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ARE PREGNANT WOMEN FETAL CONTAINERS?

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INTRODUCTION

Let me relieve your curiosity right away: yes, pregnant women are fetal containers.[1] That is, they have fetuses in their bodies. But the implication from this fact drawn by some people from the phrase – that women are nothing but cheap clay pots supporting infinitely precious flowers – is very far from being the case.[2]

Women carry fetuses in their bodies, it is true. It is equally true, however, that fetuses are part of women's bodies. The champions of fetus and woman in this latest round of the war about women's reproductive rights would argue that these claims are inconsistent. For one of the legacies of the abortion battle has been the assumption that if fetuses are part of women's bodies, they are not separate entities and women should therefore have the final say about what happens to them.

THE PROBLEM

Women, like men, want to control what happens to and in our bodies. Women's ability to do this is being threatened by proponents of the view that our choices should be subordinated to the welfare of fetuses within us.

Respect for our right, as moral agents, to control our bodies, is a keystone of liberal society. The paradigm cases of such control consist of situations common to both women and men. Those, like

[1] This paper was given at the December 1989 meeting of the Society for Philosophy and Public Policy; I would like to thank commentators Joan Callahan and Mary Anne Warren for their helpful comments. I would also like to thank Dianne Romain for her criticism of an earlier version, as well as Denise McCoskey and the two anonymous readers for *Bioethics*.

[2] The flower pot theory is elucidated by Caroline Whitbeck, 'Theories of Sex Difference', *The Philosophical Forum* 5, 1973, 1–2.

pregnancy, that are experienced only by women, have a way of being regarded as special cases and thrown into question. Such debate is perhaps innocuous when it involves moral claims. However, when, as here, it moves to the legal realm and can lead to coercion or punishment, its implications become much more serious.

Cases where women's decisions about their pregnancies have been overridden by doctors and judges are accumulating. Some involve drug use. For example, one woman was charged with child abuse last year after giving birth to her second cocaine-addicted baby; her child was placed in foster care. In another case, a woman was jailed for a week after she gave birth to a brain-damaged baby: she was accused, among other things, of drug abuse. In a third case, a woman arrested for cheque forgery was found to be using cocaine; a judge sent her to jail for four months to protect her fetus.[3] Others involve involuntary caesareans. In one such case, a Nigerian woman's husband was thrown out of the hospital and she was strapped to the table for the surgery.[4] In another, a terminally-ill cancer patient was forced to submit to surgery in order to give a marginally viable fetus a chance at life; both were dead in two days.[5] And so forth. Relatively little publicity has accompanied such cases.[6] Yet if the same things were being done to the average middle-class white man on the street, there would be public outrage. Is there then some morally relevant difference between that man in the street and pregnant women that would justify such different legal treatment?

THE FETUS'S PLACE

Fetuses live in women's bodies. This means both that what happens in and to those bodies can adversely affect fetuses and that the only way to get at a fetus is through the body that houses it.

It is now well-known that fetuses can be harmed by a variety of causes that operate before or after conception. Genetic defects, exposure to radiation or toxic substances, maternal ill-health and birth itself can lead to a diseased or handicapped baby. Research has helped us to understand and deal with some of the difficulties afflicting fetal development and birth, and this area is currently the subject of intensive scrutiny and experimentation. The list of worries is long.

[3] *Time,* May 22, 1989, 45.

[4] Janet Gallagher, 'Prenatal Invasions and Interventions: What's Wrong with Fetal Rights', *Harvard Women's Law Journal* 10, 1987, 9.

[5] See Mary Mahowald, 'Beyond Abortion: Refusal of Caesarean Section', *Bioethics* 32, April 1989, 106.

[6] See for instance, Gallagher 10.

Consider, just for a start, maternal infections such as rubella, herpes, syphilis and AIDS. Pregnant women may also suffer from a variety of diseases such as diabetes, thyroid disease, hypertension and cancer; they may also be exposed to toxic chemicals like anaesthetic gases, chemotherapeutic drugs, benzene and dioxin.[7]

Because fetuses are so vulnerable, protecting them requires a comprehensive approach. Women must avoid harmful substances, act to meet fetal needs and, at times, submit to bodily invasions. They must exercise self-discipline about so-called 'life-style' choices, keeping away from substances such as alcohol, tobacco, drugs – and no doubt hot fudge sundaes. They also need to stay away from toxic environments, including work and living places. It is also important that they get good prenatal care, eat a healthy diet, and exercise appropriately. Finally, they must make good judgements about recommended medical treatment for themselves and their fetuses.[8]

This list demonstrates how entwined fetal interests are with women's lives, and at how many points those interests might diverge. Furthermore, the more thoroughgoing our understanding of the process of pregnancy and the bolder our technology, the more acute the potential conflicts.

The existence of such conflict is denied by many of those who are thinking about the problem. Some writers conflate fetuses and children, unable to see any morally relevant differences between them: they seem oblivious to the fact that fetuses live in women's bodies. The implications of that fact are therefore ignored or dismissed.[9] They fail to recognize that women's rights might sometimes trump considerations about fetal welfare.

We should not forget that the sacrifices exacted by a well-run pregnancy may be considerable; they deserve recognition and perhaps even compensation; some may be too great to require at all. Fore

[7] For a more detailed look at fetal hazards, see Margery W. Shaw, 'Conditional Prospective Rights of the Fetus', *The Journal of Legal Medicine* 5(1), March 1984, 63-116.

[8] For a fuller description of the effects on women of recognizing fetal rights, John Robertson, 'The Right to Procreate and in Utero Fetal Therapy', *The Journal of Legal Medicine* 3(3), 1982, 355.

[9] Among the writers who appear to be unaware of the implications of their recommendations, see Shaw and E. W. Keyserlingk, 'A Right of the Unborn Child to Prenatal Care – the Civil Law Perspective', *Revue de Droit* 13, Winter 1982, 49–90. For others who dismiss women's rights to bodily integrity and determination see Eike-Henner W. Kluge, 'When Caesarean Action Operations Imposed by a Court are Justified', *Journal of Medical Ethics* 1988, 206–11; Jeffrey Parness 'The Abuse and Neglect of the Human Unborn', *Family Law Quarterly* 20, 1986, 197–212 and 'The Duty to Prevent Handicaps: Laws Promoting the Prevention of Handicaps to Newborns', *Western New England Law Review* 5, 1983, 431–64; Robertson, and a commentator in the *Whittier Law Review* 9, Summer 1987, 363–91.

going small pleasures like an occasional drink is just the beginning. Imagine a bad cold – let alone more serious illness – without pain relief. Imagine, too, foregoing the therapy that will cure your disease – or being denied, as was Angela Carder, the only drugs that may prolong your life. What is it like to be a cocaine addict voluntarily – or involuntarily – going cold turkey? Imagine losing a good job because it endangers your fetus. Imagine knowing that you need unavailable prenatal care – or that its lack increases the probability that you will need dangerous treatment. Picture being required to undergo risky therapy for the sole benefit of another. Our anger rightly flares in response to those who take these situations for granted.

And yet it seems to me that those in the opposing camp are not altogether free of the same tendency to deny the reality of conflict or dismiss rather too quickly fetus's interests.

Barbara Katz Rothman, for instance, writes that

> The perception of the fetus as a person separate from the mother draws its roots from patriarchal ideology, and can be documented at least as far back as the early use of the microscope to see the homunculus. But until recently, the effects of this ideology on the management of pregnancy could only be indirect. For all practical purposes, the mother and fetus had to be treated as one unit while the fetus lay hidden inside the mother.[10]

She goes on to argue that medical technology emphasizes and makes concrete patriarchal notions about the relationship beween woman and fetus. Woman and fetus are seen as conceptually separate, joined only by an unimportant physical bond. A woman-centred view of pregnancy is, on the contrary, holistic: 'the baby is not planted within the mother, but flesh of her flesh, part of her . . .'[11] In consequence, the vision of warring interests and rights collapses.

What takes its place? Rothman suggests an analogy between persons at various ages and the relationship between woman and fetus: 'our old selves, our ageing selves, are part of our young selves, and yet become someone very different. Can I in my old age come to sue myself for behavior I engaged in when younger . . .'[12]

Now it may well be true that a patriarchal lens colours our view of pregnancy, obscuring the fact that fetuses are part of women's bodies. However, it does not follow that diverse interests cannot co-exist in one bit of flesh. Consider Siamese twins: the surgery necessary to

[10] Barbara Katz Rothman, *Recreating Motherhood: Ideology and Technology in a Patriarchal Society* N.Y.: W. W. Norton, 1989, 157.

[11] Ibid., 161

[12] Ibid.

separate them may mutilate or kill one or both. Do we really want to say that the loss is an illusion, that there can be no conflict of interest here?

Likewise, it is undeniable that decisions a woman makes now may affect the child she later bears. Where she chooses – perhaps for good reason – to ignore physicians' recommendations, any resulting baby will share the consequences with her. A choice that is good for her may harm her fetus; one person enjoys a benefit whereas the other (eventually) bears a burden. Just societies attempt to minimize such situations.

This contrasts with Rothman's image of the self. We may feel less or more connected with our earlier selves throughout life, but we are nonetheless one person. If we are lucky, others cared enough to help us temper our youthful exuberance and rebellion with some attention to long-term consequences. To the extent that we did not, we may now be paying the costs of long-gone pleasures. But the pleasures – even if we now regret them – were *ours*, not someone else's. A woman might enjoy her nightly beer, but it is not she who reaps Fetal Alcohol Syndrome. So the fact of being one flesh now does not preclude two different fates.[13]

Christine Overall attempts to diminish the impact of this conclusion by arguing that maternal and fetal interests tend to be in harmony: what is good for the one is also good for the other. This may often be true, but it does not help us when women, for whatever reason, fail to act in their own interest or when those interests truly diverge.[14]

THE SOCIAL CONTEXT OF CONFLICT

How can we begin to sort out the moral problems created by this situation? Surely we should start with the assumption that women have at least the same basic rights as other people. Universalizability requires that to the extent situations are parallel, women's interests should garner the same degree of respect as anybody else's. Where treatment diverges, it must be possible to point to a morally relevant difference in the situation. And the connection between that difference and the treatment must be tightly argued and show the same respect for women as middle-class white men would expect.

[13] I come to this conclusion with great regret, given Mary Anne Warren's attractive proposal that *'there is room for only one person with full and equal rights inside a single human skin'* 'The Moral Significance of Birth', *Hypatia* 4, (3), Fall 1990, 46–65.

[14] Christine Overall, *Ethics and Human Reproduction,* Boston, Mass.: Allen and Unwin, 1987, 99–100.

The question before us is a special case of the most general moral question: what do we owe others? More particularly, what do we owe others who do not yet exist? And, most particularly, what legally enforceable duties towards such future persons can be exacted of us?

Several different levels of obligation are recognized, depending on the nature of the relationship between the individuals in question. Various types of agreements (marriage, for instance), as well as biological relationships (such as parenthood) raise our expectations of what is morally owed; the law tends to reflect this understanding.

The closest analogy to the relationship between woman and fetus is the one between relatives. It is therefore more than a little interesting that a court refused to order involuntary bone marrow surgery on Shimp in order to increase the probability of his leukemic cousin McFall's survival.[15]

Perhaps the proper rejoinder is that Shimp and McFall were merely cousins – surely the closer relationship between women and fetus can justify greater demands on the former. But, as Kolder, Gallagher and Parsons argue, 'the closest legal analogy would be an organ "donation" ordered over the explicit refusal of a competent adult, and such an order would be profoundly at odds with our legal tradition.[16] George Annas notes that 'no mother has ever been legally required to undergo surgery or general anaesthesia (e.g. bone marrow or kidney transplant) to save the life of her dying child. It would be ironic, to say the least, if she could be forced to submit to more invasive surgical procedures for the sake of her fetus than for her child.'[17]

Annas assumes that a woman's duty toward her fetus must be no more demanding – in fact, less so – than a parent's duty toward her child. Fetuses, after all, are not yet persons, and the call of persons upon us is stronger than that of non-persons. Those who insist that women owe their fetuses at least the equivalent of transplants, are, on the contrary, assuming that women owe their fetuses *more* than their children.

Pregnancy is, of course, unlike any other relationship in human experience: analogies go only so far, and then we venture onto new

[15] See Nancy K. Rhoden, 'The Judge in the Delivery Room: The Emergence of Court-Ordered Cesareans', *California Law Review* 74, (6), part 2 1986, 19.

[16] Veronika E. B. Kolder, Janet Gallagher, and Michael T. Parsons, 'Court-Ordered Obstetrical Interventions', *The New England Journal of Medicine* 316, (19), May 7, 1987, 1194.

[17] George J. Annas, 'Forced Cesareans: The Most Unkindest Cut of All', *Hastings Center Report*, June 1982, 17. Rhoden offers an interesting analogy for our consideration: suppose a 'recalcitrant father were very obese and securely wedged in the door, and gaining access to the sick child to provide treatment required cutting through the father', 1968.

territory. The uniquely close relationship between woman and fetus has been taken to have serious moral implications. Those who are prepared to subordinate the welfare of women to that of their fetuses see this close relationship as justification for demands on women that exceed those required for children. However, proponents of this view don't seem to feel the need for argument showing just how and why this is the case; nor do they address the question of limits.

That this uniquely close relationship has compelling moral consequences is also taken for granted by those who think it justifies women's overriding say about their fetuses. But the case is little more developed than the previous one.

This as yet undefined characteristic that takes reasoning about pregnancy out of the realm of the relatively settled assumptions about parents and children seems to me to be disturbingly amorphous. Perhaps that is why we are seeing such contradictory implications drawn from it. Future research may help us to see the matter more clearly, but for now I think it would be a good deal safer to retreat to better explored ground.

The following points seem to me to be relevant to our discussion. First, dependence is a pervasive characteristic of human society. Secondly, because of their location and state, fetuses are dependent on women in an unusally fundamental and continuous way. Thirdly, fetuses are not moral persons. Fourthly, they will probably become such persons some time after birth.

I take it that we have a moral duty to take some steps to meet the needs of those who are dependent on us. I also take it that the morally relevant feature of pregnancy is not that fetuses are not now moral persons, but that they will be affected after birth by what happens now. So I think that Annas is wrong to assume that women might owe fetuses less than children here because they are not persons. But I think that there are no grounds for holding that woman owe them more than children, either.

If we ought to try to prevent disease or handicap in our children, the same duty holds for our fetuses, even if they are not yet persons. To achieve that end, no more and no less sacrifice ought to be legally expected of us in the two cases. Thus if parents are not required to submit to bodily invasions to save a dying child, then a woman should not be expected to do so for the benefit of a fetus; the converse is also true.

Personhood becomes relevant only where preventing death is at issue. Because fetuses are not persons, it may be morally permissible to abort them. This means that a woman could avoid some demands

by aborting her fetus, whereas she cannot kill a child. In this way, pregnancy requires less of her than parenthood.

Other factors may also help us differentiate between pregnancy and parenthood. One is that the fetus's probability of survival to personhood is somewhat lower. Another is that in some cases we are much less certain of how a fetus will be affected by a given state of affairs. This uncertainty increases the burden of proof on those who would override a pregnant woman's decision about what to do.

Given the foregoing, if judges refuse to order bodily invasions of parents for their children's benefit, they certainly should not be ordering them of women for their fetus's benefit. And they are refusing to order such invasions of parents. Consider, for instance, *In re George,* a case where a leukemic adoptee wanted access to his adoption records in order to see whether he could find a good bone marrow donor. The judge contacted his father, who was unwilling either to acknowledge paternity or be tested for compatibility. The judge would not even give the petitioner his father's name.[18] It should also be noted that the invasions so far contemplated (and denied) by the courts have been of substantially lesser magnitude then the caesareans now being ordered for women.

Not only are the orders legally inconsistent with precedent, but the manner of their making violates established procedures. Despite a general legal trend toward increased respect for our right to determine what shall happen to us and our bodies, women are deprived of the safeguards routinely afforded the unconscious, criminals, and individuals with mental problems. Indeed, 'court-ordered medical treatment — even of the incompetent or of those whose legal rights are limited — is imposed only after detailed fact finding conducted through full adversarial hearings with scrupulous attention to procedural rights'.[19] The reference to incompetents is not inapposite, as some cases overriding competent women's decisions rely for precedent on those where she is judged incompetent, suggesting that pregnancy renders women incompetent or constitutes a waiver of autonomy.[20] Yet proposed surgical searches of criminal defendants, sterilization of the mentally retarded or even mind-altering drug therapy for mental patients are supposed to be conducted only after a full legal hearing.[21]

[18] Rhoden, 1978.

[19] Ibid., 20.

[20] Ibid., 37. See also Rosalind Ekman Ladd, 'Women in Labor: Some Issues About Informed Consent', *Hypatia* 4, (3), Fall 1990, 37–45.

[21] Ibid., 20.

These violations tend to be protected from appellate review because the case is moot or because the losing party is unable or unwilling to pursue such a remedy. Moreover, the time constraints on cases of this kind limit the potential for amicus briefs filed by outside experts. These factors, Gallagher contends, have serious repercussions on the resulting law: 'the procedural shortcomings rampant in these cases are not mere technical deficiencies. They undermine the authority of the decisions themselves, posing serious questions as to whether judges can, in the absence of genuine notice, adequate representation, explicit standards of proof, and right of appeal, realistically frame principled and useful legal responses to the dilemmas with which they are being confronted.'[22]

George Annas elaborates on the inadequate social context of such emergency decision making, arguing that

> In the vast majority of cases, judges were called on an emergency basis and ordered interventions within hours. The judge usually went to the hospital. Physicians should know what most lawyers and almost all judges know: When a judge arrives at a hospital in response to an emergency call, he or she is acting much more like a lay person than a jurist. Without time to analyze the issues, without representation for the pregnant woman, without briefing or thoughtful reflection on the situation, in almost total ignorance of the relevant law, and in an unfamiliar setting faced by a relatively calm physician and a woman who can easily be labelled 'hysterical', the judge will almost always order whatever the physician advises.[23]

These procedures might help explain why of the twenty-one cases where involuntary treatment orders had been sought as of May 1987, they were successfully obtained in eighty-six percent of the cases, and were received within six hours in eighty-eight percent of them. That especially powerless women are at risk is suggested by the additional fact that eighty-one percent of the women were black, Asian or Hispanic.[24]

The casual nature of these decision procedures, as well as the gravity of the intrusion, differentiates these cases from others cited by Robertson in their defence.[25] Overturning an adult's decision about a matter affecting her own body legally requires physicians to 'meet

[22] Ibid., 49.

[23] George J. Annas, 'Protecting the Liberty of Pregnant Patients', *New England Journal of Medicine* 316, (19), May 7, 1987, 1213-14; 1213.

[24] Kolder, Gallagher, and Parsons, 1192.

[25] Robertson, 353–54.

an exacting standard of proof: establishing both the necessity of the procedure and the fact that no less drastic means are available. Their burden increases with the degree of invasiveness, risk, or indignity involved.'[26] Even cursory scrutiny of existing cases suggests that physicians' decisions are not subjected to even the most minimally demanding version of this charge.

Until medicine becomes less of an art and more of a science, it is not clear whether it is possible even in principle to meet that standard of proof. Disagreements about the best way to handle many situations abound. For example, there is serious debate about whether caesareans are indicated when a woman is pregnant with triplets.[27] It is also well known that caesarean rates generally vary widely, suggesting that decisions to cut are influenced by non-medical factors.[28]

Even where there is broad agreement about the necessity for treatment, judgements are not certain. For example, a condition known as 'placenta previa', where the placenta blocks the exit of the uterus, is widely considered a clear indication for a caesarean section. However, although ultrasonography is usually accurate in diagnosing this condition, it is not foolproof: less dangerous partial cases may be difficult to distinguish from complete ones. Furthermore, the placenta can move before delivery.[29] In fact, despite dire predictions for both woman and baby, a substantial percentage of the women for whom they were ordered subsequently gave birth to healthy babies without surgery. Thus, of the cases surveyed by Kolder, Gallagher and Parson, there were fifteen court orders for caesareans; in two of those cases the patient agreed in the end to have the operation; yet in six other cases, vaginal birth proved harmless.[30] Yet this reality has not prevented a judge from ordering 'that if the pregnant woman did not admit herself to the hospital by a specified time and date, she would be picked up and transported there by the police and would have to submit to "whatever the medical personnel deemed appropriate, including caesarean section and medication".'[31]

In general, the widely varying opinions about treatment, and the unreliable nature of the technologies, such as fetal monitoring, upon

[26] Gallagher, 20-21.

[27] Gallagher, 9. This information comes from V. Kolder, *Women's Health Law: A Feminist Perspective*, 1-2, August, 1985, unpublished manuscript on file at the *Harvard Women's Law Journal*.

[28] Gallagher, 50–51.

[29] Rhoden discusses this problem and others, 2011–17.

[30] Kolder, Gallagher and Parsons, 1193, 1195.

[31] Gallagher, 47, In this particular case, the woman fled into hiding with her entire family and two weeks later gave birth normally to a healthy, nine pound, two ounce baby. This matter of caesareans is far from trivial.

which those criteria for action are based appropriately give rise to considerable scepticism about physician recommendations. It is well known, for example, that fetal monitoring yields ambiguous results and there is much disagreement about their interpretation. Worse still, the Apgar scores used to rate fetal monitoring are themselves plagued by false positives, so that large numbers of children with low scores later do well. Even if such monitoring were accurate, however, many false positives would occur because of the special problems involved in screening for rare conditions. Many such practices, including keeping women prone during labor, have a tendency to precipitate the need for further intervention.[32] It is not just ignorance, but education that might cause a woman to think twice about doing as her doctor orders.

Another important related issue is that many decisions made by physicians are value judgements, not medical decisions at all. For example, Rhoden notes that physicians' approach to risk may not be the only reasonable one. Thus American obstetricians tend to adopt

An interesting sidelight on the safety of caesareans is provided by a nineteenth century medical historian who comments that a 'pregnant woman in labour had a 50 percent chance of survival post-cesarean if she performed her own surgery, or if gored by a bull, compared to a 10 percent reported survival rate if attended to by a New York surgeon'. (Cited by Rhoden, 1951.)

This historical tidbit is now outdated, but the risks of caesareans compared to natural childbirth remain considerable. Gallagher cites figures showing that the operation still involves a much higher risk of the woman's death: it is from three to thirty times the rate associated with vaginal delivery. Furthermore, all the subjects had much more pain, weakness and difficulty holding and caring for their new babies. The latter would support studies that suggest that caesareans make it more difficult for mother and baby to bond. Many more women also get sick – 10 to 65 percent of the women developed infections like intrauterine cystitis, peritonitis, abscess, gangrene, sepsis, urinary tract infections, and respiratory infections; women delivering normally experience five to 10 times less infection (Gallagher, 50, notes 210–213). Among its risks, a caesarean apparently sextuples the risk of developing placenta previa in subsequent pregnancies (Rhoden, 1958, n.51).

Caesarean delivery is not completely unproblematic for babies either. Apart from the aforementioned consequences of possible difficult bonding, they are more at risk physically, too. Gallagher cites a National Institutes of Health Caesarean Birth Task Force report that stated that the most serious worry is respiratory distress, especially when previous caesareans render a new, earlier operation necessary. It may be that vaginal delivery performs a helpful function by compressing the lungs (50, notes 212 and 213).

Gallagher argues that despite decreased rates of perinatal mortality cannot necessarily be attributed to the increasing rate of caesareans. She quotes Dr. Helen Marieskind who lists more plausible contributing factors such as improved sanitation and nutrition, increased access to health care, and use of contraception and abortion (p.50).

[32] Rhoden, 2011-17; Gallagher, 51.

a maximin approach that 'focuses on the worst possible outcome in a situation of uncertainty (here, fetal death or damage), and takes action to prevent that outcome, regardless of the outcome's actual probability of occurrence.'[33] Not only is this strategy not the only reasonable one, but the judgement that fetal death is the worst possible outcome is a moral judgement, not a medical one: we might prefer the conclusion that the worst outcome is maternal morbidity or mortality. The problem is exacerbated by the fact that most doctors have little or no training in moral reasoning, and even if they do, we may not share their values. In any case, the medical establishment's track record on women's interests is mixed at best.

Finally, this analysis has so far assumed that the overall social context is just. This is not true: unfair assumptions about women and their importance are embedded in judgements about what actions constitute 'least restrictive alternatives' and 'least drastic intrusions' required for overriding principles about bodily integrity and privacy and blind us to alternatives.

Take for instance the question of medical care. First, a narrow case: studies show that birthing women monitored by nurses with stethoscopes and those monitored with fetal monitors had equally healthy babies, although the former had fewer caesareans.[34] Hence such human monitoring ought to be required where we otherwise risk invading women's bodies — even if it costs more.

More generally, perinatal mortality is most commonly caused by prematurity.[35] Prematurity is well known to be strongly associated with poor prenatal care. Yet, twenty-three percent of pregnant women received late or no prenatal care in 1982. Such women, writes Schott, 'are three times more likely to have babies of low birth weight, the single most important contributor to infant mortality. Low birthweight babies are also susceptible to a host of medical problems and disabilities.'[36] Poverty, lack of education, minority status and geographical location are serious barriers to such care. For instance, according to Schott, it now costs in the USA an average of $5,000 to have a child. This amount may be more than a family without health insurance can pay. In 1978, twenty-six million Americans didn't have insurance; in 1984, thirty-seven million didn't have it, an increase of more than thirty percent. This means that some thirty-six percent of the women of childbearing age do not have insurance.[37]

[33] Rhoden, 2013. She gives several specific examples of such strategies.

[34] See Rothman, 157.

[35] Rhoden, 2013.

[36] Lee A. Schott, 'The Pamela Rae Stewart Case and Fetal harm: Prosecution or Prevention? *Harvard Women's Law Journal* 11, 1988, 242.

[37] Ibid., 242.

Current medical welfare programmes are not always sufficient to guarantee adequate care. Poor and minority women face special obstacles: they may have difficulty getting time off work, paying for childcare, arranging transportation to a clinic; they may also be subjected to indignities and outrages like involuntary sterilization once there. As federal funds are repeatedly cut, care may become completely unavailable. By 1985, the percentage of poor receiving Medicaid had dropped to forty-six percent, down from sixty-three percent in 1975. Even if a woman has Medicaid, however, she is by no means guaranteed care: in some areas there are no obstetrics physicians who accept Medicaid patients; overall, only fifty-six percent of such physicians do so.[38]

Under these circumstances, invading women's bodies to impose last-minute, heroic care is stupid, mean, and unfair. It is reminiscent of proposals to dose us with contraceptives to lower the birth rate, before eradicating the pronatalist pressures and occupational discrimination that contribute significantly to overpopulation in the first place. Until we as a society act to make good, inexpensive, convenient, and respectful care a priority, punishing women for lack of prenatal care reeks of hypocrisy. It is especially inappropriate in a society where no one is required to provide the poor with care if they lack funds. Consequently, a woman may be denied life-saving treatment, yet later be subjected to life-threatening risk to attempt to save her fetus.[39] This state of affairs is all the more angering because it is cheaper to furnish good prenatal care than caesareans, gaol, neonatal intensive care, or lifetime care for damaged babies. According to Schott, full prenatal care costs about $600 per patient; the cost of neonatal intensive care for a low birthweight baby costs about $10,000-$15,000.[40] Such care can, of course, cost vastly more, and these figures, in any case, take into account neither life-time costs of disability nor pain and suffering.

Toxic exposures in the workplace raise similar considerations. Many women of childbearing age are now exposed to dangerous substances. Should they all be required to remove themselves from these environments, even at the cost of losing their job? Most women work because they must, and a well-paying safe job may be hard to find; many are in any case inaccessible to the poor and uneducated. Eradicating discrimination against women in general, and recognizing the special contribution and needs of pregnant women, would relieve them of these difficult choices.

[38] Ibid., 241-42.

[39] See George J. Annas, 'AIDS, Judges, and the Right to Medical Care', *Hastings Center Report*, 18, no. 4, August/September 1988, 21.

[40] Schott, 242.

This particular problem would also disappear if employers were required to clean up workplaces. Some employers object that the expense of doing so is prohibitive. But then they are just passing on the cost of doing safe business to women, who are among those members of society least able to bear it as they earn the least. The dilemma facing women is therefore not inevitable: it is caused by employers' desire to save money and society's willingness to let them do so at women's expense. Alleged concern about fetuses rings hollow when people attempt to pass the entire burden of protecting them onto women.[41] Such 'concern' is especially suspect when it keeps women from only high-paying jobs, not the traditionally feminine ones that may well pose equally serious risks. Lack of interest in possible damage to sperm simply reinforces this suspicion.

The focus on getting women out of certain workplaces is especially odd when we discover that there have been no lawsuits by children with birth defects caused by occupational exposures of their parents. Furthermore, there are good reasons for believing that none are likely to be successful:

> Scientifically conclusive evidence that a particular workplace exposure caused or contributed to an injury is rare . . . a court of law or a worker's compensation board may be unwilling to rely solely, or even substantially, on the results of epidemiologic or toxicologic investigations to support claims for compensation . . . Therefore, for the most part, reproductively damaged workers have very limited access to redress against their employers through the courts.[42]

Odder still is the fact that, so far, more men than women have filed legal charges of reproductive damage caused by occupational exposures.[43] Environmental pollution raises similar issues.

Some environmental exposures arise from personal habits. Like men, women drink, smoke, and take drugs. It is now obvious that these substances affect fetuses. Disease and serious handicap are among the consequences for babies[44] Shielding them from these substances is therefore highly desirable. What about the pregnant women

[41] Of course, if women are impoverished by these policies, fetuses will ultimately also suffer.

[42] Office of Technology Assessment, cited by Donna M. Randall, 'Fetal Protection Policies: A Threat to Employee Rights?' *Employee Responsibilities and Rights Journal* 1, (2), 1988, 123-24.

[43] Ibid.

[44] See Marty Jessup and Robert Roth 'Clinical and Legal Perspectives on Prenatal Drug and Alcohol Use: Guidelines for Individual and Community Response', *Medicine and Law*, 7(4), November 4, 1988, 377-89.

who use them? Non-addicted women can reasonably be expected to stop if they are pregnant or trying to get pregnant, although the moral basis for such responsbility is shaky while corporations still spew dangerous pollutants into the air.[45] However, at present we depend mostly on moral exhortation, backed up with coercion. This approach is notoriously ineffective, yet society is unwilling to make the changes that would help people to reduce their reliance on such crutches and find alternative pleasures that are less harmful. Steps could be taken to lessen the likelihood that young women (and men) would adopt these habits in the first place. How about banning the cigarette and alcohol advertising that helps ensnare them? And, instead of subsidizing tobacco growers, the government could help fund wholesome alternative sources of fun like swimming pools, ski camps and cultural centres. This issue is symptomatic of the general reluctance to undertake fundamental reform that would help eradicate problems at their root instead of punishing those caught in difficult situations. Schott demonstrates convincingly in her article on the Pamela Rae Stewart case that the apparently self-centred and callous behaviour emphasized by the media can be shown to be reasonable in the circumstances; such circumstances could have been in large part prevented by better physician-patient communication and a more supportive society.

This point suggests the importance of raising some very basic questions about our society. Why is addiction growing? Why, in the eyes of so many, is being smashed or stoned a prerequisite for having a good time? I suspect that our social and political principles and arrangements have a great deal to do with what is happening. It seems that we have available to us relatively few sources of genuine pleasure and satisfaction. Furthermore, even those who are relatively well off are constantly enticed by goods they cannot have. Few of us have any real sense of economic security. Among industrialized countries, the United States is among the least developed in terms of social programmes, and the growth of drug use in the '80s coincides with *reductions in those already inadequate* programmes; poverty is increasing. Furthermore, the philosophy of individualism, egoism and self-sufficiency coupled with a system of hierarchy and privilege that for the most part excludes women and men of colour, is singularly hostile to human welfare. Austere and unsympathetic, this world view prefers narrowly-defined notions of freedom and justice to concerns about human happiness. It also tends to hold those on the bottom responsible for their acts, no matter how difficult the circumstances,

[45] See Gallagher, 56-57, note 242.

and prefers punishment to making social and political arrangements that help people to act morally in the first place. Consider, for example, the dearth of drug treatment programmes for pregnant women: there are six-month waiting lists for the few clinics that accept them in California.[46] Given the powerful grip drugs can have on people, how can we justifiably punish such women for not quitting when they get so little help?

If there is any truth in these speculations, then we are going to be faced with a choice between increasingly harsh and inequitable treatment of women or fundamental social change. The general social bias against fair consideration of women's interests already evident in much of medicine is likely, in the absence of such change, to lead to further high-handed treatment if contemporary trends continue. For example, physicians did an involuntary caesarean on a woman *without* seeking a court order in 1984.[47] That same year, a hospital sought and got a court order granting it temporary custody of a Nigerian woman's triplet fetuses and authorization of a caesarean section against her will. Yet the woman was not even informed of these events.[48]

Taken to their logical conclusion, current attitudes and practices could lead to still more fundamental subordination of women in the interests (or alleged interests) of others. Schott suggests that:

> for a pregnant woman, the existence of a fetal harm law would make nearly every action potentially criminal. Her day-to-day movements, diet, sexual practices, recreation and other activities would be subjected to the exacting and suspicious scrutiny of doctors, the public and possibly a jury. A woman might find it difficult to explain the forces influencing her actions, and to convince a jury that she was not motivated by hostility toward her fetus.[49]

These developments would broadcast a clear message about the relative weight of pregnant women's interests in comparison with those of fetuses. Peeping out from under such judgements would be the assumption that women in general are self-centred, thoughtless individuals who cannot be expected to behave morally.[50]

These possibilities are less farfetched than they might seem at first blush. When Kolder et al. examined the attitudes of heads of fellow-

[46] *Time*, May 22, 1989, 45.
[47] Gallagher, 46.
[48] Ibid., 9.
[49] Lee A. Schott, 'The Pamela Rae Stewart Case and Fetal harm: Prosecution or Prevention?' *Harvard Women's Law Journal* 11, 1988, 239.
[50] Ibid., 239.

ship programmes in maternal-fetal medicine they discovered the following statistics. First, in a sample of 57, 46 percent thought that women who endanger a fetus by refusing medical advice should be held against their will 'so that compliance could be assured.' Second, 47 percent wanted additional potentially lifesaving procedures ordered by courts if women refuse them. Last, but not least, 26 percent 'advocated state surveillance of women in the third trimester who stay outside the hospital system'. Because of erratic patterns of answers, only 24 percent consistently supported women's right to refuse medical advice.[51] *The Handmaid's Tale* looms ever closer!

In conclusion, court orders violating a woman's decisions about her own care are dubious at best. Both the procedures leading to the orders, and the orders themselves constitute and perpetuate a legal double standard for pregnant women. The facts upon which these decisions are based are less certain than they seem, and the non-medical judgements involved are, at best, ones about which reasonable people might disagree and, at worst, are biased against women. All of this constitutes another proof that women are still second-class citizens who are tacitly excluded from supposedly universal rights whenever convenient. Americans have more say over what will happen to their bodies after death than many women do over their bodies while they are alive. Yet, as Rhoden points out, 'by way of comparison, an organ taken from a cadaver can save a life just as an emergency caesarean can.'[52]

Hence it is seriously unjust to subject women to the kinds of treatment lately visited on them. Although women in difficult circumstances have a moral duty to do what they can for their fetuses, society ought not to hold them responsible for situations that are in large part due to its own moral inadequacies. It is especially dubious for society to do so when it shows so little concern for the well-being of existing children.[53]

I do not say any of this lightly: I have argued elsewhere — and still believe — that it is seriously wrong to knowingly bring a diseased or handicapped child into the world.[54] Other things being equal, I think that a woman's right to control her body can in some cases be less morally compelling than her child's interest in not going through life with major damage.

Should this moral state of affairs ever be reflected in a legal duty

[51] Kolder et al., 1193-94.

[52] Rhoden, 1982.

[53] I am indebted to Joan Callahan for reminding me of this point.

[54] See 'Genetic Disease: Can Having Children Be Immoral?' *Moral Problems in Medicine,* ed Samuel Gorovitz et al., N.J.: Prentice Hall, 2nd edition, 1982, 377–84.

to submit to medical coercion or punishment for having refused to follow medical advice? Recognizing any limit on women's right to control their bodies would be cause for considerable anxiety. A good deal of our current social and political edifice appears to have been constructed on the premise that even the most vital of women's interests deserve little consideration. Thus for example, it is still far from clear that all are persuaded that marital prerogative or privacy do not justify wifebeating or rape. The research for this paper was eye-opening with respect to the contempt with which some of women's most basic interests can be treated. Because women's interests are in constant danger of being undervalued, I believe that in cases of conflict our inclination should be to grant them priority. It would follow from this that no legal duty to submit to medical advice should be recognized.

Suppose, though, that we manage to create a humane and fair society, one where women's interests are fully recognized, where discrimination based on race, class, sexual orientation and the like are eradicated, and much greater concern for human welfare informs social and political arrangements.

We might want to consider expecting more of each other, both morally and legally. One form such expectations might take would be to assume that people should be willing to sacrifice expendable parts of their bodies (bone marrow, paired organs) to save the lives of others. A still more demanding expectation would be that people make such sacrifices to prevent serious illness or handicap on the part of others. Although the first of these would not affect pregnant women especially, because fetuses aren't persons, the second would have a disproportionate impact on such women, despite the fact that for all the reasons suggested in this paper, a humane world would invite many fewer conflicts of interest between women and their fetuses.

Perhaps for this, or some other reason, we would reject the prospect of enforcing such expectations legally; perhaps medical science will advance sufficiently to render the point moot. If not, might we then have to countenance the possibility of a legal duty on women's part to submit to medical care? As many commentators have noticed, a duty of this kind might be counterproductive, leading women to avoid the medical establishment altogether. In that case, only extreme and unacceptable invasions of our civil liberties could then guarantee women's compliance.[55] Women might also maintain control of their bodies by being willing to see seriously damaged newborns die or be killed.

[55] Thanks to Mary Anne Warren for this point.

A more caring society would be very desirable: its coming should be encouraged by all those who are dissatisfied with the chill of the classical liberal approach to relationships. It is time for thinking about what forms such caring might reasonably take, together with their implications for our contemporary values. In the meantime, the contrast between this vision and our current world should be enough to fuel the fight against the invasions of women's bodies now occurring.

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