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1999 Symposium Remarks

MATERNAL-FETAL CONFLICTS, THE SOCIAL CONSTRUCTION OF MATERNAL DEVIANCE, AND SOME THOUGHTS ABOUT LOVE AND JUSTICE

April Cherry*

Thank you. In the short amount of time that we have together today, I would like to accomplish three tasks. First, I would like to offer a brief overview of what and whom we are talking about when we talk about "maternal-fetal conflicts." Second, I would like to discuss some of the assumptions that are held about the women involved in these "conflicts," with the hope that giving voice to these assumptions might help us better understand why we may be willing to accept the coerced medical treatment of pregnant women, or legal sanctions against pregnant women who refuse treatment for the benefit of their fetuses. And, last, if time permits, I would like to offer my thoughts on how we might find a way out of this conundrum. I would like to begin to answer the question of how the law can facilitate justice for women and their fetuses under circumstances that are perceived by everyone involved as difficult.

I had not planned to discuss the legal arguments for and against court-ordered intervention in pregnancy, since this task has been met by many others with great clarity and thought.¹ Nevertheless, I want to take a mo-

* Professor Cherry is currently an Associate Professor of Law at the Cleveland-Marshall College of Law at Cleveland State University. This essay is an expanded version of a talk given at the *Texas Journal of Women and the Law's* conference entitled, "Approaching the Millennium: Emerging Issues in Bioethics and Information Technology," in March of 1999. Because much of this essay was initially given as a talk, I have left much of the "speech" quality of the essay intact. I would like to thank the editors of the *Journal* for generously permitting me to flesh out a little more fully some of my thoughts introduced at the conference, and law student Andrea White for her help in finalizing the essay.

1. See generally Dorothy E. Roberts, *Punishing Drug Addicts Who Have Babies: Women of Color, Equality, and the Right to Privacy*, 104 HARV. L. REV. 1419 (1991); Janet Gallagher, *Prenatal Invasions and Interventions: What's Wrong with Fetal Rights*, 10

ment and disagree with Professor Robertson for a minute. I want to respond to his idea that the pregnant woman, having foregone the opportunity to abort, has thus increased her duty to her fetus.² I believe that the notion that foregoing an abortion should be interpreted as a waiver of maternal autonomy and an acceptance of an increased duty towards the fetus is deeply flawed. I'd like to use an example of the access to abortion for women in my current hometown, Tallahassee, Florida, to illustrate my frustration with this line of analysis. Tallahassee, Florida's capital city, has a population of approximately 250,000 people.³ It is a city with two non-profit women's health clinics that provide abortions at a lower cost than if the services were provided by private physicians. Abortions are provided on only one day each week. The physicians who perform abortions do not live locally, but instead travel to Tallahassee in order to insure that women in the city, county, and surrounding rural areas have some access to safe and legal abortion services. To my knowledge, there are no private doctors in the city of Tallahassee who will publicly say that they perform abortions. In fact, I know of only two physicians who will perform abortions and generally the only way to get an appointment with them for the procedure is through one of the women's health care clinics. An appointment with either physician is possible only if you have money, approximately \$350, or insurance benefits that will pay for the procedure.

Under these circumstances, not having an abortion may mean that you do not have the money to pay for it, or that no facilities are available to you. So in the lives of real women, foregoing an abortion does not necessarily mean that the woman wanted to waive her maternal autonomy and accept an increased duty to the fetus.⁴ Again, it may simply mean that she can not afford to have the procedure performed. That said, I would like to talk about "maternal-fetal conflicts."

HARV. WOMEN'S L.J. 9 (1987); Nancy K. Rhoden, *The Judge in the Delivery Room: The Emergence of Court-Ordered Cesareans*, 74 CAL. L. REV. 1951 (1986).

2. For a fuller discussion of Professor Robertson's argument, see, e.g., John A. Robertson, *Procreative Liberty and the Control of Conception, Pregnancy, and Childbirth*, 69 VA. L. REV. 405 (1983).

3. See *Estimates of Population of Metropolitan Areas Annual Time Series, July 1, 1991 to July 1, 1996* (visited Oct. 11, 1999) <<http://www.census.gov/population/estimates/metro-city/ma96-05.txt>>.

4. There are, of course, other reasons for not having an abortion, including the desire to have a baby. But the woman who desires to have a child does not necessarily intend to put her own health or life at risk in the process. Thus, without much more than the absence of an abortion, we can not in good conscience infer a maternal waiver of autonomy.

I. A Piece of Narrative:⁵ In the beginning . . .

So, now a story:

I first came to this "maternal-fetal conflict" problem very personally during my first semester of law teaching. When the semester started I was six months pregnant. It was determined through a sonogram earlier in my pregnancy that I had a condition known as partial placenta previa. Placenta previa is a condition in which the placenta of the pregnant woman covers her cervix either partially or completely. In cases of complete placenta previa, a cesarean section is generally thought to be medically indicated. In these cases, women who go into spontaneous labor may bleed to death.⁶ Cases of partial placenta previa often resolve themselves. The placenta can simply change its position during the course of the pregnancy without medical intervention. Consequently, when a pregnant woman is diagnosed with partial placenta previa, a second sonogram is routinely performed in order to determine whether or not the situation has naturally resolved itself.⁷ So, during the seventh month of my pregnancy, a second sonogram was performed. Ultrasonography is an amazing technology. It allows doctors and their patients (and the patient's family and friends) to view an image of the fetus in utero. It encourages us to imagine futures with children who are not yet born. In any event, I was presented with a copy of the sonographic image of my fetus (now a fully formed grade-schooler named Olivia). As wonderful as it was to have a copy of this image to take home with me, it was also confusing. So that afternoon, after the sonogram was performed, I walked around the law school confused about this picture, trying to figure out why this picture didn't make sense to me. Finally I came across a colleague, and dear friend of mine, Meg Baldwin, and I said something like, "Meg, what about this is troubling me?" She responded quickly and simply, "You are not in the picture." She had hit the proverbial nail on its head. The free-floating fetus in the picture did not come close to my experience of pregnancy. In no way did it reflect the relationship I had with the fetus growing inside of me—a relationship that was at many times a unitary experience, a relationship that I was having with my own body,

5. In both feminist and critical race critiques, storytelling, or narrative, is acknowledged as potentially transformative. Storytelling can help create alternative visions of reality. See generally Kim Lane Schepple, *Legal Storytelling*, 87 MICH. L. REV. 2073 (1989).

6. See Nancy Wainer Cohen & Lois J. Estner, *SILENT KNIFE: CESAREAN PREVENTION AND VAGINAL BIRTH AFTER CESAREAN* 16 (1983) (defining placenta previa and explaining why cesarean section is medically indicated for complete placenta previa); *AMERICAN HERITAGE, STEDMAN'S MEDICAL DICTIONARY* 645 (1995) (defining placenta previa).

7. See Rhoden, *supra* note 1, at 2001 (sonogram is exceptionally accurate as a diagnostic tool for placenta previa).

and at times a relationship of duality, in which I was as important to it as it was to me. Patricia Williams captured much of my own experience when she wrote, "I do not believe that a fetus is a separate person from the moment of conception. How could it be? It is so interconnected, so flesh-and-blood boned, so completely part of a woman's body. Why try to carve one from the other?"⁸

But the technology shows us a different story, that of the free-floating fetus, unattached to its mother, a singular entity. From the view of the computer screen, the fetus can look like an autonomous being, imbued with both legal and moral rights; a being in need of an advocate to protect it from a potential enemy.⁹ From the vantage point of the technology, the fetus, my fetus, could be imagined to be a separate person and a separate patient.¹⁰ All of this talk of "separateness" becomes possible because the technology, by allowing us a peek inside pregnant women's bodies, has allowed both the legal and the medical imagination to perceive separateness where there is, at least in my experience, unity.¹¹ Hence, I hope that you can see why the issue of "conflicts" between pregnant women and their fetuses has become important to me on many levels. In that law school corridor, not only was I worried about issues of justice for women in some broad sense, I also worried about what was going to happen to me and my fetus when I went to the hospital to deliver my baby. In any event, this is how I come to this topic and the work I do.

II. Two Paradigmatic Cases of the Maternal-Fetal Conflict

The issue of "maternal-fetal conflicts" comes up in a course I teach on reproductive rights. We usually see the discussion in two circumstances. The first is the compelled, or forced, medical treatment of preg-

8. Patricia J. Williams, *Fetal Fictions: An Exploration of Property Archetypes in a Racial and Gendered Context*, 42 FLA. L. REV. 81, 92 (1990).

9. See Frances Olsen, *Unraveling Compromise*, 103 HARV. L. REV. 105, 123-24 n.78 (1989) (arguing that the understanding of a fetus as a "living" being is a socially constructed belief, not a biological fact).

10. I am also curious whether the image of the fetus is also racially white, given that the technology doesn't give one a "technicolor" view. I wonder how this image plays into the debate.

11. See Rosalind Pollack Petchesky, *Fetal Images: The Power of Visual Culture in the Politics of Reproduction*, 13 FEMINIST STUDIES 263 (1987) (ability to see the fetus in utero through the use of ultrasound technology has promoted the view of the fetus as a separate individual, and as a separate patient). But see Susan Marken, *Feeding the Fetus: On Interrogating the Notion of Maternal-Fetal Conflicts*, 23 FEMINIST STUDIES 351 (1997) (arguing that emergence of fetal rights discourse is not solely attributable to technological innovation; it is also a result of anti-abortion rhetoric).

nant women, usually cesareans or blood transfusions, and the second is the use of illegal drugs by pregnant women.

A. *The Coerced Medical Treatment of Pregnant Women*

The first paradigm for the "maternal-fetal conflict" is where the apparent conflict arises between the need of the fetus for particular medical treatment and the pregnant woman's refusal of that treatment as suggested by a physician. Part of the problem with these cases is that often enough, the suggestions for a particular medical treatment are given by a physician who is not the pregnant woman's physician. This detail is important to me. The available data strongly suggest that in the vast majority of maternal-fetal conflict cases, i.e., where doctors and hospitals seek to compel treatment via law, the pregnant women are often poor, unmarried, and women of color. They present for labor and delivery at either public or teaching hospitals.¹² They have received little or no prenatal care, so they do not have a primary obstetrician. The women we are talking about often do not have a trusting relationship with a doctor. In fact, they may have no relationship with doctors, except for when they come to hospitals to deliver their babies.

In the context in which these women are birthing babies, and given poor people's and black people's lack of trust in the medical profession,¹³ it does not seem unreasonable for the woman presenting in that situation not to trust the opinion, however learned, of a doctor whom she has just met. The context also helps to explain how these women are labeled as deviant by other actors in the drama and subjected to heightened social control. But more on that later.

In any event, the doctors and hospitals seek to compel treatment. The treatments are usually suggested because the medical staff believes that without treatment, the fetus will die or be born with significant damage, or because the physician does not believe that these women are capable of making an intelligent, informed decision. The treatments range in invasiveness from blood transfusions to cesarean sections. I am inclined to believe that a cesarean section operation is the most invasive. Perhaps in utero fetal therapy is more invasive, but after reading a few descriptions of

12. See Vronika E.B. Kolder et al., *Court Ordered Obstetrical Interventions*, 316 NEW ENG. J. MED. 1192, 1193 (1987).

13. See Patricia A. King & Leslie E. Wolf, *Empowering and Protecting Patients: Lessons for Physician-Assisted Suicide from the African-American Experience*, 82 MINN. L. REV. 1015, 1020 (1998) (discussing physician-assisted suicide in light of the negative history between the medical community and black and poor peoples).

cesarean sections,¹⁴ I cannot imagine being more invaded, even though we tend to think of cesarean sections as not so dangerous. The cesarean section operation is viewed as a "normal" method of child birthing, because it is done with much frequency.¹⁵ Because cesarean sections have become normalized as a birthing method, we tend to think of them as not very serious. But in fact they are, particularly when compared to a vaginal birth. Cesarean sections are still considered major abdominal surgery, having all the risks associated therewith, including infection and death.¹⁶ Additionally, the maternal mortality rate for cesarean section patients is much higher than for those patients who give birth vaginally. Studies estimate that maternal mortality rates for cesarean delivery are two to four times higher than the maternal mortality rates associated with vaginal delivery.¹⁷ Notwithstanding all of this data, I am not arguing that cesarean sections are not relatively safe surgeries, but they do carry the risks of death and infection. In addition, it may also be important to note that cesarean section deliveries are often performed unnecessarily. For example, in 1991, there were approximately 350,000 unnecessary cesarean section operations performed in the United States.¹⁸ Thus, in the context of the danger of the procedure and its overuse, it makes perfect sense that women, when presented with the option of having a cesarean section, might say, "No, thank you."¹⁹

14. For a very graphic and poignant description of a cesarean section, see MICHELLE HARRISON, *A WOMAN IN RESIDENCE*, 8-1-84 (1982), quoted in Janet Gallagher, *Prenatal Invasions and Interventions*, *supra* note 1, at 36-37 n.137.

15. Cesarean sections are the most commonly performed major surgery in the United States. See Robert Steinbrook, *Caesarean Birth Rates Falling in the U.S., Researchers Say*, L.A. TIMES, May 13, 1992, at A1.

16. Even though cesarean sections are considered major abdominal surgery, the percentage of cesareans performed is still quite high. For example, in 1991, delivery by cesarean section comprised 23.5 percent of all deliveries. See *U.S. Says 349,000 Caesareans in 1991 Were Not Necessary*, N.Y. TIMES, April 23, 1993, at A16 [hereinafter *Not Necessary*].

17. See Dianne B. Petitti et al., *In-Hospital Maternal Mortality in the United States: Time Trends and Relation to Method of Delivery*, 50 OBSTETRICS & GYNECOLOGY 6, 11 (1982).

18. See *Not Necessary*, *supra* note 16, at A16. In the same year, Public Citizen's Health Research Group estimated that approximately 349,000 of the 1,000,000 cesarean sections performed in 1991 were unnecessary. See Leslie Laurence, *Unkindest Cuts? Caesarean Sections Come Under Watchdogs' Scrutiny*, CHR. TRIB., June 6, 1993, at 5.

19. See Leslie G. Espinoza, *Dissecting Women, Dissecting Law: The Court-Ordering of Caesarean Section Operations and the Failure of Informed Consent to Protect Women of Color*, 13 NAT'L BLACK L.J. 211, 212 n.6. (1994) ("It is, given the extent of unnecessary caesarean operations, quite reasonable for women to question the recommendation for surgery.").

Also important in understanding the coerced medical treatment of pregnant women as morally and legally problematic is the demographics, including the race, ethnicity, national origin, and class of the women so coerced. I have already mentioned briefly some of the demographics, but I would like to add a few other facts to the mix. For example, a national survey performed in 1986 by doctors at the University of Illinois College of Medicine found that in a five-year period, at least twenty-one court orders had been sought by hospitals that responded to their surveys.²⁰ Of those twenty-one court orders sought, courts issued orders compelling treatment of the women in eighteen of the twenty-one cases. Over eighty-five percent of those court orders were obtained within six hours. Eighty-one percent of the women involved were black, Asian, or Latino. Forty-four percent were unmarried. Twenty-five percent did not speak English as their language of choice, or their primary language. Finally, almost all the pregnant women involved were treated in teaching hospitals or were receiving public assistance.²¹

The survey also indicated that in one-third of the cases, the prediction of fetal harm was inaccurate.²² Despite the inaccuracy of the electronic

20. See Kolder et al., *supra* note 12, at 1192-93. Given that only 90 hospitals responded to the survey, the fact that 21 of the respondents sought court orders seems significant. It suggests that the reliance on law to enforce the physician's judgment regarding the care of pregnant women and their fetuses is widespread.

21. See *id.* at 1193.

22. See *id.* at 1195. In the majority of cases, a cesarean is recommended by the physician based on a diagnosis of "fetal distress." Fetal distress is often diagnosed by an interpretation of electronic fetal monitoring technology (EMF). EMF can be highly inaccurate. As Margaret Lent notes, "[s]tudies indicate that the inaccuracy of the technique prompts unnecessary interventions and contributes to the nation's excessively high rate of cesarean delivery, a major surgical procedure which places mother and infant at great risk of injury and death than noncesarean delivery." Margaret Lent, Note, *The Medical and Legal Risks of the Electronic Fetal Monitor*, 51 STAN. L. REV. 807, 807-08 (1999).

Another poignant point illustrated by the Kolder study was the attitude of physicians concerning pregnant women who refused to submit to physician recommendations. The survey indicated that 46 percent of heads of fellowship programs in maternal-fetal medicine (I suspect that these programs were formally called "obstetrics" before the widespread use of ultrasound technology) thought that women who refused medical treatment and thereby endangered the lives of their fetuses should be detained in the hospital, and 47 percent of these heads of fellowship programs supported seeking court orders to compel treatment. Kolder et al., *supra* note 12, at 1193-94. One of the reasons why I think that is particularly interesting is the American College of Obstetricians and Gynecologists and the American Public Health Association have taken a position that physicians should not seek court orders to compel treatment for competent pregnant women. See Committee on Ethics, American College of Obstetrics and Gynecology, Patient Choice: Maternal-Fetal Conflict, Comm. Opinion No. 55 (Oct. 1987) (quoted in James J. Nocon, *Physicians and Maternal-Fetal Conflict: Duties, Rights and Responsibilities*, 5 J.L. & HEALTH 1, 18 (1990/91) [hereinafter *ACOG Committee Report*]). This position is taken particularly out of fear that the women

fetal monitoring technology, physicians and hospitals rely on its data as a safeguard against the often-phantom threat of legal liability for medical malpractice.²³ Physicians and hospitals inform the presiding judge that, without the proposed medical and legal intervention proposed, the fetus will die. Well, in one-third of those cases, the doctors' predictions were wrong. I do not think these predictions of poor outcomes are necessarily the result of doctors' practicing bad medicine. I think the inaccuracy of the predictions is caused by the uncertainty that is intrinsic to medical judgment. As a committee on ethics of the American College of Obstetrics and Gynecology suggested, "The role of obstetrician should be one of an informed educator and counselor weighing the risks and benefits to both patients (the pregnant woman and her fetus) as well as realizing that tests, judgments, and decisions are fallible."²⁴ Medicine is art as well as science; hence, doctors make mistakes. And given that doctors make mistakes and the law nevertheless enforces their judgments, then I want to ask why don't we allow women to make decisions in these contexts that may have a negative outcome for the fetus? Why doesn't the law support the judgment of women regarding their pregnancies? Why can't a woman make a choice vis-a-vis herself and her fetus that might have a bad outcome? In other words, why can't women make mistakes? What compelled medical treatment means is that doctors get to make choices that affect both a pregnant woman and her fetus all the time, with the force of the law to back them up. Why do we put more faith in the physicians than we do in the women? Why don't we care what women want or need? Where is the justice, love, or compassion for the pregnant woman who is trying to make a difficult decision?

B. The Case of the Pregnant User of Illicit Drugs

The second situation where there seems to be an apparent maternal-fetal conflict is in the case of drug-addicted pregnant women. The cases in this category are most often discussed as the case of the pregnant woman addicted to crack as opposed to the one addicted to powder cocaine. We know that in the public mind the difference between the crack user and the powder cocaine user is a racial difference. Because crack is less expensive than powder cocaine, its use is more likely to be associated with poor peo-

who are in the most need of prenatal care, the women who most need to deliver in a hospital, the women who have the highest-risk pregnancy, will not present themselves to the hospital, and the outcomes will be worse. Perhaps if we can get the women into the hospital, we can maybe convince them through some love and justice and respect, that intervention is necessary, if it is indeed necessary.

23. See Lent, *supra* note 22, at 808.

24. See ACOG Committee Report.

ple, e.g., black folks, than with the wealthier drug users, e.g., white folks.²⁵ In fact, drug-using and drug-addicted women who have been detained in hospitals or sent to prison out of concern for their fetuses have been largely poor women of color.²⁶ Judges send these women to jails and prisons with the belief that "preventative detention" will foster fetal welfare. As Sandra Garcia reports, a well-respected state court judge has said that "he would have no compunction regarding ruling outside of sentencing guidelines if a 'doper' came before him during her pregnancy, and that he firmly believed that of the 300 judges who had just attended a conference, the vast majority would rule in ways that would favor fetal health."²⁷ Unfortunately, "preventative detention" is not necessarily conducive to either maternal or fetal health. Not only are illicit drugs available in jails and prisons,²⁸ these institutions generally lack the medical facilities necessary for good prenatal care.²⁹ Furthermore, shackling a woman during childbirth is not conducive to maternal-infant bonding, thought to be of prime importance for the in-

25. See Dorothy E. Roberts, *Crime, Race, and Reproduction*, 67 TUL. L. REV. 1945, 1958-59 (1993) (noting the harsher sentencing guidelines for crack, which is primarily used by blacks, as compared to those for cocaine, which is primarily used by whites). Of course, there are many legal substances that can cause great damage to a growing fetus, including alcohol and nicotine. In fact, the data is much more conclusive regarding fetal alcohol syndrome than the damage done to infants exposed to crack or cocaine in utero. See Lynn M. Paltrow, *Pregnant Drug Users, Fetal Persons and the Threat to Roe v. Wade*, 62 ALB. L. REV. 999, 1018 (1999) (noting a higher risk of fetal harm from exposure to alcohol and cigarettes). And, although there is a growing amount of social censure against women who smoke tobacco products and who drink alcohol while pregnant, there does not seem to be the same political will to legally sanction their behavior. I suspect the fact that the image of "the smoker" and "the drinker" are not racialized has something to do with the almost singular focus on crack-exposed fetuses and their mothers.

26. See generally Roberts, *Crime Race, and Reproduction*, *supra* note 25, at 1953 and accompanying notes (citing study that reveals that black pregnant women were 10 times more likely than white pregnant women to be reported to public health authorities even though the rates of substance abuse are similar for black and white women); Dawn Johnsen, *Shared Interests: Promoting Healthy Births Without Sacrificing Women's Liberty*, 43 HARV. L.J. 569, 576-606 (1992) (discussing statistical evidence that African-American women are the primary targets of fetal drug-related prosecutions).

27. Sandra Anderson Garcia, *Maternal Drug Abuse: Laws and Ethics as Agents of Just Balances and Therapeutic Interventions*, 28(13) INT'L J. ADDICTIONS 1311 n.3 (1993).

28. See, e.g., Elsa Walsh, *Drug Use at Lorton 'Disturbing': Increased Demand by Inmates Feared*, WASH. POST, July 3, 1989, at B01 (discussing the ready availability of illegal drugs in prison); Catherine Foster, *Fetal Endangerment Cases Increase*, CHRISTIAN SCI. MONITOR, Oct. 10, 1989, at 8 (same).

29. See *Legal Interventions During Pregnancy, Court-Ordered Medical Treatments and Legal Penalties for Potentially Harmful Behavior by Pregnant Women*, 246 J. AM. MED. ASS'N 2663, 2667 (1990) (opposing preventative detention for a variety of reasons, including the fact that prisons have inadequate health care resources, and are "shockingly deficient in attending to the health care needs of pregnant women"); see also Barrie L. Becker, *Order in the Court: Challenging Judges Who Incarcerate Pregnant Substance-Dependent Defend-*

fant. It serves merely to punish the woman and show society's contempt for poor, non-English speaking women of color and their children. If we care about infants as much as we seem to care about fetuses, we might want to reconsider "preventative detention," and consider other ways to encourage maternal and fetal health.

Because the image of "the crack-head" is so racialized, this focus on crack-exposed fetuses and pregnant crack users makes me suspicious.³⁰ Nevertheless, there is some truth to the charge that women who use crack while pregnant may under many circumstances give birth to babies whose health is, at least initially, compromised.³¹ However, the data on the long-term harm maternal crack use is not as conclusive as the public has been led to believe. Although the babies born to women who use crack during their pregnancies may be born with a host of medical problems, it is unclear as to whether these medical problems, other than any drug withdrawal that the infant might suffer, are the result of the maternal crack use, or lack of prenatal care and maternal malnutrition—just plain old poverty.³² It is also unclear as to whether the initial condition of the newborn born in these circumstances has any long-term effects. At five years old, "crack babies" look a lot like the "non-crack babies" if they are well nourished and live in fairly supportive environments.³³ Therefore, it is highly probable that the

ants to Protect Fetal Health, 19 HASTINGS CONST. L. Q. 235, 239 (1991) (discussing dangerous lack of prenatal care in jails and prisons).

30. Laura Gomez suggests that the convergence of the war on drugs with the abortion debate propelled "crack-babies" into the public imagination. See generally Laura E. Gomez, *MISCONCEIVING MOTHERS: LEGISLATORS, PROSECUTORS, AND THE POLITICS OF PRE-NATAL DRUG EXPOSURE* 1-41 (1997). One commentator notes, "The crack-baby myth was so powerful because it had something for everyone, whether one's ideological leaning called for enhancing public programs to meet the crisis, or for punishing the drug addicted mothers seen as responsible for it." Katherine Geider, *Crackpot Ideas*, MOTHER JONES, July/Aug. 1995, at 55.

31. Initial studies by Dr. Ira Chasnoff and his colleagues suggested that correlations exist between the use of cocaine during pregnancy and instances of premature birth and low birth weight. These studies also suggest that higher rates of physical, mental, and emotional problems were to be found in children who had been exposed to crack in utero. See generally Ira J. Chasnoff et al., *Cocaine Use in Pregnancy*, 313 NEW ENG. J. MED. 666 (1985); Ira J. Chasnoff et al., *Perinatal Cerebral Infarction and Maternal Cocaine Use*, 108 J. PEDIATRICS 456 (1986); Ira J. Chasnoff et al., *Prenatal Drug Exposure: Effects on Neonatal and Infant Growth and Development*, 8 NEUROBEHAVIORAL TOXICOLOGY & TERATOLOGY 357 (1986).

32. Gideon Shear Koren et al., *Bias Against the Null Hypothesis: The Reproductive Hazards of Cocaine*, LANCET (Dec. 16, 1989), at 1440-42 (criticizing the methodology of Chasnoff's early studies on the effect of fetal exposure to cocaine and suggesting other causes for poor fetal outcomes).

33. See Nancy L. Day & Gale A. Richardson, *Comparative Teratogenicity of Alcohol and other Drugs*, 18 ALCOHOL RES. WORLD 42 (1994). The authors note that:

crack-baby crisis to which the law has been responding is more myth than reality.

In summary, when we look at the demographics of those pregnant women described as being in conflict with their fetuses, we see that the group is composed of those women who are some of the most disenfranchised in our society and most subject to other forms of reproductive control.³⁴ We can also see that although physician prediction of fetal harm is often inaccurate, it is nevertheless preferred over the judgment, also often imperfect, of these pregnant women. These factors, especially when taken together, should cause us to question any policy regulating the relationship between pregnant women and their fetuses. History tells us that any such rules will be used against women, particularly women of color, as a tool of social control.

III. The Construction of Social Deviance in the Construction of the Maternal-Fetal Conflict

Next, I would like us to think about the social assumptions we make about these women that may underlie our acceptance of coerced medical treatment or legal intervention into maternal decisions and behaviors during pregnancy and childbirth. In this regard, I have been thinking about sociological theories of social deviance. Sociologists have noted that deviance, at least from a popular point of view, is behavior that is bizarre, unconventional, hard to understand, or behavior that people disapprove of.³⁵ But, from a sociological perspective, this kind of common sense definition is both incomplete and deceptive for two reasons. First, what is peculiar or bizarre in one situation may be ordinary, understandable, and/or rational in another situation. And even the most seemingly bizarre behavior can be understood as reasonable if we are cognizant of the context in

Negative effects of prenatal cocaine exposure have not been substantiated. Although some investigators have demonstrated significant effects of cocaine use during pregnancy, almost all of these relationships disappear when factors such as prenatal care, lifestyle and multiple drug use are assessed. . . . Thus previous reports may have attributed poor pregnancy outcomes to prenatal cocaine exposure because of the failure to control for associated factors.

Id.

34. See e.g., *Relf v. Weinberger*, 565 F.2d 722 (D.C. Cir. 1977) (finding that between 100,000 and 150,000 poor women were sterilized annually under federally-funded programs); *Madrigal v. Quilligan*, No. CV75-2057 (C.D. Cal. June 30, 1978), *aff'd*, 639 F.2d 789 (9th Cir. 1981) (holding that non-consensual sterilization of Mexican-American women is not compensable due to "abnormalities" of Mexican-American subculture of which white American doctors could not be expected to understand). See also Roberts, *Crime, Race, and Reproduction*, *supra* note 25; Roberts, *Punishing Drug Addicts*, *supra* note 1.

35. See, e.g., MARGARET ANDERSEN, *THINKING ABOUT WOMEN: SOCIOLOGICAL PERSPECTIVES ON SEX AND GENDER* 248 (3d ed. 1993).

which the behavior occurs.³⁶ Deviance is also a social definition. It describes whether the behavior in question is approved of or disapproved of by the larger culture. Deviance as a social definition of whether behavior is approved or disapproved depends on who is behaving and who is defining the behavior.³⁷ Deviance is socially constructed, subjecting its objects to social control.³⁸ So, deviance must be understood as behavior that is located in a social context. In the case of the maternal-fetal conflict, the context is one in which those with little social, political, or economic power are defined and controlled by those with much: the medical profession and the judicial system.³⁹ In fact women in particular are likely to be labeled deviant if their behavior does not adhere to the dominant gender norms.⁴⁰ Although many gender norms are implicit, maternity norms are clearly expressed in numerous ways by the dominant culture.⁴¹ For example, under these same gender norms, good women are thought to be, by nature, altruistic and self-sacrificing.⁴² As Janice Raymond notes:

For women, gift-giving is a source of identity, status, and relief from guilt. Women who don't give time, energy, care, sex . . . are exposed to disapproval or penalty. But the more important element here is that on a cultural level women *are expected* to

36. See *id.*

37. As one author explains, social groups create deviance by making rules and proclaiming that infractions of those rules constitutes deviance, and by applying the rules to particular people and labeling them as outsiders. Thus, deviance is not a quality of the act the person commits, but rather a consequence of the application by others of rules and sanctions to an "offender." See HOWARD S. BECKER, *THE OUTSIDERS* 9 (1963).

38. Cf. EDWIN SCHUR, *LABELING DEVIANT BEHAVIOR: ITS SOCIOLOGICAL IMPLICATIONS* 51 (1971) (stereotyping and deviance influence the substance and implementation of legal rules and political policy); BECKER, *supra* note 37, at 18 (the labeling of deviance is part of a political process).

39. John Lofland has described deviance as "the name of the conflict game in which individuals or loosely organized small groups with little power are strongly feared by a well organized sizable minority or majority who have a large amount of power." JOHN LOFLAND, *DEVIANCE AND IDENTITY* 14 (1969) (quoted in SCHUR, *LABELING DEVIANT BEHAVIOR*, *supra* note 38, at 31).

40. See EDWIN SCHUR, *LABELING WOMEN DEVIANT* 52 (1983).

41. For example, in one reported study, researchers found that married mothers were viewed as having the most positive personality traits when compared to women in general, divorced mothers, stepmothers and never-married mothers. Married mothers were viewed as more forgiving, caring, warm, and generous than women in general. On the other hand, never-married mothers were viewed as having poor childrearing abilities, and were more likely than other mothers to be characterized as irresponsible, stupid, lazy and drug abusers. See Lawrence H. Ganong & Marilyn Coleman, *The Content of Mother Stereotypes*, 32 *SEX ROLES* 495, 507-10 (1995).

42. See SCHUR, *LABELING WOMEN DEVIANT*, *supra* note 40.

donate themselves in the form of time, energy and body, particularly as mothers.⁴³

How does this relate to maternal-fetal conflicts? I believe that acceptance of deviance as social construction helps our understanding of the issue in two ways. First, it helps us comprehend that "deviance" is part of both a social and political process that is fraught with issues of dominance and subordination. Second, it may help us to understand our reaction to women whose deviance is derived from not complying with our social definition of good, nurturing, altruistic mothers.⁴⁴ So, when women, particularly mothers who are poor, of color, non-English speaking, or illicit drug users, do not comply with physicians' expectations or suggestions, they are understood as selfish and uncaring (or stupid), and just plaid old bad mothers. Women who are bad mothers (through willfulness or ignorance) are inappropriate decision-makers for their fetuses. Once they are described as deviant in these ways, pregnant women become subject to physician and judicial control.

IV. Some Thoughts About Love and Justice

I would like to suggest a way out of the kind of objectification of women that we find in the maternal-fetal conflict; that is, the construction of non-conforming or non-altruistic pregnant women as deviant and hence objects for social and legal control. My suggestion is not new, but I believe that it is nevertheless quite radical and worth repeating. My suggestion is for us to love women and infants as much as we seem to love the potentiality of the fetus. If we really loved women and cared about justice for them, we would be more apt to respect their bodies, their self-determination, and their choices, even when we don't agree with the choices made.

So if we dared to care about justice for women, then what type of social and legal policy might we develop? I think that justice for women and their infants demands that we look at the material needs of all women

43. JANICE RAYMOND, *WOMEN AS WOMBS* 52 (1993). Raymond also notes that women's altruism on behalf of their fetuses is required even in death. For example, courts have ordered postmortem and proremortem obstetrical interventions, such as keeping brain-dead women on ventilators under the flag of fetal rights. See *id.* at 47.

44. We all know that when children perform poorly in school, when they misbehave, when they commit crimes, when they present with almost any kind of psychological issue, the mothers are blamed. The mothers aren't nurturing enough. See e.g., Paula J. Caplan & Ian Hall McCorquodale, *Motherblaming in Major Clinical Journals*, 55 AM. J. ORTHOPSYCHIATRY 345, 347-48 (1985). Caplan and McCorquodale surveyed psychological journals and found that mothers were blamed for a large variety of psychological problems in their children, including bed-wetting, psychosis, sexual dysfunction, frigidity, and fears of penile shrinkage. Fathers were barely mentioned, but when mentioned, they were mentioned in only positive ways.

and infants and translate those needs into affirmative rights or affirmative obligations on the part of the state.⁴⁵ I have argued elsewhere, as have others, that rights discourse, when divorced from substantive needs, can divert political vision from the actual needs of oppressed people and thereby reinforce the rhetoric of individualism that is then used as an explanation for the material conditions of oppressed people's lives.⁴⁶ But I am not arguing for rights in some abstract form. Here I am arguing for affirmative rights for women that are connected to their very real needs before, during, and after pregnancy. So what do women need? Two needs have already been easily identified: women (and infants) need access to medical care (e.g., well-woman, prenatal, and post-natal care) that is affordable, or in many instances, free; and women, particularly drug addicted women, need access to drug treatment facilities that meet their needs (e.g., facilities that provide child care can better serve women who may have children), especially during pregnancy, when they are most likely to be open to the possibility of sobriety. Other important needs also exist, such as the necessity for adequate food, housing, and education. Women and infants are benefited by access to all of these resources. We have to find a way to translate these very real needs into affirmative obligation on the part of the state if we care about women and children. These substantive needs do not have to be addressed as long as we hold on to our love of the potentiality of the fetus. If we choose not to meet the material needs of women and children and continue to hold on only to our love of the fetus, then we are engaging in what Janet Gallagher has called "collective bad faith."⁴⁷ She argues:

Giving fetuses rights and lawyers, while failing to provide accessible pre-natal care and drug treatment on demand for women who carry them, is mere posturing—a paradigm of societal bad

45. See Nancy Fraser, *Struggle Over Needs: Outline of a Socialist-Feminist Critical Theory of Late Capitalist Political Culture*, in UNRULY PRACTICES: POWER, DISCOURSE, AND GENDER IN CONTEMPORARY SOCIAL THEORY 183 (arguing for the translation of justified needs into social rights).

46. See April L. Cherry, *A Feminist Understanding of Sex-Selective Abortion: Solely a Matter of Choice?*, 10 WISC. WOMEN'S L.J. 161, 215 (1996); see also John O. Calmore, *Critical Race Theory, Archie Shepp and Fire Music: Searching for an Authentic Intellectual Life in a Multicultural World*, 65 CAL. L. REV. 2129, 2215 (1992).

47. Janet Gallagher, *Collective Bad Faith: Protecting the Fetus*, in REPRODUCTION, ETHIC, AND THE LAW: FEMINIST PERSPECTIVES 352 (Joan C. Callahan ed., 1995) ("This insistence on pointing the finger . . . at individual women is an exercise in collective bad faith, a social self-deception which rationalizes our passivity toward the genuinely horrifying living conditions confronting many poor women."). *Id.* See also Katha Pollitt, *Fetal Rights, Women's Wrongs*, in REASONABLE CREATURES 173 (1994) (focusing on how maternal behavior allows the government to give the appearance of being concerned about babies without having to challenge the status quo).

faith. It is a refusal to shoulder our one social burden, a self-indulgent unwillingness to confront the urgent and very difficult task of healing the shattered lives of so many poor women among us.⁴⁸

Nevertheless, I may be asked, what about the health of the fetus, who may be a future child? I would like to offer two observations regarding this question. The first is that if we look at fetal outcomes under our current social, political, and economic system (where doctors and judges seem to increasingly control pregnancy and childbirth, where poor women don't have access to adequate prenatal care, good nutrition, or drug treatment facilities, where I would argue that we don't love these women), we have some poor fetal outcomes. My second observation is that if we translate the material needs of women into affirmative rights, we will undoubtedly help to create the conditions for more positive fetal outcomes, even in the worst of circumstances. We have so little to lose and so much to gain.

48. Gallagher, *supra* note 47, at 361-62.



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