COMPELLING PREGNANCY AT DEATH'S DOOR

KATHERINE A. TAYLOR[*]

---

[*]Ph.D. candidate in philosophy, lecturer, Georgetown University; B.S. University of Texas; J.D. University of Texas School of Law. Preparation of this article was funded in part by grants from the Volkswagen Foundation to the Kennedy Institute of Ethics, Georgetown University, and the Institute of Philosophy, Ruhr University, Bochum, Germany. I am indebted to Robert Veatch and Hans-Martin Saas at the Kennedy Institute of Ethics for involving me in this project. For their ongoing encouragement and thoughtful comments on earlier drafts, I thank Mark Boulding, Alisa Carse, Margaret Little, Ronald Mann, Madison Powers, Margaret Taylor, and especially John Robertson. All opinions and conclusions are my own.

In December 1995, a nurse in a Rochester nursing home noticed that a 29 year old female patient had a swollen belly. It was later discovered that the woman was pregnant, though she had been in a coma for ten years. While her rapist has since been convicted, it was not only the rape itself that caught the nation's attention, but the decision by the comatose woman's parents to continue her pregnancy. The following March, a baby boy was born two months premature, and the woman's mother was awarded guardianship. Ethicists and others lined up on both sides of the controversy, some supporting the parents' decision, and others decrying the "almost grotesque" use of the woman's body as a fetal incubator.[1]

One ethicist observed that, "The case is beyond our imagination. Something like that would never even cross our minds. And, here it is."[2] But in fact, something "like that" *has* crossed the minds of legislators in most states. Thirty-six states mandate, through their advance directive statutes,[3] that an incompetent pregnant woman be kept alive under certain circumstances, despite her earlier wishes expressed in a living will, or, in many states, the wishes of her designated healthcare decisionmaker.[4]

Obviously, the notion of using a comatose pregnant woman's body to gestate a fetus is not as far-fetched as we might think. These "pregnancy restrictions" are far more disturbing than the Rochester case, however, because they completely disregard the advance wishes of the woman, or even the desires of her family or other proxy. Also deeply troubling is that the large majority of these restrictions legally compel the woman's continued medical treatment *regardless* of such critical factors as her own pain and suffering, the fetus's age, or its prognosis for either a live birth or a healthy life after birth.[5] In essence, the restrictions literally conscript the bodies of incompetent pregnant women to serve as fetal incubators for the state. Indeed, Pennsylvania recognizes that conscription by requiring that the state pay for

---

[1]*See* Laura Accinelli, Whose Life Is It Anyway?, L.A. Times, March 26, 1996, at E1 ("That [the woman] had no choice—much less knowledge—has made the case especially unsettling, almost grotesque."). *See infra* Part III.B.1 for further discussion of this case and the Ploch case, involving the medical sustenance of a brain-dead pregnant woman.

[2]Lisa Anderson, Comatose Woman, 29, Is Pregnant: Rape Case Creating an Ethical Nightmare, Chi. Trib., January 26, 1996, at N4.

[3]By "advance directive statutes," I mean those statutes that create the right to direct one's medical care in advance, either by executing a "living will" or another type of advance written declaration, or appointing a healthcare proxy decisionmaker such as a durable power of attorney, or both. An "advance directive" refers to these various types of healthcare directives.

[4]*See* Part I below for a summary of these statutes.

[5]*Id.*

the expense of the woman's life-prolonging treatment.[6] Connecticut apparently even bars pregnant women from executing a living will or appointing a healthcare proxy altogether, statutory rights it bestows on all other competent adults.[7]

The pregnancy restrictions raise a host of grave ethical and legal concerns that, surprisingly, have engendered no sustained critique by major theorists in bioethics and health law, though the restrictions have been the focus of traditional legal commentary concerning their questionable constitutionality.[8] Rather than being statutory artifacts that have yet to be removed from the books, these laws are of relatively recent vintage. Indeed, over the last two decades, the number of states enacting pregnancy restrictions has grown, and thus presumably the number of women directly affected by the restrictions.[9] Yet even if the restrictions have been invoked in few cases, their presence alone is an affront to all women, a deeply troubling and offensive reminder of how easily their most basic liberties may be traded away for purposes of political expediency.[10]

---

[6]PA. Cons. Stat. § 5414 (Supp. 1993) reads:

> In the event that treatment, nutrition and hydration are provided to a pregnant woman who is incompetent and has a terminal condition or who is permanently unconscious, notwithstanding the existence of a declaration or direction to the contrary, the Commonwealth shall pay all usual, customary and reasonable expenses directly and indirectly incurred by the pregnant woman to whom such treatment, nutrition and hydration are provided.

[7]Conn. Gen. Stat. Ann. § 19a-574 (West 1994). This provision states that several other sections of the advance directive statute "shall not apply to a pregnant patient," including the sections (§ 19a-575 and 575a) that authorize persons to execute written advance instructions for healthcare or appoint a healthcare agent. That a woman is pregnant when she executes an advance directive would, in most cases, be irrelevant to whether she is pregnant at the time her advance directive becomes operable, the critical time period in question. Such an overly broad, unnecessary restriction illustrates the extent to which the pregnant woman is considered a second class citizen by the state, one whose rights are made contingent on whether she is pregnant, as developed in Part III.

[8]*See infra* note 64.

[9]For example, it was not until 1989 that the Uniform Rights of the Terminally Ill Act rendered its pregnancy clause mandatory; the 1985 Act allowed the woman to decide for herself, in advance, whether to be kept alive for the fetus. *See infra* note 42.

[10]The pregnancy restrictions reportedly were included in state advance directive statutes as a concession to the right to life lobby and the Catholic Church, beginning with the first living will law adopted in California in 1976. *See* Henry R. Glick, The Right To Die: Policy Innovations and its Consequences (1992) at 96, 184. *See also*, Karen H. Rothenberg, Feminism, Law, and Bioethics, 6 Kennedy Inst. Ethics J. 69, at 78 (1996)(describing how members of the

In this article, I analyze these pregnancy restrictions from a pointedly feminist perspective, which the extant legal commentary on the restrictions largely neglects. My analysis is interdisciplinary, lying at the intersection of feminist trends in bioethics, philosophy, and the law. I argue for a paradigm shift in the ethical and legal analysis of the pregnancy restrictions (indeed for so-called "maternal/fetal conflict" scenarios in general). This requires a major change in emphasis from simply a traditional balancing of the rights of the individual woman and fetus, to a broader, contextual analysis that elucidates how the restrictions are part of, and reinforce, the subordination of women's moral and political agency to men's.[11] Accordingly, I shift my evaluation from a narrow "microscopic" focus on individual harms in Part II, to a

---

drafting committee of the current Maryland Health Care Decisions Act believed that the pregnancy restrictions included in the previous law might be "non-negotiable" with the Catholic Conference; the committee nevertheless ultimately struck the provision); Janet Gallagher, Fetus as Patient, from Sherrill Cohen and Nadine Taub, eds., Reproductive Laws in the 1990s, 194-195 (1989) (in a brief discussion of the restrictions, she strongly states:

> Legislators have a responsibility to resist attempts by single-issue fanatics to poison and distort every public policy discussion by forcing it into the abortion debate. In the DNR and living will contexts, the demands for pregnancy exceptions represent an attempt to hold pregnant women, their loved ones, and the legislative process itself hostage to the narrow ideological preoccupations of one interest group. The dilemmas and tragedies of individual patients are exploited as propaganda fodder in the anti-abortion campaign).

[11]In doing so, I hope to contribute to a more general paradigm shift in bioethics and health law, one that, as described by Susan Wolf, takes into account the broader contextual complexities of any particular ethical or legal issue rather than focusing on abstract principles or legal rules. Such a contextual analysis more readily notices, among other things, how certain ethical or legal policies fail to reflect the point of view of less powerful groups in our culture, and contribute to their subordinate status. *See* Wolf, Shifting Paradigms in Bioethics and Health Law: The Rise of a New Pragmatism, 20 Am. J. L. & Med. 395 (1994). Attention to the larger context of women's lives in our society has become an invaluable tool for feminist analysts in both bioethics and law who wish to restore women's point of view to our moral and legal discourse. *See, e.g., id.* at notes 58-74 and accompanying text (brief overview of the "gender-attentive" challenges to bioethical theory, and the feminists theorists that attempt to dramatically alter traditional bioethical analysis). *See generally* Martha Minow and Elizabeth V. Spelman, In Context, 63 S. Cal. Law Rev. 1597 (1990) (extensive review of various "contextualist" approaches).

While it is difficult (and often counterproductive) to cleanly classify feminist jurisprudence into different camps, my focus on the subordinative harms caused women as a group by the restrictions borrows much from the thinking of antisubordination feminist legal theorists exemplified by Catharine MacKinnon, Ruth Colker, Sylvia Law, Reva Siegel, and others. See Part III below.

"macroscopic" analysis in Part III of how the restrictions are just one of many systematic barriers that harm all women by enabling a subordinative culture.[12]

From this broader perspective, the pregnancy restrictions echo a disturbing legal and cultural trend in which pregnant women are no longer trusted to obey the dictates of the age-old ideology of "selfless motherhood." Having largely gained the ability to control their reproductive lives, and having ventured into the public spheres of work and political discourse never again to return *en masse* to the private domain of the home, women often are perceived as leaving behind their rightful roles as mothers and nurturers. At the same time, advances in prenatal medicine,[13] tort law recognizing causes of action on the fetus's behalf,[14] and anti-choice rhetoric, have personified the fetus to the point where it is viewed as a separate moral entity, indeed as an

---

[12]I borrow this "microscopic" and "macroscopic" terminology from Marilyn Frye, The Politics of Reality: Essays in Feminist Theory (1983) (arguing that women's oppression cannot be adequately noticed from a "microscopic" perspective that fails to notice the broader cultural context within which specific actions or policies take place, a context that only a more "macroscopic" view can accurately identify as oppressive to women. Frye uses the analogy of a birdcage to illustrate her point: While each wire of the cage does not, by itself, appear sufficient to keep the bird entrapped, when the cage is seen in its totality, one can then see how the bird is indeed encaged by a system of barriers. *Id.* at 4-7).

[13]Paradoxically, medical advances enabling better prenatal diagnosis and treatment of numerous maternal and fetal ills also provide an attractive and powerful rationale for states to coerce women to be selfless mothers. The mere existence of technology offering fetal benefit may be seized upon by the state as creating a new legal obligation of women to protect the fetus. A technological imperative ensues, whereby the use of technology that might benefit the fetus is no longer optional, but required. A telling example of this mind set is illustrated by a Washington Post editorial on mandatory prenatal HIV testing. In closing, the editorial states, "There was a reasonable argument for privacy [for women] before [AZT] treatment was available. It becomes less persuasive with every new scientific breakthrough." Wash. Post., Saturday, July 13, 1996, A18. In other words, the strength of pregnant women's right to privacy hinges on the status of medical science. *See also,* Margery W. Shaw, Conditional Prospective Rights of the Fetus, 5 J. Legal Med. 63 (1984), at 83 ("Several new medical discoveries have the potential of imposing on the woman a duty to act reasonably toward her fetus during early pregnancy."); John E. B. Meyers, Abuse and Neglect of the Unborn: Can the State Intervene?, 23 Duquesne L. Rev. 1 (1984), at 31 ("In an age when medicine can treat and cure the unborn child, society will not tolerate a complete vacuum of authority to provide care in compelling cases"). For discussion of the technological imperative as applied to pregnant women, *see generally, e.g.*, George Annas, Predicting the Future of Privacy in Pregnancy: How Medical Technology Affects the Legal Rights of Pregnant Women, 13 Nova L. Rev. 329 (1989); Barbara Katz Rothman, Recreating Motherhood: Ideology and Technology in a Patriarchal Society (1989); Lisa C. Ikemoto, The Code of Perfect Pregnancy: At the Intersection of the Ideology of Motherhood, the Practice of Defaulting to Science, and the Interventionist Mindset of the Law, 53 Ohio State L. J. 1205, at 1286-1295 (1992).

[14]*See infra* note 163.

independent person or patient despite its existence inside the mother's womb.[15]

A powerful (but false) analytical paradigm is thereby erected, pitting the woman's "selfish" interests against the "rights" of the fetus. Indeed, the rhetoric used often reduces pregnant women to objects—holding cells that entrap fetuses—as if fetuses were persons wrongfully deprived of their freedom by the necessary, but irksome, fact of gestation, and who therefore must be protected during their confinement.[16] Since pregnant women can no longer be trusted to remain selfless, because their bodies are "at war" with the fetus, the state steps in to regulate women's behavior accordingly.[17]

While echoing these trends, however, the underlying justification for the pregnancy restrictions differs in a very important sense from that often offered in support of other "fetal protection" policies. Many who argue for the legal protection of fetal interests, such as in the paradigmatic case of drug-abusing pregnant women, urge not that the fetus itself has interests that deserve legal protection (at least not before viability), but rather that the child the fetus will become has such interests. Thus, the argument goes, if the fetus likely will become a child because the woman chooses not to abort it, then the "child yet to be born" is a being deserving of moral recognition, and in many cases prenatal legal protection.[18] The pregnancy restrictions, however, do not

---

[15]*See, e.g.*, Asim Kurjak and Frank A. Chervenak, The Fetus as Patient (1994) ("[Fetal medicine is increasingly in the position to do for the fetus what other medical fields offer to other patients...In other words, the fetus seems just as much a patient as any other individual, save for its being *in utero*." *Id.* at 3; *See also, e.g.*, Rothman, *supra* note 13 (especially chapter entitled "Fetal Power"); Cynthia R. Daniels, At Women's Expense: State Power and the Politics of Fetal Rights (1993) (especially the Introduction and Chapter 1, "Fetal Animation: The Political and Cultural Emergence of Fetal Rights."); Gallagher, *supra* note 10.

[16]For example, a recent law review article discussing the advisability of forced cesarean sections is entitled "The Maternal Abdominal Wall: A Fortress Against Fetal Health Care," thereby reducing the woman to a body part that in essence is a fortress holding the fetus prisoner. *See* Jeffrey P. Phelan, article of same title, 65 S. Cal. L. Rev. 461 (1991). Phelan and others likewise describe the fetus as being "captive" in the mother's body. *Id.* at 485 ("Should the potentially viable fetus remain a captive in the woman's body?"); *See, e.g.* dissent in In re A.C., 573 A.2d 1235 (D.C. 1990) (*en banc*), at 1256 ("[T]he viable unborn child is literally captive within the mother's body.") *See generally,* Gallagher, *supra* note 10, at 189 (noting Bernard Nathanson's description of the fetus as "a creature bricked in, as it were, behind what seemed an impenetrable wall of flesh, muscle, bone and blood," citing Nathanson, The Abortion Papers (1983), at 119).

[17]*See, e.g.*, Daniels, *supra* note 15, at 2- 5.

[18]In essence, this argument asserts that when a woman decides not to exercise her procreative liberty to abort the nonviable fetus, she waives her interest in protecting her bodily integrity during the course of her pregnancy, thus allowing the state to assert an interest in the

protect the fetus as a "child yet to be born," as a fetus that the woman has decided to carry to term. Rather, they protect the fetus *qua* fetus. By forcing the pregnant woman to stay alive as a fetal incubator, the restrictions in essence accord the fetus a *right* to be born, most even before fetal viability.[19]

In this respect, the pregnancy restrictions share more in common with forced cesareans[20] than with other fetal protection scenarios where the life of the fetus is not necessarily at stake (e.g., punishing drug-abusing pregnant women, or forcing pregnant women to undergo medical treatment not necessary to save the fetus's life). Both raise the central question: Should pregnant women be forced to undergo medical interventions intended to save the life of the fetus? Yet the pregnancy restrictions differ from mandated cesareans in two important ways. First, unlike a court-ordered cesarean, most restrictions compel the mother to prolong her life artificially, with the assistance of potentially invasive medical care, for the sake of the fetus *before viability*.[21] Second, the restrictions compel a more blatant and disturbing technological coercion of pregnant women than do forced cesareans. Rather than requiring one, albeit quite intrusive, medical procedure to save the fetus, the pregnancy restrictions reduce incompetent pregnant women to "host" bodies that potentially must withstand the sustained bodily invasion of medical technology to stay alive, even from the earliest stages of pregnancy.[22]

---

life of the "child yet to be born" sufficient to require her to receive medical treatment on its behalf. *See, e.g.*, John A. Robertson, Procreative Liberty and the Control of Conception, Pregnancy, and Childbirth, 69 Va. L. Rev. 405 (1983), at 437-438 [hereinafter Robertson, Procreative Liberty], and Children of Choice: Freedom and the New Reproductive Technologies (1994), at 176-177 [hereinafter Robertson, Children of Choice]; Deborah Mathieu, Preventing Prenatal Harm (1996), at 51; Shaw, *supra* note 13. More accurately called the "forfeiture" argument since the woman obviously has not knowingly and voluntarily relinquished her rights once she has decided to remain pregnant (*see* Joan C. Callahan, James W. Knight, Women, Fetuses, Medicine, and the Law, from Feminist Perspectives in Medical Ethics (Helen Bequaert Holmes & Laura M. Purdy, eds., 1992), this argument is seriously flawed in several respects, not the least of which is that it ignores the pervasive legal and social obstacles many women face in obtaining an abortion. For criticisms, *see, e.g., id.*; Annas, *supra* note 13; Gallagher, *supra* note 10, at 198-203; Daniels, *supra* note 15, at 24-25. *See infra* notes 108, 171 and accompanying text for further discussion of the "waiver" argument as applied to other specific contexts.

[19]*See infra* notes 157 -159 and accompanying text.

[20]*See* Part II. B. below. *See generally*, Eric M. Levine, Comment, The Constitutionality of Court-Ordered Cesarean Surgery: a Threshold Question, 4 Alb. L. J. Sci. & Tech. 229 (1994) for a survey of the forced cesarean legal literature.

[21]*See infra* notes 43, 54-57, 61-63 and accompanying text.

[22]*Id.*

In short, the states conscript women's bodies not to perform an isolated medical procedure such as a cesarean, but to serve as a sort of medical device necessary for the prolonged gestation, or forced rescue, of the fetus.[23]

A policy that so radically objectifies the incompetent pregnant woman renders her interests almost invisible. Here, I try to make the pregnant woman, and indeed all women, more visible. By emphasizing the harms wrought by the pregnancy restrictions on both individual women and women as a group, I attempt to restore women's neglected perspective to the debate. Part I summarizes the various types of pregnancy restrictions at issue. Part II offers a conventional substantive due process analysis that narrowly focuses on harms caused individual women by the restrictions' derogation of women's medical decisional authority. There, I clarify the woman's liberty interests violated by the restrictions, and conclude, first, that restrictions effective before fetal viability are, in most cases, patently unconstitutional. Second, and contrary to the views of others who have examined the question, I argue that the restrictions are of questionable constitutionality even as applied to women pregnant with viable fetuses. Finally, Part III analyzes, under a feminist equal protection approach, how the pregnancy restrictions are inextricably tied to the historical and continued subordination of all women, such as by according them secondary status as both moral actors and citizens. I conclude that if these larger, subordinative harms to all women are fairly taken into account, the restrictions should not be constitutionally justified.

PART I. THE PREGNANCY RESTRICTIONS

As noted, the advance directive statutes of thirty-six states require that life-prolonging medical care not be withheld or withdrawn from an incompetent pregnant woman, regardless of her own wishes previously expressed in a living will, or, in many states, the wishes of her designated proxy decisionmaker.[24] These pregnancy restrictions vary as to their exact phrasing and triggering conditions, as developed below.

The two basic forms of pregnancy restrictions track the two mechanisms through which states give effect to persons' interest in directing their medical treatment in advance: the execution of a living will or other type of written

---

[23]This is not to say that court-mandated cesareans are ever justified. *See infra* notes 127-132, 165-169 and accompanying text.

[24]*See* Sections A and B below.

declaration,[25] and the designation of a healthcare proxy decisionmaker.[26] Accordingly, as discussed in Section A, statutory "living will restrictions" effectively preclude the implementation of a woman's advance wishes, specified in a living will or other declaration, concerning whether she should be kept alive for the purpose of gestating her fetus. Further, state "proxy restrictions" prohibit the incompetent pregnant woman's designated healthcare proxy from discontinuing her medical treatment, as explained in Section B.1; some states also similarly limit surrogate decisionmakers designated by statute, as noted in Section B.2.

At the outset, it is critical to note that the pregnancy restrictions are coercive in both intent and effect, despite most advance directive statutes' disclaimer of any intent to impair or supersede a person's existing legal rights to refuse medical treatment.[27] The woman's existing common law rights in this area are murky at best, since there are no cases directly addressing whether pregnant women must be kept alive to sustain the fetus in this scenario; indeed, only two cases even indirectly address the pregnancy restrictions.[28]

The restrictions clearly are coercive in intent, since their language is mandatory.[29] The coercive effect of the restrictions is manifestly obvious. The ability of competent women to learn of and enforce any legal rights they may have in this circumstance is severely compromised. Many women who

---

[25]Forty-eight jurisdictions authorize living wills or other advance written instructions for healthcare; only Massachusetts, Michigan, and New York have no such statute. *See* Timothy J. Burch, Incubator or Individual?: The Legal and Policy Deficiencies of Pregnancy Clauses in Living Will and Advance Health Care Directive Statutes, 54 Md. L. Rev. 528 (1995), for a discussion of the different types of state advance instruction statutes.

[26]Forty-nine jurisdictions authorize the appointment of such proxy decisionmakers. *See infra* note 49. Alabama and Alaska do not provide for healthcare agents. These proxy provisions vary state to state. Most states allow for the appointment of a durable power of attorney for healthcare (DPA), in a provision separate from their living will statute. Some states have enacted integrated statutes providing for both the execution of specific advance instructions, and the appointment of a DPA. Several states also specify various family members as surrogate decisionmakers who are authorized to make healthcare decisions for a patient even in absence of a living will or formally appointed proxy. *See* Burch, *supra* note 25, at 532-535, for more in-depth discussion of proxy and surrogate statutes.

[27]*See, e.g.*, Ga. Code Ann. § 31-32-11(a) (1991) ("Nothing in this chapter shall impair or supersede any legal right or legal responsibility which any person may have to effect the withholding or withdrawal of life-sustaining treatment procedures in any lawful manner. In such respect, the provisions of this chapter are cumulative").

[28]*See* infra notes 31, 35.

[29]*See infra* notes 39, 41, and accompanying text.

execute an advance directive likely are unaware that a pregnancy restriction even exists in their state, since the model living will and proxy appointment forms in many states make absolutely no mention of a pregnancy restriction. Instead, the restriction is hidden in another section of the statute, to remain unread by most, if not all, laypersons.[30] And the rare woman who is aware of her state's pregnancy restriction cannot rely on the courts to vindicate her common law or constitutional rights to discontinue medical treatment before she becomes helpless to enforce them.[31]

In the unlikely case that the woman does express her advance wishes in this regard, once she becomes incompetent, caregivers usually will take the legal legitimacy of the pregnancy restriction at face value.[32] Given both the

---

[30]Among others states, Alabama, Colorado, Georgia, Minnesota, and Oklahoma make no mention of their living will restriction in the model living will form that most women presumably use. *See infra* note 39 for statutory citations. The deceptiveness of these restrictions is compounded by the fact that when women of childbearing age are informed of their ostensible right to execute an advance directive pursuant to the requirements of the federal Patient Self-Determination Act, they likely are not told that their right to discontinue medical treatment in fact is conditional. See 42 U.S.C. 1395-1396 (Supp. 1991). (The act requires hospitals receiving Medicaid or Medicare funds to establish policies that will ensure that adults receiving hospital care are informed of their right to direct their medical care under the advance directive laws of their state).

[31]In DiNino v. Washington *ex rel.* Gorton, No. 80-2-00266-0 (King Co. Super. Ct. 1982), *rev'd en banc*, 684 P. 2d 1297 (1984), a woman of child-bearing age attempted to execute an advance directive to the effect that she would not wish life-sustaining treatment even if she were pregnant, but her physician would not include the directive in her medical file, fearing liability in light of the state's pregnancy restriction. The woman and her physician filed an action for declaratory judgment that the pregnancy restriction was unconstitutional because it applied before fetal viability. While the lower court held the restriction constitutional if applied after fetal viability, the Washington Supreme Court evaded the constitutional issue by holding that the controversy was not justiciable because the woman was neither pregnant nor terminally ill. *See also* James M. Jordan III, Note, Incubating for the State: The Precarious Autonomy of Persistently Vegetative and Brain-Dead Pregnant Women, 22 Ga. L. Rev. 1103 (1988), at note 212.

[32]Caregivers often mistakenly believe that their state's advance directive statute comprehensively articulates the full extent of patients' legal right to refuse life-prolonging medical treatment. For instance, healthcare providers often erroneously conclude that a living will statute that expressly applies only to patients who are terminally ill precludes the implementation of advance directives that also cover the permanently unconscious, or that a healthcare surrogate law that covers only the terminally ill prevents surrogates from legally consenting to treatment termination under other circumstances. *See, e.g.*, David Orentlicher, The Limitations of Legislation, 53 Md. L. Rev. 1255 (1994) (discussing these and other ways in which the language of advance directive statutes may mislead healthcare providers about the extent of a patient's legal rights).

interventionist mind set of medicine[33] and fears of legal liability,[34] the restrictions virtually ensure that healthcare providers would refuse to terminate the life-sustaining treatment of an incompetent pregnant woman, despite either her advance wishes or the desires of her proxy, except under court order. Aside from the fact that very few families would have the financial resources, legal sophistication, or perseverance to pursue a court order, even the courts are not necessarily a reliable forum for vindicating the woman's common law or constitutional rights.[35]

A. Living Will Restrictions

Thirty-four of the 48 jurisdictions that authorize advance healthcare instructions mandate, at least under some conditions, the continued medical treatment of a pregnant woman who otherwise qualifies as a candidate for the

---

[33]*See, e.g.*, the results of the recently-completed "SUPPORT" study finding that physicians too often are either unaware of their patient's wishes at the end of life, or aggressively treat the patient despite their wishes to the contrary. A Controlled Trial to Improve Care for Seriously Ill Hospitalized Patients: The Study to Understand Prognoses and Preferences for Outcomes and Risks of Treatments (SUPPORT), 274 JAMA 1591 (1995). For discussion of this study, *see* articles at Special Supplement, Dying Well in the Hospital: The Lessons of SUPPORT, Hastings Ctr. Rep., Nov.-Dec. 1995, Special Supplement, at S-S36. *See also,* Nancy K. Rhoden, The Judge in the Delivery Room: The Emergence of Court-Ordered Cesareans, 74 Cal. L. Rev. 1951 (1986), at 1979-1980 (discussing interventionist mind set of physicians in the context of the forced cesarean dilemma).

[34]Most states likely would not extend legal immunity to physicians who comply with the directive of a pregnant patient in contravention of a pregnancy restriction, since physicians usually enjoy immunity only if they have attempted, in good faith, to meet the statutory requirements. *See, e.g.*, Conn. Gen. Stat. Ann. § 19A-571 (West 1994). In fact, healthcare providers' fears of potential liability may cause them to thwart a competent woman's attempts to even *execute* a directive that apparently is inconsistent with the pregnancy restrictions. *See* DiNino, *supra* note 31. *See generally*, S. Van McCrary, Jeffrey W. Swanson, et al., Treatment Decisions for Terminally Ill Patients: Physicians' Legal Defensiveness and Knowledge of Medical Law, 20 Law, Med. & Health Care 364 (1992).

[35]For instance, a Georgia court, holding that a brain dead pregnant woman must be sustained on life support in order to keep her fetus alive, relied on Georgia's pregnancy restriction for the proposition that "the legislature has specifically provided that the patient cannot make the decision [to terminate treatment] if it will affect an unborn child," without even mentioning the cumulative effect of Georgia's advance directive statute. *See* University Health Services, Inc. v. Piazzi, No. CV86-RCCV-464 (Super. Ct. of Richmond County, Ga., Aug. 4, 1986).

cessation of treatment.[36] Only Arizona, Georgia, Maryland, and New Jersey expressly allow a woman to choose in advance whether to prolong her life in order to keep the fetus alive, though Georgia allows her to refuse further treatment only before fetal viability.[37]

There are two basic approaches to these living will restrictions. Most obliquely instruct that the declaration of a qualified patient "shall have no force or effect" during the course of her pregnancy (at times subject to certain other conditions such as fetal viability and prognosis)[38], either in a separate statutory clause, the living will form, or both.[39] In effect, by suspending the woman's advance directive no matter what its content, these more indirect restrictions compel prolonging the woman's life regardless of what her wishes might be.[40]

---

[36]*See infra* notes 39, 41. Ten states (Florida, Louisiana, Maine, New Mexico, North Carolina, Oregon, Tennessee, Vermont, Virginia, and West Virginia) and the District of Columbia do not address the circumstance of pregnancy in their living will statute. Three states (Massachusetts, Michigan, and New York) have no living will statute.

[37]Ariz. Rev. Stat. Ann. §36-3262 (Supp. 1993); Ga. Code Ann. §§ 31-32-3(b)(5) and 31-32-8(a)(1) (1991 and Supp. 1994); Md. Code Ann., Health-Gen, § 5-603 (1994); N.J. Stat. Ann. § 26:2H-56 (West Supp. 1994).

[38]*See, e.g., infra* notes 43-47 and accompanying text.

[39]Ala. Code § 22-8A-4(a) (1990); Alaska Stat. § 18.12.040(c) (1993); Ark. Code. Ann. § 20-17-206(c) (Michie Supp. 1989); Cal. Health & Safety Code §§ 7186.5(b) and 7189.5(c) (West Supp. 1994); Colo. Rev. Stat. § 15-18-104(2) (1989); Conn. Gen. Stat. Ann. § 19a-574 (West 1994); Del. Code Ann. Tit. 16, § 2503(d) (1983); Ga. Code Ann. §§ 31-32-3(b)(5) and 31-32-8(a)(1) (1991 and Supp. 1994); Haw. Rev. Stat. § 327D-6 (1991 & Supp. 1993); Idaho Code § 39-4504(4) (1993); 755 Ill. Comp. Stat 35/3(c) (Smith-Hurd 1992); Ind. Code Ann. § 16-36-4-8(d) (Burns 1993 & Supp. 1994); Iowa Code Ann. § 144A.6(2) (West 1989); Kan. Stat. Ann. § 65-28,103(a) (1992); Minn. Stat. Ann. §145B.13(3) (West Supp. 1994); Mo. Ann. Stat. § 459.025 (Vernon 1992); Okla. Stat. Ann. Tit. 63, § 3101.4(B)(IV)(a) and § 3101.8(c) (West Supp. 1994); R.I. Gen. Laws § 23-4.11-6(c) (Supp. 1993); S.C. Code Ann. § 44-77-70 (Law Co-op. Supp. 1993); Utah Code Ann. §75-2-1109 (1993); Wash. Rev. Code Ann. § 70.122.030(1)(d) (West 1992 & Supp. 1994); Wis. Stat. Ann. § 154.07(2) (West 1989 & Supp. 1992); Wyo. Stat. § 35-22-102(b) (1994).

[40]It is excessively charitable to interpret these "suspending" restrictions, as some do, to have the worthy intent of protecting against the inadvertent cessation of a pregnancy that the woman did not anticipate in her advance declaration, since other more explicit approaches easily could have been followed. *See, e.g.*, Jordan, *supra* note 31, at 1151. For instance, these states could have included a clause in the sample declaration form, as have a few states, asking that the woman specify whether she would want treatment discontinued if she were pregnant, or could have made clear, as did the Uniform Rights of Terminally Ill Act of 1985, that a woman's declaration should be suspended *only* if it is silent as to her wishes in the event of her pregnancy. *See supra* note 37, and *infra* note 42.

In contrast, many other living will restrictions, as well as the Uniform Rights of the Terminally Ill Act (URTIA) of 1989, explicitly mandate the continued treatment of the incompetent, pregnant declarant, regardless of what her living will might direct.[41] The 1989 URTIA illustrates the nonconsensual nature of these provisions:

> Life-sustaining treatment *must not be withheld or withdrawn* pursuant to a declaration from an individual known to the attending physician to be pregnant so long as it is probable that the fetus will develop to the point of live birth with continued application of life-sustaining treatment.[42]

The living will restrictions vary as to triggering conditions. Almost half (including those enacted in the populous states of California and Texas) are silent as to fetal viability or prognosis, thus requiring the incompetent pregnant woman to remain alive to sustain the fetus *even before it is viable, and even if its prognosis for live birth is slim.*[43] Only two states, Georgia and

---

[41]Ky. Rev. Stat. Ann. § 311.629(4) (Michie 1994); Mont. Code Ann. § 50-9-202(3) (1993); Neb. Rev. Stat. § 20-408(3) (Supp. 1993); Nev. Rev. Stat. Ann. § 449.624(4) (1991); N.H. Rev. Stat. Ann. § 137-H:14(I) (Supp. 1992); N.D. Cent. Code § 23-06.4-07(3) (1991 and Supp. 1993); Ohio Rev. Code Ann. § 2133.06(B) (Anderson 1994); 20 Pa. Cons. Stat. § 5414(A) (Supp. 1993); R.I. Gen. Laws § 23-4.11-6(c) (Supp. 1993); S.D. Codified Laws Ann. § 34-12D-10 (1994); Tx. Health & Safety Code Ann. § 672.019 (West 1992 and Supp.1994). *See also* Uniform Rights of the Terminally Ill Act § 6(c) (1989).

[42]Uniform Rights of the Terminally Ill Act § 6(c) (1989) (emphasis added). This 1989 URTIA illustrates that the restrictions clearly are not merely an unintended throwback to less enlightened times, since it amended the original 1985 URTIA to *prohibit* the woman from expressing her wishes to the contrary. The 1985 URTIA included a clause identical to the one above, with the introductory phrase "Unless the declaration otherwise provides." Uniform Rights of the Terminally Ill Act, § 6(c) (1985). Thus, the original intent was to suspend the woman's declaration only if it was silent as to her wishes in the event of her pregnancy. The most recent URTIA was supplanted in 1993 by the Uniform Health Care Decisions Act, which contains no provision concerning the status of pregnant incompetent patients, and thus presumably would allow women the advance decisional authority over that circumstance. *See* Uniform Health Care Decisions Act (1993). Most states obviously have not chosen to follow this more lenient model. This approach is not ideal, however, since the absence of explicit direction would still create confusion as to whether the pregnant woman should be treated.

[43]*See* Ala. Code § 22-8A-4(a) (1990); Cal. Health & Safety Code §§ 7186.5(b) and 7189.5(c) (West Supp. 1994); Conn. Gen. Stat. Ann. § 19a-574 (West 1994); Del. Code Ann. Tit. 16, § 2503(d) (1983); Haw. Rev . Stat. §327D-6 (1991 & Supp. 1993); Idaho Code § 39-4504(4) (1993); Ind. Code Ann. § 16-36-4-8(d) (Burns 1993 & Supp. 1994); Kan. Stat. Ann. § 65-28,103(a) (1992); Miss. Code Ann. § 41-41-107(1) (1993); Mo. Ann. Stat. § 459.025 (Vernon 1992); N.H. Rev. Stat. Ann. § 137-H:14(I) (Supp. 1992); Okla. Stat. Ann. Tit. 63, §§ 3101.4(B)(IV)(a) and 3101.8(c) (West. Supp. 1994); S.C. Code Ann. § 44-77-70 (Law Co-op. Supp. 1993); Tx. Health & Safety Code Ann. § 672.019 (West 1992 and Supp. 1994); Utah Code Ann. §75-2-1109 (1993); Wash. Rev. Code Ann. § 70.122.030(1)(d) (West 1992 & Supp.

Colorado, compel continued treatment only once the fetus is viable.[44] The remaining states mandate further treatment depending on fetal prognosis for live birth, such as whether live birth would be "probable"[45] or "possible"[46] with the continued medical intervention[47]; presumably these states also would, in many cases, require sustaining the woman's life even before fetal viability. Significantly, no living will restriction considers the newborn's prognosis or quality of life *after* birth, though it is quite conceivable that the mandated treatment could seriously and permanently impair the fetus.

Finally, it is crucial to note that almost all states with living will restrictions require delaying the incompetent pregnant woman's death *regardless of whether the medical treatment, the woman's underlying condition, or the pregnancy itself causes her serious pain and suffering.* Only four states out of the 34 with living will restrictions expressly allow treatment to be withheld or withdrawn from a pregnant woman if the continued treatment will be "physically harmful to her, or will prolong severe pain that cannot be alleviated by medication."[48]

1994); Wis. Stat. Ann. § 154.07(2) (West 1989 & Supp. 1992); Wyo. Stat. § 35-22-102(b) (1994). Indeed, Arizona's non-mandatory living will form expressly envisions the continuation of treatment for an "embryo." *See supra* note 37 for statutory citation. Part II below discusses the likely unconstitutionality of restrictions effective before fetal viability.

[44]Colo. Rev. Stat. 15-18-104(2) (1989); Ga. Code Ann. § § 31-32-3(b)(5) and 31-32-8(a)(1) (1991 and Supp. 1994). Colorado also requires continued treatment if the fetus could "with a reasonable degree of medical certainty develop to live birth."

[45]Alaska Stat. § 18.12.040(c) (1993); Mont. Code Ann. § 50-9-202(3) (1993); Neb. Rev. Stat. § 20-408(3) (Supp. 1993) Nev. Rev. Stat. Ann. § 449.624(4) (1991); R.I. Gen. Laws § 23-4.11-6(c) (Supp. 1993). *See* also above discussion for text of URTIA of 1989.

[46]Ark. Code Ann. § 20-17-206(c) (Michie Supp. 1989); 755 Ill. Ann. Stat. 35/3(c) (Smith-Hurd 1992); Iowa Code Ann. § 144A.6(2) (West 1989); Minn. Stat. Ann. § 145B.13(3) (West Supp. 1994).

[47]A few states impose the more onerous condition that the woman be kept alive unless the fetus would not be born alive under a reasonable degree of medical certainty, though most of these states also include a provision that allows termination of treatment if the woman is in severe, untreatable pain, as discussed below. *See* Ky. Rev. Stat. Ann. § 311.629(4) (Michie 1994); N.D. Cent. Code § 23-06.4—07(3) (1991 and Supp. 1993); Ohio Rev. Code Ann. § 2133.06(B) (Anderson 1994); 20 Pa. Cons. Stat. § 5414(A) (Supp. 1993); S.D. Codified Laws Ann.§ 34-12D-10 (1994).

[48]Ky. Rev. Stat. Ann. § 311.629(4) (Michie 1994); N.D. Cent. Code § 23-06.4-07(3) (1991 and Supp. 1993); 20 Pa. Cons. Stat. § 5414(A) (Supp. 1993); S.D. Codified Laws Ann. § 34-12D-10 (1994).

B. Proxy and Statutory Surrogate Restrictions

1. Proxy Restrictions

Sixteen of the 49 jurisdictions that provide for the designation of a healthcare proxy decisionmaker[49] expressly prohibit the woman's appointed proxy from deciding to cease her further treatment if she is pregnant, under certain triggering conditions.[50] Further, in those states with no proxy restriction but with living will restrictions, the same result usually would be indirectly reached, since states often prohibit appointed proxies from making any decision the woman herself may not make.[51] Only four states expressly allow the proxy to withhold or withdraw life-sustaining treatment from an incompetent pregnant woman, and one of those authorizations (Florida) is quite restrictive.[52]

---

[49]Only Alabama and Alaska do not authorize such procedures; the remaining 48 states and the District of Columbia do so provide. *See* Choice in Dying, Chart, Pregnancy Restrictions in Statutes Authorizing Health Care Agents (1994). Of these 49 jurisdictions, 46 also authorize living wills (only Michigan, Massachusetts, and New York, all states that allow for designated proxies, do not have living will laws). *See supra* note 36.

[50]Ark. Code Ann. § 20-17-206(c) (Michie Supp 1989); Fla. Stat. Ann. § 765.113(2) (West 1986); Iowa Code Ann. § 144A.7(3) (West 1989); Ky. Rev. Stat. Ann. § 311.629(4) (Michie 1994); Mich. Comp. Laws Ann. §§ 700.496(7)(c), 700.496(9)(d), 700.496(17); Minn. Stat. Ann. 145B.13(3) (Supp. 1993); Mont. Code Ann. § 50-9-106(6) (1993); Neb. Rev. Stat. § 30-3417(1)(b) (Supp. 1993); N.H. Rev. Stat. Ann. § 137-J:2(V)(c) (Supp. 1992); Ohio Rev. Code Ann. § 1337.13(D) (Anderson 1994); Okla. Stat. Ann. Tit. 63, §3101.8(c) (West Supp. 1994); 20 Pa. Cons. Stat. § 5414(A) (Supp. 1993); R.I. Gen Laws § 23-4.10-5(c) (Supp. 1993); S.C. Code Ann. § 62-5-504(G) (Law Co-op Supp. 1993); S.D. Codified Laws Ann. § 59-7-2.8 (1994); Utah Code Ann. §75-2-1109 (1993).

All of these 16 states, except for Florida and Michigan, also have living will restrictions (Michigan has no living will law). Most of the 14 states with both living will and proxy restrictions impose consistent conditions for both types of restrictions, with some exceptions. For example, New Hampshire's living will restriction applies throughout pregnancy, but its proxy restriction is more lenient, since it does not apply if the fetus would not be born alive to a reasonable degree of medical certainty, or if the woman is harmed by the treatment or suffers severe, prolonged pain. N.H. Rev. Stat. Ann. §137-J:2(V)(c) (Supp. 1992). Similarly, Wisconsin expressly allows a healthcare agent to make any decision the declarant authorizes in the case of her pregnancy, but restricts the woman herself from making such a decision in advance, by completely suspending her living will if she is pregnant. Wis. Stat. Ann. § 155.20(6) (Supp. 1993).

[51]*See, e.g.*, Cal. Probate Code § 4720(b) (West Supp. 1994).

[52]Fla. Stat. Ann. § 765.113(2) (West 1986); Md. Code Ann., Health-Gen., § 5-603 (1994); N.J. Stat. Ann. § 26:2H-58(5) (West Supp. 1994); Wis. Stat. Ann. § 155.20(6) (Supp. 1993). Florida's proxy allowance only applies before viability, and also only when that authority is

While most proxy restrictions narrowly prohibit the proxy from making the specific decision to withhold or withdraw treatment from the pregnant woman, several states go so far as to suspend the woman's proxy appointment altogether during pregnancy, thus discontinuing the proxy's legal authority to make any type of decision concerning her medical care.[53] These states therefore leave the woman in a decisional limbo with no legal proxy, presumably allowing her healthcare providers to control all aspects of her medical care.

All proxy restrictions conceivably could compel medical treatment before fetal viability, despite the proxy's wishes. While a few proxy restrictions are silent as to fetal viability,[54] most restrict the proxy from discontinuing medical treatment only if the fetus "could" be born alive with continued treatment,[55] or if live birth is "probable."[56] These latter restrictions could also apply before fetal viability depending on the medical condition of the mother or fetus.[57]

Like the living will restrictions, absolutely no proxy restriction takes into account the infant's prognosis after birth, or the possibility that it could be permanently impaired by the mandated interventions. And importantly, only

---

expressly delegated in the proxy appointment, or judicial permission is obtained. The other states impose no such restrictions.

[53]Ark. Code Ann. § 20-17-206(c) (Michie Supp 1989); Minn. Stat. Ann. 145B.13(3) (Supp. 1993); Okla. Stat. Ann. Tit. 63, §3101.8(c) (West Supp. 1994); R.I. Gen. Laws § 23-4.10-5(c) (Supp. 1993); Utah Code Ann. §75-2-1109 (1993). In all of these states but Rhode Island, the woman's declaration is suspended during pregnancy, and the proxy appointment therefore also is indirectly suspended because it is included in her declaration. Rhode Island, on the other hand, expressly suspends the proxy appointment altogether during pregnancy, as long as it is probable that the fetus could develop to live birth.

[54]Mich. Comp. Laws Ann. § 700.496(7)(c) (West Supp. 1994); Okla. Stat. Ann. Tit. 63, § 3101.8(c) (West Supp. 1994); S.C. Code Ann. § 62-5-504(G) (Law Co-op Supp. 1993); Utah Code Ann. § 75-2-1109 (1993).

[55]Ark. Code Ann. § 20-17-206(c) (Michie Supp. 1989); Iowa Code Ann. § 144A.7(3) (West 1989); Minn. Stat. Ann. 145B.13(3) (Supp. 1993).

[56]Mont. Code Ann. § 50-9-106(6) (1993); Neb. Rev. Stat. § 30-3417(1)(b) (Supp. 1993); R.I. Gen. Laws § 23-4.10-5(c) (Supp. 1993). Others generally require that the woman be kept alive unless the fetus would not be born alive, to a reasonable degree of medical certainty (though most of these states also have pain provisions). *See* Ky. Rev. Stat. Ann. § 311.629(4) (Michie 1994); Ohio Rev. Code Ann. § 1337.13(D) (Anderson 1994); N.H. Rev. Stat. Ann. § 137-J:2(V)(c) (Supp. 1992); 20 Pa. Cons. Stat. § 5414(A)(1) (Supp. 1993); S.D. Codified Laws Ann. § 59-7-2.8 (1994).

[57]Florida's proxy restriction applies before fetal viability unless the woman has directed otherwise, or judicial permission is obtained. *See supra* note 52.

four states with proxy restrictions allow the woman to die if continued treatment would cause her serious pain and suffering.[58]

2. *Statutory Surrogate Restrictions*

In addition to restrictions on appointed healthcare proxies, a handful of states also prohibit statutory surrogate decision-makers (those who are designated by statute to make treatment decisions in case a patient has no living will or formally designated proxy, such as the spouse or child of the patient) from deciding to allow the incompetent pregnant woman to die a natural death.[59] These surrogate restrictions clearly have the broadest potential impact, since most patients neither execute a living will nor appoint a healthcare proxy.[60] All of these surrogate restrictions could be effective even before fetal viability, variously requiring that life-prolonging treatment be continued if it is probable,[61] or possible,[62] that the fetus will be born alive, or (more onerously) unless it is reasonably certain the fetus would not be born alive.[63] Like other pregnancy restrictions, no surrogate restriction takes account of the newborn's prognosis after live birth, or whether it will suffer permanent impairment from the mandated medical care. Nor do any include pain exceptions that would allow cessation of care if the woman endures pain or suffering.

PART II: THE "MICROSCOPIC" VIEW: NOTICING HARMS TO THE INDIVIDUAL WOMAN

Most legal analyses addressing whether the state may coerce a pregnant woman to undergo medical treatment for the sake of her fetus focus on balancing the interests of, and harms to, the individual woman and fetus (or the state's ostensible interest in the fetus), largely because traditional substantive due process analysis takes this narrow approach. Here, in Part II,

---

[58]These are the same states that include pain provisions in their living will restrictions. *See supra* note 48.

[59]Iowa Code Ann. § 144A.7(3) (West 1989); Mont. Code Ann. § 50-9-106(6) (1993); Nev. Rev. Stat. Ann. § 449.626(6) (1991); Ohio Rev. Code Ann. § 2133.08(G) (Anderson 1994).

[60]*See, e.g.*, Orentlicher, *supra* note 32, at note 25.

[61]Mont. Code Ann. § 50-9-106(6) (1993); Nev. Rev. Stat. Ann. § 449.626(6) (1991).

[62]Iowa Code Ann. § 144A.7(3) (West 1989).

[63]Ohio Rev. Code Ann. § 2133.08(G) (Anderson 1994).

I offer a similar, microscopic constitutional appraisal of the pregnancy restrictions, assessing whether the harms that befall the individual pregnant woman who is forced to undergo life-prolonging medical treatment violate substantive due process. Again, what is glaringly absent from this more limited approach, and what I take up in Part III, is a view that notices the broader social context within which that state coercion takes place, and the subordinative harms to all women that result.

A number of legal articles already address, at least to some extent, the constitutionality of the pregnancy restrictions from this more traditional constitutional perspective.[64] I undertake this examination primarily to take on the key analytical shortcomings of many of these other articles, namely: 1) their neglect of how the restrictions thwart not only the incompetent woman's present interest in avoiding coerced medical treatment and pregnancy, but also the liberty of a competent woman to direct in advance both her medical treatment and her procreative fate; and 2) their facile conclusion that the restrictions' constitutionality is assured when applied to a viable fetus.

I address these two issues in Sections A and B below, respectively. In Section A, I analyze how the restrictions unconstitutionally burden the interests of both competent and incompetent women affected by them. Importantly, in both of these contexts, my conclusions concerning constitutionality assume that the fetus is not yet viable. I address the pregnancy restrictions as applied to viable fetuses in Section B, since the pressing issues that arise in that circumstance merit a separate discussion.[65]

A. Clarifying the Woman's Interests Burdened by the Pregnancy Restrictions

As noted, extant legal analyses of the pregnancy restrictions do not explicitly address how the restrictions may in fact unconstitutionally burden

---

[64]*See* Elizabeth Carlin Benton, Note, The Constitutionality of Pregnancy Clauses in Living Will Statutes, 43 V. and. L. Rev. 1821 (1990); Burch, *supra* note 25; Molly C. Dyke, Note, A Matter of Life and Death: Pregnancy Clauses in Living Will Statutes, 70 B.U. L. Rev. 867 (1990); Jordan, *supra* note 31; Anne D. Lederman, Comment, A Womb of My Own: A Moral Evaluation of Ohio's Treatment of Pregnant Patients With Living Wills, 45 Case W. Res. L. Rev. 351 (1994); Janice MacAvoy-Smitzer, Note, Pregnancy Clauses in Living Will Statutes, 87 Colum. L. Rev. 1280 (1987); Joan Mahoney, Death With Dignity: Is There an Exception for Pregnant Women?, 57 U.M.K.C. L. Rev. 221; Kristin A. Mulholland, Note, A Time to Be Born and a Time to Die: A Pregnant Woman's Right to Die With Dignity, 20 Ind. L. Rev. 859 (1987).

[65]Nevertheless, the conceptual distinction between the relevant interests of the competent and incompetent women affected by the pregnancy restrictions also is pertinent to restrictions operable after fetal viability.

the *competent* woman's interest in exercising her prospective autonomy[66] by deciding in advance whether or not to be kept alive solely to gestate the fetus.[67] Subsections 1 and 2 below accordingly consider how the pregnancy restrictions unconstitutionally burden the distinct interests of *both* competent and incompetent women, respectively. I conclude in subsection 1 that the restrictions infringe on what should be the competent woman's constitutionally protected liberty to decide prospectively whether to be kept alive for the sake of the fetus, at least before fetal viability. Further, even if the Constitution does not protect advance treatment refusals, I conclude in subsection 2 that in many cases the pregnancy restrictions still would encumber the incompetent pregnant woman's liberty interests in bodily integrity and avoiding procreation, by forcing her to undergo burdensome medical treatment or to continue the pregnancy itself.[68]

1. Infringing the Competent Woman's Liberty Interests

The pregnancy restrictions prevent the competent woman from exercising her critical interest in prospective autonomy. As a conceptual matter, we may exercise our autonomy either presently, or prospectively by making decisions about our future life. Prospective autonomy generally involves our ability to be the author of, to control in advance, the most personal and fundamental

---

[66]*See infra* notes 69-70 and accompanying text for a discussion of the notion of "prospective autonomy."

[67]Instead, many of these authors appear to conflate the separate interests of the competent and incompetent women burdened by the restrictions, contributing to the general conceptual confusion about what exactly are the distinct interests or "rights" held by competent and incompetent patients (e.g., it is a legal fiction to say that incompetent patients have a right to "refuse" medical treatment, since they cannot make such a choice). *See* Nancy K. Rhoden, Litigating Life and Death, 102 Harv. L. Rev. 375 (1988) for discussion of this conceptual confusion. *See, e.g.*, Jordan, *supra* note 31, at 1155; Mahoney, *supra* note 64 (both arguing that the pregnancy restrictions violate the "pregnant woman's" right to refuse unwanted medical treatment, without expressly noting, first, that the incompetent pregnant women cannot "refuse" treatment, and also that competent women also might have interests affected). *But cf.*, John A. Robertson, Posthumous Reproduction, 69 Ind. L. J. 1027 (1994) (in a brief look at the pregnancy restrictions, Robertson concludes that if advance directives are constitutionally protected, then restrictions mandating treatment prior to viability would be an unconstitutional violation of the competent woman's interest in executing an advance directive. *Id.*, at 1060. Robertson, however, then goes on to criticize any constitutional protection for advance directives. *Id.*, note 119).

[68]Again, my conclusions in this section presume restrictions that force the woman to stay alive for a fetus before viability; I discuss the woman's interest in relation to the viable fetus in Section B below.

aspects of our lives based on our own values, should we later become incompetent. As Norman Cantor writes, prospective autonomy has as its object "to permit individuals to prescribe personal preferences in advance and so to maintain a measure of autonomy even after incompetency."[69]

Prospective autonomy is important to us precisely because it allows us to protect, in advance, the values, beliefs or interests that we hold most dear.[70] Significantly, the pregnancy restrictions prevent the competent woman from protecting several quite critical interests in advance, most importantly her basic liberty to protect her bodily integrity by refusing life-sustaining medical treatment, and to exercise her procreative choice,[71] both of which I briefly review here.[72]

---

[69]*See* Norman Cantor, Advance Directives and the Pursuit of Death with Dignity (1993), at 23.

[70]Nancy Rhoden observes that "[p]rior directives are the tools for projecting one's moral and spiritual values into the future." Rhoden, The Limits of Legal Objectivity, 68 N.C. L. Rev. 845, 858 (1990).

[71]The competent woman also has other interests at stake. First, she has a separate but related interest in avoiding wrongful subordination to others. I reserve my discussion of the "subordinative" harms caused by the pregnancy restrictions to Part III, as a harm caused all women, even those not directly affected by the restrictions. Second, the woman also has an interest in prospectively controlling the circumstances of her own death, as discussed *infra* note 76. Finally, the restrictions also may, in some circumstances, infringe on the woman's religious liberty by forcing her to undergo treatment that she might object to on religious grounds. I do not address this latter interest because I limit my discussion to the burdened interests common to all women.

[72]I do not list a woman's "privacy" right or interest as being violated by the pregnancy restrictions, as do most authors who discuss the restrictions, for several reasons. *Cf.*, articles listed *supra* note 64. First, the Supreme Court appears to be backing away from using a privacy right as the basis for either procreative liberty or the liberty to refuse medical treatment. *See, e.g.*, Casey, 505 U.S. 833 and Cruzan, 497 U.S. 261. Second, I believe the Court's approach generally is a correct one, at least as a basis for the liberties at issue here. The interest in privacy is in fact instrumental to our larger interest in personal autonomy, because being able to protect ourselves from state interference with our most personal decisions better enables us to live autonomously, to be the author of our own lives. Finally, the notion of privacy is vague, and has at times (notoriously) been misconstrued to shield harms caused in private, by private actors, from state interference. Since the traditional liberal "private" (or domestic) sphere is the zone within which oppressive harms to women often take place, such as violence against women and unequal divisions of labor in the home, the "right to privacy" must be viewed with healthy skepticism, and used with care and precision. *See, e.g.*, Catharine A. MacKinnon, Feminism, Marxism and the State: Towards Feminist Jurisprudence, Critical Legal Studies (Allan C. Hutchinson, ed., 1989); Susan Moller Okin, Justice, Gender and the Family (1989). *See also*, Jean L. Cohen, Redescribing Privacy: Identity, Difference, and the Abortion Controversy, 3 Columb. J. Gender & Law 43 (1992) (critique of feminist and communitarian concerns with the "privacy" right, and a reformulation of that right); Linda C. McClain, The Poverty of Privacy?,

First, the pregnancy restrictions thwart the competent woman's interest in prospectively protecting her bodily integrity through prior directive. Bodily integrity, the interest in avoiding forced physical invasions, arguably is the most fundamental of liberties. Without the liberty to resist bodily intrusion by others, especially bodily invasions sanctioned by the state, negative liberty from state interference arguably is without meaning.[73] Our interest in bodily integrity is the cornerstone of common law informed consent doctrine requiring permission for medical treatment. In Cruzan v. Director, Missouri Department of Health,[74] the Supreme Court explicitly recognized that a competent patient has a "constitutionally protected liberty interest in refusing unwanted medical treatment," one that presumably also would encompass refusals of life-prolonging care.[75] Indeed, our interest in rejecting even medical care that keeps us alive is at the heart of the rationale underlying advance directive statutes.[76]

---

id. at 119 (also responding to feminist criticisms of privacy doctrine).

[73]The Supreme Court long ago observed that "[n]o 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 the law." Union Pacific R. Co. v. Botsford, 141 U. S. 250, 251 (1891) (cited approvingly in Cruzan v. Director, Missouri Department of Health, 497 U.S. 261, 269 (1990)). The Court's Fourth Amendment jurisprudence also recognizes the fundamental nature of our interest in bodily integrity. *See, e.g.*, Winston v. Lee, 470 U.S. 753 (in holding that state could not perform surgery to obtain evidence from a suspect, the Court states "A compelled surgical intrusion into an individual's body for evidence...implicates expectations of privacy and security of such magnitude that the intrusion may be 'unreasonable' even if likely to produce evidence of a crime." *Id.* at 759).

[74]497 U.S. 261 (1990).

[75]Cruzan, 497 U.S. at 278. The Court did not specifically decide whether a person's liberty to decline medical treatment encompasses life-sustaining medical interventions such as the provision of artificial nutrition and hydration, but simply assumed for purposes of the decision that refusals of artificial food and hydration would be constitutionally protected. *Id.* at 279. Presumably the Court would include the rejection of life-prolonging interventions within the general liberty to refuse medical treatment. *See, e.g.*, O'Connor's concurrence, arguing that all refusals of care, including life-sustaining medical care, and artificial nutrition and hydration, are encompassed by the liberty to refuse treatment. *Id.* at 287-88. *See also*, Washington v. Glucksberg, 117 S.Ct. 2258 (1997) (stating that the Court in Cruzan "assumed, and strongly suggested, that the Due Process Clause protects the traditional right to refuse unwanted lifesaving medical treatment." *Id.* at 2267).

[76]Also implicit in the woman's liberty to refuse life-sustaining treatment in advance is her related but separate interest in retaining the decisional authority over how she will die, at minimum by being allowed to refuse potentially intrusive life-prolonging medical care. I do not here advocate that persons have a "right to die" in any manner they choose, even with the assistance of others, a right recently rejected by the Supreme Court in Washington v. Glucksberg

Second, by legally compelling the continued gestation of the fetus despite the woman's advance wishes, the pregnancy restrictions also impede her liberty to decide in advance her procreative fate.[77] A woman's advance decision concerning whether to be kept alive solely to sustain the life of the fetus entails not only a decision about whether to undergo life-prolonging treatment, but also (secondarily) a decision about whether to continue her pregnancy even if she otherwise qualifies for cessation of treatment under the statute.

Notably, the woman's interest in prospective autonomy is abrogated not just by the living will restrictions, but by the proxy/surrogate restrictions as well.[78] While the moral justification for the appointment of proxy

---

117 S.Ct. 2258 (1997), as noted below. Rather, I argue that persons at least should be free to choose to die without intrusive medical interventions that merely prolongs their death, or to avoid lingering in a PVS. Our ability to imbue our last days or hours with our own meaning is our final act of self-determination, the denouement of our life's narrative. *See, e.g.*, Ronald Dworkin, Life's Dominion: An Argument about Abortion, Euthanasia, and Individual Freedom (1993) ("Death has dominion because it is not only the start of nothing but the end of everything, and how we think and talk about dying—the emphasis we put on dying with 'dignity'—shows how important it is that life ends appropriately, that death keeps faith with the way we want to have lived." *Id.* at 199 (emphasis in original)). Indeed, the states protect this separate interest for all other adults by allowing them to reject a death prolonged by life-supporting care.

In the recent assisted suicide case of Glucksberg, the Court refused to consider the more general question of whether persons have a protected liberty interest in deciding the time and manner of their death, as urged by respondents. The Court instead held that the interest at issue in the case should be narrowly defined to be whether persons had a right to commit suicide with assistance of others, and then rejected that right. This holding, however, does not abrogate the conceptual and legal distinction I urge between the interest in refusing life-prolonging treatment, and the interest in determining how one will die as appropriately defined. *See, e.g.*, Stevens' Glucksberg concurrence, stating that Cruzan "did give recognition not just to vague, unbridled notions of autonomy, but to the more specific interest in making decisions about how to confront an imminent death." 117 S.Ct. at 2307. He emphasized that, as applied in certain cases, the right to assisted suicide may vindicate an interest in "choosing a final chapter that accords with [the patient's] life story, rather than one that demeans her values and poisons memories of her." *Id.* at 2308.

[77]The Supreme Court has held that the woman's procreative liberty may not be foreclosed by the state until after fetal viability (or beyond if the pregnancy threatens the woman's life or health). Roe v. Wade, 410 U.S. 113 (1973), reaffirmed by Planned Parenthood v. Casey, 505 U.S. 833 (1992). As developed in Section B. below, however, the constitutionality of the pregnancy restrictions does not simply hinge on whether they take effect after fetal viability, since the woman retains interests, such as protecting herself against the pain and suffering of forced bodily invasions, that may outweigh the state's interest in even a viable fetus.

[78]*See* Part I.B.1 above for discussion of the proxy and surrogate restrictions.

decisionmakers has been called into question,[79] the current policy consensus is that the patient's interest in having a designated proxy or surrogate make healthcare decisions for her is at least partly derived from her own interest in prospective autonomy or self-determination.[80] The proxy and statutory surrogate restrictions also hinder the woman's other-regarding interest in allowing her family to make this decision, since they presumably would in most cases raise the child.[81]

---

[79]Questions raised include: Is the proxy's moral authority based on her ability to judge what the patient would have wanted, and thus merely derivative of the patient's own interests? Can that derivative authority be justified in practice, when family members often do not accurately determine what the patient would have wanted under the circumstances? Do family members have interests of their own in deciding the medical treatment of an incompetent loved one? If so, is it permissible, or even required, that their decision be at least partly based on their own interests, rather than solely on the (perceived) wishes of the patient? *See, e.g.*, Dan W. Brock, What is the Moral Basis of the Authority of Family Members to Act as Surrogates for Incompetent Patients?, 3 J. Clin. Ethics 121 (1992); Dallas M. High, Families' Roles in Advance Directives, Hastings Ctr. Rep., Nov.-Dec. 1994, Special Supplement, at S16; Ezekiel J. Emanuel, Linda L. Emanuel, Proxy Decision Making for Incompetent Patients: An Ethical and Empirical Analysis, 267 JAMA 2067 (1992); John Hardwig, What About the Family?, Hastings Ctr. Rep., Mar.-Apr. 1990, at 5.

[80]Since a patient's interest in self-determination involves an interest in governing her life based on her own values, that interest is served by having a designated proxy or non-designated family surrogate make decisions on behalf of the patient, partly because these are the persons whom the patient preferred (or would have preferred) to make these decisions, and partly because these persons presumably are in the best position to determine what the patient would have wanted. *See, e.g.*, Dan W. Brock, Good Decisionmaking for Incompetent Patients, Hastings Ctr. Rep., Nov.-Dec. 1994, Special Supplement, at S8.

[81]Indeed, if the proxy or surrogate is a family member, such as the woman's husband or partner, the proxy restrictions also might violate an independent liberty interest of the family to decide the fate of the nonviable fetus. Arguably, justice concerns require recognition that the family, at minimum the husband, may have an independent liberty interest in deciding whether the fetus will be kept alive, since they likely would be responsible for the born child. While Cruzan held that family autonomy does *not* create an independent right of the family to refuse treatment for another family member, the Casey court recognized that state regulation of the woman's procreative liberty affects not only the woman's bodily integrity, but also the "private sphere of the family," Casey, 505 U.S. at 896, and noted that the husband has a "deep and proper concern and interest . . . in his wife's pregnancy and in the growth and development of the fetus she is carrying." Casey, 505 U.S. at 895, citing Danforth,428 U.S. 52 at 68. Thus, the incompetent pregnant woman's family, at least the fetus's father, may have an independent procreative liberty interest in deciding the fate of the nonviable fetus that is unconstitutionally burdened by the state's prohibition on such decisions. *See, e.g.*, Davis v. Davis, 842 S.W. 2d 588 (Tenn. 1992) (court recognized father's interest in "procreational autonomy" as a gamete provider, equivalent to mother's interest since embryo was not within mother's body; court held that father's interest in avoiding genetic parenthood should prevail over the mother's interest in donating embryo to another couple). Of course, Danforth rightly teaches that the father's interest in the fetus cannot outweigh the woman's own interest in deciding her procreative fate,

In short, then, all three types of pregnancy restrictions seriously harm the competent woman by prohibiting her from exercising her prospective autonomy (autonomy afforded other competent adults) over the most basic aspects of her life and death. She is prevented from exercising any control over the critical decisions concerning whether she will undergo potentially invasive life-prolonging medical treatment, and whether her body will be used to gestate a nonviable fetus whom she will never mother.

Can such substantial harms to the woman constitutionally be justified?[82] Significantly, the only relevant interest the state may offer to justify its pregnancy restriction is its interest in protecting potential fetal life. None of the four state interests traditionally asserted as contrary to a person's liberty to refuse medical treatment (the interest in preserving life, preventing suicide, protecting dependent third parties, and maintaining the ethical integrity of the medical profession) apply here.[83] The pregnancy restrictions indeed appear

---

but possibly he could assert his procreative interests in some cases, such as where his wife has refrained from deciding for herself what to do under these circumstances, she has no further interest in treatment, and the pregnancy is not a physical or emotional burden to her. *Contra,* Kevin M. Apollo, The Biological Father's Right to Require a Pregnant Women to Undergo Medical Treatment Necessary to Sustain Fetal Life, 94 Dick. L. Rev. 199 (1989) (arguing that unlike in the abortion context, the biological father should have the right to require a pregnant woman to undergo medical care intended to benefit the fetus, perhaps even before fetal viability). This line of analysis, however, would have to address the paradoxical (but perhaps not unjust) result that the husbands of these pregnant women would have separate, cognizable legal interests in deciding whether she should be kept alive, but families of nonpregnant persons would not (as held in Cruzan). *See also,* Robertson, *supra* note 67, at 1061-1062 for a brief discussion of the husband's procreative interests when his wife is comatose and pregnant.

[82]That it is unconstitutional for states, through the pregnancy restrictions, to force a woman to undergo medical treatment to save the fetus before viability is undisputed among commentators who have addressed the issue. *See, e.g.,* all articles listed *supra* note 64. Indeed, both the Alaska and Wisconsin Attorneys General have also questioned the constitutionality of their state's pregnancy restrictions, both of which operate prior to fetal viability. *See* Burch, *supra* note 25, at note 50. Further, Virginia, Maine, and the District of Columbia reportedly refused to include pregnancy restrictions in their advance directive legislation due to their questionable constitutionality. *See* MacAvoy-Snitzer, *supra* note 64, at 1292, note 82. However, these commentators did not address the issues of whether the restrictions unconstitutionally violate a competent woman's interest in prospectively directing her medical treatment and exercising her procreative choice, and whether an insentient woman's current interests would withstand the state's interest in protecting a fetus even before viability. *See* Section B.2 below for a discussion of the interests of the insentient pregnant woman.

[83]These interests are well-established in common law governing refusal of unwanted medical care. *See, e.g.,* Superintendent of Belchertown State School v. Saikewicz, 370 N.E. 2d 417 (1977) at 425-26; *see* Jordan, *supra* note 31, for more in-depth review of these cases. The state's interests in preserving life and preventing suicide both refer to the life of the woman, and not her fetus. By enacting its advance directive statute, the state has waived its interest in

to require that physicians breach their ethical obligation to their patients.[84] Of the two state interests contrary to a woman's procreative liberty, the interests in protecting the health of the woman and the potential life of the fetus,[85] the state may only assert the latter in support of the pregnancy restrictions, since the restrictions clearly are intended only to protect the fetus. In fact, the majority of states render the woman's own health interests totally irrelevant by forcing her to undergo potentially painful and invasive medical treatment that is of no benefit to her.[86]

As to the strength of the competent woman's interests, the Supreme Court has not accorded specific constitutional protection to an interest in prospectively refusing life-sustaining medical intervention or exercising procreative choice. However, while a comprehensive discussion of whether prior directives should be accorded constitutional status is beyond the scope

---

protecting the lives of citizens who refuse treatment in advance, and also has decided that such treatment refusals do not constitute suicide. The state therefore may not assert an interest in protecting the lives of incompetent pregnant women, but not the lives of its other adult citizens. Further, the state's interest in protecting the life of innocent third parties is, in the case of the pregnancy restrictions, equivalent to its interest in protecting the potential life of the fetus, since the fetus is the ostensible "third party" in question.

[84]Some argue that the ethical integrity of the medical profession is compromised when physicians are forced to honor pregnant women's treatment refusals that could result in serious harm to the fetus. *See, e.g.*, Phelan, *supra* note 16, at 471-473. However, the pregnancy restrictions may in fact *interfere* with health care providers' ethical obligations to both the woman and the fetus. Ethical guidelines of the profession unanimously advise against coercing pregnant women to undergo medical treatment to benefit the fetus. *See infra* note 148. In addition, the restrictions force physicians to abandon their ethical duty to act as the woman's advocate, and to focus instead solely on fetal interests. *Id.* Finally, many state pregnancy restrictions in essence constitute the state practice of medicine by requiring the physician to treat the woman even if the fetus would not ultimately benefit, thus interfering with the physician's own best medical judgment concerning whether treatment would benefit the woman or the fetus.

Further, even if the members of the medical profession were to agree that their ethical obligation to the fetus requires them to coerce treatment in some cases, a woman's ability to protect her bodily integrity should not be contingent on physicians' views of their ethical obligations, lest the medical profession be ceded the power of the state. *See, e.g.*, Rhoden, *supra* note 33, at 1971-1972; George Annas, Editorial, Protecting the Liberty of Pregnant Patients, 316 N. Eng. J. Med. 1213 (1987) (discussing the alarming "alliance between physicians and the state to force pregnant women to follow medical advice for the sake of their fetus"). Many state pregnancy restrictions already grant excessive power to the woman's treating physicians by allowing them to be the sole judge of whether she is kept alive or allowed to die, as discussed below in Part III.B.1.

[85]*See, e.g.*, Casey, 505 U.S. at 877-78 (1990).

[86]*See supra* notes 48, 58 and accompanying text.

of this article,[87] the strong value we place on bestowing our lives with meaning once we are incompetent lends convincing support for some such constitutional protection.[88] And in fact, it is possible that the current Supreme

---

[87]Some argue that the ability to execute a prior directives should not be constitutionally protected, since advance treatment decisions lack the immediacy of present-oriented decisions concerning medical care, and indeed that advance refusals could later harm the incompetent patient who may have a current interest in medical treatment. *See* John A. Robertson, Cruzan and the Constitutional Status of Nontreatment Decisions for Incompetent Patients, 25 Ga. L. Rev. 1139 (1991), at 1180-1181 [hereinafter Robertson, Nontreatment Decisions]. *See also*, Rebecca S. Dresser and John A. Robertson, Quality of Life and Nontreatment Decisions for Incompetent Patients: A Critique of the Orthodox Approach, 17 Law, Med. & Health Care 234 (1989); Rebecca S. Dresser, Relitigating Life and Death, 51 Ohio St. L.J. 425 (1990). Others assert that a present-oriented view that emphasizes the incompetent patient's current interests necessarily reduces the patient to an object with only physical interests, robbing her of her identity as a moral agent over time, of her past values, preferences, and indeed personhood. *See, e.g.*, Nancy K. Rhoden, *supra* note 67, at 418. *See also* Cantor, *supra* note 69, at 26-27 (arguing in favor of protecting the liberty to execute an advance directive).

Separate from this constitutional issue, the states, by enacting their advance directive statutes, have opted for a policy favoring the right of competent persons to control their medical future to some extent, regardless of what their interests may be once incompetent. The fact that women are granted only a conditional right to do so raises equal protection worries, as discussed in Part III below.

[88]I do not assert, as do others, that constitutional protection of advance directives inexorably leads to the right to assert in advance other constitutional rights we may possess, even advance decisions concerning later situations where we still would be *competent*. *See, e.g.*, Robertson, Nontreatment Decisions, *supra* note 87, at 1183. Robertson argues that the logical consequence of constitutionally protecting advance directives is that persons then should also have the constitutional right to "make enforceable directives ...regarding abortion, reproduction, child rearing, surgery, and frozen embryos," and surrogacy. *Id.* This argument assumes two premises, both of which I reject. The first premise is that it is not the particular interest being prospectively exercised that determines constitutional protection, but rather "the interest in autonomy and certainty about the future..." *Id.* The second premise is that our interest in prospective autonomy is just as strong in cases of our control over future situations where we presumably still will be competent, as in those where we will be incompetent. I reject the first premise because, at least as I envision the notion, the value of prospective autonomy partly derives from the interest being prospectively protected: One's interest in refusing in advance to be used as a fetal incubator is qualitatively different, and stronger, than, say, one's interest in controlling the fate of frozen embryos. In other words, not all advance exercises of procreative liberty are equally deserving of constitutional protection; it is not a blanket "certainty about the future" that is being protected, but rather certainty about the future *with respect to certain of our most basic and critical values and beliefs*, such as how one's body is to be used. More importantly, the second premise is wrong since prospective autonomy is valuable precisely because it gives us certainty about a future *over which we will have no control*. Autonomy, or self-determination, is the basic value underlying prospective autonomy. Competent persons, unlike incompetent persons, are perfectly able to make present autonomous choices, choices which may require them to renege on a contract made in the past. An incompetent person of course is incapable of undoing a past agreement. *See* Cantor, *supra* note 69, at 28 (control over

Court could decide that adults have a Fourteenth Amendment liberty interest in refusing medical treatment in advance by prior oral or written directive,[89] a liberty that presumably also would entail the right to appoint a healthcare proxy decision-maker.[90]

The separate issue then arises, even if the woman's interest in refusing life-prolonging treatment in advance is constitutionally protected, should she also be able *prospectively* to exercise her procreative liberty to refuse to continue a nonviable pregnancy?[91] The short answer is yes. As noted, Casey held that while the state has a substantial interest in protecting potential fetal life throughout pregnancy, it cannot unduly burden the woman's constitutional right to abort the fetus until after fetal viability, and even then not if the woman's health or life is endangered.[92] It logically follows, then, that if the woman may abort the fetus before viability, surely she also may refuse life-sustaining medical treatment mandated *solely for the purpose of saving the life*

---

one's medical fate once incompetent is the underlying justification for medical advance directives).

[89]Four dissenters in Cruzan indicated a willingness to confer constitutional status on advance treatment refusals: Justices Brennan, Marshall, Stevens, and Blackmun. While Justices Brennan, Marshall, and Blackmun are no longer on the Court, it is quite possible that Justices Breyer, Souter, and Ginsberg, relatively liberal members added since Cruzan, also would recognize such a liberty. Further, Justice O'Connor's recognition that a person's liberty to direct her medical care may require the state to give effect to the decisions of her designated proxy also implies her support for prior directives, though she did not expressly so state. Thus, at least five justices (Justices O'Connor, Stevens, Souter, Ginsberg, and Breyer) could decide to afford constitutional protection to advance directives generally. *See also*, Cantor, *supra* note 69, at 31 (predicting that "Cruzan may well mean that the clear exercise of future-oriented autonomy will be deemed to prevail (as a matter of constitutional law) against a state's asserted interest in promoting the sanctity of life principles.") *But cf.*, Robertson, Nontreatment Decisions, *supra* note 87, at 1043 (Supreme Court is not likely to give "fundamental right" status to advance treatment decisions).

[90]The Cruzan majority expressly declined to address whether a patient's designation of a healthcare proxy is constitutionally protected. However, as just noted, Justice O'Connor recognized that a person's liberty interest in directing his medical care may require the state to give effect to the decisions of a designated proxy. *Id.* Because the interest in designating a healthcare proxy also protects one's interest in self-determination, the former should enjoy the same constitutional protection as advance medical directives. *See supra* note 80.

[91]Again, in this Section A, I address the restrictions as applied to fetuses before viability.

[92]An "undue burden" is defined by the Court as a regulation that "has the purpose or effect of placing a substantial obstacle in the path of a woman seeking an abortion of a nonviable fetus." 505 U.S. 833 at 877.

of the previable fetus,[93] and that she must be allowed to refuse such treatments in advance.[94]

The state might argue that a woman's *advance* decision not to carry a nonviable fetus to term does not deserve the same protection as a present decision to abort before viability. However, the state's interest in the nonviable fetus remains the same, whether it is aborted by a competent woman, or dies along with its incompetent mother.[95] Further, it would be nonsensical to grant women the constitutional liberty to refuse medical treatment in advance, but deny them the ability to choose prospectively whether to stay alive to gestate the nonviable fetus. Both of these liberties vindicate the competent woman's larger interest in prospective autonomy, which entails control over her future destiny should she become incompetent, at least as to her most basic values and interests. Indeed, if she is not allowed this prospective procreative liberty, the states are encouraged to exploit the

---

[93]*See, e.g.*, Taft v. Taft, 446 N.E. 2d 395 (Mass. 1983) (woman pregnant with a nonviable fetus may not be compelled to undergo a "purse string" operation to ensure she would carry the fetus to term); *contra* In re Jamaica Hospital, 491 N.Y. S. 2d 898 (Sup. Ct. 1985) (court ordered woman only 18 weeks pregnant to undergo a blood transfusion, which she had refused on religious grounds, because the "State has a highly significant interest in protecting the life of a mid-term fetus." *Id.* at 900). Significantly, two more recent state appellate courts have held that the woman cannot be made to undergo a cesarean to save the life of even a viable fetus. *See, infra* notes 127-130 and accompanying text.

[94]This is not to say that after fetal viability, the constitutionality of the pregnancy restrictions is assured. *See* Section B. below.

[95]*See e.g.*, Jordan, *supra* note 31, at 1157-1159 (the state's interest in the potential life of the fetus is not strengthened by the woman's later incompetence). This same point prevents the state from asserting that while a competent pregnant woman may legally abort a nonviable fetus, she may not cause its demise by her own death. A woman's procreative freedom to refuse to remain pregnant with a nonviable fetus should not hinge on the manner of fetal death; whether the nonviable fetus dies through abortion or the natural death of its mother is immaterial. *See, e.g.*, MacAvoy-Smitzer, *supra* note 64, at 1292-1294 (a woman may permissibly terminate her pregnancy by refusing further medical treatment; while she could conceivably request in advance that an abortion be performed prior to having her living will effectuated, requiring her to do so is both "absurd and a waste of medical resources"). To argue that a woman may terminate her pregnancy by abortion, but not by ceasing her own medical treatment, results in ludicrous scenarios such as 1) a competent, terminally ill pregnant woman having to abort her fetus before dying; or 2) the family of an incompetent, terminally ill or PVS pregnant woman attempting to obtain an abortion before terminating her life-prolonging treatment. *See* Jordan, *supra* note 31, for a discussion of whether families could circumvent the pregnancy restrictions by the latter route.

incompetent pregnant woman, who is powerless to choose to abort a fetus she legally could have aborted when she was competent.[96]

Clearly, then, pregnancy restrictions operable before fetal viability (the majority of restrictions)[97] unduly burden what should be the woman's constitutionally protected liberty to decide in advance whether to undergo life-prolonging medical interventions in order to sustain her pregnancy. A woman could have a variety of legitimate reasons for not wishing to be kept alive for the sole purpose of keeping her fetus alive. She may want to protect her bereaved family from the burdens of a child left without a mother. She may (understandably) be deeply offended by the notion of her body being used as a fetal incubator for several months, and wish to die a more natural death. Regardless of the woman's reasons, however, the state has no interest in previable fetal life that is strong enough to prevent her from exercising her liberty to direct, in advance, that she die a death unimpeded by medical support, also causing the death of the nonviable fetus.

2. *Violating the Incompetent Woman's Liberty Interests*

Even if the woman has no constitutional liberty to execute an enforceable advance medical directive or to determine in advance her procreative fate, the issue remains whether the pregnancy restrictions unconstitutionally burden the incompetent woman's present liberty interests by forcing her to undergo life-prolonging medical treatment to save the life of the fetus. In fact, most state pregnancy restrictions effective before viability still would, in many cases, unduly burden the incompetent pregnant woman's constitutional liberties to protect her bodily integrity and avoid the burdens of procreation, and thus are unconstitutionally overbroad.[98]

---

[96]Some theorists thus argue that the pregnancy restrictions violate the equal protection clause by making irrational classifications between the competent and incompetent pregnant woman, and the pregnant and nonpregnant incompetent woman. *See, e.g.*, Jordan, *id.*, at 1158-1160; Burch, *supra* note 25, at 551-552. While these arguments have merit, I direct my own equal protection analysis of the restrictions to the issue of how they subordinate women to men, in Part III.

[97]Only three states expressly limit their living will restrictions to viable fetuses, and only one similarly limits its proxy restriction under narrow circumstances. *See supra* notes 37, 52.

[98]As already noted, the issues in this Section A are discussed in the context of restrictions that are operable before the fetus is viable. I address the constitutionality of pregnancy restrictions effective only after fetal viability in Section B below.

Needless to say, persons do not lose all interests once incompetent.[99] At minimum, incompetent persons retain an interest in protecting their bodily integrity, if they still may feel both physical and emotional suffering caused by mandated medical care.[100] It is highly unlikely that the Court would find that the incompetent pregnant woman's interest in bodily integrity, arguably the most basic of liberties, should yield to the state's interest in protecting previable fetal life, since her procreative liberty already outweighs that state interest. The state's interest in the nonviable fetus simply cannot justify coerced medical treatment that harms the partly sentient but incompetent pregnant woman, who shares with a competent woman an interest in avoiding state-imposed suffering. Thus, states that require the incompetent pregnant woman to suffer physically or emotionally solely for the benefit of a nonviable fetus (the majority of states)[101] unconstitutionally burden her liberty of bodily integrity.[102]

The incompetent pregnant woman also may retain an interest in procreative liberty. If at least partly sentient, she may bear physical and

---

[99]Neither does a pregnant woman lose her interest in bodily integrity once terminally ill. If at least partly sentient, she retains an interest in protecting against bodily invasions that is unaffected by her terminality. Further, her interest in procreative liberty is also unaffected by her terminality, since that interest, again, is partly based on her liberty to refuse enforced bodily burdens. *See infra* notes 102, 103-104, 132-133 and accompanying text. Thus, to argue (as some do) that a terminally ill pregnant woman has no interest in deciding the fate of the fetus because she will not parent the child seriously misconstrues the various interests protected by procreative liberty. *See, e.g.*, Gregory Gelfand, Living Will Statutes: The First Decade, 1987 Wisc. L. Rev. 737 (1987), at 780. Under Casey, procreative liberty protects the woman from state-enforced pregnancy. Whether the woman will bear responsibility for the child after birth is irrelevant to her interest in avoiding pregnancy or childbirth.

[100]Of the articles that expressly address the interests of the incompetent pregnant woman in relation to the pregnancy restrictions, few make any distinction between the interests of a sentient and insentient incompetent woman. *See* references listed at *supra* note 64, except Jordan.

[101]Only a small number of pregnancy restrictions are more narrowly tailored to require life-sustaining medical treatment only if the woman will feel little or no pain. *See supra* notes 48, 58. These restrictions, however, still fail to consider that the incompetent pregnant woman may suffer emotionally if coerced to undergo medical treatment against her will, a harm that may itself render these restrictions overly broad.

[102]*See, e.g.*, Robertson, Nontreatment Decisions, *supra* note 87, at 1186: "If [patients] are conscious and capable of suffering, state policies that require burdensome treatments with little corresponding benefit would deny them liberty. This situation might arise where an incompetent patient's death is imminent or where the patient has no interactive existence." Robertson later observes that "[t]he state may not appropriate the body or person of an incompetent conscious patient to make a symbolic statement about the importance of human life when doing so harms the incompetent patient." *Id.* at 1187.

emotional burdens imposed not only by the mandated medical treatment, but by the pregnancy itself.[103] In fact, the Supreme Court has recognized that procreative liberty may be at least partly grounded in a woman's liberty to protect her bodily integrity.[104] Therefore, in cases where the incompetent pregnant woman suffers the bodily and emotional hardships of an (en)forced pregnancy before viability, the pregnancy restrictions unconstitutionally infringe on her liberty to avert those burdens as well.

In the case of permanently insentient pregnant women, the unconstitutionality of mandating medical treatment for the benefit of the fetus before viability is less clear.[105] An insentient pregnant woman cannot suffer the physical or emotional burdens of continued medical treatment or pregnancy, and thus arguably does not possess current interests in bodily integrity or procreative liberty.[106] However, surely she still possesses an interest in having her body be treated with respect and dignity, lest she be afforded less respect that dead organ donors, or lest she become fair game for medical experimentation and the like.[107] Arguably, the value of respecting rather than exploiting her should outweigh the state's interest in using her body to gestate a nonviable fetus. In addition, as developed below in Part III, even if the

---

[103]*See, e.g.*, Jordan, *supra* note 31, at 1126-1137 (discussing the vegetative woman's procreative liberty interests).

[104]The Casey court explicitly recognizes that Roe may be viewed as having "doctrinal affinity" with cases such as Cruzan, which protect both "personal autonomy and bodily integrity." Casey, 505 U.S. at 857. The Court further observes that procreative liberty protects choices "central to personal dignity and autonomy," indeed, the "claims of the woman to retain the ultimate control over her destiny and her body." *Id.* at 869. *See also*, Christyne Neff, Woman, Womb, and Bodily Integrity, 3 Yale J. L. & Feminism 327 (1991) (in-depth discussion of how procreative liberty implicates the right to bodily integrity).

[105]Whether the woman's family, such as her husband, has a protectable interest in such a case is an interesting, but separate, question. *See supra* note 81. Though Casey held that the woman's bodily integrity before birth outweighs her husband's interest in being notified of her intent to have an abortion, here the woman arguably has no interest in bodily integrity to be protected, but her husband's interest in whether or not the fetus will be born remains intact.

[106]*See supra* notes 102-103.

[107]In Cruzan, Justice Brennan argues in his dissent that Cruzan's liberty to refuse medical treatment could not rest merely on her interest in avoiding present physical pain and discomfort, or else "it is not apparent why a State could not choose to remove one of her kidneys without consent on the ground that society would be better off if the recipient of that kidney were saved from renal poisoning...Indeed, why could the State not perform medical experiments on her body, experiments that might save countless lives, and would cause her no greater burden that she already bears..." Cruzan, 497 U.S. at 313, note 13. *See also,* Rhoden, *supra* note 67, at 417 (concerning the value of respecting patients as persons over time, rather than defining their interests only in terms of the present). *See also, supra* note 76 regarding patient dignity.

individual insentient woman suffers no constitutionally recognized harm caused by state-coerced medical care, women as a group are subordinated by the states' virtual conscription of the bodies of incompetent pregnant women for use as fetal incubators. These more diffuse, but very real, harms should also be seriously considered in any constitutional or policy analysis of the pregnancy restrictions.[108]

B. Pregnancy Restrictions Operable After Fetal Viability

Pregnancy restrictions that would suspend the woman's advance directive after fetal viability implicate her same liberty interests as discussed above. However, the Supreme Court has held that once the fetus is viable, the woman's procreative liberty is outweighed by the state's substantial interest in protecting fetal life, except where her life or health is endangered.[109] The key inquiry, then, is whether the state's interest in protecting the viable fetus not only justifies restrictions on abortion, but allows it constitutionally to impose an affirmative legal obligation on a pregnant woman to stay alive for the sake of the fetus, thus forcing her to forgo her liberty to refuse life-prolonging medical treatment.

The goal in this Section B is to address prior authors' hasty conclusion that the constitutionality of the pregnancy restrictions is easily assured when the life of a viable fetus is at stake.[110] Careful analysis suggests that a woman's right to resist medical treatment necessary to save the viable fetus's

---

[108]The forfeiture argument discussed earlier at note 18 has no more force for the incompetent woman than for the competent woman. The incompetent woman pregnant with a nonviable fetus, whether or not sentient, has neither implicitly consented to the use of her body as a fetal incubator, nor waived her interests by failing to obtain an abortion before she became incompetent. First, the fact that she was pregnant when she became incompetent does not necessarily mean that she had decided to carry the child to term. Second, since it is quite conceivable that a woman would not wish to be kept alive as life-support for a nonviable fetus even where she had intended to carry the fetus to term under normal circumstances, her consent to the medical treatment cannot be somehow implied from the fact that she had chosen to continue her pregnancy up to that point. *See, e.g.*, Hilda Lindemann Nelson, The Architect and the Bee: Some Reflections on Postmortem Pregnancy, 8 Bioethics 247, 253-54 (1994) (arguing that physicians may not assume, without more, that a brain dead pregnant woman would wish to be maintained on life support in order to gestate the fetus). *See* Section B.3.a below for related argument concerning the incompetent woman pregnant with a viable fetus.

[109]Casey, 505 U.S. 833 (1992).

[110]*See, e.g.*, Jordan, *supra* note 31, at 1158 (the pregnant woman "cannot be constitutionally compelled to undergo medical treatment for the sake of a fetus until the fetus is viable."); MacAvoy-Smitzer, *supra* note 64, at 1300 ("[T]he state may not invalidate the living will of a pregnant woman prior to the viability of her fetus").

life should be given broader protection that these writers have recognized. My argument proceeds in three steps, developed in subsections 1, 2, and 3 below. First, the abortion cases do not settle the question of the restrictions' constitutionality after fetal viability, though abortion jurisprudence does offer the important lesson that the pregnant woman should not be made to suffer for the survival of even a viable fetus. Second, when viewed within their proper analytical paradigm of "duty to rescue," the restrictions unwisely cede to the state the power to make interpersonal harm/benefit comparisons between the mother and the fetus. That state power radically alters established common law prohibiting the forcing of a person to undergo medical treatment for another, and indeed seriously threatens the doctrine of informed consent itself. Third, the pregnant woman's special relationship with the fetus (the basis for "fetal neglect" arguments) should not be grounds for forcing her to stay alive for its benefit, since, unlike other parents, her crucial interest in bodily integrity is at stake, and she has in no way waived that interest.

1. Gleaning the Right Lessons from Abortion Jurisprudence

Most analysts addressing the pregnancy restrictions simply conclude, with little argument, that because the state may usually prohibit abortion after fetal viability, it also may constitutionally compel the woman pregnant with a viable fetus to undergo life-prolonging medical treatment.[111] Such elementary analysis finds company with courts and theorists who argue more generally that the state may coerce a pregnant woman to undergo medical treatment for the sake of a viable fetus.[112] However, the state's substantial interest in prohibiting abortion after viability does not necessarily translate into unfettered power to use *any means available*, including coerced medical treatment, to protect the fetus. A profound difference exists between prohibiting intentional destruction of the fetus through abortion, and mandating that the mother undertake positive duties of assistance toward it

---

[111] *Id.*

[112] *See, e.g.*, Jefferson v. Griffin Spalding Memorial Hospital, 274 S.E. 2d 457 (Ga. 1981) (holding that woman constitutionally could be compelled to undergo a cesarean section, in light of Roe and its decedent cases) (*see infra* note 128, discussing Jefferson). *See also*, Meyers, *supra* note 13, at 18 (since the state's interest in the viable fetus allows it to prohibit abortion, it also may "proscribe other acts calculated or likely to lead to the same result. Furthermore, since the interest in preservation of fetal life authorizes intervention to prevent destructive acts, it should also authorize limited compulsion of action which is necessary to preserve fetal life...").

that require her to sacrifice her bodily integrity to forced medical invasion.[113] As Janet Gallagher succinctly notes, "Roe v. Wade may have its flaws, but granting open season on pregnant women after viability is not one of them."[114]

A more sophisticated, but nevertheless flawed, argument for the determinative authority of Roe in forced medical treatment cases is that since Roe requires that the woman bear the bodily burdens of pregnancy after fetal viability, then "more limited physical intrusions to prevent harm to the offspring," such as forced medical treatment, should be allowed as well.[115] This argument, however, fails to recognize that the source of that physical intrusion makes all the difference. In pregnancy it is not the state, but the fetus, a being with no moral culpability, that creates a bodily imposition on the woman. However, when the state, as a moral actor, also invades the pregnant woman's body, one must ask whether that additional invasion is morally (and constitutionally) justified. Surely the state's invasion of the woman's body cannot be justified merely because compelled medical intervention imposes, in part, the same type of burdens on the woman as the pregnancy itself.

Thus, the appropriate question to be asked here is not simply the threshold question, "Is the fetus viable?," but rather, "What may the state legitimately do to pursue its interest in the viable fetus?" Roe and its progeny alone do not answer that latter question, here properly framed as whether the state constitutionally may compel a woman to undergo potentially invasive and painful medical treatment to keep her viable fetus alive.

Another lesson from the abortion cases, however, is critical to the constitutionality of pregnancy restrictions operable after fetal viability. The Supreme Court has made clear that the state does not enjoy unrestricted authority to protect the viable fetus. The woman's interest in protecting her

---

[113]Rhoden, *supra* note 33, at 1965-1966. *See also, e.g.,* In re A.C., 573 A.2d 1235 (D.C. 1990); In re Baby Boy Doe, 632 N.E. 2d 326, 334 (Ill. App. Dist. 1994) ("The fact that the state may prohibit post-viability pregnancy terminations does not translate into the proposition that the state may intrude upon the woman's right to remain free from unwanted physical invasion of her person when she chooses to carry her pregnancy to term"); Lawrence J. Nelson, et al., Forced Medical Treatment of Pregnant Women: "Compelling Each to Live as Seems Good to the Rest", 37 Hastings L.J. 703, 742 (1986) ("The fallacy in this reliance on Wade is both fundamental and serious...[I]t is simply wrong to assert that Wade grants the state unqualified authority to protect the fetus..."); Janet Gallagher, Prenatal Invasions & Interventions: What's Wrong with Fetal Rights, 10 Harv. Women's L.J. 9 (1987) at 32-37 (discussing the "misinterpretation" of Roe in cases that have forced pregnant women to undergo medical treatment such as cesareans or blood transfusions).

[114]Gallagher, *supra* note 10, at 195.

[115]Robertson, Children of Choice, *supra* note 18, at 188.

life and health is paramount over the state's interest in that fetus.[116] The Court has interpreted this exception strictly against the state, holding in effect that it may not require *any* trade-offs between the mother's health and fetal well-being.[117]

The state might argue here, as do some commentators, that the medical treatment mandated by the pregnancy restrictions does not impermissibly trade off maternal for fetal health, because a terminally ill or permanently unconscious woman has no "health" interests to be protected in the first place.[118] However, a non-terminal PVS patient does have health interests at stake, even if the term is defined quite narrowly to encompass only an interest in *future* health. More importantly, state advance directive statutes recognize

---

[116]*See* Colautti v. Franklin, 439 U.S. 379 (1979) (Court characterized as problematical a statute that mandated abortion technique that would increase the likelihood of fetal survival except when a different technique would be "necessary" to save the life or health of the woman, and criticized statute for failing to specify that "the woman's life and health must always prevail over the fetus' life and health when they conflict." *Id.* at 400); Thornburgh v. American College of Obstetricians and Gynecologists, 476 U.S. 747 (1986), *overruled on other grounds by* Casey, 505 U.S. 833 (reaffirming Colautti, Court struck Pennsylvania's abortion technique provision, because, as noted by the appellate court, it "failed to require that [the mother's] health be the physician's paramount consideration" *Id.* at 769). The joint holdings of Coulatti and Thornburgh thus instruct that the state may not require physicians to employ abortion techniques that are less likely to harm the fetus, but that impose any increased health risk on the woman. *See also* Harris v. McRae, 448 U.S. 297, 316 (1980) ("[I]t could be argued that the freedom of a woman to decide whether to terminate her pregnancy for health reasons does in fact lie at the core of the constitutional liberty identified in Wade").

[117]*Id.* For more in-depth discussions of the issue of impermissible "trade-offs" between the mother and fetus, *see also* Levine, *supra* note 20, at 258-262 (observes that Coulatti and Thornburgh "stand for the proposition that there can be no trade-off between maternal health and fetal survival." *Id.* at 259); Rhoden, *supra* note 33, at 1989-1994 (interpreting relevant cases, states that "a fundamental principle of abortion law is that states cannot require trade-offs between the woman's health and the fetus's well-being" *Id.* at 1991-1992); Lawrence J. Nelson and Nancy Milliken, Compelled Medical Treatment of Pregnant Women: Life, Liberty and Law in Conflict, 259 JAMA 1060 (1988), at 1062; Nelson, et al., *supra* note 113, at 742—745 ("Even though the state's interest in protecting fetal life becomes compelling at viability, this interest is *not* sufficiently compelling under the Constitution to support a statutory requirement that the mother bear *any* increased risk to her health in order to save her viable fetus" *Id.* at 745 (emphasis in original)).

[118]*See, e.g.*, Burch, *supra* note 25, at 546 ("At [viability], the state may forbid an abortion from occurring unless the health of the mother is in danger. However, in the case of the incompetent pregnant woman whose prior directive is at issue, this last point is moot because there is no health of the mother to protect"); Lederman, *supra* note 64, at 373 ("Arguably the physical invasion mandated by the pregnancy clause does not expose the mother to risk, due to her terminally ill or vegetative condition"); Gelfand, *supra* note 99, at 780 (emphasizing that Roe and its progeny did not involve terminally ill or permanently unconscious pregnant women).

that terminally ill patients have a basic interest in avoiding physical and emotional pain and suffering caused by life-sustaining medical treatment, an interest that surely implicates a person's health. It seems counterintuitive to talk of the "health" interests of terminally ill patients only if one artificially restricts that notion to factors that permanently affect one's future well-being, excluding very real, albeit transient, physical or emotional pain and suffering. That arbitrarily narrow interpretation of health is inconsistent with the Supreme Court's instruction that the woman's health should be defined quite broadly to include threats to the woman's physical and emotional well-being.[119] There have been no later Supreme Court cases further developing this instruction, though it was generally re-articulated in Casey.[120]

In any event, the crucial issue is not whether or not the terminally ill woman has interests that fit neatly under the rubric of "health" as interpreted in abortion jurisprudence. Rather, it is that the Supreme Court appears to recognize that *if a woman might suffer physical or emotional harm from her pregnancy*, she should not be compelled to continue it regardless of fetal age. By requiring that her interest in avoiding harm be the physician's (and the state's) paramount concern, the Court implicitly instructs that the pregnant woman is not to be used solely as a means for the fetus's end, an object for the purposes of fetal gestation. Instead, she must be treated as an end in herself, a human being who at a minimum has the legally cognizable interest in protecting herself from physical and emotional harm. In this respect, the Court generally embraces the Kantian categorical imperative that no person may be used simply as a means to another's end (though in this case that "other" is not yet even a person).[121]

> Consistent with this point, the state should not be allowed to trade off a pregnant woman's critical interest in avoiding suffering to benefit even a viable fetus.[122] At bottom, the woman's interests

---

[119]*See, e.g.*, Doe v. Bolton, 410 U.S. 179 (1973); United States v. Vuitch, 402 U.S. 62 (1971). *See also* articles cited *supra* note 117.

[120]Casey, 505 U.S. at 880.

[121]Specifically, Kant instructs that we should "act in such a way that you always treat humanity, whether in your own persons or in the persons of any other, never simply as a means, but always at the same time as an end." I. Kant, Groundwork for the Metaphysics of Morals, at 96 (H.J. Paton trans. 1964). *See, e.g.*, Rhoden, *supra* note 33, at 1995-1997 (discussing how forced cesareans wrong women by treating them simply as a means). I expand on this theme when discussing the technological objectification of the pregnant woman, and how that objectification is tied to women's subordination, in Part III below.

[122]*See, e.g.*, Lederman, *supra* note 64, at 373 (woman's right to bodily integrity and self-determination should not be traded off for the sake of the fetus).

> both in ending a harmful pregnancy and in refusing medical treatment intended to help the fetus, involve her ability to protect herself from *forced suffering for the benefit of the fetus.* For the state to force the pregnant woman to physically or psychologically suffer solely for fetal benefit, indeed in this case literally to be used as the mechanical means for fetal survival, is the definitive use of the woman simply as a means for fetal ends, and is blatantly inconsistent with the Supreme Court's mandate.

Nevertheless, most state pregnancy restrictions would categorically prohibit the pregnant woman from dying despite any potential pain and suffering caused her by prolonging her life.[123] Further, it is safe to predict that most pregnant women who are forced to stay alive would suffer both physically and emotionally, given that the medical profession is notoriously bad at providing adequate pain control at the end of life,[124] and that physicians may under-utilize palliative care for fear it could harm the fetus. Yet to force the pregnant woman to suffer fails to respect her undisputed moral status as a human being, totally subordinating her critical interests to the good of a being that does not even enjoy legal protection as a person,[125] and whose status in the moral community remains in dispute. If the pregnant woman is to be treated as more than simply a fetal container with no legally cognizable interest in avoiding forced suffering, then only she or her proxy, and not the state, should be able to decide whether she will submit to potentially invasive and painful medical treatment that might be necessary to keep her alive.

In addition (though overlooked by previous authors), the forced cesarean controversy is quite relevant to the issue of the maternal/fetal trade-offs required by the pregnancy restrictions. Specifically, two state appellate cases have held that the state may not make the trade-off between the woman's bodily integrity and the viable fetus by forcing her to undergo a cesarean section. Consistent with the views of a number of theorists,[126] the D.C. and Illinois appellate courts found, in In re A.C. and In re Baby Boy Doe,

---

[123]*See* notes 48, 58 and accompanying text.

[124]*See, e.g.*, the results of the SUPPORT Study, *supra* note 33.

[125]Justice Stevens, in his Casey concurrence, observes that Casey implicitly reaffirms Roe's holding that "the State's obligation to protect the life or health of the mother must take precedence over any duty to the unborn," because, as held in Roe, the fetus, as a "developing organism," is not a person under the Fourteenth Amendment, and thus abortion is not the termination of constitutionally protected life. Casey at 912-13.

[126]*See, e.g.*, articles *supra* note 117.

respectively,[127] that the state could not constitutionally force a pregnant woman to undergo a cesarean, even to save the life of a viable fetus. After noting that these cases fit most neatly not within the abortion context, but "duty to rescue," or samaritan, jurisprudence,[128] both courts explicitly declared that the mother's wishes must govern, rather than allowing the state to balance the risks to the fetus without the cesarean against those to the mother posed by the cesarean.[129] These cases constitute strong legal precedent for the proposition that the state may not objectively balance, or trade-off, the

---

[127]In re A.C., 573 A.2d 1235 (D.C. 1990); In re Baby Boy Doe, 632 N.E. 2d 326 (Ill. App. Ct. 1994). The Supreme Court denied certiorari on appeal of the first, unwritten opinion of the Illinois appellate court. Baby Boy Doe v. Mother Doe, 114 S.Ct. 652 (1993). Given the importance of the issue, the Illinois appellate court later decided to issue the written opinion cited here.

[128]*See contra,* Jefferson v. Griffin Spalding Memorial Hospital, 274 S.E.2d 457 (Ga. 1981), where the Georgia Supreme Court held that a woman could constitutionally be compelled to undergo a cesarean section for the benefit of the fetus. The Jefferson court wrongly relied on Roe and its progeny as determinative of the state's authority to compel medical treatment after fetal viability. The court also incorrectly invoked Raleigh Fitkin-Paul Morgan Memorial Hospital and Ann May Memorial Foundation v. Anderson, 201 A.2d 537 (N.J.), cert. denied, 377 U.S. 985 (1964), which ordered a pregnant woman to undergo a blood transfusion to protect a viable fetus. The Raleigh case is of little precedential value, since it predates both Roe and Cruzan, and involves relatively noninvasive medical treatment. *See* Levine, *supra* note 20 at 241-254. The cesarean in Jefferson ostensibly was ordered to benefit maternal, rather than only fetal, health, as also was the case in In re Madyun, 114 Daily Wash. L. Rptr. 2233 (D.C. Super. Ct. July 26, 1986), reprinted in In re A.C., a fact relied on by the A.C. court to distinguish the Madyun case. It is unclear, however, why it would be more proper for a court to order a cesarean that benefits the mother, than one performed to save the fetus. If no balancing is to be done between maternal and fetal risks, as the A.C. court held, then maternal benefit should be irrelevant. Further, when the state paternalistically orders medical treatment partly because it is potentially beneficial to the mother, the doctrine of informed consent is seriously imperiled. *See* subsection 2 below.

Both courts relied on federal and state precedent to find that the woman's right to refuse medical treatment, and thus to protect her bodily integrity, extended to treatment necessary to save the life of another. As such, both correctly placed the issue squarely within the paradigm of samaritan law. *See* subsection 2 below.

[129]*See* In re A.C., 573 A.2d at 1247 ("We hold that without competent refusal of A.C. to go forward with the surgery, and without a finding through substituted judgement that A.C. would not have consented to the surgery, it was error for the trial court to proceed to a balancing analysis, weighing the rights of A.C. against the interests of the state"); In re Baby Boy Doe, 632 N.E.2d at 330 ("We hold today that Illinois courts should not engage in such a balancing [between the risks to the fetus and the mother's right to refuse medical treatment], and that a woman's competent choice in refusing medical treatment as invasive as a cesarean section during her pregnancy must be honored, even in circumstances where the choice may be harmful to her fetus").

woman's interest in bodily integrity against fetal interests,[130] at least where the medical treatment proposed is risky and physically invasive.[131]

The In re A.C. opinion is also especially instructive here because it held that the pregnant woman's terminal condition did not weaken her interest in refusing a cesarean section, stating that "the right of bodily integrity is not extinguished simply because someone is ill, or even at death's door."[132] To assert that terminally ill patients have a lesser interest in protecting their bodily integrity would establish an alarming precedent. Indeed, that view is belied by the very enactment of advance directive statutes enabling terminally ill adults to refuse medical care. Thus, if the state is to fully respect the moral personhood of the pregnant woman, as well as valuing both constitutional precedent and theoretical consistency, it may not justify the pregnancy restrictions simply by asserting that because the woman is already terminal or vegetative, she has a weakened interest in refusing the bodily invasions of life-sustaining medical interventions.[133]

2. *Requiring Harmful Rescues, and the Potential Erosion of Informed Consent Doctrine*

While the In re A.C. and In re Baby Boy Doe cases do not fully develop the point, when the state purports to determine in some "objective" fashion that a pregnant woman should be treated against her wishes to benefit the fetus, it makes, according to Nancy Rhoden, an "interpersonal risk-benefit

---

[130]The A.C. court did not rely for this finding on the Supreme Court's holdings in Coulatti and Thornburgh that the woman's health must trump the interests of the viable fetus, presumably because the court was adamant that its opinion had nothing to do with abortion. The court in In re Baby Boy Doe did cite Thornburgh as representing "[f]ederal constitutional principles prohibiting the balancing of fetal rights against maternal health [that] further bolster a woman's right to refuse a cesarean section." 632 NE.2d 333 at 403.

[131]Both courts expressly refused to decide whether a pregnant woman might constitutionally be ordered to undergo relatively non-invasive, riskless medical treatment for the benefit of the fetus. *See* In re A.C., 573 A.2d at 1246, note 10; In re Baby Boy Doe, 632 N.E. 2d 333. However, since such an order would require that the court balance maternal and fetal risks and benefits, it would be inconsistent with the courts' own prohibitions against such balancing. *See* Levine, *supra* note 20 at 252. I argue below that a pregnant woman should not be forced to undergo even a less invasive, less risky procedure such as blood transfusion, since the medical profession and the state are ill-equipped to "objectively" balance the risks and benefits to patients of any medical treatment, as presumed by informed consent doctrine. *See infra* note 149 and accompanying text.

[132]573 A.2d at 1246.

[133]*See also, supra* note 99 and 118 and accompanying text.

comparison" between the potential benefits and risks (or harms) posed to the mother and fetus with and without the proposed medical treatment.[134] However, as Rhoden so persuasively argues in the context of forced cesareans,

> The legitimacy of [the interpersonal risk-benefit comparisons] depends on the assumption that a third party can step in and weigh the risks of surgery [or other medical treatment] for someone who has competently chosen to forego them, and can then order that these risks be run. This is an assumption that has always been rejected in American jurisprudence, and that, if accepted, has far-reaching and extraordinarily frightening implications.[135]

The settled American jurisprudence to which Rhoden refers is "samaritan law," or the law concerning whether one has a legal duty to rescue another. Samaritan law is clearly the legal paradigm most relevant to the forced medical treatment of pregnant women, including the scenario envisioned by the pregnancy restrictions. Abortion jurisprudence, as noted above, does not specifically instruct concerning what steps the state may take to protect the viable fetus. And the "child neglect" paradigm often urged in support of forced medical treatment of pregnant women is not appropriate, since children, unlike fetuses, no longer reside within their mother's bodies; to dismiss that difference as irrelevant grossly trivializes the pregnant woman's interest in protecting her bodily integrity, as discussed in subsection 3 below.[136]

Under samaritan law, persons generally do not have a duty to undertake rescues that might harm them.[137] It is thus settled that the interest in bodily integrity is so sacred that a person cannot be compelled to undergo medical treatment even to save the life of another. Specifically, the courts to date have rejected the proposition that they should have the power to judge whether the

---

[134]*See* Nancy K. Rhoden, Cesareans and Samaritans, 15 Law, Med. & Health Care 118 (1987), at 121. In the context of the pregnancy restrictions I prefer to call this balancing an "interpersonal harm/benefit" comparison, since "risks" connotes, to many, only a risk to long-term health interests.

[135]*Id.* at 122.

[136]For discussion of the relevance of samaritan law as applied to the forced cesarean cases, *see* Rhoden, *supra* note 33; and the In re A.C. and In re Baby Boy Doe cases, *supra* note 127.

[137]I do not here argue for the traditional "duty to rescue" principle that, among strangers, we have no duty to undertake even easy, riskless rescues; that common law doctrine increasingly has been criticized as too harsh. *See, e.g.*, Joel Feinberg, The Moral Limits of the Criminal Law, (vol. I) (1984), at 126-185; Matheiu, *supra* note 18, at 52-55. Rather, I address whether the law should impose a duty to undertake a potentially *risky, or harmful,* rescue for another, indeed even for a member of one's family.

harms caused the patient by forced surgery or other medical intervention are outweighed by the proposed benefits to another, even a family member. For instance, in McFall v. Shimp,[138] one of few cases to directly address this issue, the court refused to order Shimp to donate bone marrow to save the life of his cousin, McFall, stating forcefully that

> The common law has consistently held to a rule which provides that one human being is under no legal compulsion to give aid or to take action to save another human being or to rescue...For our law to *compel* defendant to submit to an intrusion of his body would change every concept and principle upon which *our* society is founded...For a society which respects the rights of one individual, to sink its teeth into the jugular vein or neck of one of its members and suck from it sustenance for *another* member, is revolting to our hard-wrought concepts of jurisprudence...Such would raise the spectre of the swastika and the Inquisition, reminiscent of the horrors this portends.[139]

Other courts similarly have refused to order minor or incompetent siblings to donate organs or bone marrow for another sibling, even when the sibling's life depended on it.[140]

Yet the pregnancy restrictions violate this well-established rule against state-enforced interpersonal harm/benefit comparisons, requiring the pregnant woman to be a "splendid samaritan,"[141] one who must abide potentially intrusive, painful and sustained medical treatment to save the life of a fetus that, unlike herself and living children, is not, and should not be, accorded constitutional status as a person.[142] In this respect, the restrictions thus go far

---

[138]10 Pa.D. & C.3d 90 (1978).

[139]*Id.* at 91-92, emphasis added.

[140]*See, e.g.*, Curran v. Bosze, 566 N.E.2d 1319 (Ill. 1990); In re Pescinski, 226 N.W. 2d 180 (Wis. 1975).

[141]That term is used by Rhoden, *supra* note 134, at 121, who in turn borrows it from Judith Jarvis Thomson's classic article arguing that women forced to remain pregnant are required to be "splendid samaritans." *Id.* at note 29, citing Thomson, A Defense of Abortion, Philosophy and Public Affairs 1971, I(I): 47-66,48-52.

[142]Some argue that it is not the woman's duty to rescue the fetus that is implicated where fetal health is compromised by a pregnant woman's treatment refusal, but rather the "contractual" duty of the obstetrician to rescue the fetus, and that the "obstetrician's duty to rescue [the fetus] is not dependent on whether the pregnant woman permits the rescue." *See* Phelan, *supra* note 16, at 483. Phelan analogizes the doctor's legal duty to rescue the fetus in the forced cesarean cases to a lifeguard's duty to rescue a drowning child even against the express wishes of its mother, and concludes that "with the exception of the maternal abdominal wall, the obstetrician's position is no different that the lifeguard's. Both the obstetrician and

beyond even what could be constitutionally required of a parent to save the life of her child.[143] While the state surely has an interest in protecting the lives of its citizens, the argument that the state may order one person to undergo intrusive medical treatment for the benefit of another, even one's own child, likely would not, and should not, be positively received by any court.[144]

Critically, however, even if the states were ceded the power to make interpersonal harm/benefit comparisons in limited circumstances, the large majority would be precluded from arguing that their pregnancy restrictions even *attempt* to allow any objective comparison between the harms and benefits posed the individual woman and the fetus in any particular case. Most pregnancy restrictions blanketly mandate the continuation of any and all life-prolonging medical treatment, *regardless* of the treatment's invasiveness or duration, its potential to cause the woman serious physical or emotional

---

the lifeguard have a duty to rescue and prevent or minimize injuries." *Id.* Phelan does have it right in one respect: it is precisely the "maternal abdominal wall" that distinguishes this case from the case of the lifeguard. Perhaps Phelan would have found that difference to be more compelling if he had refrained from reducing the pregnant woman to a body part, and instead recognized that when a doctor forcibly violates that "abdominal wall" to save the fetus, he violates the body of a person. Further, for the state to condition a woman's right to bodily integrity on a perceived duty of the medical profession to save the fetus cedes far too much power to physicians. *See supra* note 84.

[143]The state's interest in protecting third parties historically has been asserted to justify the forced medical treatment of parents with minor children, such as Jehovah's Witness cases in the 1960s. *See, e.g.*, In re President and Directors of Georgetown College, 331 F. 2d 1000 (D.C. Cir.), *cert denied* 377 U.S. 978 (1964) (court held that parent could not refuse blood transfusion partly because of dependent children). These cases, decided before the burgeoning refusal of treatment jurisprudence developed in the 1970s and 1980s, are outdated, and likely would be decided differently today. *See, e.g.*, Nelson, et. al, supra note 113, at 758-759; Rhoden, *supra* note 33, at 1973-1975; Gallagher, *supra* note 113, at 34-36. Courts are increasingly skeptical of orders forcing a parent of minor children (almost always the mother) to undergo life-saving treatment. For example, in Fosmire v. Nicoleau, 551 N.E.2d 77 (N.Y. 1990), the New York Court of Appeals rejected the state's argument that it had an interest in the newly born infant sufficient to allow it to force the mother, immediately following parturition, to undergo a blood transfusion against her religious objections. *See also* In re Dubreuil, 629 So.2d 819 (Fla. 1993) (Court struck lower court's holding that a mother may constitutionally be forced to have a blood transfusion over her religious objection, in the interest of protecting her minor child); *see generally*, Levine, *supra* note 20, at 280-282, for discussion of "protection of third party" cases. These recent cases, however, do legitimate fears that the modern state has not yet reversed its propensity to attempt to force women into their "rightful" role as mother, thus subordinating their moral worth as independent moral agents to their relational worth to their children. *See* Part III below.

[144]*See supra* notes 139-140 and accompanying text, and notes 158-159 and accompanying text.

pain and suffering,[145] the fetus's prognosis for live birth, or the risk of permanent damage to the newborn.[146] In essence, these states find that even the *smallest* chance of live birth would, in every case, justify forcing the pregnant woman to undergo the most painful, invasive life-prolonging treatment imaginable. That the woman's humanity could be rendered so invisible, so clearly an object for fetal gestation, is truly frightening.

It is also disturbing that these pregnancy restrictions force the physician to violate her beneficent obligations to her patient, by requiring her to abandon her role as advocate for the woman's best interests.[147] A physician's beneficent obligation to her patient do not simply expire once the patient is pregnant or incompetent, but remain intact. Relevant ethical guidelines counsel that physician involvement in coerced medical treatment of the pregnant woman for the benefit of the fetus seriously harms the physician-patient relationship, and should be avoided.[148] Indeed, those states with both proxy and statutory surrogate restrictions leave the incompetent pregnant woman doubly abandoned, since she has neither physician nor proxy to advocate for her best interests.

As a general matter, however, why should the state not be permitted to force a pregnant woman to suffer, if it deems that suffering reasonable in light of the end it serves, specifically saving the life of a viable fetus? Why, for instance, could the state not at least order that a pregnant woman receive a blood transfusion in order to stay alive for the fetus? It may not do so, in part,

---

[145]Very few states expressly take into account the woman's physical suffering when requiring continued medical treatment. *See supra* notes 48, 58 and accompanying text. Absolutely no state considers that the woman may suffer serious emotional harm as a consequence of forcing her to undergo medical treatment.

[146]*See, e.g., supra* notes 45-47, and accompanying text.

[147]*See, e.g.*, Susan Mattingly, The Maternal-Fetal Dyad: Exploring the Two-Patient Obstetric Model, Hastings Ctr. Rep. Jan.-Feb.1992, at 13 (physician's ethical obligations to the pregnant woman precludes her from "trading off" between patients, between the woman and her fetus, since beneficence applies to patients only "one by one." *Id.* at 14.)

[148]The American College of Obstetrics and Gynecology, Committee on Ethics, Committee Opinion No. 55 (1987), at 1 ("Actions of coercion to obtain consent or force a course of action [on the pregnant woman] limit maternal freedom of choice, threaten the doctor/patient relationship, and violate the principles underlying the informed consent process"); Board of Trustees, American Medical Association, Legal Interventions During Pregnancy: Court-Ordered Medical Treatments and Legal Penalties for Potentially Harmful Behavior by Pregnant Women, 264 JAMA 2663 (1990), , at 2666 ("The physician's duty is to ensure that the pregnant woman makes an informed and thoughtful decision, not to dictate the woman's decision"). *See, e.g.*, In re Baby Boy Doe, 632 NE.2d 326, at 334-335 (court, citing the AMA guidelines, finds that by forcing the woman to have a cesarean, physician breaches his ethical duty to her).

because weighing potential harms and benefits of a medical intervention for any particular person is by necessity a deeply subjective enterprise, given that *"suffering is personal."* No one knows how any one person would physically and emotionally experience a particular forced medical treatment. While we might speculate that physical pain may be compared on an objective scale (e.g., a blood transfusion, for most persons, would not be as physically painful as major surgery), that would hold only as a general rule. And a "reasonable person" standard used to measure *emotional* suffering would be even more speculative, since personal variables abound. For instance, if the woman has objected to medical treatment on religious grounds, then to force her to violate her religious beliefs could cause profound psychic harm. Since there simply is no way to accurately predict how any given pregnant woman will subjectively experience a blood transfusion, only she should be allowed to weigh the risks and benefits to her of that procedure.[149]

Even more importantly, what would be the "far reaching and extraordinarily frightening implications" to which Rhoden refers, of allowing the state to make such interpersonal harm/benefit comparisons? To permit these types of comparisons seriously erodes the key underlying justification for informed consent doctrine itself. The established legal rule of informed consent to medical treatment is grounded on the truth that "suffering is personal": Since only the patient will experience the medical treatment being recommended, only the patient (or her proxy), and not the physician or the state, may accurately weigh the treatment's potential harms and benefits to her.[150] If the autonomy of the patient is to be meaningfully respected and paternalism rejected, then only she may decide what potential harms she is willing to suffer for any particular proposed therapeutic benefit.

One may argue that the doctrine of informed consent, which generally forbids us to make *intrapersonal* harm/benefit comparisons for another, is

---

[149]Regardless of where one comes down on the blood transfusion issue, however, much, if not most, of the life-sustaining treatment that would be mandated by the pregnancy restrictions probably would not be a relatively short and painless intervention like a blood transfusion, but rather a combination of treatments, sustained over a period of time, that could cause significant physical or emotional discomfort and suffering. For instance, artificial respiration entails extensive and extended bodily invasion and mobilization that could cause much physical and emotional suffering.

[150]*See, e.g.*, Rhoden, *supra note* 33, at 1970 ("[Informed consent doctrine] shows that risk-benefit judgments about medical treatment are the patient's to make, and not the doctor's. A physician might consider it absurd to forgo potentially beneficial surgery because of a one-percent risk of paralysis. But individuals weigh risks differently, and the informed consent doctrine respects this.") As Rhoden elsewhere observes, the old saw "Minor surgery is surgery performed on somebody else" nicely captures this notion. Rhoden, *supra* note 134, at 122.

therefore not endangered if *interpersonal* comparisons are allowed. Before one thinks it overly alarmist to draw a connection between the state's forcing pregnant women to undergo medical treatment and a lapse into legal paternalism, consider the case of Crouse Irving Memorial Hospital v. Paddock.[151] There, the court held that a pregnant woman could be forced to have a blood transfusion that she had refused as a Jehovah's Witness, not only during a consented cesarean section in order to save the fetus, but also after the cesarean *to safeguard her own life.* Thus, once the woman lost her authority to refuse the blood transfusion based on the court's interpersonal harm/benefit comparison between her and the fetus, she never regained it even when only her own fate was at stake.[152]

The Crouse case illustrates how short a step it is from purporting to "objectively" judge what risks are "reasonable" for the patient to run for the benefit of the fetus, to second guessing a competent patient's treatment refusal that would harm only her. In fact, one theorist goes so far as to argue that a pregnant woman's refusal of a cesarean section that is medically indicated for her own health is "irrational," and thus "because the irrationality will cause harm not only to the patient herself but to a third party [the fetus],...the law is justified in intervening to save the two lives."[153] Critically, the author labels the woman's treatment refusal as "irrational" *not* because it places fetal life at risk, but rather because the refusal is "self-harming" behavior not based on a "future-oriented adequate reason."[154]

This view, along with the Crouse holding, underscores what is in fact the crucial issue: *Who is to have control over the pregnant patient's medical treatment: the patient, or the physician as an agent of the state?* That a pregnant woman could be labeled "irrational" because she refuses treatment

---

[151]485 N.Y.S.2d 443 (Sup. 1985).

[152]The court reasoned that since the woman had consented to the cesarean section, her physician could dictate the terms under which the procedure would be performed; such argument contains an implicit judgement that the woman's refusal of the blood transfusion was not reasonable under the circumstances. *Id.* at 446.

[153]*See* Joel Jay Finer, Toward Guidelines for Compelling Cesarean Surgery: Of Rights, Responsibility, and Decisional Authority, 76 Minn. L. Rev. 239, 283-284 (argues that Webster v. Reproductive Health Services, 492 U.S. 490 (1989), "demonstrated the Supreme Court's willingness to uphold legislation that created some risk to the mother's health for the sake of the fetus"; statute upheld permitted physicians to perform viability testing).

[154]*Id.* at 282, note 230. Finer notes that he uses the term "irrational" consistent with Bernard Gert and Charles M. Culver in Philosophy of Medicine: Conceptual and Ethical Issues in Medicine and Psychiatry (1982). Finer also admits, however, that Gert and Culver do not use their "irrationality" argument as a basis for justifying legal paternalism. *Id.*

potentially beneficial to her, that her *reasons* for treatment refusal are scrutinized, attests not only to the precarious medical autonomy of pregnant women, but of all patients.[155] In short, to forget that "suffering is personal" threatens the very core of informed consent doctrine, risking a lapse into gross paternalism.[156]

3. *The Weakness of the "Special Relationship" and "Waiver" Arguments*

a. *The "Special Relationship" Argument*

Under child neglect doctrine, the law imposes on parents some affirmative duties to assist their children, such as obtaining necessary medical care, based

---

[155]The second-guessing of women's refusals of cesarean sections or other medical treatments raises further quite troubling concerns. Examples include the likelihood that the reasons given by pregnant women for refusing medical care will be ignored or trivialized, or the disparate enforcement of treatment refusal policies against poor and minority women, whose reasons for refusing treatment hold even less legitimacy in the eyes of responsible authorities. For a discussion of these and other related issues, *see, e.g.*, Nancy Ehrenreich, The Colonization of the Womb, 43 Duke L. J. 492 (1993); Ikemoto, *supra* note 13; Molly McNulty, Pregnancy Police: The Health Policy and Legal Implications of Punishing Pregnant Women for Harm to Their Fetuses, 16 N.Y.U. Rev. L. & Soc. Change 277 (1987-88); Dorothy E. Roberts, Punishing Drug Addicts Who Have Babies: Women of Color, Equality, and the Right of Privacy, 104 Harv. L. Rev. 1419 (1991).

[156]Of course, courts have held that the state rightly may, in limited circumstances, coerce persons to undergo medical treatment for the public good. For instance, forced vaccinations are necessary in order to protect the public health. *See* Jacobson v. Massachusetts, 197 U.S. 11 (1905). In the criminal arena, the Supreme Court conducts a balancing test, weighing the state's need for the evidence against the risks and invasiveness of the proposed medical intervention. *See, e.g.*, Winston v. Lee, 470 U.S. 753 (1985). (Court found unconstitutional forced surgery on a prisoner to remove a bullet lodged near his collarbone). Indeed, Winston illustrates the judiciary's grave hesitance to force a person to undergo medical invasions. These situations differ significantly from the forced medical treatment of pregnant women. In the former, the state is weighing the costs of a (very minor, in the case of vaccinations) physical invasion against serving a broad, quite public interest, such as avoiding an epidemic, or ensuring an effective criminal justice system. While the state's interest in potential life is surely an important one, the forced medical treatment of pregnant women in fact balances the harms to the individual woman not against the public good, but rather against the interests of an individual fetus (being asserted by the state). *See, e.g.*, Rhoden, *supra* note 33 at 1982-86 (discussing balancing of harm of mandatory invasive surgery with the state's interests). *But see* Finer, *supra* note 117, at 263-266. We all may be expected, at times, to sacrifice for the public good, but to be forced to physically suffer for the direct benefit of another (potential) person, to be literally used simply as a means for another's end, is a result traditionally abhorred by our law, and for good reason. *See supra* notes 139-140 and accompanying text.

on their special moral relationship with their child. To justify the pregnancy restrictions, the state might assert that the pregnant woman's special moral and physical relationship with the fetus renders a treatment refusal tantamount to "fetal neglect," analogous to child neglect, and thus that it may permissibly prevent the death of the viable fetus by insisting that the woman artificially prolong her life.

The fetal neglect argument, however, is seriously flawed as a justification for the pregnancy restrictions. First, as applied in the context of the restrictions, the fetal neglect argument wrongly assumes that the viable fetus has a "right to be born." By forcing the woman to stay alive to bear the fetus, the state presumes that the life of a viable fetus deserves the same protection from harm as an already-born child. Again, however, Roe and Casey make clear that even a viable fetus may not be deemed a "person" under the constitution, and therefore does not have a "right to life," a right to be born, that is superior to the mother's own interest (who is undeniably a human being with full moral status) in protecting herself from harm.[157]

Indeed, to analogize fetal neglect to child neglect accords the viable fetus even greater legal protection than that of a born child. As noted earlier, it is highly unlikely that a parent would be charged with child neglect for refusing a medical intervention proposed for the child's benefit, such as a bone marrow transplant, in light of the established common law prohibition against forcing persons to undertake "risky rescues," to undergo medical treatment for the benefit of another.[158] If pregnant women, but not parents in general, are coerced to suffer bodily invasions for the sake of the viable fetus, the fetus is in fact receiving more state protection than would a born child.[159]

---

[157]The state could not logically argue that the viable fetus, as a "child yet to be born," has the same moral and legal status as a living child. As already noted above, that argument is usually asserted to justify the state's prohibition on harms to even a nonviable fetus assuming the fetus *eventually will be born*, and thus would be question-begging in this context. *See supra* note 18. However, the state could attempt to argue that once viable, the fetus attains interests in its own right (*see, e.g., infra* notes 160, 163), but those interests still would not necessarily outweigh those of the woman.

[158]*See supra* notes 139-140 and accompanying text.

[159]As discussed in Part III, that a father would not be required to undergo medical treatment for the sake of his born child, but a pregnant woman can be compelled to do so for the fetus's benefit, also raises grave concerns about a social morality and law that impose duties of nurturance primarily on women, and thus implicates serious equal protection claims as well.

Theorists have attempted to address this double standard requiring extraordinary duties of assistance by pregnant women, but not by fathers or parents in general. For instance, Thomas Murray generally urges the use of a "child as maximum" principle in analyzing the scope of the pregnant woman's beneficent duties to the fetus, the principle that her obligations should not

Second, even assuming the viable fetus has a similar legal interest in not being fatally harmed as does a living child, for the state to force a pregnant woman to undergo medical treatment in order to prevent "fetal neglect" seriously misapplies the "child neglect" model, at the grave expense of ignoring the woman's critical interests in bodily autonomy and avoiding physical harm. Proponents of the fetal neglect paradigm generally argue that the harm principle, expanded in the familial context to require positive duties to assist one's offspring, imposes a legal duty on women to prevent harm to viable fetuses (or nonviable fetuses that will be brought to term), just as parents have the duty to prevent harm to their born children such as by providing necessary medical care.[160] But the child neglect model cannot neatly be applied to fetal harms, as opposed to harms to a child who is physically separate from her parents, without rendering meaningless the pregnant woman's interest in bodily autonomy. Because the fetus develops inside the woman, forced medical treatment intended to assist it totally

---

exceed those that we would expect of fathers toward their children. See Thomas Murray, Moral Obligations to the Not-Yet-Born: The Fetus as Patient, 14 Clinics in Perinatology 329, 336-38 (1987). Robertson more specifically argues that it would be appropriate for the state to require of *all* parents the duty to prevent harm to their child even where their autonomy may be limited, including the duty to undergo medical treatment for the benefit of their child. Robertson, Children of Choice, *supra* note 18, at 191-194. However, to afford the state the power to mandate that all parents undergo medical treatment to benefit their children is too drastic an erosion of citizens' interest in bodily integrity and autonomy. *Accord*, Mathieu, *supra* note 18, at 105) (parents should not be required to undergo invasive medical treatment to benefit their children). Further, it is indisputable that such a seemingly even-handed rule would be applied in a grossly disparate way, and thus pregnant women still would bear the brunt of state-coerced medical treatment, raising equal protection worries. *See infra* notes 257-258 and accompanying text. For more on the issue of fathers' responsibilities to their unborn children and so-called "paternal-fetal conflict" issues, *see, e.g.*, Joseph Losco and Mark Shublak, Paternal-Fetal Conflict: An Examination of Paternal Responsibilities to the Fetus, 13(1) Pol. & Life Sci. 63 (1994), and responding articles in Symposium, Paternal-Fetal Conflict, 13(2) Pol. & Life Sci. 249 (1994).

[160]Robertson, for example, argues that "[T]he idea that personal autonomy allows pregnant women to disregard the risk of prenatal harm to their offspring seems wrong. Autonomy is limited by the harm principle—the duty to avoid harming others, and clear harm often results from the prenatal conduct in question." Robertson, Children of Choice, *supra* note 18, at 173. Robertson analogizes fetal neglect to child neglect: "The mother has, if she conceives and chooses not to abort, a legal and moral duty to bring the child into the world as healthy as is reasonably possible. She has a duty to avoid actions or omissions that will damage the fetus and child, *just as she has a duty to protect the child's welfare once it is born until she transfers this duty to another.*" Robertson, Procreative Liberty, *supra* note 18, at 438 (emphasis added). *See also*, Finer, *supra* note 117, at 254 ("If a viable fetus is a child-in-waiting, i.e., a verge-of-birth fetus, then analogical inferences may be drawn from the law governing parental obligations to children"); Mathieu, *supra* note 18, at 51.

undermines her most basic liberty to avoid state-coerced bodily invasions.[161] The more fundamental problem is that the harm principle itself, the principle implicit in the child neglect paradigm, traditionally envisions a (male) model of relationships between separate, physically disconnected others, others whom we are not to harm by commission in the usual case, and by certain omissions in the case of the parent-child relationship. Yet for the pregnant woman, there simply is no model of relations with a disconnected other. Her every act or omission conceivably could harm or benefit her fetus in some way.[162] At bottom, to afford viable fetuses legal protection by analogy to the child neglect model wreaks havoc on pregnant women's most basic physical agency, causing them serious harm.[163]

---

[161]Nancy Rhoden observes that "[b]ecause there are no correlative physical burdens involved in providing medical treatment for one's child, child neglect law is far less relevant than it initially appears," and that to force a pregnant woman to undergo medical treatment for the benefit the fetus forgets that "the woman is there—and there in a more substantial role than either a mere fetal proxy or an inconvenient, albeit necessary, fetal container." Rhoden, *supra* note 33, at 1968.

[162]*See, e.g.*, Patricia A. King, Should Mom Be Constrained in the Best Interest of the Fetus?, 13 Nova L. Rev. 393 (1989) (noting that how a mother's actions affect her fetus "implicates everything a pregnant woman does from the time she gets up in the morning until the time she goes to bed at night," and "touches on the most private kinds of behavior, including the sexual relationship with her spouse or lover, not just what she does in public or at work, but also what she eats and how, or whether, she moves" *Id.* at 397).

[163]Some also argue that the viable fetus already enjoys legal status in its own right since tort and criminal law gives a cause of action for, or punishes, fetal injuries caused by third party actors. *See, e.g.*, Shaw, *supra* note 13, at 111-113. *See also*, Robertson, Procreative Liberty, supra note 18, at 439-42. Yet while this body of law rightly recognizes that the fetus or parents have interests that may be infringed upon by third party actors, it logically cannot, and should not, be applied to the actions of a pregnant woman, for a variety of reasons. Tort and criminal actions based on fetal injury do not prevent constitutionally protected, arguably justified actions in advance that might harm the fetus, but apply only to unjustified, harmful actions already completed. In addition, criminal or civil sanctions for fetal injury were initially intended to protect the interests of the mother, or parents, in the health of their child. Most importantly, third party actors stand in a different relationship to the fetus than a pregnant woman, who, again, has at stake her critical liberty interest in bodily integrity. *See* Dawn E. Johnsen, Note, The Creation of Fetal Rights: Conflicts with Women's Constitutional Rights to Liberty, Privacy and Equal Protection, 95 Yale L. J. 599 (1986), at 602-604. *See also*, Rhoden, *supra* note 33, at 1966-67; Daniels, *supra* note 15, Chapter 1. Consistent with this reasoning, the Illinois Supreme Court held that the fetus had no cause of action against its mother for the unintentional infliction of prenatal injuries, reasoning that, as opposed to third parties, holding a mother liable for such injuries "subjects to State scrutiny all the decisions a woman must make in attempting to carry a pregnancy to term, and infringes on her right to privacy and bodily autonomy." Stallman v. Youngquist, 531 N.E. 2d 355, 360 (Ill. 1988) at 360. *But cf.*, Whitner v. State, 1997 S.C. Lexis 204 (October 27, 1997) (South Carolina Supreme Court is the first state supreme court to find that a woman may be held criminally liable for harm to her unborn child, under the

Should pregnant women in fact have such unique legal duties? The state could urge that the pregnant woman's unique physical relationship with the fetus requires of her an extraordinary duty to rescue that would not be required of most parents. Thus, she may be forced by the state to be a splendid samaritan by sacrificing her bodily integrity for the sake of the viable fetus.[164] But while we may agree that the pregnant woman might have, in some cases, a *moral* responsibility to save the life of her fetus by consenting to medical treatment, it is precisely her physical connection with the fetus that mitigates against *legally* requiring of her a positive duty to undergo medical treatment for its benefit, since her most basic physical liberty is seriously compromised.

It is critical to remember that moral and legal obligations do not automatically follow from biological facts. We as a culture must decide how to respond morally and legally to the biological relationship between the woman and her fetus. Our choice about what legal duties to impose on pregnant women fetus must adequately be informed by meaningful respect for their bodily autonomy. Notably, the In re A.C. majority accorded the woman such respect when it wisely rejected the "special relationship" argument lodged by the dissent, that the woman should be forced to have a cesarean because she was in a "unique category of persons"[165] that had "undertaken to

---

state's child neglect statute; court rejected woman's constitutional privacy clauses); cf. Angela M.W. v. Kruzicki, 561 N.W.2d 729 (Wis. 1997) (Wisconsin Supreme Court holds that, as a matter of statutory construction, the state's child neglect statute does not apply to a viable fetus, and thus the state could not take the fetus into "protective custody" to prevent the woman's drug abuse; court avoided deciding the pregnant woman's constitutional claims). *See* Ariela R. Dubler, Case Note, Monitoring Motherhood, 106 Yale L.J. 935 (1996) for discussion of the Whitner case.

[164]For example, to justify coercive measures against pregnant women in some cases, Robertson argues that "[w]omen are in a special relationship with the fetus and potential child, because of its location inside their bodies. Moreover, the pregnant woman has, in an important sense, acceded to or chosen this relationship, either in getting pregnant or continuing the pregnancy." Robertson, Children of Choice, *supra* note 18, at 190. The "choice" aspect of this argument fails, however, in many cases, as Robertson concedes. *Id.* at 267, note 51. Robertson therefore must argue that the "special relationship" exists based solely on the physical connection with the fetus, regardless of whether she has acceded to it.

[165]To argue that pregnant women are a unique category of persons, as does the dissent in In re A.C., 573 A.2d 1235, 1236 (D.C. 1990), is disturbing to the extent that the characterization is based on a comparison to an (implicit) male norm of physical disconnectedness. While pregnancy is indeed in a class of its own, most women will become pregnant at some point in their lives. Yet if pregnant women's bodily autonomy may be severely restricted, indeed totally violated, because of their "unique" status as pregnant, they are deemed as "secondary citizens" based on their differences from men. *See* Part III.B.2.b below. A meaningful notion of autonomy and political agency for pregnant women (including proper application of the harm principle during pregnancy) clearly is needed to counteract the coercion of pregnant women

bear another human being,"[166] and because the fetus was "totally dependent" on her, indeed "literally captive within the mother's body."[167]

The dissent's rhetoric illustrates a particular way of "reasoning about women," of viewing their roles and worth in our culture, as applied to the biological fact of pregnancy.[168] In essence, the dissent's argument envisions the fetus as a "captive" and the woman as "captor," perhaps because she failed expectations as to what a "good" mother would do under the circumstance.[169] On the other hand, the In re A.C. majority, dealing with the same biological facts, employed a view of pregnancy that affords the woman greater respect as a person *first,* regardless of its view of her performance as a mother, and accordingly gave more weight to her interests in refusing invasive medical interventions. Properly relying on the common law rule against imposing a duty to rescue, the court held that the woman's interest in bodily integrity could not be infringed even to save the life of her viable fetus by court-ordered cesarean section.

b. The Waiver Argument

Finally, as with the "special relationship" argument, the state may attempt to weaken the force of the pregnant woman's valid interests by asserting that she has implicitly consented to medical treatment for the fetus once she has continued the pregnancy to viability. The Supreme Court in Casey, for example, argues that states may prohibit nontherapeutic abortions after fetal viability partly because "a woman who fails to act before viability has consented to the State's intervention on behalf of the developing child."[170] Relatedly, some argue that once a woman has carried the fetus to the point of viability, she has "waived" her interest in refusing medical treatment on its

---

justified by their "different" experience of physical connectedness.

[166]This language incorrectly assumes that a woman pregnant with a viable fetus has necessarily chosen that relationship. *See supra* note 164.

[167]573 A.2d at 1256 (D.C. 1990).

[168]*See* Part III.B.2.a below for further discussion of how biological facts can never alone justify a pregnant woman's moral and legal duties, and how the invisible "social reasoning" about women underlying the pregnancy restrictions, which views women foremost in terms of their social role as nurturer to others, is integrally tied with women's subordination.

[169]As George Annas argues, the dissent's characterization is one of "transforming the mother-fetus relationship into a warden-prisoner relationship." George Annas, Foreclosing the Use of Force: A.C. Reversed, Hastings Ctr. Rep., July-Aug. 1990, at 27, 29.

[170]505 U.S. 833 at 870.

behalf. Margery Shaw, for example, argues that "the mother's duties to protect the fetus from harm also increase [after viability] because she has foregone her right to choose [an] abortion."[171]

Whether one endorses the related notions of a "waiver" of rights or of implied consent in order to qualify the woman's interests, however, neither concept is appropriate in the context of the pregnancy restrictions (assuming they may be correct in other scenarios).[172] An incompetent woman pregnant with a viable fetus cannot be assumed to have made a conscious choice to forgo an abortion. And even if she had, she did not necessarily choose to continue her pregnancy *under all circumstances.*

Further, even problematically assuming that a woman pregnant with a viable fetus has implicitly consented to the state's prohibiting its intentional killing by abortion, the incompetent woman decidedly has not necessarily consented to undergo intrusive medical treatment for the fetus's benefit. An abortion is under the woman's control, at least to the extent that she is "put on notice" that if she wishes to abort, she must do so before fetal viability. The incompetent pregnant woman affected by the pregnancy restrictions had no "notice" of her impending illness and incompetency. Thus, she in no way has *knowingly* waived her right to refuse life-prolonging medical treatment, or impliedly consented to such treatment, merely because she did not obtain an abortion before fetal viability.

To conclude, admittedly no solution that could result in the death of two beings, the mother and her fetus, is ideal, and it may be difficult to understand why fetal interests should not outweigh all other concerns, as our initial intuitions may counsel us. However, the key issue here is decidedly *not* about the extent of the pregnant woman's moral duties to her viable fetus, or of a parent toward her child. Rather, it is about the state's responsibility towards its citizens. Few would deny that the pregnant woman may in some cases have a moral obligation to undergo medical treatment to assist in the fetus's healthy development. It is another thing altogether, however, for the state to transform a woman's complex moral obligations into an absolute legal duty

---

[171]Shaw, *supra* note 13, at 88. Robertson, who applies the waiver argument primarily as a mechanism to locate maternal duties before viability (*see supra* note 18), also seems to imply that the woman waives her autonomous interests once she has carried the fetus to the point of viability. *See* Robertson, Children of Choice, *supra* note 18, at note 15 to Chapter 8, interpreting Roe as holding that "if a woman has continued a pregnancy to viability, a legal duty to continue the pregnancy to term can be imposed. If this bodily imposition is justified by the interests of the fetus, more limited physical intrusions to prevent harm should be as well."

[172]*See supra* notes 18, 108 for serious conceptual and pragmatic concerns with the waiver argument, problems that would also apply to the implied consent position.

to keep the fetus alive by undergoing life-prolonging medical intervention. To do so destroys the pregnant woman's most basic constitutional liberty to avoid state-compelled bodily invasions that might cause her physical and emotional pain and suffering. Moreover, to allow the state to decide what pain and suffering is "reasonable" to require of pregnant women for their fetus (a task most states may not even *pretend* to have undertaken in the context of the pregnancy restrictions)[173] cedes far too much power to the state, power that we have heretofore wisely refused to give in other related circumstances, power that in fact threatens the very heart of informed consent doctrine itself. Accordingly, pregnancy restrictions that compel a woman pregnant with a viable fetus to undergo life-prolonging medical interventions, despite her interests in avoiding that treatment, are, at minimum, of dubious constitutionality.

Further, if the grave subordinative harm caused all women by the restrictions is taken seriously, then the pregnancy restrictions also should be found unconstitutional as a violation of equal protection doctrine. State action in these circumstances carries such an imprimatur that it must be wielded circumspectly, especially where the status of all women is at risk, as discussed immediately below.

PART III. THE MACROSCOPIC VIEW: SUBORDINATING WOMEN AS A GROUP

Part II analyzed how the pregnancy restrictions harm the individual women directly affected by them, and concluded that the restrictions, even if applied only after fetal viability, are at best of questionable constitutionality. But such a narrow analysis of the maternal-fetal relationship, focusing only on the individual woman and fetus, poses a seemingly intractable ethical and legal dilemma (especially when a viable fetus is involved) that often yields overly simplistic, unsatisfactory answers. Perhaps that apparent intractability would lessen if we broadened the incomplete lens of our analysis to better notice and accommodate the critical interests of *all* women that are at stake here. Specifically, when properly placed within their larger cultural context, state policies such as the pregnancy restrictions, which limit women's control over their reproductive fate and over their own bodies during pregnancy, are integrally and insidiously tied with women's ongoing subordination in our

[173] *See supra* notes 145, 146 and accompanying text.

society.[174] This part employs such a broader "macroscopic" analysis to demonstrate how the pregnancy restrictions subordinate women, by legally mandating women's bodily objectification, and subordinating their status as moral actors and citizens.

A. Introductory Concepts: "Group Subordination" and Feminist Equal Protection Analysis

I first introduce the feminist concepts of group subordination and equal protection upon which I rely. While the notion of group subordination is necessarily complex, reflection on the pregnancy restrictions affords an opportunity to articulate at least the beginnings of such an account.[175] By "group subordination," I mean the subordination of one social group of persons by another.[176] I here largely address women's subordination to men,

---

[174]For example, Ann Cudd observes that classic philosophical treatments of abortion, such those by John T. Noonan, Judith Jarvis Thompson, and Mary Anne Warren, do not take in the larger issue of how all women may be harmed by a policy of "enforced pregnancy" that entrenches women's subordination. Ann E. Cudd, Enforced Pregnancy, Rape, and the Image of Woman, 60 Phil. Studies 47, Nos. 1-2 (Sept.-Oct. 1990). And Susan Sherwin, responding to the argument that it may be permissible to legally sanction women who harm their offspring *in utero*, argues that the analysis fails to provide "a full accounting of how such a policy will be played out in a world where women are systematically oppressed and many are already coercively controlled in many aspects of reproduction..." Susan Sherwin, The Ethics of Babymaking, Hastings Ctr. Rep., Mar.-Apr. 1995, at 34, 35 (reviewing Robertson's Children of Choice, *supra* note 18). *See also* Sally Markowitz, Abortion and Feminism, 16 Soc. Theory and Practice 1 (Spring 1990) (contending generally that women, as an oppressed group, should not be required to make the sacrifice of continuing their pregnancy, because that sacrifice perpetuates their oppression).

[175]I attempt this more systematic description because the concept of "subordination" is oft-invoked but ill-defined in the writings of many feminist philosophers and legal scholars. In keeping with my interdisciplinary approach, this account of group subordination draws heavily from the work of feminist philosophers (especially the work of Iris Marion Young), with reliance on feminist legal theorists as well.

[176]By "group," I loosely follow Iris Marion Young to mean a "social group" that is neither merely an aggregate of persons identified by a shared trait, nor an association of persons, but rather a group of persons who share a sense of identity and relationship. *See*, Iris Marion Young, Justice and the Politics of Difference (1990), at 42-48. While women, for example, share the trait of gender, and African Americans (often) share the same skin color, that in itself does not constitute a "social group"; rather, "it is identification with a certain social status, the common history that social status produces, and self-identification that define the group as a group." *Id.* at 44. Among the social groups that are subordinated in our culture are women, African Americans and certain other minorities. In this respect, fetuses would not constitute a subordinated social group, since membership in a group, and its attendant subordination, is heavily mediated by self-identification of group members, and the social relationships both

but this description also applies to other relations of group subordination/domination, such as the dominance of whites over African Americans and other minorities (though the mechanisms of the varying types of group subordination in our culture often are quite different). Simply put, the members of the subordinate group, solely by virtue of their membership in that group, are afforded lesser social and political status than those in the more powerful group, and thus are unjustly subject (to varying degrees) to the power, control, or authority of the members of the dominant group.[177]

More specifically, group subordination is a dynamic characterized by the imposition of stereotypes, norms of behavior, social roles, and other similar restrictions on members of the subordinate group based only on their immutable physical attribute(s) such as sex or ethnic group. In turn, these imposed social norms, roles and stereotypes determine, in varying complex ways, the lesser social and political status of members of the subordinate group, such as by ostensibly justifying their exclusion from educational, employment, or political opportunities. Some simple examples: The historic stereotype of African Americans as "lazy" branded them as lesser than whites, who (by irrational implication) were not lazy, thus drastically decreasing the employment opportunities available for blacks, and unfairly enhancing them for whites. Or, the social norm that "women belong in the home" demeans

---

among members of the subordinate group and with members of the dominant group. In short, fetuses are not yet social, interactive persons who establish relations through which they may be unjustly dominated.

[177]The concept of group subordination is similar to that of "oppression" employed by many feminist theorists, the most extensive of which is set out by Young, *supra* note 176. *See also, e.g.*, Ann E. Cudd, Oppression by Choice, 25 J. of Soc. Phil., 25th Anniversary Special Issue 22 (1994) (arguing that the concept of "oppression" 1) "involves some sort of physical or psychological harm"; 2) applies to groups that are "identifiable independently of their oppressed status" (e.g., by their race or gender); 3) implies that some group of persons benefit from the oppression; and 4) involves some coercion or force); Frye, *supra* note 12 (analyzes oppression in terms of the "double binds" faced by women in our culture). I choose, however, to emphasize the relationship of domination/subordination between groups more than do these accounts, since while the concept of "oppression" may usefully describe the lived experiences of group members, I believe that oppression is, at bottom, caused (either directly or indirectly) by dynamics of group domination. In other words, I theorize that while the phenomenon of oppression and domination are inextricably tied, the dynamics of domination are more fundamental. *Cf.* Young, *supra* note 176, at 37-38 (some aspects of oppression are not caused by domination). My account of group subordination of course could be augmented or informed by these other analyses. For instance, group subordination could be partly explained or characterized by the "five faces of oppression" Young identifies: violence, marginalization, exploitation, cultural imperialism, and powerlessness. *See* Young, *supra* note 176, Chapter 2.

their status in the political and economic arenas, allowing men, who in turn are "better suited" for these spheres, to maintain control over them.[178]

Not all relations of dominance/subordination are unjust.[179] However, the group subordination to which I refer is a paradigm of social injustice,[180] injustice that captures both historical, overt subordinative practices such as slavery, disenfranchisement or segregation, as well as today's (usually) more subtle forms of subordination, such as the persistent exclusion of women or African Americans from positions of power in the workplace. Group subordination is unjust precisely because the dominant group's power and control over the subordinate group is fundamentally arbitrary. Importantly, while the dominant group members need not intentionally subordinate,[181] they nevertheless (unfairly) reap the benefits of their dominant status, such as heightened privileges and access to positions of power and leadership, greater social credibility and recognition, and so on, and thus share some measure of moral culpability.[182]

---

[178]The phenomenon of group subordination is not obviously responsible for all disadvantages faced by members of a subordinated group. For instance, one's economic status is likely a strong determinant of one's social status and opportunity. On the other hand, however, one's socioecomonic status may also be overly-determined by one's membership in a subordinated group. Few, for example, would deny that the economic, social and educational opportunities historically denied African Americans were a major cause of the disproportionate number of poor blacks for most of this century; many, indeed, would argue that today's disproportionate number of African Americans in poverty still largely is due to their ongoing (but now more subtle) subordination.

[179]The teacher/student or employee/supervisor relationship, for instance, necessarily places the student or employee in a subordinate position to their teacher or supervisor, but that subordination is not, by itself, unjust.

[180]As Young develops, social injustice cannot be adequately captured by the more traditional, Rawlsian "distributive paradigm" identifying unequal distributions of benefits and burdens, but also deeply involves relations of domination and group oppression. *See* Young, *supra* note 176, at Chapter I: Displacing the Distributive Paradigm and John Rawls, A Theory of Justice (1971).

[181]*See, e.g., infra* note 183.

[182]While clearly not all men are better off than women, or whites than African Americans, group subordination is still relatively consistent within socioeconomic status or social group: poor white men by and large dominate poor white women, African American men enjoy heightened status over African American women, and such. Further, persons may be a member of more than one subordinated group (e.g., black women). The dynamics of their subordination are complex, resisting explanation merely by adding the problems faced by both gender and race discrimination. Rather, some posit that there is an "intersection" of race and gender that complicates the subordination of such groups. *See* Kimberle Williams Crenshaw, Beyond Racism and Misogyny: Black Feminism and 2 Live Crew, from Words that Wound: Critical Race Theory, Assaultive Speech and the First Amendment (Mari Matsuda, Charles R. Lawrence

Like all types of group subordination, men's dominance over women is a complicated phenomenon that is both systemic and structural, pervading our varying social and political institutions and practices, cutting across all social classes and all spheres of life (the personal, the social, and the political realms).[183] Men dominate, or control, the statehouse, the bench, the church, and the family. The various means of that domination are both direct and indirect, overt and subtle. For instance, the systemic violence against countless women by their male partners in our society (and the state's historic, and notorious, neglect of that problem) is a quite direct and overt means of male domination. On the other hand, less direct and more subtle causes of women's subordinate status are the dual social truths that women who work outside the home usually still bear the greater work burden in the home,[184] and that the workplace is still, by and large, hostile to family concerns. Together, these practices allow men to retain not only a "home" advantage, but also a competitive edge in the workplace, thereby enabling them to exercise more power and control over that realm than women. Importantly, socially imposed gender roles play a crucial and pervasive part in women's subordination, such as by relegating them to the private sphere, or otherwise disempowering them

---

III, Richard Delgado & Kimberle Williams Crenshaw, eds.) (1993).

[183]For instance, Young observes that oppression, or what I term group subordination, is systemic, structural (built into our institutions), and often unintentional. It is :

> a consequence of often unconscious assumptions and reactions of well-meaning people in ordinary interactions, media and cultural stereotypes, and structural features of bureaucratic hierarchies and market mechanisms—in short, the normal processes of everyday life...Oppressions are systematically reproduced in major economic, political, and cultural institutions.

Young, *supra* note 176 at 41. Catharine MacKinnon similarly and powerfully states that "[l]ike other inequalities, but in its own way, the subordination of women is socially institutionalized, cumulatively and systematically shaping access to human dignity, respect, resources, physical security, credibility, membership in community, speech, and power." Catharine MacKinnon, Reflections on Sex Equality Under Law, 100 Yale L. J. 1281 (1991), at 1298-99.

[184]For social science data on the amount of "double work" performed by women who work outside the home, *see, e.g.*, Nancy C. Staudt, Taxing Housework, 84 Geo. L. J. 1571, at 1579-85 (1996) ("Studies indicate that women who perform these dual roles in the market and in the home sleep less, enjoy less leisure, and work far longer hours that the average man." *Id.* at 1581).

or affording them only second class status (e.g., women "belong with the children," or women are "passive" compared to men).[185]

Another potent tool for demeaning and dominating women is the practice that Iris Young terms "cultural imperialism" (or what I call "cultural domination" to emphasize the dominative aspect inherent in the practice).[186] Critically, it is through the process of cultural domination that the ideology of masculine power masquerades as objective, unchallenged "fact."[187] Most simply captured in the maxim "it's a man's world," this is the phenomenon where male perspectives and cultural interpretations become the seemingly objective, universal "norm" of our social and institutional definitions, practices, and values. Women are marked as the "other,"[188] their viewpoints and experiences as deviant or inferior. They thus are afforded less power than men to define and to shape our culture's practices and meanings.[189] For instance, the historical exclusion of women from research trials illustrates cultural domination in medicine: The male body becomes the medical standard, by definition rendering the female body a confounding, messy departure from that standard that must be excluded to avoid erroneous research findings.[190]

---

[185]*See, e.g.*, Debra A. Debruin, Justice and the Inclusion of Women in Clinical Studies, from A. Mastroianni, R. Faden, and D. Federman, Women and Health Research: Ethical and Legal Issues of Including Women in Clinical Studies (1994), at 134-35 (discussing how gender norms cause power imbalances of dominance and subordination); Sandra Bartky, Femininity and Domination (1990), at 24 (noting how gender stereotypes contribute to women's psychological oppression).

[186]*See* Young, supra note 176, at 189; *see also,* Section B.1.b below.

[187]*See infra* note 227 and accompanying text for discussion of the concept of "ideology."

[188]Simone de Beauvoir classicly asserts the claim that woman is the excluded "other," and man the universal norm, in her seminal work The Second Sex (H. M. Parshley, ed., Vintage Books 1989) (1952). De Beauvoir writes,

> ...[H]umanity is male and man defines woman not in herself but as relative to him; she is not regarded as an autonomous being...she is simply what man decrees; thus she is called "the sex" by which is meant she appears essentially to the male as a sexual being...She is defined and differentiated with reference to man and not his with reference to her; she is the incidental, the inessential as opposed to the essential. He is the Subject, he is the Absolute—she is the Other.

Id. at xxviii.

[189]Young, *supra* note 176, at 59.

[190]*See, e.g.*, Debruin, *supra* note 185.

Power and degradation are the two most crucial concepts in analyzing subordinative harms against women. Each of these various means of women's subordination share in common the degradation, and ultimate disempowerment, of women relative to men in the given subordinative situation. Women's subordination, or men's domination, comes about primarily by devaluing and demeaning women. Their status as persons, their differing experiences and points of view, their work, are all devalued and trivialized as compared to men's. In turn, men are arbitrarily bestowed with heightened social prestige and power.[191]

Because it largely is controlled by the group(s) in power, the law has played, and continues to play, a critical and effective role in the political and social subordination of women as well as other groups.[192] A particular law may *directly* subordinate women, indeed may itself *constitute* subordination, such as by explicitly denying women rights accorded to men, or otherwise directly degrading women's political or social status relative to men's. Laws also may more *indirectly* subordinate women, such as by having the effect of disadvantaging women relative to men in some important respect, or by somehow enforcing, sanctioning, or maintaining norms or practices that subordinate women. Of course, a law may both directly and indirectly subordinate, as do the pregnancy restrictions as discussed below.

That laws perform a central role in group subordination is a critical concern that should be addressed by constitutional equal protection analysis. A number of legal theorists now persuasively argue that equal protection doctrine should be modified to notice how, as Sylvia Law puts it, "state control of a woman's reproductive capacity and exaggeration of the significance of biological difference has historically been central to the oppression of women."[193] Contrary to traditional equal protection doctrine,

---

[191]As Virginia Wolf metaphorically said, "women have served all these centuries as looking glasses possessing the magic and delicious power of reflecting the figure of man at twice its natural size." Virginia Wolf, A Room of One's Own (1929), at 35.

[192]*See generally, e.g.*, MacKinnon, *supra* note 183, at 1300-1311 (notes that the law is "deeply implicated" in women's subordination, and then describes how the laws governing sexual assault and reproduction perpetuate women's subordinative status).

[193]Sylvia A. Law, Rethinking Sex and the Constitution, 132 U. Pa. L. Rev. 955, at 1008. *See also,* MacKinnon, *supra* note 183; Reva Siegel, Reasoning From the Body: A Historical Perspective on Abortion Regulation and Questions of Equal Protection, 44 Stan. L. Rev. 261 (1992) (extensive development of this type of analysis as applied to abortion regulation); Johnsen, *supra* note 163, at 620-625 (argues that equal protection doctrine should be interpreted to prohibit enforcement of fetal protection policies).

which, under Geduldig v. Aiello,[194] does not recognize statutory distinctions based on biological differences (such as pregnancy) as constitutionally impermissible "sex-based classifications," these analysts generally argue that the focus of equal protection inquiry should be shifted away from the questions of explicit statutory classifications and discriminatory intent, to more broadly consider the subordinative harms that a particular law may cause a social group.[195]

Accordingly, for these theorists an "antisubordination principle" underlies the equal protection clause, a principle that requires the courts to take notice of a law's subordinative role, regardless of whether the law itself explicitly classifies on the basis of gender.[196] Under this approach, statutes such as the

---

[194]417 U.S. 484 (1974), cited approvingly in Bray v. Alexandria Women's Health Clinic, 506 U.S. 263 (1993). This notorious case held that a state disability policy's exclusion of benefits for pregnancy did not discriminate on the basis of gender, but rather merely distinguished between "pregnant women and nonpregnant persons." *Id.* at 496, n. 20. The practical upshot of the case is that statutes that fail to explicitly classify on the basis of gender, but rather regulate on the basis of pregnancy or other biological grounds, do not invoke middle-tier scrutiny under the equal protection clause. The negative commentary on this holding has, as Sylvia Law put it, become a "cottage industry," most notably in the context of the feminist debate about whether women should receive "equal" treatment or "special" treatment in the workplace. *See* Law, *supra* note 183, at 983-984. *See generally, e.g.*, Seigel, *supra* note 193, at 267-272; Herma Hill Kay, Equality and Difference: The Case of Pregnancy, 1 Berkeley Women's L. J. 1 (1985); Christine A. Littleton, Reconstructing Sex Equality, 75 Ca. L. Rev. 1279 (1987); Anne C. Scales, The Emergence of Feminist Jurisprudence: An Essay, 95 Yale L. J. 1373 (1986); Wendy Williams, Equality's Riddle: Pregnancy and the Equal Treatment/Special Treatment Debate, 13 N.Y.U. Rev. L & Soc. Change 325 (1984/1985).

[195]*See* sources at *supra* note 193; *see generally*, Laurence H. Tribe, American Constitutional Law, § 16-21 (2d. ed 1987); Owen M. Fiss, Groups and the Equal Protection Clause, 5 Phil. & Pub. Aff. 107 (1976).

[196]For example, Reva Siegel argues that the equal protection clause invokes "two clusters of values": "antidiscrimination values" which go to the reasons of state actors, "prohibiting them from acting on the basis of prejudicial or traditional habits of thought that deny the full humanity, individual worth, and dignity of members of a particular group," and "antisubordination values concerned with the material and dignitary injuries inflicted on members of a particular social groups by public actions premised on such prejudicial habits of thought." Siegel, supra note 193, at 353. *See also* Tribe, *supra* note 195, § 16-21 (discussing the "antisubjugation" purpose of the equal protection clause).

Significantly, the Supreme Court appears to at least implicitly endorse some type of "antisubordination" purpose behind the equal protection clause, in United States v. Virginia, 116 S.Ct. 2264 (1996). There, holding that the Virginia Military Institute could not exclude women, Justice Ginsberg, writing for the majority, states that "[Sex classifications] may not be used, as they once were...to create or perpetuate the legal, social, and economic inferiority of women." *Id.* at 2276. Further, while the exclusionary policy before the Court did classify by gender, the Court also appears to recognize that biological differences between men and women should not be used to women's disadvantage, stating that such "inherent differences" should not

pregnancy restrictions (or abortion laws, or laws regulating women's behavior during pregnancy), should not find easy justification in the seemingly benign physiological fact of pregnancy, thereby escaping equal protection analysis altogether because they fail explicitly to classify by gender.[197] Rather, such laws should be seen as sex-based state action since they affect only women, and scrutinized to determine whether the law either directly constitutes, or has the more indirect effect of perpetuating, women's subordination.

B. How the Pregnancy Restrictions Subordinate Women

Many different tests could be devised to govern when a law subordinates women in violation of the equal protection approach set out above. I do not offer any specific test here, but rather urge that the pregnancy restrictions, like other laws governing women's bodies and reproductive fate, should not pass constitutional muster even under the strictest of such "antisubordination" approaches, given the patent role these types of laws play in subjugating women to men. Specifically, as addressed in subsection 1 below, the restrictions compel an extreme "technological objectification" of pregnant women that is inextricably bound with women's subordination in a variety of indirect, yet insidious, ways. Further, as explained in subsection 2, the restrictions enforce a moral and legal order that directly subordinates women's moral and political status to men's.[198]

---

be cause for "denigration of either sex or for artificial constraints on an individual's opportunity." *Id.* Support for the "antisubordination" purpose of the equal protection clause may also be found in previous Court decisions. *See* Siegel, *supra* note 193, at 351-354, 368-371.

[197]*See, e.g., infra* notes 240-246 and accompanying text.

[198]The subordinative role of the pregnancy restrictions also could be challenged as a form of "involuntary servitude," or the coerced personal service and labor for another, as prohibited by the Thirteenth Amendment. *See* Burch, *supra* note 25, for a Thirteenth Amendment analysis of the pregnancy restrictions. *See generally, e.g.,* Andrew Koppelman, Forced Labor: A Thirteenth Amendment Defense of Abortion, 84 NW. U. L. Rev. 480 (1990); Gallagher, *supra* note 113, at 23-26. I refrain, however, from developing a Thirteenth Amendment challenge to the pregnancy restrictions. While feminist theorists have increasingly taken the intriguing approach of challenging abortion restrictions and other coercions of pregnant women as violating the Thirteenth Amendment, equal protection doctrine arguably affords the most appropriate means of challenging statutes that perpetuate women's subordinative status, since "it is the only body of constitutional jurisprudence explicitly skeptical about the rationality of gender-based judgments and specifically concerned with the justice of gender-based impositions." Siegel, *supra* note 193, at 352. Thus, it is likely that courts will be more amenable to a (revised) equal protection challenge to the pregnancy restrictions than to a Thirteenth Amendment challenge. *See, e.g.,* Jane L. v. Bangerter, 794 F. Supp. 1537, 1549 (D.

1. Subordination and the Technological Objectification of Pregnant Women

On October 5, 1992, Marion Ploch, a German dental assistant who was only thirteen weeks pregnant, was gravely injured in a car accident. Three days later, in a hospital in Erlangen, Germany, she was declared brain dead, but her parents were persuaded by her doctors to sustain her on life support, with the blessing of a hospital ethics panel, until the fetus could be delivered by cesarean section five months later in March 1993. Reportedly, no one knew what Ms. Ploch would have wanted under the circumstances, and the child's father was unknown. One month later, on November 16, the fetus miscarried.[199]

During that month, the case of the "Erlanger baby" caused a national uproar among theologians, physicians, politicians and feminists.[200] Some critics decried the "death pregnancy," arguing that Ms. Ploch was "degraded to a nutrient fluid, disposable after use," that her sustenance was "perverse" and "macabre," a "horror-vision of a female corpse as an 'incubator.'"[201] In defense of the decision to maintain Ms. Ploch on life support, the hospital's medical director stated that "on the ground of proportionality...it is probably reasonable to impose on the mother, through the use of her body, for the

---

Utah 1992) (court dismissed plaintiff's Thirteenth Amendment challenge to abortion statute as "border[ing] on the frivolous"), *aff'd in part and rev'd in part on other grounds*, 61 F.3d 1493 (10th Cir. 1995).

[199]*See* Christoph Anstotz, Should a Brain Dead Pregnant Woman Carry Her Child to Full Term? The Case of the Erlanger Baby, 7 Bioethics 340 (1993).

[200]While there have been reported cases in the United States where brain dead pregnant women were sustained on life support, none received the attention paid the case of the "Erlanger baby." *See, e.g.*, William P. Dillon, et al., Life Support and Maternal Brain Death During Pregnancy, 248 JAMA 1089 (1982); David R. Field, et al., Maternal Brain Death During Pregnancy: Medical and Ethical Issues, 260 JAMA 816 (1988); *see also* other sources cited in Nelson, *supra* note 108. And in one legal decision, a Georgia court found that a brain dead pregnant women should be sustained on "life" support against the wishes of her husband (but consistent with the wishes of the putative father), relying in part on the legislative intent expressed in the state's pregnancy restriction. University Health Servs., Inc. v. Piazzi, No. CV86-RCCV-464 (Super. Ct. of Richmond County, Ga., Aug. 4, 1986).

[201]Anstotz, *supra* note 199, at 344-345. *See also* Brain-Dead German Woman Has Miscarriage, Wash. Post, November 17, 1992, at D2. A German public opinion poll found that the large majority of respondents disagreed with the attempts to keep Ms. Ploch alive for the duration of her pregnancy. At least some of the violent public reaction against the case probably was due to Germany's extreme sensitivity to preserving the dignity of human life following the Nazi atrocities. Anstotz, *supra* note 199, at 345.

benefit of the child," and also that "to come into this world, we all had to use our mother's bodies inconsiderately, and our mothers at least accepted that."[202] The hospital's clinic director agreed, observing that "the child's right to live demands also the use of modern and technological aids."[203] These statements leave no doubt that Ms. Ploch's (or more accurately, the fetus's) treating physicians considered fetal interests to be paramount, overriding any concerns they might have about "using" Ms. Ploch's body "inconsiderately." Indeed, the clinic director's statement perfectly illustrates both a simplistic estimation of the mother's obligations to the fetus, and the "technological imperative": if the technology exists to save the fetus, then by all means it must be used.

More recently, in January 1996, it was reported that a twenty-nine year old woman, comatose for ten years and in a nursing home in Rochester, New York, had been raped and was about four months pregnant. Her family decided to continue the pregnancy, both because they believed the young woman would have wanted that result, and based on the tenets of their Catholic faith.[204] A baby boy was delivered prematurely in March, and the woman's mother was awarded guardianship.[205] The woman later died just before her son's first birthday, only a few days before a nursing home aide was sentenced for her rape.[206] The comatose woman's bizarre and tragic story was nationally reported, and debated in the bioethics community through the popular press. Supporters argued that the parents' decision, as the appropriate decisionmakers, should not be second-guessed.[207] Critics condemned the

---

[202]Anstotz, *supra* note 199, at 341-342; Germany's Fetal Position, Wash. Post, October 29, 1992, at C1, C5. *See also* A Matter of Life and Death, Newsweek, November 16, 1993, at 55.

[203]Anstotz, supra note 199, at 342.

[204]*See* Frank Bruni, Woman, 29, Still in 10-Year Coma, is Pregnant by a Rapist, N.Y. Times, January 25, 1996, at B1, B5.

[205]*See* Grandparent Keeps Rape Victim's Baby, N.Y. Times, May 1, 1996, at B.2.

[206]*See* Woman Who Had Child While She Was in Coma Dies, Wash. Post, March 19, 1997, at A9. *Addenda*, Wash. Post, March 28, 1997 at A2.

[207]*See, e.g.*, Ben Dobbin, Rapist Impregnates Woman in Nursing Home, L.A. Times, February 18, 1996, at A10 (medical ethicist observes that situation is a case of who should decide: "She can't make that decision, so someone close to her has to make it"; whatever is decided, "we have to go with it"); *see also*, Accinelli, *supra* note 1 (lawyer states "who the hell do we think we are to think we know better than her parents on something as bizarre and complicated as this?").

pregnancy as the use of the woman as a "vessel," an "incubator," without her consent, as "almost grotesque."[208]

The furor over the Ploch and Rochester cases attests that we do feel something is macabre, or grotesque, about medically sustaining a pregnant woman's body in her absence. Certainly the "inconsiderate use" of Ms. Ploch's and the Rochester woman's bodies as incubators without their express permission challenges our culture's tradition of respecting the bodies of the dead, a tradition embodied in the practice of obtaining consent for organ donation.[209] Yet there is another important reason why we may be morally repelled by the fate of these women. These cases illustrate an extreme form of objectification, a "technological objectification" whereby the woman's dead [210] or comatose body literally is used, possibly for months, as a fetal

---

[208]*See* Dobbin, *id.* (George Annas observes that "I don't think women should be used as vessels without their consent for the sake of other people"); Accinelli, *supra* note 1.

[209]That medical technology introduces the capability to use persons literally as a means, as a medical resource, for others, is neither a new, nor necessarily morally objectionable, concept. Organ donation is but one example of that capability. Yet our morality requires that permission be sought, either from the family or the organ donor, before organs may be harvested, thus recognizing the moral agency of the donor. The technological use of a person is indeed morally objectionable when that person ceases to be viewed as a moral agent, but rather is used *solely* as a medical resource, such as where permission from the donor or her family is not sought.

[210]Theorists dispute the appropriate moral model that should be applied to the medical sustenance of brain dead pregnant women. Some argue that the woman has no moral interests once dead, and that the physician therefore has a duty to "rescue" the fetus if possible. *See, e.g.,* Dillon, *supra note* 200; Field, *supra note* 200. Others assert that the brain dead pregnant woman had, when living, a moral interest in how her body is used after death, and thus that she should be treated as a prospective organ donor. *See, e.g.*, Robert Veatch, Maternal Brain Death: An Ethicist's Thoughts, 248 JAMA 1102 (1982); Jay E. Kantor and Iffath Abbasi Hoskins, Brain Death in Pregnant Women, 4 J. Clin. Ethics 308 (1993). Still others argue that the organ donor model oversimplifies the complex moral relationships involved, and offer a family-centered model that would give some weight to the family's wishes as well. *See, e.g.*, Jacqeline J. Glover, Incubators and Organ Donors, *Id.* at 342. See also, Douglas Shrader, On Dying More Than One Death, Hastings Ctr. Rep., Jan.-Feb. 1986, at 12 (wishes of patient and family should govern). Because the pregnancy restrictions mandate treatment for living women who clearly retain moral interests of their own, the first model, regardless of its conceptual and practical problems, would be inapplicable unless the woman later dies. The latter two models are relevant to the sustenance of an incompetent pregnant woman to the extent they recognize that both the woman and her family have moral interests at stake in the decision. None of these models, however, give enough weight to the disturbing objectification required by a decision to use a woman's dead body as a fetal vessel even though she never consented to that use.

incubator without her permission, in the complete absence of her human agency and control.[211]

The pregnancy restrictions similarly envision, and in fact legally mandate, such a radical technological objectification of pregnant women, giving literal meaning to metaphors describing pregnant women as "fetal containers" or "breeders." Like the Ploch and Rochester scenarios, the restrictions require that the bodies of incompetent pregnant women be technologically supported as "fetal gestators," transformed into passive machines that simply require medical fine-tuning to stay alive. And like these cases, the incompetent woman is absent from her enforced pregnancy in a very real sense: Whether the woman is permanently unconscious, totally sentient, or somewhere in between, what made her the person she once was, most importantly her full moral agency, is now missing.

Critically, however, while the Ploch and Rochester cases are not without their critics, the technological objectification of pregnant women compelled by the pregnancy restrictions is even more callous in at least one important respect. The Ploch and Rochester families at least were given the authority to decide whether to use their daughter's bodies in this manner; in fact, the Rochester family reportedly based their decision at least partly on what they believed their daughter would have wanted under the circumstances.[212] The pregnancy restrictions, on the other hand, *require* that women be used as a medical resource despite what they, or in most cases even their families, might wish.

How is the technological objectification legally mandated by the pregnancy restrictions tied to women's subordination? Focusing only on how the restrictions harm the individual woman forced to stay alive for the fetus

---

[211]I use the term "technological objectification" to describe this more literal form of objectification, one fostered by the dual forces of technological capability and a medical ideology that tends to reduce persons, in a quite literal sense, to mere bodies, or "machines," subject to technological manipulation and control. *See, e.g.*, Rothman, *supra* note 13, at 55 (discussing medical ideology as rooted in mind-body dualism, where the body, as distinguished from the mind, is a "machine, the structure and operation of which falls within the province of human knowledge [or medicine]..."). *See also* Emily Martin, The Woman in the Body: A Cultural Analysis of Reproduction (1987) at 19 (science treats the persons "as a machine and assumes the body can be fixed by mechanical manipulations..."). Technological objectification may be distinguished from a more simple moral objectification as envisioned by Kant, which does not necessarily entail the literal use of a person's body. *See supra* note 121 and accompanying text. Clearly, however, this more radical form of nonconsensual, bodily objectification also would violate Kant's categorical imperative instructing against using persons simply as a means for the ends of another.

[212]*See supra* note 204 and accompanying text.

tends to separate that practice from its larger social context and meaning. Yet when the practice is analyzed within its broader cultural context, the problem is clear. A state policy compelling the technological objectification of pregnant women contributes to women's subordination to men in a number of indirect and complex, but nevertheless pernicious, ways.[213] Specifically, as developed below, it perpetuates women's subordination in the medical setting, serves the ideological function of normatively degrading women's role during pregnancy while privileging fetal interests, and reinforces women's alienation from male-dominated culture.

a. Reinforcing the Subordinative Practices of Medicine

First, to mandate the pregnant woman's technological objectification in essence gives control over women's pregnancies to their physicians and the state, exacerbating the unequal power dynamics in the medical enterprise. Women's subordination is instantiated by relations of unequal power and control, and the biomedical setting, like all other institutions, historically has contributed to women's disempowerment in various ways.[214] Women lose power in this setting, for instance, by being denied control over their pregnancies and the birthing process. Emily Martin, for example, insightfully describes the technological oversight of birth in our culture as a process of production, where the physician, not the woman, is clearly in control.[215]

---

[213]As Margaret Radin observes, the objectification of a particular group may be closely linked with their subordination:

> Objectification comes about through subordination when our culture conceives of certain characteristics of persons—race and sex are the ones salient for discussion now—as marks of lesser personhood. These marks license manipulation of those who bear the marks, and also license refusal to recognize in them rights and other indicia of respect otherwise conceived of as universally applicable to [other] persons.

Margaret Jane Radin, Reflections on Objectification, 65 S. Cal. L. Rev. 341 (1991), at 346. Radin generally argues that objectification may transform our conceptions of persons, as well as transform our cultural practices, primarily in the context of surrogacy.

[214]*See generally, e.g.*, Feminist Perspectives in Medical Ethics, *supra* note 18; Susan Sherwin, No Longer Patient: Feminis Ethics & Health Care (1992); Rothman, *supra* note 13; Martin, *supra* note 211; Special Issue: Feminist Perspectives on Bioethics, 6 Kennedy Inst. Ethics J. 1 (1996); Feminism and Bioethics (Susan M. Wolf, ed., 1996).

[215]Martin observes:

> Medical imagery juxtaposes two pictures: the uterus as a machine that produces the baby and the woman as laborer who produces the baby.

Seen in this context of the power dynamics in medicine, the pregnancy restrictions enable the state, using the physician as its agent, to wrest from women complete control over their pregnancies.[216] Competent women have absolutely no decisional control over their medical treatment in the case of their later pregnancy, since they are prohibited from deciding in advance whether to remain alive to sustain the fetus. And once incompetent, many states mandate women's treatment based solely on the physician's opinion concerning fetal prognosis, giving the physician final decisional authority over whether pregnant women are allowed to die, or must stay alive to artificially maintain their pregnancy.[217] In fact, some states go so far as to explicitly invalidate women's proxy appointments altogether if it is later discovered they are pregnant, leaving these women in a limbo where presumably all important decisions concerning their medical treatment likely would fall to their attending physician.[218] In short, these restrictions require that women's bodies be literally appropriated and manipulated by physicians with absolute power to decide whether the women will live or die. It is safe to predict that many, if not most, physicians and other healthcare givers usually would err on the side of overtreatment, forcing incompetent pregnant women to stay alive despite their pain and suffering, or the prognosis for the fetus or newborn.[219]

b. The Pregnancy Restrictions as Cultural Domination: Imposing a Radically Medicalized Model of Pregnancy

Second, a state policy compelling the technological objectification of pregnant women perpetuates a uniquely authoritative form of cultural domination,[220] whereby the ostensibly "objective" medical construct of pregnancy, as viewed by an outsider, is dictated by law. Such domination

---

> Perhaps at times the two come together in a consistent form as the woman-laborer whose uterus-machine produces the baby. What role is the doctor given? I think it is clear he is predominantly seen as the supervisor or foreman of the labor process.

Martin, *supra* note 211, at 63. Martin observes that the doctor is viewed as "managing" the labor of the woman, deciding the "pace" of the birth, etc. *Id.*

[216]*See, e.g.*, Annas, *supra* note 84 (discussing how the state, through its fetal protection policies, uses physicians as its agents).

[217]*See supra* notes 45-47, 55-56 and accompanying text.

[218]*See supra* note 53 and accompanying text.

[219]*See supra* notes 32-35 and accompanying text.

[220]*See supra* note 186 and accompanying text.

serves the powerful function of degrading women's role in pregnancy, in turn allowing the normative privileging of fetal interests over women's (degraded) interests.

This means of cultural domination is both subtle and complex, but the result is quite powerful. Specifically, to legally compel the use of women's bodies as fetal incubators both reflects and imposes a radical model of medicalized pregnancy, where pregnancy is transformed, through the (historically male) "objective" lens of obstetrical medicine, into simply a biological process, a medical event that, like a disease process, is divorced from the woman's human control or agency.[221] Under this model, the woman's role is primarily passive; she merely must provide a body to house the fetus, while her obstetrician works wonders with a host of available medical interventions. Her body is a machine, the obstetrician a skilled mechanic, and the baby a "product" of his, but not her, labor.[222] Indeed, this over-medicalized model of pregnancy renders the woman's moral agency so expendable that even her death is no barrier to the mechanic's skillful work.

Yet such an objectified, purely physiological construct of pregnancy eclipses the extent to which pregnancy is instead a socially-defined and mediated, active experience for women. While there are of course physiological facts about pregnancy, to view pregnancy strictly in terms of those facts degrades women by portraying them essentially as passive breeders, demeaning or ignoring their important, active contribution to pregnancy as moral agents.[223] As Hilda Lindemann Nelson perceptively argues, the medical model of pregnancy presents a false model, one that "both testifies to and reinforces social attitudes toward women that are

---

[221]*See, e.g.*, Rothman, *supra* note 13, and Martin, *supra* note 211, for extensive discussion of the "medicalization" of pregnancy and childbirth. *See also*, Adrienne Rich, Of Woman Born (10th anniversary ed. 1986) (especially Chapter 7, "Alienated Labor); Ehrenreich, *supra* note 155, at 535-549. By endorsing a view of pregnancy as essentially a "biological," rather than distinctly human, event, an extremely medicalized model of pregnancy in part reflects the historic identification of women as "closer to nature," whose moral agency is somehow weakened by their biological destiny, a destiny they, unlike men, cannot transcend. *See, e.g.*, Sherry B. Ortner, Is Female to Male as Nature is to Culture, from M. Pearsall ed., Women, and Values (1986) (arguing that women's physiology and social roles are viewed as closer to nature, thus partly explaining women's universal subordination).

[222]See Martin, *supra* note 211.

[223]This is in essence a form of "physiological reasoning" about pregnancy, which obscures the fact that there also is "social reasoning" about women taking place, reasoning that demeans women's contribution to pregnancy and values fetal life at the expense of devaluing women. *See* Section B.2. below for development of the notion of "physiological reasoning."

demeaning."[224] Mandating the medical sustenance of a pregnancy in the woman's absence, Nelson observes, sanctions an inaccurate, disturbing paradigm of pregnancy that sees a woman's contribution as like that of a bee, as "passive, as unconscious, as instinctively rather than deliberately nurturing."[225] Nelson asserts that a woman's role in her pregnancy is in fact, from her subjective point of view, more like that of an architect. Rather than merely instinctively reacting to the exigencies of her pregnancy, her experience of pregnancy is one of purposive, creative activity motivated by her agency as a moral actor.[226]

Accordingly, to legally require that women be maintained in passive, radically medicalized pregnancies subtly but powerfully enforces an ideology of male domination. An ideology often insidiously poses as non-normative, objective "fact," thus hiding the subordinative dynamics lurking behind its

---

[224]Nelson, *supra* note 108, at 262.

[225]*Id.* at 266. While Nelson's analysis addresses post-mortem pregnancies, she observes that it could just as well be asserted in the case of insentient women. I expand that application to incompetent women, because they also would lack the purposive agency during pregnancy that Nelson deems so important.

[226]*Id.* at 262. Nelson offers several examples of how, from the pregnant woman's perspective, pregnancy is a creative and purposive human activity. First, the woman often (or even usually, at least in our Western culture) conceives on purpose. Second, once she has conceived, she begins to create a relationship with her fetus, first imagining, and then physically feeling, the fetus as it grows inside her, and imbuing it with social value. While others in the family also begin this relational process, the pregnant woman's relationship with her fetus can only be fully appreciated from her subjective, internal perspective. She may begin to view the fetus as a "centrally important fact about her," "motivating her to reorient herself and to take action in a way that it cannot do for those looking on from the outside." Third, that reorientation requires her, like an architect, to make a home for the fetus. The "bodily hospitality" she extends directly implicates her purposiveness as a moral actor: she is capable (within her means) of either responsibly creating a nurturing, healthy home for the fetus, or a substandard, inhospitable environment. Finally, the pregnant woman must exercise her "ingenuity" to carry on her pregnancy within natural and social constraints. Just as an architect's creativity is fettered by the laws of nature and by social convention, the pregnant woman must navigate both the laws of nature that physically affect her, as well as the social forces that impose numerous roles and obligations upon her. To carry on her pregnancy within these constraints "is a distinctly human task, and one that can elicit quite a sophisticated exercise of creativity." *Id.* at 265-266. Nelson uses the example of a young lawyer with a stressful job, a husband, and a son. The lawyer must figure out how to negotiate her work and family responsibilities, while at the same time acceding to the physical and social demands required to carry the fetus to term. *See generally, id.* at 263-266.

subject.[227] Here, the pregnancy restrictions' seemingly benign instruction that women remain alive to save the life of their fetus subtly, but quite effectively, entrenches an ideology that degrades and disempowers women. When the "outsider," medicalized view of pregnancy predominates, women's own active contribution is branded as trivial.[228] Once women's role in pregnancy is normatively devalued to passive medical resource, their technological objectification becomes too easily justified.

Further, an ideology that devalues, or masks, women's agency during pregnancy not only degrades all women as potential passive breeders, but elevates fetal interests over those of pregnant women: Women's invisibility magnifies fetal visibility. Though it could be argued that brain dead or incompetent women simply are an exception to the usual norm of pregnant women as active agents, so justifying their "invisibility," the pregnancy restrictions do not merely *allow* the continuation of such passive pregnancies, but *legally mandate them*. The powerful ideological force of the law cannot be overstated. Under the guise of beneficent concern for a living being, and relying solely on the simple biological fact of fetal existence, the pregnancy restrictions in essence legally render the fetus as "more real than the woman."[229]

---

[227]As Iris Young defines "ideology," "an idea functions ideologically when belief in it helps reproduce relations of domination or oppression by justifying them or by obscuring possible more emancipatory social relations." Young, *supra* note 176, at 112.

[228]As Nelson concludes,

> In a society that is plagued with an endemic indifference to women's personhood, that tends to disvalue women's contributions to the common culture, and that is only too ready to regard women as inert receptacles, the image of the pregnant woman as bee can only reinforce social attitudes toward women that disvalue and dis-integrate them.

Nelson, supra note 108, at 266. *See also*, Virginia Held, Birth and Death, 99 Ethics 362 (1989) (arguing that birth, unlike death, is viewed as a purely biological process partly because of women's association with the natural, and concluding that "human birth, like human death, should be understood to be central to whatever is thought to be distinctively human and that the tradition of describing birth as a natural event has served the normative purpose of discounting the value of women's experiences and activities." *Id.* at 362. *See also*, Ortner, *supra* note 221.

[229]MacKinnon, *supra* note 183, at 1311. *See generally, id.*, for discussion of how the male point of view, instantiated into law, serves male domination by rendering the woman invisible, and the fetus the primary object of concern.

Some might argue that to privilege the fetus over women also serves male ideology by valuing men's reproductive contribution over that of women's. The pregnancy restrictions protect the "helpless" being that symbolizes men's sole biological (genetic) contribution to the procreational enterprise, usually even before viability, at the expense of devaluing women's

c. *Women's Subordination Through Alienation*

Women's "alienation" from our culture is identified by some feminist thinkers as a symptom of living in a male-governed society whose dominant values, attitudes, and even medical science, inaccurately reflect women's own reality.[230] The pregnancy restrictions perpetuate that alienation. Having been defined "from the outside"[231] by false interpretations of pregnancy with which they cannot identify, and which render their own interests virtually invisible, women may by psychically injured, experiencing a profound and harmful alienation from their community, from the state, and even from themselves.[232]

Women's alienation from dominant culture, their identification as the "other" whose interests somehow do not count for much, is a powerful

---

gestational contribution. From this perspective, the restrictions not only legally require that pregnant women be objectified as passive medical resources, but resources that serve to gestate "men's seed," a "seed" that is virtually guaranteed a right to life from the moment of conception. *See* Section B. below for more discussion of how the pregnancy restrictions exploit woman's labor, both morally and literally.

The issue of whether there is a bias in favor of men's procreational contribution also is seen in the context of socially and legally defining "motherhood" in this day of gestational surrogacy. Now that genetic and gestational motherhood may be separated, who is the "real" mother? For example, in Johnson v. Calvert, 851 P.2d 776 (Cal. 1993), the court (required by California law to deem only one mother as the "natural" mother), found that the "mother" was the genetic mother, thus favoring the (male) model of genetic parenthood and trivializing the woman's gestational role. Indeed, to even decide that there may only be one "mother" is a fiction that relies too heavily on a paternal model. *See generally*, Ruth Macklin, Artificial Means of Reproduction and Our Understanding of the Family, Hastings Ctr. Rep., Jan.-Feb. 1991, at 5.

[230]*See, e.g.*, Bartky, supra note 185 (borrowing from Marx's theory of the alienation of the worker from his product, Bartky argues for a uniquely "feminine" mode of alienation resulting from women's existence in an oppressive culture).

[231]*See* Young, *supra* note 176, at 59.

[232]As Young observes, women may be alienated from their own subjective experience of pregnancy when medical technologies "objectify internal processes in such as way that they devalue a woman's experience of those processes..." Young, Pregnant Embodiment, from Throwing Like a Girl and Other Essays in Feminist Philosophy and Social Theory (1990), at 168. Young specifically analyzes alienation from bodily depictions, defining alienation as "the objectification or appropriation by one subject of another subject's body...such that she or he does not recognize that objectification as having its origins in her or his own experience. A subject's experience...is alienated when it is defined or controlled by a subject who does not share one's assumptions or goals." *Id. See also*, Martin, supra note 211 (discusses alienation in terms of the "fragmentation of the unity of the person" *Id.* at 190).

reminder of, and tool for, their continued subordination.[233] For the large majority of states to so easily mandate women's technological objectification during pregnancy is a disquieting warning to women that their own government does not value them primarily as independent moral agents, as persons, but rather as bodies that may be put to use for others.[234] That the pregnancy restrictions are of relatively recent vintage, and exist in most states despite the fact that most are patently unconstitutional, is an overt and disturbing reminder to women that the states still may degrade and use them, and trample on their constitutional rights, with relative impunity.

2. *Women as the "Moral Proletariat" and "Secondary Citizens"*

Above, I outlined some of the more subtle, complex ways that the technological objectification mandated by the pregnancy restrictions indirectly contributes to women's subordinate status in our culture. Here, I focus on how the restrictions more directly constitute women's subordination.

Borrowing from John Rawls, Margaret Radin argues that the phenomenon of subordination can be seen as a form of "maldistribution" of the "indicia of respect" for persons, such as "social recognition" of legal rights and other goods.[235] Whether or not one agrees that the complex social processes of

---

[233]As anecdotal evidence of this harmful sense of alienation, when I first learned of the number of states that had enacted pregnancy restrictions, my first reaction, along with that of several women whom I told, was shock, followed by a profound anger and sadness. I felt deeply alienated from the state's view that my critical interests in controlling my own body and the circumstances of my death are so unimportant that I could be forced to stay alive, indeed to undergo serious pain and suffering, to gestate the fetus (in most cases, even before viability), and that this occurs despite the fact that the last few years have seen much attention on the right of all "persons" to die a natural death. One woman described to me how she revised her health care proxy to allow her husband to decide her course of medical treatment if pregnant (in deviation from statutory language requiring treatment during pregnancy), and noted how angry she was "that I, and even my family, didn't 'count' for anything if I happened to be pregnant." *See* memorandum on file with author.

[234]*See* Section B.2.b below.

[235]Radin observes:

> When a group of persons is subordinated it lacks social recognition of the rights and other indicia of respect otherwise conceived of as universally applicable to persons, and supposedly allocated (distributed) to all persons. Subordination can be thought of as a form of maldistribution because a just society would distribute to those in the subordinated position, as to all, equal opportunity and the bases of self-respect that would prevent their subordination.

Radin, *supra* note 213, at 346. *See generally* John Rawls, A Theory of Justice (1971).

group subordination or oppression can be completely captured in terms of a distribution of benefits and burdens,[236] the concept of a maldistribution of the "social recognition of rights and other indicia of respect" captures, at least in part, how the pregnancy restrictions subordinate women. Briefly, by imposing on pregnant women a legal obligation to remain alive for their fetuses, the pregnancy restrictions enforce a moral and legal order that accords lesser respect to women's independent moral and political agency than to men's, directly subordinating them to men as both moral actors and citizens.

a. "Physiological Reasoning" and Exploiting Women as the Moral Proletariat

One undisputed index of respect for persons is the extent to which a person's agency as an autonomous moral actor, as an individual person having morally valid interests of her own, is socially respected, and indeed legally protected. State advance directive statutes, for example, purport to afford universal legal protection to the interest of all persons, as autonomous choosers, to avoid a prolonged death. Yet by carving out an exception for women based on their ability to become pregnant, the restrictions legally enforce a social morality that grossly overstates women's beneficent obligations to the fetus, thereby degrading their status to fetal nurturers rather than fully respecting them as independent moral agents.

Namely, by enacting the pregnancy restrictions, state legislatures frame pregnant women's beneficent obligation[237] to their fetus as an "all or none"

---

[236]*See, e.g.*, Young, *supra* note 176, Chapter 1 (arguing that a distributive paradigm of justice that centers narrowly on end-state patterns of distribution cannot adequately identify or explain the social processes of oppression in our culture).

[237]One could argue that the restrictions actually are justified by the woman's obligation not to harm the fetus, or her duty of non-maleficence. The distinction between a pregnant woman's non-maleficent and beneficent obligations to the fetus are often necessarily blurred because of her physical connection with the fetus: the fetus may be harmed not only by the woman's actions, such as smoking, but also by her inactions, such as failing to secure adequate prenatal care. In the case of a pregnant woman on life-sustaining treatment, it could be argued that to discontinue medical treatment is an action that inflicts harm on the fetus. In actuality, however, when a woman remains on life sustaining treatment for the benefit of her fetus, she (or her caregiver or family) is taking affirmative steps to prevent fetal harm, indeed to "rescue" the fetus by staying alive rather than dying. Thus, any moral obligation the woman may have to stay alive for the sake of her fetus is more properly characterized as one of beneficence, rather than non-maleficence. This distinction is important because the scope of one's beneficent duties may be tempered by the sacrifices necessary to meet them. For a discussion of the distinction between obligations of non-maleficence and beneficence, *see* Tom L. Beauchamp and James F. Childress, Principles of Biomedical Ethics (4th ed. 1994), at Chapters 4 and 5. *See also* Part

proposition, reducing a complex moral dilemma to an absolute duty of women to prevent fetal harm regardless of the extent of their self-sacrifice.[238] This supererogatory estimation of women's duties is disturbingly illustrated by most pregnancy restrictions' mandate that women continue their pregnancies even if they are caused serious physical pain and suffering. Indeed, such extreme self-sacrifice is usually required of women even before fetal viability, or if the fetus likely would not even benefit from, and could be seriously and permanently harmed by, the medical treatment imposed to sustain its life.[239] Suffice to say, the most ardent of fetal vitalists presumably would balk at ignoring the woman's critical interest in avoiding pain and suffering, where likelihood of fetal benefit is remote.

This grossly simplistic moral analysis of women's obligations to their fetuses endorses an incredibly myopic and alarming vision of the personhood of all women. At first glance, such moral reasoning appears to find obvious justification in the biological relationship between the pregnant woman and unborn child: Biological reality simply dictates that if the fetus may be saved, then the woman must do what is necessary to save it. Such is the apparently innocuous "physiological reasoning" almost invariably used to justify legal regulation of pregnant women. Reva Siegel defines "physiological reasoning" as that which "insists that sex-specific regulation of women's conduct as parents is warranted for reasons specific to the physiology of the human body..."[240] As a wonderful example of such reasoning, Siegel cites the legal reasoning in Roe (reiterated in Casey), where the Court uses the supposed "fact" that the viable fetus *could* survive outside the womb to justify the state's compelling interest in viable fetal life, even though the fetus is not physically separate from its mother. As Siegel observes, "When the

---

II above for a discussion of the distinction between the legal prohibition on abortion and the positive legal duty to rescue the fetus.

[238]Thomas Murray analyzes what he terms the "all or none" paradigm in the context of non-fatal harms to the "not yet born," arguing that to require of pregnant women an absolute duty to prevent fetal harm imposes an overly-simplified 'all or none' clash of rights that ignores the particular morally relevant considerations of each individual woman's circumstance." *See* Murray, *supra* note 159. While Murray's analysis expressly applies to the duty to prevent non-fatal harms to a fetus that is destined to be born, it is also instructive in critiquing the moral dimensions of the pregnancy restrictions, which also seek to impose a duty to prevent fetal death without sufficient notice of the other relevant moral considerations that may be present, as discussed below. *See also* Lederman, *supra* note 64 (applying Murray's contextual analysis to Ohio's pregnancy restriction).

[239]*See supra* notes 43-48 and accompanying text.

[240]Siegel, *supra* note 193, at 333.

maternal/fetal relationship is conceptually disaggregated in this fashion, state actors can discuss regulation directed at the pregnant woman as if it merely concerned the fetus..."[241]

Importantly, as Siegel observes, this type of reasoning is deceptively benign. Siegel argues that physiological reasoning focusing regulatory concern on the fetus allows us to "reason about regulating women's conduct without seeming to reason about women at all."[242] However, this reasoning masks the *social* reasons for such regulation: biases about the roles of women as primarily mothers and caretakers. The simple fact of the biological relationship between the woman and fetus does not *by itself* offer any moral or legal justification for determining the moral and legal duties of pregnant women. Rather, we identify such moral and legal duties also based on *normative, social reasoning about women*, about their "appropriate" roles and worth in our culture. At the end of the day, given these biological facts, we as a culture *decide* what social and legal meanings to assign to those facts; we *choose* how to respond to the biological reality that women become pregnant.[243]

However we respond to pregnant women's biological relationship with the fetus, we decidedly should *not* choose a manner that is unjust, such as by pursuing policies that clearly subordinate women to men.[244] Yet this is the road the states choose by enacting the pregnancy restrictions. The restrictions degrade women's moral and political status by basing that status not on their intrinsic worth as independent moral agents, but on their biological and relational ties with others, their gender role as carers and nurturers. This way of reasoning about women is familiar, and has deep and far-reaching

---

[241] *Id.* at 333-334.

[242] *Id.* at 333.

[243] *See also, supra* notes 167-169 and accompanying text.

[244] *See, e.g.*, MacKinnon, *supra* note 183, at 1306 (observing, in the context of how the law has treated women victims of sexual assault in a biased, humiliating manner: "Law has a choice. It can inscribe this misogyny on society yet more authoritatively, promoting sex inequality, or it can move against it by promoting sex equality. Sexual assault cannot be treated as a gender neutral because sexual assault is not gender neutral."); *see also*, Law, *supra* note 193, at 1016 (concerning the state regulation of abortion, observes: "Nature demands that women alone bear the physical burdens of pregnancy, but society, through the law, can either mitigate or exaggerate the cost of these burdens. When the state denies women access to abortion, both nature and the state impose upon women burdens of unwanted pregnancy that men do not bear").

subordinative consequences.[245] For instance, pregnant women and women of childbearing potential have been barred from jobs, or clinical research trials, that might harm their offspring *in utero*, because they are valued primarily in terms of their biological relationship with their offspring.[246] The restrictions similarly deem women's relationship with the fetus as their *primary* morally relevant characteristic; full respect for women's status as sovereign moral agents (and indeed as political citizens, as noted below) is qualified by pregnancy.

Noticing this demeaning social reasoning about women does not end the inquiry, however. There is a power dynamic driving our morality that bestows status on women conditional on their value to others as mother and caregiver: women's labor (both moral and physical) is exploited for the benefit of men. Exploitation is a powerful tool of subordination.[247] By deeming women's relationship with, their use for, others as their defining moral characteristic, women are rendered, in Annette Baier's words, as the "moral proletariat."[248] Their role as the "caring sex" is exploited for the sake of a moral code where rights protecting persons' autonomy historically have been reserved for the more privileged or powerful. As Baier argues, women's status as the moral proletariat stems from our dominant ethic of justice, which emphasizes

---

[245]*See, e.g.*, Ikemoto, *supra* note 13 (discussion of the historical roots and current manifestations of an ideology of motherhood, and its relation to women's subordination; lengthy overview of the ways in which pregnant women are regulated today.); Adrienne Rich, Of Woman Born (10th ed., 1986) (comprehensive critique of how the institution of motherhood serves the ideology of patriarchy).

[246]*See, e.g.*, George J. Annas, Fetal Protection and Employment Discrimination— The Johnson Controls Case, 325 New Eng. J. Med. 740 (1991) (observing, in commenting on the Supreme Court's holding in International Union v. Johnson Controls, 499 U.S. 187 (1991) that an employer's fetal protection policy violated Title VII, that such policies aimed only at women see women primarily as "biological actors," rather than as "economic actors" (as we see men) who must make informed decisions about the risks they are willing to undertake to make a living); Debruin, *supra* note 185 (exclusion of pregnant women and women of childbearing potential from clinical trials harms women by contributing to their oppression, and thus raises a question of justice). *See also*, Ruth Faden, Nancy Kass, and Deven McGraw, Women as Vessels and Vectors: Lessons from the HIV Epidemic (from Wolf, *supra* note 214, at 252) (observing how our view of women in terms of their relational ties to men and children has affected the AIDS research agenda, by concentrating on how women serve as "vectors" of AIDS to their male partners and children rather than on how women are themselves affected by the disease).

[247]*See, e.g.*, Young, *supra* note 176, at 48-53 (discussing exploitation as one of the "five faces of oppression." Young observes that "gender exploitation has two aspects, transfers of the fruits of material labor to men and transfer of nurturing and sexual energies to men." *Id.* at 48).

[248]Annette C. Baier, The Need for More than Justice, 13 Canadian J. Phil. 41 (1987).

universal rights and obligations mediating the (supposed) freely chosen relationships between equal, autonomous individuals. Such an ethic of autonomy and noninterference, however, most accurately reflects men's more autonomous experience in our culture. That autonomy is necessarily parasitic on the moral (and physical) labor of women, in caring for and nurturing their children and families through relationships that often are unchosen and always unequal and dependent.[249] In short, women's labor is exploited for the sake of men's greater independence.

The pregnancy restrictions similarly exploit the physical and moral labor of women, by literally forcing them to bear children partly in service of a morality that requires women, but not men, to sacrifice themselves for others.[250] As such, the restrictions legally impose a moral order that views women not as independent moral agents, but as selfless mothers; a degrading perception that exploits and ultimately weakens them.[251]

---

[249]*Id.* at 48-53. Baier's thesis is that an ethic of care (as developed by Carol Gilligan) must be harmonized with the predominant Kantian ethic of universal rights and duties, but in a way that does not exploit women. However, Baier also recognizes that a Kantian ethic provides women and other subordinate groups with a powerful tool to critique their oppression. In keeping with that tradition, I appeal to a more Kantian ethic, rather than an ethic of care, to critique the pregnancy restrictions' objectification of women. *See, e.g.*, supra 211 and accompanying text. *See also*, Barbara Houston, Caring and Exploitation, 5 Hypatia 115 (1990); Alisa L. Carse and Hilda Lindemann Nelson, Rehabilitating Care, 6 Kennedy Inst. Ethics J. 17 (1996) for analyses of how an overemphasis on an ethic of care alone may perpetuate women's exploitation. As Carse and Nelson observe, "A conception of the care ethic that includes no general normative constraints to regulate its force or direct it toward worthy objects only reinforces existing stereotypes of selfless, womanly sacrifice." *Id.* at 20. *See* Burch, *supra* note 25, for a brief analysis of the pregnancy restrictions using a "care" ethic.

[250]*See* Markowitz, *supra* note 174, for a discussion, in the abortion context, of how women's required self-sacrifice is integrally connected to their oppressed status.

[251]That this is not a way we primarily reason about men is illustrated by the following hypothetical. Suppose a father is terminally ill, incompetent, and sustained by invasive and painful life-prolonging medical treatment. The father has executed a living will, and is now a "qualified patient" under that directive. Suppose further that his newborn son suffers from a medical condition that can only be treated by transplanting several of the father's organs into his son. However, the transplant must wait several months until the father's condition may be sufficiently stabilized. It is not known for certain whether the father can be medically sustained until his organs are harvested. (This hypothetical is based on one posed by Lederman, *supra* note 64 at 368-69; *see also*, Mahoney, *supra* note 64, at 230-231). Should the father have an absolute moral (and legal) duty to stay alive for the sake of his child, regardless of his wishes, his pain, and the unknown probability of a successful organ donation? What if the newborn were permanently brain damaged, without sentient existence? This hypothetical is offered not to illustrate that we would never impose such a moral duty on the father, but rather to show that once we see the question from the perspective of a potential (male) benefactor whose "paternal self-sacrifice" is not taken for granted, whose independent moral agency is unquestioned in our

b. Demoting Women's Status as Citizens

Laws that mandate pregnancy not only enforce women's degraded status as the moral proletariat, but render them "secondary citizens" in the eyes of the state.[252] As Cynthia Daniels observes:

> At the heart of the politics of fetal rights is this question: Does the ability to carry a fetus to term necessarily change women's relationship to the state and alter women's standing as citizens in the liberal polity?...Women's rights as citizens are potentially made contingent by fetal rights. They can be revoked or qualified by the state's higher interest in the fetus.[253]

The pregnancy restrictions similarly enforce a double standard for the citizenship status of men and women. Men (rightly) retain their most fundamental interest as citizens, their interest in protecting their physical liberty even where another's life requires their risky rescue, while women's same liberty is made contingent on whether their bodies may be used to medically sustain a fetus.

Significantly, the Supreme Court recently reiterated, in United States v. Virginia,[254] that the state may not employ stereotypical reasoning about the "roles and abilities of males and females" to afford women less protection under the law than men, so as to justify their exclusion from a state military academy.[255] Here, the pregnancy restrictions similarly accord women only conditional liberties, based on the social stereotype that women's role as mothers appropriately requires of them extreme self-sacrifice for their offspring. However, no matter how entrenched (or supposedly desirable) the stereotype of women as "selfless mothers" may be in our culture, the state must protect against the legal imposition of that role, lest women become

---

culture, we begin to more clearly see not only the extent of self-sacrifice required of the mother by the pregnancy restrictions, but that such sacrifice is not generally morally (or legally) expected of men. *See supra* note 159, and *infra* note 257, for discussion of how some scholars attempt to address this double standard.

[252]*See* Daniels, *supra* note 15, at 4-5.

[253]*Id.* at 2.

[254]United States v. Virginia, 116 S.Ct. 2264 (1996), at 2268.

[255]Relying on its previous holding in Mississippi Univ. for Women v. Hogan, 458 U.S. 718 (1982), the Court found it a violation of equal protection for the state to exclude women from Virginia Military Institute, partly on the grounds that the state wrongly used stereotypes about the "tendencies" of men and women to argue that women were not suited to the school's adversative training program. *Id.*. at 2300. *See also supra* note 196.

second-class citizens under law. Though women, like men, usually shoulder a complex set of relational identities, such as parent, child, sibling, and friend, it is of utmost importance that in the eyes of the state, women, like men, should be first and foremost independent persons with vital liberties deserving of vigilant protection. Just as women's moral agency should not be degraded because of their relational ties, so also their political agency should not be secondary to the uses to which they may be put for others.

In short, to mandate a legal duty of self-sacrifice for women subordinates *all* women in relation to the state, relative to men. When the state forces benefactors (women) to sacrifice their critical interest in bodily integrity to meet a positive legal duty of fetal assistance, the state grossly trivializes what is at stake for women as citizens, namely their right to self-sovereignty, a right necessary for even the most basic political agency and power.[256] While men retain their fundamental political sovereignty as citizens (and by and large still control the state apparatus in the first place), women are required by the state to sacrifice those rights in order to prevent harm to their offspring.

Finally, even if men legally were required to sacrifice their bodily integrity for their children (as they are not now), such as by requiring a father to donate an organ for his child, women still necessarily would bear the brunt of a policy of state-coerced medical treatment to benefit offspring, simply given their physical connection to the fetus.[257] Women still would remain secondary citizens, citizens whose fundamental liberty interest in physical autonomy is excessively vulnerable to state-coerced intrusion. Because such a seemingly even-handed rule would promote a gross invasion of pregnant women's autonomy, it should raise grave concerns under an equal protection doctrine that aims for substantive, rather than merely formal, equality wherein women are not subordinated to men.[258]

CONCLUSION

As Nancy Rhoden cautions, "[i]t is far better that some tragic private wrongs transpire than that state-imposed coercion of pregnant women become

---

[256]*See* Daniels, *supra* note 15, at 5, for a discussion of the notion of "self-sovereignty" as bodily integrity, the most basic aspect of a citizen's political power.

[257]Robertson, for example, proposes such a policy, whereby men, as well as women, would be required physically to sacrifice for their offspring. *See* Robertson, Children of Choice, *supra* note 18, at 190-194.

[258]*See* Rhoden, *supra* note 33, at 1988-89. *See supra* note 159 and accompanying text.

part of our legal landscape."[259] Unfortunately, the pregnancy restrictions already are very much a part of our legal landscape. That 36 states have enacted these restrictions constitutes one of the most pervasive statutory threats of "state-imposed coercion of pregnant women" existing today. The state should not be permitted to use *any means it chooses* to protect the unborn, especially means that so blatantly violate the liberties of individual women, and so plainly and disturbingly subordinate women to men. Social justice requires that constitutional constraints be imposed on the methods by which the state may protect fetal life.

Accordingly, women, rather than the state, must be allowed either to decide whether they want to delay their death for the sake of the fetus, or to leave that decision to their healthcare proxy. In order to ensure that women consider the contingency of pregnancy when executing an advance directive, states should include a question in their model living will forms asking the woman whether she would want continued treatment if she were pregnant, both before and after fetal viability. The model healthcare proxy form also should expressly ask the woman either to specifically instruct her proxy on this matter, or to direct her proxy to make that decision, along with any factors she may want the proxy to consider in making it. The harms that befall all women, the injustices that result, simply are too great to allow states to compel pregnant women to remain alive solely to serve as fetal gestators, in violation of their most basic freedoms.

---

[259]Rhoden, *supra* note 33, at 1953.