JUDICIAL ENFORCEMENT OF LIFESAVING TREATMENT FOR UNWILLING PATIENTS

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I. INTRODUCTION

An integral part of human autonomy is "the right to make choices pertaining to one's health, including the right to refuse unwanted medical treatment."\(^1\) This right of refusal extends to all medical choices.\(^2\) The weight of authority on this point is that a competent adult has the right to make choices to refuse medical treatment, however irrational or foolish that refusal may be. This notion is based on a common law right of self-determination, by which competent adults are generally permitted to refuse medical treatment, even at the risk of death.

In this Article we will explore the nature of the right to refuse medical treatment and what factors will justify a court in qualifying that right. We will examine cases in which courts have compelled medical procedures for minor children despite the refusal of the parents to consent. We will also examine situations in which courts have been asked to authorize lifesaving medical procedures against the will of competent adult patients. In addition, we will explore cases in which a patient refused to consent to medical treatment deemed necessary to save the patient's late-term fetus.

Since nonconsensual medical treatment may subject physicians and hospitals to liability for assault and battery, except in emergencies in which the patient is unconscious, the issue of an individual's refusal to consent to lifesaving medical treatment is invariably taken to the courts for resolution. Most of the cases involve hospitals and physicians that call upon the court to authorize the State, as parens patriae, to appoint a guardian or conservator to consent to the proposed medical treatment.

Our focus will be on competent adult patients who refuse to submit to a medical treatment. Competence is commonly defined to mean that the patient understands the risks and benefits of treatment and can make an informed decision to consent or refuse treatment.

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1. In re Guardianship of Browning, 568 So. 2d 4, 10 (Fla. 1990) (stating "[e]very human being of adult years and sound mind has a right to determine what shall be done with his own body" (quoting Schloendorff v. Soc'y of N.Y. Hosp., 105 N.E. 92, 93 (N.Y. 1914))).

2. In re Guardianship of Browning, 568 So. 2d at 10. See also Cruzan ex rel. Cruzan v. Dir., Mo. Dep't of Health, 497 U.S. 261, 279 (1990) (stating "for purposes of this case, we assume that the United States Constitution would grant a competent person a constitutionally protected right to refuse lifesaving hydration and nutrition").
As we will see, the right to refuse medical treatment has never been absolute. Courts have performed a balancing test to decide whether there is a compelling state interest that overrides a competent adult’s refusal of medical treatment. Courts generally balance four state interests against the patient’s rights of bodily autonomy: (1) preservation of life, (2) prevention of suicide, (3) protection of third party interests, and (4) maintaining the ethical integrity of the medical profession.3

Courts will engage in different value assessments of these state interests, with some courts finding that the right of autonomy is almost absolute, so that it will be a rare situation that persuades the court to authorize medical treatment against the patient’s will.4 In such instances, these courts will declare a patient’s right of autonomy such that the patient’s wishes must be honored even though minor children will be orphaned if the patient dies. At the other end of the spectrum are cases that emphasize the state’s interest in preserving life and protecting the interests of third parties to justify overriding the patient’s refusal to consent, particularly if the treatment is relatively noninvasive, such as a blood transfusion.

Other cases will authorize intrusive surgical procedures such as a cesarean section, to save the patient’s life or that of a late-term fetus, or both, despite the patient’s refusal to consent. Again, at the other end of the spectrum, some courts will refuse to override a patient’s refusal of a cesarean section, or even a blood transfusion, even though her late-term fetus will be jeopardized as a result.

Generally, the state’s interest in authorizing medical procedures weakens and the individual’s right of autonomy grows as the degree of bodily invasion increases and the prognosis dims. For instance, courts are more likely to authorize blood transfusions to preserve life, overriding the patient’s objections, compared to authorizing an amputation to preserve the patient’s life when the chances of survival might not be great.5

5. See, e.g., Lane v. Candura, 376 N.E.2d 1232 (Mass. App. Ct. 1978). This case involved a seventy-seven-year-old widow who suffered from gangrene in her right leg. Her doctors recommended that the leg be amputated without delay, and the patient refused to consent to the operation. Her daughter filed a petition seeking appointment of herself as temporary guardian with authority to consent to the operation on behalf of
We will also explore a line of cases that involves the mature minor doctrine, recognized in many states, which permits minors to exercise rights of medical autonomy on their own behalf. In such instances, the issue is whether a mature minor's refusal of lifesaving medical treatment should be overridden by the court.

The cases under discussion in this Article involve patients who, for the most part, wish to survive the medical crisis, but who simply refuse to consent to the procedure even though they understand death will likely result. As such, these patients are not seeking to hasten their death, a concept known as "antidysthanasia," but simply wish to adhere to their own convictions in the matter, whether based on fear of the procedure, religious beliefs, or other factors. In most instances, the patient's objection to the treatment is based on sincerely held religious beliefs. As we will see, courts generally evaluate these cases based on the patient's right of autonomy and find it unnecessary to reach the constitutional question of whether overriding the pa-

her mother. The petition was granted, and on appeal the order was reversed. The court said it could find no "countervailing" interests of the state that might outweigh the patient's right to refuse the medical treatment. The patient expressed her reasons for her decision: that she had been unhappy since the death of her husband, that she did not wish to be a burden to her children, that she did not believe the operation would cure her, that she did not wish to live as an invalid or in a nursing home, and that she did not fear death but welcomed it. She had had two earlier operations (partial amputations) to arrest the advance of the gangrene. She expressed a high degree of awareness and acuity concerning the proposed operation. There was conflicting testimony as to whether the patient was competent or incompetent, and the trial court seemed to suggest that the patient was legally incompetent based primarily on evidence of her forgetfulness and confusion. The court on appeal said the following:

[The fact that she has vacillated in her resolve not to submit to the operation does not justify a conclusion that her capacity to make the decision is impaired to the point of legal incompetence. Indeed, her reaction may be readily understandable in the light of her prior surgical experience and the prospect of living the remainder of her life nonambulatory.]

Lane, 376 N.E.2d at 1236.

This case may be contrasted with In re Schiller, 372 A.2d 360 (N.J. Super. Ct. Ch. Div. 1977), and In re Long Island Jewish-Hillside Medical Center, 342 N.Y.S.2d 356 (N.Y. Spec. Term 1973), both involving amputation in which the patient was held to be incompetent. In Schiller, the patient suffered from gangrene, and the hospital filed for appointment of a guardian to authorize amputation of his right leg because the condition was a threat to his life. Psychiatric testimony indicated the patient was mentally incapable of giving consent to the operation. The court determined the patient was incompetent and appointed a guardian with authority to consent to the operation.

The Jewish-Hillside case involved an eighty-four-year-old patient who was suffering from severe dehydration and gangrene. The patient was unable to make medical decisions on his own. His physicians said amputation of the patient's left leg above the knee was required immediately to save his life. There was conflicting testimony as to whether the patient, in moments of lucidity, had voiced his objections to the proposed amputation. The court appointed the patient's niece as guardian for the purpose of consenting to the operation.

patient's refusal in the matter would violate the Free Exercise Clause of the First Amendment.

A recurring issue in cases in which a patient is ordered to undergo a lifesaving procedure is that once the procedure has been administered, the case would seem to be moot for purposes of appellate jurisdiction. However, if an "issue presented is of substantial public interest," the following applies:

[A] well-recognized exception exists to the general rule that a case which has become moot will be dismissed upon appeal. . . . Among the criteria considered in determining the existence of the requisite degree of public interest are the public or private nature of the question presented, the desirability of an authoritative determination for the future guidance of public officers, and the likelihood of future recurrence of the question.

. . . [P]ublic authorities must act promptly if their action is to be effective, and although the precise limits of authorized conduct cannot be fixed in advance, no greater uncertainty should exist than the nature of the problems makes inevitable. In addition, the very urgency which presses for prompt action by public officials makes it probable that any similar case arising in the future will likewise become moot by ordinary standards before it can be determined by this court. For these reasons the case should not be dismissed as moot. 7

A separate matter not addressed here involves the power of courts to order or authorize discontinuation of artificial means of sustaining human life—life sustaining medical treatment ("LSMT"). These protocols are to prolong or sustain but not to save a patient's life. LSMT consists of such interventions as mechanical respirators to aid breathing or tubes to provide hydration and nutrition. LSMT is often associated with cases involving patients with a terminal illness or who are in a persistent vegetative state with little or no possibility of being restored to sapient functions. The medical technology involved may simply postpone death and carries high physical and psychological burdens and may also tend to detract from the patient's ability to undergo a humane, dignified death. 8 These situations usually involve incompetent patients who have not issued advance directives indicating their treatment choices regarding LSMT. Generally, the law seeks to protect the medical decision making rights of incompetent patients

8. For instance, in the case of In re Quinlan, 355 A.2d 647, 663 (N.J. 1976), the court noted that "the respirator cannot cure or improve [the patient's] condition but at best can only prolong her inevitable slow deterioration and death."
by allowing others to assert the rights on their behalf or by use of the substituted judgment doctrine.\textsuperscript{9}

Other situations not addressed here involve forced sterilization procedures, which sometimes are granted after detailed factfinding under strict procedural standards.\textsuperscript{10} Other topics not addressed here pertain to nonemergency use of antipsychotic drugs on institutionalized mental patients who refuse them\textsuperscript{11} and the forced administration of psychiatric drugs to prisoners.\textsuperscript{12}

\textsuperscript{9} The nature of substituted judgment with respect to an incompetent patient has been expressed this way:

[M]aintaining the integrity of the person means that we act toward him "as we have reason to believe [he] would choose for [himself] if [he] were [capable] of reason and deciding rationally." It does not provide a license to impute to him preferences he never had or to ignore previous preferences . . . If preferences are unknown, we must act with respect to the preferences a reasonable, competent person in the incompetent's situation would have.


The difficulty of ascertaining what the patient would want done under the substituted judgment doctrine has been expressed this way:

[O]ur focus must always be on what the patient would say if asked today whether the treatment in issue should be terminated. However, we can never be completely certain of the answer to our question, since the inquiry assumes that the patient is no longer able to express his or her wishes. Most often, therefore, the inquiry turns on interpretation of statements on the subject made by the patient in the past. This exercise presents inherent problems.


\textsuperscript{10} See, e.g., \textit{In re Guardianship of Hayes}, 608 P.2d 635 (Wash. 1980). Many jurisdictions have ruled that courts do not have the power to order the sterilization of a mentally disabled person. \textit{See also In re Grady}, 426 A.2d 467 (N.J. 1981) (identifying several cases holding that courts do not have the authority to order the sterilization of mentally disabled persons).

\textsuperscript{11} People v. Medina, 705 P.2d 961 (Colo. 1985) (determining that an involuntarily committed psychotic and assaultive patient could not be treated with anti-psychotic drugs without a full adversarial hearing).

\textsuperscript{12} See, e.g., \textit{Vitek v. Jones}, 445 U.S. 480, 494 (1980) (in which the Supreme Court of the United States recognized a general liberty interest of prisoners in not being arbitrarily classified as mentally ill and subjected to unwelcome treatment in a mental hospital, without minimum due process procedures). The procedures, for the purpose of imposing psychiatric treatment, include written notice to the prisoner that a transfer to a mental hospital is being considered; a hearing with an independent decision maker, at which the prisoner is permitted to hear the evidence being relied upon against him and to present documentary evidence on his behalf; testimony of witnesses; the right to confront and cross-examine witnesses called by the state; and the availability of qualified and independent assistance in connection with the hearing. \textit{Vitek}, 445 U.S. at 494-95. \textit{See also Washington v. Harper}, 494 U.S. 210, 221-22, 229 (1990) (stating "[t]he forcible injection of medication into a nonconsenting person's body represents a substantial interference with that person's liberty" and that prisoners possess "a significant liberty interest in avoiding the unwanted administration of antipsychotic drugs under the Due Process Clause of the Fourteenth Amendment"). \textit{See also Osgood v. District of Columbia}, 567 F. Supp. 1026 (D.D.C. 1983) (involving an inmate who was believed to be "delusional and actively psychotic" at the time, and who "presented a substantial danger to others"). In \textit{Osgood}, prison officials claimed the situation was a medical emergency that warranted the forcible injection of Haldol. The court said that a compelling state inter-
II. THE NATURE OF THE RIGHT OF AUTONOMY

The right of autonomy is based on the fundamental common law principle that a competent adult may refuse medical treatment even when the treatment is necessary to preserve the individual's life. The patient has the final say in matters with regard to medical consent, and "this must necessarily be so in a system of government which gives the greatest possible protection to the individual in the furtherance of his own desires."13

Perhaps a good starting point for exploring the right of autonomy is Union Pacific Railway Co. v. Botsford,14 in which the Supreme Court said, "No right is held more sacred, or is more carefully guarded by the common law, than the right of every individual to the possession and control of his own person, free from all restraint or interference of others, unless by clear and unquestionable authority of law." This principle of bodily integrity soon developed into the principle of informed consent, expressed in 1914 by Justice Cardozo, while on the Court of Appeals of New York, as follows:

Every human being of adult years and sound mind has the right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient's consent commits an assault, for which he is liable in damages . . . This is true except in cases of emergency where the patient is unconscious and where it is necessary to operate before consent can be obtained.15

The logical corollary to the doctrine of informed consent is that patients have the right to refuse treatment. In Mills v. Rogers,16 the Supreme Court said, "[T]he right to refuse any medical treatment emerged from the doctrines of trespass and battery, which were applied to unauthorized touchings by a physician."

Another approach to the right to refuse medical treatment is the concept of self-determination expressed by John Stuart Mill:

[T]he only purpose for which power can be rightfully exercised over any member of a civilised community, against his will, is to prevent harm to others. His own good, either physical or moral, is not a sufficient warrant. He cannot rightfully be compelled to do or forbear because it will be better for him
to do so, because it will make him happier, because, in the opinion of others, to do so would be wise, or even right.\textsuperscript{17}

Another component relative to bodily autonomy was expressed in \textit{Cruzan v. Director, Missouri Department of Health},\textsuperscript{18} in which the Supreme Court assumed that a person's interest in refusing medical treatment has constitutional underpinnings in the Due Process Clause of the Fourteenth Amendment,\textsuperscript{19} and that this liberty interest in refusing medical treatment must be balanced in a given case against the relevant state interests.\textsuperscript{20} Concurring in the majority opinion, Justice O'Connor said that the liberty guaranteed by the Due Process Clause must protect, if it protects anything, an individual's "deeply personal" decision to reject medical treatment: "Because our notions of liberty are inextricably entwined with our idea of physical freedom and self-determination, the Court has often deemed state incursions into the body repugnant to the interests protected by the Due Process Clause."\textsuperscript{21}

Among the commentaries in the literature, it has been observed that "[c]hoice over one's body is an essential part of being an individual with needs and rights, a concept that is the most powerful legacy of the liberal political tradition."\textsuperscript{22} Also, "the body constitutes the major locus of separation between the individual and the world and is in that sense the first object of each person's freedom."\textsuperscript{23}

Another approach to bodily autonomy can be seen in \textit{Winston v. Lee},\textsuperscript{24} in which the Supreme Court ruled that without consent of a robbery suspect, surgery to remove a bullet lodged in his muscle was constitutionally impermissible. In that case, a shopkeeper was wounded by gunshot during an attempted robbery but, also being armed with a gun, he shot the assailant. The suspect fled from the scene and entered a hospital for treatment of the gunshot wound. Police, investigating the incident, found the suspect at the hospital and charged him with, among other things, attempted robbery. The Commonwealth of Virginia filed for a court order directing the suspect to undergo surgery to remove the bullet lodged under his left collarbone, claiming that the bullet would provide evidence of his guilt or innocence. An expert testified that the surgery would require an incision of only about one-half inch, could be performed under local anesthesia,
and would result in "no danger on the basis that there's no general anesthesia employed." Later, new evidence was produced that the bullet was lodged deeper than earlier thought and that a general anesthetic would be advised for surgery. The matter ended up in the Supreme Court, after two rounds of hearings in state courts and lower federal courts. The Court held that the proposed search in this case would be unreasonable under the Fourth Amendment:

The reasonableness of surgical intrusions beneath the skin depends on a case-by-case approach, in which the individual's interests in privacy and security are weighed against society's interests in conducting the procedure. In a given case, the question whether the community's need for evidence outweighs the substantial privacy interests at stake is a delicate one admitting of few categorical answers.

The Court of Appeals had found that the respondent would suffer some risks associated with the surgical procedure, albeit minimal. The procedure could entail injury to the muscle and nerves if extensive probing for the bullet was involved, and the court found that overall the medical risks were uncertain. The Supreme Court said that in weighing the various factors of the case the operation would intrude substantially on the suspect's protected interests, that the medical risks of the operation, although not severe, were a subject of considerable dispute, and that in any event the intrusion on the respondent's privacy interests entailed by the operation "can only be characterized as severe." Moreover, the Court said that there was no compelling need for obtaining the bullet as there was substantial additional evidence available to help prove that the respondent was the person who committed the attempted robbery, including an eyewitness identification by the robbery victim.

From this, we see another basis for the right of physical freedom—privacy—which in another case was expressed thusly:

The constitutional right to privacy, as we conceive it, is an expression of the sanctity of individual free choice and self-determination as fundamental constituents of life. The value of life as so perceived is lessened not by a decision to refuse treatment, but by the failure to allow a competent human being the right of choice.

27. Id. at 760.
28. Id. at 763-64, 764 n.7.
29. Id. at 764.
30. Id. at 766.
The weight of authority holds, consistent with the *Cruzan* case, that the right of self-determination and bodily integrity is not absolute but must be balanced against whatever state interests are claimed to justify forcing a patient to undergo medical treatment. Thus, as we will see, for the most part courts have engaged in ad hoc balancing tests to weigh the patient's privacy, self-respect, and the degree of bodily invasion involved against the claimed state interests.

In utilizing a balancing test, courts seem to incorporate, in principle, the common law doctrine of necessity. The doctrine holds that certain conduct, though it violates certain rights, is justified because it averts a greater evil and hence produces a net social gain or benefit to society. Granville Williams expressed the necessity doctrine this way: "[S]ome acts that would otherwise be wrong are rendered rightful by a good purpose, or by the necessity of choosing the lesser of two evils." The question becomes—is it a lesser evil to judicially enforce medical treatment, so as to produce a greater good, e.g., to preserve life? Or, is it on balance a greater evil to override a patient's right to determine the nature and course of his or her own medical treatment?

The utilitarian idea is that certain wrongful conduct is justified because, due to the special circumstances of the situation, a net benefit to society will result. This utilitarian rationale is sometimes criticized as "ends-justifying-the-means" in that the doctrine allows that, within certain limits, it is justifiable, especially under exigent circumstances, to violate rights if doing so will avert a greater evil.

Another commentator has observed the following:

[T]hese [justified] acts are ones, as regard which, upon balancing all considerations of public policy, it seems desirable that they should be encouraged and commended even though in each case some individual may be injured or the result may be otherwise not wholly to be desired.

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34. Justice Brandeis, in a famous dissent in *Olmstead v. United States*, 277 U.S. 438, 465 (1928), said the following:

In a government of laws, existence of the government will be imperilled if it fails to observe the law scrupulously . . . Crime is contagious. If the government becomes a lawbreaker, it breeds contempt for law; it invites every man to become a law unto himself; it invites anarchy. To declare that in the administration of the criminal law the end justifies the means—to declare that the government may commit crimes in order to secure the conviction of a private criminal—would bring terrible retribution. Against that pernicious doctrine this court should resolutely set its face.

*Olmstead*, 277 U.S. at 485 (Brandeis, J., dissenting).
35. JUSTIN MILLER, HANDBOOK OF CRIMINAL LAW 189 (1934).
Another "wedge" that opens the way for courts to utilize a balancing test stems from legal principles that permit authorities to use force to prevent a person from harming himself or others. For example, an 1842 New Hampshire case, Colby v. Jackson,\(^36\) involved a plaintiff who sued for assault and battery and false imprisonment. The defendant was one of the selectmen of the community and claimed that the plaintiff was insane and so dangerous to himself and to his family that it was necessary to confine him and prevent him from going about. After doing so, the defendant made application to the proper authority to have a guardian appointed. The court held that under the circumstances there was an "obvious necessity" to restrain the plaintiff since there was no time to get a warrant to seize him.\(^37\) This restraint was justified for a reasonable time, until an application could be made to the probate court for a guardian to be appointed. The court noted the following was well settled at common law:

[T]hat a private person, without warrant, may lawfully seize and detain another, in certain cases. . . . If two persons be fighting, and there be reason to fear that one of them will be killed by the other, it will be lawful to part and imprison them till their anger shall be cooled. It is lawful for every man to lay hands upon another, to preserve public decorum; as, to turn him out of church, and prevent him from disturbing the congregation, or a funeral ceremony. So, if a person intend doing a right act, as to assist a drunken man, or prevent him from going along the street without help, and a hurt should ensue, he would not be answerable. And private persons may justify breaking and entering the plaintiff’s house, and imprisoning his person, to prevent him from murdering his wife.\(^38\)

A corollary idea is that if a person has intentionally taken an overdose of barbiturates to end his or her life, or otherwise attempts suicide, emergency medical personnel have the right to do whatever they believe is medically advisable to save the person’s life, such as pumping out his or her stomach—notwithstanding the patient’s apparent wishes to the contrary. It is also worthwhile noting that "[a]t common law, even a private person’s use of force to prevent suicide was privileged."\(^39\)

We will see that courts will tend to be reluctant to override a patient’s autonomy when there is a significant degree of bodily invasion involved (e.g., a cesarean section) compared to a relatively slight bod-

\(^{36}\) Colby v. Jackson, 12 N.H. 526, 530-31 (Super. Ct. 1842).

\(^{37}\) Colby, 12 N.H. at 530 (citations omitted).

\(^{38}\) Cruzan, 497 U.S. at 298 (Scalia, J., concurring).
ily invasion (e.g., a blood transfusion). The burden increases with the degree of "invasiveness, risk, or indignity involved." Also, in some cases courts will consider in the balancing analysis the patient's religious beliefs that forbid the procedure in question (e.g., Jehovah's Witnesses and blood transfusions).

III. PARENTAL REFUSAL TO CONSENT TO LIFESAVING TREATMENT FOR MINOR CHILDREN

A. NATURE OF THE RIGHT TO ACT AS "SURROGATE" DECISION MAKERS FOR CHILDREN

It is well established that parents speak for their minor children in matters of medical treatment. There is a long-standing assumption made by society and the medical and legal professions that parents are obvious and natural surrogate decision makers for all medical treatment of their children and will always act in their child's best interest. In Parham v. J.R., the Supreme Court said, "Most children, even in adolescence, simply are not able to make sound judgments concerning many decisions, including their need for medical care or treatment. Parents can and must make those judgments." At the same time, the Court said, "[A] child, in common with adults, has a substantial liberty interest in not being confined unnecessarily for medical treatment."

Because medical treatment includes the decision to decline life-prolonging measures, it follows that parents are empowered to make decisions regarding withdrawal or withholding of life-prolonging measures ("LSMT") on behalf of their children. In situations when there is uncontroverted medical evidence that a child is terminally ill or is in

42. 442 U.S. 584, 603 (1979).
an irreversible and persistent vegetative state, the decision of parents to withdraw or withhold LSMT overrides any interest of the state in prolonging the child's life: 44

A decision by parents [to withhold or withdraw LSMT] supported by competent medical advice ... should ordinarily be sufficient without court approval. Of course, diagnosis should always be confirmed by at least two physicians. ... Although judicial intervention need not be solicited as a matter of course, still the courts must always be open to hear these matters on request of the family, guardian, affected medical personnel, or the state. In cases where doubt exists, or there is a lack of concurrence among the family, physicians, and the hospital, or if an affected party simply desires a judicial order, then the court must be available to consider the matter. 45

However, an entirely different picture emerges with respect to the power of parents to refuse to consent to medical treatment that is important to the child's well-being, and particularly if the treatment is necessary to save the child’s life. In such instances, the state will invariably succeed in overriding the right of parents to act as surrogate decision makers, even if this means violating the parents' deeply held religious beliefs that prohibit the treatment in question.

Blackstone, in Book I, Section 447, said the following:
The duty of parents to provide for the maintenance of their children, is a principle of natural law; an obligation, says Puffendorf, laid on them not only by nature herself, but by their own proper act, in bringing them into the world; for they would be in the highest manner injurious to their issue, if they only gave their children life that they might afterwards see them perish. By begetting them, therefore, they have entered into a voluntary obligation to endeavor, as far as in them lies, that the life which they have bestowed shall be supported and preserved. And thus the children will have the perfect right of receiving maintenance from the parents. 46

B. THE DICHOTOMY BETWEEN THE RIGHT TO HOLD RELIGIOUS BELIEFS AND THE RIGHT TO ACT UPON THEM

Parental refusal to consent to medical treatment for their minor children usually involves religious beliefs that counsel against the procedure. Courts have consistently upheld the power of the State to au-

46. 1 WILLIAM BLACKSTONE, COMMENTARIES *435.
authorize the administration of medical procedures over the religious objections of parents when the procedure was shown to be necessary either to save the minor’s life or to otherwise contribute to the minor’s welfare.\textsuperscript{47} In fact, parents can face homicide charges for preventing a child from receiving life-sustaining medical treatment.\textsuperscript{48} The idea is that the right of parents to enjoy freedom of religion ends where someone else’s rights are involved. The State has the duty to protect the welfare of minors, and this necessarily includes their physical and mental well-being.

Courts have often made a distinction between the right to hold religious beliefs and the right to act upon them. In the landmark case, \textit{Reynolds v. United States},\textsuperscript{49} the Supreme Court affirmed a Mormon’s conviction for polygamy despite his contention that his actions were an expression of his religious beliefs. The Court said that “[l]aws are made for the government of actions, and while they cannot interfere with mere religious belief and opinions, they may with practices.”\textsuperscript{50} Another case applicable in addressing the religious objections is \textit{Cantwell v. Connecticut},\textsuperscript{51} in which the Supreme Court noted that the First Amendment “embraces two concepts,—freedom to believe and freedom to act. The first is absolute but, in the nature of things, the second cannot be. Conduct remains subject to regulation for the protection of society.”

In cases involving children, this belief-action dichotomy comes into even sharper focus. For example, in \textit{Kirchner v. Caughey},\textsuperscript{52} the Maryland Court of Appeals said:

When the welfare of a child is threatened . . . the task of [governmental] intervention cannot be avoided, and under some


\textsuperscript{49} 98 U.S. 145 (1878).

\textsuperscript{50} \textit{Reynolds v. United States}, 98 U.S. 145, 166 (1878).

\textsuperscript{51} 310 U.S. 296, 304 (1940).

\textsuperscript{52} 606 A.2d 257 (Md. 1992).
circumstances actions based upon the sincerely held religious beliefs of one parent or both parents must give way to the safety and welfare of the child . . . . When the life or physical safety of a child is threatened, [a tenuous balancing] between religious freedoms and an exercise of state authority is necessarily made. As the threat to the child diminishes, the balancing of interests becomes more difficult.53

Perhaps the leading case concerning the state's interest in protecting children from harm occasioned by the religious beliefs of parents is the 1944 Supreme Court case of Prince v. Massachusetts.54 The Court upheld the convictions of the aunt and custodian of a nine-year-old girl for violating Massachusetts's child labor laws by allowing the girl to sell Bible tracks on the public streets. The aunt argued that the child was exercising her First and Fourteenth Amendment rights to preach the gospel and that the aunt had a parental right that was similarly protected from infringement. The Supreme Court held that the family was not beyond regulation in the public interest as against a claim of religious liberty. Among other things, the Court said the following:

[N]either rights of religion nor rights of parenthood are beyond limitation. Acting to guard the general interest in youth's well being, the state as parens patriae may restrict the parent's control by requiring school attendance, regulating or prohibiting the child's labor, and in many other ways. Its authority is not nullified merely because the parent grounds his claim to control the child's course of conduct on religion or conscience. Thus, he cannot claim freedom from compulsory vaccination for the child more than for himself on religious grounds. The right to practice religion freely does not include liberty to expose the community or the child to communicable disease or the latter to ill health or death . . . .

. . . .

. . . Parents may be free to become martyrs themselves. But it does not follow they are free, in identical circumstances, to make martyrs of their children before they have reached the age of full and legal discretion when they can make that choice for themselves.55
C. CASE LAW OVERRIDING PARENTAL OBJECTIONS TO MEDICAL TREATMENT FOR MINOR CHILDREN

State v. Perricone56 involved parents who were Jehovah's Witnesses and who refused to grant permission for their infant son to have blood transfusions in connection with surgery for an enlarged heart. The trial court declared the parents guilty of neglect and appointed a guardian with authority to consent to a blood transfusion for the infant, who was in danger of death without it. The child died despite the blood transfusions. The New Jersey Supreme Court accepted the case rather than dismissing it as moot because of the public importance of a decision that would settle the question for parents, physicians, and hospitals in the future. The court said that "the refusal of parents, on religious grounds, to submit their infant child to a blood transfusion necessary to save its life or mental health amounted to statutory neglect, and therefore it was proper to appoint a guardian and to award custody to him for the limited purpose of authorizing transfusions."57 The court held that the state's paramount interest in preserving life and the hospital's interest in fully caring for a patient in its care outweighed the parents' decision to decline medical intervention.

Since a number of cases in this Article involve the refusal of Jehovah's Witnesses to consent to blood transfusions, it may be helpful to briefly consider the basis of their belief that blood transfusions are prohibited, even if necessary to save their lives. Founded in 1876, Jehovah's Witnesses refuse blood transfusions based upon their belief that the Bible prohibits "eating blood." This is derived from Genesis 9:4 ("But flesh with the life thereof, which is the blood thereof, shall ye not eat"), Leviticus 3:17 ("By a perpetual law for your generation, and all your habitations, neither blood nor fat shall you eat at all"), and Acts 15:29 ("That you abstain from things sacrificed to idols, and blood").58 To them, violation of this precept would deny them "both

58. Jehovah's Witnesses believe they are living in the "last days," which will culminate in the Battle of Armageddon when Christ will return to set up his earthly kingdom. Among other beliefs of Jehovah's Witnesses are the following:
   a) One should not salute the flag,
   b) Birthdays, Christmas and national holidays should not be celebrated,
   c) All governments are under the control of Satan,
   d) All other religions are false religions,
   e) All governments and false religions stand in the way of world peace,
   f) All military bodies are instruments of the devil, and
   g) No life-threatening physical force should ever be used.

See Waites v. Waites, 567 S.W.2d 326, 328-29 (Mo. 1978). See also W. Va. State Bd. of Educ. v. Barnette, 319 U.S. 624 (1943) (concerning Jehovah's Witnesses objecting, on religious grounds, to a requirement that their children salute the American flag in pub-
resurrection and eternal salvation.”

The scripture passages have to do with blood and the eating or taking thereof. Blood transfusions as administered by modern medicine were unknown to the authors of these sacred texts. “Had its beneficent effects been known to them, it is not unlikely some exception would have been made in its favor—especially by St. Luke who is said to have been a physician.” Jehovah's Witnesses apparently refuse to allow exceptions, based on medical necessity, even in situations when the individual will inevitably die as a consequence.

*In re Sampson* was a neglect proceeding brought on behalf of a fifteen-year-old boy alleging that his mother failed to provide him with proper medical and surgical care. The boy suffered from a rare neurofibromatosis disease that caused extreme disfigurement of the face and neck, and doctors recommended surgery to correct the condition. The mother consented to the proposed surgery, but based on her beliefs as a Jehovah's Witness refused to allow blood transfusions that would be needed during the course of surgery.

The court emphasized the importance of this surgery: “[T]he marked facial disfigurement from which this boy suffers constitutes such an overriding limiting factor militating against his future development that unless some constructive steps are taken to alleviate his condition, his chances for a normal, useful life are virtually nil.” The court noted that the surgical procedure in question was very risky and that in no event would doctors agree to it without authorization for blood transfusions. The court concluded the following, despite the risks inherent in the contemplated surgery:

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61. Jehovah's Witnesses apparently are unmoved by other passages in the Bible in which “exceptions” to the law are justified or excused based on the necessity of the situation. For example, David, through necessity of hunger, ate the sacred bread, and in doing so did not break the law, although he broke the words of the law, because he did it for necessity. *Matthew* 12:3-4. Another example is that in which the apostles of Christ plucked the ears of corn in a crop belonging to someone else and ate them, although in doing so they committed theft. *Matthew* 12:1.


When one considers the bleak prospect for this boy's future of the alternative of doing nothing, it is a risk which I believe must be taken. . . . The court wishes to leave the surgeons completely free to exercise their own professional judgment as to the nature, extent and timing of any surgery that may be required for the correction of Kevin's deformity.64

The court said that the religious objections of the parents must give way to the welfare of the child: "It is both illogical and impractical for Mrs. Sampson to consent to surgery for her son and then for religious reasons attempt to limit or circumscribe the surgeons in the employment of their surgical skills."65 The court also noted that it is not necessary that a child's life be in danger before the court may act to safeguard his or her health or general welfare. The court may step in when the parents refuse to authorize medical treatment and that refusal endangers his or her chance for a normal and useful life.66

The court adjudicated the minor to be a neglected child and ordered that the child's custody be under the supervision of the Commissioner of Social Services for up to one year, with the condition that Mrs. Sampson cooperate with the Department of Social Services to provide her son with such surgical care and treatment as may be necessary to alleviate his disfigurement.67 The court also authorized the surgeons to administer blood transfusions in their judgment in connection with the surgery.

The Sampson case referred to an earlier case that the Sampson court refused to follow. That was the 1955 case In re Seiferth,68 in which the New York Court of Appeals affirmed the trial court's refusal to order a corrective operation for a twelve-year-old boy's hair lip and cleft palate. That court weighed the conflicting considerations and noted that the trial court found that there was not a preponderance of evidence either that the operation would be more helpful if performed immediately or that the child's overall condition would be bettered under the circumstances. The lower court was affirmed. There was a strong dissent stating the following:

Every child has a right, so far as is possible, to lead a normal life and, if his parents, through viciousness or ignorance, act in such a way as to endanger that right, the courts should, as the legislature has provided, act on his behalf. Such is the case before us . . . .

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64. Id. at 657-58.
65. Id. at 658.
66. Id. at 653.
67. Id. at 658.
... It is quite true that the child's physical life is not at peril as would be the situation if he had an infected appendix or a growth on the brain but it may not be questioned, to quote from the opinion below, "What is in danger is his chance for a normal, useful life."69

The court in Sampson indicated that the Seiferth case is of "doubtful validity as a binding precedent"70 because statutory law since the time Seiferth was decided "is a clear indication of the Legislature's concern for [abused and neglected] children and its intention to confer upon the court the broadest power and discretion to deal with these matters."71 Thus, instead of intervening only when serious harm is threatened, it appears that a court has discretion to authorize medical treatment whenever it believes that intervention will further the child's best interests. This discretion is aided by the broad language in many abuse/neglect statutes, language that permits intervention whenever any necessary medical treatment is denied.72 In addition, there is a greater societal consensus for increased intervention in the family, based on the desire to protect children in a variety of circumstances, not just life-endangering situations.73

70. Sampson, 317 N.Y.S.2d at 654.
71. Id. at 654.
72. See, e.g., CONN. GEN. STAT. ANN. § 46b-120(9) (West 1998) (stating a child can be found neglected if "denied proper care and attention, physically, educationally, emotionally or morally, or . . . is being permitted to live under conditions, circumstances or associations injurious to the well-being of the child"); MISS. CODE ANN. § 43-21-105(i)(iv) (1998) (defining neglected child as one "[w]ho, for any reason, lacks the care necessary for his health, morals or well-being"); N.Y. FAM. CT. ACT § 1012(f)(i)(A) (McKinney 1998) (defining "neglected child" as one whose "condition has been impaired or is in imminent danger of becoming impaired" because of a parent's failure "to exercise a minimum degree of care . . . in supplying the child with adequate . . . medical, dental, optometrical, or surgical care"); UTAH CODE ANN. § 78-3a-103(1)(s)(i)(D) (Supp. 2003) (defining a neglected child as a minor whose guardian "fails or refuses to provide proper or necessary subsistence, education, or medical care, including surgery or psychiatric services . . . or any other care necessary for health, safety, morals, or well-being"). See also Robert Bennett, Allocation of Child Medical Care Decisionmaking Authority: A Suggested Interest Analysis, 62 VA. L. REV. 285 (1976) (discussing when state may intervene in health care decisions for minors).

For other cases on this subject, see Morrison v. State, 252 S.W.2d 97 (Mo. Ct. App. 1952), which involved a baby who was suffering from severe anemia for which blood transfusions were required. Her parents, Jehovah's Witnesses, refused to consent, the child was adjudged to be a ward of the court, and the child was saved with the transfusions. Following that, the child's father appealed. The lower court's ruling was affirmed.

Another case, *In re Custody of a Minor*,\(^{74}\) involved parents who refused to consent to chemotherapy for their minor child. The evidence showed that chemotherapy would offer the child a substantial chance for a cure and a normal life. There was no evidence of any alternative treatment consistent with good medical practice. The parents said that they preferred a treatment program based on dietary manipulation and prayer, yet the uncontroverted medical testimony indicated that the dietary program suggested by the parents would have no value in the child's treatment regimen. The parents also said they were concerned over the child's discomfort in the chemotherapy program and that they were pessimistic as to the chances of a cure. The Supreme Court of Massachusetts held that it was appropriate for the court to order chemotherapy for the child over the parents' objections.

**D. THE CASE OF THE CONJOINED TWINS**

Another situation of forced medical intervention against the wishes of parents came into sharp focus in a British case involving

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See *Tennessee, Department of Human Services v. Hamilton (In re Hamilton)*, 657 S.W.2d 425 (Tenn. Ct. App. 1983), which involved a twelve-year-old girl who, dying of cancer, needed blood transfusions as the only plausible way of effectuating remission. *Hamilton*, the court held that preservation of life outweighed her parents' religious beliefs. The parents in this case were members of a Protestant religious sect, The Church of God of the Union Assembly, and members of the church were forbidden to use medicine, vaccinations, or shots of any kind, but instead are taught to live by faith. The court affirmed the lower court's order declaring the child a dependent and neglected child.

In *People ex rel. Wallace v. Labrenz*, 104 N.E.2d 769 (Ill. 1952), the court held that the state can require blood transfusions for an eight-day-old infant over the religious objections of the infant's parents.

See *Mitchell v. Davis*, 205 S.W.2d 812 (Tex. Ct. App. 1947), which involved a mother charged with criminal neglect for failure to provide treatment for her son's arthritic knee condition, a non-life-threatening ailment. In *Mitchell* the mother defended on the ground that she considered healing was only possible through prayer. The court held that this religious belief did not constitute a defense to the charge of neglect.

See *Oregon, ex rel. Juvenile Department of Linn County v. Jensen (In re Jensen)*, 633 P.2d 1302 (Or. Ct. App. 1981), which involved parents who refused treatment on religious grounds of the child's condition of hydrocephalus. In *Jensen* the child faced the possibility of severe brain damage, but her life was not in immediate danger. The court ordered treatment for the child, holding that, although the parents are free to provide religious training to their child, that right does not include the right to jeopardize the child's health.

For a contentious case noted primarily for its dissenting opinion, see *In re Hudson*, 126 P.2d 765 (Wash. 1942), in which the court reversed a judgment ordering an operation on an infant child in the face of overwhelming evidence that without the operation, the child would be handicapped and dependent all of her life.

\(^{74}\) 379 N.E.2d 1053 (Mass. 1978).
conjoined twins. The two twin girls, Jodie and Mary, were born con-
joined at the abdomen, but had separate heads, brains, hearts, and
lungs.

Mary, the weaker of the twins, was not strong enough to pump
sufficient oxygenated blood through her body. Had she been born in-
dependent, she would not have survived. Mary also had other severe
neurological and cardiovascular problems. She did not have developed
lungs and was unable to cry. The heart and lungs of the stronger
twin, Jodie, provided the oxygenated blood both for herself and,
through a shared artery, for her twin sister, Mary.

Doctors said that Jodie's heart could not continue to support the
two indefinitely. Instead, her heart would, within three to six months
or perhaps a bit longer, fail under the strain of supporting two bodies,
and both twins would die. Mary, for her part, would die almost im-
mediately if separated from her sister.

The only alternative to allowing both twins to die in this manner
was to separate them surgically. The separation would give Jodie an
excellent chance of living somewhat of a normal life. However, the
procedure was certain to result in the death of Mary since her heart
and lungs were plainly inadequate to support her. If doctors waited
for an emergency situation, such as a time when Mary might start to
pass away, then Jodie's chances of survival would be severely
impaired.

The parents refused to authorize the surgical separation based in
part upon their religious beliefs as Roman Catholics that they ought
not take action that would kill their daughter Mary. Doctors ob-
tained an injunction allowing the surgery to proceed against the par-

75. The facts of the conjoined twins case are reported in In Re A (Children), [2000]
4 All E.R. 961 (A.C.). See also Tom Stacy, Acts, Omissions, and the Necessity of Killing
76. In Re A, 4 All E.R. at 969.
77. Id. at 980.
78. Id. at 985-87.

Roman Catholic moralists have generally taken the position that one should
not cause effects that are directly evil even if they are thought to be a necessary
means to a greater good. Thus, it is considered wrong to terminate the life of a
fetus even if that is the only way the mother can be saved and even if the fetus
will die in any event. On the other hand, an ordinary operation designed di-
rectly to protect the mother's health is permissible, even if an inevitable effect
is the death of the fetus, under the so-called principle of "double effect" that
death is only permitted, not intended, and is not itself a means to saving the
mother's life.

Model Penal Code § 3.02, cmt. 3 at 15 n.15 (1985). In the case of the conjoined twins,
the operation might be viewed either way. It could be viewed as terminating the life of
Mary (by the act of separating her from Jodie), or it could be viewed as being part of an
operation designed directly to protect the life of Jodie even though the inevitable result
will be the death of Mary.
ents' objections, and the injunction was upheld on appeal. The surgical separation took place and, as expected, Mary died immediately, and Jodie survived.

The opinion of the court relied somewhat on the necessity doctrine as justification for the operation. The opinion noted that given the physicians knew that the consequences of the surgery would be Mary's death, this would seem to be a prima facie case of intentional homicide. Absent the necessity doctrine, doctors would be guilty of Mary's murder. Two of the appellate judges relied mainly on the doctrine of self-defense. Self-defense entered into the reasoning, according to Lord Justice Ward, in that Mary was making use of Jodie's body in a way that put Jodie's life at risk. Although Mary was doing nothing unlawful, still the circumstances were analogous to an example of a six-year-old boy shooting at other children in a schoolyard. The police would be justified in killing the boy to protect the others even though the boy was too young to be held criminally responsible for his actions.

Another judge, Lord Justice Brooke, also justified the action based on the necessity doctrine. He noted that only Jodie could possibly survive and Mary was "self-designated for a very early death."

Lord Justice Walker took a different approach that the separation surgery was in Mary's as well as Jodie's best interests. Perhaps it is difficult to understand how the surgical separation and the certainty of death that would result was in Mary's best interests, but the judge nonetheless said that the separation would advance Mary's interests by giving her "even in death, bodily integrity as a human being."

The judge further offered that death was better for Mary in that continued life "would hold nothing for Mary except possible pain and discomfort, if indeed she can feel anything at all." He said the following:

In truth there is no helpful analogy or parallel to the situation which the court has to consider in this case. It is unprecedented and paradoxical in that in law each twin has the right to life, but Mary's dependence on Jodie is severely detrimental to Jodie, and is expected to lead to the death of both twins within a few months.

81. In re A, 4 All E.R. at 1016-17 (Ward L.J.).
82. Id. at 1051 (Brooke, L.J.).
83. Id. at 1070 (Walker, L.J.).
84. Id.
85. Id. at 1066 (Walker, L.J.).
He concluded that the law of necessity should be developed on a case-by-case basis:

I would extend it, if it needs to be extended, to cover this case. It is a case of doctors owing conflicting legal (and not merely social or moral) duties. It is a case where the test of proportionality is met, since it is a matter of life and death, and on the evidence Mary is bound to die soon in any event. . . . It should not be regarded as a further step down a slippery slope because the case of conjoined twins presents an unique problem.86

Lord Justice Brooke characterized the situation as one of quasi-self defense. He referred to the example of the mountaineer who is roped to a climber who has fallen and then decides to cut his doomed partner lose in order to save his own life. He also cited the disaster of the sinking of the ferry, Herald of Free Enterprise, at Zeebrugge, during which an Army corporal and dozens of other passengers were trapped. These situations, said Lord Justice Brooke, were analogous because there was no question of who would have to die. Moreover, in these situations, the person who was in effect self-selected for death was jeopardizing the lives of others, albeit unintentionally.87 Thus, Lord Justice Brooke placed Mary in the same category as the fallen mountaineer and the man on the ladder in the Zeebrugge disaster.

The court gave very little discussion to the parents' religious beliefs and instead emphasized the role of the court in giving due weight to the parents' wishes and balancing those against the duty of supervising the welfare of children.88 The court quoted with approval the following:

[When it comes to an assessment of the demands of the child patient's welfare, the starting point—and the finishing point too—must always be the judge's own independent assessment of the balance of advantage or disadvantage of the particular medical step under consideration. In striking that balance, the court will of course take into account as a relevant, often highly relevant, factor the attitude taken by the natural parent, and that may require examination of his or her motives. But the result of such an inquiry must never be allowed to prove determinative. . . . It is the duty of the judge to allow the court's own opinion to prevail in the perceived paramount interest of the child concerned . . . .89

A commentator has summed up the case this way:

86. Id. at 1067 (Walker, L.J.).
87. Id. at 1041 (Brooke, L.J.).
88. Id. at 1006-07.
89. Id. at 1008-09 (quoting In Re T (a minor) [1997] 1 All E.R. 906, 917-18).
[W]hether it is regarded as a case of private defence, or of necessity, the result is the same and many [sic] be summed up as follows:

Where A is, as the defendant knows, doomed to die in the near future but even the short continuation of his life will inevitably kill B as well, it is lawful to kill A, however free of fault he may be.\(^9\)

The question of the parents' refusal to consent to the surgery was scarcely discussed by the court.

IV. MINORS WHO REFUSE TO CONSENT TO LIFESAVING TREATMENT FOR THEMSELVES: THE MATURE MINOR DOCTRINE

As a rule only parents can grant or decline permission for medical treatment of their minor children, except that the State may seek to override parental choices that jeopardize their children's welfare. The power of parents to make decisions regarding medical treatment of their children does not require that there be any assessment of the child's level of maturity, nor does it allow any degree of autonomy for the child, with the emerging exception, however, of "mature minors."

In recent years a growing consensus has developed in law and medicine that some minors have sufficient maturity to understand and appreciate the benefits and risks of proposed medical treatment of all kinds, and thus mature minors should have the right to give or decline to give informed consent regarding all health care decisions. Since the 1960s, states have passed laws that allow minors to bypass the parental consent tradition and to consent to a narrow range of medical treatment, such as mental health care, treatment for drug and alcohol dependency, and treatment for sexually transmitted diseases.\(^9\) These laws recognize that minors ought to be accorded some measure of autonomy with certain types of treatment and be allowed to give informed consent on their own.

The mature minor doctrine is generally a creature of case law that extends the common law principle of self-determination to minors. The doctrine recognizes that children's decision making capacity increases with age and that this capacity is best assessed on a case-by-case basis.\(^9\)


Our focus will be on the question of whether a mature minor has the right to refuse life-sustaining medical treatment. The cases recognize that the state's interest in preserving life and in protecting the health and welfare of minors is greatest when the minor desires to refuse lifesaving treatment.

**Belcher v. Charleston Area Medical Center**\(^9\) involved seventeen-year-old Larry Belcher, who had muscular dystrophy and suffered a respiratory arrest. His parents authorized a "do not resuscitate" ("DNR") order in the event Larry suffered another arrest. The attending physician complied with the parents' request and issued a DNR order without consulting Larry. The following day Larry had another arrest, was not resuscitated, and died. His parents sued for wrongful death, alleging lack of informed consent because Larry had not consented to the DNR. The court held that a physician is required to obtain the consent of a mature minor before administering or withholding treatment.\(^9\)

The court said that physicians have an affirmative duty to find out whether their patients are mature enough to consent to DNR orders and, by implication, other kinds of protocols before authorizing them. Under this ruling, if the physician concludes that the minor is mature, then the minor's choices must be followed notwithstanding the objections of the parents.\(^9\) The court said, "[I]t is obvious that this places the doctor in the difficult position of making the determination of whether the minor at issue is mature," and that "the decision by the doctor on the maturity level of a minor will often be second-guessed," but nonetheless the decision whether to allow a minor to make medical choices should be made by the patient's doctor using "his or her best medical judgment."\(^9\) The court added that a physician who makes a good faith determination that a patient is a mature minor would not be liable for failing to obtain parental consent if the parents disagreed with the minor's decision.\(^9\)

This decision provides a strong inducement for physicians to determine whether their minor patients are mature and, if so, to obtain their consent before proceeding with treatment, notwithstanding parental authorizations, or else be held liable for wrongful death and other torts. In response to the *Belcher* decision, the West Virginia legislature subsequently enacted West Virginia Code section 16-30C-6(d), which states the following:

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95. See Belcher, 422 S.E.2d at 838.
96. Id. at 837.
97. Id. at 838.
If the minor is between the ages of sixteen and eighteen and, in the opinion of the attending physician, the minor is of sufficient maturity to understand the nature and effect of a do-not-resuscitate order, then no such order shall be valid without the consent of such minor. In the event of a conflict between the wishes of the parents or guardians and the wishes of the mature minor, the wishes of the mature minor shall prevail.

In Cardwell v. Bechtol,98 the Supreme Court of Tennessee recognized the mature minor doctrine. A minor and her parents brought an action, alleging various torts, against an osteopath, including battery and failure to obtain informed consent, because the doctor treated the minor, who was seventeen years and seven months old, without parental consent.

The court held that a mature minor had the capacity to consent, and did consent, to medical treatment and ordered dismissal with respect to issues of battery and informed consent. The court set forth criteria for determining whether a minor is mature enough to engage in informed consent:

Whether a minor has the capacity to consent to medical treatment depends upon the age, ability, experience, education, training, and degree of maturity or judgment obtained by the minor, as well as upon the conduct and demeanor of the minor at the time of the incident involved. Moreover, the totality of the circumstances, the nature of the treatment and its risks or probable consequences, and the minor's ability to appreciate the risks and consequences are to be considered.99

The court cautioned that the "[a]doption of the mature minor exception to the common law rule is by no means a general license to treat minors without parental consent and [the exception's] application is dependent on the facts of each case."100

There is always the problem of deciding whether a minor is in fact mature enough to make medical decisions. In other contexts, states have developed standards and techniques for determining whether minors have the capacity, for instance, to formulate the necessary intent to commit crimes so as to be tried as adults:

[T]he Juvenile Court Act presupposes a "sliding scale of maturity" in which young minors can be deemed mature enough to possess certain mental states and be tried and convicted as adults. . . . When a minor is mature enough to have the capac-

98. 724 S.W.2d 739 (Tenn. 1987).
100. Cardwell, 724 S.W.2d at 745.
ity to formulate criminal intent, both the common law and our Juvenile Court Act treat the minor as an adult.101

The leading case on the mature minor doctrine is In re E.G., a Minor,102 in which the Illinois Supreme Court considered whether a seventeen-year-old minor had the right to refuse lifesaving medical treatment, in this case, blood transfusions. The patient, Ernestine Gregory, was admitted to the hospital with acute non-lymphatic leukemia, a malignant disease of the white blood cells. Physicians informed Ernestine and her mother that blood transfusions were necessary in order to treat the disease.103 Ernestine and her mother refused to consent based on their religious beliefs as Jehovah’s Witnesses. Ernestine had already received several transfusions.104 Ernestine’s mother authorized doctors to treat her daughter, except for blood transfusions, and signed a waiver absolving them of liability for failure to administer transfusions.105

The Illinois State Attorney’s Office filed a neglect petition in juvenile court alleging that Ernestine was medically neglected and seeking appointment of a temporary guardian to consent to the transfusions. The trial judge heard evidence that without blood transfusions, Ernestine “would likely die within a month” and “the transfusions, along with chemotherapy, achieve remission of the disease in about 80% of all patients so afflicted.”106

Notwithstanding evidence of Ernestine’s maturity and that she was fully aware that death was likely without treatment, the trial court found that the state’s interest was greater than the interest Ernestine or her mother had in refusing to consent to the transfusions. The court appointed a temporary guardian with authority to consent to all medical treatment Ernestine required.107

On appeal, the appellate court reversed the trial court in part, holding that Ernestine was a “mature minor” and could therefore refuse the transfusions based on her religious beliefs. Nevertheless, the court affirmed the ruling of neglect against Ernestine’s mother.108

The Illinois Supreme Court heard an appeal and reversed, finding no state interest that outweighed Ernestine’s right to make her own medical decisions, even though death could result from her refusal of

102. 549 N.E.2d 322 (Ill. 1989).
104. Id. at 324. Ernestine said she was confident she would still go to Heaven because the decision to administer the transfusions had been made by the court not her. See Brief for Petitioner at 14, In re E.G., 549 N.E.2d 322, 322 (Ill. 1989).
105. E.G., 549 N.E.2d at 323.
106. Id. at 323.
107. Id. at 323-24.
108. Id. at 324.
treatment. Although the controversy was technically moot, as Ernestine had reached her eighteenth birthday and could no longer be adjudged a neglected minor, the court said the case presented "an issue of substantial public interest," and it was desirable to make an "authoritative determination for future guidance of public" officials as there was likelihood of future recurrence of the same issue.  

The court reasoned that the age of eighteen "is not an impenetrable barrier that magically precludes a minor from possessing and exercising certain rights normally associated with adulthood." The court held that a mature minor has a common law right to consent to or refuse medical treatment. Thus, a mature minor can refuse medical treatment, even if this refusal results in the minor's death.

The court said that this common law right is not absolute and, as with adults, it must be balanced against the four state interests we have mentioned: "(1) the preservation of life,” (2) preventing suicide, (3) “protecting the interests of third parties,” and (4) "maintaining the ethical integrity of the medical profession." The court said that "protecting the interests of third parties is clearly the most significant here" and did not discuss the other factors. The court noted that the only third party who might have an interest to protect here was Ernestine's mother: "If a parent or guardian opposes an unemancipated mature minor's refusal to consent to treatment for a life-threatening health problem, this opposition would weigh heavily against the minor's right to refuse." In this case, Ernestine's mother was in agreement with her daughter, so the court did not see any relevance in examining third party interests.

In determining whether a minor is mature enough to refuse lifesaving medical treatment, the court must consider evidence of the minor's maturity against public policy favoring life and health. The court said that when a minor's health and life are at stake, there is a strong policy favoring life.

When a minor's health and life are at stake, this policy becomes a critical consideration. A minor may have a long and fruitful life ahead that an immature, foolish decision could jeopardize. Consequently, when the trial judge weighs the

109. Id. at 325.
110. Id.
111. Id. at 328.
112. Id.
113. Id.
114. Id.
115. Id.
116. Id.
117. Id. at 327.
118. Id.
evidence in making a determination of whether a minor is mature enough to handle a health care decision, he must find proof of this maturity by clear and convincing evidence.\textsuperscript{119}

The court added the following:

If the evidence is clear and convincing that the minor is mature enough to appreciate the consequences of her actions, and that the minor is mature enough to exercise the judgment of an adult, then the mature minor doctrine affords her the common law right to consent to or refuse medical treatment.\textsuperscript{120}

The court reached its decision solely on the common law right to consent to or refuse medical care and declined to address the issue of whether the First Amendment's Free Exercise Clause entitles a mature minor to decline medical care because it contravenes sincerely held religious beliefs.\textsuperscript{121}

Under the ruling of the E.G. case, "The trial judge must determine whether a minor is mature enough to make health care choices on her own."\textsuperscript{122} This suggests that in order for a minor's medical choices to be valid, a judicial proceeding would be necessary to assess the minor's maturity. In situations when a minor is seriously ill, however, recourse to the courts would be impractical.

In breaking sharply with the common law requirement of parental consent the court seemed to place considerable emphasis on the fact that Ernestine's mother had actually agreed with her daughter's decision to refuse a blood transfusion. The E.G. case has been criticized as a "fatal misuse of the mature minor doctrine"\textsuperscript{123} and a judicial nod toward "death over life."\textsuperscript{124}

There were two dissents in the E.G. case, one pointing out that "this is a case of first impression. It may now be critically described by some as a holding without precedent."\textsuperscript{125}

In In re Long Island Jewish Medical Center,\textsuperscript{126} the court recognized the merit of the mature minor doctrine, but held that the minor in question was not mature enough to make his own medical decisions. The patient, Phillip Malsonl, was one month shy of his eight-

\begin{itemize}
\item \textsuperscript{119} Id.
\item \textsuperscript{120} Id. at 327-28.
\item \textsuperscript{121} Id. at 328.
\item \textsuperscript{122} Id. at 327.
\item \textsuperscript{123} Jessica A. Penkower, The Potential Right of Chronically Ill Adolescents to Refuse Life-Saving Medical Treatment—Fatal Misuse of the Mature Minor Doctrine, 45 DePaul L. Rev. 1165, 1165, 1187 (1996).
\item \textsuperscript{125} In re E.G., 549 N.E.2d at 329 (Ward, J., dissenting).
\item \textsuperscript{126} 557 N.Y.S.2d 239 (N.Y. IAS Term 1990).
\end{itemize}
teenth birthday. He was admitted to the hospital and was found to have widespread pediatric cancer. The recommended course of treatment, chemotherapy, would require that Phillip receive transfusions. Phillip and his parents refused to consent to the transfusions based on their religion (Jehovah's Witnesses). The next morning, the hospital petitioned the court for an order authorizing the medical treatment, and a hearing was held at the hospital that afternoon. Medical evidence indicated that there was no alternative to the use of blood transfusions if Phillip were to proceed with chemotherapy and that without treatment he was certain to die within a month.

The court noted that state law allowed minors over the age of sixteen to consent to inpatient mental health treatment, substance abuse treatment, treatment for sexually transmitted diseases, and other matters, and that there is "much merit" in the mature minor doctrine, but that Phillip was not a mature minor: "[H]is refusal to consent to blood transfusions [was] not based upon a mature understanding of his own religious beliefs or of the fatal consequences to himself." Phillip testified that he joined the Jehovah's Witnesses, then lost interest for a while, then returned to it. He stated that he did not know the books of the Bible, but he knew his religion prohibited blood transfusions. Phillip had never been away from home, never dated, always consulted his parents before making decisions, and when asked whether he considered himself an adult or a child, responded "child." He also said that if the court ordered the transfusion, it would not be his responsibility or sin. The court ordered a transfusion.

On the other end of the spectrum are jurisdictions that have entirely rejected the mature minor doctrine. For example, O.G. v. Baum involved a sixteen-year-old Jehovah's Witness who had been struck by a train and severely injured. Surgery was necessary to save his right arm, and a blood transfusion would be necessary as well. The boy refused to consent to a transfusion, and his parents also refused to consent during the minor's upcoming surgery, with the understanding that the refusal of a transfusion could be fatal. The lower court appointed a temporary conservator with authority to consent to a blood transfusion for the minor. On appeal, the court affirmed and noted that Texas had not adopted the mature minor doctrine, thus the minor could not refuse transfusions on his own behalf, and the court

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129. Id. at 241-42.
130. Id. at 242.
noted that the parents could not interpose their religious beliefs as a basis for refusing a lifesaving transfusion for their son.

Another case, In re Thomas B.,\textsuperscript{132} involved a fifteen-year-old boy who refused to undergo a tumor biopsy due to his "strong phobia for needles."\textsuperscript{133} His mother petitioned the court for an order requiring her son to submit to the treatment, under physical restraints if necessary. A legal guardian who advised the court expressed the boy's objections but agreed that the surgery was in the minor's best interests.\textsuperscript{134}

The court said that the issue before it was whether the court has authority to direct that the child be diagnosed at a hospital by the use of body-intrusive techniques over the vigorous personal objection of the child. The court denied the validity of the mature minor doctrine, held that a minor could neither consent to treatment nor withhold consent,\textsuperscript{135} and ordered the hospital to admit the minor and perform the surgical procedure.\textsuperscript{136}

In Novak v. Cobb County Kennestone Hosp. Authority,\textsuperscript{137} the Eleventh Circuit held that the mature minor doctrine is not recognized in Georgia. The case involved a sixteen-year-old who was in an automobile crash and taken to the hospital for treatment of numerous injuries. The youngster, anticipating that a blood transfusion might be needed, told the staff not to give him any blood because he was a Jehovah's Witness.

The boy's father arrived at the hospital and consented to surgery, but with the understanding that the boy would be given no blood during the procedure. As a result of the accident, and subsequent to surgery, the boy had lost a considerable amount of blood. His blood count and blood pressure were falling at such a rate that doctors believed the boy would likely die without a blood transfusion.\textsuperscript{138} At that point the boy's mother, who had gotten involved, rejected the physicians' recommendations. The hospital petitioned the court for appointment of a guardian ad litem for the purpose of determining whether blood transfusion would be in the patient's best interest. The judge granted the petition and ordered the treating physicians to arrange for the blood transfusion, which was promptly carried out. The judge said that the boy could not withhold his consent to medical treatment be-

\textsuperscript{132} 574 N.Y.S.2d 659 (N.Y. Misc. 1991).
\textsuperscript{134} Thomas B., 574 N.Y.S.2d at 660.
\textsuperscript{135} Id. at 660-61.
\textsuperscript{136} Id.
\textsuperscript{137} 74 F.3d 1173 (11th Cir. 1996).
\textsuperscript{138} Novak v. Cobb County Kennestone Hosp. Auth., 74 F.3d 1173, 1174 (11th Cir. 1996).
cause the mature minor doctrine was not part of Georgia law.\textsuperscript{139} In due course, the patient recovered from his injuries.

Thereafter, his parents brought an action in Federal District Court for violation of their constitutional rights and for other claims. The district court granted a summary judgment against the plaintiffs. The parents appealed, and the Court of Appeals for the Eleventh Circuit affirmed the district court, holding that there were no cognizable federal constitutional claims. The court also said that it found the appeal to be frivolous with respect to claims against the attending physician and the hospital's attorneys and awarded reasonable attorney's fees and double costs.\textsuperscript{140}

A final case under consideration involved a civil rights claim against a hospital for obtaining a court appointed conservator with authority to consent to a procedure unwanted by a twenty-year-old patient, who was a minor under state law. In \textit{Holmes v. Silver Cross Hospital of Joliet, Ill.},\textsuperscript{141} the court ruled on a motion to dismiss the complaint that alleged the hospital and doctors conspired, under color of state authority, to deprive the patient's civil rights by a scheme to obtain a decree of incompetency for the purpose of approving a blood transfusion. The patient, following an accident and while he was fully conscious and competent, informed doctors that because of his religious convictions he would not accept blood transfusions.

The doctors sought to persuade other members of the family that a transfusion was medically necessary, but all the relatives refused on religious grounds, and the patient signed a form releasing the hospital from liability if they were to operate without any blood transfusions.

The hospital filed a petition to declare the patient an incompetent minor and to appoint a conservator for the purpose of authorizing a blood transfusion. The court granted the petition and the hospital performed the transfusion. The patient later died of his injuries, and his estate sued for various causes of action, including violation of the decedent's civil rights.

The mature minor doctrine was not in issue for purposes of the motion to dismiss in this case. The court said that the hospital, even though a private institution, could be deemed to have acted under color of state law for purposes of the Civil Rights Act because of the state's pervasive regulation of hospitals coupled with the state's utilization of federal funds that required it to adopt an overall plan for state health care and the hospital's receipt of significant tax exemptions.

\textsuperscript{139} See \textit{Novak}, 74 F.3d at 1174 n.1.
\textsuperscript{140} \textit{Id.} at 1177.
\textsuperscript{141} 340 F. Supp. 125 (N.D. Ill. 1972).
The court also held that the doctors acted under color of law as far as the Civil Rights Act is concerned if they acted under the express direction and as agents of the hospital. The court denied the motion to dismiss with the exception of dismissing one defendant, the conservator who had been appointed by the court to act on behalf of the deceased patient.

V. CASES INVOLVING COMPETENT ADULTS WHO REFUSE LIFESAVING TREATMENT

A. GENERAL OVERVIEW OF PRECEDENT

Courts today are usually vigilant to protect the right of competent adults to refuse medical treatment, even lifesaving procedures. However, courts often enough will intervene at the request of attending physicians and the hospital based on evidence of a compelling state interest. We will see courts differ in their interpretation of what facts constitute a compelling state interest.

The cases in this part are in two groups. One group involves the question of whether the adult patient should be compelled to undergo a lifesaving medical procedure because the patient's minor children would be abandoned if the patient died. A second group of cases focuses on whether the patient should be forced to submit to a blood transfusion and/or cesarean section in order to protect the patient's late-term fetus.\textsuperscript{142}

Perhaps the most frequently cited case in which a court ordered a competent adult to submit to a medical procedure was \textit{Application of President & Directors of Georgetown College, Inc.}\textsuperscript{143} In that case the patient, age twenty-five and the mother of a seven-month-old child, was taken to the hospital for emergency care after "having lost two thirds of her body's blood" from a ruptured ulcer. She and her husband were Jehovah's Witnesses. The hospital faced a difficult dilemma: either obey the patient's wishes, thereby allowing her to die, and later be found liable for malpractice, or override the patient's refusal, give her the transfusion, and thereby commit assault and battery on the patient.\textsuperscript{142}

\textsuperscript{142} See \textit{In re Jamaica Hospital}, 491 N.Y.S.2d 898 (N.Y. Spec. Term 1985), regarding a pregnant patient's refusal to consent to a blood transfusion based on her religious beliefs. The patient was in critical condition from loss of blood, was eighteen weeks pregnant, and was the mother of ten children. \textit{Id.} at 899. Her only next of kin, a sister, could not be contacted. \textit{Id.} The court authorized a transfusion based on the state's interest in protecting the welfare of a viable fetus and the patient's minor children. \textit{Id.} at 900.

\textsuperscript{143} \textit{In re President & Dirs. of Georgetown Coll., Inc.}, 331 F.2d 1000, 1008 (D.C. Cir. 1964), \textit{reh'g denied}, 331 F.2d 1010 (D.C. Cir. 1964), \textit{cert. denied}, 377 U.S. 978 (1964).
When death without a transfusion became imminent, the hospital applied to the district court for permission to administer blood. No complaint, petition, or written application had been filed, but the attorneys representing the hospital appeared at the chambers of District Judge Edward Tamm and requested that he sign an order authorizing the administration of a blood transfusion to the patient.

The judge denied the application, and counsel for the hospital immediately "appealed" that decision by appearing at the chambers of a single member of the Circuit Court, Judge J. Skelly Wright. Judge Wright went to the hospital and spoke to the patient, but she was barely conscious and said the words "against my will." When the judge asked if she would consent to the transfusion if he ordered it, "[s]he indicated, as best I could make out, that it would not then be her responsibility."144 The judge then "reversed" the district court and permitted the hospital to administer blood, reasoning the following:

The state, as parens patriae, will not allow a parent to abandon a child, and so it should not allow this most ultimate of voluntary abandonments. The patient had a responsibility to the community to care for her infant. Thus the people had an interest in preserving the life of this mother.145

The court also noted that the patient was the responsibility of the doctors at the hospital to treat. If they failed to administer the proper treatment and the patient died, they would expose themselves "to the risk of civil and criminal liability."146

This decision appears to be without precedent, and it should be noted that most of the judges on the circuit court disagreed with Judge Wright, for various reasons, when they were asked to rehear the case en banc, particularly, Circuit Court Judge Miller and Circuit Court Judge Burger.147 The criticism was that, in the first place, the application for injunctive relief arose without the attorneys even filing a written complaint, so that the jurisdiction of the district court was not properly invoked. Judge Wright, the circuit court judge who issued the mandatory injunction, was not authorized to act alone, but only in conjunction with a three judge panel. Further, there was no case or controversy in that the hospital was adequately protected from liability by the patient's offer to sign a waiver to relieve the hospital of any liability for the consequences of failure to perform the transfusion.

144. Georgetown, 331 F.2d at 1007.
145. Id. at 1008.
146. Id. at 1009 n.18 (noting "[d]eath resulting from failure to extend proper medical care, where there is a duty of care, is manslaughter in the District of Columbia").
Moreover, according to Judge Burger, the patient clearly had a right to refuse medical treatment, even at great risk to herself, so that a judge has no authority to override the patient's objections to treatment, whether based on religious beliefs or other grounds.

As noted above, Judge Wright took into account a balancing of third party interests, namely, that of the patient's infant. Moreover, the degree of bodily invasion was relatively slight (a blood transfusion). On the other hand, the procedure violated the sincerely held religious tenets of the patient.

While the case is often referred to in case law and in the medical literature for the proposition that it is a "physician's duty to seek forced treatment in the face of a patient's refusal," and that the state has a compelling interest in preventing a patient from abandoning minor children, some legal commentators say that the opinion is of limited precedential value. Moreover, the Georgetown case, which was decided in 1964, has been criticized as not reflecting "the current emphasis on respect for individual self-determination and bodily integrity in the area of medical decision making."  

A 1967 case concerning Jehovah's Witnesses and the controversy over court-imposed blood transfusions was Jehovah's Witnesses of Washington v. King County Hospital. That was a class action by Jehovah's Witnesses, including minors and adults, to declare certain constitutional rights of the plaintiffs and to enjoin the defendants, who had forcibly administered blood transfusions to them in the past, from administering them to plaintiffs in the future. The defendants were individually named judges, juvenile court employees, hospitals, hospital personnel, and physicians. The plaintiffs alleged that doctors and hospitals had filed petitions in juvenile court to have the children of plaintiffs declared wards of the court simply because plaintiffs declined to accept blood transfusions for their children.

The court, relying primarily on the Supreme Court's 1944 decision in Prince v. Massachusetts, which we discussed above in Part III.B., ruled to dismiss the action as to all defendants.

Another case that suggests a "pro-intervention" approach is In re Storar. This case involved an incompetent patient, and while our focus in this Article has been on the rights of competent patients,

nonetheless this case is interesting in its own right. The patient, fifty-two-year-old John Storar, was profoundly retarded with a mental age of about eighteen months. He had terminal cancer of the bladder. He was conscious and capable of some communication. His mother, who was also his legal guardian, consented to radiation therapy and blood transfusions. However, after several weeks during which the patient received transfusions, his mother requested that the transfusions be discontinued on the ground that they would only prolong his discomfort and would be against his wishes if he were competent. The State applied for permission to administer blood transfusions, claiming that without them "death would occur within weeks."\textsuperscript{152} The transfusions would not cure the disease, but would replace the blood being lost. Without them, the patient's heart would have to work harder and he would breathe more rapidly, causing a strain on the patient, and he would become lethargic and eventually bleed to death. However, the patient could not comprehend the purpose of the transfusions, he obviously disliked the transfusions and tried to avoid them, and he was distressed by the blood and blood clots in his urine, which apparently increased immediately after a transfusion.\textsuperscript{153}

The court said the following:

[T]he transfusions did not involve excessive pain and that without them his mental and physical abilities would not be maintained at the usual level. With the transfusions on the other hand, he was essentially the same as he was before except of course he had a fatal illness which would ultimately claim his life. . . . Although we understand and respect his mother's despair, as we respect the beliefs of those who oppose transfusions on religious grounds, a court should not in the circumstances of this case allow an incompetent patient to bleed to death because someone, even someone as close as a parent or sibling, feels that this is best for one with an incurable disease.\textsuperscript{154}

The court held that the application for permission to continue the transfusions should be granted. The court noted that the substituted judgment rule could not apply in the case of a patient with lifelong incompetence, as there was no factual basis on which a surrogate decision maker, in this case the patient's mother, could decide whether the patient would want life-prolonging transfusions if he were competent.\textsuperscript{155}

\textsuperscript{153} Storar, 420 N.E.2d at 69-70.
\textsuperscript{154} \textit{Id.} at 73.
\textsuperscript{155} \textit{Id.} at 72-73.
At the other end of the spectrum are cases that take an absolutist approach in protecting the autonomy of competent adult patients, particularly if there are no minor children who might be abandoned upon the patient's death. The Illinois Supreme Court held, in *In re Estate of Brooks*, 156 that an adult may refuse medical treatment on religious grounds even if the patient would likely die as a result. That involved a patient who had a peptic ulcer. Her religious beliefs precluded her from receiving blood transfusions. Her doctor and others petitioned for appointment of a conservator with authority to consent to the administration of whole blood to the patient. The authority was given, and the patient received a transfusion. She later appealed the ruling. The court of appeals noted that there was evidence that the patient was "semi-disoriented" and not "fully capable" of providing informed consent, but that earlier, while she was in a competent state, she had clearly enunciated her wishes. She executed documents releasing her doctor and the hospital from any civil liability that might result from a failure on their part to administer blood transfusions.

The court framed the issue as follows:

When approaching death has so weakened the mental and physical faculties of a theretofore competent adult without minor children that she may properly be said to be incompetent, may she be judicially compelled to accept treatment of a nature which will probably preserve her life, but which is forbidden by her religious convictions, and which she has previously steadfastly refused to accept, knowing death would result from such refusal?157

The court focused on the religious beliefs of the patient and concluded that there was nothing in the exercise thereof that endangered the public health, welfare, or morals, so that government action violated her religious guarantees of the First Amendment: "Even though we may consider appellant's beliefs unwise, foolish or ridiculous, in the absence of an overriding danger to society we may not permit interference therewith in the form of a conservatorship . . . for the sole purpose of compelling her to accept medical treatment forbidden by her religious principles . . . ."158

This case focused fundamentally on the patient's First Amendment freedoms to refuse treatment forbidden by her religious convictions and which she had steadfastly held even though aware that death may result from her refusal to accept the treatment. The pa-

156. 205 N.E.2d 435 (Ill. 1965).
158. *Brooks*, 205 N.E.2d at 442.
tient did not have minor children, so the question of abandonment was not at issue.

In re Yetter\textsuperscript{159} was a proceeding to appoint a guardian to authorize removal of a breast of a patient who had breast cancer. The patient also had long been diagnosed with schizophrenia. There was testimony that the patient expressed fear about the surgery, expressed that it was her body, and expressed that she did not desire the operation; testimony also indicated that the patient was delusional in her reasons for not consenting to surgery. At the hearing, the patient testified to her belief that the operation would interfere with her genital system, affecting her ability to have babies, and would prohibi a movie career. However, the patient was sixty years old and therefore beyond child-bearing age. The court observed that “mere commitment to a State hospital for treatment of mental illness does not destroy a person’s competency or require the appointment of a guardian of the estate or person[.] Mental capacity must be examined on a case by case basis.”\textsuperscript{160}

The court referred to a constitutional right of privacy based on Roe v. Wade, which includes the following:

[T]he right of a mature competent adult to refuse to accept medical recommendations that may prolong one's life and which, to a third person at least, appear to be in his best interests; in short, that the right of privacy includes a right to die with which the State should not interfere where there are no minor or unborn children and no clear and present danger to public health, welfare or morals.\textsuperscript{161}

The court said that an “ordinary person’s refusal to accept medical advice based upon fear is commonly known and while the refusal may be irrational and foolish to an outside observer, it cannot be said to be incompetent in order to permit the State to override the decision.”\textsuperscript{162} The court said that, despite delusions, the patient had been steadfast in her refusal and the delusions did not appear to be her primary reason for rejecting surgery. The court therefore refused to override the patient's choice in the matter and denied the petition for appointment of a guardian.

A refusal case that garnered international attention was Bouvia v. Superior Court of Los Angeles County.\textsuperscript{163} That case involved a twenty-eight-year-old, highly intelligent, and competent “quadriplegic woman, afflicted with cerebral palsy since birth, who was confined” to

\textsuperscript{160} In re Yetter, 62 Pa. D. & C.2d 619, 623 (1973) (citation omitted).
\textsuperscript{161} Id. at 623.
\textsuperscript{162} Id. at 624.
a "hospital in total helplessness" and received "periodic morphine injections for chronic, severe arthritic pain." She "petitioned for a writ of mandate to compel hospital officials to remove a nasogastric" feeding tube inserted "after she had previously expressed an intention to starve herself in order to end a painful life that she considered to be futile and meaningless." The court granted her petition and ordered hospital officials to comply with her request. The court noted that the patient was competent, intelligent, and lucid and that she had the right to refuse medical treatment. The hospital and other parties argued that she was trying to starve herself to death and that the state will not be a party to a suicide. Also, the hospital noted that feeding the patient could give her an additional fifteen to twenty years of life and that the state's interest in preserving her life outweighed her right to decide to have the feeding tube removed. The court said that it was error to attach undue importance to the amount of time possibly available to the patient, rather than to give equal if not greater weight and consideration to the quality of that life:

[T]he quality of her life has been diminished to the point of hopelessness, uselessness, unenjoyability and frustration. She, as the patient, lying helplessly in bed, unable to care for herself, may consider her existence meaningless. She cannot be faulted for so concluding. If her right to choose may not be exercised because there remains to her, in the opinion of a court, a physician or some committee, a certain arbitrary number of years, months, or days, her right will have lost its value and meaning.\(^\text{164}\)

The court said that her right to forego medical treatment or life-support through mechanical means belongs solely to her:

It is not a medical decision for her physicians to make. Neither is it a legal question whose soundness is to be resolved by lawyers or judges. It is not a conditional right subject to approval by ethics committees or courts of law. It is a moral and philosophical decision that, being a competent adult, is her's alone.\(^\text{165}\)

After Elizabeth Bouvia won the right to have her feeding tube removed, she said that she found the process of starving to be unbearable, so she instructed the hospital personnel to replace the feeding tube. She remains alive to this very day.\(^\text{166}\)


\(^{165}\) Bouvia, 179 Cal. App. 3d at 1143.

\(^{166}\) See Sandy Stokes, She Asked a Riverside Court to Let Her Starve, PRESS ENTERPRISE, Mar. 25, 1993, at B03.
Some patient refusal cases have arisen in the context of negligence on the part of a physician. In *Shorter v. Drury*, the husband of a Jehovah's Witness brought an action against an obstetrician who had performed a dilation and curettage on his pregnant wife. Due to negligence on the doctor's part, there was perforation of the uterus and profuse bleeding. Despite the necessity of a blood transfusion, the patient refused and died from the loss of blood. The husband sued for damages, and the jury found the woman was 75% at fault because she refused a blood transfusion that would have prevented her death, found the doctor was 25% at fault for his negligence, and awarded damages accordingly. The Washington Supreme Court upheld the judgment and noted that the physician had informed the woman of the risk, and she chose to assume that risk when she refused the transfusion, and that it was her refusal that resulted in her death.

In *Corlett v. Caserta*, a physician abided by the wishes of a man who refused to receive blood transfusions following profuse bleeding after colorectal surgery. His refusal resulted in his death. As in *Shorter*, the decedent's spouse claimed that the physician had been negligent. The physician argued that the patient's refusal of blood barred a claim for wrongful death. The court held, like the court in the *Shorter* case, that the patient's refusal of blood did not completely bar recovery for the physician's negligence, but that his refusal should reduce that recovery proportionately.

**B. Cases Emphasizing the State's Interest in Protecting Minor Children from Abandonment**

Numerous cases hold that while the state's interest in preserving an individual's life is not sufficient, by itself, to outweigh the individual's interest in refusing treatment, the possible impact on minor children is a factor that affects the outcome of the balancing process. We saw this principle expressed in the *Georgetown* case, above. In Part VI, infra, we will examine cases in which courts consider the impact of pregnant patients' refusal of medical procedures on their fetus.

The case of *Wons v. Public Health Trust of Dade County* involved Norma Wons, a married Jehovah's Witness with two children. She was admitted to the hospital with a uterine condition from which she would have likely died without a blood transfusion. She refused the transfusion based on her religious beliefs. Her husband supported her decision and was prepared, in the event of her death, to care for

their children with the assistance of other family members. The trial 
court granted the hospital's petition to force Wons to undergo a trans-
fusion while she was unconscious. The judge said that Wons's refusal 
would deny the children the intangible right to be reared by two loving 
parents and the state interest in protecting the children overrode the 
patient's right to refuse lifesaving medical treatment. When she 
regained consciousness after the transfusion, Wons appealed, and the 
Third District reversed, noting that the issue was not moot because 
Wons's condition might recur and ruling that there was no showing of 
a compelling state interest that could override Wons's constitutional 
rights. The district court said the following:

[T]he societal interest in protecting Mrs. Wons' two minor 
children . . . although a vital and troubling consideration in 
this case—cannot, in our view, override Mrs. Wons' constitu-
tional right to refuse a blood transfusion under the circum-
stances of this case. This is so because, simply put, Mrs. 
Wons' probable, but not certain, demise by refusing the sub-
ject blood transfusions will not result in an abandonment of 
her two minor children. According to the undisputed testi-
mony below, she has a tightly knit family unit, all practicing 
Jehovah's Witnesses, all of whom fully support her decision to 
refuse a blood transfusion, all of whom will care for and rear 
the two minor children in the event she dies. Her husband 
will, plainly, continue supporting the two children with the 
aid of her two brothers; her mother, a sixty-two-year-old wo-
man in good health, will also care for the children while her 
husband is at work. Without dispute, these children will not 
become wards of the state and will be reared by a loving 
family.171

The Florida Supreme Court affirmed the district court's ruling.172 
In its decision the court said that there was no abandonment shown in 
the facts of the case and that it therefore would "not decide whether 
evidence of abandonment alone would be sufficient in itself to override 
the competent patient's constitutional rights."173 The court also said 
that "[w]hile . . . the nurturing and support by two parents is impor-
tant in the development of any child, it is not sufficient to override 
fundamental constitutional rights"174 and that "the state's interest in 
maintaining a home with two parents for the minor children does not 
override Mrs. Wons' constitutional rights of privacy and religion."175

App. 1987).
173. Wons, 541 So. 2d at 99 n.2 (Ehrlich, C.J., concurring specially).
174. Wons, 541 So. 2d at 97.
175. Wons, 541 So. 2d at 98.
In *In re Dubreuil*, the Florida Supreme Court took up the issue of abandonment again. Patricia Dubreuil, a Jehovah's Witness, was admitted to the hospital for an emergency cesarean section. She had a severe condition that prevented her blood from clotting, and transfusions were required to save her life during the surgical procedure. In addition to the newborn baby, Dubreuil had three other minor children, and at the time she was separated from her husband. After delivery of her newborn baby and the loss of a significant amount of blood, the patient refused a blood transfusion to save her life. The hospital contacted her estranged husband, who was not a Jehovah's Witness, and he consented to the blood transfusion.

Afterwards, physicians believed that further transfusions would be needed. The hospital, unsure of its legal obligations under the circumstances, sought and obtained an emergency court order authorizing it to perform the necessary transfusions. Dubreuil, her mother, and her estranged husband had not offered any testimony regarding what would become of the minor children if Dubreuil died. The lower court held that the patient could be compelled to receive transfusions because her death would cause the abandonment of her minor children, and that abandonment was an overriding state interest. Following the ruling, further transfusions were administered. The court distinguished the *Wons* case by the fact that Dubreuil's estranged husband no longer lived with her and the children and the patient "presented no evidence of how the children would be cared for in the event of her death."

The patient survived and appealed the ruling to the district court, which affirmed, and then appealed to the Florida Supreme Court, arguing that the lower court decision violated "her state and federal constitutional rights of privacy, bodily self-determination, and religious freedom." The Florida Supreme Court accepted the appeal, holding the matter was not moot for its purposes "because the issue is one of great public importance, is capable of repetition, and otherwise might evade review."

Dubreuil argued that the court should eliminate any consideration of a state interest in protecting innocent third parties from abandonment, claiming that this could be applied "beyond blood transfusions to major medical procedures" such as heart bypass surgery, "or it will allow courts to compel a pregnant Catholic woman who is the single parent of a minor child to have an abortion against her religious beliefs if taking the pregnancy to term would endanger the

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176. *In re Dubreuil*, 629 So. 2d 819 (Fla. 1993).
177. *See Dubreuil*, 629 So. 2d at 821.
178. *Id.* at 822.
mother's life."\textsuperscript{179} She also argued that the rule could eventually extend "well beyond the protection of minor children, compelling a single adult, who cares for her dependent elderly parent or grandparent, to receive unwanted medical treatment in order to advance the state interest in protecting the elderly dependent."\textsuperscript{180} However, the court declined to rule that the state has no compelling interest, in an appropriate case, to prevent abandonment.\textsuperscript{181}

The court said that "there was no proof in th[e] record that an abandonment would have occurred had" Dubreuil "died after refusing medical treatment." Under the law, the father, albeit estranged from the mother, would have become the sole legal guardian of the couple's four minor children and would have had full legal responsibility for their care.\textsuperscript{182} There was no evidence in the record that the father would not properly assume responsibility for the children under the circumstances. The court said, "[T]he law presumes that when one parent is no longer able to care for the couple's children, the other parent will do so."\textsuperscript{183}

A slightly different set of facts was considered in \textit{Mercy Hospital, Inc. v. Jackson}.\textsuperscript{184} In that case a patient entered the hospital in premature labor, and her doctors urged a cesarean section because of delivery problems with the position of the fetus and her previous abdominal surgery. The patient agreed to the cesarean section but refused to consent to any blood transfusions because of her religious beliefs as a Jehovah's Witness. Doctors believed that the refusal of a blood transfusion would not endanger the infant, but would likely result in the mother's death. The patient's husband supported her decision and said that in the event of her death, he would do his best to raise their child.

The hospital sought, but failed to obtain, court authorization to administer transfusions to the mother. The judge held that a competent, pregnant woman had the right to refuse a blood transfusion for religious reasons when that decision was made knowingly and voluntarily and would not endanger the delivery, survival, or support of the fetus.\textsuperscript{185} The mother underwent a cesarean section and delivered the

\begin{itemize}
  \item \textsuperscript{179} \textit{Id.} at 826.
  \item \textsuperscript{180} \textit{Id.} at 826.
  \item \textsuperscript{181} \textit{Id.} at 827.
  \item \textsuperscript{182} \textit{Id.}
  \item \textsuperscript{183} \textit{Id.} at 828.
  \item \textsuperscript{184} 489 A.2d 1130 (Md. Ct. Spec. App. 1985), \textit{vacated as moot}, 510 A.2d 562 (Md. 1986).
\end{itemize}
infant without requiring a transfusion, and both survived and were released from the hospital.  

The hospital filed an appeal, urging the Court of Special Appeals to reach the merits of the case even though the patient no longer required the medical treatment at issue because the issues presented were likely to recur and should be decided. The court agreed that it should reach the merits and affirmed the trial court's decision. The hospital then filed a petition for hearing with the Court of Appeals of Maryland, and the petition was granted.

However, the court refused to reach the merits, saying that blood transfusion controversies are so dependent on the particular factual circumstances that any ruling on the merits in this instance would afford little guidance to trial judges or parties in future cases. A dissent stated that the case, while moot, presented a clear example of when an appellate court should express its view on important questions of public concern.

Another case involving the abandonment issue was Norwood Hospital v. Munoz. The court found no compelling interest in protecting the minor child of Yolanda and Ernesto Munoz when Yolanda refused on religious grounds to receive a blood transfusion. The court said there was no evidence that the father, who supported his wife's decision, was unwilling to take care of the child, and Ernesto's sister and brother-in-law, who supported Yolanda's decision, said they would assist in caring for the child. The court held that "the State does not have an interest in maintaining a two-parent household in the absence of compelling evidence that the child will be abandoned if he is left under the care of a one-parent household."

A case involving termination of life support and the issue of abandonment was In re Farrell. The court held that a woman suffering from a debilitating disease had the right to terminate life support even though she would leave behind her husband and two teenage children, when they had a close loving family.

In In re Osborne, the patient, who was the father of two minor children, was admitted to the hospital with injuries and internal

187. Mercy Hosp., 489 A.2d at 1130-34.
190. Mercy Hosp., 510 A.2d at 566 (McAuliffe, J., dissenting).
bleeding from a tree that had fallen on him. He refused a blood transfusion, and his wife refused to give consent because of their beliefs as Jehovah's Witnesses. The patient was lucid and not under the influence of drugs that could impair his judgment. He said that although he did not wish to die, he believed that he would be deprived of the opportunity of eternal life if the court ordered a transfusion. The trial court refused to appoint a guardian to consent to a blood transfusion for the patient, and the decision was affirmed on appeal. The court noted that the patient's family had sufficient financial resources to meet the children's material needs in the event of his death, and the extended family was prepared to help care for the children.

The court distinguished the facts from United States v. George, in which the patient, a father of four children and a Jehovah's Witness, admitted himself to the hospital for treatment of a bleeding ulcer that required lifesaving blood transfusions. The patient said that if the court forced him to take a blood transfusion, his conscience would be clear since the responsibility for the act would lie upon the court. The patient in that case said that once the court ordered a transfusion he "would in no way resist" the doctor's actions and that his conscience would be clear. In Osborne, however, the patient expressed the belief that he was accountable to God even if he were forced to receive a blood transfusion.

Another element of the George case was that the patient had voluntarily admitted himself to the hospital for treatment of a bleeding ulcer and insisted upon medical care while simultaneously seeking to dictate to treating physicians a course of treatment that would require them to ignore the mandates of their own consciences. The court said, "The patient may knowingly decline treatment, but he may not demand mistreatment."

A New York case on the issue of abandonment was In re Winthrop University Hospital. This involved a woman who was the mother of two young children. She was to have surgery to remove kidney stones. The patient consented to the surgery but refused to permit any blood transfusion on religious grounds. While transfusions are rare in this type of surgery, her surgeon refused to operate without receiving authorization for a blood transfusion. Without the surgery the patient's...
life was threatened. Relying on Georgetown, the court held that the state's interest in preventing abandonment of children justified compelling the patient to submit to a transfusion.

However, in 1990, the New York Court of Appeals seemed to overrule the abandonment principle set forth in Winthrop. In Fosmire v. Nicoleau,\(^2\)\(^0\)\(^3\) Denise Nicoleau refused a blood transfusion after giving birth prematurely via cesarean section. She and her husband were Jehovah's Witnesses, and she made it clear that she refused a transfusion even though physicians believed she was in dire need of it following the cesarean birth of the child. The patient, who was fully competent, also expressed the concern for the dangers associated with transfusions in light of communicable diseases such as AIDS.

The baby itself was healthy and did not require any blood. Following delivery, the patient began to bleed from the uterus, making another surgery necessary. She lost a substantial amount of blood during this surgery, but the patient refused to consent to a transfusion. The hospital sought and obtained a court order authorizing the blood transfusions, and they were administered to the patient. Thereafter, the patient and her husband appealed the court's order, and the appellate division vacated the order, ruling that the patient's right to religious freedom as well as her right to make her own medical decisions outweighed any state interest in preventing the loss of parental support because the father and extended family agreed to take care of their minor child should the mother die.\(^2\)\(^0\)\(^4\)

The case was then appealed to the court of appeals, which held that the patient has, in effect, an absolute right, under these facts, to refuse unwanted medical treatment and that the state has no interest in preserving the life of a patient for the benefit of her child. The court's analysis focused exclusively on the nature of the rights at issue and did not make reference to whether there was evidence that the child would be cared for by the father and the extended family.

The court cautioned that the common law right to refuse medical treatment is not absolute and in some situations may have to yield to a superior state interest. For instance, the State may enact compulsory vaccination laws to protect the public from the spread of disease, the State can order essential medical care for individuals who are incapable of making medical decisions, and the State can prohibit medical procedures that pose a substantial risk to the patient alone.\(^2\)\(^0\)\(^5\) But in this case there was no showing of a state interest sufficient to

\(^{205}\) Fosmire, 551 N.E.2d at 81.
override the patient’s liberty and personal autonomy in making the choice.

The court said that the State, of course, may intervene to prevent suicide, but that “merely declining medical care, even essential treatment, is not considered a suicidal act or indication of incompetence.” Other cases that have addressed the suicide issue invariably hold that a refusal of medical treatment does not constitute suicide since the patient does not have the specific intent of dying, and even if the patient had such intent, the death would be from natural causes, and the patient did not set into motion the death-producing situation.

The court said that there is no limitation on the rights of patients who happen to be parents, so that the state cannot require medical treatment “to preserve the parent’s life for the benefit of a minor child or other dependent,” and at common law the patient’s right to decide the course of his or her medical treatment was not conditioned on this factor. The court refused to equate the patient’s choice as an “intentional abandonment” of a child, which the State, as parens patriae, will not allow. In any event, the court said that the state’s concern with “maintaining family unity and parental ties is not an interest which it enforces at the expense of all personal rights or conflicting interests.”

Thus, the Fosmire court apparently overruled the holding in Winthrop that a patient’s right to autonomy is outweighed by a child’s right to be raised by two parents. Indeed, the court refused to consider the abandonment principle as a factor that could override the patient’s choice.

Two concurring opinions in Fosmire stated that the concurring judges could not find any basis for the majority’s assertion of an absolute right to refuse a routine, safe, and painless lifesaving procedure. The concurring opinions pointed to the four standard countervailing interests that could override a patient’s refusal to consent to lifesaving medical treatment. One concurring opinion stated the following:

Circumstances that might weigh in favor of court-ordered medical treatment include: the fact that the patient is young and healthy; that her illness is curable; that the proposed

206. Id. at 82.
208. Fosmire, 551 N.E.2d at 83.
209. Id. at 84.
210. See id. at 84-85 (Simons, J., concurring); see also id. at 86-87 (Hancock, J., concurring).
treatment is relatively painless, noninvasive and routine; that the treatment is essential to the patient's life or well-being; that the patient has dependent children; and that the patient's objection consists of a refusal to consent rather than an outright demand that treatment be withheld. On the other hand, circumstances that might dictate a court's refusal to order treatment include: the fact that the prognosis, even with the proposed treatment, is poor; that the treatment is painful, invasive, complicated or not actually necessary; that the patient has no dependents; and that the patient's religious or privacy objection is directed against the treatment itself, not merely consenting to it.\footnote{211}

VI. CASES INVOLVING FETAL RIGHTS AND THE RIGHTS OF PREGNANT PATIENTS TO DECLINE TREATMENT

A. INTRODUCTION TO THIS SECTION

Even though a right of a competent adult to refuse medical treatment is well established, there is inconsistent case law on the right of a pregnant woman to refuse treatment required for her fetus's survival. Often enough, physicians feel compelled to seek court orders to force pregnant women to submit to recommended treatment.\footnote{212} There is extensive debate on both sides of the issue of maternal vs. fetal rights.\footnote{213}

\footnote{211} Id. at 89 (Hancock, J., concurring).
\footnote{212} Physicians' motivation in such cases seems to be based on three factors. First, physicians hold strong opinions about what will best promote the health of their patients. Second, obstetricians in particular desire to protect their second patient, the fetus. Finally, many physicians believe that they have a legal duty to seek a court order when a pregnant patient refuses life-saving treatment.

As indicated in a number of cases, if the life or welfare of the fetus, particularly a late-term fetus, is jeopardized by a pregnant mother's refusal to submit to a blood transfusion or, in some instances, a cesarean section, the court may well order the patient to submit to the procedure. Other cases take the view that the mother's right of autonomy is for all intents and purposes absolute, even though her decision to refuse a blood transfusion or other treatment will imperil the fetus. Some cases involve the situation in which a pregnant woman's choice to refuse a blood transfusion jeopardizes her own life as well as the fetus.

B. CASES REJECTING FETAL RIGHTS IN FAVOR OF A PREGNANT WOMAN'S RIGHT TO REFUSE UNWANTED MEDICAL TREATMENT

We will examine cases primarily from Illinois and New York, which have significant refusal-of-treatment case law involving pregnant women. The facts of these cases are roughly similar: a medical
procedure is needed to save the life of the fetus, and the pregnant patient refuses to consent.

As in the other areas we have examined, we will find that the cases fall onto opposite ends of the spectrum, with some holding that a woman cannot be compelled to undergo medical procedures against her will merely for the benefit of her unborn child, and others coming to the opposite conclusion. The courts generally do not concentrate on First Amendment issues of religious freedom, but instead focus on a pregnant woman's right to autonomy.

Illinois case law generally holds that the rights of a fetus are subordinate to those of a mother in all circumstances, so that pregnant women have an absolute right to refuse medical treatment, even if the refusal harms the health of the mother herself and/or her unborn fetus. The starting point for this approach is the precedent set in Stallman v. Youngquist, in which the Illinois Supreme Court refused to recognize a tort action against a mother for unintentional infliction of prenatal injuries. The court said that a child has a right to recover from unrelated third parties for prenatal injuries, but not against the mother, on the grounds this would intrude on her rights to privacy and bodily integrity and on her right to control her own life:

No other plaintiff depends exclusively on any other defendant for everything necessary for life itself. No other defendant must go through biological changes of the most profound type, possibly at the risk of her own life, in order to bring forth an adversary into the world. It is, after all, the whole life of the pregnant woman which impacts on the development of the fetus . . . That this is so is not a pregnant woman's fault: it is a fact of life.

This was followed by In re Baby Boy Doe. The fetus of a woman in her thirty-sixth week of pregnancy was in danger due to placenta insufficiency that prevented it from receiving adequate oxygen. The attending physician recommended immediate delivery of the fetus by cesarean section or by induced labor. The chances that the fetus would survive a natural labor were said to be close to zero, but the mother refused a cesarean section based on personal religious beliefs as a member of the Pentecostal church. Her husband agreed with her decision. Two weeks passed and she returned to the doctor's office to learn that the fetus had worsened. She again refused to have a cesarean section.

214. 531 N.E.2d 355 (Ill. 1988).
The State Attorney petitioned the trial court to adjudicate a wardship and asked that the hospital be appointed custodian of the fetus. A doctor testified that without the cesarean section, the fetus would have no chance of survival, and that the mother faced a 1 in 10,000 chance of dying during the procedure, compared to a 1 in 20,000 to 50,000 for a normal birth.\textsuperscript{217} The judge expressed doubt as to whether he had jurisdiction over a fetus in utero and certified the case for immediate appeal.

On appeal the issue was whether the court should balance the rights of a fetus against the rights of a competent woman to refuse medical advice to obtain a cesarean section. The court determined that the woman should be allowed to make her own treatment decisions.\textsuperscript{218} The State immediately appealed, and the Illinois Appellate Court affirmed, noting that Illinois courts should never balance a fetus's rights against those of its mother.\textsuperscript{219} The court said that, following \textit{Stallman v. Youngquist}, "we hold that no such balancing should be employed, and that a woman's competent choice to refuse medical treatment as invasive as a cesarean section during pregnancy must be honored, even in circumstances where the choice may be harmful to the fetus."\textsuperscript{220} The impact on the fetus under the circumstances was irrelevant.\textsuperscript{221} The court said that the mother's refusal to submit to a cesarean section would be an \textit{unintentional} infliction of prenatal injuries and hence, not actionable against her in tort. The court also said, "A woman is under no duty to guarantee the mental and physical health of her child at birth, and thus cannot be compelled to do or not do anything merely for the benefit of her unborn child."\textsuperscript{222}

The court added the following:

Applied in the context of compelled medical treatment of pregnant women, the rationale of \textit{Stallman} directs that a woman's right to refuse invasive medical treatment, derived from her rights to privacy, bodily integrity, and religious liberty, is not diminished during pregnancy. The woman retains the same right to refuse invasive treatment, even of lifesaving or other beneficial nature, that she can exercise when she is not pregnant. The potential impact upon the fetus is not legally relevant; to the contrary, the \textit{Stallman} court explicitly rejected the view that the woman's rights can be subordinated to fetal rights.\textsuperscript{223}

\begin{itemize}
  \item \textsuperscript{217} \textit{In re Baby Boy Doe}, 632 N.E.2d 326, 328 (Ill. App. Ct. 1994).
  \item \textsuperscript{218} \textit{Baby Boy Doe}, 632 N.E.2d at 329.
  \item \textsuperscript{219} \textit{Id.} at 330-31.
  \item \textsuperscript{220} \textit{Id.} at 326.
  \item \textsuperscript{221} \textit{Id.} at 334.
  \item \textsuperscript{222} \textit{Id.} at 332.
  \item \textsuperscript{223} \textit{Id.} at 332.
\end{itemize}
The court reasoned that if the procedure would compromise the health of the mother even to a small degree, the court will not override the woman's refusal to consent:

A cesarean section, by its nature, presents some additional risks to the woman's health. When the procedure is recommended solely for the benefit of the fetus, the additional risk is particularly evident. It is impossible to say that compelling a cesarean section upon a pregnant woman does not subject her to additional risks—even the circuit court's findings of fact in this case indicate increased risk to [the patient]. Under *Thornburgh*, then, it appears that a forced cesarean section, undertaken for the benefit of the fetus, cannot pass constitutional muster.224

The court indicated that it was an open question whether less invasive procedures, such as a blood transfusion, might be compelled against a pregnant woman's refusal to consent.

The *Baby Doe* court also noted the following:

Courts . . . have consistently refused to force one person to undergo medical procedures for the purpose of benefiting another person—even where the two persons share a blood relationship, and even where the risk to the first person is perceived to be minimal and the benefit to the second person may be great . . . if an incompetent brother cannot be forced to donate a kidney to save the life of his dying sister, then surely a mother cannot be forced to undergo a cesarean section to benefit her viable fetus.225

The *Baby Doe* court acknowledged that courts generally consider four state interests, which we previously mentioned, in considering

224. *Id.* at 333.

225. *Id.* at 333-34 (citations omitted). The issue concerning forcing an individual to donate an organ to save the life of a close relative has been taken up by a number of courts. In *Curran v. Bosze*, 586 N.E.2d 1319 (Ill. 1990), the Illinois Supreme Court refused to compel twin minors to donate bone marrow to a half-sibling, despite the facts that the procedures posed little risk to the twins and that the sibling's life depended on the transplant. The court even refused to compel the minors to undergo a blood test for the purpose of determining whether they would be compatible donors. Likewise, in *In re Guardianship of Pescinski*, 226 N.W.2d 180 (Wis. 1975), the Supreme Court of Wisconsin refused to force an incompetent brother to donate a kidney to save the life of his dying sister.

On the other hand, in *Strunk v. Strunk*, 445 S.W.2d 145 (Ky. Ct. App. 1969), it was held that a court of equity has the power to authorize removal of a kidney from an incompetent donor for purposes of effectuating a transplant. The court concluded that, due to the nature of their relationship, both parties would benefit from the completion of the procedure, and hence the court, in applying the doctrine of substituted judgment, found that the prospective donor would, if competent, assent to the procedure. Accord *Hart v. Brown*, 289 A.2d 386 (Conn. Super. Ct. 1972). See generally Charles H. Baron et al., *Life Organ and Tissue Transplants from Minor Donors in Massachusetts*, 55 B.U. L. Rev. 159 (1975).
whether to override competent treatment decisions—the preservation of life, the prevention of suicide, the protection of third parties, and the ethical integrity of the medical profession. However, the first factor was irrelevant because the patient's refusal did not impact the preservation of the patient's life. The proposed cesarean section was not for the purpose of preserving the mother's life or health, and in fact it would pose greater risk to her than a natural birth process. With respect to concern of the state in protecting third parties, the court said, "Where an individual's decision to refuse treatment will result in orphaning an already-born child, courts have indicated that this is one factor they might consider." However, the court considered this factor to be irrelevant because the patient had no children, just the fetus in utero.

The court also noted that the final factor—the ethical integrity of the medical profession—weighed against ordering the procedure because the medical profession strongly supports upholding a pregnant woman's autonomy in medical decision making: "The American Medical Association's Board of Trustees cautions that . . . [i]f the woman rejects the doctor's recommendation, the appropriate response is not to attempt to force the recommended procedure upon her, but to urge her to seek consultation and counseling from a variety of sources."

The court also worried how a forced cesarean section would be carried out. The Public Guardian specifically was opposed to any effort to use force to implement the procedure, and the state also opposed the use of force: "Thus, we have been asked to issue an order that no one expects to be carried out. This court, as a simple matter of policy, will not enter an order that is not intended to be enforced."

About ten days after the petition was denied, the baby was successfully delivered by natural birth.

The issue of maternal vs. fetal rights was taken up further in the landmark case of In re Fetus Brown, in which the Appellate Court of Illinois considered the "proper balance of the mother's common law and constitutional interests in bodily self-determination as against the State's recognized interest in protecting the viable fetus."

In this case a woman in the thirty-fourth week of pregnancy entered the hospital for surgery to remove a urethral cyst. The patient

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227. Id. at 334.
228. Id.
229. Id.
230. Id. at 335.
lost 700 cubic centimeters of blood during the surgery. The doctor ordered three units of blood for transfusion. Once the blood arrived in the operating room the patient, who was conscious and alert, refused the blood, explaining that she was a Jehovah's Witness. The doctors completed the surgery using other techniques to control her bleeding. Despite efforts to control the bleeding, the patient lost 1500 cubic centimeters of blood, and the patient's hemoglobin level soon dropped significantly, posing a life-threatening risk to both the patient and the fetus. The doctor warned the patient that she and her fetus could die if she did not get transfusions, but she refused.

State officials filed a petition for authorization to compel blood transfusions, and the trial court granted the request. It was noted during the hearing that the patient and her husband both refused to consent to the transfusions, and they had two young children, but that if anything happened to the mother, her husband would continue to take care of the children, and other relatives would also take care of and support them.

After the transfusions were administered the patient gave birth to a healthy baby. Thereafter, the patient appealed the court's ruling, and the appellate court took up the matter, noting that while the factual issues had become moot, the issue required authoritative determination for future guidance of public officials.233

The court said that in "balancing" the mother's right to refuse medical treatment against the state's interest in protecting a viable fetus, the state may not override a competent woman's decision to refuse a blood transfusion for the benefit of her fetus.234 In other words, the court held that the mother's rights and the fetus's rights may not be balanced at all. The court refused to consider the adverse consequences to the viable fetus in light of the mother's treatment refusal, holding that "the State may not override a pregnant woman's competent treatment decision, including refusal of recommended invasive medical procedures, to potentially save the life of the viable fetus."235

The court rejected the idea of taking into consideration the "degree" of invasion of bodily autonomy, saying that a blood transfusion is "an invasive medical procedure that interrupts a competent adult's bodily integrity," and it is irrelevant that it might be "less" invasive than a cesarean section.236 The court said that it disagreed with the Baby Doe court's determination that a transfusion constitutes a "rela-

233. Brown, 689 N.E.2d at 400.
234. Id. at 405.
235. Id.
236. Id.
tively noninvasive and risk-free procedure” as opposed to the mass-
ively invasive, risky, and painful cesarean section.\textsuperscript{237}

The Brown court said that the right of a competent adult to refuse
unwanted medical treatment is not absolute, and must be balanced
against the four state interests that we have previously articulated.
(1) As to the state’s interest in preserving life, the court noted that this
factor concerns only the life of the decision maker, and that in any
event the state has an equally important interest in preserving the
autonomy of competent adults.\textsuperscript{238} The court said that the patient in
this instance did not need the state’s protection because she was
aware that refusing a transfusion could result in her death, and that
the state’s interest in preserving her life was “not determinative in
this case.”\textsuperscript{239} (2) The court said that the patient was willing to un-
dergo any necessary procedures except blood transfusions, so that sui-
cide was “not at issue.”\textsuperscript{240} (3) As to the state’s interest in protecting
innocent third parties, the court said that there was no evidence to
indicate that the patient’s minor children would be abandoned since
the natural father of the children was willing to help support them in
the event of the patient’s death.\textsuperscript{241} (4) As to the state’s interest in
maintaining the ethical integrity of the medical profession, the court
noted the recommendation of the AMA’s Board of Trustees: “Judicial
intervention is inappropriate when a woman has made an informed
refusal of a medical treatment designed to benefit her fetus.”\textsuperscript{242}

The court also noted that from a practical standpoint, enforce-
ment of a court order would be by contempt citation against the pa-
tient should she refuse to cooperate: “We question the efficacy of a
court order requiring a blood transfusion for someone who is facing
death.”\textsuperscript{243}

Another case involving maternal vs. fetal rights was In re A.C.,\textsuperscript{244}
in which the appellate court of the District of Columbia held en banc
that a pregnant, dying woman could not be compelled to undergo a
cesarean section to deliver a viable fetus. The patient was close to
death from cancer. The patient’s ability to interact with doctors had
become severely diminished and she was on a respirator. It appeared
that she could die within twenty-four hours. The only way of saving
her late-term fetus was to conduct a cesarean section.

\textsuperscript{237} Id. at 405 (quoting Baby Doe, 632 N.E.2d at 333).
\textsuperscript{238} Id. at 403.
\textsuperscript{239} Id. at 404.
\textsuperscript{240} Id. at 403.
\textsuperscript{241} Id. at 404.
\textsuperscript{242} Id. at 403.
\textsuperscript{243} Id. at 406.
\textsuperscript{244} 573 A.2d 1235 (D.C. Cir. 1990) (en banc).
A week earlier the patient had stated that she wished to have the baby, and doctors decided to prolong her life for at least two weeks by palliative care in order to extend her life until the twenty-eighth week of pregnancy, at which time the potential outcome for the fetus would be much better. There was evidence that patient, in a moment of consciousness, said that she did not want the cesarean section, and the patient's mother opposed surgical intervention.

The hospital petitioned the court for declaratory relief, seeking permission to perform a cesarean section. The evidence was that the fetus had a 50%-60% chance of survival if a cesarean section were performed immediately. The court said that it was not clear what the patient's intent was and ordered that a cesarean section be performed. The surgery was performed, but the baby lived for only a few hours, and the mother died two days later. A few months later the District of Columbia Court of Appeals ordered an en banc hearing to decide the matter on its merits, holding that the matter was not moot even though the surgery had already been performed because of collateral consequences that may be occasioned by a decision on the merits, the hospital will likely again face a situation in which a pregnant but dying patient is either incapable of consenting to treatment or refuses treatment, and that in any event the facts are "capable of repetition, yet evading review." The court vacated the lower court decision. The court said that the record did not disclose whether the patient was ever competent, after being sedated, to make an informed choice one way or the other regarding the proposed cesarean section, and the trial court made no finding regarding her competency to decide. Moreover, the court said it was improper to presume the patient to be incompetent.

The court said the following:

We hold that in virtually all cases the question of what is to be done is to be decided by the patient—the pregnant woman—on behalf of herself and the fetus. If the patient is incompetent or otherwise unable to give an informed consent to a proposed course of medical treatment, then her decision must be ascertained through the procedure known as substituted judgment. Because the trial court did not follow that procedure, we vacate its order and remand the case for further proceedings.

246. A.C., 573 A.2d at 1242 (quoting S. Pac. Terminal Co. v. ICC, 219 U.S. 498, 515 (1911)).
247. Id. at 1247.
248. Id.
249. Id. at 1237.
The court said that in situations in which a competent patient refuses medical treatment or in which the court finds by making a substituted judgment that an incompetent patient would refuse treatment, the following is true:

[I]t would be an extraordinary case indeed in which a court might ever be justified in overriding the patient's wishes and authorizing a major surgical procedure such as a caesarean section. . . . Indeed, some may doubt that there could ever be a situation extraordinary or compelling enough to justify a massive intrusion into a person's body, such as a caesarean section, against that person's will.\textsuperscript{250}

In effect, the court held that there should be no balancing test\textsuperscript{251} because the woman's decision, not the fetus's interests, was controlling in the matter.

A dissent argued that the majority took a "narrow view . . . of the state's interest in preserving life and the unborn child's interest in life."\textsuperscript{252} The dissent said the following:

[I]n those instances, fortunately rare, in which the viable unborn child's interests in living and the state's parallel interest in protecting human life come into conflict with the mother's decision to forgo a procedure such as a caesarean section, a balancing should be struck in which the unborn child's and the state's interests are entitled to substantial weight.\textsuperscript{253}

The judge pointed out that the Supreme Court acknowledged in \textit{Roe v. Wade} that the state has a compelling interest in potential human life at the point a fetus becomes viable and that even before viability the state has an "important and legitimate interest in protecting the potentiality of human life."\textsuperscript{254} At the point of viability, "the state's interest becomes sufficiently compelling to justify what otherwise would be unduly burdensome state interference with the woman's constitutionally protected privacy interest."\textsuperscript{255} Also, the court noted the following: "When the unborn child reaches the state of viability, the child becomes a party whose interests must be considered."\textsuperscript{256}

\begin{itemize}
\item \textsuperscript{250} Id. at 1252.
\item \textsuperscript{251} Baby Doe, 632 N.E.2d at 326.
\item \textsuperscript{252} A.C., 573 A.2d at 1253 (Belson, J., concurring in part and dissenting in part).
\item \textsuperscript{253} Id. at 1254 (Belson, J., concurring in part and dissenting in part).
\item \textsuperscript{254} Id. at 1254 (Belson, J., concurring in part and dissenting in part) (quoting Roe v. Wade, 410 U.S. 113, 162 (1973)).
\item \textsuperscript{255} Id. at 1254 (Belson, J., concurring in part and dissenting in part).
\item \textsuperscript{256} Id. at 1254 (Belson, J., concurring in part and dissenting in part).
\end{itemize}
C. Cases Holding the Rights of the Fetus Override the Mother's Autonomy 257

Other courts have found that the state's interests in preserving the life of a fetus outweigh the autonomy rights of the mother in certain situations. In addition, if both the health of the woman and the fetus are in jeopardy, these courts tend to find that the mother and the fetus are so intertwined as to justify ordering treatment to protect both the mother and the fetus.

The Supreme Court of Georgia, in Jefferson v. Griffin Spalding County Hospital Authority, 258 held that if both the health of the woman and the fetus are in jeopardy, a court may intercede and force treatment to protect the health of both the mother and the fetus. In that case the patient was in the thirty-ninth week of pregnancy and had a complete placenta previa, a malposition of the placenta between the fetus and the birth canal, and there was a 99% certainty that the child could not survive natural childbirth. 259 The chances of the mother, herself, surviving natural childbirth was said to be no better than 50%. The examining physician recommended delivery by cesarean section and stated this would have an almost 100% chance of preserving the life of the child as well as of the mother. The mother refused to have a cesarean section and refused to take any blood transfusions on the basis of religious beliefs.

The hospital petitioned for a court order authorizing it to perform a cesarean section and to administer any necessary blood transfusions for the patient. The trial judge noted that the fetus was viable and fully capable of sustaining life independently of the mother. The court awarded temporary custody of the unborn child to the Georgia Department of Human Resources, with full authority to make all decisions, and ordered the mother to submit to a cesarean section and related procedures considered necessary by the attending physician to save the life of the child. The judge said the following:

[T]he State has an interest in the life of this unborn, living human being. The Court finds that the intrusion involved

257. In addition to the cases discussed in this section, for further discussion of court-ordered cesarean sections, see the following: Dawn E. Johnsen, The Creation of Fetal Rights: Conflicts with Women's Constitutional Rights to Liberty, Privacy, and Equal Protection, 95 YALE L.J. 599 (1986); Nancy K. Rhoden, The Judge in the Delivery Room: The Emergence of Court-Ordered Cesareans, 74 CAL. L. REV. 1951 (1986). See also Susan Goldberg, Medical Choices During Pregnancy: Whose Decision Is It Anyway?, 41 RUTGERS L. REV. 591, 609 (1989) (finding twelve cases of court-ordered cesarean sections). See also Alice M. Noble-Allgire, Court-Ordered Caesarean Sections, 10 J. LEGAL MED. 211, 236 (1989).


into the life of [the mother and her husband] is outweighed by the duty of the State to protect a living, unborn human being from meeting his or her death before being given the opportunity to live.\textsuperscript{260}

The patient and her husband filed a motion with the Georgia Supreme Court for an emergency stay of the lower court's order. The court denied the motion for stay.\textsuperscript{261} The court balanced the rights of the viable fetus against the rights of the mother and concluded that the state had a compelling interest in preserving the life of a viable fetus, particularly in circumstances when the risk of the medical procedure (the cesarean section) was significantly less than the alternative, a vaginal delivery complicated by placenta previa. The court also said that the state had a compelling interest in protecting a woman's children from abandonment and can therefore order a mother to submit to medical treatment in order to avert death.

A concurring opinion noted that "an expectant mother in the last weeks of pregnancy lacks the right to refuse necessary life saving surgery and medical treatment where the life of the unborn child is at stake."\textsuperscript{262}

After the court's order, the woman checked out of the hospital and later delivered a healthy child despite the physician's prognosis.\textsuperscript{263}

An earlier case that sided with fetal rights was \textit{Raleigh Fitkin-Paul Morgan Memorial Hospital v. Anderson}.\textsuperscript{264} The patient, Willimina Anderson, entered the hospital in the thirty-second week of pregnancy. She was told she would likely hemorrhage prior to or during her delivery and that she and her unborn child would therefore require blood transfusions. She refused to authorize transfusions based on her religious beliefs as a Jehovah's Witness. The hospital petitioned the court for authority to give blood transfusions to the patient should they become necessary to save her life or that of her unborn child. The lower court refused to intervene. An emergency appeal was taken to the Supreme Court of New Jersey, which held the law's protection extended to an unborn child and that a court could validly order a hospital to administer a blood transfusion to a pregnant woman to save her life or that of her viable fetus.

The court cited cases in which it had authorized blood transfusions for infants over the religious objections of parents and cases in which the New Jersey courts had permitted children to sue for injuries

\begin{itemize}
  \item \textsuperscript{260} \textit{Jefferson}, 274 S.E.2d at 460.
  \item \textsuperscript{261} \textit{Id.} at 460.
  \item \textsuperscript{262} \textit{Id.} (Hill, J., concurring).
  \item \textsuperscript{263} \textit{Id.} at 458-59.
  \item \textsuperscript{264} 201 A.2d 537 (N.J. 1964), \textit{cert. denied}, 377 U.S. 985 (1964).
\end{itemize}
negligently inflicted upon them prior to birth. The court said that the mother could be compelled to submit to the proposed medical procedures "because the welfare of the child and the mother are so intertwined and inseparable [sic] that it would be impracticable to attempt to distinguish between them . . . ."266

The court said the following:

We have no difficulty in so deciding with respect to the infant child. The more difficult question is whether an adult may be compelled to submit to such medical procedures when necessary to save his life. Here we think it is unnecessary to decide that question in broad terms because the welfare of the child and the mother are so intertwined and inseparable [sic] that it would be impracticable to attempt to distinguish between them with respect to the sundry factual patterns which may develop. The blood transfusions (including transfusions made necessary by the delivery) may be administered if necessary to save her life or the life of her child, as the physicians in charge at the time may determine.267

The court relied primarily on its own precedent in State v. Perricone, which we discussed above.268 In that case the court authorized blood transfusions in connection with an infant's surgery for an enlarged heart, over the religious objections of the parents.

Another case of importance was Pemberton v. Tallahassee Memorial Regional Medical Center, Inc. In that case, again, the court ordered a woman to undergo a cesarean section, stating, "[w]hatever the scope of Ms. Pemberton's personal constitutional rights in this situation, they clearly did not outweigh the interests of the State . . . ."270

The Superior Court of the District of Columbia followed the same logic and came to the same conclusion in the case of In re Madyun. A judge authorized a cesarean section over the religious objections of the patient. The court said it was protecting the state's interest in the viable fetus. The woman's membrane had ruptured and after sixty hours she still had not been able to deliver her baby. Doctors said that if she did not have a cesarean section the baby could die with little or no warning. The patient and her husband refused to consent to a

266. Raleigh Fitkin-Paul Morgan, 201 A.2d at 538.
267. Id. at 538.
268. See supra text accompanying notes 56-57.
269. 66 F. Supp. 2d 1247 (N.D. Fla. 1999).
cesarean section, believing that the mother would be able to have a natural delivery and also asserting that their Muslim faith permits her to decide whether to risk her health or life to save an unborn fetus. The judge said that given the significant risks to the fetus versus the minimal risks to the mother, there was a compelling interest to intervene and protect the life and safety of the fetus, and he ordered the hospital to take such steps as were medically necessary, including a cesarean section "to preserve and protect the birth and safety of the fetus." Pursuant to the trial court's order, the cesarean section was performed, and a healthy child was born.

*Crouse Irving Memorial Hospital, Inc. v. Paddock* involved a patient who, due to an intrauterine pregnancy, required a cesarean section. The patient agreed to the procedure, but said she would refuse any blood transfusions based on deeply-held religious beliefs, and her husband concurred. The hospital sought an emergency order authorizing necessary transfusions to both the mother and newborn baby. Doctors testified that excessive blood loss would be almost a certainty in this case because of the complications with the positioning of the placenta. Moreover, once the baby was delivered, it would most certainly require a blood transfusion. The court said, "Even when the parents' decision to decline necessary treatment is based on constitutional grounds, such as religious beliefs, it must yield to the State's interests, as *parens patriae*, in protecting the health and welfare of the child."

The court pointed out that, with respect to the mother, since she had consented to the cesarean section, she would be putting the hospital in an untenable position by ordering them to withhold blood transfusions after her loss of a life-threatening amount of blood. The court said the following:

When a patient puts her doctor in charge of a surgical procedure, she necessarily makes him responsible for the conduct of the operation. Every such grant of responsibility should be accompanied by authority sufficient to properly carry out the delegated responsibilities. Certainly if the medical personnel are requested to undertake a delivery which will entail incisions and this is known to the patient, the attending physi-

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icians must be permitted to stabilize the patient from the resulting loss of blood.\textsuperscript{276}

This part of the case seems to hinge on the idea that the patient sought medical attention from the hospital and then attempted to restrict the institution and physicians from rendering proper medical care, a concern expressed in other cases.\textsuperscript{277}

As to the baby, the court reviewed extensive case law holding that a parent cannot deprive a child of lifesaving treatment: "The case of a child who may bleed to death because of the parents' refusal to authorize a blood transfusion presents the classic example . . . ."\textsuperscript{278} The court did not distinguish between a child already born and a fetus and apparently assumed that the case law involving children already born applied equally to fetuses.

The court therefore authorized the attending physicians to administer blood transfusions to the patient as well as to her baby. It has been noted that the \textit{Crouse} case "stands for the rather odd proposition that a competent patient's wishes should prevail unless her physicians feel otherwise. Such reasoning makes \textit{Crouse} unique among the refusal of treatment cases."\textsuperscript{279}

In \textit{In re Jamaica Hospital},\textsuperscript{280} a woman, eighteen weeks pregnant, was in the hospital with a life-threatening condition in which the veins of the esophagus were prone to rupture. Her fetus was not yet viable. The doctors warned that the patient and her unborn child would die without a transfusion. The patient refused a transfusion due to her religious beliefs as a Jehovah's Witness.

Application was made to a judge. The judge arrived at the hospital and convened a hearing at the patient's bedside. The patient reiterated that she refused to have a transfusion and that she understood that the fetus would die without it. The judge ordered the patient to submit to a transfusion, saying the following:

While I recognize that the fetus in this case is not yet viable, and that the state's interest in protecting its life would be less than "compelling" in the context of the abortion cases, this is not such a case. In this case, the state has a highly signifi-

\textsuperscript{276} \textit{Crouse}, 485 N.Y.S.2d at 446.

\textsuperscript{277} We have seen this principle, that patients may not insist upon medical care while also seeking to direct physicians into a course of treatment contrary to medical advice, expressed in other cases. \textit{See}, \textit{e.g.}, \textit{In re President & Dirs. of Georgetown Coll., Inc.}, 331 F.2d 1000, 1008 (D.C. Cir. 1964); \textit{United States v. George}, 239 F. Supp. 752, 754 (D. Conn. 1965).

\textsuperscript{278} \textit{Crouse}, 485 N.Y.S.2d at 445.


cant interest in protecting the life of a mid-term fetus, which
outweighs the patient's right to refuse a blood transfusion on
religious grounds.\textsuperscript{281}

The judge cited the \textit{Georgetown} case as precedent, among other
cases.\textsuperscript{282} While the patient in this case was the unmarried mother of
ten children whose only other family, a sister, was unavailable at the
time of the emergency, the judge noted that the issue of abandonment
of the patient's children was not considered because of the sparseness
of the record on that point.\textsuperscript{283} The case in effect held that a nonviable
fetus has a right to protection and that these rights are superior to the
autonomy rights of the mother.

In a case that gained national media attention, Melissa Ann Row-
land, a Utah resident, was prosecuted for first degree criminal homi-
cide and child endangerment because, after refusing to have a
cesarean section that doctors said was necessary to save her twin fe-
tuses, she went into labor naturally, and one twin survived, but the
other was stillborn.\textsuperscript{284} She later pled guilty to two counts of child en-
dangerment, and the homicide charge was dropped.\textsuperscript{285}

\textbf{VII. CONCLUSION}

We have seen that courts are uniform in authorizing medical pro-
cedures to protect minor children, despite parental refusals. In some
cases, the choices of mature minors to forego lifesaving treatment
have been overridden by courts. However wrenching such actions
may be, the state as parens patriae has a special duty to protect mi-
nors and, if necessary, make vital decisions as to whether to submit a
minor to treatment necessary for the child's welfare.

In the context of competent adult patients, we have seen that
courts have construed patient autonomy with a balancing test, and in
applying that test we have opinions that are at polar opposites. One
group of cases finds that a patient's right to refuse lifesaving treat-
ment may be overridden by the state's interest in protecting the pa-
tient's minor children from abandonment; and another group of cases
rejects the abandonment concept altogether, finding that competent
adults enjoy a nearly absolute right of self-determination in medical
decisions.


\textsuperscript{282} \textit{Jamaica Hosp.}, 491 N.Y.S.2d at 900.

\textsuperscript{283} \textit{Id.} at 899-900.

\textsuperscript{284} \textit{See} Monica K. Miller, \textit{Refusal to Undergo a Cesarean Section: A Women's Right

\textsuperscript{285} \textit{See} Miller, 15 \textit{Health Matrix} at 384.
With regard to protecting the integrity of the medical profession, there is concern that a physician who enforces court-ordered treatment may be perceived to have transformed the physician-patient relationship into an adversarial relationship leading to distrust by the patient. This in turn could undermine the very foundation of physician-patient confidentiality. On the other hand, forcing a physician to treat a patient contrary to sound medical judgment would seem to impair the integrity of the medical profession.

As we have observed, a number of cases illustrate the authority of the State to take control of a woman's body during her pregnancy in order to protect the health and welfare of the fetus. Courts have imposed on pregnant women affirmative duties to their unborn children that courts have declined to impose on patients who are not pregnant. On the other hand, some cases have emphasized that a woman does not surrender her autonomy when she becomes pregnant.

One rationale for ordering pregnant women to submit to recommended treatment is the idea that once a patient presents herself for treatment at a hospital, she may not require the physician to deviate from recommended treatment:

Patients do not have a positive ethical right to obligate physicians to practice medicine in ways that are patently inconsistent with the most reliable clinical judgment.

Another rationale is that to allow pregnant women to refuse medical advice and thereby endanger the well-being of a viable fetus is to subordinate the ethical integrity of physicians to patient autonomy.

In the final analysis, there are those who argue for an absolutist kind of autonomy and those who say autonomy must give way to fetal rights: "[I]f the well-being of the potential child is at stake, [the mother] loses her autonomy, and her body may be invaded and treated for the child's sake." She has "a duty to assure that the fetus is born as healthy as possible."

The reasoning of some courts that support fetal rights has been criticized. The criticism is that the state's interest in prohibiting abor-
tion at viability pertains to limitations on abortion rights and the question of a woman's right willfully to terminate her pregnancy differs analytically from the question of a woman's right to refuse treatment that could incidentally jeopardize the fetus's survival. One involves reproductive privacy, and the other involves taking affirmative control of a woman's body and forcing her to undergo medical treatment in order to protect the health and welfare of the fetus.

Clearly, the decision of a pregnant woman to forego lifesaving treatment takes on a fundamentally different quality when that decision involves the destruction of the fetus. It is different in kind from a decision that affects her and not the fetus. At the same time, while a woman may have a moral duty with respect to her viable fetus, this does not necessarily translate into a legal one. The Brown court made explicit mention of this in referring to the pregnant woman's "apparent disparate ethical and legal obligations."


Roe has never stood for such a principle, and a careful reading of the opinion does not support such an interpretation. First, Roe held that a fetus is not a person for purposes of the Fourteenth Amendment. Despite this holding, the Supreme Court found that the state has an "important and legitimate interest in protecting the potentiality of human life." Therefore, at viability, the state's interest becomes compelling, and it may prohibit abortion except to save the life and health of the mother. The Roe court did not find that the state has an interest at viability sufficient to force a pregnant woman to undergo treatment against her will to prevent fetal demise. Such an interpretation is an interpretation of Roe that is not justified by the opinion.

Levy, 27 J. L. MED. & ETHICS at 181.


293. Brown, 689 N.E.2d at 405.