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Maternal-Fetal Conflict: Legal and Ethical Issues

by

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INTRODUCTION

Advances in obstetrics in the last two decades have led to a better understanding of both fetal development and the impact of maternal behavior on the fetus. Sonograms are a routine part of prenatal care; amniocentesis is widely recommended for pregnant women over thirty-five, and villus sampling, a more recent development, is growing in popularity. In addition, the application of new technologies has made fetal therapy, either in utero or outside the womb, a possibility.

Most pregnant women go to great lengths to ensure that their babies are born as healthy as possible. They give up alcohol, caffeine, tobacco and illegal drugs. They see a health care professional at regular intervals, maintain healthy diets, and generally follow the medical advice given them. Pregnant women may even consent to invasive or experimental procedures on themselves and on their fetuses in the hope that their children would be born healthy (64). In the words of the American Academy of Pediatrics, “women almost always are willing to undergo self-sacrifice to benefit their fetuses.”(1)

Unfortunately, not all pregnant women behave in ways that are conducive to bearing healthy children. According to one recent study, as many as eleven percent of babies born in the U.S. (375,000 annually) are born to mothers who have used illicit drugs during their pregnancies (67). A 1989 study of Pinellas County, Florida found 3.4 percent of pregnant women used cocaine while pregnant (which can cause low birth weight, growth retardation, microcephaly and neonatal seizures)(60). In 1987, the New York City Health Department found that 1.5 percent of all newborns in New York City were HIV positive, (with the majority born to mothers who used intravenous drugs)(61). Fetal alcohol syndrome, in which babies can suffer growth retardation, microcephaly, facial abnormalities and malformations of the limbs and organs appears once in every 1000 births in the U.S. (77). Smoking can also cause premature birth or low birth weight. Even aerobic exercise, usually considered healthy for women accustomed to such exercise, can harm the fetus by decreasing its supply of oxygen, or overheating the fetus.

We are only beginning to understand the medical, emotional and social impact on children exposed to dangers in utero. Just as pregnant women vary in the extent of their drug and alcohol use, the effects on their children vary. In some circumstances, the children born to these mothers suffer only limited setbacks, and live basically normal lives. Other fetuses are not so lucky; some have severe neurological and developmental handicaps, and others die before they are even born.

The medical and legal communities long ago established a person's right to refuse medical treatment and to behave as (s)he chooses, so long as that behavior is within legal limits. Of course, in pregnancy the lives of the mother and fetus are intertwined; nearly everything the woman does affects her child-to-be. Thus, when a pregnant woman uses cocaine, drinks to excess, refuses medical treatment or otherwise disregards her doctor's reasonable advice, she endangers her fetus. The last decade has seen controversies in which the rights and wishes of pregnant women were pitted against the interests of their fetuses, and the conflict has ultimately had to be referred to the courts. Legal arguments surrounding these conflicts center on the U.S. Supreme Court decision in *Roe v. Wade*, where it was established that there is compelling state interest in the welfare of the viable fetus. At issue is the degree to which the government can direct a pregnant woman's behavior based on the doctrine of compelling state interest. Other legal commentators focus on the constitutional guarantee of liberty, privacy, and equal protection under the law. As is the case with many ethical issues in medicine, the development of law and public policy has not kept pace with advances in the care of pregnant women and their fetuses. We find judges and prosecutors having to apply statutes intended for other circumstances to cases where a mother's behavior might be threatening the fetus within her.

Medical arguments have revolved around the physician-patient relationship and the physician's responsibilities to a mother who is not complying with the physician's medical advice, as well as the physician's duties to the vulnerable fetus. The gestational age of the fetus is frequently mentioned as an important issue in these cases. If the fetus is viable, that is, able to survive outside the womb,

the duties to the fetus become much more compelling.

Public policy discussions have scrutinized the issues of maternal access to health care and the dearth of treatment available to women who are involved in addictions. Some contend that the court cases in the news will scare those women who most need prenatal care away from the health care system altogether. Several authors have noted that all of the women involved in legal interventions have been poor and/or members of minority groups, usually lacking the financial and educational means to defend themselves. Some critics have seen compelling pregnant women to act for the good of the fetus as a dangerous step down the slippery slope, where eventually every pregnancy would be regulated to the last detail, regardless of the mother's past behavior. Others argue that it is society's moral obligation to protect the unborn in their most vulnerable state.

It is possible to group the various types of maternal-fetal conflicts into a few categories, although there are some central themes that run through all categories. First, representing perhaps the most drastic circumstances, are the issues dealing with brain dead mothers. These are cases in which the medical community would withdraw life support treatment from the individual, except that the patient is pregnant, and thus the potential life of the fetus has to be considered.

A second group of problems surround issues of lifestyle. Some pregnant women who have tested positive for cocaine use were subsequently held in jail, so as to prevent the mother from using cocaine again during her pregnancy. In New York City, the presence of cocaine in a newborn's system and a mother's admission of drug use is enough justification for New York City to ask for a Family Court hearing on child neglect (58). Other mothers have been considered for forced hospitalization because they were deemed unlikely to follow doctor's orders to maintain a healthy diet (diabetes or PKU patients) or to maintain complete bed rest (in order to arrest premature labor).

A third group of cases involves the problem of treatment refusal by pregnant women. In one tragic case, a terminally ill pregnant woman was thought

to have refused a cesarean section that would probably hasten her death, only to have a court order one. She lived just long enough to discover that her baby died two hours after the operation, and expired herself two days later. Other cases have involved pregnant women rejecting medical interventions such as cesarean section or blood transfusions on religious grounds. Still another case involved a woman refusing treatment based on fear of the medical procedure.

Other considerations of maternal fetal conflict appear in the arena of occupational health. In efforts to avoid possible lawsuits and to protect future offspring of employees working in hazardous environments, some employers have instituted fetal protection policies, which limit who may work in certain high-risk areas. (These positions typically have higher salaries than similar positions within the same company.) Questions arise as to whether a woman should be able to retain her position in a toxic workplace while pregnant or whether any woman of childbearing age should be allowed to hold a job that exposes her to something that could harm her future children. Some commentators have challenged the requirement by employers that their female employees prove that they are infertile or undergo sterilization in order to qualify for certain positions. While some argue that fetal protection is only common sense and a good legal defense, others condemn the practice as simply a smokescreen for sex discrimination on the job.

Decisions about abortion can be interpreted as attempts to resolve maternal-fetal conflicts. However, for the purposes of this Scope Note, we will assume that the pregnant woman has chosen to carry the pregnancy to term, and that sometime later in her pregnancy, she is faced with another issue of maternal-fetal conflict.

COMMITTEE STATEMENTS

1. American Academy of Pediatrics. Committee on Bioethics. **Fetal Therapy Ethical Considerations**. *Pediatrics* 81(6): 898-899, June 1988.

The Academy outlines considerations for physicians who may face cases where maternal and fetal interests are not synonymous, specifically in the context of fetal therapy. In cases where a

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treatment poses personal risk to the mother and her bodily integrity, a physician should honor a woman's right to refuse treatment. Under the following conditions a physician might consider actively challenging a woman on her decision: 1) the fetus will suffer irrevocable harm without the treatment, 2) the treatment is clearly indicated and likely to be effective, and 3) the risk to the woman is low. When a pregnant woman persists in refusing, the physician should consult with a hospital ethics committee; the courts should be petitioned to only as a last resort.

2. American College of Obstetricians and Gynecologists. Committee on Ethics. **PATIENT CHOICE: MATERNAL-FETAL CONFLICT**. Committee Opinion No. 55. October 1987. 2 p.

The U.S. professional society for obstetricians and gynecologists' policy statement focuses on circumstances in which a mother refuses a diagnostic or surgical procedure, and thus endangers her fetus, or in which a mother's lifestyle or health practices endanger her fetus. ACOG advocates counseling and education to convince a mother to follow her doctor's advice and condemns the use of coercion on a pregnant woman, as this threatens the physician patient relationship and violates the intent of the informed consent process. Faced with a continuing disagreement with a pregnant woman, a physician should turn to an institutional ethics committee. Resorting to the legal system is almost never justified.

COURT DECISIONS

3. California. San Diego. Municipal Court. *People v. Stewart*. (Docket No. M508197), 26 February 1987.

In October 1986 Pamela Rae Stewart Monson was advised by a doctor that the placenta supporting her near-term fetus had become detached, and that she should seek immediate medical assistance should she start bleeding. She received further advice to abstain from street drugs and sexual intercourse with her husband. Ms. Monson allegedly had sex with her husband, took amphetamines and started bleeding twelve hours before she arrived at the hospital. She subsequently gave birth to a severely brain-damaged son, who died less than two months later. Ms. Monson was charged with child abuse in the case under the California Penal Code. A California state judge later dropped the charges on the grounds that the statute was not intended to penalize women for conduct during pregnancy.

4. Colorado. Denver. Juvenile Court. *In re Unborn Baby Kenner*. (File 79-JN83), 6 March 1979. (Unavailable to public)

In the first such case taken before a court in the U.S. the University of Colorado Hospital sought to obtain a court order to perform a cesarean section on an obese woman refusing to consent to the operation. After her labor slowed and the fetal heart rate decelerated, her physicians diagnosed fetal distress, yet she refused the surgery because she was afraid. Based on the U.S. Supreme Court ruling in *Roe v. Wade* recognizing the state's compelling interest in protecting the unborn, the judge declared the full-term fetus to be a dependent and neglected child, and ordered the surgery.

5. District of Columbia. Court of Appeals. **In re A.C.** (Docket No. 87-609), 26 April 1990.

Angela Carder, dying and 26 weeks pregnant agreed to attempts to prolong her life to give her fetus a better chance to be born healthy. When her death seemed imminent, she appeared to refuse a cesarean section, and a Superior Court judge was called by the hospital on the advice of its legal counsel. After hearing from lawyers for the hospital, the patient, and the fetus, the judge

ordered the surgery. Attorneys for the family appealed the decision, but the Appeals Court concurred with the lower court. The infant died two hours after delivery, the mother two days later. The decision was vacated in March 1988; in a ruling in April 1990, the District of Columbia Court of Appeals held that the lower court should not have ordered the surgery because there was not enough evidence that it was what the mother wanted.

6. District of Columbia. Superior Court. Civil Division. *In re Madyun Fetus*. (Docket No. 189-86), 25 June 1986.

Ayesha and Mustafaa Madyun, both devout Muslims, had planned on having a large family. At 19 Mrs. Madyun found herself in D.C. General Hospital with doctors urging a cesarean section to deliver her child. Her water had broken three days before, and the doctors feared outside infection if the child was not delivered soon. She was prepared to accept a poor outcome with this, her first pregnancy rather than face a possible limitation of the number of future pregnancies caused by the necessity for repeat cesarean sections. A judge summoned to the hospital late in the evening ruled that while the Madyun's views were sincere, their rights were outweighed by the rights of the fetus.

7. District of Columbia. Superior Court. Criminal Division. *U.S. v. Vaughan*, (Case No. F-2172-88B), 23 August 1988.

Brenda Vaughan pleaded guilty to forging about \$700 worth of checks, a crime that normally receives probation for the first offense. But Ms. Vaughan was pregnant and tested positive for cocaine when she appeared for her sentencing hearing. Judge Peter Wolf sentenced her to jail, in order to keep her away from cocaine and to give her fetus a chance to be born unaddicted to the drug. She was released after twelve weeks, shortly before the birth of her child.

8. Florida. Seminole County. Circuit Court. Criminal Division. *Florida v. Johnson*. (Case No. E-89-890-CFA), 13 July 1989.

When newborn Jessica Johnson's urinalysis tested positive for cocaine, her 23-year old mother was charged with child abuse and delivering illegal substances to a minor. Jennifer

Johnson was tried and convicted of the second offense, becoming the nation's first mother sentenced to jail for endangering the health of her fetus. In the trial, the prosecution alleged that she passed the cocaine in her system on to her daughter during the 60 to 90 seconds following the child's birth, but prior to the cutting of the umbilical cord. The case has attracted much attention and has now been appealed in the Florida Fifth District Court of Appeals (Case No. 89-1765).

9. Georgia. Superior Court. Richmond County. *University Health Services v. Robert Piazza*. (Docket No. CV86-RCV-464), 4 August 1986. (In: *Issues in Law and Medicine* 2(5): 415-418, March 1987).

Donna Piazza was five months pregnant when she was found unconscious in the restroom of a shopping mall. She was diagnosed as having suffered a drug overdose and lapsed into a coma. Nearly a month later she was declared brain dead. Her husband was prepared to have her respirator disconnected, but the biological father of the child asked the hospital to keep her on life-support long enough to give her fetus a chance to reach viability. The hospital asked the court for guidance; a court order was granted to maintain Mrs. Piazza on life support. After six weeks a baby boy was delivered by cesarean section and the mother's life support was turned off. The baby lived only one day.

10. Georgia, Supreme Court. *Jefferson v. Griffin Spalding County Hospital Authority*. SOUTH EASTERN REPORTER 274: 457-462, 3 February 1981.

Two weeks before her delivery date, Jessie Mae Jefferson was diagnosed as suffering from placenta previa, (a life-threatening condition for both the mother and fetus, in which the placenta is attached near or over the birth canal). Mrs. Jefferson refused a cesarean section because of her religious belief. The hospital petitioned to obtain a court order for the surgery, and asked juvenile authorities to take temporary custody of the unborn child. The court ruled in favor of the hospital and held that the intrusion was outweighed by the duty of the state to protect a living, unborn human being from dying before being given the opportunity to live. By the time

an unsuccessful appeal had been made to the Supreme Court of Georgia, the placenta had apparently shifted, and Mrs. Jefferson delivered her daughter naturally.

11. U.S. Court of Appeals. Seventh Circuit. *United Auto Workers v. Johnson Controls, Inc.* FEDERAL SUPPLEMENT, 2nd Series, 886: 871-921, 26 September 1989.

In 1982 Johnson Controls established a fetal protection policy to protect the unborn children of its workers from exposure to lead in its factories where automobile batteries were produced. The policy barred all fertile women of childbearing age from their battery-manufacturing operations, because fetuses can tolerate a much lower blood-lead level than can adults before they are subject to serious malformations. Johnson closed the battery division only a few years later, but not before one woman underwent surgical sterilization in order to keep her position. The United Auto Workers challenged the policy, alleging that it discriminated against women on the basis of pregnancy, in violation of the Pregnancy Discrimination Act of 1978. The Appeals Court upheld Johnson's policy, but with three dissenting opinions. The case has now been appealed to the U.S. Supreme Court.

GENERAL ISSUES

12. Andrews, Lori. **A Delicate Condition**. *Student Lawyer* 13(9): 30-37, May 1985.

In an overview of maternal-fetal conflict, attorney Andrews discusses certain cases and the rights and responsibilities of pregnant women. Andrews points out that while most women will do what is best for the children they carry, society should be prepared to honor a mother's wishes, even in cases where the potential harm to her offspring is severe. This must be done in order to maintain the decision making rights and bodily freedom of the large number of women of childbearing age.

13. Field, Martha A. **Controlling the Woman to Protect the Fetus**. *Law, Medicine and Health Care* 17(2): 114-129, Summer 1989.

Controlling women to protect their fetuses, states Field, is using pregnancy to deprive women of their most basic civil rights and

threatens women's recently-gained recognition as competent individuals with the ability to make decisions. Field argues that legal control of pregnant women places all women of childbearing age at risk for government regulation of their behavior.

14. Johnsen, Dawn. **A New Threat To Pregnant Women's Autonomy.** *Hastings Center Report* 17(4): 33-40, August 1987.

Johnsen contends that the state should not attempt to transform pregnant women into ideal baby-making machines. Pregnant women make decisions about their behavior within the context of the rest of their complex lives. Society's desire to help future children by improving prenatal care would best be achieved by helping pregnant women to make informed, less constrained choices, not by coercion or depriving them of determining their own treatment or behavior.

15. Landwirth, Julius. **Fetal Abuse and Neglect: An Emerging Controversy.** *Pediatrics* 79(4): 508-514, April 1987.

Pediatrician Landwirth looks at the legal rights and duties of parents and at fetal rights. He concludes that intrusions into a woman's legal rights should occur only in very narrowly defined circumstances.

16. Murray, Thomas H. **Moral Obligations to the Not-Yet Born: The Fetus as Patient.** *Clinics in Perinatology* 14(2): 329-343, June 1987.

Ethicist Murray discusses moral duties to the fetus, and whether viability impacts our obligations. He illustrates some misuses of the concept of duties to a fetus and the difficulties of turning ethical judgments into public policy. Murray also discusses the maternal-fetal conflict in historical and social contexts.

17. Nelson, Lawrence J. **Compulsory Treatment of Pregnant Women.** *Clinical Ethics Report* 1(5): 1-8, May 1987.

Ethicist and lawyer Nelson looks at the compelling ethical and professional reasons for seeking court-ordered interventions in pregnancy and concludes that it is better to allow a few unfortunate consequences to fetuses or mothers than to introduce force into the therapeutic relationship

of physician and patient. He makes four specific recommendations for physicians who care for pregnant women: 1) anticipate potential problems and carefully discuss both patients' and physicians' values before a case of conflict occurs; 2) be aware of one's own discriminatory attitude when a patient ignores advice; 3) provide frank, even graphic disclosure of possible difficulties for child and mother; and 4) demonstrate and record the mental status of the mother.

18. **REPRODUCTIVE LAWS FOR THE 1990'S: A BRIEFING HANDBOOK** edited by Nadine Taub and Sherrill Cohen. Newark, NJ.: Rutgers University, 1988.

A project of the Women's Rights Litigation Clinic and the Rutgers School of Law in Newark, the handbook contains several chapters pertaining to maternal fetal conflicts: 1) Fetus as Patient, 2) Reproductive Hazards in the Workplace, and 3) Interference with Reproductive Choice. Each chapter provides an overview of the public policy and legal issues and presents a position paper as a conclusion.

19. Rosner, Fred et al. **Fetal Therapy and Surgery Fetal Rights Versus Maternal Obligations.** *New York State Journal of Medicine* 89(2): 80-84, February 1989.

Physicians Rosner, et al. present a broad spectrum of circumstances implementing new techniques to treat fetuses and their impact on pregnant women. They discuss the ethical and legal issues presented by other commentators and concur with the American College of Obstetrics and Gynecology's Statement on Maternal-Fetal Conflict.

20. Sise, C. Beth. **Maternal Rights Versus Fetal Interests: An Ethical Issue with Nursing Implications.** *Journal of Professional Nursing* 4(4): 262-267, July/August 1988.

Nurse Sise prefers basing treatment decisions involving maternal-fetal conflicts on an "ethic of responsibility", rather than on a "rights-based" or "win-lose orientation". This approach places importance on the value of caring and on taking responsibility for others as a method of determining what is right.

21. Strong, Carson. **Ethical Conflicts Between Mother and Fetus in Obstetrics.** *Clinics in Perinatology* 14(2): 313-328, June 1987.

Ethicist Strong looks at three circumstances in which fetal and maternal interests diverge. In treatment refusal situations, Strong argues that it is sometimes ethical to overrule such decisions. The second situation surrounds selection of delivery method in premature deliveries with breech presentations; while most mothers want to avoid cesarean section, fetal weight and survival rates may indicate that this is best for the child. Finally, Strong looks at choosing delivery methods for hydrocephalic infants who may not survive vaginal delivery with its accompanying head decompression.

BRAIN DEAD PREGNANT WOMEN

22. Field, David R.; Gates, Elena A.; Creasy, Robert K.; Jonsen, Albert R.; and Laros, Russell K. **Maternal Brain Death During Pregnancy.** *Journal of the American Medical Association* 260(6): 816-822, 12 August 1988.

In a clinical article, physicians describe a case where a brain dead woman was kept on life support for nine weeks and a successful cesarean delivery followed. The costs of maternal and neonatal care was \$217,784 in 1983. The authors note that just because the technology and medical expertise exist to support fetuses in such circumstances, it need not be employed in every case.

23. Field, David R.; Laros, Russell K.; Reilly, Philip and Shannon, Thomas. **Keeping "Dead" Mothers Alive During Pregnancy.** In: **FETAL DIAGNOSIS AND PREGNANCY** edited by Mark I. Evans; Alan O. Dixler; John C. Fletcher and Joseph D. Schulman. Philadelphia: J.B. Lippincott, 1989. pp. 296-316.

Physicians Field and Laros discuss the case presented above. The doctors describe the clinical difficulties in maintaining the mother for so long when the health care team had so little experience with such cases. Reilly analyzes the legal issues of keeping brain dead mothers on life support, and specifically the legal rationale in the Piazzi case. He determines that it would

be reasonable to extend a woman's right to terminate a pregnancy to her husband in the event of her death. Ethicist Shannon weighs the interests of the mother, fetus, and father and outlines his ethical concerns. He concludes that while maintaining a cadaver for two months is "clearly" inappropriate, a fetus closer to viability could ethically be assisted in such a manner, although there is no moral obligation to do so.

24. Jordan, James M. **Incubating for the State: The Precarious Autonomy of Persistently Vegetative and Brain-Dead Pregnant Women.** *Georgia Law Review* 22(4): 1103-65, Summer 1988.

Jordan argues that the wishes of a brain-dead pregnant woman regarding treatment or termination of a pregnancy should be honored. When her wishes are unclear, her family should make decisions regarding her treatment. Only in cases where proxies do not have the fetus's best interest at heart should the courts intervene (such as the Piazzi case). The ultimate goal is to preserve the dignity of the brain-dead pregnant women and to avoid treating women as state-controlled incubators.

25. Loewy, Erich H. **The Pregnant Brain Dead and the Fetus: Must We Always Try to Wrest Life from Death?** *American Journal of Obstetrics and Gynecology* 157(5): 1097-1101, November 1987.

Physician Loewy contends that it is morally necessary to deliver a viable fetus from a brain-dead mother. While it is acceptable to keep her alive if there is a reasonable chance that the child will reach viability (approximately 24 weeks' gestation), careful informed consent of the family needs to be obtained before proceeding with treatment that resembles experimental therapy. Financial burdens of such experimental treatment should be borne by the community. Each case must be taken individually, with fetal viability playing an important role in treatment decisions.

26. Mulholland, Kristin A. **A Time to be Born and a Time to Die: A Pregnant Woman's Right to Die with Dignity.** *Indiana Law Review* 20(4): 859-878, Fall 1987.

Mulholland advocates performing a balancing

act between the many legal and ethical variables involved in cases of maternal brain death or persistent vegetative states. Important considerations include fetal viability, physical condition of the mother, and the state's anatomical gift and living will statutes.

LIFESTYLE ISSUES

27. Annas, George J. **Pregnant Women as Fetal Containers.** *Hastings Center Report* 16(6): 13-14, December 1986.

Annas analyses the case of Pamela Monson, who was the first woman criminally prosecuted under a California child support law after the death of her newborn son. He warns that the crime of "fetal neglect" has serious ramifications for pregnant women who may lose their rights, suffer invasion of privacy, and even be forced to submit to unwanted medical or surgical procedures. Annas suggests that the state could better protect fetuses by improving the welfare of and medical services for pregnant women, rather than trying to regulate their lifestyles.

28. Balisy, Sam S. **Maternal Substance Abuse: The Need to Provide Legal Protection for the Fetus.** *Southern California Law Review* 60(4): 1209-1238, May 1987.

Balisy analyses a number of solutions for resolving conflicts in cases where maternal and fetal rights compete. He concludes that public awareness, mandatory rehabilitation programs, criminal sanctions and even a tort for diminished life are all acceptable options for restricting maternal autonomy. As established in *Roe v. Wade*, the state's primary responsibility is to the fetus, once it reaches viability.

29. Jessup, Marty, and Roth, Robert. **Clinical and Legal Perspectives on Prenatal Drug and Alcohol Use: Guidelines for Individual and Community Response.** *Medicine and Law* 7(4): 377-389, 1988.

Against a background of an increasing number of cases of drug and alcohol-addicted pregnant women, the authors discuss attempts to improve the outcome for future children. They point out that attempts to protect fetuses from exposure to dangerous substances (state interventions such as monitoring of pregnancy behavior and termina-

tion of parental rights after birth) have only served to push pregnant women involved in such behaviors farther away from health care. They advocate the cooperation of health care providers and government to promote universal prenatal care, medical payment for detoxification and warning labels for alcoholic beverages.

30. Kahn, Judith. **Of Woman's First Disobedience: Forsaking a Duty of Care to Her Fetus — Is This a Mother's Crime?** *Brooklyn Law Review* 53(3): 807-844, Fall 1987.

While every measure should be taken not to "unduly infringe" upon a mother's right to control and regulate her own body, there are circumstances in which state intervention is justified. Whenever possible, prenatal injury should be prevented before it occurs. This could be facilitated by increasing education and prenatal services available to pregnant women. Kahn argues that criminalization of fetal abuse is not a prudent alternative, for it will cause women at risk of endangering their fetus' health to avoid prenatal care for fear of later retribution.

31. Losco, Joseph. **Fetal Abuse: An Exploration of Emerging Philosophic, Legal, and Policy Issues.** *Western Political Quarterly* 42(2): 265-286, June 1989.

Ethical and legal issues are discussed, including the legal status of the fetus, the assessment of fetal harm and conflicts over claims of legal rights. Losco summarizes current judicial policy in the area of maternal-fetal conflicts and makes suggestions for future public policy on fetal abuse. He advises that health care professionals, employers and government all bear responsibilities to our future children, and that fetal abuse policies should not be targeted at pregnant women alone.

32. Manson, Rebecca, and Marolt, Judy. **A New Crime, Fetal Neglect: State Intervention to Protect the Unborn — Protection at What Cost?** *California Western Law Review* 24(1): 161-182, Winter 1987-1988.

Manson and Marolt discuss the legal implications of the criminalization of fetal neglect. They provide a history of the development of fetal rights, and discuss legal statutes as they relate to women and fetuses, and outline moral and legal

issues relating to women's privacy rights and equal protection. They conclude that criminalization of fetal neglect is one of the most intrusive measures aimed at protecting fetal life, and is therefore untenable.

33. Moss, Kary L. **Legal Issues: Drug Testing of Postpartum Women and Newborns as the Basis for Civil and Criminal Proceedings.** *Clearinghouse Review* 23(11): 1406-1414, March 1990.

Moss, an attorney for the American Civil Liberties Union, provides an overview of the legal and social issues involved in the growing practice of testing pregnant women for drug abuse and instituting neglect proceedings based on the results. She questions the accuracy of the tests as well as the wisdom of taking newborns away from their mothers only to be shuffled through the foster home system. She warns that such prosecution endangers a pregnant woman's rights to privacy, liberty, equal protection and freedom from unwarranted government intrusion into their bodies.

34. Schott, Lee A. **The Pamela Rae Stewart Case and Fetal Harm: Prosecution or Prevention?** *Harvard Women's Law Journal* 11: 227-245, Spring 1988.

Focusing on the case of Pamela Rae Stewart, Schott discusses the alternatives for lowering infant mortality in the United States. He concludes that given the high cost of health care for babies born to mothers using substances harmful to their fetuses during pregnancy, we should improve the availability and quality of prenatal care. While this alternative seems difficult to pass through our legislatures because of the substantial expenditure required, he argues that the long-term effects would be beneficial, and that it would obfuscate the need for "quick-fix" legislation criminalizing maternal behavior to protect the fetus.

35. Shaw, Margery W. **Conditional Prospective Rights of the Fetus.** *Journal of Legal Medicine* 5(1): 63-116, March 1984.

In a wide ranging article on the rights of the fetus, physician-attorney Shaw suggests that we should not allow children to become the victims of child abuse either before or after they are born. Parents' right to reproduce, even though

protected in the constitution, should be subordinated to the needs of the child. A woman's right to abuse her own body by using drugs and alcohol should not be construed as a right to deliver these substances to her fetus. Criminal sanctions and punitive damages should be sought on behalf of children exposed to such substances.

36. Thompson, Elizabeth. **Criminalization of Maternal Conduct During Pregnancy: Decision-making Model for Lawmakers.** *Indiana Law Journal* 64(2): 357-374, 1988-89.

Thompson argues that lawmakers must recognize that whatever deterrent benefit is to be gained by criminalizing fetal abuse, the benefit would be overshadowed by the chilling effect it would have on women's access to health care. Further, it would create the illusion that something constructive is being done to improve infant mortality when improved prenatal care is a more attractive approach.

37. Wolf, Peter. **The Case of Brenda Vaughan.** *Washington Post*, p.C8,4 September 1988.

The judge who sentenced Brenda Vaughan to jail offers the rationale for his decision. He weighed Ms. Vaughan's rights against his duty to protect the public (including her fetus) and ruled that the public counted more heavily. The taxpaying public would probably be financially responsible for the care of the child who suffered severe handicaps as a result of its mother's ongoing drug habit. While he thought it was Ms. Vaughan's responsibility to protect her fetus from harm, when she abdicated her responsibility, Judge Wolf felt compelled to intervene.

OCCUPATIONAL ISSUES

38. Duncan, Allyson K. **Fetal Protection and the Exclusion of Women From the Toxic Workplace.** *North Carolina Central Law Journal* 18(1): 67-86, Spring 1989.

Professor Duncan focuses on Title VII of the Civil Rights Act of 1964, which prohibited discrimination in employment on the basis of race, color, religion, sex or national origin. She also evaluates the efforts of the Equal Employment Opportunity Commission in its attempts to enforce the law. She recommends that future

fetal protection policies should be made on the basis of bona fide occupational qualities, and be fashioned narrowly so as to avoid impermissible discrimination.

39. Katz, Joni F. **Hazardous Working Conditions and Fetal Protection Policies: Woman are Going Back to the Future.** *Boston College Environmental Affairs Law Review* 17(1): 201-230, Fall 1989.

Katz advocates banning fetal protection policies as they promote the health of future generations at the expense of women's rights. Katz prefers to leave employment decisions up to the woman, and suggests increasing effort to educate women about the dangers inherent in toxic workplaces, and also increase employer efforts to clean up hazardous occupational settings for men and women alike.

40. Simon, Howard A. **Fetal Protection Policies After Johnson Controls: No Easy Answers.** *Employee Relations Law Journal* 15(4): 491-514, Spring 1990.

The law before and after the important U.S. Appeals Court decision in the Johnson Controls decision is discussed in this article. Judge Easterbrook's dissenting opinion as the basis for appeal to the U.S. Supreme Court is examined. Attorney Simon outlines considerations for employers drafting fetal protection policies, suggesting that they make them very carefully and keep them very narrow.

41. Sor, Yvonne. **Fertility or Unemployment — Should You Have to Choose?** *Journal of Law and Health* 1(2): 141-228, 1986-87.

Law Professor Sor criticizes the current legal approaches to reproductive hazards in toxic workplaces. She provides an alternative approach, using legislation to balance three competing interests: 1) the worker's interest in a safe and healthful workplace with equal employment opportunities, 2) the employers' interest in continued economic viability and profitability, and 3) society's interest in a healthy future generation.

42. U.S. Congress. Office of Technology Assessment. **REPRODUCTIVE HAZARDS IN THE WORKPLACE.** Washington, D.C., 1985. [Re-

port (No. OTA-BA-266) or Summary (No. OTA-BA267), available from NTIS) (See also **SELECTED ETHICAL ISSUES IN THE MANAGEMENT OF REPRODUCTIVE HEALTH HAZARDS IN THE WORKPLACE** (NTIS No. PB 86-172-152) prepared as working papers for above report.]

This study by the Office of Technology Assessment provides a wealth of information on reproductive hazards in the workplace. Of particular interest is the chapter on sex discrimination, which analyses the important court cases and legal statutes relevant to reproduction and occupational law. It also includes the text of several organizations' fetal protection policies and statements on the matter by two labor unions. The chapter on ethical issues looks at the concerns surrounding women, men and fetuses, emphasizing the principles of respect for persons, beneficence and justice.

TREATMENT REFUSAL ISSUES

43. Annas, George J. **Forced Cesareans: The Most Unkindest Cut of All.** *Hastings Center Report* 12(3): 16-17, 45, June 1982.

Law professor Annas discusses the Jefferson case from Georgia (see p. 5) and a case from Colorado (see p. 4). In both cases mothers were refusing cesarean sections; the first on religious grounds, the second based on fear of the operation. He maintains that the law does and should continue to uphold a woman's right to refuse surgery even if it is in her fetus' best interest.

44. Annas, George J. **She's Going To Die: The Case of Angela C.** *Hastings Center Report* 18(1): 23-25, February/March 1988.

Annas criticizes the legal reasoning in the original District of Columbia case of Angela Carder. Annas argues that the decision rested on several false assumptions about the legal rights and obligations of pregnant women. In his view, the judges "justified their brutal and unprincipled opinion on the basis that [A.C.] was almost dead," and therefore the fetus's interests outweighed hers. The decision was later overturned by the Appeals Court in the District of Columbia.

45. Goldberg, Susan. **Medical Choices During Pregnancy: Whose Decision Is It, Anyway?** *Rutgers Law Review* 41(2): 591-623, 1989.

Law professor Goldberg rejects the balancing of state interests against a woman's right to choose her own health care, and warns of the dangers of creating a new class of individuals (pregnant women) who are deemed incompetent to make their own treatment decisions, while men and non-pregnant women maintain their bodily integrity. She also outlines the practical difficulties of establishing and enforcing medically specified standards of conduct and points to the likelihood that proscribing behavior could drive the women who most need prenatal care away from the medical establishment.

46. Irwin, Susan and Jordan, Brigitte. **Knowledge, Practice and Power: Court-Ordered Cesarean Sections.** *Medical Anthropology Quarterly* 1(3): 319-334, September 1987.

Anthropologists Irwin and Jordan look at nine cases of court-ordered cesarean sections as a means of maintaining medical authority and confirming physician control over birthing. The authors view medical information as a power base that is difficult to confront and overcome. Rejection of medical advice — particularly in obstetric practices — is relatively unusual. Because of its rarity, physicians may be ill-equipped to handle the perceived affront to their authority. Challenges to the physician can be overruled by legal orders, which only serve to further empower the medical establishment.

47. Kluge, Eike-Henner W. **When Cesarean Section Operations Imposed by a Court Are Justified.** *Journal of Medical Ethics* 14(4): 206-211, December 1988.

Canadian author Kluge argues that once the fetus has reached viability, it is a person, and that issues of maternal-fetal conflict should be resolved by balancing rights: the right to life of the fetal person against the right to autonomy and inviolability of the woman. Kluge maintains that fetal rights should usually prevail.

48. Kolder, Veronika E.B.; Gallagher, Janet; Parsons, Michael T. **Court-Ordered Obstetrical Interventions.** *New England Journal of Medicine* 316(19): 1192-1196, 7 May 1987.

The results of a national survey of cases in which courts have ordered obstetrical procedures over the objections of the pregnant woman are reported. At the time, court orders had been obtained for cesarean sections in 11 states, for hospital detention in two states, and for intra-uterine transfusions in one state. Some interesting statistics are cited: court orders were granted in 86% of the cases, 81% of the women involved were black, Asian, or Hispanic and 100% were poor. Just less than half of the physicians surveyed believed that women who refused medical advice and thereby endangered the life of the fetus should be detained. The authors question the legal grounds upon which such court orders have been based, and warn of negative implications for obstetrical practice and for maternal and infant health.

49. Mackenzie, Thomas B.; Nagel, Theodore C.; Rothman, Barbara Katz. **When a Pregnant Woman Endangers Her Fetus.** [Case study and commentaries]. *Hastings Center Report* 16(1): 24-25, February 1986.

In this case study, a pregnant diabetic is risking injury to her fetus by ignoring her physician's instructions on controlling her disease. Unless she complies, the physician threatens to obtain a court order to keep her in the hospital. The commentators disagree on the legal justifications for the doctor's response. Mackenzie and Nagel determine that the physician has an obligation to the fetus, that the mother's behavior definitely risks harm to the fetus, and that controlling her behavior would not endanger the woman's health. Rothman argues that the injury to the mother's civil liberties is too great to warrant a forced hospitalization.

50. Macklin, Ruth. **The Inner Workings of an Ethics Committee: Latest Battle Over Jehovah's Witnesses.** *Hastings Center Report* 18(1): 15-20, February/March 1988.

Ethicist Macklin describes a case in which a pregnant Jehovah's Witness refuses a blood transfusion on religious grounds. She explores how one hospital ethics committee grappled with the particular problem of pregnant Jehovah's Witnesses, including the complex interdependence of maternal and fetal rights, and relates the difficulties in drafting a hospital policy for the

treatment of such patients.

51. Mahowald, Mary. **Beyond Abortion: Refusal of Caesarean Section.** *Bioethics* 3(2): 106-121, April 1989.

Using the case of Angela Carder, Mahowald criticizes the developing judicial pattern of court ordered cesarean sections. Within the context of the right to privacy and the concept of viability, which could legally override that right, Mahowald analyzes several different situations. After arguing that court ordered cesarean sections are inconsistent with court refusals to force persons to undergo less pervasive procedures (e.g., bone marrow donation for the benefit of family members), she proposes alternatives to the present inconsistent practice.

52. Noble-Allgire, Alice M. **Court-Ordered Cesarean Sections: A Judicial Standard for Resolving the Conflict Between Fetal Interests and Maternal Rights.** *Journal of Legal Medicine* 10(1): 211-249, March 1989.

Noble-Allgire presents a four-part criteria for the courts to use in ruling on cases requesting court-ordered cesarean sections: 1) the state has compelling interest in protecting this fetus; 2) this is the least drastic medical alternative; 3) the procedure poses no additional risks to the health or life of the mother; and 4) there are no doubts. If any of these statements are false or questioned, the decision should fall on the side of the mother who is refusing treatment.

53. Rauscher, Kathleen. **Fetal Surgery: A Developing Legal Dilemma.** *Saint Louis University Law Journal* 31(3): 775-795, September 1987.

Fetal surgery, experimental procedures in which the fetus is treated either in utero, or briefly outside the uterus and then reinserted, is discussed as a possible arena for treatment refusal controversies. Rauscher argues that families and mothers should be given the opportunity to evaluate options for fetal surgery, and to decline treatment if they choose. Only in cases where the decision is arbitrary, irrational or unreasonable should the courts intervene.

54. Rhoden, Nancy K. **The Judge in the Delivery Room: The Emergence of Court-Ordered Cesareans.** *California Law Review* 74(6):

1951-2030, December 1986.

Law professor Rhoden rejects both child abuse statutes and the law in *Roe v. Wade* as rationales for compelling women to undergo cesarean sections against their will. Instead she argues that the cesarean dilemma should be approached as a special issue of treatment refusal by competent patients. Faced with a case in which fetal outcome will clearly be better if surgery is performed, a judge who orders a cesarean is only achieving good by doing evil. Rhoden prefers to allow some "tragic private wrongs" rather than incorporating state-imposed coercion of pregnant women into our legal landscape.

55. Robertson, John A. and Schulman, Joseph D. **Pregnancy and Prenatal Harm to Offspring: The Case of Mothers with PKU.** *Hastings Center Report* 17(4): 23-33, August 1987.

Prenatal duties to avoid harm to offspring are discussed in the legal and ethical contexts. The authors advocate careful balancing of a baby's welfare with a pregnant woman's interest in liberty and bodily integrity. Mothers with PKU can avoid mental retardation in their offspring by maintaining an unpalatable diet low in phenylalanine. Rather than adopting coercive measures or prebirth incarcerations with PKU mothers, the authors advocate counseling and easy access to medical care, although punitive action after the birth of a severely handicapped child should not be dismissed out of hand.

56. Robertson, John A. **Procreative Liberty and the Control of Conception, Pregnancy, and Childbirth.** *Virginia Law Review* 69(3): 405-464, April 1983.

Law Professor Robertson discusses a mother's right to refuse treatment within the general framework of reproductive liberties. He places great emphasis on a pregnant woman's previous decision not to abort, but to continue a pregnancy. Once a fetus has become viable or the mother has decided to continue a pregnancy, he considers it a mother's duty to undergo surgical delivery where it is necessary to save the life of the child, or to prevent fetal injury.

57. Steinbock, Bonnie; Marquis, Don; Kayata, Sahar. **Preterm Labor and Prenatal Harm** [Case study and commentaries]. *Hastings Center Report*

19(2): 32-34, March/April 1989.

In this case study, a young pregnant woman, diagnosed as extremely immature with a personality disorder, refuses treatment to stop preterm labor. Her physician sees three options: 1) risk a premature delivery (with accompanying risk of fetal death or a handicapped child); 2) transfer her to a physician who will honor her wishes; or 3) obtain a court order to force treatment. The first commentary focuses on the psychological approach of exploring the reasons for the refusal and the art of gentle persuasion. The second is a comparison of harms analysis and suggests that the pregnant woman's right not to be confined involuntarily is not as important as a child's right not to risk permanent, severe and avoidable harm. The last comment discusses the obstetrician's conflicting legal obligations and recommends seeking a court order.

ADDITIONAL READINGS

58. Baquet, Dean. **Hearings on Neglect Upheld in Newborn Cocaine Cases.** *New York Times*, p. B3, 30 May 1990.

59. Bigge, Ellen. **Fetal Rights Controversy: A Resurfacing of Sex Discrimination in the Guise of Fetal Protection.** *UMKC Law Review* 57(2): 261-288, Winter 1989.

60. Chasnoff, Ira J.; Landress, Harvey J.; Barrett, Mark E. **The Prevalence of Illicit-Drug or Alcohol Use During Pregnancy and Discrepancies in Mandatory Reporting in Pinellas County, Florida.** *New England Journal of Medicine* 322(17): 1202-1206, 26 April 1990.

61. Chavkin, Wendy; Driver, Cynthia R. and Forman, Pat. **The Crisis In New York City's Perinatal Services.** *New York State Journal of Medicine* 89(12): 658-663, December 1989.

62. Dillon, William P., et al. **Life Support and Maternal Brain Death During Pregnancy.** *Journal of the American Medical Association* 248(9): 1089-1091, 3 September 1982.

63. Gellman, Barton. **Mother's Right Upheld Over Fetus's.** *Washington Post*, p. A1, A14, 27

April 1990.

64. Harrison, Michael R. et al. **Successful Repair of a Fetal Diaphragmatic Hernia After Removal of Herniated Viscera From the Left Thorax.** *New England Journal of Medicine* 322(22): 1582-1584, 31 May 1990.

65. Hembacher, Brian. **Fetal Protection Policies: Reasonable Protection or Unreasonable limitation on Female Employees?** *Industrial Relations Law Journal* 11(1): 32-44, 1989.

66. Gorney, Cynthia. **Whose Body Is It, Anyway?: The Legal Maelstrom that Rages When the Rights of the Mother and Fetus Collide.** *Washington Post*, pp. D1, D2, 13 December 1988.

67. Jenks, Susan. **An Ethical Quagmire for Doctors: Drug Babies.** *Medical World News* 31(3): 39, 12 February 1990.

68. Johnsen, Dawn E. **The Creation of Fetal Rights: Conflicts With Women's Constitutional Rights to Liberty, Privacy, and Equal Protection.** *Yale Law Review* 95(3): 599-625, January 1986.

69. Jost, Norman. **Mother Versus Fetus.** *Aba Journal* 75:84-88, April 1989.

70. Lewin, Tamar. **When Courts Take Charge of the Unborn.** *New York Times* pp. A1, A11, 9 January 1989.

71. Marcus, Ruth. **Court to Weigh Workplace Fetal Safety: Sex Discrimination Issue Raised in Case.** *Washington Post* p. A1, A4, 27 March 1990.

72. **Maternal Rights and Fetal Wrongs: the Case Against the Criminalization of "Fetal Abuse."** *Harvard Law Review* 101(5): 994-1012, March 1988.

73. Mishkin, Barbara and Annas, George J. **But She's Not an "Inanimate Container...."** [Letter and response]. *Hastings Center Report* 18(3): 40-42, June/July 1988.

74. **Prenatal Abuse of Licit and Illicit Drugs,**

edited by Donald E. Hutchings. *Annals of the New York Academy of Sciences* 562: 1989. 388 pp.

75. Paltrow, Lynn and Benshoof, Janet. **Fetal-Rights Case Attacks Civil Liberties of Women.** *New York Times*: p. A22, 10 November 1986.

76. Randall, Donna M. **Fetal Protection Policies: A Threat to Employee Rights?** *Employee Responsibilities and Rights Journal* 1(2): 121-128, June 1988.

77. Risemberg, Herman M. **Fetal Neglect and Abuse.** *New York State Journal of Medicine* 89: 148-151, March 1989.

78. Robertson, John A. **Gestational Burdens and Fetal Status: Justifying Roe v. Wade.** *American Journal of Law and Medicine* 13(2-3): 189-212, 1987.

79. Rosenberg, Michael J.; Feldblum, Paul J. and Marshall, Elizabeth G. **Occupational Influences on Reproduction: A Review of the Literature.** *Journal of Occupational Medicine* 29(7): 584-591, July 1987.

80. Ruddick, William; Wilcox, William. **Operating on the Fetus.** *Hastings Center Report* 12(5): 10-14, October 1982.

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83. **Woman Faces Criminal Charges over Her Conduct During Pregnancy.** *New York Times*: p. A22, 9 October 1986.

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