BIOETHICS
Prof. Mayo

The Politics of Fetal/Maternal Conflict

by Rutb Hubbard *

There are all kinds of ways in which societies interpret women's procreative abilities and use these interpretations to structure and define our participation in society. Hence, women's ability to gestate and birth children is used to control our behavior somewhat differently in the United States from the ways fecundity and procreation are used to control women in some of the other societies discussed in this collection. The new procreative technologies and the anti-abortion movement are partially responsible for what is happening in the United States, but so are other social forces.

One way to begin to explore this situation is to look at the way Americans view pregnancy in this final decade of the 20th century. Here, two trends reinforce each other. First, there is the image of the disembodied embryo or fetus, floating somewhere in space. This is illustrated by NOVA, in a television program called "How Babies Get Made." The program opens with a gowned male doctor handing a newborn to a gowned nurse who, of course, is female. The rest of the program is about eggs, sperm, cell nuclei, early and later stages of embryonic development, and the developing fetus. At one point, we get to see a piece of the placenta. That famous visitor from outer space would have no way to gather from this presentation that everything shown in the film happens inside the body of a woman. Women and pregnancy are never mentioned.

Now let us look at the changing image of mothers. In her book, *Recreating Motherhood*, Barbara Katz Rothman (1989) looks at the transformations in the image of the mother in popular culture from the 1950s and 1960s to the 1970s and 1980s. Throughout these decades mothers have always been portrayed as bad for their children, but their ways of being bad have changed. In the 1950s and 1960s, mothers damaged their children by being too self-sacrificing, like Portnoy's mother. But in the 1970s and 1980s, the smothering mother was replaced by the selfish mother, the woman out to fulfill herself at the expense of her child. The new prototype is the mother of the movie *Kramer v. Kramer* (1979), the self-absorbed woman who abandons her child to the tender mercies of its father.

Putting together the disembodied embryo and the selfish mother readily leads to the three practices I want us to think about:

1. criminal prosecutions of women for endangering the fetus within their bodies,
2. court-mandated caesarian sections, and
3. fetal protection as grounds for excluding women from jobs with relatively good pay, and health and retirement benefits, that have previously been held only by men and to which women have recently begun to gain access.

All three of these practices produce media stories that strengthen the cultural image of neglectful women putting their fetuses at risk. Although these particular practices demonize primarily poor or working-class women, the aura they create can be used to control the behavior of middle- and upper-class women as well. After all, different kinds of "experts" are always ready to make middle- and upper-class women feel guilty for putting their own career needs ahead of the needs of their future or present children. Middle- and upper-class American women may be spared accusations of fetal abuse, but they are frequently accused

of neglecting their maternal duties when they postpone childbearing or when they delegate the care of their children to others (including the fathers of those children). Meanwhile, in the United States, in contrast to several other industrialized nations, there is no public responsibility either for child care or for adequate nutrition or health care for pregnant women. Women get blamed, but there are few places where they can go for help.

Criminal Prosecutions

Numerous women - most of them poor, many of them battered -have been jailed for drinking alcohol or using drugs while pregnant. How do the authorities find out about them? In one case, because a battered women's shelter brought a pregnant woman to the hospital for treatment of her bruises. A blood test revealed alcohol, and she was promptly charged with "felony child abuse."

A case currently being litigated in Massachusetts involves Josephine Pellegrini of Brockton who in 1989 gave birth in a public hospital. The newborn was healthy, but a routine blood test showed traces of cocaine in its blood. The Commonwealth promptly charged Pellegrini with distributing cocaine to a minor via the umbilical cord and also with possession of an illegal substance (McNamara 1989). The "distributing" charge, which carries a minimum sentence of three years in state prison, was dismissed in 1992, since in Massachusetts a fetus does not have legal standing as a minor. In March 1993, however, the Supreme judicial Court upheld the "possession" charge. A legal issue that remains to be decided is whether the mandatory reporting statute, under which anyone who suspects child neglect or abuse must report the situation, can be used top prosecute someone for the harm that person may be doing to her/himself when there is no evidence that he or she has, in fact, harmed the child whom this statute is intended to protect.

Another legal issue, raised in a review by Kary Moss (1990), is that administering drug tests to an infant without the parent's consent violates parental rights, As Moss points out, "A positive toxicology [drug test] alone does not provide substantive information about the impairment of mother or child ... It does not measure frequency of drug use, but says only that a drug was introduced in the last 24 to 72 hours." In practice, using the mandatory reporting statute in this way is likely to deter pregnant women from consulting drug counselors or other providers of health or social services for fear of criminal prosecution, which could deprive the mother of custody and terminate her parental rights. Linking the healthcare or social service system with legal prosecutions erodes women's often tenuous trust of service providers and may, in fact, imperil the health of women, fetuses, and newborns.

Eventually, most charges of delivering drugs to fetuses *in utero* have been dismissed, either on technical grounds or because a fetus is not a person. As a result, state prosecutors are formulating evermore ingenious charges, such as, for example, the "possession" charge against Josephine Pellegrini. In another case, Jennifer Johnson, a woman in Florida, was convicted of a felony for passing cocaine, this time not to her fetus but to her newborn in the moments before the umbilical cord was cut (*Florida v. Johnson*, 1989). Johnson's sentence included the proviso that she get drug treatment (which she had tried to get), gainful employment (which she had tried to find), and that she not use drugs or associate with anyone who does, drink any alcohol, or enter a bar as conditions of her parole (though no provisions were made to help her move out of her neighborhood). In other words, although she tried, and was unable, to get the services she needed to stop using drugs, she was punished for not

having gotten them.

Let us take a closer look at this issue. I suppose most people would agree that it is not a good thing for pregnant women to drink excessive amounts of alcohol, to smoke, or to use drugs. But if the state wants to protect a fetus, a better strategy might be to make it possible for pregnant women - and women in general - to get proper housing, food, jobs, a decent living environment, and good prenatal care. Since 1980,however, resources available to poor women have been diminishing. Public health and nutrition programs for women and children have been slashed, as have jobs and housing. Though overall infant mortality has declined during this century, infant mortality in this country is now twice as high for African American as for Euro American infants, the same as a hundred years ago (Hogue and Hargraves, 1993).

The so-called war on drugs has produced a situation in which a single blood test on a pregnant woman or a newborn is sufficient to label that woman a drug abuser and call in the state. Courts increasingly are criminalizing poor women for behaving in ways that could endanger their fetus, irrespective of whether their babies can be shown to have been damaged. There need be no symptoms or other indications that the baby has been mistreated in any way. This way of implicating drug abuse often results in misdiagnoses and mislabeling (Moss 1990). For example, on the basis of a blood test on the newborn, in 1990 Cambridge Hospital accused a young, unmarried, African American woman of having used drugs while pregnant. The woman and her mother denied the charge and sought legal help. Further tests indicated that the chemicals which were detected in the baby's bloodstream had been administered to the woman by her medical attendants during labor.

The mandatory reporting policy can wreak havoc with the lives of women and children and the more vulnerable the woman, the more devastating the effects. A poor woman, a woman of color, or an abused woman is usually not in a position to defend herself or her parental rights, whether or not she habitually uses drugs. And even if she does use drugs regularly, the present policy is not likely to benefit her or her child, since what she needs is appropriate help and rehabilitation, not punishment.

Yet, that is not what is happening. In New York City, many babies have been taken away from their mothers for insufficient cause and kept in hospitals with insufficient care. Meanwhile, few drug treatment programs accept women and even fewer of them accept pregnant women or women on Medicaid. In a study of New York state, Wendy Chavkin (1990) found that of the 78 drug treatment programs on the state's list, 87per cent refused to serve women who were either pregnant, on Medicaid, or addicted to crack cocaine. A recent survey of services in Oregon showed that in 1989, 2140 women were probably using illicit drugs while pregnant; yet, there were only 111 programs with a total of 740 treatment slots for pregnant alcohol or drug users (Slutsker et al. 1993). Even worse, only 21 of these programs had on-site child care facilities and only 134treatment slots were available for pregnant women with children. The authors of this study estimate that "assuming a 1-year course of therapy, current treatment programs [in Oregon] could accommodate only 13% of the estimated number of recognized [pregnant] users of cocaine, methamphetamine, or heroin."

The National Association of State Alcohol and Drug Abuse Directors has reported that only about 550,000 of the approximately 4 million women needing treatment in 1989 received it. Of those 4 million, 250,000 were pregnant, but only 30,000 received treatment (Bertin 1993). All this adds up to the fact that there are few resources to enable addicted pregnant women to get off alcohol or drugs, and even fewer for addicted pregnant mothers who need to be caring for

their children.

Women resort to excessive drinking or drug use often out of an emotional and physical need, sufficient to override wanting to do what is best for their future child. Although this is true irrespective of women's economic status, and although the rates of drug use are comparable among poor and affluent women (Kolata 1990), poor women are more likely to be prosecuted for drug use during pregnancy than affluent women are. The reason is that reporting of drug or alcohol use is done almost entirely by public hospitals, where poor women go for care and not by private physicians.

How damaging the behavior is also appears to be affected by economic status. A recent study of alcohol-addicted women found that whereas the incidence of fetal alcohol syndrome was 70.9 percent among the children of the lower-class mothers, it was only 4.5 percent among the children of the upper-middle-class mothers (Bingol, 1987).

Fetal/Maternal Conflict and Legally Mandated Caesarian Sections

How did embryos or fetuses become separate beings in disregard of the women whose bodies sustain them? And how did pregnant women become criminals against whom the state must protect the fetuses growing within their bodies?

No doubt the anti-abortion movement has played into this, but there are other factors as well. Until the 1960s, there was no way of knowing anything about an embryo or fetus except by examining the pregnant woman. If you wanted to know whether the fetus moved or its heart beat, you had to ask her, touch her, or put your ear or a stethoscope up against her swollen belly.

Then, in the 1960s, medical scientists developed a first direct test of fetal health when they became able to determine the Rh-antigen status of a fetus, It was important to know the Rh-status of a pregnant woman and her fetus because, if the fetus is Rh-positive, an Rh-negative pregnant woman may develop antibodies against its Rh-antigen that can damage the fetus. Thus, the fetal Rh-test enabled physicians to be ready to treat an endangered infant as soon as it was born. Actually, today all pregnant women are given rho-gam, a substance that neutralizes Rh-antibodies, so that the fetus's Rh-status is no longer of special interest, but there is no question that this direct measure of fetal physiology was useful.

Since then, numerous other tests have been developed to assess fetal health directly. But the use of ultrasound imaging has been the most crucial innovation for changing the cultural perception of the fetus. Earlier in the century, obstetricians had used X-rays to visualize fetuses, but that needed to be discontinued when X-rays were shown to increase the incidence of childhood leukemia. (Of course, no one knows for sure that ultrasound is risk-free, but so far no problems have been documented and it has become routine to use ultrasound imaging to visualize fetuses, during pregnancy.) Real-life ultrasound imaging has rendered pregnant women transparent and encouraged the culture to bond with "the fetus." Nowadays, fetuses are not only female or male; they swallow, pee, suck their thumbs, and their pictures can be shown to relatives and friends.

Thus, the anti-abortion movement has not been alone in transforming the cultural status of embryos and fetuses. Routine technological interventions in wanted pregnancies have done

this as well, and so has the in-vitro fertilization technology. Even more recently, the combination of in-vitro fertilization and contractual pregnancy has turned not only eggs and sperm, but also embryos, fetuses, and gestation into commodities that can be ordered from catalogs. An extreme result of this has been a decision, handed down in a case of contested custody by a California judge, in which he stated that Anna Johnson, a woman who had gestated a fetus derived from another woman's egg, is a "genetic stranger" to that child and comparable to a baby-sitter. The egg donor, he ruled, is the biological mother (Reuters 1993).

Setting a pregnant woman and her fetus up as not only separate but as antagonists is of relatively recent origin. As recently as 1979, two adjoining articles were published in the medical journal Obstetrics & Gynecology, one by three physicians, the other by an attorney (Lieberman et al. 1979; Shriner 1979). Both discussed the rare situation in which a physician believes that medical circumstances call for a caesarian section, but the pregnant or birthing woman refuses to undergo this surgical procedure. And both concluded that, while physicians can use their ingenuity to try to persuade the woman, they cannot open her belly against her will. A caesarian section performed without the woman's consent would constitute assault and battery.

A mere two years later, an article in the same journal describes one of the first legally mandated caesarians (Bowes and Selegstad 1981). This situation involved a white woman on welfare who arrived at the University of Colorado Medical Center in labor, without prior prenatal care. As the labor progressed, the physician on duty decided a caesarian was indicated, but the woman was afraid of surgery and refused. A psychiatrist, called in to speak with her, testified that she understood the supposed risk to the baby. Thereupon the hospital obtained an injunction and a hearing was held in the woman's hospital room, presided over by a judge from the Colorado juvenile court, in which the hospital, the woman, and the fetus were each represented by a lawyer. At the conclusion, the judge ruled that a caesarian was in order, and at that point the woman consented, so that she did not need to be cut open against her will.

Like the prosecutions for "fetal abuse, " most court-mandated caesarians have been performed on poor women, women of color, or on aliens or recent immigrants who speak little or no English. So, again it has been very much a class and race issue (Cole 1990).

It is important to recognize that court-mandated interventions in pregnancy and birth are supported not only by "pro-lifers," whose principal concern is for the fetus, but also by some legal experts who support a woman's right to terminate her pregnancy. For example, John A. Robertson (1983), a professor of law at the University of Texas, argues that Roe v. Wade guarantees a woman the right to abortion, but that if she "waives" that right by continuing her pregnancy, she is obligated to do whatever is deemed best for the fetus.

There is a problem here, for who is to say what is best? Medical fashions change as do popular beliefs about what is, or is not, good for pregnant women and their fetuses. The amount of weight a woman should gain during pregnancy and how athletic she should be are recent examples of this. Of the several pregnant women who have escaped court-mandated caesarians, either by hiding or because they were lucky enough to go into labor and give birth before the court order could be implemented, all have given birth normally and they and their babies have been fine (Kolder et al., 1987). As physician Helene M. Cole (1990) points out: "Courts are ill-equipped to resolve conflicts concerning obstetrical interventions. " Neither physicians nor anyone else can foresee birth outcomes with certainty. So, it is wrong to give

medical predictions legal status.

Mandated caesarians may have been ended by a lawsuit, instituted by a family with access to the necessary resources. (*In re* A.C. 1990) It involved Angela Carder, a woman who had had cancer during her teens. The cancer went into remission, but years later, after she became pregnant, it was reactivated. When she was 26 weeks pregnant, it became clear that she was not going to survive until the end of her pregnancy. Georgetown Hospital in Washington, D.C., where she was receiving her obstetric care, insisted that she undergo a caesarian section so as to try to save the fetus. Initially, Carder agreed, but then changed her mind. Despite her refusal and the fact that Carder's parents, her husband, and the medical specialist who was treating her cancer supported her decision, attorneys for the hospital obtained a court order and a staff obstetrician performed the caesarian. The baby died within two hours of surgery, Carder herself two days later. Her hospital records state that the surgery probably hastened her death. The Federal Appeals Court in the District of Columbia agreed to review the court order under which the surgery took place and in 1990 handed down a very strong opinion against forcing women to undergo caesarian sections against their will. In addition, the family filed a civil suit and Georgetown Hospital had to pay considerable damages.

This dreadful story may have laid court-mandated caesarians to rest, but it is easy to extrapolate from court-mandated caesarians to court-mandated Prenatal tests and therapies. This has not happened yet, but it may once prenatal testing or therapy becomes standard medical practice. And what if courts one clay decide that, if no therapy is available and a fetus is predicted to be disabled, the woman must have an abortion.?

This suggestion is not altogether far-fetched. Insurance discrimination against families predicted to have a child with a disability has already occurred. Medical geneticist Paul Billings and his colleagues (1992), in their research into genetic discrimination, have come across an instance that is not very different from this hypothetical scenario. In this case, a woman who had borne one child with cystic fibrosis decided to have her fetus tested for this condition during a subsequent pregnancy. When the result indicated that this baby, too, was going to have cystic fibrosis and the woman decided to continue the pregnancy (which is not unusual for families who have experience caring for a child with cystic fibrosis), the HMO that provided the family's health care announced that it was prepared to pay for an abortion, but not for continued prenatal care or the health care of the future baby because that baby now had what insurers call a pre-existing condition. Only after the family threatened to publicize this decision and, if necessary, take it to court, did the decision get reversed. As prenatal tests proliferate, these kinds of situations are going to become more common, unless we get laws passed to prevent such forms of discrimination and coercion.

Fetal Protection and Workplace Discrimination Against Women

As we have seen, the ability to visualize a fetus and test for certain aspects of its health status makes that fetus more real, more of a person. And when that happens, the pregnant woman seems to become more of a fetal container and less of a person.

Further detrimental effects of this skewed view of pregnancy are illustrated by the so-called fetal protection policies by which women of childbearing age, as a class, have been excluded from certain job categories in which they run the risk of being exposed to radiation, lead, or other toxic chemicals. These concerns are not raised because the agents pose dangers to the

workers - women and men - but because of the dangers they pose to a "potential" fetus, in case the woman is pregnant. In this construct, all women of childbearing age are deemed potentially pregnant, hence excludable, unless they can show that they have been sterilized. Their life-partner being sterile is not enough; they must be unable to become pregnant.

Similar concerns are not raised to protect women who work at jobs that are more traditional for women, as nurses, hospital or chemical laboratory clean-up personnel, beauticians, pottery painters, or indeed housewives. All such women routinely come in contact with toxic chemicals, biologicals, or radiation that can endanger their fetus when they are pregnant. But the concern is reserved for women employed in jobs, traditionally occupied by men, that pay higher wages and include better benefits than traditional women's jobs do. Attorney Joan E. Bertin (1993) makes the telling point that a woman's employment is often critical to a healthy pregnancy and only she, not her employer, can judge what risks are worth taking to continue in a particular job.

So-called fetal protection policies may have been discouraged by a decision the U.S. Supreme Court rendered in 1991. The court held that it was unlawful for Johnson Controls, Inc., a manufacturer of lead batteries, with plants across the country from Vermont to California, to exclude women from working in its lead battery department. (*International Union, UAW v. Johnson Controls*, 1991). Johnson Controls had *enforced this policy irrespective of the women's marital status or their intentions not to have (more) children*, so limiting women's access to more than 20 million jobs (Bertin 1993).

Meanwhile, scientific and news articles have reported research showing that men's exposure to pesticides, radiation, and toxic work-place chemicals, as well as their consumption of alcohol and drugs, can affect the quality of their sperm and provoke death or disabilities of the fetuses or children they father (Blakeslee 1991; Friedler 1993).

It stands to reason that sperm is at least as vulnerable to toxic substances and radiation as eggs are, but this society's warped ideology about childbearing and rearing focuses disproportionately on the procreative functions of women. The usual justifications for what employers refer to as their fetal protection policies are (1) that fetuses may be more vulnerable than adult workers, and (2) that all of a woman's eggs are laid down in her ovaries at the time she is born, whereas men produce sperm continually. Therefore, the argument goes, women's eggs age with them and accumulate potential injuries throughout life, whereas sperm is always new.

Both arguments are flawed. Fetuses may be more vulnerable than adults, but no hazards affect exclusively fetuses. The best way to protect fetuses is to clean up workplaces and so protect the workers. As for aging eggs and fresh sperm, sperm is produced continuously by virtue of the fact that sperm-precursor cells keep on dividing. Men are born with these precursor cells, just as women are with eggs. In fact, the sperm-producing cells may be more vulnerable than eggs to radiation or chemical injuries precisely because they keep dividing, which is when cells are at greatest risk from environmental damage.

The Fetus as Patient and Plaintiff?

Control of women by controlling procreation underlies most of the practices discussed in this collection, but the medical-legal measures I have been describing are peculiar to the United

States. Here, as elsewhere, women not only bear children, but also are principally responsible for their children's well-being, and the inequities intrinsic to capitalism fall most heavily on them. Since this country makes few economic, social, and medical provisions for people, it has proportionately more poor women and children than other affluent countries, which offer more adequate social services. In no other industrialized country do so many women give birth without regular, or indeed any, prenatal care. As we saw earlier, this country does not have adequate drug treatment programs for women or men, but especially not for pregnant women. The United States also has a higher proportion of non-unionized workers than other industrialized countries, so that there is less protection for workers' health and safety and for the rights of pregnant workers or workers with children.

The individualistic thinking that prevails in the United States lends itself to blaming women for their low social and economic status and for their own and their children's poor health. This ideology becomes actively punitive when "the fetus" is turned into a patient and plaintiff with its own rights.

To improve this situation will require social measures that deindividualize responsibility. None of the problems I have described can be remedied at the individual level. To solve them requires a commitment, at the societal level, to care for people who need care and to provide the opportunities people need in order to be able to care for themselves.

Pitting the interests of pregnant women against those of the fetuses they are gestating does not benefit children any more than women. Women whom the state considers neglectful of the health of their fetuses, by definition, must be damaging their own health as well. It would be more productive to concentrate on their health needs and to enable them to live healthfully not only while pregnant, but after their babies are born.

As individuals, we cannot improve women's economic lot; we need to organize for political change. But throughout this work we must insist on women's bodily autonomy. Women must have access to abortions when they do not want to be pregnant, irrespective of their ability to pay. And women must be trusted to make the right decisions, recognizing that they will sometimes err and put their fetuses at risk. Have physicians never put fetuses (or people) at risk, and haven't lawyers and judges?

As far as a fetus's medical and legal rights are concerned, I insist that it does not have any. My criteria rely on simple geography: as long as one cannot get at the fetus without manipulating the woman, she is the only one with the right to make decisions. Once the baby is outside and its well-being no longer impacts her physical autonomy, then others can begin to speak for it, provided they take responsibility for what they say or do.

A society that forces a woman to bear a child when she does not wish to have one, offers her little or no support when she does, and punishes her when it decides she is acting irresponsibly, is itself guilty of fetal abuse. Unfortunately nothing in U.S. law mandates equality in access to health resources or care. In fact, the opposite is likely to happen if current discussions about health priorities lead to laws that make cost-cutting a cornerstone of health policy. In that case, present seemingly haphazard and piecemeal discriminatory practices are likely to be regularized and legalized by rationing access to services for certain sectors of the population.

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Ruth Hubbard, "The Politics of Fetal/Maternal Conflict" in Power and Decision: the Social Control of Reproduction (Cambridge: Harvard School of Public Health, 1994), pp. 311-324.

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