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Women's Rights versus the Protection of Fetuses

by Mary Anne Warren

The claim that human fetuses have rights once served primarily to underpin opposition to abortion. However, some of the newer fetal rights claims are neutral with respect to the morality of abortion. These involve the rights of fetuses which will not be aborted, but whose future well-being is thought to be endangered by the behavior of the pregnant woman. Fetal rights advocates argue that when the actions or nonactions of pregnant women endanger the health of the unborn child, coercive interventions of various kinds may be justified. John Robertson makes a useful distinction between two forms of coercion at issue here: prebirth seizures and postbirth sanctions.[1] Prebirth seizures include court-ordered caesareans or other medical interventions performed against the will of the pregnant woman, as well as the involuntary confinement of pregnant women to prevent their using alcohol or illegal drugs, or otherwise adversely affecting fetal development. Postbirth sanctions include criminal penalties for women whose infants are born with illnesses or injuries due to the woman's behavior during her pregnancy. I shall argue that these forms of coercion are unjustified.

Involuntary caesareans are already a reality. Since 1981 there have been dozens of cases in which physicians or hospital administrators have sought and obtained court orders to perform caesarean sections on competent and unconsenting women, on the grounds that a vaginal delivery would be more dangerous for the fetus, and/or for the woman herself. Some commentators have argued that as intrauterine surgery and other techniques for correcting fetal abnormalities become standard medical therapies, these too may rightly be performed on unconsenting women for the benefit of the fetus.[2] There have also been cases in which judges have imposed unusually severe sentences on pregnant drug users in order to protect the fetus from (further) harm due to prenatal drug exposure.

It has long been known that children of alcoholic women may suffer from prenatal alcohol syndrome, and more recently it has been found that even moderate drinking by pregnant women can be harmful to fetal development. But current calls for legal sanctions against "fetal abuse" are inspired largely by the recent and tragic increase in the number of infants born with mental or physical abnormalities due to prenatal exposure to cocaine or other illegal drugs. In 1986, Pamela Stewart was charged in San Diego with criminal child neglect when her son was born with brain damage and later died, allegedly because of Stewart's failure to follow her doctor's advice (to avoid sex and drugs). In that case, charges were dropped because the defense persuaded the court that the law under which Stewart had been charged was not intended to apply to cases of this kind. The implementation of criminal sanctions in such cases would probably require new legislation, defining certain actions as crimes—or as more severe crimes—when performed by pregnant women who do not subsequently abort.[3]

> A pregnant woman is one person, not two.

Fetal rights advocates maintain that these new forms of legal coercion are necessary to protect (future) persons from prenatal harms. In contrast, feminists and civil libertarians regard these forms of coercion as egregious violations of women's most basic moral and legal rights—including the constitutional right to privacy guaranteed by *Roe v. Wade* and other Supreme Court decisions. Ironically, the *Roe* decision (which established women's constitutional right to choose abortion in the first two trimesters of pregnancy) has often been used to argue for the legality of these forms of coercion. I will suggest that this is a misinterpretation of *Roe* and that these forms of coercion are both contrary to fundamental legal principles and morally unconscionable. First, however, it is necessary to comment on an underlying conceptual issue.

Maternal and Fetal Interests

Some feminist theorists have questioned whether it is even conceptually coherent to assert that fetuses have interests or rights separate and distinct from those of the pregnant woman. For instance, Barbara Katz Rothman maintains that the perception of the fetus as a person separate from the mother is a consequence of patriarchal ideology—in particular the Aristotelian notion that women do not really produce children or contribute to their formation, but only nurture the seeds which men plant within them.[4] In Rothman's view, once we recognize that "the baby is not planted within the mother, but flesh of her flesh, part of her," we are forced to abandon the model of conflicting rights and interests.[5] A pregnant woman is one person, not two. Third parties, therefore, may legitimately protect and care for the fetus only by protecting and caring for her.

I strongly agree that the fetus is not yet a person, and does not yet have a right to life comparable to that which an infant has once it is born.[6] If this is true, then abortion is not directly comparable to homicide. However, it does not follow from this that the interests of the pregnant woman can never come into conflict with those of the fetus *qua* future person.

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If the pregnancy is not to be aborted, then (nonlethal) damage to the fetus may cause harm to the future child. If serious harm to a future person is a predictable consequence of an action, then the fact that the person who will suffer that harm does not yet exist does not automatically excuse the action. Suppose, for instance, that a company's directors decide to bury toxic wastes in steel containers, knowing that these will disintegrate within a century or two, and knowing that the probable result will be the contamination of local water supplies and the poisoning of anyone who drinks the water. The directors' actions would surely be subject to moral criticism, even though the possible victims of their actions have not yet been born or even conceived.

> The vast majority of women who intend to give birth fully recognize their obligation to care for the fetal life within them, and are willing to undertake substantial personal sacrifices in fulfilling that obligation.

Thus, even if abortion is morally innocuous, inflicting damage upon fetuses which will not be aborted is not. If a pregnant woman does not intend to abort, then she and involved third parties are morally obligated to consider not only her interests but also those of the future child. In most cases, there will be no conflict between these two sets of interests. Most women who expect to give birth are more than willing to make sacrifices for the sake of optimal fetal development. At the risk of belaboring the obvious, women want healthy babies. The mistake made by the Thalidomide and DES mothers was not that of putting their own interests first, but of placing too much trust in their medical advisors, who proved all too fallible. Yet conflicts of interest between pregnant women and their future children sometimes occur. A pregnant woman will not harm her own health by taking an occasional drink, but her future child may suffer mental retardation as a result. A medical treatment that is potentially life-saving for the woman (e.g., chemotherapy for cancer) may be highly detrimental to the fetus. A woman who knowingly exposes her future child to avoidable danger is no more immune to moral criticism than is a physician who carelessly prescribes drugs that may have mutagenic or teratogenic effects.

Moral Duties vs. Legal Coercion

But to say this is not to imply that legal coercion is the best way to protect future children from harm due to maternal behavior during pregnancy. There are many actions which are morally suspect yet which are not and should not be illegal. Examples include ordinary acts of unkindness, such as speaking harshly to someone who loves you, or refusing to help a friend in need. To act in these ways is to violate important moral obligations. But many moral obligations are better left to the individual's conscience and to moral suasion than to the coercive force of law. Thomas Murray notes that,

> For good reasons, including moral ones, we are reluctant to allow the state to force its view of correct conduct on individuals unless the harm to be avoided is grave, especially when doing so requires coercion, bodily invasion, or incarceration...[7]

Of course the harms which some wish to prevent through coercive "pregnancy policing" policies are sometimes very grave. But that does not settle the issue. The appropriateness of legal coercion must be evaluated in light of its probable effectiveness, as well as its social costs. Before examining the moral arguments for and against prebirth seizures and postbirth sanctions, I want briefly to consider a common legal argument in favor of these coercive measures.

The Argument from *Roe v. Wade*

There are many legal arguments for prebirth seizures and postbirth sanctions; one, however, stands out as particularly important. Courts and legal commentators have often appealed to *Roe v. Wade* to support the state's constitutional right to protect fetuses by coercive measures against pregnant women.[8] That decision permits states to protect "potential human life" by prohibiting third-trimester abortions, except when necessary to protect the life or health of the woman. This is sometimes held to imply that the state may also protect (at least) third-trimester fetuses by requiring the woman to submit to medical interventions that are thought to be in the best interest of the fetus. Often it is argued that, in deciding not to terminate the pregnancy in the first two trimesters, the woman has voluntarily waived her right to refuse any such medical interventions. But the very fact that some women decline to undergo surgery which their physicians regard as potentially beneficial to the fetus shows that they have not voluntarily waived that right. The model which this argument presupposes is not that of the voluntary waiving of rights, but rather that of involuntary forfeiture.[9] The presupposition, in other words, is that any woman who elects to continue rather than abort a pregnancy thereby forfeits fundamental legal rights enjoyed by all (other) competent adults who have been convicted of no crime.

There is nothing in the *Roe v. Wade* decision to support such an interpretation. Fetal viability (which is assumed to occur around the start of the third trimester) is treated as a sufficient justification for the prohibition of third-trimester abortion only when continued pregnancy poses no threat to the woman's life or health. (This prohibition is one which states are permitted, but not required, to enact.) This in no way suggests that states may subject pregnant women to harmful and life-threatening surgery in order to protect the potential human life within them. Indeed, it strongly suggests the opposite: that even in the third trimester of pregnancy, the protection of the woman's life and health supersedes the state's interest in protecting potential human life.[10]

The Supreme Court's 1989 decision in *Webster v. Reproductive Health Services* has somewhat expanded the states' power to restrict access to abortion; for example, by permitting states to prohibit the use of state-supported facilities for abortion or abortion counseling, and by casting doubt on the future of the trimester system established in *Roe*. However, nothing in this decision supports the claim that a state's interest in protecting potential human life authorizes it to commit violent physical assaults against pregnant women. Nor does there appear to be any reason to believe that the legal case for postbirth sanctions has been strengthened by *Webster*.

Moral Arguments for Prebirth Seizures and Postbirth Sanctions

The most common moral arguments for prebirth seizures appear to be of a naive utilitarian kind. Many people find it natural to reason in the following way. Suppose that a woman refuses to have a caesarean section, even though her physician believes that a vaginal birth is likely to damage or even kill the infant. (In some cases, caesarean birth might be medically safer for the mother as well; but for the moment let us focus on the more typical case, where it is the infant who is most at risk.) Of course, the physician might be wrong. But on the assumption that the physician is right, it seems likely

that forcing the surgery upon the woman will do less harm to her than vaginal delivery will do to her infant. True, she will suffer significant physical harm and perhaps great mental anguish from the surgical invasion of her body; but the odds are good that she will survive with little permanent impairment.

Parallel arguments have been made for other involuntary medical interventions against pregnant women. Robertson, for instance, holds that a variety of involuntary treatments—including intrauterine surgery, blood transfusion or the administration of drugs—would be justified whenever "the benefits to the offspring clearly outweigh the burdens of the intrusion."[11] On such a view, it may seem reasonable that the weighing of those benefits and burdens not be left entirely to the woman (who is one of the interested parties), and that in disputed cases the decision should be made by a court of law (which is presumably capable of greater impartiality).

Similarly, it is argued that the involuntary incarceration of pregnant women who are addicted to legal or illegal drugs is justified because it will probably harm them less than their behavior, if they are left at liberty, will harm their future child. The woman, it is said, will lose only a few months of freedom, whereas her continued use of alcohol or cocaine may result in lifelong impairment for her child.

The utilitarian argument for postbirth sanctions may also seem quite strong. It may be argued that holding women criminally liable for actions that cause harm to their future children will help to deter such harmful behavior. After all, third parties (for example, physicians and employers) whose negligent actions result in such harm are at least civilly liable, and this liability has probably served to deter some negligent behavior. In addition to this utilitarian argument for postbirth sanctions, there is the retributivist argument: that women who negligently harm their future children ought to be punished because they are guilty, and it is just that the guilty should suffer.

In what follows, I will develop three major objections to these arguments for coercion, each of which is, I think, independently decisive. First, prebirth seizures and postbirth sanctions are morally objectionable even in narrowly utilitarian terms—that is, even if little emphasis is placed upon individual rights.[12] Second, these forms of coercion entail such severe violations of women's rights to privacy, liberty, autonomy, and physical integrity that they would be unjustifiable even were it possible confidently to predict some net benefits to future persons or to society as a whole. And third, racial and economic injustices that prevail in the United States guarantee that these forms of coercion will most often be employed against poor women and women of color. As a result of this discriminatory impact, coercive practices will be both more unjust and more socially harmful than might be the case in a more nearly just society.

Doubts about the Utility of Involuntary Medical Interventions

Consider, first, the alleged utility of forced caesareans. The case for coercion rests on the presumption that physicians are able reliably to identify those situations when caesarean birth is necessary to protect the fetus and/or the mother. But the evidence suggests otherwise. In a 1981 Georgia case, a court issued an order for an involuntary caesarean after the woman's physicians testified there was a 99 percent probability that the infant would die without the surgery; yet before the order could be carried out the woman gave birth without surgery to a normal infant.[13] And this is not the only such case.[14]

> Any law or policy that required health care workers to provide evidence of fetal neglect would probably deter many women from seeking any prenatal or obstetrical care at all.

Further evidence that American physicians are not highly reliable predictors of when nonsurgical birth will prove unsafe is found in the exceptionally high rate of caesarean deliveries in the United States, as high as 31 percent in some hospitals.[15] There is widespread agreement that this rate is much higher than it ought to be. Whether we blame the physicians' fear of malpractice suits, the desire for greater profit and convenience for hospitals and physicians, the reliance upon fetal monitoring equipment (which can lead to the overdiagnosing of fetal distress), or a combination of these and other factors, it seems clear that there are too many caesareans being performed, not too few. The result is not just a waste of medical resources and money, but increased iatrogenic harm and risk for both women and infants. The maternal mortality rate for caesarean delivery is said to be somewhere between three and thirty times higher than for vaginal delivery,[16] with five to ten times the risk of infection or other complications.[17] Recovery is apt to be slower and caring for the infant more difficult after a caesarean. Infants are also placed at some risk by caesarean delivery; for example, the risk of respiratory distress associated with prematurity, and perhaps with the absence of the compressing effect on the lungs by vaginal delivery.[18]

Since intrauterine surgery is still in the early stages of development, it is somewhat difficult to predict whether its imposition upon unconsenting women might eventually produce some net benefits for offspring. But the track record for caesareans—voluntary and otherwise—is sufficiently mixed that it would be rash to make such a prediction.

The Violation of Basic Rights

For these reasons, I doubt that a strong case can be made, even on narrowly utilitarian grounds, for involuntary medical interventions against pregnant women. But let us suppose for the sake of argument that physicians were able to identify precisely those cases in which the woman's refusal of medical treatment seriously endangered her fetus and/or herself. Perhaps in that situation the use of coercion would produce some net benefit. However, the narrowly utilitarian argument for coercion ought to shock us, because it ignores the fundamental moral and legal rights of competent adults to autonomy and security against physical assault. It presumes that merely by becoming pregnant a woman has forfeited these fundamental rights.

> To the extent that doctors' advice takes on the force of law and doctors function as police informants, the relationship between women and medical professionals can only be authoritarian, adversarial, and marked by mutual distrust.

In 1990, doctors performed the first liver transplant in the United States using a live donor rather than a cadaver organ. The recipient was an infant girl whose mother donated a part of her own liver in order to give her child a chance of survival. Her act was undoubtedly a generous and praiseworthy one. But suppose that she had declined to make such a donation. Should the child's physicians have sought a court order empowering them to seize the woman by force and cut out part of her liver? It is all but inconceiv-

able that any American court would issue such an order. Legally, the infliction of surgery upon a competent and unconsenting adult constitutes a criminal assault. Morally, not even the laudable goal of saving a human life can justify the commission of a violent, damaging, and life-threatening physical assault upon a competent adult who has done nothing to deserve such abuse.

Sanctioning such an assault is so contrary to American legal tradition that there are very few clearly analogous cases in American legal history.[19] One such case is that of *McFall v. Shimp*. In that case, a man who was dying of cancer petitioned the court to order his cousin to donate bone marrow, since there was no other compatible donor and no other therapy that promised a chance for recovery. The judge refused to issue such an order, stating that, "to compel the Defendant to submit to an intrusion of his body would change every concept and principle upon which this society is founded. To do so would defeat the sanctity of the individual and would impose a rule which would know no limits."[20]

The point illustrated by this case is that one person's medical needs cannot readily override another person's rights to autonomy and physical integrity. Perhaps one person ought to be willing to donate bone marrow when that donation might save another person's life. But to use the force of law to compel such a "donation" would be to treat the "donor" as a thing rather than a person. No clearer violation can be imagined of the principle that persons are to be treated as ends in themselves and never merely as means.

It is arguable that there are some cases in which it is right to impose involuntary medical treatment upon one person for the sake of others. For instance, requiring children or adults to be vaccinated against deadly and contagious illness might be justified under certain (rather rare) circumstances. If the vaccine is effective and the risk of harmful side-effects slight; if any individuals who are harmed by the vaccine are well cared for and adequately compensated; and if the risk of widespread contagion without mandatory vaccination is very great, then perhaps the relatively modest invasion of the autonomy and physical integrity of unconsenting individuals can be justified. But a relatively safe and simple injection is one thing, and major surgery is another. The severity of the assault involved makes both involuntary organ donation and involuntary caesareans fundamentally different from mandatory vaccinations. People's bodies are not public resources that may be invaded and parts removed for the sake of some social good, or the good of some other person.

The Case Against Postbirth Sanctions

Women who knowingly use unsafe drugs while pregnant, or otherwise risk harm to the future child, may sometimes be morally culpable. But it is not always wise to use the force of law to punish the morally guilty. From a utilitarian perspective, punishment makes sense only if it is likely to produce some net social benefits. From a retributivist perspective, by contrast, it is inherently good that the guilty should suffer; hence punishment need not be justified in terms of other social benefits. But when punitive laws are almost certain to do much more harm than good; when they will predictably worsen the very problems they are intended to solve; and when innocent as well as guilty persons will be seriously hurt, then it is time to put aside the intuition that the guilty should be made to suffer and look for nonpunitive approaches. The following problems are inherent in any proposal to use the criminal law to penalize women for prenatal negligence.

> Poor women, minority women, and pregnant teenagers will most often be subjected to involuntary obstetrical interventions.

First, any law or policy that required or permitted health care workers to provide evidence of fetal neglect by their clients would probably deter many women from seeking any prenatal or obstetrical care at all, and prevent many others from providing accurate information to their health care advisors. Pregnant women with drug problems might be wise to avoid medical care entirely, since even a simple physical examination might prove incriminating. Women with personal or religious convictions that preclude certain medical procedures would also have powerful reasons for avoiding medical care during pregnancy, lest they later be prosecuted for refusing suggested therapies. The probable results include more medically disastrous pregnancies, more premature deliveries due to the lack of prenatal care, more concealed pregnancies and unattended births, more infant abandonment, and perhaps a resurgence of infanticide, as women find themselves forced to destroy the evidence of their presumed wrongdoing.

Second, the use of health care workers to implement "pregnancy policing" policies is incompatible with an open, cooperative, and egalitarian relationship between women and health care providers. Women who are either pregnant or fertile would need to be extremely cautious about what they tell their health care advisors regarding their sex lives, diet, use of legal or illegal drugs, and anything else that could eventually lead to criminal charges against them, should they be unfortunate enough to give birth to a less-than-perfect infant. To the extent that doctors' advice takes on the force of law and doctors function as police informants, the relationship between women and medical professionals can only be authoritarian, adversarial, and marked by mutual distrust. This relationship has long been somewhat strained. Coercive pregnancy policing policies would make it much worse, undoing much of the progress made in recent decades towards informed consent and respect for patient autonomy.

Advocates of fetal abuse laws argue that these would be no more destructive of the doctor/patient relationship than are contemporary child abuse laws. They point out that the legal requirement that doctors report suspected cases of child abuse does not seem to have prevented parents from taking their children to doctors.[21] But so-called fetal abuse is very different from child abuse. Because the fetus is physically located within the woman, almost anything that she does or does not do could conceivably affect it for better or worse. To hold her legally liable for behavior that others suspect may have harmed her fetus is to expose her entire private life to hostile scrutiny by doctors, lawyers, and police. Private acts of violence towards children should be exposed to hostile scrutiny. But women's personal decisions about how to care for themselves during pregnancy are not analogous to private acts of violence toward a child already born—even though they can occasionally have equally unfortunate results. For the actions that are said to constitute fetal abuse are, in the first instance, things that the woman does to or for herself, and the consequences of those actions for the future child are often very difficult either to prove or to predict. That fact does not eliminate her moral obligation to avoid actions that are likely to harm her future child, but it does undermine the view that "fetal abuse" is directly analogous to child abuse and amenable to similar legal approaches.

The third problem is that pregnancy policing policies could not be effectively

enforced without infringing upon a wide range of basic civil liberties. Enforcement would be very difficult without resorting to such measures as police surveillance of pregnant women, unannounced searches of their homes, mandatory tests for forbidden drugs, seizure of medical records, "sting" operations in which pregnant women are offered drugs or drink, the solicitation of damaging testimony from children and other family members, and so on through the list of devices dear to totalitarian governments. Remember that one of the charges against Pamela Stewart was that she had sex with her husband against her doctor's advice. How many of our basic civil liberties would survive intact if the law were seriously committed to detecting and punishing such actions?

> Jettisoning women's fundamental rights to autonomy, privacy, and physical integrity is not the answer to dilemmas posed by conflicts between pregnant women and their future children.

Some of these ill effects could probably be minimized by carefully drafted fetal abuse laws. Health care workers could be prohibited from testifying against women accused of fetal abuse, and law enforcement agencies could be limited to minimally intrusive methods of gathering evidence. But the restrictions necessary to make fetal abuse laws compatible with decent medical care and basic civil liberties would also make them virtually impossible to enforce. Enforcement would be sporadic and arbitrary, making any beneficial deterrent effect very slight.

Involuntary Incarceration

The involuntary incarceration of pregnant women, for example to prevent their continuing to use drugs, is subject to similar pragmatic and rights-based objections. In some cases, the future child might be saved from a harm greater than that inflicted upon the woman—who might even benefit in the long run from being prevented from continuing her habitual drug use. But there would inevitably be many other pregnant alcohol or drug users who would be deterred from seeking any medical care during pregnancy and birth, or from telling the truth to their medical advisors. Moreover, it is contrary to fundamental legal principles to imprison competent adults not for crimes of which they have been convicted but to prevent their behaving irresponsibly in the future. Voluntary treatment and education programs would reach many more women and would be much more beneficial to them and their families than such punitive and coercive approaches. Those are apt only to increase the total harm to future persons caused by inadequate prenatal care, while undermining the civil liberties of all women.

The Social Context

All of these arguments gain additional force when we consider the social context in which such coercive policies would operate. Rates of perinatal mortality and morbidity are high in the United States by comparison with other industrialized nations. The most common cause of infant mortality or morbidity is premature birth, which is strongly correlated with poverty and inadequate prenatal care. The lack of adequate medical insurance, or adequately funded Medicaid and related social programs, makes it all but impossible for many women to obtain prenatal care. For poor women, minority women, and pregnant teenagers it is apt to be especially difficult. And yet it is, predictably, these and other particularly vulnerable groups of women who will most often be subjected to involuntary obstetrical interventions.[22] As Laura Purdy points out,

> Under these circumstances, invading women's bodies to impose last-minute, heroic care is stupid, mean and unfair...Until we as a society act to make good, inexpensive, convenient and respectful care a priority, punishing women for lack of prenatal care reeks of hypocrisy.[23]

Proposals to punish "fetal abuse" by pregnant women raise comparable issues of social justice. The harm to infants caused by maternal drug use is a symptom of ineffective social policies. The legal prohibition of recreational drugs that (rightly or wrongly) are considered particularly harmful has thus far done relatively little to deter their sale and use. Prohibition seems only to worsen drug-related social problems, creating warfare in the streets and political corruption in both supplying and consuming nations. While drug use is not confined to those who bear the burdens of racism and economic deprivation, it is they who are most likely to be imprisoned as drug offenders or killed in the drug wars. So too it is poor and minority women who would most often be prosecuted under fetal abuse laws. Such laws are not likely to deter drug use very much more effectively than do existing anti-drug laws, and would tend to exacerbate rather than remedy the problems of families and individuals affected by drug abuse.

It is easy to understand why those who observe firsthand the tragedy of "crack babies" and infants damaged by alcohol should want to punish those who seem most directly responsible, the mothers. But in practice this would be little more than an exercise in scapegoating. Such scapegoating distracts attention from the need for fundamental changes in social policies. The necessary changes include improved access to medical care, including contraception and abortion as well as prenatal and obstetrical services; improved economic and educational opportunities for economically disadvantaged groups; adequate funding for voluntary drug therapy programs, with priority given to pregnant users; better education about sex and contraception, and legal and illegal drugs; and perhaps a cautious process of legalization and regulation to bring some sanity to the trade in now-illegal recreational drugs. All of this will require a massive realignment of social priorities; but nothing less will effectively reduce the number of avoidable prenatal injuries to future persons.

Conclusion

I have argued that both prebirth seizures and postbirth sanctions are medically counterproductive, destructive to the physician/client relationship, and unjust in their differential impact on poor and minority women. Conflicts can occur between the interests of pregnant women and those of their future children. But jettisoning women's fundamental rights to autonomy, privacy, and physical integrity is not the answer to the dilemmas posed by those conflicts. The imposition of invasive and life-threatening medical interventions upon competent and unconsenting adults is unconscionable, regardless of whether it is done for paternalistic reasons or for the benefit of some other individual.

> Nothing less than a massive realignment of social priorities will effectively reduce the number of avoidable prenatal injuries to future persons.

The case against postbirth sanctions is based less upon fundamental rights than on the fact that punitive approaches will do a great deal more harm than good. However, basic civil liberties are at stake here too, inasmuch as the effective enforcement of criminal sanctions for fetal neglect or abuse would require signifi-

cant violations of privacy rights, as well as the erosion of medical confidentiality.

The vast majority of women who intend to give birth fully recognize their obligation to care for the fetal life within them, and are willing to undertake substantial personal sacrifices in fulfilling that obligation. As Janet Gallagher points out, treatment refusals by pregnant women are quite rare; if anything, women have been "too compliant in their dealings with the medical profession, and too willing to accept caesarean sections and other invasive procedures" without sound evidence that they or their offspring will benefit.[24] The best way to protect future persons from prenatal injuries is to provide all women with access to good quality medical services, and to empower them to make informed decisions about their own prenatal and obstetrical care. Allowing others—physicians, courts or legislators—to make these decisions is inconsistent with fundamental legal and moral rights, and is ultimately more dangerous to the well-being of future persons.[25]

The best way to protect future persons from prenatal injuries is to provide all women with access to good quality medical services, and to empower them to make informed decisions about their own prenatal and obstetrical care.

Notes

1. John A. Robertson, "Reconciling Offspring and Maternal Interests During Pregnancy," in Reproductive Laws for the 1990s, edited by Sherrill Cohen and Nadine Taub (Clifton, New Jersey: Humana Press, 1989), pp. 259-276.

2. See Robertson, "The Right to Procreate and in Utero Fetal Therapy," *Journal of Legal Medicine* 3 (1982), pp. 438-439.

3. Other fetal rights issues, which are beyond the scope of this paper, include civil liability for women whose children are harmed by the mother's behavior while pregnant; whether living will statutes should contain a pregnancy exception; and whether employers may exclude women from jobs where the working conditions might prove injurious to fetuses. For an excellent discussion of some of the issues involving civil liability and employment discrimination, see James W. Knight and Joan C. Callahan, Preventing Birth: Contemporary Methods and Related Moral Controversies (Salt Lake City: University of Utah Press, 1989). On the pregnancy exception for living wills, see Janet Gallagher, "Fetus as Patient," in Reproductive Laws for the 1990s, pp. 193-195.

4. Barbara Katz Rothman, The Tentative Pregnancy: Prenatal Diagnosis and the Future of Motherhood (New York: Viking Penguin Inc., 1986), pp. 31-32.

5. Cited by Laura M. Purdy, "Are Pregnant Women Fetal Containers?" paper delivered at American Philosophical Association convention, Atlanta, December 28, 1989.

6. See Mary Anne Warren, "On the Moral and Legal Status of Abortion," *The Monist* 57 (January 1973), pp. 43-61; and "The Moral Significance of Birth," *Hypatia* 4 (Fall 1989), pp. 46-65.

7. See Thomas H. Murray, "Moral Obligations to the Not-Yet-Born: The Fetus as Patient," in Ethical Issues in the New Reproductive Technologies, edited by Richard T. Hull (Belmont, California: Wadsworth, 1989), p. 218.

8. See, for instance, *Jefferson v. Griffin Spalding County Hospital Authority*, 247 Ga 86, 274 S.E. 2d 457 (1981), in which the Court gave a local government agency temporary custody of an unborn infant, empowering the agency to order medical interventions on its behalf—including the performance of a caesarean section against the mother's will.

9. See Knight and Callahan, pp. 268-269.

10. See Gallagher, p. 195.

11. Robertson (1989), p. 265.

12. Of course, not all utilitarian thinkers reject the concept of a moral right. In a broader utilitarian perspective, it can be argued that utility is best served by respecting individual moral rights even in cases where some immediate social goal might seem to be better served by dispensing with rights.

13. See n. 8.

14. Gallagher cites a similar case in Michigan, p. 186.

15. See, for instance, Knox and Karagianis, "Caesarean Births: High Rates, Impassioned Debate," *Boston Globe Magazine*, Oct. 21, 1984, pp. 10-11; cited by Gallagher, p. 233.

16. Gilfix, "Electronic Fetal Monitoring: Physician Liability and Informed Consent," *American Journal of Law and Medicine* 10 (1984), pp. 31, 42; cited by Gallagher, p. 233.

17. Knox and Karagianis, p. 58.

18. H. Marieskind, An Evaluation of Caesarean Section in the United States, p. 64; cited by Gallagher, p. 233.

19. There have been cases in which Jehovah's Witnesses have been forced to accept blood transfusions, for paternalistic reasons and/or for the sake of a minor child. See, for instance, *United States v. George*, 33 LW 2518 (1965). The severity of the infringement of personal autonomy and religious freedom in these cases creates grave doubt about the correctness of these decisions. Be that as it may, the case is not analogous to that of involuntary surgery, since the direct physical invasion and damage is far less severe.

20. *McFall v. Shimp*, Pittsburgh Legislative Journal 14 (July 26, 1978), p. 127.

21. Robertson (1989), p. 265.

22. Kolder *et al.*, report that of the 21 cases in which court orders had been sought for involuntary medical interventions, 81 percent of the women were black, Hispanic or Asian. See Veronika E. B. Kolder, Janet Gallagher, and Michael T. Parsons, "Court-Ordered Obstetrical Interventions," *New England Journal of Medicine* 316 (May 7, 1987), pp. 1192-1196.

23. Purdy, p. 13.

24. Gallagher, p. 187.

25. My thanks to Michael Scriven and Dianne Romaine, who made helpful comments on earlier versions of this paper.