
Reconceiving Pregnancy: Expressive Choice and Legal Reasoning

Erin Nelson*

The author discusses the issue of medical intervention in pregnancy, and suggests that what is missing from the present discourse on pregnancy and the law is a theoretical framework for choice or decision-making in pregnancy. It is suggested that the inability to formulate an adequate mode of reasoning about the problem of medical intervention in pregnancy has to do with the way in which decision-making in pregnancy is characterized. The author provides an overview of contributions made to the legal academic literature by feminist theorists of varying persuasions and notes that the debate, as framed by feminist writing on the issue, is largely about *choices*, rather than *choice*. The author outlines the underpinnings of a new approach to the question of choice in pregnancy, based on an expressive theory of choice, and considers the contribution that such a theory might make to the complex legal and ethical dilemmas that can arise when a pregnant woman refuses medical treatment proposed for the benefit of the fetus.

L'auteure discute de la question de l'intervention médicale durant la grossesse, et suggère qu'il manque, dans le discours actuel sur la grossesse et le droit, un cadre théorique pour analyser le choix et la prise de décision durant la grossesse. Selon l'auteure, l'incapacité à formuler un cadre de réflexion adapté au problème de l'intervention médicale durant la grossesse résulte de la manière dont est caractérisée la prise de décision durant la grossesse. L'auteure propose une revue des littératures juridiques féministes de toutes allégeances sur la question, et constate qu'elles ont tendance à parler de plusieurs choix plutôt que du choix en général. D'après l'auteure, la conception libérale traditionnelle, qui sous-tend ces discours, doit être revue. L'auteure trace les linéaments d'une nouvelle approche à la question du choix dans la grossesse, fondée sur une théorie expressive. Elle examine ensuite la contribution que cette théorie pourrait offrir à la résolution de dilemmes juridiques et éthiques complexes auxquels peuvent donner lieu la décision d'une femme enceinte de refuser un traitement potentiellement bénéfique au fœtus.

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Angela Carder was twenty-seven when she died. She had had osteosarcoma as an adolescent but was in remission when she married and became pregnant. When she was twenty-five weeks pregnant, she began to have trouble breathing. Angela's oncologists discovered that she had developed a large tumor in one of her lungs. Angela's doctors felt that her chances of survival were remote, but if she could live until her fetus reached twenty-eight weeks of gestation, it would have a better chance of survival. Angela emphasized to her doctors that her main priority was her own comfort and agreed to a course of palliative treatment. Angela's condition deteriorated rapidly, much more rapidly than the doctors had expected. At twenty-six weeks into her pregnancy, she was sedated and put on a ventilator to assist her breathing, interventions that seriously impaired her ability to communicate. The hospital administrators, without telling her, sought an order to permit delivery of the twenty-six-week-old fetus by Caesarean section. When Angela was told of the court order, she initially agreed to the surgery. She revoked her consent half an hour later, mouthing the words "I don't want it done. I don't want it done." The Caesarean section was performed. Angela's "baby girl weighed 1.7 pounds and had fingers the size of matchsticks. Her lungs were so underdeveloped the doctors could not even ventilate them artificially."¹ The baby died two-and-a-half hours later. Angela "cried when they told her."² She died two days later.

In 1984, a Nigerian woman in Chicago was admitted to hospital for the remainder of her pregnancy with triplets. The doctors advised that a Caesarean section was necessary for a safe birth. The woman and her husband refused, as they believed that a natural delivery would be safe. They also "planned to return to Africa, to an area where a cesarean delivery might not be possible should they have children later. They wanted to prevent future complications caused by use of cesarean section."³ As the due date approached, the hospital sought and obtained a court order "granting the hospital administrator temporary custody of the triplets and authorizing a cesarean section as soon as the woman went into labor."⁴ The woman was not informed of the court order and was not given an opportunity to seek care elsewhere. When told of the intended delivery by Caesarean section,

the woman and her husband became irate. The husband was asked to leave, refused, and was forcibly removed from the hospital by seven security officers.

¹ There are multiple accounts of Angela Carder's story; this one is taken largely from Tracey E. Spruce, "The Sound of Silence: Women's Voices in Medicine and Law" (1998) 7 *Colum. J. Gender & L.* 239 at 241. The case referred to is *Re A.C.*, 533 A.2d 611 (D.C. App. 1987); rev'd 573 A.2d 1235 (D.C. App. 1990). The trial judge's decision to order the Caesarean section was initially upheld on appeal and then reversed on rehearing by a full panel of the D.C. Court of Appeals.

² Spruce, *ibid.*

³ Lisa C. Ikemoto, "The Code of Perfect Pregnancy: At the Intersection of the Ideology of Motherhood, the Practice of Defaulting to Science, and the Interventionist Mindset of Law" (1992) 53 *Ohio St. L.J.* 1205 at 1243.

⁴ Janet Gallagher, "Prenatal Invasions & Interventions: What's Wrong with Fetal Rights" (1987) 10 *Harv. Women's L.J.* 9 at 9 [Gallagher, "Prenatal Rights"].

The woman became combative and was placed in full leathers, a term that refers to leather wrist and ankle cuffs that are attached to the four corners of a bed to prevent the patient from moving ... the woman continued to scream for help and bit through her intravenous tubing in an attempt to get free.⁵

Introduction

These are stories of anguish and of rage. They may be among the most shocking accounts of forced obstetrical intervention, or they may be typical of reports about intervention in pregnancy.⁶ They are narratives about intervention in pregnancy but they are also stories about how it might feel to be a competent, autonomous adult and to suffer bodily invasion at the hands of health care providers whom you had trusted to respect your wishes.

The past two decades can be thought of as an upswing (on the autonomy side) of the pendulum that oscillates between the values of autonomy and beneficence as paramount in health care ethics.⁷ Despite the apparent ascendance of autonomy in health care ethics and law,⁸ we continue to see instances of medical intervention in pregnancy.⁹ This is a problem that resides at the intersection of astounding progress in medical technology¹⁰ on the one hand, and regressive attitudes about the rights and responsibilities of pregnant women on the other.¹¹

⁵ *Ibid.* at 10.

⁶ As Rachel Roth points out, “[i]t is impossible to determine the full extent of court-ordered medical intervention in the lives of pregnant women”; we should consider the incidents we are aware of as “only the tip of the iceberg” (*Making Women Pay: The Hidden Costs of Fetal Rights* (Ithaca, N.Y.: Cornell University Press, 2000) at 94-95).

⁷ I borrow this metaphor from Bill Sage.

⁸ See *infra*, Part II.B. and III.A.

⁹ See Roth, *supra* note 6 at 131, referring to intervention in pregnancy as “state-sanctioned violence against women”.

¹⁰ See Janet Gallagher, “Collective Bad Faith: ‘Protecting’ the Fetus” in Joan C. Callahan, ed., *Reproduction, Ethics, and the Law: Feminist Perspectives* (Bloomington: Indiana University Press, 1995) 343 at 347 [Gallagher, “Collective Bad Faith”]. See also Nathan Stormer, “Seeing the Fetus: The Role of Technology and Image in the Maternal-Fetal Relationship” (2003) 289:13 J.A.M.A. 1700; Sozos J. Fasoulitis & Joseph G. Schenker, “Maternal-Fetal Conflict” (2000) 89 Eur. J. Obstet. Gynecol. & Reprod. Biol. 101; Barbara Duden, *Disembodying Women: Perspectives on Pregnancy and the Unborn*, trans. by Lee Hoinacki (Cambridge, Mass.: Harvard University Press, 1993) at 11-15, 51-52; Rosalind Pollack Petchesky, “Fetal Images: The Power of Visual Culture in the Politics of Reproduction” (Summer 1987) 13 Fem. Stud. 263; Krista L. Newkirk, “State-compelled Fetal Surgery: The Viability Test Is Not Viable” (1998) 4 Wm. & Mary J. Women & L. 467; John A. Robertson, *Children of Choice: Freedom and the New Reproductive Technologies* (Princeton: Princeton University Press, 1994) at 177-180 [Robertson, *Children of Choice*], Deborah Mathieu, *Preventing Prenatal Harm: Should the State Intervene?*, 2d ed. (Washington, D.C.: Georgetown University Press, 1996) at 102-22; Ron Beal, “‘Can I Sue Mommy?’ An Analysis of a Woman’s Tort Liability for Prenatal Injuries to Her Child Born Alive” (1984) 21 San Diego L. Rev. 325; Deborah M. Santello, “Maternal Tort Liability for Prenatal Injuries” (1988) 22 Suffolk University L. Rev. 747;

There is a wealth of legal commentary concerning intervention in pregnancy,¹² but no clear answer to the problem that is consistent with the values our liberal society purports to hold, such as autonomy and respect for bodily integrity, and with women's equality. In particular, what is missing from the extensive body of writing about pregnancy and the law is a theoretical framework for choice, or decision-making, in pregnancy.¹³ I suggest that, in part, the inability to discover an adequate mode of reasoning about the problem of intervention in pregnancy has to do with the way in which decision-making in pregnancy is characterized.

After defining intervention in pregnancy for the purposes of this article (Part I), I examine some themes that emerge in choice-based reasoning about intervention in pregnancy (Part II). The unhelpful legal constructs that animate such reasoning

Douglas E. Carroll, "Parental Liability for Preconception Negligence: Do Parents Owe a Legal Duty to Their Potential Children?" (1986) 22 Cal. W. L. Rev. 289; Ikemoto, *supra* note 3 at 1286; Timothy Caulfield & Erin Nelson, "Winnipeg Child and Family Services v. D.F.G.: A Commentary on the Law, Reproductive Autonomy and the Allure of Technopolicy" (1998) 36 Alta. L. Rev. 799 at 807-808.

¹¹ See e.g. Janet Gallagher, "Fetus as Patient" in Sherrill Cohen & Nadine Taub, eds., *Reproductive Laws for the 1990s* (Clifton, N.J.: Humana Press, 1989) 185 [Gallagher, "Fetus as Patient"]; Barbara Katz Rothman, *Recreating Motherhood: Ideology and Technology in a Patriarchal Society* (New York: Norton, 1989) at 40-41 [Rothman, *Recreating Motherhood*]; Laura R. Woliver, "Reproductive Technologies, Surrogacy Arrangements, and the Politics of Motherhood" in Martha Albertson Fineman & Isabel Karpin, eds., *Mothers in Law: Feminist Theory and the Legal Regulation of Motherhood* (New York: Columbia University Press, 1995) 346 at 346, 354-57; and Vangie Bergum, *A Child on Her Mind: The Experience of Becoming a Mother* (Westport, Conn.: Bergin & Garvey, 1997) at 58. Fasouliotis & Schenker, *supra* note 10 at 101, refer to the pregnant woman as the fetal "host" and as the "opaque environment" in which we find the fetus.

¹² Collections of essays and books on the topic include: Callahan, *supra* note 10; Fineman & Karpin, *ibid.*; Julia E. Hanigsberg & Sara Ruddick, eds., *Mother Troubles: Rethinking Contemporary Maternal Dilemmas* (Boston: Beacon Press, 1999); and Duden, *supra* note 10. For articles on point see George J. Annas, "Forced Caesareans: The Most Unkindest Cut of All" (1982) 12:3 Hastings Center Report 17 at 45; Nancy K. Rhoden, "The Judge in the Delivery Room: The Emergence of Court-Ordered Cesareans" (1986) 74 Cal. L. Rev. 1951; Nancy Ehrenreich, "The Colonization of the Womb" (1993) 43 Duke L.J. 492; Eric M. Levine, "The Constitutionality of Court-Ordered Cesarean Surgery: A Threshold Question" (1994) 4 Alb. L.J. Sci. & Tech. 229; F.C. DeCoste, "Winnipeg Child and Family Services (Northwest Area) v. D.F.G.: The Impossibility of Fetal Rights and the Obligations of Judicial Governance" (1998) 36 Alta. L. Rev. 725; Cheryl E. Amana, "Maternal-Fetal Conflict: A Call for Humanism and Consciousness in a Time of Crisis" (1992) 3 Colum. J. Gender & L. 351; Laura Shanner, "Pregnancy Intervention and Models of Maternal-Fetal Relationship: Philosophical Reflections on the Winnipeg C.F.S. Dissent" (1998) 36 Alta. L. Rev. 751 [Shanner, "Pregnancy Intervention"].

¹³ The theoretical framework I am referring to is distinct from theoretical ideas about women's experiences of the pregnancy relationship (as set out by, for example, Bergum, *supra* note 11, and Shanner, "Pregnancy Intervention", *ibid.*). What I am concerned about is not only how women experience pregnancy, but also how the law imposes understandings of pregnancy and decision-making in the course of pregnancy. An important issue that I leave for future work is the extent to which a theoretical framework for decision-making in pregnancy should make normative judgments about women's decision-making in pregnancy. I agree with Linda McClain that "there is an important role for normative judgment and critical evaluation of ... women's lives, choices and circumstances" ("'Irresponsible' Reproduction" (1996) 47 Hastings L.J. 339 at 444).

require a feminist response that re-examines a defining feature of legal thinking about pregnancy intervention: the notion of choice.

The difficulty lies in framing a feminist response, which is discussed more fully in Part III. The topic of intervention in pregnancy has been thoroughly canvassed in the legal academic literature, and notable contributions to this effort have been made by feminist theorists of varying persuasions, as is elaborated on in Part III. Characteristic of feminist writing on the issue, however, is that the debate is largely about *choices*, rather than about *choice*. I argue here that what is needed at this time is not further debate about whether women have choices, which ones they have, or which they ought to have but do not. Instead, the very understanding of choice that epitomizes traditional liberal ideals requires re-evaluation. In suggesting that decision-making in pregnancy needs to be reconceived, and in proposing a starting point for that task, I hope to lay a foundation upon which questions of boundaries may be answered.

I start from the point of view that intervention in pregnancy, as currently practiced, is bad public policy. There may be arguments, however, depending heavily on what is meant by intervention, that intervention might sometimes be desirable. If we take intervention to mean, for example, the positive involvement of the state in the lives of pregnant women in seeking out and helping those who need assistance with prenatal care, addiction treatment, nutrition, care of other children, or protection from a violent spouse, then there is clearly an important role for intervention. If, on the other hand, we take it to mean what it seems to mean now—forced obstetrical treatment, incarceration, detention, or other forms of punishment—my position is that intervention in pregnancy is misguided and unlikely to further the alleged goal of healthy mothers and healthy children.¹⁴

I. Intervention in Pregnancy

State intervention in pregnant women's lives can take a variety of forms, including: barring women of child-bearing age (pregnant or potentially pregnant women) from certain occupations due to potential risks to the fetus; restricting or prohibiting access to contraceptives, abortion or both; and imposing medical care or other treatment aimed at protecting the fetus where the behaviour of a pregnant woman is perceived to be adverse to the interests of her fetus.¹⁵ It is this latter form of intervention that I explore here, and it arises in two situations: (i) where a pregnant woman refuses recommended medical treatment that is intended to benefit the fetus, or, in some cases, both herself and her fetus (e.g., Caesarean section, blood transfusion); and (ii) where a pregnant woman is sought to be detained and/or treated

¹⁴ See John Seymour, *Childbirth and the Law* (New York: Oxford University Press, 2000) at 230, 238; Sanda Rodgers, "The Legal Regulation of Women's Reproductive Capacity in Canada" in Jocelyn Downie, Timothy Caulfield & Colleen Flood, eds., *Canadian Health Law and Policy*, 2d ed. (Markham, Ont.: Butterworths, 2002) 331 at 354 [Rodgers, "Legal Regulation"].

¹⁵ See Rodgers, *ibid.* at 333.

against her will for her addiction to a harmful substance such as alcohol, solvents, or crack cocaine.¹⁶

I focus here primarily on coercive medical intervention in pregnancy, which occurs when a woman's physician, hospital, or health care team seeks a court order compelling her to undergo a procedure to which she has competently withheld her consent. Examples of procedures for which orders have been sought in the past include Caesarean sections,¹⁷ blood transfusions,¹⁸ and intrauterine transfusions.¹⁹ Advance health care directives, or living wills, are in many American states rendered invalid by operation of law during pregnancy.²⁰ These statutory provisions also fall within the scope of coercive medical treatment, as providing treatment in spite of a clear and relevant advance directive instructing otherwise constitutes treatment contrary to the patient's competent refusal.

While the issue of medical intervention in pregnancy is central, I also refer to a number of cases involving court ordered detention and/or treatment for addiction to substances thought likely to be potentially harmful to the fetus,²¹ as these cases entail

¹⁶ *Ibid.*

¹⁷ See e.g. *Jefferson v. Griffin Spalding County Hospital Authority*, 274 S.E.2d 457 (Ga. 1981); *Re A.C.*, *supra* note 1; *Re Madyun*, 114 Daily Washington L. Rptr. 2233 (D.C. Sup. Ct. 1986); *Re Baby Boy Doe*, 632 N.E. 2d 326 (Ill. App. Ct. 1994); *Pemberton v. Tallahassee Memorial Regional Medical Center*, 66 F. Supp. 2d 1247 (Fla. Dist. Ct). See also Veronica E.B. Kolder, Janet Gallagher & Michael T. Parsons, "Court-Ordered Obstetrical Interventions" (1987) 316 *New England J. Med.* 1192; *Re Baby R* (1988), 53 D.L.R. (4th) 69, 30 B.C.L.R. (2d) 237 (B.C.S.C.). For discussions of the recent case involving Melissa Rowland who refused to undergo a Caesarean section, see e.g. Katha Pollitt, "Pregnant and Dangerous" *The Nation* (8 April 2004), online: <http://www.thenation.com/doc.mhtml%3Fi=20040426&s=pollitt>; "Court Cases Revive Childbirth Rights Debate" *CNN.com* (29 May 2004), online: <http://edition.cnn.com/2004/HEALTH/parenting/05/29/childbirth.rights.ap/>.

¹⁸ See e.g. *Re President and Directors of Georgetown College*, 331 F.2d 1000 (D.C. Cir. 1964); *Raleigh Fitkin Paul Morgan Memorial Hospital v. Anderson*, 201 A.2d 537 (N.J. Sup. Ct. 1964); *Re Jamaica Hospital*, 491 N.Y.S.2d 898 (Sup. Ct. 1985); *Crouse Irving Memorial Hospital v. Paddock*, 485 N.Y.S.2d 443 (Sup. Ct. 1985); *Re Fetus Brown*, 689 N.E.2d 397 (Ill. App. Ct. 1997).

¹⁹ See e.g. Kolder, Gallagher & Parsons, *supra* note 17.

²⁰ This seems to be a uniquely American phenomenon. I am not aware of similar provisions in any Canadian advance directive legislation. For discussions of these provisions, see Katherine A. Taylor, "Compelling Pregnancy at Death's Door" (1997) 7 *Colum. J. Gender & L.* 85 and Amy Lynn Jerdee, "Breaking Through the Silence: Minnesota's Pregnancy Presumption and the Right to Refuse Medical Treatment" (2000) 84 *Minn. L. Rev.* 971.

²¹ Current research conclusions on the teratogenic effects (in humans) of many substances are inconsistent. As Emily Jackson notes, fetal alcohol syndrome is relatively rare among the children of affluent women "who drink heavily during pregnancy but who have other material advantages such as good nutrition and prenatal care" (Emily Jackson, *Regulating Reproduction: Law, Technology and Autonomy* (Oxford: Hart Publishing, 2001) at 159). See also Françoise Baylis, "Dissenting with the Dissent: *Winnipeg Child and Family Services (Northwest Area) v. G (D.F.)*" (1998) 36 *Alta. L. Rev.* 785 at 794; Lisa H. Harris & Lynn M. Paltrow, "The Status of Pregnant Women and Fetuses in US Criminal Law" (2003) 289:13 *J.A.M.A.* 1697 at 1698; Dimitris Polygenis *et al.*, "Moderate Alcohol Consumption During Pregnancy and the Incidence of Fetal Malformations: A Meta-Analysis" (1998)

similar, though not identical, concerns. *Winnipeg Child and Family Services (Northwest Area) v. D.F.G.*²² is a case in point. It is a substance abuse case, but Justice Major's reasoning is virtually unlimited in scope,²³ and he does not specify that his proposed test for intervention in pregnancy would apply only to situations of substance abuse.²⁴

In addition to the coercive practices described above, less familiar potential threats also exist. As Lisa Ikemoto explains, "[t]he same legal analyses used in the forced cesarean, forced transfusion, forced cerclage, and forced detention cases could be used to support other court ordered fetal therapies."²⁵ John Robertson claims that once a woman has chosen to carry a child to term, she assumes obligations to "assure its well-being".²⁶ Such obligations, in his view, are wide-ranging, potentially requiring a pregnant woman to consent to the performance of "established" therapies on the fetus, and, in certain circumstances, agree to prenatal screening.²⁷ Although such testing is generally voluntary, there are situations in which consent to testing may not be as free as it first appears.²⁸

Further, now that medical technology permits surgery on a fetus in utero to repair certain structural problems, it is conceivable that an order might be sought to compel a woman to consent to such surgery.²⁹ And, as medical science continues to progress,

20:1 *Neurotoxicol Teratol.* 61; Antonio Addis *et al.*, "Fetal Effects of Cocaine: An Updated Meta-Analysis" (2001) 15:4 *Reprod. Toxicol.* 341 (2001); Cheryl M. Plambeck, "Divided Loyalties: Legal and Bioethical Considerations of Physician-Pregnant Patient Confidentiality and Prenatal Drug Abuse" (2002) 23 *J. Legal Med.* 1 at 11-12.

²² [1997] 3 S.C.R. 925, 152 D.L.R. (4th) 193 [*D.F.G.* cited to D.L.R.].

²³ Justice Major's reasons formed the dissenting opinion in the Supreme Court of Canada decision in *D.F.G.*, but they are nevertheless worth responding to, given their superficial appeal. See *e.g.* Caulfield & Nelson, *supra* note 10; Baylis, *supra* note 21; Bruce P. Elman & Jill Mason, "The Failure of Dialogue: *Winnipeg Child and Family Services (Northwest Area) v. G (D.F.)*" (1998) 36 *Alta. L. Rev.* 768.

²⁴ *D.F.G.*, *supra* note 22 at 229.

²⁵ Ikemoto, *supra* note 3 at 1251.

²⁶ John A. Robertson, "Procreative Liberty and the Control of Conception, Pregnancy, and Childbirth" (1983) 69 *Va. L. Rev.* 405 at 437-50 [Robertson, "Procreative Liberty"].

²⁷ *Ibid.*

²⁸ See Jackson, *supra* note 21 at 121-22; see also Carole H. Browner & Nancy Ann Press, "The Normalization of Prenatal Diagnostic Screening" in Faye D. Ginsburg & Rayna Rapp, eds., *Conceiving the New World Order: The Global Politics of Reproduction* (Berkeley: University of California Press, 1995) 307 at 314-15. It has also been suggested that so-called "opt-out" prenatal HIV screening, under which pregnant women are routinely screened for HIV infection unless they specifically choose to forego testing, may lead to testing even where there has not been true "informed consent". See Paul Weinberg, "Pregnant Women Tested for HIV/AIDS Without Consent" (25 October 2002), online: InterPress Service <<http://www.aegis.com/news/ips/2002/IP021023.html>>; Michael Yoder, "Letter to the Editor: Pregnant Women Should Not Be Forced to 'Opt-Out' of HIV Testing" (23 August 2002), online: Canadian AIDS Society <<http://www.cdnaids.ca/web/PressReleases.nsf/0/6c12e4c3f8fdda5385256c1e0071b980?OpenDocument>>.

²⁹ See Rothman, *Recreating Motherhood*, *supra* note 11 at 167 (discussing the possibility of "fetal advocates"); Newkirk, *supra* note 10 at 470-71; Robertson, *Children of Choice*, *supra* note 10 at 161-

the possibility of gene therapy may become a reality—we may be able to treat a fetus in utero to correct or repair the effects of a genetic condition.³⁰ Once this becomes possible, coercive medical treatment may be faced by women who refuse prenatal screening (to determine whether there is a problem) or who refuse therapy once results of prenatal testing are known.

II. Characterizing Decision-Making in Pregnancy: The Contradictory Legal Language of Choice

A. The Abortion Choice

In legal writing about coerced medical treatment during pregnancy, women's choices to become or remain pregnant are often invoked in support of the legitimacy of intervention.³¹ In his dissent in *D.F.G.*,³² for example, Justice Major repeatedly links the existence of an option to obtain an abortion back to the legitimacy of state intervention in pregnancy for the benefit of the fetus.³³ As he puts it:

Once the mother decides to bear the child the state has an interest in trying to ensure the child's health. ... [The majority's] approach would entail the state to stand idly by while a reckless and/or addicted mother inflicts serious and permanent harm on to a child she had decided to bring into the world.

...

Having chosen to bring a life into this world, that woman must accept some responsibility for its well-being ... It is not a question of a woman making a "declaration" of her intentions. Rather, the law will presume that she intends to carry the child to term until such time as she indicates a desire to receive, makes arrangements for or obtains an abortion.³⁴

In *Re A (in utero)*,³⁵ before reluctantly concluding that there was no basis in law to permit intervention, the judge remarked:

62; Rosalind Pollack Petchesky, *Abortion and Woman's Choice* (Boston: Northeastern University Press, 1990) at 356-57; Maggie Jones, "A Miracle and Yet" *New York Times Magazine* (15 July 2001) 38 at 39.

³⁰ See e.g. Robertson, *Children of Choice*, *supra* note 10 at 160-61. See also Rick Wiess, "Genetic Therapy Apparently Cures 2: French Team's Feat Would Be a First" *Washington Post* (28 April 2000) A01; "Bubble Boy 'Saved' by Gene Therapy" (3 April 2002), online: BBC News <<http://news.bbc.co.uk/1/hi/health/1906999.stm>>.

³¹ See Reva Siegel, "Reasoning from the Body: A Historical Perspective on Abortion Regulation and Questions of Equal Protection" (1992) 44 *Stan. L. Rev.* 261 at 350, n. 362.

³² *Supra* note 22.

³³ Another example from Justice Major's reasons: "The mother's continuing ability to elect an abortion and end her confinement makes the intrusion of her liberty relatively modest when weighed against the child from birth being seriously and permanently impaired" (*ibid.* at 241).

³⁴ *Ibid.* at 228, 237.

³⁵ (1990), 75 O.R. (2d) 82, 72 D.L.R. (4th) 722 (Ontario Unified Family Court).

It ... seems to me that the mother, having opted to give life to the foetus, and having raised it to full term, has a duty to ensure that the balance of her prenatal care and the child's birth be effected in a proper manner having regard to her apparent medical problems. This is simply a reflection of the mother's natural duty in such circumstances.³⁶

In *Planned Parenthood v. Casey*, Justice Day O'Connor explains that the rule that states may restrict access to abortion after the point of fetal viability contains "an element of fairness."³⁷ In her view, "[i]n some broad sense, it might be said that a woman who fails to act before viability has consented to the State's intervention on behalf of the developing child."³⁸ For John Robertson, a prolific and influential contributor to the legal literature on procreative liberty, the matter can be concisely summarized as follows: "Although [a woman] is under no obligation to invite the fetus in or to allow it to remain, once she has done these things she assumes obligations to the fetus that limit her freedom over her body."³⁹

As Robertson explains, the fact that "a pregnant woman's actions may affect the child that the fetus, through her own choice, will become"⁴⁰ implies that she may owe a duty to avoid harming the fetus. Robertson goes on to argue that the woman's choice to become pregnant (or to not avoid conception, or at a minimum, to carry the pregnancy to term) leads to the conclusion that she is duty bound to accept medical intrusions for the sake of the fetus: "She is responsible for the child's medical need by choosing to continue the pregnancy and giving birth to a child whose suffering could be averted by prenatal medical intervention."⁴¹

In *United States v. Vaughn*, the judge who sentenced Brenda Vaughn to a prison term of 180 days for a first offense, which would normally lead to probation, or a sentence served on weekends,⁴² said, "[b]ut Ms. Vaughn became pregnant and chose to bear the baby ... Arguably Ms. Vaughn should have demonstrated even greater responsibility toward her child."⁴³ And, in a more recent case involving a petition for habeas corpus by a pregnant woman detained in a proceeding concerning whether her viable fetus was a child in need of protection or services, the court noted that "this case is about consequences: first, the consequences of Angela's choice under *Roe*; and

³⁶ *Ibid.* at 728.

³⁷ *Planned Parenthood v. Casey*, 505 U.S. 833, 870 (1992).

³⁸ *Ibid.*

³⁹ Robertson, "Procreative Liberty", *supra* note 26 at 438; see also Robertson, *Children of Choice*, *supra* note 10; John A. Robertson, "Reconciling Offspring and Maternal Interests During Pregnancy" in Cohen & Taub, *supra* note 11, 259. See also Margery W. Shaw, "Conditional Prospective Rights of the Fetus" (1984) 5 J. Legal Med. 63 at 88 ("The mother's duties to protect the fetus from harm also increase because she has foregone her right to choose abortion").

⁴⁰ Robertson, *Children of Choice*, *ibid.* at 179.

⁴¹ *Ibid.*

⁴² Debra Cassens Moss, "Pregnant? Go Directly to Jail: Suits Hit Prenatal Care for Women Inmates" (1 November 1988) 74 A.B.A.J. 20.

⁴³ *United States v. Vaughn*, Daily Washington L. Rptr., 7 March 1989, 441 at 447.

second, the consequences of Angela's conduct which has placed her viable fetus at risk of serious physical harm or death."⁴⁴

"Choice" is a word of enormous power within legal discourse. It connotes the ability to exercise one's autonomy; in some ways, the notion of choice can be equated with that of freedom.⁴⁵ Choice is also a word with powerful resonance in feminist discourse around sexuality, motherhood, and bodily integrity.⁴⁶ How has the idea of choice in pregnancy—whether the choice to become pregnant in the first place (assuming that this is a choice, made consciously) or the choice to continue an existing pregnancy—come to have such power in legal thought? What does it mean when a judge or legal scholar insinuates that in choosing to lend her body to a pregnancy, a woman has foregone her ability to make later choices about whether she will accept physical invasions of her person for the benefit of the fetus?

In light of the importance that the law ascribes to choice, it should not be surprising that this language has powerful intuitive appeal. It makes sense to us that people should be bound by their choices. But, upon close examination of choice-based legal language in the context of pregnancy intervention, the contradictory nature of the language becomes apparent. The importance of observing the use of choice language in legal writing around pregnancy is twofold. First, it allows consideration of the problematic underpinnings of this language, which will be elaborated upon below. Second, as will be discussed at length in Part III, it throws into sharp relief the fact that choices may signify something quite different from what we assume they do.

In order for a woman's choice to carry a pregnancy to term to have meaning in the pregnancy intervention context, she must also have the option to terminate the pregnancy.⁴⁷ Undue importance is, in this way, placed upon the abortion choice.⁴⁸ As Carol Sanger has pointed out,

⁴⁴ *State ex rel. Angela M.W. v. Kruzicki*, 197 Wis. 2d 532 at 550 (Ct. of Appeals of Wis. 1995) (the conduct referred to is cocaine use). The decision was later reversed: *State ex rel. Angela M.W. v. Kruzicki*, 209 Wis. 2d 112 (Supreme Ct. of Wis. 1997).

⁴⁵ Examples of the law's focus on choice abound in the law of contract (e.g., the whole foundation of contract law as the idea of obligations freely chosen, as well as the idea that we will not recognize such obligations if we think they were not undertaken freely; hence such doctrines as undue influence, mistake, etc.). Tort law also contains examples of situations in which choice—how an actor chooses to behave—plays a role, including the *volenti* defence and the duty to rescue. Finally, the notion of choice plays an important role in the criminal law context, particularly with respect to the imposition of criminal responsibility.

⁴⁶ Indeed, the "feminist" position on abortion has been identified as the "pro-choice" position. See Joan Williams, "Gender Wars: Selfless Women in the Republic of Choice" (1991) 66 N.Y.U. L. Rev. 1559 at 1574-77.

⁴⁷ A woman's apparent decision not to terminate her pregnancy may not be an exercise of her choice. See *infra* notes 56-63 and accompanying text.

The legal theories that secured the right to abortion developed within a framework of privacy that focused on a woman's right to control her trimestered body. That analysis necessarily diverted attention from a woman's interest in controlling her post-pregnant, child-now-out-of-body life.⁴⁹

That same analysis has also diverted attention from a woman's interest in controlling her body while she is pregnant and making a decision that is not related to abortion. The shades of the questions that can arise during pregnancy are obscured by the apparent availability of the abortion option—if the woman chooses abortion, the matter is at an end. The state is free to express its dismay at and disapproval of the choice, but there is nothing more to be done.⁵⁰ The woman's choice is final.⁵¹ What the law misses in constructing the issue in this way is that the abortion decision is only the sole decision if the woman decides to have one. The law, in fixing its gaze on the existence of the abortion choice, constitutes this option as a barrier to more meaningful consideration of the unique nature of pregnancy⁵² and of decision-making therein.⁵³

This focus on the abortion choice, and the relevance of it not being chosen, is in large measure biologically driven. This is not surprising, given the attraction of science as a basis for legal decision-making.⁵⁴ And science, with its apparently neutral

⁴⁸ See Siegel, *supra* note 31 at 341, n. 331. See also Molly McNulty, "Pregnancy Police: The Health Policy and Legal Implications of Punishing Pregnant Women for Harm to Their Fetuses" (1987-88) 16 N.Y.U. Rev. L. & Soc. Change 277.

⁴⁹ Carol Sanger, "M Is for the Many Things" (1992) 1 S. Cal. Rev. L. & Women's Stud. 15 at 23 [Sanger, "M Is for the Many Things"].

⁵⁰ *Planned Parenthood v. Casey*, *supra* note 37 at 872-73, 877; *Webster v. Reproductive Health Services*, 492 U.S. 490 at 511 (1989).

⁵¹ The American cases make it very clear that the states are free to create policies that discourage abortion, but are prevented from outright prohibitions (at least in the first trimester): see *e.g.* *Planned Parenthood v. Casey*, *ibid.* at 883.

⁵² See *infra* notes 96-100 and accompanying text. Catharine A. MacKinnon, "Reflections on Sex Equality Under Law" (1991) 100 Yale L.J. 1281 at 1313-18 [MacKinnon, "Reflections"]. Others have described the pregnant woman as "not-one-but-not-two" (see Isabel Karpin, "Legislating the Female Body: Reproductive Technology and the Reconstructed Woman" (1992) 3 Colum. J. Gender & L. 325; Seymour, *supra* note 14; Jenny Morgan, "Foetal Imaginings: Searching for a Vocabulary in the Law and Politics of Reproduction" (2000) 12 Can. J. Women & L. 371), or the fetus as being "in and of" the pregnant woman. See Lynn Smith, "An Equality Approach to Reproductive Choice: *R. v. Sullivan*" (1991) 4 Yale J. L. & Feminism 93.

⁵³ This is particularly true of the US jurisprudence: see *e.g.* *Roe v. Wade*, 410 U.S. 113 (1973); *Planned Parenthood v. Casey*, *supra* note 37; *Webster v. Reproductive Health Services*, *supra* note 50; *Doe v. Bolton*, 410 U.S. 179 (1973); *R. v. Morgentaler*, [1988] 1 S.C.R. 30, 44 D.L.R. (4th) 385. See also Elizabeth Reilly, "The 'Jurisprudence of Doubt': How the Premises of the Supreme Court's Abortion Jurisprudence Undermine Procreative Liberty" (1998) 14 J. L. & Pol. 757 at 776-77; Ehrenreich, *supra* note 12 at 567.

⁵⁴ *Ibid.* See also Caulfield & Nelson, *supra* note 10 at 801-804; Ikemoto, *supra* note 3 at 1285-90; Michael Thomson, *Reproducing Narrative: Gender, Reproduction and Law* (Aldershot, England: Ashgate, 1998) [Thomson, *Reproducing Narrative*]; Rodgers, "Legal Regulation", *supra* note 14 at 342.

and objective point of view, has particular appeal for those trying to draw difficult lines.⁵⁵ In *Roe v. Wade*, the Court deferred completely to medical knowledge in crafting the abortion right and the state's interest in both women's health and prenatal life, in the following terms:

With respect to the State's important and legitimate interest in potential life, the "compelling" point is at viability. This is so because the fetus then presumably has the capability of meaningful life outside the mother's womb. State regulation protective of fetal life after viability thus has both logical and biological justifications.⁵⁶

As Alta Charo points out, the case law relies on the biological concept of viability as a substitute for a legal conclusion:

Even if the definitions were precise, it remains to be shown why "life" or "viability" represents the appropriate moment to recognize the advent of legal rights. A mosquito and my liver are alive, but neither have legal rights. Conversely, neither a ventilator-dependent quadriplegic nor a baby is viable without the active assistance of other persons or elaborate equipment, yet both clearly possess legal rights. Clearly, the demarcation point for legal rights is based on more than merely biological criteria.⁵⁷

The assertion that the failure to obtain an abortion amounts to a positive choice to carry a pregnancy to term conflates a biological fact with legally significant action. If we observe that a woman is pregnant, we are entitled to assume that she has made a positive decision to remain pregnant.⁵⁸ Implicit in this argument are some ideas that are obscured by the reasoning. First, we are required to assume that the physical reality of pregnancy has some relationship to the "chosenness" or "wantedness" of that pregnancy and, second, we have to deem the choice to become or remain pregnant to mean something well beyond what we might normally assume about other decisions that go to the core of bodily integrity.

Connecting the decision *not* to terminate a pregnancy to a woman's other decisions during pregnancy is particularly inapposite where the failure to have an abortion is a product of the woman's circumstances and not a positive decision to continue the pregnancy. The very real limitations on choices about abortion faced by some women reveal the invalidity of relying on such choices as justification for

⁵⁵ See e.g. Caulfield & Nelson, *supra* note 10; Duden, *supra* note 10; Mary C. Segers, "Can Congress Settle the Abortion Issue?" (1982) 12:3 *Hastings Ctr. Rep.* 20; Caroline Morris, "Technology and the Legal Discourse of Fetal Autonomy" (1997) 8 *U.C.L.A. Women's L.J.* 47 at 56-57; Daniel Callahan, "How Technology is Reframing the Abortion Debate" (1986) 16:1 *Hastings Ctr. Rep.* 33.

⁵⁶ *Roe v. Wade*, *supra* note 53 at 163.

⁵⁷ R. Alta Charo, "Biological Determinism in Legal Decision Making: The Parent Trap" (1994) 3 *Tex. J. Women & L.* 265 at 277-78 [footnotes omitted].

⁵⁸ In *D.F.G.*, Justice Major explains that under his test for intervention in pregnancy, the law will presume that a pregnant woman has decided to carry the pregnancy to term until she indicates otherwise, arranges for, or has an abortion (*supra* note 22 at 229).

intervention in pregnancy. Some women do not know that they are pregnant until a late enough point in the pregnancy that abortion is no longer realistically available.⁵⁹ Many women in abusive relationships legitimately fear for their safety, or are threatened with violence by their partner should they terminate the pregnancy.⁶⁰ Finally, choice can be constrained by strongly held personal or religious beliefs. It is inappropriate and objectionable to consider the failure to obtain an abortion in situations like these as synonymous with choosing pregnancy.⁶¹

A particularly significant and often overlooked difficulty many women face is basic access to abortion.⁶² In one Canadian province there are no hospitals that will perform the procedure, thus requiring that a woman travel outside her home province in order to avail herself of an abortion.⁶³ Further, the provincial health care insurance plan will reimburse a woman's out-of-province expenses only where certain statutory criteria are met, one of which is medical necessity.⁶⁴ Even for women who are able to travel (i.e., who do not have child care, work, or other obligations that prevent or constitute substantial obstacles to travel), the financial burdens imposed by this scheme may be insurmountable. Access issues also arise in the US; as in Canada, one problem is the lack of availability of abortion providers.⁶⁵ There are numerous additional legislative obstacles in many states, including mandatory waiting periods of one to twenty-four hours, parental consent or notification requirements for minors seeking abortions, and statutory restrictions on private insurers' coverage of the abortion procedure.⁶⁶

⁵⁹ See e.g. Baylis, *supra* note 21 at 788; "Facts in Brief: Induced Abortion" (2002), online: Alan Guttmacher Institute <http://www.agi-usa.org/pubs/fb_induced_abortion.pdf> (noting that the number of abortion providers declined by 11 per cent between 1996 and 2000; that 87 per cent of all US counties lacked an abortion provider in 2000, and that, while 86 per cent of all abortion facilities provide services at 12 weeks of gestation, the numbers drop sharply after that point, with only 13 per cent of providers offering abortion services at 24 weeks); Laura Eggerston, "Abortion Services in Canada: A Patchwork Quilt with Many Holes" (2001) 164:6 C.M.A.J. 847. See also Sanda Rodgers, "*Winnipeg Child and Family Services v. D.F.G.*: Juridical Interference with Pregnant Women in the Alleged Interest of the Fetus" (1998) 36 Alta. L. Rev. 711 at 718 [Rodgers, "*Winnipeg*"]; Rodgers, "Legal Regulation", *supra* note 14 at 343.

⁶⁰ Baylis, *ibid.*

⁶¹ A number of other issues raise further questions about the availability of abortion as a "choice" for many women. See Baylis, *ibid.* at 787-90; Rodgers, "*Winnipeg*", *supra* note 59 at 718.

⁶² See sources listed in *supra* note 59. See also "Protecting Abortion Rights in Canada" (2003), online: CARAL <<http://www.caral.ca/uploads/caralreporti.pdf>> [CARAL Report].

⁶³ Baylis, *supra* note 21 at 788; CARAL Report, *ibid.*

⁶⁴ Baylis, *ibid.*, citing Prince Edward Island, Department of Health and Social Services, "Policy 017: Criteria for Payment of Approved Therapeutic Abortions", in *Policy and Procedures Out of Province Referral Program* (effective date April 1, 1995, revised and approved December 23, 1997). This is also true of the Nunavut Territory, meaning that women must be flown to Ottawa or Montreal to obtain an abortion (CARAL Report, *ibid.*).

⁶⁵ See *supra* note 59.

⁶⁶ The Alan Guttmacher Institute, "State Policies in Brief: Mandatory Waiting Periods for Abortion" (1 June 2003), online: The Alan Guttmacher Institute <http://www.agi-usa.org/pubs/spib_

Even if a woman has, in fact, made an authentic election from among realistically available options, the reasoning about the implications of this choice is flawed. The choice whether or not to terminate a pregnancy is a choice about a matter that goes to the core of bodily integrity,⁶⁷ as are many other health care related decisions, such as the decision to refuse a life-saving blood transfusion. In refusing the transfusion, the individual has apparently indicated that he or she accepts the likelihood of death. Yet it would strike us as strange, to say the least, if a decision to refuse blood products were also taken to mean that the refuser wanted no medical care at all, including pain relief measures and other life support or, even more implausibly, that the refuser's physician would be justified in taking steps to hasten his or her death. Why, then, does it seem plausible (to some) to imbue a woman's decision to carry a pregnancy to term with moral and legal significance in relation to other choices that may fall to be made during her pregnancy?

Indeed, it seems inappropriate to consider the abortion decision in any way relevant in the context of a pregnancy a woman intends to carry to term. Presumably, many (if not most) women who do carry pregnancies to term do not even entertain abortion as an option. It would be more productive to think of pregnancy as a time in a woman's life that calls for a series of significant decisions: whether to seek prenatal care, and from whom; whether to accept prenatal testing, and what types; what type of birth experience is desired and with what birth attendants; what to eat; what type of exercise to do,⁶⁸ as opposed to placing such enormous significance on the decision (even assuming that such a decision was actively made) to carry the pregnancy to term.⁶⁹

B. Choice and Medical Knowledge

Another important driver of the reasoning about decision-making in pregnancy is medical paternalism, itself driven at least in part by technology. The willingness of courts to defer to medical knowledge, particularly in urgent, critical matters, bolsters such paternalistic tendencies. Michael Thomson aptly describes the relationship between medical technology and medical knowledge in this context:

Modern claims to a greater degree of knowledge than that of the pregnant woman are facilitated by reproductive technologies that are deployed once a

MWPA.pdf>; The Alan Guttmacher Institute, "State Policies in Brief: Parental Involvement in Minors' Abortions" (1 June 2003), online: The Alan Guttmacher Institute <http://www.agi-usa.org/pubs/spib_PIMA.pdf>; The Alan Guttmacher Institute, "State Policies in Brief: Restricting Insurance Coverage of Abortion" (1 June 2003), online: The Alan Guttmacher Institute <http://www.agi-usa.org/pubs/spib_RICA.pdf>.

⁶⁷ See e.g. *R. v. Morgentaler*, *supra* note 53; *Roe v. Wade*, *supra* note 53; *Planned Parenthood v. Casey*, *supra* note 37.

⁶⁸ Thanks to Michelle Oberman for the suggestion that pregnancy may be best conceptualized as a time in a woman's life calling for a series of important decisions to be made; see also Jackson, *supra* note 21 at 116.

⁶⁹ See sources cited at *supra* note 48.

woman has conceived. These technologies ... allow medicine to assert knowledge which is perceived as more quantifiable, more valid, than the woman's experiential knowledge.⁷⁰

One very obvious effect that evolving technology has had on the medical profession is the perception that there are two patients in each pregnant woman: the woman herself and the developing fetus.⁷¹ As a result, physicians are often unsure how to respond when pregnant women refuse recommended medical interventions.⁷² Jeffrey Phelan expresses these sentiments in setting out a fictional scenario in which a pregnant woman "adamantly refuses" a Caesarean section "without reason or explanation" in spite of obvious fetal distress as registered by an electronic fetal monitor. In Phelan's fictional scenario, the woman's refusal leads to the death of her fetus. Phelan asks the reader to imagine that he or she was the doctor or nurse, and inquires:

What would you have done? The life of Jane Doe's unborn child could easily have been saved by a cesarean ... should the physicians and nurses have stood idly by until the fetal monitor finally registered the death of her fetus? What if the fetus did not die but was born permanently brain damaged? ... [T]he physicians could have obtained a court order to grant or deny them permission to intervene on behalf of the unborn child and thereby insulate themselves from potential liability.⁷³

The woman's refusal of treatment places the physician in a situation of potential "conflict" between what he or she thinks best for the fetus and what the pregnant woman will accept by way of medical intervention.⁷⁴ Once this conflict arises, physicians often turn to the law for support.⁷⁵

In the past two decades, traditional medical paternalism has largely given way to a robust conception of patient autonomy in medical decision-making.⁷⁶ The notion

⁷⁰ Thomson, *Reproducing Narrative*, *supra* note 54 at 213.

⁷¹ Jeffrey P. Phelan, "The Maternal Abdominal Wall: A Fortress Against Fetal Health Care?" (1991) 65 S. Cal. L. Rev. 461 at 464; Frank A. Chervenak & Asim Kurjak, *Current Perspectives on the Fetus as a Patient* (New York: Parthenon, 1996). See also Stormer, *supra* note 10; Fasouliotis & Schenker, *supra* note 10; Joelyn Knopf Levy, "Jehovah's Witnesses, Pregnancy, and Blood Transfusions: A Paradigm for Autonomy Rights for All Pregnant Women" (1999) 27 J. L. Med. & Ethics 171.

⁷² Fasouliotis & Schenker note that when a woman refuses to comply with recommendations made by her physician, which the physician believes to be in the best interests of the fetus, the "physician may be frustrated and offended by the woman's non-compliance" (*supra* note 10 at 102).

⁷³ Phelan, *supra* note 71 at 461-62 [emphasis added]; Levy, *supra* note 71 at 171.

⁷⁴ See sources cited at *supra* note 72; see also Michelle Oberman, "Mothers and Doctors' Orders: Unmasking the Doctor's Fiduciary Role in Maternal-Fetal Conflicts" (2000) 94 N.W.U. L. Rev. 451.

⁷⁵ Kolder, Gallagher & Parsons, *supra* note 17.

⁷⁶ In Canada, see *Starson v. Swayze*, [2003] 1 S.C.R. 722, 2003 SCC 32; *Malette v. Shulman* (1990), 72 O.R. (2d) 417, 67 D.L.R. (4th) 321 (C.A.); *Fleming v. Reid* (1991), 4 O.R. (3d) 74, 82 D.L.R. (4th) 298 (C.A.); *Rodriguez v. B.C. (A.G.)*, [1993] 3 S.C.R. 519, 107 D.L.R. (4th) 342; *Ciarlariello v. Schacter* [1993] 2 S.C.R. 119, 100 D.L.R. (4th) 609; *Nancy B. v. Hôtel Dieu du Québec*, [1992]

that the physician knows best has largely been supplanted by the idea that decisions about health care—even those about life and death—are best made by patients, insofar as they are competent to do so.⁷⁷ Even the right of a patient to set out her wishes for medical treatment in advance has become firmly ingrained in North America, as is evidenced by the widespread adoption of living will or advance directive legislation.⁷⁸ In spite of this shift toward patient autonomy in health care decision-making, we still see physicians attempting to coerce pregnant women to accept unwanted medical care for the benefit of the fetus.⁷⁹

Paternalistic tendencies on the part of physicians are not unprecedented, whether motivated by fears about liability or by the notion that it is acceptable to subordinate the wishes of the patient for her own good (or, as the case may be, for the good of her fetus).⁸⁰ But what is novel, and particularly troubling, is reliance on the patient's own choice to justify paternalistic and coercive practices. Jeffrey Phelan argues that in certain circumstances, a refusal of treatment by a pregnant woman should be overridden after she has elected to continue her pregnancy. In his view, the fetus should be entitled to medically necessary care once this "election" has been made.⁸¹ Imputing the need for coercive medical treatment back to the woman's own choice disguises the violence and intrusiveness of forcing medical treatment on a competent patient who has clearly articulated her wish to refuse it.

R.J.Q. 361, 86 D.L.R. (4th) 385 (S.C.). The US cases are: *Re Quinlan*, 355 A.2d. 647 (1976) (U.S.S.C.) and *Cruzan v. Director, Missouri Department of Health*, 497 U.S. 261 (1990).

⁷⁷ See e.g. S. Elizabeth Wilborn Malloy, "Beyond Misguided Paternalism: Resuscitating the Right to Refuse Medical Treatment" (1998) 33 Wake Forest L. Rev. 1035 at 1038. See also Taylor, *supra* note 20; Timothy Caulfield & Gerald Robertson, "Eugenic Policies in Alberta: From the Systematic to the Systemic?" (1996) 35 Alta. L. Rev. 59; Alberta Law Reform Institute, *Advance Directives and Substitute Decision-Making in Personal Healthcare: A Joint Report of the Alberta Law Reform Institute and the Health Law Institute*, Report No. 64 (Edmonton: Alberta Law Reform Institute, 1993).

⁷⁸ See e.g. *Personal Directives Act*, R.S.A. 2000, c. P-6; *Representation Agreement Act*, R.S.B.C. 1996, c. 405; *Advance Health Care Directives Act*, R.S.N. 1995, c. A-4.1; *Substitute Decision Act*, S.O. 1992, c. 30, s. 46 and *Health Care Consent Act, 1996*, S.O. 1996, c. 2, Sch. A; *The Health Care Directives and Substitute Health Care Decision Maker Act*, S.S. 1997, C. H-0.001; *Consent to Treatment and Health Care Directives Act*, S.P.E.I. 1996, c. 10; *Health Act*, S.Y. 1989-1990, c. 36. For American state statutes, see Roth, *supra* note 6 at 223-28.

⁷⁹ See April L. Cherry, "The Free Exercise Rights of Pregnant Women who Refuse Medical Treatment" (2002) 69 Tenn. L. Rev. 563 at 564, where the author notes that Lori B. Andrews has been cited as reporting that "one California obstetrician stated that he obtained 49 out of 50 court orders he sought for cesarean section surgeries for non-consenting pregnant women, and that the doctor's record exceeds all published accounts of forced cesarean sections in law and medical journals." See also Levy, *supra* note 71 at 171.

⁸⁰ See e.g. Susan Sherwin, *No Longer Patient: Feminist Ethics and Health Care* (Philadelphia: Temple University Press, 1992) at 137 [Sherwin, *No Longer Patient*].

⁸¹ Phelan, *supra* note 71 at 489.

C. Pregnancy Analogized

Resort to the language of choice suggests the incorporation of other areas of law whose enforcement indeed depends on choice and consequent legal obligations into legal thinking about pregnancy.⁸² More specifically, it appears that what underlies the use of choice language is the intimation that in some way, or at least for some purposes, decision-making in pregnancy can be analogized to something like a contractual relationship.⁸³ As Justice Day O'Connor put it in *Casey*, "there is an element of fairness" here, in that the "woman who fails to act before viability has consented to the State's intervention on behalf of the developing child."⁸⁴ Or, as Robertson claims: "Although [a woman] is under no obligation to invite the fetus in or to allow it to remain, once she has done these things she assumes obligations to the fetus that limit her freedom over her body."⁸⁵

Clearly, the use of the language of choice does not indicate explicit acknowledgement that pregnancy is being viewed as a contract; there are not two parties between whom a contract could be formed, no terms are specified, and there is no consideration.⁸⁶ The examples of choice language cited throughout this paper evoke contract logic in that they suggest that consent to a specific act, such as a particular medical treatment in pregnancy, is manifested by the existence or continuance of the pregnancy. The obligations to which Robertson refers are legal in nature,⁸⁷ and contract is a good approximation of the notion of choice (to invite the fetus in or to allow it to remain) and consequent legal obligations.

Aside from doctrinal difficulties with applying choice-based relationships to the maternal-fetal relationship, there are gender implications to this type of reasoning. In any relationship involving consensual obligations there must necessarily be two persons between whom obligations are owed. Thus, the notion of consensual obligations owed by a woman to her fetus is, on its face, unsatisfactory from a

⁸² See MacKinnon, "Reflections", *supra* note 52 at 1313-18 (discussing the law's treatment of the maternal-fetal relationship).

⁸³ For an interesting discussion of the source of duties owed to children, see Gregory A. Loken, "Gratitude and the Map of Moral Duties Toward Children" (1999) 31 *Ariz. St. L.J.* 1121.

⁸⁴ *Planned Parenthood v. Casey*, *supra* note 37 at 870.

⁸⁵ Robertson, "Procreative Liberty", *supra* note 26 at 438. This language of "inviting the fetus in" is interesting in and of itself. From where does the woman "invite" the fetus in? This language denies the woman's role in gestation, much like historical ideas about fetal development. See Julia Epstein, "The Pregnant Imagination, Fetal Rights, and Women's Bodies: A Historical Inquiry" (1995) 7 *Yale J. L. & Hum.* 139 at 154-55.

⁸⁶ Jennifer Nedelsky asserts that the mother-child relationship is emphatically not like a contract: "part of the wonder of having a baby is that ... one experiences a kind of relationship whose possibility is subtly but relentlessly denied by the pervasive market mentality of negotiated self-interest as the fountain of human affairs" ("Dilemmas of Passion, Privilege and Isolation: Reflections on Mothering in a White, Middle-Class Nuclear Family" in Hanigsberg & Ruddick, *supra* note 12, 304 at 310).

⁸⁷ Robertson, "Procreative Liberty", *supra* note 26; Robertson, *Children of Choice*, *supra* note 10.

feminist point of view and is inconsistent with the law.⁸⁸ Many feminists would also reject this notion out of hand because of its reliance on liberal individualistic ideas of separateness and autonomy and its refusal to acknowledge interconnectedness—especially the interconnectedness between a woman and her fetus.⁸⁹

In pregnancy, in fact and in law, there are temporarily two beings in one person.⁹⁰ The law must acknowledge the unique nature of pregnancy and find a new way of reasoning that takes this uniqueness into account.⁹¹ That the law is capable of recognizing the singular and complex nature of pregnancy is demonstrated by cases that have done so. In *Dobson*, for example, the Supreme Court of Canada stated that “[t]he unique and special relationship between a mother-to-be and her foetus determines the outcome of this appeal. There is no other relationship in the realm of human existence which can serve as a basis for comparison.”⁹² In *Stallman v. Youngquist*, the Superior Court of Illinois made much the same point:

The relationship between a pregnant woman and her fetus is unlike the relationship between any other plaintiff and defendant. No other plaintiff depends exclusively on any other defendant for everything necessary for life itself. No other defendant must go through biological changes of the most profound type, possibly at the risk of her own life, in order to bring forth an adversary into the world.⁹³

III. Choice and Theoretical Commitments

A. Feminist Legal Theory and Choice

Intervention in pregnancy is an issue that falls at the confluence of different theoretical commitments. The notion and meaning of choice is central to liberal

⁸⁸ See e.g. *Tremblay v. Daigle*, [1989] 2 S.C.R. 530, 62 D.L.R. (4th) 634, *Roe v. Wade*, *supra* note 53; *Dobson v. Dobson (Litigation Guardian of)*, [1999] 2 S.C.R. 753, 214 N.B.R. (2d) 201 [*Dobson*]; *D.F.G.*, *supra* note 22.

⁸⁹ See e.g. Robin West, “Jurisprudence and Gender” (1988) 55 U. Chi. L. Rev. 1 at 2; Mary B. Mahowald, “As If There Were Fetuses Without Women” in Callahan, *supra* note 10, 199 at 200-201. For discussions of women’s experiences of pregnancy, see Iris Marion Young, *Throwing Like a Girl And Other Essays in Feminist Philosophy and Social Theory* (Bloomington, Ind.: Indiana University Press, 1990) at 160-74; Bergum, *supra* note 11; Shanner, “Pregnancy Intervention”, *supra* note 12. For articulations of the maternal-fetal relationship from an explicitly legal point of view, see Smith, *supra* note 52; Karpin, *supra* note 52; Morgan, *supra* note 52; Seymour, *supra* note 14.

⁹⁰ See e.g. *Tremblay v. Daigle*, *supra* note 88; *Roe v. Wade*, *supra* note 52.

⁹¹ See MacKinnon, “Reflections”, *supra* note 52. See also Marie Ashe, who describes pregnancy as “... a state of being that is neither unitary nor dual, exactly; a state to which we can apply no number known to us. Pregnancy discloses the truth of paradox” (“Law-Language of Maternity: Discourse Holding Nature in Contempt” (1988) 22 New Engl. L. Rev. 521 at 551).

⁹² *Supra* note 88 at 12.

⁹³ 531 N.E. 2d 355 at 360 (1988).

philosophy; indeed, autonomous choice is at the very foundation of liberalism.⁹⁴ Traditional liberal ideals of autonomy and bodily integrity play a crucial role; in fact, the inroads that have been made with respect to autonomous choice and refusal of treatment in medical care have been built on liberal ideals.⁹⁵ These same ideals presumably support the right of pregnant women to refuse unwanted medical interference, yet in a society committed to liberal notions of justice, we have the problem of medical intervention in pregnancy. Although liberal principles are a central factor, alone, they do not hold a solution. They take us as far as autonomy in medical decision-making but do not go the extra distance to unequivocally protect women's decisional autonomy in pregnancy. Perhaps this is inevitable, given that the pregnant woman does not conform to the paradigmatic example of the liberal individual; instead, "we have in every pregnant woman a walking contradiction to the segmentation of our lives ... In pregnancy the private self, the sexual, familial self, announces itself wherever we go [as] ... the embodied challenge to liberal philosophy ..."⁹⁶

The idea of autonomy centres on the separate individual. Pregnant women are the "embodied challenge to liberal philosophy" in that they are at once self and other; the woman as discrete individual is temporarily displaced by her pregnant self. Through pregnancy, the woman does not become a different individual (although her life is likely to change dramatically), yet she is not the same. She is, as Isabel Karpin puts it, "not-one-but-not-two".⁹⁷ The pregnant woman is at once self and somehow more than self. She is all there, but, as Catharine MacKinnon describes, "she is not all that is there."⁹⁸ The fetus is in the pregnant woman's body, "but it is also 'of' her in that it is interconnected with her in many intricate and intimate ways."⁹⁹ The transformative, interconnected nature of pregnancy is contrasted with liberal thought respecting the typically separate, atomistic liberal individual. As Susan Bordo argues:

Ontologically speaking, the pregnant woman has been seen by our legal system as the mirror-image of the abstract subject whose bodily integrity the law is so determined to protect. For the latter, subjectivity is the essence of personhood,

⁹⁴ See e.g. Williams, *supra* note 46 at 1561, who states that "[t]he rhetoric of choice stems from liberal imagery of autonomous individuals making choices in their own self-interest."

⁹⁵ The doctrine of informed consent to medical treatment is based on autonomy in health care decision-making. See e.g. Rhoden, *supra* note 12; Bernard M. Dickens, "Informed Consent" in Downie, Caulfield & Flood, *supra* note 14.

⁹⁶ Rothman, *Recreating Motherhood*, *supra* note 11 at 59.

⁹⁷ Karpin, *supra* note 52.

⁹⁸ MacKinnon, "Reflections", *supra* note 52 at 1316 [footnote omitted].

⁹⁹ Smith, *supra* note 52 at 123 (from para. XXII of the LEAF factum in *R. v. Sullivan*, reproduced in its entirety in Smith's article). See also Karpin, *supra* note 52 at 329, who envisions the maternal-fetal unit as "not-one-but-not-two".

not to be sacrificed even in the interests of the preservation of the life of another individual.¹⁰⁰

Robin West's comments about liberal notions of choice and their disjunction with women's experiences are interesting in this context.¹⁰¹ As she notes:

The descriptive account of the phenomenology of choice that underlies the liberal's conceptual defense of the moral primacy of consent may be wildly at odds with the way women phenomenologically experience the act of consent. If it is—if women "consent" to transactions not to increase our own welfare, but to increase the welfare of others—if women are "different" in this psychological way—then the liberal's ethic of consent, with its presumption of an essentially selfish human (male) actor and an essentially selfish consensual act, when even-handedly applied to both genders, will have disastrous implications for women. For if women consent to changes so as to increase the happiness of others rather than to increase our own happiness, then the ethic of consent, applied even-handedly, may indeed increase the amount of happiness in the world, but women will not be the beneficiaries.¹⁰²

West's claim speaks to the potential error in applying liberal choice language to women's experiences in pregnancy and to the moral and legal significance of the act of becoming pregnant or the choice not to terminate the pregnancy. Even if she is mistaken in her assertion that the ethic of consent is wrong as applied to women (in other words, even if the notion of moral primacy of consent is *not* wildly different from women's phenomenological experience of the act of consent), this does not necessarily mean that the ethic of consent is appropriately applied in the context of pregnancy. How is the notion of consent, when the consent is to a continued pregnancy, to be characterized as "an essentially selfish consensual act"?¹⁰³ Generally speaking, the opposite "choice"—that of abortion—is what is characterized as selfish.¹⁰⁴ This—more than West's argument—the problem with viewing pregnancy through the lens of liberal autonomy and consent. The liberal choice paradigm that constitutes our traditional understanding of consent and its legal consequences is based on a model of a self-interested actor, making self-interested choices, for self-interested ends. This could not be more different from the situation in pregnancy; surely, pregnancy must be the opposite of selfishness.¹⁰⁵ West's point helps to

¹⁰⁰ Susan Bordo, *Unbearable Weight: Feminism, Western Culture and the Body* (Berkeley: University of California Press, 1993) at 79.

¹⁰¹ See also Barbara Katz Rothman, *The Tentative Pregnancy: Prenatal Diagnosis and the Future of Motherhood* (New York: W.W. Norton & Company, 1986) at 180-81, 189 [Rothman, *The Tentative Pregnancy*].

¹⁰² Robin L. West, "The Difference in Women's Hedonic Lives: A Phenomenological Critique of Feminist Legal Theory" (1987) 3 *Wis. Women's L.J.* 81 at 92.

¹⁰³ *Ibid.*

¹⁰⁴ See e.g. Sally Sheldon, *Beyond Control: Medical Power and Abortion Law* (London: Pluto Press, 1997) at 35; Reilly, *supra* note 53 at 790-93.

¹⁰⁵ Women may become or remain pregnant for any number of reasons, some of which might be considered selfish, but the physical, emotional, and psychological reality of pregnancy itself is my concern here. See e.g. Morgan, *supra* note 52; Shanner, *supra* note 12.

highlight that even if we apply the idea of consent fairly, that is, we respect the consent of women as much as we respect the consent of men, and we require consent from women in the same situations that we require it from men, we are left with an idea that may well be incongruous in relation to pregnancy. The challenge posed to liberalism by pregnancy is fundamental: can liberal philosophy understand a relationship defined by connection as opposed to separateness?¹⁰⁶

Feminist theory is also central to questions of decision-making in pregnancy. Intervention in pregnancy is a peculiarly problematic issue for feminists, in that it lies at the intersection of so many issues important to feminism, including: the medicalization of women's bodies,¹⁰⁷ issues of women's autonomy and bodily integrity,¹⁰⁸ questions about women's social roles,¹⁰⁹ the need for support for caregivers,¹¹⁰ and the recognition that "woman" and "mother" or "caregiver" are not identical.¹¹¹ Adding complexity to the issue is the analysis of choice-based legal language presented in this paper. For many feminists,¹¹² liberal philosophical principles are themselves a central feature of women's oppression. Not surprisingly,

¹⁰⁶ See e.g. Jennifer Nedelsky, "Reconceiving Autonomy: Sources, Thoughts, and Possibilities" (1989) 1 Yale J.L. & Feminism 7. The feminists who critique the "atomistic" nature of liberalism acknowledge that they draw on the work of communitarians such as Michael J. Sandel, *Liberalism and the Limits of Justice*, 2d ed. (Cambridge, U.K.: Cambridge University Press, 1998); Alisdair Macintyre, *After Virtue*, 2d ed. (Notre Dame, Ind.: University of Notre Dame Press, 1984); Roberto Mangabeira Unger, *Knowledge and Politics* (New York: Free Press, 1975); Charles Taylor, "Atomism" in Alkis Kontos, ed., *Powers, Possessions and Freedom: Essays in Honour of C.B. Macpherson* (Toronto: University of Toronto, 1979) 39. See also Linda C. McClain, "'Atomistic Man' Revisited: Liberalism, Connection, and Feminist Jurisprudence" (1992) 65 S. Cal. L. Rev. 1171 at 1176.

¹⁰⁷ See Sherwin, *No Longer Patient*, *supra* note 80 at 179; Kathryn Pauly Morgan, "Contested Bodies, Contested Knowledges: Women, Health, and the Politics of Medicalization" in Susan Sherwin, ed., *The Politics of Women's Health: Exploring Agency and Autonomy* (Philadelphia: Temple University Press, 1998) 83 at 96-97 [Sherwin, *Politics*]; Siegel, *supra* note 31 at 284.

¹⁰⁸ See Susan Sherwin, "A Relational Approach to Autonomy in Health Care" in Sherwin, *Politics*, *ibid.* at 19; Bordo, *supra* note 100 at 71-97; Julia E. Hanigsberg, "Homologizing Pregnancy and Motherhood: A Consideration of Abortion" (1995) 94 Mich. L. Rev. 371 at 381-90.

¹⁰⁹ See Siegel, *supra* note 31 at 323-79.

¹¹⁰ See Martha Albertson Fineman, "Cracking the Foundational Myths: Independence, Autonomy, and Self-Sufficiency", 8 Am. U. J. Gender, Soc. Pol'y & L. 13 (2000) [Fineman, "Cracking the Foundational Myths"]; Martha T. McCluskey, "Subsidized Lives and the Ideology of Efficiency" (2000) 8 Am. U. J. Gender, Soc. Pol'y & L. 115; and Linda C. McClain, "Care as a Public Value: Linking Responsibility, Resources, and Republicanism" (2001) 76 Chi.-Kent L. Rev. 1673.

¹¹¹ See e.g. Sanger, "M is for the Many Things", *supra* note 49 at 31-40; Sanger, "Separating from Children" (1996) 96 Colum. L. Rev. 375 at 431-33 [Sanger, "Separating from Children"].

¹¹² The most notable example being Catharine MacKinnon.

this leads to a reluctance to focus on the notion of choice that fits so neatly into the liberal individualistic paradigm.¹¹³

For feminists, the threat of intervention in pregnancy raises the question of how best to protect women's decisional autonomy. Different branches of feminism approach this concern in distinct ways. Dominance feminists argue that women are not autonomous, that they cannot be autonomous under conditions of male domination. As a result, women either do not have options, or the options that they do have are constrained to such a degree that they simply choose what they are told they want by patriarchy. Women will not be able to become autonomous, to make authentic choices until they have more power, which can only occur when existing gendered hierarchies are dismantled. Pregnancy, like other reproductive rights issues, is a sex equality issue.¹¹⁴

Liberal feminists, on the other hand, assert that women are autonomous agents. They see women's subordination as stemming from unequal distribution of choices, rather than of power.¹¹⁵ In order to solve the problem of women's choices, we need only provide women access to the same options that men have always had. For these writers, traditional liberalism is quite obviously flawed as it deals with women's choices, but some liberal ideals, such as autonomy and decisional privacy, are essential, particularly in the context of women's reproductive decision-making. The problem lies in determining how to ensure that women retain authority and autonomy with respect to their pregnant bodies and, at the same time, to avoid the labelling of everything to do with pregnancy (especially domestic violence related to pregnancy) as "private" and therefore beyond government intervention.¹¹⁶ For both liberal and dominance feminists, the bottom line is the same: the pregnant woman must be the one to decide what will be done with and to her body.¹¹⁷

¹¹³ For an interesting argument that the liberal notion of privacy is not an individual right at all, but a relational right, see Radhika Rao, "Reconceiving Privacy: Relationships and Reproductive Technology" (1998) 45 UCLA L. Rev. 1077.

¹¹⁴ See Catharine A. MacKinnon, *Toward a Feminist Theory of the State* (Cambridge, Mass.: Harvard University Press, 1989) at 246.

¹¹⁵ This is, of course, an oversimplified recitation of the liberal feminist position, to the extent that such a position can be said to exist. Many feminists advocate liberal solutions to problems caused by women's subordination, but do so recognizing that the dominance feminist critique gets a lot of things right.

¹¹⁶ Of course, simply adopting an important role for privacy in decision-making does not mean that libertarian ideals of non-interference by government must necessarily go along. See e.g. Linda C. McClain, "Reconstructive Tasks For a Liberal Feminist Conception of Privacy" (1999) 40 Wm. & Mary L. Rev. 759; Anita L. Allen, "The Proposed Equal Protection Fix for Abortion Law: Reflections on Citizenship, Gender, and the Constitution" (1995) 18 Harv. J. L. & Pub. Pol'y 419 at 421; Anita L. Allen, "Coercing Privacy" (1999) 40 Wm. & Mary L. Rev. 723.

¹¹⁷ This brief discussion does not begin to do justice to the feminist literature on women's decisions around child-bearing and child-rearing. For example, Martha Fineman advocates for the wholesale

An important question remains: is the liberal commitment to individualism at the root of the law's problems with pregnancy, or is the law's apparent inability to cope with pregnancy a result of patriarchal (but not necessarily liberal) constructions of women and women's social roles?¹¹⁸ If it is the former, then liberalism cannot hold a solution. In any case, any response to the problem of pregnancy intervention, liberal or otherwise, must be a feminist one. This seems intuitively correct, in that pregnancy is a potentially transformative experience¹¹⁹ that a majority of women will themselves undergo. But more importantly, a feminist response is imperative because no theory having to do with pregnancy can be legitimate unless it is attentive to women's experience.¹²⁰

1. Framing a Feminist Response

Pregnancy has long been a popular topic for feminist writers, but to date none has sketched out a theoretical framework for dealing with decision-making in the context of a pregnancy that will be carried to term. This stems in part from the fact that for the past several decades, *the* issue for feminism with respect to pregnancy has been abortion.¹²¹ A more recent reason for feminist neglect of the question of decision-making in pregnancy is the ongoing technological revolution in reproduction. The increased availability of technologies to assist in various aspects of the reproductive process (as well as the genetics issues that have arisen concurrently) have given rise to myriad concerns for feminist legal scholars.¹²² This, therefore, is where feminist writers have concentrated their efforts in relation to reproductive rights.

In addition, feminists have been reluctant to take on the question of decision-making in pregnancy where the decision in question is *not* whether to have an abortion, because of the underlying uneasiness that if we are going to think about a pregnancy that will not be terminated, we must also think about intrauterine life,¹²³ an

reconceptualization of family law: *The Neutered Mother, The Sexual Family and Other Twentieth Century Tragedies* (New York: Routledge, 1995) [Fineman, *The Neutered Mother*].

¹¹⁸ See e.g. Siegel, *supra* note 31.

¹¹⁹ Nedelsky, *supra* note 106.

¹²⁰ The importance of defining pregnancy in relation to women's experience is discussed further in section III.B., below, with respect to the role of externally imposed norms on the pregnancy relationship.

¹²¹ See e.g. Sanger, "M Is for the Many Things", *supra* note 49 at 23-24 (suggesting that the focus of feminist legal writing on abortion and child custody has circumscribed discussion of motherhood in feminist literature).

¹²² These concerns include the routinization of prenatal diagnosis, medicalization of pregnancy, issues in gestational motherhood, and embryo donation. See generally Callahan, *supra* note 10; Hanigsberg & Ruddick, *supra* note 12; Gallagher, "Fetus as Patient", *supra* note 11; Rothman, *Recreating Motherhood*, *supra* note 11; Woliver, *supra* note 11 at 346; Rayna Rapp, *Testing Women, Testing the Fetus: The Social Impact of Amniocentesis in America* (New York: Routledge, 1999) [Rapp, *Testing Women*].

¹²³ Hanigsberg suggests this term for two reasons: first, to include both embryonic and fetal stages of development and, second, to "complicate the analysis of pregnancy without falling into the rhetoric

issue from which feminist legal scholars have largely recoiled. As Julia Hanigsberg articulates, the refusal by feminists to engage on the question of the value and meaning of intrauterine life has meant that we have ceded the moral “high ground” to the pro-life side of the debate.¹²⁴ It is also troubling because it denies the way that many women—including feminists—feel about intrauterine life.¹²⁵ Finally, the academic debate among feminist scholars with respect to procreative autonomy has focused on how women’s decisional authority during pregnancy is best safeguarded (i.e., by privacy doctrine, equality rights, or, as some have argued, both¹²⁶) and not about how it is best described.

Both liberal and dominance feminism make insightful contributions to the question of decision-making in pregnancy. These contributions are not without problems, however. There is an important limitation of the feminist work on pregnancy: it fails to consider how decision-making in pregnancy unfolds. From a broader feminist perspective, there are two distinct problems related to the language of choice. The first is how to ensure that women have choices. The second problem, which is not addressed in the literature, is what we understand by “choice” in the first place. Both the liberal and radical streams of feminism, in arguing about how to secure women’s choices, are talking about choice in the same way that traditional liberalism conceives of it: the notion of rational action in relation to commensurable goods. It seems that in order to come up with a framework for decision-making in pregnancy, we need to look at choice in an entirely different light. In order to discredit the language of choice and its intuitive appeal,¹²⁷ we must recognize its use and the themes that provide a foundation for it. More significantly, we must begin to talk about what we mean by choices, not just about whether women do or do not have enough of them.

of the ‘pro-life’ movement and its emphasis on the rights of the ‘fetus’ ... as static and immutable” [citation omitted] (*supra* note 108 at 371, n. 3).

¹²⁴ *Ibid.*

¹²⁵ That this must be the case seems apparent from the number of women that feel absolutely committed to the right of a woman to choose abortion, but who feel strongly that abortion would not be the right choice for them personally. Moreover, most women grieve when they miscarry and often when they abort, regardless of the reasons motivating their decisions. See e.g. Rothman, *The Tentative Pregnancy*, *supra* note 101; Rapp, *Testing Women*, *supra* note 122 at 3-4; Leslie Bender, “Genes, Parents, and Assisted Reproductive Technologies: Arts, Mistakes, Sex, Race, & Law” (2003) 12 *Colum. J. Gender & L.* 1; Ilana Hurwitz, “Collaborative Reproduction: Finding the Child in the Maze of Legal Motherhood” (2000) 33 *Conn. L. Rev.* 127.

¹²⁶ Allen, *supra* note 116 at 421. See also Morgan, *supra* note 52; Smith, *supra* note 52.

¹²⁷ There is a tension in this argument, that runs throughout the paper, in regard to the simultaneous critique of choice language and its use. When I talk about discrediting the language of choice, I mean the language as used to justify intervention in pregnancy. An interesting question for future consideration is how best to deal with this tension.

B. Reconceiving Choice: Imagining Alternative Ways of Reasoning About Decision-Making in Pregnancy

I have argued that it is time to abandon (at least temporarily) arguments about the quantity and quality of women's choices and to reflect instead on the notion of choice itself, on what we mean when we speak of individuals making choices. In *Value in Ethics and Economics*,¹²⁸ Elizabeth Anderson has posited what might be termed a relational model of choice.¹²⁹ She labels her theory an "expressive" theory of rational choice. This theory looks promising as a framework through which we can reason about decision-making in pregnancy, both because of what it has to say about our understandings of choices and what they mean to the "chooser", and because of its emphasis on the role of social norms in relation to the expression of choice.

Anderson rejects consequentialist models of rational choice and practical reason on the basis that such theories, unlike her expressive model, do not permit recognition of the plurality of goods and the ways in which we value them. As she explains:

People experience the world as infused with many different values. Friendships can be intimate, or merely convenient, charged with sexual excitement, or mellow. A subway station can be confining, menacing and dumpy, or spacious, welcoming and sleek. When people attribute goodness or badness to some thing, person, relationship, act or state of affairs, they usually do so in some respect or other: as dashing, informative, or tasty, delightful, trustworthy or honorable, or as corrupt cruel, odious, horrifying, dangerous, or ugly. Our evaluative experiences, and the judgments based on them, are deeply pluralistic.¹³⁰

According to Anderson, goods, and the ways in which we value them, are also incommensurable, not comparable in an ordinal fashion. In other words, goods and our ways of valuing them are qualitatively, not just quantitatively, different. Anderson also argues that our valuations are socially mediated, in that they are dependent on social norms. In order to value something, we have to participate in a social process of valuation; this process is governed by norms that guide the sensible (i.e., sensible to others) expression of our valuations.

¹²⁸ This brief discussion of Anderson's theory draws on the ideas set out in the first four chapters of *Value in Ethics and Economics*. See Elizabeth Anderson, *Value in Ethics and Economics* (Cambridge, Mass.: Harvard University Press, 1993) at 1-90.

¹²⁹ Anderson's theory is relational in the sense that it sees relationships as central, as forming the context within which values are expressed.

¹³⁰ Anderson, *supra* note 128 at 1. As Gillian Hadfield notes,

Anderson argues that we value things or states of affairs in multiple ways. Love is a way of valuing something or someone; respect is another; revulsion another. These modes of valuation are not merely poetic terms for "more" and "less." Rather, they relate to distinctive human experiences and, importantly, to social concepts of valuation (Gillian K. Hadfield, "An Expressive Theory of Contract: From Feminist Dilemmas to a Reconceptualization of Rational Choice in Contract Law" (1998) 146 U. Pa. L. Rev. 1235 at 1258).

Anderson claims that an expressive theory of rational action defines rational action as that which adequately expresses “one’s rational attitudes [or valuations] toward the people and things one cares about.”¹³¹ Things are valuable if it is rational for people to value, or assume a favorable attitude toward them. Adequate valuation of things involves the expression of one’s valuations in a social way; thus, a publicly intelligible vehicle is needed through which to express one’s rational attitudes. When I value something, or have an “evaluative attitude toward” it, I, in turn, govern the way I act in order to express that value through social norms that communicate meaning to others.

Because of the focus on acting in accordance with social norms, Anderson notes that her theory might be called conventionalist (i.e., it defines appropriate action based on consistency with prevailing norms). She says that this is not the case—her theory does not necessarily endorse all existing norms; rather, it allows for criticism of norms where they do not provide adequate vehicles for expression of attitudes. Her point in emphasizing the importance of social norms is that the theory is “anti-individualist”, as it claims that individuals need a social context in which to express their attitudes.¹³² If society lacks norms that allow its members to express their attitudes adequately, then the solution is to invent and institute such norms.

The expressive theory of rational action, unlike consequentialist theories,¹³³ distinguishes between two kinds of “ends”: first, the people, animals, and things it makes sense for us to value in and of themselves (intrinsically valuable things) and second, the states of affairs we hope to bring about by our actions. Usually, states of affairs are only extrinsically valuable; that is, they have value to us only because of some effect they will have in relation to intrinsically valuable goods: people, animals, and things that we value in and of themselves. The main task of a rational choice theory is to select the action it makes the most sense for a person to perform. Consequentialist theories would define this in terms of the end of realizing a valuable state of affairs; choices are rational when they bring about valued states of affairs. From a consequentialist point of view, if a woman wants to have a child, the decision to become or remain pregnant is rational. The state of affairs she desires (having a child) will be achieved through the decision to become pregnant. For the woman who desires to have a child, the rational thing to do is attempt to conceive. Conversely, it would be irrational—because it would not bring about the desired state of affairs—to continue to use birth control.

¹³¹ Anderson, *ibid.* at 19. By intrinsically valuable, Anderson means people, animals, or things that we value in and of themselves. She contrasts intrinsically valuable goods with extrinsically valuable goods, which are things (like states of affairs) that we value because of their meaning in relation to a particular intrinsically valuable good.

¹³² *Ibid.* at 18.

¹³³ In this paper, I use the phrase “consequentialist theories” to refer to consequentialist theories of rational choice, not consequentialist theories generally.

Anderson's expressive theory, by contrast, gives an alternative basis for ranking actions besides the value of their consequences, as it recognizes that rational action has dual ends: (i) it brings about states of affairs and (ii) it can be done for the sake of people and things we rationally care about. From Anderson's point of view, there are explanations for attempting to become pregnant other than the desire to have a child. A woman might become pregnant for the straightforward reason that she desires a child, or she might become pregnant for a variety of other reasons.¹³⁴ Consequentialist theories are not interested in these other reasons, but the expressive theory is.

Gillian Hadfield has built upon Anderson's expressive theory of rational action and has argued that the theory calls into question some foundational assumptions in contract law.¹³⁵ Hadfield understands Anderson's theory to be a basis on which choice in contract law, and contractual obligation itself, can be reconceptualized. Anderson's theory admits of a possibility quite foreign to conventional contract logic—that the "chooser" based her assessment of the options not on what future state of affairs each might secure, but on what the choice would express.¹³⁶ Conventional logic would view a choice to enter into a contract at this point in time as necessarily indicating a choice among *future* states of affairs. For Hadfield, Anderson's theory shows that what the chooser has really done is indicate a preference among *current* states of affairs. The choice has future consequences only to the extent that the law assigns them. As she explains:

Analytically, Anderson's challenge to conventional rational choice theory raises a question that conventional contract logic thinks it has answered, namely, why does a person's choice at one point in time determine her legal obligations at another point in time? Why does a choice in contract have legal significance? It cannot be, after Anderson, simply because the law is a neutral arm of the state, handing out to contractors what they have asked for.¹³⁷

Although I have argued that pregnancy cannot and should not be analogized to consent-based relationships recognized by the law, such as contractual relationships, Hadfield's discussion of expressive choice in the contract context is useful here because it provides a clear illustration of issues that arise from law's views on the binding nature of choice and of the problems with these traditional views as highlighted by a feminist critique.

Hadfield builds on Anderson's theory in relation to the feminist dilemma of choice, or "the conflict between promoting women's autonomy and freedom of choice

¹³⁴ See notes 185-87 and accompanying text.

¹³⁵ Hadfield, *supra* note 130.

¹³⁶ *Ibid.* at 1237.

¹³⁷ Hadfield notes that this implies that legal reasoning in contract must identify reasons "beyond the bare fact that a choice to enter a contract has been made, for attaching legal significance to this particular exercise of choice" (*ibid.* at 1238). She then goes on to identify these additional reasons as the protection of reasonable reliance interests and the importance of protecting an instrumentally valuable convention.

on the one hand, and protecting women from the harmful consequences of choices made under conditions of inequality on the other.”¹³⁸ The significance of Anderson’s theory is that it provides a way out of the feminist dilemma “by providing a foothold to a contract logic that does not see the decision to refrain from implementing a person’s earlier choice as a failure to respect her autonomy.”¹³⁹ Hadfield’s account of choice, unlike that of traditional contract law, recognizes the complexity of contractual choice. She wonders:

Who are these people who populate the economist’s ... imaginatio[n], who calmly assess the alternatives available according to a stable set of internally consistent preferences and proceed to select the obvious choice, who apparently feel no passion or emotion, who do not worry about whether they are choosing well, who never feel trapped by their choices, and who never discover over time more about themselves and their understanding of their choices? Where is love, duty, fear, self-doubt, and power?¹⁴⁰

Hadfield is addressing contract law, but her description of the materiality of choice and of the individual peculiarities that inform our choices seems well-suited to consideration of decision-making in pregnancy. Choices made in the context of pregnancy, far more than choices made in most contractual contexts,¹⁴¹ involve women’s most fundamental and closely-held values, and implicate the notion that our understandings of our choices and our selves change over time.¹⁴² A pregnant woman is engaged in the process of bringing new and dependent life into the world, a life for which she will in all likelihood bear primary responsibility.¹⁴³ In the course of pregnancy, women’s bodies and psyches are both transformed.¹⁴⁴ It might be less odd to think that a woman’s self-perception and understanding of her choices will be radically altered during pregnancy than to assume that they will remain static.

In light of the significance that choice has for the law, Anderson’s theory has relevance in relation to the use of choice language in law beyond the sphere of contract. The expressive choice model seems particularly apposite as a tool through

¹³⁸ *Ibid.* at 1238.

¹³⁹ *Ibid.* at 1258.

¹⁴⁰ *Ibid.* at 1257.

¹⁴¹ Nevertheless, the contexts Hadfield describes—surrogacy contracts, marital separation agreements, and spousal guarantees—do share some of the complexity that characterizes decision-making in pregnancy.

¹⁴² Such choices in pregnancy are also far more public than are most exercises of contractual choice. The public nature of pregnancy is another important reason why women’s choices come under scrutiny in the media and in popular culture: see Duden, *supra* note 10 at 50-55. For a discussion of the interplay of popular culture and abortion rhetoric in the late 1970s and early 1980s, see Celeste Michelle Condit, *Decoding Abortion Rhetoric: Communicating Social Change* (Urbana, Ill.: University of Illinois Press, 1990) at 123-46.

¹⁴³ See e.g. Williams, *supra* note 46 at 1595-99; Sanger, “M Is for the Many Things”, *supra* note 49 at 25; Sanger, “Separating from Children”, *supra* note 111 at 483.

¹⁴⁴ See Adrienne Rich, *Of Woman Born: Motherhood as Experience and Institution* (New York: Norton, 1986) at 63-64, 67.

which choice in pregnancy can be explored, and perhaps understood. In addition, the expressive theory's emphasis on the social nature of valuation is key with respect to societal perceptions of both pregnancy and pregnant women. As Anderson explains, rational choice, in the expressive theory, requires vehicles for the expression of choice; these vehicles are social norms. Anderson is careful to point out that her theory does not call for unreflective devotion to norms. Where existing norms are not adequate as modes for expression of rational attitudes, the theory allows for criticism of social norms. Few relationships are marked by such injurious norms as those that surround pregnancy.

1. The Role of Norms: Pregnancy and Motherhood

As previously stated, part of the reason for the law's difficulty in dealing with pregnancy is its inability to fit pregnancy neatly (or at all) into an existing legal category. One response to this problem has been to conflate pregnancy and motherhood. Rather than refer to a pregnant woman, the law refers to a mother. This is nowhere more remarkable than in the abortion regulation cases. Even in referring to women who are making the choice not to become mothers, the courts adopt this language.¹⁴⁵ The abortion cases are not the only example, however, as Hanigsberg explains:

No rhetorical differentiation is made between the pregnant woman's status before and after birth. ... In [so-called fetal protection cases] courts have referred to having nothing stand between a fetus and its "mother" but a scalpel; they have expressed a willingness to infringe upon the "mother's" "wishes" to benefit the "child"; they have described transfusions as being given to the "mother" in the case of a woman who was 18 weeks pregnant; and they have described the actions of a pregnant woman that a court deemed to be dangerous to the intrauterine life as the "mother's" conduct.¹⁴⁶

Constitutive of the problem that has led to state intervention in pregnancy is society's unwillingness to trust women to make appropriate procreative choices.¹⁴⁷ In Justice White's dissenting reasons in *Doe v. Bolton*,¹⁴⁸ he claims that the court's abortion jurisprudence demonstrates that "[d]uring the period prior to the time the fetus becomes viable, the Constitution of the United States values the convenience,

¹⁴⁵ See Hanigsberg, *supra* note 108 at 394, n. 101. In *R. v. Morgentaler*, *supra* note 53, the decision that struck down the Canadian Criminal Code provisions prohibiting abortion, the Canadian Supreme Court did not, for the most part, refer to the pregnant woman as "mother". In *Tremblay v. Daigle*, *supra* note 88, a case questioning the right of a "father" to enjoin a pregnant woman from obtaining an abortion, the only places the word "mother" appears is in the headnote to the decision (added by the legal editors at the Court) and in quoted passages.

¹⁴⁶ *Ibid.* at 394-95 [footnotes omitted]. An interesting and complicating factor here is that many pregnant women consider themselves to be mothers, and view their choices in pregnancy as mothering choices.

¹⁴⁷ Reilly, *supra* note 53 at 799. See also Petchesky, *supra* note 10.

¹⁴⁸ *Supra* note 53.

whim, or caprice of the pregnant mother [sic] more than the life of the fetus.”¹⁴⁹ Referring to this comment, Elizabeth Reilly notes the “vicious but effective attack on women as decisionmakers ... No one challenges the presumption that women are bad decision makers unless they are fulfilling the role of self-sacrificing mother.”¹⁵⁰

In order to resolve the problem of intervention in pregnancy, it is essential to first reveal the law’s failure to respect women’s capacity to make procreative decisions. Society (and hence the laws that reflect its views) does not trust women to make appropriate decisions in the context of procreation.¹⁵¹ This is the problem at the root of the perceived need for legal intervention; because pregnant women are constructed as mothers, hospitals, health care providers, and judges at a very fundamental level distrust women’s decisions, unless those decisions accord with fulfillment of the role of “self-sacrificing mother”.

Anderson makes explicit in her theory the centrality of norms as vehicles for the expression of value. Any attempt to argue that Anderson’s theory provides a credible model through which to understand pregnancy must therefore concern itself with the norms surrounding pregnancy. And the norms of pregnancy supply substantial cause for concern.¹⁵² As numerous feminist writers have illustrated, the norms that prescribe behaviour in pregnancy have developed out of patriarchal (and racist) ideas about pregnancy¹⁵³ and women’s roles.¹⁵⁴ These norms are found at the convergence of those relating to gender status, age, race, class, and motherhood.¹⁵⁵ The multiple sources of idealized pregnant behaviour serve to immeasurably complicate societal ideas about how pregnant women ought to behave. The ideal pregnant woman,¹⁵⁶ like

¹⁴⁹ *Ibid.* at 221.

¹⁵⁰ Reilly, *supra* note 53 at 778 [footnotes omitted]. See also Roth, *supra* note 6.

¹⁵¹ This is not the law’s only problem with pregnancy. As Barbara Katz Rothman points out, the law assumes that it is dealing with “atomistic, isolated” individuals, and pregnancy clearly belies this assumption. See Rothman, *Recreating Motherhood*, *supra* note 11 at 59.

¹⁵² It is worth mentioning that the very act of identifying that women’s behaviour is measured against norms is key. As Kathryn Abrams comments in “From Autonomy to Agency: Feminist Perspectives on Self-direction” ((1999) 40 *Wm. & Mary L. Rev.* 805 at 825-26), we need first to figure out that the norms we need to redefine are in fact norms that are transmitted to us through social institutions and practices, and not simply part of our own attitudes or self-definition.

¹⁵³ Ikemoto, *supra* note 3 at 1209-22. See also Dorothy E. Roberts, who asserts that the contours of the notion of “motherhood” are cast on the basis of race and gender: “Patriarchy does not treat Black and white motherhood identically” (“Racism and Patriarchy in the Meaning of Motherhood” (1993) 1 *Am. U. J. Gender & L.* 1 at 6 [Roberts, “Racism and Patriarchy”]).

¹⁵⁴ Siegel, *supra* note 31.

¹⁵⁵ Siegel, *ibid.* at 279, 372. See also Hanigsberg, *supra* note 108 at 374, 391-92.

¹⁵⁶ See Siegel, *ibid.* at 328, 342, nn. 333, 335, 343-44, 346-47, 373, 441-42; Ikemoto, *supra* note 3 at 1221-35; Sanger, “M Is for the Many Things”, *supra* note 49 at 19, 33, 35-36, 40; Marie Ashe, “Zig-Zag Stitching and the Seamless Web: Thoughts on ‘Reproduction’ and the Law” (1989) 13 *Nova L. Rev.* 355 [Ashe, “Zig-Zag Stitching”].

the ideal mother, is white,¹⁵⁷ middle class,¹⁵⁸ married,¹⁵⁹ hetero (but not sexual),¹⁶⁰ mature¹⁶¹ yet not middle-aged, and passive.¹⁶² The prescription for women's behavior in pregnancy—like their behaviour in motherhood—is self-sacrifice: the actions of the ideal pregnant woman reflect her complete devotion to the potential life she carries.¹⁶³ Departure from this ideal on any metric is less than desirable; departure on many levels is seriously problematic and may lead to attempts toward legal enforcement of the norms. In enforcing behavioural norms in pregnancy, courts are simply trying to manoeuvre the individual pregnant woman before them closer to the ideal. Those women who are prosecuted, detained, and punished are those who differ from the ideal. Indeed, it is inevitably those women who depart from the ideal, especially along race and socio-economic status lines, whose behaviour garners judicial disapproval.¹⁶⁴

Historically, the norms of pregnancy required less of women than they do now, and while potentially the site of social disapproval, they did not subject women to legal sanctions.¹⁶⁵ As for current ideals, a pregnant woman who seeks to conduct herself in

conformity with such norms will find herself making daily judgments as she attempts to accommodate her life to the process of making life: choices about what to eat and drink, about how to exercise, about securing appropriate medical care, and about negotiating quotidian forms of risk associated with travel, leisure activities, and the work she performs on the job and at home.¹⁶⁶

The norms of pregnancy do not, to borrow Anderson's phrase, provide "adequate" vehicles for expression of attitudes. The first problem is that these norms permit only one type of attitude toward pregnancy and fetal life—a loving, unselfish

¹⁵⁷ See e.g. Roberts, "Racism and Patriarchy", *supra* note 153; Dorothy E. Roberts, "Punishing Drug Addicts Who Have Babies: Women of Color, Equality, and the Right of Privacy" (1991) 104 *Harv. L. Rev.* 1419 [Roberts, "Punishing Drug Addicts"]; Ikemoto, *supra* note 3.

¹⁵⁸ *Ibid.*

¹⁵⁹ *Ibid.*

¹⁶⁰ See Rich, *supra* note 145 at 183-84. Rich describes one effect of male culture as wedging motherhood and sexuality "resolutely apart". In a widely publicized San Diego case, Pamela Rae Stewart was charged in the death of her newborn son for, *inter alia*, having sexual intercourse with her husband: see Gallagher, "Collective Bad Faith", *supra* note 10 at 344.

¹⁶¹ Bergum, *supra* note 11 at 117, 131. Bergum notes that society does not see the teenage years as an appropriate time for pregnancy.

¹⁶² Reilly, *supra* note 53 at 802.

¹⁶³ And, because of the physical dependency of the fetus on the pregnant woman, the norms arguably require more restrictions on the behaviour of pregnant women than of mothers. For example, mothers who drink alcohol "responsibly" are not criticized as much as pregnant women who drink at all.

¹⁶⁴ See e.g. Roberts, "Punishing Drug Addicts", *supra* note 157; Lynn M. Paltrow, "Punishment and Prejudice: Judging Drug Using Pregnant Women" in Hanigsberg & Ruddick, *supra* note 12; Susan C. Boyd, *Mothers and Illicit Drugs: Transcending the Myths* (Toronto: University of Toronto, 1999) at 9 (arguing that poor women and women of colour are especially excluded from the motherhood ideal).

¹⁶⁵ See Epstein, *supra* note 85 at 145.

¹⁶⁶ Siegel, *supra* note 31 at 373.

one. The second is that they look to an exceptionally restricted list of behaviours as conforming to modes of properly expressing that type of value. There is no room in the norms of pregnancy (or motherhood,¹⁶⁷ with which pregnancy is identified) for a woman to feel anything other than unconditional and selfless love toward her potential offspring.¹⁶⁸ But even the woman who does feel that way toward her fetus is caught by the norms of pregnancy: we assume that if a pregnant woman truly values her fetus, she will act in accordance with the norms. But because the norms of pregnancy are so unforgiving, there is much room for a pregnant woman to love, respect, and otherwise positively value her fetus and yet not behave in the normatively prescribed manner. When a pregnant woman is faced with a choice between consenting to a risky medical procedure that she opposes for deeply-held religious reasons, and risking the life or health of her fetus, the clear expectation is that she will opt for the former, whatever its cost to her.¹⁶⁹ If she fails to meet this expectation, fails to live up to the norms of pregnancy, she is accused of being selfish, irrational, or ambivalent about the pregnancy.¹⁷⁰

The norms of pregnancy are harmful for a number of reasons. The first is the fact that they are essentializing,¹⁷¹ in that they take for granted the fact that there is one

¹⁶⁷ See generally Rich, *supra* note 144 at 21-40.

¹⁶⁸ Pregnancy, for most women, is an emotionally and physiologically intense time, which leaves a lot of room for them to be ambivalent about how they feel, perhaps afraid to connect strongly with the fetus too early on, recognizing that it cannot be taken for granted that the end result of pregnancy is always the birth of a healthy child. See e.g. Bender, *supra* note 125; Hurwitz, *supra* note 125; Sherwin, *No Longer Patient*, *supra* note 80 at 101-102.

¹⁶⁹ As Janet Gallagher remarks, most women do act in this manner; it is rare for women to refuse medical treatment for the benefit of the fetus, even at a risk to themselves. Gallagher notes that physicians often have to discourage women from seeking out unproven procedures: Gallagher, "Prenatal Rights", *supra* note 4 at 13. See also Rhoden, *supra* note 12 at 1959.

¹⁷⁰ Phelan, *supra* note 71 at 462-63: "The reasons for maternal refusal vary, but can include an underlying fear of surgery ... religious grounds, inadequate cesarean facilities in the woman's country of origin, or latent reasons such as an unplanned pregnancy" [emphasis added]. See also Annas, *supra* note 12; Flora Scrimgeour, "Seth" in Jane Haynes & Juliet Miller, eds., *Inconceivable Conceptions: Psychological Aspects of Infertility and Reproductive Technology* (Hove: Brunner-Routledge, 2003) 109. Scrimgeour describes her experience of her pregnancy, which was conceived via IVF/ICSI using donated eggs from her sister, in the context of her first pregnancy, which led to the birth of a stillborn daughter. Scrimgeour explains:

I could not commit to this miracle pregnancy fully. I spent the time in a stupid mess, periodically committing all the crimes of pregnancy—heavy drinking, smoking, eating forbidden food, etc. This was a pathetic way to behave, but it was a reaction to our history. I had behaved immaculately during the Dora pregnancy and I was incapable of doing it again (*ibid.* at 116).

This is not a story of a woman ambivalent about her pregnancy; it is the story of a woman who had tried ARTs, with no success for four years, who twice became pregnant spontaneously (the second pregnancy ended in a miscarriage at twelve weeks) and who simply could not believe that this pregnancy had the potential to succeed.

¹⁷¹ For a discussion of maternal essentialism, see Sanger, "M Is for the Many Things", *supra* note 49 at 31-40.

right “pregnant” way for all pregnant woman to feel about their fetuses and to act in expressing their feelings. The norms thus set up a “good” versus “bad” pregnant woman dichotomy, and define only two modes of action: selfishness or sacrifice. When a woman acts outside of the norm, she is perceived to express something other than a positive value toward her fetus. This alone amounts to a failure of the pregnancy norms as adequate vehicles for the expression of values. They are not nuanced enough to capture the wide range of attitudes women may have toward pregnancy itself or the expression of values that they hold in relation to pregnancy and their potential offspring. That is, women may value pregnancy and fetal life in different ways and they may also have distinct ways of expressing the same values. The idealized behaviours reflected in the pregnancy norms embrace none of this variance.

Second, the norms—at least in terms of how they come to be cast in legal discourse—lead us to focus too narrowly on the woman. We tend to turn the “legal gaze” away from the woman’s circumstances in general and look at her behaviour out of context and in relation only to the fact of her pregnancy at a particular moment in time.¹⁷² We expect a pregnant woman to obtain appropriate prenatal care and to ensure that she is getting proper nutrition for the benefit of her fetus; when she does not, we measure her (inevitable) failure against the norm. Yet we do not inquire whether she has medical insurance, whether she can afford prenatal care or proper nutrition,¹⁷³ whether her failure to obtain these goods is a result of her life in poverty and an attempt to deny her own needs in favour of those of her children.¹⁷⁴ The pregnant woman may be caught up in trying to take care of herself, her children, her spouse, or her parents,¹⁷⁵ she may have limited resources with which to express much of anything toward the fetus she is carrying. Measured against the norms of pregnancy, this woman’s choices might fall far short, but that in no way indicates that the choices she has made (or, perhaps, has *had* to make) reflect negative valuations of her pregnancy and her potential child. The defect inheres in the societal attitudes constitutive of the norms, not in the pregnant woman.

The norms are also injurious because they inappropriately categorize women into archetypes: good, white, middle class, married mothers versus bad, black, poor, unmarried mothers.¹⁷⁶ The norms of motherhood are clearly at play here with respect

¹⁷² Baylis, *supra* note 21 at 791.

¹⁷³ See e.g. Lynn McIntyre *et al.*, “Do Low-Income Lone Mothers Compromise Their Nutrition to Feed Their Children?” (2003) 168:6 C.M.A.J. 686 at 686 (concluding that low-income single mothers “compromise their own nutritional intake in order to preserve the adequacy of their children’s diets”).

¹⁷⁴ For discussions of mothers and poverty (particularly single mothers and women of colour), see Paltrow, *supra* note 164; Fineman, “Cracking the Foundational Myths”, *supra* note 110; Martha Albertson Fineman, “Images of Mothers in Poverty Discourse”, in Fineman & Karpin, eds., *supra* note 11, 205 [Fineman, “Images”]; Roberts, “Racism and Patriarchy”, *supra* note 157 at 22-29.

¹⁷⁵ See e.g. Fineman, “Cracking the Foundational Myths”, *ibid.*, and Fineman, “Images”, *ibid.* (discussing the idea of “inevitable dependencies”).

¹⁷⁶ See e.g. Ikemoto, *supra* note 3; Roberts, “Racism and Patriarchy”, *supra* note 157.

to pregnant women.¹⁷⁷ These norms seek to direct those who fit the “good” mother caricature to become mothers and to discourage from becoming mothers—and even punish—those who fit the “bad” mother norm.¹⁷⁸ This is made strikingly plain in the disproportionate overrepresentation of women of colour and poor women in cases of intervention in pregnancy.¹⁷⁹

At a minimum, Anderson’s theory makes it clear that we need to reconceive existing norms having to do with choice and pregnancy. The process of reconceptualization requires that we acknowledge the existence of these norms, and that we discredit them, as I have attempted to do here. It is especially important that policy-makers and lawmakers understand that the norms applied to pregnancy are inadequate to the task of reflecting the diversity of values that may be engaged by women’s choices during pregnancy. We need to recognize the pluralistic nature of these values, and realize that we do not currently have vehicles that adequately explain what a particular woman means to express when she makes a particular choice in the context of her pregnancy. We need to afford all women the space to experience pregnancy in their own way, understanding that pregnancy will be experienced differently by different women and even by the same woman at different points in a pregnancy, or in different pregnancies.¹⁸⁰ Ultimately, this process will permit the evolution of new norms that will enable women to express their complex attitudes toward intrauterine life. Until we are able to reconceive the norms we apply to women’s behaviour in pregnancy, it will be difficult to succeed in convincing society that it (and the law) is looking at pregnancy in the wrong way. This is not an easy project and may not lend itself to consensus, but that in itself should indicate how completely wrong-headed current attempts at legal regulation are. If we doubt that women can come to a common understanding about the meaning of choices made during pregnancy, we must at least recognize that pregnancy is a context in which women have to be trusted to make their own “mortal decisions”.¹⁸¹

2. Expressive Choice in Pregnancy

Anderson’s expressive choice theory explains that we need to concern ourselves with the meaning of choices to the person making them. As has been articulated in the foregoing section, the meaning of choices made during pregnancy can be obscured by the inadequacy of the norms applied to the behaviour of pregnant women. Having

¹⁷⁷ Hanigsberg, *supra* note 108.

¹⁷⁸ See Roberts, “Punishing Drug Addicts”, *supra* note 157; Roberts, “Racism and Patriarchy”, *supra* note 153; Paltrow, *supra* note 164; Ikemoto, *supra* note 3.

¹⁷⁹ *Ibid.* See also Rodgers, “Legal Regulation”, *supra* note 14 at 354; Kolder, Gallagher & Parsons, *supra* note 17.

¹⁸⁰ Shanner, *supra* note 12.

¹⁸¹ Ashe, “Zig-Zag Stitching”, *supra* note 156 at 383: “I want a law that will let us be—women. That, recognizing the violence inherent in every regulation of female ‘reproduction,’ defines an area of non-regulation, within which we will make, each of us, our own ‘mortal decisions.’”

observed how the norms work, or more accurately, fail to work, we must look behind them in order to consider the complexities of the decisions pregnant women make. In other words, the problem of choice in pregnancy, seen through the lens of Anderson's theory, is multilayered, entailing an attempt to attend to what the particular choice means to the particular pregnant woman making it, as well as recognition that because we do not have adequate vehicles through which women may express their choices, what we think a woman means might not be what she intends to express in making a given choice.

Contract law, in its conventional form, is concerned with instrumental choices; choices directed at particular ends. As Hadfield points out, Anderson's theory requires a shift in focus away from explanation of choices solely in relation to their instrumentality, toward the broader dimensions of the choice. Specifically, the theory directs our attention to the meaning of the choice to the chooser, as opposed to the consequences that the chooser may (or may not) desire to result from the choice.¹⁸² In other words, following Anderson's ideas, we must think differently about the reasons for making a particular choice. It could be that the choice was made because of its known and desired consequences, or it could be that the choice was made because of what the act of choosing expressed, or meant to the chooser. The notion of choice in pregnancy has an added dimension: even if the choice to become or remain pregnant is instrumental, in that the reason for the choice, and its desired outcome, is the birth of a child, it does not necessarily follow that another consequence (the socially and sometimes legally required one)—that the woman will give herself over entirely to the needs of her potential child, that she will accept medical treatment with respect to which she has significant reservations—is equally desired.

In this light, Hadfield's observations, albeit intimately related to contract law, are relevant to pregnancy. As she explains, Anderson's theory shows us that "[r]espect for the multiplicity of frames in which a decision to contract can be made often entails looking beyond the fact of choice to the complexity of what it means to choose."¹⁸³ This is particularly important in the context of pregnancy, itself a profound event in a woman's life. We need to ask: why does (or why should) the prior choice (in this case, the choice to become pregnant, or to reject abortion) have legal significance in connection to a later, unrelated choice? By focusing on the instrumental nature of choice, we can easily overlook the fact that the consequences of a choice are legal consequences, and not natural or biological consequences. The legal "consequences" of the "not abortion" choice—the forced Caesarean section or blood transfusion (or possibly, prenatal diagnostic test or fetal therapy)—exist only if the law says they do. This is what the Anderson/Hadfield model can help us to understand.

The expressive theory of rational choice requires us to ask not just *whether* a woman has chosen to become or remain pregnant, but *what it means to her to have*

¹⁸² Hadfield, *supra* note 130 at 1265.

¹⁸³ *Ibid.* at 1285.

done so. Did she become pregnant because of the demands of her religious beliefs? Perhaps her choice was a way in which she could express her love for her partner,¹⁸⁴ prove her value as a daughter or daughter-in-law, attempt to feel worthy as a woman,¹⁸⁵ express her desire to be depended upon, to be responsible for another life,¹⁸⁶ or because she thinks that raising children will bring her unparalleled joy. When we consider these possibilities, along with the myriad other beliefs that might motivate a woman to become or remain pregnant, we can begin to observe the specious nature of the arguments that claim that in choosing not to terminate her pregnancy, a woman has acquiesced to a set of legal duties to ensure that her child is born as healthy as is possible.¹⁸⁷ If legal duties are to be imposed on pregnant women, whether they entail refraining from consuming alcohol or consenting to a Caesarean section, then we need to be honest about the fact that these duties exist because the law says they do, and not because of the woman's decision to bear a child.¹⁸⁸ "We, as a community, cannot evade these difficult questions by foisting the answer off on the [woman's] choice."¹⁸⁹

Considering decision-making in pregnancy from an expressive choice point of view emphasizes both the unique and enigmatic nature of the relationship of woman to fetus, and of the pregnancy experience itself. Analyzing specific decisions in the context of pregnancy—for example, the decision whether or not to consent to prenatal testing—can help to tease out some of this complexity. Choices respecting prenatal testing provide a good example of the nuances involved in decision-making in pregnancy, because they are difficult, complicated, emotionally wrought decisions¹⁹⁰ and because, at least arguably, in most cases they involve the actual exercise of choice.

Maternal serum screening ("MSS"), a blood test that can indicate increased risk for certain heritable or genetic conditions,¹⁹¹ is offered to most pregnant women in

¹⁸⁴ Or to attempt to shore up a faltering relationship, see *e.g.* Ellen's story in Carol Gilligan, *In a Different Voice: Psychological Theory and Women's Development* (Cambridge, Mass.: Harvard University Press, 1982) at 87-88.

¹⁸⁵ Kristin Luker, *Taking Chances: Abortion and the Decision Not to Contracept* (Berkeley: University of California Press, 1975) at 66-68.

¹⁸⁶ See *e.g.* Gilligan, *supra* note 184 at 76; Luker, *ibid.* at 68; McClain, *supra* note 13.

¹⁸⁷ Robertson, "Procreative Liberty", *supra* note 26 at 438 [footnote omitted].

¹⁸⁸ As Hadfield puts it in the context of surrogacy contracts where the woman decides she does not wish to give up the child: "We must determine the implications of her changing choice and accept responsibility for the consequences imposed on her by the law" (*supra* note 130 at 1265).

¹⁸⁹ *Ibid.*

¹⁹⁰ See *e.g.* Rapp, *supra* note 122; Browner & Press, *supra* note 28; and Rayna Rapp, "XYLO: A True Story" in Rita Arditti, Renate Duelli-Klein & Shelley Minden, eds., *Test-Tube Women: What Future for Motherhood?* (London: Pandora Press, 1984) 313.

¹⁹¹ See *e.g.* Nicholas J. Wald, Wayne J. Huttly & Allan K. Hackshaw, "Antenatal Screening for Down's Syndrome with the Quadruple Test" (2003) 361 *Lancet* 835; James E. Haddow, "Antenatal Screening for Down's Syndrome: Where Are We and Where Next?" (1998) 352 *Lancet* 336; and

North America as a routine element of prenatal care.¹⁹² The test itself poses no risk to the pregnant woman or to the fetus, and its purpose is to determine whether further (diagnostic) testing is indicated. In general terms, if a woman has a "screen positive" result, she will be referred for amniocentesis, a diagnostic test¹⁹³ that will indicate whether the fetus in fact has the genetic condition that the screening test pointed to as an increased risk. Since there are currently no therapies available to cure these conditions,¹⁹⁴ a woman who has a positive diagnostic result (in other words, amniocentesis indicates that the fetus does in fact have the suspected genetic condition), will face a decision whether to continue with or terminate the pregnancy. A "screen negative" result means that the woman will not be referred for further testing. The MSS decision is particularly useful to consider from the expressive choice point of view, because it involves so many angles. Other prenatal tests, such as amniocentesis and chorionic villus sampling ("CVS"),¹⁹⁵ involve the risk of miscarriage and, possibly, of harm to the fetus,¹⁹⁶ and these risks are likely to be dominant considerations for women deliberating about testing. MSS, by contrast, poses no risk of physical harm to woman or fetus, rendering it at first blush a less difficult decision. But because it gives rise to the possibility that the woman will ultimately have to confront a decision about a more invasive test, with all of the

Joanne A. Permaul-Woods *et al.*, "Going the Distance: The Influence of Practice Location on the Ontario Maternal Serum Screening Program" (1999) 161 *Can. Med. Assoc. J.* 381-85.

¹⁹² According to Dr. Anne Summers, it is likely that all Canadian provinces offer some form of screening, but the majority do not offer province-wide programs: Personal Communication, Dr. Anne Summers, Clinical Geneticist, Genetics Program, director MSS/IPS programme, North York General Hospital, North York, Ontario. See also Rapp, *supra* note 120 at 30-31 and Nancy Press *et al.*, "Provisional Normalcy and 'Perfect Babies': Pregnant Women's Attitudes Toward Disability in the Context of Prenatal Testing" in Sarah Franklin & Helena Ragoné, eds., *Reproducing Reproduction: Kinship, Power and Technological Innovation* (Philadelphia: University of Pennsylvania Press, 1998) 46 at 47-48.

¹⁹³ Amniocentesis involves the extraction and chromosomal analysis of amniotic fluid (the fluid that surrounds the fetus) via the insertion of a hollow needle through the pregnant woman's abdominal wall and into her uterus. See Rapp, *supra* note 120 at 27.

¹⁹⁴ See *e.g.* Timothy Caulfield, "Liability in the Genetic Era: Wrongful Life and Wrongful Birth Lawsuits" (2000) 23 *J. S.O.G.C.* 143.

¹⁹⁵ CVS is a biopsy of the chorion, which is the tissue that will ultimately become the placenta. This test can be performed in the first trimester of pregnancy (as opposed to amniocentesis, which is generally not considered to be safe until the second trimester). CVS carries a greater risk of miscarriage than does amniocentesis. See *infra* note 197. See B.N. Chordirker *et al.*, "JOGC Clinical Practice Guidelines, Canadian Guidelines for Prenatal Diagnosis: Techniques of Prenatal Diagnosis" (July 2001), online: Society of Obstetricians and Gynaecologists of Canada <http://www.sogc.org/SOGCnet/sogc_docs/common/guide/pdfs/ps105b.pdf> ["JOGC Clinical Practice Guidelines"].

¹⁹⁶ Amniocentesis involves a risk of miscarriage of 0.5 to one per cent; the risk of miscarriage as a result of CVS is between one and six per cent depending on the method used. There is also a very minor risk of fetal harm as a result of amniocentesis, but serious fetal injury is rare. CVS is thought to carry a slightly higher risk of fetal facial or limb abnormalities. See "JOGC Clinical Practice Guidelines", *ibid.*

complex considerations that invasive testing presents, it is clearly not an easy decision to make.¹⁹⁷

When a pregnant woman decides not to have MSS,¹⁹⁸ her choice may be based on any number of reasons. She simply may not be concerned about whether the baby will be born with a genetic problem, may have no intention of terminating her pregnancy as a result of a positive diagnostic result, and may therefore feel that the information the MSS can provide her with is irrelevant. Alternatively, she might be afraid that learning of a positive screen result will lead to further testing, with its attendant risks to the fetus,¹⁹⁹ and she is not comfortable taking these risks, so prefers not to know of her risk assessment based on the MSS result. A woman might also fear that a positive screen result and diagnostic testing will inform her that the fetus she is carrying does, in fact, have a genetic problem and this information, in turn, will force her to confront a decision she cannot imagine making—whether to terminate this (otherwise wanted) pregnancy. Finally, the testing may come with a price tag, which she may not be able to afford.

A woman who decides to go ahead with MSS, on the other hand, might do so because she knows that without the test results, she will worry for the remainder of her pregnancy about whether something is wrong, and wants the reassurance a negative screen result will provide. Or, she might agree to the testing because she feels strongly that she does not want to bear and raise a child with disabilities resulting from a genetic condition, and so wants to learn what her risk is and whether further testing is indicated, so that she can go ahead and terminate her pregnancy if the fetus does have such a condition. Finally, a woman may accept the MSS because it is risk-free, and she feels that it will provide her the information she needs to go on and make a more informed choice about whether to have more invasive testing, such as amniocentesis.

The foregoing sets out some, but certainly not all, of the possible reasons a pregnant woman might have for declining or accepting prenatal testing, and prenatal testing is only one decision of many²⁰⁰ that women face in relation to pregnancy and

¹⁹⁷ Generally speaking, invasive testing such as amniocentesis and CVS are offered to pregnant women based on their age; traditionally those aged 35 or over are offered such testing. MSS is offered to all women to determine whether a woman, even under the age of 35 years, should be offered the diagnostic testing. See B.N. Chordirker *et al.*, "SOGC Clinical Practice Guidelines, Canadian Guidelines on Prenatal Diagnosis: Genetic Indications for Prenatal Diagnosis" (June 2001), online: Society of Obstetricians and Gynaecologists of Canada <http://www.sogc.org/SOGCnet/sogc_docs/common/guide/pdfs/ps105.pdf>.

¹⁹⁸ See *supra* note 192.

¹⁹⁹ See *supra* note 196.

²⁰⁰ And the MSS is only one form of prenatal testing. Other decisions women make during pregnancy, to name just a few, include: where to give birth—home or hospital; who will be her birth attendants—physician, midwife, doula, or some combination thereof; other tests such as ultrasound, gestational diabetes screening, HIV testing; whether to take medications; what foods to eat; what types of exercise to do; and what form of employment to engage in.

that could be subject to similar analyses. In examining decisions about prenatal testing, we can clearly see the trouble with the normative expectations we hold with respect to choices made by pregnant women. On the one hand, the ideal pregnant woman accepts unreservedly, and feels nothing but love toward, the fetus she is carrying—the ideal pregnant woman is not a woman who would terminate her pregnancy. On the other hand, it might be considered irresponsible for the pregnant woman not to take full advantage of the technology available for prenatal testing, so that she does not bring a child into the world that will suffer from a genetic condition.²⁰¹ Having considered choices about prenatal testing from the broader perspective that the expressive choice theory directs us to, we can also clearly see the problems with resort to choice language. Having looked behind the apparently binary decision of whether to remain pregnant or terminate the pregnancy, we can no longer credit the assertion that the woman's choice to remain pregnant implies the willing assumption of obligations to her fetus, including consent to all recommended medical procedures.

Making choices around prenatal testing will obviously not be this complicated for all women, or for all of the many decisions a pregnant woman must make, but the important point is that it can be this complicated. Factors specific to each woman's life will further confound the analysis, such as: is it a wanted or unwanted pregnancy? How difficult has it been for this woman to become pregnant? Did she have to seek out fertility treatment? If so, how many attempts did it take to achieve pregnancy, and at what cost? Has she had other children? Has she had other pregnancies end in miscarriage or stillbirth? How does her partner (if she has one) feel about the pregnancy? How easy would it be for her to become pregnant again were she to miscarry or abort? How old is she? What is her socio-economic reality? With respect to treatment refusal in particular, other issues may also arise, related to the realities of the woman's life. Is she someone who has had negative interactions with the justice system in the past? With the health care system? How autonomous does she perceive

²⁰¹ This raises a number of issues around genetic conditions, discrimination, the experience of disability, and suffering that are beyond the scope of this paper. For interesting discussions, see Adrienne Asch, "Prenatal Diagnosis and Selective Abortion: A Challenge to Practice and Policy" (1999) 89 Am. J. Pub. Health 1649; Marsha Saxton, "Born and Unborn: The Implications of Reproductive Technologies for People with Disabilities" in Arditti, Duelli-Klein & Minden, *supra* note 190, 298; Deborah Kaplan, "Prenatal Screening and Diagnosis: The Impact on Persons with Disabilities" in Karen H. Rothenberg & Elizabeth J. Thomson, eds., *Women and Prenatal Testing: Facing the Challenges of Genetic Technology* (Columbus: Ohio State University Press, 1994) 49. The argument of disability rights advocates, that prenatal diagnosis and selective abortion is morally problematic, has led to some interesting explorations of the tensions inherent in advocacy of a feminist pro-choice position and, at the same time, a discomfort with the use of prenatal diagnosis and selective abortion to "prevent" the birth of children with disabilities. See e.g. E. DeVaro, "Consideration of Context in the Case of Disability Rights Activism and Selective Abortion" (1998) 6:3 Health L. Rev. 12.

herself to be?²⁰² What are her religious or spiritual beliefs that might bear on decisions about health care?

Decision-making in pregnancy is an exercise that implicates all facets of a woman's life. It can be (and probably often is) a tangled, difficult process. As noted earlier, there are a number of underlying concerns with respect to the use of choice language in legal reasoning around choices made in pregnancy. But even more than the narrow focus on the availability of abortion, the concerns about medical paternalism, and the attempts to analogize pregnancy to other legally regulated relationships, it is the failure of choice language to give effect to the pluralistic valuations that such choices entail that is cause for concern. As Elizabeth Anderson tells us, choices do not always mean what they might superficially seem to, and they might not always be directed in the way we might expect (e.g., at a set of consequences). In defaulting to choice language, the depth of the considerations behind the choices is lost, and it is therefore even more critical that we note the use of this language and that we discredit it.

It is easy to turn to choice as a justification for intervening in the lives of pregnant women and easy to declare that once a woman has invited the fetus in or allowed it to remain her freedom to choose further has been surrendered. The expressive choice model requires that we come to grips with what choice language obscures—the complex and often painful decisions that face pregnant women.

What does an expressive choice model tell us about intervention in pregnancy? That any attempt at regulation must attend to the realities of women's lives and the constructed (and often constrained) nature of their choices in pregnancy. As I state elsewhere in this article, I am of the view that intervention in pregnancy, where it involves coercive practices such as forced medical treatment, is ill-conceived. But even where intervention is more positive, in that it involves, for example, providing universal prenatal care, addiction treatment programs tailored to the needs of pregnant women,²⁰³ or protection of pregnant women from violence at the hands of their partners, it is, as the expressive theory elucidates, crucial that we take into account the complex nature of decision-making in pregnancy.

Conclusion

The foregoing discussion of choice in pregnancy has raised a multitude of issues that require further consideration in future work. The main aim of this paper, in addition to raising these issues, has been to argue that intervention in pregnancy

²⁰² Shanner, "Pregnancy Intervention", *supra* note 12. See e.g. Baylis, *supra* note 21 at 788-89; Carolyn McLeod, "Women's Autonomy and the 'G' Case" *Canadian Bioethics Society Newsletter* (May 1998) 3:2, online: Canadian Bioethics Society <<http://www.bioethics.ca/english/newsletter/3.2/#women>>.

²⁰³ Currently, there are shortages of drug treatment programs tailored to pregnant women. See e.g. Roth, *supra* note 6 at 138-39 and McLeod, *ibid*.

denies women's autonomy and bodily integrity, reinforces traditional and harmful ideas about motherhood and pregnancy, and elevates medical judgment over the views and the judgments of pregnant women. In order to prevent these harms from persisting, we need to reason about women's choices in a different way, and a theory that attends to the expressive nature of choice is proposed as a starting point for this endeavour. Such a theory allows for critique of existing norms around pregnancy and motherhood and directs attention to consideration of the meaning of choices to the person making them. Only by finding a new way of reasoning about pregnancy can we hope to resolve the problem of pregnancy intervention in a manner consistent with both autonomy and equality for women.
