ents are in fact subordinated by physicians to their duties of nonmaleficence to prospective donors, the latter's familial duties and the former's urgent medical needs notwithstanding. Again, fetal needs require that the woman's motives and concerns be explored before the physician accedes to maternal refusal. Involvement of supportive family members should not be ruled out. The goal should be to provide assistance to *enable* the woman to give consent, but the boundary separating encouragement and expectation from coercion should be observed. Where the means to fetal medical benefit is maternal medical harm, the physician's duty forbidding nontherapeutic treatment ethically overcomes the impulse toward fetal rescue.

Notes

1. Ronald Dworkin, Taking Rights Seriously (Cambridge, MA.: Harvard University Press, 1977), p. xi.

2. In making this assumption I gloss over a plethora of extenuating circumstances: barriers in our medical and social systems to timely abortion, for instance, or the woman's intention or post-delivery decision to release the infant for adoption. For these reasons among others, duties to a developed fetus should probably be considered *quasi-maternal*, stronger than a woman's moral duties to someone else's child (generic duties owed to strangers *qua* human) but weaker than a mother's moral duties to her child (true maternal duties).

3. I deliberately avoid the language of rights in this paper, but even if rights are attributed to the fetus, this does not alter the maternal duty to balance fetal claims against those of other dependents. An analogy makes this clear: Creditor has a right to be paid in full by Debtor, but in bankruptcy proceedings Creditor's claim must be balanced against claims of others whom Debtor owes according to priority rules for settlement among them. In such circumstances, Creditor's right guarantees not full but a fair-share payment.

4. In theory and training, family practice medicine is more sensitive to the need for accommodation between the traditional patient-centered medical perspective and the global perspective of the family. See Ronald J. Christie and C. Barry Hoffmaster, Ethical Issues in Family Medicine (New York: Oxford University Press, 1986).

5. The extreme difference in stringency between nonmaleficence and beneficence may, I think, be expressed in Kantian terms as the difference between *perfect* and *imperfect* duties. The physician's duty prohibiting nontherapeutic treatment is a perfect negative duty to be exercised constantly (awake and asleep, on duty and off) in relation to all persons (patients and nonpatients alike). The duty requiring therapeutic treatment is an imperfect positive duty owed to some persons (patients) at certain times and places, subject to all manner of nonethical and ethical conditions. Physicians are not always at liberty to exercise beneficence, but they are always to conform to requirements of nonmaleficence.

6. For a discussion of parallels between transplantation and pregnancy, see Susan S. Mattingly, "Viewing Abortion from the Perspective of Transplantaion: The Ethics of the Gift of Life," *Soundings*, 67 (1984), pp. 399-410.

7. See, for instance, the classic study by Roberta G. Simmons, *et al.*, Gift of Life: The Social and Psychological Impact of Organ Transplantation (New York: John Wiley and Sons, 1977). It seems to me that the transplantation ethos goes too far in trying to protect prospective donors from family moral expectations. It is not the physician's role to enforce familial duties, but neither should it be the physician's role to thwart the exercise of a family's moral authority.

The Rights of Pregnant Women

by Joan Mahoney

Not too long ago, the carrying and bearing of children took place surrounded by women. During childbirth, the women of a tribe, and, later midwives, were present and assisted the mother in the birth process. Only in the last century or so, and only in the industrialized West, has the birth process become a medical procedure. The use of hospitals and doctors became the norm; women became patients rather than participants. The development of anaesthethics made it possible for women to give birth while they were unconscious, so that they were unaware, rather than simply not in control, of what was happening to them.

In the last twenty years or so, women have begun to reassert control over the child-bearing process. The availability of contraceptives has allowed women the choice as to whether to become pregnant. After *Roe v. Wade*,[1] those who did become pregnant had the choice whether or not to continue the pregnancy. In addition, the popularity of prepared childbirth gave many women the opportunity to give birth without drugs, and new types of anaesthetics allowed pain relief without unconsciousness.

At the time these developments were occurring, medical advances were also enabling intervention to save the lives or improve the prospects for fetuses. While the rate of caesarean section has grown rather alarmingly in the United States, some of these operations have saved babies from death or serious damage. In recent years fetal surgery has been performed in instances where the fetus might otherwise have died.

These advances alone, however, do not account for the recent emphasis on the fetus as an entity separate from the mother. Certainly in those cases where a pregnant woman chooses a caesarean or prenatal surgery, the woman and her doctor can work together to do their best for her baby. But when medical care is imposed on a woman against her choice, or when she is threatened with jail or the loss of her child for what she is doing to her own body or because she has failed to follow her doctor's orders, then, rather

When medical care is imposed on a woman against her choice, or when she is threatened with jail or loss of her child for what she is doing to her own body or because she has failed to follow her doctor's orders, then, rather than a cooperative situation, mother and fetus are pitted against one another.

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than a cooperative situation, mother and fetus are pitted against one another. In these circumstances, the medical establishment may treat the fetus as the patient instead of the mother, and, more important, the state treats the fetus as if it were a person in need of protection from its mother.

This essay focuses on situations in which the interests of the pregnant woman and the interests of the fetus are, or appear to be, in conflict, and on what legal principles ought to be applied in those instances. It is clear that women—whether they are pregnant or not—have legal rights, presumably the same rights shared by all members of our society. In particular, the equal protection clause of the fourteenth amendment guarantees to women the right to equal treatment (although the definition of equality has led to a great deal of debate), while the due process clause protects the rights of all people to privacy (although, again, there is much debate over what that means and how it restricts government from acting).

> It is clear that women — whether or not they are pregnant — have legal rights, presumably the same rights shared by all members of society.

In *Roe v. Wade*, the Supreme Court made it clear that fetuses are not persons protected by the fourteenth amendment.[2] Although the amendment protects non-citizens, so long as they are within the jurisdiction of a state, the Court did not believe that the framers of the amendment intended to include as persons those who had not yet been born.[3] Nonetheless, although the fourteenth amendment has been held not to apply to fetuses, states are free to extend the protection of their laws to whomever they choose, so long as that protection does not violate some other person's rights under the Constitution. For example, the Supreme Court has held that picketing or leafletting in privately-owned shopping centers is not protected by the first amendment,[4] but the state of California is free to extend the protection of its constitution to picketers, so long as they do not interfere with the owner's property rights.[5] Similarly, states are free to extend the benefit of their laws to fetuses, so long as they are not thereby interfering with the constitutionally protected rights of the women involved.

In those cases in which the rights of the fetus and the rights of the pregnant woman are consistent—where they are, in effect, a unit in their dealings with the rest of the world—granting legal rights to the fetus is not likely to conflict with the rights of another. So if we were, for example, to allow a woman to sue the government for depriving her fetus of nutrition by failing to provide certain benefits, we would not be creating any fourteenth amendment conflict. It is only where there is a tension (real or imagined) between the rights of the fetus and the rights of the mother that a conflict of rights appears, whether it is the state that interferes to protect the fetus before birth or whether it provides a cause of action allowing a child to sue the mother after it is born for injuries that occurred before.

Until recently the area of fetal rights that attracted the most attention had to do with forced medical care for the woman. It might involve prenatal surgery or, more often, a disagreement over whether she should have a caesarean section. In some instances, conflict has arisen because a woman has refused to allow blood transfusions, usually based on religious reasons. There are a number of cases involving forced caesareans, of which the best known is probably *Jefferson v. Griffin Spalding County Hospital*.[6] In that case, a court ordered the woman to submit to a caesarean after the hospital claimed that there was a 99 percent chance the baby would not survive a vaginal delivery. She did not go in for the surgery as ordered, but instead went into hiding and delivered a healthy baby despite the predictions.

In a different context, a court granted a hospital's request to perform a caesarean on a woman who was dying of cancer, disregarding her family's opposition and the lack of any consent by the woman. Angela Carder was twenty-six weeks pregnant and not expected to live much longer when the hospital sought the order. The baby died immediately and Ms. Carder died shortly thereafter. Her life was almost certainly shortened by the surgery. The District of Columbia Court of Appeals recently overruled the trial court and held that the order in that case was improper.[7]

A second situation that could lead to a conflict between the rights of a pregnant woman and those of the fetus has to do with living will statutes, which frequently disallow the use of a living will when the woman is pregnant. Although in most states people who are terminally ill (or, in some cases, in a persistent vegetative state) can have life support systems shut down based on written (and sometimes oral) instructions given prior to the illness, that option may be denied to pregnant women. By November 1987, 38 states and the District of Columbia had enacted living will statutes, and of those 25 disallowed the use of living wills when the woman is pregnant.

The most controversial area in the fetal rights debate today, however, is the question of "prenatal child abuse." When a pregnant woman engages in behavior that may be harmful to the fetus, such as drug abuse, alcohol consumption, use of tobacco or failure generally to follow her doctor's orders, the government may wish to take action against her before the child is born, presumably to help avoid exposure to the dangers; or it may take legal action to remove the child from her care after birth. The number of babies who are born damaged as a result of drug use by their mothers has been increasing, and as part of the war on drugs the attempt to punish women in some way has attracted legislative attention in a number of states.

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All of these cases potentially interfere with a variety of rights of the women involved. Most basically, the definition of privacy established in *Roe* and the cases that followed it goes beyond the question of abortion alone. The Supreme Court has established a right to make decisions about one's body and one's medical care in a number of different contexts. This understanding is supported by a line of cases dealing with criminal defendants, in which the Court has relied on the fourth amendment to reject invasive procedures that would have assisted the prosecution in obtaining evidence.[8] Although the Supreme Court has rejected the argument that an involuntary prisoner in a state mental hospital has the right to refuse antipsychotic drugs,[9] and refused to allow Nancy Cruzan's parents to disconnect her feeding tube over the objections of the state,[10] it has never explicitly rejected a competent person's right to make decisions about his or her own medical care.

In addition, most states recognize a common law right to refuse medical treatment. Although the Missouri Supreme Court overruled the lower court's decision allowing Nancy's feeding tube to be disconnected in the Cruzan case, it did recognize the right to accept or refuse

treatment as an important state common law right.[11] Similarly, in two cases allowing kidney transplants based on the consent of the parents, the courts involved felt that the donor would, if competent, choose to undergo the procedure. One case, *Hart v. Brown,* [12] involved 7-year-old identical twins, while the other, *Strunk v. Strunk*,[13] involved a 27-year-old man incarcerated at a state hospital who was being asked to donate a kidney to a brother to whom he was very attached. On the other hand, in the case of *McFall v. Shimp*,[14] a Pittsburgh judge refused to order a competent person to donate bone marrow to his dying cousin.

> The most controversial issue in the fetal rights debate concerns "prenatal child abuse."

When a woman is subjected to surgery for the benefit of her fetus, whether it is a forced caesarean or fetal surgery, it seems clear that her body is being invaded in a way that violates her right to privacy, as well as her common law right to refuse medical treatment. Furthermore, because the state is willing to impose a burden on women it does not impose on men (as in *McFall v. Shimp*) her right to equal protection of the law is being violated as well. Unless we as a society are willing to require men to undergo surgery for the sake of their children, through organ donation or bone marrow transplant, we cannot order women to be subjected to surgery against their wills, without violating the equal protection clause of the fourteenth amendment.

Punishing a woman who uses drugs during her pregnancy differs from the situation in which she is forced to undergo surgery, but it still involves rules about what one does with one's body that do not apply to men. Obviously, the same penalties for drug <u>use</u> may be applied to men and women, but when pregnant women are sent to jail for crimes that would otherwise not lead to jail time, on the grounds that the judge is attempting to get the woman away from drugs for the sake of the fetus, then there is a distinction being made on the basis of gender.

Some commentators argue forcefully that fetuses should be held to have rights and that their mothers should be liable for damage to the fetus before birth. The argument is based on the idea of a waiver: when a woman waives her right to abortion, she then takes on certain responsibilities toward the fetus.

John Robertson, probably the best known legal spokesperson for fetal rights,[15] uses *Roe* to make his point. His approach goes something like this. *Roe v. Wade* established that women have a right to choose abortion for almost any reason during the first trimester, and that the state may regulate only to protect maternal health during the second trimester. Only after viability does the state interest become so strong that it may prohibit abortion, except where the life or health of the woman is in danger. Given that, if a woman chooses to forgo her right to abortion, the state has sufficient interest in the fetus (even before the third trimester) to regulate her activities so as to assure that she gives birth to the healthiest child that she can. As Robertson states the position,

> 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...In terms of fetal rights, a fetus has no right to be conceived—or, once conceived, to be carried to viability. But once the mother decides not to terminate the pregnancy, the viable fetus acquires rights to have the mother conduct her life in ways that will not injure it.[16]

There are several problems with this approach. First, Robertson assumes that at some point in her pregnancy every woman makes a decision whether to abort or carry to term. In fact, many women never make a decision at all, but simply allow the pregnancy to continue until it is too late for abortion. And even when a decision is made, it is always contingent. For example, a woman could conceive intentionally with every expectation of carrying to term, only to discover in the second trimester that the child would be severely deformed, and she might then decide to abort. Even in the third trimester, if the pregnancy created a grave risk to her health or threatened her life, she might choose to terminate it, especially if it appeared unlikely that the fetus would survive in any event.

More important, the waiver theory is based on a fundamental misconception of *Roe*. The Court did <u>not</u> say that at some point the rights of the fetus outweigh the rights of the woman to make decisions about her medical care, but that the state could prohibit abortion where her life or health were not in danger. In the *Thornburgh* case,[17] the Court elaborated that point in striking down a Pennsylvania statute that regulated third trimester abortions. The statute required that the physician choose the means most likely to result in the birth of a live child; the Court held that the doctor could not be required to use any means other than that best suited to preserving the health of the woman. Even in the third trimester, the state's interest in the life of a viable fetus could not be used to require a woman to bear any greater health risk than she would otherwise have to do.

If *Roe* is only about the freedom not to procreate, the waiver argument might have some force. But if *Roe* is about the freedom to avail oneself of or to refuse medical care, if it is about a right to privacy that transcends the abortion decision, then the waiver argument is less effective. Merely by choosing not to have an abortion, a woman is not choosing to give up control over her body for the next nine months, any more than all parents choose to give up control of their bodies. If women may be prosecuted or sued civilly for smoking during pregnancy, then surely men who smoke around their pregnant wives ought also to be subject to prosecution or suit. If women may be forced to have surgery for the benefit of the fetus they are carrying, then men ought also to be forced to have surgery for the sake of their children. However, while there are several cases reported in which women were required to undergo caesarean sections for the sake of their fetuses, there is not a single case that I have been able to find in which a man was compelled to donate bone marrow or a kidney for the sake of his child.

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The Supreme Court decision in *Webster v. Reproductive Health Services*,[18] has arguably modified *Roe. Webster* upheld several provisions of a Missouri statute regulating abortion, including a prohibition on performing abortions in public hospitals and the requirement that physicians perform certain tests before performing late abortions. Although a plurality of the Court rejected the trimester scheme of *Roe* in order to reach the result regarding the test requirement (Justice O'Connor believed the result could be reached within the *Roe* framework), the test in question imposed no greater burden on the women's health.

That is, while *Webster* allowed the state to impose greater financial burdens on women seeking abortions, and allowed the state to make it more difficult to find an abortion provider, it did not restructure the *Roe* framework having to do with a woman's control over her body.

After the *Webster* decision, the District of Columbia Court of Appeals issued an opinion in the case of Angela Carder, in which a caesarean was performed over her own and her family's objections, in an attempt to save the fetus. The Court held as follows: "Our analysis begins with the tenet common to all medical treatment cases: that any person has the right to make an informed choice, if competent to do so, to accept or forego medical treatment."[19] Further, when a patient is not competent to make a decision, a guardian should be appointed who should attempt to determine what the patient would wish to do. While the guardian, or a court following the guardian's recommendation, may take into account the patient's expressed wishes about her pregnancy, it is still the woman's wishes or interests that should be paramount. As the Court stated, "We hold that a court must determine the patient's wishes by any means available and must abide by them unless there are truly extraordinary or compelling reasons to override them."[20]

There are any number of practical arguments against the proponents of fetal rights. The debate about whether a woman should be subject to a lawsuit for failure to seek genetic counseling seems almost fanciful in a world in which many women receive no prenatal care at all. If a woman were threatening to miscarry, and she had the choice of staying home with her feet up or taking a bus (or two or three) to a clinic where she would have to sit in an uncomfortable chair for several hours in order to be seen, it would be terribly unfair to prosecute her for making the "wrong" choice. Or in cases where a pregnant drug addict seeks treatment only to be told that no program in her city is willing to take Medicaid or treat pregnant women, how can she be prosecuted for not finding treatment?

As for those who suggest that the babies of women who test positive for drugs (whether the women are addicts or not) should be removed from their care, one wonders what they propose to do with the babies. Put them into foster care systems that are already over-burdened and are in some cases under court order to increase the number of caseworkers or reduce the number of children? If states are unwilling to provide maternity care and drug treatment for pregnant women, how can we expect them to provide well-supervised foster care for the children once they are born?

Finally, if the goal is to encourage women to seek medical treatment, it seems counterproductive to enlist the aid of physicians as pregnancy police, inviting or requiring them to turn in their patients who take drugs or otherwise fail to provide the best environment for their fetuses. If failure to follow doctor's orders is grounds for criminal liability, the best solution is probably to avoid the doctor. Similarly, if hospitals report women who give birth and test positive for drugs, women may then avoid the hospital, if they are unable or unwilling to avoid the drugs.

However, even if the fetal rights argument made sense from a practical point of view, it would still involve a violation of the right of pregnant women to control their own bodies. It seems like a bad idea, both theoretically and practically, to treat women and fetuses like enemies, like contestants in a lawsuit from which only one will emerge victorious. Pregnant women ought to have the same rights to control their bodies that all other members of our society enjoy. Most of the time most women do what is best for their fetuses. As for those who do not, we may look on it as their failure or as a failure of society to make better choices available. In any event, many people make bad choices, or fail to make the best choices, for their children. It is one of the prices we pay for the freedom to make choices.

> The notion that a woman should be liable to a lawsuit for failure to seek genetic counseling seems fanciful in a world where many women receive no prenatal care at all.

Notes

1. 410 U.S. 113 (1973).

2. The fourteenth amendment provides as follows: "All persons born or naturalized in the United States, and subject to the jurisdiction thereof, are citizens of the United States and of the State wherein they reside. No State shall make or enforce any law which shall abridge the privileges or immunities of citizens of the United States; nor shall any State deprive any person of life, liberty, or property, without due process of law; nor deny to any person within its jurisdiction the equal protection of the laws."

3. 410 U.S. 113, 158 (1973).

4. *Hudgens v. NLRB*, 424 U.S. 507 (1976).

5. *PruneYard Shopping Center v. Robins*, 447 U.S. 74 (1980) rejected the argument of the owner that California was interfering with his property rights by requiring him to allow a portion of the property to be used by person soliciting signatures on petitions.

6. 247 Ga. 86, 274 S.E. 2d 457 (1981).

7. *In re A.C.*, 58 LW 2644 (DC CtApp [en banc] 1990).

8. For example, in *Winston v. Lee*, 470 U.S. 753 (1985), the Supreme Court refused to allow the surgical removal of a bullet from a suspect over his objection, and in *Rochin v. California*, 342 U.S. 165 (1952), the Court held that forcibly pumping a suspect's stomach was a violation of the fourth amendment.

9. *Washington v. Harper*, 110 S.Ct. 1026 (1990).

10. *Cruzan v. Director, Missouri Department of Health,* 58 L.W. 4916 (June 26, 1990).

11. *Cruzan v. Harmon,* 760 S.W. 2d 408, 416 (Mo. banc 1988).

12. 29 Conn.Supp. 368, 289 A.2d 386.

13. 445 S.W. 2d 145.

14. 127 *Pitts. Leg. J.* 14 (Allegheny County, July 26, 1978); cited in Gallagher, "Prenatal Invasions & Interventions: What's Wrong with Fetal Rights", 10 *Harvard Women's Law Journal* 9 (1987).

15. See, e.g., Robertson, "Procreative Liberty and the Control of Conception, Pregnancy and Childbirth," 69 *Va. L. Rev.* 405 (1983); "The Right to Procreate and in Utero Fetal Therapy," 3 *J. Leg. Med.* 333 (1982).

16. Robertson, "Procreative Liberty," at 438 (footnotes omitted).

17. *Thornburgh v. American College of Obstetricians and Gynecologists,* 476 U.S. 747 (1986).

18. 109 S.Ct. 3040 (1989).

19. *In re A.C.*, 58 L.W. 2644 (DC CtApp [en banc] 1990).

20. Id.