Angela's condition could possibly deteriorate so quickly[52] and did not seek Angela's consent in the event a cesarean might be indicated.[53] They thought Angela was too sedated to

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46. *Id.* at 1195.
47. *Id.*
48. Robertson & Schulman, *Pregnancy and Prenatal Harm to Offspring: The Case of Mothers with PKU*, HASTINGS CENTER REP. Aug. 1987 at 23.
49. *See, e.g.*, Petition for Rehearing, *supra* note 28, at 10 n. 23.
50. *In re* A.C., 533 A.2d 611, 613 (D.C. 1987).
51. *See, e.g.*, Rhoden, *Judge*, *supra* note 42, at 2025.
52. Washington Post, *supra* note 2, at 19, col. 1.
53. *In re* A.C., 533 A.2d at 613. *See also* Raines, *Editorial Comment*, 63 OBSTET. & GYNECOL. 598, 598-99 (1984) (stating that informed consent should be pursued with vigor upon admission to the hospital); Petition for Rehearing, *supra* note 28, at 9 n.21 (stating that "no one had ever raised the idea of a cesarean section to

testify on her own behalf and believed that bringing her out of sedation might shorten her survival time. Yet when the physicians prepared Angela for surgery they "discovered (contrary to their earlier assertions) that her medication had worn off and she was rousable."[54]

Finally, among the many ironies in this tragedy of errors[55] is the after-the-fact statement by Angela's obstetrician, who opposed the cesarean and refused to perform it, that "[s]urgery is a big stress on the body - it could lessen the life by several hours, but with Angie it probably *improved* things" by removing the stress of pregnancy from her body.[56] When the fetus's attorney called the hospital the day after the surgery, she was told "Angela was much stronger than she had been prior to the surgery."[57] Had Angela been informed that a cesarean would help relieve her pain and make her stronger as well as improve her fetus's chance of survival, she might have consented all along.

The solution to the problem, therefore, may be for hospital administrators to see that solutions to bioethical dilemmas are in place alongside new technology.[58] In doing so, hospital attorneys can avoid laying

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54. Mishkin, *Letters - But She's Not an "Inanimate Container . . . ,"* 18 HASTINGS CENTER REP. 40, 40-41 (1988) [hereinafter Mishkin, *Letters*] (Note this author, Barbara Mishkin, was counsel for the fetus and thus intimately familiar with the facts in Angela's case).

55. *See, e.g.*, Petition for Rehearing, *supra* note 28, at 7 n.16 (Stating that "[o]ne of the many disturbing ironies in this case is that [Angela] was legally free to choose an abortion at the time the court ordered her to risk her life for the fetus"). *But see* Rhoden, *Caesareans*, *supra* note 43, at 119, col. 2 (Stating that "after a fetus is viable, the methods of abortion and of premature delivery simply merge"). *See also*, Kolder, *supra* note 44, at 1196 ("Ironically . . . an interventionist professional climate may give rise to a new standard of care and expand liability," which is what hospitals seek to avoid through judicial intervention). While an interventionist climate may backfire on hospitals in the future, it appears that in the instant case the doctors and administrators and judges are immune from liability. Angela's mother is suing the hospital and the judges. The medical malpractice claim alleges wrongful death and deprivation of human rights. However, " 'hospital authorities and the physicians that acted at a judge's orders [probably] are given immunity even if the decision was wrong and it is reversed.' And the judge could not be sued even if his decision was blatantly contrary to existing law." Sherman, *Forced Caesarean: A Pyrrhic Victory, A Court Battle*, Nat'l Law J., Jan. 16, 1989, at 3, col. 3 (quoting Robert A. Burt, professor at Yale University Law School).

56. Washington Post, *supra* note 2, at 21, col. 2 (emphasis added).

57. Mishkin, *Letters*, *supra* note 54, at 41, col. 2.

58. Robertson, *The Right to Procreate and In Utero Fetal Therapy*, 3 J. LEGAL MED. 333, 362 n.133 [hereinafter Robertson, *Right to Procreate*] (stating that there is

a fetus at the judge's doorstep swaddled in medical miscalculations yet naked of its mother's wishes.[59]

III. BALANCING THE INTERESTS

The appellate court held that Angela's right against bodily intrusion must be subordinated to the interests of the child and the state.[60] The court balanced the various interests of three distinct parties: 1) the mother's rights against bodily intrusion and her right to make decisions regarding her fetus's medical treatment, 2) the right of the fetus as a patient, and 3) the right of the state to protect the "health of the unborn, and [to promote] responsible private medical care decisions."[61] The court reasoned that:

> [t]he [cesarean] section would not significantly affect [Angela's] condition because she had, at best, two days left of sedated life; the complications arising from the surgery would not significantly alter that prognosis. The child, on the other hand, had a chance of surviving delivery, despite the possibility that it would be born handicapped.[62]

However, in addition to merely identifying these rights, other factors, such as the potential seriousness and the likelihood of harm to both Angela and her child, must be weighed. Further, "[r]ights are not always conclusive; they must be understood in the context of often competing moral principles and values."[63]

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a "need for hospital lawyers and administrators to plan for handling disputes between fetal and maternal interests").

59. *See generally Patient Choice: Maternal-Fetal Conflict*, AM. C. OBSTET. & GYNECOL. COMM. OPINION 55 (Oct. 1987) (stating that "resort to the courts is almost never justified . . . to seek orders for treatment which has been refused by a pregnant woman." The Committee on Ethics reasons that such judicial intervention is destructive of the pregnant woman's autonomy and the physician-patient relationship, and speedy judicial decisions "may have serious limitations and unexpected outcomes").

60. *In re* A.C., 533 A.2d 611, 617, (D.C. 1987).

61. Hallisey, *The Fetal Patient and the Unwilling Mother: A Standard for Judicial Intervention*, 14 PAC. L.J. 1065, 1094 (1983).

62. *Id.*

63. Mathieu, *supra* note 14, at 22.

A. THE RIGHTS OF THE MOTHER

Under the common law, "[n]o right is held more sacred, or is more carefully guarded [than the right to privacy and] to be let alone."[64] Further, the right to privacy includes the right of an individual to make decisions affecting her own body.[65] This penumbral right is particularly sensitive to government intrusion.[66] The protection against governmental invasion of privacy is "especially strong where issues of childbearing are involved."[67]

Justice Cardozo stated that "[e]very human being of adult years and sound mind has a right to determine what shall be done with her own body; and a surgeon who performs an operation without the patient's consent commits an assault . . . ."[68] At first blush, it would thus appear that Angela's refusal to consent to the cesarean after learning of the trial court's order should have been dispositive.[69] How-

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64. Union Pac. R.R. v. Botsford, 141 U.S. 250, 251 (1891); *see also* Jacobson v. Mass., 197 U.S. 11 (1905); Skinner v. Okla., 316 U.S. 535, 541 (1942).

65. Rochin v. California, 342 U.S. 165, 169 (1952); *see also* Note, *Maternal Rights and Fetal Wrongs: The Case Against the Criminalization of "Fetal Abuse,"* 101 HARV. L. REV. 994, 1001-05 [hereinafter Harvard Note] (The "state's interest may be trumped by a privacy right when maternal conduct is in question").

66. *See, e.g.*, Ingraham v. Wright, 430 U.S. 651 (1977) (right of privacy as founded in the fourteenth amendment); Winston v. Lee, 105 S. Ct. 1611 (1985), *aff'g* 717 F.2d 888 (4th Cir. 1983); Schmerber v. California, 384 U.S. 757 (1966) (noting the fourth amendment foundation of the right to personal privacy).

67. Johnsen, *The Creation of Fetal Rights: Conflicts with Women's Constitutional Rights to Liberty, Privacy, and Equal Protection*, 95 YALE L.J. 599, 617 (1986).

68. Schloendorff v. Soc'y of N.Y. Hosp., 211 N.Y. 125, 129-30, 105 N.E. 92, 93 (1914). *See also* Clarke, *The Choice to Refuse or Withhold Medical Treatment: The Emerging Technology and Medical-Ethical Consensus*, 13 CREIGHTON L. REV. 795, 797 (1980); Jurow & Paul, *Cesarean Delivery for Fetal Distress Without Maternal Consent*, 63 OBSTET. & GYNECOL. 596, 598 (1985) ("In the legal sense, the performance of a cesarean section against the mother's wishes might constitute assault and battery"); *but see* Bell, *Medical Ethics Case Conference: Ethical and Legal Issues in a Court Ordered Cesarean Section*, MED. HUMANITIES REP. (Michigan State U. ed. 1984) (stating that "non-consent is not equated with an assault and battery").

69. Tune v. Walter Reed Army Med. Hosp., 602 F. Supp. 1452, 1456 (1985) (A competent adult whose death is imminent is the only true judge of how the remainder of his life should be spent); Pratt v. Davis, 118 Ill. App. 161 (1905), *aff'd*, 224 Ill. 300, 79 N.E. 562 (1906) (Consent to surgery is essential); Lane V. Candura, 6 Mass. App. Ct. 377, 376 N.E.2d 1232, 1236 (1978) (stating that vacillation in resolve does not indicate incompetence); *In re* Storar, 52 N.Y.2d 363, 420 N.E.2d 64 (1981) (The "patient's right to determine the course of his own medical treatment [is] paramount to . . . the doctor's obligation to provide needed medical care").

ever, the trial judge concurred when counsel for the District of Columbia stated the obvious, "I don't think we would be here if she had said she wants [the cesarean]."[70]

The trial judge, therefore, reasoned that if Angela consented to an emergency cesarean, the hospital would not have sought a court order before performing the surgery. The judge determined that any judicial proceeding must be prefaced with the assumption that Angela had not consented.

Since the court presumed that Angela had not consented to the surgery, the issue of competence to refuse consent became moot. Angela's competence was never in question;[71] no request was made to have her declared incompetent and no guardian was appointed on her behalf.[72] Even though the trial proceedings took place in the hospital, no judge ever spoke with Angela. Thus, Angela's lack of consent and her competency to make such a decision was implicitly deemed irrelevant. The decision was predicated on her refusal.[73]

Many commentators urge that "no matter how difficult the decision, a woman has the right to refuse a [cesarean] section, even when the physician feels certain that the operation offers the only chance of saving the fetus' life."[74] These writers further argue that "current law . . . essentially precludes superseding her decision in the interest of the fetus."[75]

Forced medical treatment ignores the mother's right to self-deter-

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70. Annas, *She's Going to Die*, *supra* note 9, at 24, col. 2. *But see*, Fletcher, *The Fetus as Patient: Ethical Issues*, 246 J.A.M.A. 772 (1981) ("As long as the fetus is not separate from the mother, choices about treatment ought to be maae only with her informed consent").

71. Brief of Amici Curiae at 2, *In re* A.C., 533 A.2d 611 (D.C. 1987) (No. 87-609).

72. Annas, *Reply*, *supra* note 17, at 42.

73. *See generally*, Shultz *From Informed Consent to Patient Choice: A New Protected Interest*, 95 YALE L.J. 219, 228-31 (1985) (If a patient gives routine consent upon entering the hospital and it later "becomes clear that a . . . the patient's condition is medically hopeless, the patient may not get a renewed opportunity to consent to the doctor's recommended course of treatment").

74. Hubbard, *Legal and Policy Implications of Recent Advances In Prenatal Diagnosis and Fetal Therapy*, 7 WOMEN RIGHTS LAW REP. 201, 211 (1982) (referring to Leiberman, Mazor, Chaim & Cohen, *The Fetal Right to Live*, 53 OBSTET. & GYNECOL. 515 (1979)).

75. Bowes & Selgestad, *Fetal Versus Maternal Rights: Medical and Legal Perspectives*, 58 OBSTET. & GYNECOL. 209, 213 (1981) (referring to Shriner, *Maternal Versus Fetal Rights - A Clinical Dilemma*, 53 OBSTET. & GYNECOL. 518 (1979)).

mination and her fundamental rights to privacy and bodily integrity - "whether it is with a fist, a bullet, a drug, or a scalpel."[76] To allow someone the right to bodily integrity without the right to refuse bodily intrusion is tantamount to allowing someone the right to free speech as you remove her vocal cords. Such violent analogies are difficult to avoid.[77] This article returns to the issue of consent in section IV: "The Transplant Analogy."[78]

Parental autonomy, however, is not absolute.[79] Some argue the right to refuse recommended fetal therapy is limited.[80] Some commentators believe that when a woman decides to forego an abortion, "the woman loses the liberty to act in ways that would adversely affect the fetus. Restrictions on pregnancy management significantly limit a woman's freedom of action and even lead to forcible bodily intrusions to protect the unborn child."[81] The final extension of this limitation on parental autonomy is the proposition that the mother's right to bodily integrity is measured in proportion to the risk of harm to the mother[82] versus the benefit to the fetus.[83]

This sort of limitation on parental autonomy presents profound equal protection and civil liberties problems[84] and perhaps even sexual equality dilemmas[85] since only pregnant women are affected. "Indeed, if courts continue to compel Caesareans, pregnant women will be sub-

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76. Nelson, Buggy & Weil, *Forced Medical Treatment of Pregnant Women: "Compelling Each to Live as Seems Good to the Rest,"* 37 HASTINGS L.J. 703, 719 (1986) [hereinafter Nelson].

77. *See, e.g.*, Rhoden, *Caesareans*, *supra* note 43, at 122 (With court ordered caesareans there is "violence lurking here, whether or not it is ever actually committed . . . the court has authorized an act of violence against the woman . . . . ").

78. *See infra* notes 154-58 and accompanying text.

79. *See* Parham v. J.R., 442 U.S. 584 (1979); Prince v. Massachusetts, 321 U.S. 158 (1943); Custody of a Minor, 375 Mass. 733, 747, 379 N.E.2d 1053, 1062 n.8 (1978).

80. Hallisey, *supra* note 61, at 1072.

81. Robertson, *Procreative liberty and the Control of Conception, Pregnancy, and Childbirth*, 69 VA. L. REV. 405, 437 (1983) [hereinafter Robertson, *Procreative Liberty*].

82. Robertson, *Right to Procreate*, *supra* note 58 at 355. *See also* Raleigh-Fitkin-Paul Morgan Memorial Hosp. v. Anderson, 42 N.J. 421, 201 A.2d 537 (N.J. Sup. Ct. 1964) (ordering blood transfusions over pregnant mother's religious objections).

83. Robertson & Schulman, *supra* note 48, at 29.

84. Rhoden, *Judge*, *supra* note 42, at 2028.

85. Johnsen, *supra* note 67, at 620-22 ("The ability to bear children is to sex discrimination what dark skin is to race discrimination").

jected to intrusions deemed unconstitutional for any other person in society."[86] They may become "nonperson[s] without rights to bodily integrity."[87]

B. THE RIGHTS OF THE FETUS

Constitutionally, a fetus is not a person.[88] Several amendments to the United States Constitution have been proposed to elevate the fetus's status to that of a live-born child,[89] but currently only technology has been able to elevate the fetus's status[90] to that of a patient.[91] Thus, a fetus is not currently entitled to constitutional rights such as the due process protections of life, liberty or property.[92] This does not mean, however, that the state has no power to protect the fetus[93] or to extend the benefits of personhood outside of the constitutional context.[94] The notion of the fetus as a patient is "alarmingly modern,"[95] and the issue turns on whether the mother and the fetus are seen as a single biological entity or two.[96] On the one hand, a physician cannot protect the fetus without going through the mother.[97] In order to argue for fetal rights, one has to ignore an organic unity and create an artificial di-

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86. Rhoden, *Judge*, *supra* note 42, at 1986.

87. Annas, *Protecting the Liberty of Pregnant Patients*, 316 N. ENGLAND. J. MED. 1213, 1214 (1987).

88. Roe v. Wade, 410 U.S. 113, 158 (1973). *See also* Manner, *Family Law - Court-Ordered Surgery for the Protection of a Viable Fetus*, 5 W. NEW ENGLAND L. REV. 125, 147 (1982) ("The fetus, viable or otherwise, is simply not the legal equivalent of a live-born child . . . . ").

89. *E.g.*, S.J. Res. 17, 97th Cong., 1st Sess. (1982); H.R.J. Res. 62, 97th Cong., 1st Sess. (1981).

90. Hallisey, *supra* note 61, at 1074.

91. *See generally* Shaw & Damme, *Legal Status of the Fetus*, GENETICS & LAW 3 (1976).

92. *Roe*, 410 U.S. at 157-58.

93. Myers, *Abuse and Neglect of the Unborn: Can the State Intervene?*, 23 DUQ. L. REV. 1, 15 (1984).

94. *Id.* (quoting Parness & Pritchard, *To Be Or Not To Be: Protecting the Unborn's Potentiality of Life*, 51 U. CIN. L. REV. 257, 258 (1982)).

95. Lenow, *The Fetus as a Patient: Emerging Rights as a Person?*, 9 AM. J. LAW MED. 1, 15 (1983) (quoting Harrison, *Unborn: Historical Perspective of the Fetus as a Patient*, THE PHAROS 19 (1982)).

96. Lenow, *supra* note 95, at 2 (Most physicians prefer to view the mother and fetus as one patient, but that new technology and most perinatologists advocate the fetus as an independent patient).

97. Manner, *supra*, note 88, at 145.

chotomy.[98] It does not make social sense to juxtapose the rights of the mother and fetus as if they are adversaries.[99] Knowing the "geography of the situation,"[100] any conflict between the mother's health and the fetus's potential life must be reconciled in the mother's favor.[101]

On the other hand, the Supreme Court has ruled that once a fetus becomes viable and is "potentially able to live outside the mother's womb,"[102] the state has a compelling interest in protecting the fetus.[103] *Roe v. Wade* places viability at twenty four to twenty eight weeks.[104] Although several court decisions established rights of protection for a fetus prior to *Roe*,[105] the viability benchmark in *Roe* is most often used to mark the moment when the fetus's rights vest.[106]

However, the moment of viability is illusive and often arbitrary. Terms such as 'viability,' 'alive,' or 'able to live' when applied to a fetus do not refer to a natural biological event, but rather to fluctuating social values and legal decisions.[107] "In 'nature,' things just *are*; only people classify . . . ."[108] Thus, it is neither the courts nor the legislature who should determine viability,[109] but each patient's physician.[110] Consequently, the appearance of inconsistency regarding viability and the treatment of fetal rights[111] is merely a reflection of advancing technol-

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98. Hubbard, *supra* note 74, at 216.

99. *Id.*

100. Gallagher, *Prenatal Invasions & Interventions: What's Wrong With Fetal Rights*, 10 HARV. WOMEN'S L.J. 9, 13 (1987).

101. Thornburgh v. Am. C. of Obstetricians, 106 S. Ct. 2169, 2182-83 (1986).

102. Roe v. Wade, 410 U.S. 113, 160 (1973).

103. *Id.* at 162.

104. *Id.* at 160. *See also* Lenow, *supra* note 95, at 10 n.70 (citing studies of infant survival rates at various stages of gestation).

105. *See, e.g.*, People v. Estergard, 169 Colo. 445, 457 P. 2d 698 (Colo. S. Ct. 1969); Hoener v. Bertinato, 67 N.J. Super. 517, 171 A.2d 140 (N.J. Super. Ct. 1961); Raleigh Fitkin-Paul Morgan Memorial Hosp. v. Anderson, 42 N.J. 421, 201 A.2d 537 (N.J. Sup. Ct. 1964).

106. Mathieu, *supra*, note 14, at 37.

107. Johnsen, *supra* note 67, at 599, n.1.

108. *Id.* (quoting Leff, *The Leff Dictionary of Law: A Fragment*, 94 YALE L.J. 1855, 1997 (1985) (emphasis in original)).

109. Colautti v. Franklin, 439 U.S. 379, 388-89 (1979).

110. Roe v. Wade, 410 U.S. 113, 159 (1973); Planned Parenthood of Cent. Mo. v. Danforth, 428 U.S. 52, 64 (1976).

111. *See, e.g.*, Manner, *supra* note 88, at 140 (A court which ordered a cesarean without consent of the mother "gave [to the fetus] the same legal protection as that given to a newborn child, but in order to do so, relied on rationale borrowed from the very decision which denied the fetus constitutional protection as a person" [referring to

ogy, social values and legal policies.[112]

Tort law abandoned the demarcation line of viability in order to find liability.[113] Moreover, viability has little moral significance and is an inadequate guide when assigning legal rights or the benefits of personhood.[114] For example, as technology gradually lowers the gestation period at which a fetus may become viable, thus moving viability closer and closer to conception, *Roe* may actually become an anti-abortion decision,[115] and women's reproductive rights will gradually be curbed in the process.[116]

Discussions about the rights of the fetus are interesting, but they distract attention from the real issue, which is whether a mother's body can be invaded against her will to protect her fetus.[117]

C. THE RIGHTS OF THE STATE

As discussed earlier, every person has a fundamental right to bodily integrity, which includes the right to refuse to consent to any medical treatment.[118] However, after explaining that an adult's right to re-

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Roe v. Wade]).

112. Nelson, *supra* note 76, at 739 (citing Baron, *"If You Prick Us, Do We Not Bleed?": Of Shylock, Fetuses, and the Concept of Person in the Law*, 11 LAW MED. & HEALTH CARE 52, 55 (1983).

113. Myers, *supra* note 93, at 68.

114. Fost, Chudwin & Wikler, *The Limited Moral Significance of 'Fetal Viability,'* 10 HASTINGS CENTER REP. 10 (1980).

115. *Id.* at 13; *see also* City of Akron v. Akron Center Reproductive Health, Inc., 462 U.S. 416, 456-57 (O'Connor, J., dissenting). Justice O'Connor's dissent in *Akron*, joined by Justices White and Rehnquist, may have marked the beginning of the end for both the rationale of *Roe* and its trimester analysis. The Court may soon abort *Roe*. *See generally* Note, *The Emerging Jurisprudence of Justice O'Connor*, 52 U. CHI. L. REV. 389, 394-402 (1985); Note, *Justice Scalia & Judicial Restraint: A Conservative Resolution of Conflict Between Individual & State*, 62 TUL. L. REV. 225, 228 (1987); *Why Bush Will Enhance Reagan's Supreme Court Legacy*, Manhattan Law., Jan. 17, 1989-Jan. 23, 1989 at 15.

Three days after his inauguration, President Bush said, "the Supreme Court's decision in *Roe vs. Wade* was wrong and should be overturned." *See* Wicker, *Supreme Court Displays Real Reagan Legacy*, Miami Herald, Jan. 31, 1989, at 16A.

116. Lynn, *Technology and Reproductive Rights: How Advances in Technology Can be Used to Limit Women's Reproductive Rights*, 7 WOMEN RIGHTS LAW REP. 223, 226 (1982).

117. Kolder, *supra* note 44, at 1194.

118. *In re* A.C., 533 A.2d 611, 615 (D.C. 1987) (citing *In re* Osborne, 294 A.2d 372 (D.C.1972); *In re* Melideo, 88 Misc.2d 974, 390 N.Y.S.2d 523 (Sup. Ct. 1976)).

fuse medical treatment is not absolute,[119] the District of Columbia Court of Appeals made a critical error by wholly relying on the doctrine that "[t]he state has four countervailing [compelling] interests in sustaining a person's life, [and the relevant interest here is] protecting innocent third parties."[120]

The "countervailing interest" must be one that is juxtaposed to the right to refuse medical treatment. This article has already established that a fetus is not a "person,"[121] and since the fetus is not refusing medical treatment, the "person" referred to must be, in this context, the mother. The interest of the state in the person is that of *sustaining* the life of *that* person. Therefore, the court was saying that the state has an interest in "sustaining" Angela's life to protect the fetus. Somehow, the court used this reasoning to order a surgical operation which could have resulted in Angela's death,[122] and which, in the court's opinion, probably hastened her death.[123]

The court was also willing to extend the meaning of "innocent third parties"[124] to include unborn children.[125] However, in support of this proposition, the court cited two cases in which the court-ordered intervention sustained the life of the mother as well as protected the fetus[126] and two cases in which the court-ordered intervention amounted to a non-surgical, extremely low risk blood transfusion.[127] Fi-

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Contra In re President & Directors of Georgetown C. Inc., 118 U.S. App. D.C. 80, 331 F.2d 1000, *cert. denied*, 377 U.S. 978 (1964). *But see* Rhoden, *Caesareans*, *supra* note 43, at 121 (That this entire line of cases is easily distinguished from the cesarean dilemma).

119. *In re* A.C., 533 A.2d at 615.

120. *Id.* (citing Brophy v. New England Sinai Hosp., Inc., 398 Mass. 417, 431-33, 497 N.E.2d 626, 634 (1986); Superintendent of Belchertown St. Sch. v. Saikewicz, 373 Mass. 728, 740-41, 370 N.E.2d 417, 425 (1977); *In re* Farrell, 108 N.J. 335, 529 A.2d 404 (1987)).

121. Roe v. Wade, 410 U.S. 113, 158 (1973); Dunn v. Rose Way, Inc., 333 N.W.2d 830, 831 (Iowa 1973).

122. *In re* A.C., 533 A.2d at 617.

123. *Id.* at 613.

124. *But see* Nelson, *supra* note 76, at 758 ("The state's interest in the protection of innocent third parties . . . is highly questionable both in origin and as a matter of intelligent public policy").

125. *In re* A.C., 533 A.2d at 616.

126. Jefferson v. Griffin Spalding County Hosp. Auth., 247 Ga. 86, 274 S.E.2d 457 (1981); Raleigh Fitkin-Paul Morgan Memorial Hosp. v. Anderson, 42 N.J. 421, 201 A.2d 537 (N.J. Sup. Ct.) *cert. denied*, 377 U.S. 985 (1964).

127. *In re* Jamaica Hosp., 128 Misc.2d 1006, 491 N.Y.S.2d 898 (Sup. Ct. 1985); Crouse Irving Memorial Hosp., Inc. v. Paddock, 127 Misc.2d 101, 485 N.Y.S.2d 443

nally, the court concluded that since Angela was going to die,[128] her health[129] and condition[130] would not be significantly affected[131] by submitting to potentially deadly surgery against her will.

The state has a fundamental interest in protecting the welfare of infants and incompetents under the doctrine of *parens patriae*.[132] Because a fetus is not able to express its interests, the state uses it *parens patriae* power to protect the interests of the fetus.[133] The interests of the state add weight to those of the fetus, tending to outweigh the interests of the mother.[134]

The District of Columbia Court of Appeals' after-the-fact reasoning does indeed appear self-justifying. First, without a viable fetus the state would have not found a compelling interest.[135] However, the trial court found that Angela's fetus was viable[136] and the appeals court found that it was not.[137] Second, if the state had intervened on Angela's behalf, as well as the fetus', the combined interests of the fetus and the state would not have outweighed Angela's prerogative.[138] However, the court would have had to have found Angela incompetent for the state to intervene on her behalf as *parens patriae*,[139] and the court made no attempt to determine whether Angela was competent.[140] Had the state not found a compelling interest in protecting the fetus, or had the state found a compelling interest in protecting Angela, the scales may well have tipped in favor of Angela's wishes.

(Sup. Ct. 1985).

128. Annas, *She's Going to Die*, *supra* note 9, at 23 (quoting the trial court judge as summarizing, "She's going to die . . . ." in response to Angela's attorney's objection that a cesarean may kill Angela).

129. *In re* A.C., 533 A.2d 611, 617 (D.C. 1987).

130. *Id.*

131. *Id.*

132. Clarke, *supra* note 68, at 814.

133. Myers, *supra* note 93, at 60.

134. *Id.* ("[T]he interests of the fetus will dovetail with those of the state, adding force to the argument in favor of intervention").

135. Roe v. Wade, 410 U.S. 113, 150, 154, 162 (1973).

136. *In re* A.C., 533 A.2d 611, 613 (D.C. 1987).

137. *See supra* text accompanying notes 32-33.

138. Myers, *supra* note 93, at 64-65.

139. Clarke, *supra* note 68, at 814 ("The state also exercises its authority on behalf of incompetents, either to advance their traditional best interests or to determine and give effect to their actual wishes and interests."). *See also In re* Weberlist, 79 Misc. 2d 753, 258 N.Y.S.2d 783 (1974); *In re* Long Island Jewish-Hillside Med. Center, 73 Misc. 2d 395, 342 N.Y.S.2d 356 (Sup. Ct. 1973).

140. *See supra* text accompanying notes 71-73.

IV. THE TRANSPLANT ANALOGY

By creating a conflict of rights between the mother and fetus, the state usurped a great deal of power for itself over the autonomy of pregnant women.[141] As a result, physicians and judges find themselves "locked in battle on the rather inconvenient battleground of the woman's belly."[142]

The District of Columbia Court of Appeals stated that the closest analogy to Angela's case was the right to refuse medical treatment by an adult, either on behalf of herself or her offspring.[143] The truer analogy, however, is that of a nonconsensual organ removal for the purpose of transplanting the organ to save the life of another person.[144] While new technology bangs the drum for therapeutic aggressiveness,[145] physicians march ahead beneath the banner of the "higher, more important good."[146]

A judge cannot order a mother to donate an organ even if it is needed to save the life of her child.[147] Would it make a difference if the mother had only a short time to live? Would it make a difference if the dying mother could save ten other people if her organs were harvested? The answer is no. It is constitutionally impermissible[148] to allow such trade-offs.[149]

The absurdity of nonconsensual organ donations has not been overlooked by modern satirists. For example, imagine a physician coming to a man's door and saying:

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141. Johnsen, *supra* note 67, at 600.

142. Rhoden, *Caesareans*, *supra* note 43, at 118.

143. *In re* A.C., 533 A.2d 611, 615 (D.C. 1987).

144. Rhoden, *Caesareans*, *supra* note 43, at 121; Kolder, *supra* note 44, at 1194; Brody, *Medical Ethics Case Conference: Ethical and Legal Issues in a Court Ordered Cesarean Section*, 6 MED. HUMANITIES REP. (Michigan State Univ. 1984).

145. *See, e.g.*, Angell, *Handicapped Children: Baby Doe and Uncle Sam*, 309 N. ENGLAND J. MED. 659-60 (1983).

146. McCormick, *To Save or Let Die: The Dilemma of Modern Medicine*, 229 J.A.M.A. 172, 175 (1974).

147. Kolder, *supra*, note 44 at 1194.

148. Rochin v. Cal., 342 U.S. 165 (1952) (Forcible pumping of a suspect's stomach is a flagrant violation of fourteenth amendment due process because it "shocks the conscience"); *see generally* L. TRIBE, *American Constitutional Law* §§ 15-19 (1988).

149. Rhoden, *Judge*, *supra* note 42, at 1996 ("If we use harming another as the means to our end, then we assert that another person may indeed *be* our means . . . ." (emphasis in original)) (quoting C. FRIED, *Right and Wrong* 29 (1978)).

Physician: "Hello. Can we have your liver?"
Man: "What?"
Physician: "It's the large reddish-brown glandular . . . ."
Man: "Yes, yes. I know what it is. But, I'm using it!"
Physician: Barges in on the man and removes a card from the man's wallet. "What's this then?"
Man: "A liver donor's card."
Physician: "Need we say more?"
Man: "I can't give it to you now! It says in the event of death!"
Physician: "But someone needs it now."[150]
Man's Wife: As she watches the physician remove the liver from her screaming husband, she asks, "What do you do with them?"
Physician: "It all goes to saving lives, madam."[151]

Mandatory organ donations are clearly against the law,[152] whether to save the life of a child, relative or anyone else.[153] If a person cannot lose her rights against bodily intrusion for the sake of a live person, certainly that person cannot lose the same rights for the sake of the potential life of a fetus, who is not a person.

There is no duty to rescue absent some special relationship, such as that between parent and child.[154] However, this duty does not include acts that may harm the parent.[155] While some courts allowed organ removal without the patient's consent,[156] these decisions have been predicated on the best interests of an incompetent donor[157] as well

150. Rhoden, *Caesareans*, *supra* note 43, at 121.

151. Chapman, Cleese, Gilliam, Idle, Jones & Palin, *Monty Python's: The Meaning of Life* (Celandine Films 1983) (In regard to the possibility of technology overwhelming womens' interests, this same film depicts a woman giving birth in a hospital which has surrounded her with high-tech machinery. Bewildered by the machines, she asks, "What do I do?" The physician replies, "Nothing, dear. You're not qualified").

152. L. Tribe, American Constitutional Law § 1334 (1988).

153. Holder, Legal Issues in Pediatrics and Adolescent Medicine 178 (2d ed. 1985).

154. Prosser & Keeton, The Law of Torts § 56 (5th ed. 1984).

155. *See* McFall v. Shimp, 10 Pa. D. & C. 3d 90, 92 (Allegheny County Ct., Pa. 1978).

156. Strunk v. Strunk, 445 S.W.2d 145 (Ky. Ct. App. 1969) (Ordering kidney transplant from incompetent to save the life of a sibling); Hart v. Brown, 29 Conn. Supp. 368, 289 A.2d 386 (1972). *But see In re* Pescinski, 67 Wis. 2d 4, 226 N.W.2d 180, (1975) (Refusing to order kidney transplant from incompetent to save the life of a sibling; refusing to adopt the "substituted judgment" doctrine).

157. *See, e.g., In re* Boyd, 403 A.2d 744 (D.C. 1979).

as the best interests of the donee.[158] Because the court considered Angela's competence to refuse consent a non-issue, the court oversimplified its task by not having to consider Angela's wishes and best interests.[159]

The implications of mandatory surgery to remove a part of a person's body to save another are frightening. Will we start harvesting and retailing human organs from dying patients?[160] How could this type of organ harvesting be reconciled with the fact that organs cannot be removed from a cadaver without the consent of the next of kin in addition to the donor's consent prior to death?[161] Will we begin to view pregnant women as a mere vehicle to rescue an endangered fetus?[162]

Consider the case of the twenty-seven-year-old pregnant woman who became brain dead at twenty-two weeks gestation.[163] Referred to as a "beating heart cadaver,"[164] she was kept alive artificially for nine weeks until a successful cesarean could be performed. The mother was disconnected from her life support after the cesarean, and she died almost immediately.[165] With surprising bravado, the physicians announced,

> *[e]ven a maternal refusal expressed before death does not, itself, carry weight against the possibility of fetal survival.* The mother is not harmed; no right of hers is violated, and great good can be done for another. Thus, this case seems to present a straightfor-

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158. *See* Robertson, *Organ Donations by Incompetents and the Substituted Judgment Doctrine*, 76 COLUM. L. REV. 49 (1976).

159. *See supra* text accompanying notes 70-77.

160. *See* Note, *Retailing Human Organs Under the Uniform Commercial Code*, 16 J. MARSHALL L. REV. 393 (1983).

161. Overcast, Evans, Bowen, Hoe & Livak, *Problems in the Identification of Potential Organ Donors*, 251 J.A.M.A. 1559, 1561 (1984) (Even when the deceased had signed an organ donor card, "almost every state also requires formal consent from the donor's next of kin to remove organs"). *See also* Caplan, *Ethical and Policy Issues in the Procurement of Cadaver Organs for Transplantation*, 311 N. ENGLAND J. MED. 981-83 (1984).

162. *See* generally Gallagher, *supra* note 100, at 57 (warning against viewing pregnant women as "vessels or means to an end"); Rhoden, *Judge*, *supra* note 42, at 1953 ("[T]he court that mandates surgery is treating the woman solely as a means to the goal of saving the baby"); Chavkin, *Woman as Baby Vehicle*, 7 WOMEN'S RTS. L. REP. 219 (1982).

163. Field, Hates, Creasy, Jonsen & Laros, *Maternal Brain Death During Pregnancy: Medical and Ethical Issues*, 260 J.A.M.A. 816 (1988).

164. *Id.* at 818-19.

165. *Id.* at 817.

ward instance of the medical rescue of the fetus from death.[166]

These are quality-of-life judgments. Physicians and judges fear them, and they should.[167] As technological advancements continue to raise questions which outpace bioethical answers, we are in danger of valuing a life for what she can do rather than for who she is.[168] Ominously, the court in Angela's case began its analysis by saying that the quality of Angela's life during her last hours was not a relevant concern.[169] Given the extraordinary need for life-saving human organs,[170] it is hard to visualize the court perched on a more slippery slope.[171]

V. CONCLUSION

Physicians are fallible. Physicians tell people they are going to die, but those people often survive. Physicians once told a pregnant woman that without a cesarean her fetus had less than a one percent chance of survival, and that chance happened. Angela's physicians believed her fetus was viable, that she was sedated, that coming out of sedation might kill her, and that a cesarean would be detrimental to her. They were wrong on all four counts. In addition, the physicians never thought Angela's condition could deteriorate so quickly, and they never discussed the cesarean option with her.

The hospital administrators feared liability, panicked, and asked the court to make an emergency legal decision. The court had no choice but to rely on the testimony of obviously fallible physicians and the arguments of unprepared counsel. In fact, the court heard from everyone but Angela, who was treated as if she were already dead.

Emergency and emotional judicial decisions make bad law. In Angela's case, the court inadvertently made the correct decision. Accord-

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166. *Id.* at 821 (emphasis added).

167. McCormick, *supra* note 146, at 174.

168. *Id.* at 176 ("[I]t is the potential for relationships that is at the heart of these agonizing decisions").

169. *In re* A.C., 533 A.2d 611, 614 (D.C. 1987) ("We do not think we should opine whether the decision would have or should have been different if her quality of life during that period had been better than it was").

170. *See* Iglehart, *Health Policy Report - Transplantation: The Problem of Limited Resources*, 309 N. ENGLAND J. MED. 123, 124 (1983).

171. *Contra* Robertson & Schulman, *supra* note 48 at 27 (Rejecting notion of a slippery slope where "every conceivable protective measure is required of pregnant women").

ing to the physicians, Angela's fetus was given its best chance to live and Angela was made stronger and more comfortable because the cesarean was performed. That is what Angela wanted. However, the court predicated its decision on Angela's refusal to consent to the surgery, thereby setting morbidly dangerous precedent.

The court twisted a compelling state interest in sustaining life into a justification for possibly shortening a life for the sake of a potential life. Saving the life of a child or an adult seems more compelling than saving the life of a questionably viable fetus. One must wonder what the court would have done if the hospital administrators had asked for Angela's kidneys, liver, bone marrow, and heart to save other patients in the hospital.

Robert H. Sturgess