MATERNAL SUBSTANCE ABUSE AND THE LIMITS OF LAW: A RELATIONAL CHALLENGE

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In an effort to respond to the issue of maternal substance abuse, the following article aims to explore potential alternatives to a paradigm which posits maternal autonomy and fetal interests as inherently conflictual. More specifically, it investigates whether, in the context of maternal civil liability for alcohol and drug use, a relational perspective that promotes healthy maternal and fetal outcomes can be reconciled with an approach that respects women's reproductive autonomy. In responding to this question, the following discussion will examine the concerns that surround legal intervention, assess current approaches of common law courts to the maternal-fetal relationship, and finally, suggest the need for facilitative strategies that extend beyond the limits of tort.

Afin de réagir au problème de toxicomanie maternelle, l'article vise à explorer les solutions de rechange éventuelles au paradigme qui pose comme postulat que l'autonomie maternelle et les intérêts du fœtus sont conflictuels de par leur nature. Tout spécialement, il examine si, dans le contexte de la responsabilité civile de la mère à l'égard de l'abus d'alcool et de drogues, une perspective relationnelle promouvant des résultats positifs pour la mère et l'enfant peut être conciliée avec une approche qui respecte l'autonomie reproductrice de la mère. Dans le but de répondre à cette question, la discussion examine les problèmes relatifs à l'intervention juridique, évalue les approches utilisées actuellement par les tribunaux de la common law à l'égard de la relation mère-enfant, et propose la nécessité d'avoir des stratégies d'aide qui vont au-delà des limites du délit civil.

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I. INTRODUCTION

Her story is one of many. In August of 1996, a pregnant woman who was addicted to sniffing toxic solvents was ordered into forced detention and treatment by a Manitoba court.[1] The judge declared that such measures of state intervention were justified by the need to protect her developing fetus.[2] Although her voice is missing from the court records,[3] the facts indicate that Ms. G was young, unmarried, poor, and Aboriginal. Having experienced repeated pregnancies since the age of 16, G's history of solvent abuse had led to the birth of two children with disabilities and the removal of three children from her care. She had sought treatment earlier on in the pregnancy, but had been refused due to lack of space.[4] By the time G's case reached the Supreme Court of Canada, she had given birth to a healthy baby and had sparked a controversy that reflects the complex issues and interests implicated in legal and social responses to protecting maternal and fetal health.[5] The question of state intervention, and maternal civil liability in particular, places into stark terms the tension between the consequences of alcohol and drug use by pregnant women and concerns relating to women's reproductive rights and autonomy.

A. THE CONSEQUENCES OF ALCOHOL AND DRUG USE BY PREGNANT WOMEN

The consequences of maternal alcohol and drug use are serious, and all the more devastating because they are preventable. According to *Blueprints Pediatrics*,[6] maternal ingestion of substances such as alcohol, solvents, and gasoline results in a wide range of effects, including fetal alcohol syndrome. It is estimated that fetal alcohol syndrome occurs in one in 1,000 newborns, although the incidence is much higher in the Native American

1 *Winnipeg Child and Family Services (Northwest Area) v. G.(D.F.)* (1996), 11 Man R. (2d) 219 (Q.B.).
2 *Winnipeg Child and Family Services (Northwest Area) v. G.(D.F.)*, [1997] 3 S.C.R. 925 at para. 1 [*D.F.G.*].
3 Thelma McCormack, "Fetal Syndromes and the Charter: The Winnipeg Glue-Sniffing Case" (1999) 14:2 C.J.L.S. 77 at 79.
4 *Supra* note 2 at para. 5.
5 Melanie Randall, "Pregnant Embodiment and Women's Autonomy Rights in Law: An Analysis of the Language and Politics of *Winnipeg Child and Family Services v. D.F.G.*" (1999) 62 Sask. L. Rev. 515 at 516.
6 Bradley S. Marino & Katie S. Fine, *Blueprints Pediatrics*, 4th ed. (Philadelphia: Lippincott Williams & Wilkins, 2007).

population.[7] Its clinical manifestations include microcephaly, mental retardation, facial anomalies, and renal and cardiac defects.[8]

Similarly, maternal use of cocaine and narcotics is associated with cardiac defects, skull abnormalities, respiratory problems, and genitory malformations. Drug-exposed infants are subject to increased risks of sudden infant death syndrome (SIDS), pre-term birth, and low birth weight.[9] Long-term defects include attention deficits and learning disabilities. Infants may undergo narcotic withdrawal syndrome in their first few days of life, which is characterized by irritability, poor sleeping, a high-pitched cry, an inability to be consoled, diarrhea, sweating, seizures, and poor feeding.[10] Moreover, drug use during pregnancy places women themselves at risk of medical and obstetrical complications. These complications include premature labour, placental abruption, uterine rupture, cardiovascular complications, and death.[11]

B. BROADER CONCERNS RELATING TO WOMEN'S REPRODUCTIVE RIGHTS AND AUTONOMY

Simone de Beauvoir asserted that woman's reproductive capacity led to her subordination within the sexual hierarchy, to her oppression by men, and even to her alienation from herself.[12] Reproductive autonomy has been understood by feminists as a means of escaping the shackles of biology and of resisting patriarchal domination. Historically, women's struggle for reproductive control has been contested by a wide range of actors and social institutions.[13] Despite gains through access to the contraceptive pill and to abortion, women's reproductive self-determination is far from a global reality. Worldwide, approximately 123 million women have an unmet need for family planning and about 20 million women resort to unsafe abortion every year.[14] In many developing countries, pregnancy and childbirth are the leading causes of disability and death for women of reproductive age.[15] More strikingly,

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7 *Ibid.* at 223.

8 *Ibid.*

9 *Ibid.* See also William F. Rayburn, "Maternal and Fetal Effects from Substance Use" (2007) 34 Clinics in Perinatology 559 at 563.

10 Marino & Fine, *ibid.* at 224.

11 Krzysztof M. Kuczkowski, "The effects of drug abuse on pregnancy" (2007) 19 Current Opinion in Obstetrics and Gynecology 578.

12 Simone de Beauvoir, *Le deuxième sexe* (Paris: Gallimard, 1949).

13 These have included the state, family, religious, and cultural authorities. For example, the Vatican has been extremely vocal in its opposition to contraception and abortion. Judges, politicians, and abortion providers have been excommunicated by the Catholic Church for their roles in granting women access to abortion. See e.g. Constanza Vieira, "Colombia: Magistrates Excommunicated for Partially Lifting Abortion Ban" *Inter Press Service News Agency* (11 May 2006), online: Inter Press Service News Agency <http://ipsnews.net/print.asp?idnews=33214>.

14 World Health Organization, *Unsafe abortion: Global and regional estimates of the incidence of unsafe abortion and associated mortality in 2003*, 5th ed. (Geneva: World Health Organization, 2007) at 1-2.

15 United Nations Population Fund (UNFPA), *State of World Population 2004: The Cairo Consensus at Ten: Population, Reproductive Health and the Global Effort to End Poverty* (New York: United Nations Population Fund, 2004), online: UNFPA <http://www.unfpa.org/swp/2004/pdf/en_swp04.pdf> at 51.

in countries where the criminalization of abortion persists, unsafe abortion remains one of the major causes of maternal death.[16]

Women have experienced a long history of state interference with their bodies, reproductive lives, and autonomy.[17] In Canada, examples of this include the limitation of access to employment for "protective" reasons, the use of the criminal law to control women's fertility through a prohibition on access to contraception, and coercive sterilization procedures.[18] Until the fairly recent *R. v. Morgentaler*[19] decision in 1988, abortion was highly restricted and regulated, and stood otherwise as a criminal offence for both women and abortion providers.[20] Access to abortion is still not comprehensively covered by health insurance or even available in all Canadian provinces.[21] According to a 2003 report, abortion services are only available in 17.8 percent of Canadian hospitals, and are entirely unavailable in Prince Edward Island and Nunavut.[22]

Similarly, in the United States, feminists have expressed concern with coercive government intrusion into women's fundamental liberties. In addition to civil penalties for prenatal negligence, criminal charges have been brought for "prenatal child neglect," pregnant women have been imprisoned and civilly committed,[23] and courts in 11 states have ordered pregnant women to undergo Caesarean sections against their will.[24]

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16 United Nations Population Fund, *State of the World Population 2005: The Promise of Equality: Gender Equality, Reproductive Health and the Millennium Development Goals* (New York: United Nations Population Fund, 2005), online: UNFPA <http://www.unfpa.org/swp/2005/pdf/en_swp05.pdf> at 35.

17 Sanda Rodgers, "The Legal Regulation of Women's Reproductive Capacity in Canada" in Jocelyn Downie, Timothy Caulfield & Colleen Flood, eds., *Canadian Health Law and Policy*, 2d ed. (Markham: Butterworths, 2002) 331 at 331 [Rodgers, "Legal Regulation"].

18 *Ibid.* at 331-32.

19 [1988] 1 S.C.R. 30.

20 *Ibid.* at 161-62.

21 Joanna N. Erdman, "In the Back Alleys of Health Care: Abortion, Equality, and Community in Canada" (2007) 56 Emory L.J. 1093.

22 *Ibid.* at 1095.

23 Civil commitment or detention of pregnant women for using drugs is permitted in three states. In South Carolina, the child endangerment statute was applied to a pregnant woman, essentially criminalizing drug use and addiction during pregnancy. Lisa H. Harris & Lynn Paltrow, "The Status of Pregnant Women and Fetuses in US Criminal Law" (2003) 289 Journal of the American Medical Association 1697 at 1697-98. See also *Whitner v. South Carolina*, 492 S.E.2d 777 (S.C. 1997), cert. denied, 118 S. Ct. 1857 (1998).

24 Dawn Johnsen, "Shared Interests: Promoting Healthy Births Without Sacrificing Women's Liberty" (1992) 43 Hastings L.J. 569 at 571 [footnotes omitted, Johnsen, "Shared Interests"]. See also Veronica E.B. Kolder, Janet Gallagher & Michael T. Parsons, "Court-Ordered Obstetrical Inverventions" (1987) 316 New England Journal of Medicine 1192 at 1193. A number of courts have ordered forced Caesareans despite a woman's refusal, on the grounds of preserving and protecting the health and survival of the unborn fetus. See e.g. *Jefferson v. Griffin Spalding County Hospital Authority*, 274 S.E.2d 457 at 459-60 (Ga. 1981) [*Jefferson*]; *Re A.C.*, 573 A.2d 1235 (D.C. Ct. App. 1990); *WVHCS-Hospital v. Doe*, No 3-E 2004 (Pa. Ct. Com. Pl. Luzerne County filed 14 January 2004) [*WVHCS-Hospital*]. In the case of *Re A.C.*, both the child and mother, who suffered from cancer, died shortly after the Caesarean.

C. A RELATIONAL LENS

While the tension between state intervention and women's reproductive autonomy has traditionally been understood in adversarial terms, it has been suggested that positing a conflict between women's rights and fetal rights "ignores complexity and denies interrelatedness in understanding the process and experience of pregnancy."[25] As such, it may be useful to look to the feminist relational approach for new ideas on bridging the supposed impasse between maternal and fetal interests.

As Colleen Sheppard explains, a key theme in feminist theory is "the need to situate legal rights within a web of social relationships."[26] This recognition of interdependence forms the basis of the relational approach, which was first articulated by Carol Gilligan.[27] A relational perspective seeks to challenge the individual self of classical liberalism by "seeing a world comprised of relationships rather than of people standing alone, a world that coheres through human connection rather than through systems of rules."[28] In formulating her theory centred upon an "ethic of care," Gilligan suggests that women relate more to a moral framework that sees "the actors in the dilemma arrayed not as opponents in a contest of rights, but as members of a network of relationships on whose continuation they all depend."[29] Thus, the focus shifts from separation to sustaining connection, as Gilligan maintains that "in the different voice of women lies the truth of an ethic of care, the tie between relationship and responsibility, and the origins of aggression in the failure of connection."[30]

Building upon this idea, Jennifer Nedelsky suggests a reconceptualization of autonomy that focuses on "the emergence of autonomy through relationship with others."[31] This awareness highlights the role of relationships in providing the "support and guidance necessary for the development and experience of autonomy." Looking to the parent-child relationship as a prime example of this reality, Nedelsky posits a perspective that acknowledges "relatedness … and interdependence [as] a constant component of autonomy."[32]

In an effort to face the tension posed by the issue of maternal substance abuse, the following article aims to explore potential alternatives to a paradigm which posits maternal autonomy and fetal interests as inherently conflictual. More specifically, it investigates whether, in the context of maternal civil liability for alcohol and drug use, a relational perspective that promotes healthy maternal and fetal outcomes can be reconciled with an approach that respects women's reproductive autonomy. In responding to this question, the following discussion will examine the concerns that surround legal intervention, assess

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25 *Supra* note 5 at 527.

26 Colleen Sheppard, "Intimacy, Rights and the Parent-Child Relationship: Rethinking Freedom of Association in Canada" (2004) 16 N.J.C.L. 103 at 107 [footnotes omitted].

27 Carol Gilligan, *In a Different Voice: Psychological Theory and Women's Development* (Cambridge, Mass.: Harvard University Press, 1982).

28 *Ibid.* at 29.

29 *Ibid.* at 30.

30 *Ibid.* at 173.

31 Jennifer Nedelsky, "Reconceiving Autonomy: Sources, Thoughts and Possibilities" (1989) 1 Yale J.L. & Feminism 7 at 12.

32 *Ibid.*

current approaches of common law courts to the maternal-fetal relationship, and finally, suggest the need for facilitative strategies that extend beyond the limits of tort.

II. CONCERNS WITH LEGAL INTERVENTION

The central issue in *D.F.G.* centred upon whether the law of tort should be extended to "permit an order detaining a pregnant woman against her will in order to protect her unborn child from conduct that may harm the child."[33] The nature of the intervention in question has thus been defined as "imposing medical care or other treatment aimed at protecting the fetus where the behaviour of a pregnant woman is perceived to be adverse to the interests of her fetus."[34] The issue of intervention typically arises in situations "where a pregnant woman refuses recommended medical treatment that is intended to benefit the fetus, or, in some cases, both herself and her fetus (for example, Caesarean section)," and "where a pregnant woman is sought to be detained and/or treated against her will for her addiction to a harmful substance such as alcohol, solvents, or crack cocaine."[35] The question of legal intervention with the autonomous decisions of pregnant women has raised a variety of concerns. These concerns involve: (1) the invasion of women's rights to liberty, privacy, and bodily integrity; (2) equality and discrimination; (3) fear of floodgates; (4) the politics of fetal rights; (5) complex realities and systemic causes; and (6) adverse effects of legal intervention.

A. THE INVASION OF WOMEN'S RIGHTS TO LIBERTY, PRIVACY, AND BODILY INTEGRITY

In 1993, a report by the Royal Commission on New Reproductive Technologies, entitled *Proceed With Care*,[36] explicitly rejected state intervention into pregnancy and childbirth, underlining the need to support maternal and fetal health without intruding into the liberty, autonomy, and bodily integrity of pregnant women. In particular, it explicitly recommended that "civil liability never be imposed upon a woman for harm done to her fetus during pregnancy," and that "[u]nwanted medical treatment and other interferences, or threatened interferences, with the physical autonomy of pregnant women be recognized explicitly under the *Criminal Code* as criminal assault."[37] Furthermore, the Commission maintained that allowing judicial intervention would have "serious implications for the autonomy of individual women and for the status of women collectively in our society."[38] Recognizing the right of all individuals "to make personal decisions, to control their bodily integrity, and to refuse unwanted medical treatment,"[39] the report asserted that

> [t]hese are not mere legal technicalities; they represent some of the most deeply held values in society and form the basis for fundamental and constitutional human rights.

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33 *Supra* note 2 at para. 9.

34 Erin Nelson, "Reconceiving Pregnancy: Expressive Choice and Legal Reasoning" (2004) 49 McGill L.J. 593 at 598 [footnotes omitted].

35 *Ibid.* at 598-99 [footnotes omitted].

36 *Proceed With Care: Final Report of the Royal Commission on New Reproductive Technologies*, vol. 2 (Ottawa: Minister of Government Services, 1993).

37 *Ibid.* at 964-65.

38 *Ibid.* at 955.

39 *Ibid.*

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> A woman has the right to make her own choices, whether they are good or bad, because it is the woman whose body and health are affected, the woman who must live with her decision, and the woman who must bear the consequences of that decision for the rest of her life.[40]

The Supreme Court of Canada has responded to the question of intervention in a similar manner. In *Dobson (Litigation Guardian of) v. Dobson*, Cory J., for the majority, wrote that "for reasons of public policy, the Court should not impose a duty of care upon a pregnant woman towards her foetus or subsequently born child. To do so would result in very extensive and unacceptable intrusions into the bodily integrity, privacy and autonomy rights of women."[41] Justice McLachlin's (as she was then) majority judgment in *D.F.G.* echoed similar concerns, maintaining that "to make orders protecting fetuses would radically impinge on the fundamental liberties of the pregnant woman, both as to lifestyle choices and how and as to where she chooses to live and be."[42]

In the U.S., the issue of legal intervention has posed a serious threat to women's liberty and bodily integrity, given that courts in 11 states have ordered that women undergo Caesarean sections against their will.[43] In response, the American Medical Association (AMA) has taken a strong stance against the practice, maintaining that physicians should not seek court-ordered obstetrical interventions,[44] and that "judicial intervention is inappropriate when a woman has made an informed refusal of medical treatment designed to benefit her fetus."[45] In explaining this position, the association noted that "[p]erforming medical procedures against the pregnant woman's will violates her right to informed consent and her constitutional right to bodily integrity."[46]

B. EQUALITY AND DISCRIMINATION

The issue of legal intervention into the lives of pregnant women has similarly raised equality concerns, given the links between intervention and different grounds of discrimination. To begin with, intrusion with the bodily integrity of pregnant women clearly points to an issue of sex discrimination. In *Dobson*, McLachlin J. (as she was then) asserted that "[t]he intrusion upon the pregnant woman's autonomy [posed by maternal civil liability] would … violate her right to equal treatment."[47] She underlined that

> [t]o say women choose pregnancy is no answer. Pregnancy is essentially related to womanhood. It is an inexorable and essential fact of human history that women and only women become pregnant. Women should

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40 *Ibid.* at 955-56.

41 [1999] 2 S.C.R. 753 at para. 23 [*Dobson*].

42 *Supra* note 2 at para. 55.

43 Kolder, Gallagher & Parsons, *supra* note 24 at 1193. See also *Jefferson*, *supra* note 24; *Re A.C.*, *supra* note 24; *WVHCS-Hospital*, *supra* note 24.

44 Board of Trustees, American Medical Association, "Legal Interventions During Pregnancy: Court-Ordered Medical Treatments and Legal Penalties for Potentially Harmful Behavior by Pregnant Women" (1990) 264 Journal of the American Medical Association 2663 at 2665 [AMA].

45 *Ibid.* at 2670.

46 *Ibid.* at 2663.

47 *Supra* note 41 at para. 86.

> not be penalized because it is their sex that bears children: *Brooks v. Canada Safeway Ltd*., [1989] 1 S.C.R. 1219. To say that broad legal constraints on the conduct of pregnant women do not constitute unequal treatment because women choose to become pregnant is to reinforce inequality by the fiction of deemed consent and the denial of what it is to be a woman.[48]

Furthermore, Jacqueline Berrien critiques the fact that harmful behaviour towards the fetus by men has not been subjected to similar judicial scrutiny. For example:

> [T]here have been no prosecutorial efforts to arrest men for damage that secondhand cigarette smoke may cause to a fetus; men have not been required to avoid exposure to drugs or chemicals known to cause damage to the sperm; nor have male partners of pregnant battered women been targeted by prosecutors for their infliction of injuries to the fetus in the course of physically abusing the women.[49]

Finally, intervention policies reflect the intersections between sex, race, and other forms of discrimination. Sanda Rodgers notes that "[s]tate policy regarding women's reproductive capacity … reflects the differential treatment of the various communities of women within Canada."[50] Thus, a disproportionate level of intervention has typically fallen on "poor women, women of colour, aboriginal women and women who are already the subject of state scrutiny."[51]

C. FEAR OF FLOODGATES

The control of women's autonomy in the interest of protecting the fetus has led many commentators to ask "*where will it end*?" Dawn Johnsen notes that "[g]iven the fetus's complete physical dependence on and interrelatedness with the body of the woman, virtually every act of the pregnant woman has some effect on the fetus."[52] As such, it has been suggested that a woman might be held liable for poor nutrition, smoking, negligent driving, exposing herself to workplace hazards, vigorous exercise, engaging in sexual intercourse, or involvement with abusive men.[53]

The majority in *D.F.G.* recognizes this concern, questioning the parameters of scrutiny over women's choices. Justice McLachlin asks:

> Are children to be permitted to sue their parents for second-hand smoke inhaled around the family dinner table?... Are children to be permitted to sue their parents for spanking causing psychological trauma or poor grades due to alcoholism or a parent's undue fondness for the office or the golf course? If we permit lifestyle actions, where do we draw the line?[54]

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48 *Ibid.* at para. 87.

49 Jacqueline Berrien, "Pregnancy and Drug Use: Incarceration is Not the Answer" in Marlene Gerber Fried, ed., *From Abortion to Reproductive Freedom: Transforming a Movement* (Boston: South End Press, 1990) 263 at 265.

50 Rodgers, "Legal Regulation," *supra* note 17 at 332.

51 *Ibid.* at 352. See also Janean Acevedo Daniels, "Court-Ordered Cesareans: A Growing Concern for Indigent Women" (1988) 21 Clearinghouse Review 1064.

52 Dawn E. Johnsen, "The Creation of Fetal Rights: Conflicts with Women's Constitutional Rights to Liberty, Privacy, and Equal Protection" (1986) 95 Yale L.J. 599 at 605-606.

53 *Ibid.*; see also Randall, *supra* note 5 at 532.

54 *Supra* note 2 at para. 33.

D. THE POLITICS OF FETAL RIGHTS

The potential implications of recognizing fetal rights or interests raise additional concerns regarding women's right to reproductive self-determination. Melanie Randall explains that "[t]he attachment of separate rights to fetuses has been problematic because the manoeuvre has traditionally been undertaken by those with agendas antithetical to women's reproductive freedom and social equality."[55] Arguments for fetal personhood have been strongly advanced by the anti-abortion movement. Similarly, Rodgers underlines that "[t]here can be no doubt that unqualified and uncritical recognition of the rights of the fetus … when they are considered to conflict with maternal rights — would have significant implications for the abortion question."[56]

Moreover, intervention on behalf of the fetus has been characterized by some commentators as "yet another attempt to reinstate social domination over women. Feminists argue that fetal rights cases represent an effort to reassert masculine control of the female body through the power of the state."[57] They suggest that the politics of fetal rights concern the "boundaries within which women reproduce," and contend that proponents of fetal rights seek "to regulate and control not just reproductive choice, but the internal relationship between the pregnant woman and the fetus."[58] Thus, the fetal rights debate in the context of legal intervention is "inevitably bound up in larger political contestations about women's social position and the kinds of reproductive 'freedoms' and choices that attach to it."[59] Consequently, it remains important to recognize that cases such as *D.F.G.* may have implications beyond the specific issue of maternal substance abuse. Such cases serve to inform social debates and legal approaches to women's reproductive autonomy more generally.

E. COMPLEX REALITIES AND SYSTEMIC CAUSES

The discourse that surrounds maternal alcohol and drug use often employs the language of "bad mother" versus "good mother," portraying "pregnant women as *the abuser*, and the exercise of the rights of pregnant women as *the barrier* to protecting fetal well-being."[60] However, this simplistic separation of mother as abuser and fetus as victim ignores the interconnectedness of maternal and fetal victimization, as well as the complex ways in which patterns of victimization are transferred from mother to child. Constance MacIntosh points to issues that have been left out of the public definition of fetal abuse, such as the battering of pregnant women and the links between battering and maternal substance abuse.

These social realities highlight systemic problems that often lead to maternal and fetal ill health. Noting that "male spousal violence against pregnant women has been identified as

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55 *Supra* note 5 at 527.

56 Sanda Rodgers, "Fetal Rights and Maternal Rights: Is There a Conflict?" (1986) 1 C.J.W.L. 456 at 458.

57 Cynthia R. Daniels, *At Women's Expense: State Power and the Politics of Fetal Rights* (Cambridge, Mass.: Harvard University Press, 1993) at 3-4.

58 *Ibid.* at 4.

59 *Supra* note 5 at 529.

60 Constance MacIntosh, "Conceiving Fetal Abuse" (1998) 15:2 Can. J. Fam. L. 178 at 186-87 [emphasis in original].

one of the most unaddressed sources of fetal abuse,"[61] MacIntosh argues that "[t]his form of abuse makes clear that the reinforced protection and support of the rights of the pregnant woman, as carrier of the fetus, would be the most effective means of protecting the well-being of the fetus."[62] A recent study in Ontario indicated that "6.6% of pregnant women … receiving prenatal care … experienced physical abuse during their current pregnancy."[63] Research in the U.S. has found that "pregnant women are more likely than non-pregnant women to be battered, and that the battering is usually more intense."[64] A Canadian study similarly concluded that domestic violence often begins or is intensified during pregnancy.[65] Furthermore, violence against pregnant women is most often directed at their abdominal region. The resulting harm is self-evident; "[b]attered … women are twice as likely to miscarry as non-battered … women."[66] In addition to causing miscarriage, "blows to a pregnant woman's abdomen [are] known to directly affect pregnancy by causing *abruptio placentae*, fetal loss, premature labour, fetal fractures, low birth weight, and premature delivery," as well as injuries to the woman herself.[67] MacIntosh underlines that "[t]he fact that battered women are often prevented by their battering partners from receiving medical care while pregnant suggests both that statistics on and perceptions of abuse may be low — since they are often gathered in prenatal care settings — and that other health complications would be caused by lack of medical treatment."[68]

Research also points to a disturbing connection between female substance abuse and histories of being subject to violence.[69] A report by the AMA indicated that 70 percent of the women in one substance abuse treatment program had been victims of sexual abuse as children, and 70 percent claimed to have been victims of beatings.[70] Other studies have found that up to "80 to 90% of female drug addicts or alcoholics have been victims of rape or incest."[71] Research regarding alcohol use has yielded similar results, indicating that while under 20 percent of non-abused women drink regularly while pregnant, the percentage of abused women who exhibit similar behaviour is 70 percent.[72]

Ultimately, "medical researchers have explicitly acknowledged a causal link between abuse while pregnant and subsequent substance abuse during pregnancy."[73] Their data indicates that "pregnant women tend to increase their usage of drugs and alcohol following episodes of abuse, and that women who are abused often 'self-medicate' with alcohol, illicit drugs and prescription medicine 'in order to cope with the violence.'"[74] Thus, substance

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61 *Ibid.* at 187 [footnotes omitted].
62 *Ibid.*
63 *Ibid.* at 188.
64 *Ibid.* at 189 [footnotes omitted].
65 *Ibid.*
66 *Ibid.* [footnotes omitted].
67 *Ibid.*
68 *Ibid.* at 190 [footnotes omitted].
69 *Ibid.* at 192.
70 AMA, *supra* note 44 at 2667-68.
71 *Supra* note 60 at 193 [footnotes omitted]; Janet Gallagher, "Collective Bad Faith: 'Protecting' the Fetus" in Joan C. Callahan, ed., *Reproduction, Ethics, and the Law: Feminist Perspectives* (Indianapolis: Indiana University Press, 1995) 343 at 363.
72 MacIntosh, *ibid.*
73 *Ibid.* at 194 [footnotes omitted].
74 *Ibid.* [footnotes omitted].

abuse emerges as a maladaptive coping method, as a response to "the anxiety and depression associated with abuse," and as a symptom of desperation and feelings of powerlessness.[75]

A troubling picture emerges from these statistics. They suggest a narrative of "women pursuing extreme paths following harm at the hands of families and partners."[76] They depict a story of women who are being labelled abusers and being "held accountable while those who systematically victimize them remain out of the spotlight, and out of the definition of the problem of fetal abuse."[77] An understanding of these complex realities and systemic causes thus remains critical to the formulation of effective legal and policy responses to the issue of maternal substance abuse.

F. ADVERSE EFFECTS OF LEGAL INTERVENTION

Members of the medical community and those who provide health and social services to women have taken a strong stance against legal intervention on the grounds that it may deter pregnant women from seeking treatment and actually undermine fetal and maternal health. Commentators have argued that coercive approaches are counterproductive, as women will be discouraged from seeking help due to fear of prosecution, incarceration, civil liability, court-ordered surgery, and even loss of custody of their children.[78]

The Ethics Committee of the Society of Obstetricians and Gynaecologists of Canada (SOGC) has opposed involuntary medical intervention. While recommending that physicians refer and encourage women with substance abuse problems to seek treatment,[79] its statements effectively recognize that "the threat of imposed intervention erodes the trust necessary to allow pregnant women to access prenatal care and other services necessary to their own health and the health of the fetus."[80] The AMA has similarly stated that "women may withhold information from the physician that they feel might lead the physician to seek judicial intervention. Or they may reject medical or prenatal care altogether, seriously impairing a physician's ability to treat both the pregnant woman and her fetus."[81] Equivalent positions have been taken by the Royal College of Physicians and Surgeons and the American College of Obstetricians and Gynecologists.[82]

Ultimately, the many concerns articulated regarding legal intervention speak to the limitations of current approaches to the problem of maternal drug and alcohol use. They suggest that individualistic and case-based intervention may be an inadequate response in light of the broader contextual factors that affect maternal and fetal health. They call for an

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75 *Ibid.*

76 *Ibid.* at 195.

77 *Ibid.*

78 *Supra* note 5 at 531; Johnsen, *supra* note 24 at 572, 603.

79 Society of Obstetricians and Gynaecologists of Canada, Clinical Practice Guidelines for Obstetrics Policy Statement, 55, "Healthy Beginnings: Guidelines for Care During Pregnancy and Childbirth" (December 1998) at 21; Society of Obstetricians and Gynaecologists of Canada, Clinical Practice Guidelines for Obstetrics Policy Statement, 18, "Healthy Beginnings: Guidelines for Care During Pregnancy and Childbirth" (December 1995) at 21.

80 Rodgers, "Legal Regulation," *supra* note 17 at 354-55.

81 AMA, *supra* note 44 at 2666 [footnotes omitted].

82 Rodgers, "Legal Regulation," *supra* note 17 at 355.

approach that takes into account "[p]overty, racism, sex discrimination, inadequate medical care, poor nutrition, and a lack of education" — that recognizes "the social problems that construct the conditions in women's lives that make reproductive freedom and reproductive choice relative abstractions (if not actual luxuries)."[83] A facilitative approach, which is outlined in greater detail in Part III, responds to these challenges by promoting more positive forms of intervention. It seeks to support and empower women by reinforcing their ability to make healthy decisions.[84]

III. APPROACHES OF COMMON LAW COURTS TO THE MATERNAL-FETAL RELATIONSHIP

The approaches of common law courts to the question of maternal civil liability have varied across different jurisdictions. In general, however, divergent approaches to the maternal-fetal relationship have reflected difficulties in addressing the unique condition of pregnancy. It has been pointed out that different conceptions of the relationship between a mother and her fetus — conceptions that have positioned the mother and fetus either as adversaries or as an inseparable whole — have informed the balancing of maternal and fetal interests. Less attention has been paid, however, to the fact that despite acknowledging the *interconnection* between maternal and fetal interests — outcomes have been necessarily *adversarial*, ultimately prioritizing one over the other. In other words, "relational" approaches by courts to the issue of intervention have not led to relational outcomes that respond to both maternal and fetal health needs. A feminist relational perspective may thus be helpful in identifying what has been omitted from the discourse; that is, that both approaches that understand the mother and fetus as opposed and approaches that see the mother and fetus as interdependent, have ultimately resulted in adversarial outcomes that favour either maternal autonomy or fetal interests.

A. OVERVIEW OF APPROACHES TO MATERNAL CIVIL LIABILITY IN THE UNITED STATES AND THE UNITED KINGDOM

To begin with, common law courts have responded in various ways to tort claims on behalf of the fetus. In the U.S., there is no judicial consensus on the issue of maternal civil liability.[85] Some state courts have recognized a child's right of action against his or her mother for prenatal negligence,[86] while others have adamantly rejected it.[87] State intervention with pregnant women on behalf of the fetus has also taken place through court orders imposing forced Caesarean sections,[88] criminal prosecution and incarceration for drug use while pregnant,[89] and prosecution under child welfare statutes for prenatal child abuse.[90]

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83 *Supra* note 5 at 532.

84 This facilitative model was developed by Dawn Johnsen. See also Johnsen, "Shared Interests," *supra* note 24.

85 *Supra* note 41 at para. 37.

86 See e.g. *Bonte v. Bonte*, 616 A.2d 464 (N.H. 1992).

87 See e.g. *Stallman v. Youngquist*, 531 N.E.2d 355 (Ill. 1988).

88 Kolder, Gallagher & Parsons, *supra* note 24; *Jefferson*, *supra* note 24; *Re A.C.*, *supra* note 24; *WVHCS-Hospital*, *supra* note 24.

89 *Re Steven S.*, 178 Cal. App.3d 23 (Ct. App. 1981).

90 *People v. Stewart*, No. M508197 (Cal. Mun. Ct. San Diego Cty. 26 February 1987).

In the United Kingdom, the Parliament of the U.K. has enacted legislation, the *Congenital Disabilities (Civil Liability) Act 1976*,[91] outlining a rule of maternal tort immunity for prenatal negligence, with a limited exception for negligent driving. The *Act* provides compensation for children who have been injured as a result of negligent driving by their mothers while pregnant, but simultaneously protects mothers by prohibiting claims against them that extend beyond the limits of their insurance policies.[92]

B. CANADIAN COURTS AND THE "BORN ALIVE" RULE

In Canada, courts have affirmed the common law "born alive" rule, which states that the fetus is not a person and has no rights until it is born. Furthermore, Canadian courts have rejected the imposition of a legal duty of care upon a mother towards her fetus. The "born alive" rule was articulated in *Montreal Tramways v. Léveillé*,[93] which established that a fetus is not a legal person, but that certain rights accrue and may be asserted by the infant upon being "born alive and viable."[94] In this case, a disabled child was granted the right to bring an action against a tramcar company for negligence that led to prenatal injuries.

The "born alive" rule has been consistently upheld by Canadian courts. In *Tremblay v. Daigle*,[95] where a man tried to prevent his former girlfriend from obtaining an abortion on the grounds that the fetus was a "human being" and had a "right to life" under s. 1 of the Quebec Charter, his request for an injunction was denied because the fetus was not recognized as a juridical person in Canadian law.[96] Similarly, in *R. v. Sullivan*,[97] it was determined that midwives could not be convicted for criminal negligence causing death to a baby, as the Court found that a fetus not yet born alive was not a "person" for the purposes of s. 203 (now s. 220) of the *Criminal Code*.[98]

The "born alive" rule essentially permits a child that has been born alive to bring a claim against third parties for injuries sustained while in utero. This distinction does not constitute a recognition of a duty of care owed to the fetus. Rather, it emphasizes the unity principle during pregnancy, and asserts that *at birth*, "[a] relationship [crystallizes] and out of it [arises] a duty on the defendant in relation to the child."[99] The fact that the damage occurred at the fetal development stage is "merely an evidentiary fact relevant to the issue of causation."[100] Nevertheless, this rule has raised several concerns with regards to the potential duty of care owed by doctors to unborn (or not yet conceived) children. Wrongful life claims,

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91 (U.K.), 1976, c. 28.
92 *Supra* note 41 at para. 36.
93 [1933] S.C.R. 456.
94 *Ibid.* at 464.
95 [1989] 2 S.C.R. 530.
96 *Supra* note 5 at 524.
97 [1991] 1 S.C.R. 489.
98 R.S.C. 1985, c. C-46.
99 *Watt v. Rama*, [1972] V.R. 353 (Australia Vic. Sup. Ct.) at 360-61, cited in *D.F.G., supra* note 2 at para. 22.
100 *Ibid.*

for example, have been rejected by Canadian and English courts for a wide range of policy reasons.[101]

The question of whether a doctor owes a duty of care to future children when prescribing medication for the mother which may harm a fetus has also raised difficulties. In the case of *Lacroix*,[102] where a doctor prescribed medication to treat the mother's epilepsy, the Court ruled that "[a] doctor cannot withhold the medication from the mother, and put her at risk, for the sake of avoiding risk to a yet unconceived fetus."[103] Moreover, the Court emphasized that "[t]he imposition of such a duty would immediately create an irreconcilable conflict between the duty owed by the doctor to the child and that owed to the mother."[104] Similarly, in the recent case of *Bovingdon v. Hergott*,[105] where an obstetrician prescribed a fertility drug which led to the conception and premature birth of twins, the Court ruled that "[t]he doctor owed a duty of care only to the mother, which duty consisted of ensuring that she possessed knowledge sufficient to make an informed decision whether to take [the fertility drug]."[106] The conclusion that the doctor owed no legal duty to the unborn children in this case was based on "the policy of ensuring that women's choice of treatment be preserved."[107] While this position has generally been accepted in Canada, the recent case of *Paxton v. Ramji*[108] challenged this stance with regards to a drug that was contraindicated for pregnancy. Essentially recognizing a duty of care to a child preconception, Eberhard J. of the Ontario Superior Court of Justice found a duty of care on the part of the doctor to the unconceived child of a woman seeking Accutane either not to prescribe it, or to ensure that she would not become pregnant.[109] While currently on appeal, the implications of this judgment for women's rights and choices, particularly women of "child-bearing potential," remain to be seen.[110]

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101 Wrongful life claims have been advanced by children (born disabled) against doctors for failing to inform their mothers of the possibility of bearing a disabled child. In such cases, the doctor's omission has not caused the harm itself, but has caused the child to be born by depriving the mother of the option of not conceiving or of having an abortion. For example, in *McKay v. Essex Area Health Authority*, [1982] 2 All E.R. 771 (C.A.), a doctor failed to diagnose an infection contracted by the mother in the early stages of her pregnancy. The infection (rubella) led to serious birth defects in the child. The English Court of Appeal ruled that there was no duty to the child to provide the option of terminating his existence. Similar decisions have been made by Canadian courts in regard to wrongful life claims. See *Lacroix (Litigation guardian of) v. Dominique*, 2001 MBCA 122, 202 D.L.R. (4th) 121 [*Lacroix*]; *Arndt v. Smith*, [1994] 8 W.W.R. 568 (B.C.S.C.); *Mickle v. Salvation Army Grace Hospital Windsor Ontario* (1998), 166 D.L.R. (4th) 743 (Ont. Ct. J. (Gen. Div.)); *Jones (Guardian ad litem of) v. Rostvig* (1999), 44 C.C.L.T. (2d) 313. (B.C.S.C.).

102 *Ibid.*

103 *Ibid.* at para. 39.

104 *Ibid.*

105 2008 ONCA 2, 88 O.R. (3d) 641.

106 *Ibid.* at para. 70.

107 *Ibid.* at para. 71 [footnotes omitted].

108 [2006] O.J. No. 1179 (Sup. Ct. J.) (QL).

109 *Ibid.* at para. 208.

110 This case is currently under reserve at the Ontario Court of Appeal.

C. JUDICIAL APPROACHES TO THE MATERNAL-FETAL RELATIONSHIP

The specific question of whether tort law should be extended to include a maternal duty of care to the fetus has been addressed by the Supreme Court of Canada in the fairly recent cases of *D.F.G.* and *Dobson*. In *D.F.G.*, the issue at stake was whether the law of tort should be extended to permit an order for the detention and treatment of a pregnant woman for the purpose of preventing harm to her unborn child. Upholding the "born alive" rule, the majority maintained that the fetus possessed no legal rights, and that Winnipeg Child and Family Services had no right to seek injunctive relief on the unborn child's behalf until the child was born alive and viable.[111] More particularly, the Court rejected both the torts argument for intervention and the parens patriae analysis. Among its justifications, the Court cited policy reasons, deference to the legislature, concerns about adverse effects on maternal and child health, and most notably, intrusion on the rights of women.

Of particular interest is the approach of the Court in *D.F.G.* to the maternal-fetal relationship. As Randall notes:

> [In refusing] to cede a separate legal identity to the fetus, which is seen as an inextricable part of the woman's body, the majority judgment ends up making the woman's autonomy interests the most salient concern, warranting the greatest legal protection. The dissent, on the other hand … argues that the separate *rights* of the fetus must be legally recognized and made paramount, regardless of the implications for, or violation of, the pregnant woman's autonomy rights.[112]

As such, their opposing decisions rely on "fundamentally different conceptions of whose rights matter most."[113]

Examining this observation is crucial, as an in-depth analysis reveals that, although progressive in recognizing women's reproductive autonomy, the Supreme Court of Canada's approach to the maternal-fetal relationship may not in fact promote "relational" solutions in the sense envisioned by relational feminism — that is, responses that reinforce autonomy through relationship and through the promotion of healthy maternal and fetal outcomes. While this may be a result of the necessarily adversarial legal framework, which forces courts to decide between women's liberty and the implications of recognizing fetal personhood, the distinction is still important to recognize.

Writing for the majority, McLachlin J. recognizes that "[t]he 'life' of the foetus is intimately connected with, and cannot be regarded in isolation from, the life of the pregnant woman."[114] She asserts that "[t]o permit an unborn child to sue its pregnant mother-to-be would introduce a radically new conception into the law; the unborn child and its mother as separate juristic persons in a mutually separable and antagonistic relation."[115] Such a conceptualization, she argues, "is belied by the reality of the physical situation; for practical purposes, the unborn child and its mother-to-be are bonded in a union separable only by

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111 *Supra* note 2 at para. 51.
112 *Supra* note 5 at 521 [emphasis in original].
113 *Ibid.*
114 *D.F.G., supra* note 2 at para. 27, citing *Paton v. U.K.* (1980), 3 E.H.R.R. 408 (Comm.) at 415.
115 *D.F.G., ibid.* at para. 29.

birth."[116] Her judgment concludes that "[t]he pregnant woman and her unborn child are one.… [T]o make orders protecting fetuses would radically impinge on the fundamental liberties of the pregnant woman, both as to lifestyle choices and how and as to where she chooses to live and be."[117] Thus, despite attempting to recognize the unique relationship of pregnancy in relational terms, through an emphasis on connection and interdependence, the majority ends up with an individualized conception that essentially interprets the unified maternal-fetal interest in terms of the pregnant woman's autonomy. While this may have been the most desirable outcome from a public policy perspective, for the purposes of protecting women's reproductive freedom and responding to the concerns of the medical community, it does not necessarily reflect a capacity to address the shared health needs of addicted pregnant women and their fetuses.

Justice Major's dissenting opinion in *D.F.G.* forms an interesting comparison. Premised on a model of maternal/fetal conflict, his argument asserts that the "born alive" rule "is a legal anachronism based on rudimentary medical knowledge [that] should no longer be followed."[118] Supporting a conceptualization of the fetus as a separate legal person, he maintains that "[p]resent medical technology renders the 'born alive' rule outdated and indefensible,"[119] given the ability of technologies such as ultrasound and fetoscopy to ascertain that the fetus is alive. Calling for intervention, he contends that "[i]f our society is to protect the health and well-being of children, there must exist jurisdiction to order a pre-birth remedy preventing a mother from causing serious harm to her foetus. Someone must speak for those who cannot speak for themselves."[120]

Justice Major's position presents the opposite danger; it presents a view of women as "fetal container[s]"[121] whose autonomy and bodily integrity may be violated through state-sanctioned intervention. It rejects the values of connection and interrelatedness advanced by the relational approach. Furthermore, in challenging the stance of the obstetricians, gynecologists, and physicians that provide care for pregnant women, it threatens to undermine both maternal and fetal health needs. Ultimately, what appears to be missing in both *D.F.G.* judgments is an approach that can speak for both maternal and fetal interests.

In *Dobson*, where a child brought an action against his mother for injuries caused by her prenatal negligence while driving, similar contradictions in understanding the maternal/fetal relationship arise. In this case, the majority held that "a legal duty of care should not be imposed upon a pregnant woman towards her foetus or subsequently born child"[122] as it constituted a severe intrusion into the lives of pregnant women with potentially damaging effects on the family unit.

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116 *Ibid.*
117 *Ibid.* at para. 55.
118 *Ibid.* at para. 102.
119 *Ibid.* at para. 109.
120 *Ibid.* at para. 140.
121 *Supra* note 5 at 525.
122 *Supra* note 41 at para. 21.

As in *D.F.G.*, the majority judgment in *Dobson* emphasizes the "unique and special relationship between a mother-to-be and her foetus."[123] Justice Cory writes that "[t]here is no other relationship in the realm of human existence which can serve as a basis for comparison,"[124] characterizing the expectant mother and her fetus as an "inseparable unity."[125] Thus, he contends that "[w]hether it be considered a life-giving miracle or a matter of harsh reality, it is the biology of the human race" that marks the relationship as one of "complete dependence," of "[physical, psychological, and emotional]" connection.[126] Finally, in keeping with the values of the feminist relational approach, Cory J. underlines the significance of future relationships, noting that "the relationship between a pregnant woman and her foetus is of fundamental importance to the future mother and her born alive child, to their immediate family and to our society."[127]

The dissent, on the other hand, applies the adversarial model, and presents an argument advancing the rights of the child in opposition to those of the mother. Distinguishing the child in *Dobson* as a "born alive child," Major J. maintains that "[t]he bare assertion of social policy concerns expressly and unilaterally centred on a pregnant woman's rights are not a sufficient answer to the question whether a pregnant woman's rights should prevail over the equally recognized rights of her born alive child."[128] Further, he contends that "[t]he legal or social policy implications to be drawn from [the special relationship between a pregnant woman and her fetus] cannot be ascertained in the absence of equal acknowledgment of the rights of the child."[129]

The opposing judgments in *Dobson* resonate awkwardly with the reality of the case, which involved a mother attempting to obtain insurance compensation for the costly care of a severely disabled child. Thus, both judgments fail to practically address the actual needs of mother and child, or to recognize their complex interdependence. While the decision in *Dobson* was premised upon broad public policy concerns regarding the autonomy of pregnant women, it highlights the limitations of tort law, and the inability of legal mechanisms such as maternal civil liability to effectively address the needs of pregnant women and their children — born and unborn.

Perhaps the difficulty lies in the framework of the adjudicatory model itself, which belies attempts by the courts to recognize relationship, connection, and interdependence in the maternal-fetal context — for it ultimately forces judges to choose. A feminist relational approach, and the reality of the above situations themselves, suggests that the very act of choosing undermines both maternal and fetal health interests; that it potentially fails to support pregnant women's autonomy in concrete terms; and that it betrays the tragic circumstances of individual mothers and their children.

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123 *Ibid.* at para. 25.
124 *Ibid.*
125 *Ibid.*
126 *Ibid.* at para. 29.
127 *Ibid.*
128 *Ibid.* at para. 127.
129 *Ibid.* at para. 129.

IV. LOOKING BEYOND TORT TO FACILITATIVE STRATEGIES

The limitations of tort in dealing with the problem of maternal alcohol and drug use are evidenced by the fact that available legal remedies — "[swooping] in [to] rescue fetuses from their negligent 'mothers,'"[130] or refusing to intervene at all — fail to effectively address the needs of addicted women and their children. Furthermore, given that the issue of child health does not end at birth, strategies concerned with child welfare must extend beyond intervention to support the relationships that affect, support, and endanger children's development.

These realizations point to a host of questions: does going beyond the adversarial model involve going beyond the courts? Is it possible to promote healthy maternal and fetal outcomes, while respecting women's reproductive autonomy, through non-legal means? *How* can broader public policy initiatives begin to address systemic causes of substance abuse and inequality in concrete terms? Johnsen's "facilitative model" provides insight into these questions, and offers a strategy that promotes relational thinking by empowering women to make healthy decisions for maternal and fetal interests.

A. DAWN JOHNSEN'S FACILITATIVE MODEL

As opposed to adversarial approaches that "create conflict between women's liberty and the promotion of healthy births,"[131] Johnsen's facilitative model seeks "to improve maternal and infant health through an expansion of women's choices and options in the provision of a wider range of support services and resources."[132] It endeavours to empower women and to reinforce their "ability to make individual decisions that promote healthy births."[133] The facilitative model is premised upon a belief "that women who decide to bear children wish to have healthy pregnancies and healthy babies and typically will go to great lengths to make this possible."[134] The model recognizes that while pregnant women share state objectives of promoting healthy births, "existing obstacles — and not bad intentions — impede the attainment of this common goal."[135] Thus, "[r]ather than depriving women of the right to make these judgments or punishing women after the fact for making 'wrong' choices, facilitative policies seek to expand women's choices by, for example, improving access to prenatal care, food, shelter, and treatment for drug and alcohol dependency."[136]

B. CONCRETE APPLICATIONS OF THE FACILITATIVE MODEL

As such, the facilitative model strives to address systemic problems that contribute to maternal and fetal ill health. It highlights a need to respond to domestic violence, inadequate health care, racial discrimination, and women's social and economic marginalization. It

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130 *Supra* note 5 at 528.
131 Johnsen, "Shared Interests," *supra* note 24 at 571.
132 *Supra* note 5 at 530.
133 Johnsen, "Shared Interests," *supra* note 24 at 574.
134 *Ibid.* at 573.
135 *Ibid.* at 571.
136 *Ibid.*

acknowledges the obstacles that women face in achieving healthy pregnancies, such as "illness, addiction, poor information, lack of health insurance, and poverty."[137]

With regards to the specific context of maternal drug and alcohol use, "[t]he facilitative model accommodates the reality that some women engage in behavior that both presents a relatively high risk of harm to fetal development and also is viewed by society as having little or no redeeming value."[138] Johnsen maintains that even in these situations, a facilitative approach is helpful. She argues that "[t]he overwhelming majority of women who use substances such as cocaine, alcohol, and tobacco during pregnancy do so because they suffer from strong physical and psychological dependencies developed prior to pregnancy, not because they desire to give birth to an unhealthy baby."[139] In support of this, she points out that "providers of health care and drug and alcohol treatment find that women are highly motivated during pregnancy to seek help in overcoming their dependencies precisely because they want to minimize risks to fetal development and deliver healthy babies."[140] Reports by social service providers and the AMA have agreed with this assertion, noting that "[p]regnancy is a motivating factor for most women to seek treatment because of concern for their soon to be born child."[141] This perspective suggests the potential of facilitative strategies to promote healthy birth outcomes by empowering women to channel this motivation into positive directions.

C. PROMOTING ACCESS TO TREATMENT PROGRAMS

One of the major impediments to maternal and fetal health is the lack of effective and available treatment services for drug and alcohol dependent pregnant women. Commentators have pointed out that despite the great demand for treatment, "the vast majority of pregnant women seeking assistance to overcome drug dependency cannot obtain the help they need."[142] It has been observed that "[d]rug treatment programs routinely deny admission to pregnant women, and the few that will treat women during pregnancy typically have long waiting lists,"[143] with waiting times that are "often longer than the duration of the woman's pregnancy."[144] The case of G highlights this problem, for in criticizing the young woman for "consistently [refusing] all offers of treatment to deal with her addiction problem,"[145] the dissent ignored the important fact that G had sought treatment earlier on in her pregnancy, but had been turned away due to lack of facilities.[146] Reducing delays in access to treatment is particularly important in the context of maternal alcohol and drug use, as the highest risk of harm to fetal development occurs during the first trimester of pregnancy.[147] Such realities

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137 *Ibid.* at 574.
138 *Ibid.* at 575.
139 *Ibid.*
140 *Ibid.*
141 *Ibid.* at 575-76, n. 18, citing National Governors Association, "NGA National Forum on Prevention Programs for Children" *NGA In Brief* (21 September 1990) 2.
142 *Ibid.* at 605 [footnotes omitted].
143 *Ibid.* at 576 [footnotes omitted].
144 *Ibid.* at 605 [footnotes omitted].
145 *Supra* note 2 at para. 73.
146 *Ibid.* at para. 5.
147 Michael C. Lu & Calvin J. Hobel, "Antepartum Care: Preconception and Prenatal Care, Genetic Evaluation and Teratology, and Antenatal Fetal Assessment" in Neville F. Hackner, J. George Moore & Joseph C. Gambone, eds., *Essentials of Obstetrics and Gynecology*, 4th ed. (Philadelphia: Elsevier

have prompted the American Medical Association to assert that "[i]t would be an injustice to punish a pregnant woman for not receiving treatment for her substance abuse when treatment is not an available option to her."[148]

Facilitative approaches to this problem focus on promoting access to treatment, making more treatment programs available to women, and establishing prevention programs that encourage public education about the harmful effects of drug and alcohol use during pregnancy.[149] Johnsen underlines that in order to be effective, accessible, and responsive to pregnant women's needs, "treatment programs must provide comprehensive community-based medical, educational, psychological, and social services."[150] They represent a positive, proactive way to address the harmful effects of maternal alcohol and drug use, to promote women's autonomy, and to support the interdependent interests of mothers and their fetuses.

D. ADDRESSING BROADER SYSTEMIC INEQUALITIES

Furthermore, a facilitative approach signals the need to address broader systemic inequalities. The late Dr. Maxie T. Collier, former Commissioner of Health of Baltimore, Maryland, demanded that the drug abuse problem be understood as a public health problem.[151] He argued that maternal substance abuse "should not be viewed in isolation from its frequent accompaniments: economic deprivation and racial discrimination."[152] For example, he pointed out that "lack of prenatal health care is by far the biggest threat to infant health. It is often exacerbated by poverty, youth, and/or lack of education of the mother."[153] The SOGC has similarly insisted that "adequate resources be made available for the development of effective programs and services to ensure that all pregnant women have access to good health care, proper counselling and rehabilitation, safe living conditions, and nutrition."[154]

Rodgers has maintained that "concern about fetal welfare is problematic where only limited provision for prenatal care, newborn and infant care, and housing and nutrition is made for children after birth."[155] Noting the intersection of different forms of discrimination, she points out that "First Nations women and infants have a health status that falls well below that of the general Canadian population. Their need is for basic reproductive health care, not for coercive measures."[156]

Saunders, 2004) 83 at 94.

148 AMA, *supra* note 44 at 2669.

149 Johnsen, "Shared Interests," *supra* note 24 at 576.

150 *Ibid.* at 605 [footnotes omitted].

151 See e.g. Maxie T. Collier & Anne E. Walker, "US drug policy and public health" *Drugtext*, online: Drugtext <http://www.drugtext.org/library/articles/923208.htm>.

152 *Supra* note 49 at 266-67.

153 *Ibid.* at 267.

154 Rodgers, "Legal Regulation," *supra* note 17 at 355, citing Society of Obstetricians and Gynaecologists of Canada, Clinical Practice Guidelines for Obstetrics, Policy Statement, 67, "Involuntary Medical Intervention in the Lives of Pregnant Women" (October 1997).

155 *Ibid.*

156 *Ibid.*

Such examples highlight the potential contribution of a relational perspective to public policy initiatives and underline the importance of supporting women's needs in order to promote fetal health. Thus, the recognition of pregnancy as a complex and interdependent relationship, and of maternal and fetal needs as interconnected, suggests a way forward through positive forms of intervention. Erin Nelson argues that although "intervention in pregnancy, as currently practised, is bad public policy," there may be arguments, "depending heavily on what is meant by intervention, that intervention might sometimes be desirable."[157] She asserts that if we interpret intervention to mean "the positive involvement of the state in the lives of pregnant women in seeking out and helping those who need assistance with prenatal care, addiction treatment, nutrition, care of other children, or protection from a violence spouse, then there is clearly an important role for intervention."[158]

V. CONCLUSION

The implications of going beyond the courts raise difficult issues. What does this mean in terms of individual cases? Do we stand by — as jurists, as social workers, as a community — while a pregnant woman engages in substance abuse that causes serious harm to herself and to her unborn child? The object of this article is not to challenge the current state of the law in Canada on legal intervention. Rather, it suggests that the law itself is an inadequate tool and an ineffective means to deal with the problem of maternal substance abuse. Forced intervention violates women's reproductive autonomy and is unethical in a context where services and support remain largely unavailable. As jurists, this recognition is critical if we are to link our practice to the realities of the social issues that we struggle with. Pregnancy will not disappear from the courtroom and the maternal-fetal relationship will continue to drive debates. A relational approach calls upon all sides to respond; to identify the deep systemic causes of maternal substance abuse; to acknowledge the shared needs and realities of pregnant women and their fetuses; and to recognize that we are all responsible to the woman who suffers alone with her addiction and to the children that are born with permanent damage as a result of it.

In his dissent in *D.F.G.*, Major J. declared that "[s]omeone must speak for those who cannot speak for themselves."[159] Unfortunately, it is not only fetuses who cannot speak for themselves. The issue of drug and alcohol abuse introduces a complex picture of systemic discrimination, inequality, and violence; it speaks to conditions that perpetuate marginalization, poverty, and powerlessness. Women themselves are voiceless in the current system. While violating women's rights to liberty and bodily integrity has been recognized as unjustifiable, an outcome that respects women's autonomy without promoting its realization also ignores and reinforces the cycle of silence. Facilitative strategies signal the need to move beyond current legal responses and beyond the courtroom itself; they indicate a need to imagine broader solutions, to support women's ability to make healthy choices, and to empower mothers and their children by providing them with a voice to challenge the cycles that define them.

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157 *Supra* note 34 at 598.
158 *Ibid.*
159 *Supra* note 2 at para. 140.