Should Mom be Constrained in the Best Interests of the Fetus?

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Abstract

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KEYWORDS: fetus, mom, constrained
Should Mom be Constrained in the Best Interests of the Fetus?*

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I. Introduction

There is a growing judicial conundrum. Should pregnant women be compelled to act in the best interests of their fetuses? Judges are undoubtedly familiar with the issue of whether a woman should be compelled to deliver by cesarean section if the procedure is considered to be in the best interest of her fetus, but conflicts between maternal and fetal interests also arise in other settings. Two recent cases from my own jurisdiction, the District of Columbia, illustrate these conflicts.

In re A.C.* involved a dying pregnant woman, Angela Carder, and her twenty-six and one half week old fetus. Angela was diagnosed as suffering from cancer at the age of thirteen and underwent extensive treatment. She later married. At age twenty-six, believing her cancer to be in remission, she became pregnant. When her fetus was approximately twenty-six weeks of age, Angela suffered a recurrence of the cancer which eventually proved to be fatal. The hospital where she was being treated requested a declaratory judgment for guidance about what to do concerning the fetus. The trial court held that a cesarean should be performed. The trial court order was appealed but a panel of the District of Columbia Court of Appeals rejected a request for stay of the order. The surgery was performed. A baby girl died two hours after surgery. Angela died two days later. Several months later the

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** Professor, Georgetown University Law Center; J.D., 1969, Harvard University Law School. This commentary is the product of a long dialogue between Dean Judith Arnet, to whom I owe special thanks, and myself. We started discussing these issues and trading drafts in 1984 when we were both pregnant. This issue is very complex and it is not surprising that our views have changed many times since then.


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panel issued a written opinion affirming its earlier decision. On March 17, 1988, the full court vacated the panel’s opinion and granted rehearing en banc. No decision has been entered to date.

On February 5, 1988, Brenda Vaughan was arrested on charges of uttering after forging a check against her employer who had previously paid for a private drug rehabilitation program to help her overcome her addiction. She pled guilty to a lesser charge of second degree theft. Despite a prosecutor’s recommendation of probation, she was sentenced to jail for one hundred and eighty days because she tested positive for cocaine, and she was pregnant. Her sentence was subject to a motion to reduce the time to be served after the baby’s birth. In a memorandum the judge stated,

The court has not ignored Vaughan’s rights as a woman in this case; it has weighed her rights as a defendant in a reckoning of all the factors . . . and concluded that protection of the public counted more heavily. In this judge’s mind that “public” included an unborn child and the taxpaying public . . . .”

Brenda Vaughan was released on September 14, 1988 to await the birth of her baby. The judge, during an interview with the Washington Post at the time of Vaughan’s release said,

[The controversy over Brenda Vaughan seems to have hit a well spring of something that has not been openly discussed for too long. And whether my decision with respect to her was right or wrong, it’s high time that these things were discussed and responsibly allocated.”

I agree!

Before I go further — a caveat. It is extremely difficult to present neutrally the issues involved in conflicts between maternal and fetal interests. This issue implicates deeply held values about women, family and the status of the fetus. Do not be surprised, therefore, if I do not elaborate on the views of the many commentators with approaches to these matters different from my own.

Most commentators, particularly legal commentators, tend to approach the subject of conflict between fetal and maternal interests as a question of rights. Some commentators conclude that the mother’s rights should prevail in all circumstances. Others conclude that fetal rights should have priority. A few have argued that an effort should be made to balance the interests of mother and fetus according to a prescribed set of factors to be applied case by case.

I start at a slightly different point and focus not on the rights of the parties involved but rather on the connections between prospective parents and the fetus, between the pregnant woman and the fetus in particular. By focusing on the relationship, I am able to consider what obligations, if any, prospective parents owe the fetus. It seems to me that the decision to have a child puts the decisionmaker into a parentlike relationship. Moreover, at least one prospective parent and the fetus are physically and emotionally linked. I prefer this approach because the interests of prospective parents and the fetus are not posed as being distinct and possibly conflicting. By focusing on roles and relationships between prospective parents and fetuses, we capture the complexity of the interaction rather than concentrating our attention on individuals only.

I begin, therefore, with an examination of the moral duties a parent, specifically a pregnant woman, might owe to the fetus. I next ask, if we conclude that the pregnant women has a moral obligation to the fetus, does it follow that she ought to have a legal obligation as well? I conclude that both mothers and fetuses have interests that are important and should be respected, but that other societal values are decisive in deciding that law should not constrain women to act in the best interests of their fetus contrary to their preferences in matters of medical treatment and lifestyle.

II. What Moral Obligation, If Any, Does A Pregnant Woman Owe Her Fetus?

It seems that mothering has long been celebrated as the paradigm benevolent relationship between human beings. Even though we think of mothering in such a special way, it is surprising to find that we re-

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ally have spent very little time considering the nature and scope of the mother-fetal relationship except in the context of abortion.

In part, we have not spent a great deal of time talking about the maternal-fetal relationship because of the inaccessible nature of the fetus and our lack of data about fetal development. New scientific and technical developments have produced, however, a wealth of information about how a woman and the acts that she takes or omits to take, can affect the fetus. If one were to peruse some of the literature about fetal development and therapies to ameliorate or avoid disabilities in fetuses, one would get a list that looks a little bit like the following:

- Eat a balanced diet.
- Take vitamins.
- Obtain prenatal care. Do not smoke and avoid spending time in a room with somebody who does smoke.
- Do not drink alcohol.
- Avoid all over the counter drugs and all prescription drugs.
- Do not use abusive substances of any kind.
- If necessary, as in the case of mothers who have phenylketonuria, return to a highly restrictive and very unpleasant diet.
- Avoid unnecessary exercise.
- Avoid certain workplaces, as an example, where X-rays are used.
- Avoid sexual intercourse with her spouse or lover, if recommended by her physician.
- Do not travel late in pregnancy.
- Stay in bed for the duration if need be.
- Agree to surgery if it is in the interest of the fetus.
- Agree to cesarean delivery, if recommended.
- Agree to stay hooked to life support, in the case of brain death, in the interests of the fetus.
- Decline to terminate lifesaving procedures, if terminally ill.


9. Many states have natural death acts which permit competent adults to specify, within a given set of conditions, how they would like to be treated if terminally ill with

This list does not begin to exhaust all the things that a pregnant woman might do or not do in order to benefit her fetus.

In considering whether a pregnant woman has obligations to her fetus, there are several things to note about this list, in addition to its length. First, the list implicates everything a pregnant woman does, from the time she gets up in the morning until the time she goes to bed at night. Second, it touches on the most private kinds of behavior, including the sexual relationship with her spouse or lover, not just what she does in public or at work, but also what she eats and how, or whether, she moves. Third, this list leaves little room for a mother's own needs and normal desires and preferences. She may not attend to the needs of her spouse, her other children or her parents. We might, and indeed we do, admire a pregnant woman who follows the "ideal" list, but it is equally likely that we would find fault or blame if her dedication to her developing fetus led her entirely to disregard her other obligations to family and co-workers.

Fourth, to comply with the mandate would be asking too much of any pregnant woman. We would be asking her to be a saint. If she chose to be a saint, that would be commendable. Requiring her to be a saint is something else. The possibility of being a saint is not something that is peculiar to pregnant women. We could all be saints. Yet, we do not require sainthood of ourselves. And, we could all do more. We could save the life of one child per year by providing food, or save the life of one homeless person by providing shelter. Even if we saved one life, with greater effort we could save two. Most of us do not believe that we are required to do that much. Impositions on a pregnant woman's time, liberty of action, economic resources and her own needs could well approach the level we would not require of ourselves.

The fact that a pregnant woman might not be required to do everything on the list does not mean that we cannot require of her some of the things on the list. But how to distinguish among the items? There is a range of conduct that we might try to distinguish. Requiring that harm or evil not be inflicted is different from requiring that harm or evil be removed. The proposition that we have a greater obligation to respect to life support systems. Many of these statutes do not permit, however, a pregnant woman to make such decisions.

10. William Frankena, for example, has suggested that the principle of beneficence encompasses four distinct elements: (1) One ought not to inflict evil or harm, (2) One ought to prevent evil or harm, (3) One ought to remove evil and (4) One ought to do or promote good. FRANKENA, ETHICS 47 (2nd ed. 1973).
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Do not travel late in pregnancy.

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refrain from causing harm than to promote good finds support in common notions of morality as well as law. In thinking about what is required, we might take account of several factors. We might consider the degree of risk that we would require of a pregnant woman and the degree of risk to the fetus if action were not taken. We might take into account requirements based upon actions or omissions to act. We might compare what we would require of pregnant women with what we do require of parents with respect to their children. With respect to this latter consideration, it is worth noting that we have no consensus on the nature and extent of obligations of parents to existing children. For example, would we require that a parent donate a kidney to his/her child if that were the only hope for the child? Finally, we might take account of the obligations a pregnant woman owes to others and herself when considering the obligations owed to her fetus. Jeffrey Blustein notes:

The interests child rearers have in raising children are limited not only by social interests and children's interests but by the child rearers' interests in being free to engage in other, unrelated activities. Child rearers cannot be completely defined by their role as child rearers. Usually they wish to pursue other desires and interests that are quite independent of child rearing. But if the child rearers perceive the raising of their children as an overwhelming burden which makes it impossible to pursue these other desires and interests, child rearing becomes intolerable and they are likely to become resentful of their children. Hence, children too have an interest in their rearers being free to pursue other desires and interests.11

Blustein's analysis underscores the difficulty of imposing moral duties on a person who must carry them out day in and day out, all day long as well. This is especially important to bear in mind when discussing obligations of pregnant women. They might be encouraged to exercise their legal option to terminate pregnancy if their obligations become too burdensome.

In summary then, we might agree that pregnant women have moral obligations to the fetuses that they carry. We could probably all agree that she should not be required to be a saint. But we would have difficulty in defining with precision what the scope of that obligation should be in part because we have not yet worked out an adequate account of what parental obligations should be. We turn then to ask, in view of our conclusions about a pregnant woman's moral obligations and their scope, what, if anything, law should require of pregnant women.

III. What Ought Law to Require of Pregnant Women?

If one takes the position that a woman has some moral obligation to act in the best interests of her fetus, does it follow that law, both judge-made and legislative statutory law, ought to require a woman to do or fulfill her moral obligation? A way of thinking about this is to say, why of course, the law ought to follow morality. Making moral obligations legal obligations, is a good and useful way for courts in our society, to coerce the least willing members of the community to conform to a moral norm. Moreover, the relationship between a pregnant woman and fetus is analogous to the relationship between parent and child where the law does indeed impose legal obligations. Perhaps the need for legal intervention is even stronger in the case of a fetus that is particularly vulnerable and dependent and in a position where no other person other than the pregnant woman can supply needed assistance. It is, in short, not difficult to understand why judges, faced with the conflict between a pregnant woman and her fetus, all too often have decided that the pregnant woman and her interests should be constrained in the best interests of her fetus.

Let me suggest that the matter is more complicated. There are other, and perhaps even compelling, reasons for not constraining a pregnant woman's interests.

I suggest that there are two categories of considerations that deserve our attention. For the sake of simplicity I designate these categories as equity concerns and privacy concerns. In privacy considerations, I group together the autonomy and privacy concerns of the pregnant woman and the distinct privacy concerns of the family of which the pregnant woman is a part.

A. Equity Concerns

I believe that we should not examine the interests of the pregnant woman in isolation from our treatment of analogous interests of other members of society. We should be concerned that the pregnant woman

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A. Equity Concerns

I believe that we should not examine the interests of the pregnant woman in isolation from our treatment of analogous interests of other members of society. We should be concerned that the pregnant woman
is not singled out or treated in a *sui generis* fashion. Historically, when the pregnant woman or women in general have been treated in some isolated way, the treatment has all too often turned out to be in fact discriminatory and limiting. First, we should not ask more of pregnant women than we are willing to ask of parents in general. Since the fetus is not as developmentally advanced as is the newborn, society should be reluctant to ask of the pregnant woman more than it would ask of parents. For example, some courts have required that the pregnant woman have a cesarean operation — a procedure that is risky and physically invasive. Yet, we have not been willing to require of parents that they be required to donate kidneys to children who might otherwise die in the absence of a kidney transplant. I realize that children are not physically linked to their parents in the way that a fetus is linked to the pregnant woman. But there will not always be someone else around to provide an organ, and we should not lose sight of the fact that a fetus does not have the legal, and for many, the moral status of a child.

The second equity concern is that we should not single out pregnant women for special attention. What about the prospective father? Many of the cases that have involved women objecting to medical treatment have been cases in which the woman was married. In some of these cases husbands, too, have objected to compelled medical treatment. Perhaps more to the point, all too often we have ignored the fact that prospective fathers have responsibilities too. In some instances they have perhaps contributed to fetal harm. In the Pamela Rae Stewart Monson case in California, where a woman was unsuccessfully criminally prosecuted after the birth of an injured child, the prosecutor alleged that she had endangered her fetus by engaging in intercourse with her husband. 13 The last time that I examined the issue, the act of intercourse required two people. Yet, her husband was not criminally indicted. But the problem is more serious. What of the prospective father who possibly harms the fetus by supplying illicit drugs to the pregnant woman or who is a heavy smoker or who abuses the pregnant woman? To focus only on the pregnant woman is to ignore the fact that, if we are serious about children and serious about fetuses, then we have to be equally serious about examining the responsibilities of both men and women.

The third equity concern is that we should be careful about creating legal obligations for the pregnant woman that are out of line with


those that we impose on members of society in general. In our society there is no general obligation to be a good samaritan. Indeed, the ruling of one court underscores this point. In the case of *McFall v. Shimp*, 13 one man suffered from leukemia. He needed a bone marrow transplantation and his cousin was an appropriate match. The cousin, however, who had previously agreed to take the test to determine whether he was an appropriate match, refused to donate bone marrow. McFall went to court to see if he could compel his cousin to provide bone marrow. Keep in mind that bone marrow is something that persons regenerate, so the cousin was not going to lose the bone marrow forever. Also keep in mind that, while bone marrow transplantation is uncomfortable and inconvenient, it surely does not carry with it some of the risks that cesareans do. Nevertheless, the court held that the cousin had no obligation to provide bone marrow even if it meant that the proposed transplantation procedure offered the only hope of saving a human life.

My final equity concern is that if you look at cases of coerced medical treatment in the United States, two characteristics stand out. Almost all of these pregnant women were members of a minority group and/or poor. In one study of women forced to accept treatment, 81% were minority, 44% were unmarried, and 24% did not have English as a primary language. They were all in teaching hospitals since the study itself was conducted in teaching hospitals, but more importantly, they were all on public assistance. 14 Moreover, these women will already be disadvantaged by inadequate education and access to prenatal care. So, one of my primary worries in discussing imposition of legal obligations on pregnant women is that some women will be more heavily burdened than others.

B. Privacy Concerns

As I mentioned previously, privacy concerns include those concerns of the pregnant woman herself and the distinct concerns of her family. I will first address the pregnant woman’s pregnancy concerns. In addressing the woman’s privacy and autonomy concerns, I start with


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a famous statement of Judge Benjamin Cardozo, who wrote many years ago, "[e]very human being of adult years and sound mind has a right to determine what shall be done with his own body; . . . " His view was for a long time heeded more in theory than in practice. But certainly within the last twenty years we have come slowly to the conclusion that competent adults at least are persons who are in the best position to make medical care decisions for themselves. They are in the best position to know their own interests. They know the value and the context of their own lives in terms of making a decision. And society has afforded them great respect in permitting them to do so, because we understand we are a pluralist society, and that reasonable, competent persons can have different views about very fundamental things.

Pregnant women should be afforded the same respect. Imagine, if you can, the prospect of tying a pregnant woman to an operating table so that we can perform surgery over her objection. Or consider the prospect of force-feeding a special diet to a woman suffering from phenylketonuria. I picked two particularly horrible examples to underscore that one of the reasons we recognize and respect autonomy is that we appreciate the importance of having voluntary cooperation in treatment decisions, not to mention our interest in the value of preserving bodily integrity.

Moreover, physicians do make mistakes. For example, in at least one reported case, the diagnosis of risk to the fetus was inaccurate. In light of the problems of medical uncertainty, it is preferable that patients rather than physicians make health care decisions. It is patients who will bear the burden of inaccurate diagnosis and prognosis.

Finally, the fact that a competent patient places priority on her own needs ought not disqualify her as a decisionmaker. The fact that many women would and indeed do place fetal interests ahead of their own interests should not be a reason for forcing all women to do so. The positions that women find themselves in vary enormously. Women are in the best position to take account of the many constraints that operate on them.

A second reason for respecting a pregnant woman’s autonomy is that to do otherwise would severely burden the doctor-patient relationship. Pregnant women would have to worry that if they disagreed with their physicians’ advice that they would be at risk of court intervention. Pregnant women would not be able to trust their physicians. This issue is obviously a bigger problem for women who use publicly provided medical services rather than privately provided medical services, but it would be a problem for private care as well. If we are not careful, we might actually encourage women to avoid prenatal care. This is particularly a problem in a country that does not provide adequate prenatal care to its women to begin with. The prospect of penalizing women for seeking prenatal treatment when we do not make it generally available, at least for those who cannot afford it, is surely unacceptable.

In addition to the privacy and autonomy interests of the pregnant woman herself, interests of the family are implicated by any thought of imposing legal obligations on the pregnant woman. There is a doctrine in family law that the State ordinarily should not intervene in the ongoing family or in the decisionmaking of the ongoing family. The assumption has been that the family can ordinarily be expected to reach decisions that are in the best interest of the family and its members. The doctrine respects the pluralism that is a hallmark of this society. If a pregnant woman’s husband supports the decision not to permit intervention in the interest of the fetus, but the state nonetheless intervenes, in a very real way, the family’s interests have been as ignored as those of the pregnant woman.

Moreover, state intervention to override family decisionmaking has the effect of the state working in conjunction with physicians to reallocate decisionmaking with respect to the pregnant women’s health care to the physician. Judges do not have medical expertise. They are dependent upon the expertise of physicians in deciding whether to constrain pregnant women. Often physicians who act in knowledgeable, assured and confident ways can only really offer educated guesses about the prognosis of any particular case. This is particularly true of obstetrics, where what we know with respect to treatment of fetuses — and newborns as well — is rapidly undergoing change. You should not be surprised to learn that in some of the cases where coerced treatment was sought it turned out that the physicians were wrong and indeed the women delivered naturally without injury to themselves or to the fetus. Medical uncertainty is, thus, a major factor not only in considering the woman’s privacy concerns but in considering the family’s interests as well. Medical decisionmaking strategy, which has been described in an article by Professor Nancy Rhoden, is even more disturbing. She documents that what physicians really do in the face of uncertainty, especially where there is a fetus involved, is adopt a maximum treatment

a famous statement of Judge Benjamin Cardozo, who wrote many
years ago, "[e]very human being of adult years and sound mind has a
right to determine what shall be done with his own body; . . . "14 His
view was for a long time heeded more in theory than in practice. But
certainly within the last twenty years we have come slowly to the con-
clusion that competent adults at least are persons who are in the best
position to make medical care decisions for themselves. They are in the
best position to know their own interests. They know the value and the
context of their own lives in terms of making a decision. And society
has afforded them great respect in permitting them to do so, because
we understand we are a pluralist society, and that reasonable, com-
tent persons can have different views about very fundamental things.

Pregnant women should be afforded the same respect. Imagine, if
you can, the prospect of tying a pregnant woman to an operating table
so that we can perform surgery over her objection. Or consider the
prospect of force-feeding a special diet to a woman suffering from
phenylketonuria. I picked two particularly horrible examples to under-
score that one of the reasons we recognize and respect autonomy is that
we appreciate the importance of having voluntary cooperation in treatment
decisions, not to mention our interest in the value of preserving
bodily integrity.

Moreover, physicians do make mistakes. For example, in at least
one reported case,16 the diagnosis of risk to the fetus was inaccurate. In
light of the problems of medical uncertainty, it is preferable that pa-
tients rather than physicians make health care decisions. It is patients
who will bear the burden of inaccurate diagnosis and prognosis.

Finally, the fact that a competent patient places priority on her
own needs ought not disqualify her as a decisionmaker. The fact that
many women would and indeed do place fetal interests ahead of their
own interests should not be a reason for forcing all women to do so.
The positions that women find themselves in vary enormously. Women
are in the best position to take account of the many constraints that
operate on them.

A second reason for respecting a pregnant woman’s autonomy is
that to do otherwise would severely burden the doctor-patient relation-
ship. Pregnant women would have to worry that if they disagreed with

(1914).
strategy or last hope strategy. In the emergency situation — and most of the cases that I am discussing arise in an emergency context — with no information about current law or current medicine, no time to get it, and often no time to appoint counsel for all the parties involved, the likelihood of the judge in effect reallocating decisionmaking to the physician is even greater. The judge often must travel to the hospital to hold a hearing. And it takes a mighty courageous judge to disagree with the doctors because judges, like the rest of us, are intimidated when we are outside of our own setting and in the setting of other professionals.

IV. Conclusion

The hardest kind of case that a judge or anyone else faces is a situation where moral considerations seem to require or permit a particular result but, social considerations seem to dictate an opposite conclusion. Let me give you an example. I have had lots of reasons to think recently about active euthanasia for very ill, elderly persons in a great deal of pain and suffering. I can justify in own mind that in some instances a lethal injection for a competent elderly person who is asking not to have to survive additional painful weeks or months is ethically acceptable. However, I am not prepared to argue that as a matter of public policy, we should permit the use of a lethal injection for that one elderly person or in general. It seems to me that there are social considerations involved in this issue that go beyond the needs of a particular individual. Similarly, it is possible and just as tough to say that society should not coerce women to act in the best interests of their fetuses even if they have a moral obligation to act. Equity and privacy concerns deserve consideration and perhaps greater priority than the fact that, in a particular case, the pregnant woman seems to be doing the morally wrong thing. Thank you.


Whose Egg Is It Anyway?: Reproductive Rights of Incarcerated, Institutionalized and Incompetent Women

Susan Stefan*

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