Ch20-A03753 12/1/06 9:55 AM Page 201

Chapter 20
Legal Interests of the Fetal Patient

Jeffrey L. Lenow, MD, JD, FCLM, FAAFP

Key Questions/Issues
Roe v. Wade: **Benchmark for Analysis of Fetal Rights**
New Challenges and the Future Legal Status of the Fetal Patient
Conclusion

Noted pediatric surgeon, Karlis Adamsons, MD, proclaimed in a *New England Journal of Medicine* article in 1966, "It appears unlikely that even in the distant future, fetal surgery will become a field of major concern to the clinician…."[1] However, it would only be 14 years before *Williams Obstetrics*, the leading textbook in the discipline, would state in the preface: "Happily, we have entered an era in which the fetus can be rightfully considered and treated as our second patient … we are of a view that it is the most exciting of times to be an obstetrician. Who would have dreamed—even a few years ago—that we could serve the fetus as physician?"[2] The era of fetal treatment had arrived.

Bolognese notes, "Perinatologists are the advocates of the fetus…."[3] The notion of the maternal–fetal unit as a single treatment focus would come into question as the developing subspecialty disciplines of maternal/fetal medicine (high-risk obstetrics) and neonatology (high-risk pediatrics in the newborn period) began to flourish in the early 1980s. In fact the field of fetal therapy and treatment has grown dramatically since Clewell's first report of proposed fetal surgery on a hydrocephalic fetus in the Denver Fetal Treatment program, and Harrison and his team's landmark ex utero surgical approach to a fetus with a posterior urethral valve obstruction, both in 1982.[4] The current ruling principles regarding fetal rights, "personhood," and proper recommendations in the face of very real "maternal–fetal" and "fetal–fetal" conflicts (in multiple gestations) have not changed significantly since the subject had been initially formally reviewed in the literature.[5] There have been nonetheless interesting legal "twists" along the way that warrant review in this chapter. Whether it presages an upheaval in the maternal–fetal rights "balance" is difficult to predict.

The maturation of the field of fetal therapy has been truly remarkable.[6] While it is beyond the scope of this chapter to review with explicit clinical detail the remarkable scientific accomplishments of the fetal treatment teams worldwide[7], the fact that many such procedures may pass from "experimental/investigational" to accepted standards of reimbursable care suggests that ongoing dialogue about the challenging ethical and legal challenges presented by this discipline is even more critical than ever.[8]

In the following, we explore some key questions/issues arising from the legal review of the fetal patient. This overview first looks at the historical development of the fetus in the eyes of the law, with a critical focus on the unavoidably controlling doctrine as defined in the landmark and highly controversial U.S. Supreme Court ruling in *Roe v. Wade*.[9] The chapter then surveys recent trends in the last decade that have offered interesting new perspectives on the issue of fetal personhood and may be predictive of directions in which the legislatures at the state and federal levels may be moving in attempts to redefine the status of the fetus and, derivatively, the fetal patient.

KEY QUESTIONS/ISSUES

While we can marvel at the truly remarkable progress in the science of fetal treatment, it heightens both critical ethical[10] and legal issues raised by the evolution of this discipline:[11]

- Are the maternal patient and fetal patient separable entities, medically and legally?
- Are the rights of the maternal patient the same as or superseding those of the fetal patient?
- Does the prebirth fetal patient enjoy the same legal protection as the postbirth?
- How to resolve potential of maternal–fetal conflicts (i.e., if the maternal patient should refuse a recommended therapy for the fetus).
- How to resolve fetus–fetus conflict (i.e., can a procedure for a compromised fetus in a multiple gestation scenario be a risk for an unaffected fetus?).
- How do evolving state pressures toward recognition of fetal injury and feticide statutes affect the core issues of fetal "personhood"?

The History of the Fetal Person in the Law

In the context of tort law, a number of states would seem to have recognized fetal rights through their wrongful death determinations.[12] Although most states have come to recognize the concept of wrongful death on behalf of an unborn fetus, the circumstances vary from state to state, and generally recognize such "rights" only after the fetus has been born alive.[13] The seeming contradiction between the right of wrongful death of a fetus as contrasted to the Supreme Court's clearly stated position that the unborn fetus has no constitutional rights is resolved by a clear

understanding of Justice Blackmun's explanation. The Roe court noted that its decision was not inconsistent with the policy of some states to allow the parents of a stillborn child to file an action for wrongful death as a result of prenatal injuries.[14] Justice Blackmun noted that wrongful death suits were brought to vindicate the parent's right to recover for the loss of "potentiality of life", not of a person "in the whole sense." Since parents bring prenatal wrongful death actions on their own behalf, parental consent to an abortion constitutes a waiver of any prenatal wrongful death action.[15] It is probably therefore not very useful in a discussion of the recognition of fetal rights to utilize wrongful death cases as an appropriate resource.[16] A noteworthy event occurred in June 2001, however, when the Arkansas Supreme Court, in allowing a wrongful death claim for an unborn fetus which died during a labor induction, overturned a lower court ruling and did agree that an unborn child meets the legal definition of "a person."[17]

In criminal law some states have begun to recognize feticide statues in order to prevent abuses such as was evidenced in *Keeler v. Superior Court,*[18] where an individual was not convicted for the death of a viable stillborn fetus as a result of an assault. The *Keeler* dissent noted that the violent act of "stomping the child to death" was no different from killing a newborn because the fetus with its "unbounded potential for life" was entitled to protection.[19] Following this dramatic outcome, the California legislature amended its homicide statute making it unlawful to kill a human being or a fetus regardless of age.[20]

ROE V. WADE: BENCHMARK FOR ANALYSIS OF FETAL RIGHTS

The unique concept of separability of fetus and mother in a legal context is best viewed with an appropriate understanding of the dicta in *Roe v. Wade*.[21] With all that has been written, analyzed, and debated since the ruling in 1973 (including first commentaries on the fetal patient perspective over 20 years ago[22]), the primary determinant for any legal discussion on the rights of the fetus and derivatively the fetal patient revolve around the still intact *Roe* case. In determining whether a Texas statute properly applied the word "person" to an unborn fetus, the *Roe* court suggested that the use of the Fourteenth Amendment or any other part of the U. S. Constitution and its amendments was not applicable in the *prebirth* state and for that reason did not confer any constitutional recognition to the unborn fetus. The court, however, recognized a portion of pregnancy beyond the point of "viability," adopting essentially a medical definition of this term where the state could recognize a "compelling interest" in the well-being of the fetus.[23] Thus the court set the stage for a still hotly debated subject—what did they mean by the use of the clinical term "viability" and could the Justices have ever imagined the technological advances soon to arrive that would pit the dicta of the 1970s against the reproductive advances that would soon follow and would challenge the application of fetal rights interpretation in a new scenario.[24]

Viability: A Critical Concept in Any Discussion of Fetal "Personhood"

Viability is a concept "widely used to identify a reasonable potential for subsequent survival if the fetus were to be removed from the uterus."[25] In essence, then, it is a nonlegal definition that is defined in terms of practicality (i.e., how early a fetus can be delivered with hopes of reasonable survival), and since no single factor determines fetal survival the prediction of viability is at best a moving target and imprecise.[26] The progeny of abortion cases to follow *Roe* would manifest consistency in the court's subsequent avoidance of the viability issues despite the fact that viability would be a major future determinant in any discussion of the fetal patient. In *Planned Parenthood of Central Missouri v. Danforth*, the Supreme Court said, "It is not the proper function of the legislature or the courts to place viability, which essentially is a medical concept, at a specific point in the gestation period… and the determination of whether a particular fetus is viable is, and must be, a matter for the judgment of the responsible attending physician."[27] In *Colautti* v. *Franklin* the court ruled that the attending physician would make a viability assessment on the particular facts of the case before him, "based in part on whether there was a reasonable likelihood of the fetus' sustained survival outside the womb, with or without artificial support."[28] According to a brief filed with the Supreme Court in *Webster v. Reproductive Health Services* by the American Medical Association, the American Academy of Pediatrics, and the American College of Obstetricians and Gynecologists, viability "is dependent upon a large number of factors. . . The importance of each of these factors and the medically appropriate method of measuring them will vary with the circumstances of the individual pregnancy."[29] In *Planned Parenthood of Southeastern Pennsylvania v. Casey*, the court focused on the precise point of viability as "an imprecision within tolerable limits given that the medical community and all those who must apply its discoveries will continue to explore the matter."[30]

Ultimately the question arises as to the real impact of the viability standard. Does a group of patients exist for whom the "compelling state interest in a viable fetus" clause applies? Data would demonstrate that the number of fetuses aborted beyond the viable state is extremely limited.[31] Clearly the import of the quasi-Constitutional rights conferred by this clause has had little practical import from the perspective of the *Roe* court protecting interests of viable fetuses as a class in the abortion context.[32] However, the Justices could never have imagined the "double-edged" impact this clause might have in the near future, with the advent of new fetal treatment modalities and the potential for viable fetal patients to come into conflict with both the maternal patient and also with other fetuses in a multiple gestation setting.[33]

Conflict Scenarios (Maternal vs. Fetal and Fetal vs. Fetal)

As noted earlier, the advancements in fetal therapy, both medical and surgical, are dynamic. Since most of these fetal

patients with potentially "correctable" defects manifest well beyond the viable state, issues of conflict when treatment determinations are offered begin to surface. So concerned were the early pioneers in the field of fetal therapy with such conflict potential and the unclear legal issues surrounding them, they convened the first conference to define ethical guidelines and standards for the future.[34] The predictable scenario of pitting the rights and interests of the maternal patient with those of the unborn fetus beyond the point of "viability" when the state might exercise its "compelling state interest" formally manifested itself dramatically in *Jessie Mae Jefferson v. Griffin Spaulding County Hospital*.[35] In *Jefferson* the mother of a 39-week-old fetus suffered from a complete placenta previa,[36] a condition in which the placenta blocks the birth canal. There was a 99% chance that the fetus would die if natural delivery were attempted and a 50% chance that the mother would also not survive. The physicians predicted that both the mother and the child had excellent chances of surviving delivery by cesarean section. The maternal patient objected to surgery on religious grounds. The attending physicians petitioned the court for authorization to perform a cesarean section, sonogram, and blood transfusions on Mrs. Jefferson. In affirming the order of the lower court granting the physician's petition, the Georgia Supreme Court stated that, according to *Roe v Wade,*[37] the state had a compelling interest in the life of a fetus after the point of viability. It was this interest, the court reasoned, which permitted intrusion on the mother's rights in order to protect the fetus. Justice Hill, in a concurrence to the court's per curiam opinion, noted: "We weighted the right of the mother to practice her religion and to refuse surgery on herself, against her unborn child's right to live. We found in favor of her child's right to live."[38]

Chervernak argues for exceptional situations where forced fetal treatment near term is allowable.[39] The American College of Obstetricians and Gynecologists takes a balanced perspective in this regard.[40] The ACOG Committee on Ethics has come to the following conclusions:

- The role of the obstetrician is that of educator and counselor, who must weigh the risks and benefits to both patients, while realizing that tests, judgments, and decisions are fallible.
- Consultation with others, including an institutional ethics committee, ought to be sought when appropriate.
- Obstetricians should refrain from performing procedures that are unwanted by a pregnant woman.
- The use of the courts to resolve conflicts violates the pregnant woman's autonomy, and it is almost never warranted.

This recommendation would become a critical feature in the leading case to date regarding forced fetal therapy, the matter of Angela Carder, or "*in re A.C.*"[41] In June 1987, a judge in Washington, D.C., ordered a cesarean section to be performed on Angela Carder, who was 26 weeks pregnant and near death from cancer. She had discussed with her physicians the hope that her life could be prolonged to the 28th week of pregnancy, when the potential outcome for the fetus would be much better. When it appeared her death was imminent, however, the hospital, unable to get consent for a cesarean section from the patient or her family, obtained a court order for immediate delivery of the fetus. The cesarean surgery was performed; the infant died within a few hours; Carder died two days later. Three years later, the District of Columbia Court of Appeals noted that it would have deferred to the patient's level of competency to make her own choice. If she had not been competent, the court should have used substituted judgment. The appeals court noted, "We hold that in virtually all cases the question of what is to be done is to be decided by the patient—the pregnant woman—on behalf of herself and the fetus."

The decision holds precedent only for its own jurisdiction, but there have been no higher level determinations of this specificity to date and other courts that may some day face this type of decision are prone to deferring to such judgments. It is a legal determination that aligns with policy statements of both the American College of Obstetricians and Gynecologists (ACOG), the American Academy of Pediatrics Committee on Bioethics,[42] and the American Medical Association (AMA).[43]

In an era of significant achievement in the area of assisted reproductive technologies, scenarios with multiple gestations are not unusual. Postulated is the potential fetus vs. fetus conflict when a procedure to aid a compromised fetus might be considered unnecessarily risky to the unaffected "fetal siblings." What rights in action would the unaffected fetus have in this case and who would represent these interests in a legal challenge? These are indeed rare scenarios, but conjure dilemmas in the analysis. There simply is no precedent in the law, no "on point" case law that answers these situations. If the viable compromised fetal patient has quasi-protected rights under the "compelling state interest" clause of *Roe*, are these "rights" no different for the unaffected sibling(s)? Several examples exist as well where selective fetal reduction via cardiac puncture under ultrasound guidance places two or more fetuses directly in this situation.[44] The closest analogous case law derives from cases of "substituted judgment" as demonstrated in the *Strunk v. Strunk* case, where the court had to determine if a surrogate can make a determination of care for an incompetent individual.[45] In *Strunk*, the Kentucky Court of Appeals, in permitting a kidney transplant from a mentally retarded person to his brother, was willing to imply the consent of an incompetent individual to an intrusive and burdensome procedure on the grounds that the resulting benefits were in the incompetent's best interests. Given that the transplant was necessary for the recipient brother's survival, the court utilized the substituted judgment doctrine and authorized the transplant on the grounds that the brother's death would have an "extremely traumatic effect upon [incompetent]."[46] In *Hart v. Brown*,[47] the Connecticut Supreme Court relied on the *Strunk* precedent and permitted a kidney transplant from one twin to another.[48] The difficulty in applying these cases to the fetus vs. fetus conflict scenario is that there must be a demonstrated benefit to the unaffected fetus to "allow" the procedures to occur on the affected fetus. Such demonstration is implausible at best, unless there is evidence of the future benefits of

Ch20-A03753 12/1/06 9:55 AM Page 204

sibling company, love, and attention, or simply evidence of improved existence generally.[49]

Consequences of Forced Fetal Therapy

The specter of *Roe* becoming an unintended vehicle for forced fetal interventions (be they dramatic, such as forcing cesarian sections, or even seemingly limited to the taking of a digoxin pill by the maternal patient to limit the risk of fetal cardiac arrhythmias[50]) is offset by the sobering observation that there may indeed be common law consequences for unsuccessful outcomes ranging from the tort of battery to the damages that ensue from "creation of a peril" and a catastrophic outcome.[51] The suggestion here is that, while perhaps well intended, emotional moves to intervene, above and beyond the wishes of the maternal patient and her family, can result in secondary outcomes that were perhaps unforeseeable but for which reasonable arguments could be fashioned to hold the interveners liable.

NEW CHALLENGES AND THE FUTURE LEGAL STATUS OF THE FETAL PATIENT

There have been numerous attempts at both state and federal levels to institute fetal rights legislation. This is bothersome to abortion rights proponents as they argue it constitutes what is essentially an "end run" to ultimately prohibit women access to abortion, thus effectively dismantling the current standing of *Roe v. Wade*.[52]

Attempts to Limit Types of Abortion

There have been several rulings at the state court level dealing with the issue of late-term abortions. State Supreme Courts in these jurisdictions (New Jersey, Alaska, Montana, Arizona, Illinois, Michigan, Arkansas, Nebraska, and Florida) have consistently overturned attempts by state legislatures to ban late-term abortions as unconstitutional and impairing the rights of bodily self-determination outlined in *Roe v. Wade*.[53] In a more recent Supreme Court determination on this subject,[54] the court ruled that this constituted a violation of a woman's right under *Roe* to make the free choice of bodily self-determination. Thus, all serious attempts to erode the core premise of *Roe v. Wade* have been thus far ineffective, certainly as it impacts on fetal "personhood" as discussed in the context of this chapter.

New Criminalization Strategies in the Prenatal State

There has been considerable attention paid to the issue of fetal rights in the context of crimes against pregnant women. Some 24 states have "unborn victim laws," with another 15 states looking at similar legislation.[55] In April 2001, Congress considered passage of H.R.503/S.480, the "Unborn Victims of Violence Act," which would amend the federal criminal code to create a separate offense if a defendant causes the death of, or bodily injury to, an "unborn child" during the commission of a federal crime.[56] The punishment for the separate offense would be the same as if the defendant had caused the death of, or injury to, the woman herself. Opponents of the law argue that such a law creating criminal protection for a pregnancy would establish new and bad precedent, encouraging the extension of "fetal rights" to other areas of the law.[57] There has been a strong editorial condemnation of this law and related state laws.[58]

In a peculiar standoff between the Texas Medical Association and the Texas District and County Attorneys Association (a nonpartisan educational group), there is disagreement over state law (Medical Practices Act of the state's Occupations Code, effective September 2005) that presumably allows state prosecutors to bring capital murder charges against physicians who violate the latest abortion restrictions in the state.[59] The dispute arises over whether the new abortion law in Texas fits with the existing fetal protection law, which allows prosecutors to charge with assault or murder individuals who harm or kill a fetus—there are two abortion-related items of "prohibited practices" in the Occupations code.

Feticide statutes have become important actions in 33 states and there is a federal version known as "Laci and Conner's Law" after the 2004 killing of Laci Peterson in California.[60] It is not likely that such statutes will impact on the body of abortion law currently in place.

Pursuit of Fetal Rights Through Vehicle of Child Abuse, Search, and Seizure Issues

There have been several cases in the last few years where various jurisdictions have attempted to protect the unborn fetus from different types of prenatal abuse, such as a history of prior child abuse, drug abuse, and related issues. In *Ferguson v. City of Charleston,*[61] affirming the right to confidential medical care for all Americans, the U.S. Supreme Court struck down a drug-testing scheme targeting pregnant women developed by local police and prosecutors in collaboration with doctors in a South Carolina hospital. In its 6–3 decision in *Ferguson*, the court found that the Medical University of South Carolina drug-testing scheme was in direct violation of the Fourth Amendment, which provides all Americans with protection from unreasonable searches.

The case involves ten petitioners accused of cocaine abuse during pregnancy. One woman was arrested at the hospital shortly after giving birth and another, who had sought prenatal care, was arrested and jailed for 3 weeks until she delivered her child. In arguments before the court, Justice Steven G. Breyer strongly suggested that the hospital's policy would harm fetuses more than it would help by discouraging women from seeking prenatal care.

In May 2001 Regina McKnight was convicted and sentenced to 12 years in prison for killing her unborn child by using crack cocaine during her pregnancy.[62] She was

Ch20-A03753 12/1/06 9:55 AM Page 205

$8^1/_2$ months pregnant when she delivered the stillborn baby in May 1999. Four doctors who testified at her trial gave differing opinions as to whether her addiction to crack caused the baby's death. In 1997, the South Carolina Supreme Court upheld the conviction of a woman who had been charged with child abuse for using cocaine during her pregnancy, ruling that a viable fetus was considered a person under the state's criminal code. The ruling was the only one of its kind in the country. The U.S. Supreme Court has let stand the homicide conviction of the woman. By refusing to consider the case, the high–court let stand a South Carolina Supreme Court ruling that the punishment was not too harsh because she should have known that using cocaine would harm her child.

In another case in Bristol County, Massachusetts, prosecutors held Rebecca Corneau in a prison hospital in order to protect her unborn fetus.[63] At 9 months gestation, this member of a fundamentalist Christian group that shuns modern medicine had refused to see a physician. Prosecutors were concerned that two other children from this cult, including one of Corneau's, had died from neglect and starvation. Fearing that the fetus she was carrying might meet the same fate as her other child, Attleboro Juvenile Court Judge Kenneth P. Nassif imprisoned Corneau to await the birth and to submit to prenatal medical exams against the beliefs of what he called her ''bizarre and dangerous cult.'' Her newborn daughter was placed in foster care with her three other children. Nassif's assertion of jurisdiction over the body of a pregnant woman never charged with a crime was never subject to appellate review because Corneau refused legal representation. The Massachusetts Supreme Judicial Court dismissed a challenge to a court-ordered exam. Boston attorney Wendy Murphy, a teacher at the New England School of Law, had unsuccessfully appealed the state juvenile court's ruling. Supported by the National Organization for Women and ACLU, she argued that jailing a pregnant woman because she has refused medical treatment violated her right to privacy guaranteed in *Roe v. Wade*.

Bush Administration Foray into Fetal Rights

On September 27, 2002 the Bush administration through the Department of Health and Human Services issued final rules for allowing states to define a fetus as a child eligible for government-subsidized health care under the State Children's Health Insurance Program (SCHIP).[64] The Bush administration said it saw no contradiction between the ruling in *Roe v. Wade* that did not recognize the fetus as a "person" under the Fourteenth Amendment to the Constitution and this new SCHIP interpretation.[65] It noted that the rule would not set up "an adversarial relationship between the mother and her unborn child." The DHHS press release promoted the importance of opening health care options to low-income mothers regardless of immigration status.[66] The administration calculated the new rule would increase federal spending by $330 million over 5 years and that 13 states would choose to cover "unborn children," with 30,000 fetuses gaining coverage as a result.

CONCLUSION

It has been over 20 years since the first reported fetal surgical interventions.[67] With this new class of "viable" fetal patient, the potential for conflicts between mother and fetus continues to manifest. The issue of what constitutes fetal rights is still unsettled despite recent Supreme Court determinations that continue to uphold the original *Roe* protection of a woman's right to bodily self-determination and free right to choose abortion (despite the cloudy meaning of "state compelling interest" in the viable fetus). But as more challenges present to the intent of *Roe*, the likelihood of the viability standard surviving is not great. The court's determination occurred in 1973, before today's technological miracles existed and well before any of the Justices or their researchers could have comprehended this new class of patient, the "viable" fetus, let alone the potential for conflict that could manifest. One can only surmise the premise for Blackmun's interpretations, the use of the trimester analysis and the viability discussion. But rapid changes in health care technology are essentially rendering the value of this interpretation more and more ineffectual. Predictions are difficult. With the Bush administration in place, the opportunities to stack the court with conservative viewpoints relative to abortion rights is significant. Additionally, other Supreme Court rulings subsequently have shown language, specifically from Justice Sandra Day O'Connor, which point to the *Roe* determination's weakest link, the vagueness of the trimester approach.[68] Curiously, Laura Bush, the President's wife, was quoted in January 2001 as suggesting that she did not believe the *Roe* ruling should be undone, implying that the administration should look for other ways to limit the need for abortion.[69]

Endnotes

1. K. Adamsons, *Fetal Surgery*. 275 N. Engl. J. Med. 204, 205 (1966).
2. J. Pritchard, & P. McDonald, *Williams Obstetrics*, 16th ed. (1980).
3. R. Bolognese, *Medico-Legal Aspects of a Human Life Amendment,* 5 Pa, Law Journal-Reporter 13 (1982) (commenting on attempts by several state legislatures to define life at the moment of conception).
4. W.H. Clewell, M.L. Johnson, P.R. Meier, et al., *Placement of Ventriculo-Amniotic Shunt for Hydrocephalus in a Fetus* [letter] 305 N. Engl. J. Med. 955 (Oct. 15, 1981). *See also* Harrison, Golbus, Filly, et al.,*Fetal Surgery for Congenital Hydrohephrosis,* 306 N. Engl. J. Med. 591 (1982). Surgery was performed in April 1981 and was the first ex utero surgery performed on a fetus.
5. J.L. Lenow, *The Fetus as a Patient: Emerging Rights as a Person?*, 9 Am. J. Law Med. (1983).
6. H.L. Hedrick & T.M. Cromblehome *Current Status of Fetal Surgery*, Contemp. Obstet. Gynecol. (Dec. 2001). *See also* D.S. Walsh & N.S. Adzick, *Fetal Intervention: Where We're Going,* Contemp. Pediatr. (June 2000).
7. N.S. Adzick, M.I. Evans, & W. Holzgreve (eds.), *The Unborn Patient: The Art and Science of Fetal Therapy*, 3d ed. (W.B. Saunders, Philadelphia, 2000). Additional information on two leading centers for fetal treatment includes the Fetal Treatment Center of the University of California, San Francisco (http://www.fetus.ucsf.edu/index.htm) and the Center for Fetal Diagnosis and Treatment, The Children's Hospital of Philadelphia (http://fetalsurgery.chop.edu/contact.cfm).

Ch20-A03753 12/1/06 9:55 AM Page 206

8. J.L. Simpson, *Fetal Surgery for Myelomeningocele: Promise, Profess, and Problems*, 282(19) J.A.M.A. 1873–74 (1999).
9. 410 U.S. 113 (1973).
10. Barclay, McCormick, Sidbury, et al., *The Ethics of In Utero Surgery*, 246 J.A.M.A. 1550 (1981). *See also* Ruddick and Wilcox, *Operating on the Fetus*. 12 Hastings Center Rep. 10 (Oct. 1982).
11. Lenow, *supra* note 5.
12. A detailed analysis of the historical perspective of property, tort, and criminal law on the question of fetal personhood is evident in Lenow, *supra* note 5, at 3–11.
13. Lenow, *supra* note 5.
14. 410 U.S. 113, at 162.
15. Lenow, *supra* note 5, at 8.
16. Janet Gallagher, *Prenatal Invasions and Interventions: What's Wrong with Fetal Rights*, 10 Harvard Women's Law J. 9, 37, 57 (1987).
17. T. Albert, American Medical News (AMA News) (June 2001).
18. 2 Cal. 3d 619, 470 P. 2d 617 (1981).
19. *Id.* at 663.
20. Cal. Penal Code Section 187 (West 1970 and Supp. 1983).
21. 410 U.S. 113 (1973).
22. Lenow, *supra* note 5. *See also* G. Annas, *Forced Cesareans: The Most Unkindest Cut of All,* 12 Hastings Center Rep. 16 (June 1982).
23. 410 U.S.113 at 159.
24. Lenow, *supra* note 5, at 10–15.
25. *Williams Obstetrics*, *supra* note 2, at 587.
26. The choice of 24–28 weeks gestational age or 600–750 grams in fetal weight as the point of viability accruing is arbitrary. The best estimates come from experts in high-risk obstetrics and neonatology having observed thousands of premature births and correlating best evidence to match up to these numbers. Vital to survival is adequate development of the major organ systems. *See* R. Bolognese & N. Roberts, *Amniotic Fluid, in: Perinatal Medicine: Management of the High Risk Fetus and Neonate,* 198–203 (2d ed. 1982). *See also* Hershel, Kennedy, et al., *Survival of Infants Born 24–28 Weeks Gestation,* 60 Obstet. Gynecol. 154, 154 (1982), wherein the authors note a 45% survival rate at 26 weeks gestation and a 92% rate at 28 weeks. *See also* Williams, Creasy, Cunningham, et al., *Fetal Growth and Perinatal Viability in California,* 59 Obstet. and Gynecol. 624 (May 1982), who conclude that mortality rates are more sensitive to birth weight than to gestational age.
27. 428 U.S. 52 (1976). "When those trained in the discipline of medicine…are unable to arrive at any consensus, the judiciary…is not in a position to speculate as to when viability occurs."
28. 439 U.S. 379 (1979).
29. *Webster v. Reproductive Health Services*, No. 88-605, October Term, 1988, p. 7. 492 U.S. 490 (1989).
30. *Planned Parenthood of Southeastern Pennsylvania v. Casey*, 112 S.Ct. 2791 (1992).
31. National Center for Disease Control, *Abortion Surveillance Report 1978* (Nov. 1980). Only 0.9% of abortions done (1.2 million in 1978) were performed beyond 21 weeks gestation. *See also* S.K. Henshaw, L.M. Koonin, & J.C. Smith, *Characteristics of U.S. Women Having Abortions, 1987,* 23 Family Planning Perspectives 75 (1991), who noted that half of the 1.5 million abortions in the United States each year take place within the first 8 weeks of pregnancy; 9 in 10 occur within the first 12 weeks. Less than 1% are performed after 20 weeks. *See also* the Alan Guttmacher Institute, *The Limitations of U.S. Statistics on Abortion* (Washington, D.C., 1997), where it is noted that 300–600 abortions—or up to four one-hundredths of 1%—are performed after 26 weeks.
32. Lenow, *supra* note 5 (term defined by Lenow).
33. Lenow, *supra* note 5.
34. Harrison, Filly, & Golbus. *Fetal Treatment 1982*, 307 N. Engl. J. Med. 1651 (1982). Leaders from around the world met in the Santa Ynez Valley, California.
35. 247 Ga. 86, 274 S.E. 2d 457 (1981).
36. A condition where the placenta (afterbirth) lies too low in the uterine wall and over the internal cervical os (opening to the birth canal). This is one of the major obstetrical complications of the latter half of pregnancy and can be the cause of fetal or maternal demise if not quickly and properly treated. Death results when the placenta separates partially from the wall of the uterus and causes hemorrhage. Treatment usually involves strict bed rest, blood replacement if needed, serial ultrasound exams, and often cesarean section. See *Williams Obstetrics*, *supra* note 2, at 508.
37. 410 U.S. 113 (1973).
38. 274 S.E. 2d at 460 (Hill J, concurring). Ultimately, a subsequent ultrasound examination revealed an extremely rare shift of the placenta, which enabled the mother to vaginally deliver a healthy girl. It was reported in the *Southern Medical Journal* under the headline, "Mother Nature Reverses on Appeal."
39. F.A. Chervenak, L.B. McCullough, & D.W. Skupski, *An Ethical Justification for Emergency, Coerced Cesarean Delivery,* 82 Obstet. Gynecol. 1029–35 (1993).
40. Committee on Ethics, American College of Obstetricians and Gynecologists, *Patient Choice: Maternal-Fetal Conflict*, Opinion, Aug. 11, 1987 (relying in part on Lenow, *supra* note 5).
41. *In re A.C.,* 573 Atl. Rpt. 2d 1235, 1237 (D.C. Court of Appeals, April 26, 1990).
42. Committee on Ethics, American College of Obstetricians and Gynecologists, *Patient Choice: Maternal-Fetal Conflict,* Opinion, Aug. 11, 1987. (Note that the Academy of Pediatrics has adopted balanced guidelines as well on the subject. *See* American Academy of Pediatrics, Committee on Bioethics. *Fetal Therapy—Ethical Considerations* (RE9817), 101 Pediatrics 1061–63 (1999).
43. Law and Medicine/Board of Trustees Report, *Legal Interventions during Pregnancy*, J.A.M.A. 2663–70, (Nov. 28, 1990).
44. Kerenyi & Chitkara, *Selective Birth in Twin Pregnancy with Discordancy for Down's Syndrome,* 304 N. Engl. J. Med. 1525 (1981). *See also* Aberg, Mitelman, Cantz & Gehler, *Cardiac Puncture of Fetus with Hurler's Disease Avoiding Abortion of Unaffected Co-Twin,* 2 Lancet 990 (1978).
45. 445 S.W. 2d 145 (Ky. 1969).
46. *Id.* at 146.
47. 29 Conn. Supp. 368, 289 A. 2d 386 (Conn. Super. Ct. 1972).
48. The use of the benefits rationale to authorize transplants for incompetents has not been unanimously adopted. *See Lausier v. Pescinski*, 67 Wis. 2d 4, 226 N.W. 2d 180 (1975).
49. I. Moilanen, *Are Twins' Behavioural/Emotional Problems Different from Singletons'?*, 8 Eur. Child. Adolesc. Psychiatry, Suppl 4, 62–67 (Jan. 1999) (suggestion that there may be evidence of fewer behavioral problems in twins).
50. Harrigan, Kangos, et al., *Successful Treatment of Fetal Congestive Heart Failure Secondary to Tachycardia,* 304 N. Engl. J. Med. 1527 (1981).
51. J.L. Lenow, *Prenatal Intervention—Duty vs. Liability,* 3 (6) Legal Aspects of Medical Practice (June 1985). Accepted for presentation (25th Annual International Meeting of American College of Legal Medicine, May 1985) as *Of Fetal Patients Becoming Defective Newborns—New Duty Concepts Emerge.*
52. Reported on the Kaiser Daily Reproductive Health section of the Kaiser Family Foundation website, http://report.kff.org/archive/repro/2001/5/kr010529.3.htm (May 29, 2001).

Ch20-A03753 12/1/06 9:55 AM Page 207

53. E. Walsh & A. Goldstein, *Supreme Court Upholds Two Key Abortion Rights,* Washington Post (June 29, 2000).
54. *Don Stenberg, et al. v. Leroy Carhart, M.D,* 120 S.Ct. 2597.
55. Kaiser report, *supra* note 52. These 24 states all exempt abortion, but 11 states "recognize unborn children as potential victims from the moment of conception." *See also* Los Angeles Times (May 28, 2001).
56. There are four versions of Bill Number H.R.503 for the 107th Congress:
    - Unborn Victims of Violence Act of 2001 (Engrossed as Agreed to or Passed by House) [H.R.503.EH]
    - Unborn Victims of Violence Act of 2001 (Introduced in House) [H.R.503.IH]
    - Unborn Victims of Violence Act of 2001 (Placed on Calendar in Senate) [H.R.503.PCS]
    - Unborn Victims of Violence Act of 2001 (Reported in House) [H.R.503.RH]

    Available on http://thomas.loc.gov/cgi-bin/query/z?c107:h.r.503 Note that in 1999 the House passed an identical bill, S.1673, by a vote of 254–172, but it did not pass the Senate. In 2001, the House of Representatives passed the bill by a vote of 252–172. *See also* J. Reaves *A New President—a New Path for Fetal Murder Bill?,* Time Magazine (Apr. 26, 2001).
57. Center for Reproductive Law and Policy, www.crlp.org/pub_fac_unborn.htm.
58. Washington Post (Oct. 2, 1999), calling it "analytically incoherent"; New York Times (Apr. 25, 2001), noting the "bill's sponsors are more interested in furthering a political agenda than in preventing and punishing criminal conduct"; Seattle Times (Sept. 28, 1999).
59. A.S. Landa, *Abortion Law Raises Question of Murder Charges,* Amednews.com (Oct. 10, 2005).
60. E. Lounsberry, *Fetal-Homicide Laws Raise Questions on Roe,* Philadelphia Inquirer, (Aug. 28, 2005).
61. *Ferguson v. City of Charleston,* 532 U.S. 67 (2001). *See also* J. Cloud, *Protecting the Unborn: How Far Can Police Go to Prevent a Mother from Harming Her Fetus? The Supreme Court Will Decide,* Time Magazine (Oct. 9, 2000).
62. *Court Lets Stand "Crack Mom" Conviction: Supreme Court Refuses McKnight vs. South Carolina Appeal,* http://alcoholism.about.com/cs/preg/a/aa0301006a.htm; *See also Crack Mom Gets 12 yrs. for Killing Fetus,* Associated Press (May 18, 2001).
63. B. McGrory, *Cult Baby in Grave Danger,* Philadelphia Daily News (Sept. 13, 2000). *See also State Searching for Attleboro Sect Newborn Witnesses Say Corneau Gave Birth,* Boston Channel.com, http://www.thebostonchannel.com/News/1185174/detail.html (Jan. 10, 2002). Update involves state officials pursing whereabouts of a newborn baby. *See also* A. Cannon, *A Case of Fetal Rights*. U.S. News (Sept. 25, 2000).
64. R. Pear, *Bush Rule Makes Fetuses Eligible for Health Benefits,* New York Times (Sept. 27, 2002).
65. Department of Health and Human Services press release, *States May Provide SCHIP Coverage for Prenatal Care. A New Rule to Expand Health Care Coverage for Babies, Mothers,* http://cms.hhs.gov/schip/unborn.pdf (Sept. 27, 2002).
66. Pear, *supra* note 64.
67. *Supra* note 4.
68. *City of Akron v. Akron Center for Reproductive Health*, 462 U.S. 416, 419–20 (1983). Justice O'Connor, joined by Justices White and Rehnquist, dissented from the Court's *stare decisis* approach to leaving Roe intact, voicing disagreement with the trimester approach and suggesting instead that throughout pregnancy the test should be the same: whether state regulation constitutes "unduly burdensome interference with [a woman's] freedom to decide whether to terminate her pregnancy." 462 U.S. at 452, 461. In the 1986 case of *Thornburgh v. American College of Obstetricians and Gynecologists*, 476 U.S. 747 (1986), Justice White, joined by Justice Rehnquist, favored the overruling of *Roe v. Wade.* Chief Justice Burger felt it was time for *Roe* to be reexamined and that it had less validity over the test of time, and Justice O'Connor continued to express prior concerns as per the *Akron* dissent.
69. Laura Bush, *Don't Undo Roe v. Wade,* Associated Press (Jan. 19, 2001).