# MATERNAL-FETAL CONFLICT: A CALL FOR HUMANISM AND CONSCIOUSNESS IN A TIME OF CRISIS†

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## INTRODUCTION

This Article examines state intervention in the life of the pregnant woman whereby medical treatment is imposed upon her over her objection. It focuses specifically on obstetrical intervention and the fundamental danger of using this intervention coercively in an attempt to regulate a woman's medical care, lifestyle, and personal decisions during the course of her pregnancy. This Article suggests that the woman, to the extent that she is competent, is the appropriate decision maker regarding medical care for her

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† This Article looks specifically at conflict in the area of obstetrical intervention. It is the first of a trilogy. The second part examines state intervention into the lives of substance-dependent pregnant woman (presented in September 1992 at a symposium on Discovering Our Connections: Race and Gender in Theory and Practice of the Law sponsored by the American University School of Law). The final part, still in progress, explores reproductive decision making of HIV-positive women.

Although I have used the construct of maternal-fetal conflict, I want to make it clear that I do not perceive this as a conflict between the woman and the fetus, but rather one between the woman and the state with respect to who should properly make decisions on behalf of the fetus. Couching the debate in terms of woman against fetus or in terms of fetal rights is counterproductive and fails to recognize the autonomy of the woman and the unique relationship of woman and fetus during pregnancy.

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fetus. To decide otherwise violates the woman's right to make informed choices and to give informed consent, two of the underlying principles supporting autonomy in decision making about medical care. Moreover it impugns her constitutional right to bodily integrity.[1]

The Article raises questions of whether the legal resolution of conflicts between the woman and her doctor regarding fetal health care is appropriate. Of particular concern is the manner in which such intervention, to the extent that it is considered necessary, should be implemented. The initial movement in this area seems to be in the direction of coercive intervention. However, use of the coercive powers of the state is neither the most efficient nor the most effective way to approach this problem.

Part I of this Article examines the evolution of the doctor-patient relationship over the last decade. This evolution has led doctors to view both the woman and her fetus as patients. Such a view, when combined with the advances in medical technology, has contributed to the current movement toward a recognition of fetal rights. Part II of the Article looks at the historical treatment of the fetus in substantive law. Part III addresses the state's interest in protecting its children and, by extension, the fetus. By recognizing a compelling state interest in the life of the fetus throughout pregnancy, *Webster v. Reproductive Health Services*[2] can be interpreted as enabling states to promulgate extensive intervention to protect the health of the fetus as long as the pregnant woman evinces an intent to continue her pregnancy. Determining the extent of state intervention which will best protect the pregnant woman's autonomy and bodily integrity will be crucial to the resolution of this problem. Part IV surveys evolving technology and its impact on the health of mother and fetus, which has resulted in a vision of fetal health as separate and distinct from the health of the pregnant woman. This section will look at the well-developed doctrines of informed consent and autonomy that are applicable in determining decisional capacity. The final portion of the Article offers some culturally sensitive solutions to this very difficult problem which has reached crisis proportions. I propose

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[1] See Terry v. Ohio, 392 U.S. 1, 9 (1968) (supporting "the right of every individual to the possession and control of his own person, free from all restraint and interference of others, unless [supported] by clear and unquestionable authority of law"); see also U.S. Const. amend. IV; the line of cases supporting the right of a competent person to refuse medical care, even when judicially ordered and even where such a refusal would lead to the patient's death: Planned Parenthood v. Casey, 112 S. Ct. 2791 (1992); Roe v. Wade, 410 U.S. 113 (1973); Schmerber v. California, 384 U.S. 757 (1966); Bowden v. State, 510 S.W.2d 879, 881 (Ark. 1974); People v. Smith, 362 N.Y.S.2d 909, 914 (N.Y. Sup. Ct. 1974), aff'd, 487 N.Y.S.2d 585 (N.Y. App. Div. 1985), rev'd, 497 N.E.2d 689 (N.Y. 1986), cert. denied, 479 U.S. 953 (1986); infra notes 88–93 and accompanying text.

[2] 492 U.S. 490 (1989).

limiting coercive intervention to a remedy of last resort, and suggest education, access to care, and the fostering of a positive doctor-patient relationship as alternatives to legal intervention.

## I.

Evolving medical technology and substantial scientific breakthroughs now allow the physician to detect fetal abnormalities far earlier and more extensively than what could have been imagined even a decade ago. Equally as spectacular is the ability to correct a significant number of problems through microsurgery.[3] The obstetrician who traditionally viewed the pregnant woman as his or her patient now freely acknowledges that the fetus is a second patient.[4] Nonetheless, it is particularly important not to forget that the primary patient is the woman, and that when given proper education and support she is best suited to make decisions regarding care for herself and her fetus.

These advances in medical technology come at a time when the law seems progressively more willing to infringe on the reproductive choices of women ostensibly on behalf of the fetus. Due to these advances and the emerging ability to quantify the effect a woman's lifestyle decisions have on her fetus, courts and legislatures have become increasingly involved in determining how pregnant women should behave and what conduct they should require to best protect the fetuses women carry.[5] Physicians seem ready to impose medical treatment and lifestyle prohibitions upon the woman in the interest of perceived superior claims on behalf of the fetus.[6] The perinatologist's ability to intervene on behalf of the fetus makes it tempting to justify the invasion, or to forget that intervention can be accomplished only by directly involving and invading the body of the woman.

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[3] See, e.g., Nicole Baer, The Brave New World of Fetal Surgery, Ottawa Citizen, Aug. 21, 1992, at B6.

[4] See, e.g., Jack A. Pritchard et al., Williams Textbook of Obstetrics at xi (1985) ("Quality of life for the mother and her infant is our most important concern. Happily we live and work in an era in which the fetus is established as our second patient with many rights and privileges comparable to those previously achieved only after birth.").

[5] See, e.g., Cal. Penal Code § 270 (West 1988); Grodin v. Grodin, 301 N.W.2d 869 (Mich. Ct. App. 1980) (holding a mother liable for injuries sustained by her child as a result of the mother's conduct during pregnancy).

[6] See Veronika E.B. Kolder et al., Court Ordered Obstetrical Intervention, 316 New Eng. J. Med. 1192, 1193-94 (1987); see also Rosa H. Kim, Reconciling Fetal/Maternal Conflicts, 27 Idaho L. Rev. 223, 236-37 (1991); Lawrence J. Nelson & Nancy Milliken, Compelled Medical Treatment of Pregnant Women: Life, Liberty, and Law in Conflict, 259 JAMA 1060 (1988); discussion infra parts III-IV.

As fetal surgery becomes an accepted medical practice, the potential for medicolegal conflict increases. Rights of the fetus are often gained at the expense of a woman's rights to privacy, bodily integrity, and autonomy. States have taken the opportunity to intervene coercively in medical and life- style decisions which they view as adversely impacting on the fetus. If the pregnant woman decides that she does not want medical intervention, but that she does intend to continue her pregnancy, the physician is faced with the dilemma of honoring the mother's decision not to intervene or forcing intervention over her objection. Increasingly, physicians resolve the dilemma by seeking court authority to override pregnant women's decisions. Rather than looking at the problem from a perspective that recognizes the woman as an integral, positive part of the solution, physicians, legislatures, and courts have increasingly found an independent and adversarial right on behalf of the fetus which is viewed as paramount to the woman's right.[7] Development of interest in fetal protection results in a simultaneous erosion of maternal rights. Well-established concerns for the woman's autonomy and privacy during pregnancy are set aside by the state in favor of the fetus.[8]

It is also becoming increasingly apparent that coercive intervention occurs in inordinately high numbers when poor women and women of color are involved.[9] Use of high-tech intervention at extraordinary costs removes resources from equally compelling medical care issues—the tremendous lack of prenatal services for poor communities and women of color, as well as higher rates of fetal defects and mortality for African-American women

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[7] See, e.g., Kenneth Jost, Mother Versus Child, A.B.A. J., Apr. 1989, at 84 (1989); Kolder et al., supra note 6; Nelson & Milliken, supra note 6. Particularly disturbing are statistics indicating that among 21 cases where court orders were sought for forced Cesarean sections, 81% of the women involved were Black, Asian, or Hispanic, 24% did not speak English as their primary language, and all were receiving their prenatal care in a teaching-hospital clinic. Equally disturbing was the fact that nearly half (47%) of the fellowship directors (programs in maternal-infant health) thought that judicial force should be used to impose treatment thought to be lifesaving, including surgery and forced confinement, on the unconsenting pregnant woman. See Kolder et al., supra note 6, at 1193.

[8] For example, the Supreme Court initially recognized and protected these rights in cases such as Roe v. Wade, 410 U.S. 113, 153 (1973); Eisenstadt v. Baird, 405 U.S. 438, 453–54 (1972); Griswold v. Connecticut, 381 U.S. 479, 484 (1965), but now shows increasing willingness to encroach upon them in cases such as Webster v. Reproductive Health Services, 492 U.S. 490 (1989); the dissents in Thornburgh v. American College of Obstetricians & Gynecologists, 476 U.S. 747 (1986) (White, J., dissenting) (Burger, C.J., dissenting) (O'Connor, J., dissenting); and most recently in the decision rendered in Planned Parenthood v. Casey, 112 S. Ct. 2791 (1992). See also discussion infra part III.

[9] See, e.g., Nelson & Milliken, supra note 6; see also supra note 7; discussion infra parts III–IV.

across income lines.[10] The lack of care, poor nutrition, and poverty of spirit result in far greater damage in terms of infant mortality and morbidity than does the failure of a physician to intervene over a woman's objection to a specific treatment modality.

These issues are not distinctly legal, nor are the resolutions those that the law is in the best position to facilitate. The judicial system traditionally does not move quickly. It is built on careful analysis of precedent, allowing time for reflection, research, and informed representation. In contrast, in the typical obstetrical case, time is of the essence when a crisis arises, and neither the court nor representatives for the pregnant woman or fetus are in a position to gather information, interview those involved, and implement the support that fairness and due process would require.[11] Even if a system could be devised that would more fairly incorporate the legal system in this debate, I would oppose such intervention. I propose a humanistic approach that trusts the pregnant woman's decision-making ability, and which provides her with sufficient resources and education to make her decisions.

Adding fuel to the fetal rights fire is the Supreme Court's recognition of a compelling state interest in the potentiality of life. *Roe v. Wade*[12] found this interest compelling at viability. In *Webster v. Reproductive Health Services*[13] the Court seemed prepared to find a compelling state interest in potential life throughout the pregnancy. *Planned Parenthood v. Casey,*[14] while retaining *Roe's* protection for a woman's choice to continue or terminate her pregnancy, certainly recognizes a state's compelling interest in the fetus and would allow provisions in furtherance of that interest if they do not unduly burden a woman's choice. The Court

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[10] See, e.g., Children's Defense Fund, A Vision for America's Future (1989); Children's Defense Fund, The Health of America's Children (1991) [hereinafter CDF, The Health]; Dana Hughes et al., The Health of America's Children, Clearinghouse Rev. 472 (Special Summer Issue 1986); Lori A. Leu, Legislative Research Bureau Report: A Proposal to Strengthen State Measures for the Reduction of Infant Mortality, 23 Harv. J. on Legis. 559 (1986).

[11] See, e.g., Kolder et al., supra note 6, at 1193. In 70% of the cases in which intervention was sought, hospital administrators and lawyers were aware of the situation for a day or less, and once a court order was sought it took six or fewer hours to obtain one in 88% of the cases. In 19% of the cases, court orders were obtained in an hour or less and at least one was granted by telephone. See id; see also George J. Annas, Protecting the Liberty of Pregnant Patients, 316 New Eng. J. Med. 1213 (1987). Professor Annas points out that it is unlikely judges will be familiar with the policy concerns and applicable precedents on such short notice. He also notes that if a wrong result is reached, a meaningful appeal is not available.

[12] 410 U.S. 113 (1973).

[13] 492 U.S. 490 (1989).

[14] 112 S. Ct. 2791 (1992).

interprets restrictive provisions such as those in *Casey* liberally, evidencing a clear stance for affirming such provisions elsewhere and encouraging their implementation.[15]

In calling for a humanistic approach to medical care decision making by pregnant women, I propose a model that recognizes alternatives to state intervention as the first course of action, allowing intervention only as a matter of last resort. I suggest an interdisciplinary paradigm, geared toward empowerment, education, and treatment. This has not been the direction of fetal rights discourse to date. Even the notion of "fetal rights" feeds into the negative construct of "conflict." Rather than conceding that the law and coercive state/medical intervention are ill-suited to resolving potential problems, states have increasingly adopted a politically popular adversarial posture that advocates both criminal and civil sanctions and results in invasive intervention on behalf of the fetus well beyond what has been authorized in other health contexts.[16]

## II.

This section is intended to set out an overview of the historical recognition and treatment of fetal rights in substantive jurisprudence. An

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[15] See id. (upholding a waiting period, parental consent, reporting requirements, and an informed consent provision, and finding only a spousal notification provision to be an "undue burden"); see also George J. Annas, The Supreme Court, Liberty, and Abortion, 327 New Eng. J. Med. 651, 652–54 (1992).

[16] See, e.g., John A. Robertson, Legal Issues in Fetal Therapy, 9 Seminars Perinatology 136 (1985); John A. Robertson, Procreative Liberty and the Control of Conception, Pregnancy, and Childbirth, 69 Va. L. Rev. 405, 437–58 (1983) [hereinafter Robertson, Procreative Liberty]; John A. Robertson, The Right to Procreate and In Utero Fetal Therapy, 3 J. Legal Med. 333 (1982). Professor Robertson is a vociferous advocate for fetal rights and calls for much more in the way of maternal liability and physician intervention than I believe is warranted. He believes that a mother who chooses to continue her pregnancy forfeits her rights to choice and autonomy. See Robertson, Procreative Liberty, supra, at 438. He is joined in this position by Professor Margery Shaw, among others. See Margery Shaw, Conditional Prospective Rights of the Fetus, 5 J. Legal Med. 63 (1984). Moreover, these commentators are apparently supported by the public at large, particularly in the context of substance dependency. I discuss this in more depth in my second article, see supra note †, but popular support for coercive intervention is demonstrated by a poll, the results of which indicated that 8 in 10 people questioned felt a pregnant drug addict whose child inherits the addiction should be imprisoned for child abuse. Richard Morin, Many in Polls Say Bush Plan Is Not Stringent Enough, Mandatory Drug Tests, Searches Backed, Wash. Post, Sept. 8, 1989, at A1. Further derogation of the status of the pregnant woman is illustrated in specific suggestions advocating restraint on her conduct and activities as well as unequal treatment, such as her exclusion from basic protections under living will statutes in certain states.

infant in *ventre sa mere*[17] has been recognized in substantive law for many years.[18] The law of property was the first to recognize the fetus, primarily for purposes of inheritance.[19] At common law a fetus could be named as an heir from the moment of conception.[20] The right to take, however, was contingent on live birth. This common-law recognition is codified in the Uniform Probate Code.[21] Property law's recognition of the fetus fosters the orderly disposition of property in a manner that recognizes the future heir's right to inherit. The purpose, however, is not to expand fetal rights overall, since "[t]he unborn have never been recognized in the law as persons in the whole sense."[22]

Criminal law recognition of the fetus is most often found in criminal prohibitions against assault, feticide, and abortion. Historically, the law applied penalties only after "quickening."[23] More recently, courts have been reluctant to continue requiring live birth as a prerequisite to a finding of guilt. California's legislature, for example, amended its homicide statute in 1970 to define murder as "the unlawful killing of a human being, or a fetus."[24] Other jurisdictions continue to make punishment contingent upon a live birth.[25]

Tort law has recognized fetal rights in the context of claims for wrongful death or wrongful life. Wrongful death actions are statutory and, along with survival statutes, were designed to compensate survivors for the death of a family member.[26] Initially the majority of jurisdictions required

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[17] An infant in *ventre sa mere* is a "'child in its mother's womb, and for the benefit of the child civil law regards an infant in its mother's womb in the same condition as if born.'" John E.B. Myers, Abuse and Neglect of the Unborn: Can the State Intervene?, 23 Duq. L. Rev. 1, 5 n.6 (1984) (citing Ransom H. Tyler, Commentaries on the Law of Infancy § 151, at 223-24).

[18] See generally, Dawn E. Johnsen, The Creation of Fetal Rights: Conflicts with Women's Constitutional Rights to Liberty, Privacy and Equal Protection, 95 Yale L.J. 599, 600-04 (1986); Jeffrey L. Lenow, The Fetus as a Patient: Emerging Rights as a Person?, 9 Am. J.L. & Med. 1, 3-4 (1983); Myers, supra note 17, at 4-14; Jeffrey A. Parness & Susan K. Pritchard, To Be or Not To Be: Protecting the Unborn's Potentiality of Life, 51 U. Cin. L. Rev. 257, 264-67 (1982).

[19] 95 C.J.S. Wills § 655 (1976).

[20] Id.

[21] Unif. Probate Code § 2-108 (1991) (providing that "[a]n individual in gestation at a particular time is treated as living at that time if the individual lives 120 hours or more after birth").

[22] Roe v. Wade, 410 U.S. 113, 162 (1973).

[23] "Quickening" is a term used to describe the mother's first awareness of fetal movement. This generally occurs between the 16th and 20th week of pregnancy. See Pritchard et al., supra note 4, at 218.

[24] Cal. Penal Code § 187 (West 1988) (excepting therapeutic abortions).

[25] See, e.g., Wis. Stat. Ann. § 939.22(16) (West 1992).

[26] See 22 Am. Jur. 2d Death §§ 1-2 (1965); W.E. Shipley, Annotation, Modern

live birth as a condition of recovery. In recent years, however, the live birth requirement has been recognized as illogical and now only a minority of jurisdictions have such a requirement.[27] Denying a cause of action to a child who is stillborn rewards a tortfeasor who kills rather than maims the fetus.[28] "Under such a rule, there is the absurd result that the greater the harm, the better the chance of immunity, and the tortfeasor could foreclose his own liability."[29] It might be tempting to argue that this reasoning could be applied to a pregnant woman. Such an argument, however, does not recognize the special status of the pregnant woman and the fetus, as well as tort law's historical recognition of parental immunity in the context of parent-child torts.[30]

Because many of my students will practice in North Carolina, I was particularly interested in determining how that state handled this issue. The North Carolina Supreme Court has interpreted its wrongful death statute[31] to include the fetus.[32] Its reasoning in *DiDonato v. Wortmann* is typical of the position of a majority of states on this issue.[33] The court states, "In plain English, an action for wrongful death exists if the decedent could have maintained an action for negligence or some other misconduct if he had survived."[34] The court concedes that the statute, on its face, gave no clear-cut answer to the question of whether a viable fetus would be considered a "person" for purposes of North Carolina's Wrongful Death Act. It went on to say, however, that

> [c]ase law regarding recovery by children for fetal injuries is instructive. Tort claims brought by children to recover for fetal injuries are recognized in virtually every state, including North Carolina. It would be logical and consistent with these decisions, and would further the policy of deterring dangerous conduct that underlies them, to allow such claims when the fetus does not

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Status of Rule Denying a Common-Law Recovery for Wrongful Death, 61 A.L.R.3d 906 (1975).

[27] See Sheldon R. Shapiro, Annotation, Right to Maintain Action or to Recover Damages for Death of Unborn Child, 84 A.L.R.3d 411,.415 (1979). For more on the development of wrongful death actions, see W. Page Keeton et al., Prosser and Keeton on the Law of Torts § 127, at 945-60, § 55, at 367 n.1 (5th ed. 1984).

[28] See Verkennes v. Corniea, 38 N.W.2d 838, 840 (Minn. 1949).

[29] Vaillancourt v. Medical Ctr. Hosp., 425 A.2d 92, 95 (Vt. 1980). The court in *Vaillancourt* also stated, "A viable unborn child is, in fact, biologically speaking, a presently existing person and a living human being." Id. at 94.

[30] See Keeton et al., supra note 27.

[31] N.C. Gen. Stat. § 28A-18-2 (1984).

[32] See DiDonato v. Wortman, 358 S.E.2d 489 (N.C. 1987).

[33] See Keeton et al., supra note 27, at 370 n.32 (listing states).

[34] Id. at 491 (citing Nelson v. United States, 541 F. Supp. 816 (N.D.N.C. 1982)).

survive.[35]

Following closely on the heels of *DiDonato*, the North Carolina Court of Appeals in *Johnson v. Ruark Obstetric & Gynecology Associates*[36] held when a baby was stillborn due to the physician's alleged negligence, neither the mother's nor the father's emotional distress was so remote as a matter of law as to prohibit recovery.[37] Although the injury addressed in *Johnson* is that of the parents, the court's reasoning is helpful as an example of a state's increased willingness to recognize fetal rights and injury to the parent as a result of injury to the fetus.

Some jurisdictions have been reluctant to apply their wrongful death statutes on behalf of the fetus because of a perceived conflict with *Roe*.[38] courts have been even more reluctant to recognize claims for wrongful life.[39] Sentiment seems to be that life, no matter how poor, is to be preferred over non-existence.[40] Courts and legislatures recently, however, have allowed recovery to patients for doctor or clinic negligence while denying recovery for wrongful life to infant plaintiffs.[41] California is one

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[35] Id. (citation omitted).

[36] 365 S.E.2d 909 (N.C. Ct. App. 1988), aff'd, 395 S.E.2d 85 (N.C. 1990).

[37] Id. at 918.

[38] 410 U.S. 113 (1973). Michigan, for example, held that its wrongful death statute was not applicable to the fetus, stating: "If the mother can intentionally terminate the pregnancy at three months, without regard to the rights of the fetus, it becomes increasingly difficult to justify holding a third person liable to the fetus for unknowingly and unintentionally, but negligently, causing the pregnancy to end at the same stage." Toth v. Goree, 237 N.W.2d 297, 301 (Mich. Ct. App. 1975). This issue was readdressed by the Michigan Supreme Court in the case of Fryover v. Forbes, 446 N.W.2d 292 (Mich. 1989). The court stated, "We do not find any basis in the legislative history or in the case law of this state to conclude that the Legislature intended to create a cause of action for a nonviable fetus not born alive when it enacted and later amended the Wrongful Death Act." Id. at 292.

[39] The concept of wrongful life generally embraces wrongful conception, wrongful pregnancy, and wrongful birth. See Alexander Morgan Capron, Tort Liability in Genetic Counseling, 79 Colum. L. Rev. 618, 634 n.62 (1979); Myers, supra note 17, at 9 n.26 (explaining that in "wrongful life," the plaintiff is the infant who is born because of the defendant's wrongful conduct, and the plaintiff contends that rather than have been born defective, it would have been better never to have been born at all) (quoting Michael D. Morrison, Torts Involving the Unborn—A Limited Cosmology, 31 Baylor L. Rev. 131, 161-62 (1979)); see also Keeton et al., supra note 27, at 370-73.

[40] See Azzolino v. Dingfelder, 337 S.E.2d 528, 532 (N.C. 1985) (disallowing wrongful life claim), cert. denied, 479 U.S. 835 (1986); see also Gregory G. Sarno, Annotation, Tort Liability for Wrongfully Causing One To Be Born, 83 A.L.R.3d 15 (1978 & Supp. 1992).

[41] See Gildiner v. Thomas Jefferson Univ. Hosp., 451 F. Supp. 692 (E.D. Pa. 1978); see also Speck v. Feingold, 408 A.2d 496 (Pa. Super. Ct. 1979); Jacobs v. Theimer, 519 S.W.2d 846 (Tex. 1975).

of the few jurisdictions to allow a claim for wrongful life, even though the California Supreme Court refused to base its decision on the asserted right not to be born.[42] More normative is the New Jersey Supreme Court's position that "life—whether experienced with or without a major physical handicap—is more precious than non-life."[43]

## III.

During the 1980s, the United States saw an immense increase in states' willingness to intervene in the life of a pregnant woman on behalf of the fetus. Intervention is based on the claim of a state's interest in the "potential life" of the fetus, as well as the state's reinterpretation of its child abuse and neglect statutes to incorporate a fetus. This section will explain why states feel that they may use these sources as justification for intervention.

We see the beginnings of the state's articulated interest in the potential life of the fetus in *Roe v. Wade*, where the Supreme Court explicitly recognized a legitimate state interest in the "potentiality of human life."[44] *Webster* questions whether this interest should not adhere throughout pregnancy.[45] Consistent with the state's interest in life and in its preservation is the state's interest in the care and protection of its children. The state has exercised its authority on behalf of its children primarily through the use of its police powers and its authority under the doctrine of *parens patriae*, a doctrine which functions to enable the state to provide for the welfare of minors and incompetents who otherwise would be uncared for.[46] In *Prince v. Massachusetts*, one of the pole-star rulings in this area,

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[42] See Curlender v. Bio-Science Lab., 165 Cal. Rptr. 477 (Cal. Ct. App. 1980).

[43] Berman v. Allan, 404 A.2d 8, 12 (N.J. 1979). But see Procanik ex rel. Procanik v. Cillo, 478 A.2d 755 (N.J. 1984) which, although declining to recognize a wrongful life claim, did allow for payment of extraordinary medical expenses necessitated by the plaintiff infant's handicaps.

[44] Roe v. Wade, 410 U.S. 113, 162 (1973); see also Patricia A. King, The Juridical Status of the Fetus: A Proposal for Legal Protection of the Unborn, 77 Mich. L. Rev. 1647 (1979).

[45] Webster v. Reproductive Health Servs., 492 U.S. 490 (1990) (quoting with approval Justice White's dissent in Thornburgh, "[T]he state's interest if compelling after viability is equally compelling before viability." (citation omitted)).

[46] The words *parens patriae* mean "the father of the country," and were originally applied to the king. "The doctrine of *parens patriae* expresses the inherent power and authority of the state to provide protection of the person and property of a person *non sui juris*, and under the doctrine the state has sovereign power of guardianship over persons of disability." 67A C.J.S. Parens Patriae § 195 (1978). See also William Blackstone, Commentaries § 41 (describing the crown as "the general guardian of all

the Supreme Court stated:

> 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 . . . . [T]he state has a wide range of power for limiting parental freedom and authority in things affecting the child's welfare.[47]

This power is most often given regulatory expression in the form of state statutes governing abuse and neglect of minor children.

With the marked increase in the use of drugs and alcohol by women during pregnancy and the resultant damage to the neonate, both courts and legislatures are being pressured to address the issue of children born addicted to drugs or suffering the effects of fetal alcohol syndrome.[48] Early attempts to address the issue through use of existing child abuse and neglect statutes have been unsuccessful because the statutes were interpreted as not encompassing the fetus within their definition of child. Some states have responded by explicitly amending child abuse and neglect statutes to incorporate the fetus.[49]

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infants, idiots and lunatics"); 59 Am. Jur. 2d Parent & Child § 1-149 (1987 & Supp. 1990); Development in the Law—The Constitution and the Family, 93 Harv. L. Rev. 1156, 1199 (1980).

[47] 321 U.S. 166, 166-67 (1943).

[48] One in 10 infants born have experienced some exposure to cocaine (385,000 in 1988). The incidence of fetal alcohol syndrome is up markedly. (Figures are from research of Dr. Ira Chasnoff, Director, National Association for Perinatal Addiction Research & Education (NAPARE)). "Estimates of pre-natal exposure to alcohol and drugs are as high as 15% in some studies." Ira Chasnoff et al., The Prevalence of Illicit-Drug or Alcohol Use During Pregnancy and Discrepancies in Mandatory Reporting in Pinellas County, Florida, 322 New Eng. J. Med. 1202, 1203 (1990); see also Judith Larsen et al., Medical Evidence in Cases of Intrauterine Drug and Alcohol Exposure, 18 Pepp. L. Rev. 279 (1991).

[49] See, e.g., Fla. Stat. ch. 415.503(9)(a)(2) (1991) (defining "harm" for purposes of child abuse and neglect as including "physical dependency of a newborn infant upon any drug . . . [in statutory schedules, except for] drugs administered in conjunction with a detoxification program . . . or . . . drugs administered in conjunction with medically approved treatment procedures"); Ill. Rev. Stat. ch. 37 para. 802-3(1)(c) (1990) (amending Juvenile Court Act's definition of neglected minor to include infants born with controlled substances in their system); Ind. Code § 31-6-4-3.1 (1990) (including a child born with fetal alcohol syndrome or an addiction to a controlled substance within its definition of a child in need of services); N.J. Rev. Stat. § 30: 4C-11 (1991) (providing that "the provisions of this section [a child endangerment statute] shall be deemed to include an application *on behalf of an unborn child*") (emphasis added); N.Y. Fam. Ct. Law § 1012(f)(i)(B) (McKinney 1979) (defining a neglected child as one "whose physical, mental or emotional condition has been impaired . . . as a result of the failure of his parent . . . to exercise a minimum degree of care . . . in providing the child with proper supervision or guardianship . . . or by *misusing a drug or drugs;*

As indicated above, states have articulated an interest in protecting the potential life of the fetus and in promoting the interest of the fetus in being born healthy. Any measures promulgated in furtherance of this interest, however, must also recognize the pregnant woman's interest in privacy, autonomy, and bodily integrity. Although the Constitution does not explicitly provide for a "right to privacy," such a right has been recognized within the "penumbras" of the Bill of Rights[50] and within the Fourteenth Amendment's concept of personal liberty and restrictions upon state actions.[51] This privacy right has also been recognized in the context of contraception,[52] procreation,[53] and family relations.[54]

Even though the recent trend has been to extend fetal rights at the expense of women's rights, they need not be viewed as mutually exclusive. *Roe* and its progeny have recognized, and continue to recognize, the pregnant woman's constitutional liberty and privacy interests. While it is true that the recognition and expansion of fetal rights could lead to increased resources available to pregnant women, placing the focus on fetal rights often results in changes made at the expense of the pregnant woman herself. Except in a very narrow range of circumstances, the pregnant woman should be the appropriate person to make decisions concerning the welfare of her fetus. "[T]he Constitution protects individual decisions in matters of childbearing from unjustified intrusion by the state."[55] The dangers in trying to impose any type of state-mandated behavior on the pregnant woman are both the unacceptable level of intrusion which would be required in order to monitor compliance and the impact such intrusion would have on the pregnant woman's ability to control her body. How can the state, for instance, be sure that a pregnant woman does not smoke, drink alcoholic or caffeinated beverages, use drugs, or work near potential-

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*or by misusing alcoholic beverages.*") (emphasis added); Okla. Stat. tit. 10, § 1101(4)(c) (1991) (including in its definition of deprived child one "born in a condition of dependence on a controlled dangerous substance"). New York courts have interpreted the New York statute as applying to a child born with a positive drug toxicology. See In re Stefanel Tyesha, 556 N.Y.S.2d 280 (N.Y. App. Div. 1990). In relying on the statute the court indicated that evidence of prenatal use of drugs may support a finding of neglect on the theory that the parent would not be able to provide adequate supervision.

[50] Griswold v. Connecticut, 381 U.S. 479, 484 (1965).

[51] See Roe v. Wade, 410 U.S. 113, 153 (1973).

[52] See Eisenstadt v. Baird, 405 U.S. 438, 453-54 (1972).

[53] See, e.g., Carey v. Population Servs. Int'l, 431 U.S. 678 (1977); Roe, 410 U.S. 113; Skinner v. Oklahoma, 316 U.S. 535, 541-42 (1942); Buck v. Bell, 274 U.S. 200 (1927).

[54] Prince v. Massachusetts, 321 U.S. 166 (1943).

[55] Carey, 431 U.S. at 687 (1977) (commenting on the significance of *Griswold*).

ly toxic substances?[56] In addition to privacy considerations, the pregnant woman has the right to be free from "unjustified intrusions" on her personal security,[57] as well as to be protected from "nonconsensual invasion of . . . [her] bodily integrity."[58]

The Fourteenth Amendment, in the context of due process and equal protection, supports the pregnant woman's ability to make choices regarding her conduct during pregnancy and validates her resistance to government intervention into her decision making. As will be discussed in the next section, this is not to say that the government may not have some compelling interest in the health and well-being of the fetus. My concern however, is that, given the Court's language in *Webster*[59] and pressures on state legislatures to expand fetal rights at the expense of maternal rights, the government may seek to intrude in a manner that is counterproductive. Rights rhetoric must seek to reconcile the unique—and at times apparently competing—interests in the maternal-fetal relationship.

In addition to judicial intervention in the area of obstetrics, we have seen a significant movement toward intervention in the area of substance-dependent pregnant women. Although this subject is addressed extensively in my second article[60] I mention it here because the issues overlap when considering state intervention. The state has the authority to intervene through its *parens patriae* and police powers, and, increasingly, through specific statutory provisions.

The form this intervention takes is critical not only to protect the delicate balance of interests, but also to avoid driving underground the population most in need of care. Currently, mothers who are poor and who

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[56] The issue of employment discrimination based on reproductive capacity seems to be alive and well at the moment but is outside the scope of this Article. See UAW v. Johnson Controls, Inc., 111 S. Ct. 1196 (1991), in which the Supreme Court for the first time addressed the issue of maternal-fetal conflict in the employment setting. This case involved a challenge to Johnson Control's fetal protection policy. The Court concluded that the policy, which excluded all potentially fertile women from positions involving high lead exposure, overtly discriminated against women. See also Hayes v. Shelby Memorial Hosp., 726 F.2d 1543 (11th Cir. 1984); Wright v. Olin Corp., 697 F.2d 1172 (4th Cir. 1982); Zuniga v. Kleberg County Hosp., 692 F.2d 986 (5th Cir. 1982); Thomas Brierton & Laurie Lichter-Heath, Fetal Protection Policies: Balancing the Interests of the Employee, Employer and the Unborn Under Title VII, 41 Lab. L.J. 725 (1990); George M. Sullivan & William A. Nowlin, Gender-Based Fetal Protection Policies: Impermissible Sex Discrimination, 42 Lab. L.J. 387 (1991).

[57] Ingraham v. Wright, 430 U.S. 651, 673 (1977).

[58] Superintendent of Belchertown v. Saikewicz, 370 N.E.2d 417, 424 (Mass. 1977).

[59] Webster v. Reproductive Health Servs., 492 U.S. 490 (1989).

[60] See supra note †.

abuse drugs and alcohol do not obtain adequate prenatal care.[61] If those who seek prenatal care are faced with forced obstetrical interventions and/or the very real possibilities that their children may be taken from them or that they may be prosecuted, they will have additional incentive to shy away from the medical care they need. Abandoned newborns and unattended home births are increasing in major urban areas.[62]

Cases that exemplify the attempts by courts and/or prosecutors to construct somewhat innovative, although not particularly compelling solutions based upon existing statutes (spanning several substantive areas), can be found in the stories of Pamela Rae Stewart, Brenda Vaughn, and Jennifer Johnson.[63] Each has received relatively widespread attention.

In September of 1986, Pamela Rae Stewart was charged with causing the death of her son by failing to seek adequate medical care during her pregnancy and by engaging in sexual intercourse and taking amphetamines, both against her doctor's orders.[64] The deputy district attorney stated that he was prosecuting Mrs. Stewart because she "didn't follow through on the medical advice she was given."[65] The charges were dismissed on February 26, 1987. The court found that Mrs. Stewart's conduct was not illegal under the child support statute that the prosecution relied upon in bringing the charges.

In June of 1989, a District of Columbia Superior Court judge ordered Brenda Vaughn to serve the remainder of the term of her pregnancy in jail for a second degree theft conviction, her first offense. Ms. Vaughn had tested positive for cocaine when she was arrested. The judge stated, "I'll be darned if I'm going to have a baby born that way."[66]

On July 13, 1989, the state of Florida attempted to prosecute Jennifer Johnson for delivering cocaine to her newborn through the umbilical cord. Ms. Johnson's daughter was her fourth child to be born testing positive for cocaine. At the trial level she received a sentence of fifteen years probation. This ruling was affirmed by the District Court of Appeal of

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[61] See, e.g., CDF, The Health, supra note 10, at 4 (table I) (1991).

[62] See, e.g., J.C. Barden, Hospitals Housing Healthy Infants, N.Y. Times, July 26, 1992, at A20; When a Baby Is So Unaffordable It Is Abandoned, N.Y. Times, Sept. 20, 1992, at A40.

[63] See Mark Curriden, Holding Mom Accountable, A.B.A. J., Mar. 1990, at 50; Jost, supra note 7, at 84–88.

[64] People v. Stewart, No. M508197, slip op. (San Diego Mun. Ct., Cal. Feb. 6, 1987).

[65] Jim Schachter, Of Drugs and Death: Prosecutors Raise the Ante, Woman Accused of Contributing to Baby's Demise During Pregnancy, L.A. Times, Oct. 1, 1986, at B1.

[66] United States v. Vaughn, Crim. No. F 2172-88 B (D.C. Sup. Ct. 1988).

Florida.[67] On July 23, 1992, the Florida Supreme Court, in a unanimous ruling, concluded that the state legislature never intended the drug trafficking law to be used against a woman for giving birth to a drug-exposed infant.[68] The court further held that "the Legislature expressly chose to treat the problem of drug dependent mothers and newborns as a public health problem and that it considered but rejected imposing criminal sanctions, via section 893.13 (1)(c)1 [the statute in question]."[69]

## IV.

Advances in microsurgery, dramatic breakthroughs in medical technology, and diagnostic tools such as ultrasonography, amniocentesis, and chorionic villus sampling can all be used to detect fetal abnormalities with varying degrees of accuracy.[70] Physicians may now diagnose specific hereditary disorders as well as certain neural tube and other developmental defects. Moreover, many of these abnormalities can be treated through prenatal therapy or fetal surgery.[71] For example, the University of California at San Francisco's Fetal Treatment Program performed successful "ex utero" surgery on a twenty-one-week-old fetus.[72]

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[67] See Johnson v. Florida, 578 So. 2d 419 (Fla. Dist. Ct. App. 1991), overruled by Johnson v. Florida, 602 So. 2d 1288 (Fla. 1992).

[68] The court stated: "We find that the legislative history does not show a manifest intent to use the word 'delivery' in the context of criminally prosecuting mothers for delivery of a controlled substance to a minor by way of the umbilical cord." Johnson, 602 So. 2d at 1290.

[69] Id. at 1293. Michigan likewise has rejected the use of drug trafficking statutes to prosecute pregnant women. See People v. Hardy, 469 N.W.2d 50 (Mich. Ct. App. 1991), appeal denied, 471 N.W.2d 619 (Mich. 1991). Three weeks after the *Johnson* decision the Connecticut Supreme Court held that a mother's prenatal drug use could not be used to terminate her parental rights. The court specifically stated that the state's child abuse statute was never meant to encompass prenatal conduct. See In re Valerie D., 613 A.2d 748, 753 (Conn. 1992).

[70] Amniocentesis, which involves removing a small amount of amniotic fluid from the amniotic sac of the pregnant woman, allows the geneticist to detect numerous fetal genetic abnormalities. Chorionic villus sampling is another tool used to detect genetic disorders and can be used earlier in the pregnancy than amniocentesis. Ultrasonography is advanced enough to enable the doctor to see a visible image of the fetus including organs, limbs, and parts as small as an upper lip. See Frank A. Chervenak et al., Current Concepts: Advances in the Diagnosis of Fetal Defects, 315 New Eng. J. Med. 305 (1986); Robin Marantz Henig, Saving Babies Before Birth, N.Y. Times, Feb. 28, 1982, § 6 (Magazine), at 18.

[71] See Gina Kolata, A Major Operation on a Fetus Works for the First Time, N.Y. Times, May 31, 1990, at A1; Mary Ann Limauro, Connecticut Q & A: Jodi K. Rucquoi; Guiding Parents with Genetic Diseases, N.Y. Times, July 26, 1992, § 13, at 3.

[72] See Michael R. Harrison et al., Fetal Surgery for Congenital Hydronephrosis,

The ability to treat the fetus in utero has enabled physicians to focus medical care directly on the fetus,[73] and has given rise to the question of whether a pregnant woman has an obligation either morally or legally to undergo medical treatments that would be beneficial to her fetus.[74] Before the more recent medical advances, physicians' efforts were geared to promoting the health of the mother and in so doing, the well-being of the fetus. Increased capacity to treat the fetus, notwithstanding the mother's consent, provides fertile ground for conflict between physicians representing fetal interests and those representing maternal interests. Supporting monitoring of the use of developing technology is data indicating that physicians are more likely to intervene on the treatment decisions of poor, uneducated, and minority women.[75] It is important to recognize the substantial risk of fetal surgery to the pregnant woman and the significant bodily invasion involved. For example, in cases of Cesarean section, there is a risk of uterine rupture at the scar during the surgery as well as in future pregnancies and deliveries.[76]

The balancing that courts do when considering forced obstetrical intervention most often results in a recognition of expanded fetal rights and diminished maternal rights.[77] Use of the *Roe* trimester framework is not

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306 New Eng. J. Med. 591 (1982).

[73] For a discussion of the types of available interventions, see generally National Symposium on Genetics and the Law, Genetics and the Law III (Aubrey Milunsky & George J. Annas eds., 1985); Susan Goldberg, Medical Choices During Pregnancy: Whose Decision Is It Anyway?, 41 Rutgers L. Rev. 591 (1989); Jeffrey L. Lenow, The Fetus as a Patient: Emerging Rights as a Person, 9 Am. J.L. & Med. 1 (1983); Nelson & Milliken, supra note 6; Alice M. Noble-Allgire, Court Ordered Cesarean Sections: A Judicial Standard for Resolving the Conflict Between Fetal Interests and Maternal Rights, 10 J. Legal Med. 211 (1989); Nancy K. Rhoden, The Judge in the Delivery Room: The Emergence of Court-Ordered Cesareans, 74 Cal. L. Rev. 1951 (1986).

[74] See, e.g., Katherine A. Knopoff, Can a Pregnant Woman Morally Refuse Fetal Surgery?, 79 Cal. L. Rev. 499 (1991). The author uses the traditional ethical theories of utilitarianism and deontology to examine the pregnant woman's right to refuse fetal surgery.

[75] See supra note 10; see also Watson A. Bowes, Jr. & Brad Selgestad, Fetal Versus Maternal Rights: Medical and Legal Perspectives, 58 Obstetrics & Gynecology 209 (1981); Martha A. Field, Controlling the Woman to Protect the Fetus, 17 Law Med. & Health Care 114 (1989); infra notes 95-104 and accompanying text.

[76] See Colautti v. Franklin, 439 U.S. 379, 399 (1979) (accepting testimony indicating that a woman who had a Cesarean section (hysterotomy) would be required to have future deliveries by C-section due to the risk of rupturing the scar); see also Sandra Blakeslee, Fetus Returned to Womb Following Surgery, N.Y. Times, Oct. 7, 1986, at C1.

[77] See, e.g., Bowes & Selgestad, supra note 75; George J. Annas, Pregnant Women as Fetal Containers, Hastings Center Rep., Dec. 1986, at 13; Annas, supra note 11; Dawn Johnsen, A New Threat to Pregnant Women's Autonomy, Hastings Center Rep., Aug. 1987, at 33.

particularly helpful in this context. While it is clear in this framework that a woman may have the option to terminate her pregnancy during the first trimester, the *Roe* Court also made clear that as long as a woman chooses to continue her pregnancy, she can be challenged for engaging in conduct that is perceived as being adverse to the health of the fetus.[78] The issues are further complicated by ambiguities over the legal definition of viability, advances in microsurgery and diagnostic technology, and existing precedent which has overridden competent women's refusal to authorize fetal surgery.[79]

A New York court addressed this issue in the case of *In re Jamaica Hospital*.[80] There, the court ordered "a blood transfusion necessary to stabilize her condition and to save the life of the unborn child" for a woman who was eighteen weeks pregnant and who had refused the transfusion on religious grounds.[81] The court relied on *Jefferson v. Griffin Spalding County Hospital Authority*[82] but extended its analysis to provide protection to the non-viable fetus and specifically referred to its *parens patriae* powers in doing so. The court reasoned:

> 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 significant interest in protecting the life of the mid-term fetus, which outweighs the patient's right to refuse a blood transfusion on religious grounds . . . .[83]

A decision of the District of Columbia Court of Appeals on April 26, 1990 deserves discussion at length. In *In re A.C.*, the court was faced for

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[78] Roe, 410 U.S. at 154.

[79] See, e.g., Jefferson v. Griffin Spalding County Hosp. Auth., 274 S.E.2d 457 (Ga. 1981), where the Georgia Supreme Court affirmed a juvenile court opinion ordering a woman to undergo a Cesarean section. This case, which involved a mother in her 39th week of pregnancy diagnosed with placenta previa, shows how imprecise even the best estimates of danger to the fetus may be. The court considered a Cesarean section to be the least invasive procedure available to Mrs. Jefferson. The juvenile court stated: "There is a 99 to 100 percent certainty that the unborn child will die if she [Mrs. Jefferson] attempts to have the child by vaginal delivery. There is a 99 to 100 percent chance that the child will live if the baby is delivered by Caesarean section . . . ." Id. at 459. Mrs. Jefferson, who refused to consent to the surgery because of her religious beliefs, apparently had her prayers answered because the placenta shifted and she delivered a healthy baby vaginally. See Around the Nation: Pregnant Woman Believes Prayers Obviated Cesarian, N.Y. Times, Jan. 26, 1981, at A12.

[80] 491 N.Y.S.2d 898 (N.Y. Sup. Ct. 1985).

[81] Id. at 899.

[82] See supra note 79.

[83] In re Jamaica Hosp., 491 N.Y.S.2d at 899-900.

the first time with a situation where all agreed that intervention on behalf of the fetus would have an adverse impact on the health of the pregnant woman.[84] In setting aside an order for a forced Cesarean, the court held that "a fetus cannot have rights in this respect superior to those of a person who has already been born."[85]

This case involved a pregnant woman, Angela Carder, who was dying of cancer. Her twenty-six-week-old fetus was given a chance of surviving, but only if it were delivered immediately. The trial judge ordered delivery by Cesarean section. The order was executed, but neither the woman nor the baby survived. The baby died within a few hours of surgery, and Ms. Carder expired two days later. Her parents appealed the trial judge's order because they said their daughter had not consented to the surgery. The appeals court agreed to retain jurisdiction "despite [the case's] apparent mootness," because "what occurred here is 'capable of repetition yet evading review.'"[86]

In addition, the family filed a civil suit against the hospital for damages. The court determined that, to the extent that the pregnant woman had objections to the surgery, those objections should not be overridden. It quoted from the *amicus* brief of the American Public Health Association:

> Rather than protecting the health of women and children, court-ordered caesareans erode the element of trust that permits a pregnant woman to communicate to her physician—without fear of reprisal—all information relevant to her proper diagnosis and treatment. An even more serious consequence of court-ordered intervention is that it drives women at high risk of complications during pregnancy and childbirth out of the health care system to avoid coerced treatment.[87]

The court also expressed its concern that pressing time constraints make it difficult for a pregnant woman to communicate with counsel and organize an "effective factual and legal presentation in defense of her liberty and privacy interest and bodily integrity."[88] The court relied on, among other cases, *Winston v. Lee*,[89] for the proposition that an individual has a right, stemming from an implicit right to bodily integrity, to accept or refuse

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[84] In re A.C., 573 A.2d 1235 (D.C. 1980).

[85] Id. at 1261.

[86] Id. at 1241, 1242 (citation omitted).

[87] Id. at 1247 n.16.

[88] Id. at 1247.

[89] 470 U.S. 753 (1985) (involving a robbery suspect who challenged the state's authority to compel him to submit to surgery for removal of a bullet lodged in his chest muscle).

medical treatment or other bodily invasions.

Allowing such an invasive procedure in this context flies in the face of developed law regarding patient autonomy and privacy.[90] This area of law has evolved precisely because of our regard for individual rights. A patient's right to refuse treatment, when based on a competent choice, is protected even if death will result.[91] This right has been recognized as one which is broad-based and extensive, applying to prisoners as well as to patients who have been involuntarily committed to mental institutions.[92]

Proponents of fetal rights might try to distinguish the above line of cases by pointing to the fact that none of them involved a risk to a third party. The fact remains, however, that there is no precedential authority compelling one person to submit to a medical procedure for the good of another, not even for children or family members.[93] A mother is not legally required to donate a kidney to her child who needs it, nor is an identical twin forced to donate bone marrow to her sibling. Treating pregnant women differently simply because of their pregnant status would result in subjugation of one human being to another. Moreover, it would result in an undue burden on a woman who exercises her constitutional right to bear a child. There are no guarantees that such conduct will result in perfect babies, nor should such a standard be sought in this manner.[94]

*In re A.C.* is particularly notable because the court correctly recognizes that forced treatment is likely to drive women at highest risk outside of the health care system.[95] Furthermore, the sorts of invasive intervention being sought are such as would not be allowed outside of the context of preg-

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[90] See Schloendorff v. Society of N.Y. Hosps., 105 N.E. 92, 93 (N.Y. 1914) ("Every human being of adult years and sound mind has a right to determine what shall be done with his own body . . . .").

[91] See, e.g., Cruzan v. Director of Mo. Dep't of Health, 497 U.S. 261 (1990); Bouvia v. Superior Court, 225 Cal. Rptr. 297 (Cal. Ct. App. 1986); Superintendent of Belchertown v. Saikewicz, 370 N.E.2d 417 (Mass. 1977); In re Conroy, 486 A.2d 1209 (N.J. 1989); In re Quinlan, 355 A.2d 647 (N.J. 1976), cert. denied, 429 U.S. 922 (1976).

[92] See Washington v. Harper, 494 U.S. 210 (1990); Mills v. Rogers, 457 U.S. 291 (1982).

[93] See Keeton et al., supra note 27 (indicating that even in cases of special relationships there is no obligation to render aid where to do so would endanger oneself); see also McFall v. Shimp, 10 Pa. D. & C.3d 90 (1978) (refusing to compel a man to donate bone marrow to his terminally ill cousin even though he was the only compatible donor).

[94] See generally Annas, supra note 77; Ruth Hubbard, Eugenics: New Tools, Old Ideas, 13 Women & Health 225 (1987); Sanda Rodgers, Fetal Rights and Maternal Rights: Is There a Conflict?, 1 Can. J. Women & L. 456 (1986); Christine Overall, Mother/Fetus/State Conflict, 9 Health Law in Canada 101 (1989).

[95] See supra text accompanying note 87.

nancy, even if the result were to save the life of another.[96]

If the physician intervenes out of a concern for his or her own liability by turning to the judicial system when there is a conflict, the doctor-patient relationship will be damaged. Also significant is the overwhelming impact of coercive intervention on poor women of color.[97] Initially, only anecdotal evidence indicated that poor and minority women were more likely to experience coercive intervention in their lives regarding reproductive choices. Recently, this evidence has been confirmed in several studies and law review articles.[98] One of these, an article in the New England Journal of Medicine, spoke to the bias in reporting of maternal drug use.[99] The author noted that although substance use was uniform along racial lines, African-American women were *ten times* more likely to be reported for substance abuse then were white women.[100] Women of color are also disproportionately victims of sterilization.[101] Low-income women are faced with restricted access to abortion further limiting their reproductive choices.[102] Professor Dorothy Roberts has written extensively about the devaluation of African-American women and the fact that women who are prosecuted or subjected to state intervention are overwhelmingly poor and black.[103] Deborah Krauss and Dwight Green have both noted the broad discretion of prosecutors in these matters and clear bias in prosecution.[104] Complicating the problem of disparate intervention is the problem of disparate access. Women of color are twice as likely as white women to

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[96] See George J. Annas, Forced Caesareans: The Most Unkindest Cut of All, Hastings Center Rep., June 1982, at 16; George J. Annas, She's Going To Die: The Case of Angela C., Hastings Center Rep., Feb.-Mar. 1982, at 23; Field, supra note 75; Caroline L. Kaufmann & Paul R. Williams, Fetal Surgery: The Social Implications of Medical and Surgical Treatment of the Unborn Child, 10 Women & Health 25 (1985).

[97] See supra note 10 and accompanying text.

[98] See Kolder et al., supra note 6; Nelson & Milliken, supra note 6.

[99] See Chasnoff et al., supra note 48.

[100] See id.

[101] See, e.g., Walker v. Pierce, 560 F.2d 609 (4th Cir. 1977), cert. denied, 434 U.S. 1075 (1977).

[102] See Harris v. McRae, 448 U.S. 297 (1980); Maher v. Roe, 432 U.S. 464 (1977).

[103] See Dorothy E. Roberts, Punishing Drug Addicts Who Have Babies: Women of Color, Equality, and the Right of Privacy, 104 Harv. L. Rev. 1419 (1991); see also Dorothy E. Roberts, The Bias in Drug Arrests of Pregnant Women, N.Y. Times, Aug. 11, 1990, at A25; Dorothy E. Roberts, Mother as Martyr, Essence, May 1991, at 140.

[104] See Dwight Green, Abusive Prosecutors: Gender Race & Class Discretion and the Prosecution of Drug Addicted Mothers, 39 Buff. L. Rev. 735 (1991); Deborah J. Krauss, Regulating Women's Bodies: The Adverse Effect of Fetal Theory on Childbirth Decisions and Women of Color, 26 Harv. C.R.-C.L. L. Rev. 523 (1991).

either receive no prenatal care or start care late in a pregnancy.[105] Not surprisingly they also have a greater risk of premature delivery, infant mortality, and death during pregnancy and delivery.[106] One does not have to be a lawyer or a law student to realize that decisions based on class and gender have resulted in discrimination and bias since this country's beginning. It is especially important that we are able to support our allegations and stress that such bias cannot be tolerated.

## V. RECOMMENDATIONS

It is critical that the model for positive prenatal care be that of the woman in consultation with her physician, making decisions that represent the best health care options for the woman and her fetus. Data indicate that when given relevant information, women will make appropriate choices regarding this care.[107] Physicians are "frequently impressed with the amount of personal health risk undertaken and voluntary self-restraint exhibited by the pregnant woman for the sake of her fetus and to help ensure that her child will be as healthy as possible."[108] Physicians have traditionally viewed themselves as advisors to their patients and this view should be encouraged. Doctors should not police women's medical choices.

Success of the model that I propose will depend upon the effective implementation of a program of information, education, and treatment, and upon an appreciation for children that equals that given to the fetus in utero. Both drug treatment and maternal-infant health programs have suffered substantial cutbacks in recent years.[109] This must be remedied. Primary access to treatment and health care, and availability of information in community-based settings can render much better results than coercive sanctions. Communication with both the pregnant woman and her support group (e.g., mate, family, church, community, and friends) are crucial.

In many urban areas where drug abuse is rampant, there are insuffi-

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[105] See Lorna McBarnette, Women and Poverty: The Effects on Reproductive Status, 12 Women & Health 55 (1988).

[106] See Dana Hughes et al., Maternal and Child Data Book 5, 42, 274 (Children's Defense Fund 1986).

[107] See Helene M. Cole, Legal Intervention During Pregnancy: Court-Ordered Medical Treatments and Legal Penalties for Potentially Harmful Behavior by Pregnant Women, 264 JAMA 2663 (1990); see also Nelson & Milliken, supra note 6.

[108] Cole, supra note 107, at 2663.

[109] For example, 54% of the 87 drug treatment programs in New York City refuse to treat pregnant women; 67% refuse to treat pregnant women on Medicaid; and 87% have no services available to treat pregnant women on Medicaid who are addicted to crack. See Wendy Chavkin, Help, Don't Jail, Addicted Mothers, N.Y. Times, July 18, 1989, at A21.

cient resources to care for drug-addicted infants, especially if they were to be removed from their homes and their mothers incarcerated. One must be concerned with the use of such coercive measures on a population that is largely indigent and disenfranchised. Such mothers deserve the same respect and treatment provided as a matter of course to their better-educated and more affluent counterparts. Studies show, however, that this is not always the case.[110]

Even with the most responsible and supportive programs in place, a small number of women may still make choices which could endanger their fetuses. In that small category of cases, the potential benefits to the fetus, the woman, and her family should be weighed against the risk and extent of the proposed intervention. Certainly, viability and the ability of the fetus to survive apart from its mother without extraordinary medical care strengthens its position when assessing a course of action.

The use of pre-birth or post-birth sanctions should be narrowly circumscribed. Such sanctions, in order to be effective, would have to infringe extensively on the personal liberty of the mother. Such interventions should be limited to circumstances where harm to the mother is minimal and the probability of serious, preventable harm to the baby is high. Specific recommendations made by the Board of Trustees for the American Medical Association are worthy of review. In a report from its section on law and medicine it adopted the following considerations:

> 1. Judicial intervention is inappropriate when a woman has made an informed refusal of a medical treatment designed to benefit her fetus.
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> If an exceptional circumstance could be found in which a medical treatment poses an insignificant or no health risk to the woman, entails a minimum invasion of her bodily integrity, and would clearly prevent substantial and irreversible harm to her fetus, it might be appropriate for a physician to seek judicial intervention. *However, the fundamental principle against compelled medical procedure should control in all cases that do not present such exceptional circumstances.*
>
> 2. The Physician's duty is to provide appropriate information, such that the pregnant woman may make an informed and thoughtful decision, not to dictate the woman's decision.
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> 3. A physician should not be liable for honoring a pregnant woman's informed refusal of medical treatment designed to

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[110] See, e.g., Kolder et al., supra note 6, at 1195; supra text accompanying note 6. See generally Nelson & Milliken, supra note 6.

benefit the fetus.

4. Criminal sanctions or civil liability for harmful behavior by the pregnant woman toward her fetus is inappropriate.

5. Pregnant substance abusers should be provided with rehabilitative treatment appropriate to their specific physiological and psychological needs.

6. To minimize the risk of legal action by a pregnant patient or an injured child or fetus, the physician should document medical recommendations made including the consequences of failure to comply with the physician's recommendations.[111]

These recommendations respect the autonomy of the patient while, at the same time, addressing the physician's concern for her potential legal liability. It remains to be seen whether these recommendations will result in some meaningful change in doctors' behavior when a conflict arises. They are at least a good place to begin addressing this issue in a more humanitarian and just way. Communication in a trusting environment, with mutual respect and recognition of cultural norms, can go a long way towards saving us from that slippery slope where women would be increasingly required to be models of maternal virtue.

Advances in microsurgery and medical technology that allow physicians to treat the fetus have the potential to result in diminished autonomy for the pregnant woman. Pregnant women are more often than not going to consent to treatment that will ensure the well-being of the fetus.[112] Access to information and communication is essential to that consent.

The child, the state, and the parent all have interests that are important and deserving of recognition. Balance and sensitivity are the hallmarks of my call for a paradigm which is neither strictly legal nor strictly medical. It would take the most innovative ideas from the law, medicine, ethics, and social services to develop a solution to this problem, one which ultimately affects us all.

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[111] Cole, supra note 107, at 2670 (emphasis added).

[112] Id. at 2663.