PREGNANCY INTERVENTION AND MODELS OF MATERNAL-FETAL RELATIONSHIP: PHILOSOPHICAL REFLECTIONS ON THE *WINNIPEG C.F.S.* DISSENT

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Medical intervention in pregnancy is a matter of very high stakes: the well-being of future children who may face a lifetime of disability is countered by the civil rights and well-being of women who too easily may be viewed as mere "fetal containers."[1] Decisions about pregnancy intervention will affect maternal lifestyle choices, non-reproductive medical treatments needed by pregnant women, wrongful birth and wrongful life lawsuits, abortion, prenatal genetic testing, "surrogate" pregnancy contracts, tort and negligence claims related to a prenatal accidents, forced fetal therapy or caesarian section,[2] research into ectogenesis,[3] and the continuation of pregnancy in the bodies of brain-dead women.[4]

Establishing the legal and moral balance between maternal liberty and the protection of offspring will require, it seems to me, something much more radical than can be offered by traditional ethical norms or legal precedents such as the "born-alive rule" or the doctrine of *parens patriae.* We need to re-think our understandings of pregnancy itself before we can reach good conclusions about how to intervene in it. The problem is that the conflicting parties in pregnancy stand in a relationship to each other that is *sui generis*: in no other human situation does one party physically live inside - or even depend necessarily upon - the body of another. No existing legal or ethical analogy therefore suffices to resolve problems that arise in pregnancy, as no other human situation is remotely analogous to pregnancy.[5]

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1 G. Annas, "Pregnant Women as Fetal Containers" (1986) 16 Hastings Cent. Rep. 13; L.M. Purdy, "Are Pregnant Women Fetal Containers?" (1990) 4 Bioethics 273.

2 D. Brown and T.E. Elkins, "Ethical Issues in Obstetric Cases Involving Prematurity" (1992) 19 Clinics in Perinatology 469; J. Callahan and J.W. Knight, "Women, Fetuses, Medicine, and the Law" in H.B. Holmes & L.M. Purdy, eds., *Feminist Perspectives in Medical Ethics* (Bloomington: Indiana University Press, 1992) 224; D. Ginn, "Pregnant Women and Consent to Medical Treatment" (1994) 15:2 Health L. Can. 41; M. Mahowald, "Beyond Abortion: Refusal of Caesarian Section" (1989) 3:2 Bioethics 106; N.K. Rhoden, "The Judge in the Delivery Room: the Emergence of Court-ordered Caesarians" (1986) 74:6 Calif. L. Rev. 1951.

3 Ectogenesis is the development of offspring outside the body, as in an artificial womb: J.S. Murphy, "Is Pregnancy Necessary? Feminist Concerns about Ectogenesis" in H.B. Holmes & L.M. Purdy, eds., *Feminist Perspectives in Medical Ethics* (Bloomington: Indiana University Press, 1992) 181.

4 H.L. Nelson, "The Architect and the Bee: Some Reflections on Postmortem Pregnancy" (1994) 8 Bioethics 247; C. Anstötz, "Should a Brain-Dead Pregnant Woman Carry her Child to Full Term? The Case of the Erlanger Baby" (1993) 7 Bioethics 340; J.M. Jordan, "Incubating for the State: the Precarious Autonomy of Persistently Vegetative and Brain-dead Vegetative Women" (1988) 22 G.L.R. 1103.

5 H.L. Nelson's discussion of problematic analogies in reproductive technologies helpfully explores the limits of analogical reasoning: "Dethroning Choice: Analogy, Personhood, and the New Reproductive Technologies" (1995) 23 J. Law, Medicine and Ethics 129.

Most of our legal structures and dominant ethical frameworks depict human beings as discrete individuals whose bodies or selves do not overlap. Physically and metaphysically, this assumption of individuation is shown to be false when a female individual becomes a pregnant person, when one body (hers) also houses another body, and when one emerging identity takes shape within the identity of a pre-existing person. We need to explain how pregnant women and non-pregnant women are similar yet different, how fetuses are unique but not independent, and how these two entities together create the singular phenomenon of pregnancy. In short, in order to resolve the ethical and legal problems in pregnancy intervention, we must first clarify our understandings of the physical and metaphysical relationship between pregnant women and fetuses.

In this essay, I explore three traditional models of maternal-fetal relationships (woman-centred, fetus-centred, and woman and fetus as distinct individuals) and also a more promising model of pregnant embodiment that emphasizes transcendence, process, gradual recognition and renewed moral commitment. I will argue that this newer model, which provides grounds for the dissent authored by Major J. in the *Winnipeg C.F.S.* pregnancy intervention case,[6] is persuasive philosophically and ethically. However, Major J. erred in attempting to embody this promising framework prematurely in law. Given the current social climate regarding pregnancy and abortion, holding women legally responsible for pregnancy outcomes is unfair and even dangerous. While important advances have been made, resolutions are far from clear in these issues.

I. THE FACTS OF THE CASE

D.G., a 21-year-old Native Canadian woman, was pregnant and addicted to sniffing glue and solvents. Her previous three children, two of whom suffered serious and permanent brain damage from prenatal exposure to solvents, had been removed from her custody. As a consequence of her long-term solvent abuse, D.G. was incontinent, frequently unable to walk, nearly constantly intoxicated, and would frequently go for days without eating.

On May 28, 1996, D.G. entered hospital with symptoms of nausea, confusion, loss of balance and weakness. A routine work-up revealed pregnancy at approximately 13 weeks; she had not received prenatal care to date. She was discharged on June 6, but was returned to hospital by ambulance on June 27. Winnipeg Child and Family Services (C.F.S.) was called for assistance. Previously, Ms. G. had resisted efforts by C.F.S. to obtain help for her, but during a home visit on July 18, D.G. told a C.F.S. worker that she would enter a residential treatment program for substance abuse. The C.F.S. worker returned to D.G.'s home on July 23 to transport her to the treatment facility, but at this time D.G. was obviously intoxicated and refused to attend the treatment program. On August 1, C.F.S. petitioned for a court order to force her to spend the remainder of her pregnancy in a medical facility.

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[6] *Winnipeg Child and Family Services (Northwest Area)* v. *G.(D.F.)*, [1997] 3 S.C.R. 925, [1997] S.C.J. No. 96 (QL) [hereinafter *Winnipeg C.F.S.* cited to S.C.J.].

The initial court arguments pitted the standard of care owed by a mother-to-be to her offspring against the claim that fetuses have no legal standing or protection. Schulman J. rejected both arguments on August 6,[7] ordering instead that Ms. G. undergo a psychiatric examination; if her addiction compromised her ability to make decisions, then treatment could be compelled under the existing Manitoba *Mental Health Act*.[8] The psychiatric assessment done later that day determined that Ms. G. did not fit the legal definition of incompetence due to mental illness. Schulman J. rejected the psychiatric assessment and ordered that Ms. G. be taken into the custody of social welfare authorities until the birth of the child. Two days later, the Manitoba Court of Appeal[9] overturned Schulman J.'s order on the grounds that his expansion of the *Mental Health Act* was unjustified and violated Ms. G.'s civil rights. Ms. G. nevertheless remained in hospital voluntarily until she overcame her addiction, during which time both she and the fetus suffered seizures as part of the withdrawal process.

In October 1996, C.F.S. appealed to the Supreme Court of Canada. Although the case technically became moot with the birth of the child that December, the Court continued deliberation upon the issues and handed down their ruling on October 31, 1997.[10] By a 7-to-2 majority, the Court ruled that judicial interference in pregnancy cannot be justified.

The child was born, apparently healthy, on December 6, 1996. Twenty-four hour, in-home support was provided by D.G.'s sister and C.F.S. for at least the ten months between the birth and the Supreme Court's ruling, and it appears that Ms. G. remained free of solvent use during that time. Ms. G. married the baby's father on November 1, 1997.

II. THE ISSUES

I leave it to another time to discuss the majority's reasoning and the appropriate roles of the judiciary and legislature in changing the application of the law. I am also unable to consider at length the many important social issues that underlie the case.[11] For this discussion, I focus on the reasoning of the Supreme Court dissent authored by Major J: once a woman has decided not to terminate the pregnancy, her moral and legal obligations to the fetus change such that she should be held responsible for (and *parens patriae* may be invoked to prevent) injury to the future child. More specifically, rather than offering an extensive legal analysis of the *parens patriae* and "born alive rule"

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7 (1996), 138 D.L.R. (4th) 238.

8 R.S.M. 1987, c. M-110.

9 (1996), 138 D.L.R. (4th) 254.

10 *Winnipeg C.F.S.*, *supra* note 6.

11 We must consider seriously why an Aboriginal rather than Caucasian woman became the test-case defendant; why solvent sniffing (associated with poor communities) rather than cocaine, alcohol or tobacco (also associated with higher socioeconomic groups) was the teratogen of concern; why addiction treatment facilities were not immediately available to a pregnant, chronic substance abuser who responsibly agreed to seek help; and why our protection of offspring is more often focused on the fetal period than on the underlying health of women prior to conception or on the conditions of poverty into which many children are born.

precedents, I will direct attention to the underlying *philosophical* foundations of Major J.'s argument.

Distinguishing fetuses from future children and depicting continuation of pregnancy as an act of commitment may open a new avenue for understanding pregnancy and resolving maternal-fetal conflicts. I will argue that the distinctions drawn are philosophically and ethically compelling, but that this understanding of the pregnancy relationship may be impossible to embody into law or policy.

III. THE DISSENTING ARGUMENT

Major J.'s argument in the dissent is as follows: Women have legal access to abortion in Canada, following *Morgentaler*.[12] By choosing not to have an abortion, D.G. made a commitment to continue the pregnancy and bring the child to birth.[13] Her continued solvent abuse constitutes a clear risk to the future child, and the state is therefore justified in intervening to prevent harm.

Central to this argument is a distinction between the moral or legal status of *fetuses qua fetuses* and *fetuses qua future persons*. This distinction is philosophically important and logically valid. Joel Feinberg[14] argues that children clearly have moral and legal status that should not be extended to fetuses *qua* fetuses. However, fetuses that are destined to become children in the future will, when they are actual children, have children's moral and legal status. The fact that some future children exist currently as fetuses rather than actual children does not remove our moral obligations to prevent the real harm that they will experience at a future time, when they are persons with moral and legal standing that they do not yet (but will in the future) possess.

Feinberg offers two analogies to clarify the difficult concept of future-looking obligations to persons not yet here: protection of the environment for future generations, and setting a bomb to explode in several years, injuring someone who was not yet born at the time the bomb was set. The claim is not that possible or potential persons have innate moral or legal status; it is instead that a person with moral and legal standing *in the future* will suffer injury in the future from actions undertaken in the present. Major J., following similar reasoning, reaffirms the right of a woman to have an abortion and does not expand fetal rights or status under the law. However, he notes that when abortion has been rejected, a child is on the way and this future person may suffer injury that is felt in the future.

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12 *R.* v. *Morgentaler*, [1988] 1 S.C.R. 30.

13 A similar argument is offered by J. Robertson "Procreative Liberty and the Control of Conception, Pregnancy, and Childbirth" (1983) 69 Virginia L. Rev. 405 at 437-39.

14 J. Feinberg, "The Rights of Animals and Unborn Generations" in W.T. Blackstone, ed., *Philosophy and Enviromental Crisis* (Athens: University of Georgia Press, 1974) 43.

This distinction supports Major J.'s further argument that the "born-alive" rule is a legal anachronism, grounded in a problem of evidence rather than substance.[15] Advances in prenatal monitoring allow us to tell when a living future child is on the way, without having to wait for live birth to confirm the (future) child's existence. Abandoning this rule thus would not grant new status to fetuses *qua* fetuses, but would help us to protect future children.

While each case must be decided on its facts, and with a presumption that the facts in a given case may change over time, Major J. identifies four elements to justify intervention in pregnancy:

1. The woman must have decided to carry the child to term;

2. Proof must be presented to a civil standard that the abusive activity will cause serious and irreparable harm to the fetus;

3. The remedy must be the least intrusive option; and

4. The process must be procedurally fair.

The first threshold test of Major J.'s framework, the claim regarding the mother's choice to continue the pregnancy, is critical to his argument but is its weakest link. How ought we understand what happens in pregnancy, how choice or commitment is exercised in pregnancy, and how the law should respond to matters of choice within this process?

IV. FOUR MODELS OF PREGNANCY

As noted above, an often-overlooked but obvious truth is that the relationship entailed by pregnancy is unique. In no other human relationship or experience do we find one human entity literally living inside and wholly physically dependent upon the body of another. A process of elimination is therefore an important first step in developing a clearer definition: by identifying what the maternal-fetal relationship is *not*, we can begin to close in on a more accurate description of what it is.[16]

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[15] Summarizing Forsythe's analysis, Major J. argues that live birth used to be the only way to confirm whether the fetus had been alive prior to the injury-causing event. The technology-mediated change in evidentiary presumptions about fetal health means that the state's *parens patriae* interests may rightly be exercised when there is reasonable probability that the mother's behavior will cause serious and irreparable harm to the fetus within her. While I agree with Major J.'s challenges to the born-alive rule, I have serious reservations about the logical leap from evidence of prenatal health to the expansion of *parens patriae*; unfortunately, this element of Major J.'s reasoning cannot be addressed at length here. C.D. Forsythe, "Homicide of the Unborn Child: The Born Alive Rule and Other Legal Anachronisms" (1987) 21 Val. U.L. Rev. 563.

[16] Before discussing the four models of human pregnancy, it may be helpful to consider biological analogies involving non-humans. Non-pregnant models of physical inter-relationship found in nature, such as infection, parasitism and symbiosis, fail to illustrate the nature of the maternal-fetal relationship. The human body routinely responds to the presence of foreign proteins by mounting a massive immune response to eliminate them. In pregnancy, however, the woman's body typically

A. WOMAN-CENTRED MODEL

It is often tempting to focus on only one of the two primary parties, the pregnant woman or the fetus, at the expense of the other. Some people discount embryos and fetuses as mere tissue carried by women: the interests of women in avoiding pregnancy, initiating pregnancy, or exercising other liberties are therefore always seen to be the primary ethical or legal concerns in reproduction. The medical term for the maternal-fetal patient, "gravida," means "weighted down" and clearly refers to the pregnant woman who is weighted rather than the fetus who weighs upon her.[17]

The woman-centred approach has been predominant in Canadian law and policy. The Royal Commission on New Reproductive Technologies concluded in 1993 that coercive intervention in pregnancy should never be allowed. The majority argued that such intrusions into the lives and bodies of women constituted a violation of their civil rights and that forcible intervention is likely to *increase* prenatal injury because those who pose the greatest risk to their offspring will be afraid to seek help or health care.[18] This reasoning was echoed in *Winnipeg C.F.S.* by the Supreme Court majority. Further analysis of the history of fetal standing is summarized at paragraph 15 of the majority opinion:

> The position is clear. Neither the common law nor the civil law of Quebec recognizes the unborn child as a legal person possessing rights. This principle applies generally, whether the case falls under the rubric of family law, succession law or tort. Any right or interest the fetus may have remains inchoate and incomplete until the birth of the child.

It does make sense to count women, men, and children – but not fetuses or embryos – in a census of the population, and to grant standing in matters of law to women but

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does not expel or fight the presence of an embryo/fetus with a different genetic code, tissue type, or blood type (with the exception of Rh-factor incompatibility and a few rare complications). Although pregnancy typically causes a variety of symptoms for the pregnant woman, these are not compatible with a model of infection.

Whether an embryo/fetus is more like a parasite or symbiont depends largely upon the degree of physical duress that the pregnancy poses for the woman/host. Some women experience relief from endometriosis and a reduced risk of some cancers, making pregnancy seem more symbiotic or mutually profitable in nature. Other women experience the fetus as a parasite that induces diabetes, loss of bone density, cardiovascular complications or worsened symptoms of underlying illness, in addition to the very common problems of nausea, incontinence, backache, and pain of labor and delivery. The social nature of pregnancy must also be considered: a wanted pregnancy is of enormous non-medical value to the woman, while an unwanted pregnancy that threatens the woman's social, psychological or economic well-being presents clear loss with few benefits for her in return. Even the same pregnancy may be perceived differently by an individual pregnant woman and by others around her as the pregnancy progresses.

17 E. Gatens-Robinson, "A Defense of Women's Choice: Abortion and the Ethics of Care" (1982) 20 South. J. Phil. 39.

18 Royal Commission on New Reproductive Technologies, *Proceed with Care: Final Report of the Royal Commission on New Reproductive Technologies*, vol. 2 (Ottawa: Minister of Supply and Services Canada, 1993) (Chairperson: P. Baird). Suzanne Scorsone offered a dissenting opinion, arguing that while interventions should be very rare, it is irresponsible to say that the state should never intervene in pregnancy.

not the embryos or fetuses they carry. Great moral and legal significance should be attached to birth, which allows the infant to form social relationships, allows others to recognize the infant as a member of the community, and allows someone other than the pregnant woman to provide support and care for the child.[19] Social and legal standing seem reasonably contingent upon live birth and the issuance of a birth certificate; if we were to push this recognition back, how exactly would we consistently identify, count, and interact with fetuses prior to birth?

On the other hand, I find the woman-only model of pregnancy to be incomplete and potentially misguided. The great importance of the fetal period for the future health and well-being of any child or adult makes dismissal of the developing human entity short-sighted and morally negligent regarding our duties to future persons.[20]

Further, it ignores the heart of a physical and philosophical puzzle: during pregnancy, the woman seems temporarily to be self-and-other, rather than simply the self she was prior to and after the pregnancy. How are we to understand this unique situation and the obvious changes in her way of being? As a practical matter, does the obstetrician have one patient or two? Without an account of the ontology[21] of the condition pregnancy as it differs from non-pregnant human ontology, it seems impossible for us to develop clear and meaningful guidance for legal and ethical problems in reproductive interventions.

B. FETUS-CENTRED MODEL

The opposite extreme recognizes the interests or value of human embryos (conception to nine weeks) or fetuses (nine weeks of gestation to birth), but tends to forget that such entities normally exist only inside the bodies of women. *In vitro* fertilization (IVF) allows us to create human embryos outside the human body, to observe their development over a period of several days, and even to keep them indefinitely in a state of frozen suspended animation. We therefore have several unresolved moral and legal issues regarding embryos *qua* embryos. However, we should note that human embryos are exceedingly rarely within our literal grasp in a laboratory; the vast majority of embryos are conceived within the bodies of women and most laboratory embryos are created with the intention to transfer them to a uterus for development. Insights into the legal and moral status of embryos *qua* embryos, including common arguments related to potentiality and genetic heritage, therefore may

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[19] M.A. Warren, "The Moral Significance of Birth" in H.B. Holmes & L.M. Purdy, eds., *Feminist Perspectives in Medical Ethics* (Bloomington: Indiana University Press, 1992) 198; V. Held, "Birth and Death" (1989) 99 Ethics 362.

[20] L.M. Purdy, "Loving Future People" in *Reproducing Persons: Issues in Feminist Bioethics* (Ithica, New York: Cornell University Press, 1996) 50; Feinberg, *supra* note 14.

[21] Ontology is the philosophical study of being or existence. In addition to questions about whether material objects and non-material entities (*e.g.* souls, God) really exist at all, there are several categories or types of being that it is helpful to distinguish. Relevant ontological categories in discussions of reproduction include being vs. becoming; possible, potential and actual; and necessary and contingent.

or may not give insight into the nature of embryos (or fetuses) *qua* physiologically interactive, relational and developing entities.

As I have argued elsewhere,[22] it is pure fiction to speak of fetuses *qua* fetuses as if they were freestanding entities. In reality and by definition, they reside in the bodies of women and demand substantial investments of energy for their own continued growth and development. A fetus outside of a woman's body is either dead fetal tissue or a premature infant; "leaving fetuses alone" to lead their own lives is thus biologically impossible.

At least two lines of influence support misperceptions that embryos and fetuses are distinct human entities (rather than inherently connected to and in relation with the women who bear them) and cause us frequently to devote greater attention to them than to the women who bear them. The first is the development of medical imaging technologies, such as fetoscopes and ultrasound, which literally allow us to view the fetus without focusing on the woman's body that surrounds it.[23] We may view either the pregnant female or the developing fetus, but never both together. A second influence, much discussed by feminist writers on reproductive issues,[24] is that the worth and interests of women are widely discounted relative to those of men in a patriarchal culture. Patriarchs would reasonably be interested in their offspring who stand to inherit their genes, names and fortunes; the women who bear these offspring are not, themselves, seen to be as important as the man's own progeny.

C. WOMAN AND FETUS AS DISTINCT INDIVIDUALS

If emphasizing either the woman or the fetus at the expense of the other fails to resolve our problems, then we might attempt to balance the interests of women and fetuses. The most common maneuver is to posit women and fetuses as separate rights-bearers, so that any conflict of interests might be resolved by the same legal remedies and moral reasoning patterns that adjudicate disputes between two adults. This attempt fails, however, because the parties are *not* independent entities: they are inseparably linked biologically, unlike any other two disputants in our society can be. Specific

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22 L. Shanner, "The Right to Procreate: When Rights Claims have gone Wrong" (1995) 40 McGill L.J. 823. Also see M. Mahowald, "As If There Were Fetuses Without Women: A Remedial Essay" in J. Callahan, ed., *Reproduction, Ethics and the Law* (Bloomington: Indiana University Press, 1995) 199.

23 R.P. Petchesky, "Foetal Images: the Power of Visual Culture in the Politics of Reproduction" in M. Stanworth, ed., *Reproductive Technologies: Gender, Motherhood and Medicine* (Minneapolis: University of Minnesota Press, 1987) 57; C.A. Stabile, "Shooting the Mother: Fetal Photography and the Politics of Disappearance" (1992) 28 Camera Obscura 179; V. Hartouni, "Fetal Exposures: Abortion Politics and the Optics of Allusion" (1992) 29 Camera Obscura 132.

24 C. Overall, *Human Reproduction: Principles, Practices, Policies* (Toronto: Oxford University Press, 1993); B.K. Rothman, *Recreating Motherhood: Ideology and Technology in a Patriarchal Society* (New York: Norton, 1989); S. Sherwin, *No Longer Patient: Feminist Ethics and Health Care* (Philadelphia: Temple University Press, 1992); C. Whitbeck, "The Moral Implications of Regarding Woman as People: New Perspectives on Pregnancy and Motherhood" in W.B. Bondeson, ed., *Abortion and the Status of the Fetus* (Dordrecht/Boston/Lancaster: D. Reidel Publishing Company, 1983).

performance is unavoidable, as it is impossible to find any compensatory mechanism or third-party assumption of obligation to remedy complications in pregnancy. Either the fetus is removed from the womb (and thus almost certainly killed) to relieve the imposition it causes in the woman's life, or the fetus remains in, affects and is affected by the woman's body for the duration of its development. Thus the balancing model relies on an all-or-nothing dichotomy that invariably leads us to adopt one of the previous two inadequate models.

Judith Jarvis Thomson's classic "famous violinist example"[25] is a notable attempt to provide an analogy for the maternal-fetal relationship, but it, too, is inadequate. Thomson asks us to imagine that a famous violinist is dying of a rare disease that can be cured by temporary physical attachment to another person whose body provides metabolic support. If the Society of Music Lovers had hooked the violinist up to your body, would you be obligated to provide continued physical life support? Thomson rightly argues that the violinist's acknowledged right to life does not imply a right to use another's body.

Depicting the violinist and host as originally separate and equal adults was necessary for Thomson to make her point about the limits of a claimed fetal right to life, but it fails to capture accurately what the maternal-fetal relationship actually entails. The violinist might have been connected to any of several hosts, but a fetus cannot be removed and reconnected to another, more willing host. While the example may justify why parents have no moral or legal obligation to provide, for example, a life-saving organ transplant for their child after birth, it insufficiently explains our relations or duties during pregnancy.

Importantly, the conflict-of-individual-rights model fails to explain the nature and significance of a non-conflicted pregnancy. Most attempts to posit the embryo/fetus and woman as distinct and potentially conflicting parties fail to account for the physiological connection and interactions of the pregnant body and the developing body. The fully developed violinist is not an embryonic or fetal violinist, and thus cannot account for the coming-into-being that is the hallmark of pregnancy. The model also fails to account for the perception by many pregnant women that they have become an embodied self-and-other in a uniquely transcendent way that is quite unlike any non-pregnant relationship, including self-connected-to-other as in the violinist example.

The Supreme Court majority acknowledged some of the difficulties in this model at paragraph 29 of *Winnipeg C.F.S.*:

> To permit an unborn child to sue its pregnant mother-to-be would introduce a radically new conception into the law; the unborn child and its mother as separate juristic persons in a mutually separable and antagonistic relation. Such a legal conception, moreover, is belied by the reality of the physical situation; for practical purposes, the unborn child and its mother-to-be are bonded in a union separable only by birth. Such a dramatic departure from the traditional legal characterization of the relationship

[25] J.J. Thomson, "A Defense of Abortion" (1971) 1 Phil. & Pub. Aff. 47.

between the unborn child and its future mother is better left to the legislature than effected by the courts.

D. PREGNANT EMBODIMENT: TRANSCENDENCE, PROCESS, GRADUAL RECOGNITION AND COMMITMENT

With previous attempts to define the maternal-fetal relationship resulting in obvious omissions and problems, it is clear that we need to adopt a wholly different understanding of pregnancy. I suggest that our new model must replace either/or dichotomies of woman *or* fetus with the more complex logic of both/and: pregnancy is both unity and duality, both woman and fetus, entities not identical and yet inseparable. The metaphysics of this state of being are anything but clear, and our language to describe such concepts is deeply impoverished, but it seems to me that this is the direction in which the solution to pregnant ontology will lie.[26]

A key weakness of the woman-centred model was that, temporarily during the pregnancy, the woman seems to be something additional to[27] or different from her previous, non-pregnant self. Her identity remains fully intact, insofar as she does not lose any of her capacities, competencies, personal traits or civil status; however, her pregnant self is also not precisely like her non-pregnant self. The best word to describe her change of state is "transcendence," understood as a state in which she becomes something more than her previous self or transcends the usual boundaries of the self.

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[26] The descriptions in this passage have been developed by countless authors in bioethics and women's studies, and through conversations with women outside of academic contexts. It is impossible to provide due credit to all who have shaped this model. My own philosophic thinking in this passage has been shaped most by E. Gatens-Robinson, *supra* note 17; C. Mackenzie, "Abortion and Embodiment" (1992) 70 Aust. J. Phil. 136; I.M. Young, "Pregnant Embodiment: Subjectivity and Alienation" (1984) 9 J. Med. Phil. 45; H.L. Nelson, "The Architect and the Bee," *supra* note 4; and V. Held, "Birth and Death" (1989) 99 Ethics 362. I owe special gratitude to Alisa Carse for her course offerings and personal reflections on pregnancy, and to John Burgess for extensive discussions in 1990 on process, transcendence and relation in pregnancy, and for introducing me to a pre-publication manuscript of Mackenzie's article.

Excellent documentation and interpretation of women's narratives of reproductive experiences are found in V. Bergum, *A Child on Her Mind* (Westport: Bergin & Garvey, 1997); see especially 34-41 and 142-68 for descriptions similar to the model described here. Contrasts between women's narratives of experience and medical observations of reproductive processes are documented in E. Martin, *The Woman in the Body: a Cultural Analysis of Reproduction* (Boston: Beacon Press, 1987). Narratives of the psychological relationship that some women experience with their fetuses, leading to ethical conclusions that adoption, inadequate parenting and abortion are all forms of abandonment, are discussed in C. Gilligan, *In a Different Voice: Psychological Theory & Women's Development* (Cambridge: Harvard University Press, 1982).

The model described in this article emphasizes the positive aspects of pregnancy, but many writers also document and consider the negative aspects of pregnancy as an embodied experience. See, for example, S. Firestone, *The Dialectic of Sex* (New York: William Morrow, 1970); S. Sherwin, "Abortion" in *No Longer Patient* (Philadelphia: Temple University Press, 1992) 99; and G. Corea, *The Mother Machine: Reproductive Technologies from Artificial Insemination to Artificial Womb* (New York: Harper & Row, 1985) especially Part Five, 271-317.

[27] I use words like "greater than," "additional to" or "more than" with great uneasiness here, as such terms may imply an additive value or that pregnant women are somehow "worth more" than non-pregnant women. I strongly reject such a view.

She becomes "self-and-other" at the same time; at birth, the "other" fully emerges as an individual and the woman returns to a non-transcendent, non-pregnant state in which she is once again herself alone.

Eugenie Gatens-Robinson describes pregnancy as a relationship in which, at first, the fetus and woman are in such a tight community that it makes sense to speak of them as a unity. Throughout the pregnancy, the unity/community of mother and fetus (situated within the larger social community) evolves through different stages or forms of relationship, culminating in a true community of individuals at birth.[28] The woman is, in traditional terminology, "with child" in a profound and intimate way.

This transcendent "being-self-and-other" can be understood in terms of both physical bodies and non-physical elements of personal identity. The pregnant person carries within her body the body of another, and thus is not a discrete, non-overlapping physical entity as she was prior to pregnancy. It is clear that someone else lives with her inside her body, especially when she is kicked from within; women frequently use metaphors like "the little alien who moved in" to describe this other presence.

The sense of personal identity is a more mysterious issue: the pregnant person may feel herself to be different from her former, non-pregnant self in ways that are difficult to articulate. At the heart of this question of identity is the sense that she *is* pregnant, not merely *doing* a pregnancy; her sense of self and of her way of being in the world thus often seem radically changed. A pregnant woman also commonly perceives herself to be viewed and treated differently by others; strangers may unabashedly gaze at her belly, ask personal questions, and even touch her abdomen without permission.

The presence of the other within her is also not merely a physical sensation. Late term fetuses may become more active *in utero* after the maternal ingestion of certain foods, and are then frequently described as "not liking" coffee or onions. Many women perceive that fetal activity mirrors the pregnant woman's own emotional states, and thus emotional states are attributed to the fetus as well. Over-achieving expectant parents may even play music or read books to the fetus *in utero*, in the hope of giving the child an educational advantage. All of these activities presume that the fetus is aware of his/her environment and is developing an intellectual and emotional identity distinct from the pregnant adult. Presumptions aside, it is clear that sentient awareness begins to develop in late pregnancy; the offspring's unique self-awareness and personal identity thus originate within and are shaped by the body and identity of the mother.

Central to the transcendental model of pregnancy is a notion of pregnancy as process rather than event. That is, marker points with all-or-nothing significance seem not to fit well into an account of pregnancy as a lived phenomenon, which is perceived subjectively and observed objectively to occur in gradual stages rather than in sudden, discrete moments of transition. Gatens-Robinson asks how it could possibly be true that conception creates fully formed babies, or how a female suddenly transforms into a

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[28] Gatens-Robinson, *supra* note 17 at 62.

"mother" when she may still be a child herself.[29] Both babies and mothers come into being gradually, over time and through tiny, imperceptible changes.

The most cursory glance at any embryology textbook confirms that fertilized eggs are not extremely tiny, fully formed babies.[30] Rather, a single cell gradually develops through stages of undifferentiated cell clusters, differentiated cells, primordial organs, functional organs and eventually to integrated organ systems. Many arguments on embryo or fetal status focus upon the formation of a unique human genetic code, which does not appear in a discrete moment.[31] The presence of a heartbeat, quickening, viability, sentience, and other traits of fetuses that might be morally or legally relevant not only develop at different times in different pregnancies, but may at first appear intermittently for a given fetus. The only fully unambiguous marker event in fetal development would seem to be the child's first breath of air after birth.

Pregnancy is also a process of gradual development and physical change from the woman's perspective. The woman's body reacts to the presence of a conceptus by establishing over several days the hormonal environment necessary to continue the pregnancy rather than expel the conceptus in menstruation. A pregnant woman's body gradually, not instantaneously, gains weight, relocates its centre of gravity, doubles the blood supply in her veins, and undergoes several changes in immune system functioning, hormonal regulation, and metabolism.

The epistemological or evidentiary nature of pregnancy is also one of gradual, growing recognition rather than a clear moment or event of revelation. Most women gain their first awareness of pregnancy in an almost purely abstract, intellectual manner: either she calculates that her period is delayed and pregnancy is possible, or a test with abstract markers ("the rabbit died" or "the stick turned blue") reveals the pregnancy. She does not yet *feel* pregnant. The early symptoms of pregnancy, including nausea, fatigue and mood changes, may just as easily be caused by a flu; clarification of the source of symptoms is usually a rational fact mediated by a clinician or test.

As the pregnancy progresses, the woman and others become aware not only of her increasingly obvious bodily changes, but of the presence of the fetus as an "other." This recognition of the other is especially profound at quickening or first perception of fetal movement, and increases with anticipation of the child's arrival as the pregnancy progresses. The recognition of the child as a distinct "other" is greatest at birth, when separation occurs and the pregnancy ends. It is only at birth that other people are able to interact in any meaningful way with the fetus, or the fetus with someone other than the mother.

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29 *Ibid.* at 50.

30 The ancient theory of the homunculus posited that sperm carried forward fully formed, tiny humans that merely needed to be planted in a receptive womb to grow to full size.

31 Conception is not the instantaneous event that many people believe it to be: after the sperm penetrates the egg, it takes approximately twenty-four hours for the maternal and paternal genetic material to shed their membranes, unite, and begin to divide as a functional genetic code. Fertilization often fails to result in a functional, growing embryo, and twinning can occur as late as two weeks after conception.

Pregnancy has traditionally been viewed as an instinctive or animal act rather than one of morally significant choice or commitment; the pregnant person is typically viewed as passive and thus not is rewarded for her physical and moral activity.[32] Catriona Mackenzie argues that causal responsibility for pregnancy is shared and equal for males and females; causal responsibility for pregnancy initiation is not the same thing as moral responsibility for pregnancy continuation, however, which is uniquely shouldered by females.[33] Accordingly, we can (and should) understand pregnancy as an opportunity for active female moral agency.

The gradual recognition of the presence of the fetus, reflected in both fetal development and the gradual changes in the woman's body, requires a woman constantly to make decisions about pregnancy continuation and take responsibility for the outcomes of her decisions at each stage. Mackenzie argues, and I concur, that we ought to replace the passive view of pregnancy with recognition of and respect for the active commitments, sacrifices, contributions, and responsibility that a woman undertakes in carrying a pregnancy.

1. ADVANTAGES OF THE EMBODIMENT MODEL

A model of pregnant embodiment that rests on concepts of transcendence, process, gradual recognition and ongoing commitment is more clearly consistent with the real-life experiences described by pregnant women than are the either/or models. It is consistent with the widely shared view that abortions are more objectionable in late pregnancy than in the early stages, which is embodied in U.S. law by the trimester framework of *Roe v. Wade*.[34] It accounts for the distress of the "tentative pregnancy"[35] entailed by waiting for the results of ultrasound and prenatal genetic tests for anomalies.

This new model acknowledges and rewards women's moral agency in reproductive matters, rather than taking reproductive effort for granted, and emphasizes the need for continued commitment and responsibility rather than the abdication of responsibility for pregnancy outcomes. Women who assert their moral agency and accept this responsibility deserve support and recognition for their sacrifices in bringing children to birth. The carrot of moral reward is also more effective than the stick of social or legal censure in changing the behavior of women who are capable but unwilling to accept responsibility for prenatal care. This is an important advance both for the status and recognition of women in the community as well as for the well-being of future children; we need not necessarily sacrifice the interests of one to promote the other.

Making a commitment to bear a child would seem to require informed and voluntary consent, and this model of pregnant embodiment with reaffirmed commitment has the

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32 Mackenzie, *supra* note 26; H.L. Nelson, *supra* note 4.

33 Mackenzie, *ibid.*

34 *Roe* v. *Wade*, 410 U.S. 113, 93 S.Ct. 705 (1973).

35 B.K. Rothman, *The Tentative Pregnancy: Prenatal Diagnosis and the Future of Motherhood* (New York: Viking, 1986).

advantage of embracing such a notion. Our laws and ethics require informed consent for medical treatments done for the patient's own benefit; surely informed and voluntary consent would also be required to allow invasive bodily interventions not for one's own good but for a future child's benefit. This consent, when required, can be incorporated (and be rewarded, rather than taken for granted) in renewed commitments to continue the pregnancy as it progresses and poses new difficulties. For these reasons, I would strongly advocate that this model of pregnant embodiment be adopted in our medical and social discourse around pregnancy.

2. PROBLEMS WITH THE COMMITMENT TO PREGNANCY MODEL AS A LEGAL STANDARD

Despite the many positive aspects of this model of pregnancy as embodied transcendence and reaffirmed commitment, it is exceedingly premature to use it as the foundation of a legal framework to justify intervention in pregnancy. It is unfair and dangerous to hold women morally or legally responsible for pregnancy outcomes until the barriers to truly informed, voluntary consent and commitment for pregnancy are overcome.

An important problem is the distinction between implied consent and explicit consent. Is declining to have an abortion truly equivalent to deciding to carry the child to term, as Major J. claims? The psychological, philosophical and legal distinctions between assent and consent (and other variations) are compelling. Note, for example, how much trouble was generated by "negative marketing" undertaken by the Rogers cable television company in 1997, when new channels were automatically provided and billed to customers unless the customer took steps to prevent the addition. Failing to take active steps to avoid an outcome is clearly not always equivalent to embracing that outcome as a positive commitment.

A related problem is the conflation of two different, albeit related, decisions. A common but unpersuasive anti-abortion argument is that women who did not want to get pregnant ought not have had sex; clearly, having sex and having babies are not identical propositions, and agreement for one does not necessarily entail agreement for the other. Similarly, one might reject abortion (perhaps on religious grounds) but not positively commit to continued pregnancy.

Any discussion about reproductive decisions must take account of the sociopolitical context of abortion in North America. Abortion was decriminalized only 25 years ago in the U.S.,[36] and only 10 years ago in Canada.[37] Although abortion is legally available, it is not always practically available: women living in poverty, and especially in rural or remote communities, may have little or no access to abortion providers. North American medical schools are increasingly making abortion procedures an elective rather than standard component of obstetrics/gynaecology education, which means that finding qualified abortion providers will become increasingly difficult. The

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[36] *Roe* v. *Wade*, *supra* note 34.

[37] *Morgentaler*, *supra* note 12.

continued social and political strife surrounding abortion – including protests and harassment at abortion clinics, bombing of clinics and violence against abortion providers – indicates clearly that abortion is not considered to be equally attractive or acceptable as continuing pregnancy. Thus, while abortion is a legally available choice, the social attitudes and behaviors surrounding abortion in our communities undermine genuinely informed and voluntary consent to continue pregnancy rather than terminate it. Some women are denied access to abortion, while for others the choice not to abort a pregnancy may be nothing more than a choice to avoid harassment.

The gendered inequality of commitments or moral responsibility for pregnancy despite shared causal responsibility[38] presents a larger frame of reference on the social context of pregnancy. While it would be a good thing to reward women for their active commitments and efforts in continuing pregnancies, will men shoulder their fair share of moral responsibility for healthy pregnancy continuation? This challenge is not intended to castigate men, but to call attention to larger systemic issues of gender inequality, economic disparities, the lack of adequate day care and parenting assistance, minimal maternity leave and job security after pregnancy, etc. While women bear the physical and moral responsibility for pregnancy continuation, women cannot, by themselves, change the social and economic contexts in which pregnancies occur; men must also take active responsibility for creating conditions that make the continuation of pregnancy – as well as the termination of pregnancy — equally possible and attractive commitments if we are to adopt Major J.'s framework.

Aspects of individual human psychology that affect reproductive decisions must also be considered. An important element of choice involves a person's locus of control, which is the subjective placing of oneself on a gradient from fully autonomous to fully coerced. People with an internal locus of control feel themselves to be autonomous and capable of making choices that lead to anticipated outcomes, and thus they feel responsible for their choices, successes and failures. Those with an external locus of control either feel unable to make choices at all, or perceive that the outcomes of their choices are determined by fate, God, or people other than themselves. A person's locus of control frequently changes throughout his/her life and may vary at a given time in reference to different situations. We should note that stereotypical gender roles define different appropriate loci of control for men and women: men are expected to be autonomous and in control, while women are more likely to be depicted as dependent and irrational. Indeed, it is common for women who actively take control of aspects of their lives to be chastised as unfeminine and aggressive.

There is evidence that an internal locus of control is correlated with more reliable and effective contraceptive use, and thus that women with an external locus of control are more likely to have unintended pregnancies.[39] Why ought we believe that unexpectedly becoming pregnant would suddenly shift a woman's locus of control inward, such that she would actively choose to abort or choose to remain pregnant

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[38] Mackenzie, *supra* note 26.

[39] M.K. Moos, *et al.*, "Pregnant Women's Perspectives on Intendedness of Pregnancy" (1997) 7 Women's Health Issues 385.

rather than merely muddle through the pregnancy? It seems far more plausible that women with an external locus of control are not only more likely to experience unintended pregnancies, but also to feel stuck with them rather than capable of altering their own fate. Locus of control problems may be especially acute for women who suffer abuse, who are in marginalized economic or ethnic groups, or who (like D.G.) are influenced by substance addiction.

Further, there is an important distinction in the category of "unintended" pregnancy between "unwanted" and "mistimed" pregnancies.[40] This distinction might be characterized as not wanting to be a mother at all versus wanting to be a mother someday, but not right now. This difference may have important ramifications for abortion decisions, as it would likely be far easier to terminate an unwanted pregnancy than to terminate a pregnancy that is earlier than expected, but in principle wanted. Additional common psychological phenomena, such as denial in the face of bad news, may make it difficult or impossible to make a timely decision about abortion or commitment to pregnancy.

Assuming that women were free of such external and internal constraints on their free and informed choices about abortion, we would face further legal difficulties in establishing a procedural mechanism for documenting pregnancy commitments. When, exactly, in a pregnancy can we rightly assume that the option of abortion has been abandoned and that the mother does intend to bring the child to term? It is not clear where we might plausibly establish a time limit beyond which women are assumed to have made such a commitment, nor whether a late abortion would be allowed after this deadline if the woman's medical, social, or economic circumstances changed.

It would be inappropriate to ask women to commit either to pregnancy or to abortion at the time the pregnancy is identified, as a decision this weighty requires time and reflection. Incorporating pregnancy commitments into routine prenatal care will be redundant for those women who actively seek regular care because they want a healthy child, and it will miss the women who pose the greatest risk to their offspring who, like D.G., receive inadequate or no prenatal care.

Even under the best of circumstances, it is difficult to establish the exact gestational age of a fetus. Under less than ideal medical or social circumstances, pregnancy testing or identification may be delayed: D.G.'s pregnancy was undetected for 13 weeks, and there are cases of women who apparently never realized they were pregnant until labor started and the birth occurred. The moral and legal requirements of informed consent for commitment to pregnancy could not possibly be met unless the pregnancy is identified. Thus, D.G. appears not to have rejected abortion or committed to continuing pregnancy at all, as she likely had no idea that she was pregnant or that such a choice was needed.

Further problems arise for prenatal genetic testing, ultrasound, and related techniques to monitor genetic or developmental abnormalities of the fetus. If we take seriously a

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[40] *Ibid.*

claim that non-abortion entails a commitment to continue the pregnancy, then late termination for fetal abnormalities acquires a new hurdle. Indeed, some prenatal diagnostic techniques themselves may be challenged under such a law: amniocentesis can cause infection or trigger a miscarriage, and there are concerns that ultrasound may cause hearing damage to the offspring.

Judicial intervention in pregnancy (or an actionable tort on behalf of an injured fetus or child) would seem to require some form of documentation or other legally binding recognition that a commitment was made to the pregnancy. The simple fact that abortion has not (yet) been chosen is a massive – and often incorrect — assumption upon which to justify such serious intervention. Unfortunately, many current "informed consent" procedures are nothing more than vaguely worded permission slips that protect clinics and health care providers from later liability, rather than mechanisms that genuinely enable patients to explore options and make informed choices. I am deeply concerned that "informed consent to continue pregnancy" will similarly be merely procedural rather than substantive, and not in the best interests of either pregnant women or future children.

V. CONCLUSIONS

If we lived in a utopia where every pregnancy were planned, and where every woman had access to social supports, medical care, and genuine liberty regarding the continuation or ending of a pregnancy, then Major J.'s reasoning in the dissent to *Winnipeg C.F.S.* would provide a compelling framework for policy in pregnancy intervention. However, pregnancy continuation and termination are not in any physical, emotional, social, or practical sense equally available options for most women. Non-abortion is very often not equivalent to a choice to commit to the pregnancy, but may be the only available option, may involve ignorance or denial of the situation, or may be a grudging tolerance of a condition perceived to be beyond avoidance.

Understanding pregnancy as a process of transcendence, gradual development, recognition and commitment is a helpful and more accurate model, both philosophically and ethically, than models that posit the woman and fetus as distinct or separable individuals. It promises to promote the interests of women as well as of children, which is the best possible outcome. We therefore ought to adopt this understanding in our medical and social discourse surrounding pregnancy. However, it is premature and dangerous to introduce this model as a legal standard for pregnancy intervention, given the current practical context within which women make their choices about reproducing.