Ideal Mother/Ideal Body

Constructions of the Maternal Body in Legal, Medical and Cultural Discourses

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TABLE OF CONTENTS

ABSTRACT

This thesis argues that women's bodies are constituted by discourses about them. It explores the operations of power over women's bodies by analyzing the way in which the maternal body is constructed in the discourses of law, medicine and culture. Chapter One provides a theoretical context for this thesis. It examines the organization of knowledge and its relationship to power within the Western liberal tradition. Power is implicated in the production and dissemination of knowledge about the maternal body in two ways. First, scientific knowledge is privileged in legal and cultural discourses with the effect that knowledge claims based on experience are discredited. Second, scientific knowledge about the fetus, divined through the routine application of diagnostic technologies, has generated new opportunities for scrutinizing the maternal body. This information has been used to create expectations about which bodies are appropriate for reproductive purposes. These points are explored in Chapters Two and Three. Chapter Two is a study of cultural discourses about two women whose pregnancies were condemned on the basis that their bodies deviated from the ideal maternal body. In these stories, each woman was represented as a bad mother for pursuing her pregnancy against medical advice. Chapter Three is a study of the law's response to women who have failed to comply with medical advice deemed necessary for fetal well-being. It analyzes the strategies and implications of legally regulating pregnant women. Overall, this thesis poses a challenge to the way that the maternal body is represented by excavating the partial nature of the claims upon which these representations are based. Further, it argues for a re-conceptualization of the maternal body.

RÉSUMÉ

Il est soutenu dans la présente thèse l'idée que les corps des femmes sont définis par les discours qui s'y rapportent. Elle explore les effets du pouvoir en analysant la façon par laquelle le corps maternel est construit par les discours du droit, de la médecine et de la culture. Le chapitre I fournit le contexte théorique de cette thèse. Il examine l'organisation du savoir à l'intérieur de la tradition libérale occidentale et sa relation avec le pouvoir. Le pouvoir est impliqué dans la création et la dissémination du savoir sur le corps maternel de deux façons. En premier lieu, les discours légaux et culturels privilégient la connaissance scientifique, ce qui a pour effet de discréditer les affirmations basées sur l'expérience. En second lieu, les connaissances scientifiques sur le foetus, découvertes au moyen de l'utilisation courante des techniques de diagnostique, ont créé de nouvelles occasions d'examiner le corps maternel. Ces informations ont été utilisées de façon à créer des attentes sur les corps qui sont appropriés aux fins de reproduction. Ces questions sont développées aux chapitres II et III. Le chapitre II est l'étude des discours culturels au sujet de deux femmes dont les grossesses ont été condamnées au motif que leurs corps ne correspondaient pas au corps maternel idéal. Dans chacun de ces cas, ces femmes étaient représentées comme des mauvaises mères pour continuer leur grossesse en dépit des conseils médicaux. Le chapitre III est une étude des solutions données par le Droit quant aux femmes n'ayant pas respecté les conseils médicaux estimés nécessaires afin d'assurer le bien-être du foetus. Ce chapitre analyse les stratégies et les implications de la réglementation légale applicable aux femmes enceintes. De façon générale, il est questionné dans cette thèse la façon dont le corps maternel est représenté, en faisant ressortir la nature partielle des affirmations sur lesquelles ces représentations sont basées. L'idée d'une reconceptualisation du corps maternel y est également soutenue.

INTRODUCTION

The law exerts its authority in relation to bodies in many ways. But how does law define the body? Bodies are highly differentiated by signifiers such as sex, race, class, sexual orientation, health and age. Do these factors affect the uniformity with which the law confers its protection, or imposes its force, upon them?

The subject of this thesis is the maternal body. This body has challenged the law with a range of complex questions relating to issues of protection and control. These challenges arise largely because, although still a single person, the maternal body embodies the potential to become two people. This has prompted questions about the measure of recognition and protection to be accorded the fetus in relation to the acts of third parties (doctors, negligent motorists, criminal assailants), and in relation to the acts of its mother. Although in other contexts the law has assumed the authority to restrain one person in order to protect others, this authority assumes a different complexion when the body of the pregnant woman is notionally dissected in order to fit within this framework. Such cases have arisen when pregnant women have refused to consent to a recommended medical treatment such as birthing by cesarean section,[1] proper prenatal care,[2] or drug rehabilitation.[3]

These cases raise fundamental questions about what the maternal body is, and how rights and responsibilities should be ascribed to, and within, it. Broadly speaking, therefore, I will be considering two interrelated questions. How is the maternal body defined, and how does this affect the operations of power over the bodies of pregnant women? To investigate these questions, I will analyze the way that the maternal body is represented in law, medicine and culture. Although case law relating to the forced medical treatment of pregnant women offers a concrete illustration of

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[1] *Re Baby R* (1988) 15 R.F.L. (3d) 225 (S.C.) reversing *Re R* (1987) 9 R.F.L. (3d) 415 (Prov. Ct).

[2] *Re Children's Aid Society of Belleville and T* (1987) 59 O.R. (2d) 204 (Fam. Ct.); *Re A (in utero)* (1990) 28 R.F.L. (3d) 288 (Fam.Ct); *Nouveau-Brunswick (Ministre de la Santé et des Services communautaires)* v A.D. (1990) 109 N.B.R. (2d) 192 (Q.B).

[3] *Joe v Y.T. Director of Family and Children's Services* (1986) 5 B.C.L.R. (2d) 267 (S.C.); *Winnipeg Child & Family Services v G (D.F.)* (1996) 138 D.L.R. (4th) 254 (C.A) (appeal to the Supreme Court of Canada heard on 18 June 1997, decision reserved), reversing (1996) 138 DLR (4th) 238 (Q.B.).

the direct application of power to the maternal body, I have deliberately adopted an approach that looks beyond legal discourses in isolation. Cultural and medical discourses are also critical in the processes that determine the nature of the maternal body and the exercise of control over it.

Representations of the maternal body involve determinations about the nature of the relationship between the pregnant woman and her fetus. This relationship is typically conceived through the lens of science, which is thought to present the body objectively and without distortion. However, advances in medical technology that have penetrated the body of the pregnant woman to expose the fetus and permit it to be visualized on a screen, have had a transformative effect on the way the maternal body is seen. The body of a pregnant woman can now be represented as two entities without imagination. Further developments in diagnostic technology permit physicians to diagnose genetic disease, fetal distress, and risks posed to fetal health by HIV or drugs in the body of the pregnant woman. These enhance the possibilities for treating the fetus as a separate patient. Moreover, they expand the scope for prescribing appropriate modes of behavior for pregnant women. These might include abstaining from behaviors that could harm the fetus (e.g. poor diet or drug use), accepting surgical interventions (e.g. in utero therapy or cesarean section) or refraining from pregnancy altogether (e.g. for women who are HIV positive or carriers of deleterious genes).

The exercise of power over the pregnant body cannot be separated from the way it is represented. This is because power and knowledge are indivisibly linked. Representations of the maternal body based on scientific knowledge are incorporated into the discourses of culture and law to ground claims about the moral duties or legal obligations of the mother, or the state, toward the fetus. This complicates the mechanisms of power over the body and suggests that power cannot be seen as issuing from a single source (such as a court of law). Although law can be seen as exercising direct power over the bodies of women by the granting of orders for prenatal intervention, this authority is connected to medical and cultural discourses about the maternal body. The impetus for the intervention, the knowledge upon which it is based, or the form that it will take, is not purely a matter of law. Legal

intervention usually rests on a range of prior interventions and assumptions about the nature of the maternal body and about the social condition of mothering. Applications to courts for orders permitting prenatal intervention are initiated by medical or social welfare authorities that have already surveilled and monitored the body and behavior of the pregnant woman, and concluded that she poses a threat to the fetus. Courts may, in addition, hear scientific evidence about the relationship between the body of the fetus and the pregnant woman, and the ill effects of her behavior and, by extension, her body, on the fetus. These bodily deficiencies and their consequences might raise questions about the suitability of the particular woman to mother, or her capacity to make decisions about medical treatment. The corollary is that suitable mothers will conform to a particular standard of bodily health and, in the event that it becomes necessary, will accept medical treatment designed to achieve that goal. Finally, the form that the intervention will take will be, in large measure, determined and executed by doctors and social workers.

This dispersion of power through discourses is also apparent in a second sense. The invocation of legal power is not the only method (and perhaps not even the most important method) of exercising control over the pregnant body. The increasingly routine use of diagnostic technologies during pregnancy can elicit a considerable amount of information about the body of the pregnant woman. In doing so, they expand the possibilities for identifying pregnant women whose health deviates from that which is considered acceptable, and for proposing medical treatments to minimize danger to the fetus. In many cases, these interventions are welcomed. There is also a danger, however, that pregnant women may be pressured or coerced to accept medical treatment that they feel is unnecessary, or that they do not wish to undergo, without any recourse to a courtroom.

In order to understand the how power operates in relation to the maternal body then, it is necessary to unpack the connections between language, knowledge, and norms and the various modes of control to which they give effect. Chapter One offers a theoretical framework within which to examine these connections. In this Chapter, I focus on the relationship between knowledge, power and bodies by critiquing the epistemological assumptions that underscore Western liberal discourses, particularly

science and law. I consider the importance of scientific knowledge in defining the nature of the maternal body, and the concomitant exclusion of women's experiences of pregnancy from these processes of definition. In order to challenge the resultant constructions of the maternal body, I map out how a feminist theory of embodiment might be used to generate counter-discourses that re-conceptualize the maternal body.

Chapters Two and Three are studies that examine medical, cultural and legal texts about medical treatment during pregnancy. I will analyze these to demonstrate how the maternal body is constituted and constrained by them. I also propose alternative readings of these texts in an effort to resist the conceptualizations they create, as a step toward re-conceptualizing the maternal body.

Chapter Two focuses primarily on the connections between culture and medicine. Here I examine interactions between cultural and medical discourses by analyzing the newspaper reporting of two stories about pregnant women. The first story is about an HIV positive woman, known only as Sheila, who wanted to become pregnant with the assistance of IVF. The second story is about Mandy Allwood who was pregnant with eight fetuses, but refused medical advice to terminate some of them. I consider the importance of scientific knowledge about these women's bodies in structuring the issues considered relevant. In each of these stories, the women's bodies are represented as unsuitable for reproduction. Sheila is represented as a hostile environment for the potential fetus and, Mandy Allwood, as massively productive and similarly dangerous to her fetuses. In each case, medical discussions about the physical limitations of the reproductive bodies in question are interwoven with discourses about maternal responsibility and motherhood. The knowledges of the women themselves are not considered as factors that could bear any relevance to the issue of pursuing 'risky' pregnancies.

In Chapter Three, I will examine interactions between medical and legal discourses by analyzing the Canadian cases on prenatal intervention. This Chapter builds on the earlier chapters by first, investigating the manner in which scientific knowledge about the maternal body, and cultural expectations about motherhood, are integrated into

law's attempts to define the maternal body; and second, by considering how these interactions influence strategies and affect legal outcomes.

Different strategies have been adopted for the purpose of justifying prenatal intervention. Courts have been asked to decide whether a fetus may be the subject of an order for wardship (pursuant to the court's parens patriae jurisdiction[4]) or guardianship (pursuant to jurisdiction conferred by Child Welfare legislation[5]) as a 'child' in need of protection. These strategies focus on the fetus as an entity that is separate from the mother and, therefore, deserving of protection against her. These strategies, although successful in earlier cases, have been rejected by appellate courts in British Columbia[6] and Manitoba.[7] This rejection is underscored by an acute sense of the connections between the fetus and the pregnant woman, suggesting a different conceptualization of the maternal body.

The question has, however, recently resurfaced in the form of a new strategy. In *Winnipeg Child and Family Services v G*, the court was asked to decide whether Mental Health legislation, or the parens patriae jurisdiction over non-competent adults, might be invoked in order to override the refusals of pregnant women to consent to medical treatment.[8] These strategies differ superficially from the former strategies in that they

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[4] This was considered and rejected in *Re A*, supra note 2, and affirmed in *Winnipeg Child and Family Services v G* (C.A.), ibid.

[5] Orders for guardianship of fetuses were granted in *Children's Aid Society of Belleville v T* (broadly construing the *Child and Family Services Act* S.O. 1984, c.55 to confer jurisdiction over fetuses) and *Nouveau-Brunswick (Ministre de la Santé et des Services communautaires)* v A.D. (applying section 1 of the *Family Services Act*, S.N.B. 1980, c. F-2.2 which expressly includes "unborn child" in the definition of "child") supra note 2. An order for guardianship of the fetus was also granted by a British Columbia Provincial Court pursuant to the *Family and Child Service Act*, S.B.C. 1980, c.11 in *Re Baby R*. This decision was reversed on appeal, supra note 1. Applications for guardianship based on Child Welfare legislation or the parens patriae power over minors have also been rejected by the Ontario Family Court (*Re A*), supra note 2, and the Manitoba Court of Appeal in *Winnipeg Child and Family Services v G*, supra note 3.

[6] *Re Baby R*, supra note 1 (followed by the Ontario Family Court in *Re A (in utero)*, supra note 2).

[7] *Winnipeg Child and Family Services v G* supra note 3.

[8] In *Winnipeg Child & Family Services v G* (1996) 138 D.L.R. (4th) 238 (QB) the *Mental Health Act* R.S.M. 1987, c.M110 was invoked to commit Ms G to the custody of the Child and Family Services Agency or the Director of Child and Family Services and further orders were made to confer the Director with power to arrange drug rehabilitation treatment for Ms G pending the birth of her child. The Manitoba Court of Appeal set aside the orders made by the Queen's Bench on the basis that the court did not have sufficient evidence of mental disorder upon which to base its order. It specifically left open the question of whether,

purport to consider only the capacity of the pregnant woman to make treatment decisions and, in the event that she is incompetent, to authorize doctors to perform treatment that is in her best interests. I will consider the implications of this shift and the extent to which it is driven by the increasing power of modern discourses of discipline and normalization, particularly psychiatry.

Overall, I attempt to demonstrate that the discourses of law, medicine and culture work together to construct a normative maternal body. This Ideal is a body that does not pose risks to the fetus. Against this Ideal, the bodies of particular women are distinguished as deviant by the operations of medical surveillance and monitoring. These women may be offered redemption in the form of medical interventions calculated to prevent harm to the fetus. Within this frame, pregnant women who refuse to co-operate with doctors are not only distinguished from the Ideal maternal body, but also from the Ideal mother.

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in circumstances where the evidence supported the presence of a mental disorder, a pregnant woman might be committed and compelled to submit to medical treatment beneficial to the fetus. However, the court clearly stated that a pregnant woman could only be committed under the *Mental Health Act* in circumstances where her mental health is substantially impaired and for her own protection without regard to the unborn child, supra note 3 at 257.

CHAPTER ONE

Talking Heads & Docile Bodies: Meanings & Beings

> [W]here feminism remains committed to the project of knowing women, of making women objects of knowledge, without in turn submitting the position of the knower or subject of knowledge to a reorganization, it remains as problematic as the knowledges it attempts to supplement or replace.[9]

> The question might be raised how well women understand themselves. I would not dare try to answer this as regards the subtler details of their psychological makeup, but I am sure that most of them have an imperfect understanding of their bodies and of the various disorders to which female flesh is heir. This is unfortunate, since it would be easier and more satisfactory for doctors to take care of well-informed patients than those who only have a vague idea about what is going on.[10]

Introduction

In the above quoted passage, Dr Samuel Raynor Meaker speaks from the perspective of a gynaecologist whose "whole life-work is the study of women who are sick or worried".[11] His words reveal how women appear from this vantage point, that is, ignorant about the structure and function of their bodies. His words also reveal something about the position from which he speaks as a knower of women's bodies. His claim, that most women have an imperfect understanding of their bodies and their ailments, rests on three assumptions. First, that he has knowledge about the structure and function of female bodies. Second, that this knowledge constitutes that which can be known, or that which is relevantly known, about female bodies; and third, that most women do not have this knowledge. Because his patients do not know what he knows, their knowledge is imperfect, and their ignorance makes his task in healing them all the more difficult.

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[9] E. Grosz, "Bodies and Knowledges" in *Space, Time and Perversion: The Politics of Bodies* (Sydney: Allen & Unwin, 1996) 25 at 40.

[10] S. Meaker, *A Doctor Talks To Women* (London: Herbert Jenkins, 1957) at 13.

[11] Ibid.

Within this schema, the doctor's objective knowledge, which is legitimated by his professional training and years of dedicated study, is the reference point for judging what is known, and knowable, about female bodies. This manner of distinguishing and privileging medical knowledge is mirrored by a series of associations between mind and body within the text. The doctor is strongly associated with the mind because he holds important knowledge (his body is absent), and women are strongly associated with the body as the objects of Dr Meaker's knowledge. Both references to women's minds are arguably negative ones. Women have a limited knowledge about their bodies (vague ideas, imperfect understandings, ill-informed) and a slightly baffling psychological makeup.

I have tried to problematize Dr Meaker's account of women's knowledge about their bodies in order to show its partiality. Whilst it may be true that Dr Meaker has a greater knowledge of his patient's bodies as they are described in his medical books—and I don't want to suggest that this is not an important source of knowledge—it is questionable whether this knowledge represents all there is to know about female bodies. However, by privileging medical knowledge as the reference, he is able to represent women as having an imperfect and vague understanding about what is going on in their bodies. This makes it unnecessary to consider whether there might be other complimentary or competing knowledges about the body which are accessible to women or others but not to him. The effect is to construct a singular, stable, known and uncontested representation of the female body.

Dr Meaker's account is a diminutive narrative but many of his assumptions resonate in other discourses about women's bodies. My purpose is to show that the way that knowledge about the female body is produced, organized and discussed determines its shape, boundaries and capacities. These particular configurations, especially in the case of pregnant women, are built upon assumptions about natural, pre-given boundaries and passive bodily processes which together have the effect of designating pregnant women's bodies as resources rather than agents. Legal discourses can play a pivotal role in the construction of these configurations, although they do not act alone in doing so. A close examination of legal discourses about the female body discloses a

heavy reliance on both scientific understandings of the nature of the "physical body" and on cultural representations about the way female bodies should behave.

Part I focuses on the epistemology of the Western liberal intellectual and cultural tradition. This is important because scientific knowledge about the female body claims to be an objective account of a universal 'reality'. This knowledge commands respect in legal discourses which are likewise founded on the tradition of rationality and objectivity.[12] Scientific accounts about the nature of women's reproductive bodies are important because they form a basis for the legal regulation of women's bodies. Law's deference to objective and rational methods of reasoning and argument precludes its recognition of knowledge claims based on the subjective, embodied experiences of pregnant women.

Part II explores the social constructionist critique of knowledge which calls into question the objectivity of knowledge, the mechanisms of power in society and the constraint and constitution of bodies through the workings of power and knowledge. In this Part I examine the processes of knowledge production and its implications for the constitution of bodies; and second, the importance of discourses in facilitating the exercise of power over the body (or particular bodies).

Part III considers the usefulness and pitfalls of the social constructionist insights for feminist analyses of the relationship between knowledge, power and female bodies. I will also map some new directions in feminist theorizing about knowledge, power and embodiment that promise to negotiate the gulf between the twin evils of a universal objectivity that excludes the realities of women and a crippling relativism that precludes a feminist politics.

Part IV will consider how these insights might be applied to a critique of legal discourses and its relations with other discourses in exercising power over pregnant bodies.

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[12] C. Smart, "Penetrating Women's Bodies: The Problem of Law and Medical Technology" in P. Abbott & C. Wallace, eds. *Gender, Power and Sexuality* (London: MacMillan, 1991) 157 at 157.

I. Traditional Epistemologies

Traditional approaches to knowledge are based on three assumptions. First, that reality exists independently of human interpretation and understanding of it.[13] Second, that knowledge of this objective reality can be discovered through the application of reason.[14] This involves the use of particular methods, techniques, criteria and data collection, usually regarded in a general sense as 'rational' or 'scientific'.[15] Importantly, the results yielded by scientific method must be capable of replication. Third, the knowledge produced by the application of rational method is objective and true—that is, it accurately describes objective reality.[16] It is also universally valid.[17]

The organization and production of knowledge according to these assumptions has a number of consequences. First, because reality exists independently of human understanding and interpretation of it, there is no possibility that reality can be distorted during the process of discovery. In addition, the methods used to discover reality are assumed to be neutral conceptual tools that merely describe or explain their objects of investigation.[18] These tools are believed to be neutral because they are the products of reason and, moreover, their use is dictated by reason. This is significant because "reason itself has transcendental and universal qualities [which exist] independently of the self's contingent existence (e.g. bodily, historical, and social experiences do not affect reason's structure or its capacity to produce atemporal knowledge)".[19] In other words, the objectivity of knowledge is not contaminated by the cultural contingency, power and interests of the investigator because it is acquired through the application of reason which transcends the investigator's material self. There is, therefore, a disavowal of the significance of the materiality of the investigator to the knowledge produced. Accordingly, the traditional approach to

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[13] S. Williams, "Feminist Legal Epistemology" (1993) 8 Berkeley Women's Law Journal 63 at 65.

[14] Ibid.

[15] E. Grosz, supra note 9 at 27.

[16] Williams, supra note 13 at 65.

[17] Ibid at 66.

[18] Grosz, supra note 9 at 27.

[19] J. Flax, "Postmodernism and Gender Relations in Feminist Theory" in L. Nicholson, ed. *Feminism/Postmodernism* (London: Routledge, 1990) 39 at 41.

knowledge can not, and does not, ask the question—"how does this knowledge, this method, this technique constitute its object?"[20]

Second, because knowledge is discovered by the application of rational method, then 'knowledge' discovered by other means (e.g. experience) is not really knowledge. Knowledge that can not be verified by accepted method, data or technique is relegated to the subordinate status of "perspective". [21] According to Catherine MacKinnon:

> Scientific epistemology defines itself in the stance of "objectivity", whose polar opposite is subjectivity. . . Objectivity as a stance toward the world erects two tests to which its method must conform: distance and aperspectivity. To perceive reality accurately, one must be distant from what one is looking at and view it from no place and at no time in particular, hence all places and all times at once. This stance defines the relevant world as that which can be objectively known, as that which can be known in this way. An epistemology decisively controls not only the form of knowing but its content, by defining how to proceed, the process of knowing, and by confining what is worth knowing to that which can be known in this way.[22]

In this sense, traditional epistemology provides a basis for distinguishing between knowledge and perspective. This distinction also has the effect of ascribing the former a privileged status in relation to the latter. Thus, knowledge is true, objective and universal, whereas perspective is, to varying degrees, false, subjective and particular.

Third, because rational method produces knowledge that accurately describes or explains reality, there is no basis for questioning its truth, objectivity or universality. In addition, it is assumed that language can communicate the knowledge so discovered, without causing distortion of any kind. In this regard, Jane Flax observes that:

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[20] Grosz, supra note 9 at 27.

[21] Williams, supra note 13 at 66.

[22] C. MacKinnon, *Toward a Feminist Theory of the State* (Cambridge: Harvard University Press, 1989) at 97.

> Just as the right use of reason can result in knowledge that represents the real, so, too, language is merely the medium in and through which such representation occurs. There is a correspondence between the word and thing (as between a correct truth claim and the real). Objects are not linguistically or socially constructed; they are merely made present to consciousness by naming and the right use of language. [23]

Separating Mind from Body

The mind is the cornerstone of this system of discovering and organizing knowledge because it is the mind that possesses the capacity to reason. Indeed, traditional epistemology depends on a separation of the mind from the body. This is because the body is perceived as prone to emotion and irrational impulses and, therefore, inimical to reason.[24] As such, it needs to be subordinated to the controlling influence of the mind in order to ensure the proper application of rational method. The need for a "controlling mind" applies to the process of knowledge discovery in two senses. First, the individual investigator must use his reason to exercise control over the material part of himself in order to prevent compromising his access to objective reality.[25] Second, the investigator must exercise control over the object about which knowledge is sought. In this way, "the external world, the things to be known, are constructed on an analogy to the part of the self to be subdued. Those things are conceived as passive, not in the sense of being inactive, but in the sense of being reactive rather than self-initiating."[26]

The separation of mind and body, therefore, is considered necessary to ensure that knowledge maintains its rationality and objectivity. To this extent, the body is seen as a potential threat to knowledge. Indeed, traditional Western philosophical discourses have treated the body as either an impediment or a distraction to discovering truth.[27] The body, unlike the mind, has been conceived as particular and concrete, rather than transcendent and universal. Accordingly, it has been largely excluded from traditional

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[23] Flax, supra note 19 at 42.

[24] Ibid.

[25] Williams, supra note 13 at 67.

[26] Ibid.

[27] R. Mykitiuk, "Fragmenting the Body" (1994) 2 Australian Feminist Law Journal 63 at 79.

Western philosophical discourses where possessive, abstracted, instrumental, rational actors predominate.[28]

The distinction and hierarchy that determines the relationship between the mind and the body is matched by a number of other binarized opposites in traditional epistemology. These categories tend to function in lateral alignments and are cross-correlated with other dichotomies[29]—agent/resource, culture/nature, self/other, male/female, subject/object, rational/emotional, universal/particular. This not only means that the dominant value or quality in each pair is privileged in relation to the other, but also that each of the first, and each of the second terms, tend to be closely associated with one another—mind, agent, culture, self, male, subject, rational and universal on the one hand—and body, resource, nature, other, female, object, emotional and particular—on the other.[30] The meanings and values (or lack of value) attached to each term of the binary pair are produced and reproduced through knowledges and language.[31] Susan Williams summarizes:

> [T]he culture/nature dichotomy often functions as a summation of all the previous dichotomies. Nature represents all that is physical, moved by emotion or instinct rather than by reason, sunk in subjectivity and particularity. Culture is the triumph of mind and reason, imposing objective and universal constraints (perhaps most clearly, although not exclusively in the form of law) over these forces of chaos, danger and ignorance. Nature may be the non-human physical world—the resources and raw materials over which man stands as the representative of culture. But nature may also be people—the "barbarian" hordes of another nation, the subset of our own population in need of control (e.g. women, the poor, minorities), or even the part of each individual that sometimes threatens to overwhelm his reason.[32]

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[28] Ibid. This is true of legal and other objectivist discourses, where the experience of embodiment and the knowledges which emanate from embodiment are similarly disavowed. These forms of knowing are sullied by subjectivity and, accordingly, can have no place in a discourse which insists on objectivity and rationality.

[29] Grosz, supra note 9 at 32.

[30] Ibid.

[31] Smart, supra note 12 at 159.

[32] Williams, supra note 13 at 66-67.

The concept of boundary is central to this project. The effect of arranging terms in binary pairs is that their content is mutually defining by a process in which "positive or negative evaluation is attributed to each side of the oppositional pole."[13] The term that attracts the negative evaluation is cast as lacking in the value prized in the positive term. In this way, the content of each term is bounded and set apart from the other, preventing ambiguity. A thing cannot be simultaneously male and female, self and other, nature and culture, agent and resource, reason and emotion or object and subject. In Williams' analysis, the boundary metaphor serves another purpose by relegating the negative terms to the dangerous status of chaos and disorder, and therefore things that must be controlled—women's bodies being notable among these.[14]

We can see many of these assumptions underscoring Dr Meaker's claim about women's knowledges about their bodies. Although his account does not go so far as to suggest that women are simply bodies, and in need of supervision and control on that basis alone, his account both devalues the minds (and knowledges) of women and obscures his own corporeal presence. He is a doctor with knowledge derived from scientific method that, presumably, is objective and true for all women. This accentuates his mental faculties. He keeps a critical distance from the objects of his study which enables him to know them and their bodies. The measure against which their knowledge is judged is determined by him. The effect is to devalue the mental faculties and potential knowledges of women.

Legal Knowledge and Legal Method

Law also claims to be a form of knowledge that can be distilled from reason. Its authority rests on the neutral application of universal principles, properly selected and

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[13] Smart, supra note 12 at 158.

[14] In this regard, Williams states that "In other words, the nature/culture distinction does not, as it might first appear, mark the boundary between human beings and the rest of existence. It constructs instead, the boundary between the orderly and the productive realm in which reason and objectivity rule and the confused, inarticulate and possibly dangerous area beyond the wall, which has yet to be subdued. Human beings can, and do, live on both sides of that wall." supra note 13 at 67.

applied in a rational way.[15] Like science, its methods, practices and language are believed to be objective and, accordingly, resistant to cultural, political and sexual bias.[16] In law too, the subject of inquiry is separated from the object of knowledge.[17] This applies both to the process of discovering facts and to the process of applying the law to those facts.

In a trial, for example, a court is presented with competing stories. These stories are a collection of facts. It is by no means certain, however, that the entirety of any particular story will be placed before the court. The rules of admissibility perform an editing function by determining which facts may be considered. In this way, legal rules will rationally and objectively separate the admissible from the inadmissible facts. The resulting set of facts, therefore, make up an abstracted version of the story to be judged. The trial itself involves a judge or jury in the process of selecting between competing or contradictory facts. By a process of impartial adjudication, particular facts are assigned more importance or weight than others. In the end, the relevant legal rules will be applied to the accepted facts, or if you like, the authorized version of the story. This process of selection and of privileging certain facts over others is traditionally conceived as an objective one. In this way, it is assumed that the facts (and therefore the truth) are fixed and are not altered by the perceptions of those judging them.

The selection of true facts is followed by an equally impartial application of rules in accordance with logic and rationality. The process of deciding what the rules are, and which ones should be applied, is itself a process of knowledge discovery requiring an impartial reading of legal texts. Once again, the materiality of the inquirer is never relevant to the knowledge discovered, as Judith Grbich explains:

> Knowledge of law and authority is regarded as non-situated, knowledge which will "hold good" under different social conditions of inquiry. It will be objective in the scientific

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[15] S. Bottomley, N. Gunningham & S. Parker, "Liberalism, Formalism and the Rule of Law" in *Law in Context* (Sydney: Federation Press, 1991) 9 at 40.

[16] M. Troup, "Rupturing the Veil: Feminism, Deconstruction and the Law" (1993) 1 Australian Feminist Law Journal 63 at 63.

[17] J. Grbich, "The Body in Legal Theory" (1992) 11 University of Tasmania Law Review 26 at 31.

sense of able to be replicated or understood as valid regardless of the social relations in which the beliefs about authority are sustained, justified and reworked. [38]

II. The Social Constructionist Critique of Knowledge

Postmodern critiques have emerged to challenge the assumptions outlined in the previous section. These critiques allege that reality is not independent of human interpretation and understanding of it, but rather, constructed through the processes of human discovery and interaction. As a result, the assumptions that knowledge is objective and that rational method is neutral, have been contested.[39] This is currently manifested in epistemological debates about whether facts are mediated by the theories and values of the knower, whether it is possible to rationally decide between competing methods and paradigms produced from different positions, and whether objective methodologies can capture the specificities of subjects.[40]

I do not intend to provide an exhaustive coverage of the challenges posed by these critiques. Rather, I will focus briefly on three particular challenges. These are first, that knowledge is not value-free and language is not a neutral medium for communicating knowledge. Second, that power is exercised through the organization of knowledge into discourses. Third, that bodies are constrained and constituted by the workings of knowledge-power, that is, by and through their representation in discourses. The purpose of considering these challenges is to provide a basis for examining the effects of scientific and legal discourses about women's bodies in constituting them in such a way that their regulation (either direct in the case of law, or indirect, in the case of medical supervision) seems natural and inevitable.

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[38] Ibid.

[39] See generally L. Nicholson, ed., *Feminism/Postmodernism* (London: Routledge, 1990).

[40] Grosz supra note 9 at 29.

Knowledge as Value-Laden

One of the central challenges of social constructionism is a denial of the fixity of meaning.[41] In other words, knowledges are not objective and are, in fact, deeply influenced by cultural context (and materiality) in at least three ways. First, facts are made by a process of selection which is, in turn, determined by an individual's own experiences.[42] In other words, because individuals each possess potentially unique conceptual categories for understanding their experience, what will be noticed and collected as "fact" is inevitably influenced by cultural forces.[43] Susan Williams uses the example of women being taught to notice subtle changes in emotional states which may result in women perceiving and identifying facts that men do not.[44] This, as Williams points out, will not be the only basis for differences between individuals "the more particular context surrounding an individual—family, neighborhood, religious association, ethnic group, etc.—may add to or alter the cultural impact of the larger society on that individual's way of knowing."[45] Put simply, the actual process of recognition is influenced by the investigator's cultural context.

Second, value judgements are made when organizing and interpreting the data. These choices may be explicit or implicit, but by no means inevitable.[46] A scientist (or lawyer) might choose the theory that is simpler—but he or she might equally choose a theory which is most likely to produce control over the object or phenomenon.[47]

Third, value judgements will often determine which questions or phenomena are deemed worthy of investigation.[48] This has been highlighted by feminist empiricists who claim that decisions about what to study have traditionally ignored the interests,

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[41] Smart, supra note 12 at 158.

[42] Williams, supra note 13 at 69.

[43] Ibid.

[44] Ibid.

[45] Ibid.

[46] Ibid.

[47] Ibid at 70.

[48] Williams, supra note 13 at 70.

concerns and problems faced by women. The silences and gaps in scientific knowledge therefore create a bias.[49] Legal method has also been criticized on this basis.[50] Rules relating to jurisdiction and standing, for instance, delimit those matters which can be properly decided by a court. Matters that do not fit within these rules are therefore not permitted into the legal forum. The importance of these and other rules that define law's boundaries is not, according to Carol Smart, "where the boundaries are drawn, but the way in which the drawing of boundaries confers neutrality on law."[51] She argues that these boundaries, although part of law's claim to truth, are based on value judgements.[52]

These criticisms strike at the very heart of traditional epistemologies. They claim that knowledge is constructed rather than discovered—that is, knowledge is not neutral with respect to power, but it is shaped and produced by power. They reject the assumptions of individualism, universality and disembodied rationality, arguing that knowledges are critically influenced by the political and moral context in which they are created and are, therefore, historical, partial and contingent. It is claimed that traditional epistemologies have merely been successful in rationalizing the legitimacy of the interests and beliefs of the powerful rather than discovering universal truths.[53] As Susan Williams concludes "the vision of knowledge that emerges is one in which the known and the knower are intimately connected, indeed mutually defining, and exist only within a particular cultural context."[54]

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[49] "Sexist and Androcentric distortions in the results of research in biology and the social sciences are caused by social biases . . . Androcentric biases enter the research process particularly at the stage when scientific problems are identified and defined, and when concepts and hypotheses are formulated. But they also appear in the design of research and in the collection and interpretation of data." S. Harding, "Feminism, Science and the Enlightenment Critiques" in L. Nicholson, ed. *Feminism/Postmodernism* (London: Routledge, 1990) 83 at 90-91.

[50] See generally, Mary Jane Mossman, "Feminism and Legal Method: The Difference It Makes" (1986) Australian Journal of Law & Society 30.

[51] Smart, supra note 12 at 160.

[52] "In doing so, law positions itself in a political hierarchy and is better able to silence alternative discourses." Ibid at 161.

[53] Harding, supra note 49 at 87.

[54] Williams, supra note 13 at 72.

These claims cast doubt over the objectivity of knowledges but they also mount a challenge to traditional understandings of power. Foucault, for instance, claims that traditional understandings of power as emanating from a centralized state is inadequate to explain 20th century mechanisms of power.[55] His theory of the "micro-physics" of power posits power as a force that circulates throughout the entire social body in a network of force-relations. [56] Power, he argues, is dispersed and localized, and resistance occurs at every site that power meets with spontaneous reaction within that network.[57]

In this account, power and knowledge are mutually dependent.[58] Power plays a critical role in the production of knowledges by establishing the criteria for determining them.[59] These criteria, in effect, distinguish between truth and falsity because only those knowledge claims produced in accordance with accepted criteria can be accepted as true accounts of reality.[60] Other knowledge claims are silenced and excluded.

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[55] "By power, I do not mean, "Power" as a group of institutions and mechanisms that ensure the subservience of the citizens in a given state. By power, I do not mean either, a mode of subjugation which, in contrast to violence, has the form of the rule. Finally, I do not have in mind a general system of domination exerted by one group over another, a system whose effects through successive derivations, pervade the entire social body. . . Power must be understood . . . as the multiplicity of force relations in which they operate and which constitute their own organization; as the process which, through ceaseless struggles and confrontations, transforms, strengthens or reverses them; as the support these force relations find in one another, thus forming a chain or system, or on the contrary, the disjunctions and contradictions which isolate them from one another; and lastly, as the strategies in which they take effect, whose general design or institutional crystallization is embodied in the state apparatus, in the formulation of law, in the various social hegemonies." M. Foucault, *The History of Sexuality Vol.I, An Introduction* trans. R. Hurley (London: Allen Lane, 1978) at 92.

[56] Ibid.

[57] "Where there is power there is resistance, and yet, or rather consequently, this resistance is never in a position of exteriority in relation to power . . . These points of resistance are present everywhere in the power network" ibid at 95-96.

[58] E. Grosz *Volatile Bodies: Toward a Corporeal Feminism* (Sydney: Allen and Unwin, 1994) 138 at 148 [hereafter *Volatile Bodies*].

[59] Ibid.

[60] A. Bunting, "Feminism, Foucault and Law as Power/Knowledge" (1992) 30 Alberta Law Review 829 at 831.

> Power produces knowledge . . . power and knowledge directly imply one another; there is no power relation without the correlative constitution of a field of knowledge, nor any knowledge that does not presuppose and constitute at the same time power relations.[61]

Knowledge is not only shaped by power but is also the means by which power operates. This occurs through discourses, non-discursive events and their effects.[62] Discourses have been described as particular domains of language-use—that is, particular ways of talking, thinking and writing based on shared assumptions. [63] In other words, discourses comprise legitimized and sanctioned knowledge:

> "[D]iscourse" focuses on the politics of language and knowledge—the awareness that power is constructed in and through language, which crisscrosses the realm of "fact" (the real) and "interpretation"(the ideal). Language as a discourse transects the splits between objective and subjective, empirical and normative, value-free and biased.[64]

This necessarily contradicts the traditional stance which, it will be recalled, claims that language is a neutral means of representing and communicating knowledges. The claim here is that language shapes both meaning and reality:

> Language is not neutral. It is always embedded in discourse. It constructs meaning at the same time it reflects meaning. It sets the limits for what we can see and in some sense think. It defines, as Michel Foucault notes, "the limits and the forms of expressability: What is it possible to speak of? What has been constituted as the field of discourse?" Which terms disappear, and which become part of the ritual, pedagogy, and control? Any discourse puts into play a privileged set of viewpoints; it makes certain thoughts and ideas present, others absent.[65]

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[61] M. Foucault, *Discipline and Punish: The Birth of the Prison* trans. A. Sheridan (London: Allen Lane, 1977) at 28.

[62] E. Grosz, "Contemporary Theories of Power and Subjectivity" in S. Gunen, ed. *Feminist Knowledge: Critique and Construct* (London, Routledge, 1990) 59 at 89 [hereafter *Contemporary Theories*].

[63] C. Besley, *Critical Practice* (London: Methuen, 1980) at 5.

[64] Z. Eisenstein, *The Female Body and the Law* (Berkeley: University of California Press, 1988) at 10.

[65] Ibid at 9-10, citing M. Foucault, "History, Discourse and Continuity" Salmagundi 20 (Summer-Fall 1972) 234.

At the level of non-discursive practices, it is argued that knowledge-power establishes technologies of surveillance of the body and its behaviors; and, at the level of effects, develops methods of extracting information that help to constitute broad, pervasive systems of control for particular moments in space and time—by creating passive and observable bodies, groups and populations.[66] Together, these comprise Foucault's micro-physics of power—an individuated and technical form of disciplinary control over bodies.[67] This finds its ultimate expression in what Foucault sees as the emergence of the disciplinary society, marked by an increasingly medicalized discourse with "health, well-being, clinical supervision, and surgical intervention [becoming] ever more crucial to legal, juridical and political domains."[68] His argument, therefore, is that power in its juridical form, that is, a form based on the distribution of rights and penalties through centralized state instrumentalities, has been superseded by a new form of power. This change has been brought about by the growth of new knowledges (medicine, psychiatry, criminology, pedagogy, epidemiology) which have "create[d] new fields of exploration and bring within them new modes of surveillance and regulation of the population."[69]

Knowledge and the Body

Unlike the traditional stance, which conceived the individual person existing prior to society and entering it with a fully formed identity, this account conceives the body as constituted by the effects of power:

> [P]ower produces the body as a determinate type, with particular features, skills, and attributes. . . . Power does not control the subject through systems of ideas—ideologies—or through coercive force; rather it surveys, supervises, observes, measures the body's behaviour and interactions with others in order to produce knowledges. It punishes those resistant to its rules and forms; it extracts information to create new

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[66] Grosz, *Contemporary Theories*, supra note 62 at 89.

[67] Bunting, supra note 60 at 831.

[68] Grosz, supra note 9 at 35.

[69] C. Smart, *Feminism and the Power of Law* (London, Routledge, 1989) at 7.

> modes of control, new forms of observation, and thus new regimes of power-knowledge. . .[70]

The claim that language produces meaning by shaping thought and reality, has material consequences for bodies. It rests on the basis that the characteristics of bodies, that is, their shape, capacities, habits and desires, are produced through the processes of investigating, talking about, and representing them in discourses. The picture that emerges from these claims seems to be as follows: discourses are deployed by power to establish and represent the truth about particular bodies.[71] In doing so, discourses engage with bodies and behaviors, to construct them as such.[72] To this extent the body is "directly involved in a political field" in which "power relations have an immediate hold on it . . . they invest it, mark it, train it, torture it, force it to carry out tasks, to perform ceremonies, to emit signs."[73] The body is analogized to a surface that is inscribed by the workings of power. These markings are invested with meanings, signs that can be read by others and themselves, which constitute the body in a particular way.[74]

III. Feminist Insights on the Social Constructionist Critique of Knowledge

These claims about the partiality of knowledge and the interactions between knowledge and power, generate new possibilities for excavating subjugated knowledges and for examining the mechanisms of power that have excluded them. Some feminist theorists have found these critiques useful in demonstrating the particularity of knowledges, which, although generalizing a male norm, were hitherto presented as universal and true. This has facilitated a more critical analysis of objectivist discourses. In addition, it has permitted the development of alternative

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[70] Grosz, *Volatile Bodies*, supra note 58 at 149.

[71] Ibid.

[72] Ibid at 150.

[73] Foucault, supra note 61 at 26.

[74] See Grosz, *Volatile Bodies* supra note 58.

methods to ground competing knowledge claims, for example, women's experiences.[75]

The abandonment of objectivity, however, raises the specter of relativism. If truth claims cannot be objective, then how do we distinguish between the numerous competing and, presumably, equally valid claims to knowledge?[76] Elizabeth Grosz has called this the "crisis of perspectivism".[77] It poses difficulties for feminist theorists in two ways. First, feminist theories seeking to supplant traditional (male-biased) knowledges with knowledge derived from its more inclusive, gender sensitive methods remain open to the relativist challenge that its claims deserve no more weight than other non-feminist claims to knowledge.[78] Second, feminist methods that focus almost exclusively on gender as the categorical basis for women's oppression, and on women's experience as a source of empirical truth, must face the challenge that they do not capture the range of women's experiences, and therefore, exclude many women from their claims:[79]

> Essentialism in feminist theory has two characteristics that ensure that black women's voices will be ignored. First, in the pursuit of the essential feminine, Woman leached of all color and irrelevant social circumstance, issues of race are bracketed as belonging to a

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[75] In law, for example, some feminist theorists claim that conventional legal understandings of objectivity merely disguise as "point-of-viewlessness" the very specific masculine reference at the centre of legal discourses:

> [T]he state is male in that objectivity is its norm . . . It legitimates itself by reflecting its view of society, a society it helps make by so seeing it, and calling that view and that relation, rationality. Since rationality is measured by point-of-viewlessness, what counts as reason is what corresponds to the way things are . . . Objectivist epistemology is the law of law. It ensures that law will most reinforce existing distributions of power when it most closely adheres to its own ideal of fairness. Like the science it emulates, this epistemological stance cannot see the social specificity of reflexion as method or its choice to embrace that which it reflects.

MacKinnon, supra note 22 at 162-163. This theory focuses on differences in power between men and women. Its method seeks to expose the masculine bias in law's objective and rational accounts by using women's experiences of law's practices and rules as a source of empirical truth. See generally C. MacKinnon, "Feminism, Marxism, Method and the State: An Agenda for Theory (1982) 7 Signs 515; K. Bartlett, "Feminist Legal Methods" (1990) 103 Harvard Law Review 829, 837-67 [hereinafter *Feminist Legal Methods*].

[76] Williams, supra note 13 at 71.

[77] Grosz, supra note 9 at 30.

[78] Ibid.

> separate and distinct discourse—a process which leaves black women's selves fragmented beyond recognition. Second, feminist essentialists find that in removing issues of "race" they have only managed to remove black women—meaning that white women now stand as the epitome of Woman.[80]

The claim is that characteristics other than gender such as race, sexual orientation, class, age, disability and ethnicity shape women's experiences in significant ways so that Woman is actually an exclusionary category. [81] The uncomplicated category of Woman, it is argued, contains unstated reference points—white, middle class, heterosexual, able-bodied—that marginalize women who do not share those characteristics, and accordingly, those experiences of reality.[82] In this way, the use of "women's experience" as a basis for theorizing women's oppression has been criticized as a falsely generalizing a white, middle class, female norm. This echoes the way that feminists have challenged the disembodied knower, or the rational individual, as falsely universalizing a white, middle class male norm.

This "essentialist critique" has, however, raised concerns about the plausibility of addressing systemic patterns of gender-based oppression.[83] This has led Christine Di Stefano to argue that the abandonment of the category of Woman, forecloses the

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[79] Bartlett, *Feminist Legal Methods*, supra note 75 at 873.

[80] A. Harris, "Race and Essentialism in Feminist Theory" (1988) 42 Stanford Law Review 581 at 592.

[81] See generally E. V. Spelman, *Inessential Woman: Problems of Exclusion in Feminist Thought* (Boston: Women's Press, 1988); M.Minow, "Feminist Reason: Getting It and Losing It" (1988) 38 Journal of Legal Education 47; Harris, ibid; N. Duclos, "Lessons of Difference: Feminist Theory on Cultural Diversity" (1990) 38 Buffalo Law Review 325; M. Kline, "Race, Racism and Feminist Legal Theory" (1989) 12 Harvard Women's Law Journal 115.

[82] Kline, ibid at 141.

[83] Catharine MacKinnon remains committed to a version of "women's experience" as a basis for theory in C. MacKinnon, "From Practice to Theory, or What is a White Woman Anyway?" (1991) 4 Yale Journal of Law and Feminism 13. Many authors have questioned the postmodern tendency to abandon theory, arguing that women need a basis for a coherent theory and politics and, at the same time, to avoid the dangers of essentialism. See C. Di Stefano, "Dilemmas of Difference: Feminism, Modernity and Post-Modernism" in L. Nicholson, ed. *Feminism/Postmodernism* (London: Routledge, 1990) at 63; S. Bordo, "Feminism, Postmodernism and Gender-Scepticism" in L. Nicholson, ed. *Feminism/Postmodernism* (London: Routledge, 1990) at 133; N. Harstock "Foucault on Power" L. Nicholson, ed. Feminism/Postmodernism (London: Routledge, 1990) at 157; J. Williams "Dissolving the Sameness/Difference Debate: A Postmodern Path Beyond Essentialism in Feminist and Critical Race Theory" (1991) Duke Law Review 296.

possibility of engaging in feminist politics. "To the extent that feminist politics is bound up with a specific constituency or "subject", namely women, the postmodern prohibition against subject-centred inquiry and theory undermines the legitimacy of a broad-based organized movement dedicated to articulating and implementing the goals of such a constituency."[84]

Situated Knowledges

In an attempt to respond to the bias engendered in traditional epistemologies and some feminist epistemologies, Donna Haraway argues for a feminist vision of objectivity based on a concept that she calls "situated knowledges".[85] This is her attempt to negotiate the gulf between the totalizing view from nowhere and the equally totalizing relativist view from everywhere.[86] Haraway rejects the view that the alternative to totalization and single vision is relativism.[87] Her account of situated knowledges is based on location, embodiment and partial perspective. Commencing from the position that general claims about the nature of reality and oppression cannot capture the range and specificity of experiences of all women, "situated knowledges" seek out and include discourses about the nature of reality as it is actually experienced by embodied beings. In short, "knowing cannot be done in the abstract but only from a multiplicity of embodied, partial perspectives".[88] Haraway insists that meanings and experiences are explicitly connected to embodiment, so that to acknowledge our own (and others) embodiment is to acknowledge the partiality and particularity of our perspective. They are a view from somewhere:[89]

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[84] Di Stefano, ibid at 76.

[85] D. Haraway, "Situated Knowledges: The Science Question in Feminism and the Privilege of the Partial Perspective" in *Simians, Cyborgs, and Women: The Reinvention of Nature* (New York: Routledge, 1991) 183 at 188.

[86] She describes the view from nowhere as the "the gaze that mythically inscribes all the marked bodies, that makes the unmarked category claim the power to see and not be seen, to represent while escaping representation. . . [the] gaze [that] signifies the unmarked positions of Man and White" ibid. The view from everywhere, on the other hand, is equally unlocatable (being everywhere at once) and accordingly, denies criticism and accountability; ibid at 191.

[87] Ibid at 191.

[88] P. Halewood, "White Men Can't Jump: Critical Epistemologies, Embodiment and the Praxis of Legal Scholarship" (1995) 7 Yale Journal of Law and Feminism 1 at 20.

> [O]ur insisting on the particularity and embodiment of all vision. . . and not giving in to the tempting myths of vision as a route to disembodiment and second-birthing, allows us to construct a usable, but not innocent doctrine of objectivity. . .We need to learn in our bodies. . . how to attach the objective to our theoretical and political scanners in order to name where we are and where we are not. . . objectivity turns out to be about particular and specific embodiment and definitely not about the false vision promising transcendence of all limits of responsibility.[89]

This claim acknowledges that women experience subjugation in complex ways that implicate various aspects of, and intersections between, the characteristics that constitute their identities. It also acknowledges that some women have special access to knowledges that may not be available to differently positioned women.[91] It does, however, caution that the positions of the subjugated (who are also constructed by ideological and institutional forces) are not "innocent" and are therefore not exempt from critical reevaluation.[92] This accommodates the need for a critical distance from the source of a truth claim, without compromising accountability.[93] Making claims about reality means making claims on peoples' lives, and Haraway insists that we must accept responsibility for the consequences of the claims we make.[94]

Situated knowledges means that meanings can never be fixed or closed— "there is no single feminist standpoint because our maps require too many dimensions for that

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[89] Supra note 85 at 196.

[90] Ibid at 189-190.

[91] For a full account of the claim that knowledge of subordination is best illuminated from below—that is, those who embody subordination; see Harding, supra note 49. The underlying rationale of feminist standpoint epistemologies is that because women speak from a standpoint of subjugation, they have access to knowledge (based on their oppressed position) that men do not have. Women's experiences as victims of patriarchal oppression allow them to criticize conventional explanations of "reality"—untainted by the distortions of dominant paradigms. Bartlett, *Feminist Legal Methods*, supra note 75 at 872

[92] Supra note 85 at 191.

[93] "I am arguing for politics and epistemologies of location, positioning and situating, where partiality and not universality is the condition of being heard to make rational knowledge claims. These are claims on people's lives; the view from a body, always a complex, contradictory, structuring and structured body, versus the view from above, from nowhere, from simplicity"; Ibid at 195.

[94] Ibid at 191. On the question of the responsibility of white male scholars who write about the oppression of white women and women of color and/or men of color see Halewood, supra note 88.

metaphor to ground our visions".[95] Her hope is that local, critical knowledges will sustain the possibility of a web of connections:[96]

> We do not seek partiality for its own sake, but for the sake of the connections and unexpected openings situated knowledges make possible. The only way to find a larger vision is to be somewhere in particular.[97]

This epistemological model of embodiment clearly rejects the possibility of universal truth claims and argues for a partial, local objectivity. As such, it seeks to supplant objective meta-narratives for embodied perspectives. This raises the question of bodies themselves.

Reconceptualizing Bodies

Elizabeth Grosz argues for a reconceptualization of the body as a socio-cultural, and not merely biological, entity. She also claims that bodies are essential to critiques of knowledge and accounts of power.[98] Like Haraway, she argues that all knowledges must be seen as perspectival and partial products of historically specific, political imperatives.[99] In her account, the masculinity of knowledge is largely a result of the obfuscation of male corporeality in the process of producing knowledges.[100]

Grosz sees the relationship between the body and knowledge as important because traditional representations of the "human" necessarily take as their ideal a particular body, that is, a specific mode of corporeality that is male. The effect of this particular but unstated bodily norm is to erase differences between bodies by converting them

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[95] Supra note 85 at 195.

[96] Ibid at 191.

[97] Ibid at 196.

[98] Grosz, supra note 9 at 32.

[99] Ibid at 43.

[100] "Men have taken on the role of neutral knowers because they have evacuated their own specific forms of corporeality and repressed all its traces from the knowledges they produce. In appropriating the realm of the mind for themselves, men have nonetheless required a support and cover for their now disavowed physicality. Women thus function as the body for men—correlative with the effacement of the sexual concreteness of their (womanly) bodies"; Ibid at 38.

to variations on the norm.[101] By obliterating the sexual concreteness of women's bodies, women are represented as lacking or incomplete.[102] This, she argues, is the result of the sexualization of knowledges, that is, men projecting their own corporeal forms onto knowledge.[103] In her view, differences between subjects can only be understood if bodies in their variety, and the processes of producing them as "different", are acknowledged.[104]

This leads us back to accounts of power and its effects in constituting bodies. If we can understand the processes that constitute particular bodies as inferior on the basis of difference, those claims can be contested with a view to re-constituting those bodies in more empowering configurations.[105] Grosz's suggestion is to trace and expose the distortions in knowledges that are attributable to the sexually specific nature of the body of the traditional knower.[106] This "entails an acknowledgment of the sexually particular positions from which knowledges emanate and by which they are interpreted."[107]

The advantage of this analysis is that subjects can be theorized in their complexity and without reduction to single identifying causes of oppression. In this framework, bodily differences (sex, gender, race, class) have particular meanings because they are inscribed on the body and experienced by and through the body.[108]

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[101] "There are always only specific types of body, concrete in their determinations, with a particular sex, race, physiognomy. Where one body (in the West, the white, youthful, able, male body) takes on the function or model or ideal, the human body, for all other types of body, its domination may be undermined through a defiant affirmation of multiplicity, a field of differences, of other kinds of bodies and subjectivities." Grosz, *Volatile Bodies*, supra note 58 at 19.

[102] Supra note 9 at 38.

[103] Ibid

[104] Ibid at 32.

[105] "If bodies are inscribed in particular ways, if these inscriptions have thus far served to constitute women's bodies as a lack relative to men's fullness, a mode of women's naturalness and immanence compared with men's transcendence, then these kinds of inscription are capable of reinscription, of transformation, are capable of being lived and represented in quite different terms, terms that may grant women the capacity for independence and autonomy, which thus far have been attributed only to men" Grosz, *Volatile Bodies*, supra note 58 at 1.

[106] Grosz, supra note 9 at 40.

[107] Ibid at 43.

[108] Ibid.

> I will deny that there is a "real" material body on the one hand and its various cultural and historical representations on the other. It is my claim . . . that these representations and cultural inscriptions quite literally constitute bodies and help to produce them as such. The bodies in which I am interested are culturally, sexually, racially specific bodies, the mobile and changeable terms of cultural production. As an essential internal condition of human bodies, a consequence perhaps of their organic openness to cultural completion, bodies must take the social order as their productive nucleus. Part of their own nature is an organic or ontological "incompleteness" or lack of finality, an amenability to social completion, social ordering organization.[109]

In other words, bodies themselves are not stable or fixed but, rather, structure the fields in which they move, and are, in turn, structured by them.[110] This means that an embodied subject is a subject that acts, and is acted upon, within a field of power relations that determine its shape. It is not, in other words, an object that exists prior to society with natural and pre-determined boundaries. Its boundaries "materialise in social interaction". [111] For this reason, Haraway cautions that "Siting (sighting) boundaries is a risky practice."[112]

For Grosz, it is possible to conceptualize women as an oppressed group by specifying female bodies and their place in locating women's experiences and social positions.[113] Drawing on the insights of Foucault and phenomenology, Grosz theorizes the body as "a kind of hinge or threshold . . . placed between a psychic or lived interiority and a more socio-political exteriority that produces interiority through the inscription of the body's outer surface"[114]

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[109] Grosz, *Volatile Bodies*, supra note 58 at xi.

[110] "Feminist accountability requires a knowledge tuned to resonance, not to dichotomy. Gender is a field of structured and structuring difference, where the tones of extreme localization, of the intimately personal and individualized body, vibrate in the same field with global high tension emissions. Feminist embodiment, then, is not about fixed location in a reified body, female or otherwise, but about nodes in fields, inflections in orientations, and responsibility for difference in material-semiotic fields of meaning. Embodiment is significant prosthesis; objectivity cannot be about fixed vision when what counts as an object is precisely what world history turns out to be about. . . ." Haraway, supra note 85 at 195.

[111] Ibid at 201.

[112] Ibid.

[113] Ibid.

[114] Grosz, supra note 9 at 43.

The theory that the body's boundaries are constructed and therefore open to challenge is a particularly useful insight when thinking about the way that the boundaries of the pregnant body have been drawn in legal and scientific discourses. It provides a basis from which to critically examine existing and agreed-upon boundaries and permits the possibility of contesting and re-drawing these boundaries in more empowering configurations.

IV. Embodied Women as Legal Subjects

Legal feminist theorists have long suggested that women in their multiplicity experience reality in ways that do not accord with the law's account of reality. Given that women experience the law by and through their bodies, an examination of how women's bodies are constituted and constrained by legal discourses may be a useful direction for feminist jurisprudence.[115] Such an inquiry might be taken further to consider how a positive account of embodiment would transform the legal subject, that is, the person or self. Such accounts would necessarily take as a starting point the conventional normative framework of the law and the position of the female body within that framework. To do this, we might consider the following. What is the relationship between embodiment and personhood in law? What does the law accept as authoritative accounts of female bodies[116] (its knowledge of female bodies)? How are legal rights and duties ascribed to and, in the case of pregnant women, within, female bodies? What is the relationship between the way the female body is represented and the exercise of power over it?[117] How do the answers to these questions affect particular female bodies?

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[115] Mykitiuk, supra note 27 at 80.

[116] See generally Smart, supra note 12; J. Terry "The Body Invaded: Medical Surveillance of Women as Reproducers" (1989) 19 Socialist Review 13; M. Ashe, "Law-Language of Maternity: Discourse Holding Nature in Contempt" [hereinafter *Law-Language of Maternity*] (1988) 22 New England Law Review 521.

[117] See generally I. Karpin, "Reimagining Maternal Selfhood: Transgressing Body Boundaries and the Law" (1994) 2 Australian Feminist Law Journal 36 [hereinafter *Maternal Selfhood*], I. Karpin, "Legislating the Female Body: Reproductive Technology and the Reconstructed Woman" (1992) 3 Columbia Journal of Gender and Law 325 [hereinafter *Reconstructed Woman*], Ashe, *Law-Language Maternity* ibid, and M. Ashe, "Zig-Zag Stitching and the Seamless Web: Thoughts on Reproduction and the Law" (1988) 13 Nova Law Review 355 [hereinafter *Seamless Web*].

The Body of Law

Roxanne Mykitiuk argues that the experience of embodiment has been excluded from liberal legal constructions of personhood and the self. Although the person theorized and positioned at the centre of legal discourse is the "abstracted, disembodied, rational, universal rights bearing, contracting, possessive individual",[118] that person has a particular body:

> [I]t has been important to critique the unencumbered or generalized self. . . to determine who is hiding behind it and in whose interests the current moral principles, conceptual systems and epistemological order have been constructed. Thus, at the center of liberal legal discourse we find not an absent body, but a particular body—one who is white, male, heterosexual, able-bodied, young, adult, and it is this body which has been generalized as the normative body of liberal discourse.[119]

Mykitiuk argues that liberal legal tradition is unable to see either the corporeal particularity of the person at its centre or the impact that this unacknowledged particularity has on other bodies.[120]

Within a framework which conceptualizes the self as occupying a particular corporeal mode, the bodies of pregnant women occupy an ambiguous position. They are seen as problematic because they embody the potential for separation into two distinct individuals, each with distinct rights and responsibilities. In this transitory state, the relationship between the embodied subject and personhood is not straightforward. Yet the way that law incorporates the pregnant body into its framework has important consequences for the agency of pregnant women.

Does the law regard the pregnant woman as one person or two, or more than one, but less than two? The characterization of this relationship, in legal terms, has a

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[118] Mykitiuk, supra note 27 at 79.

[119] Ibid at 80.

[120] Ibid.

number of consequences. It determines both the nature and extent of rights and duties ascribed to third parties (including the state), the pregnant woman and the fetus. The way in which this is done can produce vastly different results. The ascription of an absolute right of bodily integrity to pregnant women, for example, will have the effect of protecting pregnant women from non-consensual medical treatment. This might follow a conceptualization of the pregnant woman as a single entity, with equivalent protections accorded to other individuals. On the other hand, the ascription of a fetal right to be born healthy might have the effect of legitimizing the non-consensual medical treatment of pregnant women if the treatment is needed to prevent an anticipated deterioration in the health of the fetus. This might follow a conceptualization of the pregnant woman as two entities. If the law were to recognize both rights, a method for resolving competing claims would need to be determined. Likewise, if the right to bodily integrity was qualified on the basis that the state has an interest in fetal life (even in the absence of fetal rights), a competition is constructed. Both alternatives would require some basis for balancing the bodily integrity of the pregnant woman against either the right of, or interest in, the fetus. Again, this basis would be shaped by the manner in which the pregnant body is conceptualized.

Alliances between Legal and Scientific Discourses

My preliminary point is that the way that the pregnant body is conceptualized is embedded in the workings of power over that body. In this sense, I am using a notion of power as traditionally conceived, that is, the determining of rights and penalties by a centralized state instrumentality. This seems to contradict Foucault's account of power in the modern episteme as a de-centralized force operating in and through discourses about the body. On the other hand, if we examine the conceptual basis for the assignation of rights, we can identify law's dependence on medical discourses for a range of purposes (e.g. for defining the nature of the pregnant body, extracting information about the flow of substances or viruses from mother to fetus and for generating the need to perform particular medical treatments to assist the fetus). Scientific discourses about the body, therefore, are very much implicated in law's exercise of power over that body.

This suggests that Foucault's account of power provides some useful insights. The major problem with Foucault's account of power from a feminist perspective, however, is that power is everywhere, "as a discursive background, rather than a force used by some particular people against others."[121] This has been rejected by some theorists as counter-intuitive and, once again, potentially fatal to a feminist politics. In the words of Williams:

> Given the continuing pattern of patriarchal violence against women, however, women cannot afford to dispense with the notion of power as violence against the subject. The directionality of power—its use by some particular people against others—is as significant for feminist purposes as its background persuasiveness.[122]

Eisenstein agrees that Foucault's dispersion of power is inadequate for feminist reasoning. However, she argues that the "dispersion of power in and through discourse operates within concentrated forms of power that discourses about "the" state establish."[123] So although the state may not represent a coherent stable centre of power, it is a centre of concentrated power—even if it has this appearance because liberal discourses construct it as such.[124]

It is possible to incorporate Foucault's theory of power operating through discourses of normalization, without ignoring the operations of traditional forms of juridical power. In fact, as the brief sketch at the beginning of this section was intended to foreshadow, the operation of juridical forms of power over the pregnant body is connected to modern discourses about the body.[125] Carol Smart suggests that discourses of rights and discourses of normalization constitute two parallel systems of power which actually merge in the context of law's relationship to the female body:

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[121] Williams, supra note 13 at 90.

[122] Ibid.

[123] Eisenstein, supra note 65 at 12.

[124] Ibid.

[125] For this reason, Foucault suggests that turning to rights discourse as a strategy to prevent the encroachment of surveillance is unlikely to be successful because these mechanisms of power are symbolically linked. C. Smart, *Feminism & The Power of Law*, supra note 69 at 9.

> Through the appropriation of medical categorizations and welfare-oriented practices, law itself becomes part of a method of regulation and surveillance. Law, therefore, has recourse to both methods, namely control through the allocation of rights and penalties, and regulation through the incorporation of medicine, psychiatry, social work and other professional discourses of the modern episteme.[126]

This allows us to see systems of power operating in and through discourses in a range of contexts—for example, the prenatal clinic and the courtroom—without denying the relations between them. The boundaries and capacities of pregnant bodies are constituted in both locations with considerable consistency, indicating that as "sites of power" they may not be autonomous. The dominant discourses in both locations are directed by particular knowledges about women's bodies and thus they are connected. The law, therefore, can be seen as "stand[ing] in a symbiotic relationship to other forms of disciplinary power relations".[127] Medicine has created "new terrains so that law can extend its authority, not just in discovering new objects for scrutiny [e.g. the fetus] but in terms of new methods of application"[128] [e.g. forced medical treatment and forced drug rehabilitation for pregnant drug users].

Constructing the Maternal Body as Separate Entities

In order to appreciate the nature of the coalitions between legal and scientific discourses, it is useful to examine the manner in which scientific discourses represent the pregnant body. The following passage is a description of the commencement of pregnancy:

> . . . Pregnancy begins following coitus at or near the time of ovulation. . . Of the millions of ejaculated sperm cells, thousands reach the female ovum in the outer end of the fallopian tube, but usually only one penetrates the egg for union of the male and female pronuclei and conception. The zygote, genetically a unique identity, begins cell division as it is transported to the uterine cavity where it implants in the uterine wall. Maternal and embryologic elements together form the beginnings of the placenta, which grows

[126] Ibid at 96.

[127] Bunting, supra note 60 at 837-38.

> into the substance of the uterus. The placenta functions in maternal-fetal exchange of nutrients and waste products, though the maternal and fetal bloods do not normally mix. The conceptus is, in some aspects, like a foreign graft or transplant in the mother. . .[129]

This text emphasizes both the separateness of the zygote and the body of the pregnant woman and, in so doing, focuses on the newly created entity. This has a number of effects. First, the body of the pregnant woman is largely excluded from the frame. By positioning us within the body of the woman, we see her uterus only. Second, we can see the genetically unique zygote. It is surrounded by the hybrid placenta—half maternal and half embryologic—which forms the boundary between this unique identity and the maternal being, and prevents the mixing of blood. Third, the new entity is represented as a foreign graft or transplant inside the mother. This view of the other from inside dominates scientific accounts of pregnancy and has the effect of constructing the body of the pregnant woman as a receptacle for the foreign, unique, self-contained fetal identity.

The advent of ultrasound imaging has brought pictures to enhance this text, so that imagination is no longer required to see the fetus and mother as separate entities:

> The foetus as we know it is a fetish. Barbara Katz Rothman observes: 'The fetus in utero has become a metaphor for "man" in space, floating free, attached only by the umbilical cord to the spaceship. But where is the mother in that metaphor? She has become empty space.' Inside the futurizing spacesuit, however, lies a much older image. For the autonomous, free-floating foetus merely extends to gestation the Hobbesian view of born human beings as disconnected solitary individuals. It is this abstract individualism, effacing the pregnant woman and the foetuses dependence on her, that gives the foetal image its symbolic transparency, so that we can read in it our selves, our lost babies, our mythic secure past.[130]

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[128] C. Smart, supra note 69 at 96.

[129] L. Urdang and H. Harding Swallow, *Mosby's Medical & Nursing Dictionary* (St Louis: Mosby Press, 1983) at 878.

[130] R. Petchesky, "Foetal Images: The Power of Visual Culture in the Politics of Reproduction" in M. Stanford, ed., *Reproductive Technologies - Gender, Motherhood and Medicine* (Oxford: Polity Press, 1987) 57 at 59 (footnote omitted).

Ultrasound imaging has been accompanied by the proliferation of scientific diagnostic techniques that allow doctors to detect the presence of substances or contagions that might diminish the quality of the maternal environment and pose a threat to the fetus. In addition, fetal heart monitors provide information about the condition of the fetus during labour, and are used to diagnose the need for invasive surgical delivery. As forms of knowledge about the fetus and the pregnant woman, these developments have the cumulative effect of representing these entities as separate. Indeed, they have contributed to the emergence of the 'fetal patient'. [131]

These developments have precipitated legal analyses of the respective rights and obligations of pregnant women, fetuses, physicians and the state. Christian Witting puts the threshold issue in the following way:

> Recent advances in obstetrics have called for a judicial re-examination of the status of the unborn. Through ultrasound, the foetus can now be visualised and abnormalities detected before birth. This has opened up possibilities for surgery on the foetus or delivery by caesarean section. The courts are thus placed in a dilemma because the foetus is potentially a patient in its own right. If a foetus can be seen as a patient, the question arises as to what legal and ethical duties are owed to it. [132]

This demonstrates a connection between the way that science and its methods construct the pregnant body and the way that law's power might be applied to regulate it. Isabel Karpin explores this direction in her examination of the intersections between law and other discourses about the female body. She argues that in regulating the female body, the law determines its shape and boundaries. She contests the claim that "Woman" is represented in these discourses in a manner which reflects the "nature" of the female body but, rather, that these attempts to

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[131] This idea of 'two patients' also generates new possibilities for conceptualizing the relationship between these patients and physicians. Jeffrey Lenow suggests that two physicians could be required for some pregnancies, an obstetrician/gynecologist with primary responsibility for maternal health and a perinatal surgeon with primary responsibility for fetal health, with the correlative possibility of conflicts between physicians. J. Lenow, "The Fetus as a Patient: Emerging Rights as a Person?" (1983) 9 American Journal of Law and Medicine 1 at 3.

[132] C. Witting, "Forced Operations on Pregnant Women: *In re S* Examined" (1994) 2 Tort Law Journal 193 at 203.

define and regulate the female body construct and reconstruct Woman.[133] This means that although the pregnant body might be represented as two separate entities, this is not a natural or inevitable configuration, but rather a political choice that offers more scope for controlling that body. [134]

Further, although the fetus may be visualised and conceptualized as an entity separate from the pregnant woman, it is, nonetheless, dependent on and encompassed by her.[135] This points to a paradox in the dominant discourses about pregnancy. On the one hand, the mother's body is synonymous with a uterus, a conceptualization that erases the absolute dependence of the fetus on the mother's whole body for its survival. This enables us to see the fetus and the mother as separate entities. But this project is not completely successful because, on the other hand, the mother's body is also a potentially threatening environment. Her ingestion of substances, for example, may threaten the health of the fetus. This implies that the fetus is very much a part of her body and the boundary that has been constructed for the purpose of differentiating the fetus from the mother is not fixed—it is permeable and unstable. The recognition of the permeability of the boundary gives rise to a fear that the fetus may be harmed by the mother's body if she behaves inappropriately. Scientific discourses about the flow of substances across the "boundary" and the attendant harm to the fetus or other dangers posed by the body of the pregnant woman, provides the inspiration for a regulatory project to restore differentiated stability and to control the body. Law is implicated in the acts of policing the boundary. For example, the invocation of child welfare statutes to constrain the mother become a way of maintaining the construction of separateness in the face of unstable boundaries.[136] The boundary is made to appear more stable by restraining the mother from harming someone who is not her self (although she achieved this by doing, or

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[133] Karpin, *Reconstructed Woman*, supra note 117 at 325.

[134] Ibid at 327.

[135] This point has been made by Isabel Karpin who argues that: "there is a paradox at the very center of any discussion of women's rights and "fetal" rights. As scientific advances reveal more and more ways in which the mother who carries the fetus is able to have an impact upon that fetus, or is integral to it the response as a point of competition between mother and fetus and as a mark of their separate trajectories" I. Karpin, *Reconstructed Woman*, ibid at 329-330.

[136] Karpin, *Maternal Selfhood*, supra note 117 at 53.

not doing something, to her own body), thus rhetorically re-instating the fetus and mother as separate entities.[137]

Conclusion

The remainder of this work will draw upon the insights mapped out so far. In an effort to explore the way that discourses construct and control of the maternal body, I will present two studies. The first looks at the interplay between science, law and culture through an analysis of the media stories concerning Sheila and Mandy Allwood. This examines, in particular, how discourses about motherhood are enmeshed in discourses about pregnant bodies. The second study examines these connections through an analysis of the Canadian cases relating to prenatal intervention. This examines, in particular, the mechanisms by which pregnant women can become the objects of State interests and scrutiny through boundary mapping exercises within the body. In both studies, I will draw on the contributions of those theorists who argue for a re-conceptualization of the body by pointing to an alternative reading of the texts inspired by a recognition of embodiment and situated knowledges.

[137] ibid at 41.

CHAPTER TWO

Maternal Monstrosities and other Catastrophes

> Now this wretched woman has turned into some sort of maternal monstrosity, the sort of baby making blunder that all those scientists who worked on fertility drugs must have dreaded . . . Mandy Allwood isn't a mother. She's a mistake.[138]

> These doctors are architects of a bizarre society where, out of the patient's selfishness and the doctor's collusion, we create deliberately disadvantaged children.[139]

Introduction

These extracts are taken from media stories about two women whose aspirations to become mothers aroused significant public debate. The first extract concerns the story of Mandy Allwood who, after receiving fertility treatment, conceived eight fetuses. She was subsequently advised by doctors to abort some of the fetuses in order to improve the chances of producing a smaller number of healthy babies. This she refused to do, preferring to allow nature to take its course. The second extract concerns the story of Sheila an HIV positive woman who was permitted access to an IVF program. Sheila's desire to become a mother and the doctor's decision to treat her, received public censure on the basis that the prospective child may contract HIV in Sheila's womb.

In a general sense, these stories represent cultural narratives about reproduction and mothering. They also touch on public enthusiasm and anxiety about the involvement of medical technology in pregnancy. A strong theme in both stories was the ethics of pursuing risky pregnancies. The focal objection was that the children born of Sheila or Mandy Allwood might be born with disabilities. In Sheila's case, her child might be born with HIV. In Mandy Allwood's case, any surviving children might be

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[138] M. Gibson, "Fertile Ground For Mistakes" *The Daily Telegraph* (14 August 1996) 10.

[139] Dr Adrian Rogers, quoted in A. Ferriman "The Gift of Life" *The Independent on Sunday* (19 May 1996) 17.

'handicapped' as a result of prematurity. The dangerousness of each pregnancy was, therefore, measured in terms of the risk to the fetus(es). There was no equivalent concern for the risk to either Sheila or Mandy Allwood. This particular approach to the circumstances of Mandy Allwood and Sheila shadows a number of assumptions. First, that the purpose of pregnancy is to produce healthy children. Second, that where a pregnancy carries a risk of producing unhealthy children, the pregnant woman should accept all medical interventions to minimise the danger of disability, or the pregnancy should be abandoned. Third, women who pursue risky pregnancies and/or do not accept medical interventions are not good mothers. Each of these assumptions can be located in the cultural narratives about Sheila and Mandy Allwood.

The primary purpose of this chapter is to demonstrate how these women were constructed as bad mothers. This was achieved by differentiating these women both bodily and socially. The effect of this process of differentiation is to mark these women as deviations from the normative maternal body and the normative good mother. To do this, the texts assimilate scientific knowledge about the body together with a range of social indicia usually associated with unfitness to mother. In this sense there is a convergence between medico-scientific discourses about healthy bodies and cultural discourses about motherhood. The interpolation of standards for responsible maternal behavior occurs at the intersection of these discourses. Put simply, scientific knowledge provides information about the body, and the projected health of the fetus. This in turn creates opportunities for action, either in the form of medical intervention, termination or avoidance of pregnancy. Choices that are consistent with medical expectations and are designed to improve fetal health, or prevent the birth of a disabled child are responsible choices. They indicate responsible behavior and, accordingly, that which a good mother would do. Conversely, the rejection of these choices indicates irresponsible behavior and, accordingly, form a basis for exclusion from the category of good mother.

Part I will examine some of the broader discussions which form the backdrop against which the stories of Sheila and Mandy Allwood were told. Discussions about maternal responsibilities to the fetus in light of diagnostic technologies can be found

in the discourses of public health and medical ethics. Similarly, discussions about societal responses to diagnostic technologies can be found in the discourses of public health and law. These discourses raise questions about the application of prenatal diagnostic technologies, the uses to which this information should be put and, accordingly, emergent discussions about appropriate maternal behavior in light of the information yielded by these technologies. The stories of Sheila and Mandy Allwood provide specific illustrations of the interactions between information about the health of fetuses and responsible maternal behavior.

Part II will examine more specifically the stories of Sheila and Mandy Allwood. In this Part, I will consider the issue of responsibility for, and control over, conception. This issue was essential to the construction of each woman as an undeserving mother because it canvassed the decision to conceive, and/or circumstances surrounding the conception. Sheila knew her HIV status and Mandy Allwood apparently knew that sexual intercourse might have given rise to a multiple pregnancy. The actions of both women were, therefore, cast as irresponsible. Although fertility treatment was provided to both women, their doctors were positioned differently with respect to the question of responsibility for the conception. In this sense, the stories provide a useful contrast. Although it is implied that Sheila's decision to mother is irresponsible, the doctor's decision to permit her access to IVF is the focus of censure. He is seen as the 'creator' and Sheila is represented as passive. By contrast, Mandy Allwood's is constructed as active and, accordingly, almost wholly responsible for her pregnancy. It is alleged that the multiple pregnancy occurred as a result of her deviousness and wanton rejection of medical advice. The doctor who supervised her fertility treatment is seen as having lost control through Mandy Allwood's non-compliance.

Part III will examine the way that the particular bodies of these women were described and subsequently represented as incompatible with an ideal maternal body. This was achieved in each case by engaging in assessments of how each woman's body threatened the health of existing or potential fetuses. These assessments are rooted in scientific facts and medical opinions which, accordingly, form the corpus of the evidence about the nature of the threats posed by these deficient bodies to the fetus. In this sense, the texts privilege scientific explanations as authoritative sources

of knowledge about these women's bodies. Moreover, medical priorities tend to dominate the issues that are singled out for attention and comment. Each story is strongly underwritten by an imperative that venerates health and the absence of disability. Importantly, each woman decided to pursue pregnancy notwithstanding her deviance from the ideal maternal body. This becomes the focus of scrutiny and upon which the suitability of each woman as a mother is impugned. Mandy Allwood could have agreed to selective termination in accordance with the wishes of her doctors. Sheila could have foregone motherhood altogether. It is because each woman acted in a manner contrary to a large body of medical opinion that the stories were newsworthy.

Part IV examines the incorporation of other characteristics and behaviors to support the constructions of undeserving motherhood. Although both women are stigmatised as bad or irresponsible mothers (or potential mothers) it is not only their defective bodies that are used to support this conclusion—sexual history, past drug behavior, marital status and welfare status are also woven into the stories. This points to the possibility that particular groups of pregnant women are more susceptible to bodily scrutiny, regulation or public censure based on a complex web of characteristics of which bodily deficiencies is but one.

Part V observes the recourse to legal solutions as a means of prevention. This is relevant to the telling of Sheila's story where explicit references are made to the failure of law to prevent the situation from recurring.

Part VI considers the silences and gaps in these stories. In their focus on scientific conceptions of the ideal maternal body and cultural conceptions of the good mother, the knowledges, aspirations, hopes and fears of the women concerned are largely excluded from attention. The effect is to subjugate these potential forms of knowledge from the inquiry and, therefore, limit its scope and humanity.

I. Situating The Stories

In this section, I will provide a brief overview of medical and legal discourses relating to the responsibilities of women following prenatal diagnosis of fetal disability and/or HIV diagnosis to provide a broader context for the particular stories of Sheila and Mandy Allwood. These discussions have been driven by the advent of diagnostic technologies and the questions these technologies raise. When science provides information about the anticipated health of a child before that child comes into being as a separate person, what should be done with that information? What should individual women do? Should society compel them to act on that information in particular ways? If so, what methods should be used to effect the desired outcome? Will (or should) the law be used to prescribe enforceable duties to the fetus? Will (or should) doctors engage in coercive practices? Will social pressures achieve the desired results? The discourses examined in this Part are concerned with these questions. Some discussions urge the systematization of methods for eliciting information from the bodies of pregnant women (eg genetic and HIV screening programmes), or for legal responses to the perceived failures of pregnant women to behave responsibly (eg non-consensual medical treatment of pregnant women or an enforceable duty of care in relation to fetuses). As such, they form a good exemplar of Foucault's thesis about the exertion of power over the body in the modern episteme. Through these discourses knowledge about the body is organised as a basis for extracting information from particular bodies and sanctioning particular types of behavior.[140]

[140] This connection has been made by Jennifer Terry who argues that prenatal diagnostic technologies form part of a regime of disciplinary mechanisms and surveillance which have the effect of monitoring the population of childbearing women with the purpose of excluding unhealthy bodies from reproductive activities. J. Terry, "The Body Invaded: Medical Surveillance of Women as Reproducers" (1989) 19 Socialist Review 13.

The Right to be Born Healthy

Formerly, the fetus was beyond the diagnostic reach of physicians and, accordingly, physicians saw their role as maintaining and promoting maternal health, which would, presumably, also enhance the health of the fetus.[141] Advances in technology have, however, permitted researchers and doctors to see, access and treat the fetus in ways previously not possible.[142] This, according to Nelson & Milliken, has changed the way we see the fetus:

> Medicine's enhanced ability to treat the fetus directly has profoundly affected, perhaps even created, physicians' perception of the fetus as a separate patient. Such a perception is reinforced by clinical experience of the fetus as a technically interesting and challenging patient."[143]

In response to these developments, a number of commentators have argued for the ascription to fetuses of a right to be born healthy. According to Edward Keyserlingk:

> Since the unborn child has health needs and vulnerabilities analogous to those of children, and since between the child when unborn and after birth there is continuity in all essential respects, then it would seem logical and just to assign to parents duties to their unborn children (when applicable), and to recognise in unborn children analogous rights (when applicable) to those already granted to their children.[144]

This raises a number of questions about the scope of maternal responsibilities before and during pregnancy. Keyserlingk and other writers[145] propose a regulatory project

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[141] L. J. Nelson & J. D. Milliken, "Compelled Medical Treatment of Pregnant Women: Life, Liberty and Law in Conflict" (1988) 259 Journal of the American Medical Association 1060 at 1060.

[142] According to Nelson and Milliken: "Advances in knowledge of fetal physiology and the development of new technology have enabled physicians to see the fetal in detail with ultrasound, to assess its condition with fetal heart monitoring, and to operate on it in utero." Ibid.

[143] Ibid.

[144] E.W. Keyserlingk, *The Unborn Child's Right to Prenatal Care. A Comparative Law Perspective* (Montreal: Quebec Research Center of Private and Comparative Law, 1983) at 103.

[145] See Flannery, who argues for an enlarged application of child abuse statutes as a basis for confining pregnant women who use illicit drugs during pregnancy. M. Flannery, "Court-Ordered Intervention: A Final Means to the End of Gestational Substance Abuse" (1991-92) 30 Journal of Family Law 519 at 529-540.

in order to ensure that these duties are fulfilled. Keyserlingk argues for the extension of child protection laws to fetuses to provide a mechanism for the enforcement of maternal duties. He cites drug use, alcohol, cigarettes, inadequate maternal diet, exposure to infectious disease and failure to acquire adequate pre-natal care or treatment as examples of conduct that could require state intervention.[146] It will be noticed that these are the same kinds of restrictions proposed by John Robertson who, also arguing from the position that the fetus has a right to be born healthy, says:

> Once [a woman] chooses to carry the child to term, she acquires obligations to ensure its well-being. These obligations may require her to avoid work, recreation and medical care choices that are hazardous to the fetus. They also obligate her to preserve her health for the fetus' sake or even allow established therapies to be performed on an affected fetus. Finally, they require that she undergo prenatal screening where there is reason to believe that this screening may identify congenital defects correctable with available therapies.[147]

It is thus argued that the recognition of such a right could be used as a basis for compelling pregnant women to accept recommended medical treatment to enhance fetal health. It has also been argued that pregnant women should be held to account by the operation of civil or criminal law for injury caused prenatally, or more drastically, for the birth of genetically impaired children. I will deal with each of these in turn.

Medical Intervention During Pregnancy

Fetal rights have garnered limited judicial support in Canada and the United States.[148] Overall, however, it seems clear in England,[149] Canada[150] and the United States[151] that

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[146] E. W. Keyserlingk, "The Unborn Child's Right to Prenatal Care (Part I)" (1982) 3 Health Law in Canada 10 at 18.

[147] J. Robertson, "Procreative Liberty and the Control of Conception, Pregnancy and Childbirth" (1983) 69 Virginia Law Review 405 at 450.

[148] There are some instances of judicial support for the right to be born healthy. In the Ontario case of *Re Brown* (1975) 9 OR (2d) 185 (Co.Ct), Justice Stortini "unhesitatingly" adopted the view that: "every child should have certain basic rights such as: the right to be wanted, the right to be born healthy, the right to live in a healthy environment, the right to such basic needs as food, housing and education and the right to continuous loving care" (at 192). However, this case concerned the adequacy of parenting provided for

the fetus does not have legal personality and, therefore, is not accorded the same rights as born individuals. Having said this, legally sanctioned interventions in pregnancy have been contended for on the basis of the state's interest in potential life.[152] Indeed, it is not always clear in the academic literature whether the basis for engaging in such an exercise is a competing fetal right or a competing state interest in potential life, or both.[153] It has been argued in the context of recommended caesarean

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already born children and so, did not touch on how this might translate into legal obligations for women whilst pregnant. In the United States case of *Jefferson v Griffin Spalding County Hospital Authority* 274 S.E.2d 457 (1981) two members of the Supreme Court of Georgia used rights language in their decision. There the Court held that a woman who had been diagnosed with complete placenta praevia could be ordered to submit to caesarean section. According to the evidence, her condition posed a 50% risk of her own death and 99% risk of death to the fetus in the absence of surgical intervention. Justices Hill and Marshall apparently decided the case on the basis of a balancing of competing rights: "we weighed the right of the mother to practice her religion and to refuse surgery on herself, against her unborn child's right to live. We found in favour of her child's right to live" (ibid at 460). Justice Smith, however, relying on *Raleigh Fitkin-Paul Memorial Hospital v Anderson* 201 A 2d 537 (1964), ordered the caesarean section on the basis of the state's compelling interest in preserving the life of the fetus (ibid at 461.) In a case concerning prenatal drug abuse, *In re Fathima Ashanti K J.* 558 NYS 2d 447 (1990), the Court stated that: "the unborn child possess[es] a right to gestation undisturbed by wrongful injury and the right to be born with a sound body and body free from parentally inflicted abuse and neglect" (ibid at 449).

[149] *Paton v British Pregnancy Advisory Service Trustees* [1977] QB 276; *C v S* [1980] QB 135.

[150] The Canadian Supreme Court has also declined to attribute personhood to the fetus based on biological or metaphysical arguments, holding that "[a]scribing personhood to a fetus in law is a fundamentally normative task." *Tremblay v Daigle* (1989) 62 DLR (4th) 634 (S.C.C.) at 650. In *R v Morgentaler* [1988] 1 S.C.R 30, the Canadian Supreme Court acknowledged that the State could assert an interest in potential life, although the statutory regime proscribing abortion under consideration was held by a majority to violate section 7 of the *Canadian Charter of Rights and Freedoms.*

[151] *Roe v Wade* 410 US 113 (1972). The Supreme Court declined to give the fetus full legal personality stating that, "the word "person" as used in the Fourteenth Amendment, does not include the unborn" (at 158). The Court did, however, find that the state's interest in the protection of fetal life became "compelling" at viability. After this point, the state can legitimately proscribe abortion except where the health or life of the mother is at stake (ibid at 164-165).

[152] See Christian Witting who states that: "the question for the courts, or more appropriately, the legislature, is whether advances in obstetrics should now be reflected by recognition of legal personality in unborn children. It seems far easier to recognise the unborn as warranting protection than to ascribe them actual legal rights which have the potential to conflict with those of the woman." He goes on to say, however, that "it may be difficult to deny that the unborn have interests which the law should protect, especially where there is seemingly no justification for refusals of consent to medical treatment" C. Witting, "Forced Operations on Pregnant Women: In re S Examined" (1994) 2 Tort Law Journal 193 at 204.

[153] See for example, J. Lenow, "The Fetus as patient: Emerging Rights as a Person?" (1983) 9 American Journal of Law and Medicine 1; Note, "The Fetal Patient and the Unwilling Mother: A Standard for Judicial Intervention" (1983) 14 Pacific Law Journal 1065, W.A. Bowes & B. Selgestad "Fetal Versus Maternal Rights: Medical and Legal Perspectives" (1981) 58 Obstetrics and Gynecology 209; which, in

sections, that the state has two main interests that may justify intervention during pregnancy to protect the fetus. These are the state's interest in protecting potential life, and its interest in preventing children being born with abnormalities.[154] Judicial recognition of these interests, and how they might be weighed in the balance against the rights of the pregnant woman against unwanted bodily interferences, most closely resembles the approach taken by some courts in the United States. Interpreting *Roe v Wade*[155] as authority for the proposition that the state's interest in protecting fetal life becomes 'compelling' at the point of viability, a number of courts have overridden maternal treatment refusals and ordered caesarean sections to be performed.[156] The

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addition to arguing for distinct fetal rights, also outline the state's interests in protecting fetal life. Michael Flannery, who discusses the issue of fetal rights in the context of gestational substance abuse, also relies on fetal rights and state interests in protecting the health of potential life, supra note 145.

[154] Witting, supra note 152 at 198.

[155] 410 US 113 (1972). The legal reasoning adopted in *Roe v Wade* embraces the scientific conceptualization of mother and fetus as separate by asserting legitimate State interests in each (although these interests become compelling at different times). The United States Supreme Court held that the State has legitimate interests in both preserving the mother's health and life and in protecting the potentiality of human life. The explicit construction of these interests as separate and distinct, made it necessary to devise a framework within which these "distinct" interests could be rationalized in the event that they came into conflict with one another. The Supreme Court did not have to look far for such a framework. The trimester system provided a rational and objective basis for dissecting the pregnant woman's experience into categorical zones of State restraint or regulation. By synchronizing the State's legal interests in regulating pregnancy with scientific explanations, the Supreme Court discovered a compelling amalgam of both "logical and biological justifications" for its conclusions:

> With respect to the State's important and legitimate interest in the health of the mother, the "compelling" point, in light of present medical knowledge, is at approximately the end of the first trimester . . . It follows that, from and after this point, a State may regulate the abortion procedure to the extent that the regulation reasonably relates to the preservation and protection of maternal health. . . This means, on the other hand, that, for the period of pregnancy prior to this "compelling" point, the attending physician, in consultation with his patient, is free to determine, without regulation by the State, that, in his medical judgement, the patient's pregnancy should be terminated. . . With respect to the State's important legitimate interest in potential life, the "compelling" point is at viability. This is so because the fetus then presumably has the capability of meaningful life outside the mother's womb. State regulation of fetal life after viability thus has both logical and biological justifications. If the State is interested in protecting fetal life, it may go so far as to proscribe abortion during that period, except when it is necessary to preserve the life or health of the mother (ibid at 162-64).

[156] See *Raleigh Finkin-Paul Memorial Hospital v Anderson* 201 A 2d 537 (1964) where the Supreme Court of New Jersey ordered that the treatment refusal of a Jehovah's witness could be overridden to save the lives of both the pregnant woman and her fetus. This case did not rely on *Roe v Wade*, but did nonetheless conclude that "[W]e are satisfied that the unborn child is entitled to the law's protection . . . The more difficult question is whether an adult may be compelled to submit to such medical procedures when

most recent decisions in the United States indicate an aversion to overriding treatment refusals, although the framework of balancing interests has not been unequivocally rejected.[157]

Child protection measures have been invoked in some Canadian provinces in an attempt to ensure that fetuses acquire proper prenatal care and, in one case, a caesarean delivery.[158] Subsequently, however, Canadian courts have rejected the

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necessary to save his life. Here we think it is unnecessary to decide that question in broad terms because the welfare of the child and the mother are so intertwined and inseparable that it would be impracticable to distinguish between them with respect to sundry factual patterns which may develop. The blood transfusions (including transfusions made necessary by the delivery) may be administered if necessary to save her life or the life of her child, as the physician in charge at the time may determine" (ibid at 538-39); *In the Matter of the Application of Jamaica Hospital* 491 N Y S 2d 898 (1985) where the court held that although it had no power to interfere with a patient's right to refuse treatment in pursuance of their religious beliefs, this was restricted to circumstances where the patient's life was the only life involved. In the case of a pregnant woman, the state's interest in protecting the life of an unborn child was sufficient to override the women's interest in the exercise of her religious beliefs. In this, the Court relied on *Roe v Wade* as authority for the proposition that the state's interest in protecting the life of the fetus became compelling at viability. Although the fetus in this case was 18 weeks old, and therefore, not yet viable, the Court still held that "the state has a highly significant interest in protecting the life of a mid-term fetus, which outweighs the patient's right to refuse a blood transfusion on religious grounds" (ibid at 900); *In re Madyun* (Appended to *In re AC*) 573 A 2d 1259 (1990) where the Court ordered a Muslim woman in protracted labour to undergo a caesarean section in order to avert the risk of infection to her fetus on the basis that the state had a compelling interest in the fetus after viability. But more recent authorities indicate a change in this trend.

[157] In *Re AC* 573 A 2d 1235 (1990), a case concerning a court-ordered caesarean section on a dying woman in the 26th week of pregnancy, the District of Columbia Court of Appeals held that the trial court had erred in balancing AC's rights against the state's interest in protecting potential life. The Court considered that the decision of the pregnant woman if competent, or the decision reached by substituted judgement if not competent, should prevail in "virtually all cases" (ibid at 1249). It stated that "[W]e do not quite foreclose the possibility that a conflicting state interest may be so compelling that the patient's wishes must yield, but we anticipate that such cases will be exceptionally rare and truly exceptional. . . [W]e need not decide whether, or in what circumstances, the state's interests can ever prevail over the interests of a pregnant patient. We emphasize, nevertheless, that it would be an extraordinary case indeed in which a court might ever be justified in overriding the patient's wishes and authorizing a major surgical procedure such as a caesarean section" (ibid at 1252). The Court did not, however, specifically approve or disapprove of the holding in *In re Madyun*. Finally, the Appellate Court of Illinois declined to override the woman's refusal, for religious reasons, to undergo a recommended caesarean section holding that "a woman's competent choice in refusing medical treatment as invasive as a caesarean section during her pregnancy must be honored, even in circumstances where the choice may be harmful to her fetus." *In re Baby Doe* 632 NE 2d 326 (1994).

[158] See *Re Children's Aid Society of City of Belleville and T* (1987) 59 OR (2d) 204 (Prov.Ct.) where the Court held that the fetus was in need of protection and made it a ward of the court for three months. In *Re R* (1987) 9 RFL (3d) 415 (Prov.Ct), Davis Prov. J found that the Superintendent of Family and Child Services had power under the *Family and Child Service Act* S.B.C. 1980, c.11 to effect the pre-birth apprehension of a

applicability of child welfare legislation to fetuses in the absence of express statutory intention.[159] Express statutory provisions regarding fetuses do exist in the Family Services legislation of New Brunswick and Yukon Territory. New Brunswick's *Child and Family Services and Family Relations Act*,[160] defines child to include unborn child. Accordingly, an unborn child can be the subject of a supervisory order in circumstances where neglect is shown, and this power has been exercised.[161] Section 134(1) of the Yukon Territory's *Children's Act*,[162] enables the Director of Children to apply to the court for an order to require a pregnant woman to receive counselling or supervision in respect of alcohol use if the fetus is at serious risk of suffering fetal alcohol syndrome.[163]

A Negligent Pregnancy?

John Robertson indicates that prenatal screening is a maternal obligation in cases where there is reason to believe that the fetus may be at risk. He is not, however, explicit about the responsibilities of women following a positive diagnosis. In fleshing out her general position on the maternal obligations that arise as a result of the "right" to be born healthy, Margery Shaw argues that:

> Once a pregnant women has abandoned her right to abort and has decided to carry her fetus to term, she incurs a 'conditional prospective liability' for negligent acts toward her

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fetus in the process of being born and for the purposes of ensuring a surgical delivery. This decision was overturned on appeal. See infa, note 159.

[159] See *Re Baby R* (1988) 15 RFL (3d) 225 (S.C.) reversing *Re R* (1987) 9 RFL (3d) 415, *Re A (in utero)* 1990 28 RFL (3d) 288 (Fam.Ct) and most recently *Winnipeg Child And Family Services v. G* (1996) 138 DLR (4th) 254 (C.A.) (appeal to Supreme Court of Canada heard on 18 June 1997, decision reserved) reversing *Winnipeg Child & Family Services v G* (1996) 138 DLR 238 (Q.B).

[160] SNB. 1980 c. C-2.1

[161] *Nouveau-Brunswick (Ministre de la Santé et des Services communautaires) v A.D.* (1990) 109 NBR (2d) 192 (QB).

[162] R.S.Y.T 1986, c.22

[163] See *Joe v Yukon Territories Director of Family and Children's Services* (1986), 5 B.C.L.R. (2d) 267 (Y.T.S.C.). This was an appeal from an earlier order granted pursuant to s134. Although the point was moot, since the woman had complied with the order and given birth to her child, the Court questioned the constitutionality of the section. It held that the section clearly infringed the woman's right to life, liberty and security of the person guaranteed by section 7 of the *Canadian Charter of Rights and Freedoms*, but declined to decide whether it could be saved by section 1 of the Charter since the point was not raised at trial.

> fetus if it should be born alive. These acts could be considered negligent fetal abuse resulting in an injured child. A decision to carry a genetically defective fetus to term would be an example. . . . Withholding of necessary prenatal care, improper nutrition, exposure to mutagens and teratogens, or even exposure to the mother's defective uterine environment caused by her genotype . . . could all result in an injured infant who might claim that his right to be born physically and mentally sound had been invaded".[164]

According to this position, therefore, a woman who chooses to continue with a pregnancy after the in utero diagnosis of a disease should be liable in negligence. Were this to be accepted, both Sheila and Mandy Allwood may, by analogy, be liable should their children be born disabled. English courts have so far refused to recognise any right to be born healthy and sound in the context of granting a genetically impaired child a cause of action against a doctor who failed to diagnose its condition in utero. In the words of Stephenson LJ:

> I am therefore compelled to hold that neither defendant was under any duty to the child to give the child's mother an opportunity to terminate the child's life. That duty may be owed to the mother, but it cannot be owed to the child. To impose such a duty towards the child would, in my opinion, make a further inroad on the sanctity of human life which would be contrary to public policy. It would mean regarding the life of a handicapped child as not only less valuable than the life of a normal child, but so much less valuable that it was not worth preserving. . . These are the consequences of the necessary basic assumption that a child has a right to be born whole or not at all . . . ."[165]

Ruth Hubbard's concern is that the focus on prenatal testing is likely to lead to the assumption that disability can be prevented, the corollary being that if a child is born disabled then the parents must be at fault in some way:

> . . as long as childbearing is privatized as women's individual responsibility and as long as bearing a disabled child is viewed as personal failure for which parents (and especially mothers) feel shame and guilt, pregnant women are virtually forced to hail medical advances that promise to lessen the social and financial burden of bearing a disabled

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[164] M. Shaw, "The Potential Plaintiff: Preconception and Prenatal Torts" in A. Milunsky & G. Annas, eds. *Genetics and the Law II* (New York: Plenum, 1980) 225 at 228.

[165] *McKay v Essex Health Authority* [1982] 2 WLR 890.

> child. . . The very availability of the new techniques. . . increases women's isolation by playing on our sense of individual responsibility to produce healthy children. [166]

It seems that there is already significant pressure to "choose" abortion in circumstances where children may be born with severe disabilities. Ruth Macklin considers that "it is hard to imagine that most people will choose to burden themselves and society with defective children when other options are open to them."[167] Fletcher & Evans report that whilst "the statistical incidence of positive findings after prenatal diagnosis does not exceed 4% of all cases. . . most couples in this situation choose abortion."[168] Robyn Rowland refers to a survey of consultant obstetricians in England which indicated that 75% of physicians insisted that women agree to abort an abnormal fetus before amniocentesis would be carried out.[169]

This challenges us to consider the context within which choices are made. Leslie Hershey questions the assumptions that may inform the decision to terminate a previously wanted pregnancy after prenatal diagnosis. These include: children with disabilities are burdensome, the lives of disabled people are "scarcely worth living", it is an act of kindness to prevent the birth of a disabled child and women who produce and mother disabled children are failures. She also argues that the language of prenatal diagnosis reinforces this negative stereotyping. "Terms like "fetal deformity" and "defective fetus" are deeply stigmatising, carrying connotations of inadequacy and shame."[170]

A significant obstacle to the recognition of a "right" to be born healthy, then, is that this presupposes some shared understanding of what we mean when we use the terms "a good life" and "disability". Is a "good life" to be measured in terms of

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[166] R. Hubbard, "Personal Courage Is Not Enough" in R. Arditti, R. Klein & S. Minden eds. *Test-Tube Women, What Future for Motherhood?* (London: Pandora, 1984) 331 at 350.

[167] R. Macklin "Moral Issues in Human Genetics: Counseling or Control?" in R. Munson. ed. *Intervention and Reflection: Basic Issues in Medical Ethics* (California: Wadsworth, 1992) 444 at 445.

[168] J. Fletcher and M. Evans "Ethics in Reproductive Genetics" (1992) 35 Clinical Obstetrics and Gynecology 763 at 769.

[169] R. Rowland, *Living Laboratories: Woman and Reproductive Technologies* (Sydney: Pan McMillan,1992) at 116.

[170] L. Hershey, "Choosing Disability: Many Women Assume They Should Abort a Disabled Fetus. Why?" (1994) V(1) Ms Magazine 26.

productivity, social worthiness, the capacity to love and be loved? Perhaps more importantly, who will determine the relevant standard to be adopted? Similarly, it is unlikely there is any clear universal standard for drawing the line between disabilities which will result in "a considerably worse than average life" and those which will not. This is largely because the concept of disability has both factual and normative dimensions. Whilst for many, it might be clear that Tay-Sachs disease inflicts much physical pain and suffering and, on principle, avoidance of this harm should override interests in procreation or being born, a disability such as congenital blindness is not comparable. Put simply, even though there may be general agreement about the degree of suffering associated with certain genetic diseases, there is clearly a "grey" area where consensus about where to draw the line is unlikely to be reached.

These questions are not confronted in analyses like Ruth Macklin's who argue that the critics of genetic screening have nothing to fear from eugenic slippery slopes because parents are in control of the decision making process. Accordingly, there is no question of state coercion in the decisions of parents to continue or terminate pregnancies. Ruth Hubbard is cautious about this claim. In the context of societies that devalue and discriminate against disabled people, she argues, eugenic legislation is not necessary. "Physicians and scientists need merely provide techniques that make individual women responsible for implementing society's prejudices, so to speak, by choice.[171] The point of her critique is to draw attention to the fact that reproductive "choices" occur within particular contexts that may have the effect of limiting rather than expanding real choice. This concern is accentuated in Mandy Allwood's story where we see her condemned for continuing with a high risk pregnancy. Implicit in this condemnation is her responsibility to the fetuses and her failure to discharge her maternal responsibilities.

HIV and Motherhood

The interplay between screening policies and reproductive choice is particularly apposite in the case of women with HIV. The risk of HIV transmission to the fetus

[171] R. Hubbard, "Legal and Policy Implications of Recent Advances In Prenatal Diagnosis and Fetal Therapy" (1982) 7 Women's Rights Law Reporter 208 at 232.

during pregnancy[172] and the benefits of prophylactic treatments for infants have fuelled intense debate about prenatal testing for pregnant women and mandatory HIV testing of newborns in the discourses of law,[173] public health[174] and popular culture.[175]

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[172] Vertical or perinatal (mother-to-child) transmission of HIV accounts for almost 80% of pediatric HIV infection. Studies prior to 1995 conducted in North America and Europe documented transmission rates between 15 and 30%. Some studies have described an additional 14% risk of transmission in breastfed children. Transmission rates are thought to be affected by maternal characteristics such as advanced maternal HIV disease (indicated by increased viral burden, higher viral titres, altered immune status, particularly low CD4 count or clinical AIDS) and seroconversion during pregnancy; G. Oxtoby "Vertically Acquired HIV Infection in the United States" in P. A. Pizzo & C. M. Wilfert, eds., *Pediatric AIDS: The Challenge of HIV Infection in Infants, Children and Adolescents*, 2nd ed. (Baltimore: Williams & Wilkins, 1994) at 10-12. The diagnosis of HIV infection in newborns is difficult because maternal antibodies will have been acquired transplacentally. This means that a positive test in a newborn baby does not definitively establish HIV infection in the child, but may simply indicate the presence of maternal antibodies to the virus. Studies suggest that a HIV positive result in a child 15 months or older is more likely to reflect the child's rather than the mother's antibody status (ibid).

[173] See S. Sangree, "Control of Childbearing by HIV-Positive Women: Some Responses to Emerging Legal Policies" (1993) 41 Buffalo Law Review 309; J. Weiss "Controlling HIV-Positive Women's Procreative Destiny (1992) 2 Constitutional Law Journal 643; K. Boockvar, "Beyond Survival: The Procreative Rights of Women with HIV" (1994) 14 Boston College Third World Journal 1; S. Isaacman "Are We Outlawing Motherhood for HIV-Infected Women?" (1991) 22 Loyola University Law Journal 479; A. Zarembka & K. Franke, "Woman in the AIDS Epidemic: A Portrait of Unmet Needs" (1990) 9 Saint Louis University Public Law Review 519; "Prenatal/Newborn HIV Testing—A Report by the Association of the Bar of the City of New York" (Paper included in Conference materials for session "Pregnancy, Privacy, and Proposed Mandatory HIV Testing: Whose Right Is It, Anyway?", 7 August 1995, American Bar Association Annual Conference 1995) [unpublished].

[174] The following is a selective list of medico-scientific, ethical and public health sources on testing pregnant women: S. Kuvin, "Mandatory Testing Of All Pregnant Women" (Paper presented in "Pregnancy, Privacy, and Proposed Mandatory HIV Testing: Whose Right Is It, Anyway?", 7 August 1995, American Bar Association Annual Conference 1995) [unpublished]; D. Mercey, "Antenatal HIV Testing: The Case For Universal Voluntary Named Testing" (1993) 5 AIDS Care 131; Working Group on HIV Testing of Pregnant Women and Children, "HIV Infection, Pregnant Women, and Newborns: A Policy Proposal for Information and Testing" (1990) 264 J.A.M.A. 2416; B. Steinbeck & R. McClamrock, "When is Birth Unfair to the Child?" (1994) Hastings Centre Report 15; J. Meadows, J. Catalan, L. Sherr, Y. Stone, and B. Gazzard, "Testing for HIV in the Antenatal Clinic: The Views of Midwives" (1992) 4 AIDS Care 157; C. Davidson, F. Holland, M. Newell, C. Hudson & C. Peckham "Screening for HIV Infection in Pregnancy" (1993) 5 AIDS Care 135; I. Chrystie, L. Zander, A.Tilzey, A. Wolfe, A. Kenney & J. Banatvala "Is HIV testing in Antenatal Clinics Worthwhile? Can We Afford It? (1995) 7 AIDS Care 135;V. Bhushan & L. Cushman, "Paediatric AIDS: Selected Attitudes and Behaviours of Paediatricians in New York City Hospitals" (1995) 5 AIDS Care 27; G. Macquart-Moulin, D. Harmon, P. Auquier & C. Manuel, "Vertical Transmission of HIV—A Rediscussion of Testing" (1995) 7 AIDS Care 657; and importantly, Pediatric AIDS Clinical Trials Group Protocol 076 Study Group, "Reduction of Maternal-Infant Transmission of Human Immunodeficiency Virus Type 1 with Zidovudine Treatment" (1994) 331 The New England Journal of Medicine 1173 [*hereinafter 076 Protocol*]; R. Bayer "Ethical Challenges Posed By Zidovudine Treatment to Reduce Vertical Transmission of HIV" (1994) 331 The New England Journal of Medicine

These discourses raise similar issues to those raised by discussions about genetic screening. They also, either expressly or impliedly, raise questions about whether HIV positive women should become pregnant, whether they should remain pregnant and, if so, how their pregnancies should be managed.

The recognition of paediatric AIDS has had the effect of increasing the focus on women with HIV.[176] Lorraine Sherr suggests that "despite the fact that childbirth is only one of a number of life roles for women, it may well be that long-awaited attention is now being focused on women not so much in their own right, but more as the mothers of potentially infected infants".[177] This focus on pregnant women has intensified as a result of the findings of a US study in 1994.[178] Protocol 076, as it is referred to in the literature, found that the administration of zidovudine (AZT) to mildly symptomatic HIV positive pregnant women during pregnancy and birthing, and to the newborn for six weeks after birth, reduced the risk of transmission to the fetus by approximately two thirds (from 25.5% to 8.3%).[179]

The long-term side effects of AZT on the pregnant woman or the infant are not yet known.[180] It is known that an asymptomatic HIV positive woman who takes AZT

1223; M. Rogers & H. Jaffe, "Reducing the Risk of Maternal-Infant Transmission of HIV: A Door is Opened" (1994) 331 The New England Journal of Medicine 1222.

[175] A sampling includes: J. Seigel, "US Expert: All Pregnant Women Should Have AIDS Tests" *The Jerusalem Post* (22 June 1994) 1; J. Seigel-Itzkovich "Expert, Test Pregnant Women for HIV" *The Jerusalem Post* (16 July 1995); Commentary, "Prenatal AIDS Test Will Help Save Lives" *Chicago Sun-Times* (9 July 1995) 37; J. Schwartz, "AIDS Testing Urged in All Pregnancies: Drug 'Breakthrough' Prompted Policy Shift" *Washington Post* (7 July 1995) 1; E. Goodman, "Nurturing a New View on Prenatal AIDS Testing" *Boston Sunday Globe* (16 July 1995) 1.

[176] L. Sherr, "Pregnancy and Paediatrics" (1990) 2 AIDS Care 403.

[177] Ibid. She notes that of the papers in the category of "pregnancy and paediatrics" at the International AIDS Conference in 1990, 308 papers were on children compared to 83 papers on women.

[178] *076 Protocol*, supra note 174.

[179] The zidovudine regimen used in the Protocol seems fairly rigorous and the intake of the drug considerable. The pregnant women were required to take 100mg orally five times a day until the onset of labour; 2 mg per kilogram (2mg/kg) of body weight administered intravenously over a one hour period then 1 mg/kg per hour until birth. The newborn child received 2mg/kg orally every 6 hours for 6 weeks; Ibid at 1173.

[180] This has caused Ronald Bayer to query: "Many questions remain unanswered. Most critically, will the administration of zidovudine to pregnant women and their newborns pose a risk to the 70 to 80 percent of children who, though born to infected women , would not themselves have been infected?" Bayer supra

during pregnancy will probably not receive any benefit from the AZT, apart from the increased chance of reducing the risk of transmission to her fetus. Of course, a number of women might be desirous of using the drug for that purpose alone. In the longer term, the risk that early use of AZT might reduce its effectiveness in prolonging the mother's life when she does require it, has not yet been ascertained.[181] A number of women might also consider that to be a relevant consideration in making a choice about using AZT during pregnancy.

The U.S. Public Health Service responded to Protocol 076 by publishing recommendations for HIV counselling and testing for pregnant women ("CDC guidelines"). Despite mounting pressure to institute mandatory testing, the recommendations do not support mandatory testing for pregnant women.[182] Rather, they recommend that all pregnant women be counselled about the modes of HIV transmission, the risk of HIV transmission to the fetus, and the treatments available to reduce the risk of transmission to the fetus.[183] It is further recommended that, after such counselling, all pregnant women[184] be encouraged to test for HIV on a voluntary

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note 174 at 1224; and for a good short summary of the concerns about the findings of Protocol 076, see W. Senterfitt, "Women Under Attack: It's Time For Action Now" (1995) March, Being Alive, 4.

[181] Ronald Bayer asks "Is there some risk that the use of zidovudine during pregnancy will diminish the effectiveness of the drug when the women's own clinical course would suggest the advisability of antiretroviral treatment?" [citing "Zidovudine for Mother, Fetus and Child: Hope or Poison?" (1994) 344 Lancet 207-209] supra note 174 at 1224.

[182] Mandatory testing would mean that women could be tested for HIV without their consent.

[183] "HIV counseling and testing for women of child bearing age offer important prevention opportunities for both uninfected and infected women and their infants. HIV counseling is intended to a) assist women in assessing their current or future risk of HIV infection; b) initiate or reinforce HIV risk reduction behavior; and c) allow for referral to other HIV prevention services (eg, treatment for substance abuse and other sexually transmitted diseases) when appropriate. For infected women, knowledge of their infection status provides opportunities to a) obtain early diagnosis and treatment for themselves and their infants, b) make informed reproductive decisions, and c) use methods to reduce the risk for perinatal transmission , d) receive information to prevent transmission to others, and e) obtain referral for psychological and social services needed." "US Public Health Service Recommendations for Human Immunodeficiency Virus Counseling and Voluntary Testing for Pregnant Women" (1995) 44 Mortality and Morbidity Weekly Report RR-7, 1 at 3.

[184] As opposed women from high-risk groups. In the United States "Blacks and Hispanics have been disproportionately affected by the HIV epidemic. In 1993, HIV infection was the leading cause of death among black women 25-44 years of age and the third leading cause of death among Hispanic women in this age group. In 1991, HIV infection was second leading cause of death among black children 1-4 years of

basis. Women who test positive and who continue with their pregnancies should then be invited to take AZT to reduce the risk of transmission to the fetus.[185] Although the CDC guidelines are carefully couched in terms that appear to respect the decision-making capacities of pregnant women, some concerns have been raised about the CDC guidelines. Walt Senterfitt claims that mandatory counselling is "the first step on a slippery slope of coercion."[186]

Containment of HIV+ Pregnant Women

The question that immediately presents itself after the testing has been done, is how this knowledge will be used. Will it be used to coerce women into satisfying medical or social imperatives in the management or termination of their pregnancies? Will it be used to punish women who do not act in accordance with socially or medically approved behavior? These are large questions, and I do not propose to provide a detailed exposition of the various policy debates and law reform proposals that have surfaced in response to the perceived problem of HIV in pregnancy. In this section I will simply sketch some of the discussions as they relate to the availability of choice in medical decision-making for HIV pregnant women. These are relevant to the reporting of Sheila's case because they give a sense for how medical knowledge can create normative expectations about how HIV positive women should behave.

According to the CDC guidelines, the pregnant woman with HIV may eliminate the risk of fetal infection by terminating the pregnancy, or she may reduce the risk by delivering by caesarean section, taking AZT throughout pregnancy and by refraining from breastfeeding. In the context of a lengthy history of coercive intervention into women's reproductive decision-making,[187] each of these options raise concerns about

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age in New Jersey, Massachusetts, New York, and Florida and among Hispanic children in this age group in New York (CDC unpublished data)" ibid at 2-3.

[185] "The PHS recommendations for ZDV [AZT] therapy emphasise that HIV infected women should be informed of both benefits and potential risks when making decisions to receive such therapy. Discussions of treatment options should be non-coercive—the final decision to accept of reject ZDV therapy is the responsibility of the woman." Ibid at 4.

[186] Senterfitt, supra note 180 at 5.

[187] Sangree, supra note 173 at 335, and Bayer, supra note 174 at 1224.

coercion or punishment (either criminal or civil) of HIV positive women for failing to conform to any of the recommended treatments for the benefit of the fetus. [188]

A number of academic legal commentators have discussed the potential application of criminal HIV transmission statutes and the extension of child abuse/neglect statutes to perinatal exposure to, or transmission of, HIV.[189] These would have the effect of punishing women who continue with pregnancies knowing their HIV status. Elisabeth Van Viliet, in the context of the Canadian case *R v Summer*,[190] speculates that:

> Once the baby has been born alive and HIV positive. . .the woman could be charged for acts that occurred during her pregnancy. Such indictment would be especially likely in the case where the indicted behavior is the refusal either of a caesarean section or the administration of AZT. . [191]

There are, as yet, no laws that specifically aim to punish HIV positive women for continuing with their pregnancies in Canada. However, the extension of drug supply statutes to pregnant women and their newly born children in the United States, has caused some writers to express concern about ambiguities in the HIV criminal transmission statutes.[192] If extended to cover perinatal HIV transmission, they would clearly have the effect of dissuading HIV positive pregnant women from continuing with their pregnancies or, alternatively, constraining their choices in relation to treatment to reduce transmission. It is worth noting, however, that the absence of such enacted laws does not necessarily preclude these outcomes. The manner in which HIV positive mothers or potential mothers are discussed by policy makers and treated by health professionals and the general community may achieve similar results. Both Susan Sangree and Jennifer Terry provide reports of HIV positive women being

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[188] Sangree, ibid at 342-343; and J. Terry, supra note 140 at 29.

[189] See generally, Isaacman, Sangree, & Boockvar, supra note 173.

[190] (1989) 69 Alberta Law Reports (2d) 303 (C.A.) which held that knowingly exposing a person to the risk of contracting AIDS was punishable by a substantial period of imprisonment.

[191] E. Van Viliet, "Law, Medicine, HIV and Women: Constructions of Guilt and Innocence" (1993) 1 Health Law Journal 191 at 202.

[192] Elisabeth Van Viliet does this in the Canadian context (ibid), and Isaacman, Sangree, & Boockvar, discuss these issues in the United States context, see supra note 173.

coerced in prenatal clinics into terminations or, in some cases, sterilizations. Jennifer Terry, for example, reports the story of a pregnant Latino woman seeking gynaecological care at a health clinic in Arizona. First, she was tested for HIV without her consent. Second, when her test returned positive, the clinic gave her two options—she could have an abortion at her own expense, or she could agree to a sterilization which would be paid for by the state.[193]

In the arena of public health policy, Sanford Kuvin, Vice Chairperson of the United States National Foundation for Infectious Diseases (US), urges that:

> If mothers know their HIV status, not only could many of these infections in their newborns be avoided, but these same women could receive medical care for themselves and reduce the risk of transmission of the virus to their future sexual partner or partners . . . the critical beginning point and the reason for focusing on the pregnant woman is that there is so much that we can do to protect the unborn child . . . Medical logic . . appears not to have been taught or implemented in strategies for dealing with HIV in regard to preventing thousands of children from dying needlessly of AIDS by the simple public health measure of mandatory HIV testing for all pregnant women.[194]

It is important to look behind the rhetoric and question the claim that the "simple public health measure of mandatory testing for all pregnant women" can reduce perinatal transmission. It is that which comes after the positive test result that may or may not reduce transmission. The focus on mandatory screening of pregnant women for HIV, it seems, is not simply about providing women with information about their HIV status. There seems to be an expectation that the extraction of that information from their pregnant bodies will precipitate certain behavioural modifications—either abortion,[195] or failing that, medically indicated treatments for the benefit of the fetus.

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[193] J. Terry, supra note 140 at 29.

[194] Kuvin, supra note 174, at 6-7.

[195] Beardsell's discussion of HIV testing in the context of pregnant women includes references to eleven studies that defined HIV prevention in terms of seropositive pregnant women electing to abort. Beardsell notes that "this definition of prevention is somewhat value-laden and perhaps reflects the pressure on seropositive women to terminate in order not to infect the fetus, despite more recent evidence from the European Collaborative Study (1991) of a 13% perinatal transmission rate (in women who were mainly asymptomatic)." S. Beardsell, "Should wider HIV Testing be encouraged on the grounds of HIV prevention?" (1994) 6 AIDS Care 5 at 9.

The mounting empirical evidence which suggests that knowledge of HIV status does not significantly affect women's decisions about terminating their pregnancies,[196] may also signal an increasing emphasis on treatment decision-making.

II. Constructions of Doctor and Mother as Responsible Agents

At 27, Sheila was happily married to Alan. Together they had decided to start a family. When fertility problems later became evident, Sheila turned to the fertility treatment program at her local hospital for advice. There she was told that her fallopian tubes were blocked and that IVF treatment would be required to facilitate conception. But there was another problem. Routine screening had revealed that Sheila was HIV positive.[197] Sheila's resolve to have a child became newsworthy when Lord Robert Winston, the director of Britain's largest IVF clinic, agreed to admit her to the IVF program at Hammersmith hospital.[198]

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[196] In relation to a 1989 study on HIV status and termination, Dooley Worth writes that "Women's feelings about the value of pregnancy were explored by a Montefiore Medical Centre study among high-risk minority women in methadone treatment programs. Most of these women did not consider their HIV status crucial when considering whether to continue a pregnancy, but based their consideration on the desirability of having a child, depending on whether they saw pregnancy as a positive experience. The researchers found that, over a two year period, the seropositive and seronegative women made similar decisions about continuing their pregnancies, but the seropositives had a slightly higher rate of abortion—50 per cent versus 44 per cent among the seronegatives." D. Worth, "Sexual Decision-Making and AIDS: Why Condom Promotion Among Vulnerable Women is Likely to Fail" (1989) 20 Studies in Family Planning 297 at 303 (citing Selwyn et al, "Knowledge of HIV antibody status and decisions to continue of terminate pregnancy among intravenous drug-users" (1989) 261 JAMA 3567); See also Zarembka and Franke, supra note 173 at 524, and S. Beardsell supra note 195 at 5 who report that serostatus did not affect termination decisions in eleven studies analyzed. But see Y. Obadia, D. Rey, J-P. Moatt, C. Pradier, E. Couturier, Y. Brossard & J. Brunet, "HIV Screening in South-Eastern France: Differences in Seroprevalence and Screening Policies by Pregnancy Outcome" (1994) 6 AIDS Care 29 who found that seroprevalance rates were higher among women seeking terminations than women who continued with their pregnancies.

[197] R. Winston, "Fertility, AIDS and Prejudice - Opinion" *The Times* (14 May 1996) available in Lexis library TXTLNE. The "routine" testing for HIV in a prenatal clinic itself raises a plethora of questions: was Sheila told that the blood sample taken from her would be tested for HIV? Was she counseled as to the implications of the test prior to and after the result was known? Was her consent to the test free and informed?

[198] S. Quinn, "Fertility Treatment For HIV Woman Sparks Controversy" *The Guardian* (13 May 1996) 1.

Doctors as Procreative Agents

One remarkable aspect of the story was the doctor's decision to allow IVF in this case.[199] The effect, however, of focusing on the doctor's role in the story was to further alienate Sheila from her potential pregnancy.

In an article entitled "The Man Who Makes Babies", Professor Winston is credited with "feel[ing] passionately about human life, and as head of the fertility unit at the Hammersmith Hospital in London, has made it his purpose to *create* more of it" (my emphasis).[200] I do not deny that the treating doctor in an IVF case does play a significant role in facilitating conception, but the interesting aspect of Sheila's case is that the doctor's creative role is so enlarged that Sheila is not only obscured as an active participant, but the doctor is also attributed with responsibility for the pregnancy. This point is emphasised in the following passage where the correctness of Sheila receiving IVF treatment is debated in terms of what other doctors would have done in the circumstances:

> Doctors in the field, for example, disagree strongly about the wisdom of treating an HIV-infected woman and about the life chances of any child born to an HIV-infected mother. Last week I approached doctors at four centres and asked if they would have provided the treatment, as Lord Winston did. Three centres said that they would definitely not treat such a case, and staff at the fourth said only that they would have considered it. And none of the four had knowingly treated such a case in the past. Simon Fishel, scientific director of the Nottingham University Research and Treatment Unit in Reproduction, said: "We would turn down such a case. Given that there is a chance that the child might catch HIV, I could not be party to that child's demise. . . "[201]

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[199] The public protest over the decision to treat Sheila might be seen as a loss of faith in the ability of doctors to use this "power" responsibly. On this analysis, subsequent calls to broaden doctors accountability—by insisting that ethics committees be consulted or that the public interest be taken into account—were not so much a challenge to the practice itself, but rather an attempt to ensure that doctors will only make the "right" decision.

[200] *Ibid.*

[201] Ferriman, quoting Dr Fishel, "The Gift of Life" *The Independent on Sunday* (19 May 1996) 17.

The focus on the responsibility of doctors could be part of a broader phenomenon that Roxanne Mykitiuk describes as the scientific effort to appropriate procreation.[202] In this respect she claims that:

> If birthing can be mastered, the shame of relationality and dependence can be overcome. All is as it should be - man makes himself, reason vanquishes embodiment. Dissected, analyzed and replicated, woman-nature becomes a passive object, a bundle of inert fragments brought to life only through the intervention of reason.[203]

The effect of the various representations about providing IVF treatment is to construct the issue, in large measure, as the failure of a doctor to act according to the expectations of the profession or the community. The attack seems to be that reason did not prevail, and the doctor-scientist made an inadvisable decision in relation to the suitability of the raw material—namely Sheila. On this basis, the intended pregnancy can be seen as an overstepping of the procreative mark, hence the attribution of personal responsibility to the treating doctor:

> These doctors are architects of a bizarre society where, out of the patient's selfishness and the doctor's collusion, we create deliberately disadvantaged children. When this child's mother dies, the doctor should get the bill for the child's upbringing.[204]

The spectre of responsibility inevitably raises the question of accountability. This raises another interesting aspect of the story. Because the doctor is represented as the person responsible for the pregnancy, then it is the doctor who becomes the site at which additional controls are required to ensure that the socially sanctioned outcome is preserved in every case:

> Should a lone doctor have the right to decide who should get treatment and who should be denied it? And when he is considering his decision, should he follow his own conscience or should he try to reflect society's views as a whole? Should doctors be forced to take all contentious questions to their hospital ethics committee and be made

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[202] R. Mykituk, "Fragmenting The Body" (1994) 2 Australian Feminist Law Journal 63 at 89.

[203] Ibid at 88.

[204] Ferriman, quoting Dr Adrian Rogers, Director of the Conservative Family Institute, supra note 201.

> to abide by their decisions?. . . All we can hope is that doctors will share their decision-making more widely in the future - with colleagues, ethics committees and the public. With greater public debate, their decisions might appear less capricious.[315]

Significantly, it is not suggested that doctors should not decide who may become a mother, or, that doctors are not responsible for a pregnancy even when they do facilitate conception. Rather, a far more modest claim is being made. The claim is that doctors should be discouraged from exercising their procreative powers in ways that do not accord with reason. The suggestion is that this might be achieved by ensuring that doctors are made answerable to ethics committees.

The construction of the doctor as the procreative agent or architect has a number of implications. Most importantly, it diminishes the role, aspirations and participation of Sheila. This diminution of Sheila's agency is also underwritten by the repeated references to her being treated with AZT, undergoing caesarean section and refraining from breast-feeding.[316] We have no direct knowledge of how Sheila actually felt about these various invasions of her body. Perhaps it was assumed that she would, like a good mother, comply with these measures. Despite scientific conjecture about almost every other aspect of the story, there was complete silence on the question of how these procedures would affect Sheila. It is noteworthy that these treatments were cast in terms of Sheila "doing everything right". The implication seems to be that should Sheila decline to accept any or all of the treatments, she would be doing something "wrong". In this way the standard for good maternal behaviour in the circumstances is established by reference to disputed scientific fact, and without any reference to Sheila herself.

Bad Mothers Make Good Scapegoats

At the time her story broke, Mandy Allwood was a 31 year old British woman. She suffered from polycystic ovarian syndrome, a genetic condition that is associated with infertility, and on that basis had received fertility treatment under medical supervision.

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[315] Fernman, Ibid.

Following this treatment, she conceived eight fetuses. As a result, she was described as a "hormonal horror story, nature's nightmare, a pregnant catastrophe".[207] The catastrophic nature of her situation did not, however, stem from the fact that doctors prescribed her inappropriate doses of fertility drugs which facilitated her multiple pregnancy. The catastrophe was attributed to her decision to ignore doctors advice to abort some of the fetuses and to "let nature take its course".[208] Mandy could not reconcile herself to selectively terminating the fetuses she was carrying.

Although Mandy Allwood's multiple conception followed fertility treatment under medical supervision, the question of her doctor's responsibility was never raised. On the contrary, the multiple conception was cast as Mandy Allwood's responsibility. This was so because she either lied to her doctor about being infertile[209] or she wilfully disregarded her doctor's advice not to have unprotected intercourse when she was hyper-ovulating in response to fertility drugs. There is almost complete silence on the question of whether she hyper-ovulated because her doctor had overprescribed the drugs or kept her on the treatment for too long.[210] This is interesting because it dovetails with other indicia of her unsuitability to mother. The images of Mandy Allwood as a liar and manipulator distanced her from the ideal of the good mother. The circumstances surrounding her conceiving simultaneously explained and compounded the "irresponsibility" of her actions and confirmed her ultimate responsibility for the undesirable outcome:

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[206] See Quinn, supra note 198; Winston, supra note 197; M. Adler, "Ethics of Fertility Treatment for People with HIV" *The Times* (18 May 1996) available in Lexis library TXTLNE.; & Ferriman, supra note 201.

[207] M.Gibson, "Fertile Ground for Mistakes" *The Daily Telegraph* (14 August 1996) 10.

[208] B. Loudon, "I'll Keep All My 8 Babies - Pregnant Mum Defies Doctors" *The Daily Telegraph* (12 August 1996) 1, quoting Mandy Allwood: "I'm deliriously happy. I want nature to take its course."

[209] "The private clinic which treated Mandy Allwood yesterday admitted that the consultant who dealt with her could have been deceived. Gynaecologist Manjit Obhrai saw Ms Allwood at the Priory Hospital in Birmingham. Colleague, Robert Sawers, asked if Mr Obhrai might have been hoodwinked by her and her partner, Paul Hudson, replied: "Yes, absolutely. . .". E. Sprawson, "Gambling Her Babies' Lives Away" *The Daily Telegraph* (14 August 1996) 28.

[210] Professor Roger Pepperll of the Royal Women's Hospital and chair of the Department of Obstetrics and Gynaecology, University of Melbourne, stated that in his opinion: "They probably treated her for too long, given her too much of the hormone". . "It's not her fault, she should never have that many mature eggs and be allowed to ovulate." Quoted in B.McDougall "Baby Drama 'Could Not Happen Here'" *The Daily Telegraph* (13 August 1996) 4.

> For reasons best known to herself, Mandy got stuck into the fertility drugs. Then she suddenly stopped taking them, upon which she was warned by her doctor that if she had unprotected sex in the near future, she ran the distinct risk of a massive multiple pregnancy. So what does she do? Without taking the slightest precaution, without informing Mr Hudson [her partner] of the possible consequences, she leaps into bed with an out of work bankrupt who is living on welfare. To describe her actions as irresponsible is an absolute understatement.
>
> Now this wretched woman has turned into some sort of maternal monstrosity, the sort of baby making blunder that all those scientists who worked on fertility drugs must have dreaded. . . At their best, fertility programs have produced heart-warming results for couples who feared they would never have children, couples for whom having a baby was always a dream. . . Mandy Allwood isn't a mother. She's a mistake.[211]

The reasoning underpinning this construction of the relationship between Mandy Allwood and her doctor, and the attribution of responsibility here is simplistic. There is no wholesale rejection of reproductive technology but rather a careful demarcation between its successes and failures. This demarcation centres on the issue of control. When the scientist-doctor controls the technology and uses it for the benefit of "couples" which can "conceive a baby after having dreamt about doing so for a very long time", the technology is hailed a success. On the other hand, when single women who trick doctors into making them hyperovulate subsequently "leap into bed" with unemployed bankrupts, the technology is a failure.[212] The latter scenario differs essentially from the former in that the doctor is represented as lacking in control. This ties in with the issue of responsibility. Doctors cannot be responsible

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[211] Gibson, supra note 207.

[212] Isabel Karpin discusses the intersections between discourses on poverty and reproduction and argues that the focus on women as welfare "abusers" constructs poor women as unethical and massively productive. The contradiction is that impoverished women—whose autonomy may be critically undermined by extrinsic economic circumstances —are constructed as actively subversive through their reproductive capacities. I. Karpin, "Legislating the Female Body: Reproductive Technology and the Reconstructed Woman" (1991) 3 Columbia Journal of Gender and Law 325 at 339. This resonates in the case of Mandy Allwood at a number of levels. First, Mandy Allwood is presented as a woman who has consciously and deliberately duped doctors in order to procreate on a massive scale in order to secure financial gain (from selling the story rather than welfare). Secondly, the discourse contains constant references to Mandy and Paul's status as welfare recipients —implying that Mandy Allwood will be an unreasonable burden on the welfare system because she does not have the financial means to cover the costs associated with bearing and rearing the potential children.

for recalcitrant women who will not do as their told. Moreover, women who will not do as their doctors tell them are not good mothers.

The Vanishing Mother

The positive side of reproductive technology was hinted at in accompanying articles about the artificial gestation of fetuses.[213] These stories inform us that scientists are working on an artificial womb "which may enable women to have babies without carrying them through pregnancy".[214] One article explains that:

> The process involves suspending a fetus in a tank of artificial amniotic fluid and feeding oxygenated blood and nutrients through a tube into an artery where the umbilical cord normally would connect.[215]

The research team working on the venture had enjoyed recent success in bringing a goat fetus to term, and the hope was that within a few years, research would be sufficiently advanced to incubate human fetuses "that might otherwise die."[216] The next step would be to:

> extend the technique to ever younger foetuses and eventually embryos, realising the vision of artificial wombs described more than 60 years ago in Aldous Huxley's novel, Brave New World.[217]

These stories represent the fantastic culmination of what Isabel Karpin describes as the modern project to wrest control of the fetus from the woman by "removing it to a place of masculine scrutiny and control—the clinic, the laboratory, and if need be, the courtroom".[218] We can see certain parallels here also with the casting of Lord Winston as procreative agent for Sheila's pregnancy. The positioning of these stories

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[213] "Tanks Replace Wombs", *The Daily Telegraph* (afternoon edition) (12 August 1996) 5; and "Tank Tests To Replace Womb", *The Daily Telegraph* (12 August 1996) 4.

[214] "Tanks Replace Wombs" ibid.

[215] Ibid.

[216] "Scientists Hail Birth of Artificial Womb" *The Australian* (12 August 1996) 3.

[217] Ibid.

[218] Karpin, supra note 212 at 333.

in relation to Mandy Allwood's story is also significant. The complete control of pregnancy which artificial gestation portends is juxtaposed against the disasterous circumstances of Mandy Allwood.

III. The Maternal Body

Both stories focus on the bodies of Sheila and Mandy Allwood. Their particular fascination is the negative impact that each woman's body might have on the developing fetus(es). This information then forms the basis for condemning each woman's decision to pursue pregnancy. The narratives about Sheila concentrated, in large measure, on the chance that HIV might be transmitted through her body to the fetus. The threat of perinatal transmission, therefore, was a central objection to the decision to permit Sheila access to IVF. The narratives about Mandy Allwood also focused on her body, which was presented as incapable of producing eight healthy babies. The extreme improbability that Mandy Allwood would deliver eight healthy babies, therefore, was the trigger for the criticism of her refusal to terminate some of the fetuses. In both cases, scientific fact or medical opinion form the basis for assessments about the nature of each woman's body, and the likelihood of it producing a healthy child or children.

Intolerable Boundary Transgressions

The primary emphasis in the reporting of Sheila's story was the perinatal transmission rate. This statistic represents the likelihood that the HIV virus will be transferred to the fetus during its development in utero. The focus on the perinatal transmission rate created two effects. First, it differentiated Sheila's body as a disease carrier with the potential to impose her disease on the fetus. This distanced her body from an ideal maternal body which, by implication, must pose no such threat to the fetus. The second effect was the instatement of fetal health as the paramount value in pregnancy. Within this frame, the quantification of the risk of transference of HIV to the fetus became the measure against which the decision to treat Sheila was judged.

Knowledge about the rate of HIV transmission in utero is specialist knowledge and as such has two characteristics. First, it is created by scientific experts through the application of rational method, and second, non-specialists are dependent on experts to make that knowledge available to them. Taken together, these qualities render specialist scientific knowledge more or less immune from effective challenge by the non-specialist. Sheila herself, for example, was in no position to discredit her detractors by refuting the risk of HIV transmission. However, because IVF treatment would not have been possible without the approval of her specialist, Lord Winston, his decision to treat her also became implicated in the condemnation. The effect was that the characterisation of Sheila's body as dangerous and threatening could be tempered by at least one expert (Lord Winston) who could challenge the objections raised by other medical experts.

An analysis of the texts revealed a startling variation in the HIV perinatal transmission rate. This ranged from as high as 30% to as low as 7%. Experts that generally opposed the decision to treat Sheila claimed that the perinatal transmission rate was between 15 and 30%.[219] By contrast, commentators that did not oppose the decision claimed that the probability was in the vicinity of 7 -10%.[220] The treating doctor, Lord Winston, claimed that the probability was 7% "if she does everything right".[221] This presumably means if Sheila agrees to a range of medical interventions including the administration of AZT during pregnancy and labour, a caesarean delivery, and refraining from breast-feeding.

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[219] See S. Reeve, "Fertility Help for HIV Woman" *Sunday Times* (19 May 1996) available in Lexis library TXTLNE; "Fertile With Error" *The Times* (15 May 1996) available in Lexis library TXTLNE. Ferriman cites a statistic of 10 to 15%, *supra* note 201.

[220] According to the Chairperson of the National AIDS Trust in a letter to *The Times*:

> It is misleading to label HIV, as your leader does, as automatically "highly communicable" from mother to child when the great majority of babies in this situation can now be delivered free of HIV infection. Your report alludes to US clinical trials where anti-viral treatments administered during pregnancy reduced the rate of HIV transmission to the region of 7-10%. Future protocols and innovations at the respective stages of conception, pregnancy and delivery are likely to further reduce this risk".

M. Adler, supra note 206.

[221] Ferriman quoting Lord Winston, *supra* note 201.

It is impossible to say whether particular rates were instrumental in shaping each commentator's opinion about the desirability of IVF for HIV positive women or whether particular rates were selected to sustain the case in favour or against. The critical point, however, is that these transmission rates are presented as a distillation of objective scientific knowledge. This implies that they are immune from the vagaries of subjective opinion or prejudice. It is true that sometimes experts do not agree, and that scientific knowledge is recognisably incomplete. What is interesting about the way that scientific knowledge is translated into the cultural narratives in this case, however, is that there was no explicit recognition that disagreement existed about the rate of transmission (each article simply states a particular rate).

It is suggested that characteristics other than HIV status may complicate this picture. In a story about another HIV positive woman seeking IVF that was reported a few days later, the perinatal transmission rate was not 30%, 15%, or 7%, but rather, "as low as 5%".[222] This woman, whose name was suppressed,[223] contracted the virus during the course of her employment in the health service. Although both Sheila and the unnamed health worker were both HIV positive and seeking IVF, their stories were reported quite differently. This could be because these women are not comparable in other respects. It is suggested that the mode of transmission is significant here because it connotes a range of other assumptions about the sort of women involved and, accordingly, their suitability as mothers. This is a point to which I will return in the Part IV.

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[222] V. MacDonald, "Woman Who Caught AIDS in Hospital Wins Fertility Help" *The Sunday Telegraph* (19 May 1996) 1.

[223] A point that should not be overlooked, although without more information it is difficult to know how much can be made of it. However, the suppression of this woman's name could indicate a greater respect for confidentiality or, alternatively, a greater ability to protect herself from publicity made possible because of this woman's class or socio-economic position. It was reported that this woman "may be a nurse, doctor or surgeon" Reeve, *supra* note 219. By contrast, Lord Winston states in reference to Sheila that "what troubles me most about this arbitrary process . . [is the imposition of] . . our values on others perhaps *less articulate or knowledgeable than ourselves* . . ."(my emphasis) Winston, supra note 197. A study of the attitudes and practices of health care professionals in the United States and Central America found that HIV positive mothers with economic, social or political standing can expect to have greater control over how their confidentiality is respected than mothers who are less economically fortunate: K. Brown, "Descriptive and Normative Ethics: Class, Context and Confidentiality for Mothers with HIV" (1993) 36 Social Science & Medicine. 195.

Importantly, there was no real challenge to the notion that HIV transmission rates should determine whether Sheila should receive IVF. The perinatal transmission rate would have been important to Sheila, but it is not clear that this is the only form of knowledge that is relevant. This indicates how the privileging of scientific knowledge obscures other important considerations and sources of knowledge—how Sheila felt about the impact of the pregnancy on her body and her relationships, about her abilities and capacity to cope with the pregnancy and the possibility that her child could be born with HIV, how she would and could care for her child, and who she could rely on to care for the child if she died. By excluding this knowledge the only relevance that Sheila's physical body and her role in the pregnancy holds for the story is the extent to which it represents a danger to the potential fetus, that is, a hostile and defective maternal environment.

The Overpopulated Womb

A similar focus on the maternal body as a danger to the fetus was apparent in Mandy Allwood's story. However, her story differed in that the specialist medical community was unanimous in its assessment of the risks posed to the fetuses. The reports were replete with the opinions of eminent commentators:

> "Dr Robert Sawers, consultant gynaecologist at the Priory and Birmingham Maternity Hospitals said: "Sadly, its extremely unlikely these eight will be born and survive." Dr Sawers said his only advice would be to reduce the number of foetuses. Professor Kypros Nikolaides, of Kings College Hospital in London, said: "I'm not aware of a single case in the history of the human race where somebody successfully delivered eight babies." Dr Nikolaides said Ms Allwood was in "a dreadful, dreadful situation."[224]
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> Dr Peter Bromwich, medical director of Midland Fertility Services, said he believed the chances of all Ms Allwood's babies being born healthy were "extremely remote". "Women who are pregnant with a high number of babies rarely have all the babies alive and normal" he said. "The chances are that this woman may miscarry or go into early labour." He said there was a high risk of the babies being handicapped if the mother

[224] Loudon, supra note 208.

> carried too many, or if they were born too early. . . . A doctor quoted in a British newspaper said: "There is simply not enough room for them all in the womb, and nature will take its course and push them out shortly."[225]

In this story then, the experts speak with one voice about the danger Mandy Allwood's pregnancy portends. In common with Sheila' s story, the paramount concern is the prospect of Mandy Allwood delivering healthy babies. This emphasis on health and normality merits consideration. A number of the above commentators refer to the danger that the children will be born with disabilities by virtue of their anticipated prematurity. The reasoning seems to be as follows. Experts agree that Mandy Allwood's body is not capable of birthing eight healthy babies. If she continues with her pregnancy, her fetuses will die or, if born alive, will almost certainly be handicapped. It is better for some fetuses to die in order to ensure the healthy survival of the others. Her refusal to agree to the termination of six or so fetuses, therefore, is an irresponsible act. The irony of this approach is that the mother can still be seen as a threat to her fetuses even though the treatment that she is refusing is intended to kill some of them. At some level this indicates that the potential for healthy life is considered to be more important than potential life per se. This observation also goes to the question of what constitutes the ideal maternal body. This body produces healthy children.

Another effect of this characterisation is to see Mandy Allwood as an overpopulated womb, and not much more. This emphasis tends to obscure other considerations including how the multiple pregnancy will affect her, or how a selective termination at 18 weeks would affect her. Indeed, these accounts do not recognise that Mandy Allwood is faced with a mortal decision,[226] that is, a choice of considerable

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[225] Ibid at 4.

[226] Marie Ashe uses the term "mortal decisions" to describe the choices that women face in relation to abortion—the power and responsibility of determining life and death. She argues that women who consciously experience abortion become acutely aware of the violent bodily reality of terminating a pregnancy although women will undoubtedly have different reactions to this reality. A proper acknowledgement of these subjective bodily realities poses a serious challenge to the notion that these decisions can be regulated by anyone other than the women in whose body the fetus lives; M. Ashe, "Zig-zag Stitching and the Seamless Web: Thoughts on "Reproduction" and the Law" (1988) 13 Nova Law Review 355 at 371-379.

consequence that she must weigh for herself. The unanimity of the medical community, it seems, heralds the belief that she must abort some of the fetuses:

> There is almost unanimous agreement among experts that only the termination of some of the three month old foetuses—most recommend six should be aborted—would give a chance of life to the remaining babies.[227]

Again, this reinforces the belief that women should produce healthy babies. This pressure is translated here into maternal responsibility in order to mandate a particular course of action. The "action" is a very risky mid-term abortion. This abortion would actually happen to Mandy Allwood's body, a factor that is not directly addressed in any of the reports.

The "almost unanimous agreement of the medical community" raises some other issues, namely that this is not a case of competing knowledges. There can be no competition where there is only one form of knowledge that counts. Cast in this way, anything less than selective abortion is constructed as a grossly irresponsible act which (in one instance) goes further than intimating her unfitness to mother—it actually denies that she is a mother. This interplay between medico-scientific constructions of biological 'reality' and cultural conceptions of good motherhood makes it very difficult for mothers to reject medically mandated treatment.[228] In this case, Mandy Allwood's unfitness to mother is constructed through her decision to reject medical advice and to accept the risks associated with the continuation of her pregnancy. There is no room in this analysis for Mandy Allwood's experience. It matters little that she is refusing because she can not "live with the thought that if I reduced the number of babies, I'd never know whether they may all have survived."[229]

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[227] Sprawson, supra note 209.

[228] Isabel Karpin suggests that:

> A discourse that frames women as equivalent to their biology, and at the same time analogises that biology to the maternal, renders the non-biological woman anti-maternal. In this way a "good" mother can only be a passive disempowered woman.

Karpin, supra note 212 at 329.

[229] J. Murnie, "I'm Doing it For Love — Multiple Birth Mum Hits Out At Critics" *The Daily Telegraph* (19 August 1996) 21.

Rather, her refusal to abort categorically indicates her selfishness and irresponsibility.[230]

IV. Undesirable Candidates For Motherhood

The proposition that Sheila and Mandy Allwood were not good candidates for motherhood received further support in the form of information about the lifestyle, economic and marital status of each woman. These supplement the discourses about unhealthy maternal bodies in the construction of these women as bad mothers. A critical examination of the newspaper reports reveals that although the norms against which each woman is measured are never overtly stated, their content subsists in Sheila and Mandy Allwood's deviance from them.[231] We have already seen in the case of Mandy Allwood explicit references to a range of indicia of maternal deficiency—she is single, she is on welfare, she is white, her partner is black,[232] he is bankrupt, he is involved with another woman, and they have accepted money for the story.[233]

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[230] Gibson exclaimed: "A woman with eight babies conceived after doctors say that she probably overdosed on fertility drugs, claims she wants to have them because it's the natural thing to do! . . Sound sick? Sound crazy? I guess it does." Gibson, supra note 207.

[231] A similar process of norm creation and maintenance has been identified in legal reasoning. The influence in legal reasoning of popular myths and stereotypes about good mothering, and the responsibilities of mothers, has been the subject of feminist critique. See for example; Note, "Rethinking (M)otherhood: Feminist Theory and State Regulation of Pregnancy" (1990) 103 Harvard Law Review 1325; M. Fineman, *The Neutered Mother, The Sexual Family and Other Twentieth Century Tragedies* New York: Routledge, 1995); M. Henley, "The Creation of the Mother/Body Myth: Judicial and Legislative Enlistment of Norplant" (1993) 41 Buffalo Law Review 703; D. Roberts, "Punishing Drug Addicts Who Have Babies: Women of Color, Equality and the Right of Privacy" (1991) 104 Harvard Law Review 1419.

[232] The racial characteristics of Mandy Allwood and her partner Paul Hudson are not noted in the text of the reports. However, two articles appear alongside photographs of the couple. See E. Sprawson, "Mother All Alone" *The Daily Telegraph* (afternoon edition) (13 August 1996) 5; and E. Sprawson, "Mother of Eight Left Standing Alone" *The Daily Telegraph* (13 August 1996) 1.

[233] See S. Dabkowski, "Million-Dollar Mum-to-be Has Dirty Linen Aired" *The Sydney Morning Herald* (August 14 1996) 12; Gibson supra note 207, Loudon, supra note 208, Sprawson, supra note 209.

Screening Applicants

As I have already pointed out, the narratives repeatedly state that Sheila was a former heroin addict who contracted the virus from a boyfriend about 8 years earlier.[234] In addition, Sheila is unfavourably compared with other women whose vital characteristics differ from hers. These comparisons serve to further highlight Sheila's distance from the ideal mother. By way of example, the following passage compares Sheila's circumstances to those of a healthy (not HIV positive), middle class, heterosexual woman who was refused IVF treatment by the same doctor:

> [Jane Smith]. . was in a stable relationship, in excellent health, with a good job and lived in a comfortable house in North London. Everyone thought she and her partner would make excellent parents. The only thing they needed was a child. Unfortunately, she was 41 years old. [Jane Smith approached Lord Winston who refused to permit her into the IVF program he administered.] The encounter, although 10 years ago, is engraved on Jane's memory, so she was astonished to read last week that the same doctor (now Lord Winston), who had refused her therapy, had agreed to provide IVF for a woman who was HIV-positive. The woman, in her thirties, who is a former drug addict, is thought to have caught the virus from her former boyfriend who has been HIV positive for 10 years (the average length of time between infection and development to full-blown AIDS). Her life expectancy is considered poor and there is a 10 to 15 per cent chance that she will pass on the infection to her child.[235]

I have already referred to the discrepancy in transmission rates in connection with Sheila and the unnamed HIV positive health worker in separate reports. In the following passage, a direct comparison between the two women discloses an emphasis on the different modes by which they acquired the virus. This then becomes the point of differentiation between them:

> A woman carrying the HIV virus is to receive fertility treatment on the National Health Service at the Chelsea and Westminster hospital in London. . . . A health worker, she is believed to have contracted the virus from a hospital patient. The news comes just days

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[234] See Ibid; supra note 197; A. Ferriman, supra note 201; S. Reeve, supra note 219.

[235] Ferriman, Ibid.

> after protests erupted when it was revealed that another HIV sufferer, a former heroin addict believed to have caught the virus from a former boyfriend, received a similar treatment paid for by a charity at Hammersmith hospital in west London.[236]

Significantly, protests did not erupt over the decision to offer this unnamed woman IVF treatment.[237] Elsewhere in the reporting of her story, references were made to the possibility that she may have been a "a doctor or surgeon".[238] This reference imports a range of assumptions about the class and educational background of this woman which may explain the comparatively sympathetic reporting of her story. Sheila, on the other hand, was a former heroin addict who contracted the virus from a sexual partner. Such a history excludes her from the category of good mother, and this is further compounded by her HIV positive diagnosis. The selection of scientific data about perinatal transmission for this story also helps to construct the image of the more deserving mother by minimising fears about the health of the fetus. On this analysis, the popular and scientific discourses can be seen to co-operate in the construction of norms about motherhood.

The power of these representations was implicitly recognised by Lord Winston who was very careful to contest the image of the "bad" or "unsuitable" mother in defence of his decision to treat Sheila.[239] This was achieved partly by emphasising the passage of time eclipsing the shadier aspects of Sheila's past, and partly, by emphasising her

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[236] Reeve, supra note 219.

[237] "Much of the criticism of Professor Winston dwelt on the fact that his patient was a former heroin addict and that having the virus was her "fault". . . . A few days after the Winston story broke, another hospital, the Chelsea and Westminster, was reported to be giving fertility treatment to a woman with HIV, but this time, the tone of moral outrage had disappeared from the news reports. The woman being treated was a health worker who had contracted the virus from a patient—a blameless "victim" of HIV." E. Brooker "You've Got to Accentuate the Positive" *The Independent* (7 June 1996) 4.

[238] Reeve, supra note 219.

[239] Although the protest indicated that Lord Winston's assessment of Sheila's suitability as a mother was highly contested, the disagreement does not appear to reflect radically competing visions of motherhood. If that was the case, Lord Winston might have cast his defence in terms of a more plural understanding of motherhood or, perhaps, on the risks and benefits faced by Sheila as mother (rather than her potential fetus). Although his reasoning contains some interesting ambiguities, I suggest that it is broadly consistent with the dominant vision of motherhood. On the one hand, his refusal to categorize Sheila on the basis of past behavior does present a challenge. However, his defence rests firmly on one of the most powerful symbols of desirable Motherhood—a woman in a stable and loving relationship with a man.

involvement in a close and loving relationship with a man.[240] Notably, Lord Winston was prepared to reject Sheila's request but was, ultimately, deeply impressed by Alan and Sheila. Indeed, he expressed considerable sympathy for Alan, who, as prospective father, had some "rights".[241]

Public Mothers and Economic Realities

The question of Sheila's life expectancy was a further objection to her pursuing maternity. Like HIV transmission rates, this too was also debated in terms of current scientific knowledge and medical practice.[242] Although Lord Winston remarked that "Sheila has by now been completely well for ten years, and there might be a cure around the corner",[243] there was no serious dispute as to Sheila's reduced life expectancy. This fuelled concerns about the cost of caring for orphaned children, HIV positive children and IVF treatment:

> There are undoubtedly couples who, knowing that one or other partner is a carrier of a fatal disease or severe disability, decide to take the gamble of pregnancy in the hope that they will have a normal child. Society leaves the decision to them, and underwrites the medical and other costs, which can be considerable, of caring for the child should it prove to have inherited the genetic defect. From there, it may seem a short step to justify the use of medical science to induce pregnancy in an infertile woman who has a disease which is almost always fatal, and also highly communicable. . . . It is, on the contrary, a gigantic step and a step too far. . . The treatment was not on the NHS but

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[240] "Ten years had now passed since she was first infected and gave up drugs. Her GP referred her to me, and I saw her very reluctantly, because I was aware that I would be faced with a very difficult decision. At first I was convinced that I would not offer her IVF, and told her this firmly. . . [However] . . . [d]iscussion with Alan and Sheila was remarkably easy and without embarrassment, because they were quite open and because they had obviously thought extremely carefully about the decision they were taking. During our second protracted consultation, I found myself being increasingly impressed by them, and by the loving relationship they so obviously shared . . . I am sorry that people can be so critical of a decision carefully taken by a deeply loving couple who have thought things through with great maturity. Winston, *supra* note 197.

[241] Lord Winston was quoted as saying that: "I think the prospective father in this case has some rights. The father, who is not infected, has been using safe sex so that he does not get infected, wants a child by his partner, whom he loves very much, and is prepared to bring it up, in the event of her death. He feels his rights are being imposed on if the couple are refused treatment". Ferriman, *supra* note 234.

[242] "Fertile with Error", supra note 219.

[243] Winston, supra note 197.

> that should not license irrationality: and the real costs to society of caring for an HIV positive child also have to be factored in.[244]

And:

> The British Medical Association yesterday said that it could not support Professor Winston's treatment of the woman and that it viewed the case with concern because of the danger of the child being orphaned.[245]

These concerns also speak to us about norms relating to motherhood and, perhaps, social dependency more generally. Implicit in the suggestion that Sheila should not become a mother because she has a shortened life expectancy, is the assumption that only mothers can, or should, care for children. This meaning is also conveyed by describing the potential child as an orphan. Although this child would have a willing and supportive father, it is referred to as an orphan on the basis that its mother may die during its childhood. The other theme present throughout the above-quoted passages is that families, and not the community, should bear the bulk of the financial cost of caring for sick children.

V. Looking to the Law for Answers

Although Mandy Allwood's refusal to terminate some of her fetuses was the subject of extreme censure, there was no suggestion that the law should be changed to compel her to accept a termination. In Sheila's case, on the other hand, there was discussion about the need for tighter legal controls to prevent a recurrence. First, there was a general scepticism about existing legal principles being adequate to prevent injustice or abuse. This concern was expressed in a criticism of the wide margin conceded to doctors for interpreting their obligations under the *Human Fertilisation and Embryology Act* 1990:

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[244] "Fertile with Error" supra note 219.

[245] Quinn, supra note 198.

> Dr Anne McLaren, a member of the Human Fertilisation and Embryology Authority (HFEA), the statutory agency that licenses hospitals to conduct IVF treatment, says that doctors do not have an obligation to get approval for their decisions from their ethics committees because IVF is a clinical treatment, and not a research procedure. . .The HFEA believes that the chief criterion for deciding whether a patient should be offered treatment should be the welfare of the child. This is codified in law. The Human Fertilisation and Embryology Act 1990 says: A woman shall not be provided with treatment services unless account has been taken of the welfare of any child who may be born as a result of the treatment.
>
> That may be the law, but in practice many other criteria come into play. The two most important are the likelihood of the treatment succeeding and the willingness of a health authority to pay for it. . . and, even if resources were limitless, difficult ethical questions would still remain. The obligation on a doctor to consider the welfare of any child born as a result of treatment is open to widely different interpretations. . .[246]

This poses a challenge to the quality of the judgements some doctors are making with respect to IVF. It also highlights the central point that there is no absolute unanimity about the content of an organising norm like "the best interests of the child".

Second, there was a concern about the dearth of legal authority to provide authoritative guidance on whether Sheila should have been granted access to IVF. It was explicitly suggested, for instance, that the regulations covering infertility treatment should be tightened.[247] This is symptomatic of a general tendency to look to the law for authoritative answers when difficult moral issues arise. It indicates a belief that the law can and will provide the answers and clarity sought.

The other interesting point to consider is how legal discourses interact with popular and scientific discourse in this context. As a matter of law, a doctor is required to consider the "welfare of the child" who may be born as a result of IVF treatment.[248]

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[246] Fernman, supra note 201.

[247] MacDonald supra note 222.

[248] Section 25(2) of the *Human Fertilisation and Embryology Act* 1990 c.37 specifies that the HFEA maintain a code of practice giving guidance about the "account to be taken of the welfare of the children who may be born as a result of the treatment services (including the child's need for a father), and of other children who may be affected by such births".

This requires doctors to make an assessment about the suitability of the patient as a prospective mother before offering treatment. In this case, that involved detailed consideration of the suitabililty of Sheila's body as a vehicle for delivering a child. The effect of considering Sheila in this way is to emphasise the points of differentiation between her body and the fetus and, accordingly, to relegate her to the status of a passive by-stander in her own pregnancy. However, this effect is never completely achieved for two reasons. First, her body cannot be separated from her fetus (except in an abstract way). The controversy exists precisely because HIV might cross the placental boundary. Second, her desire to have a child in her unfit bodily state represents an active transgression of cultural expectations of how a good mother should act. There is, in this story, a convergence of circular reasoning, interconnection and paradox. Science constructs a "model" of the mother and the fetus as separate entities. This construction is, in a sense, easier to maintain in a case where conception would take place by IVF because at least in the very early stages of pregnancy the embryo would be physically separated from Sheila. This notion of separateness forms the basis for prescribing standards of maternal responsibility from the moment of, or even before, conception. This is evident in questions like: should an HIV positive woman seek pregnancy, or continue with a pregnancy? The questions, and their answers, are influenced by the extant ideological structures that determine what constitutes a "good" mother. To the extent that law insists that the doctor make some determination about whether his or her particular patient would be a "good" mother, the law then privileges the scientist-doctor's "knowledge" about what this is.

VI. Excluded Knowledge

One of the most troubling aspects of Sheila's story as it was told in cultural discourses is that each of the central concerns were represented to readers through the lens of either the doctor who sparked the controversy, his colleagues in the medical profession, or the public interest, but never Sheila herself. To this extent, the "doctor" and the "public" were able to make claims about the nature of motherhood and HIV, while Sheila was not. How could such an obvious source of knowledge be

overlooked? Part of the answer to this question lies in a critical appreciation of the manner in which Sheila's body was represented in the cultural discourses. By focusing exclusively on questions like the probability of HIV transmission across the placental boundary and the nature of medical interventions that could reduce these risks, Sheila's body—her importance in the process of pregnancy, and any subjective knowledge that she may possess about her body and her maternal capacities—was excluded. The attention focused on Professor Winston as treating doctor compounded this effect. Sheila's potential pregnancy was cast as his responsibility and a potentiality that he had to justify.

Likewise, the content of the media reports about Mandy Allwood focused almost exclusively on the enormous weight of learned medical opinion that recommended selective abortion. This knowledge is rarely challenged in the popular discourse and, in this way, is privileged as the authoritative view of what is right in the circumstances. It is easy to lose sight of the fact that the pregnancy is actually happening to Mandy Allwood's body. A single report gives some insight into how she feels about the pregnancy:

> When I go to bed at night I lie there and I can feel the babies moving. I put my hands on my stomach and I speak to them. I tell them 'Come on, we can get through this thing together, everything's going to be O.K.'[249]

Very few women have been in Mandy Allwood's shoes. Geraldine Broderick, however, is an Australian woman who experienced a multiple pregnancy and birthed 9 babies in 1971. She did not condemn Mandy Allwood's decision as irresponsible or crazy. She considered it courageous:[250]

> Mrs Broderick said: "I don't regret what I went through [but] I don't wish it on anyone else either."

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[249] Sprawson, supra note 227.

[250] E. Gelastopoulos, "I'd Keep 8, Says Mum Who Lost 9" *The Daily Telegraph* (12 August 1996) 4.

> She said that despite her own experience, she did not feel comfortable offering advice to Ms Allwood. "I wouldn't like to tell anyone what to do. But I think I'd be doing the same as her and keeping them," she said.
>
> "If she makes this decision—to destroy some of them— she is the one who will have to explain to the others when they're older that she had to sacrifice those babies."[251]

Although we might consider Geraldine Broderick as an "expert" on multiple births, she is not presented as such in the popular discourse. Interestingly, her view is strikingly different from that of the other experts. Geraldine Broderick does not presume to advise Mandy Allwood. Her humility implies a recognition that her embodied experience of her own multiple pregnancy is her experience. She does not assume that this qualifies her to speak for other women similarly situated. The essence of her "knowledge" is a respect for the subjectivity of bodily realities—a wisdom which acknowledges that each woman must decide according to her own bodily reality.

This echoes the thoughts of Marie Ashe who claims that:

> [w]hatever our commonalities, each individual woman is a singular body. And each singular body is the site of a singular subjectivity, a unique personhood. My experience is not identical to those of my sisters. For some women, abortion is nothing other than a relief, it appears, while for others it becomes nothing more than a kind of dying — suicidal if not murderous.[252]

Recognizing that women experience subjective embodied realities does not necessarily entail a wholesale rejection of commonality. What it does entail is a sensitivity to differently constructed bodily realities—realities that are shaped by the infinite combinations and permutations of colour, health, class, ability, religion, sexuality and age—realities that generate different accounts of experience. While this means that extrapolations from women's self accounts will sometimes conflict,[253] Marie Ashe

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[251] Ibid.

[252] Ashe, supra note 226 at 379.

[253] Ibid at 382.

suggests that when women attend to one another, various truths emerge from the multiplicity of realities—truths that are closer to women's experiences than any formulation of law or medicine.[254] The claim that each woman embodies her own subjective reality leads Ashe to query "whether any legal regulation of reproduction can avoid a perpetration of violence upon women."[255]

Conclusion

The stories about Sheila and Mandy Allwood are particularly useful in the broader context of this thesis for a number of reasons. First, the maternal body is constructed as a hostile environment for the fetus. In Sheila's story, this is achieved by focusing on the possibility that HIV will cross the placental boundary to her fetus. In Mandy's story, it is achieved by focusing on the improbability of her body being capable of birthing eight healthy fetuses. Whilst the deficiencies of the bodies of the pregnant women form a common ground between the stories, they also focus on the notion of responsibility. In this regard, some critical differences between the stories emerge.

In Sheila's case, the involvement of the doctor is the focus of the inquiry into locating "responsibility" for endangering the fetus. Here we see the doctor cast as procreative agent and therefore responsible for the intended pregnancy. It is the doctor's decision that comes under fire as being irresponsible. The decision is criticized because Sheila is HIV positive, but also because she possesses other indicators of "bad" motherhood that should have persuaded the doctor against permitting IVF in her case. In these circumstances, Sheila's role, her agency and responsibilities for the pregnancy are obscured. She is ultimately disembodied as the controversial pregnancy is cast as the result of her defective body and the doctor's irresponsible agency.

In Mandy Allwood's case, the location of the responsibility for endangering the fetus(es) shifts. This controversial pregnancy occurred because fertility drugs were

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[254] Ibid.

[255] Ibid at 379.

taken. However, the doctors do not attract criticism. Instead, Mandy Allwood is cast as the responsible agent. Unlike Sheila's story, then, Mandy Allwood's decision to continue with the pregnancy against medical advice is attacked as irresponsible. Her 'choosing' not to have an abortion which scientific discourses advise, implicates her ability to mother. This raises the very real concern that women's reproductive choices are constrained and directed by scientific explanations of risk.

Although the stories about Sheila and Mandy Allwood were told in a particular way, it is possible to consider alternative readings of these stories. The first step in this process is to acknowledge the particularity of the claims made upon these women. This involves a careful appraisal of the use of scientific knowledge about their bodies, and a questioning of its priority in the stories. This questioning could take the form of looking to Sheila and Mandy Allwood to uncover other sources of knowledge that may contribute to our formulation and understanding of the issues at stake. The inclusion of this knowledge would have expanded the limited nature of the debates as they were presented. It would also have affirmed the significance of both Sheila and Mandy Allwood as embodied women making difficult choices for themselves and their families.

CHAPTER THREE

Legal Strategies for Prenatal Intervention

> The judge said her physical and mental state convinced him he must act. She walks with an unbalanced shuffle and her body is covered in bruises and scabs from her life on the streets. She already has three children. Two are handicapped as a result of her addiction and all are in the custody of family-service agencies.[256]

> Social-services officials have failed again and again to persuade the woman to accept treatment for her problem. So, fearing she would bear another damaged child, they asked the court to step in. It did. . . Sad to say, the woman in the Manitoba case is not alone. There are many others like her. Sooner or later, we will have to deal with them. The alternative is to condemn a host of children to a limited and perhaps painful life. [257]

Introduction

These extracts are taken from Canadian newspaper reports of the decision in *Winnipeg Child & Family Services v G.*[258] In this case, a pregnant aboriginal woman who was addicted to solvents was confined by court order to a secure drug treatment facility for the remainder of her pregnancy. She was, therefore, deprived of her liberty and forced to accept medical treatment to which she did not consent.[259] These actions are, in the very least, coercive. However, embedded in these media reports are a range of images, assumptions and silences which have the effect of representing G in such a way that the action of confining her during her pregnancy not only seems reasonable, but also caring and benign.

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[256] S. Edmonds "Pregnant glue-sniffing addict appeals treatment order", *The Gazette, Montreal* (8 August 1996) A10.

[257] "To protect the not-yet-born", *The Globe and Mail* (14 September 1996) D6.

[258] (1996) 138 DLR (4th) 238 (QB).

[259] G was not in fact confined for the duration of her pregnancy, however, because these orders were reversed on appeal; *Winnipeg Child & Family Services v G* (1996) 138 DLR (4th) 254 (CA). Leave was granted

This is achieved by a combination of factors. First, G's body is represented as dangerous and unhealthy. It is drug-addicted and covered in bruises and scabs conjuring vivid images of contamination and impurity. Second, G's body is out of control. Her bodily movements are out of control because she cannot walk in a balanced fashion, and her reproductive capacities are out of control because she has reproduced herself in the form of damaged offspring three times already, and is threatening to do so again. Third, the images of G as a mother, like those images of her body, are contrary to the ideal of responsible and caring mothers. She already has three children that have suffered the effects of her addiction, yet she continues to bear children in her unhealthy bodily state. She has been offered treatment for her addiction but she has refused it. She can not take care of her children and they have been removed to the care of social services. The references to G's treatment refusals, together with the removal for her children, signify her abject inability to care and to nurture.

Thus, by a combination of images that draw attention to G's deviance from the bodily and behavioral ideals of motherhood, G's situation seems to demand action. The crucial question is what form that action should take. The answer to that question cannot be separated from the framework already established by the descriptions which marginalize G both bodily and behaviorally. In this context, court-ordered prenatal intervention is represented as a form of action that will serve a number of noble and very desirable purposes. It will restore G's decrepit body to a healthier state and, perhaps, modify her behaviors so that the same mistakes will not be repeated. Intervention will also, it is thought, protect the fetus from the effects of G's addiction. It is assumed that this will be a good thing for G, and for the fetus, and therefore a responsible course to adopt. In this way, the violent and coercive underside of court-ordered prenatal intervention is obscured.

These assumptions need to be brought out into the open and scrutinized. Can we simply assume that forcing G into treatment would be a good thing for G? Or for

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to appeal to the Supreme Court of Canada and the case was heard on 18 June 1997. The decision has not yet been released.

G's fetus? This simple presentation of the solution to G's problem overlooks a number of potentially relevant considerations. Why does G have a solvent addiction? Why has G been singled out for medical and legal scrutiny? How will it affect G psychologically to be forced into treatment that she does not want? How will it affect her future relationship with her child?

But even these questions just scrape the surface of the processes of construction at work. The extracts also disclose an interventionist logic that has implications beyond G's unfortunate situation. This logic rests on individual and collective notions of responsibility. The responsibility for G's unhealthy body and unsuitable behavior rests with her because she has been offered treatment that will ostensibly improve her biological capacity to bear a healthy child, and she has refused it. This has the effect of individualizing the cause of the problem, which is an important link in the chain of reasoning that ultimately leads to G's confinement. If the problem is seen as G's refusal to accept treatment, then it makes sense to launch into a detailed analysis of the quality and validity of that refusal, since the refusal will not be valid if G lacks the mental capacity to make the decision. This, however, raises a number of questions. Is a pregnant woman who refuses medical treatment more likely to be seen as lacking mental capacity than other people? Is there a greater willingness to force her to have treatment in circumstances where the fetus may be affected by her conduct?

At the same time that the story focuses on G's individual responsibility for the problem, it effectively generalizes the consequences. This has the effect of substantiating the claim for a societal rather than an individual response. This is done, first, by emphasizing the impact of G's maternal body on her children, and second, by claiming that the deleterious intergenerational effects of drug-use during pregnancy are widespread in the community. The extracts also tell us that in these cases, which are numerous, health professionals can not always effect the desired outcome on their own, so the law needs to sanction the supervision and rehabilitary procedures that the health professions deem desirable. In this way, G's unfortunate situation becomes a social evil warranting a collective response as signified by the deployment of law's coercive force not only against her, but others like her. Again, this perceived need for the law to respond by laying down general principles for the

use of force against pregnant women raises a plethora of important questions. How does it affect the way we think about pregnancy and motherhood when the law lends its coercive force to medical advice? How will this affect relations between women and their medical advisors? What does it tell us about the relationships between the way that science organizes knowledge about the body and proposes treatments to rehabilitate deviant ones, and the role of law in sanctioning these forms of power?

Law's attempts to resolve the very complex issues that inevitably arise when pregnant women and doctors disagree about treatment which may benefit the fetus also involve broader questions about the relationships between knowledge, power and bodies. As I have argued in earlier chapters, these concepts are not determinate, nor are the relationships between them predictable or clear. I will further that inquiry in this chapter by analyzing the Canadian cases relating to prenatal intervention. In Chapter Two, I provided a brief survey of the United States and Canadian decisions on forced medical treatment during pregnancy. In this chapter, I focus exclusively on the Canadian cases for two reasons. First, a number of legal strategies have been attempted in Canada with varying degrees of success. These, as I have mentioned elsewhere, fall into two broad categories. First, the application of Child Welfare legislation or the parens patriae jurisdiction over minors to fetuses on the basis that they are children; and, second, the use of Mental Health legislation and the parens patriae jurisdiction over adults of unsound mind on the basis that the woman cannot make treatment decisions regarding her pregnancy. These diverse strategies provide considerable scope for considering why particular strategies may have succeeded or failed. Second, these strategies are underscored by discourses of rights and discourses of normalization respectively. This permits us to examine the connections between them in a specific context and, accordingly, to consider whether these discourses constitute two parallel systems of power which actually merge in the context of law's relationship to the female body, as suggested in Chapter One.[260] Overall, these cases provide a very useful basis for analyzing the connections between the organization of knowledge about women's bodies, the ways that women's bodies are constituted in

[260] There, it will be remembered, I introduced the arguments of Carol Smart on this issue. See C. Smart, *Feminism and the Power of Law* (London: Routledge, 1989) at 96.

legal discourses, and the ways that law's power is invoked to exercise control over the bodies of women.

Part I will analyze the cases that have considered the question of prenatal intervention pursuant to Child Welfare legislation. In these cases, courts have been asked to order intervention on the basis that the fetus is a child in need of protection within the terms of the relevant provincial statute. [261] To this extent, they involve a consideration of whether the fetus is a child and, therefore, deserving of the law's protection.[262] This strategy, although successful in the early cases, has been subsequently questioned on the bases that such intervention infringes the liberty rights of the pregnant woman, and that the fetus has no legal personality.[263]

Part II will analyze the first instance and Manitoba Court of Appeal decision in *Winnipeg Child & Family Services v G.* This case signals a shift in strategy away from a strict focus on the fetus, towards the mental capacity of the pregnant woman. Thus, the intervention is justified on the basis that the woman is incapable of consenting to treatment which is in *her* best interests. This may still be an indirect method for controlling the pregnant woman in the interests of the fetus. However, the focus on the pregnant woman and the language of best interests make this strategy less open to

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[261] See *Re Children's Aid Society of City of Belleville and T* (1987) 59 OR (2d) 204 (Prov Ct.) where the court held that the fetus was in need of protection and made it a ward of the court for three months. In *Re R* (1987) 9 RFL (3d) 415 (Prov.Ct), Davis Prov. J found that the Superintendent of Family and Child Services had power under the *Family and Child Service Act* S.B.C. 1980, c.11 to effect the pre-birth apprehension of a fetus in the process of being born and for the purposes of ensuring a surgical delivery. This decision was overturned on appeal. See infa, note 263.

[262] Express statutory provisions regarding fetuses also exist in the Family Services legislation of New Brunswick and Yukon Territory. New Brunswick's *Child and Family Services and Family Relations Act* SNB. 1980 c. C-2.1 defines child to include unborn child. Accordingly, an unborn child can be the subject of a supervisory order in circumstances where neglect is shown, and this power has been exercised; *Nouveau-Brunswick (Ministre de la Santé et des Services communautaires) v A.D.* (1990) 109 NBR (2d) 192 (QB). Section 134(1) of the Yukon Territory's *Children's Act*, R.S.Y.T. 1986, c.22 enables the Director of Children to apply to the court for an order to require a pregnant woman to receive counseling or supervision in respect of alcohol use if the fetus is at serious risk of suffering fetal alcohol syndrome.

[263] See *Re Baby R* (1988) 15 RFL (3d) 225 (SC) reversing *Re R* (1987) 9 RFL (3d) 415; and *Re A (in utero)* 1990 28 RFL (3d) 288 (Fam.Ct).

challenge based on rights arguments.[264] This shift in strategy is particularly interesting in the context of Foucault's thesis about the mechanisms of power operating through the discourses of the modern episteme. It draws heavily on psychiatric and medical evidence about mental disorder for its legitimation, and it relies on surveillance and normalization practices as remedial activities. It also forces a consideration of the efficacy of rights-based strategies, pointing to the possibility that, given the interconnectedness of juridical and non-juridical forms of power, recourse to rights discourses may be insufficient to prevent the encroachment of disciplinary surveillance.

In the following analysis of these legal discourses I will focus on three particular questions. First, how is the pregnant body of the woman described and, accordingly, represented in these legal discourses? This raises questions about the assimilation of scientific discourses about the female body into law, and draws attention to the privileging of particular forms of knowledge in legal discourses. Second, how are the woman's motivations in refusing medical treatment described and interpreted by judges? This question is intended to discern the extent to which discourses about motherhood and appropriate maternal behavior influence the way in which a pregnant patient's decision to refuse medical treatment is judged. It is also designed to illuminate how legal discourses participate in the process of ascribing specific cultural meanings to women's bodies. My third line of inquiry is to consider the relationship between these descriptions of the bodies and behaviors of pregnant women on the one hand, and the course of action adopted by the court, on the other. This question is intended to illuminate the connections between knowledge about the body, the growing number of mechanisms available to exercise power over it, and the co-opting of judicial power to buttress these methods of surveillance and normalization.

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[264] Although the Manitoba Court of Appeal criticized the lower court for seeking to do indirectly, that which could not be done directly (supra note 259 at 257), it is not clear that the intention will always be so obviously open to challenge. Two points made the intention obvious in the Queen's Bench decision. First, the orders terminated on the day of birth, a point that was referred to by the Court of Appeal as revealing the true motivation behind the order. Second, Justice Schulman indicated in his obiter remarks that the focus of the court's orders should be the "child to be born"; supra note 258 at 253.

The primary limitation of this approach is that it risks reinforcing the Cartesian division between mind and body. This division resonates in the approaches taken in many of the prenatal intervention cases, and it is already written into the general legal principle relating to refusals of medical treatment. That principle, stated simply, is that competent adult patients have the right to decide whether to consent to medical treatment.[265] If they do not consent, then the treatment cannot be forced upon them even if it means that they will die without it.[266] The notion of mental competency is critical. If the patient does not have the requisite mental capacity, then the refusal to consent to treatment is not valid. In this schema, the mind is posited as the controller of the body, the corollary being that the absence of mental capacity signals a body without control and, therefore, in need of control. The danger, of course, is that a body so represented might be devalued as a person, especially when a principal characteristic of personhood is a rational mind. This has obvious implications, but it is also important to note that this danger might be compounded when the body in question shares many other characteristics that correspond to the devalued term in the binary pairs that constitute Cartesian thinking—not only body but also woman, nature, and resource. I hope to go some way toward overcoming the problems inherent in repeating this mind/body division in my analysis by demonstrating the points at which different interpretations might have been open to courts had the embodied perspective of the pregnant woman been incorporated into legal reasoning.

The advantage of considering law's attention to the corporeality of the pregnant women, separately from its consideration of her mind and, by extension, her behavior, is that the points of intersection between the law and medical discourses about the body, and law and cultural discourses about motherhood, can be differentiated and highlighted. In this regard, the decisions themselves can be compared and contrasted by reference to the degree of judicial regard accorded evidence about the risks posed to the fetus based on scientific evidence and evidence about 'bad' mothering in the past. The cases themselves show that the law's approach has been inconsistent on the question of whether court-ordered intervention is legal, a

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[265] *Reibl v Hughes* (1980) 114 DLR (3d) 1 (S.C.C.).

[266] *Malette v Shulman* (1990) 67 DLR (4th) 321 (Ont C.A).

factor that may in part be attributable to the incomplete integration of non-legal discourses about the maternal body.

I. Prenatal Intervention Based on Child Welfare Statutes

The circumstances giving rise to the interventions sought can be grouped into three categories. First, the woman's body allegedly poses some threat to the fetus which medical intervention could fix or at least, alleviate. Second, the woman refuses to co-operate with doctors or child welfare representatives in relation to the proposed treatment. Third, doctors or child welfare representatives wish to force the woman to comply with the proposed treatment regimen in the interests of the fetus. When these general conditions have been met, courts have been asked to determine whether the treatment can be imposed despite the absence of the woman's consent.

Re Superintendent of Family & Child Services and MacDonald[267]

Barbara MacDonald had been addicted to heroin since she was 12 years old. When she became pregnant with D.J. she was taking methadone.[268] By the time she consulted her doctor, she was too far into the pregnancy to cease taking methadone without injury to the fetus.[269] The evidence was that she was treated by four doctors who, among other things, managed her methadone intake during the remainder of her pregnancy.[270] D.J was born on December 10, 1981 showing symptoms of drug addiction. She was treated for drug withdrawal and kept in the hospital. The Superintendent of Family and Child Services apprehended D.J. and sought an order under the *Family and Child Service Act* S.B.C. 1980, c.11 that the child was in need of protection.

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[267] (1982) 135 DLR (3d) 330 (SC).

[268] Ibid at 331.

[269] Ibid at 332.

[270] Ibid.

The hearing took place before P. d'A Colllings on February 22, 1981. Justice P. d'A. Collings was referred to section 1(c) of the Act which provided that "in need of protection means, in relation to a child, that he is deprived of necessary care through the death, absence or disability of his parent." The Superintendent relied on evidence about the fragile health of the baby, her need for specialized care and attention, and the inability of her drug-addicted mother to provide the necessary care. In the result, the Court found that the Act had no application unless and until there was evidence that the child was deprived of necessary care.[271] Since the child had not yet been in the custody of her parents, there was no evidence of actual deprivation.

This decision was reversed by the Supreme Court of British Columbia. The Court relied on section 1(a) of the Act which provided that "in need of protection means, in relation to a child, that he is abused or neglected so that his safety or well-being is endangered". Justice Proudfoot concluded that this section applied to DJ on the bases that (i) she had been abused during gestation, and was therefore born abused; and (ii) there was sufficient evidence of anticipated neglect owing to the special health needs of the child, and the likelihood that her parents would not adequately meet those needs.

Although this was not a case about prenatal intervention in the sense that the court was not asked to prevent Barbara MacDonald from using drugs during her pregnancy, it merits consideration for two reasons. First, the finding that a fetus could be abused during pregnancy was, as we will see, used in subsequent cases as authority for intervention prior to birth. Second, it provides a good example of the nature of interactions between medical and legal discourses about the body and, accordingly, some insights into the mechanisms of control that these interactions facilitate.

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[271] "The problem is that the child has never been in the care of Mrs MacDonald and so Mrs MacDonald has had no chance to demonstrate ability or disability to care for her. In view of that, any concept of disability that I could use to have found a finding that the child was in need of protection would have to be pretty speculative", quoted, ibid at 333.

Born Abused

There was detailed evidence about the effects of drug use during pregnancy and of the catalogue of symptoms suffered by D.J. at birth. These included: "incessant, inconsolable crying, vomiting, inability to sleep, twitching, reluctance to feed, poor sucking performance, irritability, reluctance to being held, explosive diarrhea, profuse sweating, jittery limbs, barking cough, physical tension and squirming."[272] Persuaded by medical evidence of the "physical problems that a baby born drug-addicted has to endure,"[273] the Court decided that "it would be incredible to come to any other conclusion than that a drug-addicted baby is born abused. That abuse has occurred during the gestation period".[274]

The significance of this finding lies in the fact that it purported to expand the operation of the Act to fetuses by identifying acts taking place before the child came into existence as child abuse. Justice Proudfoot found some support for this conclusion in *Re Children's Aid Society for the District of Kenora and J.L.*[275] That case involved care proceedings in respect of an infant born with fetal alcohol syndrome. There, the Court did "not preclude a finding that a child "en ventre sa mere" is in fact a child for the purpose of the Act."[276] However, the Ontario Act included a section that had no equivalent in the British Columbia Act. Section 6(2)(g) of the *Child Welfare Act* R.S.O. 1980, c.66 provided that the Society assist the "parents of children born or likely to be born outside of marriage and their children born outside of marriage."[277] The reference to 'likely to be born' was read as extending the definition of child to fetuses. In addition, the child in *Re Children's Aid Society for the District of Kenora and J.L.* had been in the custody of her mother since her birth and her mother had refused to obtain proper remedial care and medical treatment for the child. Accordingly, the finding that the child was in need of protection prior to birth was not essential to the

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[272] Supra note 267 at 332.

[273] Ibid at 335.

[274] Ibid.

[275] (1981) 134 DLR (3d) 249 (Prov.Ct).

[276] Ibid at 252.

[277] Section 6(2)(g). This section was not included in the later *Child and Family Services Act* S.O., 1984 c55.

orders made. Taken together, these factors make *Re Children's Aid Society for the District of Kenora and J.L.* a dubious authority for *MacDonald's* case.

Treatment and Supervision Regimen

In relation to the issue of endangerment to the health and well-being of the child, the Court heard evidence about the sort of caring she required in light of her current health susceptibilities. The medical evidence was that the baby required:

> careful nutritional maintenance as drug-addicted babies require twice the calories of a normal child for brain and organ growth. The severe anaemia requires close observation by experienced personnel for symptoms of further withdrawal or infection. The baby requires daily weighing and skilled personnel to assess the conduct of the withdrawal process and to determine whether the level of stress in the home is such that a child is in danger of abuse or neglect.[278]

This evidence, in effect, indicates that the child needed care which no parent could provide. The references to 'experienced personnel' and 'skilled personnel' reinforce this point. This was further reinforced with evidence from a 'neo-natal withdrawal syndrome' and 'child abuse' expert who deposed that "a drug addicted baby may invoke exasperation by his or her incessant and inconsolable crying. . . "drug-addicted babies like D.J. can invite abuse in any home and place a tremendous burden on even the best of parents."[279] The clear implication was that DJ's parents were a far cry from 'the best of parents'. He went on to describe for the court a "typical scenario for child abuse and infanticide".[280] This involved the presence of a step-father who may use violence against the child. Such abuse could be prompted by feelings of resentment because he must compete with the child for the mother's affection, and by his inability to cope with the child's crying.[281] There was, in addition, evidence of concern about the particular abusive tendencies of Mr O'Brian, Barbara MacDonald's partner, which made this hypothetical scenario likely to materialize in DJ's home.

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[278] Supra note 267 at 333.

[279] Ibid at 336.

[280] Ibid.

[281] Ibid.

Among the characteristics singled out, the court heard evidence that he was "abusive toward staff at the hospital",[282] that he had "much less than the usual endowment of patience and tolerance",[283] that he had "many irrational beliefs" including that the medical treatment recommended for D.J. was unnecessary,[284] and that he seemed to "totally dominate the mother".[285]

Although there was no current evidence available of inadequate care or neglect, the Court found that anticipated neglect, in addition to the current manifestations of drug use during pregnancy, sufficed to make DJ a child in need of protection. In the Court's view "since immediately after birth, she has undergone severe physical pain during the withdrawal process. Her safety and well-being, has been and continues to be endangered."[286]

Supervision

The Court received affidavit evidence from Dr Segal detailing the extensive supervision required to ensure the safety and well-being of the child. This included homemakers services seven days a week, visits by the community health nurse three times a week and daily visits by a social worker.[287] In addition, he deposed that "it is my diagnosis and prognosis that voluntary supervision and voluntary support services would not ensure the safety and well-being of this child. . . If the support services are not in place on an involuntary basis then the child would be in a high risk situation. The death of the child being one of the very real consequences."[288]

The Court ordered that the child remain with her mother under the supervision of the Superintendent. In addition, the following conditions were imposed:

(1) There are to be no overnight visits with the baby;

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[282] Ibid.

[283] Ibid.

[284] Ibid.

[285] Ibid at 337.

[286] Ibid at 335.

[287] Ibid at 338.

[288] Ibid.

(2) The family is to reside in Vancouver to ensure the continuance of the social services support team which has been established;

(3) Dr Segal is to have the sole discretion as to the level of support services required to ensure the safety and well-being of this child; and

(4) The child is to remain in the home and not be taken on excursions to public places.[289]

A number of aspects of this case bear special mention. First, the finding that, as a matter of law, a fetus could be abused during gestation opened up new possibilities for child protection applications before birth. This raises a host of issues that do not arise in applications taking place after the birth of the child. Since it is more difficult to establish harm to an entity encased within the mother's body (especially in the absence of her co-operation), how will harm be established? How will any orders made in respect of the fetus be enforced? How will this infringement of the mother's liberty interests be justified?

Second, medical and psychological knowledge played a prominent role in this case in three important respects. First, the finding that drug use during pregnancy amounted to child abuse, is premised on a construction of the pregnant body as two entities. Medical evidence about the harmful effects of drug use on the fetus supports this construction because it characterizes the mother's drug use as an act causing harm to another, rather than an act in relation to her body.[290]

Third, Barbara MacDonald, it will be remembered, was using methadone during her pregnancy under medical supervision, and there was no evidence that she did not co-operate in the medical management of her pregnancy. Barbara MacDonald was, therefore, already subject to medical surveillance prior to judicial intervention. Her presence in the courtroom was no doubt facilitated by this prior surveillance. These

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[289] Ibid at 339.

[290] In her work on maternal selfhood, Isabel Karpin analyses how the boundary metaphor is used in legal discourses to effectively disembody the mother and to delineate and redefine her agency. This is achieved, she argues, when the interpretive acts of judges describe the actions of a pregnant woman as impacting on some subject other than herself. See I. Karpin, "Reimagining Maternal Selfhood: Transgressing Body Boundaries and the Law" (1994) 2 The Australian Feminist law Journal 36 at 41.

coalitions effectively removed any possibility of Barbara MacDonald maintaining custody of her child. Her mistake was to become pregnant while she was using methadone. Although she continued to use methadone during the course of her pregnancy, under medical supervision and pursuant to medical advice, her acts were characterized as acts of child abuse.

Fourth, psychological profiling formed the basis for predictions about the risks to the child in the absence of extensive, involuntary supervision. It was accepted that the risk to the child was enhanced by Mr O'Brian's opposition towards the interventions. This resistance was treated as a danger, and formed a basis for the court's orders. The form of those orders reflected the opinion of a doctor as to the level of supervision required and, further, conferred additional power on him to determine the nature and scope of supervision. In this way, the exercise of control over the family can be characterized as operating in the form of a coalition between judicial power and mechanisms of disciplinary surveillance.

Re Children's Aid Society of City of Belleville and T

The primary issue before the court in *Re Children's Aid Society of City of Belleville and T*[291] was whether Linda T.'s fetus was a child in need of protection within the meaning of the *Child and Family Services Act*, S.O. 1984, c.55. Linda T was 26 years old, unmarried, and without permanent accommodation. She was also between 37 and 38 weeks pregnant. The Children's Aid Society alleged that Linda T had refused to obtain medical assistance and her behavior demonstrated a lack of concern for the health of her fetus. It was on this basis that the Children's Aid Society sought wardship orders in relation to the fetus for a period of three months.[292]

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[291] (1987) 59 O.R. (2d) 204.

[292] It was also accepted that there was reasonable cause to believe that Linda T. was suffering from a mental disorder which would likely result in serious bodily harm to herself or another person. The court regarded the fetus as another person within the meaning of the *Mental Health Act* R.S.O. 1982, c.262 and ordered her to undergo psychiatric assessment, ibid at 207-208.

This was the second application brought by the Society in relation to Linda T's fetus. In the first application, heard by the same judge two days previously, Justice Kirkland held that he had "authority to find a child en ventre sa mere to be in need of protection"[293] although there was insufficient evidence at that time to establish that the fetus was a child in need of protection within the scope of the Act. In concluding that the statute conferred jurisdiction over fetuses he relied on *Re Superintendent of Family & Child Services and MacDonald*[294] and *Re Brown*.[295] Both cases involved already born children.

The Court also examined section 37(2) of the Act which sets out the circumstances in which a child might be found to be in need of protection. It found that the fetus fell within the circumstances covered by clauses (b), (e) and "to some extent" (h).[296] Clause (b) specifies that a child is in need of protection where there is a substantial risk that the child will suffer physical harm inflicted by the person having charge of the child, or caused by their failure to care for, or adequately protect and supervise the child. Clause (e) relates to circumstances in which the child requires medical treatment to cure, prevent or alleviate physical harm, and where the person having charge of the child fails to, refuses to or is unable to provide or consent to the treatment. A child is in need of protection pursuant to clause (h) if she or he suffers from a mental, emotional or developmental condition that, if not remedied, could seriously impair the child's development, and the person in charge does not provide the required treatment.

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[293] *Re Children's Aid Society of Belleville and Unborn Child of L.T. and G.K.* (March 30, 1987), Belleville 10/87 (Ont. Prov. Ct. Fam. Div) (unreported) at 9.

[294] (1982) 135 DLR (3d) 330 (S.C.).

[295] (1974) 9 OR (2d) 185 (Co. Ct.). This case concerned the inability of the children's parents to adequately care for their children owing to their own disabilities. The passage relied upon by in *Re Children's Aid Society of City of Belleville and T* was the opinion of a "local psychiatrist" which was unhesitatingly adopted by Stortini J: "Every child should have basic rights such as: the right to be wanted, the right to be born healthy, the right to live in a healthy environment, the right to such basic needs as food, housing and education, and the right to continuous loving care." (ibid at 192).

[296] Ibid.

Linda's Body

The court specifically considered the evidence relating to the body of Linda T. as significant in its determination to grant the orders, relying in particular on evidence of "abdominal discharge" and "abdominal pain". The judgement reveals contradictory evidence on these issues.[297] Ultimately, however, the judge rejected Linda T.'s evidence about what was happening to her body and adopted instead the evidence of her husband and his sister:

> The four significant aspects of the evidence that bear on my decision are firstly that there has been some form of discharge that may or may not be normal in this particular situation. The evidence of N.K. and G.K. [Linda's husband and his sister] is that there has been considerable discharge of an odorous nature. Linda has essentially denied it. I have considered her evidence as being a denial of discharge, although I think it is somewhat qualified in that regard. Secondly, there is the evidence of abdominal pain, at times severe, lasting for a period of at least up to an hour and a half. Again, Linda in a qualified way, has denied abdominal pain, but has referred to "discomfort".[298]

Clearly, Linda's evidence about the intensity of pain she was experiencing and about the amount of discharge emanating from her own body was not believed. The Court explicitly relied on evidence of severe abdominal pain and discharge from other sources, namely Linda's common law husband and his sister. Justice Kirkland does not make clear his basis for accepting the evidence of these third parties and rejecting the evidence of Linda. The fact that Linda did not want to accept medical treatment might have been reason for assuming that she would minimize the level of discomfort that she may have been experiencing. On the other hand, it seems strange to dismiss the evidence of the person whose 'bodily infirmities' are at issue without giving reasons for doing so. It remains an inescapable conclusion surely, that Linda T is the only person who can really know how much abdominal pain she is experiencing.

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[297] Interestingly, one of the aspects that sets this case apart from the other cases relating to prenatal intervention is that the pregnant woman was not only represented at the application but also gave evidence.
[298] Supra note 291 at 205.

The consequences of these bodily symptoms were also the subject of evidence. In particular, the Court heard evidence about the risks that the abdominal discomfort and discharge posed to the fetus. Justice Kirkland states:

> Considering the developmental condition of the child, as related in the evidence of the public health nurse, the child would indeed be in a serious risk situation where there exists an abdominal discharge and abdominal pain. These could be symptoms of infection in the fetus itself. The doctor's evidence I heard last Thursday night indicates an infection can lead to pneumonia. This could thereby result in the death of the unborn child.[299]

This passage contains references to child, fetus and unborn child indicating some confusion about the nature of the entity that the court is being asked to protect. His Honour uses the language of child in connection with the description of Linda's bodily pain and discharge. By contrast he uses the language of fetus in connection with a visual image of the entity inside the body of Linda T, and unborn child in connection with its possible death. This confusion enables the court to proceed without offering any clear basis for conflating the status of the fetus and a child.

A number of silences also exist. It is not clear from the judgement whether this doctor actually examined Linda T, nor is any attempt made to quantify the risk that this pain and discharge could be symptoms of pneumonia, and if so, the risk that this could result in fetal death. In short, the passage consists of a string of possibilities, which together culminate in the ominous and rather grim image of the death of the 'child' inside Linda T.'s body. This is important because this knowledge forms the basis of the judge's decision to compel Linda to accept medical treatment. In the context of this particular case, it seems quite clear that medical knowledge is privileged with a status greater than Linda T.'s own experience, and yet the basis for that knowledge is vague and imprecise. The effect, however, was to construct Linda's body as a dangerous environment for the fetus and, accordingly, a deviation from the ideal maternal body.

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[299] Ibid at 205-206.

Linda's Behavior

The Court also relied on evidence of Linda T's behavior and attitude to find the fetus in need of protection under s37(2)(b) & (e). Her behavior was described as "erratic" and, according to the evidence, she had moved residences a number of times in the previous month. Linda T's counsel submitted that this had been for economic reasons, but the judge did not accept that explanation.[300] On one occasion, Linda T had spent the night in an underground parking lot, and had sat in a puddle of cold water whilst improperly dressed.[301] His Honour concluded that this was "significant as to the state of mind of Linda and the danger that this represents to the unborn child."[302]

Linda's state of mind was, therefore, used as evidence of the danger she posed to the fetus. In addition to her inability to properly clothe and house herself, she refused medical treatment.[303] This was seen as an attitude that was "not conducive to the safe and healthy delivery of the child."[304] In conjunction with her unfit bodily state, the court reached the conclusion that the fetus was a child in need of protection. [305]

The Court also found, in the absence of psychiatric evidence, that there was reasonable cause to believe that Linda T was suffering from a mental disorder. This finding was based on the evidence of her unwillingness to accept medical treatment, and other conduct thought inappropriate for a pregnant woman. In the context of the *Mental Health Act* R.S.O. c.262, this behavior was taken as evidence of an attempt to cause bodily harm to herself or the fetus. There was enough information for the judge to conclude that there was reasonable cause to believe that Linda was suffering from a mental disorder which would likely result in serious bodily harm to herself or

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[300] Ibid at 206.

[301] Ibid at 207.

[302] Ibid at 206.

[303] "She refuses to seek, maintain or accept any form of medical assistance which is clearly necessary for the delivery of the child, particularly where there is a fear that the child could be born in an unhealthy state or in a situation where the child's life is at risk." Ibid.

[304] Ibid.

[305] Ibid at 205.

another person. On the basis of these findings, the Court ordered that Linda T be assessed pursuant to s10 of the *Mental Health Act*, 1980. By contemplating the risk that Linda's behavior might harm another, the judge interpreted 'another person' as covering fetuses. This is a further example of the notional separation of the fetus from the mother.

The significance of this interpretation of Linda T's behavior is twofold. First, her refusal of medical treatment and her indigent circumstances set her apart for the ideal mother to be. Second, the suggestion that she is mentally disordered has the effect of representing her as a pregnant body out of control. The mind, which is traditionally understood as the means of controlling the body, is not functioning and therefore, intervention is required. There is no concerted effort to understand the explanations offered by Linda T. in relation to her body or behavior. Evidence about economic difficulties and pain and discomfort were disregarded.

Orders

The Court ordered that the "child be a ward of the society for three months."[906] The judgement was completely silent on the logistics of this order, and on the infringement of Linda T's rights.[907] This silence sustains the fragile conceptualization of the mother and fetus as separate entities. The challenges to this conceptualization inherent in the physical realities of warding a fetus were thus obfuscated.

Re R

In *Re R*[908] the Superintendent of Family and Child Service apprehended the fetus of a woman refusing to consent to a caesarean section. The purpose of the apprehension

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[906] Ibid.

[907] Susan Tatelshi recounts that media reports at the time indicated that the C.A.S. intended to offer a range of options to Linda and the option ultimately pursued would depend on the level of co-operation they received form her. They did not recoil from the prospect of seeking Linda's arrest in the event of any failure to comply with their directions. S. Tatelshi, "Apprehending the Fetus *En L'entre Sa Mere*: A Study in Judicial Sleight of Hand" (1989) 53 Saskatchewan Law Review 113, 126.

[908] (1987) 9 RFL (3d) 415 (Prov.Ct).

was to enable the Superintendent to advise the doctor to do what was medically required to ensure the safety and well-being of the 'child'. Although Mrs R agreed to the procedure prior to its being performed, the apprehension order was used as a further basis to maintain custody of the child after its birth and so was subsequently challenged. The court was, therefore, required to determine whether the pre-birth apprehension was validly obtained under the powers conferred by the *Family and Child Service Act*, S.B.C. 1980, c.11. The Superintendent argued that the apprehension was valid on the basis that the 'child' was deprived of necessary medical care by reason of its mother's disabilty. This required an assessment of the circumstances giving rise to the apprehension, namely, the alleged danger posed to the fetus by the mother's refusal to consent to a caesarean delivery.

Mrs R's Body

The Superintendent of Child and Family Services was telephoned by Mrs R's treating doctor, Dr Zourves, while she was in labor.[109] He informed the Superintendent that the fetus would die if a caesarean section was not performed, and that Mrs R would not consent to that procedure. Within an hour of the telephone call, Dr Zourves was notified that the Superintendent was apprehending the 'child' and that he was directed to do what "was medically required for the child but that he was not consenting to any medical procedure to be performed on the mother."[110]

In the judgement, Mrs R.'s body was described in the following way:

> . . the cervix, or opening to the uterus, was opened 5-6 cm, which is fifty per cent of the complete opening required; and bulging through it was the sac of fluid containing at least one limb and the umbilical cord. The baby was in a footling breech presentation (head up with a foot or both feet protruding through the partially opened cervix). The

[109] Ibid at 416.

[110] Ibid.

> concern was that, should the sac of fluid rupture, the umbilical cord would be compressed, thus cutting off the baby's oxygen.[111]

This passage focuses on the contact between the 'baby's' body and the body of Mrs R, particularly her cervix. In the opinion of the medical experts, this was threatening. The judge unambiguously accepted the veracity of this knowledge, and went on to state that:

> The evidence is clear and concise. The cesarean section was mandatory for the safety and well-being of the child. Dr Zouvres said "there was no grey area . . . what I saw, [there was] only one safe way for the patient and the baby". [112]

As events unfolded Mrs R, who was not informed of the apprehension order, consented to the caesarean section. It is difficult to say whether this was voluntary or whether she yielded to the pressure brought to bear by medical staff. If it was a voluntary consent, her decision to reverse her earlier refusal could have reflected a change in her experience of how her labor was progressing, a possibility not considered in the judgement. Like *Re Children's Aid Society of City of Belleville and T*, there is no room in this legal discussion for the possibility of pregnant women having legally relevant knowledge about their bodies. Indeed, the judgement also contains a description of events as they occurred immediately after Mrs R had agreed to the operation. This seems to serve the purpose of vindicating the doctor's predictions:

> As Mrs [R.] was being transferred from the stretcher to the operating table the sac ruptured with a gush of fluid. Immediate examination found the cord and lower limb felt high in the vagina and the cervix still only partially opened. The cord was pulsating and monitoring of the heart did not show any immediate distress. In view of Mrs [R.]'s chronic bronchitis due to heavy cigarette use an epidural anaesthetic was used. An uneventful Cesarean Section was performed resulting in the delivery of a healthy male infant at 2249 hours. The baby weighed 2500 gms. and was vigorous at birth.[113]

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[111] Ibid.

[112] Ibid.

[113] Ibid.

Although uncritically accepted by the court as an objective report, the partiality of this account is embedded in the contrasting visual images of Mrs R and the baby, as well as the contrasting constructions of the contact between the bodies of Mrs R and the fetus, and Mrs R and the surgeons. Mrs R appears in this account in the form of a vagina and cervix causing obstruction to the birth of her baby, and as a heavy smoker. In this way our vision of her is negative and she is easily seen as a dangerous and unhealthy body. In stark contrast, the baby is seen as vigorous and healthy. Similarly, the "gush of fluid" and the "pulsating cord" convey a contact between Mrs R and the fetus that is threatening and abhorrent. By contrast, the use of the words "uneventful" to describe the caesarean section convey a sense that the contact between Mrs R's body and the medical staff is safe and non-threatening. What is meant, I suppose, is that once Mrs R was sedated, the operation proceeded without any medical complications. However, the descriptor "uneventful" presupposes that the operation itself could be divorced from the potentially violent context in which it was performed. It also obscures the physical dangers to Mrs R inherent in major surgery.

Mrs R's Behavior

There was extensive and detailed evidence about Mrs R's parenting skills and general chaotic lifestyle. This evidence addressed the further issue of whether a permanent guardianship order should have been granted and is therefore not strictly relevant to the pre-birth apprehension. It does, however, contribute to the overall picture of Mrs R as a bad mother. As such, it cannot be easily separated from the Court's decision regarding the legality of the pre-birth apprehension. The Court was quite explicit about Mrs R's parenting abilities. There was overwhelming evidence from medical staff and social workers that Mrs R was "incapable of parenting a child."[114] She was unable to "effectively, appropriately and safely, nurture and parent a child of any age."[115] She had already produced four children, all of whom were the subject of permanent wardship orders.

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[114] Ibid at 417.

[115] Ibid.

The Court concluded that the pre-birth apprehension was 'entirely proper', relying on *Superintendent of Family and Child Service v MacDonald* as authority. In a manner consistent with the approach taken in *Re Children's Aid Society of City of Belleville and T*, the Court sidestepped the serious question of what such an apprehension meant as regards the rights of Mrs R. In this case, however, the disavowal of their relevance was explicit:

> The purpose of the apprehension was to ensure proper medical attention for the baby. This is not a case of women's rights; Mrs R consented without coercion or threat to the operation . . . This is simply a case to determine what is best for the safety and well-being of this child. It is clear that this child was in the process of being born and the intervention and redirection of its birth were required for its survival. It was at or near term. It required no life support; it was vigorous at birth and indeed he was born healthy.[116]

This language achieves the twin purposes of constructing Mrs R and her child as separate, and of privileging the knowledge of doctors about what action was required. Importantly, the fact that Mrs R was apparently not coerced into the procedure was not interpreted as evidence that she too may have decided that intervention was appropriate for her. Nor did the court consider her consent as a basis for vitiating the basis for the apprehension. This point was, however, considered by the appellate court which overruled Justice Davis' decision on the legality of the pre-birth apprehension.[117]

The British Columbia Supreme Court set aside the decision of the Provincial Court.[118] It found no basis in fact[119] or in law[120] to support a pre-birth apprehension. It clearly

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[116] Ibid at 420.

[117] Re Baby R (1988) 53 DLR (4th) 69 (S.C.).

[118] Ibid.

[119] Justice MacDonnell stated that: " [A]ssuming there was any right in the first place to apprehend an unborn child. . It is apparent from looking at the sections of the Act relied upon that with the consent to the caesarean section the foundation must surely fall. The first allegation was that the child was deprived of necessary medical care through the disability of its parent. That surely cannot stand, as the child

distinguished between a fetus and a child, and concluded that the powers under the Act could only be exercised in respect of born children. It is particularly interesting to consider the manner in which the Supreme Court framed the relevant question and the influence this exerted over the considerations deemed relevant to the application and the reasoning adopted. The Court limited the legal question before it to the issue of whether the fetus was a child within the meaning of the Act.[121] In doing so, it specifically stated that:

> The background leading up to these proceedings can be briefly put, as I see no need to review the evidence of the character and conduct of the mother that came out in evidence, not her treatment of her previous children, as this is not germane to the topic I need to address.[122]

Thus, a range of evidence about Mrs R's character and bad mothering were excluded from consideration. Another factor which distinguished the approach taken by the Supreme Court was its acknowledgement of the physical interconnectedness of the fetus and Mrs R, and the ramifications of this connection for Mrs R in light of the action proposed. This was evident in two respects. First, the court questioned the claim that the apprehension was for the purpose of providing medical care to the fetus and not in any way intended to authorize the performance of any medical procedure on the mother. On this point the Court stated that "at the pre-birth stage, it is hard to imagine how treatment could be given to the child without invading the body of the mother".[123] Second, the Court was unable to ignore the infringement of

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ultimately did not need any medical care, aside from a caesarean section if that was imperative. I make no comment on that. . . The second allegation of being deprived of necessary medical attention also must surely fall, because medical attention, although late in the day, was authorized and consented to by the mother, so there was no deprivation of necessary medical attention. I have looked at the report to the court to see the basis of the apprehension, and have looked at the evidence led, and I am unable to conclude that there was a foundation at law for the apprehension when it was done." Ibid at 75.

[120] After reviewing the definition of child in the Act, together with English and Canadian authority for the proposition that the fetus has no legal personality, the Court concluded that a fetus is not a child for the purposes of the Act. "I conclude, therefore, after examining the *Family and Child Service Act* and the other relevant law, that the powers of the Superintendent to apprehend are restricted to living children that have been delivered. Ibid at 80.

[121] Ibid at 71.

[122] Ibid.

[123] Ibid at 74.

Mrs R's rights inherent in a pre-birth apprehension. In this, it was persuaded by the English decision of *Re F (in utero)*: [124]

> For the apprehension of a child to be effective there must be a measure of control over the body of the mother. Should it be lawful in this case to apprehend an unborn child hours before birth, then it would logically follow that an apprehension could take place a month or more before term. Such powers to interfere with the rights of women, if granted and if lawful, must be done by specific legislation and anything less will not do.[125]

The Court reached a different conclusion, in part I suggest, because it adopted a conceptualisation of the mother and fetus as intimately connected. From this position, the Court was unable to disregard or ignore the material effects of the orders on Mrs R. In other words, it considered the ramifications of intervention from the embodied perspective of Mrs R. This approach was also followed in *Re A (in utero)*.[126]

In concluding this section, I want to offer some thoughts on how these divergent approaches to the question of prenatal intervention might be explained. It seems that Courts which relied heavily on detailed descriptions provided by scientific explanations of the body of the mother and the fetus as separate entities were more likely to exercise coercive power over the body of the pregnant woman. These decisions do not expressly consider how the intervention proposed will affect the woman whose body the fetus forms a part. The notional dissection of the body of the pregnant woman with a focus on the fetus, it seems, has the effect of relegating the pregnant woman to the realm of the insignificant. Conversely, it seems that courts which conceptualized the body of the pregnant woman as being intimately connected to the fetus were more likely to reach the opposite result.

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[124] [1988] 2 WLR 1288. The Supreme Court quoted extensively from the headnote: "[S]ince a foetus at whatever stage of its development had no existence independent of its mother, the court could not exercise the rights, powers and duties over the foetus without controlling the mother's actions; that the court could not extend its wardship jurisdiction over minors to a jurisdiction over a mother for the protection of an unborn child, which had no legal rights or existence. . .Ibid at 79-80.

[125] Ibid at 80.

[126] (1990) 28 R.F.L. (3d) 288 (Fam.Ct).

II. Intervention Based on Mental Incapacity

It will be recalled that in *Re Children's Aid Society of City of Belleville and T*, the Court ordered that Linda T submit to a psychiatric assessment. Although Linda T was forced to accept prenatal care and supervision for the remainder of her pregnancy under the *Child and Family Service Act*, the Court also made an order under the *Mental Health Act* for the psychiatric assessment of Linda T. This points to a connection between the failure to accept medical treatment for the benefit of the fetus and mental disorder. This reasoning is advanced in the case of *Winnipeg Child & Family Services v G*, where the Queens Bench of Manitoba issued interlocutory orders committing Ms. G to drug treatment during her pregnancy on the basis of mental incompetence, without any recourse to child protection legislation.

Winnipeg Child & Family Services v G

In *Winnipeg Child and Family Services v G*,[127] the Winnipeg Child And Family Services Agency sued Ms. G by statement of claim for an order that G remain in a place of safety and refrain from taking intoxicating substances until the birth of her child.[128] More immediately, the Agency sought a mandatory injunction at common law to order G to enter a treatment programme until the birth of her child pending the trial or, in the alternative, an order committing G to the custody of the Agency or Director of Child and Family Services pursuant to the *Mental Health Act*, R.S.M. 1987, c.M110.

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[127] (1996) 138 DLR (4th) 238 (C.A.).

[128] The reported decision of the Queen's Bench relates to the interlocutory issues and does not elaborate on the precise nature of the primary claim. It can be inferred, however, that the plaintiff sought to rely alternatively on the parens patriae jurisdiction over minors and the common law of tort to ground a claim that G's negligent conduct toward her unborn child could be restrained. Each of these claims were considered and rejected in the Court of Appeal decision. In rejecting these arguments, the Court restated the principle that the fetus was not a person in law and, accordingly, had no basis for bringing an action in tort. Similarly, without a 'minor' to protect, the parens patriae jurisdiction could not be invoked; *Winnipeg Child & Family Services v G* (1996) 138 D.L.R. (4th) 254 (CA) at 258-262.

G was a 22 year old aboriginal woman who was pregnant for the fourth time. She was described as a "chronic" solvent abuser[329] who, as a result, had an "unstable lifestyle" which included incidents of prostitution.[330]

G's Parenting History

As was the case in *Re R*, the Court heard extensive evidence about G's parenting history. Unlike Mrs R, however, G's children were described as physically damaged as a result of G's substance abuse during pregnancy. G's lengthy history of contact with the Social Services appear to have commenced with their knowledge of her first pregnancy in 1991, and subsequent contacts with her appear to have been motivated by her pregnancies.[331] In the first instance, she was placed at the Seven Oaks Centre "presumably on a voluntary basis",[332] and was moved to a different centre after the birth of the child. Social Services later sought permanent guardianship of the child when she failed to comply with the conditions imposed at the centre.[333] Her second and third children were born in hospital, apprehended at birth, and later became permanent wards of the Service.[334] In June 1996, the Agency was informed that G was pregnant again and they attempted to locate her "to determine if she would co-operate in taking treatment for substance abuse".[335] She refused.[336]

G's Body

The Court heard evidence from a large number of social workers, psychiatrists and doctors. There were at least five doctors who gave evidence about the state of G's body and its threatening and dangerous impact on the fetus. Lengthy and intricate descriptions of the inner chaos and disintegration of G's body formed a significant

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[329] Ibid at 243.

[330] Ibid.

[331] Ibid.

[332] Ibid.

[333] Ibid.

[334] Ibid.

[335] Ibid.

[336] Ibid at 244.

corpus of the evidence reproduced in the judgement.[337] Outward signs of disease and disability were also reported. G's sister gave evidence that, on a recent occasion, G was so intoxicated that she was "unable to walk" or "go to the washroom".[338] A doctor gave evidence that on examination she had "a marked failure of muscular co-ordination in her gait, with marked intention tremor and inco-ordination on shin heel testing."[339] A psychiatrist also noted that she was "very unstable in her gait, using walls and furniture for support when walking".[340] G's state of bodily disintegration was, therefore, acutely apparent to anyone who saw her. This, at least, seemed to have been the common sense view taken by the judge:

> During the course of the hearing before me, Ms G walked across the court room several times on her own initiative. I observed her clinging to desks, chairs and railings to keep her balance through-out each of the trips. . . the evidence is very clear that her brain damage is causing her to lose her balance.[341]

There was evidence that G's lack of co-ordination was an indication of cerebellar degeneration caused by solvent abuse. An expert described the impact of solvent abuse on the brain in the following terms:

> The most important site of organ damage from glue sniffing is the brain. Substance abuse of this kind can cause a decrease in intellectual capacity. In addition to intellectual impairment, there is considerable evidence that solvent abuse causes damage to the *cerebellum*, the part of the brain which controls motor co-ordination. The abuse can also cause peripheral neuropathy. The peripheral nerves which control the sensation and motor power in a person's arms and legs can be damaged to the point where the user suffers loss of sensation and generalized muscle weakness. She deposed that solvents take a long time to come out of the body, particularly the brain. She deposed that

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[337] Dr Hoersch, for example, was called as an expert to give evidence about the ill-effects of glue sniffing. These included a " multitude of acute effects such as nausea, vomiting, tremors, blurred vision, joint pain, chest pain, decreased levels of consciousness, and seizures. The most severe effects are a progression to coma and respiratory or cardiac arrest, leading to death. Kidney, liver and bone marrow failure can result from chronic use." Ibid at 241.

[338] Ibid at 241.

[339] Ibid at 244.

[340] Ibid at 245.

[341] Ibid at 246.

> substance abuse causes considerable *cognitive impairment*, and it continues for some time even after the abuse stops [judge's emphasis][142].

The evidence of damage to G's brain was highlighted throughout the judgement with the italicization of every reference to the impact of solvent use on brain functioning.[143] This, as in the earlier cases, has the effect of representing G as a body absent the mind's controlling influence, a particularly frightening spectre given that G is pregnant. The implication is that she is unable to take steps to restore her body to a healthy state, or to prevent its imposition on the developing fetus.

The impact of glue sniffing on the fetus was also described in detail:

> Dr Chudley Head stated that these children when born, exhibit "central nervous system dysfunction, developmental delay, attention deficit disorder, microcephaly, growth deficiency, short palprebal fissures, deep-set eyes, micrognathia, abnormal auricles and small fingernails." He stated . . . that the damage done to an unborn child can be reduced if exposure to glue is eliminated during the second and third trimesters. It is self-evident that if the fetus is damaged, the child will be damaged."[144]

The cumulative effect of the evidence was to construct G's body as a dangerous maternal environment. Equally important, however, was that G consistently refused treatment for her addiction. Unlike the women concerned in *Re* R and *Re Children's Aid Society of City of Belleville and T*, however, her brain functioning was the subject of intense scrutiny. The effect was to understand her treatment refusals as evidence of mental incompetence caused by brain damage rather than active resistance or mental illness.

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[142] Ibid at 241-242.

[143] The following words were italicized by the judge: "damage to the *cerebellum*" (at 242), "causes considerable *cognitive impairment*" (at 242), "*cerebellar disease*" and "*cognitive impairment*" (at 244), "*cerebellar degeneration*" (at 244), "*chronic solvent and mixed personality disorder*" (at 245).

[144] Ibid at 242.

Jurisdictional Bases for the Orders

It will be recalled that orders to confine G were sought on the basis of powers conferred by the *Mental Health Act* or the *parens patriae* power over adults of unsound mind. These strategies differ from those adopted in the earlier cases because they do not rest on any overt claim that the fetus requires protection.[145]

Section 56 of the *Mental Health Act* confers jurisdiction to makes orders to declare that a person is mentally disordered, and for committing that person to custody. Although two psychiatrists examined G and concluded that she was not suffering a mental disorder within the meaning of the Act, the Court made a contrary finding. This merits special attention. The judge declined to adopt the findings of the both psychiatrists on the basis that they did not address themselves directly to the question of whether G had a "disorder of thought, mood perception . . . that grossly impairs . . (her) ability to meet the ordinary demands of life".[146] Accordingly, the judge made his own findings based on the evidence of other medical experts and that which he could see with his own eyes.[147] On the basis of the power contained in the *Mental Health Act*, then, the court made orders that (i) G remain in the custody of the Director of Child and Family Services who was conferred with power to arrange to have G treated, and (ii) in the event that G fails to complete the treatment prescribed by the Director, the Director may apply for an order committing G for treatment. The orders were expressed to terminate when G gave birth to her child.

As an alternative basis for grounding these orders, the Court relied on the *parens patriae* jurisdiction over adults of unsound mind.[148] This is a discretionary power to permit the treatment of a mentally incompetent adult who is, by reason of their

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[145] Although, as noted above, these claims were advanced as issues to be determined at trial. See supra note 328.

[146] Section 1 of the Act defines "mental disorder" as: "a substantial disorder of thought, mood, perception, orientation or memory that grossly impairs judgement, behavior, capacity to recognize reality or to meet the ordinary demands of life and except in Part I includes mental retardation."

[147] Ibid at 246.

[148] Ibid at 247.

incompetence unable to consent to treatment.[149] The Court held that there was sufficient evidence of mental incompetence to make out a prima facie case in support of an interim injunction pursuant to the parens patriae power over adults of unsound mind.[150]

These orders were set aside by the Manitoba Court of Appeal.[151] It found that the judge was not entitled, on the evidence, to make the finding of mental incompetence upon which the application under the *Mental Health Act* and the exercise of the *parens patriae* power was based.[152] In doing so, the court drew attention to the evidence of the psychiatrists which contradicted Schulman J's findings, and the fact that the orders were expressed to terminate on the birth of the child. This it held, was a strong indicator that the treatment was not intended for the primary benefit of G but, rather, for the fetus.[153] However, as there was no basis in law for intervening for the benefit of the fetus, the court could not use its others powers to do indirectly what could not be done directly.[154] Importantly, the court did not rule out this form of intervention in the future, it simply stated that the facts did not support it in this case.

The obiter comments of Schulman J indicated his view that "the focus should be on the child to be born".[155] Schulman J took the opportunity to record the view that the parens patriae jurisdiction over minors should be extended to include fetuses. He states that: "provided the court can be satisfied by adequate means that the child will be born, then I see no reason why the parens patriae jurisdiction should not be

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[149] Ibid.

[150] Ibid at 248-49.

[151] (1996) 138, DLR (4th) 254 (CA).

[152] Ibid at 257.

[153] Ibid.

[154] Ibid. The Court relied on *Tremblay v Daigle* [1989] 2 S.C.R. 530 (S.C.C.) and *R v Sullivan* [1991] 1 S.C.R. 489 (S.C.C.) as authority for the proposition that the fetus is not a legal person. Accordingly, no tortious action could be initiated by it on or its behalf. Nor could the court exercise its parens patriae jurisdiction over minors to protect it. The Court went further to state that, even if the parens patriae jurisdiction was broad enough to include fetuses, it should not be exercised because the deprivation of the pregnant woman's liberty was too serious. The exercise of such powers would have to be determined by Parliament; ibid at 258-263.

[155] Supra note 327 at 253.

enlarged in relation to that child prior to birth, to protect the health of the child."[156] This is an attempt to revive the causes of action relied upon in the early prenatal intervention cases, relying on the common law rather than statutory foundations. The Court of Appeal recognized this, and concluded that no such extension was possible or desirable, relying on the same authorities cited in *Re Baby R.*[157]

Conclusions

My first conclusion is that the cases show different knowledges about women's bodies competing for judicial attention. Although medical knowledge about the body is routinely privileged in these legal discourses, other types of knowledge (eg the judge's 'common sense' knowledge, or the woman's experiential knowledge) occasionally surface in the reports. I take this as a basis for suggesting that the primacy accorded a particular type of knowledge points to the operation of a *hierarchy of knowledges*, rather than the existence of some universal form of knowledge about the body. The recognition of a range of competing knowledges is significant because it admits the possibility that privileged forms of knowledge might be challenged.

My second conclusion is that the pregnant woman is constructed through legal discourses. Her body is cast as dangerous and unhealthy with consequences for herself and her fetus, and her mental faculties are impugned. These processes of characterization have implicated non-legal forms of knowledge, namely, biological explanations about the body of the pregnant woman and cultural explanations about motherhood and maternal behavior. However, the influence of these non-legal discourses on the law does not appear to have been uniform. Some cases reveal a much greater reliance on detailed and elaborate scientific explanations of the body of the pregnant woman than others. This might go some way to explaining why the law has not adopted a consistent position on the question of whether prenatal intervention is lawful. It is noteworthy that among the reported cases, most

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[156] Ibid.

[157] Supra note 351 at 258-263.

applications have been granted[158] and both appeals have reversed the earlier decisions. The applications routinely involve quite detailed medical evidence about the body and state of mind of the pregnant women, including descriptions of her behaviors and attitudes.

My third conclusion, again intimately related to the first and second, relates to the operation of power. A theory that assumes power to be unitary and issuing from a single source is an inadequate basis for understanding the regulation of the bodies of pregnant women. These cases disclose shifts between traditional forms of legal reasoning based on rights, and a more hybridized form of reasoning based on discourses about healthy bodies, reasonable choices and State interests. This supports the thesis that in certain areas of legal discourse we can discern a merger between rights discourse which has been the traditional paradigm for law's mediation of the exercise of State power over citizens, and discourses which effect disciplinary mechanisms of surveillance and normalization. The latter grouping is clearly linked to a decentralized notion of power, as suggested by Foucault, where power is located in and through discourses and practices relating to deviance and rehabilitation. There is also support in these cases for Carol Smart's argument that medicine generates new opportunities for law to extend its power over the bodies of women by creating new objects for scrutiny and new applications of medical technology.[159] The judicial sanctioning of surveillance of pregnant women to monitor their drug intake, ceasarean sections based on medical opinion as to the best interests of the fetus, and compulsory prenatal treatment and hospital births for itinerant women support this analysis.

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[158] *Re A (in utero)* is the exception, supra note 263.

[159] C. Smart, *Feminism and the Power of Law* (London: Routledge, 1989) at 96.

CONCLUSION

In this age of genetic and reproductive technologies, the Ideal maternal body should be seen as an increasingly important dimension of the Ideal mother. This Ideal body is constructed through the discourses of law, medicine and culture which collaborate to define its nature, to identify and condemn deviant bodies, and ultimately, to force women to comply with the dictates of the Ideal body in the interests of the fetus. This is achieved by a series of correspondences between these discourses. Medical discourses construct the maternal body as two entities with the effect that the fetus is seen as threatened by the bodily deficiencies of its mother. This is transposed onto moral frameworks about how mother should behave to create new expectations about the acceptance of medical treatment during pregnancy. When moral pressure to comply with the standard of the Ideal maternal body fail, the law has, in some circumstances, forced such compliance in the interests of the fetal patient.

In Chapter One, I explored the relationship between knowledge and embodiment as a basis for further exploration of the importance of discourses in facilitating the exercise of power over the body. One of the central aims of that chapter was to show that the production of knowledge relies upon the separation of the investigator from the object to be studied. The investigator employs his or her mind, together with armada of tools, tests and concepts, to guarantee the requisite neutrality and objectivity to validate the results. Within this framework, knowledge can be distilled from the exercise of reason, a task that requires mental work. Correlatively, the body, presenting as it does the threat of irrationality, is a thing to be controlled by the mind. It was also shown that the privileging of mind over body is mirrored in traditional epistemologies by a series of other dichotomies such as man/woman, culture/nature, agent/resource, and self/other. The pairs are mutually defining and bounded so that there is no overlap between them. Moreover, the second term in each pair encompasses the dangerous forces of chaos and disorder, and therefore create a need to be controlled. Within this schema, a pregnant woman who refuses medical treatment might be seen as the archetypal subject in need of control. She can be seen as simultaneously woman, body, nature, resource and, by virtue of her rejection of medical help, irrational. In one sense, however, the pregnant woman sits uneasily in

the Cartesian world-view and it is this aspect that lies at the root of legal disagreements about prenatal intervention. A pregnant woman, especially in the late stages of pregnancy, may be conceptualized (and with the aid of ultrasound, even visualized) as two people—ambiguously and simultaneously self and other. This conceptualization has been facilitated by the primacy accorded to scientific accounts of the body, and has had the effect of subjugating experiences of pregnancy that deviate from that conceptualization.

It is this particular conceptualization of a pregnant woman as more than one person that precedes the position the fetus has certain entitlements or claims that it can make on the pregnant woman. This position seeks to transpose the mother and a child relationship with its attendant entitlements and obligations onto the pregnant woman. This is sometimes reflected in language which identifies the non-compliant pregnant woman as mother, and the fetus as baby or child. Mother is a cultural symbol that evokes a range of meanings and behavioral expectations. Mothers are caring, nurturing and self-sacrificing. Children are vulnerable, needy and dependent.

The way in which language of cultural discourses constructs and reinforces these images of mother and child within the body of the pregnant woman was the subject of Chapter Two. There it was argued, using the examples of Mandy Allwood and Sheila, that the body of the pregnant woman was scrutinized as an environment for the fetus. In each case, medical knowledge claimed that the health or life of the fetus was endangered by the body of the pregnant woman. In Mandy Allwood's case, this was because her body was not thought capable of gestating eight fetuses, and in Sheila's case, because her body was tainted by HIV which could have been transmitted to the fetus. Subsequent discussions about each woman's insistence on pursuing pregnancy despite their bodily deficiencies became discourses about mothering, and in particular, each woman's suitability as a potential mother. In these discourses, the distinctions between mother and pregnant woman, fetus and child were not clear, and it was argued that this also contributed to a particular construction of the pregnant woman as two entities. This conceptualization was also reinforced by the primacy of scientific knowledge in structuring the issues deemed morally relevant. Although this knowledge was neither infallible nor consistent, it was never

questioned. This suggests a blind spot and, further, an uncritical acceptance of scientific knowledge and the priorities it establishes. By contrast, the experiences, motivations and desires of the women concerned were not considered relevant. There was a more or less complete disregard for these factors, and for the possibility that they may have shed some critical light on the structuring of the dilemma. The cumulative effect, I suggest, was to cast the women as dangerous bodies without agency and, therefore, in need of control. In this respect, Sheila was represented as incapable of assuming responsibility. Her role was largely overshadowed by the agency of her doctor. On the other hand, Mandy Allwood was represented as wholly irresponsible for failing to exercise her agency in conformity with medical advice.

This pressure to conform to the dictates of medical advisors during pregnancy as a sign of proper maternal behavior, raises serious questions about the possibility of achieving maternal autonomy. The most direct illustration of the denial of autonomy during pregnancy is legal intervention. This was examined in Chapter Three. In the Canadian cases relating to prenatal intervention, a number of themes from the earlier chapters could be discerned. Many of these discourses reinforced the notional separation of mother and fetus, by privileging scientific accounts of the dangers posed to the fetus and by uncritically accepting medical accounts of how to remove that danger. In some cases, the fetus was accorded a status equivalent to a child with the effect that the body of the pregnant woman was effaced. This effect was not, however, consistent. Two appeal cases have overruled earlier decisions to treat the fetus and mother as separate. In these cases, the incongruity of treating the mother and fetus as separate was central to the decision. Adopting an analysis of rights derived from personhood, these decisions effectively reinstate the integrity of the maternal body. They resisted the urge to see two individuals, and to control one for the benefit of the other. From this I concluded that the effect of non-legal discourses on the law is uneven, and I noted that these appellate decisions relied comparatively less on medical knowledge, and paid more attention to a traditional rights-based legal analysis.

In my analysis of *Winnipeg Child & Family Services v G*, I noted a further shift in law's approach to intervention. In this case, the law purported to intervene on the basis

that the woman was mentally incapable. The insinuation of mental incapacity stands as further testament to the assumption that mothers will do everything possible to procure the birth of a healthy child. Here, cultural expectations about maternal behavior could be to influence the mind of the judge. This approach, however, also recalls the cleavage of mind and body in traditional epistemologies by witnessing a deviant body, and assuming that the mind is absent. This presents a real threat to pregnant women's autonomy in the future because it does not rely on a competing assertion of fetal rights but rather, on a complex of assumptions about what mothers should do, and in the event that they fail to, about their mental competence.

In one sense, this analysis strikes an ominous chord. I have painted a picture of the exercise power over the maternal body as a complex of mechanisms that construct the body, and in doing so, control it directly and indirectly. However, I have also tried to present an alternative reading of the texts considered by pointing out their silences, or by offering different interpretations of the 'facts' concerned. In doing so, I have tried to resist the authoritative accounts of the maternal body as natural by challenging them as constructions. Further, I have pointed to their deficiencies as complete accounts by noting their exclusion of the experiences or agency of the women concerned.

BIBLIOGRAPHY

BOOKS

Abbott P. & Wallace C., eds. *Gender, Power and Sexuality* (London: MacMillan, 1991).

Arditti R., Klein R. & Minden S., eds. *Test-Tube Women, What Future for Motherhood?* (London: Pandora, 1984).

Bartlett K. and Kennedy R., eds. *Feminist Legal Theory: Readings in Law and Gender* (Boulder: Westview, 1991)

Besley C., *Critical Practice* (London: Methuen, 1980).

Bottomley S., Gunningham N. & Parker S., *Law in Context* (Sydney: Federation Press, 1991).

Bridgeman J. and Millns S., eds. *Law and Body Politics: Regulating the Female Body* (Hants: Dartmouth, 1995).

Callahan S. & Callahan D., eds. *Abortion - Understanding Differences* (New York: Plenum, 1984).

Eisenstein Z., *The Female Body and the Law* (Berkeley: University of California Press, 1988).

Fineman M., *The Neutered Mother, The Sexual Family and Other Twentieth Century Tragedies* New York: Routledge, 1995).

Foucault M., *Discipline & Punish - The Birth of the Prison* trans. A. Sheridan (London: Penguin, 1977).

Foucault M., *The History of Sexuality Vol.I, An Introduction* trans. R. Hurley (London: Allen Lane, 1978).

Grosz E., *Space, Time and Perversion: The Politics of Bodies* (Sydney: Allen & Unwin, 1996).

Grosz E., *Volatile Bodies: Toward a Corporeal Feminism* (Sydney: Allen and Unwin, 1994).

Gurien S., ed. *Feminist Knowledge: Critique and Construct* (London: Routledge, 1990).

Haraway D., *Simians, Cyborgs, and Women: The Reinvention of Nature* (New York: Routledge, 1991).

Kennedy I. and Grubb A., *Medical Law: Cases and Materials* 2nd ed. (London: Butterworths, 1994).

Keyserlingk E.W., *The Unborn Child's Right to Prenatal Care. A Comparative Law Perspective* (Montréal: Quebec Research Center of Private and Comparative Law, 1983).

MacKinnon C., *Toward a Feminist Theory of the State* (Cambridge: Harvard University Press, 1989).

Meaker S., *A Doctor Talks To Women* (London: Herbert Jenkins, 1957).

Milunsky A. and Annas G., eds. *Genetics and the Law II* (New York: Plenum, 1980).

Munson R., ed. *Intervention and Reflection: Basic Issues in Medical Ethics* (California: Wadsworth, 1992).

Nicholson L., ed. *Feminism/Postmodernism* (New York: Routledge, 1990).

Nicholson L., ed. *Feminist Contentions - A Philosophical Exchange* (New York: Routledge, 1996).

Pizzo P.A. & Wilfert C.M., eds. *Pediatric AIDS: The Challenge of HIV Infection in Infants, Children and Adolescents*, 2nd ed. (Baltimore: Williams & Wilkins, 1994).

Rowland R., *Living Laboratories: Woman and Reproductive Technologies* (Sydney: Pan McMillan,1992).

Seymour J., *Fetal Welfare and the Law* (Canberra: Australian Medical Association, 1993).

Sherwin S., *No Longer Patient: Feminist Ethics and Health Care* (Philadelphia: Temple University Press, 1992).

Smart C., *Feminism and the Power of Law* (London: Routledge, 1989).

Spelman E. V., *Inessential Woman: Problems of Exclusion in Feminist Thought* (Boston: Women's Press, 1988).

Stanford M., ed. *Reproductive Technologies - Gender, Motherhood and Medicine* (Oxford: Polity Press, 1987).

Urdang L. & Harding Swallow H., *Mosby's Medical & Nursing Dictionary* (St Louis: Mosby Press, 1983).

ARTICLES

Ashe M., "Law-Language of Maternity: Discourse Holding Nature in Contempt" (1988) 22 New England Law Review 521.

Ashe M., "Mind's Opportunity: Birthing a Poststructuralist Feminist Jurisprudence" (1987) 38 Syracuse Law Review 1129.

Ashe M., "Zig-zag Stitching and the Seamless Web: Thoughts on Reproduction and the Law" (1989) 13 Nova Law Review 355.

Bartlett K., "Feminist Legal Methods" (1990) 103 Harvard Law Review 829.

Bartlett K., "Feminist Legal Methods" in Bartlett K. and Kennedy R., eds. *Feminist Legal Theory: Readings in Law and Gender* (Boulder: Westview, 1991), 370.

Bayer R., "Ethical Challenges Posed By Zidovudine Treatment to Reduce Vertical Transmission of HIV" (1994) 331 The New England Journal of Medicine 1223.

Beardsell S., "Should Wider HIV Testing be Encouraged on the Grounds of HIV Prevention?" (1994) 6 AIDS Care 5.

Bennett B., "Pregnant Women and the Duty to Rescue" (1991) 9 Law in Context 70.

Berrien J., "Pregnancy and Drug Use: The Dangerous and Unequal Use of Punitive Measures" (1990) 2 Yale Journal of Law and Feminism 239.

Bhushan V. & Cushman L., "Paediatric AIDS: Selected Attitudes and Behaviours of Paediatricians in New York City Hospitals" (1995) 5 AIDS Care 27.

Boockvar K., "Beyond Survival: The Procreative Rights of Women with HIV" (1994) 14 Boston College Third World Journal 1.

Bordo S., "Feminism, Postmodernism and Gender-Scepticism" in Nicholson L., ed. *Feminism/Postmodernism* (London: Routledge, 1990), 133.

Bowes W. A., & Selgestad B., "Fetal Versus Maternal Rights: Medical & Legal Perspectives" (1981) 58 Obstetrics and Gynecology 209.

Brown K., "Descriptive and Normative Ethics: Class, Context and Confidentiality for Mothers with HIV" (1993) 36 Social Science & Medicine. 195.

Bunting A., "Feminism, Foucault and Law as Power/Knowledge" (1992) 30 Alberta Law Review 829.

Caddick A., "Feminism and the Body" (1986) 74 Arena 84.

Chervenak F. A., & McCullough L. B., "Perinatal Ethics: A Practical Method of Analysis of Obligations to Mother and Fetus" (1985) 66 Obstetrics and Gynecology 442.

Chrystie I., Zander L., Tilzey A., Wolfe A., Kenney A. & Banatvala J., "Is HIV testing in Antenatal Clinics Worthwhile? Can We Afford It? (1995) 7 AIDS Care 135.

Cover R., "The Supreme Court 1982 Term - Forward: Nomos and Narrative" (1983) 97 Harvard Law Review 4.

Crenshawe K., "Demarginalising the Intersection of Race and Sex: A Black Feminist Critique of Antidiscrimination Doctrine, Feminist Theory, and Antiracist Politics" in Bartlett K. and Kennedy R., eds. *Feminist Legal Theory: Readings in Law and Gender* (Boulder: Westview, 1991), 57.

Davidson C., Holland F., Newell M., Hudson C. & Peckham C., "Screening for HIV Infection in Pregnancy" (1993) 5 AIDS Care 135.

De Gama K., "A Brave New World? Rights Discourse and the Politics of Reproductive Autonomy" (1993) 20 Journal of Law and Society 114.

Di Stefano C., "Dilemmas of Difference: Feminism, Modernity and Post-Modernism" in Nicholson L., ed. *Feminism/Postmodernism* (London: Routledge, 1990), 63.

Duclos N., "Lessons of Difference: Feminist Theory on Cultural Diversity" (1990) 38 Buffalo Law Review 325.

Elliot C., "Where Ethics Come From and What To Do About It?" (1992) Hastings Center Report 28.

Flannery M., "Court-Ordered Intervention: A Final Means to the End of Gestational Substance Abuse" (1991-92) 30 Journal of Family Law 519.

Flax J., "Postmodernism and Gender Relations in Feminist Theory" in Nicholson L., ed. *Feminism/Postmodernism* (London: Routledge, 1990), 39.

Fletcher J. & Evans M., "Ethics in Reproductive Genetics" (1992) 35 Clinical Obstetrics and Gynecology 763.

Gallagher J.,"Prenatal Invasions & Interventions: What's Wrong with Fetal Rights?" (1987) 10 Harvard Women's Law Journal 9.

Goldberg S., "Medical Choices During Pregnancy: Whose Decision Is It Anyway? (1989) 41 Rutgers Law Review 591.

Grant I., "Forced Obstetrical Intervention: A Charter Analysis (1989) 39 University of Toronto Law Journal 217.

Grbich J., "The Body in Legal Theory" (1992) 11 University of Tasmania Law Review 26.

Grosz E., "Contemporary Theories of Power and Subjectivity" in Gurien S., ed. *Feminist Knowledge: Critique and Construct* (London, Routledge, 1990), 59.

Halewood P., "White Men Can't Jump: Critical Epistemologies, Embodiment and the Praxis of Legal Scholarship" (1995) 7 Yale Journal of Law and Feminism 1.

Hanigsberg J., "Power and Procreation: State Interference in Pregnancy (1991) 23 Ottawa Law Review 1.

Harding S., "Feminism, Science and the Enlightenment Critiques" in Nicholson L., ed. *Feminism/Postmodernism* (London: Routledge, 1990), 83.

Harris A., "Race and Essentialism in Feminist Theory" (1988) 42 Stanford Law Review 581.

Harstock N., "Foucault on Power" L. Nicholson, ed., *Feminism/Postmodernism* (London: Routledge, 1990), 157.

Henley A., "The Creation of the Mother/Body Myth: Judicial and Legislative Enlistment of Norplant" (1993) 41 Buffalo Law Review 703.

Hershey L., "Choosing Disability: Many Women Assume They Should Abort a Disabled Fetus. Why?" (1994) V(1) Ms Magazine 26.

Hubbard R., "Legal and Policy Implications of Recent Advances In Prenatal Diagnosis and Fetal Therapy" (1982) 7 Women's Rights Law Reporter 208.

Hubbard R., "Personal Courage Is Not Enough" in Arditti R., Klein R. & Minden S., eds. *Test-Tube Women, What Future for Motherhood?* (London: Pandora, 1984), 331.

Ikemoto L., "Furthering the Inquiry: Race, Class and Culture in the Forced Medical Treatment of Pregnant Women" (1992) 59 Tennessee Law Review 487.

Isaacman S., "Are We Outlawing Motherhood for HIV-Infected Women?" (1991) 22 Loyola University Law Journal 479.

Jackman M., "The Canadian Charter as a Barrier to Unwanted Medical Treatment of Pregnant Woman in the Interests of the Foetus" (1993) 14 Health Law in Canada 49.

Johnsen D., "The Creation of Fetal Rights: Conflicts with Women's Constitutional Rights to Liberty, Privacy and Equal Protection" (1986) 95 The Yale Law Journal 599.

Karpin I., "Legislating the Female Body: Reproductive Technology and the Reconstructed Woman" (1992) 3 Columbia Journal of Gender and Law 325.

Karpin I., "Reimagining Maternal Selfhood: Transgressing Body Boundaries and the Law" (1994) 2 Australian Feminist Law Journal 36.

Keyserlingk E.W., "The Unborn Child's Right to Prenatal Care (Part I)" (1982) 3 Health Law in Canada 10.

King P., "Should Mom be Constrained in the Best Interests of the Fetus?" (1989) 13 Nova Law Review 393.

Kingdom E., "Body Politics and Rights" in Bridgeman J. and Millns S., eds. *Law and Body Politics: Regulating the Female Body* (Hants: Dartmouth, 1995), 1.

Kline M., "Race, Racism and Feminist Legal Theory" (1989) 12 Harvard Women's Law Journal 115.

Lenow J., "The Fetus as a Patient: Emerging Rights as a Person?" (1983) 9 American Journal of Law and Medicine 1.

MacKinnon C., "Difference and Dominance: On Sex Discrimination" in Bartlett K. and Kennedy R., eds. *Feminist Legal Theory: Readings in Law and Gender* (Boulder: Westview, 1991), 81.

MacKinnon C., "Feminism, Marxism, Method and the State: An Agenda for Theory (1982) 7 Signs 515.

MacKinnon C., "From Practice to Theory, or What is a White Woman Anyway?" (1991) 4 Yale Journal of Law and Feminism 13.

Macklin R., "Moral Issues in Human Genetics: Counseling or Control?" in Munson R., ed. *Intervention and Reflection: Basic Issues in Medical Ethics* (California: Wadsworth, 1992), 444.

Macquart-Moulin G., Hairion D., Auquier P. & Manuel C., "Vertical Transmission of HIV—A Rediscussion of Testing" (1995) 7 AIDS Care 657.

Martin S., and Coleman M., "Judicial Intervention in Pregnancy" (1995) 40 McGill Law Journal 947.

Meadows J., Catalan J., Sherr L., Stone Y., and Gazzard B., "Testing for HIV in the Antenatal Clinic: The Views of Midwives" (1992) 4 AIDS Care 157.

Mercey D., "Antenatal HIV Testing: The Case For Universal Voluntary Named Testing" (1993) 5 AIDS Care 131.

Millns S., "Making "social judgements that go beyond the purely medical": The Reproductive Revolution and Access to Fertility Treatment Services" in Bridgeman J. and Millns S., eds. *Law and Body Politics: Regulating the Female Body* (Hants: Dartmouth, 1995), 79.

Minow M., "Feminist Reason: Getting It and Losing It" (1988) 38 Journal of Legal Education 47.

Morris A., and Nott S., "Law's Engagement with Pregnancy" in Bridgeman J. and Millns S., eds. *Law and Body Politics: Regulating the Female Body* (Hants: Dartmouth, 1995), 53.

Mossman M.J., "Feminism and Legal Method: The Difference It Makes" (1986) Australian Journal of Law & Society 30.

Mykitiuk R., "Fragmenting the Body" (1994) 2 Australian Feminist Law Journal 63.

Neff C., "Woman, Womb and Bodily Integrity" (1991) 3 Yale Journal of Law and Feminism 327.

Nelson L. and Milliken J., "Compelled Medical Treatment of Pregnant Women: Life, Liberty and Law in Conflict (1988) 259 Journal of the Amercian Medical Association 1060.

Nelson L., Buggy B., & Weil C., "Forced Medical Treatment of Pregnant Women: Compelling Each to Live Seems as Good to the Rest" (1986) 37 Hastings Law Journal 703.

Note, "Rethinking (M)otherhood: Feminist Theory and State Regulation of Pregnancy" (1990) 103 Harvard Law Review 1325.

Note, "The Fetal Patient and the Unwilling Mother: A Standard for Judicial Intervention" (1983) 14 Pacific Law Journal 1065.

Obadia Y., Rey D., Moatt J-P., Pradier C., Couturier E., Brossard Y. & Brunet J., "HIV Screening in South-Eastern France: Differences in Seroprevalence and Screening Policies by Pregnancy Outcome" (1994) 6 AIDS Care 29.

Oxtoby G., "Vertically Acquired HIV Infection in the United States" in P. A. Pizzo & C. M. Wilfert, eds. *Pediatric AIDS: The Challenge of HIV Infection in Infants, Children and Adolescents*, 2nd ed. (Baltimore: Williams & Wilkins, 1994), 10.

Pediatric AIDS Clinical Trials Group Protocol 076 Study Group, "Reduction of Maternal-Infant Transmission of Human Immunodeficiency Virus Type 1 with Zidovudine Treatment" (1994) 331 The New England Journal of Medicine 1173.

Petchesky R., "Foetal Images: The Power of Visual Culture in the Politics of Reproduction" in Stanford M., ed. *Reproductive Technologies - Gender, Motherhood and Medicine* (Oxford: Polity Press, 1987), 57.

Rhoden N., "The Judge in the Delivery Room: The Emergence of Court-Ordered Cesareans" (1986) 74 California Law Review 1951.

Roberts D., "Crime, Race and Reproduction" (1993) 67 Tulane Law Review 1945.

Roberts D., "Punishing Drug Addicts Who Have Babies: Women of Color, Equality, and the Right of Privacy" (1991) 11 Harvard Law Review 1419.

Robertson J., "Procreative Liberty and the Control of Conception, Pregnancy and Childbirth" (1983) 69 Virginia Law Review 405.

Rogers M. & Jaffe H., "Reducing the Risk of Maternal-Infant Transmission of HIV: A Door is Opened" (1994) 331 The New England Journal of Medicine 1222.

Sangree S., "Control of Childbearing by HIV-Positive Women: Some Responses to Emerging Legal Policies" (1993) 41 Buffalo Law Review 309.

Schneider E., "The Dialectic of Rights and Politics: Perspectives from the Women's Movement" in Bartlett K. and Kennedy R., eds. *Feminist Legal Theory: Readings in Law and Gender* (Boulder: Westview, 1991), 318.

Segers M., "Abortions and the Culture" in Callahan S. & Callahan D., eds. *Abortion - Understanding Differences* (New York: Plenum, 1984), 247.

Senterfitt W., "Women Under Attack: It's Time For Action Now" (1995) March, Being Alive, 4.

Shaw M., "The Potential Plaintiff: Preconception and Prenatal Torts" in Milunsky A. & Annas G., eds. *Genetics and the Law II* (New York: Plenum, 1980), 225.

Sherr L., "Pregnancy and Paediatrics" (1990) 2 AIDS Care 403.

Smart C., "Penetrating Women's Bodies: The Problem of Law and Medical Technology" in P. Abbott & C. Wallace, eds. *Gender, Power and Sexuality* (London: MacMillan, 1991).

Steinbeck B., & McClamrock R., "When is Birth Unfair to the Child?" (1994) Hastings Centre Report 15.

Tateishi S., "Apprehending the Fetus *En Ventre Sa Mere*: A Study in Judicial Sleight of Hand" (1989) 53 Saskatchewan Law Review 113.

Terry J., "The Body Invaded: Medical Surveillance of Women as Reproducers" (1989) 19 Socialist Review 13.

Troup M., "Rupturing the Veil: Feminism, Deconstruction and the Law" (1993) 1 Australian Feminist Law Journal 63.

"US Public Health Service Recommendations for Human Immunodeficiency Virus Counseling and Voluntary Testing for Pregnant Women" (1995) 44 Mortality and Morbidity Weekly Report RR-7, 1.

Van Viliet E., "Law, Medicine, HIV and Women: Constructions of Guilt and Innocence" (1993) 1 Health Law Journal 191.

Weiss J., "Controlling HIV-Positive Women's Procreative Destiny (1992) 2 Constitutional Law Journal 643.

West R., "Jurisprudence and Gender" in Bartlett K. and Kennedy R., eds. *Feminist Legal Theory: Readings in Law and Gender* (Boulder: Westview, 1991), 201.

Williams J., "Deconstructing Gender" in Bartlett K. and Kennedy R., eds. *Feminist Legal Theory: Readings in Law and Gender* (Boulder: Westview, 1991), 95.

Williams J., "Dissolving the Sameness/Difference Debate: A Postmodern Path Beyond Essentialism in Feminist and Critical Race Theory" (1991) Duke Law Review 296.

Williams S., "Feminist Legal Epistemology" (1993) 8 Berkeley Women's Law Journal 63.

Witting C., "Forced Operations on Pregnant Women: In re S Examined" (1994) 2 Torts Law Journal 193.

Working Group on HIV Testing of Pregnant Women and Children, "HIV Infection, Pregnant Women, and Newborns: A Policy Proposal for Information and Testing" (1990) 264 J.A.M.A. 2416.

Worth D., "Sexual Decision-Making and AIDS: Why Condom Promotion Among Vulnerable Women is Likely to Fail" (1989) 20 Studies in Family Planning 297.

Zarembka A., & Franke K., "Woman in the AIDS Epidemic: A Portrait of Unmet Needs" (1990) 9 Saint Louis University Public Law Review 519.

CASES

Britain

C v S [1980] Q.B 135.
McKay v Essex Health Authority [1982] 2 W.L.R 890.
Paton v British Pregnancy Advisory Service Trustees [1977] Q.B. 276.
Re F (in utero) [1988] 2 W.L.R. 1288.

Canada

Joe v Yukon Territories Director of Family and Children's Services (1986) 5 B.C.L.R (2d) 267 (SC.).
Malette v Shulman (1990) 67 D.L.R (4th) 321 (C.A.).
Nouveau-Brunswick (Ministre de la Santé et des Services communautaires) v A.D. (1990) 109 N.B.R (2d) 192 (Q.B.).
R v Morgentaler [1988] 1 S.C.R 30 (S.C.C.).
R v Summer (1989) 69 A.L.R. (2d) 303 (C.A.).
R v Sullivan [1991] 1 S.C.R. 530 (S.C.C.).
Re A (in utero) 1990 28 R.F.L. (3d) 288 (Fam. Ct).
Re Baby R (1988) 15 R.F.L. (3d) 225 (S.C.).
Re Brown (1975) 9 O.R. (2d) 185 (Co.Ct).
Re Children's Aid Society For the District of Re Children's Aid Society for the District of Kenora and J.L. (1981) 134 D.L.R. (3d) 249 (Prov. Ct).
Re Children's Aid Society of Belleville and Unborn Child of L.T. and G.K. (March 30, 1987) Belleville 10/87 (Prov. Ct.) (unreported).
Re Children's Aid Society of City of Belleville and T (1987) 59 OR (2d) 204 (Prov.Ct.).
Re R (1987) 9 R.F.L. (3d) 415 (Prov.Ct).
Re Superintendent of Family & Child Service and MacDonald (1982) 135 D.L.R. (3d) 330 (S.C.).
Reibl v Hughes (1980) 114 D.L.R. (3d) 1 (S.C.C.).
Tremblay v Daigle (1989) 62 D.L.R. (4th) 634 (S.C.C.).
Winnipeg Child & Family Services v G (1996) 138 D.L.R. (4th) 238 (Q.B.).
Winnipeg Child & Family Services v G (1996) 138 D.L.R. (4th) 254 (C.A).

United States

In re AC 573 A 2d 1235 (1990).

In re Baby Doe 632 NE 2d 326 (1994).
In re Fathima Ashanti K J. 558 NYS 2d 447 (1990).
In re Madyun (Appended to *In re AC*) 573 A 2d 1259 (1990).
In the Matter of the Application of Jamaica Hospital 491 N Y S 2d 898 (1985).
Jefferson v Griffin Spalding County Hospital Authority 274 S.E.2d 457 (1981).
Raleigh Fitkin-Paul Memorial Hospital v Anderson 201 A 2d 537 (1964).
Roe v Wade 410 US 113 (1972).

LEGISLATION

Canada

Canadian Charter of Rights and Freedoms
Child and Family Services Act S.O. 1984, c.55.
Child and Family Services and Family Relations Act S.N.B. 1980, c.C-2.1.
Child Welfare Act R.S.O. 1980, c.66.
Children's Act R.S.Y.T. 1986, c.22.
Family and Child Service Act S.B.C. 1980, c.11.
Mental Health Act R.S.M. 1987, c.M110.
Mental Health Act R.S.O. 1982, c.262.

Britain

Human Fertilisation and Embryology Act 1990, c.37.

NEWSPAPER ARTICLES

"Fertile With Error" *The Times* (15 May 1996) available in Lexis library TXTLNE.

"Scientists Hail Birth of Artificial Womb" *The Australian* (12 August 1996) 3.

"Tank Tests To Replace Womb", *The Daily Telegraph* (12 August 1996) 4.

"Tanks Replace Wombs", *The Daily Telegraph* (afternoon edition) (12 August 1996) 5.

"To protect the not-yet-born", *The Globe and Mail* (14 September 1996) D6.

Adler M., "Ethics of Fertility Treatment for People with HIV" *The Times* (18 May 1996) available in Lexis library TXTLNE.

Brooker E., "You've Got to Accentuate the Positive" *The Independent* (7 June 1996) 4.

Commentary, "Prenatal AIDS Test Will Help Save Lives" *Chicago Sun-Times* (9 July 1995) 37.

Dabkowski E., "Million-Dollar Mum-to-be Has Dirty Linen Aired" *The Sydney Morning Herald* (14 August 1996) 12.

Edmonds S., "Pregnant glue-sniffing addict appeals treatment order", *The Gazette, Montréal* (8 August 1996) A10.

Ferriman A., "The Gift of Life" *The Independent on Sunday* (19 May 1996) 17.

Gelastopoulos E., "I'd Keep 8, Says Mum Who Lost 9" *The Daily Telegraph* (12 August 1996) 4.

Gibson M., "Fertile Ground For Mistakes" *The Daily Telegraph* (14 August 1996) 10.

Goodman E., "Nurturing a New View on Prenatal AIDS Testing" *Boston Sunday Globe* (16 July 1995) 1.

Loudon B., "I'll Keep All My 8 Babies - Pregnant Mum Defies Doctors" *The Daily Telegraph* (12 August 1996) 1.

MacDonald V., "Woman Who Caught AIDS in Hospital Wins Fertility Help" *The Sunday Telegraph* (19 May 1996) 1.

McDougall B., "Baby Drama 'Could Not Happen Here'" *The Daily Telegraph* (13 August 1996) 4.

Murrie J., "I'm Doing it For Love — Multiple Birth Mum Hits Out At Critics" *The Daily Telegraph* (19 August 1996) 21.

Quinn S., "Fertility Treatment For HIV Woman Sparks Controversy" *The Guardian* (13 May 1996) 1.

Reeve S., "Fertility Help for HIV Woman" *Sunday Times* (19 May 1996) available in Lexis library TXTLNE.

Schwartz J., "AIDS Testing Urged in All Pregnancies: Drug 'Breakthrough' Prompted Policy Shift" *Washington Post* (7 July 1995) 1.

Seigel J., "US Expert: All Pregnant Women Should Have AIDS Tests" *The Jerusalem Post* (22 June 1994) 1.

Seigel-Itzkovich J., "Expert, Test Pregnant Women for HIV" *The Jerusalem Post* (16 July 1995).

Sprawson E., "Gambling Her Babies' Lives Away" *The Daily Telegraph* (14 August 1996) 28.

Sprawson E., "Mother All Alone" *The Daily Telegraph* (afternoon edition) (13 August 1996) 5.

Sprawson E., "Mother of Eight Left Standing Alone" *The Daily Telegraph* (13 August 1996) 1.

Winston R., "Fertility, AIDS and Prejudice - Opinion" *The Times* (14 May 1996) available in Lexis library TXTLNE.

UNPUBLISHED MATERIAL

"Prenatal/Newborn HIV Testing—A Report by the Association of the Bar of the City of New York" (Paper included in Conference materials for session "Pregnancy, Privacy, and Proposed Mandatory HIV Testing: Whose Right Is It, Anyway?", 7 August 1995, American Bar Association Annual Conference 1995) [unpublished].

Kuvin S., "Mandatory Testing Of All Pregnant Women" (Paper presented in "Pregnancy, Privacy, and Proposed Mandatory HIV Testing: Whose Right Is It, Anyway?", 7 August 1995, American Bar Association Annual Conference 1995) [unpublished].