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Wrong without a Remedy - North Carolina and the Wrongful Death of a Stillborn

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COMMENT

WRONG WITHOUT A REMEDY—NORTH CAROLINA AND THE WRONGFUL DEATH OF A STILLBORN*

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I. INTRODUCTION

Thus far, North Carolina courts have failed to follow the majority rule recognizing a civil cause of action for the wrongful death of a stillborn infant.[1] Failure to provide such redress is a serious injustice and is not in keeping with the modern trend towards rec-

* The author wishes to express her appreciation to Donna Sams, R.N. of Community Hospital of Roanoke Valley, Roanoke, Virginia, Dr. Jim Thullen, and Representative Frank Ballance.

1. DiDonato v. Wortman, 80 N.C. App. 117, 341 S.E.2d 58 (1986), *appeal docketed*, No. 280A86 (argued Dec. 11, 1986); Yow v. Nance, 29 N.C. App. 419, 224 S.E.2d 292, *disc. review denied*, 290 N.C. 312, 225 S.E.2d 833 (1976); Cardwell v. Welch, 25 N.C. App. 390, 213 S.E.2d 382, *cert. denied*, 287 N.C. 464, 215 S.E.2d 623 (1975). A stillborn is "born dead" and therefore dies in the fetal stage. ENCYCLOPEDIA AND DICTIONARY OF MEDICINE, NURSING, AND ALLIED HEALTH 954 (2d ed. 1978).

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ognizing the fetus as a "person." This issue becomes even more critical when considering the third trimester fetus who possesses significant attributes of personhood, most notably, higher brain functions.

This comment does not address the pro-choice/right-to-life debate.[2] Rather, it presents a legal argument supporting a civil action for the wrongful death of *some* stillborns and suggests that a gestational age of twenty-six weeks represents an appropriate viability standard in interpreting the North Carolina wrongful death statute. It also attempts to bridge the perceptual gap between certain aspects of medical and social sciences and the law regarding the fetus. The argument in support of the twenty-six week viability standard is presented in four parts. First, this comment illustrates why the fetus now enjoys an elevated status in society. Second, it illustrates the devastating impact of a stillbirth on the survivors. Third, it examines the "born alive" requirement and demonstrates that this requirement does not represent a well-defined line of demarcation, nor is it in the best interest of the public. Finally, it recommends that North Carolina courts interpret the wrongful death statute to include fetuses who have reached a gestational age of twenty-six weeks, because this age is: an age consistent with a medical viability standard; an age at which abortion ceases to be a maternal, medical, or legal option; an age at which maternal attachment is well-developed; and an age during which the fetus exhibits true attributes of personhood.

II. Status of the Fetus

A. *Historical Perspective*

The killing of newborn infants[3] is the oldest method of family planning known to man. This "birth control" method dates back to prehistoric times. Infants, particularly females, were killed or abandoned as a means of balancing reproduction and survival.[4] Early Hebrews viewed a child under one month of age as not a

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2. In fact, the viability standard recommended in this comment appears to be one with which both groups would agree.

3. This comment discusses infants and fetuses together in this section because their status from a societal perspective has not been dependent on birth or on being born alive.

4. Silverman, *Mismatched Attitudes About Neonatal Death*, 11 HASTINGS CENTER REP. 12 (Dec. 1981).

"person" and the child's death was equivalent to an abortion.[5] Similarly, Athenian mothers could kill their infants any time prior to the infants' ceremonial entrance into the tribe.[6] Infants and fetuses were not protected, were not considered persons, and were therefore considered quite dispensable.

The killing of infants and fetuses eventually decreased, not for moral or religious reasons, but because the need for armies increased. Early Spartans and Hebrews enacted severe penalties for the killing of a fetus or infant who was a potential warrior.[7]

In Europe, during the early Middle Ages, active infanticide was a crime, and women who killed their infants by affirmative means were buried alive, drowned, or decapitated.[8] Abandonment, however, was not a crime,[9] and "was practiced on a gigantic scale with absolute impunity."[10] In response to this practice, society attempted to protect these infants by making abandonment a crime. During the eighteenth century, the punishment for both killing and abandoning a baby was especially cruel. For example, in one case an infanticidal mother was stuffed into a sack with a dog, a cat, a rooster, and a viper. The sack and its contents were then submerged in water.[11]

> [I]t is clear that large numbers of women . . . continued to risk barbaric punishments by committing offensive acts in what appears (from this distance) to have been attempts to control their own lives. Although parents who could afford it sometimes showed a striking degree of concern over neonatal mortality, infanticide persisted despite all denunciations by the church and all penalties of the law.[12]

In the mid-1800's, the crimes of infanticide and abortion increased and anti-abortion laws were established to supplement the laws against infanticide.[13] By the twentieth century, these infants and fetuses were even more actively protected. In the 1900's, the

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5. *Id.*

6. Note, *The Non-Consensual Killing of an Unborn Infant: A Criminal Act?*, 20 BUFFALO L. REV. 535, 536 (1971).

7. *Id.*

8. Silverman, *supra* note 4, at 12-13.

9. *Id.* at 12.

10. *Id.*

11. *Id.* at 13.

12. *Id.*

13. Suprisingly, the move to protect infants in the United States came not from religious authorities, but from the medical profession. *Id.* at 14.

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move to save small infants became more successful through improved medical expertise. This success aroused the public's curiosity. Expositions, such as those at the 1939 World's Fair in New York, displayed live premature infants. Shortly thereafter, intensive care nurseries became increasingly common throughout the United States and in the 1960's, when life-support techniques became more effective, infants previously considered nonviable survived.[14]

B. Modern Perspective

Today, the fetus enjoys the highest status it has ever known, especially after the first trimester of pregnancy. Among the factors contributing to this gradual evolution are a woman's ability to control her childbearing and her new role in society. Additionally, the growth of medical specialities and remarkable advances in medical science have led to this new concept of regarding the fetus as a person.

A woman's ability to control her reproduction is perhaps the most significant factor in considering the increased importance of the fetus. A fetus who is planned, or who is not intentionally aborted, and survives until the mother perceives fetal movement, is generally a wanted child.[15] Today, temporary birth control methods are reliable, safe, easy to use, and socially accepted. Permanent methods of birth control, specifically tubal ligations and vasectomies, are also reliable and the risks of serious complications are slight.[16] In addition, *Roe v. Wade*[17] made abortion in the first trimester available to all women as part of a fourteenth amendment privacy right. Pregnancy can be determined quite early by home pregnancy tests and by urine and blood tests performed at medical facilities.[18] Since abortions in the first trimester are safe and relatively inexpensive, unwanted pregnancies can be terminated before fetal development becomes advanced.

The fetus is especially valuable because of the changing role of

14. *Id.*

15. M. KLAUS & J. KENNELL, PARENT-INFANT BONDING 13-14 (1982). *See infra* notes 49-62 and accompanying text for an explanation of the bonding or attachment process.

16. *See* K. NISWANDER, MANUAL OF OBSTETRICS 3-25 (1983).

17. 410 U.S. 113 (1973).

18. For a table of tests and their effectiveness, *see* S. CORSON, R. DERMAN, & L. TYRER, FERTILITY CONTROL 50-57 (1985). Pregnancy can be determined before the first missed menstrual period. *Id.* at 52.

women in society. Women are having fewer babies.[19] They frequently marry later, are better educated, and become established in their careers before deciding to become mothers. These women (and their husbands) carefully plan their lives to offer their children the financial, cultural and emotional advantages that older, more stable parents can provide. Frequently, women between the ages of thirty and forty give birth to their first babies.[20] After limiting the number of childbearing years, many women are able to conceive only one child or may even find that they are unable to conceive at all. The importance of each fetus and each pregnancy increases as the mother's biological clock continues to tick.

The medical community has played a major role in elevating the status of the fetus. Several medical specialties regarding the fetus have developed. These specialties focus on facilitating conception, prenatal care of the mother and fetus, high-risk perinatal care, and care of the high-risk newborn.

The first area of specialty involves infertility. In the United States, more than ten million people, or one out of five married couples, experience some degree of infertility. In fact, over the last twenty years, infertility has increased by fifty percent.[21] Women spend thousands of dollars in hopes of becoming pregnant. They may undergo expensive and painful diagnostic tests and surgical procedures. Test-tube fertilizations, sperm banks, fertility drugs, artificial insemination and surrogate mothers are options for these couples. Furthermore, infertility is often a difficult psychological and emotional experience. Couples react to infertility with feelings of anger, guilt, and helplessness. Some communities have formed support groups to help victims of infertility cope with these feel-

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19. North Carolina's birth rate has shown a general decline since the baby boom years of the mid 1950's. The rates were 26.8 in 1954, 19.4 in 1970, and 14.4 in 1980. Furthermore, the fertility rate (number of live births per 1000 women aged 15-44 years) has also shown a general decline; it was 109.4 in 1950, 88.7 in 1970, and 60.4 in 1980.

1 N.C. DEPT. OF HUMAN RESOURCES, NORTH CAROLINA VITAL STATISTICS 1984 1-6 (1985).

20. In 1980, 17.8% of first infants were born to mothers between the ages of 30 and 44. In 1984, that figure increased to 27.5%. U.S. BUREAU OF THE CENSUS, STATISTICAL ABSTRACT OF THE UNITED STATES 60 (106th ed. 1985). In women, fertility decreases steadily after age thirty. A. DECHERNEY, REPRODUCTIVE FAILURE 22 (1986).

21. *A Medical Times Patient Information Sheet—Infertility Facts and Figures,* 114 MED. TIMES 102 (Mar. 1986).

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ings.[22] When conception does occur, this fetus is indeed special.

Other medical specialties have also evolved. For example, large medical centers hire neonatologists[23] to manage intensive care nurseries for the support of newborn infants who formerly would have died. Women are transported from hundreds of miles away to deliver their infants at these centers.[24] The complex care provided by neonatologists, intensive care nurses, and respiratory therapists is expensive and involves equipment that is overwhelming to laymen and medical personnel alike. The survival and well-being of the fetus depends upon identification of and preparation for the high-risk fetus. The development of this specialty illustrates the degree of importance placed upon the health of the fetus.

Perinatology is another specialty which regards the fetus as a person. A perinatologist is a physician who assists obstetricians, pediatricians and neonatologists with the care of mothers and fetuses in the perinatal period.[25] The consultation of a perinatologist is especially important when both mother and infant present critical medical dilemmas.

Each of these specialties regards the fetus as a separate patient.[26] Surgeons now perform fetal surgery.[27] Furthermore, in caring for these tiny patients, physicians have kept brain dead mothers alive until the fetuses reached a gestational age which allowed survival.[28] The courts themselves have recognized the fetus

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22. *Id.*

23. Neonatal is defined as "newborn; relating to the period immediately succeeding birth and continuing through the first 28 days." STEDMAN'S MED. DICTIONARY 931 (24th ed. 1982).

24. "If time and circumstances permit and if the need for intensive neonatal care is anticipated, early transfer of the patient and her undelivered fetus to a perinatal center is not only advisable but offers the best long-term results." E. BISHOP & D. BISHOP, PERINATAL MEDICINE: PRACTICAL DIAGNOSIS AND MANAGEMENT 157 (1982).

25. Perinatal is defined as "occurring during, or pertaining to, the periods before, during, or after the time of birth; i.e., before delivery from the 28th week of gestation through the first seven days after delivery." STEDMAN'S MED. DICTIONARY 1055 (24th ed. 1982).

26. M. HARRISON, M. GOLBUS, & R. FILLY, THE UNBORN PATIENT, PRENATAL DIAGNOSIS AND TREATMENT 1-10 (1984). The introduction of this book, entitled "The Fetus as Patient: Historical Perspective," notes the radical change that has occurred in treating and understanding the fetus.

27. Ruddick & Wilcox, *Operating on the Fetus*, 12 HASTINGS CENTER REP. 10-11 (Oct. 1982).

28. *To Save a Fetus, Should A Brain-Dead Woman Be Kept Alive?*, 12 HASTINGS CENTER REP. 3 (Dec. 1982).

as a patient. They have elevated fetal rights above maternal rights by ordering mothers to undergo cesarean sections in order to protect fetal health.[29]

> The fetus has come a long way—from the biblical 'seed' and mystical 'homonculus' to an individual with medical problems that can be diagnosed and treated: that is, a patient. Although the fetus cannot make an appointment and seldom even complains, this patient will at all times need a physician.[30]

Medical science has given the world new insight into the character and development of the fetus. This information dispels the myths which depict the fetus and newborn as deaf, dumb, blind and inhuman creatures and illustrates that fetuses do not magically become "persons" at birth. Rather, they become people in utero and certainly qualify as people by the last trimester.

Scientists study the fetus in utero to determine fetal well-being and to better understand fetal development. Perception of the fetus has changed immensely because of the use of ultrasound. Scientists have identified stages of fetal consciousness and behavior,[31] identified fetal adaptation to sounds[32] and can even examine fetal eye movements.[33]

A fetus is capable of simple movement at seven to eight weeks

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29. Annas, *Forced Cesareans: The Most Unkindest Cut of All,* 12 HASTINGS CENTER REP. 16 (June 1982).

30. M. HARRISON, M. GOLBUS, & R. FILLY, *supra* note 26, at 9. The development and use of a "high-risk hotline" in Connecticut illustrates the importance of the fetus as a patient. The purpose of the hotline is to decrease fetal deaths and injuries. Outlying hospitals transmit fetal monitor tracings to experts in perinatology who evaluate fetal status in high-risk pregnancies and during labor. Medical personnel use the hotline most frequently for antepartal stress testing. A stress test allows evaluation of the fetus's ability to withstand labor. *Data Link May Reduce Fetal Injuries, Death,* 1 CLINICAL ASPECTS OF HIGH-RISK PREGNANCY 2 (Mar. 1983). *See infra* note 174 for a further explanation of stress tests.

31. Nijhuis, Martin, Gommers, Bouws, Bots, & Jongsma, *The Rhythmicity of Fetal Breathing Varies With Behavioral State in the Human Fetus*; 9 EARLY HUMAN DEV. 1, 7 (Dec. 1983).

32. Leader, Baillie, Martin, & Vermeulen, *The Assessment and Significance of Habituation to a Repeated Stimulus by the Human Fetus,* 7 EARLY HUMAN DEV. 211 (Dec. 1982). "Habituation is the progressive decrease in response by an organism when it is stimulated repeatedly. This process is a basic form of *learning* . . . . The gestational age at which the fetus first responded to the stimulus ranged from 22-30 weeks." *Id.*, (emphasis added). *See also* M. KLAUS & P. KLAUS, THE AMAZING NEWBORN 135 (1985).

33. Awoust & Levi, *New Aspects of Fetal Dynamics with a Special Emphasis on Eye Movements,* 10 ULTRASOUND IN MED. & BIOL. 107 (1984).

and by thirteen to fourteen weeks can move about with its legs. At nineteen weeks, the fetus can hold itself erect and scoot about by bracing against its hand.[34] The fetus develops a sense of taste to some degree by twenty-eight to thirty weeks.[35] Infants in utero yawn, swallow, have breathing movements, root,[36] smile and suck.[37] Newborn infants are often born with blisters on their arms and hands from sucking in utero.[38]

At birth, an infant can discriminate between a female voice and a male voice, preferring the female voice.[39] Newborns can also remember and discriminate between stories heard while in utero and different stories heard after birth. For example, in one study, the examiner recorded sixteen mothers while they read Dr. Seuss's *The Cat in the Hat* and a poem called *The King, the Mice and the Cheese.* Each fetus heard only one story while in utero. The mother read the story to her fetus twice a day. At three days of age, the examiner equipped the infants with padded earphones and played both stories to them. If the infants sucked rapidly, the examiner would play the first story. If the infants sucked slowly, the examiner would play the other story. Fifteen of the sixteen infants determined which sucking pattern would trigger the story that they heard while still in utero.[40]

A fetus is sensitive to light several months before term, even though its eyelids are fused. Premature infants as young as thirty weeks have exhibited visual preferences.[41] A newborn exhibits its well-developed sense of sight and visual preferences at birth. Human faces, sharp outlines, and moving objects are especially attractive to newborns. Newborn vision is the best at about eight to ten inches, the distance that most mothers hold their infants from their faces.[42]

Not only do infants see well, they can also process and remember what they have seen. Newborns exposed to the same picture over a long period of time become bored, but become interested

34. M. Klaus & P. Klaus, *supra* note 32, at 132.
35. *Id.* at 136.
36. *Id.* at 132.
37. *Id.* at 129.
38. This comment discusses studies regarding the newborn and fetus together because fetal development is not dependent upon birth, but upon gestational age.
39. M. Klaus & P. Klaus, *supra* note 32, at 50.
40. *Id.* at 51-52.
41. *Id.* at 138.
42. *Id.* at 22, 30.

anew as different pictures are introduced. Similarly, infants as young as eight days old become restless and take less milk when their mothers wear masks and fail to speak during feedings.[43] "Such feats of visual perception and memory by the baby indicate that the infant's visual talent is based not only on reflex movement but on higher brain function as well."[44]

A newborn also possesses a highly developed sense of smell. "[B]y the fifth day of life breastfeeding infants can discriminate their mother's own breastpad from the breastpads of other mothers with significant reliability."[45] Frequently, infants who had previously consistently nursed well reject their mothers' breasts by crying and turning away once their mothers have bathed.

Newborn infants also possess the ability to mimic facial expressions. Mothers first reported this ability and psychologists and physicians have now proven it true. Newborns will yawn, purse their lips, and protrude their tongues in response to an adult.[46] Newborns also show fear, sadness, joy, anger, and disgust by facial expressions,[47] illustrating yet another complex method of communication.

Another fascinating ability of the newborn is its use of rhythmic movement in response to human communication. Scientists have noted that adults move in rhythm when communicating, creating a kind of dance. Newborns are also able to coordinate their movements in rhythm with voices. For example, when a speaker pauses, the infant may raise an eyebrow or lower a foot.[48]

> By this subtle entrainment of [its] movements to the rhythm of her speech, the newborn gives the mother feedback that she can hardly resist. We have found that this synchrony becomes the important ambience for their effective communications thereafter. Their communications become a sort of "mating dance" . . . when they are analyzed on film by frame-by-frame analysis.[49]

The fetus may no longer be classified as a nonentity. As illustrated, the status of the fetus has changed dramatically. Society, parents, and the medical community recognize the value of the

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43. *Id.* at 38.
44. *Id.*
45. M. KLAUS & J. KENNELL, *supra* note 15, at 79.
46. M. KLAUS & P. KLAUS, *supra* note 32, at 84-87.
47. *Id.* at 88.
48. M. KLAUS & J. KENNELL, *supra* note 15, at 76-77.
49. *Id.* at 77, quoting T.B. Brazleton.

third trimester fetus as a person and the law should recognize its value as well.

III. The Impact of the Stillborn on the Family

Legal scholars and lawmakers have no trouble in recognizing losses suffered by relatives of persons wrongfully killed. They may not, however, recognize that the loss of a stillborn is just as great. These legal scholars and lawmakers should understand the psychological and sociological impact on a family when a stillborn is delivered. One of the keys in understanding this loss is to examine the normal process of bonding or attachment and the grieving process accompanying the loss of a stillborn.

The bonding process begins early in pregnancy. During the first trimester, even mothers who planned their pregnancies experience some ambivalence. Suddenly, they face the reality of the changes that are about to occur in their lives. They experience conflicts in regard to the changes in body image, lack of freedom, fear of pain, the health of the child, and reactions of spouses or mates.[50] If the mother is worrying about how she will support the infant or other children, her own health, or whether her mate will injure her or leave her, these conflicts may be difficult or impossible to resolve. The mother may resolve these conflicts with an abortion. As the mother thinks through these problems, she generally resolves these conflicts and fantasizes about the future of her child.[51]

Quickening, the sensation of fetal movement,[52] is an extremely significant event in the bonding process. When the mother experiences quickening, she attributes human characteristics to the fetus and develops intense feelings of attachment. She begins to purchase clothes, a crib, select a name, and otherwise prepare for her child. She becomes aware of her infant as a separate individual.[53] Mothers have reported quickening as early as sixteen weeks.[54]

Modern science can intensify this stage of attachment. Researchers have found that mothers who have "seen" their fetuses via ultrasound may experience this attachment earlier in their

50. *Id.* at 12-13.
51. *Id.* at 13.
52. *Id.*
53. *Id.*
54. Reading, *Psychological Changes Over the Course of Pregnancy: A Study of Attitudes Toward the Fetus/Neonate*, 3 HEALTH PSYCHOLOGY 211, 216 (1984).

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pregnancies and may resolve any early ambivalence about the pregnancy in favor of the fetus.[55] As the mother recognizes the infant as a separate person, the likelihood that she will opt for abortion decreases.[56] Similarly, discovering fetal gender through amniocentesis or ultrasound tends to increase prenatal attachment.[57]

In the third trimester, attachment to the fetus increases, in part, because of the knowledge that the infant could survive if born. Fantasies increase and the mother becomes consumed by the pregnancy.[58] By the same or a similar process, fathers also attach or bond with the fetus.[59] At birth, the mother's task is to "let go" of her fantasy child and accept this new child.[60] She does this gradually with the help of her newborn. The special ability of the newborn to enthrall its mother (and father and family) is manifested in its behavior through its senses of sight, hearing, smell, touch, its rhythmical movements and other unique characteristics. A mother exhibits typical behavior, keeping the infant at some distance initially, stroking the extremities with her fingertips. Gradually, the mother uses her hands and arms to cradle the infant close to her body and establishes an "en face" position with the child.[61] In this position, mother and infant look into each others' eyes and woo each other into the most special of relationships.[62]

When an infant is stillborn, the "letting go" of the perfect infant and acceptance of the new infant does not occur, nor can the parents grieve in a normal way. Their only relationship with this infant was in their fantasies. They must grieve for someone abstract and unknown and must attach and detach simultaneously.[63]

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55. *Id.* This article indicates that women with positive feelings about their pregnancies become aware of fetal movements earlier. *Id.* at 219.

56. Fletcher & Evans, *Maternal Bonding in Early Fetal Ultrasound Examinations,* 308 NEW ENG. J. MED. 392 (1983).

57. Grace, *Does A Mother's Knowledge of Fetal Gender Affect Attachment?,* 9 MCN 42 (Jan./Feb. 1984). This article suggests that prenatal knowledge of gender does not alter the postpartal attachment process. MCN is an acronym for THE AMERICAN JOURNAL OF MATERNAL/CHILD NURSING.

58. M. KLAUS & J. KENNELL, *supra* note 15, at 13.

59. *Id.* at 56-57.

60. Hall & Stoops, *Acquainting A New Mother with Her Less-Than-Perfect Baby,* 9 MCN 136 (Mar./Apr. 1984).

61. Kowalski, *Managing Perinatal Loss*, 23 CLINICAL OBSTETRICS AND GYNECOLOGY 1113, 1119 (Dec. 1980); M. KLAUS AND A. FANAROFF, CARE OF THE HIGH-RISK NEONATE, 101-02 (1973).

62. M. KLAUS AND J. KENNELL, *supra* note 15, at 71-72.

63. Thullen, *Grief in the Perinatal Period,* 2 CURRENT PRACTICES 1 (Dec.

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> [T]here is a double sense of loss for the bereaved mother who now has a void where there was so evidently a fullness. Even with the live birth the mother feels a sense of loss, but the consolation of a surviving 'outside baby' helps the mother to overcome her puzzling and bewildering sadness at losing her "inside baby."[64]
>
> . . . .
>
> When a baby dies, the parents not only lose a real baby, but also part of themselves, and their dreams and hopes of the future. The baby has not yet become a person to be loved in his own right, and his or her death represents primarily a loss of self and of self-esteem to the parents. . . .[65]

Parents who do not see their stillborn infant often erroneously imagine it to be grotesque.[66] Although medical personnel attempt to help parents resolve this grief and misperception by encouraging them to view and hold their stillborn babies, the sense of guilt experienced by the parents of stillborns is severe and the potential for pathological grief is great.[67] The birth of a stillborn can, for instance,

> precipitate depression, frigidity, and phobic states; some women, apparently untouched at the time, may be at high risk of breakdown in the next pregnancy; there may be matrimonial disturbances, impotence, and other signs or symptoms in the husband and far reaching effects on other children. Personality development and gender identity on subsequent children may be riveted to the imagined shape of the baby who was lost, with crippling effects.[68]

Society treats the parents as if the stillborn never existed. Family members mourn in isolation, for the rest of the world has no sense of having lost a person. Others suggest that the couple can have replacement children and that they should get on with life. When parents have reflectively compared their reactions to the death of a spouse or an older child, "[t]hey have consistently agreed that the loss of the stillborn or liveborn infant was more distressing."[69]

1981).

64. M. KLAUS AND J. KENNELL, *supra* note 15, at 263.

65. *Id.* at 261.

66. Kowalski, *supra* note 61, at 1119.

67. Kowalski & Osborn, *Helping Mothers of Stillborn Infants Grieve,* 2 MCN 29, 32 (Jan./Feb. 1977).

68. Thullen, *supra* note 63, at 1, 2.

69. M. KLAUS & J. KENNELL, *supra* note 15, at 267. In an interview with Dr.

Certainly, when a third party causes the death of an unborn child through negligent or willful and wanton conduct, the parents should have a legal remedy. The inability to seek any legal redress further adds to parents' feelings of guilt and impotence, and reaffirms that society does not value their feelings or the life of their child.

IV. THE CRIMINAL LAW REGARDING THE FETUS

A. *Historical Overview*

The early common law attached great importance to the moment of quickening in determining whether the fetus was a person. If a person caused the death of a fetus before quickening had occurred, that person committed no crime. If a person caused the intrauterine death of a quickened fetus, that person committed a misdemeanor. However, if that quickened fetus survived birth and later died, the crime committed was common law murder.[70] The English common law discarded the quickening standard and replaced it with the "born alive" rule, which required that a fetus be born alive to receive any legal protection.[71]

American courts adopted the born alive rule for purposes of convicting defendants of both murder and manslaughter. They adopted this standard for several reasons. First, the causal connection between the crime and the death was difficult to prove because of the primitive state of technology. Second, prenatal mortality rates were extremely high and a view that infants would be born dead prevailed. Finally, society considered a pregnant woman irrational and not accountable for any acts which might lead to the demise of the fetus.[72]

The born alive rule created some ghastly results. In one case, the defendant stabbed an infant in the head with a fork as the head was delivered, but prior to the delivery of the body. The infant expired before "birth", and therefore was not "born alive."

Thullen, he reported that to add to this feeling of dismay and isolation, a stillborn infant does not receive a birth certificate, only a death certificate. Similarly, Dr. Thullen indicated that an infant at any gestational age born with any sign of life who later dies is still allowed as an income tax deduction, while a stillborn at any gestational age is not.

70. Doudera, *Fetal Rights? It Depends*, 18 TRIAL 39, 40 (Apr. 1982).

71. Note, *supra* note 6, at 536.

72. *Id.* at 536-37.

Consequently, the defendant was not guilty.[73] Similarly, an infant strangled upon birth of the head but before birth of the body was not born alive.[74]

The born alive standard produced other problems as well. The moment of complete independent existence was impossible to define. In *Morgan v. State*,[75] a "hydrostatic" test was performed; the baby's lungs were removed from the body and placed in water. This test was performed on the theory that if the infant had breathed, its lungs would float. However, the state could not show beyond a reasonable doubt why the lungs floated; that is, whether the lungs floated because the infant breathed or because the lungs contained gases caused by decomposure. Other courts formulated tests of independent circulation, physical separation from the mother, or cutting of the umbilical cord to answer the question of when independent existence occurred. Such tests produced illogical results. For example, in one case, the defendant cut an infant's throat and the infant bled to death.[76] The state could not prove that independent circulation existed (that the cord had already been cut), or that the infant had an independent existence; therefore, the state could not prove that the defendant had committed a crime.[77]

Many states have altered the born alive rule by enacting criminal statutes which specifically apply to the wrongful killing of the unborn. The scope of these statutes ranges from protecting any fetus, regardless of maturity or gestational age, when its mother did not consent to its death[78] (thereby avoiding conflict with *Roe v. Wade* and abortion statutes), to protecting quickened fetuses,[79] to protecting viable fetuses.[80] Most of the statutes require a willful or

73. Rex v. Enoch, 5 Carr. & Pay. 539, 172 Eng. Rep. 1089 (1833).

74. Rex v. Crutchley, 7 Carr. & Pay. 813, 173 Eng. Rep. 355 (1837).

75. 148 Tenn. 417, 256 S.W. 433 (1923).

76. Montgomery v. State, 202 Ga. 678, 44 S.E.2d 242 (1947).

77. Some states have defined "born alive" and the results have been inconsistent. *See* People v. Bolar, 109 Ill. App. 3d 384, 440 N.E.2d 639 (1982), (infant with only a few heartbeats was born alive); Duncan v. Glynn, 358 So.2d 178 (Fla. 1978), (fetus was born alive only after the cord had been cut and independent circulation existed. This determination might allow for the killing of a healthy infant several minutes after birth without adverse consequences to the killer.) *See also*, Britt v. Sears, 150 Ind. App. 487, 277 N.E.2d 20 (1971), (fetus is "born alive" if it evidences any sign of life after it is entirely outside of the mother).

78. *See* CAL. PENAL CODE § 187 (West 1970).

79. *See* R.I. GEN. LAWS § 11-23-5 (1981).

80. *See* IOWA CODE ANN. § 702.20 (West 1979).

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intentional state of mind on the part of the defendant.

Generally, courts have been reluctant to independently interpret homicide statutes to include fetuses for two reasons. First, they do not want to undermine the legislative prerogative. Second, a judicial determination that a fetus is a person might deprive the defendant of due process.[81] Recently, Minnesota refused to expand the definition of human being to protect a viable fetus.[82]

South Carolina[83] and Massachusetts[84] have interpreted homicide statutes to include fetuses within the definition of persons. In *Commonwealth v. Cass*,[85] an automobile struck a pregnant pedestrian, killing her viable fetus. The state charged the driver with vehicular homicide. The Massachusetts court noted, "We are cognizant of the constitutional limits imposed by such cases as . . . *Roe v. Wade*."[86] The court further noted that it was free to develop common law rules of criminal law and that the criminal law in the commonwealth was largely common law.[87] It rejected the suggestion that in using the term "person", the legislature intended to crystallize preexisting common law which had not recognized the fetus as a person.[88] It also rejected the contention that rules of strict construction of criminal statutes prevented it from construing the word "person" to include viable fetuses.[89] The court stated, "We may address and remedy unfairness through prospectivity [sic] analysis rather than mechanical application . . . ."[90] The court found that the rationale for the common law "born alive" standard was no longer applicable because medical science was able to provide competent evidence on whether the fetus was alive at the time of the mother's injury.[91] Furthermore, the court had previously recognized a civil cause of action for the wrongful death of a stillborn.[92]

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81. People v. Guthrie, 97 Mich. App. 226, 293 N.W.2d 775 (1980).

82. State v. Soto, 378 N.W.2d 625 (Minn. 1985).

83. State v. Horne, 282 S.C. 444, 319 S.E.2d 703 (1984).

84. Commonwealth v. Cass, 392 Mass. 799, 467 N.E.2d 1324 (1984). Kansas has hinted in dicta that it would do the same. State v. Burrell, 237 Kan. 303, 699 P.2d 499 (1985).

85. 392 Mass. 799, 467 N.E.2d 1324 (1984).

86. *Id.* at 807 n.11, 467 N.E.2d at 1329 n.11.

87. *Id.* at 803, 467 N.E.2d at 1327.

88. *Id.*

89. *Id.*

90. *Id.* at 805, 467 N.E.2d at 1328.

91. *Id.*

92. *Id.* at 801, 467 N.E.2d at 1325.

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In the South Carolina case of *State v. Horne*,[93] the defendant had maliciously stabbed his estranged wife, resulting in the death of her full-term fetus. Like the Massachusetts court, the South Carolina Supreme Court found that it would be "grossly inconsistent"[94] to recognize a civil cause of action and refuse to protect the child from criminal actions. The Court refused to apply the ruling to this case, however, making the crime of feticide prospective.[95]

B. The Criminal Law in North Carolina

North Carolina clings to the born alive rule in spite of growing support from the public to adopt a feticide statute. In May of 1985, Representative Frank Ballance (Dem., 7th Dist.) introduced a bill to make feticide a crime.[96] The statute would have protected a fetus "capable of sustained life outside the mother's womb," specifying this time as six months or more after the date of conception.[97]

The deaths of Denise Minick Cveticanin and her unborn infant daughter, who weighed six pounds, ten ounces and was due to be delivered ten days later, prompted the introduction of the bill. Mrs. Cveticanin, who was murdered in New Jersey, suffered over one hundred wounds, her killer using two knives, a hacksaw and a ten pound sump pump to accomplish her death. Lynn Jett Minick, Mrs. Cveticanin's mother and a North Carolina resident, was shocked to learn that the state of New Jersey would not punish the murderer for the death of her granddaughter—that her granddaughter's right to life was meaningless in the eyes of the New Jersey law. She soon discovered that North Carolina's laws also failed to protect unborn children from criminal acts. Mrs. Minick, with the help of Representative Ballance and other interested citizens, was the force behind the introduction of the bill.[98]

The House postponed the bill indefinitely.[99] According to Representative Ballance, the legislators did not dispute the injustice of

93. 282 S.C. 444, 319 S.E.2d 703 (1984).

94. *Id.* at 447, 319 S.E.2d at 704.

95. *Id.*

96. H.R. 1276, N.C. Gen. Assembly, Reg. Sess. (1985).

97. *Id.*

98. Interviews with Representative Ballance and Lynn Jett Minick, the victim's mother, and information on a letter from "People Assisting Victims" provided the history regarding the introduction of the bill.

99. *Minutes of House Judiciary IV Committee*, N.C. Gen. Assembly 11, Reg. Sess. (July 11, 1985).

killing an unborn child, but they feared that voting for this bill would associate them with anti-abortion forces. Also, the insurance lobby strongly opposed the bill, presumably seeing this criminal statute as a method of opening the door to civil actions under the wrongful death statute. In refusing to vote on the bill, the legislature effectively allowed the "tail to wag the dog."

V. WRONGFUL DEATH OF A STILLBORN

A. *Historical Overview*

Wrongful death statutes provide the mechanism for recovery for deaths caused by the negligent or intentional misconduct of a tortfeasor. The recovery for wrongful death is a relatively new cause of action. The early common law denied such recovery.

The Fatal Accidents Act of 1846[100] provided the first legal remedy for any wrongful death. The Act, commonly known as Lord Campbell's Act, abrogated the unjust common law rule of *Baker v. Bolton*.[101] The court in *Baker* had determined that "the death of a human being could not be complained of as an injury."[102] Lord Campbell's Act provided that:

> Whenever the death of any person is caused by the wrongful act, neglect or default of another, in such a manner as would have entitled the party injured to have sued had death not ensued, an action may be maintained if brought within twelve months after his death in the name of his executor or administrator *for the benefit of certain relatives*.[103]

This Act created a new cause of action measuring damages by the loss suffered by the beneficiaries.[104]

Since that time all American states have provided a statutory remedy for wrongful death,[105] New York enacting the first such statute in 1847.[106] However, the application of these statutes to the fetus and newborn has been inconsistent.

In 1884, the Supreme Judicial Court of Massachusetts denied recovery for the postnatal death of an infant caused by prenatal

100. W. PROSSER, LAW OF TORTS § 127, at 902 (4th ed. 1971).
101. 1 Camp. 493, 170 Eng. Rep. 1033 (1808).
102. *Id.*
103. S. SPEISER, RECOVERY FOR WRONGFUL DEATH § 1:8, at 28 (4th ed. 1975) (emphasis added).
104. *Id.*
105. *Id.* at Appendix A.
106. *Id.* at 29.

injuries.[107] The mother, who was four to five months pregnant, fell because of a defect in the highway. Because of the fall, she labored prematurely and delivered the infant, who lived for approximately ten to fifteen minutes.[108] The court denied recovery, reasoning that the child was a part of its mother at the time of the injury and therefore not a separate human being.[109]

In 1946, however, a District of Columbia decision[110] was the catalyst for a number of cases which expressly overruled holdings disallowing recovery for prenatal injuries.[111] In this case, the court allowed an infant injured in utero during delivery to recover damages from the negligent physician. The court emphasized the infant's viability, stating:

> As to a viable child being "part" of its mother—this argument seems to me to be a contradiction in terms. True, it is in the womb, but it is capable now of extrauterine life—and while dependent for its continued development on sustenance derived from its peculiar relationship to its mother, it is not a "part" of the mother in the sense of a constituent element—as that term is generally understood. Modern medicine is replete with cases of living children being taken from dead mothers. Indeed, apart from viability, a nonviable foetus is not a part of its mother.[112]

In 1949, the right of a viable stillborn to recover was first recognized.[113] The infant, who was alive at the beginning of labor, died when his mother's uterus ruptured because of the alleged negligence of her physician.[114] Since that time, thirty-five states and the District of Columbia have recognized a cause of action for infants negligently or intentionally killed in utero.[115] Ten states have

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107. Dietrich v. Inhabitants of Northhampton, 138 Mass. 14 (1884).

108. *Id.*

109. *Id.*

110. Bonbrest v. Kotz, 65 F. Supp. 138 (D.D.C. 1946).

111. W. PROSSER AND W. KEETON, PROSSER AND KEETON ON TORTS § 55 at 368 (5th ed. 1984).

112. *Bonbrest*, 65 F. Supp. at 140.

113. Verkennes v. Corniea, 229 Minn. 365, 38 N.W.2d 838 (1949).

114. *Id.* at 366-67, 38 N.W.2d at 839.

115. Alabama: Eich v. Town of Gulf Shores, 293 Ala. 95, 300 So. 2d 354 (1974); Arizona: Summerfield v. Superior Ct., Maricopa County, 144 Ariz. 467, 698 P.2d 712 (1985); Connecticut: Hatala v. Markiewicz, 26 Conn. Supp. 358, 244 A.2d 406 (1966); Delaware: Worgan v. Greggo & Ferrara, Inc., 50 Del. 258, 128 A.2d 557 (1956); District of Columbia: Greater Southeast Community Hosp. v. Williams, 482 A.2d 394 (D.C. App. 1984); Georgia: Porter v. Lassiter, 91 Ga. App. 712, 87 S.E.2d 100 (1955); Idaho: Volk v. Baldazo, 103 Idaho 570, 651 P.2d 11 (1982);

rejected the cause of action,[116] and five states have not considered the question.[117] The scope of the application of statutes allowing recovery ranges from requiring that the fetus be viable, which is the majority rule, to allowing recovery when the fetus is killed at any point after conception.[118]

Courts generally have been willing to interpret wrongful death and other statutes as protecting the unborn, without awaiting clear intent from the legislature. The Supreme Court of Pennsylvania

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Illinois: Crisafogeorgis v. Brandenburg, 55 Ill.2d 368, 304 N.E.2d 88 (1973); Indiana: Britt v. Sears, 150 Ind. App. 487, 277 N.E.2d 20 (1971); Kansas: Hale v. Manion, 189 Kan. 143, 368 P.2d 1 (1962); Kentucky: Mitchell v. Couch, 285 S.W.2d 901 (Ky. 1955); Louisiana: Danos v. St. Pierre, 402 So. 2d 633 (La. 1981); Maryland: State *ex rel* Odham v. Sherman, 234 Md. 179, 198 A.2d 71 (1964); Massachusetts: Mone v. Greyhound Lines, Inc., 368 Mass. 354, 331 N.E.2d 916 (1975); Michigan: O'Neill v. Morse, 385 Mich. 130, 188 N.W.2d 785 (1971); Minnesota: Verkennes v. Corniea, 229 Minn. 365, 38 N.W.2d 838 (1949); Mississippi: Rainey v. Horn, 221 Miss. 269, 72 So. 2d 434 (1954); Missouri: O'Grady v. Brown, 654 S.W.2d 904 (Mo. 1983); Nevada: White v. Yup, 85 Nev. 527, 458 P.2d 617 (1969); New Hampshire: Poliquin v. MacDonald, 101 N.H. 104, 135 A.2d 249 (1957); New Mexico: Salazar v. St. Vincent Hosp., 95 N.M. 150, 619 P.2d 826 (1980); North Dakota: Hopkins v. McBane, 359 N.W.2d 862 (N.D. 1984); Ohio: Werling v. Sandy, 17 Ohio St. 3d 45, 476 N.E.2d 1053 (1985); Oklahoma: Evans v. Olson, 550 P.2d 924 (Okla. 1976); Oregon: Libbee v. Permanente Clinic, 268 Or. 258, 518 P.2d 636 (1974); Pennsylvania: Amadio v. Levin, 509 Pa. 199, 501 A.2d 1085 (1985); Rhode Island: Presley v. Newport Hosp. 117 R.I. 177, 365 A.2d 748 (1976); South Carolina: Fowler v. Woodward, 244 S.C. 608, 138 S.E.2d 42 (1964); South Dakota: Farley v. Mt. Marty Hosp. Ass'n., 387 N.W.2d 42 (S.D. 1986); Tennessee: TENN. CODE ANN. § 20-5-106 (1980); Texas: Lobdell v. Tarrant County Hosp. Dist., 710 S.W.2d 811 (Tex. 1986); Utah: Nelson v. Peterson, 542 P.2d 1075 (Utah 1975) (allows by implication); Vermont: Vaillancourt v. Medical Center Hosp. of Vt., Inc., 139 Vt. 138, 425 A.2d 92 (1980); Washington: Moen v. Hanson, 85 Wash. 2d 597, 537 P.2d 266 (1975); West Virginia: Baldwin v. Butcher, 155 W. Va. 431, 184 S.E.2d 428 (1971); Wisconsin: Kwaterski v. State Farm Mut. Auto Ins. Co., 34 Wis. 2d 14, 148 N.W.2d 107 (1967).

116. Alaska: Mace v. Jung, 210 F. Supp. 706 (D.C. Alaska 1962) (denying a cause of action for a *nonviable* stillborn infant); California: Justus v. Atchison, 19 Cal. 3d 564, 139 Cal. Rptr. 97, 565 P.2d 122 (1977); Florida: Hernandez v. Garwood, 390 So. 2d 357 (Fla. 1980); Iowa: Dunn v. Rose Way, Inc., 333 N.W.2d 830 (Iowa 1983); Montana: Kuhnke v. Fisher, 683 P.2d 916 (Mont. 1984); Nebraska: Egbert v. Wenzl, 199 Neb. 573, 260 N.W.2d 480 (1977); New Jersey: Graf v. Taggert, 43 N.J. 303, 204 A.2d 140 (1964); New York: Endresz v. Friedberg, 24 N.Y.2d 478, 301 N.Y.S.2d 65, 248 N.E.2d 901 (1969); North Carolina: *See* cases *supra* at note 1; Virginia: Lawrence v. Craven Tire Co., 210 Va. 138, 169 S.E.2d 440 (1969).

117. These states are Arkansas, Colorado, Hawaii, Maine, and Wyoming.

118. Alabama, Rhode Island, Louisiana and Pennsylvania allow recovery at any stage of fetal development. *See supra* note 115.

recently recognized a cause of action for the wrongful death of a stillborn. In *Amadio v. Levin*,[119] the parents of Jennifer Amadio brought a negligence suit against her mother's obstetricians under the wrongful death statute, seeking recovery of medical expenses, burial expenses, loss of earnings, loss of enjoyment of life, and physical pain and mental anguish. Jennifer was born dead, a perfectly proportioned seven-pound, eight-ounce full-term infant.[120] The court overruled prior decisions which uniformly required that an infant survive birth to recover.[121] This court recognized that the child was an individual "having existence as a separate creature from the moment of conception."[122] The court noted that limiting the right of action to live born infants made it "more profitable for the defendant to kill the plaintiff than to scratch him,"[123] and that it would "no longer . . . sanction a legal doctrine that enable[d] a tortfeasor who causes death to escape *full* liability, while rendering one whose wrongdoing [was] less severe . . . answerable . . . . "[124]

Similarly, in the case of *O'Grady v. Brown*,[125] the Missouri Supreme Court overruled its previous decisions which held that a fetus was not a "person"[126] for purposes of the Missouri wrongful death statute. In this case, ten days before her due date and after an uneventful pregnancy, Terri O'Grady entered the hospital with severe back pain. Her uterus ruptured after about twenty-four hours and her unborn fetus perished. Mrs. O'Grady and her husband brought suit for their infant's wrongful death against the physicians, hospital, and nurse who cared for her and her fetus, alleging that these defendants had not properly monitored, observed, or treated Mrs. O'Grady or her fetus.[127]

The court rejected the defendants' arguments and held that a viable fetus was a "person" under the Missouri wrongful death statute.[128] The defendants first argued that the wrongful death

119. 509 Pa. 199, 501 A.2d 1085 (1985).

120. *Id.* at 201, 501 A.2d at 1085.

121. *Id.* at 202, 501 A.2d at 1086.

122. *Id.* at 204, 501 A.2d at 1087 (quoting Sinkler v. Kneale, 401 Pa. 267, 273, 164 A.2d 93, 96 (1960).

123. *Id.* at 205, 501 A.2d at 1088 (citing W. PROSSER, LAW OF TORTS § 127 (4th ed. 1971)).

124. *Id.* (emphasis in original).

125. 654 S.W.2d 904 (Mo. 1983) (en banc).

126. *See* State *ex rel* Hardin v. Sanders, 538 S.W.2d 336 (Mo. 1976) (en banc).

127. *O'Grady*, 654 S.W.2d at 906.

128. *Id.* at 910.

statute must be strictly construed because it was in derogation of the common law. The court noted that the word "derogation" was defined as "repealing" or "taking away" and that the wrongful death statute did neither. Rather, the legislature intended the statute to mend the fabric of the common law and intended the court to apply the statutory language in a way that promoted the object of the statute.[129]

The defendants next argued that the fetus was not a person. The court rejected this argument and stated that the word "person" had no plain and ordinary meaning. It was used for different purposes by different disciplines and was even used differently within the law.[130] The court construed the word in accordance with the purposes for which the legislature enacted the wrongful death statute: first, to compensate plaintiffs for their losses; second, to ensure that tortfeasors pay for the consequences of their tortious acts; and, third, to deter harmful conduct.[131] The court determined that "these reasons [applied] with equal force whether the deceased [was] born or unborn."[132] The court noted that *Roe v. Wade* recognized that a state might have a legitimate interest in protecting a fetus and that *Roe* did not require that a state consider a fetus a nonentity. It further noted that regardless of the rights that *Roe* might grant a pregnant woman, a third party tortfeasor did not enjoy those same rights.[133]

The court also looked at the plain meaning of the words "entitled . . . to recover damages . . . if death had not ensued." The court determined that the statute did not condition recovery on

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> Whenever the death of a person results from any act, conduct, occurrence, transaction, or circumstance which, if death had not ensued, would have entitled such person to recover damages in respect thereof, the person or party who, or the corporation which, would have been liable if death had not ensued shall be liable in an action for damages, notwithstanding the death of the person injured, which damages may be sued for [by the spouse, children, parents, brother, sister, descendant, plaintiff *ad litem*]; Provided further that only one action may be brought under this section against any one defendant for the death of any one person.

Mo. Ann. Stat. § 537.080 (Vernon Cum. Supp. 1986).

129. *O'Grady*, 654 S.W.2d at 908.

130. *Id.* at 909.

131. *Id.*

132. *Id.*

133. *O'Grady*, 654 S.W.2d at 910 (quoting Note, *Torts—Wrongful Death—Unborn Child*, 70 Mich. L. Rev. 729, 746-47 (1972)).

whether the decedent could maintain a cause of action at the time of the injury or the time of death,[134] but rather on whether "the person injured would have been entitled to recover . . . *but for* the fact that the injury resulted in death . . . . But for the fact that the injuries resulted in death, the child would have been born [alive] and 'entitled to recover' from respondents."[135]

Furthermore, in response to the defendants' argument that the issue was one for the legislature and not the courts and that the legislature had indicated its satisfaction with prior decisions by not redefining "person," the court reasoned that the drafters expected the cause of action to keep pace with common law developments and that "[a]ny legislative intent to foreclose . . . traditional judicial activity should require positive expression."[136] Finally the court reasoned that it was untenable to deny recovery for the wrongful death of a stillborn in light of modern knowledge regarding fetal development, health and treatment.[137]

Interestingly, Missouri's wrongful death statute and its history is substantially similar to the North Carolina wrongful death statute[138] and its history.[139] Furthermore, Missouri courts based their decisions prior to *O'Grady* on reasoning similar to that used by

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134. *Id.*

135. *Id.* at 910-11 (emphasis in original).

136. *Id.* at 911 (quoting Justus v. Atchison, 139 Cal. Rptr. 97, 104, 565 P.2d 122, 129 (1977)).

137. *Id.*

138. (a) When the death of a person is caused by a wrongful act, neglect or default of another, such as would, if the injured person had lived, have entitled him to an action for damages therefor, the person or corporation that would have been so liable, and his or their personal representatives or collectors, shall be liable to an action for damages, to be brought by the personal representative or collector of the decedent; and this notwithstanding the death, and although the wrongful act, neglect or default, causing the death, amounts in law to a felony . . . .

N.C. GEN. STAT. § 28A-18-2 (1981).

139. Missouri revised its wrongful death statute in 1979 because the courts had not allowed recovery when pecuniary damages were speculative. *O'Grady*, 654 S.W.2d at 907. MO. ANN. STAT. § 537.90 (Vernon Cum. Supp. 1986) expanded the language of the previous statute which provided for such damages as would "fairly and justly compensate" the plaintiff to expressly provide for "loss of . . . services, consortium, companionship, comfort, instruction, guidance, counsel, training, and support" of the decedent, as well as pain and suffering. North Carolina's wrongful death statute underwent a similar revision for precisely the same reason. *See infra* notes 141-53 and accompanying text.

North Carolina courts.[140]

B. The Law in North Carolina Regarding the Wrongful Death Of A Stillborn

The North Carolina Supreme Court has not decided the issue of whether a stillborn has a cause of action under the North Carolina wrongful death statute.[141] In *Gay v. Thompson*,[142] the court determined that it was not necessary "to decide . . . the debatable question as to whether a viable child *en ventre sa mere*, who is born dead, is a person within the meaning of our wrongful death statute."[143]

In *Gay*, the plaintiff alleged that the defendant physician advised his wife, who was eight months pregnant, to enter the hospital and have her labor induced prematurely. He alleged that his wife experienced no complications during her pregnancy and that no medical reason existed for the induction.[144] Dr. Thompson ruptured her amniotic membranes and administered labor-inducing drugs without success for a period of approximately forty-one hours.[145] Mrs. Gay returned home at Dr. Thompson's direction where she developed chills and fever. Dr. Thompson readmitted her to the hospital and she died from an acute uterine infection.[146] Prior to her death, her baby boy died in utero. Plaintiff alleged that Dr. Thompson's negligence was the proximate cause of his son's death and sued for damages in the amount of $50,000.[147]

The supreme court based its denial of recovery on the ground that damages were speculative, stating, "there can be no evidence from which to infer 'pecuniary injury resulting from' the wrongful prenatal death of a viable child *en ventre sa mere*; it is all sheer speculation."[148] It noted that the court had consistently confined recovery to "such damages as are a fair and just compensation for the pecuniary injury resulting from such death."[149]

140. *See O'Grady*, 654 S.W.2d 904.

141. N.C. GEN. STAT. § 28A-18-2 (1981). *See supra* note 138.

142. 266 N.C. 394, 146 S.E.2d 425 (1966).

143. *Id.* at 402, 146 S.E.2d at 431.

144. M.KLAUS & A. FANAROFF, *supra* note 61, at 420, listing premature rupture of membranes as a high risk factor.

145. *Gay*, 266 N.C. at 395, 146 S.E.2d at 425-26.

146. *Id.*

147. *Id.*

148. *Id.* at 400, 146 S.E.2d at 429.

149. *Id.* at 398, 146 S.E.2d at 428, (referring to N.C. GEN. STAT. §§ 28-173 and

Since that time, the legislature has enacted North Carolina General Statutes Section 28A-18-2,[150] correcting the deficiencies in the old law and precluding the possibility that difficulties in proving damages would be a bar to recovery. The legislature stated its purpose in rewriting the act as follows:

> WHEREAS, human life is inherently valuable; and WHEREAS, the present statute is so written and construed that damages recoverable from a person who has caused death by a wrongful act are effectually limited to such figure as can be calculated from the expected earnings of the deceased, which is far from an adequate measure of the value of human life . . . .[151]

"[T]he enactment eliminated any basis for ever dismissing a wrongful death claim on the ground that no damage resulted . . . ."[152]

Significantly, the purpose of the statute recognizes the value of "human life" and does not specifically use the word person, implying that a fetus would fall within the act's protection. However, in 1978 Judge Phillips wrote, "But the few cases involving the 1969 damages act that our appellate courts have decided are rather disturbing, as they clearly indicate that the act is not going to have nearly the broad sweep that the legislature intended."[153]

Since the revision of the North Carolina wrongful death statute, the North Carolina Court of Appeals has considered on three occasions the issue of whether the wrongful death statute protects a stillborn: in 1975, in the case of *Cardwell v. Welch*;[154] in 1976, in the case of *Yow v. Nance*;[155] and, in 1986, in the case of *DiDonato v. Wortman*.[156]

In *Cardwell*, the plaintiff sought to recover for the wrongful death of his stillborn child, conceived seven months earlier, who

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28-174 as originally written).

150. *See supra* note 138.

151. 1969 N.C. Sess. Laws 194.

152. Phillips, *The North Carolina Wrongful Death Law—A Brief Summary*, N.C. ACAD. OF TRIAL LAWS. WRONGFUL DEATH 1, 4 (1978).

153. *Id.* at 5. Note the similarity between the history of the North Carolina wrongful death statute and the Missouri wrongful death statute; *See supra* note 139.

154. 25 N.C. App. 390, 213 S.E.2d 382, *cert. denied*, 287 N.C. 464, 215 S.E.2d 623 (1975).

155. 29 N.C. App. 419, 224 S.E.2d 292, *disc. review denied*, 290 N.C. 312, 225 S.E.2d 833 (1976).

156. 80 N.C. App. 117, 341 S.E.2d 58 (1986).

allegedly died from injuries sustained in a motor vehicle collision caused by the defendant's negligence.[157] The trial court dismissed the action, holding that the child was not a "person" under the wrongful death statute.[158]

The court of appeals agreed, basing its decision on three grounds. First, the court determined from the wording of the statute that the legislature did not intend to protect an unborn child. It reasoned that the legislature easily could have expressly included the fetus within the statute's protection. It focused on the words "person" and "decedent" stating, "[c]ertainly, in common understanding a 'person' is one who has a separate identity as such, and to become a 'decedent' one must first have been born."[159] Next, the court of appeals based its decision on practical considerations. While recognizing that parents of a stillborn may suffer "intense anguish",[160] it reasoned that the born alive rule had the merit of providing a degree of certainty.[161] Finally, the court supported its decision with decisions from nine other jurisdictions which failed to hold that their wrongful death statutes protected stillborns.[162] Since *Cardwell*, three of these states have recognized a cause of action for the wrongful death of a stillborn.[163]

In *Yow v. Nance*,[164] the plaintiff sued for the death of a near full-term fetus who was killed as a result of an accident.[165] The court of appeals summarily dismissed the action by quoting two paragraphs from *Cardwell*.[166] The Supreme Court of North Carolina refused to review either *Yow* or *Cardwell*.[167]

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157. *Cardwell*, 25 N.C. App. at 390, 213 S.E.2d at 382.

158. *Id.* at 391, 213 S.E.2d at 382.

159. *Id.* at 392, 213 S.E.2d at 383. *But see*, N.C. GEN. STAT. §§ 130A-112 to 130A-115 (Cum. Supp. 1985), which includes fetuses of twenty weeks and more in the requirements that deaths be registered and that permits be obtained for burial-transit, cremation, disinternment, and reinternment.

160. *Cardwell*, 25 N.C. App. at 392, 213 S.E.2d at 383.

161. *Id.* at 393, 213 S.E.2d at 384. *But see infra* text at Section VI.

162. *Cardwell*, 25 N.C. App. at 393, 213 S.E.2d at 384.

163. Leccese v. McDonough, 361 Mass. 64, 279 N.E.2d 339 (1972) and Carroll v. Skloff, 415 Pa. 47, 202 A.2d 9 (1964) have been overruled. Tennessee expressly included the fetus within the protection of its wrongful death statute. *See supra* note 115.

164. 29 N.C. App. 419, 224 S.E.2d 292, *disc. review denied*, 290 N.C. 312, 225 S.E.2d 833 (1976).

165. *Id.*

166. *Id.*

167. *See* cases at *supra* notes 154-55.

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Recently, in the first reported case regarding the wrongful death of a stillborn since 1976, the North Carolina Court of Appeals again refused to allow recovery. In *DiDonato v. Wortman*,[168] the father of Joseph Edward DiDonato brought suit against his wife's obstetrician. According to the plaintiff, Mrs. DiDonato had been a patient of Dr. Wortman's since 1973. She initially contacted him because of her inability to conceive. During the next eight years Mrs. DiDonato's continued efforts to become pregnant under Dr. Wortman's care were unsuccessful. Mr. DiDonato had even undergone minor urological surgery to enhance the chance of conception.[169]

Mrs. DiDonato finally became pregnant in 1982 at the age of thirty-six.[170] Dr. Wortman calculated her due date as October 10, 1982. Dr. Wortman was aware that Mrs. DiDonato had a family history of diabetes, as well as a personal history of infertility.[171] On each of six consecutive visits, Mrs. DiDonato had sugar in her urine.[172] In spite of her infertility, her age, her family history of diabetes, and the persistent spilling of sugar in her urine,[173] Dr.

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168. 80 N.C. App. 117, 341 S.E.2d 58 (1986).

169. Brief for Appellant at 8, DiDonato v. Wortman, 80 N.C. App. 117, 341 S.E.2d 58 (1986).

170. *Id.*

171. *Id.*

172. *Id.* Mrs.DiDonato's history of prolonged infertility, her age, and the fact that she was pregnant for the first time (an elderly primipara) contributed to a classification of high-risk. *See* M. KLAUS & A. FANAROFF, CARE OF THE HIGH-RISK NEONATE 418-19 (2d ed. 1979); K. NISWANDER, MANUAL OF OBSTETRICS 32 (2d ed. 1983).

173. Sugar in the urine is a sign of diabetes. Maternal diabetes also results in a classification of high-risk. *Id. See* J. NEESON & C. STOCKDALE, THE PRACTITIONER'S HANDBOOK OF AMBULATORY OB/GYN 111-17 (1981).

> It is generally accepted that diabetes (or susceptibility to diabetes) is transmitted genetically. However, the specific mode of inheritance is unknown and probably multifactoral. Historical and clinical factors known to be associated with diabetes in pregnancy are:
>
> —History of stillborn or malformed infants
> —History of macrosomic infants (over 4,000g)
> —Family history of diabetes
> —History of recurrent pre-eclampsia-eclampsia
> Other complications of pregnancy . . .
> —Glycosuria [sugar in the urine] in pregnancy (usually defined as glycosuria occurring on two or more occasions).

Id. at 112-13. *See id.* at 114-15 for "Management & Treatment." *See also,* E. BISHOP & D. BISHOP, PERINATAL MEDICINE: PRACTICAL DIAGNOSIS AND MANAGEMENT 78-85 (1982).

Wortman made the notation of "no risk" on her records and never investigated the possibility of gestational diabetes. The infant was alive on October 10th, the due date, and on October 25th, when at Mrs. DiDonato's insistence, a nonstress test was conducted.[174] On October 30th, twenty days after her due date,[175] Mrs. DiDonato delivered a stillborn twelve-pound, eleven-ounce male infant by cesarean section.[176]

The court of appeals followed its previous decisions, holding that a child must be born alive to be recognized as a person within the meaning of the North Carolina wrongful death statute.[177] The court traced the history of the issue in North Carolina and found that "the creation of a right of action for wrongful death of an unborn fetus was an appropriate subject for legislative action, not

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> Successful management depends not only on expert obstetric and pediatric care by physicians knowledgeable regarding the special problems of this disease, but also on the availability of essential equipment, including laboratory, sonographic monitoring, and neonatal intensive care facilities. *The quality of outcome is directly related to early diagnosis, meticulous control of maternal glycemia* [sugar in the blood], *early recognition of maternal complications, constant evaluation of fetal condition, careful selection of the time and method of delivery, and expert evaluation and care of the neonate . . . . Unless other complications arise, the pregnancy of the gestational diabetic can be continued to term, but not beyond.* However, because there is some increased perinatal risk with this complication, the fetal condition should be monitored meticulously throughout the last weeks of pregnancy . . . .

Id. at 80. (emphasis added). *See also*, S. KORONES, HIGH-RISK NEWBORN INFANTS 24 (2d ed. 1976) for a list of high-risk factors. "Neonatal mortality and morbidity are significantly greater among diabetic gravidas." *Id.*

174. Brief at 4, *DiDonato*, 80 N.C. App. 117, 341 S.E.2d 58 (1986). A nonstress test (NST) and an oxytocin challenge test (OCT) are methods of evaluating a fetus's ability to withstand the stress of labor by monitoring its heart rate with (OCT) or without (NST) oxytocin, a medication which causes the uterus to contract. *See*, J. QUEEN, MANAGEMENT OF HIGH-RISK PREGNANCY 567-70 (2d ed. 1985).

175. "Perinatal mortality and morbidity are two to three times higher in prolonged pregnancies than in gestations of normal length." J. NEESON & C. STOCKDALE, *supra* note 173, at 419.

176. Brief at 4, *DiDonato*, 80 N.C. App. 117, 341 S.E.2d 58 (1986).

177. *Yow*, 29 N.C. App. 419, 224 S.E.2d 292, *disc. rev. denied*, 290 N.C. 312, 226 S.E.2d 833 (1976); *Cardwell*, 25 N.C. App. 390, 213 S.E.2d 382, *cert. denied*, 287 N.C. 464, 215 S.E.2d 623 (1975). *See also* Azzolino v. Dingfelder, 315 N.C. 103, 337 S.E.2d 528 (1985), *cert. denied*, ___ U.S. ___, 107 S. Ct. 131 (1986), in which the North Carolina Supreme Court held that there was no cause of action for wrongful birth or wrongful life. These decisions significantly immunize health care providers from their negligence in the treatment of women and fetuses.

judicial construction."[178] Judge Phillips dissented on the basis of the statute's legislative history, opining that the legislature intended the statute to apply to all "human beings wrongfully killed in the state."[179]

In *O'Grady v. Brown,*[180] the Missouri Supreme Court addressed many of the grounds upon which the North Carolina Court of Appeals based its opinions. North Carolina should look to *O'Grady* for guidance. While North Carolina has not recognized a fetus as a person entitled to the unlimited protection of the North Carolina Constitution,[181] it has recognized that the state has a legitimate interest in protecting the fetus by enacting anti-abortion laws,[182] and in *Perry v. Cullipher,*[183] the court of appeals rejected the argument that a stillborn was not a deceased person in an action for the desecration of a grave. Another consideration is that the plain and ordinary meaning of the word "person" could certainly include the fetus. Furthermore, as discussed in the next section, live birth is not truly a well-defined line of demarcation.[184]

Clearly, a viable human fetus is a human being and falls within the expressed purpose of the wrongful death act. The time has come for North Carolina to abandon its minority position, discard the born alive rule, and adopt a standard consistent with the views of society and the current state of scientific knowledge.

VI. EXAMINING STANDARDS

Opponents of recovery argue that discarding the born alive rule would replace a well recognized line of demarcation with a vague and arbitrary concept. In reality, the born alive rule is also vague.

The first area of ambiguity is that of when a child is "born." A legal definition of the word "born" has not been explicitly established. The born alive standard can produce some unconscionable

178. *DiDonato*, 80 N.C. App. at 119, 341 S.E.2d at 59.

179. *Id.* at 121, 341 S.E.2d at 61.

180. 654 S.W.2d 404. *See also* notes 125-40 and accompanying text.

181. Stam v. State, 47 N.C. App. 209, 267 S.E.2d 335 (1980), *aff'd in relevant part*, 302 N.C. 357, 275 S.E.2d 439 (1981).

182. N.C. GEN. STAT. §§ 14-44, 45, 45.1 (1981).

183. 69 N.C. App. 761, 318 S.E.2d 354 (1984). Although the court rejected the defendant's argument, it did not expressly hold that a fetus is a person.

184. *See* Turner v. Battle, 175 N.C. 219, 95 S.E. 362 (1918), stating that North Carolina recognizes a presumption that a child was alive when born.

results, as illustrated earlier,[185] in terms of defining "born." Is an infant who is stabbed or strangled or whose throat is cut before birth of the body, "born" at the time of the killing? Or is it only born upon birth of the entire body? Consider the breach baby whose entire body is born, but whose head is undelivered. If this infant dies before birth of the head, was it nonetheless "born?" Consider, also, the infant being delivered by cesarean section who cries in utero, before any body part passes through the incision. Surely, an infant who has breathed and cried is a "live birth" in spite of the fact that it is not yet "born." Such situations are not uncommon and the law should not ignore them.

The live birth rule creates other unpalatable results. For example, an infant at twenty weeks gestation, with no chance of survival, may be born with a heart rate and may gasp once and be allowed to recover under the wrongful death statute. But a normal full term infant of forty weeks, who was alive only moments before birth, and the at risk infant, who dies in utero three weeks after his due date, will be denied recovery.

Another ambiguity lies in the question, "What is alive?" Courts and legal scholars fail to recognize that the legal definition and the medical definition may vary considerably. Is an infant with a heart rate, but no respiratory effort, alive? This situation frequently occurs with infants of very young gestational age. Is mere electrical cardiac activity, visible through the chest wall or by EKG, an indication that the infant is alive, although such cardiac activity is ineffective and incapable of sustaining life? Whether to resuscitate is a judgment call.[186] Should a stillborn who was a candidate for resuscitation be denied a cause of action simply because resuscitative efforts were not pursued?

Medical personnel use Apgar scores[187] as a quick method of determining the well-being of a newborn. They evaluate the infant at one minute and at five minutes after birth of the entire body. Five areas of evaluation are used to determine the score—heart rate, respiratory effort, color, reflex irritability, and muscle tone. An experienced physician or nurse can generally evaluate an infant and assign an Apgar score in a matter of seconds. If the infant is in

185. *See supra* notes 73-77 and accompanying text.

186. The decision not to resuscitate, may be based, among other things, on gestational age, the degree of hypoxia experienced in utero, defects that are incompatible with life, and the overall condition of the infant.

187. M. KLAUS & A. FANAROFF, *supra* note 61, at 11.

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poor shape at birth, medical personnel generally institute resuscitative measures immediately. The heart rate, which usually remains after other signs of life have disappeared, may be evaluated for only a few seconds, or may not be evaluated at all. If the heart rate is very slow, it may not be heard. If it is absent, or not evaluated, it will not be heard. Who then, determines whether the infant was born alive? If the infant was truly without life, but is resuscitated and then dies, as frequently happens, was it born alive? If so, and the statute imposes liability on a negligent physician, midwife, or nurse only for live births, they have no legal incentive to resuscitate such an infant.

Other incentives exist for labeling an infant stillborn. Medical personnel feel less of a sense of failure at the death of a fetus in utero than at the inability to resuscitate and stabilize an infant barely alive at birth. Statistically, a stillborn may "look better" on paper than a nursery death. Although the legal and medical definitions of stillborn may differ, situations exist where a medical label of stillborn determines whether a legal cause of action exists.[188]

The viability standard itself can be vague. Jurisdictions adopting a cause of action for the wrongful death of a stillborn based on viability use the term inconsistently. Some states consider viability to be the point at which a fetus, if the pregnancy were to continue until term, would have a ninety-nine percent chance of survival. The state may set this point at twenty weeks. An infant born at twenty weeks, however, has no chance of survival, and therefore is not viable when the word is given its ordinary meaning.[189]

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188. Once, this author attended an emergency cesarean section for an infant whose umbilical cord had prolapsed through the mother's cervix and into the vagina. An infant cannot be born vaginally when the cord has prolapsed because the cord would be compressed and would cut off the blood supply and oxygen to the infant. This infant was born limp and blue and vigorous resuscitative measures were initiated—including intubation, umbilical catheterization, and intracardiac drugs. The efforts were unsuccessful, yet after fifteen to twenty minutes when resuscitation was terminated, cardiac activity was visible through the infant's chest wall. The physician labeled the infant stillborn. Had there been a question of negligence, the medical label of stillborn would have barred recovery.

189. Definitions of viable vary. It is defined as "able to live; specifically, . . . at that stage of development that will permit it to live and develop under normal conditions, outside of the uterus." WEBSTER'S NEW TWENTIETH CENTURY DICTIONARY UNABRIDGED 2035 (2nd ed. 1979); "livable; . . . such a state of organic development as to make possible the continuance of its life," BLACK'S LAW DICTIONARY 1404 (5th ed. 1979); "denoting a fetus sufficiently developed to live outside of the uterus," STEDMAN'S MED. DICTIONARY 1551 (4th ed. 1976). *See also* Alistair, Little,

Twenty weeks is also the point at which, barring unusual circumstances, abortions in North Carolina are no longer legal.[190] A viability standard of twenty weeks is too rigid and can run afoul of *Roe v. Wade* by failing to provide a clear line for determining when maternal rights cease to outweigh fetal rights. Theoretically, a twenty week viability standard provides a clear line of demarcation. Practically, however, it will chill maternal rights because of the perceived overlap of viability and the right to abort.

All but the most extreme recognize that the point of personhood is unknown.[191] Philosophers, physicians, religious leaders, and the public in general cannot agree among themselves. As we learn more about the fetus, ideas about personhood may be less diverse. In the meantime, the law should leave some room to accomodate this unknown. A woman should not be allowed to abort a fetus one day and have a cause of action for the fetus's death on the next day. Nor should a woman be able to sue the drunken driver who kills her fetus as she is on her way to have an abortion. Similarly, the father of an aborted first trimester fetus should not have a cause of action against the mother who exercises her constitutional right.

Such results are possible if a cause of action for wrongful death exists from the point of conception. Additionally, before we are sure of the point at which personhood begins, the law should avoid decisions which will grant frozen embryos and test tube fertilizations legal rights.[192]

The appellees' brief in *DiDonato* states, "A viable fetus does not exist independently of its mother prior to its birth, it merely has the potential to do so. A zygote at any point after conception has the same potential."[193] While potential to exist independently is omnipresent, the law must distinguish between potential to sur-

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Polivy, & Lucey, *Neonatal Mortality Risk for the Eighties: The Importance of Birth Weight/Gestational Age Groups*, 68 PEDIATRICS 122 (July 1981).

190. N.C. GEN. STAT. § 14-45.1 (1981).

191. *See Human Life Bill: Report on S. 158 Before the Subcomm. on the Separation of Powers of the Senate Comm. on the Judiciary*, 97th Cong., 1st Sess. 33-53 (1981) (testimony of Leon E. Rosenberg, M.D., April 24, 1981).

192. Donovan, *When Does Personhood Begin?*, 15 FAM. PLAN. PERSP. 40, 43 (1983).

193. Brief for Appellee at 9, DiDonato v. Wortman, 80 N.C. App. 117, 341 S.E.2d 58 (1986).

vive and ability to survive.[194] A twenty week viability standard, as well as a standard which would protect the fetus from conception forward, speaks to potential, not to ability.

When considering the ability to survive, one must also consider the many variables involved. These variables include the infant's genetic makeup, where it is born, how long it must survive, and whether it requires the use of artificial aid.[195] A thirty-two weeker may survive nicely with support only for warmth and feedings. A twenty-eight weeker generally needs prolonged and complex intensive care, and still has a relatively high degree of morbidity and mortality. A twenty-two weeker may survive for several minutes with vigorous resuscitative measures.

Generally, the medical community considers an infant of twenty-six weeks viable, however a lack of consensus exists regarding the gestational age when an infant is absolutely too immature to survive. According to Dr. Jim Thullen,[196] most neonatologists would aggressively treat infants with an estimated gestational age of twenty-six weeks or more and a birthweight of at least 700 to 750 grams. Most centers report a high mortality rate at gestational ages less than twenty-six weeks and birthweights less than 700 grams. Of those infants who do survive, many suffer major handicaps, such as mental retardation, cerebral palsy, blindness, and deafness, as well as minor handicaps, such as learning disabilities and poor growth patterns.

Granted, the mortality rate for premature infants has decreased in the last decade, as has the morbidity rate.[197] However, reluctance to find a cause of action based on viability because of the possibility that the point at which fetuses may be able to develop and grow outside of the uterus may eventually occur at con-

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194. Jones, *Fetal Brain Waves and Personhood,* 10 J. MED. ETHICS 216, 216-17 (1984).

195. Fost, *The Limited Moral Significance of 'Fetal Viability',* 10 HASTINGS CENTER REP. 10, 11 (1980).

196. Dr. Thullen is a neonatologist at Wake Medical Center in Raleigh, North Carolina, and an Associate Professor of Pediatrics at the University of North Carolina School of Medicine.

197. *See* Alistair, Little, Polivy, & Lucey, *Neonatal Mortality Risk for the Eighties: The Importance of Birth Weight/Gestational Age Groups,* 68 PEDIATRICS 122 (July 1981). Note that in this article, mortality rates for infants weighing less than 750 grams range between 75% to 100%. For a table correlating gestational age and weight, *see* J. KATTWINKEL *et al,* COMPLEX NEWBORN CARE 104 (1979) (adapted from Lubchenco, Hansman, & Boyd, 37 PEDIATRICS 403 (1966) and Battaglia & Lubchenco, 71 J. OF PEDIATRICS 159 (1967)).

ception is unfounded, especially if the term is well-defined. The likelihood of viability and conception colliding at any time in the near future is slight. Rights cannot be denied because of a contingency that may never occur. But, more importantly, if the law is to be trusted and respected, it should remain fluid and adapt to society as needed to ensure justice.

In determining how to define viability, we must consider the rights of women, the stage of development of the fetus, and the attachment process. A holding that viability occurs at twenty-six weeks would coincide with the definition given by medical experts. It encompasses an age when fetuses have demonstrated higher brain function, a most significant attribute of personhood. It would also provide some leeway between the twenty week abortion limit and the time when the law provides protection for fetal life. Furthermore, it would coincide with a time in pregnancy when maternal attachment is generally well-established, abortion is no longer a medical, maternal, or legal option, and the loss of an infant is most difficult to resolve.

Although a gray area in terms of the legal status of the fetus would exist in the period from twenty to twenty-six weeks, lawmakers can rest assured that it is truly a gray area in terms of science, unlike the law now, which completely disregards knowledge about the capabilities of fetuses, the bonding process, the grieving process, and the realities of the importance of the viable fetus today. North Carolina can justify the denial of a cause of action to those fetuses between twenty and twenty-six weeks, particularly if it allows a cause of action for the wrongful deaths of those infants from twenty-six to forty-plus weeks.

VII. CONCLUSION

Philosophically, the time has come for North Carolina to take a stand on the point in time at which it will protect a fetus. No one can deny that a person has committed a serious wrong when he negligently or intentionally kills a fetus in the last trimester. Without a doubt, the fetus and the mother suffer, and in North Carolina, the tortfeasor escapes liability.

The law of North Carolina provides redress for many wrongs, yet it does not provide redress for one of the greatest losses suffered by women and by many men, a loss that is quite difficult to resolve—the loss of the life of a wanted child. North Carolina Courts may do justice by allowing a cause of action for the wrongful death of a stillborn by acquiescing to legislative intent and by

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fulfilling the traditional role of courts. As Chief Justice Stone so aptly stated:

> If, with discerning eye, we see differences as well as resemblances in the facts and experiences of the present when compared with those recorded in the precedents, we take the decisive step toward the achievement of a progressive science of law. If our appraisals are mechanical and superficial, the law which they generate will likewise be mechanical and superficial, to become at last but a dry and sterile formalism.
>
> It is just here, within the limited area where the judge has freedom of choice of the rule which he is to adopt, and in his comparison of the experiences of the past with those of the present, that occurs the most critical and delicate operation in the process of judicial lawmaking. Strictly speaking, he is often engaged not so much in extracting a rule of law from the precedents, as we were once accustomed to believe, as in making an appraisal and comparison of social values, the result of which may be decisive weight in determining what rule he is to apply. The skill, resourcefulness and insight with which judges and lawyers weigh competing demands of social advantage, not unmindful that continuity and symmetry of the law are themselves such advantages, and with which they make choices among them in determining whether precedents shall be extended or restricted, chiefly give the measure of the vitality of the common-law system and its capacity for growth.
>
> The absence of precedent should afford no refuge to those who by their wrongful act, if such be proved, have invaded the right of an individual . . . . And what right is more inherent, and more sacrosanct, than that of the individual in his possession and enjoyment of his life, his limbs and his body?[198]

*Susan D. Crooks**

198. Bonbrest v. Kotz, 65 F. Supp. 138, 142 (D.D.C. 1946) (quoting Stone, *Common Law and the United States*, 50 HARV. L. REV. 4-7 (1936)).

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