ABORTION AND MATERNAL-FETAL CONFLICT: BROADENING OUR CONCERNS

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Altering our angle of vision changes what we see. Many who grapple with the problems of fetal rights and abortion do so either from the vantage point of feminist theory or from within the framework of constitutional law. My work provides different sightlines—those generated by a specialization in law and medicine. Consequently, the issues I assess, and the questions I find myself asking about abortion and fetal rights diverge from those that typically command center stage among feminists specializing in gender discrimination. Nonetheless, I speak from within the feminist tradition, building upon its rich insights and vital truths, seeking to refine its perspective. I offer these thoughts not with the conviction that they are more fundamental or more comprehensive than others on the conversational table, but with the aspiration that they might add to the discussions that proceed among women in hallways, classrooms, and restaurants, in political and legal strategy sessions, as well as in formal briefs and law review articles.

Dire consequences understandably narrow perspective. When the pervasive reality of gender oppression continues to be ignored, the resulting frustration can breed an advocacy that “sees” only one category—gender—that insists upon only one issue—abortion. I understand these tendencies, recognizing them in my own life and thought. I also warn myself that only little minds are bedeviled by the hobgoblin of inconsistency. But still, I fear even more the impoverished legalism identified by Thomas Reed Powell: “If you can think of something which is connected with something without thinking of the something it is connected to, you have a ‘legal mind.’”¹ I do not want that kind of legal mind.

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What I want and need are arguments, principles, and frameworks that protect women's equality and autonomy in reproductive decisions, while extending in a comprehensive and principled way to the multiplicity of issues surrounding medical intervention and scientific development. Seen from the vantage point of law and medicine generally, maternal and fetal rights implicate issues from preconception, through pregnancy and birth, to decisions concerning newborn infants. Reproductive policies affect decisions not only about childbirth versus abortion, but also about in vitro fertilization, frozen embryos, artificial insemination, and surrogacy. Abortion arguments connect not only to court-ordered caesareans, but also to fetal tissue research and transplant therapy; not only to drug-addicted mothers, but also to in utero fetal surgery and genetic intervention; not only to pregnancy, but to medical care generally. Analyses of reproductive hazards in the workplace not only impact the pro-choice agenda, but also affect the health of children and grandchildren. Policies governing procreation and pregnancy must protect women's choices, but must also consider the concerns of the disabled community. They must responsibly facilitate genetic therapy as well as take account of women's demands for equality.

Women's interests in bodily and psychological autonomy in reproduction are unquestionably vital. The risks of gender and race bias in reproductive policy are demonstrably real. However, the issues are also extraordinarily complex—at once uniquely sensitive and densely interconnected. Their resolution demands that precisely because our stake is so great, we as feminists must think about our positions and arguments in unusually measured and broad-gauged ways, for reasons both of principle and of strategy. The task is daunting—balancing the short against the long term, weighing the claims of ultimate principle against the known risks of non-ideal reality, distinguishing arguments about power from those regarding prudence, visualizing the widest possibilities with imaginations that savor the construction of habit and necessity, seeking equity for women in ways that also value equity for men, and assessing

the interplay of each new question with factors of race and class. Conclusions regarding such sensitive and complex issues will sometimes converge, sometimes diverge even for those sharing common ground. Some convictions will solidify, others evolve. The only constant may be the need continually to reassess our assumptions and views.

My concern in this essay is with the implications of some claims and arguments advanced in support of an absolute right to abortion, or in defense of a woman's absolute immunity and non-reviewable discretion during pregnancy. However understandable and tempting it may be, uncritical embrace of extreme autonomy rhetoric and of exclusively woman-regarding positions seems to me to undermine our persuasiveness, to render us vulnerable on grounds of principle, and to damage our aspirations for a humane and responsible world. I do not attempt an affirmative or comprehensive proposal. In a reflective rather than a dispositive mood, I raise questions about concerns that are getting relegated to the margin in the present all-or-nothing climate of debate. Seeking a broadened context for discussion, I consider some connections between women's abortion and pregnancy rights and aspects of third party rescue, fetal status, and women's and men's autonomy and responsibility in reproduction.

Consider first the problem of prenatal harm. Are we willing, for example, to jeopardize the right to hold third parties, such as doctors and other health care workers, employers, and other tortfeasors responsible for in utero or preconception injuries in order to reject liability of pregnant women for conduct injurious to a fetus? Do we oppose the notion that such actors ought to be cognizant of, ought to foresee potential injuries that flow from their behavior? Consider doctors who carelessly fail to discover pregnancy or to consider fetal harm when prescribing drugs, treating illness or conducting research; those who intentionally destroy a pre-embryo awaiting implant in a woman's womb after in vitro fertilization; those who negligently perform amniocentesis or fail to complete an abortion; those who carelessly provide incomplete or inaccurate genetic screening or counselling. Surely these individuals should be subject to

liability. Yet, in discussions of the Johnson Controls cases, some feminists, fearing any implication that fetuses have legally cognizable interests, take positions resisting such developments, especially any further extension of them. Others simply ignore or downplay the relevance of third party liability cases when discussing the liability of pregnant women for injury to their fetuses.

Alternatively, assuming the acceptance of third party liability for prenatal harm, do we choose to defend the narrower view that parents alone should be immune from accountability for actions that injure later born children in utero? Certainly, parents are distinguishable in responsibility and relationship from other tortfeasors who injure fetuses. It is wholly appropriate to consider both the extent to which the defendant's harm-causing behavior implicates her own protected interests and the degree to which the defendant ought be accorded discretion on the basis of context and relationship. Both variables would be standard factors in determining negligence; each would likely give greater protection to a parent-defendant than to other third party defendants. However, in my view neither variable would justify a categorical exemption from liability for parents.


7. Intra-family tort immunities were a feature of the patriarchal family model, reflecting parents' absolute power over children and husbands' unfettered control over wives. Changing notions of family along with other factors have eroded these categorical exemptions. Although the traditional rationale for such immunities has, happily, been left behind, more modern and equitably based claims for intra-family immunity might yet be debated. For example, if pregnant women were to emerge as the sole or main target of intra-family liability actions, the sexist roots and effects of such an outcome might render some form of categorical parental immunity preferable to a policy of selective persecution of women. Similarly, if women of color were disproportionately singled out for breach of duty or prosecution, I would attack such practices as impermissible racial discrimination. Unfortunately, there is already evidence of such racism in pregnancy intervention. See Kolder, Gallagher & Parsons, supra note 2; Roberts, supra note 2. If current doctrine defined race discrimination so as to exclude such outcomes from review or remedy, I would be faced with a difficult dilemma. Would it be better to urge categorical immunity for pregnant women even at the expense


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Even if parents were to be treated as a separate category for purposes of liability, would we favor extending such parental immunity to battering boyfriends or husbands who injure or kill fetuses? Or to fathers who knowingly use drugs that damage sperm and as a result cause teratogenic effects in their offspring? If not, how would we isolate harm-causing mothers from such harm-causing fathers? By arguing their different and greater bodily connection to the fetus? To be sure, we cannot and should not ignore that regulation of pregnancy powerfully and uniquely impinges on women. Yet, surely we have ambivalent stakes in arguing that biology should conclusively determine rights and responsibilities. Nor would we want to argue that women as a class deserve immunized discretion because they are always the ones who really care for children. In this society, most women unquestionably bear different and greater responsibility for children than do most men. In striking the negligence balance between the benefits and burdens of proposed duties of care or in assessing the tortiousness of particular defendants' conduct in particular circumstances, such differences in responsibility and relationship should clearly be relevant. However, women's asymmetrical responsibility for children is not a state of affairs that I want to lock in to the social and legal landscape by resting categorical, dispositive rules upon it.

Moreover, bodily autonomy is not generally a valid defense to allegations of having inflicted harm on others. The point is enshrined in the cliché that one's freedom to swing one's fist terminates at the tip of another's nose. Does it best advance our credibility and concerns to maintain that even if others can be liable, nevertheless, because their bodies are involved, women should be immune to liability for harm, whatever their conduct, whatever their knowledge or intentions, whatever the outcomes? I might argue that imposing tort or criminal liability on pregnant women is generally imprudent or counter-productive, but I would not argue that such liability is impermissible. Similarly, I would argue that selective prosecution of women of color could and should be enjoined when it reflects racial stereotyping, punitiveness and discrimination, or that prosecution of women but not of men for drug-

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8. See Gertner, supra note 5.

induced damage to offspring could and should be barred as gender discrimination, but not that pregnant women, qua women, should be categorically immune from liability for harm to fetuses they carry. I also find myself unwilling to argue that because women have a constitutionally protected right to abort, any lesser harm flowing from a pregnant woman's behavior should be exempt from accountability. Nor would I within this context cite precedents about abortion autonomy without acknowledging the significant fact that abortion means no new life will come to be, while criminal or tort liability for pregnant women arises where a harmed fetus will be born and suffer. Indeed, it seems that philosophically as well as legally, our demand that women's agency regarding procreation decisions be respected would ordinarily heighten rather than lessen women's responsibilities as correlative to their rights.

Some have argued against tort or criminal liability for pregnant women by noting the unfairness of holding women accountable for deeply uncertain and debatable judgments, or by urging the greater efficacy of collaborative and educational strategies in achieving the desired policy outcomes. Such arguments have considerable persuasive force. However, they seemingly overlook the fact that analogous arguments are made against tort or criminal liability in widely varied circumstances where liability is nonetheless imposed. For example, doctors faced with indeterminate treatment decisions, or parents accused of child abuse or neglect, may be held liable for acts deemed to be culpable even where uncertainty is profound or the prudence of punitive strategies is highly debatable. Admittedly, the constitutional status of gender equality adds a vital dimension not present in many other tort and criminal contexts, but the crosscurrents of gender policy—to say nothing of gender doctrine—make the analysis multifaceted and problematic at best. Arguing in stark categorical terms that pregnant women should never be liable for prenatal harm, rather than deriving optimal policy from a more complex and nuanced balancing of interests, seems shortsighted and ultimately damaging to the intricate tapestry of women's concerns.

Another path to the no-liability-for-women result has been to resist the recognition of any entity capable of incurring harm. The reasons are obvious if assessed only in terms of pro-choice advocacy. In a related vein, some argue that recognition of causes of action for prenatal harm for laterborn children has been primarily a vindication of parental rights,

or that at the least, such policies did not create an adversarial relationship between parent and child. Such analyses, however, fail to distinguish fathers from mothers, and seem to be shaped as much by the desire to exempt women from liability as by actual analysis of children's interests. In the overwhelming majority of circumstances the interests of children and women are not adversarial, but that conclusion does not eliminate the possibility that given relationships embody tragic conflict. Tort and criminal liability are by definition about the unreasonable or deviant members of groups—doctors, drivers, landlords, and pregnant women. Once again, such arguments address questions of prudent policy and discretion more than they negate the scope of legal power.

Moreover, other issues are implicated in determining the legal status of the fetus. Do we want to insist that fetuses are simply not a cognizable form of life? Do we want to buttress the view that birth is the only definitive point with arguments that fetuses are wholly dependent, or are lacking in higher cognition and consciousness, without considering the impact of such analyses on other arenas? For instance, how absolutely should we maintain that a near full-term fetus is wholly different as a moral, physical, and legal matter from the neonate a few hours later, or from the prematurely born infant whose treatment, or lack thereof, may occasion homicide or neglect charges against parents or health care providers? Do we intend the implications that such advocacy may have for the medical, legal, and social treatment of those disabled or retarded individuals who may also be largely dependent, or substantially lacking in higher cognition or consciousness? Alternatively, if late term fetuses are shown to have sentience, and perhaps even consciousness, or if such fetuses eventually can be transferred or can survive outside the womb, how adequately will a birth-based framework that rests on dependency or consciousness serve us in addressing resulting disputes? These issues are so excruciatingly difficult that I have no clear or comprehensive solution to propose. However, I do know that I am deeply troubled


12. See, e.g., MICHAEL TOOLEY, ABORTION AND INFanticIDE 419 (1983). Tooley argues that continuity between a fetus and a neonate shows that neither abortion, nor infanticide, in the first few weeks after birth is wrong because biological life does not equate with moral personhood. Of course, converse types of arguments can be grounded on the similarity between the two life forms.

by thinking of one set of issues without keeping the other sets of issues firmly in view.

Recently, issues of pregnant women's duty to rescue have also been raised. The most distressing examples arise in the context of unconsented cesarean sections ordered by courts to protect a fetus. The issues are intractably complex and deeply controversial, involving considerations such as imposition on women's bodily and procreative autonomy, fetal life and health, and sex discrimination among others. In weighing the arguments, an additional often neglected consideration should be kept in mind; whether any affirmative duty should be recognized is an issue distinct from the question whether any such duty should be enforceable prospectively, by means of an injunction, or only retrospectively, by means of civil or criminal liability.

I do not argue for the imposition of affirmative duties in the context of pregnancy, and in particular I believe that only in the rarest of circumstances would their enforcement by injunction ever be appropriate. There are deep and persuasive reasons for the rejection of such approaches, particularly as a matter of prudent policy. Nevertheless, I believe the legal, as opposed to the legislative, issue is not wholly determinable on the grounds of existing precedent. Standard analytic considerations allow strong arguments in favor of such duties, as well as important arguments in opposition to them. Moreover, I am distressed that some arguments against such duties are, both on their own terms and by dint of their wider implications, troublesome at best.

For example, in order to foreclose the possibility of unconsented cesarean sections, do we want to attack the legitimacy of affirmative duties in the law generally? Certainly there are both philosophical and doctrinal precedents for doing so. However, such a choice is shortsighted, and it identifies us with the most aggressively individualistic and

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Other contexts of analogous dispute will almost certainly arise. For instance, as fetal surgery becomes more routine and successful, and less experimental, conflicts over who must give consent for such surgery may develop.


16. See, e.g., Kolder, Gallagher & Parsons, supra note 2, at 1194 (arguing affirmative duty would be "profoundly at odds with our legal tradition"); Developments in the Law, supra note 6, at 1570 (fundamental tenet of law is the absence of a duty to rescue).
interpersonally regressive tendencies of the common law. Our larger concerns about responsible and caring relationships are surely not well served by such advocacy.

Moreover, analyses of affirmative duty typically assess whether a special relationship of care or dependency exists, as well as whether the person on whom such a duty is imposed played a role in placing the parties in the situation where rescue is needed. Parents' relational duties to children apart,¹⁷ are we prepared to imply that pregnant women bear a relationship to their fetuses that is less significant and less care-evoking than that of psychiatrists to those whom their patients threaten,¹⁸ or of landlords to their prospective tenants,¹⁹ or of universities to their students,²⁰ or of doctors and medical researchers to those who depend upon them?²¹ Of course, some of those affirmative duties require the less significant burden of providing information rather than undergoing bodily invasion. But even granting that crucial difference, is the appropriate precedential analogue for bodily intrusion during pregnancy the relationship of distant cousins?²² And even granting that gender realities in this society mean that many women have little meaningful choice about intercourse or pregnancy, surely the connection between many other women and their fetuses is not appropriately analogized to that between strangers.²³

¹⁸. Tarasoff v. Regents of Univ. of Cal., 17 Cal.3d 425, 551 P.2d 334, 131 Cal. Rptr. 14 (1976) (psychiatrist has duty to warn third party about whom threats were made by psychiatrist's patient during counselling sessions).
²¹. See, e.g., In re Eisele, 125 B.R. 922 (1991) (real estate broker owed fiduciary duty to make known all important matters that may have affected transaction); Moore v. Regents of Univ. of Cal., 51 Cal. 3d 120, 793 P.2d 479, 271 Cal. Rptr. 146 (1990) (doctor has fiduciary duty to disclose commercial and research interests that could affect medical judgment); Truman v. Thomas, 27 Cal. 3d 285, 611 P.2d 902, 165 Cal. Rptr. 308 (1980) (doctor must adequately inform patient about risks incurred by refusing recommended care). Only two states impose a general duty to rescue. MINN. STAT. ANN. § 604.05 (West 1988); VT. STAT. ANN. tit. 12, § 519 (1973).
²². McFall v. Shimp, 10 Pa. D. & C. 3d 90 (1978) (no duty for cousin to allow bone marrow donation to prevent cousin's death). This case has frequently been argued to support a holding that a pregnant woman has no affirmative duty to aid her fetus by agreeing to a cesarean section. See Developments in the Law, supra note 6, at 1570-72.
²³. Judith Jarvis Thompson, A Defense of Abortion, 1 PHIL. & PUB. AFF. 47 (1971) (arguing against women having affirmative duties to fetuses by posing a hypothetical involving kidnapping, physically restraining, and using the blood of a person whose blood type offers the best hope to rescue a famous unconscious violinist).
Ultimately, no other circumstance squarely parallels the situation of gestation. Thus, no decided case from other contexts can dispositively resolve questions about the imposition of affirmative duties during pregnancy. While cases such as McFall v. Shimp, which refused to impose an affirmative duty between cousins, are certainly relevant, so are others. For example, a mother’s religiously-based refusal of blood transfusions for herself was overridden because of the state’s desire to protect her minor children from abandonment. Although subsequent legal development casts major doubt on the continued viability of the decision, some factors suggest its continuing relevance in the particular context under discussion here. Or to take another instance, decisions allowing parents of minors or incompetents to consent to donations of the ward’s organs or tissue allow invasion of the body of one individual for the benefit of another without the actual donor’s consent. In an important sense these are forced bodily intrusions. Of course, such examples are in other ways not analogous. A pregnant woman in a forced cesarean section case is competent and is refusing the intervention, whereas the donor in the organ transplant cases is not competent and is spoken for by a surrogate decisionmaker who consents through “substituted judgment.” Nevertheless, the idea that substituted consent speaks for an adult with an IQ of thirty-five and a mental age of six years is largely a convenient fiction. Functionally, these decisions allow one person (the surrogate) to

24. In fact, different types of pregnancy interventions themselves raise different legal issues. See Developments in the Law, supra, note 6, at 1556-84 (categorizing and discussing various types of state intervention during pregnancy).


26. In re President and Directors of Georgetown College, Inc., 331 F.2d 1000 (D.C. Cir. 1964), cert. denied, 377 U.S. 978 (1964). See also In re Jamaica Hospital, 128 Misc.2d 1006, 491 N.Y.S.2d 898 (Sup. Ct. 1985) (blood transfusion ordered to save a fetus not yet viable); Raleigh Fitkin-Paul Morgan Memorial Hosp. v. Anderson, 42 N.J. 421, 201 A.2d 537 (1964) (ordering blood transfusion to save life of the “unborn child”). The latter case, like In re Georgetown College, 331 F.2d 1000, pre-dates Roe, the modern feminist movement, and the recent trend to accept a right-to-die. Many statutes recognizing right-to-die directives make such directives ineffective if the signatory is pregnant at the time the directive would become operative. See CAL. HEALTH & SAFETY CODE § 7189.5(c) (1991 revision found on Lexis).

27. See, e.g., Hart v. Brown, 29 Conn. Supp. 368, 289 A.2d 386 (1972) (allowing parents to consent to kidney donation by one 7 year old twin to the other); Strunk v. Strunk, 445 S.W.2d 145 (Ky. Ct. App. 1969) (allowing parents to consent to kidney donation by an mentally retarded adult son to a healthy son). But see, Lausier v. Pesceinski, 67 Wis. 2d 4, 226 N.W.2d 180 (1975) (refusing to allow consent by substituted judgment for donation of kidney by mentally ill adult brother to sister). Compare also the widely reported facts regarding infant conceived for the purpose of providing bone marrow to her cancer-stricken sister. Irene Chang, Baby Girl’s Bone Marrow Transplanted Into Sister, L.A. Times, June 5, 1991, at A1, col. 1. Interestingly, no legal approval appears to have been sought by the hospital or the parents in this case.
decide that another person (the donor) must submit to bodily intrusion in order to aid a third person (the recipient). Perhaps parents are adequately situated to judge on behalf of the incompetent donor. However, particularly where the donor is mentally ill or retarded, the consenting surrogate usually has conflicting interests—the recipient is typically a healthy relative whose needs are a major concern of that same decisionmaker. Surrogate judgment is far from tantamount to actual personal consent. Like McFall, then, these cases provide partially, but only partially, relevant precedents.

I do not pretend to have exhausted the discussion of these cases or of unconsented interventions during pregnancy. What I do suggest is that the issues are more complex, the balancing of interests and risks more appropriate, and the constellation of relevant precedents broader than some extreme or expediency-driven arguments recognize. I reject the claim that decided cases which find no affirmative duty definitively settle the issues surrounding pregnancy implies positions about affirmative duties and about the relationship between a pregnant woman and a fetus. Although in the short term the no-duty precedents may be helpful to women defendants, and disregarding those precedents in the context of pregnancy may well reflect sexism, I am unwilling to treat as dispositive arguments that so substantially undermine responsible relationships.

Other closely related questions also play a role in the assessment of affirmative duties. For instance, the likelihood of risk to be incurred in rescue is a traditionally relevant consideration. In evaluating whether to override a pregnant woman's refusal to undergo surgery, or treatment for her drug addiction, what weight should be given to possible risks and dignitary harms attendant on the unconsented invasion of her body? Certainly, surgery is a major intervention rarely to be imposed. Yet in opposing mandates to override a pregnant woman's refusal, do we want to argue that risks to her body, even when small in absolute terms, should categorically and automatically outweigh even high probabilities of harm or death to a nearly full-term fetus? Do we want to argue that the body is always inviolable no matter what the stakes in lives, injury, or

29. For instance, such cases might also be seen as creating a precedent for parents having the authority to risk a child's welfare in order to assist another family member. From this perspective, they suggest that a pregnant woman has a right to prefer imposing risks on her fetus over imposing risks on herself.

30. A related argument reasons that because the courts have held it impermissible in the abortion context to try to protect the fetus at the expense of imposing risks on the mother, any risk to the mother's health must always trump any concern about the fetus. See Lawrence J. Nelson & Nancy Milliken, Compelled Medical Treatment of Pregnant Women: Life, Liberty, and Law in Conflict, 259 J.A.M.A. 1060 (1988). A key difference is that in the former instance the fetus will never be born,
ethical responsiveness? Do we believe it is plausible to do so despite rulings about the permissibility of involuntary drug or HIV testing,\textsuperscript{31} of compelled vaccination for contagious disease,\textsuperscript{32} and of involuntary civil commitment of those dangerous to self or others? Moreover, until transferable or artificial gestation after implant become possible, the pregnant woman may be the only person able to prevent the harm. Such uniqueness, provides a precise basis for singling out a particular potential rescuer, another traditional consideration in deciding whether to impose affirmative obligations.

Admittedly, imposing affirmative duties on pregnant women opens the door to serious overreaching by medical personnel. Doctors who overstate risks or preempt patients’ reasonable judgments about inevitably uncertain outcomes make interest-balancing decisions dangerous to women where serious bodily intrusion is involved.\textsuperscript{33} It is extraordinarily difficult to constrain paternalistic imposition by and de facto discretion of experts. Traditionally sexist as well as racist instincts potentially reflected in paternalistic or punitive practices greatly aggravate the problem. Such difficulties justify a claim that, \textit{ordinarily}, and particularly

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\item whereas in other instances, such as forced cesarean sections, a child will be born who may suffer consequences from the mother's behavior and decisions.
\item There are also cases in the criminal setting that allow some degree of unconsented bodily invasion, albeit less intrusive interventions than a cesarean section. Because these cases involve criminal actions, they raise different policy considerations than do the civil cases under discussion here. Pregnant women, of course, are not criminals. Moreover, these cases are not necessarily rightly decided. Nonetheless, the cases are also part of the larger constellation of relevance where the absoluteness of bodily privacy is at issue. \textit{See}, e.g., Schmerber v. California, 384 U.S. 757 (1966) (upholding the constitutional validity of blood tests for criminal suspects; adopting balancing test between individual's interest in privacy versus societal interest in having the procedure done); Jones v. Murray, 763 F. Supp. 842 (W.D. Va. 1991) (DNA testing of convicted felons does not violate fourth amendment); Love v. Superior Court of San Francisco, 226 Cal. App. 3d 736, 276 Cal. Rptr. 660 (1990) (statute ordering persons convicted of prostitution to undergo AIDS testing does not violate fourth amendment or the Equal Protection Clause); Commissioner of Correction v. Myers, 379 Mass. 255, 399 N.E.2d 452 (1979) (ordering unconsented-to kidney dialysis of prisoner on grounds of state's need for orderly prison administration). \textit{But see} Winston, Sheriff, et al. v. Lee, 470 U.S. 753 (1985) (refusing to order surgery to remove a bullet from a criminal suspect).
\item 32. Jacobson v. Massachusetts, 197 U.S. 11 (1905) (statute requiring compulsory vaccination for smallpox held constitutional).
\item 33. \textit{See}, e.g., Jefferson v. Griffin Spalding County Hosp. Auth., 247 Ga. 86, 274 S.E.2d 457 (1981) (despite testimony indicating 99% probability of baby's death and 50% probability of mother's death if cesarean section not performed, mother fled the jurisdiction, gave birth vaginally, and both baby and mother were fine).
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where prospective intervention is sought, placing decisional authority in
the hands of pregnant women offers the best combination of fairness and
administrability. However, this is a radically different argument, with
radically different consequences for other issues in the medico-legal field,
than a claim that simply because their bodies and their dignitary interests
are involved, pregnant women should never be compelled to undergo any
involuntary procedure no matter how small the intrusion or risk, to gain
an improved outcome, no matter how likely or compelling. Even in
advocacy contexts, we undermine our intellectual and moral credibility
by claiming such categorical exemptions from traditional analytic bal-
ancing of risks and burdens.

Questions other than those involving liability during pregnancy also
implicate the coherence and credibility of our positions and arguments.
For example, how consistent is our vision of women as decisionmakers?
My regard for women as responsible decisionmakers, along with my con-
cern about the discriminatory impact of stereotyped sexual and repro-
ductive roles, supports my conviction that broad access to abortion is
essential to women’s quest for equality and freedom. I am, however,
troubled when we demand society’s respect for women’s autonomy in
respect to abortion decisions and pregnancy behavior and yet ourselves
deny women’s agency in other contexts, as many do in regard, for
instance, to women’s choices to become surrogate mothers. Even in re-
ference to abortion itself, our attitudes about women’s moral agency seem
sometimes inconsistent. For example, certain viewpoints that might be
understood as being about women’s responsibility as decisionmakers
have been sharply criticized. Feminists, correctly no doubt, suspect that
gender scripting produces lesser public acceptance of career motives for
abortion, as compared to reasons such as incest or rape.34 Yet those pub-
lic reactions likely also reflect judgments about women’s agency in incur-
ing particular pregnancies. While we believe broad abortion rights are
justified and vital, such alternate public reactions ought not be scorned as
wholly incomprehensible or necessarily sexist in origin. Even knowing
there is abuse of the principle of consent in regard to women’s sexual and
reproductive lives, and even recognizing that I personally might disagree
with particular choices of particular women, an insistence that women’s
agency is important mandates an embrace both of women’s freedom and

(89% approval of abortion after rape or incest versus 79% opposition when reason is to avoid career
interruption). See also, Siegel, supra note 2, at 327-28, 360-61 (arguing that gender scripting plays an
important role in the variation of public approval of abortion depending on the reason the abortion is
sought).
of their responsibility. The precise scope of these two principles remains highly debatable, but if we are inconsistent about freedom, or if we seem unduly preoccupied with freedom at the expense of responsibility, our arguments are rendered less persuasive to much of our audience.

Feminists have also argued strongly that because they unduly burden both women's choices and the professional prerogatives of doctors, statutory requirements for information disclosure and waiting periods for abortion should be struck down.\textsuperscript{35} We seem strangely unconcerned that we have eliminated such obstacles to abortion at the cost of portraying women as easily swayed, distressingly fragile decisionmakers. Does entrenching that particular stereotype aid us in the long run in getting women's decisions deferred to? Moreover, the arguments against information mandating statutes have potentially important implications for informed consent in medicine generally. The very same arguments—that patients' anxiety may be raised and that their decisions may be distorted by such disclosure, or that legislatures should not intrude on doctors' professional judgment and discretion—were the mainstay of medical resistance to patient control of decisionmaking in health care generally. How will decisions which invalidate abortion information statutes affect statutes which require medical professionals to honor living wills or those which mandate disclosure to patients regarding alternative breast cancer treatments?\textsuperscript{36} Women have been at the forefront of the consumer rights movement in health care. Women's dissatisfaction with the traditionally male medical establishment has fueled demands for greater disclosure regarding everything from sterilization to hysterectomy to alternative birth methods to the low success rates of in vitro fertilization. Progress in those arenas has been hard won. Perhaps intimidation and information can be adequately distinguished, but blanket efforts to eliminate information and deliberation provisions regarding abortion should be sensitive indeed to potential consequences in the wider medical context.

Finally, I cannot demand respect for women's agency, interests, or autonomy without endorsing the same respect for others. It has become


\textsuperscript{36} CAL. HEALTH & SAFETY CODE, § 1704.5 (West 1990) (informed consent requirement for treatment of breast cancer).
an article of feminist faith that men should not have a mandatory role in abortion decisions. Do we intend, as some seem to suggest, that that stance extend to prenatal decisionmaking generally? If so, on what basis would we urge that fathers be excluded? We have argued that men should be excluded from abortion choices partly on the basis that pregnancy occurs within women's bodies. But does that rationale justify preventing informational notice to fathers about pregnancy and abortion decisions? Moreover, to the degree that exclusion of men from abortion decisions rests on women's bodily involvement, these claims would presumably not extend to other prenatal issues such as who decides custody, implant, ownership, discard, research upon or gestation of a frozen embryo which is outside anyone's body. Nor would these claims determine who should decide the use of fetal tissue after an abortion when the aborted tissue, too, is outside of anyone's body. Similarly, decisions will soon arise regarding prenatal gene therapy. To the extent that our moral and practical authority regarding abortion rests on our bodily involvement, decisions about extracorporeal embryos and tissues are less likely a woman's alone than are abortion decisions. In addition, emerging health care decisions involving both a woman's body and a future neonate's health, such as in utero fetal surgery, pose exceedingly complex problems regarding decisional authority. We need affirmatively to recognize that current policies governing abortion do not adequately address this larger array of issues.

Yet often when faced with such issues, women simply broaden the definition of their interest rather than rethinking the analysis. We are, women say, concerned not simply about our bodies, but also about our genetic progeny and our reproductive autonomy. True. However, crossing into that territory necessarily implicates men. Men also have interests in their genetic progeny and in their reproductive autonomy. If we object to what some characterize as coerced motherhood, can we close our ears to pleas about coerced fatherhood? A few years ago, a male


39. Arguments against compelled fatherhood were made by Junior Davis in the widely publicized divorce dispute involving custody of frozen embryos. Davis v. Davis, 1992 WL 11 5574
student in my law and medicine seminar made a striking comment. He said that women complain of being used as baby factories, vessels for fetuses, and stepping stones to men’s genetic agenda. We women appeal to the Kantian imperative that persons should never be treated as means rather than ends. The student commented that women in the seminar, myself included, spoke with little apparent concern about using male sperm to conceive either through sexual relations, IVF, or artificial insemination. Those same women also urged that men should have no authority over any of an array of related decisions including embryo implant, abortion, and adoption. He explained that the overall effect made him feel like a means used to women’s ends. He had a point. For all my anger, I cannot redeem the insult, the obliteration of women’s autonomy and interests, by myself ignoring men’s autonomy and interests. Furthermore, wholly apart from consistency or equity, women have a powerful affirmative interest in increasing and intensifying men’s meaningful involvement with children. It seems conceptually difficult and strategically counterproductive to deny men’s intellectual, emotional, and decisional roles in prenatal contexts at the very time that we seek, and even demand, their greater engagement with children. Admittedly, there is a problem about whether authority should follow or precede responsibility. I believe that we would progress faster, as well as be on conceptually more defensible ground, if we moved along both dimensions at once.

Underlying our often brave and correct, but sometimes myopic and inconsistent, state regarding these issues of women’s and men’s authority and responsibility, I sense in myself and in others, intensely schizophrenic feelings about the role of biology in life and in policy. While this huge generalization is so sweeping as to be arguably empty, we must face how deeply troubled we are about this problem. Biology is both the source of our power and the source of our oppression. It is hard to decide when it is which, or whether it is always necessarily both. It is harder still to decide when to resist it, and when to affirm it.

(Tenn.) (holding that disposition of frozen embryos should be governed by analysis of relative interests of genetic progenitors, and that, ordinarily, the rights of the party wishing to avoid procreation should prevail). See John A. Robertson, Resolving Disputes over Frozen Embryos, in HASTINGS CENTER REPORT 7 (Nov./Dec. 1989) (arguing that the embryos should not be implanted in part because of Mr. Davis’ objection to involuntary fatherhood).

Often, biology is treated as determining family statuses. Sometimes however, other factors, such as intentional commitments, actual behavior, or roles approved by conventional morality, compete to influence the assignment of intimate responsibilities. Over the past decade, I have thought a great deal about what role the law should give to intention in family and intimate life. Individual intention, in the sense of purposeful choice among alternatives, has the potential to play a far greater part in our lives now than in the past. This is especially evident in the field of law and medicine where developments in all areas from reproduction to death result in a lessened hold of biological inevitability, and an increased opportunity for individual choice and responsibility. In addition, a host of social and ideological developments now emphasize pluralism and diversity over authoritative or conventional morality. The resulting debates over policy sharply highlight our ambivalence about whether legal policy should privilege biology, conventional morality, or voluntary individual decision. The emerging issues are particularly difficult for feminists in the areas of procreation and family policy. For instance, due to women’s role in gestation, biologically oriented criteria for weighing parental rights, especially regarding infants, seem likely to give women greater control and dominance. But biology may also assign women more responsibility and burden than other kinds of criteria.

Recently, I analyzed what comparative priority should be accorded to biology and to intention in determining parental status in surrogacy disputes. The issues are illustrative of deeply difficult questions regarding gender and family policy. Many, including the New Jersey Supreme Court, deem it essential to allow a surrogate to renege on her agreement after the birth of the planned child. The issues remain very tough ones for me, but I reach a contrary conclusion. To insist that the gestational experience trumps a woman’s earlier decision to become a surrogate argues that biology and hormones should override a woman’s conscious intended commitments. Although the prospect of separating a resisting birth mother from her baby is painful, arguments against doing this seem dangerous as well. Enforcing a surrogacy contract after reviewing it for any defenses such as unconscionability, duress, etc., could be understood

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41. Feminists have faced analogous dilemmas in deciding, for example, whether to analyze pregnancy as sui generis or as merely a form of physical disability in addressing problems of employment discrimination. See California Fed. Sav. & Loan v. Guerra, 479 U.S. 272 (1987) (upholding pregnancy disability leave statute).


as a decision to protect vital expectations and reliance, rather than as one that simply privileges genetics, especially male genetics, as some have suggested. While genetic linkage may be one reason individuals seek a surrogate, it is not the only possible reason. By contrast, arguments that surrogates and only surrogates should be allowed to change their minds urge that women, uniquely, cannot or should not make, or be allowed to make decisions about procreation and parenting, at least until they see how pregnancy affects their emotions. Whichever of these outcomes one favors, the intense arguments surrounding surrogacy illustrate our continuing disturbance about the role to be given to biology as compared to other variables in reproductive and family law.

Conflicts over how biology should interplay with intention and conventional morality in legal policy are also visible in a related development that I find particularly intriguing. Adoption aside, it used to be self-evident who a child's mother was. The mother of a given child was verifiable as an unequivocal and sensate fact. Modern reproductive techniques, however, have rendered this problematic. For the first time in history, we can split gestation from genetics. One interesting result is a loosening of the connection between motherhood and biology. Although social norms and policies have always played a role in the construction of "family-ness", including motherhood, there has been a ho-hum obviousness to the power of biology in determining maternal status. Now, the frozen "given-ness" of the historic connection has melted. A degree of fluidity must be incorporated in the definition of motherhood. My hunch is that that fluidity will have implications, both in ideological and perceptual terms, that extend far beyond the small number of instances where a decision about maternal status is literally required.

Meanwhile, modern technology has brought reverse developments to paternity. It used to be that we were never sure who the father of a given child was. Remote from birth in time and space, fatherhood has historically been assigned by inference and presumption. Legally, we enshrined our best guesses and our fond hopes in rules determining legal paternity. Now, however, modern techniques—first HLA, now DNA analysis—allow definitive clarity about who is the biological father of a given child. This occurs at the very same time that we no longer have a biologically unequivocal answer about who is the mother. The weakened link between biology and motherhood, combined with the tightened

44. Adoption, for instance, is clearly a socially constructed policy for defining parenthood. Similarly, concepts used in resolving custody disputes, such as psychological parent or primary caretaker, illustrate the role of normative judgments in determining legal parental rights.
nexus between legal and biological fatherhood, could have interesting consequences. The age-old scenario of men tied to children only by inference or presumption, often escaping the burdens of fatherhood—could that change? Could women’s choices and preferences, their decisions rather than just their biological “facts,” play a more central role in the embrace or rejection of motherhood? If so, we feminists may not be wholly comfortable with such potential changes. We do not feel clear about what we want to do with them. Our confusion stems from what I have called our “schizy-ness” about biology—the source of our oppression, the source of our power.

I, too, am confused. But at a minimum, these changes offer the continuing opportunity and, I believe, the continuing obligation to rethink social and legal policy regarding families and gender roles, particularly the comparative roles of biology, intention, and the conventions of moral behavior. To do so, we may need to lengthen our timelines, broaden our comparisons, and renew our analyses.

Answers to some of the questions I raise in this essay turn on what Peggy Radin has identified as the double bind:45 in choosing positions and policies, do we attend to the short term or to the long term balance of risks and benefits? For me, response depends on how distant meaningful realization of the long-term goal seems to be. It turns on whether—regarding a given time, place, or issue—understanding and addressing where we came from, or where we need to go, seems more exigent.

It also makes a difference whether we exercise judgment from the vantage point of theory, as opposed to that of strategy. To me, a number of the arguments I criticize seem more appropriate when framed as appeals to political prudence (policymakers should not incarcerate drug-addicted pregnant women) than when urged, as they often are, as constitutional restraints on state power (the state may not punish drug-addicted pregnant women). Implicit in that view is my obligation to be politically, as well as legally and theoretically, active.

Overall, my academic role, however, predicts that I especially value defensible theories; I am also concerned that there are long term practical costs to views that are too narrowly assessed in terms of too small a range of issues or too short a span of time. At a minimum, we ought to understand when we speak as political actors within the limits of existing systems, and when we speak in terms of principles and goals. We ought always to consider trade-offs, weigh alternative approaches, recognize

and assess the implications of our positions and arguments for contexts beyond our most immediate frame of concern. Certainly, we cannot bury our heads in some sand of theoretical or formal reason. In particular, we must recognize how cruelly the racism and sexism of social practice distort the best of ideals. Yet in recognizing and fighting these realities, we need also to prevent hyperbole or myopia from unbalancing our fundamental principles or undermining our persuasive integrity.

Women have multiple stakes. Reasonably broad and meaningful access to abortion, protection of reproductive autonomy, recognition of bodily integrity, acceptance of diverse personal choices regarding social interests and roles, and freedom from discrimination or oppression on the basis of race or class are certainly among them. However, women also have stakes in a health care system that provides information and respects their choices, whether they are patients or doctors. They have stakes in men's identification with, and involvement in reproduction and the care of children. They have stakes in the well-being of future generations. Most of all, they have stakes in the creation and maintenance of a humane and caring society in which they and others as well are free and responsible moral agents.