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A Maternal Duty to Protect Fetal Health

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A Maternal Duty to Protect Fetal Health?

Recent cases indicate a trend toward recognizing a duty to protect fetal health. Medical advances have precipitated the issue of whether such a duty ought to be enforceable in a civil action against a pregnant woman. Although a variety of medical techniques may be performed on the pregnant woman to correct fetal anomalies, in order to utilize these medical advances some cooperation by the pregnant woman is inherently necessary. All techniques for treating the fetus during the pregnancy have some impact on the mother, and her constitutional rights may be infringed if she is forced to undergo treatment to benefit the fetus.

By canvassing some examples of prenatal treatment and by considering cases in which courts have required the mother to undergo treatment against her wishes to benefit the fetus, this note will examine whether there should be a duty to protect fetal health. The mother's constitutional rights will be limned and weighed against such a duty. Foreseeable problems in enforcing this duty will be explored to explain why practical considerations lead to the conclusion that enforcing a duty to protect fetal health by either monetary or injunctive relief would be undesirable in many cases.

MEDICAL BACKGROUND

To be able to gauge the nature of the treatment the pregnant woman might be asked to undergo to benefit the fetus, it is first necessary to lay the groundwork by providing some medical background of the procedures entailed, the benefits to the fetus, and the risks of foregoing treatment. Recognized methods of preserving or improving fetal health vary in their level of intrusiveness to the mother. Whether a court would be persuaded to order a specific treatment may partially depend on its impact on the mother. Some examples of possible prenatal treatment should suffice to illustrate the range of intrusiveness of medical intervention.

Before beginning the discussion of specific forms of prenatal treatment, it is appropriate to note that the risks involved in fetal diagnosis and treatment are generally greater for the fetus than for the mother; however, the risks vary with the magnitude and invasiveness of the procedure. Proceeding from most to least invasive, in utero surgery exemplifies the greatest intrusion.

To illustrate, hydronephrosis, an obstruction of the ureter, has recently been successfully treated by fetal surgery. In this case, the risks of direct

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fetal surgery are numerous: mother or fetus might die; post-operative bleeding or infection might cause an abortion or require reoperation; an hysterectomy may be necessary; Caesarean section delivery would be necessary for this child and any subsequent children; the fetus might have other, undetected defects; the surgery might be unsuccessful; or the surgery might not allow the fetus to survive after birth. A mother carrying a fetus with severe bilateral hydronephrosis must weigh the risks associated with correction against the risks of neonatal death or severe disability from renal or pulmonary failure.

Further examples of treatable fetal anomalies involving invasive procedures include hydrocephaly, an accumulation of fluid in the brain which may be treated by fluid extraction before birth. This anomaly occurs in approximately one of 2,000 fetuses, and increases the risk of fetal morbidity, as well as complicating vaginal delivery. If untreated, fetal cerebral growth will be retarded. However, hydrocephaly may be alleviated by inserting a shunt. The treatment entails insertion of a needle guided by ultrasound imagery through the maternal abdomen into the fetus. This procedure is repeated six times over a seven week period.

Erythroblastosis, incompatibility between maternal and fetal Rh factor, is treatable via intratuterine transfusions. This condition occurs in very few pregnancies. If untreated, fetal and infant symptoms include subcutaneous edema, jaundice, skin lesions, heart enlargement, pulmonary hemorrhage, and neurological disorders. Alternatively, the fetus might die in utero. Without treatment, the fetal mortality rate is thirty percent. Expression of the disease is variant.

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5 Id. The surgery itself would begin with anesthetization of both mother and fetus. Sonography is used to determine the fetal position. An incision is then made into the maternal abdomen through which the uterus may be opened and the lower fetal body removed. The dilated ureters of the fetus are then opened and "marsupialized" to the skin. Twenty-five minutes later, the fetus is returned to the uterus. The amniotic cavity must be irrigated and the uterus closed to complete the procedure. The fetus must be delivered by Caesarean section. Id.

4 Harrison, Golbus & Filly, supra note 1, at 777.


6 J. Pritchard & P. MacDonald, William's Obstetrics 822 (16th ed. 1980). This anomaly accounts for roughly 12% of all severe malformations at birth. Id.

7 Burnholz & Frigoletto, supra note 5, at 1021.

8 Id. at 1022.

9 Id. at 1023.

10 Id. at 1021.

11 Id.

12 J. Pritchard & P. MacDonald, supra note 6, at 970.

13 Id. at 962-63.

14 Id. at 966-70.

15 Id. at 968.

16 Id. at 965.

17 Id. at 966. Maternal antibodies cross into the fetal circulatory system. Absorbed antibodies accelerate the destruction of fetal red blood cells; the sooner this process begins and the greater its intensity, the more severe is the effect on the fetus. Id.
With aggressive management, however, the fetal mortality rate is reduced to ten percent. Aggressive management involves diagnostic amniocentesis, intrauterine transfusions in some cases, and early delivery in most cases. Transfusions are accomplished by first administering a local anesthetic to the fetal abdomen by injection into the amniotic cavity. A local anesthetic is also administered to the mother. A catheter is then inserted through which the fetus may be transfused in utero. This process is repeated at two to three week intervals, beginning between the twenty-fourth and thirtieth weeks of gestation and lasting until delivery. Delivery is best accomplished by Caesarean section at thirty-four weeks gestation.

Other conditions may be treated by drug therapy. For instance, fetal red blood cell deficiency may be treated by injecting red blood cells into the fetal peritoneal cavity. Likewise, congenital hypothyroidism, which might lead to cretinism if untreated, may be treated by injecting intraamniotic thyroid hormone into the amniotic fluid. Intrauterine growth retardation may be corrected by instilling nutrients into the amniotic fluid to orally feed the fetus.

Other fetal diseases may be treated indirectly by administering drugs to the mother. For example, respiratory distress syndrome may be alleviated by administering glucocorticoids to the mother. This treatment increases otherwise deficient pulmonary surfactant, alleviating the disease.

Fetal hydrops, an accumulation of fluid throughout the body of the fetus, may be treated by administering diuretics and digitalis along with red blood cells into the fetal peritoneal cavity. A fetus with vitamin B12-responsive methylmalonic acidemia may be treated by giving massive doses of vitamin B12 to the mother, and a fetal biotin-dependent multiple carboxylase deficiency may be treated by giving the mother pharmacologic doses of biotin during the last half of her pregnancy.

The imposition of dietary restrictions involves the same level of in-
trusiveness as drug therapy. Mothers of fetuses with specific biochemical genetic errors may benefit their babies by following a special diet during pregnancy. One such biochemical genetic error is phenylketonuria (PKU).33 Mothers of fetuses with PKU should follow a low phenylalanine diet to minimize the incidence of mental retardation in their children.34

Restrictions of maternal conduct are equally intrusive, albeit in a less direct, physical sense than are bodily invasions. Alcohol consumption and smoking are two activities upon which restrictions might be imposed. Maternal alcohol abuse has been linked to multiple congenital abnormalities, including heart defects and prenatal growth retardation.35 Children of alcoholic mothers risk higher perinatal mortality, lower birthweight, and fetal alcohol syndrome.36 The symptoms of fetal alcohol syndrome include prenatal and postnatal growth deficiency, eye and ear anomalies, heart defects, and varied degrees of mental retardation.37 The incidence of fetal alcohol syndrome in the United States is one in 750 births.38 Maternal smoking increases the risks of prematurity and abortion.39

In considering whether a duty to protect fetal health ought to be imposed, one should bear in mind that the nature of the remedy a court might order could take any of these forms. Remedies would vary on an individual basis, subject to the needs of the fetus in each case. The complexity injected by myriad possible forms of relief would not easily allow courts to classify appropriate instances for relief using a general rule. Additionally, the technical nature of the problems and remedies, combined with the variability of the cases, would make any litigation complicated, protracted, and expensive.

LEGAL BACKGROUND

Cases Imposing a Duty to Protect Fetal Health

The courts do not seem concerned by the unavailability of a general rule

33 PKU is a congenital deficiency of phenylalanine hydroxylase which causes metabolic errors. Stedman's Medical Dictionary, supra note 28, at 1072.
35 Little and Streissguth, Effects of Alcohol on the Fetus: Impact and Prevention, 125 CAN. MED. A.J. 159, 159 (1981). If alcohol intake by pregnant women who drink heavily is reduced, the likelihood of having a normal infant increases. In contrast, only seven percent of the women who drink heavily during pregnancy may expect to deliver normal babies. "Heavily" is defined as 174 ml of absolute alcohol per day. (This equals about 5.9 oz.) Quellette, Rosett, Rosman & Weiner, Adverse Effects on Offspring of Maternal Alcohol Abuse During Pregnancy, 297 NEW ENG. J. MED. 528, 528-30 (1977).
36 Little and Streissguth, supra note 35 at 159.
37 Id.
38 Id. at 162.
for allowing recovery. Three recent cases suggest a trend toward recognizing a duty to protect fetal health. In *Jefferson v. Griffin Spaulding County Hospital*, a woman had placenta previa which created a fifty percent risk of maternal death and a ninety-nine percent risk of fetal death if the baby were delivered vaginally. The Georgia Supreme Court authorized the hospital to perform a Caesarean section on the woman against her objection on religious grounds to save the life of her unborn child. The per curiam opinion began by noting the risks of vaginal delivery to both mother and fetus. The proposed method of delivery had a ninety-nine percent chance of allowing both mother and fetus to live. The court mentioned that an abortion this late in the pregnancy would constitute a criminal offense in Georgia. Remarkably, the court proceeded without elaboration from these statements to its holding that the intrusion to the mother was warranted by the fetus's right to be born alive.

A New Jersey court also has ordered medical treatment of a pregnant woman against her wishes when necessary to protect the life of her unborn child. In *Raleigh Fitkin-Paul Morgan Memorial Hospital v. Anderson*, the New Jersey Supreme Court authorized blood transfusions if necessary to save the life of either the pregnant woman or the unborn child. As in *Jefferson*, the fetus was viable and the woman's objection to treatment was based on religious grounds. Also as in *Jefferson*, the court noted the risks to both mother and fetus of foregoing treatment. The New Jersey court based its order on prior decisions which allowed blood transfusions for an infant contrary to the parents' wishes and recognized a cause of action for prenatal injury.

A recent holding by the Michigan Court of Appeals went beyond those of the Georgia and New Jersey courts, recognizing a fetal right to be born healthy rather than merely to be born alive. In *Grodin v. Grodin*, the

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41 Placenta previa describes a placenta which develops in the lower uterine section, blocking the internal opening. DORLAND'S ILLUSTRATED MEDICAL DICTIONARY 1165 (24th ed. 1965).
42 "Id. at 86, 274 S.E.2d at 458.
43 Id. at 86, 274 S.E.2d at 458.
44 "Id. at 86, 274 S.E.2d at 458.
45 "Id. at 87, 274 S.E.2d at 458.
46 "Id.
47 "Id. at 87, 274 S.E.2d at 458.
48 Id. at 89, 274 S.E.2d at 460.
50 "Id.
51 "Id. at 422, 201 A.2d at 537.
52 "Id. at 422, 201 A.2d at 537-38.
53 "Id. at 423, 201 A.2d at 538.
54 "Id.
Michigan court indicated a woman would be liable to her child for taking tetracycline while pregnant if her conduct was held to be unreasonable. Ingestion of the drug during her pregnancy caused her son's teeth to be discolored. This court explained its holding by noting that the Michigan Supreme Court decision in Womack v. Buckhorn,\textsuperscript{57} which allowed a child to sue for negligent infliction of prenatal injury, did "not limit those who may be held liable."\textsuperscript{58} Consequently, according to the appellate court, the child's mother would bear the same liability as a third person.\textsuperscript{59}

The obvious similarity in all three opinions is their lack of analysis. The courts failed to explain why decisions to allow infringement of the mother's rights and to hold the mother liable followed from the stated premises. It is conceivable that the state's power to prohibit abortion of viable fetuses, the abrogation of intrafamilial tort immunity, the recognition of a cause of action for negligent infliction of prenatal injury, and/or the parens patriae power of the state to order medical treatment for children against the wishes of the parents justify the decisions. While any or all of these legal developments may logically pave the way for courts to impose a duty to protect fetal health, such a result is not mandated.

\textit{Rights Versus Duty}

Courts could analyze the issue of whether to impose a maternal duty to protect fetal health by applying a balancing test which weighs the constitutional rights of the mother against the implications of imposing such a duty in each case.\textsuperscript{60} The mother's rights to refuse medical treatment, to practice a religion, and to exercise parental discretion may all be subject to invasion if there is a duty to protect fetal health. These rights can be extrapolated from existing cases\textsuperscript{61} as easily as can the duty to protect fetal health, and sound arguments can be made regarding the importance of each, thus creating a conflict.

In Jefferson, Anderson, and Grodin, the mother's constitutional right to refuse medical treatment conflicted with the duty to protect fetal health. The mother's right to refuse medical treatment is derived from the right of privacy. In Andrews v. Ballard,\textsuperscript{62} a Texas district court stated that the constitutional right of privacy protects personal and important decisions. The decision to obtain or reject medical treatment was held to meet this criterion.\textsuperscript{63} State courts have also declared that the constitutional right of

\textsuperscript{57} 384 Mich. 718, 187 N.W.2d 218 (1971).
\textsuperscript{58} 102 Mich. App. at 400, 301 N.W.2d at 870.
\textsuperscript{59} Id.
\textsuperscript{60} See generally Note, Constitutional Limitations on State Intervention in Prenatal Care, 67 VA. L. REV. 1051 (1981).
\textsuperscript{61} See infra text accompanying notes 62, 64 and 72.
\textsuperscript{62} 498 F. Supp. 1038 (D. Tex. 1980).
\textsuperscript{63} Id. at 1046-47.
privacy encompasses the right to refuse medical treatment.\textsuperscript{44} The right of privacy, however, is not absolute. In \textit{Roe v. Wade},\textsuperscript{45} the United States Supreme Court held that the right of privacy was subject to infringement when a compelling state interest could be shown and when infringement involved the least intrusive means.\textsuperscript{46} The Court held that the state's interest in the life of the fetus becomes compelling at the point of viability.\textsuperscript{47} Thus, in the abortion context, prior to viability, the pregnant woman's constitutional right of privacy, encompassing the right to refuse medical treatment, may not be infringed by the state.\textsuperscript{48}

However, infringement for other reasons, such as to protect maternal health, is permitted regardless of viability.\textsuperscript{49} While viability is the compelling point in the abortion context, it is not necessarily the compelling point as to the entire right of privacy. Interests that would place abortion within the right of privacy are different from interests that would place the refusal of care within the right of privacy; the former involves an interest in procreative choices, while the latter may involve interests in personal integrity or the right to die. Thus, different state interests may suffice to allow infringement of the right of privacy in each instance. Viability is not the only recognized ground for infringing the right of privacy.\textsuperscript{50}

The woman's right to refuse medical treatment may be subject to infringement if she has young children, since the state has an important interest in insuring that she lives to care for them. At least one court has postulated that this interest may be sufficient to override the wishes of a competent woman to forego medical treatment.\textsuperscript{51}

The woman's constitutional right to practice a religion may also be subject to circumscription to protect the fetus. In \textit{Jefferson} and \textit{Anderson}, the mother's constitutional right to practice her religion was infringed to allow the fetus to be born healthy. In \textit{Reynolds v. United States},\textsuperscript{72} the Supreme Court held that the law may not interfere with religious beliefs, but may

\begin{footnotesize}
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\item The Massachusetts Supreme Judicial Court, in \textit{Superintendent of Belchertown v. Saikewicz}, 373 Mass. 728, 739, 370 N.E.2d 417, 424 (1977), stated that the constitutional right of privacy protects against unwarranted infringements of bodily integrity. In \textit{In re Quinlan} 70 N.J. 10, 4142, 355 A.2d 647, 664 (1976), cert. denied sub nom. Gorger v. New Jersey, 429 U.S. 922 (1976), the New Jersey Supreme Court declared that a once competent patient's right to refuse medical treatment could be asserted on her behalf by her father to preserve her constitutional right of privacy. Both of these cases involved the issue whether one has the right to die.\textsuperscript{44}
\item 410 U.S. 113 (1973).
\item See \textit{id.} at 155.
\item Id. at 163.
\item But see infra text accompanying notes 110, 111 and 112.
\item See infra text accompanying note 71.
\item See, \textit{e.g.}, Commissioner of Correction v. Myers, 379 Mass. 255, 264-65, 399 N.E.2d 452, 457-58 (1979) (right to die implicit in the right of privacy may be overcome by state's interest in maintaining prison discipline). See also supra note 61 and accompanying text.
\item Matter of Melideo, 88 Misc. 2d 974, 975, 390 N.Y.S.2d 523, 524 (1976).
\item 98 U.S. 145 (1878).
\end{itemize}
\end{footnotesize}
regulate religious practices. In *Sherbert v. Verner,* such regulation was held to be justified only by a compelling state interest. The regulation must also be accomplished by the least restrictive means. The Supreme Court has outlined a two step analysis to determine whether a given infringement is permissible. The first step is to determine whether the claim is deeply rooted in religious belief; the second step is to weigh the state’s interest. Neither the *Jefferson* nor the *Anderson* court questioned the validity of the woman’s belief. As noted above, the state’s interest in the life of the unborn child would not be compelling until viability.

A third constitutional right of the mother, the right to exercise parental discretion, was also restricted in *Anderson* and *Grodin.* In *Anderson,* if the mother intended to have her child follow the tenets of her religion, the ordered transfusions would impair her exercise of parental discretion. In *Grodin,* the woman’s decision to take tetracycline during her pregnancy was arguably an exercise of parental discretion. The parental right to rear children was held to be a “sacred” interest in *Prince v. Massachusetts.* In a different context, the Supreme Court recently upheld this view. The relationship between parent and child is constitutionally protected and the due process clause protects free choice in family matters. However, this right is not absolute. As is true of the constitutional rights to refuse medical treatment and to practice a religion, the right to exercise parental discretion may be infringed if a compelling state interest exits. Restriction of this right may be justified if a minor child’s health is at stake, but the state’s interest in protecting fetal life does not become compelling until viability.

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73 Id. at 166.
75 Id. at 403.
78 Id. at 215. A personal preference will not suffice; the claim must be a “deep religious conviction” which is “shared by an organized group.” Id. at 216.
79 Id. at 221.
80 If the court were to find she was unaware she was pregnant when she took the drug, then taking tetracycline would not be an exercise of parental discretion.
81 This right may differ in the prenatal context because the privacy right of the mother will necessarily also be affected by the decisions made regarding the fetus.
83 In *Parham v. J.R.*, 442 U.S. 584 (1979), the Supreme Court held that parents “retain plenary authority to seek such care [commitment to a mental institution] for their children, subject to a physician’s independent examination and medical judgment.” Id. at 604. The Court declared that the presumption that parents will act in their child’s best interest applies to support the parent’s dominant decision-making role. Id.
The propriety of an intrusion into the constitutional rights of a mother depends not only upon whether there are compelling state interests, but also upon whether there is some duty to protect fetal health. No constitutional precedent establishes such a duty, although some cases suggest a compelling state interest from which this result may be derived. Cases such as Jefferson and Anderson recognize the duty to allow a viable fetus to be born alive. Although these cases indicate a trend toward imposing some duty to protect fetal health, they do not indicate how far this duty should extend. The next logical extension that courts could make from the state's interest in protecting the life of a viable fetus, however, is that once the fetus is viable, the mother has a duty to allow it to be born healthy. Arguably, the court in Grodin accepted this extension by allowing the trial court to hold a mother responsible for negligently impairing fetal health. Roe and its progeny also may be read as supporting such an extension. A woman may seek an abortion only prior to viability, and then only under certain conditions. Once the fetus is viable, the mother is restricted from seeking an abortion. Since the mother would not be free to abort, it is arguable that she should not be free to disregard fetal anomalies or injure the fetus.

In order to evaluate whether such a duty should be imposed, this note will consider the duty as if it were already established. Drawing hypothetical parameters for a duty to protect fetal health is thus facilitated. Once limited, the implications of imposing this duty may be explored.

**Viability as a Criterion**

Foreseeable problems arise if the duty to protect fetal health is contingent on viability. As a matter of medical fact, the organogenetic period, from day 13 to day 60, is the time of greatest sensitivity for the embryo. This is prior to viability. Teratogens are likely to cause major morphological abnormalities at this stage in the pregnancy; in the third trimester the fetus is less sensitive to teratogenic influences. As an example, as early as the third week of gestation the embryo reaches a critical period of susceptibility to abnormalities of the heart and central nervous system. Between the fourth and fifth weeks of gestation, the embryonic eyes and limbs undergo a critical period of development. By the eighth week, sensitivity of these

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* Id.

* Id. at 117 (see accompanying chart).

* Id.
developing structures is lessened. Consequently, reliance on viability as a criterion for recovery would disallow recovery for most injuries, including the most severe injuries. In other contexts, courts have recognized the injustice of applying viability as a prerequisite to recovery for the negligent infliction of prenatal injury. Viability was rejected in 1953 by the New York court in Kelly v. Gregory, other jurisdictions have followed New York's lead. Thus, if viability were essential to impose the duty to protect fetal health, the result would be both unsound and inconsistent with stare decisis.

Another consideration militates against conditioning a duty to protect fetal health on viability. As medical technology improves, the point at which viability occurs becomes increasingly early; even now the determination of viability varies from pregnancy to pregnancy. The duty to protect fetal health would attach earlier in some cases than in others. Also, the duty will attach earlier in all cases as medical skill and knowledge advance. The viability criterion therefore serves to complicate the decision of whether to allow recovery.

Nonetheless, conditioning the duty to protect fetal health on viability would avoid certain undesirable results. Early in the pregnancy, when the risk to the fetus is greatest, the woman may be unaware she is pregnant. One consequence of ignoring whether the fetus is viable is that the mother may be liable for behavior which occurred before she knew she was pregnant. This result could be avoided by setting a reasonableness standard for liability. This standard, however, would negate liability for most injuries and for the most severe injuries.

Imposing liability before viability may also encourage mothers to abort. Roe allows women to seek an abortion without state interference in the first trimester. If a court were to order a pregnant alcoholic not to drink, she might opt to abort to avoid compliance. Thus, a failure to condition the duty to protect fetal health on viability may not effectuate either the goal of preserving potential life or insuring that the fetus remains healthy. If a duty to protect fetal health is imposed, courts will be faced with the Hobson's choice of resting that duty on viability, in which event determining viability will complicate the decision and the most meritorious claims will be barred, or ignoring viability, in which event liability may be imposed

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9 Id.
10 282 A.D. 542, 125 N.Y.S.2d 696 (1953). This case involved an action by a child for prenatal injuries sustained when the defendant's car hit the child's mother during the third month of the pregnancy.
for behavior which is not culpable and mothers may be encouraged to abort to avoid compliance.

**REMEDIES**

Regardless of whether fetal viability is a prerequisite to a duty to protect fetal health, courts must grapple with enforcement difficulties. Both monetary and injunctive relief would be possible. In *Jefferson* and *Anderson*, the courts ordered medical treatment of the pregnant woman to benefit the fetus. In *Grodin*, monetary damages were sought by the father and son.

Monetary Damages

An objective in imposing the duty to protect fetal health is to improve or preserve fetal well-being. This goal will not be met by awarding damages after the injury is manifested, although general deterrence may be effected. However, if a duty were imposed early in the pregnancy, before the woman was aware she was pregnant, the threat of monetary damages would not influence her conduct as she would be oblivious to the possibility of her liability. Further, maternal behavior is not insured; loss distribution in cases of non-business individual defendants is not achievable without insurance coverage.

As to culpability, there is a wide range of behavior that might injure the fetus and yet is not opprobrious. To illustrate, there is no level of radiation exposure which does not increase the risk of leukemia to the unborn child. Also, the embryo is more sensitive to radiation than is the fetus. Therefore, a woman whose employment involves exposure to radiation, such as an x-ray technician, may, by her continued employment, increase the risk of harm to her unborn child early in the pregnancy, before she knows she is pregnant. Yet, it may be necessary for her to work to support herself and her future child, and she may have intended to go on leave once she determined she was pregnant. It seems unfair to impose monetary damages in such a case because of the lack of culpability. Further, there is a possibility that the mother will suffer guilt, occasioned by her unwitting causation of any resultant injury to the child; she should not also be forced to suffer monetary damages.

At the other extreme, a woman may act with careless disregard for the health of her unborn child by not following a proper diet during pregnancy, even though it is possible for her to do so and although she realizes the

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99 Id.
resultant risk to her unborn child. This is a stronger case for monetary relief than Grodin; in the latter case the woman allegedly took tetracycline with the assurance of her physician that she could not possibly be pregnant. The Grodin court remanded for a determination of the reasonableness of the mother's behavior.

The standard of care necessary to avoid liability might be defined as that of the "reasonably prudent expecting parent." This standard would impose a duty on the pregnant woman to realize the limits of her knowledge. For imposition of the maternal duty to effect general deterrence, mothers would need to know what sort of behavior might endanger the fetus in order to avoid endangering fetal health. At a minimum, prenatal care and counseling would be necessary. Mothers might need to consult a physician to insure optimal fetal health. If the mother were to negligently choose a negligent physician, both might be liable for any resultant fetal injury.

Allowing fetal recovery for breaches of this duty might benefit someone other than the fetus. Should the child die, the mother, as the beneficiary of the child's estate, would be the real beneficiary of the damage award assessed against her. In this event, monetary damages would be worse than ineffective.

**Injunctive Relief**

Injunctive relief would be more appropriate than monetary damages because the injury to the fetus could thus be mitigated or averted. However, major drawbacks exist to affording injunctive relief. Enforcement difficulties are foreseeable. For instance, the imposition of dietary restrictions on pregnant women would be difficult to monitor for compliance. The diet prescribed for PKU mothers requires both abstinence from eating sources of protein and consumption of Lofenalac, an unpalatable therapeutic agent. The combination of the extraordinary restrictiveness of the diet and the disagreeable taste of Lofenalac would provide a strong incentive not to comply with a court order to follow the PKU diet. Consequently, hospitalizing the woman, or otherwise insuring that her food intake would be strictly controlled, would be necessary to enforce the dietary restriction. A similar problem would arise if drugs were prescribed or proscribed. In utero surgery might be the easiest treatment to compel; however, it is also the most invasive.

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101 Id. at 402, 301 N.W.2d at 871.
103 See generally, Conner v. Winton, 8 Ind. 315 (1856) and Commonwealth v. Pierce, 138 Mass. 165 (1884). Both cases involved the duty of knowledge imposed on lay people giving medical treatment.
Enforcement difficulties aside, injunctive relief, although more timely than monetary damages, still may come too late. The critical development period occurs early in gestation, when the woman may not realize she is pregnant. Others who might initiate a lawsuit may similarly be unaware of the danger to fetal health created by maternal behavior. As noted above, an injunctive order issued early in the pregnancy may also encourage abortion.

The Right to Injure

By withholding injunctive relief prior to viability, courts would impliedly create a right to injure the fetus as a corollary of the right to seek an abortion. The creation of such a right would raise an intuitive dilemma analogous to that created by the issue of damages in the wrongful life context. Wrongful life actions involve a claim by a child that he or she would have been better off not born. The child in such cases seeks damages to compensate for the injury of being born. The claim requires consideration of whether death or no life at all would be preferable to a life of suffering. The same question is posed in considering the right of the mother to expose the fetus to danger as a corollary of the right to seek an abortion. If death would be preferable, the former right should not follow from the latter. Endangering fetal health would thus constitute a greater harm than abortion. One court has adopted this view. In Curlender v. Bio-Science Laboratories, a California court found no policy reasons against holding parents liable for the failure to abort when they knew that the child would be born with congenital anomalies.

The California court thought the issue was one of proximate cause. If the parents knew a seriously impaired infant would be born, and still elected to proceed with the pregnancy, their choice would be an intervening act, precluding other defendants' liability. By imposing liability on the parents, the court would provide a powerful disincentive to continue the pregnancy if the fetus would be born with congenital anomalies.

Although the court did not discuss this, it may have been concerned about who would bear the burden attendant to the birth of a defective child. The monetary cost of treating and caring for seriously impaired children can be substantial. If parents were immune from liability and negligence was not attributable to any other defendant, the state might bear the cost of the child's care. A related concern was reflected in Buck v. Bell. In that

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106 Id. at 829, 165 Cal. Rptr. at 488. However, the California legislature, in apparent response to this case, passed a statute relieving parents of liability in such a situation. CAL. CIV. CODE § 43.6 (West 1982).
107 106 Cal. App. 3d at 829, 165 Cal. Rptr. at 488.
case, the United States Supreme Court sustained a law for the sterilization of institutionalized mental defectives. The purpose of the statute was to preclude any further drain on the economy by future generations of mental incompetents whose parents were likewise supported by the state. The Supreme Court cited *Buck* with approval as recently as 1973.09

After *Roe*, the constitutional right of privacy, which encompasses procreation,10 may only be infringed when there is evidence of a compelling state interest. Thus, if *Buck* remains good law,11 the state has a compelling interest in the birth of healthy children. If so, the right to injure the fetus would not follow from the right to seek an abortion. As long as the pregnancy continued, the pregnant woman would not be free to injure the fetus, although prior to viability she would be free to seek an abortion.

However, in *Buck* the plaintiff was institutionalized, a ward of the state. Some parents might be able to pay the cost of raising impaired children. If the parents were to bear this burden, the monetary cost to the state would be lessened, as would the state's interest in insuring the child would be born healthy. This lesser interest might be insufficient to justify infringing the woman's right of privacy.

*Initiation of Litigation*

Before the mother may be held liable to the fetus, someone must initiate litigation. The group of persons most likely to be cognizant of the risk to the fetus would be the mother, her physician, and others close to her.

Clearly, the mother would not initiate a lawsuit. Requiring that a physician do so would be unwise. The threat of a lawsuit by a physician might discourage women from seeking prenatal care or fully confiding in their doctors; this limited access to information might impair the doctors' ability to provide the best patient care. In a different context, the California Supreme Court in *Tarasoff v. Regents of University of California*12 disagreed. That court held that a psychotherapist has a duty to take reasonable steps to warn endangered potential victims if his patient threatens to harm them.13 If the factors to be weighed in the decision to impose the duty, foreseeability of the risk was weighted most heavily.14 Reliance on

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11 For the conclusion that it is not good law, see Comment, *Eugenic Sterilization Statutes: A Constitutional Re-evaluation*, 14 J. Fam. L. 280 (1975). The author suggests that if the case arose today, "increased legal sensitivity to fundamental human rights" would require a different outcome. Id. at 297. The same view was expressed by the New Jersey court in *In re Grady*, 85 N.J. 235, 246, 426 A.2d 467, 472 (1981).
12 17 Cal. 3d 425, 551 P.2d 334, 131 Cal. Rptr. 14 (1976). The context of this case was quite different; it involved a psychotherapist whose patient told him he would kill someone and later did. The psychotherapist failed to warn the victim.
13 Id. at 439, 551 P.2d at 344, 131 Cal. Rptr. at 25.
14 Id. at 435, 551 P.2d at 342, 131 Cal. Rptr. at 22.
foreseeability prior to fetal viability would place doctors in the awkward position of determining whether the patient would elect to abort in the face of a court order enjoining or mandating behavior to protect the fetus. If the patient would choose to abort, the doctor would have to decide whether abortion or the risk to fetal health would be the greater harm. Also, if Tarasoff was wrongly decided, only the patient would be injured by his or her failure to fully confide in the physician. If the patient were pregnant, both she and the fetus would receive less than optimal care. For these reasons, the Tarasoff holding is unpersuasive in this context.

Relying on others beside the doctor to sue would not be efficacious. They may be unaware of the pregnancy until it is too late, and they may lack the requisite medical knowledge to be aware of any danger to the fetus.

**CONCLUSION**

Medical advances have precipitated the issue of whether a duty to protect fetal health ought to be imposed on pregnant women. In utero surgery, drug therapy, and diet are available means of prenatal treatment. To insure fetal well-being, courts might choose any of these ways to minister to the fetus. All involve exerting control over the mother, although the level of intrusiveness varies.

In three recent cases courts have infringed upon the rights of the mother in order to protect the fetus. Unfortunately, cogent analysis was missing from all three opinions. One hypothetical method of analysis is to weigh the constitutional rights of the mother against the duty to the fetus in each instance. However, if fetal viability is a criterion, recovery will not be allowed for most injuries or for the most severe injuries, and the decision whether to permit recovery will be complicated. Conversely, if viability is ignored, liability may be imposed for behavior which is not culpable, and mothers may be encouraged to abort.

Regardless of whether fetal viability is a prerequisite to recovery, enforcement of a duty to protect fetal health would be difficult at best. Monetary relief would not be timely and may not effect general deterrence. Additionally, loss distribution is not now possible, and monetary damages may only compound the grief attendant to the birth of a child with congenital anomalies. Problems also exist if a duty to act reasonably is to be imposed on pregnant women. In some cases, the mother may be the true beneficiary of the damage award.

Other problems impede the effectiveness of injunctive relief. Compliance may be difficult to monitor. Also, no one may know of the risk of harm until too late to prevent its occurrence. An injunctive order early in the pregnancy may encourage abortion.

If the duty to protect fetal health only attaches after viability, courts may impliedly give women the right to injure the fetus as a corollary of the right to seek an abortion. The extent of the state's interest in the birth
of healthy children is unclear and may be insufficient to limit this right. Policy dictates that physicians should not be the ones to initiate lawsuits to enforce the duty to protect fetal health. Yet, others may lack knowledge of the pregnancy or the medical facts and therefore be unable to do so.

In light of the dearth of analysis offered by the courts which have imposed a duty to provide an optimal in utero environment, the implications of protecting fetal health militate against imposition of such a duty without attention to the problems of enforcement and fairness in imposing liability. The blanket adoption of a duty to protect fetal health would otherwise not adequately protect the fetus. Although constitutionally permissible and logically acceptable in the abstract, practical considerations require that courts deny absolute enforcement of a duty to protect fetal health. In those cases in which the imposition of such a duty is warranted, the courts should clarify the process by which the decision to impose a duty was reached. Following a conventional tort analysis, the courts should weigh the relative intrusion to the mother and any medical risks to her against the benefits to the fetus, including the likelihood of success. The successfulness of the remedy will depend on the courts' ability to monitor and compel compliance; this factor should also be weighed. In cases where the intrusion is slight and the potential benefit to the fetus significant, if there is a substantial probability of compliance with the court's order, injunctive relief should issue as required to protect fetal health. These decisions would necessarily be made on a case-by-case basis.

Case-by-case adjudication is preferable because any uniform rule would either ineffectively protect fetal health or effectively emasculate the mother's right of privacy. To avoid these harsh extremes, each case should be decided on its particular facts. Some consistency should be achieved if the above factors are clearly balanced in each instance.

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