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BIOETHICAL CONSIDERATION OF MATERNAL-FETAL ISSUES

Linda Farber Post*

Introduction

Bioethics deals in large part with decisions about health care, often hard choices requiring close scrutiny and the sensitive balancing of rights, principles, values, and interests. Not surprisingly, some of the most difficult of these choices take place at the beginning and the end of life.

The relationship between a pregnant woman and her fetus is unlike any other in law, medicine, or ethics. Within the same body, there exist one person and one potential person with both similar and separate interests and, for the fetus, developing rights. This set of circumstances gives mother and fetus a biological, psychological, moral, and legal connection that is unique.

This article examines the complexity of the maternal-fetal conflict, focusing on the interests of the woman and the sometimes conflicting interests of her fetus. Part I discusses the typical analytical background of the conflict, explaining the various ethical principles, rights, and obligations involved. Part II explores the various choices made by the pregnant woman, as well as the state's attempts to regulate those choices on behalf of the fetus. This article concludes that, while the maternal-fetal relationship may give rise to certain *moral* rights in the fetus and obligations in the woman, these are not the same as *legal* rights and responsibilities on the basis of which the state can or should intervene.

I. Analytic Framework

Because the maternal-fetal relationship is complex and unique, it gives rise to dilemmas with both legal and ethical implications. Of

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particular concern are situations in which the welfare of the woman and fetus appear to be at odds. In such cases, it is often the perceived responsibility of society to promote the well-being of both or, if that is not possible, to choose between them. These are extremely difficult and troubling issues about which people of intelligence, compassion, and social responsibility feel passionately. In some instances, matters that used to be confined to the doctor-patient relationship have come within the legal and public policy domain, often with unhelpful results.

A. Maternal-Fetal Conflict

Maternal-fetal conflict is a term used to identify those situations in which there is a discordance between the interests of a pregnant woman and the fetus she is carrying. The existence and degree of perceived conflict can be seen to depend on:

- whether the woman and fetus have independent interests and rights deserving respect and support;
- whether obligations attach to pregnancy; and
- whether the risk to the fetus posed by the prenatal behavior of the woman should be subject to state or medical intervention.

The ethical principles that classically inform a bioethical analysis are *autonomy* (respecting the privacy and self-determination of the individual), *beneficence* (providing benefits and balancing risks or burdens against those benefits), *nonmaleficence* (avoiding harm), and *justice* (fairly distributing the risks, burdens, and benefits).¹ When the perceived interests of the pregnant woman, her fetus, and society come into conflict, these principles are weighed and balanced as part of the ethical calculus.²

1. Autonomy

The ethical principle of autonomy is central to the concept of the individual and independent self,³ an idea accorded near reverence

1. See TOM L. BEAUCHAMP & JAMES F. CHILDRESS, *PRINCIPLES OF BIOMEDICAL ETHICS* 38 (4th ed. 1994).

2. For a discussion applying the ethical principles of autonomy and beneficence to maternal-fetal issues, see Frank A. Chervenak & Laurence B. McCullough, *Perinatal Ethics: A Practical Method of Analysis of Obligations to Mother and Fetus*, 66 *OBSTETRICS & GYNECOLOGY* 442 (1985).

3. See BEAUCHAMP & CHILDRESS, *supra* note 1, at 120-81. Among the meanings included in the term are "self-governance, liberty rights, privacy, individual choice, freedom of the will, causing one's behavior, and being one's own person." *Id.* at 120.

in Western cultures.⁴ Indeed, notions of self-determination are so important in our society that the principle of autonomy is frequently held to trump the other three ethical principles. Increasingly reflected in legislative and judicial reasoning,⁵ autonomy is one of the two aspects of the constitutional right to privacy,⁶ the other being the right of selective informational disclosure.⁷

The principle of autonomy underlies healthcare decision making that gives priority to the values and wishes of the individual when they are not legitimately restricted by the rights of others. It is only when the individual's wishes are obscure, inaccessible, or overridden by competing principles that the judgment of others is substituted.⁸ In the healthcare setting, autonomy is reflected most prominently in the doctrine of informed consent, upholding the right of the patient to authorize or refuse medical treatment. This right to determine what is done to one's body⁹ is protected by both

4. See, e.g., H. Shaw Warren, *Unlimited Human Autonomy—A Cultural Bias?*, 336 NEW ENGL. J. MED. 953 (1997); Edmund S. Pellegrino, *Patient and Physician Autonomy: Conflicting Rights and Obligations in the Patient-Physician Relationship*, 10 J. CONTEMP. HEALTH L. & POL'Y 47 (1993).

5. See, e.g., *Whalen v. Roe*, 429 U.S. 589, 599-600 (1977) (upholding statute requiring copies of prescriptions for certain drugs despite the Court's recognition of an "interest in independence in making certain kinds of important decisions"); *Eisenstadt v. Baird*, 405 U.S. 438, 453 (1972) (extending to unmarried as well as married people the right to use contraception and expressing that people have the right to be free from "unwanted governmental intrusion into matters . . . fundamentally affecting a person").

6. See *Griswold v. Connecticut*, 381 U.S. 479, 485 (1965) (finding a protected right of privacy both in withholding information from public view and in personal decision making); see also Margaret G. Farrell, *Revisiting Roe v. Wade: Substance and Process in the Abortion Debate*, 68 IND. L.J. 269, 300-02 (1993). Farrell contrasts Justice Brandeis's concept of the "right to privacy as solitude" with the "right to privacy . . . [as] autonomy" articulated by Justice Brennan in *Eisenstadt*, 405 U.S. at 302. For a comprehensive discussion of the two meanings of privacy, see Tyler Baker, *Roe and Paris: Does Privacy Have a Principle?*, 26 STAN. L. REV. 1161, 1163-64 (1974).

7. See, e.g., *Whalen*, 429 U.S. at 599 (recognizing an "interest in avoiding disclosure of personal matters"); *Stanley v. Georgia*, 394 U.S. 557, 564 (1969) (holding that, in support of one's right to be free from "unwanted governmental intrusion into one's privacy," mere private possession of obscene matter cannot constitutionally be made a crime).

8. See BEAUCHAMP & CHILDRESS, *supra* note 1, at 170-80; see also NEW YORK TASK FORCE ON LIFE AND THE LAW, WHEN OTHERS MUST CHOOSE: DECIDING FOR PATIENTS WITHOUT CAPACITY 103-07 (1992); *In re Conroy*, 486 A.2d 1209 (N.J. 1985) (affirming the primacy of individual autonomy and establishing standards for making treatment decisions on behalf of incompetent individuals).

9. One of the most well known and widely quoted expressions of this philosophy comes from a 1914 New York State Court of Appeals decision in which Justice Benjamin N. Cardozo wrote, "every human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient's consent commits an assault for which he is liable in

the New York State Constitution¹⁰ and the United States Constitution.¹¹

2. *Beneficence and Nonmaleficence*

Beneficence is the principle that underlies obligations to benefit others and the ways in which these obligations are fulfilled.¹² These behaviors include actions that defend, prevent harm, and rescue those in danger. Nonmaleficence, in contrast, is the obligation to avoid doing things that are harmful.¹³ Some commentators distinguish these two principles by saying that beneficence is concerned with *positive* responsibilities that must be discharged through affirmative actions *to do* something, while nonmaleficence, involves *negative* obligations to *avoid* doing something.¹⁴ It is suggested, therefore, that nonmaleficence assumes primacy, while beneficence can be seen as ideal, rather than obligatory.¹⁵ For this reason, it is argued, neither common morality nor common law imposes general duties of affirmative action to rescue and, even in the limited circumstances where rescue is required, there is no obligation to take action that would place the rescuer in danger.¹⁶

damages." *Schloendorff v. Soc'y of N.Y. Hosp.*, 211 N.Y. 125, 129-30, 105 N.E. 92, 93 (1914) (Cardozo, J.).

10. In *Rivers v. Katz*, 67 N.Y.2d 485, 495 N.E.2d 337, 504 N.Y.S.2d 74 (1986), involuntarily committed mental patients sought a declaratory judgment regarding their right to refuse antipsychotic medication. The Court of Appeals held that both common law and the due process clause of the state constitution protected the individual's right to determine the course of medical treatment, notwithstanding mental illness. *See id.* at 492-93, 495 N.E.2d at 341, 504 N.Y.S.2d at 78. Thus, unless the state can show a compelling interest, including the risk of a patient's self-inflicted harm or harm to others, treatment may not be administered without the individual's consent. *See id.* at 495-96, 495 N.E.2d at 343, 504 N.Y.S.2d 80.

11. In *Cruzan v. Director, Missouri Dep't of Health*, 497 U.S. 261 (1990), the United States Supreme Court affirmed the liberty interest of the individual in refusing unwanted treatment, but also affirmed the right of the state to require clear and convincing evidence of the individual's wish to discontinue life-sustaining treatment.

12. *See generally* BEAUCHAMP & CHILDRESS, *supra* note 1, at 259-325.

13. *Id.* at 189-258.

14. *See* TOM L. BEAUCHAMP & LEROY WALTERS, *CONTEMPORARY ISSUES IN BIOETHICS* 24 (4th ed. 1994); BEAUCHAMP & CHILDRESS, *supra* note 1, at 190-93.

15. *See* BEAUCHAMP & CHILDRESS, *supra* note 1, at 189-249, 259-318; RICHARD B. MILLER, *CASUISTRY AND MODERN ETHICS* 34 (1996).

16. W. PROSSER & W. KEETON, *THE LAW OF TORTS* § 56, at 375 (5th ed. 1984). In the healthcare setting, this principle is illustrated by the case of a patient with aplastic anemia whose cousin, the only sufficiently compatible relative, refused to be a bone marrow donor. The court found that, notwithstanding the urgency of the medical situation and the morally reprehensible nature of the refusal, the law cannot compel an individual to undergo physical invasion for the benefit of another. *See* *McFall v. Shimp*, 10 Pa. D. & C.3d 90 (Allegheny County 1978).

The principle of beneficence is the one with the greatest resonance for caregivers, whose mission is to provide patients with the greatest therapeutic benefit and shelter from harm. This sense of nurturing and protection reaches fullest expression in caring for those who are most vulnerable. It confers a special responsibility on those who care for the very young, the very old, and those who are incapable of looking after themselves.

3. Justice

The principle of justice concerns the reciprocal nature of morality, the balance between rights and duties, and the equitable distribution of risk, benefits, and burdens.¹⁷ Justice speaks to the *fairness* of a situation and the analysis by which an equitable resolution to conflict is achieved. In the healthcare setting, the principle of justice is reflected in the notions of access to health care and the allocation and rationing of healthcare resources. In the past, these discussions and decisions concerned patients as a population rather than as individuals and took place at a policy-making level that was removed from the bedside. More recently, the advent of managed care has insinuated into the clinical setting the burden of decision making about resource allocation, bringing potential conflicts of interest and a new dynamic to the caregiver-patient relationship.¹⁸

B. Fetal Status

Attempts to qualify who or what is a person sometimes distinguish between biological and psychological human life, the latter signifying qualities that are distinctively human, including the communicative and cognitive functions. Some commentators have proposed lists of characteristics considered to represent personhood, including self-awareness, a sense of time, and the ability to relate to others.¹⁹ Others tie personhood to stages of development such as conception, viability, or birth.²⁰ This latter approach allowed the

17. See BEAUCHAMP & CHILDRESS, *supra* note 1, at 326-87.

18. See Nancy Neveloff Dubler, *Ethics in Managed Care: The Obligation of Administration to Attending to Consequences*, 2 AM. J. MANAGED CARE 443 (1996); Jonathan Showstack et al., *Health of the Public: The Private-Sector Challenge*, 276 J. AM. MED. ASS'N 1071 (1996); Marcia Angell & Jerome P. Kassirer, *Quality and the Medical Marketplace—Following Elephants*, 335 NEW ENGL. J. MED. 883 (1996).

19. See, e.g., JOSEPH FLETCHER, *Humanness*, in HUMANHOOD: ESSAYS IN BIOMEDICAL ETHICS 7, 12-14 (1979).

20. See, e.g., John T. Noonan, Jr., *An Almost Absolute Value in History*, in BEAUCHAMP & WALTERS, *supra* note 14, at 279-82; Baruch Brody, *The Morality of*

Supreme Court in *Roe v. Wade*²¹ to adopt the trimester framework for regulating abortion and the Court in *Planned Parenthood v. Casey*²² to abandon it and adopt viability as the litmus test.

Still another way to frame the discussion is to look at the moral and legal status in terms of the rights and protections accorded to the individual. Upon birth, a baby is considered to acquire both moral and legal standing as a separate person, and the state assumes some responsibility for its well-being.²³ Invoking its police powers to protect the public health, safety, and welfare, and its *parens patriae* power to protect the helpless and vulnerable, the state on occasion will even intervene in the constitutionally protected right of parents to determine the best interests of their children when the well-being of those children is threatened.²⁴

But, prior to birth, when it is *becoming* a person, does the fetus have interests *independent* of its host and, when those interests are adverse, can it lay claim to the protection of the state *against* its host? What are the obligations of the state to intervene on behalf of the unborn?²⁵ In the past, courts have been reluctant to accord legal personhood to the fetus, finding instead the *potential* for personhood.²⁶ For example, attempts to prosecute as homicide the criminally caused death of a fetus have been largely unsuccessful.²⁷

Abortion, in BEAUCHAMP & WALTERS, *supra* note 14, at 292-302. See also Susan Sherwin, *Abortion: A Feminist Perspective*, in ETHICAL ISSUES IN MODERN MEDICINE 361-69 (John D. Arras & Bonnie Steinbock eds., 1995); Bonnie Steinbock, *Abortion: A Pro-Choice Perspective*, in ETHICAL ISSUES IN MODERN MEDICINE *supra*, at 329-43.

21. 410 U.S. 113 (1973) (holding that a state statute that prohibits abortion except to save the life of the mother, regardless of the stage of pregnancy or other factors, is violative of the due process clause of the Fourteenth Amendment and denies a woman's right to privacy).

22. 505 U.S. 833 (1992) (striking down state law provisions that unduly burden a woman's right to an abortion).

23. See, e.g., N.Y. JUD. LAW § 711 (McKinney 1983) (establishing the structure for child protective proceedings governing state intervention to protect the welfare of children).

24. See, e.g., *Prince v. Massachusetts*, 321 U.S. 158, 166 (1944) ("The right of parents to rear their children in accordance with their personal and religious beliefs gives way when the health or safety of children is threatened or when parental conduct poses some substantial threat to public safety").

25. See generally Thomas H. Murray, *Moral Obligations to the Not-Yet-Born: The Fetus as Patient*, 14 CLINICS IN PERINATOLOGY 329 (1987).

26. See, e.g., *Roe v. Wade*, 410 U.S. 113, 162 (1973) (observing that, rather than protecting the interests of the fetus, tort action appears "to vindicate the parents' interest and is thus consistent with the view that the fetus, at most, represents only the potentiality of life").

27. See, e.g., *Keeler v. Superior Court*, 470 P.2d 617 (Cal. 1970). But see *State v. Merrill*, 450 N.W.2d 318 (Minn. 1990) (upholding a statute designed to protect "human life," not "persons," and distinguishing between the two).

The vast majority of these decisions are consistent with the common law "born alive" rule, finding no homicide unless a live birth has occurred and there has been even a brief independent life.²⁸ The rare cases in which courts have found protectable fetal interests have tended to address matters beyond the confines of the particular case.²⁹

The more common approach has been to claim that child abuse and neglect statutes include "fetus" within the meaning of the term "child" for purposes of finding liability for failure to protect the health and safety of the unborn.³⁰ Some courts have found fetuses to be deprived and neglected children,³¹ while others have rejected this line of reasoning, noting lack of legislative intent to include fetuses in the statutory protections.³²

Fetal rights doctrines grant implicit legal status to the unborn.³³ Recognition of this "contingent legal personhood"³⁴ not only fundamentally alters the maternal-fetal relationship, it makes a woman vulnerable to civil and even criminal liability for any acts or

28. See, e.g., *State v. Soto*, 378 N.W.2d 625 (Minn. 1985).

29. For a discussion of the implications of judicial recognition of protectable fetal rights, see Janet Gallagher, *Prenatal Invasions & Interventions: What's Wrong With Fetal Rights?*, 10 HARV. WOMEN'S L.J. 9 n.164 (1987).

30. For a discussion of child abuse and neglect laws and their relevance to maternal-fetal conflict, see Nancy K. Rhoden, *Judges in the Delivery Room: The Emergence of Court-Ordered Caesareans*, 74 CAL. L. REV. 1951, nn.63-107 (1986).

31. See, e.g., *Jefferson v. Griffin Spalding County Hosp. Auth.*, 247 Ga. 86 (1981) (finding that denial of necessary medical care, including a caesarean section, renders a fetus a neglected unborn child). Recently, for the first time, a state court of last appeal upheld a woman's conviction for criminal neglect of her unborn child because she used cocaine while pregnant. The court found that the state abuse statute included fetuses within the meaning of the term "child." *Whitner v. State*, 1996 WL 393164 (S.C. Jul. 15, 1996). For an analysis of the implications of this decision, see Ariela R. Dubler, *Monitoring Motherhood*, 106 YALE L.J. 935 (1996).

32. See, e.g., *In re Steven S.*, 126 Cal. App. 3d 23 (Ct. App. 1981) (disapproving a lower court order of civil commitment for fetal protection, and finding the state statute inapplicable to a fetus). Analyzing the legal implications of New York State legislation mandating neonatal HIV testing, an ad hoc committee of the Association of the Bar of the City of New York observed, "It is imperative to note that the existing laws regarding child abuse and neglect cover infants only after birth." ASS'N OF THE BAR OF THE CITY OF N.Y., *PRENATAL/NEWBORN HIV TESTING* 15 (May 9, 1994).

33. See John Robertson, *The Right to Procreate and In Utero Fetal Therapy*, 3 J. LEGAL MED. 333 (1982) [hereinafter, Robertson, *The Right to Procreate*]; John Robertson, *Procreative Liberty and the Control of Conception, Pregnancy and Childbirth*, 69 VA. L. REV. 405 (1983) [hereinafter, Robertson, *Procreative Liberty*]; Margery Shaw, *Conditional Prospective Rights of the Fetus*, 5 J. LEGAL MED. 63 (1984). For an extensive analysis of fetal rights doctrines, see generally Gallagher, *supra* note 29.

34. Robertson, *The Right to Procreate*, *supra* note 33, at 352 n.92.

failures to act during pregnancy that are or could possibly be harmful to her fetus.³⁵

C. Instances of Maternal-Fetal Conflict

Abortion serves as one example of maternal-fetal conflict. The most liberal position accords the fetus no moral or legal standing, while the most conservative view holds that the fetus is a full human being from the moment of conception. Between these two extremes, the principle of respect for the autonomy of the woman collides with the principle of nonmaleficence toward the fetus. It is worth noting that the law has never come close to embodying the most conservative view.

Abortion is not, however, the paradigm for the maternal-fetal conflict analysis. Although some insist that abortion law sets viability as the bright line where society can elevate fetal rights over maternal rights,³⁶ in fact courts have repeatedly affirmed the primacy of the woman's health, interpreted broadly, in all abortion considerations.³⁷ In addition, it has been held that the state cannot require the kinds of trade-offs that would base the choice of abortion technique on enhancing the chances for fetal survival.³⁸ Perhaps most important, the constitutionality of states proscribing postviability abortions should not be interpreted to create new and unique affirmative legal duties for the woman who chooses to carry a pregnancy to term.³⁹

35. This liability for potentially harmful behaviors was illustrated in the *Whitner* decision. In *Whitner*, the court found that, under the child abuse statute, the woman's actions need not actually damage the fetus. *Whitner*, 1996 WL 393164, at *4. Rather, the statute only requires that her actions be "likely to endanger" the fetus. *Id.*; see also *Dubler*, *supra* note 31, at 937 n.21.

36. For an analysis of this misreading of *Roe*, see Gallagher, *supra* note 29, at 15-16.

37. See, e.g., *Roe v. Wade*, 410 U.S. 113, 164 (1973) (finding a state right to proscribe abortion to protect the life of the viable fetus "except when it is necessary to preserve the life or health of the mother."); *Doe v. Bolton*, 410 U.S. 179, 192 (1973); *United States v. Vuitch*, 402 U.S. 62, 72 (1971); *Colautti v. Franklin*, 439 U.S. 379, 400 (1979) (finding that psychological and emotional factors, as well as physical factors, must be considered in determining the health of the woman).

38. See, e.g., *Thornburgh v. American College of Surgeons*, 476 U.S. 747, 767 (1986) (invalidating a state statute that required using the abortion method least harmful to the fetus unless the woman's life could only be saved with an alternate technique).

39. For a creative and provocative illustration of society's unwillingness to impose the same burdens on others that it imposes on pregnant women, see Judith Jarvis Thomson's hypothetical about a woman who is forced to be connected for nine months to a famous violinist so he can use her circulatory system. Judith Jarvis Thomson, *A Defense of Abortion*, 1 PHIL. & PUB. AFF. 47 (1971).

The intended-to-be-born presents another, more complex set of issues because of the generally shared belief that the decision to give birth carries significant self-imposed responsibilities. It is logically consistent to support the notion of a woman's legal right to terminate a pregnancy in her own best interest and also the notion of her accepting certain moral obligations should she choose to carry the pregnancy to term. In this context, it is sometimes suggested that we are looking at the heightened rights of the fetus that is *intended* to be born.⁴⁰ Such fetal rights advocates also argue that the woman who chooses to forgo an abortion has executed some implicit waiver, giving the life of the intended-to-be-born, if not greater worth, then at least a greater claim on society's protection.⁴¹

D. Rights and Obligations

Once it is accepted that society has the *right* to promote the well-being of the unborn, it is a short distance to recognizing a state *obligation* to protect the fetus from harm, even when that harm is seen to come from the mother. The controversy has been framed in terms of two issues: "(1) what constitutes a risk of harm to the fetus that is sufficiently grave to justify limitation of the woman's liberty, and (2) what constitutes a legitimate reason for the woman not to take appropriate steps to prevent harm."⁴² The former focus elevates the rights of the fetus over the rights of the mother, a notion that is inconsistent with abortion law.⁴³ The latter perspective places the burden on the woman to justify her behavior, rather than on the state to justify its intrusion into her life, a notion that is inconsistent with constitutional protections.⁴⁴ Together, they form an overarching question: "What constitutes a sufficiently compelling state interest to justify legal coercion of pregnant women in the name of fetal protection?"⁴⁵ In this, as in any analysis, much depends on the perspective of those framing the issues. For advocates of fetal rights doctrines, the focus is on the legal status and

40. See John A. Robertson, *Legal Issues in Prenatal Therapy*, 29 CLINICAL OBSTETRICS & GYNECOLOGY 603 (1986).

41. For a discussion of the notion of heightened maternal responsibilities, see Rhoden, *supra* note 30, at 1979-81.

42. BEAUCHAMP & WALTERS, *supra* note 14, at 276 (1994).

43. See *supra* notes 36-39 and accompanying text.

44. See, e.g., *Nixon v. Administrator of Gen. Serv.*, 433 U.S. 425 (1977); *Carey v. Population Serv. Int'l.*, 431 U.S. 687, 686 (1977) (finding that only a compelling state interest will justify intrusion on an individual's privacy right, and that the intrusion must be "narrowly tailored" to achieve the interest).

45. BEAUCHAMP & WALTERS, *supra* note 14, at 276.

protection of the fetus. This article argues, as has been argued elsewhere, that the more appropriate focus is “the legal and moral status of women, pregnant or not.”⁴⁶

Attempts to justify legal intrusion for fetal benefit have resorted to:

- prosecution of women under child abuse/neglect statutes by attempting to find within the statutory meaning that “child” includes a fetus;⁴⁷
- creation of a duty to prevent harm that might occur despite the fact that there is no common law duty to rescue and the law has never imposed the same positive legal duties on women toward their fetuses as toward their children;⁴⁸ and
- medical paternalism, suggesting that any woman who does not act in her child’s best interest simply does not comprehend the issues and would agree to the proposed intervention if she did understand. This notion reduces pregnant women to the level of children or others without capacity.⁴⁹ Just as we cannot use the making of poor patient decisions (*i.e.*, those with which we do not agree) as a proxy for a finding of incapacity, we cannot use poor maternal behavior that presents fetal risk as a reason to suspend due process, including the requirement of informed consent.

E. Legal and Moral Rights and Responsibilities

It is critical to distinguish between legal and moral rights and responsibilities. The law recognizes certain rights, which, taken together, create a strong presumption that a woman has a protectable interest in not having the state intrude on her life or her pregnancy. These rights include the collection of interests identified in the right to privacy. While the jurisprudential parameters of the privacy right continue to shift,⁵⁰ its foundation remains in substantive

46. Gallagher, *supra* note 29, at 14.

47. See *supra* notes 24-26 and accompanying text. For an analysis of the extension of child abuse and neglect law to cover fetal well-being, see Rhoden, *supra* note 30, at 1964.

48. See *supra* notes 15-16 and accompanying text.

49. See Rhoden, *supra* note 30, at 2005-08.

50. The substantive right to the privacy of personal decision making was first articulated in *Griswold v. Connecticut*, 381 U.S. 479 (1965) (striking down a state law prohibiting the distribution and use of contraceptives by married couples and finding a “right to privacy” in the “penumbras” of the First, Third, Fourth, Fifth, and Ninth Amendments). In expanding the scope of protected personal interests, the Supreme Court recognized that the right to privacy as autonomy is violated when the individual is deprived of the right of personal decision making and action. However, in *Bowers*

due process, those Fourteenth Amendment guarantees against state actions that intrude into the lives of individuals, restrict their autonomous decision making, and infringe certain fundamental freedoms. Specific fundamental rights protected by the Constitution bear directly upon maternal-fetal issues, including the rights of procreation⁵¹ and childrearing.⁵² The presumption that parents will behave in ways that further their children's best interests is so well established⁵³ that only a showing of significant risk to a child will overcome the deference generally accorded to parental decision making.⁵⁴ In these rare cases, courts have ordered medical treatment for children over parental objection.⁵⁵ It is important to note that, although some courts have chosen to apply this line of reasoning to the notion of fetal abuse or neglect,⁵⁶ this approach is generally rejected.⁵⁷

When moral obligations are confused with legal duties, the result may be a misplaced notion of state responsibility to promote fetal well-being by intervening in maternal conduct. A woman's decision to carry a pregnancy to term does not automatically mean that

v. Hardwick, 478 U.S. 186 (1986) (holding that the right to privacy does not include a fundamental right to engage in homosexual sodomy, even within the privacy of one's home), the Court signaled its reluctance to further expand the definition of fundamental rights. The Court adopted yet a different approach in *Planned Parenthood v. Casey*, 505 U.S. 833 (1992) (recognizing a constitutional limit to states' rights to intervene in the personal decision making about family and parenting), when it replaced the language of fundamental rights by describing privacy in terms of "substantive liberties" that the state must not subject to an "undue burden." *Id.* at 2808, 2819.

51. *See, e.g., Skinner v. Oklahoma*, 316 U.S. 535 (1942) (holding that the familial right to procreate is fundamental, and, therefore, constitutionally protected).

52. *See, e.g., Santosky v. Kramer*, 455 U.S. 745 (1982) (recognizing Fourteenth Amendment protection of the fundamental liberty interests of parents in the custody, care, and upbringing of their children).

53. *See, e.g., Parham v. J.R.*, 442 U.S. 584 (1979) (holding that a minor's substantial liberty interest in avoiding unnecessary confinement is outweighed by the superior decisionmaking capacity of his parents who are presumed to act in their child's best interest).

54. *See, e.g., In re Marie B.*, 62 N.Y.2d 352, 358, 465 N.E.2d 807, 810, 477 N.Y.S.2d 87, 90 (1984) (holding that "[f]undamental constitutional principles of due process and protected privacy prohibit governmental interference with the liberty of a parent to supervise and rear a child except on a showing of overriding necessity").

55. *See, e.g., Joswick by Joswick v. Lenox Hill Hosp.*, 134 Misc.2d 295, 510 N.Y.S.2d 803 (N.Y. Sup. Ct. N.Y. County 1986) (holding that parents could not refuse cardiac surgery that might save the life of their child); *Custody of a Minor*, 375 Mass. 733 (1978) (rejecting parents' choice of laetrile treatment and ordering chemotherapy for a child with leukemia).

56. *See, e.g., In re Fathima Ashanti K.J.*, 147 Misc.2d 551, 558 N.Y.S.2d 447 (N.Y. Fam. Ct. 1990) (interpreting child abuse and neglect statutes to require therapy for fetal benefit).

57. *See ASS'N OF THE BAR OF THE CITY OF N.Y., supra* note 32, at 15-17.

she will put the interests of the fetus ahead of her own and, however repugnant that may be to some, it does not by itself give rise to a state obligation to inhibit maternal behavior for fetal benefit. This in no way diminishes what most would agree is the substantial moral obligation assumed by a woman who decides to carry a pregnancy to term. What must be resisted is the tendency to transform a *moral* duty of nonmaleficence into a *legal* duty to limit autonomy.⁵⁸

The urge to invoke governmental authority in the name of fetal protection may be seen to arise from commonly held notions about women, their proper roles, and their responsibilities to their offspring—what have been called “unarticulated assumptions about the maternal role.”⁵⁹ These assumptions underlie broader and more disturbing convictions about the *purpose* of women (to produce strong, healthy members of society) and the corresponding obligation of society to ensure the realization of that purpose.⁶⁰

The justification for a presumption of social responsibility to the unborn rests on a consequentialist or utilitarian ethical theory.⁶¹ The ethically right action (here, coercion of maternal behavior) is the one producing the optimal outcome or consequences (here, the preservation or promotion of fetal health). The notion that the end justifies the means becomes more acceptable as the end becomes more important and the means less harmful.⁶² This is countered by the deontological or Kantian ethic: Some actions are wrong, in and

58. See, e.g., Patricia A. King, *Should Mom Be Constrained in the Best Interests of the Fetus?*, 13 NOVA L. REV. 393 (1989).

59. Dubler, *supra* note 31, at 938 (quoting Reva Siegel, *Reasoning From the Body: a Historical Perspective on Abortion Regulation and Questions of Equal Protection*, 44 STAN. L. REV. 261, 341 n.331 (1992)).

60. See, e.g., *Muller v. Oregon*, 208 U.S. 412, 421 (1908) (“[A]s healthy mothers are essential to vigorous offspring, the physical well-being of woman becomes an object of public interest and care in order to preserve the strength and vigor of the race.”).

61. For a review of consequentialist and deontological ethical reasoning, see BEAUCHAMP & CHILDRESS, *supra* note 42, at 47-62. For an analysis of these philosophies as applied to maternal-fetal conflicts, see Rhoden, *supra* note 30, nn.242-73.

62. The utilitarian ethic is also invoked to point out the negative consequences of maternal coercion in the name of fetal benefit: 1) pregnant women tending toward behavior harmful to their fetuses will avoid necessary prenatal care because facilities are required to report suspected child abuse to authorities; 2) the confidentiality and trust in the doctor-patient relationship will be diminished; and 3) committing a pregnant woman to a correctional facility consigns her and her fetus to inferior medical care. See Martha A. Field, *Controlling the Woman to Protect the Fetus*, 17 LAW, MEDICINE & HEALTH CARE 114 (1989); Wendy Chavkin, *Drug Addiction and Pregnancy: Policy Crossroads*, 80 AM. J. PUB. HEALTH 483 (1990).

of themselves, no matter how desirable or important the goal.⁶³ Using people as means to ends is always wrong, even though some tragic consequences may result from not acting.⁶⁴

II. Issues Giving Rise to Maternal-Fetal Conflict

Under any analysis, it is clear that the developing organism is completely dependent on the gestational environment, which determines in large part its safety and future health. Traditionally, society in general and medicine in particular attended to the well-being of the inaccessible fetus only by focusing on the health and safety of the mother. In recent decades, however, greater knowledge of prenatal behavior and its effects on gestation, and more sophisticated techniques of intrauterine therapy allow more direct intervention to promote fetal health. In addition, surgical techniques have improved. Procedures such as caesarean sections and even fetal surgery have become far less risky for the mother and far more beneficial for the fetus, thereby altering the benefit-burden analysis.

Likewise, there are voluntary behavioral implications. The pregnant woman has sole custody of this potential human life during gestation and what she does to her own body she does also to her boarder. For this reason, fetal advocates argue that, in choosing to become or at least remain pregnant, a woman assumes certain responsibilities and implicitly agrees to safeguard the developing fetus, even at a cost to herself.⁶⁵ Others also point to these responsibilities, but distinguish the moral nature of the obligation.⁶⁶ It is essential to recognize, however, that this is not simply another custodial relationship. Whatever intervention is done for fetal benefit is done also to the woman. Therefore, it is argued that, even where the threat to the unborn is great, where the benefits of the proposed intervention are established "society's relationship to the fetus must be mediated by the woman in whose body it is."⁶⁷

Maternal-fetal conflict arises most often out of choices made by the woman that risk harm to the fetus, including those based on

63. "When the judiciary acts in [a] consequentialist manner it compromises its own integrity, because it can achieve good only by doing evil. It is far better that some tragic private wrongs transpire than that state-imposed coercion of pregnant women become part of our legal landscape." Rhoden, *supra* note 30, at 1953.

64. *Id.*

65. See, e.g., Robertson, *Procreative Liberty*, *supra* note 33, at 437.

66. See, e.g., Rhoden, *supra* note 30, at 1980-81.

67. Gallagher, *supra* note 29, at 13.

religious or ethical motivation, ignorance or self-destructive habit, or economic imperatives.

A. Medical and Lifestyle Choices

Pregnant women may choose to do or not to do something based on a deeply held religious or ethical tenet. In the past, these situations generally concerned refusal to undergo certain kinds of invasive medical treatments, such as caesarean sections⁶⁸ and blood transfusions.⁶⁹ These cases implicate the mother's fundamental right of religious freedom and her liberty interest in refusing unwanted treatment as against the state's interest in protecting the life of the unborn. Courts have generally opted to save the fetus where possible,⁷⁰ although more recent cases place greater emphasis on trends honoring rights to refuse medical treatment or the opportunity to donate organs or tissue, as well as respect for self-determination and bodily integrity.⁷¹

A different analysis applies when dealing with voluntary and often harmful lifestyle choices. These cases usually focus on abuse of substances, including illegal drugs and alcohol, and depend on state abuse and neglect laws.⁷² It is worth noting the distinction between behaviors that are harmful to the fetus and independently illegal (*e.g.*, abuse of controlled substances) and those that are harmful but not illegal (*e.g.*, consumption of alcohol). Depending on the statute under which the mother is charged, she may be liable for criminal sanctions, including imprisonment, or civil sanctions, including commitment. One might ask whether a woman imprisoned to protect a fetus is being punished for abusing drugs or for being pregnant. Likewise, if she is committed, who is being treated?

68. *See, e.g.*, *Jefferson v. Griffin Spalding County Hosp. Auth.*, 247 Ga. 86 (1981) (ordering a caesarean section against the religiously motivated refusal of the mother in order to save both, and based on the "duty of the state to protect a living, unborn human being from meeting . . . death before being given the opportunity to live").

69. *See, e.g.*, *Raleigh Fitkin-Paul Morgan Mem'l Hosp. v. Anderson*, 42 N.J. 421 (1964) (holding that, contrary to religious objections of Jehovah's Witness mother, blood transfusions must be given to save life of fetus).

70. *See, e.g.*, *In re Application of Jamaica Hosp.*, 128 Misc.2d 1006, 491 N.Y.S.2d 898 (N.Y. Sup. Ct. 1985) (ordering blood transfusion to save unborn).

71. *See, e.g.*, *In re A.C.*, 573 A.2d 1235 (D.C. 1990) (holding that a terminally ill woman must undergo a caesarean section to save her fetus).

72. *See, e.g.*, Wendy Chavkin, *Drug Addiction and Pregnancy: Policy Crossroads*, 80 AM. J. PUB. HEALTH 483 (1990) (examining the three ways in which society has responded to the problem of chemical addiction during pregnancy and arguing that it is both unethical and counterproductive for physicians to function as law enforcement agents).

These cases generally have rested on two theories of prosecution:⁷³ delivery of drugs⁷⁴ and violation of child abuse or neglect laws.⁷⁵

B. Employment Choices and Employer “Fetal Protection” Policies

Another area giving rise to maternal-fetal conflict is the workplace where some practices and conditions considered safe for female employees may not be safe for their yet-to-be-born (or even yet-to-be-conceived). Women of childbearing age, exposed to chemical or mechanical hazards, present health risks for themselves and their offspring, as well as legal liability for their employer. The conflict pits the interests of the female employee (financial advantage and work satisfaction) against those of the fetus (protection from developmental risk). Employers hoping to avoid fetal injury, adverse publicity, increased insurance costs, and legal liability have sometimes adopted policies excluding women of childbearing years from certain jobs.⁷⁶ On occasion, employers have even tried to condition job eligibility on “voluntary” sterilization.⁷⁷

C. Mandatory HIV Testing of Newborns

One of the most recent and troubling manifestations of the society-as-mother-surrogate philosophy is the move to legislatively mandate HIV screening of neonates. Because it involves the health of newborns and the rights of women, this issue predictably has come to be framed in terms of the maternal-child relationship.

73. See Dubler, *supra* note 31, at 936 n.9.

74. See, e.g., *Johnson v. State*, 602 So.2d 1288 (Fla. 1992) (rejecting lower court ruling that, although ingestion of drugs took place during pregnancy, delivery took place during the 30- to 90-second period between birth and cutting the umbilical cord). This line of reasoning has been rejected on appeal.

75. See, e.g., *In re Stefanel Tyesha C.*, 157 A.D.2d 322, 556 N.Y.S.2d 280 (App. Div. 1990) (finding that positive neonatal cocaine toxicology established a causal connection between maternal drug use during pregnancy and harm to the child). *Whitner v. State* is the first case of this kind that has not been overturned on appeal. 1996 WL 393164 (S.C. Jul. 15, 1996).

76. See, e.g., *International Union, UAW v. Johnson Controls, Inc.*, 499 U.S. 197 (1991) (holding that employment policies that exclude women of childbearing age from a hazardous workplace are unconstitutional because they illegally discriminate based on gender).

77. *Id.*

New York, like most states, had routinely tested newborns anonymously for the presence of the HIV antibody.⁷⁸ This type of survey is a blinded public health study, intended to provide information about the distribution of the disease, not about the individuals affected by the disease. As such, epidemiological surveys represent an exception to the requirement for disclosure of results to those tested, as well as the requirement for informed consent.

A new law, enacted in 1996,⁷⁹ mandates the testing of newborns for the presence of HIV antibodies and the disclosure of the test results to the mothers.⁸⁰ This law and the regulations that implement it have disturbing repercussions for pregnant women and new mothers. All infants born to HIV-infected women carry the maternal HIV antibodies, but this does not provide proof of pediatric infection, because approximately 75% will throw off the maternal antibodies within 15-18 months. The results of the seroprevalence survey are thus reliable indicators only of infection trends in *childbearing women*, not their children.⁸¹

In effect, the new law does not achieve its stated intention—identification and treatment of HIV-infected newborns; rather, it avoids the disclosure and informed consent requirements of the HIV confidentiality laws, and identifies HIV-infected women without their consent. It has been shown that, when counseled, the overwhelming majority of women volunteer to be tested and learn their HIV status.⁸² Moreover, although the law does mandate pre-test and post-test counseling of women, it does not allocate funding for additional post-test counseling at the time of disclosure or for tracking, retesting, or treating newborns who test positive. This is

78. See NEW YORK AIDS ADVISORY COUNCIL, REPORT OF THE SUBCOMMITTEE ON NEWBORN SCREENING 2-4 (February 10, 1994) (testimony, data, and report on file with the author); ASS'N OF THE BAR OF THE CITY OF N.Y., *supra* note 32, at 15.

79. N.Y. PUB. HEALTH LAW § 2500-f (McKinney 1996).

80. For a thorough discussion of the legal issues raised by mandatory neonatal HIV testing, see Elizabeth B. Cooper, *Why Mandatory HIV Testing of Pregnant Women and Newborns Must Fail: A Legal, Historical, and Public Policy Analysis*, 3 CARDOZO WOMEN'S L. J. 13 (1996); Linda Farber Post, *Unblinded Mandatory HIV Screening of Newborns: Care or Coercion?* 16 CARDOZO L. REV. 169 (1994); Kevin J. Curnin, *Newborn HIV Screening and New York Assembly Bill No. 6747-B: Privacy and Equal Protection of Pregnant Women*, 21 FORDHAM URB. L.J. 857 (1994); ASS'N OF THE BAR OF THE CITY OF N.Y., *supra* note 32; Letter from Association of the Bar of the City of New York to William F. Johnson, New York State Department of Health (Dec. 2, 1996) (on file with author) [hereinafter ABCNY Letter].

81. REPORT OF THE SUBCOMMITTEE ON NEWBORN HIV SCREENING OF THE NEW YORK STATE AIDS ADVISORY COUNCIL 6 (February 10, 1994) (on file with author) [hereinafter RSNHIVS]; see also Cooper, *supra* note 80, at 31.

82. See ABCNY Letter, *supra* note 80, at 1; Cooper, *supra* note 80, at 22.

particularly troubling in light of the approximately 30-day lag between the test and the receipt of lab results which are to be disclosed to the mother.⁸³ During this time, mother and infant have left the hospital, and the mother may have already begun breast feeding or having unprotected sex, activities that carry risk for the woman, her sexual partner, and her baby.

Perhaps most disappointing, the provision is only for postnatal rather than voluntary prenatal testing. Because it has been shown that prenatal and perinatal administration of AZT reduces dramatically maternal-fetal transmission of HIV,⁸⁴ it may be far more effective for women to be tested and treated during rather than after pregnancy. Nevertheless, even assuming the effectiveness of prenatal testing and AZT treatment of HIV positive women, mandatory screening would still suffer from the same infirmities as other coercive measures. It would still be necessary to prove that unconsented-to screening was the most effective and least restrictive way⁸⁵ to get women and children into treatment, and that has not been shown.

D. Implications of State Intervention in Maternal Behavior

Any policy of state intervention in maternal behavior for fetal benefit has ominous implications, not only for pregnant women, but for all women of childbearing age. Once society undertakes the responsibility for providing every fetus with a safe and healthy gestational environment, the state assumes the obligation to restrict all potentially harmful behavior of any woman who is or may become pregnant. This notion is especially discriminatory because the burden falls only on women⁸⁶ and customarily falls most heavily on women of color and those who are poor.⁸⁷ Maternal restric-

83. See RSNHIVS, *supra* note 81, at apps. F, G.

84. The number is reduced from 23 percent to 8 percent. See NATIONAL INST. OF ALLERGY AND INFECTIOUS DISEASES, CLINICAL ALERT, IMPORTANT THERAPEUTIC INFORMATION ON THE BENEFIT OF ZIDOVUDIN FOR THE PREVENTION OF THE TRANSMISSION OF HIV FROM MOTHER TO INFANT (1994).

85. State measures that infringe constitutional rights, such as privacy rights, must use the least restrictive means to accomplish ends directly related to state goals. See *Nixon v. Administrator of Gen. Services*, 433 U.S. 425 (1977); *Carey v. Population Services Int'l*, 431 U.S. 678 (1977).

86. For a discussion of pregnancy discrimination and gender discrimination, see Curnin, *supra* note 80, at 273-313.

87. See, e.g., ASS'N OF THE BAR OF THE CITY OF N.Y., *supra* note 32, at 75; Dubler, *supra* note 31, at 25; George J. Annas, *Protecting the Liberty of Pregnant Patients*, 316 NEW ENG. J. MED. 1213 (1987); Veronika E.B. Kolder et al., *Court-Ordered Obstetrical Interventions*, 316 NEW ENG. J. MED. 1192 (1987).

tions and medical interventions have either been enforced or suggested as appropriate to enforce in the interests of fetal benefit. These restrictions and medical interventions include actual fetal protection interventions⁸⁸ and suggested fetal protection interventions.⁸⁹

Assuming that the appropriate analytic focus is on the moral and legal status of the woman, when contemplating interventions it is necessary to consider the potential harms to a woman, as well as the potential benefits to her fetus. Ultimately, policies of legal coercion of maternal behavior for fetal benefit harm women by:

- impermissibly broadening state intrusion into traditionally protected areas of privacy and autonomy, including rights of procreative and familial decision making;⁹⁰
- violating doctrines of informed consent and the right to refuse medical treatment;⁹¹
- violating the right of women to be free from unique civil or criminal liability;⁹²
- violating equal protection rights by targeting women, especially women of color;⁹³
- imposing new affirmative duties to rescue not imposed on others;⁹⁴ and
- violating due process rights.⁹⁵

88. Such interventions include compulsory blood transfusions, *Raleigh Fitkin-Paul Morgan Memorial Hosp. v. Anderson*, 42 N.J. 421, *cert. denied*, 377 U.S. 985 (1964); *In re Jamaica Hospital*, N.Y.L.J., May 17, 1985, at 15 (Queens Cty., Sup. Ct., Special Term, Part 2); compulsory medication, such as insulin, *see, e.g., In re Unborn Baby Wilson*, No. 81-108 AV (Mich. Ct. App. Mar. 9, 1981); compulsory caesarean sections, *see, e.g., Jefferson v. Griffin Spalding County Hosp. Auth.*, 247 Ga. 86 (1981); incarceration to prevent harmful behavior and commitment for schizophrenia, *see, e.g., In re Steven S.*, 126 Cal. App. 3d 23 (Ct. App. 1981); and prosecutions of women for legal activities, such as drinking alcohol or having sex, during pregnancy, *see, e.g., In re Danielle Smith*, 128 Misc. 2d 976, 492 N.Y.S.2d 331 (N.Y. Fam. Ct. 1985).

89. These interventions include surveillance and involuntary hospitalization for medication, surgery, diet; compulsory inutero and even extrauterine surgery; and compulsory genetic testing and even abortion of severely defective fetuses. *See, e.g., Gallagher*, *supra* note 29, at 11, 41-46; *Rhoden*, *supra* note 30, at 2027; notes 387-88; *Murray*, *supra* note 25, at 333.

90. *See supra* notes 50-54.

91. *See supra* notes 9-11 and 68-69 and accompanying text.

92. *See supra* notes 58-60 and accompanying text.

93. *See supra* notes 86-87 and accompanying text.

94. *See supra* notes 42-63, and 86-89 and accompanying text.

95. *See supra* notes 50-57 and accompanying text.

Conclusion

The issue here is not simply the interests of pregnant or even fertile women. Rather, the issue is the legal and moral status of *all* women. If society assumes the position of moral arbiter and pregnancy police, then women become defined by their reproductive roles and are reduced to what have been called "fetal containers"⁹⁶ and "Handmaids,"⁹⁷ whose only purpose is breeding. This, in turn, says a great deal about how society values women who cannot or choose not to bear children and those who are past their fertility, as well as those who are pregnant.

96. See George J. Annas, *Pregnant Women As Fetal Containers*, 16 HASTINGS CTR. REP. 13 (Dec. 1986).

97. See MARGARET ATWOOD, *THE HANDMAID'S TALE* (1986).

