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James J. Nocon
Indiana University

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PHYSICIANS AND MATERNAL-FETAL CONFLICTS: DUTIES, RIGHTS AND RESPONSIBILITIES

JAMES J. NOCON*

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I. INTRODUCTION

Ms. Jane Doe raised the fluted glass to her lips and took a sip of the champagne. After all, it was New Year's Eve and she was only going to take a sip or two. How could one little sip cause any harm to the baby she carried, she thought rhetorically. A few moments later the doorbell chimed. It was the police. She was informed that the telemetry device clipped to her cervix at her first prenatal visit months ago alerted the computer at the hospital that it detected a sudden increase in her blood alcohol level. Thus, by law, she would have to accompany the police to the hospital for further testing. The officer also advised her to bring her personal items since she may be required to be detoxified prior to discharge from the hospital.

If this scenario seems improbable in a kindler and gentler America, think again. The medical technology required to evaluate the blood pres-

*James J. Nocon, M.D., J.D., is an Assistant Professor with the Department of Obstetrics and Gynecology at Indiana University School of Medicine, Indianapolis, Indiana. He received his Medical degree from Jefferson Medical College, Philadelphia, Pennsylvania in 1971 and his Juris Doctor degree from Marquette University School of Law, Milwaukee, Wisconsin in 1987. Dr. Nocon is Board Certified and a Fellow of the American College of Obstetricians and Gynecologists, and a member of the Indiana and Wisconsin Bar Associations.

sure, pulse rate, and oxygen saturation of the blood is currently available and can be found in the form of a small pressure pad attached to the handlebar of expensive home exercise equipment. Miniature transmitting devices (telemetry) have been relaying biophysical information from our astronauts for two decades. The legal framework necessary to incarcerate a woman over the conduct in her pregnancy has been in operation in some jurisdictions for at least the last few years.¹ Women have been jailed for failing to follow medical advice², alcohol abuse³ and drug addiction.⁴

Recent advances in medical technology, which allow physicians to mon-

¹ *In re Ruiz*, 27 Ohio Misc. 2d 31, 500 N.E.2d 935 (C. P. Wood Co. 1986). In this case, the trial court held that a "viable" fetus is a "child" under the child abuse statute, OHIO REV. CODE ANN. § 2151.031 (Pages 1990), and harm to it caused by the mother's prenatal use of heroin may be considered child abuse. However, in a subsequent case which involved a woman in her seventh month of pregnancy who had failed twenty-three drug screenings during her pregnancy, the juvenile court held that it had no jurisdiction to regulate the conduct of a pregnant adult for the purpose of protecting the health of her unborn child. *Cox v. Franklin City*, 42 Ohio App. 3d 171 (C. P. Franklin Co. 1988). The court distinguished this case from *In re Ruiz*, where the child had been born and jurisdiction was appropriate. *Cox*, 42 Ohio App. 3d at 174.

² Chambers, *Dead Baby's Mother Faces Criminal Charges On Acts in Pregnancy*, N.Y. Times, Sept. 9, 1986, at A10, col. 1. This article describes the criminal action taken against Pamela Rae Stewart Monson by the state of California. She was charged with child abuse for willful disregard of medical advice, namely, to discontinue amphetamine use, abstain from sexual intercourse because her placenta was in an abnormal position, and to seek medical care if vaginal bleeding reoccurred. She allegedly took drugs, had sex and delayed coming to the hospital. She gave birth to a term infant who died, apparently of brain damage. The charges were brought even though there was not enough evidence to show that her conduct was causally related to the tragic outcome. The charges were eventually dismissed, mainly because they were brought under an inappropriate statute, that is, one that was intended to enforce child support. The inclusion of a fetus within the definition of a child was aimed at husbands who abandon their pregnant wives. Interestingly, although it was alleged that Ms. Monson engaged in sexual intercourse, no charges were brought against her spouse. *Id.* See also Comment, *A New Crime, Fetal Neglect: State Intervention to protect the Unborn - Protection at What Cost?*, 24 CAL. W.L. REV. 161, 168-69 & n.65 (1988).

³ See *Case Against Pregnant Woman is Dismissed*, N.Y. Times, Feb. 3, 1990, A10, col. 3 (an account of the dismissal of a felony charge against a woman whose blood alcohol level was elevated at about four months duration of her pregnancy - a time when a woman could electively terminate the pregnancy without interference by the state); see also Rickhoff, *Protecting the Fetus from Maternal Drug and Alcohol Abuse: A Proposal for Texas*, 21 ST. MARY'S L. J. 259 (1989).

⁴ See Lewin, *Drug Use During Pregnancy: New Issue For the Courts*, N.Y. Times, Feb. 5, 1990, at A1, col. 5, which describes the case, among others, of Jennifer Johnson, who was charged with delivering controlled substances (cocaine) to a minor. The prosecutor advanced the novel theory that a woman could be convicted of delivering a controlled substance to a minor if the fetus, after birth but still attached to its mother by its umbilical cord, is a "child" under Florida Law. The Judge stated, "I am convinced and find that a child that is born but whose umbilical cord has not been severed is a 'person' within the intent and meaning of the Florida Statute 893.13(1)(c)1." *Florida v. Johnson* No. E89-890-CFA, slip op. (Fla. July 13, 1989) (Jennifer Johnson was sentenced to fifteen years probation.).

itor, diagnose and treat problems during fetal development and birth, create a perception that a fetus is an individual patient with needs distinct from its mother.⁵ Logically, this perspective will eventually lead to conflicts between the mother and her fetus. In fact, the current approach in the area of medical jurisprudence which embodies state regulation of reproductive health frames this issue in terms of a mother's right to physical autonomy versus a fetus' right to physical integrity.⁶ This approach has virtually ignored the nature of the physician-patient relationship in this quandary, as well as the therapeutic alliance created in this unique association.⁷ When so-called maternal-fetal conflicts are examined from the perspective of the physician-patient relationship, it becomes obvious that the characterization of these conflicts is illegitimate⁸, counterproductive,⁹ and leads to an impermissible legislative intrusion into the medical decision-making process.¹⁰

The physician-patient relationship is substantially influenced by issues involving ethics, morality, law, and politics. Throughout this article, the nexus between law and medicine will be emphasized. Perhaps the most important of these associations is the relationship between principles, duties and rights. Justice Holmes aptly stated that since no rights were absolute, they were poor tools for analysis in any case because they were not truly fundamental considerations.¹¹ "Duties precede rights logically and chronologically."¹² Holmes eventually came to view "duties" as derivative notions and thought that it was essential to understand the principles at work, not the moral sounding labels attached to the results.¹³

⁵ See Note, *Developments - Medical Technology and the Law. Ill. State Intervention During Pregnancy*, 103 HARV. L. REV. 1557 (1990) [hereinafter Note, *Developments*].

⁶ Note, *Rethinking (M)Otherhood: Feminist Theory and State Regulation of Pregnancy*, 103 HARV. L. REV. 1325 (1990) (hereinafter Note, *Rethinking Motherhood*).

⁷ A tragic example of this occurred in the case, *In Re A.C.*, 539 A.2d 203 (D.C. App. 1987), *reh'g granted*, 573 A.2d 1235 (D.C. App. 1990). In this case, the legal department at George Washington University Hospital initiated a court action, arguably perceived to be in the best interests of the unborn fetus, which sought to compel a pregnant patient with terminal cancer to undergo Cesarean section. This action was taken against the wishes of the patient, her family, and her physicians. Treating physicians testified in a hearing at the hospital that the chances for the fetus were grim, that the patient would probably not recover from the surgery and "the department as a whole" wanted to abide by the wishes of the family. The judge ordered the surgery; the extremely premature infant died about two hours afterward and the mother died two days later. The death certificate listed the cesarian section as a contributing cause of her death. *Id.*

⁸ See *Rethinking Motherhood*, *supra* note 6, at 1326.

⁹ Note, *Maternal Rights and Fetal Wrongs: The Case Against the Criminalization of 'Fetal Abuse'*, 101 HARV. L. REV. 994 (1988).

¹⁰ See *supra* notes 5, 6 & 9; Note, *The Criminalization of Maternal Conduct During Pregnancy: A Decisionmaking Model For Lawyers*, 64 IND. L. J. 357 (1989); Gallagher, *Prenatal v. Parental Rights: What a Difference an "A" Makes*, 21 ST. MARY'S L. J. 301 (1989).

¹¹ Novick, *Justice Holmes and Roe v. Wade*, 25 TRIAL 58, 59 (December 1989).

¹² *Id.* at 59 citing Holmes, *Codes and the Arrangement of Laws*, 5 AM. L. REV. 1, 3 (1870).

¹³ *Id.*

Consistent with this reasoning, this article will explore the nature of the ethical and legal foundations of the physician-patient relationship and its most important principle, the doctrine of informed consent. In addition, it will review the constitutional legitimacy of the relationship, the duties imposed upon it, which rights, if any, flow to the mother and the fetus, and how these principles interact with the physician's role in so-called maternal-fetal conflicts.¹⁴

The ultimate question is whether the state can formulate a compelling interest in overruling the autonomy of the individual patient, in this case, a pregnant woman. The entire area of reproductive technology, prenatal care, and the approach to the fetus is affected by this issue, and this analysis should provide a clearer understanding of the physician's medical and legal role in such controversies.

II. THE PHYSICIAN-PATIENT RELATIONSHIP IN GENERAL

A. *The Creation of a Duty of Care*

At two places in the Hippocratic Oath a fundamental moral principle, termed the Hippocratic principle, is stated. The physician acknowledges, "I will apply . . . measures for the benefit of the sick according to my ability and judgment; I will keep them from harm and injustice."¹⁵ This principle underscores two distinct duties: to promote the welfare of the patient and to protect them from harm and injustice. *Primum non nocere*, the latinized maxim for, "first, do no harm" has also come to represent a physician's duty of care.¹⁶ The ancient Greek physicians couched this doctrine in a collection of clinical observations and occasional therapeutic remarks as they made their rounds or "epidemia."¹⁷ The passage containing this aphorism is left unexplained and reads:

Declare the past, diagnose the present, foretell the future; practice these acts. As to diseases, make a habit of two things to help, or at least do no harm. The art has three factors, the disease, the patient, the physician. The physician is servant of the art. The patient must cooperate with the physician in combatting the disease.¹⁸

¹⁴ Incidentally, the traditional approach to the obstetrical patient may be at the crux of this discord, suggesting that such conflicts may be iatrogenic, that is, caused by the physician. Rhoden, *Informed Consent in Obstetrics: Some Special Problems*, 9 W. N. ENG. L. REV. 67 (1987) (hereinafter *Informed Consent*); Brody & Thompson, *The Maximin Strategy in Obstetrics*, 12 J. FAM. PRAC. 977 (1981).

¹⁵ Veatch, *A Theory of Medical Ethics: The Hippocratic Tradition*, in LAW, SCIENCE AND MEDICINE 273-74 (1984).

¹⁶ *Id.* Although modern proponents, especially "pro-life" advocates in the abortion debate, have attempted to give a priority of "avoiding harm" over the "benefit to the patient," no such priority exists in the passage itself nor was one followed.

¹⁷ Jonsen, *Do No Harm*, in MORAL PROBLEMS IN MEDICINE 99, 100 (2d ed 1983).

¹⁸ *Id.* citing JONES, HIPPOCRATES I 165 (1923). Cf. Jonsen, *Do No Harm*, in *Philosophical Medical Ethics: Its Nature and Significance*, in 3 PHILOSOPHY AND MEDICINE SERIES 27-41 (Sprickler ed. 1977).

Although unexplained, there are three clear concepts that "flow" from this passage. A physician's duty of care is to help, or at least do no harm. Second, the duty develops from a *cooperative physician-patient relationship*. Finally, the duty is not finite, that is, it extends over a continuum which examines the past (history), functions in the present (illness), and considers the future (prognosis). Incidentally, pregnancy was generally not treated by the ancient Greek physicians since they believed it was beneath their dignity. Obstetrical care was the province of the midwives, including the use of abortifacients.¹⁹

B. *The Physician-Patient Relationship*

The nature of the relationship is unique.²⁰ It is a consensual one based on mutuality of contract. "At the heart of a contract is informed consent rather than blind trust; a contractual understanding of the therapeutic relationship encourages full respect for the dignity of the patient, who has not, because of illness, forfeited his sovereignty as a human being."²¹ Thus, this contract instills a covenant of compassion and faithfulness into the relationship.²²

Legally, the relationship is characteristic of a fiduciary one where one party has superior knowledge or skill (doctor) in which the other (patient) voluntarily entrusts her care. The physician-patient relationship is a fiduciary one whose policy is to promote a full and free disclosure of all information by the patient to her treating physician.²³ Consistent with a cooperative relationship, the law recognizes that this information flows in both directions.²⁴ Thus, it is the fiduciary nature of the relationship which creates a *legal duty* to pursue the relationship in good faith and candor, that is, to fully inform the patient in the undertaking and maintain confidentiality.

¹⁹ SPEERT, *Chapter 3: The Midwives*, in *ICONOGRAPHIA GYNIATRICA: A PICTORIAL HISTORY OF GYNECOLOGY AND OBSTETRICS* (1973).

²⁰ Brody, *The Physician-Patient Contract: Legal and Ethical Aspects*, 4 *J. LEGAL MED.* 25 (1976).

²¹ May, *Code and Covenant or Philanthropy and Contract?*, in *MORAL PROBLEMS IN MEDICINE* 92 (2d ed. 1983). This essay was originally published in 5 *HASTINGS CENTER REP.* 25-38 (1975).

²² Bleich, *Compassion in Medicine: Toward New Definitions and New Institutions*, 295 *N. ENG. J. MED.* 939 (1976).

²³ *Hammonds v. Aetna Casualty & Sur. Co.*, 237 *F. Supp.* 96 (N.D. Ohio 1965), *motion denied*, 243 *F. Supp.* 793 (N.D. Ohio 1965).

²⁴ *Ott v. Weinstock*, 444 *N.E.2d* 1227 (Ind. Ct. App. 1983) (Because of the fiduciary nature of physician-patient relationship, the physician has a duty to disclose material information to the patient. Failure to do so results in fraudulent concealment but the duty to disclose ends when physician-patient relationship is terminated.). See also *Jordan v. Sinai Hosp. of Detroit, Inc.*, 171 *Mich. App.* 328, 429 *N.W.2d* 891 (1988) (physician's fiduciary duty to his patient precludes any ex parte conferences with his patient's adversary) citing *MICH. STAT. ANN.* §§ 2.302(B)(1)(b), 2.310, 2.314(A)(1)(b), (B)(1,2), (C)(1)(b)

The relationship originates by a request for treatment. When the patient accepts the services of a physician, the traditional physician-patient relationship is created.²⁵ It is the request of the patient that triggers the association because the doctor-patient relationship cannot be imposed upon a competent patient without her consent.²⁶ However, a physician is not obliged to respond to every call made and is not liable under any circumstances unless the doctor has entered into a contract to render such services.²⁷

A duty of care exists and continues to manifest as long as there is a relationship, whether active or passive, unless there is some express or clearly implied effort to terminate the relationship.²⁸ The termination of the relationship is no easy task and has been characterized as a divorce.²⁹ Hence, there are continuing duties following termination, most of which focus on referral for appropriate follow up.³⁰ The failure to terminate the professional relationship in an appropriate manner gives rise to an action of abandonment.³¹

C. Duties Imposed by the Relationship

The physician must follow the standard of care: The standard of care has its origins in the custom of local practice, however, reliance on custom is not entirely dispositive.³² Generally, the modern standard to which a physician is held is that of reasonable care and diligence ordinarily exercised by members of the profession in similar cases in like conditions

²⁵ *Traveler's Ins. Co. v. Bergeron*, 25 F.2d 680, (8th Cir. 1928), *cert. denied*, 278 U.S. 638 (1928).

²⁶ *Stowers v. Armore Acres Hosp.*, 19 Mich. App. 115, 172 N.W.2d 497 (1969), *aff'd sub nom. Stowers v. Wolodzko*, 386 Mich. 119, 191 N.W.2d 355 (1971).

²⁷ *Rice v. Rinaldo*, 95 N.E.2d 30 (Ohio C. P., Montgomery Co. 1950), *aff'd* 119 N.E.2d 30 (1951).

²⁸ *Kraus v. Cleveland Clinic*, 442 F. Supp. 310 (N.D. Ohio 1977) (ordinary care and skill must be exercised by doctor in decision to terminate relationship).

²⁹ *Hayes-Bautista, Termination of the Patient-Practitioner Relationship: Divorce, Patient Style*, 17 J. HEALTH SOC. BEHAVIOR, 12-21 (March, 1976).

³⁰ *Kay, Terminating the Doctor-Patient Relationship*, 53 J. MED. ED. 186, 189 (1978).

³¹ *Supra* note 24; *McManus v. Donlan*, 23 Wis. 2d 289, 127 N.W.2d 22 (1964). See generally *Weber, The Up and Coming Theory of Abandonment*, 3 J. LEG. MED. 19-21 (1975).

³² *Morgan v. Sheppard*, 188 N.E.2d 808 (1963). (The court held that the customary conduct or methods of treatment generally employed do not furnish the controlling test on the issue of negligence or the standard of care, but evidence of conformity to those usual and customary methods should be considered along with all other circumstances. For example, the observance of the custom of relying on the nurse's sponge count does not conclusively show that the surgeon exercised care that no foreign substance was left in the patient.). *Ault v. Hall*, 119 Ohio St. 422, 164 N.E. 518 (1929).

in the doctor's locality or similar locality.³³ The standard for a board certified medical specialist should be that of a reasonable specialist practicing medicine in that same specialty in light of scientific knowledge in that specialty field.³⁴ All physicians involved in the case, including consulting physicians involved only in a limited manner, share in the same duties and responsibilities as the primary physician to the extent of their involvement.³⁵ Even interns must act as reasonably as other interns would in like or similar circumstances.³⁶

Physicians are not obligated to treat anyone with whom they have no special relationship. This is recognized by the Principles of Medical Ethics of the American Medical Association and case law.³⁷ A doctor may refuse to respond to a call from a person, even one urgently in need of care, if the relation does not exist at the time the call is made.³⁸ However, a physician employed by an insurer who, while examining an insured, discovers a significant medical condition or information relating to treatment, has a duty to disclose the discovery to the insured.³⁹ Although patients are generally obligated to participate and cooperate in their treatment, the failure to follow the physician's instructions does not, *per se*, terminate the relationship and relieve the physician of obligations.⁴⁰

The physician must observe the doctrine of informed consent: As previously noted, a physician has a fiduciary duty to fully inform the patient about a medical treatment or procedure. The failure to do so has tradi-

³³ Jenkins v. Clark, 7 Ohio App.3d 93, 454 N.E.2d 541 (1982). See Swaneck v. Hutzl Hosp., 320 N.W.2d 234 (Mich.App. 1982)(standard of care applicable in medical malpractice action brought against obstetricians and gynecologists alleging negligence in allowing plaintiff's newborn son to be deprived of oxygen during the birth process was a *national standard* equal to that of a specialist practicing in the fields of obstetrics and gynecology). But see Wilson v. Sligar, 516 N.E.2d 1099 (Ind. App. 1987)(where expert witness must testify either from knowledge of the local standard or with regard to certain minimum standards of care that were uniform throughout the country for particular practice).

³⁴ Mayhorn v. Pavey, 8 Ohio App.3d 189, 456 N.E.2d 1222 (1982).

³⁵ Phillips v. Good Samaritan Hosp., 65 Ohio App. 2d 112, 416 N.E.2d 646 (1979).

³⁶ Rush v. Akron Gen. Hosp., 171 N.E.2d 378 (1957).

³⁷ Childers v. Frye, 201 N.C. 42, 158 S.E. 744 (1931)(physician may arbitrarily refuse to treat nonpatient); see *Current Opinions*, The Council of Ethical and Judicial Affairs of the American Medical Association, § 8.11(1989) [hereinafter *Current Opinions*].

³⁸ Childs v. Weiss, 440 S.W.2d 104 (Tex.Civ.App. 1969). But see *Current Opinions*, *supra* note 37: "The physician should, however, respond to the best of his ability in cases of emergency where first aid treatment is essential." *Id.*

³⁹ Meinze v. Holmes, 40 Ohio App.3d 143, 532 N.E.2d 170 (1987); compare Sexton v. Petz, 170 Mich. App. 561, 428 N.W.2d 715 (1988)(Physician examines firefighter at request of employer after employee files workers compensation claim; held no physician-patient relationship upon which to base malpractice claim where physician did not consider significance of employee's heart condition in relation to demands of occupation and incorrectly diagnosed medical condition).

⁴⁰ Annotations, *Physician-Patient Relationship for Malpractice Purposes*, 17 A.L.R. 4th 132 (1982).

tionally created a cause of action in battery.⁴¹ The most often quoted case in medical jurisprudence illustrates this issue eloquently: "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 damages."⁴² However, the modern cause of action for failure to properly inform a patient lies in negligence.⁴³

In general, the doctrine of informed consent has three elements: knowledge, autonomy, and competence.⁴⁴ Appropriate information (knowledge) must be relayed to the patient.⁴⁵ The essence of autonomy is that the patient ultimately has the option to withdraw from the care.⁴⁶ Finally, the doctor must make some reasonable determination that the patient is competent to make a decision.⁴⁷ The importance of this process is that it forms the cornerstone of the therapeutic alliance. For example, it provides for an "open door" policy of communication, an additional opportunity to review treatment in explicit risk-benefit terms, and it fosters trust.⁴⁸

⁴¹ DeMay v. Roberts, 46 Mich. 160, 9 N.W. 146 (1881)(Where a physician takes an unprofessional married man with him to attend a confinement case when there was no emergency, both are liable in damages to the woman. It makes no difference that the patient or her husband thought that the intruder was a medical man and, therefore, submitted without objection to his presence.).

⁴² Schoendorff v. New York Hosp., 211 N.Y. 125, 105 N.E. 92 (1914)(J. Cardozo). See also W. KEETON, D. DOBBS, R. KEETON & D. OWEN, PROSSER AND KEETON ON LAW OF TORTS, § 9 (1984) (hereinafter PROSSER AND KEETON).

⁴³ Saxe v. U.S., 577 F. Supp. 135 (N.D. Ohio 1983), *aff'd*, 751 F.2d 386 (1984). This case reflects the "reasonable-patient standard" for establishing the claim of informed consent. The plaintiff must show that she was not informed if the material risks and dangers of the proposed treatment, the unrevealed risk and dangers which should have been disclosed actually occurred, and a reasonable person would have refused the proposed treatment upon disclosure of the risks. *Id.* This is a very difficult standard to prove. Expert testimony is not always required. Other jurisdictions utilize the "professional standard." This examines what the average competent physician would have done. The plaintiff must prove that she was not informed of the diagnoses, diagnostic procedures and therapies, the material risks, alternatives and expectations, and the doctor deviated from the standard of care in the specialty in terms of what physicians would ordinarily reveal. This requires expert testimony. Logan v. Greenwich Hosp., 191 Conn. 282, 465 A.2d 294 (1983).

⁴⁴ Chervenak & McCullough, *Clinical Guides to Preventing Ethical Conflicts Between Pregnant Women and their Physicians*, 162 A. J. OBSTET. GYNECOL. 303 (1990).

⁴⁵ Indiana has codified this element as an amendment to its Medical Malpractice Act, IND. CODE ANN. § 16-9.5-1-4 (Burns 1987). Accordingly, the knowledge must include: (1) the general nature of the patient's condition, (2) the proposed treatment, procedure, exam or test, (3) the expected outcome of the treatment, procedure, exam or test, (4) the material risks of the treatment, procedure, exam or test, and (5) the reasonable alternatives to the treatment, procedure, exam or test. IND. CODE ANN. § 16-9.5-1-4(c) (Burns 1987).

⁴⁶ Voluntary means uncoerced and free of controlling influences. *Supra* note 44, at 304, *citing* R. FADEN & T. BEAUCHAMP, HISTORY AND THEORY OF INFORMED CONSENT (1986).

⁴⁷ For an excellent discussion of the evolution and ethics of the doctrine of informed consent, see Flannery, Armitage, Hirsh & Wachman, *Consent to Treatment*, in LEGAL MEDICINE: LEGAL DYNAMICS IN MEDICAL ENCOUNTERS 196-207 (1988).

⁴⁸ Gutheil, Bursztajn, & Brodsky, *Malpractice Prevention Through the Sharing of Uncertainty: Informed Consent and the Therapeutic Alliance*, 311 N. ENG. J. MED. 49 (1984).

The physician must maintain confidentiality in the relationship: Generally, a physician may not disclose a patient's medical records without the patient's consent.⁴⁹ It is improper for a physician to discuss a patient's case with a lawyer representing the insurance company sued by the patient.⁵⁰ The patient is entitled to legal recourse and damages against a doctor's breach of secrecy or undivided loyalty.⁵¹ This confidentiality becomes the foundation for the physician-patient privilege and the medical records hearsay exceptions.⁵²

In summary, the ethical principles grounding the physician patient relationship and the fiduciary nature of this association create various duties for the physician. There are fiduciary duties to render care, to do no harm, to protect against injustice, to inform in good faith, and to maintain confidentiality. Thus, the physician is clearly the patient's advocate and not merely a neutral caregiver. Accordingly, the physician is not required to accept passively a patient's refusal for care. The doctor may inquire, argue, protest, or even withdraw from the care, but he may not use threats or deception to coerce a patient.⁵³

There is an ethical obligation of beneficence and an ethical and legal duty to respect autonomy. "Beneficence" is the duty to recommend the best therapy while minimizing potential harm. "Autonomy" is the patient's right to accept or reject such recommendations based on personal priorities and values. These rights are recognized and protected by law.⁵⁴ Thus, there is neither an affirmative duty nor an ethical obligation to seek a court order for care contrary to a patient's request. The courts have flatly refused to hold a physician liable for respecting a competent adult's informed decision to refuse even life saving care.⁵⁵

In the next section, this article will explore the constitutionality of the physician-patient relationship and the doctrine of informed consent. There will be an analysis of the duties created by these principles with

⁴⁹ OHIO REV. CODE ANN. §§ 2317.02, 4731.22 (Baldwin 1990); *Gen. Motors Corp. v. Director of Nat'l Inst. of Occupational Safety and Health (NIOSH)*, 459 F. Supp. 235 (D.C. Ohio 1978), *remanded* 636 F.2d 163, *cert. denied*, 454 U.S. 857 (1981).

⁵⁰ *Supra* note 24. The physician's ethical and legal duty not to reveal confidences and the importance and necessity of trust to both the patient and the medical profession requires that both patient and physician be protected by use of only formal methods of discovery.

⁵¹ *Id.*

⁵² E. CLEARY, MCCORMICK ON EVIDENCE, §§ 98, 99 at 243-48, § 313 at 882 (3d ed. 1984).

⁵³ J. KATZ, THE SILENT WORLD OF DOCTOR AND PATIENT (1984). *See also* Vogt & Armitage, *Physician-Patient Relationship*, in *Legal Medicine: Legal Dynamics Of Medical Encounters*, A. C. LEGAL MED. 188-95 (1988).

⁵⁴ *In re Conroy*, 98 N.J. 321, 332, 486, A.2d 1209, 1222 (1985) (personal integrity for adults means that medical procedures cannot be performed without consent). *See also* *Cruzan v. Director, Missouri Dept. of Health*, 110 S. Ct. 2841, 2851 (1990) (principle that a competent person has a constitutionally protected liberty interest in refusing unwanted medical treatment).

⁵⁵ *In re Storar*, 52 N.Y.2d 363, 420 N.E.2d 64, 438 N.Y.S.2d 266, *cert. denied*, 454 U.S. 858, (1981).

special attention paid to the reproductive health care of women. In addition, this article will focus on the rights, if any, which flow from the physician-patient relationship to the mother and the fetus and the medical-ethical principles underlying such rights.

III. THE PHYSICIAN-PATIENT RELATIONSHIP IN REPRODUCTIVE HEALTH CARE

Consider the following scenario: *A thirty-nine year old attorney, about eight months into her first pregnancy, after reading everything that she can find about pregnancy, labor and delivery, requests that she have a cesarian section two weeks prior to her due date. She states that the discomfort of pregnancy and the risks of labor and delivery, in her opinion, are outweighed by the benefits and low risk of morbidity of cesarian section, for both her and the fetus. She argues that if a patient with a previous cesarian section is given the option of trial of labor versus an operative delivery, then she should have the same option, being a fully informed and competent adult. She asks, "if a competent adult has the legal right to refuse life saving care, why can't I request a cesarian section?"*⁶⁶

A purely legal analysis of this scenario may lead to the same conclusion as reached by the above patient. In contrast, a medical-legal risk-benefit analysis may indicate that the patient with a previous cesarian section has incurred specific risks and personal experiences which can be distinguished from this patient. Thus, the offer of a repeat cesarian section is part of the standard of care that an obstetrician has a duty to provide to a patient who has undergone a prior cesarian section. The risk-benefit analysis offered by the woman in this scenario does not really apply to her situation. Simply put, an elective cesarian section, as requested by the patient, is an unindicated procedure which the doctor has no duty to perform.

However, an analysis from the perspective of the physician-patient relationship may lead to an entirely different resolution. A frank discussion between the doctor and patient may reveal that she was quite frightened of the pain of labor and the possibility of having the baby damaged as a result of labor. This type of open-ended dialogue may uncover that the patient's experience as a personal injury attorney was at the root of her fear. The therapeutic alliance engendered in the physician-patient relationship would allow for a more compassionate discussion of her fears and may eventually lead to a normal labor and delivery.

⁶⁶ The issue presented has been the subject of debate in the obstetrical literature and also on "ACOGnet", the American College of Obstetrics and Gynecology computer network which allows for "on-line" consultation and discussion. See also address by Gates, *University of Michigan Medical Center Conference* (Aug. 17-19, 1990) (conference entitled ETHICS, HUMANITIES AND LAW IN OBSTETRICS AND GYNECOLOGY) (workbook available from author).

There are two points to be garnered from this scenario. First, where there is no duty for a physician to provide an unindicated procedure, there does not appear to be any inherent right of the patient to demand such care. Hence, Holmes' axiom that duties precede rights holds true. Second, the unique nature of the physician-patient relationship allows for a resolution of problems that would not flow from a purely legal or a medical-legal analysis. This section will illustrate these points as they occur in the area of reproductive health care.

A. *The Constitutional Legitimacy of the Physician-Patient Relationship*

It is not ironic that the physician-patient relationship was granted constitutional respect in the abortion cases. Physicians have been performing abortions for forty centuries.⁵⁷ Abortion practice was widespread in the United States from 1840-1870, and abortionists routinely advertised for patients.⁵⁸ Interestingly, the laws governing abortion at that time were based on English Common Law. Women were free to have abortions until "quickening" (the perception of first fetal movement that occurs at about twenty weeks of gestation); thereafter abortion was prohibited. Given the *Webster* decision, this situation is no different today.⁵⁹

*Roe v. Wade*⁶⁰ underscores the physician-patient relationship. "This means, on the other hand, that, for the period of pregnancy prior to this 'compelling' point, the attending physician, in consultation with his pa-

⁵⁷ Allen & Pearse, *The Implications of Webster for Practicing Physicians*, 262 J.A.M.A. 1510 (1989).

⁵⁸ H. SPEERT, *OBSTETRICS AND GYNECOLOGY IN AMERICA: A HISTORY*, (1980). Medical societies formed in response to such "quackery" which was diverting patients away from the more "respectable" physicians who did not advertise. The recently formed American Medical Association started an "anti-abortion crusade" where the goal was to consolidate its control over the provision of health care. This crusade resulted in forty anti-abortion laws enacted from 1860-1880. K. LUKER, *ABORTION AND THE POLITICS OF MOTHERHOOD* 29-35 (1984). Abortion in any state was illegal for the next one hundred years. However, abortions continued in spite of the laws which were more often ignored than unenforced. Actually, there were as many abortions prior to *Roe* (1950-73) as thereafter. See also J. MOHR, *ABORTION IN AMERICA: THE ORIGINS AND EVOLUTION OF NATIONAL POLICY, 1800-1900* (1978).

⁵⁹ See *supra* note 57. The Supreme Court upheld a Missouri law requiring physicians to perform tests to determine viability before performing an abortion on a woman the physician reasonably believes may be twenty weeks pregnant or more. *Webster v. Reproductive Health Services*, 109 S.Ct 3040 (1989). What is striking about this decision is the lack of virtually any discussion of the physician-patient relationship and the standard of medical care pertaining to abortion of the viable fetus. Specifically, the abortion of a viable fetus, not otherwise impaired, has always been contrary to the standard of medical care, replete with many sanctions including loss of medical licensure. See, e.g., Eastman, *Induced Abortion and Contraception: A Consideration of Ethical Philosophy in Obstetrics*, 22 OB. GYN. SURVEY 3 (1967); Sauer, *Attitudes to Abortion in America: 1800-1973*, 28 POP. STUDIES 66 (1974).

⁶⁰ 410 U.S. 113 (1973).

tient, is free to determine, without regulation by the state, that, in his medical judgment, the patient's pregnancy should be terminated."⁶¹ "With respect to the State's important and legitimate interest in potential life, the 'compelling' point is at viability.⁶² But note, "[f]or the stage subsequent to viability, the State in promoting its interest in the potentiality of human life may, if it chooses, regulate, and even proscribe, abortion except where it is necessary, *in appropriate medical judgment*, for the preservation of the life or health of the mother."⁶³

The subsequent abortion decisions continue to emphasize the physician-patient relationship, as well as the importance of informed consent. In *Planned Parenthood of Missouri v. Danforth*,⁶⁴ the Court construed informed consent to mean the giving of information to the patient as to what would be done and its consequences. "To ascribe more meaning than this might well confine the attending physician in an undesired and uncomfortable straightjacket in the practice of his profession."⁶⁵ The Court grappled with limits on informed consent in *City of Akron v. Akron Center for Reproductive Health*.⁶⁶ "This does not mean, however, that a State has unreviewable authority to decide what information a woman must be given before she chooses to have an abortion. It remains primarily the responsibility of the physician to ensure that appropriate information is conveyed to his patient, depending on her circumstances."⁶⁷ "In accordance with the ethical standards of the profession, a physician will advise the patient to defer the abortion when he thinks this will be beneficial to her."⁶⁸ Otherwise, after appropriate written consent, a State may not demand that she delay the effectuation of that decision.⁶⁹ In *Thornburgh v. American College of Obstetrics and Gynecology*,⁷⁰ the Court struck down various Pennsylvania statutes that infringed upon the physician-patient decision-making process.⁷¹ Even *Webster*,⁷² which upheld

⁶¹ *Id.* at 163.

⁶² *Id.*

⁶³ *Id.*, at 164 (emphasis added). The limiting factor in this landmark case appears to be the decision of the physician.

⁶⁴ 428 U.S. 52 (1976). The Missouri laws struck down were spousal consent, parental consent, arbitrary limits on available abortion procedures, and criminal and civil liability for physicians. For an excellent analysis of the issue of spousal consent and paternal rights, see Note, *Whose Womb is it Anyway: Are Paternal Rights Alive and Well Despite Danforth?* 11 CARDOZO L. REV. 686 (1990).

⁶⁵ *Danforth*, 428 U.S. at 67, n. 8.

⁶⁶ 462 U.S. 416 (1983). The Court found unconstitutional Ohio Statute § 1870.07 which prohibited a physician from performing an abortion until twenty-four hours after the pregnant woman signs a consent form. *Id.* at 450.

⁶⁷ *Id.* at 443.

⁶⁸ *Id.* at 450, n. 43.

⁶⁹ *Id.*

⁷⁰ 476 U.S. 747 (1986).

⁷¹ *Id.* at 763. The statutes required descriptions of fetal development at two week intervals as part of the information exchanged during informed consent. "All this is, or comes close to being, state medicine imposed upon the woman, not the professional medical guidance she seeks, and it officially structures - as it obviously was intended to do - the dialogue between the woman and her physician." *Id.*

⁷² 109 S. Ct. 3040 (1989).

the constitutionality of the Missouri statutes requiring viability testing of a fetus prior to an abortion at nineteen weeks or beyond, still gives voice to the physician's judgment.⁷³

In the first case to address the so-called right to die, the Court in *Cruzan v. Director, Missouri Department of Health*,⁷⁴ acknowledged that the informed consent doctrine has become firmly entrenched in American tort law.⁷⁵ This Court also noted that "the common law doctrine of informed consent is viewed as generally encompassing the right of a competent individual to refuse medical treatment."⁷⁶ This was echoed in the holding of the case, specifically "[t]he principle that a competent person has a constitutionally protected liberty interest in refusing unwanted medical treatment may be inferred from our prior decisions."⁷⁷

The Supreme Court continues to apply to Holmes' axiom the theory that principles elicit duties which generate rights. In the abortion decisions, the Court holds that the responsibility for informed consent lies with the physician whose duty is to insure that appropriate information flows to the patient. In *Cruzan*, the Court acknowledges that the physician's duty to inform transforms into a patient's right to refuse. "The logical corollary of the doctrine of informed consent is that the patient generally possesses *the right* not to consent, that is, to refuse treatment."⁷⁸ As will be observed in the next section, the scientific principles of medical treatment which formulate the standard of medical care for the pregnant patient, develop into various duties to render such care. Subsequently, these duties mature into maternal rights.

B. *The Physician-Patient Relationship in Pregnancy*

The physician's role in pregnancy care is relatively new in the history of medicine. Childbearing was almost exclusively the province of the midwife. In 1765, William Shippen in Philadelphia announced his course in midwifery and shocked the world.⁷⁹ The thought of delivery by a "man midwife" was scandalous in late 18th century America, and this attitude was quite pervasive. Obstetrics was finally accepted into the curriculum of the country's four medical schools by 1800. This was accomplished over the outcry of conservative men and women that it was against God's

⁷³ *Id.* at 3055. The holding notes that "amniocentesis" or "ultrasound" testing is required if, in his or her judgment, one or both of these tests are relevant to determine viability. *Id.* "Amniocentesis" describes a test which entails placing a needle into the sac of fluid, in which the fetus grows, to retrieve a sample for analysis. "Ultrasound" testing involves focusing a high frequency sound wave into the womb at the fetus and measuring the size of the fetal parts as determined from the echo of the sound wave. This will give a relative estimate of the gestational age of the fetus based upon its size.

⁷⁴ 110 S.Ct 2841 (1990).

⁷⁵ *Id.* at 2847.

⁷⁶ *Id.* at 2851.

⁷⁷ *Id.*

⁷⁸ *Id.* at 2847 (emphasis added).

⁷⁹ H. SPEERT, *supra* note 58, at 14.

ordination to allow a male to attend a delivery.⁸⁰ Not surprisingly, it was advantaged urban women who started a trend which ultimately accepted the physician's role in pregnancy by including a trained physician at the bedside, in addition to the midwife, friends and family.⁸¹

Although the section of Obstetrics of the American Medical Association was started in 1860, it was not until 1931 that the American Board of Obstetrics and Gynecology administered its first certification exam for this specialty.⁸² The basic principles of the specialty of obstetrics insured that these physicians were especially equipped, by training and experience, to recognize, diagnose, and treat the complications that beset the pregnant woman.⁸³ The American College of Obstetrics and Gynecology was founded in 1951. Its immediate directive focused on the mother to lower the incidence of maternal mortality in America.⁸⁴

In 1977, maternal mortality had substantially decreased and the "College" initiated a second directive, that is, to lower the prenatal mortality rate.⁸⁵ The essential approach to the pregnant patient has been predicated

⁸⁰ *Id.* In 1809, while Ephriam McDowell, the "father of abdominal surgery," performed an operation on the ovary of Mrs. Todd, protestors actually rocked his house and waited, "rope in hand," should anything go wrong. *Id.* at 175.

⁸¹ For the social historian's approach to obstetrical practice in America, see J.W. LEAVITT, *BROUGHT TO BED: CHILDBEARING IN AMERICA, 1750-1950* (1986). See also Scholten, *CHILDBEARING IN AMERICAN SOCIETY, 1650-1850* (1985).

⁸² H. SPEERT, *supra* note 58, at 83.

⁸³ Nocon & Collman, *Perinatal Malpractice: Risks and Prevention*, 32 J. REPRO. MED. 83, 87 (1987).

⁸⁴ Beacham, *A History of American Obstetric and Gynecologic Organizations and the Genesis of the American Academy*, 1 OBSTET. GYNECOL. 115 (1953). The maternal death rate was about 600 per 100,000 live births in 1930. With the advent of antibiotics, improved accessibility to blood supplies and improved treatment during labor, the rate dropped to about 30/100,000 by 1960. The major causes of death were hemorrhage, toxemia (high blood pressure), infection (including septic abortion), abortion, and medical complications. Immediately after 1973, there was a striking drop in death due to abortion (all causes). This accounted for approximately 20% of all maternal deaths. The current rate has been 7-10 maternal deaths per 100,000 live births. Ragan, *Maternal Mortality in Indiana*, 82 IND. MED. 712 (1989). See also Rochat, *Maternal Mortality in the United States: Report for the Maternal Mortality Collaborative*, 72 OBSTET. GYNECOL. 91 (1988). In contrast, the maternal death rate for first trimester abortion is 0.5 per 100,000 abortions and increases to 6/100,000 by 16 weeks. Thus, through at least the first 16 weeks of pregnancy, abortion is the safest treatment of pregnancy with respect to a woman's chances of survival. W. HERN, *ABORTION PRACTICE* 26 (1984).

⁸⁵ National Foundation - March of Dimes, Committee on Perinatal Health, *Toward Improving the Outcome of Pregnancy: Recommendations for the Regional Development of Maternal and Perinatal Health Services* (1977). The perinatal death rate is the combination of fetal deaths (stillborn fetuses greater than 500 grams or more than 20 weeks gestation) plus neonatal deaths (newborn deaths in the first 28 days of life) per 1000 live births. In 1974, the average perinatal mortality rate was 25-30 /1000; now it varies from 12-18/1000. In comparison, infant mortality pertains to deaths from the first months to the end of the first year of life. About 70% of all perinatal mortality and subsequent infant mortality is due to premature birth. Behrman, *Preventing Low Birthweight: Summary*, Committee to Study the Prevention of Low Birth Weight, Division of Health Promotion and Disease Prevention, Institute of Medicine (1985). See also Cren-

upon these two directives:

The transcendent objective of obstetrics is that every pregnancy be wanted and that it culminate in a healthy mother and a healthy baby. Obstetrics strives to minimize the number of women and infants who die as a result of the reproductive process or who are left physically, intellectually, or emotionally injured therefrom.⁸⁶

The legal standard of care, that is, the obstetrician's duty to provide reasonable medical care, has evolved from these principles. The specialty of obstetrics has always held that the welfare of the mother and fetus are so intertwined and inseparable that it is impractical to attempt to distinguish between them. Nor was the fetus perceived as separate from the mother in the legal sense.⁸⁷ Clearly, the physician has a legal duty to promote maternal well being. Although the fetus is often perceived as a patient to whom doctors owe some duty, the standard of care only requires that the physician monitor the fetus appropriately and recommend treatment to the mother. The obligation to promote fetal health is derived from the duty to the pregnant patient. Thus, there is no requirement or need to view the fetus as a separate entity in order to conform to a duty of care. Due to the fiduciary nature of the obstetrician-patient relationship, the doctor owes all legal duties to the mother.

C. *The Status of the Fetus in the Physician-Patient Relationship*

Historically, there does not appear to be a legal duty to the fetus which, *per se*, would supersede one to the mother.⁸⁸ According to *Roe v. Wade*,⁸⁹

shaw, Payne & Blackmon, *Prematurity and the Obstetrician: A Regional Neonatal Intensive Care Nursery is Not Enough*, 147 AM. J. OBSTET. GYNECOL. 125 (1983); Bloom, *Changing Infant Mortality; The Need to Spend More While Getting Less*, 73 PEDIATR. 862 (1984).

Unfortunately, traditional obstetrical care is quite limited in ability to prevent the effects of preterm labor. Iams, *Current Status of Prematurity Prevention*, 262 J.A.M.A. 265 (1989) (simple improvements in access to care produce striking improvements in outcome). See also Yawn & Yawn, *Preterm Birth Prevention In a Rural Practice*, 262 J.A.M.A. 230 (1989) (increased emphasis placed on education and reassessment of "low risk" women reduced the overall preterm birth rate by 30%.)

⁸⁶ F. CUNNINGHAM, P. MACDONALD & N. GANT, *WILLIAMS OBSTETRICS* 1 (18th ed. 1989) (hereinafter cited as *WILLIAMS OBSTETRICS*).

⁸⁷ *Dietrich v. Northampton*, 138 Mass. 14 (1884). This is the first reported case alleging a cause of action for prenatal injuries. Justice Holmes denied separate recovery on behalf of the fetus explaining that the fetus was part of the mother at the time of injury and any damage to it, recoverable by the mother. *Id.* It should be noted that Holmes' father was a venerated obstetrician.

⁸⁸ See generally J. FEINBERG, *THE PROBLEM OF ABORTION* (2d ed. 1984).

⁸⁹ 410 U.S. 113 (1973).

nowhere in our ordered scheme of liberty or tradition is the fetus considered a person.⁹⁰ "[T]hroughout the major portion of the 19th century prevailing legal abortion practices were far freer than they are today, [which] persuades us that the word "person", as used in the Fourteenth Amendment, does not include the unborn."⁹¹ Even though the *Webster* decision has recognized a state interest in the well being of the fetus,⁹² the Court has not declared that interest superior to the mother's due process rights.⁹³ *Roe* is still the rule on this point and refuses to elevate the common law interests in the fetus to a constitutional right.⁹⁴

In contrast, virtually all of what is currently argued as a foundation for autonomous fetal "rights" comes from the common law. For example, although property laws have recognized a "child in being" as entitled to an estate or inheritance, such entitlements have always been contingent upon a live birth.⁹⁵ The common law crime of feticide has been inconsistently recognized. If the fetus survived birth and then died, it is actionable, but not otherwise.⁹⁶ Although the Model Penal Code does not recognize feticide,⁹⁷ modern feticide statutes impose criminal sanctions against *third parties* no matter when the fetus dies, and usually require both the fetus to be viable and the perpetrator to intend to kill the fetus or its mother.⁹⁸ Acknowledgement of the fetus as a legal entity, entitled to a recovery for prenatal injury, has only recently occurred in tort law.⁹⁹

⁹⁰ *Id.* at 158.

⁹¹ *Id.*

⁹² *Webster v. Reproductive Health Servs.*, 109 S. Ct. 3040, 3055 (1989).

⁹³ Note, *Developments, supra* note 5, at 1561.

⁹⁴ *Id.*

⁹⁵ Johnson, *The Creation of Fetal Rights: Conflicts with Women's Constitutional Rights to Liberty, Privacy, and Equal Protection*, 95 YALE L. J. 599, 601 (1986) (courts have only recognized the fetus as a legal entity in limited contexts contingent upon live birth). The Uniform Probate Code has codified a common law right of inheritance which accrues to a fetus when born. UNIF. PROBATE CODE § 2-108, 8 U.L.A. 66 (1983). The common law has also allowed courts to appoint guardians to protect such fetal interests. Myers, *Abuse and Neglect of the Unborn: Can the State Intervene?*, 23 DUQ. L. REV. 1, 14 (1984).

⁹⁶ See Myers, *supra* note 95, at 12.

⁹⁷ MODEL PENAL CODE § 210.1(1) comment 4(c)(1980).

⁹⁸ Note, *Developments, supra* note 5, at 1560 (emphasis added). CAL. PENAL CODE § 187(b)(3) (West 1988). See IND. CODE ANN. 35-42-1-6 (Burns 1988) (a person who knowingly or intentionally terminates a human pregnancy with an intention other than to produce a live birth or remove a dead fetus, commits feticide, a Class C felony). This statute clashes headlong with the physician's standard of care in terminating a pregnancy to protect the life or health of the mother. See *infra* note 120. Compare to California, which holds that it is first degree murder to kill a viable fetus with malice aforethought, but it is not murder at all if the act is "solicited, aided, abetted, or consented to by the mother." *People v. Smith*, 59 Cal.App.3d 751, 129 Cal. Rptr. 498 (1976).

⁹⁹ *Bonbrest v. Kotz*, 65 F.Supp 138 (D.C. Cir. 1946) (when direct tortious injury is inflicted upon a viable fetus, subsequently born alive, the child has a cognizable cause of action. This case reversed the holding in *Dietrich v. Inhabitants of Northampton*, 138 Mass. 14 (1884), which denied recovery to the estate of a fetus for wrongful death.).

Generally, recovery has been limited for the tortious conduct of a third party which inflicts harm to a viable fetus, even if the fetus is stillborn.¹⁰⁰ It should be noted, however, that such a recovery is intended to protect the mother's expectation of having a liveborn, healthy child.¹⁰¹

Interestingly, in *Grodin v. Grodin*,¹⁰² the Michigan Court of Appeals found in favor of a child who alleged that its mother, who took the antibiotic tetracycline, was negligent by failing to inform her doctor or request a pregnancy test. The court apparently relied on the holding in *Womack v. Buchhorn*,¹⁰³ that "a child has a legal right to begin life with a sound mind and body. If the wrongful conduct of another interferes with that right . . . damages for such harm should be recoverable by the child."¹⁰⁴ The *Womack* holding only recognizes that the child has a right, distinct from its parents, to recovery against third parties (doctors) for prenatal injuries. But upon what duty is this right predicated? In an earlier Michigan Court of Appeals case, which was not addressed by *Grodin*, the court held that the state is not empowered to enforce upon parents and doctors legal duties to the fetus.¹⁰⁵ It appears that the *Grodin* court violated the inseparability of the mother and fetus and held the mother to the same standard of conduct as a third party.¹⁰⁶

In contrast, the Illinois Supreme Court reversed and criticized a lower court's decision which relied on *Grodin*, holding that a child has a right to recovery for prenatal injuries caused by the negligent operation of a motor vehicle by its parent.¹⁰⁷ The court suggested that such a "legal fiction" would infringe upon a mother's right to autonomy pitting mother against fetus as adversaries from conception until birth.¹⁰⁸ The Illinois

¹⁰⁰ See W. KEETON, D. DOBBS, R. KEETON & D. OWEN, PROSSER AND KEETON ON LAW OF TORTS, § 55 at 369-70 (1984).

¹⁰¹ Gallagher, *Prenatal Invasions and Interventions: What's Wrong with Fetal Rights*, 10 HARV. WOMEN'S L. J. 9, 38 (1987).

¹⁰² 102 Mich. App. 396, 301 N.W.2d 869 (1980). This drug will eventually cause discoloration of the child's permanent teeth.

¹⁰³ 384 Mich. 718, 187 N.W.2d 218 (1971).

¹⁰⁴ *Id.* at 725, 187 N.W.2d at 222 (quoting *Smith v. Brennan*, 31 N.J. 353, 364, 157 A.2d 497, 503 (1960)). *But see* S. ELLAS & G. ANNAS, REPRODUCTIVE GENETICS AND THE LAW 118-20 (1987)(the authors conclude that there is no "right" to be born physically and mentally sound.)

¹⁰⁵ *In Re Dittrick Infant*, 80 Mich. App. 219, 263, N.W.2d 37 (1977)(fetuses are not "children" over whom a court can assume control due to parental abuse).

¹⁰⁶ *Grodin*, 102 Mich. App. at 397, 301 N.W.2d at 870. The case merely creates a novel approach to find a deep pocket. That is, it's holding would allow the homeowner's liability policy to compensate the child for negligent conduct of the policyholder, which did, in fact, occur in the home.

¹⁰⁷ *Stallman v. Youngquist*, 125 Ill. 2d 267, 531 N.E. 2d 355 (1988). Again, it appears that the child was seeking a recovery from the mother's auto insurance policy. This issue really comes within the rubric of an automobile "guest statute" analysis in which most jurisdictions limit liability, by statute, to wanton and willful misconduct causing injury to a guest passenger unless the guest passenger is a spouse, parent, child or stepchild of any age, brother, sister, or hitchiker. IND. CODE § 9-3-3-1 (1988). Is a fetus a "child of any age?"

¹⁰⁸ *Stallman*, 125 Ill. 2d at 278, 531 N.E.2d at 359.

court also stated that it should be left to the legislature, not tort liability, to determine if pregnant women had a legal duty to their fetus. In addition, the court stated that the way to ensure healthy babies was through "before-the-fact education of all women and families about prenatal development."¹⁰⁹ This is entirely consistent with the physician's perspective regarding care of the fetus.

The physician-fetal relationship is simple; it exists because of and through the mother. The fact that modern technology has allowed the fetus to become more accessible for diagnosis and treatment does not negate the truly unique and inseparable nature of the maternal-fetal relationship. They are two patients with access to one through the other.¹¹⁰ The medical principles that formulate the standards for pregnancy care focus attention on both the mother and the fetus within her as a unit, "assessing the attendant risks to each during the course of care."¹¹¹ Since the welfare of the fetus is of paramount concern to the overwhelming majority of women, conflicts are infrequent. "The role of the obstetrician should be one of an informed educator and counselor weighing the risks and benefits to both patients as well as realizing that tests, judgments and decisions are fallible."¹¹² Obstetricians should refrain from performing procedures unwanted by the woman who is obviously the only one who could give informed consent in the maternal-fetal duality. The use of judicial authority to resolve conflicts is almost never warranted.¹¹³

It was not coincidence that the American College of Obstetricians and Gynecologists (ACOG), Committee on Ethics, made the preceding comments at the time *In re A.C.* was decided.¹¹⁴ These comments were a direct response to a decision that ignored the physician-patient relationship and violated the inseparability of the maternal-fetal duality. Most recently, in a seven to one *en banc* decision, the Appellate Justices of the District of Columbia reversed the earlier *In re A.C.* holding.¹¹⁵ At first glance, it seems persuasive to argue that, within the framework of *Roe v. Wade*, women who chose to bear children have an ethical duty to accept reasonable medical care to benefit themselves and their fetuses. However, the D.C. Court of Appeals noted that *Roe v. Wade* never gave the fetus primary or usual status with its mother, even in the third trimester.¹¹⁶ The forceful decision mirrored the ACOG opinion which stated that "in virtually all cases the question of what is to be done is to be decided by the patient - the pregnant woman - on behalf of herself and the fetus."¹¹⁷

¹⁰⁹ *Id.* at 280, 531 N.E.2d at 361.

¹¹⁰ See Committee on Ethics, American College of Obstetrics and Gynecology, *Patient Choice: Maternal-Fetal Conflict*, Comm. Opinion No. 55 (Oct. 1987).

¹¹¹ *Id.*

¹¹² *Id.*

¹¹³ *Id.*

¹¹⁴ See *supra* note 7; *In Re A.C.*, 539 A.2d 203 (D.C.App. 1988), *reh'g granted*, 573 A.2d 1235 (D.C. App. 1990).

¹¹⁵ *In Re A.C.*, 573 A.2d 1235 (D.C. App. 1990).

¹¹⁶ Curran, *Court Ordered Cesarean Sections Receive Judicial Defeat*, 323 N. ENG. J. MED. 489 (1990).

¹¹⁷ *Id.* at 491.

In summary, the obstetrician is the mother's advocate. Clearly, all legal and ethical duties flow to the mother, and it is critical to focus upon the physician-patient relationship when controversy occurs. Decisions by physicians that force their patients into undesired treatment breach their fiduciary duties, especially those to prevent injustice. In addition, compelled medical care also violates traditional norms of ethics and law. Nevertheless, the physician may be a fetal advocate, especially since there is an ethical obligation to promote fetal health. However, fetal advocacy does not mean that the state can coerce a doctor under penalty to follow this obligation as if it were a legal duty. Although it is correctly assumed that a well informed woman will desire to protect the fetus, this does not mature into an inherent fetal "right" to such protection. This is because the pregnant woman, like any other adult, has the essential right to accept or reject medical recommendations based on their personal priorities and values.¹¹⁸

IV. THE MATERNAL-FETAL CONFLICTS

This section will focus on the so-called maternal-fetal conflicts, their legitimate and not so legitimate foundations, their implications for society, and the physician's role in their resolution. There are two basic situations that lead to divergence between the mother's interests in herself and the fetus. In one, she may refuse a diagnostic procedure or treatment that may benefit the fetus and, if denied, may lead to fetal morbidity or mortality. This setting encompasses the area of court ordered obstetrical care. In the other situation, her behavior with respect to her health or lifestyle may be adverse to the well being of the fetus.¹¹⁹ The latter circumstance embodies the conflicts associated with abortion, the "toxic" workplace, and the criminalization of harmful maternal conduct, specifically for substance abuse in pregnancy. "Ultimately, the characterization of the maternal-fetal relationship as one of conflicting rights denies the physical and social context of pregnancy . . . undermines the importance of connection between mother and fetus . . . [and] has led to policies that effectively protect neither."¹²⁰

A. Court Ordered Obstetrical Care

There are a number of articles in the medical literature which address the compulsory treatment of pregnant women. Unfortunately, many contain incorrect and misleading statements about the law, especially regarding the legal liability of physicians for either accepting or rejecting a patient's desires.¹²¹ One common mistake is to state that *Roe v. Wade*

¹¹⁸ Allen & Pearse, *supra* note 57.

¹¹⁹ *Supra* note 111.

¹²⁰ Note, *Rethinking Motherhood*, *supra* note 6, at 1337.

¹²¹ Nelson & Milliken, *Compelled Medical Treatment of Pregnant Women: Life, Liberty, and Law in Conflict*, 259 J.A.M.A. 1060, 1061 nn. 16-26 (1988).

supports compulsory care of the mother for the benefit of the fetus. This is based on the misinterpretation of the Court's holding that the state has a compelling interest in protecting the potentiality of human life at the point of viability. *Roe* clearly asserts that the state may restrict abortion after viability is established only if it does not affect the mother's life or health. *Roe* is entirely silent on the issue of enforced treatment to promote fetal health.¹²²

A corollary to this argument is the "waiver" of maternal due process rights. In this context, once a woman elects to waive her right to abortion and carry the fetus to term, she is no longer free to take action that would endanger the fetus.¹²³ This argument is ineffective on three accounts. First, a woman may elect to terminate a pregnancy after viability to preserve her health.¹²⁴ Second, no actual waiver can occur until viability. This is well after the fetus has been exposed to the greatest risk of harm as it is in the first trimester when the fetus is most sensitive to adverse maternal behavior like cigarette smoking, occasional use of alcohol, and environmental pollution. Finally, even after the mother decides to carry to term, she does not waive her right to conduct the labor and delivery in a manner she desires.¹²⁵ Constitutionally, no cases have established a woman's legal duty to accept any risk for the sake of the fetus.¹²⁶

¹²² *Id.* at 1062.

¹²³ *Id.* See also Robertson, *Procreative Liberty and the Control of Conception, Pregnancy and Childbirth*, 69 VA. L. REV. 405, 437 (1983).

¹²⁴ The author faces this situation virtually every week in his obstetrical practice. When a condition known as toxemia becomes severe (high blood pressure, kidney failure, blood clotting dysfunction leading to hemorrhage, and liver failure), the patient is at high risk for serious bodily harm although women rarely die of this condition. If this should occur at 24 - 28 weeks, the outlook for the fetus is grim. The standard of medical care expects that a competent physician will offer the patient the option to terminate the pregnancy. In the author's experience, no patient has ever refused that option. The waiver theory would be an unethical and meaningless solution to this problem, since it would simultaneously force the doctor to violate the standard of care and subject the mother to a high risk of permanent damage such as paralyzing stroke, kidney failure, liver failure, or death. Similarly, a broad restriction of abortion to only those situations which are life threatening would create the same dilemma, that is, a physician would face violating the standard of care or violating a law prohibiting abortion.

¹²⁵ Abortions after viability cannot be totally forbidden because the mother's interest in the preservation of her life is superior to the state's compelling interest in the preservation of viable fetal life. Nelson, Buggy & Weill, *Forced Medical Treatment of Pregnant Women: Compelling Each to Live as Seems Good to the Rest*, 37 HASTINGS L. J. 703, 742 (1986).

¹²⁶ *Colautti v. Franklin*, 439 U.S. 379 (1979) (struck down a law requiring the mother, in second trimester abortion, to undergo a hysterotomy, that is, a mini cesarian section because it offered the best opportunity for the fetus to be aborted alive. The law was struck because it did not specify that a woman's health must always prevail over fetus's life and health when they conflict). See *Thornburgh v. A. College of Obstetrics and Gynecology*, 476 U.S. 747 (1986) (struck down a Pennsylvania law that required a woman to accept an increased medical risk to save her viable fetus. Laws requiring a trade-off between a woman's health and fetal survival are unconstitutional.).

Another argument which would appeal to physicians focuses on the "good Samaritan" nature of the medical profession. This view establishes a state's interest in maintaining the integrity of the medical profession by supporting the position that doctors must be allowed to save the fetus in jeopardy. This argument would assert that the fetus, as a third party, has some inherent "right" to medical care distinct from its mother. However, the medical model for obstetrical care does not perceive the fetus or infant as separate from its mother.¹²⁷ Furthermore, the artifice of a distinct fetal "right" to care oversimplifies the complexities of the interdependence of the maternal-fetal unit and the more important issues of dependence and responsibility.¹²⁸

This approach confuses the duty to care with the duty to rescue. Although a parent has a legal duty to care for its child because of the "fiduciary" nature of the parent-child relationship, there is no legal duty to rescue a child at the risk of any peril to the parent.¹²⁹ Thus, a parent cannot be compelled to save a child from a burning building or donate bone marrow to a leukemic child.¹³⁰ If there is no duty to rescue a child, that is, a person with cognizable rights, it does not follow that there should be a duty to rescue a fetus or a corresponding fetal "right" to be rescued.¹³¹

An insidious problem arises within the obstetrician-patient relationship concerning the basic decision-making strategies utilized to provide care and the use of informed consent.¹³² Due to the concerns for her baby during pregnancy, a woman is in a particularly vulnerable situation regarding consent. Given the high degree of uncertainty that can occur in pregnancy, the doctor's approach to a crisis may be presented and perceived as the only legitimate approach. This viewpoint virtually guarantees acceptance of the doctor's recommendation and circumvents the process of informed consent.¹³³ Thus, the decision-making strategies currently used in obstetrical practice may be a substantial factor involved in the so-called maternal-fetal conflicts.

¹²⁷ For an excellent discussion of this concept see Thoman, *Infant Development Viewed in the Mother-Infant Relationship*, in *FETAL AND MATERNAL MEDICINE* 243 (1980).

¹²⁸ Note, *Rethinking Motherhood*, *supra* note 6, at 1337.

¹²⁹ A fundamental tenet of American law is the absence of a duty to rescue. See PROSSER & KEETON, *supra* note 42, § 56, at 365 (when the duty to care, in a special relationship involves risk, any duty to rescue is diminished); RESTATEMENT (SECOND) OF TORTS § 324 Comment D (1979) (a rescuing actor is not required to subordinate his interests to those of another).

¹³⁰ *McFall v. Shimp*, 10 Pa. D. & C.3d 90 (1978) (forcible extraction of living body tissue causes revulsion to the judicial mind).

¹³¹ See also S. ELIAS, et al., *supra* note 104, at 118-20 (1987) (the authors conclude that there is no "right" to be born physically and mentally sound). See generally Rhoden, *The Judge in the Delivery Room: The Emergence of Court Ordered Caesarians*, 74 CALIF. L. REV. 1951, 1975 (1986) (it seems reasonable to hold that the states power to protect fetus should not exceed its power to protect independently existing individuals).

¹³² See *Informed Consent*, *supra* note 14.

¹³³ *Id.* at 68.

The basic strategy in American obstetrical practice is to monitor the fetus and mother during the entire course of pregnancy, labor, and delivery. Some examples include the use of routine electronic fetal monitoring (EFM) during labor and routine amniotomy for internal fetal monitoring. Physicians also perform a routine episiotomy for delivery.¹³⁴ This strategy is an appropriate risk averse approach which is best applied when the level of uncertainty is high, and the worst potential outcome is extremely bad. Although it would appear to be ideally suited to obstetrical care, in reality, most obstetrical patients are low risk requiring minimal intervention. There is a growing body of medical literature indicating that these procedures are meddlesome, unnecessary, and cause far more complications than they prevent.¹³⁵

Since doctors accept these routine procedures as "state of the art" obstetrical care, the uncertainties are not often questioned or discussed with patients. This leads to a problem with informed consent when a mother questions the use of these procedures. First, some doctors are not comfortable revealing their uncertainty. Second, this strategy focuses on fetal risk and while it takes aggressive means to prevent fetal risk, it increases the maternal risks by increasing surgical delivery.¹³⁶ Finally, this strategy creates barriers. The focus on the fetus views the mother as a barrier to be overcome in order to assess the fetus. As medical technology improves the ability to penetrate this barrier, the possibility for value conflicts increases proportionately.¹³⁷ Where the doctor may view these conflicts as between the mother and baby, they actually are between the doctor and patient.

Another strategy that occurs in obstetrical care applies when the fetus is in great peril and allows for aggressive intervention to give the fetus

¹³⁴ *Id.* at 70. "Amniotomy" is the rupture of the protective bag of waters, in which the fetus floats. It is often done to induce labor, enhance labor, and to attach EFM devices. WILLIAMS OBSTETRICS, *supra* note 86, at 313. "Episiotomy" is a surgical incision made in the opening of the vagina to prevent spontaneous laceration, arguably considered more difficult to repair. *Id.* at 316.

¹³⁵ U.S. Dept. Health and Human Services, Public Health Service, National Institute of Health, CESARIAN CHILDBIRTH, NIH Pub. No. 82-2067 (1982). The consensus indicates that the use of routine EFM is the most substantial factor causing the high cesarian section rate in the U.S. This rate is currently about 25%. Routine EFM has yet to prove its value, especially in predicting those fetuses at risk for neurologic damage. Freeman, *Intrapartum Fetal Monitoring - A Disappointing Story*, 322 N. ENG. J. MED. 624 (1990); Shy, *Effects of Electronic-Fetal-Heart Rate Monitoring, As Compared with Periodic Auscultation, on the Neurologic Development of Premature Infants*, 322 N. ENG. J. MED. 588 (1990). Routine amniotomy causes an increased incidence of infection. Okada, Chow & Bruce, *Neonatal Scalp Abscess and Fetal Monitoring: Factors Associated with Infection*, 129 A. J. OBSTET. GYNECOL. 185 (1977). Finally, routine episiotomy is itself associated with more severe lacerations than it is presumed to prevent. Shiono, Klebanoff & Carey, *Midline Episiotomies: More harm Than Good?* 75 OBSTET. GYNECOL. 765 (1990).

¹³⁶ *Informed Consent*, *supra* note 14, at 72.

¹³⁷ *Id.* at 77.

its "only hope," even when the chance of success is extremely low.¹³⁸ The problems for informed consent in this approach becomes self evident when the physician says, "don't you want to do everything for your baby?" This attitude smothers the patient's concerns about the surgery and future reproduction. As it fulfills a strong need to "do something," the recommended procedure is almost always performed.¹³⁹ This strategy forces a value judgment directed only at the fetus and does not do justice to the quality of the life issue inherent in these problems.¹⁴⁰ Likewise, when a mother objects to the recommended procedure, she is perceived as being in conflict with her fetus, rather than the doctor.

It is in these emotionally charged situations, clouded by a high degree of uncertainty, that a dysfunctional physician-patient relationship can occur. The result is the pursuit of some form of court order to mandate medical care, ostensibly to protect the fetus. Most of these orders occur at the trial court level and go unreported.¹⁴¹ There are few reported appellate court decisions that support judicial sanction of medical inter-

¹³⁸ *Id.* at 72. See *supra* note 7. *In re A.C.* is the prime example of all the problems associated with the "only hope" approach. Another example of this approach is to perform a cesarian section for the under 1000 gram infant whose mother is in premature labor that cannot be stopped. The theoretical basis for this approach is if a cesarian section is a less traumatic route for a term infant, then it must be so for the preterm. No empirical evidence supports the benefit of cesarian section for all preterm infants. Malloy, Rhoads, Schramm & Land, *Increasing Cesarian Section Rates on Very Low Birth Weight Infants: Effects on Outcome*, 262 J.A.M.A. 1475 (1989) (the authors were unable to find reasons to justify the sharp increase in the use of cesarian sections for these small infants). The cesarian section is almost always of the "classical" variety, that is, it invades the uppermost, contractile portion of the uterus placing the mother at substantial risk for rupture in a subsequent pregnancy. In effect, the patient becomes an "obstetrical cripple," doomed to undergo repeat cesarian sections thereafter. By contrast, a woman who has a cesarian section at term, perhaps for "fetal distress," will have the lower, noncontractile portion of her uterus cut in a transverse manner. The risk of rupture in subsequent pregnancy is so low that she is a candidate for a "vaginal delivery after cesarian" (VBAC). Taffel, *Cesarian Section in America: Dramatic Trends, 1970 to 1987*, STAS. BULL. 2-11 (Oct.-Dec. 1989).

¹³⁹ *Informed Consent*, *supra* note 14, at 75.

¹⁴⁰ Although some very low birth weight infants may survive the "heroic" cesarian section, those between 500 and 1000 grams (1-2 lbs) will have a greater than 50% incidence of cerebral palsy and chronic respiratory problems. Wood, Katz, Bose, Gollisby & Kraybill, *Survival and Morbidity of Extremely Premature Infants Based on Obstetric Assessment of Gestational Age*, 74 OBSTET. GYNECOL. 889 (1989).

¹⁴¹ Kolder, Gallagher & Parsons, *Court-Ordered Obstetrical Interventions*, 316 N. ENG. J. MED. 1192 (1987). Kolder's survey of 15 cases of court ordered cesarian section revealed that only two were found in the state and federal reporters. Her study involved a total of 21 cases of mandated medical care and indicated that 81% were Black, Asian, or Hispanic woman, 24% of whom did not speak English. The cases revealed a critical inability on the part of physicians to communicate with their patients in these circumstances. Thus, the refusal of treatment could not have been "against medical advice" if such advice was poorly explained or incomprehensible. In addition, 46% of the directors of maternal-fetal medicine programs felt that women who jeopardized their fetuses should be forcibly detained while 47% endorsed court ordered cesarian section. *Id.*

vention, none of which rest on solid medical or legal foundations.¹⁴² In actual practice, it appears that court ordered obstetrical intervention is not predicated upon a true maternal-fetal conflict. Rather, it denotes a maternal-physician conflict where there was a problem in communication, no true informed consent, and a one sided imposition of the physician's will.¹⁴³ Thus, the approach to obstetrical care was the decisive factor in these interventions.

The most often cited case with the most appealing set of facts for compelling cesarian section, *Jefferson v. Griffin Spalding County Hospital Authority*,¹⁴⁴ illustrates the iatrogenic nature of this issue.¹⁴⁵ A woman at thirty-nine weeks gestation was diagnosed with a placenta previa, a condition where the placenta blocks the birth canal and can cause fatal hemorrhage when labor starts. The physicians argued that there was a 99% chance that the baby would die and a 50% chance that the mother would die if vaginal delivery were permitted.¹⁴⁶ The patient refused the surgery on religious grounds.¹⁴⁷ The court held that the fetus was a human being and that the rights of the patient were "outweighed by the duty of the state, to protect a living, unborn human being from meeting his or her death, before being given the opportunity to live."¹⁴⁸ Subsequently, the patient had an uneventful vaginal delivery. Apparently, "mother nature" reversed the Georgia Supreme Courts decision on appeal. Shortly after the court upheld the order, ultasonography studies revealed the placenta "shifted".¹⁴⁹ In fact, placentas do not shift in their position. Clearly, the diagnosis was entirely erroneous. The characterization of maternal-physician conflicts as maternal-fetal ones, in this context, is clearly illegitimate.

The physician-patient relationship, through the therapeutic alliance of the doctrine of informed consent, can achieve truly shared decision-making in obstetrics.¹⁵⁰ It would require physicians to understand their biases,

¹⁴² *In Re A.C.*, 539 A.2d 203 (D.C.App. 1987). One of the earliest cases involving enforced care was *Raliegth Fitkin-Paul Morgan Memorial Hosp. v. Anderson*, 42 N.J. 421, 201 A.2d 537, cert. denied, 377 U.S. 985 (1964) (the state interest in the life of the fetus justified a blood transfusion for the mother who objected on religious grounds; since it was impractical to separate the mother from the fetus, the court ordered the transfusion). It should be noted that the patient left the hospital and was never forced to do anything.

¹⁴³ Kolder, et al., *supra* note 14 at 1192.

¹⁴⁴ 247 Ga. 86, 274 S.E.2d 457 (1981)(per curiam).

¹⁴⁵ "Iatrogenic" means caused by the doctor.

¹⁴⁶ *See Id.*

¹⁴⁷ *Id.* at 86, 274 S.E.2d at 459.

¹⁴⁸ *Id.* at 89, 274 S.E.2d at 460.

¹⁴⁹ Kolder, et al., *supra* note 141, at 1192.

¹⁵⁰ *See Informed Consent*, *supra* note 14. Rhoden's perspective on the likelihood that such decision-making will occur is grim. However, the author has been pleasantly surprised that not only is it possible, it actually takes very little effort to achieve the required open-ended dialogue. This is especially surprising given the nature of this obstetrical practice: a county institution with 3500 deliveries per year, 95% of the population is indigent of which a large proportion is semi-literate, and a substantial percentage are adolescents.

enter into open-ended dialogues with their patients, and share the uncertainties of the proposed care and outcome. An exploration of the patient's values must take place early in pregnancy before emergency decisions are necessary so that serious conflicts may warrant a change in the physician.¹⁵¹ This is important because in cases of apparent irreconcilable conflict, the patient is in an extremely vulnerable position as she is often without benefit of counsel, and judges are inclined to distrust patients and uphold medical opinion.¹⁵² Given the problem of uncertainty, there appears to be no legal or ethical duty to ask the courts to replace informed consent with enforced acquiescence.¹⁵³

The medical-ethical strategy in maternal-physician conflicts involves a balancing test which sets forth three conditions for intervention: the fetus is at great risk of harm, the treatment is a great benefit for the fetus, and the risk of treatment to mother and fetus is low.¹⁵⁴ However, in the recent reversal of the court ordered cesarian section in *In re A.C.*,¹⁵⁵ the lower court judge was admonished for his engaging in a balancing exercise, weighing the interests of the woman against those of the fetus.¹⁵⁶ This is because the primacy of the woman's rights is supported in the common law and the Constitution.¹⁵⁷ The ethical approach still pits the physician's evaluation against two factors, uncertainty and his patient's concerns.¹⁵⁸ Although the ethical balancing of risks appears attractive and arguably may reduce uncertainty, it still fosters the uneasy alliance of physician and state against the patient.¹⁵⁹

One area where ethical balancing tests and court involvement may be appropriate is in the care and delivery of brain-dead pregnant patients.¹⁶⁰

¹⁵¹ Chervenak & McCullough, *supra* note 44; *Informed Consent*, *supra* note 14, at 84.

¹⁵² *Informed Consent*, *supra* note 14, at 86.

¹⁵³ Chervenak & McCullough, *Perinatal Ethics: A Practical Method of Analysis of Obligations to Mother and Fetus*, 66 *OBSTET. GYNECOL.* 442 (1985).

¹⁵⁴ Elkins, *Court ordered Cesarian Section: An Analysis of Ethical Concerns in Compelling Cases*, 161 *A. J. Obstet. Gynecol.* 150 (1989). The problems inherent with this balancing approach lie in defining a standard of harm. The uncertainties encountered in these situations pose a substantial risk of arbitrary and capricious interpretation, a risk of unequal treatment in similar medical situations, and difficulty with the definition of an acceptable level of risk of harm to the mother.

¹⁵⁵ *In Re A.C.*, 573 A.2d 1235 (D.C. App. 1990).

¹⁵⁶ Curran, *Court Ordered Cesarian Sections Receive Judicial Defeat*, 323 *N. ENG. J. MED.* 489, 491 (1990). The majority noted that if the patient were incompetent, the judge's duty would have been to inquire into what the patient would have wanted. He was only to investigate her past conduct and personal values to obtain evidence of her desires. *Id.*

¹⁵⁷ *Id.*

¹⁵⁸ A basic principle in bioethical decision-making is that the degree of autonomy operating is directly proportionate to the degree of uncertainty involved.

¹⁵⁹ Annas, *Protecting the Liberty of Pregnant Patients*, 316 *N. ENG. J. MED.* 1213 (1987).

¹⁶⁰ Field, Gates, Creasy, Jonsen & Laros, *Maternal Brain Death During Pregnancy: Medical and Ethical Issues*, 260 *J.A.M.A.* 816 (1988).

In one such case, the husband requested a court order to sustain his wife's life long enough to perform a cesarian section to save the baby.¹⁶¹ The order was necessary to supersede the wishes of the patient's family, and a child was successfully delivered at seven and one half months of pregnancy.¹⁶² But here, there was no issue of maternal-fetal conflict.¹⁶³

B. Abortion as a Maternal-Fetal Conflict

At first thought, there can be no doubt that the decision to abort a pregnancy represents an ultimate issue in terms of a maternal-fetal conflict. However, when the process of abortion is placed into the entire perspective of pregnancy, labor, childbirth and parenthood, it would appear that the risks of the former are substantially less than the risks and the burdens of the latter.¹⁶⁴ Actually, abortion occurs very commonly in nature. For every one thousand women with fertile ova who are exposed to normal sperm, one hundred and sixty ova will not fertilize, one hundred and fifty will fertilize but fail to cleave (divide), three hundred and twenty pregnancies will abort at the time of the expected menses, twenty-nine will abort by six weeks, seventeen will abort by ten weeks, eight will abort by twenty weeks, and six fetuses will die after viability but before birth (stillborn).¹⁶⁵ By far, the major causes of fetal wastage are genetic.¹⁶⁶

¹⁶¹ See Comment, *Legal Representation of a Fetus: The Mother and Child Division?* 18 CAP. U. L. REV. 591, 598 (1989) [hereinafter Comment, *Legal Representative*]. The comment describes the case of *Poole v. Santa Clara County Kaiser Hospital*, unreported, 604575, (Sup. Ct., Santa Clara Co., Calif. 1986).

¹⁶² See Comment, *Legal Representation*, *supra* note 161.

¹⁶³ However, if an otherwise competent woman, clearly and convincingly, elucides her desire not to have life prolonging procedures applied, even in the presence of pregnancy, then the recent *Cruzan* decision may control to forbid a court order for life prolongation and cesarian section. This would square with *In Re A.C.*, 573 A.2d 1235 (D.C. App. 1990), which determined that a terminally ill patient who is pregnant with a viable fetus has the right to decide what will be done with the fetus.

¹⁶⁴ See Beacham, *supra* note 84.

¹⁶⁵ W. DROGEMULLER, A. HERBST, D. MISHALL, JR. & M. STERCHEVER, *COMPREHENSIVE GYNECOLOGY* 376 (1987). Human reproduction is not very efficient, that is, fetal wastage is 69%. In addition, the 31% of liveborns include prematures (7%) and congenital anomalies (3%). If the state passes a law that states human life begins at conception and such an unborn child has interests in life, health, and well being that are capable of being protected, then physicians may be required to prevent a miscarriage where the fetus is most likely chromosomally abnormal or environmentally damaged. This requirement would conflict with the current standard of care for patients that are threatening to miscarry. A tragic example of this thinking occurred in the early 1950's when pregnant women were treated with the medication, diethylstilbesterol (DES) to prevent spontaneous abortion. DES had no effect on the abortion rate but did, in fact, cause permanent harm to those fetuses that were otherwise normal. See *Collins v. Eli Lilly Co.*, 116 Wis. 2d 166, 342 N.W. 2d 37 (1984). See also Linn, Lieberman, Schoenbaum, Monson, Stubblefield & Ryan, *Adverse Outcomes of Pregnancy in Women Exposed to Diethylstilbesterol in Utero*, 33 J. REPRO. MED. 3 (1988).

¹⁶⁶ W. DROGEMULLER, et al., *supra* note 165 at 378. If the body would naturally reject an abnormal fetus, then should not the person be able to reject an abnormal fetus that slipped by the body's defenses, so to speak?

Abortion does very little to disrupt the physical status quo of the woman while her entire life is changed via a pregnancy. In this context, pregnancy may represent a far greater source of maternal-fetal conflict.

The role of the physician in this issue is to be the patient's advocate, provide informed consent, and participate in the decision-making process.¹⁶⁷ The informed consent process would include a discussion of the risks, benefits and burdens of abortion, the alternatives to abortion, and the patient's right to an abortion as an alternative to pregnancy.¹⁶⁸ The discussion should take place at preconceptual counselling or at the first prenatal visit. The failure to do so may invoke a malpractice claim for lack of informed consent, wrongful birth or wrongful life.¹⁶⁹ Withholding abortion as an alternative to pregnancy may also result in a charge of deception.¹⁷⁰

There is an area of abortion where the issue of maternal-fetal conflict is particularly interesting. In multifetal pregnancy, that is, twins or more, the incidence of preterm labor increases substantially. In infertility situations, the drugs to induce ovulation often stimulate multiple eggs with the result of four, five or six embryos eventually transferred to the mother. In the situation of quadruplets or greater, whether naturally occurring or as a result of infertility treatment, the likelihood that all the fetuses will survive intact is low. Thus, within the standard of medical care, the patient is given the option of selective termination to reduce the number of embryos, to a number where the likelihood of normal survival is high.¹⁷¹

¹⁶⁷ See *supra* notes 60-78 and accompanying text.

¹⁶⁸ *Proffitt v. Bartolo*, 162 Mich. App. 35, 412 N.W.2d 232 (1987) (as long as abortion remains an option allowed by law, a physician owes a duty to furnish parents with adequate information for them to decide whether to choose that course of action.)

¹⁶⁹ See Devries & Rifkin, *Wrongful Life, Wrongful Birth, and Wrongful Pregnancy: Judicial Divergence in Birth Related Torts*, 20 THE FORUM 209 (1985); Rogers, *Wrongful Life and Wrongful Birth: Medical Malpractice in Genetic Counseling and Prenatal Testing*, 33 S.C.L. REV. 713 (1982). The courts have generally recognized the parents' claim for damages when the doctor negligently performs genetic tests and a genetically abnormal baby is born - wrongful birth. Only three jurisdictions have recognized a fetus' "right" to such a claim, contingent on livebirth - wrongful life. See generally *Curlender v. Bio. Science Laboratories*, *Turpin v. Sortini*, 31 Cal. 3d 320, 182 Cal. Rptr. 337, 613 P. 2d 954 (1982); 106 Cal. App. 3d 811, 165 Cal.Rptr. 477 (1980); *Procanik v. Cillo*, 97 N.J. 339, 478 A. 2d 755 (1984); *Harbeson v. Parke-Davis, Inc.*, 98 Wash. 2d 460, 656 P. 2d 483 (1983).

¹⁷⁰ See *Mother & Unborn Baby Care of N. Texas Inc., v. Texas*, 749 S.W. 2d 533 (Tex. Ct. App., 1988), *reh'g denied*, 109 S. Ct. 2431 (1989) (anti-abortion group and its principal were guilty of violating Deceptive Trade Practices Act; advertisement for abortion services actually resulted in showing women anti-abortion materials and films of graphic scenes and pictures pertaining to abortion).

¹⁷¹ Berkowitz, Lynch, Chitkara, Wilkins, Mehalek & Alvarez, *Selective Reduction of Multifetal Pregnancies in the First Trimester*, 318 N. ENG. J. MED. 1043 (1988). Evans, *Selective First Trimester Termination in Octuplet and Quadruplet Pregnancies: Clinical and Ethical Issues*, 71 OBSTET. GYNECOL. 289 (1988).

In this situation the maternal-fetal conflict focuses on how many embryos to carry. The ethical "consensus" has been to reduce the multifetal gestation to two. This preserves the conception as multifetal and also allows the patient to have two children, in the event that this may be her only chance to have any children.¹⁷²

To summarize, the physician-patient relationship is the fundamental element in the decision-making process in abortion. The characterization of this decision as a maternal-fetal conflict, however, is ingenuous, especially in light of the enormous consequences embodied in carrying a pregnancy to term.

C. *Employment in the Toxic Workplace*

Many analogies can be drawn between the physician-patient relationship and the employer-employee one. Thus, it is a useful tool for analyzing the problems in the hazardous workplace. The analogy to the duty to provide informed consent in the physician-patient relationship is overwhelming. There is also an analogous fiduciary relationship when the employer is privy to information about hazardous employment. In the employer-employee relationship, the onus of duty is on the employer to state the conditions that exist in the workplace and the risks that such conditions pose. It should be the employee's decision to take the risks.¹⁷³ Why should the level of self determination be different in the workplace than it would be regarding health care? By similar analogy, the characterization of maternal-fetal conflict to the issues involved in the hazardous workplace is also misbegotten because it clouds the real issue - an employer-employee conflict.

The central issue in this perplexing area is whether a ban of fertile women from employment entailing exposure to substances that may cause birth defects in dangerous sex discrimination or appropriate business policy for high risk enterprises with open-ended tort liability.¹⁷⁴ Proponents of "fetal protection" policies indicate that safety in the work place is paramount, and employers should have the right to transfer any worker, male or female, from a toxic environment. Opponents note that an employer's policy of banning fertile women from a toxic workplace, whether or not they are pregnant, or intend to become so, violates the 1964 Civil Rights Act, barring workplace discrimination against women. In effect, such a policy may exclude women from twenty million jobs. Otherwise, women would have to choose between fertility or employment.¹⁷⁵

¹⁷² Generally, this pertains to women whose multifetal pregnancy is a result of infertility treatment.

¹⁷³ See Kilborn, *Who Decides Who Works at Jobs Imperiling Fetuses?* N.Y. Times, Sept. 2, 1990, at Y1, col. 1.

¹⁷⁴ Presser & Bertin, *Women At Work: Should "Fetal Protection" Policies be Upheld?* 76 J.A.B.A. 38 (1990).

¹⁷⁵ *Id.* at 39.

The case that has centralized these issues, *International Union, UAW v. Johnson Controls, Inc.*,¹⁷⁶ involves employment bans against women in the battery manufacturing business. The court, sitting *en banc*, held seven to four, that available scientific data indicated that the risk of transmission of harm to a fetus as a result of exposure to lead is substantially confined to fertile females and that the employer's policy was based on real differences between men and women relating to child bearing capacity which is consistent with Title VII.¹⁷⁷ Apparently, the court, in *Johnson Controls*, ignored the inconvenient data on the health risks to male workers in their decision.¹⁷⁸

The physician's role in this debate is to fairly state the risks involved. Essentially, there are two problems with the medical data regarding environmental risks in the workplace. First, the data comes from epidemiological research and, by its very nature, this type of data cannot determine which particular event was a substantial factor or the cause in fact of a particular person's disease.¹⁷⁹ Consistent with this principle is the fact that no one has been able to show any harm to the offspring of women who worked at Johnson Controls during their pregnancies.

Second, the data about environmental pollution and pregnancy reveals

¹⁷⁶ 886 F. 2d 871 (7th Cir. 1989).

¹⁷⁷ *Id.* at 886. This court followed the recommendations of the Equal Employment Opportunity Commission (EEOC), the agency responsible for administering Title VII. Equal Employment Opportunity Commission, *Policy Statement on Reproductive and Fetal Hazards Under Title VII*, (October 3, 1988)(found in Fair Employment Practice Manual (BNA) 401:6013). See also Becker, *From Muller v. Oregon to Fetal Vulnerability Policies*, 53 U. CHI. L. REV. 1219 (1986); Comment, *Fetal Protection Programs Under Title VII - Rebutting the Procreation Presumption*, 46 U. PITT. L. REV. 755 (1985).

¹⁷⁸ The majority apparently relied on the outmoded theory that males do not need protection because the fertilization process weeded out defective sperm; those that were damaged would not fertilize. However, recent data contradicts this theory. Since the sperm "turn over" in their production relatively rapidly, they are very sensitive to environmental toxins. Welch, Schrader, Turner & Cullen, *Effects of Exposure to Ethylene Glycol Ethers on Shipyard Painters. II. Male Reproduction*, 14 A. J. INDUS. MED. 509 (1988). "Safe" male workers should have included only those who do not produce sperm, either by disease or vasectomy. The only real difference between men and women, in this environment, is that women who are too old to procreate, those aged 50-65, could continue to work. This does not apply to males since it is well established that men can sire children well beyond their retirement years.

¹⁷⁹ *Johnson Controls, Inc.*, 886 F. 2d at 875. See also Novick, *Use of Epidemiologic Studies to Prove Legal Causation: Aspirin and Reye's Syndrome, A Case in Point*, 22 TORT & INS. L. J. 536 (1987); Dore, *A Commentary on the Use of Epidemiological Evidence in Demonstrating Cause-in-Fact*, 7 HARV. ENVTL. L. REV. 429 (1983). However, in *Allen v. United States*, 588 F. Supp. 247 (D. Utah 1984), *rev'd on other grounds*, 816 F. 2d 1417 (10th Cir. 1987), *cert. denied*, 108 S. Ct. 644 (1988) (an action to recover for leukemia caused by atomic device testing prior to 1963, the court allowed the use of epidemiologic studies to prove causation based on public policy grounds and shifted the burden of proof to the defendant.).

considerable uncertainties.¹⁸⁰ Although the effects of environmental toxins on the male reproductive system have been reported,¹⁸¹ it is only recently that studies have been published which link sperm damage to children's disabilities.¹⁸² For example, it is more likely that damaged sperm may cause fetal damage because the ovary is less sensitive to lower levels of toxic exposure than sperm production.¹⁸³

The characterization of the issues affecting women in potentially hazardous employment as a maternal-fetal conflict is truly a misnomer. In this respect, it is as illegitimate as the portrayal of maternal-physician conflicts as maternal-fetal ones. A more appropriate representation, from the medical perspective, would be gender neutral and focus on occupational safety.

D. Criminalization of Maternal Conduct

Your local district attorney comes to you, as chief of your obstetrical unit, with a proposal. She explains that there is an epidemic of drug use in the community, and she is pledged to combat it. She acknowledges that performing routine drug screens prenatally may drive people away from seeking prenatal care. Thus, she wants you to obtain drug screens on all cord blood samples taken at delivery¹⁸⁴ so that she may use those samples that test positive for controlled substances to coerce the respective patients into drug rehabilitation programs. She argues, quite persuasively, that this represents a medical benefit for the patient. When asked if she would prosecute a woman for murder if her child subsequently dies and the cord blood sample tested positive for a controlled substance, she replies in the affirmative.

¹⁸⁰ Longo, *Environmental Pollution and Pregnancy: Risks and Uncertainties for the Fetus and Infant*, 137 A. J. OBSTET. GYNECOL. 162 (1980). Malchol, *Environmental Hazards: What They'll Mean To Your Patients In The 1980s*, 15 CONTEMP. OB/GYN. 22 (1980). Environmental toxins generally comprise two major areas: carcinogens-agents that cause cancer, and teratogens-agents that cause genetic abnormalities, mutations, defects and abortions. Lead is a particularly well known teratogen which has been linked to sterility, spontaneous abortion, stillbirth, birth defects, prematurity, and chromosomal abnormalities. *Id.* at 32.

¹⁸¹ Machol, *supra* note 180, at 37.

¹⁸² See Scripps Howard News Service, *Studies Link Sperm Damage to Children's Disabilities*, Indianapolis Star, Aug. 18, 1990, at B6, col. 2. This account reveals the difficulty that authors of such studies encountered. Although the data linking sperm damage to disability was buried in the scientific literature, publishers were reluctant to print these reports. This is contrary to biologic fact, that is, a well established principle in animal husbandry is that "[i]f you had a bull in a field full of cows and something was wrong with the calves, you would look at the bull." *Id.*

¹⁸³ *Id.* The epidemiologic studies in nuclear plants reveal that even low levels of radiation exposure were linked to an increase in leukemia in male worker's offspring. See also Rowley, Leach, Warner & Heller, *Effect of Graded Doses of Ionizing Radiation on the Human Testis*, 59 RADIAT. RES. 665 (1974).

¹⁸⁴ At each delivery, the standard of care requires that a sample of the blood from the umbilical cord be taken and tested for blood count, blood type, Rh factor, and a screen for antibodies that may cause jaundice in the newborn. In most states, at 48 hours of life, a blood sample is taken from each newborn to test for metabolic diseases, such as phenylketonuria and thyroid disease.

This scenario is being played and replayed in medical centers throughout the country. Some hospital clinics are routinely testing for drugs at the first prenatal visit, without the patient's consent or knowledge of such testing. Those that test positive are "channeled" into social service consultations designed to direct the patients into drug treatment programs; some are directed to the local district attorney.¹⁸⁵ Other clinics, interested in epidemiological research, are testing with consent and judicial writs of confidentiality.¹⁸⁶ Still, others are testing under state laws which mandate the reporting of births to mothers who used drugs or alcohol during pregnancy.¹⁸⁷ All of this has been under the rubric that maternal conduct during labor, potentially harmful to the fetus, should be prosecuted and result in punitive sanctions.

The war on drugs has extended to a war on pregnancy. "The nation's legal system has begun to take drastic measures aimed at making pregnant women legally accountable for the fetuses they carry."¹⁸⁸ The basic principle espoused by the state to achieve this accountability is that fetal abuse is tantamount to child abuse which would require the immediate removal of an infant from the mother. Since there are no fetal abuse statutes, prosecutors have applied existing statutes to address this issue, either those that prohibit child abuse and neglect or those that prohibit the delivery of a controlled substance to a minor.¹⁸⁹

The fetal abuse-child abuse polemic is the crucial argument used to justify state intervention in maternal conduct. The argument is attractive. Since parents cannot violate their duty to care for their children, even at the expense of personal religious value, then mothers should not be able to refuse care necessary for the fetus.¹⁹⁰ This is the prenatal equivalent of child neglect or abuse. However, lurking beneath the facade of this argument are insidious and alarming implications. "Fetal neglect" implies that there is some legally cognizable duty to the fetus.¹⁹¹ Although a child is a "person" physically separate from its mother, the fetus is inseparably tied to its mother and is not a "person" as used in the Fourteenth Amendment.¹⁹² Thus, what the state must do to end "fetal neglect" - physically invade the maternal barrier - is entirely different than what

¹⁸⁵ See Hoffman, *Pregnant, Addicted - And Guilty?* New York Times Magazine, Sun., Aug. 19, 1990 at 32.

¹⁸⁶ Frank, Zuckerman, Amaro, Abagye, Bauchner, Cabral, Fried, Hingson, Kayne, Levensoh, Parker, Reece & Vinci, *Cocaine Use During Pregnancy: Prevalence and Correlates*, 82 PEDI. 888 (1988).

¹⁸⁷ Chasnoff, Landress & Barrett, *The Prevalence of Illicit-Drug or Alcohol Use During Pregnancy and Discrepancies in Mandatory Reporting in Pinellas County, Florida*, 322 N. ENG. J. MED. 1202 (1990).

¹⁸⁸ Sherman, *Keeping Baby Safe From Mom*, Nat'l L. J., Oct. 3, 1988, at 1, col. 1.

¹⁸⁹ See *supra* notes 1-10 and accompanying text.

¹⁹⁰ Rhoden, *Cesareans and Samaritans*, 15 LAW, MED. & HEALTH CARE 118, 120 (Fall 1987).

¹⁹¹ *Id.*

¹⁹² *Roe v. Wade*, 410 U.S. 113 (1973).

it may do to end child neglect.¹⁹³ The analogy drawn between the two issues is erroneous.¹⁹⁴

Compelling parents to provide medical care for their children does not involve the same issues as enforced fetal treatment. Thus, use of the child abuse laws to compel such treatment is entirely irrelevant. These laws severely threaten the physician-patient relationship and may promote fetal injury through noncompliance by pregnant women who are fearful of prosecution. Physicians should refuse to support such statutes because they create a genuine conflict of interest between the doctor's duty to care and prevent injustice and the status of the physician's license. Moreover, these statutes represent an impermissible legislative intrusion into the traditional medical decision-making process. They achieve no benefit other than to promote political agendas, fulfill quotas, and advance the careers of the prosecutors who will vow to enforce these statutes, most earnestly, before election time. The reasoned solution to promote fetal health and the future of our society is to increase funding and promote education for accessible prenatal care.

The threshold question for a punitive approach for undesired maternal conduct is defined by the right upon which the state seeks to infringe.¹⁹⁵ There are two possibilities. First, there may be a maternal right to privacy which grants autonomy to the woman to make all relevant lifestyle decisions during pregnancy.¹⁹⁶ Fetal protection advocates hold that the right to privacy, which is broad enough to embody the right to procreate, is distinct from freedom in procreation.¹⁹⁷ They utilize the "waiver" argument, that is, once a woman waives her right to abortion, she should not take any action to abuse the fetus.¹⁹⁸ But this argument fails fundamentally because it cannot be tailored narrowly enough to specifically define abusive conduct.

The second possibility is for the state to enact a narrowly tailored statute prohibiting a right to use drugs or alcohol during pregnancy. This would not involve a fundamental right protected for other citizens. It may pass constitutional muster because illegal use of controlled substances, cocaine, for example, would not implicate a fundamental right of the mother. Here, the state interest is strong compared to a vague notion of preventing "fetal abuse" as it bears a strong relation to the harm it seeks to prevent, and there may be no other lesser alternative.¹⁹⁹

¹⁹³ Rhoden, *supra* note 190, at 120.

¹⁹⁴ *Id.*

¹⁹⁵ Note, *Developments, supra* note 5, at 1580.

¹⁹⁶ Annas, *The Impact of Medical Technology on the Pregnant Woman's Right to Privacy*, 13 A. J. L. & MED. 213, 227 (88).

¹⁹⁷ Robertson, *Procreative Liberty and the Control of Conception, Pregnancy, and Childbirth*, 69 VA. L. REV. 405, 410 (1983).

¹⁹⁸ *Id.* at 437.

¹⁹⁹ Note, *Maternal Rights and Fetal Wrongs: The Case Against the Criminalization of "Fetal Abuse"*, 101 HARV. L. REV. 994, 1007 (1988).

However, permissible laws criminalizing maternal conduct, that is, those that apply sanctions after delivery for prenatal substance abuse, eventually become counterproductive. They are merely punitive and achieve no reasonable hope of deterrence of this type of conduct. Although one may argue that women choose to take drugs and alcohol, no one chooses to become an addict or alcoholic. It is a well known phenomenon that pregnant drug addicts avoid prenatal care for fear of prosecution.²⁰⁰ Conversely, when offered the chance of detoxification, "no questions asked," drug abuse programs rapidly become overwhelmed. Similarly, such laws tend to divert attention away from developing the very programs of medical care most effective in correcting illicit maternal conduct. A strong therapeutic alliance exists between the pregnant patient and her physician, and this relationship should be utilized thoroughly in treating maternal substance abuse.

A more recent governmental approach to the problem of substance abuse in pregnancy is mandated prenatal drug screening. Without a reasonable basis of probable cause that a specific pregnant woman is violating the law, this is a clear violation of the Fourth Amendment's guarantee against intrusive search and seizure. The only ethically permissible basis for such screening without the patient's consent is to perform it as an epidemiological study, preserving confidentiality at all times. This preserves the physician-patient relationship and engenders the promotion of healthy behavior.

Schemes that would utilize blood tested at the time of delivery to coerce women into drug rehabilitation sound like they may be of medical benefit, but they are inherently unethical. They merely document the presence of a drug at the end of a pregnancy and uphold the spurious argument that the mother was delivering drugs to a minor.²⁰¹ More importantly, mandated testing schemes draw attention away from the help that needs to be offered earlier in the pregnancy, or even preconceptionally, to prevent the drug from causing damage at a time when the fetus is most susceptible. But most distressing is the bias that occurs when doctors and the state form an alliance in mandated drug testing and reporting. African-Americans and the poor are unfairly singled out in drug arrests of pregnant women.²⁰² This bias cuts at one of the fundamental tenets of the

²⁰⁰ Field, *Controlling the Women to Protect the Fetus*, 17 LAW, MED. & HEALTH CARE 114, 121 (1989).

²⁰¹ Criminal sanctions applied to pregnant women who use controlled substances on the basis of "delivering drugs to a minor" essentially apply laws to pregnant women which are intended for drug dealers.

²⁰² Roberts, *The Bias in Drug Arrests of Pregnant Women*, N.Y. Times, Aug. 11, 1990, at A17, col. 2. It was noted in a study of pregnant women in Pinellas County, Florida, that the reason African-American women are the primary targets of prosecutors is not because they are more guilty of drug abuse, but, rather because of the underlying racism inherent in our society. Chasnoff, et al., *supra* note 187, at 1202. In this study, wealthy white women were found to use harmful substances as frequently as blacks and the poor. The main difference was that whites tended to abuse alcohol and mood altering pills more frequently than cocaine, while the reverse was true for blacks. However, when it came to reporting those suspected of drug use, the doctors in Pinellas County singled out black women ten times more often than whites. American College of Obstetrics and

physician-patient relationship, that is, the duty of care also includes a duty to prevent injustice. As the authors of the Pinellas County study concluded, "[i]f legally mandated reporting is to be free of racial or economic bias, it must be based on objective medical criteria."²⁰³

Physicians generally disagree with the punitive approach to stemming drug abuse during pregnancy.²⁰⁴ "We need to treat the problem, not hide it in prison."²⁰⁵ Criminalization singles out pregnant drug users and penalizes them more heavily than others. "If you honestly believe that women should be criminalized for possibly harming their fetuses, then you will have to do it for all reasons, not just drugs."²⁰⁶ Laws on fetal abuse erode the trust developed in the physician-patient relationship and deter prenatal care.²⁰⁷ Hence, the overwhelming reason health providers oppose such policies is that they drive away those who are in the greatest need of help.

V. CONCLUSION

The physician-patient relationship is a remarkable piece of work. It has evolved into a "Magna Carta" of sorts, establishing the fundamental principles of mutual duties, rights, autonomy and beneficence within the context of providing health care, especially to women. It has achieved constitutionally protected status. It is at once an ethical, moral, legal and social doctrine that applies equally to all people of all persuasion in all lands. The principles embodied in the physician-patient relationship establish the role of the physician which is to render care, be an informed educator and advocate, participate in the decision-making process and protect against injustice, while realizing that tests, judgments and decisions are fallible. A serious examination of the concept of maternal-fetal conflict from the perspective of the doctor-patient relationship reveals that this concept is insidiously misleading. It focuses guilt on the outcome of pregnancy to women alone. The characterization of disagreement regarding the nature of obstetrical care as a maternal-fetal conflict is improper when it truly is one of physician-patient conflict.

Gynecology, *Few Stereotypes Can Be Drawn of the Pregnant Substance Abuser*, 34 ACOG Newsletter 5 (Aug. 1990). This article very adroitly characterized the racism encountered in Dr. Chasnoff's study as the "Not in My Office Syndrome."

²⁰³ Chasnoff, et al., *supra* note 187, at 1202. See generally Roland & Volpe, *Effect of Maternal Cocaine Use on the Fetus and Newborn: Review of the Literature*, 15 PEDIATR. NEUROSCI. 88 (1989); Howard & Hill, *Drugs in Pregnancy*, 34 OBSTET. GYNECOL. SURV. 643 (1979). The singling out of crack (cocaine) users for prosecution cannot be justified by either the number of abusers or the degree of harm to the fetus. Although cocaine is definitely harmful to the mother and fetus, there is no empirical evidence to suggest that it is more so than excessive alcohol or nicotine use.

²⁰⁴ American College of Obstetrics and Gynecology, *Many Disagree with the Punitive Approach to Stemming Drug Abuse During Pregnancy*, 34 ACOG Newsletter 1 (May 1990). This article reveals an excellent summary of state action related to drug use during pregnancy. *Id.* at 11.

²⁰⁵ *Id.* The quote is attributed to Mary Jo O'Sullivan, M.D., Secretary, American College of Obstetrics and Gynecology.

²⁰⁶ *Id.* The medical profession echoes the legal critics regarding this issue.

²⁰⁷ See *Laws on Fetal Abuse Expected to Erode Trust in MDs and Deter Prenatal Care*, Ob. Gyn. News, Feb. 15-28, 1990, at 1, col. 1.