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Pregnant with Meaning: A Foucauldian Analysis of Foetal Harm Cases

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A thesis submitted in partial fulfilment of the requirements for the degree of Master of Bioethics and Health Law of the University of Otago, Dunedin

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This thesis explores the conventional problem of maternal-foetal conflict as it has arisen in cases of foetal harm in Canada, the United States, England and New Zealand. The examination of these judgments is undertaken by using philosopher Michel Foucault’s notion of the “medical gaze” and physician Howard Brody’s work on power in the clinical setting as analytical tools.

By viewing the obstetric arena through the lens of the Foucauldian medical gaze it becomes apparent that a silent pregnant body is created when Courts uncritically rely on clinical evidence, presented to them by medical experts, to determine the outcome of a particular case. Although, Brody’s understanding of the healer’s power can account for why expert medical opinion in general holds so much sway in determining legal judgments, it cannot necessarily account for why the Courts would choose one expert testimony over another when the experts appear to occupy equal positions on the hierarchical clinical ladder.

Foucault’s understanding of the medical gaze also reveals that the traditional problem of maternal-foetal conflict is created by viewing the obstetric world in a particular way. The conflict between the pregnant woman and her unborn child does not necessarily exist. Many of the superior Courts do not view this relationship in this adversarial light and thus the conflict is not necessarily brought into existence. Viewing the obstetric world through the lens of the “narrative gaze” reveals that the conflict is not between the pregnant woman and her unborn child but between the pregnant woman and the medical establishment.

Four general conclusions are arrived at in this thesis: 1) Foucault’s understanding of the medical gaze is a useful tool for analysing cases of foetal harm even though physicians may not actually perceive the clinical world in this manner; 2) when Courts rely solely on medical evidence to determine the outcome of a particular case the “audible” pregnant body is excluded; 3) the use of the pregnant woman’s narrative by superior Courts to gather facts about a particular pregnancy or childbirth proves valuable; 4) when medical professionals use adversarial terminology, such as “maternal-foetal conflict”, to describe the relationship a pregnant woman has with her unborn child a conflict is created where one may not necessarily exist in the first place.
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The woman’s body, with its potential for gestating, bringing forth and nourishing new life, has been through the ages a field of contradictions: a space invested with power, and an acute vulnerability; a numinous figure with the incarnation of evil; a hoard of ambivalences, most of which have worked to disqualify women from the collective set of defining culture.¹

- Adrienne Rich
  *Of Woman Born* (1986)

The aim of this thesis is to examine the problem of maternal-foetal conflict as it has appeared in contemporary Western case law in Canada, the United States, England and New Zealand using philosopher Michel Foucault’s postmodern understanding of clinical perception or what he has termed the *medical gaze*, and physician Howard Brody’s work on power in the medical profession.² After surveying a plethora of legal judgments involving cases of prenatal harm – more specifically, allegations of child neglect based on prenatal substance abuse, and compelled caesarean sections and blood transfusions – it becomes apparent that many of the lower Courts exclude the “audible” pregnant body by solely relying on expert medical opinion to determine the legal outcome of a particular case. The exclusion of the pregnant woman’s narrative in lower Court judgments is apparent by its inclusion along side of the medical facts and clinical evidence in the decisions of superior Courts.

The conventional problem of maternal-foetal conflict originally arose in Western society with the medicalisation of the management of pregnancy and childbirth.³ This began

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in the seventeenth and eighteenth centuries when the human body was perceived as a compartmentalised mechanical device. The uterus also fit this notion of a machine and was regarded as a “pump” for expelling the foetus from the body. Advances in obstetric and foetal technologies in the 1950’s contributed to the reconfiguration of the reproductive processes in terms of illnesses and pathologies, and “exposed” the growing foetus to the healthcare profession and society in general. These medical innovations have contributed to the move from perceiving the pregnant body as one to perceiving it as two entities. Although the biological nature of the maternal-foetal relationship has not evolved over time, these new medical technologies have contributed to the recreation of this dyad in terms of two distinct and separate patients who now have potential conflicting interests. Some of the social implications of this new medical knowledge are found in the increasing number of cases of alleged foetal harm being brought before Western Courts, others are found in early diagnosis of foetal abnormalities and treatable ailments. The legalisation of the previously moral debate between the conflicting interests of the gravid woman and her foetus has now become socially reconstructed as a matter of public health policy.

The social concern for the good outcome of pregnancies and childbirths is legitimatised when one considers recent American statistics surrounding the number of infants born suffering the ill effects of certain prenatal behaviours. It has been estimated that eleven percent of children born in American hospitals are born having been exposed to dangerous substances and are consequently at risk of poor health and occasionally death. In more than twenty cases, Court orders have been sought for compelled medical treatment, such as blood transfusions, hospital detentions, and caesarean sections, and in more than three-quarters of the cases the Courts have ruled in favour of forced treatment in order to protect the well-being of the foetus. Overriding the interests of pregnant women in favour of unborn children was standard legal view in the United States in the 1980’s. This is now held

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to be more or less obsolete since Courts in the 1990's generally rule in favour of the rights and interests of competent gravid women. The judgments in these Court cases are similarly echoed in recent English and Canadian law. Chapter One of this thesis provides a detailed outline of the legal decisions in some of the more legally significant prenatal harm cases arising in Western case law.

In Chapter Two, one interesting way of exploring the underpinnings of cases involving alleged foetal harm by using the analytical methodology of French historian and philosopher Michel Foucault (1926-1984) is discussed. The reason for examining these cases using Foucault's methodology is because his work, especially on sexuality and the body, has recently become very appealing to many postmodern feminist writers. One reason for the appeal is that his work creates space for a subjective account of how the world is perceived. This is particularly useful for foetal harm cases since it allows for varying perceptions and experiences that many women have of pregnancy and childbirth. For the purposes here, the prenatal harm cases outlined in Chapter One will be explored through Foucault's understanding of how medical professionals perceive the clinical world or the medical gaze.

According to Foucault, the strategies of the medical gaze such as confessional technologies, the organization and control of time, normalisation, and permanent registration are employed by medical professionals to control and monitor healthcare consumers. This conception of what is occurring in the clinical encounter is derived from Foucault's notion of power. For Foucault, the essence of power is a multidirectional force that comes from the top down, bottom up and from a lateral direction, and envelops each member of Western society. For the purposes here, which is to explore a situation where medical power is being abused, Foucault's conception of power as a force that contains multiple and dynamic points of resistance will be rejected. It is not clear that individuals exercising bottom up power to challenge the top down power being exercised upon them can be successful. Although, the essence of power in the way that Foucault has conceived it cannot necessarily be abused, his understanding of power as something that is not inherently negative or coercive will be

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13 Foucault, The Birth of the Clinic, p. ix, see n. 2.
Chapter Three shows that when the medical gaze as an analytical tool is used to explore the lower Court judgments in cases of foetal harm a silent pregnant body is revealed. Through the medical strategy of “confession”, which includes medical history-taking, physical examinations, interpretations of outputs from monitoring devices, and results from maternal and foetal testing, information is obtained with regard to the prenatal conduct of pregnant women. In cases of foetal harm this information is used to legally sanction gravid women for undesirable prenatal behaviour. Another strategy of the medical gaze is the control and organization of time. An analysis of the lower Court judgments in foetal harm cases using the strategy of temporal organization shows that when pregnancies or births do not progress within specific time constraints healthcare professionals pathologise the situation and assert that time is of the essence and a matter of urgency. Evidence of this sense of urgency is found in the use of *ex parte* applications to hasten Court proceedings and the lack of legal representation before the Courts. Often, the pregnant woman is unaware that proceedings about her particular pregnancy or childbirth have been brought before a Court. These applications, as well as the lack of legal representation literally silence pregnant women from being heard. One implication of acknowledging a sense of urgency in foetal harm cases is what Brody calls the *rescue fantasy* which involves a need to rescue the unborn child from the dangerous confines of the maternal body.15 Two basic claims drive this fantasy: first, unborn children are tiny, distinct patients, and second, pregnant women who fail to conform to popular medical opinion are wilfully harming their gestating offspring. These claims also contribute to the silencing of pregnant bodies by formulating the obstetric situation as a need to rescue an “innocent” body from a malicious one.

As well as confessional technologies and temporal organization, the medical gaze invokes the strategy of normalisation to control healthcare consumers. Not only are stages of pregnancy and foetal development placed into specific categories of “normal” and “abnormal” but methods of managing pregnancy and childbirth are also categorised. Methods of care that do not conform to the medical norm are viewed as unconventional and problematic. In addition, if a pregnant woman has unconventional ideas about appropriate and acceptable obstetric treatment for her particular condition she can be normalised into a category of “mentally incompetent” and be judged as lacking the capacity to refuse to consent to medical treatment. Illegitimate detention of pregnant women under mental health


15 Brody, p. 140, see n. 2.
legislation silences them from making competent decisions about their own healthcare.

In addition to the revelation of a silent body, using the Foucauldian conception of the medical gaze to explore lower Court judgments in cases of foetal harm also reveals that Courts often appear to uncritically rely on expert medical opinion. Medical experts are relied upon not only to obtain the clinical facts pertaining to a particular case but also to determine the legal outcome. Letting medical facts and clinical evidence alone shape the legal decisions in foetal harm cases is problematic since decision-making in this manner fails to recognise that the facts about any particular pregnancy or childbirth are much wider than the mere medical facts. Also, relying solely on clinical evidence assumes that an action that leads to a medically undesirable outcome, such as drug abuse or refusing a caesarean section, is not only morally repugnant but also legally sanctionable. One does not necessarily follow from the other. A father-child analogy elucidated by Thomas H. Murray helps to clarify this claim.\textsuperscript{16}

On way of accounting for why expert medical opinion presented by healthcare professionals holds so much sway in determining the legal outcome of foetal harm cases is through exploring Brody's work on the healer's power.\textsuperscript{17} According to Brody, Western medical professionals possess: Aesculapian power, by virtue of their academic training and clinical skills; Social power, by virtue of the relationship they have with society; and, Charismatic power, by virtue of their personality characteristics.\textsuperscript{18} In addition to these three components of power that physicians possess, Hierarchical power can be added to the framework.\textsuperscript{19} These descriptions of medical power fail to account for discrepancies between healthcare professional who occupy an equal position on the hierarchical ladder and who also appear to be presenting equally legitimate clinical evidence about a particular pregnancy or childbirth.

In Chapter Four, the conventional problem of maternal-foetal conflict is revisited to determine whether there is a correlation between how the Courts view the maternal body – as one or two biological entities – and the legal outcomes of the cases of prenatal harm. From examining the cases it appears that no necessary correlation exists. Perhaps legal ethicists should not be grappling with whether the pregnant body is one complex biological unit or two distinct and separate bodies but rather exploring the nature of the maternal relationship as it pertains to images of interaction. There is a strong correlation between Courts that view

\textsuperscript{17} Brody, p. 16-20, see n. 2.
\textsuperscript{18} Ibid.
the relationship as one of conflict or adversarial in nature and legal judgments that favour the interests of the foetus. Using language that implies an adversarial relationship, such as maternal-foetal conflict, to describe the image of interaction between a pregnant woman and her unborn child should be rejected. By exploring the judgments of superior Courts it becomes evident that the conventional understanding of the “maternal-foetal conflict” is created in light of healthcare professionals’ attitude towards pregnancy and childbirth. Foucault’s notion of the medical gaze is useful for revealing that perceiving the obstetric arena in this manner creates a conflict when one does not necessarily exist. Also, by viewing this world through the lens of the “narrative gaze”, as the superior Courts have tended to do, a conflict between the pregnant woman and her unborn foetus will not necessarily be brought into existence. Instead, this gaze reveals that the conflict is between the pregnant woman and the medical establishment.

In essence, this thesis makes three general conclusions: first, although medical professionals may not in fact perceive the clinical world in the manner that Foucault describes, exploring cases of foetal harm through this lens is useful; second, relying solely on clinical evidence or medical opinion, presented by experts, to determine the legal outcome in cases of foetal harm has negative implications for pregnant women and thus should be supplemented with other non-medical facts, such as the woman’s narrative; and third, using terminology such as “maternal-foetal conflict” to describe situations where pregnant women opt for unconventional medical treatment should be abandoned since it unnecessarily creates conflicts where conflicts may not necessarily exist.
CHAPTER I

MATERNAL-FOETAL CONFLICT & PRENATAL HARM CASES

For ages, medicine has had poor access to the fetus inside the mother’s womb. But in relatively recent years, the human body has become transparent. The latest breakthroughs of technology have made it possible, from the very beginning of pregnancy, to consider the fetus as an individual who can be examined and sampled. His or her physician may now establish a diagnosis and prognosis and prescribe a treatment in the same way as in traditional medicine.¹ - Fernand Daffos (1989) Seminars in Perinatology

INTRODUCTION

Contemporary innovations in obstetric and foetal technologies have caused society to perceive pregnancy and childbirth in a different way. Prior to the discovery of the foetal heart monitor and the development of ultrasound in the 1960’s the pregnant body was more or less within the woman’s own private sphere. Now many feminist writers consider the maternal body to be transparent, or even invisible, as these medical innovations allow healthcare professionals to see beyond the maternal skin into the depths of the womb and shift pregnancy into the realm of the public.² Medicalisation of the pregnant body is the factor most regarded as contributing to this shift. Part One of this chapter will outline how pregnancy and

childbirth have become medicalised in three stages: treating the body as a fragmented and compartmentalised machine, shifting understandings of pregnancy and childbirth from “natural state” to pathological, and advances in obstetric and foetal technologies which allow the foetus to become visible, in turn, rendering the pregnant body invisible. These three stages of medicalisation lead to the establishment of a causal relationship between maternal conduct and foetal well-being.

As the human foetus becomes more “knowable” to healthcare professionals - who then share their newfound knowledge with the general public - it becomes constructed as an innocent and vulnerable object of societal interest and concern. Society takes on the responsibility to ensure that the foetus is kept safe from harm which often involves passing judgment on the lifestyle choices of the pregnant mother. Occasions where the woman appears not to be acting in the best interests of her gestating child can lead to a socially constructed discord between mother and unborn child. From this understanding of maternal-foetal conflict, Court cases have emerged in which members of the legal profession have attempted to, and on some occasions succeeded in, subjecting women to social and political sanctions regarding the manner in which they govern their pregnant bodies. Novel interpretations of statutes and case law have been used in an endeavour to accuse pregnant addicts of child abuse or neglect and delivering a controlled substance to a minor. They have also been used to compel gravid women - often under the auspices of mental health or child protection legislation - to undergo unwanted caesarean sections, blood transfusions or

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5 Johnson v. State of Florida 578 So.2d 419 (Fla.App.5 Dist. 1991); 602 So.2d 1288 (Fla. 1992)


hospital detentions. The majority of these judgments have been overturned by superior Courts and it can be concluded that American, Canadian, New Zealand and English Courts have generally held that the body of a pregnant woman should not be compelled to undergo medical treatment in order to protect the life or health of her foetus. Part Two of this chapter will provide an outline of some of the leading cases that focus on foetal harm. This will demonstrate the legal shift from compelling pregnant women to undergo medical treatment for the benefit of their foetuses to recognising that competent, adult pregnant women legally ought to be able to refuse medical treatment.

I. MATERNAL-FOETAL CONFLICT

A Brief History of Medicalisation

In the Western world, the increasing medical and scientific knowledge of the processes of procreation, pregnancy and childbirth, and the roles both men and women play in those processes have led to the medicalisation of reproduction. This medicalisation occurs in three stages. The first stage involves the pregnant body being regarded as a machine with its fragmented and compartmentalised parts and the uterus being perceived as a "mechanical pump...to expel the fetus". In the seventeenth and eighteenth centuries, the body was commonly spoken of as a machine and the development of anatomical atlases helped to perpetuate this understanding. Anthropologist Emily Martin says that the mechanical metaphor combines the uterus as a machine with the use of actual mechanical devices (such as forceps): "during the 1940's, 1950's and 1960's, birth was the processing of a machine by machines and skilled technicians." Perceiving the body as a machine directs focus to the specific ailing parts of the body and results in a fragmented and objectified understanding of the body. For pregnant women this means focusing on the abdominal area while ignoring the

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8 Crouse Irving Memorial Hospital Inc. v. Paddock 485 N.Y.S.2d 443 (Sup. 1985); Jefferson v. Griffin Spalding County Hospital Authority 247 S.E.2d 457 (Ga. 1981); Raleigh Fitkin-Paul Morgan Memorial Hospital v. Anderson, 201 A.2d 537; 377 U.S. 985 (N.J. 1964)
10 John Seymour. "Legal Intervention to Protect a Foetus?" Otago Bioethics Report, Volume 8, Number 3 (October 1999): p. 12.
12 Duden, p. 86, see n. 2.
13 Martin, p. 54, see n. 11.
14 Wertz and Wertz, p. 165, see n. 11.
rest unless another health matter is in direct relation to the well-being of the foetus.  
Under the mechanical metaphor, physicians are perceived as glorified mechanics or technicians whose job it is to repair whatever is broken on the human body.  
As technology advances, the role of these physicians becomes redefined, from a “specialized practice that involves the exercise of professional judgment”, to a “scientistic, clinical and technological protocol” through dictating what to monitor, how to interpret the output of the monitoring device and when to intervene.  
This metaphor not only divides the body into its ailing components but also fragments it from the mind, thus establishing a mind-body duality and a justification of the use of technology to control pregnancy and childbirth.  
Under this model, pregnancy slowly becomes transformed into a process requiring management and intervention.

The second stage of medicalisation began in the 1950’s with the reconstruction of pregnancy as a “medical phenomenon akin to illness” or as a pathology.  
In the seventeenth and eighteenth centuries, pregnancy was incorporated into medical discourse as a “natural state” of women’s bodies.  
During this time there was no division between normal or abnormal (low risk and high risk) pregnancies as there is in Western medicine today and the dramatically altered physiology of the pregnant body was regarded as a common state of women’s corporeal nature.  
By the eighteenth century, advances in science and technology were employed to prove that the social roles of men and women, established in English society and other Western cultures, were produced as a result of the differences in biology and bodies.  
This was the time when menstruation became labelled as pathological due to the pain and “wounds” women endured each month.

The reconstruction of pregnancy as pathological, and requiring management and intervention began with the transfer of childbirth from the home to the hospital.  
In the eighteenth and nineteenth centuries, pregnant women did not have routine antenatal care nor

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16 Martin, p. 54, see n. 11.
17 Balsamo, p. 90, see n. 2.
18 Martin, p. 17 and 21, see n. 11.
19 Ibid, p. 54.
20 Duden, p. 2, see n. 2.
22 Oakley, p. 15-16, see n. 21.
23 Ibid.
24 Martin, p. 32, see n. 11.
25 Martin, p. 35, see n. 11; Sherwin, p. 180-183, see n. 21.
did they feel it necessary. Pregnancy in general did not constitute a medical phenomenon and so no professional body had laid claim to the care of pregnant women. 26 Modern hospitals originally began as Dispensaries or Lying-in Hospitals where those who could not afford the care of a midwife could come to receive inexpensive or free care. 27 By the nineteenth century many of these institutions provided midwifery services to clients from which emerged the profession of obstetrics. By situating pregnancy and childbirth within the hospital setting competition from female midwives was restricted, paternalistic practicing on the part of physicians was established, clinical expertise was able to be taught to others and the stage was set for the depiction of reproduction as an illness. 28 The association of pregnancy with disease diverts medical attention away from the patient to the disease and the disease process is viewed as independent from the patient. 29 The medical profession now perceives the bodies of pregnant women as broken-down machines in need of repair. It is important to point out that on some occasions pregnancies do in fact require medical intervention. The argument here, though, is that medicalisation perceives all pregnancies and childbirths as potentially pathological.

The third, and most recent, stage of the medicalisation of pregnancy and childbirth involves the development and advancement of technologies which seek to expose the growing foetus to the medical profession and to society in general. The research conducted by German historian Barbara Duden explores how the female peritoneum, as a result of this foetal revelation, acquired transparency. 30 She says that prior to the development of ultrasonography and foetology, 31 pregnancy was a bodily state or physiological event that only women could touch or experience. 32 Foetal assessment was reduced to palpation through the maternal abdominal wall and uterus, and to measuring hormone levels through maternal urine and serum. 33 Now the foetus can be seen and its blood, urine and tissues sampled while the pregnant body and the subject are made invisible. 34 Although it is still only women who can have the full experience of being pregnant and giving birth, these technologies make the foetus accessible in a manner that is almost independent of the pregnant body. For example,
with obstetric innovations physicians are able to move beyond the previous confines of collecting information from the woman about her pregnancy experience and palpating the abdominal area. The development condition of the foetus can be indirectly viewed through imaging technology and can also be directly viewed through removal of the foetus from the uterus. Essentially, foetuses have become more accessible and knowable to physicians.

Although the strictly biological nature of the maternal-foetal relationship has not evolved over time, advances in obstetric and foetal technologies have re-created the maternal-foetal dyad as a duality; both the gravid woman and the foetus are often regarded as distinct patients, both with meaningful rights and interests. This re-creation began in the 1880’s when most physicians carried a stethoscope used primarily for listening to the beating hearts of patients. The utility of this medical device greatly increased when a pupil of French physician Rene-Theophile-Hyacinthe Laennec positioned it on the abdomen of a pregnant woman to hear the “ebbing and flowing of the amniotic sea” - to his surprise he heard the foetal heart beating at 145 beats per minute. The later half of the nineteenth century brought with it advances in radiological technology capable of producing vague outlines of the foetal cranium and developing bone structure. A break through in embryonic visualisation was made in the 1960’s and 1970’s with the development of an echo outline of inaudible “sound”. Ultrasound is now a standard technology used in most Western hospitals and medical centres to reveal the growing foetus to healthcare professionals for scrutiny and to eager parents-to-be causing bewilderment, adoration and occasionally reluctance.

As well as becoming visible through ultrasonic devices, foetuses are now able to be touched through perinatal technologies such as blood transfusions, the implantation of shunts and subcutaneous electrodes that read foetal blood pH, and their entire removal from the womb for minor bladder surgery. In June 1989, University of California at San Francisco surgeon, Dr. Michael R. Harrison successfully repaired a diaphragmatic hernia in a twenty-
four week foetus. Due to his medical innovations Baby Schultz survived to normal birth. Advances in foetal technologies, such as those employed by Dr. Harrison, contribute to the creation of new patients for physicians to have under their care. Prior to the 1940’s it was generally felt that the foetus was protected within the uterus from external harm. Advances in foetal medicine have revealed the notion that whatever the pregnant woman does can negatively or positively affect the health and well-being of her unborn child. For example, if she contracts rubella while pregnant her foetus may be stillborn, deaf, blind or intellectually challenged. If she fails to get proper nutrition or smokes cigarettes, her baby may have a low birth-weight. Foetal exposure to cocaine causes intrauterine growth retardation, subtle neurological abnormalities and, in extreme cases, loss of the small intestine and brain-damaging strokes. Drinking alcohol, using illicit drugs or even taking over-the-counter medication can adversely affect foetal health and development. Even in literature the gravid woman is treated as a “national resource” who must be vigilant about taking vitamins and eating healthy food. In Margaret Atwood’s novel, A Handmaid’s Tale, Aunt Lydia instructs Handmaid Offred: “You must be a worthy vessel. No coffee or tea though, no alcohol. Studies have been done.” Although it could be difficult to link early prenatal events to the particular injuries suffered by a child, according to some medical and

42 In this foetus, the stomach, spleen and large intestine had migrated through a hole in the diaphragm and took up so much space that the lungs could not grow and breathing became impossible. Detection of the hernia was possible through ultrasonic devices. Steinbock, Life Before Birth, p. 146, see n. 41.
44 Fletcher and Evans argue that advances in foetal technologies such as ultrasonography could create a “new stage of human existence, ‘prenatality’, previously only mirrored in poets’ and mothers’ dreams about the fetus, [which] will be as real to our descendants as childhood is to us”. p. 393, see n. 40; Michael R. Harrison, Mitchell S. Golbus, Roy A. Filly. “Management of the Fetus with a Correctable Congenital Defect.” Journal of American Medical Association, Volume 246, Number 7 (August 14, 1981): p. 774-777.
46 A good example of this is the thalidomide tragedy in the 1960’s which resulted in thousands of severely malformed infants and the discovery of foetal alcohol syndrome in the late 1960’s and early 1970’s which caused prenatal or postnatal growth retardation, central nervous system damage (neurological abnormality, developmental delay or learning disabilities), and characteristic facial dysmorphism, such as microcephaly and a flattened nose. Smoking has often been cited as a cause of miscarriage, stillbirth, prematurity, foetal growth retardation and low birth weight. Steinbock, Life Before Birth, p. 129-30, see n. 41; Balsamo, p. 101, see n.2.
47 Steinbock points out that it is often difficult to tell whether the symptoms exhibited by the child are specifically due to maternal cocaine use or to other features of poverty such as poor nutrition, poor maternal health, and little or no prenatal care. Life Before Birth, p. 130-131, see n. 41.
48 Steinbock, “Mother-Fetus Conflict,” p. 135, see n. 45; Steinbock, Life Before Birth, p. 128, see n. 41.
legal professionals, “with recent advances in embryology and medical technology, medical proof of causation in these cases has become increasingly reliable...”\textsuperscript{51}

Even leaving aside advances in technology, pregnant women are still not free from the “fascinated gaze” that brings pregnancy into the public realm.\textsuperscript{52} As her pregnant abdomen swells, taking up more and more public space, everyone becomes aware that she is carrying a potential human person and thus feels it is their duty to cast a surveying gaze on her behaviour, choice of food and drink, decision to smoke or refrain from consuming alcohol or illicit drugs, to exercise or quite her job: “in the office, on the street, it’s everybody’s baby.”\textsuperscript{53}

In the late 1940’s the “organizing concept of obstetrics changed from ‘confinement’ to ‘surveillance’... the hospital became the center of a system [of] obstetrical surveillance that extended throughout the community” and into women’s personal lives.\textsuperscript{54} In contemporary society, American philosopher William Ray Arney asserts, “every aspect of a woman’s life is subject to the obstetrical gaze because every aspect of every individual is potentially important, obstetrically speaking.”\textsuperscript{55} The increased monitoring of childbirth not only brings the gravid body and foetus into the broader system of surveillance, it also functions to control and monitor the obstetricians themselves by giving them further responsibility for interpreting the output of monitoring devices.\textsuperscript{56}

As has been shown above, the pregnant body is now a part of the public domain due in part to the mechanical model of the human body, treating pregnancy and childbirth as pathologies requiring medical intervention, and advances in obstetric and foetal technology. Technical innovations and medicalisation have not created the public pregnancy, but instead, they have contributed to a particular trend towards “public ownership”. Consider the eugenics movement of the late nineteenth and early twentieth century and a move to a welfare state – these factors might also have contributed to pregnancies becoming part of the public arena. Essentially, obstetric technology may just have aided in this ideological move, rather than creating it.\textsuperscript{57} Due to many of these considerations, wombs are now occupying more and more public space in the medical arena and are now also occupying more and more public space in

\textsuperscript{52} Balsamo, p. 80, see n. 2.
\textsuperscript{54} Balsamo, p. 89, see n. 2; William Ray Arney, Power and the Profession of Obstetrics. (Chicago: University of Chicago Press, 1982), p. 123.
\textsuperscript{55} Arney, p. 153, see n. 54.
\textsuperscript{56} Balsamo, p. 89-90, see n. 2.
\textsuperscript{57} I wish to thank Claire Gallop at the University of Otago Bioethics Centre for bringing this to my attention.
the political arena. The problem of maternal-foetal conflict, which will be outlined below, is an example of a strong social interest in the well-being of potential human life.

The Traditional Problem

It has become more accepted in recent times, by both the medical establishment and the public in general, that certain habits and life decisions of the gravid woman have an important impact on the health and chances for complication-free birth of the foetus. Any medical treatment designed to aid the mother or the foetus will inevitably affect the other and since the foetus cannot speak for itself healthcare professionals and the general public often take on its voice in support of foetal interests and rights. In order to construct an apparent contention between the gravid woman and her foetus, it is necessary that the rights and interests of both be recognised. The understandings of obstetric technologies, alterations in women's social roles and expectations, and public pregnancies mentioned above essentially set the stage for conflict between the woman and her foetus should she refuse a recommended medical treatment that is felt to be beneficial for her unborn child. In legal, ethical and medical terms this alleged controversy between the pregnant woman and her growing foetus is traditionally known as "maternal-foetal conflict". Generally, this conflict can be defined as a situation in which a gravid woman’s rights of bodily integrity, privacy, and autonomy are in direct contention with the welfare of the foetus and the surviving child as perceived by the medical establishment - essentially a balancing act between the principles of autonomy and beneficence. It is worth noting that many writers dispute the use of this

62 Smith, p. 324, see n. 43.
64 Steinbock, "Mother-Fetus Conflict," p. 145, see n. 45; Wayne R. Cohen, "Maternal-Fetal Conflicts: Ethical and Policy Issues," in Ethics and Perinatology. Edited by Annon Goldworth, William Silverman, David K. Stevenson, Ernie W. D. Young, and Rodney Rivers (New York: Oxford University Press, 1995), p. 10; Stein, p. 91-92, see n. 64; Flagler et al., p. 1730, see n. 35; Stein and Redman, p. 230, see n. 61.
adversarial-like terminology and argue that the conflict is not between the pregnant woman and her foetus but rather between the pregnant woman and the medical profession. This issue will be addressed further in Chapter Four where it will also be shown that the conflict between mother and unborn child is the result of a particular perception of how physicians view the clinical world.

Those who discuss maternal-foetal conflict can generally be placed along a moral, legal and social spectrum. At the one end of this spectrum is the view that where there is a conflict between the interests of the foetus and the gravid woman, the legal rights, interests and wishes of the woman must prevail. At the other end of this spectrum is the view that once the woman has decided to carry the child to term and forgo her legal right to obtain an abortion the interests and well-being of the foetus must prevail and her moral obligations to her unborn child should now become legalised. Though the most common form of this debate is the polarised positions mentioned above, there are those who advocate a position in the middle of the spectrum. This involves considering both the fundamental importance of autonomy, privacy, and bodily integrity to women and the interests of a viable, wanted foetus. American lawyer Bonnie Steinbock points out that when considering maternal-foetal conflict it must be acknowledged that it is not merely undesirable behaviours such as substance abuse or refusing medical interventions for seemingly selfish reasons that are the
topics of this conflict. She says that often pregnant women have legitimate medical interests that may conflict with the well-being of the foetus. For example, cancer treatments that provide a gravid woman with the best chance of survival may also be fatal to her growing foetus.

The traditional problem of the maternal-foetal conflict can be divided into two distinct periods: conflicts that emerge during pregnancy between the freedom of the gravid woman to behave in a certain manner and the healthy development of the foetus, and those conflicts that emerge at the point of birth between the right of the woman to consent to or refuse medical treatment, such as caesarean sections, foetal surgery or transfusions, and the live birth of her child. In the foetal harm cases that will be outlined below examples of both areas of conflict will be given.

II. WESTERN CASE LAW

Prior to the medicalisation of pregnancy and childbirth, and to the development of high-resolution ultrasonography and other foetal technologies, the maternal-foetal dyad was perceived by healthcare professionals, working under the medical model, as one complex patient - the pregnant woman and her parasitic-like foetus. With the development of techniques that render the pregnant body clinically transparent and the foetus visible, knowable and able to be directly examined and treated, the rights and well-being of the foetus as a distinct patient and the autonomy of the gravid woman became perceived as being in conflict. Because society has a stake in the outcome of a pregnancy, public intervention, in what once was a private act, becomes justified. These political and social interests in the unborn child are exercised through both the medical and legal establishments. As will be evident from the national and international cases outlined below, the conceptual slope from maternal-foetal conflict to foetal abuse and neglect has proved slippery indeed.

American Cases From 1980 to 1999

In the last twenty years, there has been a shift in American case law on foetal abuse. In the 1980’s, pregnant women were compelled to undergo medical treatment and some were

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71 Steinbock, “Mother-Fetus Conflict,” p. 138, see n. 45.
72 Ibid, p. 138-139.
74 Mattingly, p. 13, see n. 31.
75 Ibid, p. 14, 16-17; Miller, p. 113, see n. 60.
76 Stein, p. 104, see n. 64.
convicted of child abuse or neglect for ingesting illicit substances. In the 1990’s, many Courts ruled that a foetus was not a child as defined under state legislation and that gravid women could not be sanctioned for lifestyle choices or refusing to consent to medical treatment deemed beneficial for the foetus. The New Jersey case Raleigh Fitkin-Paul Morgan Memorial Hospital v. Anderson, in the 1960’s, set the stage for what was to be standard judgment twenty years later. On June 17th, 1964 the Supreme Court of New Jersey ruled that the trial Court wrongly held that it did not have jurisdiction to compel a pregnant Jehovah’s Witness to be administered a blood transfusion in order to benefit her life and that of her unborn child. The Court reversed the decision holding that the unborn child is entitled to the law’s protection and thus a special guardian should be appointed to consent to blood transfusions on behalf of the foetus.

The judgment in Raleigh Fitkin-Paul Morgan Memorial Hospital v. Anderson has been cited in many other cases as reason to compel pregnant women to undergo medical treatment. An example of this is found in Jefferson v. Griffin Spalding County Hospital Authority. In this case, the Supreme Court of Georgia ordered that Jessie Mae Jefferson, who was thirty-nine weeks pregnant and suffering from complete placenta praevia, submit to an ultrasound and then to a caesarean section and other necessary procedures if the placenta did not shift on its own. Due to her religious convictions, Mrs. Jefferson refused to consent to the surgical removal of her unborn child and to any blood transfusions. Both she and her husband believed that the Lord would heal her body and that whatever happened to the child would be the Lord’s will. The Court felt that the unborn child is a “viable human being and entitled to the protection of the Juvenile Court Code of Georgia”. Based on these findings, it concluded that since the unborn child was not being provided with adequate parental care nor subsistence, temporary custody would be granted to the State until he or she had been delivered completely from Mrs. Jefferson’s body or death occurred. Likewise, the Supreme Court of Onondaga County in New York ordered that Stacey Paddock, who had an intrauterine pregnancy and was anaemic, submit to any blood transfusions deemed necessary

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77 Raleigh Fitkin-Paul Morgan Memorial Hospital v. Anderson 201 A.2d 537; 377 U.S. 985 (N.J. 1964)
78 201 A.2d 537 (N.J. 1964)
79 Ibid at 538.
80 Jefferson v. Griffin Spalding County Hospital Authority 247 Ga. 86; 274 S.E.2d 457 (Ga. 1981)
81 According to the evidence presented before the Supreme Court of Georgia, placenta praevia carries with it a 99-100 percent certainty that the unborn child will die if delivered vaginally and also that Mrs. Jefferson will only have a 50 percent chance of survival if she attempts to deliver the child in this manner. Ibid at 459.
82 Ibid at 459-460.
83 Ibid at 458-459.
84 Ibid at 459.
by her physician following a caesarean section. Both Stacey Paddock and her husband Scott refused to consent to the administration of blood products due to their deeply-held religious beliefs. The Court based its decision on previous cases that argued that a parent may consent to medical treatment on behalf of an infant but they may not deprive a child of lifesaving treatment and thus interdicted Mrs. Paddock’s freedom to consent to or refuse medical treatment after the surgical procedure so long as it was necessary to stabilise her condition.

Many judges have relied on the judgment in *Roe v. Wade* to criminally convict pregnant women, who abuse controlled substances, of child abuse or neglect on the basis that the state has an interest in protecting viable foetuses. An example of this is found in the 1980 case, *In the Matter of Baby X*, where the prenatal conduct of Mother X, namely her heroin addiction, constitutes child neglect or abuse under the Probate Code. Within twenty-four hours of birth Baby X began exhibiting signs of narcotics withdrawal. The Court of Appeals of Michigan held that due to Mother X’s prenatal drug addiction Baby X was considered a neglected child within the jurisdiction of the Court and temporary custody of the child was taken. Similarly, the Family Court in Monroe County, Florida determined that a mother who refused to seek treatment for her alcohol abuse or to seek proper antenatal care for her unborn child was putting her unborn child in “...‘imminent danger’ of impairment of physical condition, including the possibility of fetal alcohol syndrome...,” and therefore the unborn child was neglected. Citing *Roe v. Wade*, the Court held that an unborn child could be regarded as a “person” entitled to protection under the Family Court Act and the state had an interest in protecting potential human life which included a viable foetus. One year later, the Court of Common Pleas of Ohio, also relying on *Roe v. Wade*, ordered that the Wood County Department of Human Services remove Luciano Ruiz from his parents. Baby Luciano was born at thirty-five weeks gestation and suffering from cocaine and heroin withdrawal. His removal was based on the notion that a viable foetus is considered a “child” under child abuse statutes and that prenatal use of heroin by Nora Ruiz was considered to be

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85 Ibid.
86 *Crouse Irving Memorial Hospital Inc. v. Paddock* 485 N.Y.S.2d 443 (Sup. 1985)
87 Ibid at 444, 446.
88 *Roe v. Wade* (1973) 410 U.S. 113
90 *In the Matter of Baby X* 293 N.W.2d 736 (Mich. App. 1980)
91 Ibid at 739.
92 *In the Matter of Smith* 492 N.Y.S.2d 331 (1985)
93 *Roe v. Wade* 93 S.C.R. 705 at 731
94 *In the Matter of Smith* 492 N.Y.S.2d 331 (1985) at 331-332
95 *Roe v. Wade* (1973) 410 U.S. 113 at 162.
child abuse.\textsuperscript{96}

A similar outcome was found in \textit{In re Troy D}, where the Court of Appeal of San Diego held that Troy D’s mother’s prenatal drug abuse (codeine and methamphetamines) constituted child neglect.\textsuperscript{97} Evidence of her prenatal addiction was found in a urine toxicology test performed on Troy D, after his birth on February 10\textsuperscript{th}, 1988, that tested positive for morphine, metamphetamine and amphetamine. Due to Troy D’s mother’s prenatal drug abuse, her child was found to be neglected and in need of protection and was thus removed from her and placed in the custody of his paternal grandmother.\textsuperscript{98} The Court cited \textit{In the Matter of Baby X}\textsuperscript{99} to illustrate that a woman’s prenatal conduct, such as the ingestion of illicit substances, could constitute child neglect or abuse and recognised that the interests of Troy D and his mother, Kelly B, are potentially conflicting.\textsuperscript{100} In \textit{In re Valerie D}, the Superior Court of Hartford-New Britain found that Valerie D had been abused and neglected, and uncared for as a result of her mother’s prenatal abuse of cocaine.\textsuperscript{101} This decision was appealed by Valerie D’s mother and the Appellate Court of Connecticut held that a “petition for neglect or termination of parental rights [could] be based solely on a mother’s prenatal conduct” and affirmed the lower Court’s decision.\textsuperscript{102} The Family Court of Nassau County, New York in \textit{Department of Social Services v. Felicia B}, held that a woman who ingests cocaine, resulting in her child being born with a positive toxicology for the drug, could be found guilty of child neglect.\textsuperscript{103} Felicia B, by ingesting a dangerous controlled substance while pregnant with Naquann W, had caused him impairment and had failed to recognise the “right of every human being to begin life unimpaired by physical, mental or emotional defects...”.\textsuperscript{104}

Probably the most discussed prenatal harm case arising in the United States in the late 1980’s is \textit{In re A.C.}\textsuperscript{105} In this case, the Superior Court of the District of Columbia granted an order allowing a caesarean section to be performed against the wishes of Angela Carder who was terminally ill with leukaemia and twenty-six weeks pregnant.\textsuperscript{106} Angela’s rights to bodily integrity were viewed by the trial Court as subordinate to the state’s interest in potential life

\begin{itemize}
\item \textsuperscript{96} \textit{In re Ruiz} 500 N.E.2d 935 (Ohio Com.Pl. 1986)
\item \textsuperscript{97} \textit{In re Troy D} 263 Cal. Rpt. 869 (Cal. App. 4 Dist. 1989)
\item \textsuperscript{98} Ibid at 870-871.
\item \textsuperscript{99} \textit{In the Matter of Baby X} 293 N.W.2d 736 (Mich. App. 1980)
\item \textsuperscript{100} \textit{In re Troy D} 263 Cal. Rpt. 869 (Cal. App. 4 Dist. 1989) at 874.
\item \textsuperscript{101} \textit{In re Valerie D} 494 A.2d 922 (Conn.App.1991)
\item \textsuperscript{102} Ibid at 925.
\item \textsuperscript{103} \textit{Department of Social Services v. Felicia B} 543 N.Y.S.2d 637 (Fam. Ct. 1989)
\item \textsuperscript{104} Ibid at 638.
\item \textsuperscript{105} \textit{In re A.C.} 573 A.2d 1235 (D.C. App. 1990); \textit{In the Matter of A.C.} 539 A.2d 203 (D.C. App. 1988); 533 A.2d 611 (D.C.App. 1987)
\item \textsuperscript{106} \textit{In re A.C.} 533 A.2d 611 (D.C.App. 1987) at 612.
\end{itemize}
based on the understanding that her foetus was viable and that the District of Columbia had an interest in protecting its potential life.\textsuperscript{107} The Court cited their earlier decision \textit{In re Madyun} in support of this conclusion. In the \textit{Madyun} case, the Superior Court of the District of Columbia Civil Division held that an order for a caesarean section to be performed on Ayesha Madyun, who was at term and opposed to surgical procedures to remove the unborn child from her body based on her Muslim religious beliefs, be granted.\textsuperscript{108} The Madyun’s argued that Muslim women have the “right to decide whether or not to risk [their] own health to eliminate a possible risk to the life of [an] undelivered fetus”.\textsuperscript{109} The Court based its ruling on the notion that a competent adult has the right to decline medical treatment on the basis of religious grounds unless the state has a compelling interest in overriding that right which in this case, they hold, includes potential human life.\textsuperscript{110} In \textit{In re A.C.}, a motion for a stay was brought before the District of Columbia Court of Appeals which held that Angela’s penumbral privacy right against bodily intrusion was properly subordinated, by the trial Court, to the interests of her unborn child and to the state.\textsuperscript{111} The caesarean section was performed on Angela and a baby girl, L.M.C., was delivered who died two and a half hours later, followed by her mother two days after the procedure.\textsuperscript{112} Though the motion for a stay was denied, subsequently the Court granted a petition for a rehearing \textit{en banc}.\textsuperscript{113} On April 26\textsuperscript{th}, 1990, \textit{In re A.C.} was brought once more before the District of Columbia Court of Appeals which vacated and remanded its previous decision on the basis that a competent pregnant woman, carrying a viable foetus, must be allowed to determine for herself which medical treatment she should undertake.\textsuperscript{114} If the pregnant woman is incompetent or unable to give informed consent to medical procedures her wishes must be ascertained through substituted judgment.\textsuperscript{115}

Beginning with the judgment of the Court of Appeals in \textit{In re A.C.},\textsuperscript{115} in 1990, most American superior Courts since then have ruled in favour of the rights of gravid women to refuse to consent to medical procedures or to engage in certain lifestyles. On February 12\textsuperscript{th}, 1992 the Supreme Court of Ohio affirmed judgments by the Lucas County Court of Common

\textsuperscript{107} Ibid at 613.; \textit{In re A.C.} 573 A.2d 1235 (D.C.App. 1990) at 1238.
\textsuperscript{109} Ibid at 1260.
\textsuperscript{110} Ibid at 1263-1262.
\textsuperscript{111} \textit{In re A.C.} 533 A.2d 611 (D.C.App. 1987) at 611.
\textsuperscript{112} \textit{In re A.C.} 573 A.2d 1235 (D.C.App. 1990) at 1238.
\textsuperscript{113} \textit{In the Matter of A.C.} 539 A.2d 203 (D.C.App. 1988)
\textsuperscript{114} \textit{In re A.C.} 533 A.2d 611 (D.C.App. 1987)
\textsuperscript{115} \textit{In re A.C.} 573 A.2d 1235 (D.C.App. 1990) at 1235.
\textsuperscript{116} Ibid.
Pleas and the Court of Appeals for Lucas County that dismissed the charges that Tammy Gray, by ingesting cocaine in the third trimester of her pregnancy, recklessly created substantial risk to the health or safety of her daughter, Sierra Gray.\textsuperscript{117} The Supreme Court held that a pregnant woman may not be prosecuted for child endangerment for substance abuse occurring before the birth of the child on the grounds that Tammy did not become a "parent" until Sierra was born and that Sierra was not to be considered a "child" while still \textit{in utero}.\textsuperscript{118} Similarly, on January 29\textsuperscript{th}, 1992, the City Court of Geneva in Ontario County, New York held that a pregnant woman who ingests cocaine could not be prosecuted for endangering the welfare of a child since an unborn child did not constitute a "child" within the meaning of the criminal statute prohibiting such actions.\textsuperscript{119} It was alleged that on March 4\textsuperscript{th}, 1991 Melissa Morabito smoked cocaine which caused Lacreesha Morabito to be born prematurely and with cocaine in her blood system.\textsuperscript{120} The City Court held that convicting Melissa Morabito with endangering the welfare of her child would deny her the right to due process as guaranteed by Federal and State Constitutions.\textsuperscript{121} On November 30\textsuperscript{th}, 1994, the Supreme Court of Nevada in \textit{Sheriff v. Encoe} granted Cathy Encoe's petition for a writ of \textit{habeas corpus} on the basis that the statute criminalising child endangerment does not apply to prenatal ingestion of controlled substances and the resulting transmission of substances to the child through the umbilical cord after birth and prior to the severing of the cord.\textsuperscript{122} After the birth of her son in December 1992 a urine sample tested positive for amphetamines and metamphetamines which were the result of Encoe's prenatal use of marijuana and she was thus charged with child endangerment.\textsuperscript{123}

A novel interpretation of Section 893.13(1)(c) of the Florida Statutes (1989) involving the delivering of controlled substances to minors was taken in \textit{Johnson v. State of Florida}.\textsuperscript{124} In this case, the Supreme Court of Florida quashed a decision by the Circuit Court of Seminole County and by the District Court of Appeal\textsuperscript{125} that convicted Jennifer Clarice Johnson of knowingly delivering a controlled substance to her children through the umbilical

\textsuperscript{117} \textit{State of Ohio v. Gray} 584 N.E.2d 710 (Ohio 1992)
\textsuperscript{118} Ibid at 711.
\textsuperscript{119} \textit{People v. Morabito} 580 N.Y.S.2d 843 (City Ct. 1992)
\textsuperscript{120} Ibid at 844.
\textsuperscript{121} Ibid at 843.
\textsuperscript{122} \textit{Sheriff v. Encoe} 885 P.2d 596 (Nev. 1994)
\textsuperscript{123} Ibid at 598.
\textsuperscript{124} \textit{Johnson v. State of Florida} 602 So.2d 1288 (Fla. 1992); 578 So.2d 419 (Fla.App. 5 Dist. 1991); Section 893.13(1)(c), Florida Statutes (1989) says:
\begin{itemize}
  \item (c) Except as authorised by this chapter, it is unlawful for any person
  \begin{itemize}
    \item 18 years of age or older to deliver any controlled substance to a
    \item person under the age of 18 years...
\end{itemize}
cord after birth. The Supreme Court held that cocaine passing from mother to child through the umbilical cord after birth and prior to cutting the cord did not violate statutory prohibition against adult delivery of a controlled substance to a minor. 126 The Court reasoned that the means of delivery of a controlled substance, namely through the umbilical cord, did not fit the requirements of the Florida Statutes (1989).

Following the ruling in In re A.C., the Illinois Court of Appeals in Re Baby Boy Doe held that the decision of a competent woman to refuse to consent to a caesarean section during pregnancy must be honoured, even in circumstances where refusing the medical procedure may be harmful to her foetus. 127 When Dr. James Meserow, a board-certified obstetrician and gynaecologist, and expert in the field of maternal/foetal medicine, examined Doe on November 24th, 1993 he found that the thirty-five week old viable foetus was receiving insufficient oxygen from the placenta and recommended an emergency caesarean section be performed immediately. 128 Doe and her husband refused to consent to the procedure based on personal religious beliefs. Dr. Meserow and the St. Joseph’s Hospital, out of concern for the well-being of the foetus, brought the issue before the Circuit Court, Cook County where the motion to make the foetus ward of Court and compel the caesarean section was denied. 129 On appeal to the Appellate Court of Illinois, DiVito J. affirmed the decision of the Circuit Court and on December 29th, 1993 Doe vaginally delivered a “normal health, although somewhat underweight, baby boy”. 130

In State of Wisconsin ex rel. Angela M.W. v. Kruzicki 131, the Supreme Court of Wisconsin, reversing the decision of the Court of Appeal, held that a foetus was not included within the Children’s Code definition of “child” and thus the CHIPS (child alleged to be in need of protection or services) statute did not confer jurisdiction over Angela nor her viable foetus. 132 While receiving prenatal care, Angela’s obstetrician suspected, and later confirmed through blood testing, that she was using cocaine and possibly other controlled substances. When she failed to keep scheduled appointments her obstetrician became concerned for the well-being of her unborn child and reported his concerns to the Waukesha County

125 Johnson v. State of Florida 578 So.2d 419 (Fla.App. 5 Dist. 1991)
126 Johnson v. State of Florida 602 So.2d 1288 (Fla. 1992) at 1289.
129 Ibid at 327-329.
130 Ibid at 329, 335.
131 State of Wisconsin ex rel. Angela M.W. v. Kruzicki 541 N.W.2d 482 (Wis.App. 1995); 561 N.W.2d 729 (Wisconsin 1997)
On September 5th, 1995 the Waukesha County Department of Health and Human Services filed a motion to “take an unborn child into custody” and Foster J. of the Waukesha County Circuit Court exercised jurisdiction in a CHIPS proceeding. Eight days later, Angela requested from the Court of Appeal either a writ of *habeas corpus* or a supervisory writ to prohibit the Circuit Court’s CHIPS proceeding. Both writ petitions were denied on September 21st, 1995 and the case was appealed to the Supreme Court of Wisconsin which granted the petitions and released her from the constraints of a protective custody order which detained her for the protection of her viable foetus.

In the most recent case to date involving prenatal harm in the United States, the Appellate Court of Illinois held that Darlene Brown, who was thirty-four weeks pregnant with a viable foetus, could not be compelled to undergo blood transfusions for the benefit of her unborn child. After surgery to perform a cystoscopy and removal of a urethral mass, Darlene had lost approximately 1500 cubic centimetres of blood and had a haemoglobin level of 3.4 grams per decilitre (a normal level for a woman at this stage of pregnancy would be between nine to twelve grams per decilitre). Despite using alternative methods compatible with the beliefs of Jehovah’s Witnesses, Dr. Robert Walsh was unable to stabilize Darlene’s haemoglobin levels. He believed that if she did not consent to a blood transfusion her chances of survival, as well as those of her foetus, were only five per cent.

On June 28th, 1996 the State filed a petition for adjudication of wardship and a motion for temporary custody of Foetus Brown which was granted by William F. Ward, Jr. J. of the Circuit Court, Cook County along with “the right to consent to one or more blood transfusions for Darlene Brown, when advised of such necessity by any attending physician”. Darlene was later transfused with six units of packed red blood cells, against her resistance, while the attending physicians “yelled at and forcibly restrained, overpowered and sedated her”; seven days later she delivered a healthy baby body. On appeal the Appellate Court of Illinois reversed the trial Court’s decision, finding that it had erred in appointing a temporary guardian for Foetus Brown with the ability to consent to blood transfusions on behalf of Darlene and

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132 Ibid at 731.
133 Ibid at 732.
134 Ibid at 732-733.
135 Ibid at 729.
136 *In re Fetus Brown* 689 N.E.2d 397 (Ill.App. 1 Dist. 1997)
137 Ibid at 399.
138 Ibid.
139 Ibid at 339-400.
140 Ibid at 400.
Errred in appointing the public guardian as guardian ad litem for Foetus Brown.\textsuperscript{141}

**English Cases From 1988 to 1998**

There has not been the abundance nor diversity of prenatal harm cases in English law as there has been in the United States. Nonetheless, there still has been a plethora of legal, ethical and social issues that have arisen in the four prenatal harm cases that will be outlined here. In *Re F (in utero)*\textsuperscript{142}, the Court of Appeal ruled that a foetus cannot be made a ward of Court on the grounds that since it has not been “born alive” it cannot be considered a person with legal rights and interests.\textsuperscript{143} At the time of her pregnancy, F’s mother was thirty-six years of age and suffered from severe mental disturbance and occasional drug abuse. After a prolonged nomadic existence in Europe with her first child, he was placed in the sole care of long-term foster parents. In January 1988, the local authorities discovered that she was pregnant with her second child, F, who was due to be born at the end of that month. Neighbours notified authorities that she had fled her flat and could not be located.\textsuperscript{144} Fearing for the well-being of F, the local authorities made a motion to have F made a ward of Court. On January 15\textsuperscript{th}, 1988, Hollings J. of the lower Court ruled that it was beyond the Court’s jurisdiction to make an unborn child a ward of Court. The local authority appealed this judgment and, on January 15\textsuperscript{th}, 1988, the Court of Appeal dismissed that same appeal.\textsuperscript{145} The Court of Appeal also held that it did not have the jurisdiction to make an unborn child a ward of Court on the basis that the foetus does not exist independently of its mother and thus extending jurisdiction to include a foetus would only serve the paternalistic purpose of controlling the mother’s actions.\textsuperscript{146}

In contrast with the judgment in *Re F (in utero)*, Sir Steven Brown P. of the Family Division Court, on October 12\textsuperscript{th}, 1992, granted a declaration sought to authorise surgeons and healthcare staff to carry out a caesarean section on Mrs. S. against her refusal to consent to the procedure based on firm religious beliefs.\textsuperscript{147} Mrs. S was in labour with her third pregnancy, six days past her due date and the unborn child was in a “transverse lie” with its elbow projecting through the cervix and its head on the right side. The evidence that was presented to the Court indicated that there was a serious risk that the uterus would rupture, causing

\textsuperscript{141} Ibid at 406.
\textsuperscript{142} *Re F (in utero)* [1988] 2 All E.R. 193.
\textsuperscript{143} Ibid at 196.
\textsuperscript{144} Ibid at 194.
\textsuperscript{145} Ibid at 197.
\textsuperscript{146} Ibid at 200.
injury to both mother and child, if a caesarean section was not performed immediately and for this reason Sir Steven Brown P. granted the declaration as sought. A similar outcome was found in Re MB where Butler-Sloss LJ of the Court of Appeal dismissed MB’s appeal of the judgment handed down by Hollis J. of the High Court. Butler-Sloss LJ stated that their decision to dismiss the appeal was not based on the interests of the foetus (as was done in Re S mentioned above), which she says were not within the jurisdiction of the Court to consider, but rather on whether M.B. was competent to refuse the insertion of the needle for anaesthetic purposes. Hollis J. held that the operation should proceed including the insertion of needles for the purposes of intravenous infusions and anaesthesia. To make his decision he relied on affidavit evidence from Dr. F, the consultant psychiatrist, which confirmed that M.B. clearly understood the need for and consented to a caesarean section but due to her needle phobia she was found to be temporarily incompetent. In addition, Hollis J. relied on the judgment in Re L given by Kirkwood J. wherein L, who also suffered from a needle phobia, refused to consent to the insertion of the anaesthesia needle for the purposes of the caesarean section procedure. Kirkwood J. held that this serious aversion to needles clouded L’s judgment and thus a declaration was granted allowing authorities to insert needles for anaesthetic purposes and undertake the caesarean section.

In the most recent English prenatal harm case, a thirty-six week pregnant woman, M.S., was found to be suffering from severe pre-eclampsia and was informed that a caesarean section would be required to save her life and that of her unborn child. She refused to consent to the surgical treatment, saying that she wanted to give birth naturally in a barn in Wales. She was admitted against her wishes, on April 25th, 1996, to Springfield Hospital for psychiatric assessment under Section 2 of the Mental Health Act 1983. On that same day she was then transferred to St. George’s Hospital and an order dispensing her consent to the caesarean section was granted, ex parte, by the Family Division the following day. A

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148 Ibid at 672.
149 Re MB (CA) [1997] 8 Med LR 217 at 221.
150 Ibid at 225.
151 Ibid at 220-221.
152 Re L [December 5th, 1996] (unreported). Patient ‘L’ had been in labour for many hours when her labour finally became obstructed. An emergency caesarean section was strongly indicated to protect the life of the foetus. ‘L’ wanted her baby to be born alive but, like M.B., she suffered from a needle phobia. Kirkwood J said that “...her extreme needle phobia amounted to an involuntary compulsion that disabled ‘L’ from weighing treatment information in the balance to make a choice. Indeed it was an affliction of a psychological nature that compelled ‘L’ against medical advice with such force that her own life would be in serious peril.”
155 Ibid at 941.
caesarean section was performed on M.S. and a baby girl was delivered at 10:00 p.m. On April 30th, 1996 she was returned to Springfield Hospital and on May 2nd her detention under Section 2 of the Mental Health Act 1983 was terminated, and against medical advice, she immediately discharged herself from the hospital. While she was a patient at Springfield and at St. George’s Hospitals, M.S. was not given any specific treatment for a mental disorder nor for a mental illness and, in fact, the psychiatrist found her to be of sound mind. M.S. appealed to the Court of Appeal against the granting of the declaration dispensing her consent to treatment and applied for judicial review of her transfer, admission and treatment at both hospitals and her return to Springfield Hospital after the caesarean section had been performed. The Court of Appeal held that the declaration involving the removal of an unborn child from M.S., against her wishes, amounted to trespass of the person. In addition, the Court held that the Mental Health Act 1983 could not be used to detain an individual against her wishes nor compel her into medical treatment unconnected with her alleged mental illness on the mere basis that her thinking process was perceived as unusual. Accordingly, the Court held that M.S.’s transfer, detention and treatment were all unlawful, granted the application for judicial review and ordered declaratory relief.

Canadian Cases From 1996 to 1999

Results similar to those found in two of the English cases outlined above and the American cases in the 1990’s were found in the recent Canadian case, Winnipeg Child and Family Services (Northwest Area) v. G. (D.F.). The Supreme Court of Canada ruled that pregnant women cannot be confined nor forced to accept medical treatment on the grounds that the parens patriae jurisdiction of the Court - designed to enable the Court to “act in the stead of a parent for the protection of a child” does not extend to the protection of a foetus. At the age of sixteen, G gave birth to her first child in March 1991 and, one month later, due to her habit of solvent abuse, the Winnipeg Child and Family Services (C.F.S.) obtained permanent guardianship of her child. On August 6th, 1992 at age eighteen, G gave birth to a second child born with permanent disabilities and C.F.S. also became guardian of this child. G’s third child was born on November 5th, 1993 also with permanent disabilities due to

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157 Ibid.
158 Ibid at 673.
159 Ibid at 673-674 and 937.
160 Ibid at 674 and 937-938
solvent abuse and for a third time C.F.S. obtained custody of the child. On May 28th, 1996 during a visit to the hospital for extreme loss of balance, weakness and nausea, G discovered that she was thirteen weeks pregnant with her fourth child. After speaking with a social worker from C.F.S., she agreed to enter a residential treatment program for substance abuse but when the worker returned to G’s home five days later G was found intoxicated and refused to attend the program.163

On August 1st, 1996, Winnipeg Child and Family Services brought a motion before Shulman J. of the Manitoba Court of Queen’s Bench for an order compelling G to live at a place of safety and to refrain from consuming any intoxicating substance or drug until the birth of her child.164 The motion was granted and G entered the Health Sciences Centre on August 6th, 1996 to begin the withdrawal process from her solvent addiction. Even though the order was stayed by Helper J.A. of the Manitoba Court of Appeal on August 8th, 1996 G chose to voluntarily remain at the Centre to continue treatment until her physician discharged her on August 14th, 1996.165 She stopped sniffing glue and in December 1996 gave birth to an apparently healthy child who she is now raising.166 On September 12th, 1996 the order of Shulman J. requiring G to enter a treatment program for her substance addiction was set aside by the Manitoba Court of Appeal on the basis that the facts of the case did not establish incompetence under the Mental Health Act 1987 and that the trial judge had incorrectly relied on the Court’s parens patriae jurisdiction in this alleged case of mental illness.167 The decision of the Court of Appeal was appealed by the Winnipeg Child and Family Services and was brought before the Supreme Court of Canada in June 1997 where the appeal was dismissed and the decision of the Court of Appeal affirmed.168

In Dobson (Litigation Guardian of) v. Dobson, the most recent Canadian case involving foetal harm, Cory J. held that a born child has no capacity to bring action against the negligent prenatal conduct of its mother since to allow these types of actions would open the door to subjecting every aspect of maternal daily life to judicial scrutiny.169 On March 14th, 1993 Cynthia Dobson, twenty-seven weeks pregnant with Ryan Dobson, was driving her car towards Moncton, New Brunswick on Route 126 which was covered in patches of drifted

163 Ibid at 964-966.
166 Ibid at 934.
snow and slush.\textsuperscript{170} Her vehicle went out of control and collided with another on-coming vehicle driven by John Carter. Ryan was born prematurely by caesarean section later that same day and was found to have suffered permanent mental and physical impairment, including cerebral palsy, due to his mother’s careless driving.\textsuperscript{171} Ryan’s grandfather and the litigation guardian launched a tort claim against Cynthia Dobson for the damages Ryan sustained. Miller J. of the New Brunswick Court of Queen’s Bench found that Ryan had the legal capacity to sue his mother for injuries caused by her prenatal negligence.\textsuperscript{172} This was appealed to the New Brunswick Court of Appeal where Hoyt C.J. affirmed the trial Court’s decision and found that the narrow issue at hand concerned the allegedly negligent driving of pregnant women resulting in injuries to born alive children and not injuries sustained as a result of her lifestyle “choices”.\textsuperscript{173} This decision was appealed to the Supreme Court of Canada where the majority allowed the appeal without costs and set aside the order of the Court of Appeal and the trial judgment.\textsuperscript{174} Relying on the decision in the \textit{Winnipeg} case the Supreme Court held that because the pregnant woman and her foetus were bonded in a union, the relationship is very distinct from the relationship that a mother-to-be has with a third party. The Court felt that holding her liable for prenatal negligence could subject even mundane daily activities, such as the amount of physical exercise she partakes in or the food she ingests, to the scrutiny of others.\textsuperscript{175}

\textbf{New Zealand Cases in the 1990’s}

At time of writing there were no reported Australian cases involving foetal harm and the only relevant New Zealand case is the 1995 case \textit{Re Baby P [an unborn child]} in which the unborn child of a fifteen-year-old was vested interim custody in the Director-General of Social Welfare.\textsuperscript{176} The unborn foetus was found to be included under the definition of “child” in the \textit{Children, Young Persons and Their Families Act 1989}. The criteria for this is achieving a state of viability and being beyond twenty weeks gestation at which point the \textit{Crimes Act 1961} gave protection to the life of an unborn child. Citing \textit{R v. Henderson}\textsuperscript{177}, the Court also held that should his death occur, the accused could be charged under Section 182 of the \textit{Crimes Act 1961} for causing the death of an unborn child in the same manner as if the

\begin{footnotesize}
\begin{itemize}
  \item \textsuperscript{170} Ibid at 36.
  \item \textsuperscript{171} Ibid.
  \item \textsuperscript{172} \textit{Dobson (Litigation Guardian of) v. Dobson} [1997] 143 D.L.R. (4th) 189
  \item \textsuperscript{173} \textit{Dobson (Litigation Guardian of) v. Dobson} [1997] 148 D.L.R. (4th) 332
  \item \textsuperscript{174} \textit{Dobson (Litigation Guardian of) v. Dobson} [1999] 174 D.L.R. (4th) 1, at 33.
  \item \textsuperscript{175} Ibid at 12-13; Manning, p. 571, see n. 127.
  \item \textsuperscript{176} \textit{Re Baby P [an unborn child]} 13 FRNZ 472 (1995).
\end{itemize}
\end{footnotesize}
The foetus had been born alive. The Court found that Baby P was in need of care and protection due to the violent nature of his father, H, and due to the persistence of H’s relationship with Baby P’s mother. Despite H’s violence towards the mother, his threats to kidnap and kill Baby P, and an interim restraining order the mother continued to have a relationship with H. Not only did Baby P require care and protection from his father, H, but also from his mother’s “immaturity and apparent infatuation with the father”. On June 7th, 1995, B.D. Inglis J. of the Family Court, New Plymouth made declaration that Baby P was in need of care and protection and vested his interim custody in the Director-General of Social Welfare.

Though there have not been substantial foetal harm cases that have come before New Zealand Courts there have been some media-reported cases of applications being made by the Children, Young Persons and Their Families Service (CYPFS) and the police to place pregnant substance abusers in safe houses until the birth of their children. For example, on April 5th, 1997 the Otago Daily Times reported that police in Rotorua were contemplating applying to the Courts to have an eighteen-year-old pregnant solvent and alcohol abuser institutionalised until the birth of her unborn child in order to protect her foetus from further harm. When she was pregnant with her first child in 1996 CYPFS made an unsuccessful application to the Courts to authorise the placement of the woman in a safe house. The Alcoholism and Drug Addiction Act 1966 allows agencies, such as the police or CYPFS, to apply for a Court order to place a pregnant woman in a protected environment until her baby is born.

CONCLUSION

With the advances in obstetric and foetal technologies described above and the perception of pregnancy as a public event, evidence of the law taking a more active role in the gravid woman/foetus relationship is found in the increasing number of cases being brought

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177 R v. Henderson [1990] 3 NZLR 174; (1990) 6 CRNZ 137 (CA)  
178 Ibid at 477-478.  
179 Ibid at 479.  
180 Ibid at 472, 480.  
182 Ibid. The Alcoholism and Drug Addiction Act 1966  
Section 9 – Power of District Court Judge to order detention and treatment on application of relative or other reputable person  
(1) On the application in the prescribed form of a relative...of any person, or on the application in the prescribed form of a member of the Police or of any other reputable person, that the person to whom the application relates is an alcoholic, any [District Court Judge] may if he thinks fit issue his summons to the alleged alcoholic to show cause why an order should not be made requiring him [sic] to be detained for treatment for alcoholism in an institution.
before the Courts. Though these Courts have long recognised that a competent adult can refuse to consent to medical treatment and cannot be legally compelled to undergo surgery, take medications or generally risk his or her own health or life for the benefit of another human being, when the competent adult under consideration is a pregnant woman this all appears to change. The foetus becomes a new category of patient for healthcare professionals to heal and, in some cases, for judges to protect under the law. The legalisation of the previously moral debate between the allegedly conflicting interests of the gravid woman and her foetus becomes socially reconstructed as a matter of public health policy.

From reading the judgments of the cases outlined above, it becomes evident that the Courts rely strongly on the medical opinion given by healthcare professionals and essentially appear to base their decisions on those opinions alone. This will be discussed more fully in Chapter Four. The Courts are taking on an unhealthy attitude towards medical opinion by letting the mere facts obtained from medical experts, such as the necessity for certain procedures or the affects of illicit substances on the growing foetus, sway their legal judgment. As will be outlined in Chapter Two and further in the latter part of the thesis, individuals often act in ways that society may deem immoral, or somehow less than ideal, but it does not then necessarily follow that these individuals ought to be legally punished for their morally repugnant behaviour. Analysing legal judgments in foetal harm cases through the lens of the Foucauldian notion of the medical gaze reveals a silent pregnant body, on the

183 Meyers, p. 3, seen. 59.
185 Miller, p. 119, seen. 60; McFall v. Shimp (1978) 10 Pa. D & C. 3d. 90. Robert McFall was dying of aplastic anaemia and asked the Court to order his cousin David Shimp, the only family member with potentially compatible bone marrow to donate. The Court refused to order Shimp to donate even though it found his behaviour in not wanting to do it morally reprehensible; Steinbock, Life Before Birth, p. 152-153, see n. 41; Canadian Medical Association Code of Ethics stipulates that a physician “must respect the right of a competent patient to accept or reject any medical care recommended”. Canadian Medical Association Journal, Volume 155 (1996): p. 1176A-B. Not even parents of born children are under legal obligation to allow the use of their body in order to save the life of their child. See Jones, p. 95, see n. 35; Eckelaar, p. 65, see n. 69; Murray uses an analogy of a father who is a donor match for his child’s liver to argue that, like parents’ obligations towards born children, pregnant women do not have a legal, although unarguably a moral, obligation towards unborn children to undergo invasive treatment such as caesarean sections. He says “the prospect of forcibly restraining a man in order to take out a piece of vital organ for someone else’s benefit - even his own child’s - gives us pause, for the same reasons we were reluctant to take the other father’s marrow.” Thomas H. Murray, “Moral Obligations to the Not-Yet-Born Child,” in The Worth of a Child. (Berkeley: University of California Press, 1996), p. 112-114; Flager et al., p. 1730, see n. 35.
186 Steinbock, Life Before Birth, p. 147, see n. 41; Balsamo, p. 110, see n. 2.
one hand, and a strong correlation between medical opinion and judicial judgment, on the other hand.
INTRODUCTION

In Chapter One an account was presented of the medicalisation of pregnancy and childbirth and the traditional problem of maternal-foetal conflict that arose from perceiving the body as a machine, treating pregnancy as a pathological event, and advances in foetal and obstetric technologies which render the womb transparent. Case law involving compelled caesarean sections or blood transfusions, and abuse of illicit substances is a social and political product of the medicalisation of pregnancy and childbirth in many contemporary Western societies. One interesting way of looking at this explanation of medicalisation is found in French historian and philosopher Michel Foucault’s (1926-1984) understanding of the medical gaze. This approach is able to provide valuable insights into the underpinnings of the legal judgments in cases of foetal harm. This will be demonstrated in the latter parts of the thesis. Prior to undertaking an analysis of Foucault’s understanding of the medical gaze, his work on power will be outlined and critiqued with regard to its utility for analysing abuses of power between pregnant women, one the one hand, and members of the judiciary and healthcare profession, on the other hand. It is important to critique Foucault’s understanding

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of power before proceeding to outline his notion of the medical gaze since this gaze falls out of his concept of power. Some feminist writers, such as American philosopher Jana Sawicki, find Foucault’s work on power to be particularly useful for examining the social and political implications of the emergence of new reproductive technologies for women in Western societies. Both an expositional and a critical account of Foucault’s notions of power and clinical perception will be put forth in the chapter that follows.

I. A FOUCAULDIAN PERSPECTIVE OF POWER

Foucault’s most fundamental concern in books such as Discipline and Punish, The Birth of the Clinic and The History of Sexuality is with the functioning of power within social and historical contexts. He is also concerned with establishing an historical or “genealogical” account of the essence of power. The aim of his discussions on power is not to develop a universally applicable or objective theory of power. Rather, he seeks to develop a specific understanding of power that offers insights into certain situations and relationships such as those involving sexuality or punishment. In The History of Sexuality Foucault provides a description of what the essence of power is not. First, for Foucault, the essence of power is not something localised or situated within a social or political institution, such as the State or government, which ensures the subservience of its citizens. In history, an example of this sort of tyrannical power is found in the way Adolph Hitler and the National Socialist party presided over the Jews and other subjugated groups during the Second World War. A literary example is found in the way Big Brother in Nineteen Eighty-Four and the World State in Brave New World condition all human behaviour and strictly monitor every aspect of daily life, including even mundane activities such as what food is consumed and what material is read. For Foucault, the essence of power is not a sovereign-like institution.

Second, the essence of power is not something that functions in the form of rules that

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5 Gutting, p. 20, see n. 4.
6 Foucault, The History of Sexuality, p. 92, see n. 4.
7 Ibid, p. 92, 96.
8 Orwell, see n. 1.
are created and enforced by legal bodies. An example of this type of power—-in the form of the law—is found in the federal criminal codes of most Western countries and in municipal traffic or land zoning by-laws. In literature, an example of power in the form of rules and laws is found in Rudyard Kipling’s short story *As Easy as A.B.C.* The primary rule of the Planet is “do not interfere with the traffic and all that it implies”; its motto is “Transportation is Civilization”. Punishment is the result of this rule being broken. For Foucault, the essence of power is not found in rules or laws.

Finally, for Foucault, the essence of power is not found in the form of domination exerted by one social group over another. This is probably the most widespread understanding of the colloquial use of the word power. An historical example of this type of power is found in the apartheid in South Africa where Europeans were segregated from non-Europeans on the basis of racial identity. A further historical example of this type of racial domination is found in the nineteenth century when slavery was prevalent in the southern part of the United States. Slavery was so common during this time that there was even a disease—“Drapetomania”—coined for slaves who ran away from their owners. In summary, the essence of power for Foucault is not a sovereign state, rules or laws, nor in the form of domination of one group by another. Foucault refers to this group of ideas of power as the “Law-and-Sovereign” view of power which he considers to lay on the outskirts of the essence of power rather than to be power itself.

It has been outlined what power is not, so the question can be asked: what is power in Foucauldian terms? Foucault says that “power must be understood in the first instance as the multiplicity of force relations immanent in the sphere in which they operate and which constitute their own organization.” This statement from *The History of Sexuality* basically sums up his understanding of the essence of power. For Foucault, power is a force that operates in a very subtle and multidirectional manner; power comes from the top down, bottom up and from a lateral direction. All members of a particular culture or society are inevitably enmeshed in power relationships which are constantly changing and are specific to their individual place in the world. According to Foucault, “[p]ower is everywhere; not

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11 Foucault, *The History of Sexuality*, p. 92, see n. 4.
13 Ibid, p. 221.
14 Foucault, *The History of Sexuality*, p. 92, see n. 4.
16 Foucault, *The History of Sexuality*, p. 97, see n. 4.
17 Ibid, p. 92.
18 Ibid, p. 94.
because it embraces everything, but because it comes from everywhere."¹⁹ Even those who occupy a lower rung on the socio-economic ladder are in a position to challenge or rebel against power by exerting their own power from below.²⁰ Foucault asserts that at the very root of power there is never absolute opposition between the ruler and the ruled because of this constant ability to challenge power.²¹ Foucauldian power is seen in terms of a sliding scale which moves easily between members involved in power relationships. Within these relationships there are dynamic "points of resistance" where power can be challenged.²² These points are not stationary, fixed points along a power continuum but rather are "mobile and transitory" points within a dense, interconnected web of relationships.²³

**The Panopticon**

Foucault's most celebrated, paradigmatic example of the operation of power is found in his adaptation of English philosopher Jeremy Bentham's (1748-1832) Penitentiary Panopticon (See Figures 2.1 and 2.2 on page 31).²⁴ Bentham’s plan for the construction of a panoptic prison system involved a central, circular compound with an one hundred foot diameter allowing for forty-eight prisoners' cells, six feet wide at the outside, with a passage through the building of eight or nine feet. The inspector's tower or lodge, thirty-five feet in diameter and standing in the middle of a large Courtyard with buildings of holding cells on the periphery, comprises the core of this model system. Each holding cell has two windows: one which faces the outside of the prison and allows sunlight to be cast into the cell through to the corresponding section of the tower and the second which faces the inspector's lodge and allows for continual observation of the prisoner.²⁵ Lamps placed outside each window of the inspector's lodge reflect light back into the corresponding cell so even throughout the night the inmates are visible to the invisible inspector. As a mode of communication, small tin tubes travel from the inspector's lodge, passing across the annular area, to each prisoner's cell. The inmate can now be heard, as well as viewed, at all times by the inspector who takes the position of an all-seeing, omniscient and omnipotent entity.²⁶ For Bentham, the Panopticon functions as an ideal punitive system due to the constant visibility of the inmates

¹⁹ Ibid, p. 93.
²⁰ Ibid, p. 94.
²¹ Ibid.
²² Ibid, p. 96.
²³ Ibid.
²⁴ Foucault, *Discipline and Punish*, p. 195-228, see n. 4; Jeremy Bentham, *The Panopticon Writings*, Edited by Miran Bozovic (London and New York: Wo Es War Series from Verso, 1995); William Ray Arney, *Power and the Profession of Obstetrics*. (Chicago: University of Chicago Press, 1982), p. 87; Dreyfus and Rabinow point out that the Panopticon is not itself the essence of power but rather a clear example of how power functions, p. 188, see n. 10.
²⁵ Bentham, p. 36, see n. 24; Foucault, *Discipline and Punish*, p. 200, see n. 4; Dreyfus and Rabinow, p. 189, see n. 10.
²⁶ Bentham, p. 10, see n. 24.

Figure 2.2 – An additional diagram of Jeremy Bentham’s Panopticon taken from the cover of Jeremy Bentham, *The Panopticon Writings*. Edited by Miran Bozovic, (London and New York: Wo Es War Series from Verso, 1995).
and constant invisibility of the inspector. The prisoners tend to regulate their own behaviour due to the fact that they never know when they are being watched. Like Lyman Frank Baum’s (1856-1919) Wizard in The Wonderful Wizard of Oz, once the voice and the watchful gaze of the inspector are given a body he becomes reduced to a “powerless, vulnerable creature” with no more authority than the inmates themselves.27

One criticism of Foucault’s use of Bentham’s Penitentiary Panopticon as an ideal model for the functioning of power is that it appears, on the outset, to represent power in a form that Foucault rejects. Power relationships that are immanent within a prison system seem to be in the form of domination of one group – the inspector and the State – over another group – the prisoners. Rather than focusing on the punitive measures of the Panopticon, Foucault moves beyond its architectural design to focus on how it serves as a paradigmatic example of the “control of bodies and spaces” through constant surveillance.28 As an ideal schema of power, the Panopticon exercises power in a manner that is depersonalised or non-subjective.29 Power in the panoptic form is anonymous; “power is not totally entrusted to someone who would exercise it alone”.30 Rather, Foucauldian power is multidirectional which implies that it can be exercised by anyone who so desires. This is a multipurposeful device that can be readily adaptable to a prison, psychiatric institution, place of employment, school or hospital.31

Power and Feminism

Foucault’s account of power outlined above is appealing, especially to postmodern feminist writers, since it allows for a subjective account of power relationships. Traditionally, commentators on maternal-foetal conflict and prenatal harm cases have formulated their analyses in terms of modernist Western political thought. This involves an appeal to “universal normative standards and...absolute values”.32 For instance, philosopher Wayne R. Cohen takes a consequentialist or outcome-based approach to weighing the harms and

28 Dreyfus and Rabinow, p. 192, see n. 10.
30 Foucault, “The Eye of Power,” p. 156, see n. 29.
31 Dreyfus and Rabinow, p. 189, see n. 10.
benefits in cases where the pregnant woman is refusing medical treatment.\textsuperscript{33} American legal philosopher Deborah Mathieu discusses the maternal-foetal conflict in terms of maternal rights to privacy and self-determination and the interests of future children.\textsuperscript{34} Foucault’s understanding of power moves beyond these modernist approaches to recognise that members of Western society “live in a different [sort] of world from that theorised by…” modernist thinkers.\textsuperscript{35} The world that Foucault describes breaks away from the traditional assumptions of universality and takes a more subjective approach to perception. Even though many thinkers do believe that subjective preferences, beliefs and attitudes both exist and are ethically relevant, what distinguishes Foucault’s work from this is his ability to inhabit a new epistemological space.\textsuperscript{36} In this space he challenges the basic definitions of terms such as knowledge, power, and the subject developed in modern Western philosophy.\textsuperscript{37} His methodology is of particular interest to women and other oppressed groups who share “common cause with Foucault in his challenge to the canon”.\textsuperscript{38} Foucault’s methodological approach to challenging the canon is especially useful for women who seek to challenge the objective notion that the female experience of pregnancy and childbirth is essentially universalizable. Foucault’s work allows for the recognition that not all women will experience pregnancy and childbirth in the same manner; accounts of this experience will vary due to the plethora of standpoints that women occupy in the Western world.

Contemporary American feminist writer and political scientist Susan J. Hekman raises three issues questioning the usefulness of Foucault’s work on power for feminist writers: first, “[c]an the master’s tools dismantle the master’s house”; second, Foucault fails to discuss women and gender despite his interest in sexuality; and third, through Foucault’s deconstruction of the subject, “woman” disappears.\textsuperscript{39} In the first criticism of Foucault’s work Hekman questions whether Foucault’s “location as a malestream theorist” can prove useful for feminist thinkers who are attempting to tackle these male-centred or “androcentric” views of Western society. She says that “Foucault is, despite is iconoclastic stance, yet one more androcentric European male theorist that feminists are exhorted to follow.”\textsuperscript{40} This assessment places Foucault in the same category as many of the modernists briefly mentioned above and


\textsuperscript{35} Hekman, p. 3, see n. 32.

\textsuperscript{36} Ibid, p. 3.

\textsuperscript{37} Hekman, p. 1, see n. 32.

\textsuperscript{38} Ibid.

\textsuperscript{39} Ibid, p. 1-2.

\textsuperscript{40} Ibid, p. 1.
perceives him as another, though undoubtedly less orthodox, author of the canon of Western philosophical texts. Sandra Lee Bartky asserts that "...his analysis as a whole reproduces that sexism which is endemic throughout Western political theory." Reduced to its elements, the question put forth above is concerned with whether Foucault's analytics and methodologies, such as his notion of power, can aid feminist thinkers in moving beyond the male-centred or androcentric view of the world adopted by many traditional liberals. This view of the world is essentially a "gender blind" view which fails to recognise that the traditional modernist position embraced since the Enlightenment era is based on a male privileged perspective. The charge is that Foucault may have membership in this exclusive "boys club" and have a privileged perspective of the world due to the mere fact that he is a European male intellectual.

Hekman's second issue is the primary criticism that many feminist writers have of Foucault's work. Although he discusses sexuality in great detail, he fails to recognise that these "docile bodies" are in fact gendered bodies. According to Sawicki, Foucault intended to write a volume in The History of Sexuality entitled Woman, Mother and Hysteric which was to be a history of the sexualisation of women's bodies focusing on relative pathological concepts such as "hysteria, neurasthenia, and frigidity". The intent was to locate the mechanisms of power and discipline through which women's bodies were controlled. Many feminist thinkers see beyond Foucault's failure to concern himself with gendered bodies and find his analytical methodology useful for dismantling central tenets of the modern Western canon such as the mind/body dualism that places women on the side of the body. His methodology is also used to dismantle the tenet that power emanates from a central source. In addition, Foucault's writings on the body and sexuality have stimulated feminist writing by Judith Butler, Honi Fern Haber, Susan Bordo and others.

41 Ibid.
44 Sawicki, "Disciplining Mothers," p. 67-94, see n. 3; Susan J. Hekman, Gender and Knowledge: Elements of a Postmodern Feminism. (Boston: Northeastern University Press, 1990); Irene Diamond and Lee Quinby, Editors. Feminism and Foucault: Reflections on Resistance. (Boston: Northeastern University Press, 1988); Hekman, "Editor's Introduction," p. 2, see n. 32; Bartky, see n. 38; Simons, p. 179-209, see n. 43.
45 Sawicki, p. 67, see n. 3.
46 Ibid.
48 Hekman, "Editor's Introduction," p. 4 and 8, see n. 32.
A third critique of Foucault’s work is that his deconstruction of the subject will allow for the likelihood of the disappearance of “woman” altogether. How can feminists seek the liberation of “woman” if no such entity exists? In objection to this criticism and the question of whether the master’s tools can dismantle the master’s house, Hekman asserts that Foucault’s work moves philosophy into a new epistemological terrain. In this new space the traditional, liberal understanding of the modernist subject is dismantled to reveal categories of power relationships which have the potential to contribute to the oppression of women. These categories can begin to be subverted without referring to universal normative standards. Another criticism of Foucault that is tied up in Hekman’s claim above is that his work is deficient since he can only describe what goes on in the world rather than offering a prescription of morality. To counter this claim, Hekman says that “the line between description and prescription is necessarily and deliberately blurred” due to the fact that the world that Foucault discovers no longer has a “universal standard that grounds our knowledge”. It appears that Hekman feels a necessity to mould Foucault’s work into something that it is not in order for it to appeal to traditional political thought. The claim is correct that Foucault only offers descriptions rather than prescriptions of the world but this should not be considered a deficiency in his work. Foucault himself makes it very clear that he is not attempting to put forth a “theory” of power, which would involve prescription, but rather his task is to give an historical account of power relationships. In order for prescriptions of power to take place it is necessary for those relationships to be dismantled and described in detail. Foucault’s work provides the “spade work” upon which theories of power can be built.

The Abuse of Power

The Foucauldian notion of power outlined above may be useful for feminist thinkers concerned with power relationships in general but this understanding of power is not necessarily useful for relationships where power is being abused. The decisions made by the lower Courts in the cases of foetal harm outlined in Chapter One are a prime example of abusive relationships of power. In these cases both the medical and judicial professionals

50 Hekman, “Editor’s Introduction,” p. 2, see n. 32.
51 Ibid.
52 Ibid, p. 3-4.
53 Ibid.
54 Ibid, p. 2.
55 Ibid, p. 4.
56 Foucault, The History of Sexuality, p. 96, 98, see n. 4.
have abused their positions of power by compelling pregnant women to undergo medical
treatment. Feminist writer Amy Allen also recognises that this is where Foucault’s notion of
power fails.⁵⁷ Foucault does acknowledge that situations of dominance exist but he spends no
time discussing how power relationships can turn into situations of power abuse or become
“deep structures of domination – such as gender-division of labor…”⁵⁸ In addition, he claims
that individuals are always in a position to challenge the power exercised on them by
dominant groups.

Foucault’s account of power is problematic for situations involving abuse of power for
two reasons. First, Foucault says that power cannot be defined as the domination of one
social group over another.⁵⁹ Although he does not deny the existence of situations of
dominance where one individual or institution is subordinating another individual or social
group, he describes these situations as “radical ruptures...[of] massive binary division” which
are rarely occurring and extraordinary.⁶⁰ He views relationships where power only comes
from above – abusive power – as uncommon and thus he prefers to focus on general power
relationships such as those found when outlining the genealogy of sexuality. On the contrary,
these situations of abusive power occur much more frequently than Foucault acknowledges.

Two historical examples of this occurrence were given above of the apartheid in South Africa
and slavery in the southern United States. Abuse of power does not need to occur on scales as
grand as these historical examples but can involve a single individual who, for example, does
not receive adequate health care because he or she is a member of an oppressed group. A
good example of abuse of power on a smaller scale is found in the foetal harm cases outlined
above wherein pregnant women are compelled to undergo caesarean sections or blood
transfusions, or are forced into rehabilitation for drug addiction to protect the health and well-
being of their gestating foetus. Prenatal harm cases can be tagged as situations involving
abuse of power since competent adult women are refusing to consent to medical treatment and
members of the healthcare profession and judiciary are overriding those decisions in the
interests of an unborn child. American physician Thomas Murray asserts that “the prospect of
forcibly restraining a man in order to take out a piece of vital organ for someone else’s benefit
– even his own child’s – gives us pause...”⁶¹ Unfortunately, the prospect of compelling a
pregnant woman to undergo a caesarean section or a blood transfusion, or forcibly committing

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⁵⁸ Ibid.
⁵⁹ Foucault, The History of Sexuality, p. 92, 94, see n. 4.
⁶⁰ Ibid, p. 96.
her to an institution for substance abuse rehabilitation did not give the lower Courts suitable pause. In most cases, healthcare professionals would not consider forcibly removing an organ from any competent adult who refuses to consent to the procedure. But, when that competent adult is a pregnant woman who is refusing to consent to medical procedures recommended by members of the healthcare profession to be beneficial for her own health and that of her unborn child all this changes. Physicians, in conjunction with the Courts, are in a position to legally override this refusal and overriding the refusal to consent of a competent adult woman is an abuse of power.

A second reason why Foucault’s understanding of power is not useful for discussing cases where power is abused is because, for Foucault, power relations are “both intentional and nonsubjective”. Power relations are intentional on the basis that those exercising power—top down, bottom up or laterally-directed power—use this power with specific purposes, aims and objectives in mind. For Foucault, power is not something exercised randomly or accidentally applied. Though he asserts that those exercising power have specific objectives in mind he denies that there is one individual or institutional agent who is actively making choices and decisions with regard to what these aims should entail. Instead, Foucault feels that power is nonsubjective and anonymous—there are no inventors or decisionmakers who can be identified as the origin of these objectives. On the contrary, in many of the judgments of the lower Courts in the cases of foetal harm outlined in Chapter One those who hold and abuse positions of power are readily identifiable. The obstetricians and psychiatrists who bring forth applications for declarations authorising compelled treatment and the members of the judiciary who grant these declarations allowing healthcare professionals to “treat” competent adult women against their wishes are the “inventors and decisionmakers”. This situation where members of the healthcare and judicial profession abuse power will be discussed in greater detail in following chapters.

Finally, Foucault’s understanding of power is not useful for discussing cases of abusive power relationships since he claims that even subordinated or oppressed individuals are in a position to challenge or rebel against “top down” power. He asserts that there are many dynamic points of resistance along the network or web of power relations where individuals can confront power and exercise their own bottom up form of power. Like Foucault’s understanding that there is no one individual or institutional agent who can be

62 Foucault, The History of Sexuality, p. 94, see n. 4.
63 Ibid, p. 95.
64 Ibid.
65 Ibid.
66 Ibid, p. 92, 94-96.
67 Ibid, p. 96.
deemed responsible for inventing top down power, there is also no individual or group who can be responsible for causing rebellions against this power. There is no single institution that is responsible for the “great Refusal, no soul of Revolt, [nor] source of all rebellions”. \(^{68}\) This may be the case that there is no single source of resistance but Foucault does not adequately explain where the constantly changing points of resistance come from nor does he discuss how individuals can possibly go about challenging subordinating power at these points. In the lower Court judgments in foetal harm cases these women initially challenged the traditional medical model of pregnancy and childbirth management by refusing to consent to caesarean sections, blood transfusions or compelled institutionalisation for addiction rehabilitation. Suppose that this challenging of the medical model is an example of one source of resistance. The attending members of the healthcare profession again exercised their power by seeking out Court orders forcing these unwanted treatments on pregnant women and in many of the cases occurring in the 1980’s or even in the judgments handed down by lower Courts in the 1990’s they were successful. Once the Court orders were granted these pregnant women would be physically forced to undergo the unwanted procedures if they did not co-operate. There is no point of resistance here where these women can challenge the power of the medical and legal professions. Essentially, from the Foucauldian definition of power given above it becomes apparent that one cannot abuse this understanding of power. \(^{69}\) For Foucault, power is all-encompassing and any form of top down power that appears oppressive or abusive can always be challenged by exercising bottom up power. From the example of the pregnant women attempting unsuccessfully to challenge the healthcare profession mentioned above it becomes apparent that Foucault’s understanding of power cannot always be challenged from the bottom up.

**Bio-Power**

Although a Foucauldian notion of power is insufficient to use as a tool for dismantling judgments in cases of foetal harm and understanding abuses of power, there is still one component of power that is extremely useful and will be strongly advocated throughout this thesis. This component is what Foucault has termed *bio-power*. \(^{70}\) This type of power focuses on the scientific understandings of the body that are capable of being manipulated. \(^{71}\) Foucault’s primary purpose for developing this new understanding of power is to allow for an account of power that does not have inherent to it understandings of “constraint, negativity,

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\(^{68}\) Ibid.  
\(^{69}\) Much appreciation to Dr. Neil Pickering at the University of Otago Bioethics Centre for making this point clear.  
\(^{70}\) Dreyfus and Rabinow, p. 7-8, 127-128, see n. 10; Foucault, *The History of Sexuality*, p. 140-141, see n. 4.  
\(^{71}\) Foucault, *Discipline and Punish*, p. 135-169, see n. 4; Dreyfus and Rabinow, p. 134-135, see n. 10.
and coercion."\textsuperscript{72} Foucault refers to this negative, subordinating view of power as the \textit{juridico-discursive}.\textsuperscript{73} Under this view, power essentially involves domination, repression and imposition of the law which ultimately demands submission.\textsuperscript{74} Though this thesis is concerned with the abuse of power in foetal harm cases it does not hold the position that power is inherently a negative phenomena. Rather, power imbalances can often be beneficial for the individual on whom power is being exercised. For example, in the healthcare setting patients who willingly seek out the advice and practical skills of a physician in order to regain their health are relying on the notion that their physician possesses power. Undoubtedly in patient-doctor relationships it is the physician who is seen as possessing greater power and the patient who is the subject of this power imbalance. The different types of power that members of the healing profession possess will be discussed further in Chapter Four when a critical analysis of Howard Brody’s position on the healer’s power is undertaken. The healer’s power is one way of accounting for the influence that medical opinion has on members of the judiciary when deciding cases of foetal harm. It is important to keep in mind that the idea of power used throughout this thesis is not that power is inherently oppressive and dominating but rather that the \textit{abuse} of this power perpetuates the subordination of oppressed social groups.

**II. AN ARCHAEOLOGY OF MEDICAL PERCEPTION\textsuperscript{75}**

In his work prior to \textit{The Birth of the Clinic} (1963) Foucault’s methodological approach to exploring the world involved interpreting social practices to explain human behaviour such as the practice of institutionalising the mad or the insane.\textsuperscript{76} In \textit{The Birth of the Clinic} Foucault describes medical practice and experience by analysing the systematic structures of medicine such as the hospital, medical examination, division of pregnancy into trimesters and so on, rather than merely exploring the function of these structures.\textsuperscript{77} Foucault begins by explaining that the development of pathological anatomy in the nineteenth century gave the human body a new transparency that it did not otherwise possess.\textsuperscript{78} Medical professionals

\textsuperscript{72}Dreyfus and Rabinow, p. 129, see n. 10.
\textsuperscript{73}Foucault, \textit{The History of Sexuality}, p. 82, see n. 4.
\textsuperscript{74}Dreyfus and Rabinow, p. 130, see n. 10.
\textsuperscript{75}The title of this section is taken from the subtitle of Foucault, \textit{The Birth of the Clinic}, see n. 2.
\textsuperscript{76}Dreyfus and Rabinow, p. 14-15, see n. 10; Foucault \textit{The Birth of the Clinic}, p. ix, see n. 2. This type of approach is referred to as a hermeneutical approach which involves interpretation of texts, especially Scripture, to explain human behaviour.
\textsuperscript{77}Foucault, \textit{The Birth of the Clinic}, see n. 2; Dreyfus and Rabinow, p. 14, see n. 10; This approach is referred to as structuralism which involves analysing a particular society’s language, cultural practices, etc. by dismantling the structure of these things rather than explaining their function.
\textsuperscript{78}Foucault, \textit{The Birth of the Clinic}, p. ix, see n. 2.
were able to peel back the skin of a human corpse to reveal the inner workings of the body; the human corpse is now “laid out before the doctor’s gaze”.\(^79\) This information can then be transferred and applied to ailments and workings of the living body. The gaze that Foucault refers to in the passage above is a form of clinical perception or one medical way of viewing the world.\(^80\) One interesting way of perceiving the traditional problem of maternal-foetal conflict which developed out of the medicalisation of pregnancy and childbirth, outlined in Chapter One, is through the Foucauldian notion of this clinical gaze. This section will undertake to provide an expositional account of the medical gaze and will critically analyse Foucault’s description of how medical professionals perceive the medical arena. Although this thesis will not advocate Foucault’s description of how physicians view the world, it will utilise his understanding of the medical gaze as an analytical tool for illuminating the underpinnings of the lower Court judgments in cases of foetal harm where medical and judicial power is often abused.

**The Medical Gaze**

Using the term “gaze” is probably rather deceptive since, for Foucault, this gaze embraces much more than visual perception. In Foucauldian terms it refers to an entire vantage point from which events of clinical importance are understood. The gaze involves the sensorial fields of sight, touch, and listening to the body as well as the interpretation of outputs from medical devices, test results and measurements, and the obtaining of clinical information.\(^81\) For Foucault, the medical gaze is a model which serves as an explanation or is a “paradigm” of the clinical encounter.\(^82\) The medical gaze is not restricted to this encounter but is also applicable in anatomy theory and in researching bacteria and viruses. For the purposes here, the clinical gaze arises when medical power is localised on the human body in a clinical setting. Foucault’s understanding of the medical gaze can be used in both a de facto manner for describing how physicians and judges perceive the world of obstetrics, as well as used as an analytical tool for perceiving the world in a certain manner to obtain valuable insight into the judgments in cases of foetal harm.\(^83\) It is important to point out that Foucault fails to make this distinction between the use of the medical gaze as an analytical tool — merely one of many possibilities for perceiving the world — for explaining and describing the social activity of doctoring and the use of the medical gaze as an indication of how pregnancy and childbirth are actually regarded within the clinical setting. Foucault incorrectly collapses

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\(^79\) Ibid, p. ix.

\(^80\) Ibid, p. 164.

\(^81\) Ibid, p. 164.

\(^82\) A kind thank you to Claire Gallop for making this clear to me.

\(^83\) I wish to thank Dr. Neil Pickering at the University of Otago Bioethics Centre for pointing out this distinction.
these two conceptions of the medical gaze into one. This section will show that when the concept of the medical gaze is unpacked it becomes apparent that it is undesirable to advocate it on a *de facto* basis since this is not necessarily the only way physicians perceive medical events. Although Foucault’s acceptance of the medical gaze in the *de facto* manner as the only way of viewing the medical world is problematic, using Foucault’s methodology of describing the world in this way will offer valuable insights into the underpinnings of the foetal harm cases outlined in Chapter One.

**Strategies of the Gaze**

The Foucauldian understanding of the medical gaze essentially involves a description and interpretation of how physicians function in healthcare settings as well as how they perceive the clinical world. This is a way of describing how members of the healthcare profession exercise power over healthcare consumers. In *The Birth of the Clinic*, Foucault describes the way in which healthcare professionals perceive the medical world.84 He asserts that physicians use mechanisms or “strategies” such as the strategy of confession, organisation of space and time, and normalisation to exert power. This section will provide an expositional account of these different strategies that Foucault claims medical professionals apply in healthcare settings.

One way the medical gaze exercises power over healthcare consumers is through the tactical organisation and control of spatiality.85 According to Foucault,

> [d]isciplinary space tends to be divided into as many sections as there are bodies or elements to be distributed...Its aim was to establish presences and absences, to know where and how to locate individuals, to set up useful communications, to interrupt others, to be able at each moment to supervise the conduct of each individual, to assess it, to judge it, to calculate its qualities or merits. It was a procedure, therefore, aimed at knowing, mastering, and using.86

In *Discipline and Punish*, Foucault uses the functioning of a leper colony and a quarantined city during the seventeenth century plague as an example of how power can operate in a regulation of bound, structural space.87 During the time of the plague, each town was closed to visitors and divided into distinct quarters which were each governed by an intendant. Under the authority of the intendant were the syndics who each took responsibility for a particular street in the town. If the street’s occupants neglected to meet the required

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84 Foucault, *The Birth of the Clinic*, see n. 2.
86 Foucault, *Discipline and Punish*, p. 143, see n. 4.
expectations set down by the presiding magistrate or mayor they would find themselves condemned to death. The syndics locked every house, from the outside, and handed the key over to the intendant until quarantine was concluded. Each resident was confined to his or her home and was able to leave, only if absolutely necessary, escorted by a guard, syndic or intendant.\textsuperscript{88} Permanent registration of each inhabitant occurred when reports, bearing his or her name, age, sex and medical condition, were handed from the syndics up the hierarchical chain to the magistrate or mayor of each town.\textsuperscript{89}

Permanent registration occurs in the healthcare setting when information gathered from medical examinations or history-taking is compiled in a patient dossier.\textsuperscript{90} The importance of the medical examination in the hospital or clinic is based on a reversal of the operation of power.\textsuperscript{91} Traditionally, power held by the sovereign is visible and constantly on display and the citizens or populace over which the sovereign has this power are made invisible. In the period of the sovereign, it was those individuals who were regarded as heroes or who held great power that had details of their honourable lives scrupulously recorded and recognised. Now, it is those individuals who are perceived as being at the bottom of the power hierarchy whose lives are made known. This is the case in the clinic when it is the holders of medical power who seek invisibility and the objects of this power, such as the patients or healthcare consumers, who are given visibility.\textsuperscript{92} The compilation of the patient dossier is one example of this reversal of the role of power where the details and mundane activities of a patient’s life are recorded with great care.\textsuperscript{93} In addition, this is how Bentham’s Panopticon Penitentiary functions; the inspector in the tower maintains anonymity and invisibility while the prisoners are closely monitored, and their behaviour recorded and scrutinized.

Another strategy employed by holders of the medical gaze \textit{de facto}, according to Foucault, is the organisation of time.\textsuperscript{94} The development and implementation of schedules, programmed movements, and exercises “served to economize the time of life, to accumulate it in a useful form and to exercise power over men through the mediation of time...”.\textsuperscript{95} Within the obstetrics setting time is controlled through the division of gestation into trimesters and through the division of foetal development into specific stages. In some of the foetal harm cases outlined in Chapter One the different stages of labour are monitored on the basis of

\begin{itemize}
\item \textsuperscript{88} Ibid.
\item \textsuperscript{89} Ibid, p. 196.
\item \textsuperscript{90} Ibid.
\item \textsuperscript{91} Dreyfus and Rabinow, p. 159, see n. 10.
\item \textsuperscript{92} Ibid.
\item \textsuperscript{93} Ibid.
\item \textsuperscript{94} Foucault, \textit{Discipline and Punish}, p. 143, see n. 4.
\item \textsuperscript{95} Ibid, p. 162; Rouse, p. 95, see n. 85.
\end{itemize}
time. Unconventional progression or a lack of progression altogether indicates to the holders of the medical gaze that the birth must be induced or that a caesarean section must be performed for the benefit of both mother and unborn child. Although time may be the only guide that obstetricians and midwives have to judge whether a pregnancy or foetal development is progressing “normally”, time as a guide becomes problematic when stages are too strictly structured and fail to allow for variations of “normal”. Some of the foetal harm cases that were brought before the Court were done so on the basis that the pregnancy had progressed beyond the anticipated due date and the foetus was thought to be in distress. For example, in the American case In re Madyun the Superior Court of the District of Columbia Civil Division granted a declaration authorising the performance of a caesarean section on Ayesha Madyun who was at full term. The problem is not necessarily with using time as a guide to determine whether a pregnancy or childbirth ought to be considered normal. Instead, the problem is with medical definitions that place “normal pregnancy or childbirth” within very narrow time frames and fail to allow for variations. Rather than abandoning time as a guide for determining whether a specific pregnancy or childbirth is problematic, the definitions of “normal” should be placed within much broader time frames to recognise the uniqueness of each individual pregnancy.

The Foucauldian understanding of normalisation is also another strategy used by holders of the medical gaze to control healthcare consumers. For Foucault, normalisation involves the establishment of a common definition of goals and procedures, and agreement of how a well-ordered domain of human activity should be organised. For example, in obstetrics all pregnancies are divided into either low risk or high risk categories and viewed as potential pathologies. Normalisation produces a whole range of degrees of normality indicating membership of a homogeneous social body but also playing a part in classification, hierarchization and distribution of rank. In a sense, the power of normalization imposes homogeneity; but it individualizes by making it possible to measure gaps, to determine levels, to fix specialities and to render the differences useful by fitting them one to another.

Through normalising judgment, new kinds of objects for knowledge to be about or what Foucault refers to as “biographical unities” are developed such as foetal patients in the obstetric setting or the hyperactive in the paediatric arena. In addition, “significant distributions” such as a family history of heart disease, a low-income household or an “advanced maternal age pregnancy” and signs of a condition of life such as high cholesterol

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96 Dreyfus and Rabinow, p. 198, see n. 10.
97 Foucault, Discipline and Punish, p. 184, see n. 4.
98 Rouse, p. 97, see n. 85, Foucault, Discipline and Punish, p. 254, see n. 4.
levels or a high uric acid reading are developed. The knowledge gained through normalisation is also used to create what Foucault calls “binary division and branding” or dualisms. In *Discipline and Punish*, Foucault uses the example of the exclusion of lepers into separate communities to illustrate an act of “massive, binary division between one set of people and another.” Further examples of binary divisions are mad/sane, dangerous/harmless, high risk/low risk pregnancy or suitable/unsuitable parent.

A final strategy of the holders of the medical gaze, according to Foucault, is the *confession*. In Volume One of *The History of Sexuality* Foucault discusses the confession in terms of sexuality. In the Middle Ages the confession played a central role in “the order of civil and religious power” through the development of “methods of interrogation and inquest, the increased participation of the royal administration in the prosecution of infractions, [and] the setting of tribunals of Inquisition.” By the seventeenth century it became entrenched in the practice of penance. The sexual confession in the nineteenth century came to be constituted in scientific terms. For example, the information gathered through examinations was put into clinical terms and a sexual causality to explain all maladies or physical disturbances was put forth. In contemporary Western society, confession occurs on a daily basis: “one confesses one’s crimes, one’s sins, one’s thoughts and desires, one’s illnesses and troubles; one goes about telling, with the greatest precision, whatever is most difficult to tell.” For Foucault, the confession is not only something that is orally revealed but is something that is revealed through practices such as medical history-taking or physical examinations. The confession “unfolds within a power relationship” in the physical or “virtual” presence of a partner who is not only the interlocutor but is also the “authority who requires the confession, prescribes and appreciates it, and intervenes in order to judge, punish, forgive, console, and reconcile.” Through confessions the clinical gaze renders bodies “audible” as well as visible.

**An Analytical Tool**

In his discussion on bio-power in *The History of Sexuality*, Foucault rejects the possibility of having a medical gaze that is absolutely objective and rejects the notion of a

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99 Rouse, p. 97, see n. 85.
100 Foucault, *Discipline and Punish*, p. 198, see n. 4; Dreyfus and Rabinow, p. 190, see n. 10.
101 Foucault, *Discipline and Punish*, p. 199, see n. 4.
102 Foucault, *The History of Sexuality*, p. 61-2, see n. 4; Dreyfus and Rabinow, p. 119, see n. 10.
103 Foucault, *The History of Sexuality*, p. 58, see n. 4.
physician who can take a "view from nowhere". According to Foucault, with the Enlightenment area came the development of the "god-trick" based on the assumption that one can see everything from nowhere thus developing an accurate and objective account of the world. Foucault rejects the gaze from nowhere and criticises the "self-proclaimed master of truth and justice, the intellectual who claimed to speak truth to power and thereby to resist power's supposed repressive effect"; the "speaker's benefit" was revealed. In addition, Foucault also criticises the individual who claims to be gathering knowledge from a disembodied standpoint or from a position in the world that claims to be neutral since it transcends the body.

Although Foucault rejects the possibility of a view from nowhere, in The Birth of the Clinic he appears to be unsuccessfully attempting to describe just that – a medical gaze from nowhere. He does not acknowledge that what he is actually doing is describing how members of the medical profession perceive clinical events from a particular standpoint. Instead, he alludes to the fact that he is describing medical perception as it actually occurs in the clinical setting. American political scientist Nancy C.M. Hartsock claims that this particular standpoint that Foucault occupies is that of a particular group – "Euro-American, masculine, and racially as well as economically privileged". By failing to acknowledge that he is describing that world from a particular standpoint, Foucault is claiming that the medical gaze employed by members of the healthcare profession is essentially just seeing what is happening in the medical arena. This thesis will hold the position that Foucault's understanding of the medical gaze is merely one of many ways of describing how members of the medical profession view the world – the medical gaze is not the only method. Although this account of the medical gaze will not be advocated as the only way in which medical professionals view the clinical world, this methodology will be used as an analytical tool with which to illuminate the underpinnings of the legal judgments in cases of foetal harm.

Initially it may appear problematic to analytically apply Foucault's understanding of

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107 This phrase was taken from Thomas Nagel, The View from Nowhere. (New York: Oxford University Press, 1986).
109 Dreyfus and Rabinow, p. 202, see n. 10.
111 Foucault, The Birth of the Clinic, see n. 2.
112 Hartsock, p. 46, 108.
the medical gaze to women since this gaze is typically applied to male gendered bodies. A similar feminist criticism of Foucault's work was raised above. Although pregnant bodies are distinct from both the male and the non-pregnant female body, Foucault's understanding of clinical perception is still applicable. With the advances in foetal and obstetric technologies the pregnant abdomen becomes "see-through" or transparent to reveal the gestating foetus. Similar to uncovering the foetus, in a compelling article entitled The Mouth and the Clinical Gaze, Australian philosopher Cathryn Vasseleu embarks on a journal into the depths of the oral orifice from the visual perspective of the dentistry profession. As technology advances, private dentists in the United States and Australia are increasingly using tiny, pencil-shaped intra-oral cameras placed in the mouth. This allows both doctor and patient simultaneously to view the interior of the oral cavity on a computer screen containing digitally manipulated images of x-rays, diagrams and charts. The mouth, along with the pregnant abdomen, has become another "portal of the body" through which both patient and healthcare professional can view the inner workings of the human body. Extending the medical gaze to include the interior of the mouth as a focal point is one way of learning about a patient's practices of personal hygiene, socio-economic status, diet, lifestyle choices such as smoking or drinking, and even the existence of eating disorders such as bulimia. This is often beneficial for both patient and dentist since the patient can now have a more active role in their own oral hygiene by being able to view the inner workings of their mouth. Ideally, the mouth as another portal of the human body is a useful phenomena but can have negative implications if the information is used in a discriminator manner.

Similarly, the gestating foetus also becomes visually known through innovations such as ultrasonography and foetal surgery and through common procedures such as maternal blood and urine tests. The obstetrician can learn about the pregnant woman's lifestyle "choices" such as alcohol, drug or solvent abuse, diet, and general state of physical fitness by examining her and her foetus. In dentistry, Vasseleu points out that there is a correlation between good oral hygiene and the morally good person. A shift occurs from "orality to morality" wherein the loss of teeth or the onset of gingivitis indicate a "degenerate, scarred

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114 Ibid, p. 66.
115 Ibid.
118 Vasseleu, p. 75, see n. 113.
and impotent body". University of Otago Physical Education lecturer, Annemarie Jutel, also finds that a similar correlation exists between the individual who is physically active and eats a healthy, well-balanced diet, and the morally good person. Likewise, the pregnant woman also has the status of morally good person conferred upon her if she follows doctor’s orders, eats a well-balanced diet, engages in moderate exercise, and abstains from alcohol and illicit drugs. If, on the other hand, she indulges in an unhealthy diet, consumes alcohol and drugs, and is resistant to doctor’s orders she is often considered to be a morally bad individual and thus an unsuitable parent.

In The Worth of a Child, Thomas H. Murray uses a compelling father-child analogy to illustrate why pregnant women should not be compelled to undergo caesarean sections or other unwanted medical treatment. In this analogy a father who is a very good match as a liver donor for his child refuses to consent to the procedure. Murray asks “[d]oes he have a moral obligation to donate a lobe of his liver to his child if it is the only available treatment, and is very likely to save his child’s life?” Most likely the answer would be yes, he does have a moral obligation due to the special relationship he has with his child. The next question Murray poses to his readers is “[s]hould our public policy [then] compel him to submit to anesthesia and surgery against his will?” The answer is no, it does not follow from the moral obligation to donate that the father now has a legal obligation to donate part of his liver to save the life of his child. There are many activities that individuals morally ought to engage in, such as aiding the poor or protesting against violence. It does not follow that these individuals ought to be legally compelled to engage in these activities based merely on their moral obligation to do so. Like the father-child analogy, the pregnant woman may be considered to be an uncaring parent since she refuses to consent to medical treatment or an unsuitable mother since she ingests illicit drugs or alcohol while pregnant. She may have a moral obligation to consent to medical treatment for the benefit of her unborn child but it does not follow that she therefore has a legal obligation to undergo treatment.

CONCLUSION

The aim of this chapter was to provide both an expositional and a critical account of...
Foucault’s work on power and clinical perception as it applies to cases of prenatal harm. His understanding of power as something that is all-encompassing and multidirectional is not useful for examining situations where power imbalances are being abused as are found in many of the lower Court judgments outlined in Chapter One. It is not necessary to accept the totality of Foucault’s work in order to use his methodology for this thesis. Rather than rejecting his entire notion of power, this thesis will advocate his understanding of power as something that is not inherently negative or coercive. In many instances, such as in a physician-patient relationship where the patient seeks out the power of the physician in order to get well, power imbalances of a certain kind are often desired and perceived in a favourable light. However, it is important to note that not all power imbalances are advantageous. By using this notion of power a distinction can be made between abuses of power in cases where pregnant women are compelled to undergo unwanted medical treatment and instances where power imbalances provide women with desirable medical treatment.

From this understanding of power relationships Foucault has developed his work on medical perception within the clinical setting. Although he rejects the possibility of an objective view from nowhere, he appears to be taking this position when he describes how healthcare professionals perceive medical events. His understanding of the medical gaze is not the only lens through which doctors’ perception of the medical world can be described. Instead, the medical gaze is only one particular way of describing medical occurrences. In the following chapters his understanding of clinical perception will be used as an analytical tool for illuminating the foundations of the lower Court judgments in the cases of foetal harm outlined in Chapter One. This methodology reveals that the pregnant woman in these cases is often excluded from the decision-making process and thus a silent body is created by members of the medical and judicial professions. Foucault’s methodology illuminates the idea that the “audible” pregnant body – one that is legally represented, notified of Court proceedings, and is allowed to consent to or refuse medical treatment – is being excluded from the legal judgments of the lower Courts in prenatal harm cases.

127 Hekman, p. 9, see n. 32.
CHAPTER III

REVEALING THE SILENT BODY

One of our most difficult duties as human beings is to listen to the voices of those who suffer. The voices of the ill are easy to ignore, because these voices are often faltering in tone and mixed in message, particularly in their spoken form before some editor has rendered them fit for reading by the healthy.

- Arthur W. Frank


INTRODUCTION

In “Reading the Silent Body”, New Zealand feminist writer Victoria Grace discusses women’s experiences of the clinical encounter when seeking healthcare for chronic pelvic pain (CPP). She asserts that in these encounters the entity “woman” is reconfigured in a “split between an anatomical body devoid of consciousness on the one hand and an embodied agent subject on the other” hand. That is, women with CPP are being subjected to the mind/body dualism that places them on the side of the unconscious body. Through dismissing their pain, implying that it is ‘all in your head’, or finding them to be neurotic on the basis that no organic pathology was found, women who suffer from CPP are often configured as “unstable and intensely problematic”. The pain experienced by these “women-as-subjects” is silenced in the clinical encounter by the “voice of medicine” whose agency

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1 This title was taken from Victoria Grace, “Reading the Silent Body: Women, Doctors and Pelvic Pain,” in Bodily Boundaries, Sexualised Genders and Medical Discourses. Edited and Introduced by Marion de Ras and Victoria Grace (Palmerston North, NZ: The Dunmore Press, 1997), p. 85-98.
3 Grace, p. 85, see n. 1.
forces the "pain into greater invisibility". 6 Medical professionals are perceived as possessing the authority to determine who is sick and who is well and thus, because women who suffer from chronic pelvic pain do not necessarily conform to the medical discourse, the existence of their pain is denied and their bodies are silenced. 7 Similarly, in the lower Court judgments of cases involving foetal harm outlined in Chapter One, pregnant women are silenced in a variety of ways. Firstly, they are silenced by a lack of legal representation before the Courts and _ex parte_ applications brought on behalf of medical professionals. Also, they are silenced by the physicians’ alleged duty to rescue the unborn child from the dangerous maternal body in which it makes its home. The failure to consider alternative treatments of pregnancy management and the illegitimate use of mental health legislation to treat a physical condition all negate the pregnant woman’s experience. Directing Foucault’s notion of the medical gaze, as an analytical tool, at the judgments of the lower Courts by employing strategies of confessional technologies, permanent registration and normalisation, and the control of space and time reveals this silent pregnant body.

I. CONFESSIONAL TECHNOLOGIES

In the obstetrics arena, the Foucauldian "confession" is the primary means through which a truth about a particular pregnancy is produced. For Foucault, the confession in the medical arena is not only a device that is orally revealed but also a device that is revealed through non-verbal practices such as medical history-taking or physical examinations. This understanding of confession can be distinguished from an explanation since it is given in the presence of an authority who not only hears the information but also makes value-laden judgments about the information once it is revealed. 8 The confession "unfolds within a power relationship" usually involving members of the medical profession, the pregnant woman, and in cases of foetal harm, members of the judiciary, a representative from the local child welfare authority or hospital, and possibly the police. 9 For Foucault, confessional technologies involve information gathered through non-verbal interaction as well as oral admissions. These confessional technologies include medical history-taking, physical examinations, interpretations of outputs from monitoring devices, and the results from maternal and foetal testing. In the cases of foetal harm outlined in Chapter One, information regarding a woman’s prenatal conduct can be obtained in three ways: physical examination of the recently-born

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6 Ibid, p. 94.
infant, non-verbal maternal examinations, and through verbal confessions, such as medical history-taking revealed by the pregnant woman.

First, non-verbal confessions, such as the revelation of prenatal addiction, can be obtained through observing or examining the health of the newborn infant. In *Winnipeg Child and Family Services v. G. (D.F.)* and other cases involving prenatal drug addiction, certain clinical signs in newborns indicate to members of the healthcare profession the possibility of the child being born under the influence of an illicit substance. In this case, Ms. G., smelling strongly of solvents, gave birth to a jittery and drug addicted third child. From the physical symptoms of drug withdrawal exhibited by Ms. G’s child it was inferred by healthcare professionals that Ms. G. was most likely abusing illicit substances. Later that day, Ms. G. admitted to healthcare staff that she had sniffed glue while in labour. Members of the judiciary in *In the Matter of Baby X* also relied on non-verbal confessions to find the mother of Baby X guilty of neglecting her child. Within twenty-four hours of birth, Baby X began exhibiting symptoms of withdrawal from heroin such as a rise in temperature, quick breathing and shakiness.

A second way in which information can be collected with regard to a pregnant woman’s prenatal conduct is through non-verbal confessions obtained from maternal medical examinations or drug-screening tests. An example of this can be found in *State ex rel. Angela M. W. v. Kruzicki*. Based on observations made during routine clinical visits, Angela’s obstetrician suspected that she was using cocaine or other drugs and performed drug-screening tests which confirmed the presence of cocaine in Angela’s blood. Similarly, the judiciary in *In re Troy D.* relied on the results of the maternal and neonatal urine toxicology screen tests, performed over a two-day period, which positively indicated that Troy D. was born under the influence of morphine, methamphetamine, and amphetamine. This indicated that Kelly D., Troy’s mother, had taken amphetamines and opiates while pregnant with her son. Kelly and the genetic father of Troy D. were both found to be unable to protect their son and thus he was removed from their care and placed in the custody of his paternal grandmother.

As well as information elicited through non-verbal medical examinations of both mother and child, and interpretations of outputs from clinical devices, a third way in which

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11 Ibid at 243.
12 *In the Matter of Baby X* 293 N.W. 2d 736 (Mich. App. 1980)
13 Ibid at 738.
15 Ibid.
17 Ibid at 871.
information is collected about prenatal conduct is through the verbal confessions of the pregnant women. In many of the prenatal harm cases outlined in Chapter One, the pregnant women themselves have verbally informed healthcare professionals of their addiction or use of illicit substances. An example of this is found in Johnson v. State wherein Jennifer Clarice Johnson admitted to her son’s paediatrician that she had used cocaine the night prior to the delivery of her son on October 3rd, 1987.\(^{18}\) In December 1988, while pregnant with her daughter, Jennifer suffered a crack overdose. She admitted to the attending paramedics, out of concern about the effects of the drug on her unborn daughter, that she took $200 worth of crack cocaine earlier that evening. She was again hospitalised on January 23rd, 1989 when in labour with her daughter and told her obstetrician that she had used cocaine that morning after her membranes had ruptured.\(^{19}\) While investigating a report of an abused cocaine baby that was filed against Jennifer, an investigator from the Department of Health and Rehabilitative Services learned from her that she had smoked marijuana and crack cocaine three to four times every other day throughout the duration of her pregnancy. Jennifer’s mother attested that her daughter had been using cocaine for at least three years prior to the birth of Jennifer’s son and daughter.\(^{20}\) This information gathered from the verbal and non-verbal confessions was used by Dauksch J. of the District Court of Appeal of Florida to convict Jennifer of delivering a controlled substance to a minor.\(^{21}\) Harding J. of the Supreme Court of Florida later quashed this decision.\(^{22}\)

Similarly, in In re Ruiz it was brought to the attention of the treating physician that Nora Ruiz was a self-admitted heroin addict and had used heroin intravenously at least in the last two weeks prior to delivery.\(^{23}\) In Sheriff v. Encoe, Cathy Encoe completed a prenatal questionnaire stating that she used marijuana during her pregnancy and the state used this information to file a criminal complaint against her alleging one count of Wilfully Endangering A Child as the Result of Child Abuse.\(^{24}\) In the American case In the Matter of Smith the pregnant woman acknowledged having had a problem with alcohol abuse since she was fifteen years old.\(^{25}\) Shortly after the birth of her child she admitted to hospital personnel that she consumed approximately ten alcoholic beverages on an average of three or four days every week throughout her entire pregnancy.\(^{26}\) In the Winnipeg case, Ms. G. informed

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18 Johnson v. State 578 So.2d 419 (Fla. App. 5 Dist. 1991) at 421; 602 So.2d 1288 (Fla. 1992) at 1290.
19 Ibid at 421.
20 Ibid at 422.
21 Ibid at 420.
22 Johnson v. State 602 So.2d 1288 (Fla. 1992) at 1289.
23 In re Ruiz 500 N.E.2d 935 (Ohio Com.Pl. 1986) at 936.
25 In the Matter of Smith 492 N.Y.S.2d 331 (Fam.Ct. 1985)
26 Ibid at 332.
psychiatrist Dr. Michael Eleff that she found some aspects of the Court hearing held on August 3rd, 1996 to be so distressful that she considered killing herself. This self-confessed information, as well as other information that will be discussed in more detail in the section regarding mental health, was used to force Ms. G. into a treatment facility until the birth of her child.

It is important to point out here that in a clinical encounter it is necessary for members of the healthcare profession to have adequate information about a patient’s current health, previous illnesses, and in the case of a pregnant woman, previous obstetric history as well as a history of prescribed and illicit drugs. Without this information patient’s who are in need of legitimate medical treatment might not receive the best care from their physician. The problem with confessional technologies is not necessarily how the information is gathered nor that the physicians have this information in their possession, instead, the problem is with how this information is used. In many of the cases outlined in Chapter One this information is used to legally sanction pregnant women for undesirable prenatal conduct. One difficulty with prosecuting pregnant women on the basis of this health information collected through various confessional technologies is that it may dissuade them from confessing to healthcare providers in the first place or provoke them to provide inaccurate information out of fear of self-incrimination.

As well as using health information to legally sanction pregnant women for undesirable prenatal conduct, in some cases outlined in Chapter One this information collected from pregnant women was not accepted as legitimate knowledge nor found to be a suitable account of a decision-making process. (In Chapter Four Howard Brody’s understanding of the healer’s Social power will be discussed in relation to who defines the truth of a particular account of illness). For example, in *St. George’s Healthcare N.H.S. Trust v. S.*, M.S. continued to assert her belief that pregnancy was a natural process and any intervention was to be avoided. Even though M.S. gave the attending physicians her reasons for not consenting to a caesarean section the physicians still did not place any value or weight on those reasons and instead felt that M.S. had no concern for her own well-being. Hogg J. of the Family Division Court felt that M.S. was not able to “adequately explain” to Dr. Siobhan Jeffreys, a qualified practitioner registered under the English *Mental Health Act 1983*, why she cared so little about what happened to her. This lack of rationale (as defined by the medical model) was one reason why healthcare professionals sought to detain M.S., against

30 Ibid.
her will, at the Springfield Hospital until the birth of her child. The various confessional technologies outlined above contribute to the creation of a silent pregnant body who, out of fear of legal or social sanction, will not reveal all the information about her pregnancy nor her prenatal conduct. The social implications of this are pregnant women receiving inadequate prenatal care and infants being born suffering from preventable anomalies. These results are likely to be more prevalent in areas of low socio-economic status and in ethnic minority communities thus continuing to disadvantage these already disadvantaged groups. 31

II. TEMPORAL ORGANISATION

Urgency

Another strategy of the Foucauldian understanding of the medical gaze, which contributes to the perpetuation of the silent pregnant body, is the tactical organisation and control of time. In cases involving alleged foetal harm, the various steps and stages of pregnancy, labour and childbirth are normalised into timelines such as the trimesters of pregnancy and the progression of labour to birth. When pregnancies do not progress within these time constraints members of the medical profession appear to assert that time is of the essence and a matter of urgency; necessary medical procedures must be performed immediately in order to benefit both mother and unborn child. 32

In the past, decisions surrounding healthcare emergencies were usually made by the patient and his or her family in conjunction with members of the medical profession. Rarely was a judge called upon to make these difficult biomedical decisions. With the advances in medical and foetal technologies, and the increase in lawsuits involving assault and battery especially in the United States, physicians are increasingly seeking “declaratory action approving or directing active or passive treatment of ill or injured patients”. 33 In these prenatal harm cases the judge is usually summoned to the hospital by physicians in despair and is required to hand down a decision within a matter of hours, making pressure to decide in favour of popular medical opinion overwhelming. 34 For example, in Crouse Irving Memorial Hospital v. Paddock Hayes J. deemed the situation extremely urgent and authorised the administration of blood to both Mrs. Paddock and her child despite her refusal based on

33 In re A.C. 533 A.2d 611 (D.C. App. 1987) at 612.
The Court based its decision on the fact that it was necessary for medical procedures to begin in approximately three days from the date of the hearing and on the testimony of Mrs. Paddock's attending physician, Dr. M. Robert Neulander that "delivery of [her baby] by caesarean section may entail her loss of a life-threatening amount of blood."36

*In re A.C.* also provides another good example of a strong sense of urgency in foetal harm cases.37 On June 16th, 1987 Sullivan J. of the District of Columbia Superior Court rushed to the hospital, with a police escort, to commence a hearing that would determine whether Angela Carder, a twenty-six week pregnant terminally ill cancer patient, ought to be compelled to undergo a caesarean section for the welfare of her foetus.38 After a three hour hearing, Sullivan J. authorised a caesarean section to be performed on Angela and her lawyer immediately sought a stay. The surgery was scheduled for 6:30p.m. that same day which left approximately sixteen minutes for three judges of the appeals Court to hear, by telephone conference call, a request for a stay.39 The appellate hearing also involved the judges hearing directly from one of the attending physicians which is apparently atypical of this type of Court proceeding.40 The hearing concluded at 6:40p.m. at which point Nebeker A.J. denied the stay while admitting later in the written opinion that "there was no time to have the transcript read or to do effective research."41 In the majority opinion of the District of Columbia Court of Appeals, given almost two years after the *en banc* hearing in *In re A.C.*, Terry J. recognises that the trial judge "was called in during the worst emergencies, with little time for reflection, to make a decision which under the best of circumstances is extraordinarily difficult."42 He argues that the enactment of legislation would avoid having to summon judges into "patients' bedsides" requiring them to make "quick decisions on issues of life and death".43

*In re Madyun*, an unreported case appended to *In re A.C.*, a similar outcome occurred wherein a hearing was convened at the District of Columbia General Hospital at 10:30p.m. on July 25th, 1996 to determine whether Ayesha Madyun could be compelled to undergo a caesarean section.44 At 1:05a.m. on July 26th the Superior Court of the District of Columbia held that the hospital was authorised to perform a caesarean section on Mrs. Madyun despite her refusal based on her Muslim beliefs. Mr. and Mrs. Madyun's motion for a stay was

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35 *Crouse Irving Memorial Hospital v. Paddock* 485 N.Y.S.2d 443 (Sup. 1985)
36 Ibid at 444.
37 *In re A.C.* 533 A.2d 611 (D.C. App. 1987)
38 Annas, "She's Going to Die," p. 23, see n. 32.
40 *In re A.C.* 533 A.2d 611 (D.C. App. 1987) at 613.
41 Ibid at 611 and 613.
43 Ibid.
denied and an appeal, which affirmed the decision of the Superior Court, was heard by telephone.\textsuperscript{45}

Further examples of urgency in foetal harm cases can be found in the English cases \textit{St. George’s Healthcare NHS Trust v. S}, \textit{Re S (adult: refusal of medical treatment)} and \textit{Re MB} outlined in Chapter One. In the \textit{St. George’s Hospital} case an \textit{ex parte} application to compel M.S. to undergo a caesarean section came before Mrs. Justice Hogg who then granted the declaration within thirty minutes.\textsuperscript{46} In the opinion of Hogg J., most likely due in part to the incorrect information that M.S. had been in labour for twenty-four hours which was compromising her life and that of her unborn child, this was a “life and death situation with minutes to spare.”\textsuperscript{47} In \textit{Re S}, Sir Stephen Brown P. declared that Mrs. S’s situation, being six days beyond the expected date of birth, was “desperately serious, as is also the situation of the as yet unborn child...we [the Court] are concerned with ‘minutes rather than hours’ and it is a ‘life and death’ situation.”\textsuperscript{48} The application for a compelled caesarean section was first brought to the attention of the Court officials at 1:30p.m. on October 12\textsuperscript{th}, 1992, the hearing began just before 2:00p.m. on that same day, and approximately twenty minutes later, at 2:18p.m., Sir Stephen Brown P. made the declaration as sought.\textsuperscript{49} Similarly, in \textit{Re MB} the breech position of the foetus and Miss MB’s refusal to undergo a caesarean section compelled the hospital to seek a Court order at 9:25p.m. on February 18\textsuperscript{th}, 1997 to force medical treatment on Miss MB. By 9:55p.m. that same night Hollis J. made the declaration to authorise the procedure which was appealed and heard by Butler-Sloss LJ moments later.\textsuperscript{50}

\textbf{Ex Parte Applications & Legal Representation}

Evidence of this sense of urgency is found in the use of \textit{ex parte} applications that are often used in clinical emergencies to hasten Court proceedings. Of the cases outlined in Chapter One, two English cases – \textit{St. George’s Healthcare NHS Trust v. S} and \textit{In re F (in utero)} – involve \textit{ex parte} applications.\textsuperscript{51} According to \textit{Black’s Law Dictionary} “\textit{ex parte}” essentially means “on one side only; by or for one party; done for, in behalf of, or on the application, or, one party only”.\textsuperscript{52} In foetal harm cases, an \textit{ex parte} application indicates that the pregnant woman most likely is not aware of the Court proceedings being brought against

\textsuperscript{45} Ibid at 1260.
\textsuperscript{48} \textit{Re S (adult: refusal of medical treatment)} [1992] 4 All ER 671 at 672.
\textsuperscript{49} Ibid.
\textsuperscript{50} \textit{Re MB} [1997] 8 Med LR 217 at 220.
her. Such cases do not allow the pregnant woman’s voice to be heard and often offer a one-sided, clinically-directed description of her particular situation. For example, in *St. George’s Healthcare NHS Trust v. S* an *ex parte* application was made on April 26th, 1996 by St. George’s Hospital to the Family Division of the High Court for a declaration authorising a caesarean section and dispensing with M.S.’s consent to the procedure. Hogg J. granted the order *ex parte* in her chambers and neither M.S. nor her solicitor had any knowledge of this application and thus she was not given an opportunity to be heard. The *ex parte* application was made by Mr. Nigel Pitt, counsel for the hospital, who inadvertently mislead Hogg J. by informing her that M.S. had been in labour for twenty-four hours and that her life and that of her unborn child were in imminent danger. Because the application did not “fully and frankly disclose all the material facts” Hogg J. made a decision based on the false understanding that M.S. was in labour and that her cognitive capacity was not intact.

In the case *In re F (in utero)* an *ex parte* application was made by a local authority to Hollings J. of a lower Court to make the unborn child a ward of Court. The application was made in absence of the pregnant woman and she was not represented at the hearing. Hollings J. adjourned the hearing in order for the Official Solicitor to appear before him as *amicus curiae* for the foetus. With the Official Solicitor present, the matter was still brought before the Court on an *ex parte* basis without F’s mother being legally represented. Similarly, in *Re S* Sir Stephen Brown P. of the Family Division felt that it was not possible for Mrs. S to be represented at the hearing due to the fact that only twenty minutes was allocated for the Court proceedings to take place due to the urgency of the matter. In *State ex rel. Angela M.W. v. Kruzicki* two hearings were conducted on consecutive days by the juvenile Court. At the first hearing, Angela appeared via the telephone, but without counsel and at the second hearing she again appeared via the telephone but this time with legal representation.

In some cases, a Court-appointed solicitor legally represented the pregnant woman before the Court. Having some degree of legal representation, even if it is provided through

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54 Ibid at 941.
55 Ibid at 947.
56 Peart, p. 398, see n. 46.
57 *In re F (in utero)* [1988] Fam. 122 (C.A.)
58 According to *Black’s Law Dictionary* *amicus curiae* can be literally translated as “friend of the Court”. “A person with strong interests in or views on the subject matter of an action, but not a party to the action, may petition the Court for permission to file a brief ostensibly on behalf of a party but actually to suggest a rationale consistent with its own views.” Henry Campbell Black, *Black’s Law Dictionary*. Sixth Edition (St. Paul, MN: West Publishing Co., 1990), p. 82.
60 *Re MB* [1997] 8 Med LR 217 at 223.
61 *State ex rel. Angela M.W. v. Kruzicki* 541 N.W.2d 482 (Wis. App. 1995) at 486.
62 Ibid.
the Courts, allows pregnant women to be heard. The gravid woman is less likely to be heard if she is not represented nor present at Court hearings at all. One example of the pregnant woman being represented by counsel was the *Baby Boy Doe* case where the juvenile Court judge appointed an assistant public defender as counsel for Doe and her husband.\(^{63}\) At the hearing for an emergency petition both Doe and her husband appeared before Gary L. Brownfield J. of the Circuit Court, Cook County to discuss whether it was lawful for a custodian to be appointed to consent to a caesarean section on behalf of Baby Boy Doe.\(^{64}\) The petition was granted and Doe and her husband appealed. They retained counsel from the Roger Baldwin Foundation of the ACLU Inc. to act as their attorneys on appeal. DiVito J. of the Appellate Court of Illinois ruled that Doe could not be compelled to undergo a caesarean section since Baby Boy Doe was not a “minor” within the meaning of the *Juvenile Court Act 1992*.\(^{65}\)

In some cases the pregnant woman is not always so fortunate. In the case *In re A.C.*, in which a terminally ill pregnant woman was refusing a caesarean section, the Court-appointed attorney was not even able to meet with his client prior to the hearing to discuss her wishes.\(^{66}\) According to American Professor of Health Law George J. Annas, Angela’s appointed lawyer simply argued before the Court that his client was opposed to any surgical intervention to remove the foetus from her body.\(^{67}\) Hospital counsel and the lawyer for the foetus based their arguments solely on what would be most beneficial for the foetus. They urged that a caesarean section should be performed immediately because, “sadly, the life of the mother is lost to us no matter what decision is made at this point”.\(^{68}\) A stay was requested and the lawyer for the foetus argued that Angela had no “important interests in this decision because she was dying; ‘unintended consequences on the mother’ are ‘insignificant in respect to the mother’s very short life expectancy’”.\(^{69}\) Before making his decision Emmett Sullivan J. did not even make an effort to consult with Angela to determine her wishes with respect to this matter. The entire Court proceedings were based on the premise that Angela was refusing to consent to the caesarean section; counsel for the state said “I don’t think we would be here if she [Angela] had said she wants it”.\(^{70}\)

Similarly, in the English case *Re MB* the High Court also ruled in favour of the

\(^{63}\) *In re Baby Boy Doe* 632 N.E.2d 326 (Ill. App. 1 Dist. 1994) at 327.
\(^{64}\) Ibid at 326, 328.
\(^{65}\) Ibid at 329.
\(^{66}\) *In re A.C. In re A.C.* 573 A.2d 1235 (D.C. App. 1990) at 1248.
\(^{67}\) Annas, p. 23, see n. 32.
\(^{68}\) Ibid.
\(^{69}\) Ibid, p. 24.
\(^{70}\) Ibid, p. 24.
foetus.\textsuperscript{71} (In both \textit{In re A.C.} and in \textit{Re MB} Courts of Appeal over turned these lower Court decisions to rule in favour of a competent pregnant woman’s ability to refuse to consent to medical treatment). In this case the Court proceedings were heard before Hollis J. of the High Court with Court-appointed counsel to represent the legal interests of MB.\textsuperscript{72} She had spoken to her counsel Mr. Francis, via telephone, approximately fifty-five minutes prior to the granting of the declaration that it would be lawful for a caesarean section to be performed as well as the insertion of needles for the purposes of intravenous infusions and anaesthesia.\textsuperscript{73} In this case, MB was fully aware of the legal proceedings and was able to instruct Mr. Francis to appeal the decision.\textsuperscript{74}

In the New Zealand case \textit{Re Baby P}, the pregnant woman appeared before BD. Inglis J. of the Family Court, New Plymouth with Miss Emma Smith as Court-appointed counsel to represent her legal interests.\textsuperscript{75} The pregnant woman’s request to declare that Baby P was in need of care and protection was granted as well as a final restraining order made against H, Baby P’s father.\textsuperscript{76} It is important to make a distinction here between cases where members of the medical profession seek declaratory orders authorising medical treatment and cases where the pregnant women themselves have sought out the aid of the Court. The \textit{Baby P} case is a particularly unusual case in this regard since it was Baby P’s mother who approached the Court to ask that her unborn child be protected from the abusive behaviour of H.

In some of the more recent cases involving accusations of foetal harm, the pregnant woman and her unborn child were represented by her own independent solicitors. An example of this is found in the \textit{St. George’s Hospital} case wherein upon being transferred to St. George’s Hospital M.S. contacted solicitors by telephone who advised her that she was entitled to refuse any unwanted medical treatment.\textsuperscript{77} Unfortunately for this pregnant woman Hogg J. of the Family Division Court did not agree with M.S.’s solicitors and granted a declaration that dispensed with her consent to treatment.\textsuperscript{78} Butler-Sloss J. of the Court of Appeal allowed M.S.’s appeal and held that an adult of sound mind was entitled to refuse any medical treatment even if it was deemed beneficial for her foetus by members of the healthcare profession.\textsuperscript{79} Similarly, in the recent American case \textit{In re Brown} Darlene Brown was represented by her own solicitors at the hearing before William F. Ward Jr. J. of the

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\item \textsuperscript{71} \textit{Re MB} [1997] 8 Med LR 217
\item \textsuperscript{72} Ibid.
\item \textsuperscript{73} Ibid at 217, 220.
\item \textsuperscript{74} Ibid.
\item \textsuperscript{75} \textit{Re Baby P [an unborn child]} 13 FRNZ 472 (1995) at 479.
\item \textsuperscript{76} Ibid at 472, 479.
\item \textsuperscript{77} \textit{St. George’s Healthcare NHS Trust v. S., Regina v. Collins and Others, ex parte S} [1998] 3 W.L.R. 936 at 946.
\item \textsuperscript{78} Ibid at 937, 941.
\item \textsuperscript{79} Ibid at 937.
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Circuit Court, Cook County.\textsuperscript{80} Her husband Lester Brown was also present to represent the wishes of his wife who was refusing to consent to a blood transfusion based on religious convictions.\textsuperscript{81} Ward Jr. J. appointed the hospital administrator as a temporary custodian of Foetus Brown to act in the circumstance when any attending physician advised of the necessity of a blood transfusion.\textsuperscript{82} Theis J. of the Appellate Court of Illinois held that the Circuit Court erred in appointing a guardian \textit{ad litem} for Foetus Brown and that Darlene Brown could not be compelled to undergo blood transfusions.\textsuperscript{83}

It is important to point out that Butler-Sloss J. of the Court of Appeal in the \textit{St. George’s} case was very critical of the use of \textit{ex parte} applications for medical or surgical treatment.\textsuperscript{84} The Court felt that an injustice was done to M.S. by failing to inform her or “even to...attempt to inform her...solicitor of the application” being brought before the Court to authorise a declaration allowing St. George’s Hospital to disregard her refusal to consent to treatment and undertake a caesarean section.\textsuperscript{85} In addition, the Court felt that it was inappropriate for the lower Court to make a declaratory order “without any evidence, oral or by affidavit, and...without any provision for M.S. to apply to vary or discharge the order”.\textsuperscript{86} In guidelines set out in the Court of Appeal judgment Butler-Sloss asserts that hearings in foetal harm cases should be \textit{inter partes} and the pregnant woman should be represented either by a guardian \textit{ad litem} if she is incapable of giving instructions or by counsel or a solicitor if she is in fact capable.\textsuperscript{87} The Court says that an order made in the absence of a pregnant woman “will not be binding on the patient” unless she is represented in some manner.\textsuperscript{88}

\section*{The Rescue Fantasy}

In addition to the urgency of cases involving foetal harm and \textit{ex parte} applications used to hasten Court proceedings, another example of the concern that healthcare professionals have for the Foucauldian understanding of clinical control and organisation of time is through the adoption of the \textit{rescue fantasy}.\textsuperscript{89} Applying Foucault’s understanding of temporal organisation to these cases of foetal harm reveals that the urgency of particular childbirth situations leads to a need to rescue the foetus from the dangerous maternal body in

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\item \textsuperscript{80} \textit{In re Fetus Brown} 689 N.E.2d 397 (Ill. App. 1 Dist. 1997) at 399.
\item \textsuperscript{81} Ibid.
\item \textsuperscript{82} Ibid at 400.
\item \textsuperscript{83} Ibid at 397.
\item \textsuperscript{84} \textit{St. George’s Healthcare N.H.S. Trust v. S., Regina v. Collins and Others, Ex parte S.} (C.A.) [1998] 3 W.L.R. 936
\item \textsuperscript{85} Ibid at 967.
\item \textsuperscript{86} Ibid.
\item \textsuperscript{87} Ibid at 969.
\item \textsuperscript{88} Ibid.
\item \textsuperscript{89} Brody, p. 140, see n. 7.
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which it makes its home. The biblical story of Jesus raising Lazarus from the dead is reminiscent of this need to rescue.  

In the Book of John, a tale is told of how Jesus was summoned to Bethany by two sisters, Mary and Martha, to heal their dying brother Lazarus.  

When Jesus arrived in Bethany he learned that Lazarus had been dead for four days. At the entrance to Lazarus’ tomb the stone was rolled away and Jesus “...cried with a loud voice, ‘Lazarus, come forth!' And he who had died came out bound hand and foot with graveclothes, and his face was wrapped with a cloth.” Jesus had performed another miracle and his third raising of the dead.  

Although contemporary medical practitioners are not in the habit of raising patients from the dead - although it does occur on occasion when the heart of a patient deemed clinically dead is restarted – the common thread that underpins the foetal harm cases outlined in Chapter One is suggestive of this “Lazarus imagery” or “rescue fantasy”.  

According to Howard Brody, the rescue fantasy is essentially a “power trip” wherein the healthcare professional is envisioned as “having the power to snatch the patient from the jaws of death”. Brody says that most patients encountered on an everyday basis by primary-care physicians do not necessitate or incite in the doctor the desire to rescue since they either have nothing medically wrong with them, have an ailment that will eventually cure itself, or suffer from a chronic disorder that can be effectively managed with medication, physiotherapy or alternative treatments. In these cases, the degree of urgency is wrong for a provocation of the rescue fantasy: the medical situation reveals itself slowly over days or weeks and if the healthcare professional does not immediately diagnose or heal the ailment there is usually no permanent harm done.  

Circumstances that fit the description of the rescue fantasy incite in the physician notions of “if I don’t act now, and if I don’t do the right thing, this patient will lose his [sic] life or his [sic] health” and a strong sense of power to control bad outcomes. According to attorney Nancy Rhoden, many physicians perceive a patient’s death as a failure on their part both professionally as a member of the medical field and personally as a human being.  

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90 Ibid, p. 140.  
92 Ibid, John 11:1-44.  
93 In Mark 5:21-43, Jesus raised Jairus’ daughter from the dead and in Luke 7:11-17 he raised the widow’s son Nain from the dead.  
94 The terminology “Lazarus imagery” is taken from Brody, p. 140, see n. 7; “rescue fantasy” was taken from Brody, p. 137-156, see n. 7. Brody takes the notion of rescue from Albert R. Johnsen, “Bentham in a Box: Technology Assessment and Health Care Allocation,” Law, Medicine and Health Care, Volume 14 (November 1986): p. 172-174 where he discusses notions of a “rule of rescue” or an “age of rescue”, Brody, p. 137 footnote 1, see n. 7.  
95 Brody, p. 139, see n. 7.  
96 Ibid, p. 139-140.  
97 Ibid.  
98 Ibid, p. 140.
profession and personally as an empathetic human being. 99

Using "power trip" as Brody does to describe the desire that physicians have to rescue their patients from ill health or death is not always appropriate terminology to use in situations where physicians are merely attempting to provide adequate healthcare. Even if Foucault’s understanding of the term power as something that is not inherently negative or coercive is appealed to in this instance the term “power trip” still has negative connotations. In situations where power imbalances are being abused such as between pregnant women and the medical or legal profession in many of the lower Court judgments outlined in Chapter One the term “power trip” might actually be accurate. These prenatal harm cases are ideal examples of the kind of emergency circumstances that incite rescue fantasy responses in members of the healthcare profession and the judiciary. Brody asserts that circumstances involving pregnant women and unborn children may support and perpetuate the rescue fantasy even more so than hospital resuscitations and other non-obstetric emergency procedures. This is due to the fact that emergency caesarean sections or blood transfusions, and even compelling treatment for substance addiction will eventually produce a “viable and apparently healthy infant most of the time”. 100 The outcome of a successful rescue is very emotionally, socially and professionally rewarding.

Two basic driving components of the rescue fantasy, as it pertains to physicians and judges involved in cases of foetal harm, can be extrapolated from Brody’s work on the Lazarus role. 101 These components involve the notion that unborn children are tiny patients distinct from their mothers and thus are innocently being subjected to harm, and the notion that pregnant women who refuse to consent to medical treatment are wilfully and maliciously seeking to cause undue harm to their unborn children.

The first driving component involves an understanding that the rights and interests of the competent pregnant woman, such as bodily integrity and self-governance regarding medical treatment, are somehow in conflict with the interests of the foetus, such as the interests the foetus may have in being afforded a healthy start to life. One necessary condition for the existence of a maternal-foetal conflict is the understanding that pregnancy involves two distinct bodies – maternal and foetal. This is most obvious in the judgments of the lower Courts when declarations authorising compelled medical treatment are granted. For example, in Winnipeg Child and Family Services v. G. (D.F.) Twaddle J. of the Manitoba Court of Appeal talks about a “classic dilemma” where an “expectant mother sniffs solvents to the

100 Ibid, p. 145.
probable detriment of her unborn child". Froehlich J. in the American case In re Troy D. views the interests of Troy D. and this mother Kelly as “potentially conflicting”. Similarly, Wright J. in the dissenting opinion in State v. Gray asserts that what is being balanced is not the “woman’s significant interest in bodily integrity against the States’ interest in the health and welfare of its [sic] children” but rather what is being balanced is “a woman’s desire to use illegal drugs, while she happens to be pregnant, with the health and welfare of her child”. The superior Courts in the St. George’s Hospital, Winnipeg and Angela M.W. v. Kruzicki cases involved in overturning declarations of compelled treatment handed down by lower Courts recognise that the pregnant body is essentially one intertwined entity rather than two distinct and separate bodies. Butler-Sloss J. in St. George’s Hospital declared that an unborn child was not a separate person from its mother and McLachlin J., citing Paton v. UK, in the Winnipeg case says that “[t]he ‘life’ of the foetus is intimately connected with, and cannot be regarded in isolation from, the life of the pregnant woman.” Likewise, Nettesheim J. of the Court of Appeals of Wisconsin says that Angela and her viable foetus are physically and biologically one.

The second component that drives the rescue fantasy in cases of foetal harm is the notion that pregnant women who refuse to consent to medically prescribed treatment are maliciously and wilfully causing harm to their unborn children. For example, in the St. George’s Hospital case Dr. Caroline Chill, a qualified practitioner under the Mental Health Act 1983, explained

patient [M.S.] depressed and self neglectful refusing voluntary treatment. Has pre-eclampsia with potential severe physical complications which needs assessment, monitoring and treatment. Potential risk of self-harm or harm to unborn child if not treated.

In Sheriff v. Encoe, a criminal complaint was filed against Cathy Encoe which alleged one count of “Wilfully Endangering a Child as the Result of Child Abuse”. A lower Court later charged her with the crime of wilfully endangering her unborn child pursuant to NRS 200.508.

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104 State v. Gray 584 N.E.2d 710 (Ohio 1992) at 714.
which reads in part

[a]ny person who...[w]ilfully causes a child who is less than 18 years of age to suffer unjustifiable physical pain or mental suffering as a result of abuse or neglect or to be placed in a situation where the child may suffer physical pain or mental suffering as the result of abuse or neglect...is guilty of gross misdemeanour...\(^{112}\)

Likewise, Inglis J. of the Family Court in *Re Baby P* asserted that the unborn child was in danger of being harmed due to his mother’s “immaturity and apparent infatuation with the father”.\(^{113}\) His opinion indicates that the young mother is knowingly endangering her unborn child by remaining in the violent relationship with H. despite his previous imprisonment in respect of his violence towards her and his threats to “kidnap and kill” Baby P.\(^{114}\)

In prenatal harm cases involving substance or alcohol abuse, members of the medical and legal profession have claimed that pregnant women who suffer from addiction willingly ingest illicit substances or consume alcoholic beverages with the knowledge that it will reach, and most likely harm, their gestating foetus. For example, in *Johnson v. State* Dauksch J. said that Jennifer Clarice Johnson “voluntarily took cocaine into her body, knowing it would pass to her fetus...[and that] the placing of cocaine into the blood flow is a voluntary act, and the cocaine destination is far more certain than if it were placed into the United States Mail.”\(^{115}\) In addition, he asserted “certainly it is no undue burden upon an expectant mother to avoid cocaine use during the last several days of her pregnancy.”\(^{116}\) Similarly, in the dissenting opinion in *State v. Gray* Wright J. claimed that “a woman who knowingly abuses cocaine while pregnant violates a duty of care to her unborn child...”\(^{117}\) He also asserts that “any person of ordinary intelligence has to know that *in utero* exposure to cocaine poses an unacceptable risk to the unborn child.”\(^{118}\) The judge in this case has failed to take into consideration that often substance abusers do not make a conscious decision to ingest illicit drugs but rather their habit is driven by an uncontrollable addiction.

Many of the cases of foetal harm outlined in Chapter One involve a pregnant woman refusing to consent to medically prescribed treatments such as caesarean sections, blood transfusions or inpatient rehabilitation for substance abuse. In some judgments of the lower Court it is implied that by refusing to undergo treatment the pregnant woman disregards the health and well-being of her gestating foetus. For example, in *In re Troy D.* Froehlich J.

\(^{112}\) Ibid at 597-598.
\(^{113}\) *Re Baby P [an unborn child]* 13 FRNZ 472 (1995) at 479.
\(^{114}\) Ibid at 478-479.
\(^{115}\) *State v. Johnson* 578 So.2d 419 (Fla. App. 5 Dist. 1991) at 420 and footnote 1 at 420.
\(^{116}\) Ibid at 421.
\(^{117}\) *State v. Gray* 584 N.E.2d 710 (Ohio 1992) at 713.
\(^{118}\) Ibid at 714.
asserts that Troy was "in need of the Court's protection" because of his mother's prenatal drug use and Work J., who concurred in this case, explains that after having Troy's older sibling removed from her care the mother continued to abuse illegal drugs in conscious disregard of Courts orders designed to assist her in regaining custody of the other child.

Similarly, lower Courts in *In the Matter of Smith*, *In re Valerie D.*, *Angela M.W. v. Kruzicki* and in the *Winnipeg* case all acknowledged a wilfulness to disobey Court orders with total disregard for the potential life that is gestating within their body. In *In the matter of Smith*, Cornelis J. outlined how the mother was directed by the Court to complete a residential alcohol treatment program at a specified facility and to refrain from the abuse of alcoholic beverages after the birth of a previous child. With regard to the present child, the mother did not comply with any provisions of the Court order and failed to make any effort to obtain either inpatient or outpatient treatment for her alcohol addiction. In the case *In re Valerie D.*, while pregnant with Valerie her mother ingested cocaine eight to ten hours prior to delivery and the trial Court ordered her to participate in inpatient treatment which she refused, and to participate in the outpatient program, which she dropped out of after the fifth session when she tested positive for cocaine. The initial failure to abide by an obstetrician's advice to seek voluntary inpatient treatment resulted in judicial intervention and a Court order to undergo drug rehabilitation treatment in *Angela M.W. v. Kruzicki*. On July 21st, 1995 an obstetrician confronted Angela M.W. about her drug use and its effects on her viable foetus. She expressed remorse but declined the obstetrician's advice to seek treatment.

In the *Winnipeg* case, Ms. G.'s social worker employed by the City of Winnipeg Social Services Department testified that Ms. G. consistently refused all offers of services or treatments despite the Child and Family Service's arrangement for the St. Norbert Foundation to make available a bed and pay the cost of treatment. In the Supreme Court dissenting opinion Major J. says that Ms. G. "chose to continue her pregnancy and to continue her glue sniffing which in the past had resulted in two serious and permanently handicapped children being born who are now permanent wards of the state." In addition, "the respondent, on becoming pregnant for the fourth time, made the decision not to have an abortion. She chose

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120 Ibid at 878.
121 *In the Matter of Smith* 492 N.Y.S.2d 331 (Fam.Ct. 1985) at 332.
122 Ibid.
125 *State ex rel. Angela M.W. v. Kruzicki* 561 N.W.2d 729 (Wis. 1997) at 732.
to remain pregnant, deliver the child, and continue her substance abuse." Major J. also feels that Ms. G. has ample knowledge of the effects of substance abuse on her foetus since she was sadly aware of giving birth to two children with permanent disabilities.

The cases mentioned above involve situations which incite in healthcare professionals feelings of an urgent need to save the life of a dying patient and of power to control bad outcomes which may arise unnecessarily. Medical emergencies at both the beginning of life and at the end of life are filled with great emotional responses and a need to act with haste. The cases of foetal harm outlined above perpetuate the need to rescue even more so than other medical situations at the end of life since what often drives healthcare professionals to rescue unborn children from the "malicious" wombs of their mothers is to prospect of a favourable outcome involving a healthy, viable foetus. This understanding of the rescue fantasy perpetuates the creation of a silent body in prenatal harm cases since it continually overlooks the needs of the pregnant woman, such as the need for addiction treatment or counselling, to focus specifically on rescuing the foetus from harm.

III. NORMALISATION

Alternative Childbirth Management

According to Foucault’s notion of the medical gaze, another strategy to control healthcare consumers is the normalisation of patients and medical treatments into different categories especially high risk/low risk categories of pregnancy. Normalisation in the medical arena involves the common definition of goals and procedures, and agreement of how a well-ordered medical clinic or hospital should be organised. In addition, normalising information can also result in the creation of what Foucault calls "binary divisions" or dualisms such as mad/sane or dangerous/harmless. Once information is gather about a particular individual with regard to a certain disease or medical condition, he or she is slotted into one of these categories for appropriate treatment. Normalisation becomes problematic when categories are used unnecessarily to segregate and oppress patients, and when the only option appears to be either being placed on one side of the dualism or the other; there is no room for areas of uncertainty when binary divisions are created between one set of individuals and another. Also, when using the term normalisation it is not immediately obvious or
transparent what is considered normal or abnormal

In some of the prenatal harm cases outlined in Chapter One a "binary division" is created between acceptable and unacceptable methods of managing pregnancy and childbirth. More conventional methods of managing care that are advocated by the majority of the members of the healthcare profession are considered acceptable under the medical model, whereas, alternative treatments are often seen as unacceptable especially if the pregnant woman is advocating them against the recommendations of medical professionals. As well as failing to inform pregnant women of Court proceedings by bringing forth *ex parte* applications and not ensuring her presence at Court hearings, and attempting to rescue foetuses that are not necessarily in need of rescue, lower Courts have also failed to entertain alternative non-medical methods of treatment. This also contributes to the perpetuation of a voiceless pregnant body. For example, in the *St. George's Hospital* case, although M.S. fully comprehended the alleged risks to her health and that of her unborn child she nonetheless asserted that she wanted her foetus to be born "naturally" without medical or surgical interventions; her position was that "nature should take its course".\(^{132}\) Upon forced admission to St. George's Hospital, M.S. continued to maintain that she wanted to go to Wales to give birth to her baby in a barn rather than undergo a caesarean section which she felt to be very unnatural and invasive.\(^{133}\) Similarly, in *In re Madyun*, Ayesha Madyun refused to consent to undergo a caesarean section and "reiterated her preference for a natural delivery and expressed her belief that a Caesarean section was not necessary".\(^{134}\) Yahya Madyun felt that his wife was not given sufficient opportunity to deliver vaginally and that the D.C. General Hospital had not allowed Ayesha to stand up or walk around to assist her in the delivery.\(^{135}\) Levie J. of the Superior Court of the District of Columbia Civil Division, accepting the expert testimony of Dr. John Cummings, asserted that "no alternative medical procedures are available at this time."\(^{136}\)

The examples given above show that the failure on the part of the Courts to entertain ideas of alternative medical or non-medical treatments due to the mainstreaming of pregnancy and childbirth as medical phenomenon and the normalisation into categories of high risk/low risk perpetuates a silent body. The pregnant body is made silent through viewing the biological process of reproduction as involving a potential risk and treating it as a pathology waiting to arise. This is not to deny that there legitimate circumstances in which pregnancies

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\(^{133}\) Ibid at 945.

\(^{134}\) *In re Madyun* as appended in *In re A.C.* 573 A.2d 1235 (D.C. App. 1990) at 1260.

\(^{135}\) Ibid at 1260.

\(^{136}\) Ibid at 1264.
or childbirths go wrong and require medical intervention but perceiving all pregnancies and childbirth as potentially problematic itself silences the pregnant body.

**Mental Illness & the Capacity to Refuse Treatment**

Likewise, when Foucault’s understanding of normalisation is applied to cases where pregnant women are illegitimately deemed to be incompetent to refuse medical treatment it becomes apparent that the mental health of these women is being questioned due to their unconventional ideas of pregnancy and childbirth management. University of Otago Law lecturer Nicola Peart argues that legal cases which involve the illegitimate detention of pregnant women, due to alleged mental incompetence, the detention is solely to treat a physical condition, such as placenta praevia or pre-eclampsia, rather than an alleged mental illness.\(^{137}\) This is not to assert that there are no legitimate circumstances under which a pregnant woman ought to be detained under mental health legislation, but rather to point out that the misuse of this legislation to force pregnant women to undergo treatment for a strictly medical condition is unacceptable.\(^ {138}\)

An example of legal proceedings in which a pregnant woman was illegitimately detained under mental health legislation is found in the recent decision of the English Court of Appeal in *St. George’s Healthcare v. S.*\(^ {139}\) In this case, the attending physicians found M.S.’s thought process to differ greatly from the norm and to be unusual, bizarre, and allegedly irrational.\(^ {140}\) Her decision to refuse to consent to a caesarean section and opt for natural childbirth were contrary to a course of action advocated by an overwhelming majority of the medical professionals.\(^ {141}\) When M.S. refused to consent to a recommended caesarean section social worker Louize Collins and two qualified practitioners registered under the *Mental Health Act 1983* Dr. Caroline Chill and Dr. Siobhan Jeffreys, had her admitted against her will to Springfield Hospital for mental health assessment.\(^ {142}\) Dr. Chill and Dr. Jeffreys both felt that “M.S. is suffering from mental disorder of nature or degree which warrants detention” in a psychiatric hospital for assessment.\(^ {143}\) In addition, they felt that M.S. “ought to be so detained” in the interests of her own health and safety and “with a view to the

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137 Peart, p. 398, see n. 46.
140 Ibid, at 942.
141 Peart p. 397, see n. 46; *St. George’s Healthcare N.H.S. Trust v. S, Regina v. Collins and Others, ex parte S* [1998] 3 W.L.R. 936 at 942.
142 Ibid at 942.
143 Ibid.
protection of other persons". A few hours later M.S. was unlawfully transferred to St. George’s Hospital where she was examined by Dr. Jeffreys who recorded that “M.S. appeared at times to be sad and distressed but denied feeling depressed or having suffered any biological symptoms of depression recently.” She found M.S.’s capacity to refuse treatment to be intact and not affected by her current mental state. At no point during her unlawful detention at Springfield Hospital or at St. George’s Hospital did M.S. receive any treatment for her mental condition. Butler-Sloss J. of the English Court of Appeal recognises that the Mental Health Act 1983 cannot be deployed to detain a pregnant woman on the mere basis that she holds eccentric thoughts with regard to her obstetric treatment.

A further example of normalising the views of a pregnant woman regarding the unorthodox management of pregnancy and childbirth to result in her unlawful detention under the auspices of mental health legislation is found in Winnipeg Child and Family Services v. G. (D.F.). On May 31st, 1996 psychiatrist Dr. Mark Etkin examined Ms. G. and found that she made numerous suicide attempts in the past and engaged in self-mutilation. Despite these findings, in the opinion of Dr. Etkin, this was not sufficient evidence to warrant an acute psychiatric intervention such as forced detention. Dr. Michael Eleff also examined Ms. G. and found that although she suffered from a “chronic solvent and mixed personality disorder, and antisocial and dependent features” he did not have grounds to detain her under The Mental Health Act 1987. Schulman J. of the Manitoba Court of Queen’s Bench explicitly mentions that the opinions of Dr. Eleff and Dr. Etkin do not bind the Court and he finds, to the contrary, that Ms. G. does in fact suffer from a mental disorder within the meaning of the Act. He seeks to “emphasize that irrational behaviour per se is not justification for finding a person to be mentally disordered...[h]owever, it is a legitimate factor to consider in the context of the total picture when deciding this question.” The Court ordered that the Director of Child and Family Services is to have custody of Ms. G. with the power to have her treated at the Health Sciences Centre and St. Norbert Foundation for her solvent abuse until

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144 Ibid at 944. Butler Sloss J. of the Court of Appeal clarifies that this statement can only refer to the foetus carried by M.S.
145 Ibid at 945.
146 Ibid at 948.
148 Ibid at 957.
150 Ibid at 244.
151 Ibid at 245.
152 Ibid at 245-246; Section 1 of the Canadian Mental Health Act 1987 defines “mental disorder” as: "a substantial disorder of thought, mood, perception, orientation or memory that grossly impairs judgment, behaviour, capacity to recognize reality or ability to meet the ordinary demands of life and except in Part I includes mental retardation."
153 Ibid at p. 246.
CONCLUSION

The goal of this chapter was to show that Foucault's understanding of the medical gaze as an analytical tool is useful for examining cases of foetal harm. The application of strategies of the gaze such as confessional technologies, permanent registration and normalisation, and the tactical control and organisation of time to the clinical and legal encounter reveals the existence of a voiceless pregnant body. Evidence of the exclusion of an oral, speaking pregnant body from these Court proceedings is found in the granting of _ex parte_ applications, lack of legal representation before the Court, failure to consider alternative methods of managing pregnancy and childbirth, and using information about prenatal conduct to illegitimately detain or legally sanction pregnant women.

In conclusion, the silent body revealed by analysing lower Court judgments in foetal harm cases through the lens of the medical gaze and its strategies is an unfortunate outcome of the conventional problem of maternal-foetal conflict. In the following chapter an exploration of the influence that medical opinion has on members of the judiciary in cases of foetal harm will be undertaken in light of the medical gaze in the clinical encounter. In this instance, the medical gaze will reveal that the traditional understanding of maternal-foetal conflict, as outlined in Chapter One, is configured in these terms due to the lens that the clinical encounter in pregnancy and childbirth is viewed through. The notion of maternal-foetal conflict comes about merely as a result of how the clinical encounter in pregnancy and childbirth is perceived. The Foucauldian medical gaze also reveals that decisions handed down by superior Courts are not always viewed in terms of the traditional maternal-foetal conflict. Instead, this conflict is configured in terms of the pregnant woman in opposition to the medical profession rather than in conflict with her foetus. This reconfiguration of the traditional problem comes about when cases of foetal harm are viewed through the lens of narrative ethics.

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154 Ibid at 240.
CHAPTER IV

MEDICAL OPINION IN CASES OF FOETAL HARM

Thus the law would be secure, even in the new mechanics of power. For this is the paradox of a society in which, from the eighteenth century to the present, has created so many technologies of power that are foreign to the concept of the law: it fears the effects and proliferations of those technologies and attempts to recode them in forms of law.\(^1\)

- Michel Foucault

*The History of Sexuality* (1976)

INTRODUCTION

As well as revealing the presence of a silent body in the cases of foetal harm outlined in Chapter One, the use of the Foucauldian conception of the medical gaze also reveals that members of the judiciary often appear to uncritically reinforce medical opinion. The Courts, especially in lower Court judgments, allow the clinical facts of a particular pregnancy or childbirth, obtained from the testimony of medical experts, to sway their legal judgment. Often the facts about a particular case are much wider than just the mere medical facts. Limiting legal decision-making to these facts alone is problematic since it fails to consider other important aspects of the case such as the non-medical facts of a pregnant woman’s narrative. This approach also fails to consider that Western society does not always legally sanction individuals for making choices that result in undesirable medical outcomes. Individuals often conduct themselves in ways that may be deemed socially immoral or less than ideal by Western society, such as acts of lying or committing adultery, but it does not necessarily follow that these individuals should then be legally sanctioned for their repugnant

behaviour. In cases of foetal harm there is a distinction to be made between using expert testimony to obtain the clinical facts about a particular case and letting these facts determine the legal outcome. This will be explained more fully later in the chapter. The lower Courts do not appear to make this distinction and use medical experts not only to obtain the facts of the case but also to determine the ruling. It is important to point out that the use of medical evidence or clinical facts in prenatal harm cases is not necessarily wrong simply because they are “medical” facts and evidence. Rather, the undesirable use of clinical knowledge arises when the medical facts are used inappropriately to determine the legal outcomes of these cases.

One explanation for why lower Courts may take on medical opinion in such a manner is because of the power that members of the healthcare profession possess. This chapter will explore American physician Howard Brody’s claim that the notion of physicians possessing Aesculapian power, Social power and Charismatic power can account for power imbalances between physicians and patients. Brody’s perception of the healer’s power will be applied to the foetal harm cases outlined in Chapter One to determine whether it can account for the unhealthy attitude that lower Courts in these cases often have towards medical opinion. The healer’s power can lead to an abusive power imbalance if the facts of a particular case are based merely on clinical evidence. In addition, this chapter will revisit the traditional problem of maternal-foetal conflict outlined in Chapter One and put forth the argument that the conventional notion of maternal-foetal conflict is created in light of the healthcare professionals’ attitude towards pregnancy and childbirth management. That is, viewing the obstetric arena through the lens of the medical gaze creates a notion of a maternal-foetal conflict when one does not necessarily exist.

I. EXPERT TESTIMONY

Medical Evidence in Legal Judgments

Courts in Western society have relied on expert opinion since as long ago as the sixteenth century when Saunders J. asserted that “[i]f matters arise in our law which concern other sciences or faculties we commonly apply for the aid of that science or faculty which it concerns.” In *Folkes v. Chadd*, an expert engineer was enlisted to give his expert opinion as

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2 I wish to thank Adjunct Professor of Law, John Seymour, of the Australian National University in Canberra, Australia for pointing this out to me.
to whether an embankment had caused the silting of a harbour. The duty of expert witnesses has been set out succinctly by Lord President Cooper in *Davie v. Edinburgh Magistrates*:

Their duty is to furnish the Judge or jury with the necessary scientific criteria for testing the accuracy of their conclusions, so as to enable the Judge or jury to form their own independent judgment by the application of these criteria to the facts proved in evidence.

According to Cross, the clinical evidence presented to the Court is likely to carry more weight than evidence presented by an ordinary witness. Cresswell J. in *National Justice Cia Naviera SA v. Prudential Assurance Co. Ltd., The Ikarian Reefer* remarked that “[a]n expert witness should provide independent assistance to the Court by way of objective unbiased opinion in relation to matters within his expertise...An expert witness in the High Court should never assume the role of an advocate.” In essence, the role of an expert in legal cases is to present accurate, unprejudiced professional testimony about a particular matter to provide the Court with technical facts that be applied to the greater context.

In the lower Court judgments of the foetal harm cases outlined in Chapter One, the members of the judiciary use medical experts not only to provide the medical facts and clinical evidence surrounding a particular pregnancy or childbirth but also to seemingly determine the legal outcome of the case. Each case concerning prenatal harm that has come before the Courts has obtained some amount of clinical evidence from a medical expert such as an obstetrician, psychiatrist, or neonatologist. The testimony or clinical evidence that is presented to the Courts in obstetric cases can involve the seriousness of a particular medical condition, mortality and morbidity statistics, whether holding an alternative view to pregnancy and childbirth management indicates incompetence, as well as how maternal abuse of illicit substances affects the morphology of the gestating foetus. It is important to mention that all Courts, even those that rule in favour of the pregnant woman, rely on expert medical testimony to some degree to make a legal ruling. Relying on expert testimony becomes problematic when Courts fail to recognise that the medical facts are not the only relevant facts of a prenatal harm case. The acknowledgment of this by some of the higher Court judgments outlined in Chapter One will be discussed in more detail further in this chapter. The present concern is with lower Courts that rely solely on medical opinion or clinical evidence to determine the legal outcome of foetal harm cases.

As was mentioned above, there is a distinction to be made between using the medical

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5 *Folkes v. Chadd* (1782) 3 Doug KB 157
7 Cross, p. 680, see n. 4.
8 *National Justice Cia Naviera SA v. Prudential Assurance Co. Ltd., The Ikarian Reefer* [1993] 2 Lloyd’s Rep 68 at 81; Cross, p. 680, see n. 4.
experts to obtain clinical facts or medical evidence about a particular pregnancy or childbirth and using medical experts for determining the legal outcome of a case. On the one hand, it is important for members of the judiciary in foetal harm cases to be presented with legitimate medical information to consider when making a legal ruling on a particular case. The role of the medical expert is not to determine how the case should be decided on the basis of medical evidence but rather to present a professional, unbiased account of the clinical facts surrounding a particular pregnancy or childbirth. In cases involving prenatal harm, medical experts may be required to provide evidence about a particular obstetric complication or disorder, or how carcinogens and other toxins affect foetal morphology. On the other hand, in many of the lower Court decisions outlined in Chapter One the clinical evidence provided by the medical expert was used to determine the outcome rather than just to provide an account of an obstetric situation. In essence, advocacy is not the role of medical experts in foetal harm cases nor does it necessarily follow that the clinical facts are the only facts that ought to be considered by the Courts.

Medical Experts

Analysing the foetal harm cases outlined in Chapter One in terms of Foucault’s understanding of how healthcare professionals perceive the clinical world or in terms of the Foucauldian notion of the “medical gaze”, reveals that the lower Courts often rely solely on medical evidence to determine the legal outcomes of cases. For example, in the American case *In re Madyun*, Levie J. outlines the entire medical career of Dr. Cummings, who provides testimony that Mrs. Madyun has gone beyond the normal time allowed for the delivery of a baby after the membranes have ruptured:

After receiving his M.D. degree at the George Washington University, Dr. Cummings took a two-year general surgery program at Emory University. This was followed by a four-year period as a physician in the U.S. Navy Medical Corps. He is now in the final year of a four-year obstetrical/gynecological program at Georgetown, and is Chief Resident of the Georgetown Service at the Hospital...None of the counsel present at the hearing questioned the competence or expertise of Dr. Cummings. Based upon [his] education and experience, the Court was satisfied with respect to the doctor’s expertise and competence. According to Dr. Cummings, normal labour for uncomplicated first pregnancies lasts between ten and fifteen hours and it is customary obstetrical procedure with full term pregnancies to have the baby delivered within twenty-four hours of the rupture of the membranes to avoid

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9 Cross, p. 680, see n. 4.
10 Ibid.
sepsis. According to expert testimony, it is considered abnormal for the cervix of a pregnant woman in labour to remain statically dilated at 7cm for twelve hours. Levine J. also asserts that the strongest basis for the Madyun’s refusal to consent to a caesarean section was not their religious beliefs but rather their belief that the surgical procedure was not necessary and that additional steps could be taken to enhance the possibility of a vaginal delivery. However, he says “neither parent... is a trained physician...[and Courts should not] ignore the undisputed opinion of a skilled and trained physician to indulge the desires of the parents.”

Howard Brody’s account of a physician’s Social power, which gives him or her the authority to determine who is sick and who is well, can account for this statement made by the Levine J. This will be discussed further in the chapter. This normalisation of Mrs. Madyun’s labour in this manner is consistent with what Foucault has discussed as the strategic organisation and control of space and time. Normalisation under the medical gaze is essentially a “procedure... aimed at knowing, mastering and using”.

Further examples of lower Courts uncritically relying on expert medical testimony to determine the legal outcome of a case can be found in Re MB, In re Troy D., State ex. rel. Angela M.W. v. Kruzicki and In re A.C. In the recent English case Re MB, the consultant psychiatrist Dr. F. confirmed that Miss MB was suffering from the

...abnormal mental condition of needle phobia which he described as...the term which is used conventionally...Usually [a phobia] means that the patient suffers from an abnormal fear in relation to some specific object or procedure...If [Miss MB] felt that she could not tolerate the thought of a needle penetrating her skin it would be perfectly capable of inducing a panic reaction.

Hollis J. made a declaration based on Dr. F.’s testimony that since MB was not “really capable of considering matters lucidly” the “plaintiff’s responsible doctors...[should] carry out such treatment as may in their opinion be necessary...including...cesarian section...[and] the insertion of needles for the purposes of intravenous infusions and anaesthesia.” In In re Troy D. paediatrician Dr. Suzanne Dixon testified at great lengths about the harmful effects and potential long-term consequences of prenatal exposure to opiates and other dangerous drugs including “prematurity and low birth weight...poor feeding, lethargy, and weight

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12 Ibid at 1261.
13 Ibid.
14 Ibid at 1263.
16 Re MB (CA) [1997] 8 Med LR 217 at 220-221
17 Ibid at 217, 221.
Kelly D., Troy D.'s mother, claims that the medical records and the expert medical testimony are insufficient to establish the jurisdictional allegations of failing to protect the child. Nonetheless, Froehlich held that Troy D. was in need of protection from his mother and was to be placed in his paternal grandmother's custody.

In *State ex. rel. Angela M.W. v. Kruzicki*, Kathryn W. Foster J. of the Circuit Court, Waukesha County, Wisconsin held that Angela’s viable foetus was to be confined to a hospital to protect it from its mother’s drug abuse based on the medical opinion of Angela’s obstetrician. Angela’s treating obstetrician asserts

it is in my opinion that without intervention forcing [Angela] to cease her drug use she will continue using cocaine and other drugs with the following likely effects on her unborn child: low weight gain, abruptio placentae, increased infectious diseases, hypertension and tachycardia, preterm labor and delivery, possible precipitous delivery, and increased risks for pregnancy loss, including spontaneous abortion and still birth, SIDS, congenital malformations, intraventricular hemorrhage and precipitous labour.

According to Nettesheim J. of the Court of Appeals of Wisconsin, the affidavit of Angela’s obstetrician recites medical facts clearly sufficient to satisfy a statute that vests the juvenile Court with jurisdiction over a child whose parent “neglects, refuses or is unable for reasons other than poverty to provide necessary care…” The medical facts also satisfy a statute that authorises the juvenile Court to issue an order for the custody of the child. In this case, the clinical evidence about the affects of cocaine on the morphology of the developing foetus and the complications that it may suffer as a born child is found to be sufficient to establish child neglect. In this case, the Court fails to acknowledge factors such as socio-economic status, access to drug rehabilitation services, the perils of addiction, and whether legally sanctioning pregnant drug abusers will actually meet the Court’s goal of protecting children from harm.

In a partial dissenting opinion *In re A.C.* Belson J. of the District of Columbia Court of Appeals claims that when weighing the invasive and serious nature of the proposed surgery against the interests of the unborn child it must be considered that “caesarean deliveries are quite common”. He justifies the procedure in this case by citing statistics complied by the Bureau of the Census in the Department of Commerce for the year 1986, the latest year for which it furnished statistics at that particular time, that 24.1 percent of all American births
Essentially, Belson J. is implying that physicians know best, based on their medical knowledge and clinical experience, what procedures are the most effective in managing complicated childbirth. Emmett G. Sullivan J. of the Superior Court of the District of Columbia based his decision on the medical evidence that Angela would probably die within the next forty-eight hours and that her twenty-six week foetus had a fifty to sixty percent chance of surviving if a caesarean section was performed immediately. When this decision was appealed, Terry J. of the Court of Appeals pointed out that the trial judge incorrectly relied exclusively on hearsay evidence from the doctor about Angela’s wishes and her medical condition.

Neonatologist Dr. Maureen Edwards also gave expert testimony before the Court in *In re A.C.* Although she had no direct involvement or interaction with Angela or her family, she strongly supported surgical intervention to remove the twenty-six-week foetus from Angela’s womb. Her recommendation was based on statistical evidence that a twenty-six week foetus had an eighty percent chance of surviving independently from its mother. She placed the likelihood of the procedure resulting in foetal viability for this particular foetus at between fifty and sixty percent, and the risk of serious foetal impairment at less than twenty percent. To justify the acceptability of the expert’s position, Terry J. pointed out that although Dr. Edwards was testifying only as a medical expert rather than as a treating physician, she did in fact hear testimony from treating physicians who were familiar with A.C.’s condition.

In the Canadian case *Winnipeg Child and Family Services v. G. (D.F.)*, Shulman J. of the Manitoba Court of Queen’s Bench uses the medical facts to determine the outcome in this case. While expert testimony was presented by physicians, psychiatrists and social workers, it appeared to be the testimony of Dr. Albert Chudley, Head of the Section of Genetics and Metabolism at the Health Sciences Centre and a Professor of the Department of Paediatrics and Child Health, and the Department of Human Genetics that held most sway. His testimony held that an unborn child can be seriously harmed when its mother chronically abuses alcohol or chronically sniffs glue while pregnant and this is especially problematic.

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26 Ibid at 1259.
27 Ibid at 1240.
28 Ibid at 1247.
29 Ibid at 1239.
30 Ibid.
34 Ibid at 240, 242.
during the first sixteen weeks of development.  

Children who have been exposed, *in utero*, to these substances exhibit “central nervous system dysfunction, developmental delay, attention deficit disorder, microcephaly, growth deficiency, short palpebral fissures, deep-set eyes, micrognathia, abnormal auricles and small fingernails.”

He also indicated that damage to an unborn child can be reduced if exposure to glue is eliminated during the second and third trimesters.

As well as receiving testimony from Dr. Chudley in this case, expert medical testimony from psychiatrists Dr. Mark Etkin and Dr. Michael Eleff was presented to Shulman J. The psychiatrists found that although Ms. G. had a long-standing history of solvent abuse and suicide attempts, “there was no evidence that an acute psychiatric intervention was necessary at that time”. Clinical evidence was also presented that there were no “grounds to detain Ms. G. under the [*Mental Health*] Act”. Despite this evidence presented by Drs. Etkin and Eleff, Shulman J. based his legal opinion on the medical testimony that a foetus will suffer morphological defects due to prenatal solvent abuse. The Court ordered that Ms. G. be committed to a treatment facility, and refrain from the use of intoxicating substances, until the birth of her child in order to prevent any further foetal harm.

Likewise, in *Johnson v. State*, the Court not only used medical experts to gather clinical evidence but also used the facts that were presented to determine the legal outcome of the case. In this case, pathologist and toxicologist, Dr. Shashi Gore, and neonatologist, Dr. Stephen Kandall, gave two relatively opposing testimonies. Both experts were asked whether a woman who had smoked cocaine (which has a half-life of approximately sixty minutes) at 10:00p.m. on a particular day and again between 6:00 and 7:00a.m. the following morning would still have cocaine or benzoylecogonine present in her bloodstream at 1:00pm. that afternoon when she gave birth. Dr. Gore answered that the pregnant woman would in fact have traces of cocaine in her bloodstream. Whereas, Dr. Kandall testified for the defence that it was impossible to tell whether the cocaine derivatives found in the urine of Jennifer Clarice Johnson’s children, shortly after their birth, were the result of the exchange from

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36 Ibid.
37 Ibid.
38 Ibid at 244-245.
39 Ibid.
40 Ibid.
41 Ibid at 238.
42 *Johnson v. State* 602 So.2d 1288 (Fla. 1992)
43 Ibid at 1291-1292.
44 Ibid.
Johnson to her children before or after they were born. In addition, Dr. Kandall said that the blood flow from the placenta to the foetus through the umbilical cord is dramatically restricted when the uterus is contracting and when cocaine enters the blood stream. O.H. Eaton Jr., J. of the Circuit Court in Seminole County, Florida used the clinical facts presented to the Court by medical expert Dr. Gore to convict Jennifer Johnson of delivering a controlled substance to her child through the umbilical cord after birth. The rescue fantasy can be appealed to in order to account for the Court's decision to accept the medical evidence of Dr. Gore over the expert evidence presented by Dr. Kandall. In this case, it appears that the Court felt that sentencing Jennifer Johnson to fifteen years' probation for delivering illicit substances to her children at birth was one way of protecting them from a mother who is wilfully harmful.

In the English case *Re S (adult: refusal of medical treatment)*, P, a Fellow of the Royal College of Surgeons who is the attending physician of Mrs. S., gave succinct and graphic clinical evidence of his patient's condition. P asserted that "the child is in what is described as a position of 'transverse lie', with the elbow projecting through the cervix and the head being on the right side." Sir Stephen Brown P of the Family Division Court declares that he "wholly accepts the evidence of P as to the desperate nature of this situation" and granted the declaration to authorise a caesarean section. In *Crouse Irving Memorial Hospital v. Paddock*, Hayes J. said that "when a patient puts her doctor in charge of a surgical procedure [such as a caesarean section], she necessarily makes him responsible for conduct of the operation, and such grant of responsibility should be accompanied by authority sufficient to properly carry out the delegated responsibilities [blood transfusions if necessary]." In both of these cases, the Courts have indicated that they are relying on the clinical evidence or medical facts presented in expert testimony to determine the ruling of the case.

**Moral Judgments in Law**

In the lower Court judgments of the prenatal harm cases discussed above, letting expert testimony alone guide the legal outcome is problematic. First, determining legal cases in this manner fails to consider that the facts about any particular pregnancy or childbirth are

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46 *Johnson v. State* 602 So.2d 1288 (Fla.1992) at 1292.
47 Ibid at 1288-1289.
48 Hansen, p. 18, see n. 45.
50 Ibid.
51 Ibid.
52 *Crouse Irving Memorial Hospital v. Paddock* 485 N.Y.S.2d 443 (Sup. 1985) at 443.
much wider than just the mere medical facts or clinical evidence. Applying Foucault’s understanding of the medical gaze to cases of so-called “maternal-foetal conflict” illuminates the idea that what is missing when Courts rely only on expert medical testimony to determine the outcome of cases is the consideration of psychological or social reasons for why these women are refusing to consent to treatment. As previously stated, relying solely on medical testimony is not unacceptable merely because it involves medical evidence, but because it fails to consider other aspects of the pregnancy or childbirth that might be important to the pregnant woman. For instance, in an Israeli case that occurred many years ago, a pregnant woman who was at full term (forty weeks) refused to consent to a caesarean section that would provide her unborn child with great benefit. The physicians complied with her wishes and the foetus was delivered stillborn. After the delivery, the woman confessed to a nurse that the death of her child was a fortunate thing since it solved many personal problems for her. Although this case never came before a Court, it nonetheless illuminates a non-medical reason why this pregnant Israeli woman opted to refuse to consent to the caesarean section procedure. According to Ruth Macklin, women refuse caesarean sections and other medical procedures for many reasons including religious grounds, out of fear of operations, needles or hospitals, due to personal relationships or for other reasons – some rational, others irrational. These reasons and other relevant facts or evidence need to be considered alongside medical evidence to determine the legal outcome of a particular case.

Second, allowing expert testimony alone to guide legal judgment is problematic since it assumes that an action that leads to a medically undesirable outcome is not only morally repugnant but also legally sanctionable. It does not necessarily follow that what is socially frowned upon should be found abhorrent before the Courts. To strengthen and clarify this point, Thomas H. Murray’s discussion of the “father-child analogy” in relation to cases of compelled caesarean sections is useful. (This analogy was also used in Chapter Two to show that morally reprehensible actions are not necessarily legally reprehensible ones). Murray develops an analogy of a case wherein a father is an ideal donor match for his child who requires a liver as a tool; however, the father refuses to give up part of his liver. This analogy is used as a tool for exploring the boundaries of the claim that pregnant women are morally

54 Leiberman et al, p. 517-717, see n. 53.
56 Murray, p. 112, see n. 53.
Murray draws a parallel between the notion that a father has a moral obligation to donate a lobe of his liver to his son and the notion that a pregnant woman has a moral obligation to consent to a caesarean section if it will benefit her foetus. This is due to the special relationship that parents or parents-to-be have with their children and is distinct from relationships that they have with other third parties. If such a situation were to arise where a father was an ideal donor match for his child, Murray asserts that most parents “would need little persuading to become a donor”. Likewise, most pregnant women would consent to a caesarean section if it were required to benefit their unborn child. Murray asks what should be done if this father refuses to be a liver donor for his son and answers that public policy should not compel him to undergo the procedure. He asserts that “[t]he prospect of forcibly restraining a man in order to take out a piece of vital organ for someone else’s benefit – even his own child’s – gives us pause...” If the pregnant woman in this hypothetical situation were to refuse to consent to the caesarean section then public policy should not force her, under legal order, to undergo the procedure. The existence of a moral obligation to consent to medical treatment to benefit a child – born or in utero – does not thus create a similar legal obligation that can be enforced through the Courts.

II. THE HEALER’S POWER

Now that it has been established that lower Courts often uncritically rely on medical opinion to determine the ruling in a particular case, the question that needs to be addressed is: what is it about medical experts and the testimony that they present that causes Courts to rely so heavily on medical evidence in foetal harm cases? One way of accounting for this unhealthy attitude towards medical opinion is through the power that healthcare professionals possess. In The Healer’s Power, Howard Brody argues that “medical ethics is about power and its responsible use”. He outlines three components of power possessed by members of contemporary Western medicine: Aesculapian power, by virtue of medical training and clinical skills; Charismatic power, by virtue of ability to empathise and console; and Social power, by virtue of the relationship that physicians have with society.

Named after Asklepios, Greek God of Medicine, Aesculapian power refers to the
power that the physician possesses as a result of academic and clinical training.\textsuperscript{65} This type of power arises from the physician's possession of knowledge about the systems, components and functions of the human body, practical skills for the manipulation of medical instruments and body parts, and ability to apply this knowledge and learned skill in a pragmatic manner.\textsuperscript{66} Aesculapian power is also impersonal since any physician having reasonable skill and experience can have it in his or her possession; this power is fundamental to the description of the physician itself.\textsuperscript{67} In essence, this type of power is composed of a physician's ability to heal patients through application of acquired medical knowledge and skill.\textsuperscript{68}

Evidence of the weight of the Aesculapian power that medical experts possess is found in the legal judgments of prenatal harm cases where their academic and clinical experience is outlined in great and succinct detail. An example of this, which was also given above, is found in the American case \textit{In re Madyun}.\textsuperscript{69} The Court precisely outlines the entire academic and clinical career of expert witness Dr. Cummings – from his M.D. at George Washington University to his position as Chief Resident of the Georgetown Service. This is done not only as justification for his competence as a medical expert but also as justification for the Court's reliance on his opinion to dispense with Mrs. Madyun's consent and compel her to undergo a caesarean section.\textsuperscript{70}

\textit{Charismatic power} is the second type of healer's power that Brody identifies and it refers to the personality characteristics of the physician such as “courage, decisiveness, firmness, kindness, and so on”.\textsuperscript{71} Unlike Aesculapian power, Charismatic power cannot be readily transferred from one physician to another. Citing J.C. Moskop, Brody says that physicians are uniquely placed because they are involved in emotionally charged events of great social importance such as birth, death, or trauma, and are in a position which provides a unique opportunity to offer guidance and condolence to patients and families, they are expected, almost as a component of their Aesculapian power, to display “strong interpersonal skills and psychological strength”.\textsuperscript{72} This type of power may not be directly evident in a healthcare professional's capacity as a medical expert as it is more applicable to a clinical setting rather than the Courtroom. However, “strong interpersonal skills” are very useful for

\begin{itemize}
\item \textsuperscript{65} Ibid, p. 16.
\item \textsuperscript{66} Ibid.
\item \textsuperscript{67} Ibid.
\item \textsuperscript{69} \textit{In re Madyun} Misc. No. 189-86 as appended in \textit{In re A.C. 573} A.2d 1235 (D.C.App. 1990) footnote 7 at 1261.
\item \textsuperscript{70} Ibid.
\item \textsuperscript{71} Brody, p. 16-17, see n. 3.
\end{itemize}
medical experts to possess when giving expert testimony at a Court proceeding and can account, in part, for why their opinion is so persuasive.

A good example of the possession of Charismatic power is found in a recent New Zealand case *A v. B*.\(^{73}\) This case involved a midwife whose alleged negligence in childbirth management lead to the stillbirth of a baby boy and registered midwife Ms. Yates was summoned to give expert testimony.\(^{74}\) In her expert opinion, Ms. Yates felt that midwife *B* had acted in a “reasonable and appropriate” manner as any reasonable midwife would.\(^{75}\) This was the first time in New Zealand legal history that a midwife has been called to give expert testimony before a Court of law. Ellis J. found Ms. Yates’ evidence to be “impressive and measured, and her authorities were cited” and her medical opinion was “authoritative and compelling”.\(^{76}\) He held that *B* was not negligent and thus was not responsible for the unexplained stillbirth. Although this case does not involve prenatal harm or maternal-foetal conflict, it serves as a good example of how much sway expert testimony in obstetric cases can have in legal proceedings. The Court, in their judgment, seemed to be persuaded by much more than Ms. Yates’ knowledge and professional skills. Ellis J. accepted her expert testimony over that of specialist obstetrician Dr. Wilde who asserts that “the management of this [A’s] pregnancy by midwife *B* was unsatisfactory and...[he] believes that this sad outcome could have been averted”.\(^{77}\) Brody’s understanding of Charismatic power, especially the notion of displaying strong interpersonal skills, can account for why Ellis J. chose to rely on Ms. Yates’ expert testimony over that given by Dr. Wilde.

The third type of power that physicians possess, according to Brody, is *Social power*.\(^{78}\) This is a condition of the social status of the physician and it delegates the authority to determine who is sick and who is well.\(^{79}\) There exists a sort of contract between society and the medical profession which gives healthcare professionals the power to decide what counts as medical knowledge and medical truth. Brody says that “the physician’s word on the subject is sufficient to set in motion various social roles and practices (such as the “sick” role) in a way that no word from a lay person could do.”\(^{80}\) Contemporary Western society generally accords the physician a high social status that places him or her in a certain neighbourhood, lends to driving a certain car, wearing certain clothes and using articulate,

\(^{73}\) *A v. B* unreported, High Court of New Zealand, Palmerston North Registry, October 18\(^{th}\), 1999, CP9/98
\(^{74}\) Ibid.
\(^{75}\) Ibid at 17.
\(^{76}\) Ibid, p. 16, 19.
\(^{77}\) Ibid at 15.
\(^{78}\) Brody, p. 17, see n. 3.
\(^{79}\) Ibid.
\(^{80}\) Ibid.
influential language.\textsuperscript{81}

The medical expert's possession of Social power can account, in part, for the Courts' uncritical reliance on medical opinion when determining that the life of a foetus is in imminent danger. The Courts accept the authority of the expert to determine who is sick and who is well. In cases of foetal harm, this extends to the advising the Courts of the degree of endangerment faced by the maternal and foetal bodies as well as the truth about a particular pregnancy or childbirth. For example, in \textit{In re A.C.} the medical expert gave evidence that Angela's twenty-six week foetus had a fifty to sixty percent chance of surviving a caesarean section and that Angela would probably die within the next forty-eight hours.\textsuperscript{82} As well as just stating the medical odds of having a successful outcome, the expert in this case was essentially flexing his "Social power muscle" in determining the truth about Angela's pregnancy and assigning her foetus the sick role to justify rescuing it from its mother's dying body.

In addition to Aesculapian, Charismatic and Social power possessed by physicians, according to New Zealand bioethicists John McMillan and Lynley Anderson, the category of Hierarchical power should be added to Brody's framework.\textsuperscript{83} McMillan and Anderson argue that there is a need to recognise the discrepancy in power not only between physician and patient but also between senior and junior healthcare professionals within the clinical setting.\textsuperscript{84} Using an obstetrics case involving a Registrar who had determined that a labouring woman required an emergency caesarean section and an Obstetrics and Gynaecology Specialist who overrode that decision and delivered a dead baby via vacuum extraction, McMillan and Anderson have applied Brody's three categories of power in order to understand the Specialist's dominance.\textsuperscript{85} They show that analysing these types of cases using Brody's model of the healer's power cannot account for this dominance and, thus, they propose that a "distinction needs to be drawn between general social power and an individual physician's social power."\textsuperscript{86} The Specialist in this case is attributed social power because of the place within the medical hierarchy that he occupies and an increased Aesculapian ability, evidently possessed by the Registrar, does not necessarily give him the medical authority to make "knowledge claims".\textsuperscript{87}

In \textit{Winnipeg Child and Family Services v. G. (D.F.)}, this understanding of
Hierarchical power can account for the discrepancy in power between Dr. Albert Chudley, Head of the Section of Genetics and Metabolism at the Health Sciences Centre and a Professor of the Department of Paediatrics and Child Health, and the Department of Human Genetics, and psychiatrists Dr. Mark Etkin and Dr. Michael Eleff.88 While physicians, psychiatrists and social workers presented expert testimony, it appeared to be the testimony of Dr. Albert Chudley, that held most sway.89 The trial Court judge accepted the medical testimony of Dr. Chudley that solvent abuse can lead to serious foetal abnormalities over that of Drs. Etkin and Eleff who indicated that there were no “grounds to detain Ms. G. under the [Mental Health] Act”.90 From the detailed description of Dr. Chudley’s clinical and academic position outlined by the Court, it appears that in the Court’s opinion he holds a superior position on the hierarchical ladder to that held by Drs. Etkin and Eleff.

If Dr. Chudley does not hold a superior hierarchical position to the two psychiatrists and in fact holds an equal position, applying these four components of a healer’s power to this situation will not necessarily account for discrepancy between expert testimonies. Applying the rescue fantasy in this situation may be useful for illuminating why the Court accepted Dr. Chudley’s expert opinion or that presented by Drs. Etkin and Eleff. The rescue fantasy, according to Brody, incites the desire to rescue patients from death or bad outcomes. Since Dr. Chudley’s testimony indicates to the Court that Ms. G. ought to be detained until the birth of her child so as to not cause any further morphological harm to the unborn child, it may be reasonable to assume that the Court is also taking on the need to rescue.

In essence, the healer’s power – Aesculapian, Charismatic and Social – outlined by Brody and the addition of Hierarchical power by McMillan and Anderson can account for why many of the lower Courts uncritically rely on expert medical opinion to determine the legal outcome of foetal harm cases. In these cases, the healer’s power has been abused when Courts rely solely on clinical evidence and medical facts to determine the ruling of a case and when the nature of the relationship between the pregnant woman and her unborn child is slanted to reflect an adversarial situation.

III. MATERNAL-FOETAL CONFLICT REVISITED

One Body or Two?

In Chapter One of this thesis, an explanation was given for how the traditional problem of the maternal-foetal conflict arose, in part, from the medicalisation of pregnancy

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89 Ibid.
90 Ibid, at 244-245.
and childbirth in Western society. Pregnancy and childbirth are now occupying more public space in the medical and political sectors, and the foetus as patient is now visible, knowable and within reach of medical professionals. The movement of pregnancy and childbirth into the public domain and the social interest in the outcome of childbirth provides justification for legal intervention into cases where the pregnant woman’s interests are perceived to be in conflict with those of her foetus. In the prenatal harm cases outlined in previous chapters there appears to be some discrepancy with how different Courts view the maternal body – as one body or two. There is no necessary correlation between how the Courts view the maternal body and the legal outcome of the case. For example, the Court of Appeal in St. George’s Healthcare N.H.S. Trust v. S. held that the declaration dispensing the consent of M.S. and authorising the performance of a caesarean section amounted to trespass of the person. Their decision was based on the understanding that “an unborn child is not a separate person from its mother”. Similarly, in Paton v. UK, the European Commission of Human Rights held that “the ‘life’ of the foetus is intimately connected with, and cannot be regarded in isolation from, the life of the pregnant woman…” Citing this statement, McLachlin J. of the Supreme Court of Canada in Winnipeg Child and Family Services v. G. ruled that pregnant women cannot be confined nor forced to accept medical treatment on the grounds that the parens patriae jurisdiction does not extend to the protection of the foetus.

In other cases, the Courts ruled in favour of the unborn child while still advocating the position that the maternal and foetal bodies are one complex biological entity. For example, the Supreme Court of Georgia in Jefferson v. Griffin Spalding County Hospital held that “because the life of the defendant and of the unborn child are, at the moment, inseparable, the Court deems it appropriate to infringe upon the wishes of the mother to the extent that it is necessary to give the child an opportunity to live.” In the New Zealand case Re Baby P [an unborn child] Inglis J. of the Family Court, New Plymouth held that the interests of the mother “…and those of the child run in tandem” and since Baby P was in need of care and protection, his interim custody should be vested in the Director-General of Social Welfare.

Ruling in favour of the pregnant woman, the Courts decided that pregnant women could not be compelled to undergo unwanted medical treatment nor be legally sanctioned for engaging in socially repugnant prenatal behaviour. For example, the Court in Johnson v.

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92 Ibid at 692.
93 Paton v. UK (1980) 3 EHRR 408 at 415.
State asserted that there was no adequate medical testimony to support the trial Court's findings that Jennifer Johnson delivered a controlled substance to her newborn infant. 97 This was due to the claim that the blood flow through the umbilical cord is that of the child’s, as is the placenta through which it flows; these components of the foetus are separate from the maternal body. 98

Australian Law Professor John Seymour says that in these prenatal harm cases there is a need to formulate a clear understanding of the nature of the relationship between a pregnant woman and her foetus. 99 He rejects the position that the foetal body is nothing more than a body part (like an arm or leg) and the position that the pregnant and foetal bodies are separate entities. 100 The pregnant woman and her foetus are not one biological entity since her prenatal conduct has the potential to inadvertently harm another human being - her foetus. Equally, the pregnant woman and her foetus are not two distinct and separate bodies; taking this position fails to consider “their unique interdependence”. 101 Instead, Seymour advocates the position that the pregnant body is “not-one-but-not-two.” 102 The Supreme Court of Canada in Dobson (Litigation Guardian of) v. Dobson also advocated this position and held that “the biological relationship is that a pregnant woman and her foetus are bonded in a union”. 103

The Adversarial Model & the Medical Gaze

Rather than the concern with establishing a clear understanding of the biological composition of the maternal body, what is at stake in these cases of alleged foetal harm is how the maternal-foetal relationship is perceived. That is, whether the pregnant woman is perceived as acting in opposition to her unborn child. This concern can be addressed independently from the debate regarding whether the maternal body should be viewed as one biological entity or two. It appears that it may be impossible for a conflict to exist if the pregnant body is viewed as one biological entity but some of the lower Court decisions mentioned above have found that the justification for infringing upon the interests of the pregnant woman is due to the inseparable nature of the two bodies. That is, in order to protect the interests of the foetus, it is necessary to compel the pregnant woman to undergo medical treatment. The configuration of the maternal-foetal relationship is one way of accounting, in

98 Johnson v. State of Florida 578 So.2d 419 (Fla. App. 5 Dist. 1991) at 422.
100 Ibid.
101 Ibid.
102 Ibid.
part, for the discrepancy in how Courts perceive the maternal body. Courts that describe the maternal-foetal relationship in terms of a conflict will most likely make a legal decision in favour of the unborn child. For example, in Crouse Irving Memorial Hospital Inc. v. Paddock, the Supreme Court of Onondaga County in New York felt that Stacey Paddock was depriving her unborn child of lifesaving treatment for refusing to consent to a blood transfusion and ordered that Stacey submit to any blood transfusions deemed necessary by her physician.104

Defining the nature of the relationship that the pregnant woman has with her unborn child in terms of a conflict has been termed the “adversarial” position by some modern feminist thinkers.105 This polarised ideology suggests that there is a clear-cut dichotomy between the pregnant woman and her unborn child whereas this division is no so obvious.106 Formulating the relationship in terms of conflict is one contributory factor to the movement of pregnancy and childbirth management into the realm of public policy.107

Canadian bioethicists Elizabeth Flagler, Françoise Baylis, Sandra Rodgers as well as other commentators argue that using maternal-foetal conflict as terminology to describe the nature of the prenatal relationship is undesirable and should be abandoned for three reasons.108 First, this terminology situates the conflict between the pregnant woman and her foetus when the conflict is really between the woman and healthcare professionals. Second, this term assumes that what is problematic is a clash of maternal rights with foetal rights when, at best, there is a clash between the pregnant woman’s autonomy and the best interests of her unborn child. Third, using maternal-foetal conflict to describe the nature of this relationship suggests the “existence of a parental obligation toward the fetus, whereas the woman is yet to become a mother the fetus she is carrying”.109

The conventional understanding of the adversarial position or the maternal-foetal conflict is created in light of the healthcare professionals’ attitude towards the management of pregnancy and childbirth. Viewing the nature of the relationship that a pregnant woman has

104 Crouse Irving Memorial Hospital Inc. v. Paddock 485 N.Y.S.2d 443 (Sup. 1985)
107 Ibid, p. 93.
109 Flagler et al, p. 1730, see n. 108.
with her foetus through the lens of Foucault's understanding of the medical gaze reveals a conflict when one does not necessarily exist. According to Foucault, members of the healthcare profession perceive the clinical world, and for the purposes here the pregnant body, in a specific manner. As was mentioned in Chapter Two, although Foucault fails to acknowledge that the medical gaze is only one possible way of describing how physicians perceive the world, adopting his methodology as an analytical tool reveals that medical professionals create an adversarial position by perceiving pregnancy in terms of a conflict. In Chapter Three, evidence for the creation of a voiceless pregnant body by lower Courts was outlined which occupies one side of the maternal-foetal conflict paradigm. Through verbal and non-verbal confessions the information collected with regard to a pregnant woman's prenatal conduct, if morally loathsome, is used for the purposes of legal sanction. The tactical control and organisation of time surrounding pregnancy and childbirth causes a sense of urgency to arise when labour does not progress within the confines of obstetric timelines and ex parte applications are used to hasten Court proceedings. The most convincing evidence for the claim that the maternal-foetal conflict is created as a result of perceiving the clinical world through the medical gaze is the rescue fantasy. In cases of foetal harm, healthcare professionals and members of the judiciary assert that pregnant women who are substance abusers or who refuse medically beneficial treatment for their foetuses are in some way wilfully harming their unborn children. Thus, the foetus is in need of being rescued from the malicious maternal body. The view of the obstetric world from through the lens of the medical gaze unnecessarily creates a maternal-foetal conflict.

**Narrative Ethics & Superior Court Judgments**

The implications for perceiving the obstetric arena as involving an ongoing conflict between the pregnant woman and her unborn child are evident in many of the foetal harm cases brought before the Courts in the 1980's and some of the lower Court judgments in the 1990's where pregnant women were legally sanction for morally undesirable prenatal conduct. This conventional notion of the maternal-foetal conflict is created in light of the healthcare professionals' attitude towards pregnancy and childbirth management. Foucault's understanding of the medical gaze reveals that perceiving the obstetric world in this manner creates a maternal-foetal conflict when one does not necessarily exist. If the obstetric arena is viewed through a different lens, such as through the lens of the "narrative gaze" the notion of a maternal-foetal conflict will not necessarily be created. The superior Courts in foetal harm cases occurring in the 1990's appear to be viewing the obstetric world in such a light and
finding that the conflict is not between the pregnant woman and her foetus but is between the pregnant woman and the healthcare professionals.

According to American feminist philosopher, Hilde Lindemann Nelson, there are four narrative approaches to bioethics. The first approach involves the historical narrative which uses stories by invoking them. The “just so” stories of a culture like Rudyard Kipling’s story of how the elephant got his trunk, functions as a particular society’s “source of moral normativity” and is invoked as a “means of ethical justification”. Lindemann Nelson uses the example of medical professionals refusing to participate in physician-assisted suicide to illustrate this approach to bioethics. A physician who takes this position on euthanasia might look to the Hippocratic tradition for ethical justification in refusing to offer this type of service to patients. Second, the literary, theatrical or cinematic approach focuses on how moral sensibilities and moral formative experiences can be broadened through carefully considering the stories told in literature, cinema or theatre. Writer Rita Charon claims that “literary methods help doctors and patients to achieve contextual understandings of singular human experiences, supporting the recognition of multiple contradictory meanings of complex events”. Third, the approach of casuistry in narrative ethics is concerned with comparing the specifics of a particular case with those of a paradigm case – “one that displays most visibly the moral maxims and principles that guide action in ‘cases of this sort’”. The action-guiding principles that are extracted from these paradigm cases are thought to serve as models against which to morally analyse or compare new cases. Essentially, this is the approach used by “judges, lawyers, and juries in the...[United States] and other English-speaking countries [to] build the body of common law” and is used by members of the healthcare profession, including midwives and physicians, to decide treatment regimens for patients or clients.

Telling stories of sickness or illness is a fourth narrative approach to bioethics and is the lens through which the superior Courts in the cases of foetal harm outlined in Chapter One appear to view the obstetric world. Kathryn Montgomery says that stories of illness as told

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111 Ibid, p. 4-5.
112 Ibid, p. 5.
113 Ibid, p. 5.
116 Nelson, p. 3-4, see n. 110
117 Ibid, p. 17.
118 Ibid, p. 18.
by patients are morally valuable since they help the physician “both to know and treat the
patient”. 120 Howard Brody feels that to best treat a patient in clinical practice it is imperative
that he understand what the “illness or debility means to that [particular] patient”.121 He says

[a]s a general rule, if physicians are most effectively to understand the meaning
an illness has for the patient so as to be able to alter it positively, they must be
attuned to the role that the illness plays in the unfolding story of the patient’s
life.122

This form of the narrative approach to bioethics is the epistemic tool that underpins the New
Zealand midwifery paradigm of managing pregnancy and childbirth.123 Though, in most
cases, pregnant women are not ill their midwife can nonetheless benefit from hearing the story
of the importance of this pregnancy to them, how it will affect relationships they have with
their other children, partner, friends and whānau, and the experiences they hope to reap from
the process. For Canadian sociologist Arthur W. Frank, stories that patients tell “are their
own truth” and he acknowledges that he would be unsure of “what a ‘false’ personal account
would be”.124 In the exploration of recent cases of foetal harm that will be conducted below,
it will become evident that there is something else besides the medical gaze occurring in these
judgments. Not only are the stories of these pregnant women being told but the information
extracted from the stories is heard by members of the judiciary and is being included with the
medical evidence or clinical facts presented by medical experts to make a legal decision.

In the recent American case In re Fetus Brown the Appellate Court of Illinois were
presented with expert testimony from Dr. Robert Walsh, Darlene’s treating physician and
Kurt Johnson, the hospital administrator.125 The clinical evidence indicated that if Darlene
did not accept the blood transfusion to control her bleeding and regulate her haemoglobin
levels her chances of survival, as well as those of her foetus, were only five percent.126 When
considering the medical facts of this case, the Court also took into consideration the fact that
Darlene Brown was a competent adult woman who was refusing blood products because of
her Jehovah’s Witness beliefs.127 In addition, the Brown’s informed the Court that they had
been married for two years and both participated in the care of Darlene’s two young
daughters. If Darlene were not to survive as a result of refusing to consent to the blood

120 Kathryn Montgomery, Doctor’s Stories: The Narrative Structure of Medical Knowledge. (Princeton:
121 Brody, p. 133, see n. 3; Nelson, p. 14, see n. 110.
122 Brody, p. 133, see n. 3.
123 I wish to thank Lynley Anderson and Professor Grant Gillett at the University of Otago Bioethics Centre for
pointing this out to me.
125 In re Fetus Brown 689 N.E.2d 397 (Ill.App. 1 Dist. 1997) at 399.
126 Ibid at 399.
127 Ibid.
transfusion then Lester Brown would continue to care for the two daughters with the support of both Darlene’s and Lester’s parents. However, the trial Court perceived the case in light of a maternal-foetal conflict and granted the State’s petition to administer Darlene with blood products. The appeal Court reversed this decision arguing that a pregnant woman could not be compelled to undergo blood transfusions for the benefit of her viable foetus.

The Court of Appeal in *St. George’s Healthcare N.H.S. Trust v. S* recognised that the narrative of the pregnant woman is important in providing information, other than medical facts and clinical evidence, about the case. This claim can be supported by Butler-Sloss J.’s condemnation of the use of *ex parte* applications by the trial Court. Since M.S. had no knowledge that the application for declaration authorising a compulsory caesarean section was even being brought before the Court her views were unable to be considered amongst the medical facts. In addition, if M.S. was informed of the application Hogg J. would not have been inadvertently mislead by the incorrect information that M.S. was in labour at the time of the hearing. The Court set out guidelines with regard to *ex parte* applications which indicated that hearings should be *inter partes* rather than unjustly excluding the interests of one party and that an order made in the absence of the pregnant woman will not be binding. Likewise, Terry J. of the District of Columbia Court of Appeal in the *In re A.C.* case asserted that the trial judge should have “personally attempted to speak with” Angela to directly ascertain her wishes rather than relying on “hearsay evidence, even from doctors”. Instead of using only the expert testimony presented by neonatologist Dr. Maureen Edwards and by obstetrician Dr. Alan Weingold to determine the legal outcome of the case, Terry J. felt that it was important to take into consideration what Angela wanted.

In the Canadian case *Winnipeg Child and Family Services (Northwest Area) v. G. (D.F.),* McLachlin J. of the Supreme Court recognises that cases of alleged foetal harm are about more than just the pregnant woman abusing drugs, refusing to consent to medical procedures or otherwise wilfully causing harm to her unborn child. In cases like the *Winnipeg* case that involve pregnant substance abuses, when the Courts relying solely on the medical evidence to determine the legal outcome they are inadvertently treating these women

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128 Ibid at 400.
129 Ibid at 397.
130 *St. George’s Healthcare N.H.S. Trust v. S., Regina v. Collins and Others, ex parte S* [1998] 3 W.L.R. 936
133 *In re A.C.* 573 A.2d 1235 (D.C.App. 1990) at 1247.
as "foetal abusers". Citing Hanigsberg, McLachlin J. says that this "ignores the range of conditions that contribute to problems like drug addiction and lack of nutrition, such as limited quality pre-natal care, lack of food for impoverished women, and lack of treatment for substance abusers." The Court in the Winnipeg case does not view this situation of alleged prenatal harm in terms of a maternal-foetal conflict. McLachlin J. recognises that what appear to be lifestyle "choices"—alcohol consumption, drug abuse, and poor nutrition—freely undertaken may not in fact involve "free choice" at all but may be the products of unfortunate circumstance and illness.

In contrast with Foucault’s understanding of the medical gaze, viewing the obstetric arena through the lens of a "narrative gaze" does not imply a conflict between pregnant woman and unborn child. Instead, perceiving the world in this manner reveals that, in lower Court judgments, the stories of pregnant women are being pushed aside to allow for the narratives of the medical profession to be heard. When superior Courts frame the nature of the relationship between these two biological entities in terms of non-adversarial language they are also recognising the narrative of the pregnant woman. Through recognising this narrative, the Court takes into consideration information other than medical evidence or clinical facts when determining the legal outcome of a particular case; struggles with addiction, poverty, mental illness, and social circumstance are revealed and acknowledged. Appropriately, Terry J. of the District of Columbia Court of Appeals acknowledges that in In re A.C. "there was no clear maternal-fetal conflict...arising from a competent decision by the mother to forego a procedure for the benefit of the fetus."137

CONCLUSION

In Chapter Three, Foucault’s understanding of the medical gaze was used as an analytical tool to reveal a voiceless pregnant body that comprised one pole of the "maternal-foetal conflict" dichotomy. By again using the medical gaze, this chapter reveals that the other pole of this dichotomy is not in fact the unborn child but rather is the medical profession. The perception of the clinical encounter through the lens of the medical gaze creates a maternal-foetal conflict when one does not necessarily exist. The creation of this conflict stems from the idea that lower Courts uncritically allow clinical facts or medical evidence, obtained through expert testimony, to be the sole guide for determining the legal outcome of a particular case. Legal decision-making that is limited to the medical facts alone fails to consider that other non-medical facts are just as important when making a legal

136 Ibid.
137 In re A.C. 573 A.2d 1235 (D.C.App. 1990) at 1243.
decision. In addition, this attitude towards medical opinion incorrectly implies a necessary connection between morally repugnant prenatal conduct that produces medically undesirable outcomes and legal sanctionability in cases of prenatal harm. Lower Courts often fail to make this distinction between using expert testimony to obtain clinical evidence about a particular pregnancy or childbirth and letting this evidence be the sole determinant of legal outcome.

To account for why expert medical opinion holds so much influence with the lower Courts in cases of foetal harm, an appeal to Howard Brody’s discussion of the healer’s power is made. By virtue of their Aesculapian power, members of the healthcare profession are able to provide convincing expert testimony which can be vindicated by their academic and clinical training. Abuses of this power arise when lower Courts rely solely on medical evidence or clinical facts to determine the ruling of a particular case. A healer’s possession of Charismatic power can account for why medical testimony is accepted by the Courts in such a favourable manner; the interpersonal skills developed by physicians, almost as a requirement of their Aesculapian power, provides them with the ability to communicate. By virtue of their Social power, healers are accorded the ability to determine who is sick – in prenatal harm cases, who must undergo a caesarean section, blood transfusion, or drug rehabilitation – and who is well. An abuse of power can also arise in this instance when pregnant women are illegitimately deemed to be mentally ill in order for their physical condition, such as placenta praevia, to be treated. In conclusion, this chapter provided a critical examination of the reliance on expert medical opinion in cases of foetal harm by viewing the obstetrics arena through the lens of the Foucauldian medical gaze.
CONCLUSION

It is very little to me to have the right to vote, to own property, etcetera, if I may not keep my body, and its uses, in my absolute right.1

- Lucy Stone (1855)

INTRODUCTION

This thesis undertook a critical examination of foetal harm cases involving allegations of child abuse or neglect based on prenatal substance abuse or other undesirable conduct, compelled caesarean sections or blood transfusions, and the legitimacy of detention under mental health legislation. This analysis was explored through Michel Foucault’s understanding of how healthcare professionals perceive the clinical encounter or the “medical gaze”, and Howard Brody’s discussions of medical power.2

This thesis draws three general conclusions from the exploration of the conventional problem of maternal-foetal conflict as it arises in legal judgments. The first is that Foucault’s understanding of what is happening in the clinical world, or the “medical gaze”, is useful as an analytical tool for exploring cases of prenatal harm even though Foucault’s description of the actual clinical encounter may not be completely accurate. The second conclusion is that the lower Courts appear to rely solely on clinical evidence or medical facts, presented to them by medical experts, to determine the legal outcome of a particular case and thus fail to consider other non-medical facts such as psychosocial factors that may portray the case in a different light. The third and final conclusion is about the construction of the “dilemma” in foetal harm cases. Exploring these cases through the lens of the medical gaze reveals that the conventional problem of maternal-foetal conflict is essentially a product of viewing the


clinical world in a certain way. Another product of the conventional understanding of foetal harm cases is adversarial terminology such as “maternal-foetal conflict”. This should be rejected since it creates a conflict where one may not exist. Viewing the clinical encounter through a lens other than that of the medical gaze, such as the narrative approach to bioethics, reveals that there need not be a conflict between the pregnant woman and her foetus.

Rather than unpacking these three general conclusions one by one to reveal the underlying arguments of the thesis, the fundamental themes that arise out of analysing the conventional problem of maternal-foetal conflict as it is revealed in cases of foetal harm will be outlined. There are essentially three important themes that are interspersed throughout this thesis: the aims of feminism, metaphors of visibility, and medical power. All three will be discussed in relation to the triad of conclusions mentioned above.

I. THREE THEMES

Feminist Aims

Although the theme of feminism is perhaps the most subtle of the three themes identified as underpinning this thesis, it is nonetheless central to the aim of the thesis which is to unpack the legal judgments in Western cases of foetal harm in light of the pathologisation of pregnancy and childbirth. As American feminist philosopher Hilde Lindemann Nelson has pointed out, there is often a misguided assumption that feminist theory is solely about women.3 This assumption incorrectly perceives women as problematic “Others” in a society where men’s roles are considered “normal and unproblematic”.4 Basically, Lindemann Nelson asserts, “what makes any ethics feminist is that it looks through the lens of gender as it explores how power circulates through our practices of responsibility and accountability” rather than focuses solely on the plight of women: “feminist ethics examines how gender influences who gets to do what to whom, and who as to answer to whom.”5 Similarly, Canadian feminist philosopher Susan Sherwin sees feminism as “the perception of the power relations that structure gender relations.”6 According to American feminist writer Susan M. Wolf, feminist ethics can broadly be defined as a field of study that “takes gender and sex as centrally important analytic categories, seeks to understand their operation in the world, and

4 Ibid.
6 Sherwin, p. 19, see n. 5.
strives to change the distribution and use of power to stop...oppression.”7 In law, feminist ethics is employed to
uncover gender bias in the law as written and applied; to show how gender bias is a means of domination;...to discover the way gender and gender bias are manifest in the language and constructs of law;...to critique the sufficiency and even the desirability of rights concepts; and to show how gender bias interlocks with other forms of bias and domination based on race, class, and sexual orientation.8

The primary contribution of feminism to bioethics is its ability to detail how power imbalances in areas of sex and gender are revealed in medical practice and in medical theory.9 Wolf discusses modern feminist bioethics as taking a perspective that is situated rather than neutral and having different subjects, epistemology and analytic methodology than a non-feminist bioethics approach.10 Probably feminist bioethics’ most important task is to confront the medical model’s fundamental tenet of androcentrism wherein healthy, White, Western men are the norm against which all other human beings are measured.11 Challenging this “standing assumption” will illuminate ways in which women are often marked as “unimportant or pathological”.12

This thesis challenges the standing assumption in the medical arena that managing pregnancy and childbirth in an unconventional manner – one that is not generally advocated by members of the medical profession – indicates the existence of a conflict between the pregnant woman and her unborn child. This assumption contributes to the understanding of pregnancy and childbirth as something that is pathological and thus in need of medical intervention. This is not to deny that there are circumstances in which pregnancies and childbirths are in need of medical intervention but rather to illuminate the fact that not all pregnancies should be perceived as potentially pathological.13 Discussions of maternal-foetal conflict in the medical and legal arena is an area that often intrigues feminist writers since the female reproductive processes are perhaps the part of women’s health that is most unnecessarily pathologised by the medical establishment.14 As was outlined in Chapter One, the medicalisation of pregnancy and childbirth began in the seventeenth and eighteenth

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9 Lindemann Nelson, p. 4, see n. 3.
10 Wolf, p. 21-22, see n. 9.
11 Ibid, p. 3.
12 Ibid.
centuries when the body was perceived as a fragmented and compartmentalised machine.\textsuperscript{15} Perceiving the pregnant body in this manner often objectifies women by focusing on their abdominal area (the biological) while ignoring social or psychological aspects of her pregnancy.\textsuperscript{16} The second stage of medicalisation began in the middle of the twentieth century when the female reproductive processes such as pregnancy and menstruation were labelled as illnesses and childbirth management was moved from the home to the hospital.\textsuperscript{17} The third and most recent stage of medicalisation involves the development of obstetric and foetal technologies which aim to make the growing foetus visible to the medical eye. The pregnant body becomes “transparent” in light of these technologies while the foetus is examined and its blood, urine and tissues sampled by members of the medical profession.\textsuperscript{18} As the pregnancy becomes increasingly medicalised and a greater social interest in a good outcome develops, the pregnancy moves from the private to the public domain. The conventional problem of maternal-foetal conflict arises from this strong social interest in potential human life.

The public interest in good outcomes is characterised by the many Western cases involving allegations of child neglect or abuse and compelled medical treatment that arise in Canada, the United States, England and New Zealand. For feminists, Foucault’s methodology and work on the body and clinical power is appealing since it allows for a subjective account of relationships. Nevertheless, some feminists argue that Foucault’s work is problematic. Critics question the ability of Foucauldian theory to stand up under the weight of its own criticisms: “[c]an the master’s tools dismantle the master’s house”? Foucault’s failure to discuss women and gender despite his interest in sexuality is cited as another weakness. Finally, there is concern that through Foucault’s deconstruction of the subject “woman” disappears.\textsuperscript{19}

These criticisms can be addressed by asserting that Foucault’s work allows feminist thinkers to move into a new epistemological space where the subjective account of power relationships is acknowledged. Thus, his work does not necessarily confine feminists to the conventional androcentric view of the world. To counter the claim that his work is not useful for feminist theory, it is asserted that his analytical methodology is useful for dismantling central tenets of the modern Western canon such as the mind/body dualism that places women

\textsuperscript{15} Duden, p. 86, see n. 13.
\textsuperscript{17} The midwifery movement in New Zealand is causing women with uncomplicated pregnancies to give choose homebirths rather hospital births.
\textsuperscript{18} Duden, p. 7, see n. 13.
on the side of the body or the tenet that power emanates from a central source.20 In essence, Foucault’s analytical methodology is useful for feminist thinkers exploring the conventional problem of maternal-foetal conflict as it arises in cases of foetal harm since it allows for a subjective account of pregnancy and childbirth as well as acknowledging that unconventional ways of managing reproductive processes do not necessarily indicate a conflict between the future mother and her unborn child.

Metaphors of Visibility

Throughout this thesis metaphors of seeing or viewing the medical world are apparent. Notions of visibility, transparency, and Foucault’s understanding of the medical gaze21 are used to reveal an alternative understanding of the conventional view of foetal harm. Advances in obstetric and foetal technologies, such as ultrasonography and foetal surgeries, are one way of accounting for how the pregnant body and the gestating foetus have become transparent before the careful gaze of the medical profession. Prior to the development of obstetric innovations, the foetus was only “knowable” through palpation via the maternal abdominal wall and uterus.22 Now the womb has become another portal of the body through which medical professionals can covertly peer at the gestating foetus and at the inner workings of the female reproductive processes. The ability to see, created by new technologies, is not devoid of social meaning.

In The Birth of the Clinic, Foucault describes how healthcare professionals view the clinical world in terms of the clinical gaze. This gaze is a vantage point from which events of medical importance are understood in light of the obstetric profession. One of the criticisms about Foucault’s understanding of the medical gaze that is raised in this thesis is that he uses the gaze to describe how things are in the clinical world rather than as one particular way of viewing the events of medicine. He fails to make the distinction between the use of the medical gaze as an analytical tool for describing and explaining the social activity of doctoring and the use of it as an indication of how pregnancy and childbirth are actually regarded within the clinic. This thesis asserts that as a description of real world clinical encounters, Foucault’s claims are largely untenable. However, using the medical gaze, as an analytical tool to explore cases of foetal harm, will offer valuable insights into the conventional problem of maternal-foetal conflict.

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21 Foucault, The Birth of the Clinic, see n. 2.
One of the most important conclusions that this thesis draws by viewing the world through the lens of the medical gaze is that the conventional problem of maternal-foetal conflict is created in light of healthcare professional’s attitude towards the management of pregnancy and childbirth. Perceiving this biological relationship in adversarial terms creates a conflict between the pregnant woman and her unborn child where one does not necessarily exist in the first place. Further proof of the unnecessary portrayal of pregnancy in adversarial terms is evident when the judgments in the foetal harm cases are analysed in terms of the “narrative gaze” which considers the stories of all those involved, including the pregnant woman’s, and not just those owned by healthcare professionals. In the superior Court decisions it becomes apparent that the narrative of an audible pregnant body is included alongside medical facts and clinical evidence obtained through the medical expert’s narrative about a particular pregnancy. In addition, viewing the clinical encounter through the lens of the medical gaze reveals that there is no necessary correlation between whether the Courts perceive the maternal body as one or two biological entities and the legal outcomes of the cases. Instead, there appears to be a strong correlation between Courts that view the maternal-foetal relationship in terms of a conflict and the legal judgments that they make in favour of the interests of the foetus. In essence, the metaphors of perception that are found intertwined throughout this thesis show that the conflict that exists in cases of foetal harm is between the pregnant woman and the medical establishment rather than between the pregnant woman and her gestating foetus.

Medical Power

The third theme that is present throughout this thesis is that of medical power. This type of power arises in Western foetal harm cases when the silent body is discussed as occupying one pole of the maternal-foetal conflict dichotomy. The pregnant body becomes silenced and unheard when ex parte applications are used by Courts, by the failure to recognise the importance of facts other than the medical facts of a particular pregnancy, and when mental health legislation is used in an illegitimate manner to detain pregnant women for holding unconventional opinions with the regard to pregnancy and childbirth management. In addition, this theme is present in the exploration of Howard Brody’s notion of the healer’s power to account for why testimony given by medical experts holds so much sway in determining the legal outcome of cases.23

Although, Michel Foucault’s understanding of power as being something that is subtle and comes from the top down, bottom up and from a lateral direction where there are “points

23 Brody, p. 16-20, see n. 2.
of resistance” is rejected, this does not render his entire methodology useless for the purposes here. For Foucault, power is not institutionalised, not in the form of the law, and not in the form of domination exerted by one social group over another. Power configured in this manner cannot be abused since there are always points within the interconnected web of power relationships at which top down power can be resisted or challenged. Since, in many of the foetal harm cases outlined in Chapter One, there is an abuse of medical power occurring, an understanding of power as something that can always be challenged is not necessarily applicable to situations of maternal-foetal conflict. There is one component of Foucault’s notion of power, namely “bio-power”, that is endorsed and underlies the use of power in this thesis: power is not inherently negative or coercive.

This thesis explores situations when medical and judicial power is being abused such as are found in Western cases of prenatal harm. Abusive power in these cases creates a silent body in three ways. First, the use of ex parte applications to hasten Court proceedings and the lack of legal representation before the Court literally does not allow pregnant women to express their wishes regarding the management of their particular pregnancy and childbirth. The exclusion of audible pregnant bodies from lower Court proceedings becomes more evident in light of analysing the judgments of superior Courts. This reveals a speaking pregnant body whose wishes, as well as the medical facts or clinical evidence of a particular pregnancy or childbirth, are taken into consideration by the Court. Second, a silent body is created when verbal and non-verbal confessions obtained through medical examinations, history-taking or maternal and foetal testing are used to legally sanction the pregnant woman. One problem with prosecuting pregnant women on the basis of this health information is that it may dissuade them from confessing to healthcare providers in the first place or provoke them to provide inaccurate information out of fear of self-incrimination. This will also result in the creation of a silent pregnant body who, out of fear of legal sanction, will not discuss her pregnancy nor her prenatal conduct honestly. The third way the abuse of medical and judicial power creates a silent body is through the normalisation of pregnancy and childbirth into various categories such as high risk/low risk categories of pregnancy. When Courts fail to entertain alternative or non-medical ideas about how pregnancy and childbirth should be managed, the wishes of the pregnant woman, and thus her narrative, is not recognised as having importance. In two cases outlined in Chapter One, the illegitimate use of mental health legislation was used to detain a pregnant woman who held views about


pregnancy and childbirth management that differed from the norm and were seen as bizarre and irrational.\textsuperscript{26} When the Courts fail to even consider variations in management of reproductive processes the pregnant body is silenced into conforming to the medical norm.

A further way in which the theme of power arises in this thesis is through Brody’s discussion of the healer’s power.\textsuperscript{27} In many of the prenatal harm cases discussed in Chapter One, the lower Courts uncritically rely on clinical evidence or medical facts to sway the outcome of the case. One way of accounting for this unhealthy attitude towards medical opinion is through the power that medical professionals possess. According to Brody, healers possess Aesculapian power, by virtue of their medical training; Charismatic power, by virtue of their personality characteristics; and Social power, by virtue of the relationship they have with society.\textsuperscript{28} In addition, Hierarchical power can be added to this framework.\textsuperscript{29} When these descriptions of medical power are applied to situations of power abuse in the clinical or juridical setting, such as cases involving allegations of prenatal harm, they fail to account for the discrepancies between healthcare professionals who occupy equal positions on the hierarchical ladder and also appear to be presenting equally legitimate clinical evidence about a particular pregnancy or childbirth. There appears to be something more than just the possibility of one medical professional possessing greater Aesculapian power than another medical professional that can account for the power discrepancies in these situations.

\section*{CLOSINGS}

In closing, the exploration of the themes of feminism, medical power and metaphors of the gaze outlined above show that the conventional problem of maternal-foetal conflict – an adversarial relationship between future mother and unborn child – is exacerbated when it becomes legally manifested in contemporary Western case law. The outcome of foetal harm cases, including allegations of child abuse or neglect due to maternal drug abuse and compelled caesarean sections or blood transfusions, that arise in Canada, the United States, England and New Zealand have shifted significantly: from legally sanctioning pregnant women on the basis of morally repugnant behaviour to deciding that competent pregnant women should not be compelled to undergo unwanted medical treatment. This shift from deciding legal cases in favour of the foetus and adopting an adversarial-like understanding of the maternal-foetal relationship to deciding in favour of the pregnant woman is due, in part, to

\textsuperscript{27} Brody, p. 16-20, see n. 2.
\textsuperscript{28} Ibid.
the inclusion of the complex stories of women which have proved to be pregnant with possibilities.


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