MEDICAL DECISION MAKING DURING A SURROGATE PREGNANCY

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1. W. Williams, The Use of Force, in The Doctor Stories 59-60 (1984). In this sketch, Williams was describing a doctor's frustration in attempting to examine the tonsils of a particularly resistant young girl whom he suspected had diphtheria.

Much of this article is concerned with a tradition of paternalism within the medical and legal professions toward pregnant women, their children, and the medical decisions that pregnant women make affecting both. A full blown discussion of the moral and sociological aspects of paternalism is beyond the scope of the article, but it is worth exploring some of the ways the Williams quotation illustrates the equivocal nature of the tradition.

Williams' comment betrays the feelings of moral superiority that can be produced by superior technical knowledge, as well as the anger that can result when a patient rejects that technical knowledge and the benefits it is supposed to confer. When the patient is an infant, the substitution of an adult's will for the child's may seem harsh at times, but justifiable and even "necessary." When the patient is an adult, the urge to substitute one will for another is more pernicious. One physician's statement about his adult patient provides an example: "[W]hen a patient places herself in the care of a surgeon for treatment without [express limitations] upon his authority, she thereby in law consents that he may perform such operation as in his best judgment is proper and essential to her welfare." Pratt v. Davis, 118 Ill. App. 161, 166 (1905) (testimony of the defendant). The appellate court's opinion, which rejected the defendant's position, is discussed briefly in J. Katz, The Silent World of Doctor and Patient 50-51 (1984). Professor Katz describes and criticizes the temptation of many doctors to treat adult patients like children, to be their "Mommy" or "Daddy" and to make wise decisions for them. Id. at 126.

On the other hand, as Professor William F. May has observed, the paternal image has provided one of the most durable models of medical professionalism. W. May, The Physician's Covenant 13-62 (1983). Although he acknowledges the dangers of paternalism, or at least unbridled paternalism, he argues that "[t]he image . . . signals the need for a compassionate, sometimes sacrificial, authoritative, and nurturant devotion to another's good." Id. at 62. Thus, viewed constructively, paternalism can be a lens through which the physician views "the dependence, vulnerability, and exploitability of the sick person [as] impos[ing] the obligation to enhance the autonomy of the patient." Pellegrino, Letter to the Editor, 269 J.A.M.A. 517 (1988).
I. Introduction

It is no exaggeration to say that the attention of the nation was captured by the celebrated case of “Baby M” as it was tried in a New Jersey courtroom during the winter of 1987. Custody battles are not usually front-page news, but this, of course, was no ordinary custody battle. “Baby M” was conceived by artificial insemination pursuant to a contract between her biological father, Dr. William Stern, and Mary Beth Whitehead, a “surrogate mother” hired by Dr. Stern to conceive, carry to term, and turn


3. The term “surrogate mother” is rejected by some, who view the surrogate as the “natural” or “real” mother, and the wife of the biological father as the true “surrogate.” See Capron, Alternative Birth Technologies: Legislative Challenges, 20 U.C. DAVIS L. Rev. 679, 679 n.1 (1987). To avoid confusion, however, this article adopts the more common usage of the term to identify the woman who receives the donor’s sperm, whether the point of reference is before entering into the contract, after artificial insemination, or following the birth of the child.

Surrogacy arrangements may take a number of genetic forms. The most common, and the one exemplified by the Baby M case, involves the artificial insemination of S, the surrogate, who is unrelated to H, the sperm donor; H and his wife, W, will be the social parents of the offspring. See American Fertility Society, Ethics Committee, Ethical Considerations of the New Reproductive Technologies, 46 FERTILITY & STERILITY 1S, 62S (Supp. 1986). In a variation of this pattern, H and W contribute the genetic material to the embryo, either by natural or artificial insemination or through in vitro fertilization, with the embryo then transplanted to the “rented womb” of S. See id. at 58S. For a table describing various “reproductive possibilities,” from “traditional reproduction” (gametes from married couple, natural method of fertilization, gestation in the wife) to “Brave New World” (five different and unrelated persons provide the male and female gametes, gestation, and social parents of the offspring), see Capron, supra, at 682.

While noting the genetic differences among the possibilities for surrogacy, most commentators have tended to minimize the significance of these distinctions for purposes of public policy analysis. See, e.g., American Fertility Society, Ethics Committee, supra, at 58S (“The reservations about surrogate gestational mothers [i.e., women who gestate a genetically unrelated embryo] are similar to those [concerning surrogates who gestate a genetically related embryo]”); DEPARTMENT OF HEALTH & SOCIAL SECURITY, REPORT OF THE COMMITTEE OF INQUIRY INTO HUMAN FERTILISATION AND EMBRYOLOGY 42-47 (M. Warnock, chair, 1984)
over after birth a child who would then be raised by Dr. Stern and his wife, Dr. Elizabeth Stern. Moreover, this was the first time a surrogate mother's refusal to abide by the custody provisions of her contract—a refusal that added Old Testament overtones to a late twentieth-century problem—had gone to a trial. Thus, it seemed at least likely that the trial court would rule, also for the first time in a United States jurisdiction, on the legality and enforceability of a surrogacy contract in the context of a surrogate mother's refusal to renounce her parental rights. Despite these

(both types of surrogacy discussed generally without distinction).

For purposes of this article, no distinction will be observed based on the genetic relationship of the surrogate to the child she is carrying.


"firsts," the public's appetite for news of the case defies easy explanation. The uniqueness of the central issue of the status of the surrogacy contract justifies a certain level of interest, but hardly the preoccupation evidenced by the press coverage. While the frequency with which infertile couples turn to surrogacy arrangements is not susceptible to reliable estimates, the practice does


7. It is certainly true, as the Wall Street Journal stated, that the Baby M case "deal[s] with one corner of the enormous complexity surrounding the most fundamental of human drives and instincts," see Beyond Baby M, Wall St. J., April 2, 1987, at 28, but it is far from clear that "[t]hat is no doubt why it has generated so much emotion and contention." Id. The case exists in a context that includes issues of procreative liberty, abortion and adoption, but that is only a partial explanation for the notoriety of the case.


Even the number of infertile couples in the United States — and, thus, the number of couples who might consider surrogacy — is uncertain. This is due in part to the fact that infertility may be defined at least three ways:

(1) Infertility may be defined as the inability to conceive, see In re Baby "M", 217 N.J. Super. 313, 525 A.2d 1128, 1161 (N.J. Super. Ct. Ch. Div. 1987), aff'd in part and rev'd in part, No. A-39-87 (N.J. Feb. 3, 1988), or, more broadly, the ability to conceive "no or only a few offspring," 1 The Oxford Companion to Medicine 604 (1986).

not appear to be widespread. Furthermore, the percentage of cases in which the surrogate mother refuses to give custody of her child to the father and his wife is apparently quite low. In view of the remote applicability of the Baby M case to the lives of most of us, we must look elsewhere for clues to its grip on our attention. In particular, it is important to ask what messages the case carries into the field of law and medicine.

The relevancy of this case to issues concerning advancing

at 1661, which suggests that 1 couple in 11 cannot conceive, even after medical treatment.

(3) The percentage of infertile couples increases, and becomes more indeterminate, under a third definition: "the inability to conceive, carry or bear a child without significant risk to either the mother or the fetus." In re Baby "M", 525 A.2d at 1161. The concept of "risk" might be broadly defined to include not only pregnancies that present a high risk of morbidity or mortality to mother or child, but also "voluntary" infertility due to genetic concerns or frequent miscarriages.

9. There are reasons to believe that surrogacy will not become widespread. The number of women who are willing to conceive and carry a child to term and then renounce all parental rights is presumably limited. Moreover, some infertile couples undoubtedly view surrogacy as an unsavory option. See Fleming, Our Fascination With Baby M, N.Y. Times, March 29, 1987, §6, at 33, 36 (Magazine) (likening surrogacy to "conceptual adultery"). Further, as long as the legal rights of the parents are in doubt, risks attach to nearly every aspect of the arrangement, including the risk (as illustrated by the Baby M case itself) that the surrogate mother may decide not to yield custody of the infant to the biological father and his wife. These uncertainties will deter many infertile couples from trying surrogacy. Also, alternatives to surrogacy are available (adoption, for instance) and are becoming more available with each passing year (in vitro fertilization is an example). But see Note, The Rights of the Biological Father: From Adoption and Custody to Surrogate Motherhood, 12 Vt. L. Rev. 87, 101 (1987) [hereinafter Note, Rights of Biological Father] (Noel Keane, a leading advocate of surrogacy, estimates that the number of couples involved in surrogacy will double annually).

In addition, state legislation is likely to make surrogacy a less available option for some infertile couples, and a less attractive option even in some jurisdictions that don't ban the practice. In the nine months after the Baby M trial court's decision was handed down, 70 bills addressing surrogacy were reportedly introduced in 27 states, see Peterson, States Assess Surrogate Motherhood, N.Y. Times, Dec. 13, 1987, §1, at 42, col. 3, and a number of other bills were pending even before Baby M was decided. See Surrogate Parenthood: A Legislative Update, 13 Fam. L. Rep. (BNA) 1442 (July 14, 1987). The bills in a minority of jurisdictions would ban surrogacy (paid, unpaid, or both), and bills pending in at least six states would allow the surrogate mother to revoke her consent to surrendering the child and renouncing her parental rights. Andrews, The Aftermath of Baby M: Proposed State Laws on Surrogate Motherhood, Hastings Center Rep., Oct./Nov. 1987, at 31, 38 [hereinafter Andrews, Proposed State Laws]. See also Note, Surrogate Motherhood Legislation: A Sensible Starting Point, 20 Ind. L. Rev. 879, 890-98 (1987). This latter option (revocable consent) may eventually be adopted by a larger number of states, since it appears to appeal to both opponents and supporters of surrogacy. Compare Annas, Baby M: Babies (and Justice) for Sale, Hastings Center Rep., June 1987, at 13, 15 [hereinafter Annas, Babies for Sale] with Lessons, supra note 8, at 16, 17.

10. The Economist has put the number of litigated disputes at three, as of March 1987. Lessons, supra note 8, at 16, 17.
medical technology is slight, at best. As George Annas has observed, "[s]urrogate motherhood is a nontechnical application of artificial insemination that requires no sophisticated medical or scientific knowledge or medical intervention." There is, however, one central aspect of the surrogacy arrangement that has important implications for law and medicine. In most surrogacy contracts, the surrogate mother agrees not to have an abortion and to refrain from certain types of harmful conduct, including the consumption of alcoholic beverages, smoking, and the use of illegal drugs. In the Baby M case, Mary Beth Whitehead also consented to a psychiatric evaluation, amniocentesis, medical consultations, and apparently to all medical interventions deemed desirable for the health of the mother or the child. This article will consider the implications these provisions have for medical decision making during pregnancy, and for the concepts of individual autonomy, informed consent and the developing doctrine of fetal rights.

After this article was written, the New Jersey Supreme Court

11. Annas, The Baby Broker Boom, HASTINGS CENTER REP., June 1986, at 30 [hereinafter Annas, Baby Broker Boom]. As Professor Annas points out, however, the nontechnical aspect of the procedure did not stop the Kentucky Supreme Court from justifying its refusal to equate surrogacy with baby selling by stating that it "did not want to interfere with 'a new era of genetics,' 'solutions offered by science,' and 'new medical services.'" Annas, supra, quoting Surrogate Parenting Assocs. v. Kentucky, 704 S.W.2d 209 (Ky. 1986). See also In re Adoption of Baby Girl L.J., 132 Misc. 2d 972, 505 N.Y.S.2d 813, 817-18 (Sur. Ct. 1986) ("biomedical science has advanced man into a new era of genetics which was not contemplated by either the Kentucky legislature nor [sic] by the New York legislature"); Comment, Surrogate Motherhood: The Attorney's Legal and Ethical Dilemma, 11 CAP. U. L. REV. 593, 609 (1982) ("surrogate-motherhood is a recent phenomenon, made possible only through modern-day technological advances"); Whose Baby M?, Wall St. J., Jan. 22, 1987, at 30 ("surrogate motherhood is a feat of medical technology that outdistances our certainty on how to use it").


14. Annas, Protecting Liberty, supra note 5, at 1213 ("contracts, like the one Mary Beth Whitehead signed, require the pregnant woman to follow 'all medical instructions'").

15. Because the focus of this article is on the effect to be given to contract provisions concerning medical decision making during a surrogate pregnancy, the discussion that follows assumes that within the relevant jurisdiction, as was the case in New Jersey before the New Jersey Supreme Court's Baby M decision, the contract itself has not been declared unlawful or void and unenforceable. The prospects for surrogacy contracts in the United States are uncertain following Baby M. Although a majority of the bills introduced in state legislatures since the trial court's decision reflect the position that some form of surrogacy should be permitted, 23 bills pending in 18 states would either criminalize or refuse to enforce certain forms of surrogacy arrangements. See Andrews, Proposed State Laws, supra note 5, at 31, 32, 34.
announced its decision in the *Baby M* case. The court ruled that the surrogate contract in that case—with its payments to Mary Beth Whitehead and her irrevocable promise to surrender custody of the child and to agree to a termination of her parental rights—"conflicts with the law and public policy of [New Jersey]," "is illegal and invalid," and is "perhaps criminal." Because after this opinion only voluntary surrogacy arrangements in which the surrogate mother has the right to change her mind about custody are permitted, without legislation validating paid surrogacy there will be very few, if any, surrogates in New Jersey. For New Jersey, therefore, the issues of contract interpretation and enforcement discussed in this article are, as a practical matter, largely moot.

There are at least two reasons, however, why the trial court's opinion in *Baby M* remains an appropriate vehicle for a discussion of medical decision making during a surrogate pregnancy. First, many of the problems that can be expected to arise with respect to medical decisions inhere in the surrogate relationship itself, without regard to the existence of a valid, enforceable contract. To be sure, in any jurisdiction in which surrogacy contracts are void and unenforceable, the number of surrogacy arrangements can be expected to dwindle. But surrogacy will not go away, even in New Jersey, and many of the ethical and legal issues discussed in this article remain relevant.

More significantly, surrogacy contracts have not been declared void as against public policy in most other states. Moreover, most jurisdictions have bills pending in their legislatures that approve of surrogacy in one form or another.

Any state that recognizes the validity of surrogacy contracts, whether by decision or by statute, without specifically addressing the issues discussed in this article, will create a confused and potentially dangerous regime of law. One need only review the *Baby M* trial court opinion to appreciate the magnitude of the problems. Accordingly, while the problems identified here are less acute in New Jersey after their supreme court's decision to invalidate the contract, they are unfortunately very much with us in most other jurisdictions.

17. *Id.*, slip op. at 4-5.
18. *See id.* at 23.
19. Refer to notes 9, 15 supra and accompanying text.
II. MEDICAL DECISIONS: BY OR FOR THE SURROGATE?

A. Background: The Contract and the Baby M Opinion

The surrogacy contract in the *Baby M* case provided for the payment by William Stern of Mary Beth Whitehead's medical expenses (including dental and psychiatric evaluation expenses “for performing her contractual obligations”21), her legal expenses incurred in connection with her execution and performance under the contract,22 and an additional fee of $10,000.23 Most surrogacy contracts provide for similar payments.24

Perhaps the most compelling (and commented upon) aspect of the *Baby M* case is the notion that these arrangements make the practice of surrogacy nothing more or less than baby selling, a practice that is forbidden by the adoption statutes of most states.25 In the view of many,26 the exchange of cash payments by the bio-


22. 525 A.2d at 1160.

23. *Id.* at 1143.


26. *See, e.g., Annas, Baby Broker Boom, supra* note 11, at 30; *Surrogate Parenthood*, 73 A.B.A.J. 38 (June 1, 1987) (surrogate parenting contracts should not be enforced “[b]ecause they're basically contracts for the purchase and sale of a baby, and baby selling is against the law”); Harrison, *The Social Construction of Mary Beth Whitehead in Expert Testimony* 17 (1987) (unpublished manuscript on file at Houston Law Center Library) (“the commodification of infants to be, the breeding of human beings for transfer of ownership, creates a new class of people whose lineage and ownership most clearly reflect our society's worst biases in regard to class, race, and gender”). *See also* Surrogate Parenting Assocs. v. Commonwealth, 704 S.W.2d 209, 214 (Ky. 1986) (Vance, J., dissenting) (“a portion of the payment is withheld and not paid until [the surrogate’s] living child is delivered unto the purchaser, along with the equivalent of a bill of sale, or quit-claim deed, to wit—the judgment terminating her parental rights”); Johnson, *The Baby “M” Decision: Specific Performance of a Contract for Specially Manufactured Goods*, 11 S. ILL. U.L. REV. 1339, 1343-46 (1987) (“I used to think of Property Law and Health Law as being two unrelated subjects. Well, apparently I was wrong.”). *But see* Frinz, *supra* note 6, at 2, 3; *Lessons, supra*
logical father and a newborn child by the surrogate mother is indistinguishable from the exchange of money (beyond certain enumerated expenses in some states) for children that is forbidden in the adoption statutes. This view gets some support from the fact that payment of the full amount of the fee was required in the Baby M case only upon delivery of a live child, and that the fee was to be reduced from $10,000 to $1,000 if the surrogate mother suffered a miscarriage.

The trial court’s opinion in the Baby M case rejected altogether the argument that surrogacy is the same as baby selling, a conclusion with which other courts had earlier both agreed and disagreed. The Baby M court found that the father paid the fee to “the surrogate for her willingness to be impregnated and carry his child to term.” There was no sale and purchase of a baby, wrote the court, because the biological father “cannot purchase what is already his.” This argument, of course, begs the very question being litigated by assuming that the child is the biological father’s and not the biological (surrogate) mother’s. It also ignores entirely that at least a part of the fee is allocable solely to the delivery of the child to the father.

Although the baby-selling argument is a serious one, it also implicates more than a narrow dispute over the construction to be given to the adoption statutes in those jurisdictions where excess payments to the mother are prohibited. The Baby M case brought surrogacy dramatically into focus at a time when the medical world was reporting breakthroughs in fetal tissue transplantation and other “brave new world” technological developments, and when

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note 8, at 16.
27. Annas, Babies for Sale, supra note 9, at 13, 14.
30. See Surrogate Parenting Assocs. Inc. v. Kentucky, 704 S.W.2d 209 (Ky. 1986). The Kentucky Supreme Court held that surrogacy does not violate the state’s prohibition against baby selling because the price was agreed to before conception and the surrogate mother had the right to cancel the contract up to the point of relinquishing her parental rights. Id. at 211-12.
33. 525 A.2d at 1157.
34. Reports in professional journals as well as the popular press prompted critical
the dominant health story of 1987—the worldwide pandemic of acquired immune deficiency syndrome (AIDS)—was regarded by some as a warning against the costs of drug abuse and profligate, unprotected sex. Baby M's theme of the commercialization of sex and of life itself, the idea that life may be bought and sold like a commodity, seemed to reinforce the public's fears that the way we view ourselves and others, our conception of the body and of body parts, as well as traditional notions of individual autonomy, have changed too fast and in a direction that is more to be feared than embraced.35 As Professor Alexander Capron has reminded us, "The


The level of professional and lay concern over the ethical issues raised by new medical technologies exemplifies a much older notion. "Bertrand Russell had hold of some truth when he said, 'Whatever else is mechanical, values are not.' But the remark was libelous of machinery. A flipped over version of Russell's remark would be the analysis that philosophers probably need more to hear: Whatever else is valueless, machines are not." S. TANENBAUM, ENGINEERING DISABILITY: PUBLIC POLICY AND COMPENSATORY TECHNOLOGY 17 (1986) (emphasis in original), quoting Shriver, Invisible Doorway: Hope As A Technological Virtue, in TECHNOLOGY AND THE FUTURE OF MAN (J. Haberer ed. 1973). Although Shriver's remark was limited to machines, it has obvious but useful implications for technology generally, as well as specifically for medical technology and "the brave new world of human manufacture that is now dawning," Krauthammer, supra note 8, at 17.

35. Diana Brahams has argued that a similar confluence of events and fears focused British attention on surrogacy, also in a particularly negative way, in 1985. Brahams, The Hasty British Ban on Commercial Surrogacy, HASTINGS CENTER REP., Feb. 1987, at 18. Brahams describes the basis for the anxiety produced by what "some regard as the dismal slide into today's rudderless society." Id. The first manifestation of that anxiety was the Warnock Report, which recommended the criminalization of commercial surrogacy agencies and a statutory declaration that "all surrogacy arrangements are illegal contracts and therefore unenforceable in the courts." See DEPARTMENT OF HEALTH & SOCIAL SECURITY, REPORT OF THE COMMITTEE OF INQUIRY INTO HUMAN FERTILISATION AND EMBRYOLOGY 85-86 (Dame Mary Warnock, chairman, 1984). The second manifestation was the Surrogacy Arrangements Act, 1985, ch. 49, which implemented the recommendations of the Warnock Report on surrogacy.

The relatively restricted scope of this article is not meant to suggest that there are not other issues of profound importance raised by the practice of surrogacy and by the court's opinion in the Baby M case. Motherhood, parenthood, gender and class bias and exploitation, procreative liberty: these and many other issues have been commented upon at some length in the massive and growing body of literature on the subject. See, e.g., Alexander,
Baby M case... involves at its core the interest of a child who is not a party to the contract. The decision, therefore, shares at least one central concern common to fetal tissue transplantation, organ donations from anencephalic newborns, and the various forms of in vitro fertilization: establishing the human and legal rights of an unrepresented and unprotected third party of especial vulnerability.

The recognition and reconciliation of potentially conflicting rights—those of the baby, the surrogate mother, and the biological father—begin with the surrogacy contract. Surrogacy arrangements vary from case to case, but standard elements (allowing for variations on each theme) are well known. One element deals with lifestyle and medical care decisions during gestation; these have an impact on the health of the child, either directly or by affecting the health of the surrogate mother. Another set of provisions deals more specifically with a subset of those general health care concerns: the decision to have or to forego an abortion.

1. Restrictions on the Right to Abortion. The abortion provisions of surrogate contracts generally work together to produce one result: for purposes of the contract, both the decision to abort the


36. Capron, supra note 3, at 700.

37. In addition to the lifestyle and medical care provisions applicable during gestation, surrogate contracts typically include provisions that require psychiatric and psychological reviews before artificial insemination, physical examinations before insemination (including genetic evaluations and testing for venereal diseases), testing to determine whether insemination has resulted in conception, and post-delivery tests (e.g., blood group, serum proteins, red cell enzymes, or white cell/H.L.A.) to establish paternity. See Brophy, supra note 12, at 274-77. Although these tests and reviews may raise some of the same issues discussed in the text, they are probably less likely to do so and, where they do, the issues are largely the same as for health care issues that arise during gestation.

38. The abortion provisions attempt to establish the rules for the respective rights and
fetus and the decision not to abort are placed entirely in the hands of persons other than the surrogate mother. In a model surrogate mother contract proposed by Katie Marie Brophy, this is done in a single provision, which provides:

The Surrogate agrees that she will not abort the child once conceived except, if in the opinion of the inseminating physician, such action is necessary for the physical health of the Surrogate or the child has been determined by said physician to be physiologically abnormal. In the event of either of those two (2) contingencies, the Surrogate desires and agrees to have said abortion.89

Thus, the surrogate waives the right she would otherwise have to an abortion and simultaneously consents to have an abortion if, in the opinion of the inseminating physician, the surrogate’s health is imperiled or the child is physiologically abnormal. Significantly, no “physiological abnormalities” are specified in the contract, nor does the contract place any limit upon the physician’s discretion in determining the existence of an abnormality or the father’s discretion in suggesting the existence of one. Under the contract, a fetus with a neural tube defect (such as anencephaly40) that will result in either a stillbirth or death within a few days of birth is indistinguishable from a fetus with a permanent medical condition, such as Downs syndrome, or one with a congenital heart defect that is surgically correctable after birth. Given the imprecision of the contract, any of these fetuses could be determined to be “abnormal” and subject to the contract’s abortion provision.

The abortion provision in the contract in the Baby M case differs slightly from the Brophy model.41 Mary Beth Whitehead agreed not to have an abortion unless the fetus was “found to have a genetic or congenital abnormality” and “if Mr. Stern requested obligations of the surrogate mother and the biological father with respect to, for example, medical expenses, support obligations, payment of the surrogate’s fee and expenses.


40. “Anencephaly, absence of cerebral hemispheres, is incompatible with life.” Merck Manual, supra note 7, at 1950. Anencephaly, as well as other categories of neurulation defects (craniorachischisis and meningomyelocele) may be prenatally diagnosed by testing for the level of alpha-fetoprotein in the amniotic fluid, amniocentesis, and ultrasonography. See Lemire, Neural Tube Defects, 259 J.A.M.A. 558, 559 (1988).

The practical effect of this provision is probably the same as the abortion clause in the Brophy contract, given the unlikelihood that an abortion would be performed under the latter agreement if the biological father objected.

Although the case did not involve the abortion issue, the Baby M trial court nevertheless struck down the abortion provision in its entirety, on the ground that its enforcement would violate the surrogate's constitutionally protected right, under Roe v. Wade, to decide whether to have an abortion. In so doing, the court followed the nearly universal criticisms of such limitations in the commentary on surrogate contracts. It was clearly the court's view that the abortion provision could not be enforced by an action for injunctive relief, either to prohibit an otherwise lawful abortion or to force the unwilling surrogate mother to have an abortion. The full implications of the trial court's declaration that the abortion provision is "void and unenforceable," however, are far from clear.

Consider the situation in which a surrogate, after she is told that the baby has Downs syndrome and the natural father invokes the abortion clause of the contract, refuses to have the abortion. When the child is born, the father states that the surrogate's refusal to abort was a material breach of the contract and argues that he should be able to avoid his promise in the contract to take custody of the baby. Alternatively, the father states that he has no support obligation. Katie Marie Brophy is presumably correct when she states "that breach by [the surrogate] would not affect the child's right to support from its natural father." Whether the surrogate could insist that the natural father accept custody raises a "reverse-Baby M" issue (one which, it is hoped, would rarely if ever arise) that should probably be resolved in accordance with the best interests of the child.

43. 410 U.S. 113 (1973).
44. Cf., e.g., Capron, supra note 3, at 696 (no specific performance or award of damages in contract or tort should be available for the surrogate's exercise of her protected right to choose whether or not to abort).
46. Brophy, supra note 12, at 282. See also Note, Rights of Biological Father, supra note 9, at 119, in which the author proposes a statutory amendment to avoid this result by providing that "the [biological father] should not be liable for future child support payments."
Another set of more difficult issues is created when the surrogate wants to obtain an abortion and the father wants her to carry the baby to term. It is worth asking at the outset why, as the Baby M court clearly believed, the agreement not to have an abortion should not be specifically enforceable.47 The United States Supreme Court’s decisions are not much help. In Roe v. Wade48 and subsequent abortion cases,49 the Court has stated that the scope of the state’s interest in the mother’s decision to have an abortion during the first two trimesters is limited to the protection of maternal health. The lack of a nexus to maternal health led the Court in Planned Parenthood v. Danforth50 to strike down a state statute that required a pregnant woman to obtain the consent of her spouse before she could have a first-trimester abortion. The Court’s rationale was based upon an application of the nondelegation doctrine to Roe: the state lacked the power to veto a woman’s abortion decision and therefore could not delegate to another a right that the state itself lacked. Although the statute in Danforth presents an appealing analogy to the surrogacy contract,51 that

47. Admittedly, the injunction would be easy enough to violate. It probably would not run against the surrogate’s obstetrician or her hospital, and in any event she could go to a different doctor, hospital, or city to obtain the abortion. Depending upon the availability of timely appellate review of the injunction, the surrogate might then face the possibility of contempt sanctions. Cf. Walker v. City of Birmingham, 388 U.S. 307 (1967)(petitioner could not bypass order by judicial review of temporary injunction before disobeying order); United States v. United Mine Workers, 330 U.S. 258 (1947)(district court had power to issue a restraining order; disobedience punishable as criminal contempt). Although, as a general rule, the lawfulness of the underlying order that was violated will not be reviewed on appeal from the imposition of the contempt sanction, the nature of the rights involved and the possibility in a given case of irreparable harm as a result of obeying the injunction might lead a reviewing court to consider the validity of the underlying order. Cf. Maness v. Meyers, 419 U.S. 449 (1975)(although even correct orders must be obeyed until set aside, party may not be held in contempt for asserting fifth amendment privilege even in an injunction action).


51. The argument would be this: If the state may not condition a woman’s right to abortion on the consent of her spouse, it surely could not allow the right to be conditioned upon the consent of an unrelated third party. This argument ignores the existence of the contract in which the surrogate purported to give the father that veto power and then, paradoxically, assumes the existence of a bright-line distinction between rights within traditional family relationships and the contract-based rights within an artificial, surrogate-family relationship. The distinction may not be strong enough to sustain the argument. See Note, supra note 35, at 1939 & n.17.
case dealt only with the situation where the state unilaterally imposed the spousal consent requirement upon a pregnant woman by statute. Neither Danforth nor Roe presented the Court with an opportunity to decide the contract-based rights of spouses or of other contracting persons.62

The question raised by the existence of an explicit promise not to abort is a particular example of a more general concern: whether a person is free to alienate her right of autonomy.63 A different particular case that raises the same question is slavery: May a person contract away her freedom and sell herself into slavery? The thirteenth amendment64 and cases decided under it65 provide an answer to that question: no. Similarly, under common law principles, a person is free to enter into an employment contract, but she may not be compelled to perform against her will.66 A more apposite contract doctrine makes unenforceable an antenuptial promise that purports to waive the promisor’s right to obtain a divorce.67 Professor Kronman’s justification for the latter rule—the promisor

52. A recent commentator has argued that Roe and Danforth do not “preclude enforcing the [surrogate’s] promise not to abort.” See Note, supra note 35, at 1940. In the commentator’s view, Roe made the right to a first-trimester abortion indefeasible, and “Danforth makes the right nondelegable.” Id. The surrogate’s promise, argues the author, raises an analytically distinct issue: whether the right to abortion is freely alienable. Id. The author argues against alienability of the right to abortion, not for reasons of paternalism, but because of the importance of that right to the mother’s sense of personhood and the comparatively lesser impact of an abortion on the personhood of the biological father. Id.

53. There may be a sense in which autonomy cannot be contracted away, a sense in which the rational abdication of one’s status as an autonomous moral agent is a contradiction in terms. After critically reviewing the relevant writings of Locke, Spinoza, Rousseau, Kant, and Mill on the subject, Arthur Kuflik has written, “[t]he right to function as a rationally self-accountable moral agent can be lost (if one loses the capacity to so function) or perhaps even forfeited (through criminal conduct), but it cannot be legitimately abdicated.” Kuflik, The Inalienability of Autonomy, 13 Phil. & Pub. Aff. 271, 295-96 (1984). Kuflik summarizes his central argument as follows: “[i]nsofar as the agent’s decision is rationally defensible, it is not actually a decision to abdicate autonomy; insofar as it is a decision to abdicate autonomy, it is demonstrably irrational.” Id. at 285. Kuflik’s thesis does not consider whether a moral justification exists for the state to enforce a contract that was entered into rationally but which the promisor subsequently repudiates through an exercise of moral autonomy.

54. See U.S. Const., amend. XIII (“Neither slavery nor involuntary servitude, except as a punishment for crime whereof the party shall have been duly convicted, shall exist within the United States, or any place subject to their jurisdiction.”). See also Peonage Abolition Act, 42 U.S.C. § 1994 (1982).

55. See United States v. Reynolds, 235 U.S. 133, 150 (1914); Heflin v. Sandford, 142 F.2d 798, 799 (5th Cir. 1944); State v. Oliva, 144 La. 51, 51-52, 80 So. 195, 196 (1918).


has "contract[ed] away too large a part of [her] personal liberty"—provides an equally persuasive statement of the reasons why a surrogate's promise not to abort should not be specifically enforced:

When someone assumes a contractual obligation, he generally has certain goals he believes will be promoted by the arrangement. . . . If, however, a person's goals have changed significantly, his earlier decision may now appear irrational, for his original aims no longer provide the framework for his deliberations. . . . From the standpoint of his present values, which he cannot shake off or suspend, his past actions may seem pointless or evil . . . . This can be especially demoralizing. Although there are countless ways in which a person's aspirations can be defeated by the senselessness of the world, if he himself is somehow responsible for the defeat, he may feel not only that he has been overborne by reality, but that he has, in Aristotle's words, failed to be a friend to himself.59

In Kronman's view, specific performance of the promise, as opposed to permitting the promisor to substitute money damages for performance, only intensifies the promisor's sense of self-betrayal, further weakening the promisor's self-confidence and self-respect.60 It is with these evils in mind, argues Kronman, that the law properly permits the promisor to avoid such dire results by allowing him to substitute payment of damages for performance of the promise.61

Professor Kronman's justification for the concededly paternalistic imposition of limitations on the freedom to contract in certain situations is particularly helpful in understanding the position of the surrogate mother whose goals have changed and who no longer wants to (or perhaps no longer feels she can) perform her part of the bargain. Performance of the surrogacy contract requires personal services of the most intimate kind that strike at a fundamental level of personal identity and self-worth.62 The thirteenth amendment and common-law contract doctrine should not be interpreted so as to compel such services to be rendered against the surrogate mother's will. The Baby M trial court's statement that

58. Id. at 775.
59. Id. at 780-82 (footnote omitted).
60. Id. at 782.
61. Id. at 783.
the abortion provision is unenforceable presumably meant at least this much.

But did the court mean to say more? If a surrogate mother cannot be enjoined from doing so and voluntarily aborts the fetus during the first trimester of her pregnancy without the biological father's consent, may the father sue for breach of contract to avoid any further liability under the agreement or to recover any fees or expenses already paid? The court's conclusion that the abortion provision is unenforceable is apparently based upon its inconsistency with Roe v. Wade, but a contractual provision that violates public policy is not automatically "void" and may sometimes support, as a matter of contract law, an award of monetary damages. The first issue, however, is one of more general interest: whether an award of damages for the surrogate's breach of her promise not to abort would be constitutional.

At least in other contexts, the United States Supreme Court has stated that one's constitutional right to engage in certain conduct does not necessarily provide immunity from civil liability for doing so. The Court's first amendment speech decisions, for example, demonstrate that the right to be free from the government's prior restraint does not immunize a publisher from liability for damages for the resulting libel or for infringement of the plaintiff's copyright or right of publicity. In addition, the Court has declared that, although federal and state governments generally may not interfere with a woman's right to abortion during the first trimester, they may withhold public funding for both therapeutic and nontherapeutic abortions.

64. See New York Times Co. v. Sullivan, 376 U.S. 254 (1964)(reversing $500,000 libel judgment against newspaper finding that the rule of law applied by Alabama courts was constitutionally deficient for failure to provide safeguards for freedom of speech and press required by first and fourteenth amendments).
65. See Harper & Row, Publishers Inc. v. Nation Enter., 471 U.S. 539 (1985)(holding magazine's unauthorized publication of verbatim quotes from presidential memoirs was commercially valuable right of first publication, and was not a "fair use" within meaning of Copyright Revision Act).
66. See Zacchini v. Scripps-Howard Broadcasting Co., 433 U.S. 562 (1977)(holding that although the state of Ohio might, as a matter of its own law, allow the press special privilege, the first and fourteenth amendments did not require it).
67. See Williams v. Zbaraz, 448 U.S. 358 (1980); Harris v. McRae, 448 U.S. 297 (1980); Maher v. Roe, 432 U.S. 464 (1977). The Court's focus in these cases was principally upon a different issue than the one raised by the breach of contract hypothetical, namely, whether the first or fourteenth amendment required the state and federal governments to budget for expenditures that would provide pregnant women with adequate funds to choose to have an
Neither line of cases, however, answers the question whether, under the Supreme Court's decision in *Roe v. Wade*, a state court could award damages against a surrogate mother for having a first-trimester abortion. Obviously, the speech cases do not involve abortion. More significantly, the speech cases do involve conduct which, unlike a first-trimester abortion, is itself independently tortious. Moreover, the abortion funding decisions raised the question whether public funds for abortions were benefits to which indigent women were constitutionally entitled; these cases involved separation of powers and federalism issues of great sensitivity. By contrast, the breach of contract issue asks whether the award of damages to the biological father would be an impermissible *ex post facto* penalty for the surrogate mother's prior exercise of her right to abort the fetus.

Under *Roe*, the relevant question is whether the state's interest, if any, in vindicating the contractual interests of the biological father, or in promoting the practice of surrogacy, rises to the level of a "compelling state interest" that would justify imposing a limitation (in the form of money damages for the breach of contract) on the surrogate's fundamental right to have an abortion. Presumably neither interest is "compelling" for purposes of the *Roe* case, especially in light of the Court's repeated statements that the scope of the state's interest during the first two trimesters is limited to protecting maternal health. If this is correct, then an award of damages for breach of the surrogate contract would be permissible under *Roe* and its progeny only if the incidental restriction on the surrogate mother's right to an abortion were deemed not to be "significant" or if the surrogate mother has the power to contract away her rights under *Roe*.

On the issue of the significance of money damages, an argu-
ment—one that is instructive but ultimately inadequate — can be built upon the Supreme Court's cases dealing with racial covenants. After holding in *Shelley v. Kraemer*\(^\text{71}\) that a state court's order enforcing a racially restrictive covenant would violate the fourteenth amendment, the Court in *Barrows v. Jackson*\(^\text{72}\) held that an award of monetary damages against a white property owner who breached his racially restrictive covenant and sold land to a buyer who was black also violated the fourteenth amendment. Both the order of specific performance and the award of damages were forms of coercion by which the state either commanded or encouraged racial discrimination. If the analogy between state ordered racial discrimination and active state interference with first trimester abortions is accepted, the logic of *Barrows* is clear: with respect to abortions, as with racial discrimination, a state may not penalize conduct that it lacks the power to forbid.

This conclusion finds further support, although still no proof of its correctness, in another of the Court's abortion decisions. As noted above, the Court in *Danforth*\(^\text{73}\) ruled that a state could not condition a woman's right to a first trimester abortion upon the written consent of her husband. Borrowing from *Barrows*, the state should also be prohibited from doing through the award of contract damages what it could not do by statute. If the state may not require spousal consent for a first trimester abortion, it should not be able to penalize a woman with an award of damages on the basis of her failure to obtain the biological father's consent before having an abortion.\(^\text{74}\)

What the *Shelley-Barrows-Roe-Danforth* line of cases fails to take into account, however, is that—unlike the blacks in the restrictive covenant cases or the pregnant women in the abortion cases—the surrogate mother has purported to contract away her first and fourteenth amendment protections as part of her bar-

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71. 334 U.S. 1 (1948).
74. For purposes of the argument presented here, the distinction between a pregnant woman's spouse and, in the surrogacy context, an unrelated biological father is not particularly valuable. It seems likely that the state in *Danforth* required spousal consent because a pregnant woman's husband is presumed to be the father of the child. Thus, despite the lack of a marriage relationship with the surrogate mother, the biological father could at least claim the same status (paternity) as the spouse of a pregnant woman on the basis of the surrogacy contract and the execution of other documents that would overcome the common-law or statutory presumption that the husband of the surrogate is the father of the child.
gained-for exchange with the biological father.\textsuperscript{75} May she do so and be held liable in damages for failing to keep her promise? The Supreme Court's opinion in \textit{Snepp v. United States}\textsuperscript{76} suggests that she may.

Snepp, a former employee of the Central Intelligence Agency, had published a book about the agency without first submitting the manuscript to the agency for a pre-publication review.\textsuperscript{77} At the time he accepted employment with the CIA, Snepp agreed not to publish any information about the agency without presenting it to his employer for a review.\textsuperscript{78} The CIA sued for a declaration that Snepp had breached the contract, an injunction against publishing information in the future without submitting it to the CIA first, and an award of damages.\textsuperscript{79} In the presentation before the Supreme Court, Snepp's principal argument was that the contract and subsequent injunction constituted an unenforceable prior restraint. The Court disposed of his argument in a single footnote: Snepp signed the contract, apparently without duress or coercion, and he must now live with the consequences of that act, including the award of damages for his breach of the contract.\textsuperscript{80} Since the chilling effect of money damages on Snepp's right of free speech was an incident of his prior exercise of his freedom of contract, there was no first amendment basis for setting aside the award of damages. Significantly, the government had stipulated that Snepp's book contained no confidential information.\textsuperscript{81} Thus, the Court affirmed the award of damages against Snepp for breaching his employment contract under circumstances where there would almost surely have been no grounds for a lawful prior restraint against publication, even on national security grounds.

The result in \textit{Snepp} suggests that the Court is not particularly troubled by an award of damages to \textit{penalize} conduct that the gov-

\textsuperscript{75} The \textit{Shelley-Barrows-Roe-Danforth} line of cases does accomplish one thing: It demonstrates that, in the absence of a contract (or, if the surrogate mother is unable to contract away her abortion rights), the state probably lacks the power to award damages to the biological father in tort. Thus, the question whether the surrogate may validly contract her abortion rights away is critically important to the father's claim for damages.
\textsuperscript{76} 444 U.S. 507 (1980).
\textsuperscript{77} \textit{Id.} at 507.
\textsuperscript{78} \textit{Id.} at 507-08.
\textsuperscript{79} \textit{Id.} at 508.
\textsuperscript{80} \textit{Id.} at 509 n.3. The Court also noted that the CIA's action was within the scope of its broad authority to protect the national security. \textit{Id.}
\textsuperscript{81} \textit{See id.} at 516 (Stevens, Brennan & Marshall, JJ., dissenting).
ernment would have been powerless to enjoin, at least where the damages flow from the breach of a voluntary, explicit contract. Because both freedom of speech and privacy-based abortion rights involve core values protected by the first amendment, the result in Snepp is suggestive. If anything, Snepp was a weaker case for the Court to uphold the constitutionality of an award of damages than is the surrogacy case, because Snepp's contract was with the federal government, not simply another private citizen. The potential for conflict with the restrictions of the first amendment was presumably greater in Snepp, or was raised in an important sense more directly, than it would be if a court were to award damages to a biological father for the surrogate's breach. Consequently, a surrogate mother's explicit agreement, absent any indications of duress or coercion (which will be rare), may tip the scales in favor of the constitutionality of an award of damages for her breach of the promise not to have an abortion.

The damages award would also be consistent with the underlying contract law rationale for refusing to compel performance of the contract, by which the surrogate is free to choose to substitute money damages for performance. As a matter of contract law, then, a court should also be free to choose an appropriate measure of damages for such cases unless, of course, such an award would

82. This seems to be the point Professor Charles Fried argues for when he states that compassion for a promisor who "no longer values the promise as highly as when he made it . . . may lead a promisee to release an obligation in such a case, but he releases as an act of generosity, not as a duty, and certainly not because the promisor's repentance destroys the force of the original obligation." C. Fried, CONTRACT AS PROMISE 20 (1981). In Fried's view, this attitude affirms the promisor's autonomy because showing "respect for others as free and rational requires taking seriously their capacity to determine their own values." Id. This version of autonomy has been termed "wide autonomy" and includes the right to bind oneself to the will of outside authority as an act of personal autonomy. See McMahon, Autonomy and Authority, 16 Phil. & Pub. Aff. 303, 304 (1987).

83. Of the usual measures of damages—expectancy, restitution, and reliance—restitution seems the most appropriate. Expectation-based damages—an amount that would put the biological father in as good a position as he would have been if the surrogate had not had an abortion—would be too speculative and potentially too generous. Reliance damages—an award that would put the biological father back in his original, pre-contract position—would require the surrogate to pay not only her fee, but all sums paid to reimburse her for expenses, as well as all payments to third parties. Both expectation and reliance-based damages ignore the fact that the surrogate partially performed the contract by submitting to psychological and medical testing, artificial insemination, and the medical risks of pregnancy before the abortion. The return of all of the father's expenditures in reliance on the contract also unrealistically ignores that the contract itself included some significant risk that—because of accident, injury, or illness—a live, healthy baby would not be produced by the surrogate pregnancy. But see Brophy, supra note 12, at 279 (proposing
2. Provisions Dealing With Life-Style and Medical Care Decisions.

The Baby M trial court did not consider the surrogacy contract's lifestyle and medical care provisions. In most surrogacy contracts, these provisions take a number of different forms. Most often, the surrogate agrees: (1) not to smoke cigarettes, drink alcohol, take any medications without written consent from a physician, or consume illicit drugs during pregnancy; (2) to visit the inseminating physician or obstetrical specialist regularly (or according to a fixed schedule specified in the contract); (3) to submit to genetic screening, including amniocentesis, after conception; (4) to follow reasonable medical instructions; and (5) to submit to reasonable pregnancy-related medical care or treatment. So that compliance with these various provisions may be monitored and the biological father may exercise his rights under the contract, the surrogate also agrees to waive the confidentiality of psychological and psychiatric test results and medical information developed during the pregnancy.

There can be no doubt that these provisions seek to further the laudable goal of promoting maternal and fetal health. In doing so, however, the contractual imposition of rights and obligations

contractual provision for the payment to the biological father of all monies paid by him on her behalf); Note, Rights of Biological Father, supra note 9, at 119-20 (supporting the award of something approaching expectancy-based damages: "all money which the biological father has paid for medical and other expenses associated with the pregnancy" plus "an amount of money established by the legislature to compensate the biological father for the breach of contract").

Damages based on the father's restitution interest—an amount that would require the surrogate mother to disgorge her gains and would return the surrogate to her original, pre-contract position—eliminates the problem of unjust enrichment, recognizes the risks of the contract, and avoids imposing too great a penalty on the surrogate mother's abortion decision. On the other hand, restitution will provide a small recovery compared to the disappointment and feeling of loss that the biological father and his wife will feel. See Eaton, Comparative Responses to Surrogate Motherhood, 65 Neb. L. Rev. 686, 722 (1986). Bills pending in Illinois and Missouri appear to adopt a restitution theory of damages in the case of a voluntary abortion that is not medically necessary, permitting the biological father to recover fees and expenses "paid to the surrogate" plus a reasonable attorneys' fee. See Andrews, Proposed State Laws, supra note 9, at 37. See generally Comment, supra note 24, at 421-22.


85. Brophy, supra note 12, at 283.
raises, at a minimum, difficult issues under the surrogacy contract itself. In particular, what consequences will flow from a surrogate’s refusal to abide by these terms of the contract? May the biological father treat her refusal as a breach? If so, may he terminate the contract? Will he be entitled to restitution of all payments made before the breach? May he obtain specific performance?

The answer to these questions turns on the legality and enforceability of the medical care provisions.\textsuperscript{86} The surrogacy contract has been described as containing many “gentlemen’s agreements”\textsuperscript{87} of doubtful enforceability. But in suggesting the form a uniform state surrogacy statute might take, one commentator has stated that “[t]he availability of specific performance to enforce the surrogate’s agreement to follow reasonable medical instructions and to abstain from behaviors harmful to the child’s prenatal health . . . is essential to this Act’s provisions.”\textsuperscript{88} Another author has observed that, “when there is potential harm to the child and small burden to the surrogate, a court might enforce this [medical care] provision.”\textsuperscript{89}

The \textit{Baby M} trial opinion appeared to adopt these views. Admittedly, as to all contract issues that the court addressed—the existence of a contract; its enforceability; the criteria, means, and manner of enforcement—the court acknowledged that its opinion “constitute[s] commentary.”\textsuperscript{90} Although its comments on the contract issues may have been dicta, they were far from \textit{obiter}. The opinion very deliberately moved beyond the issue of the best interests of the child and mapped out a virtual manifesto for the practice of surrogacy in New Jersey. It expansively concluded that sur-
rogate contracts are legal and enforceable in New Jersey, with the exception noted above of the provisions limiting the surrogate mother's right to an abortion. The court did not consider, and made no exception for, the medical care provisions in the contract. Because the court was aware of the existence of those provisions in the surrogacy contract, the court presumably intended to make no exception for them.

Various courts and commentators have expressed their opinion that traditional equity powers, combined with the state's powers of parens patriae or other state interest in preserving fetal life, are broad enough to include the power to authorize medical or surgical treatments to be performed on a pregnant woman despite her refusal to consent. More fundamentally, however, there is also the question of the obligation of the surrogate's physician to his or her patient. Section B of this article discusses the significance of the contract for the physician-patient relationship. The role of the courts in dealing with a surrogate's refusal to consent to treatment is discussed in Section C.

B. The Surrogate and Her Physician

In discussing the source and extent of a surrogate mother's right to refuse medical treatment, the starting point is the doctrine of informed consent. As Angela Holder has written, “It is a fundamental principle of our legal system that all persons have the right to make major decisions involving their bodies.” The source of that principle may be found in the existence of a fiduciary relationship between the medical professional and the layperson, or perhaps in the rights of self-determination, autonomy, and privacy that every competent adult patient enjoys. As a matter of legal right, the principle was given early and influential expression in Justice Cardozo's well-known opinion in Schloendorff v. Society of New York Hospital: “Every human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient's consent commits an assault, for which he is liable in

91. Refer to supra text accompanying notes 44-45.
92. In re Baby "M", 525 A.2d at 1159.
93. Id. at 1143.
94. Refer to notes 138-58 infra and accompanying text.
96. 211 N.Y. 125, 105 N.E. 92 (1914).
The legal requirement aside for a moment, informed consent nourishes not only the physician's identity as a professional but also the patient's autonomy and rights of self-determination and privacy. Informed consent also enhances the practice of medicine itself by respecting the patient's right to participate in making decisions about her own health care. As Lori Andrews has argued, informed consent "may improve the quality of medical care" in at least three ways.\(^9\) First, the sharing of information and decisional authority reduces fear and stress, improves the patient's capacity to adjust and cope with recuperation, and may reduce the level of pain medication and number of days of hospitalization required.\(^9\) Second, informed consent provides an opportunity for the patient to reject unnecessary or inappropriate care.\(^1\) Third, by requiring the physician to articulate the patient's choices for alternative treatments and describe the relative risks and benefits of each, the physician's own decision making may be improved.\(^1\)

To be sure, the scope and limits of the doctrine of informed consent can be difficult to discern. The doctrine is riddled with fact-dependent limitations, and medical decision making during a pregnancy is a uniquely complex matter. Recognizing that the question of exceptions and limitations will need to be separately considered, the principle itself may be stated simply: for the patient who is pregnant, informed consent is obviously no less a requirement, and no less important an aspect of patient care, than it is for the patient who is not.\(^1\)

What makes a surrogate pregnancy different from the usual

\(^{97}\) Id. at 129-30, 105 N.E. at 93.


\(^{99}\) Id. at 165.

\(^{100}\) Id. at 168-69.

\(^{101}\) Id. at 170.

\(^{102}\) See generally Ballard v. Anderson, 4 Cal. 3d 873, 484 P.2d 1345, 95 Cal. Rptr. 1 (1971)(allowing minor women to obtain therapeutic abortions without obtaining parental consent); Public Health Trust v. Valcin, 507 So. 2d 596 (Fla. 1987)(action against public hospital for failing to apprise woman of risks of tubal pregnancy after tubal ligation surgery); Siemieniec v. Lutheran Gen. Hosp., 117 Ill. 2d 230, 512 N.E.2d 691 (1987)(wrongful life action in which parents sought damages for failure of physician to inform mother of risk her child would be born a hemophiliac); Rhoden, Informed Consent in Obstetrics: Some Special Problems, 9 W. New Eng. L. Rev. 67 (1987)[hereinafter Rhoden, Consent in Obstetrics](a pregnant woman is in a vulnerable position, often compelled to consent to risky or unwise treatment out of concern for her baby's welfare).
case is the presence of the contract itself, and the inclusion of a provision by which the surrogate mother purports to consent to reasonable or necessary medical treatment. For a number of reasons, however, the doctrine of informed consent provides no justification for a doctor to perform invasive and inherently risky interventions on a surrogate mother who objects to a diagnostic test or course of treatment.

The “consent” contained in the surrogacy contract is not “informed” in any meaningful sense. Because it is given before the artificial insemination and before the advent of the medical condition for which intervention is proposed, the surrogate’s consent is hopelessly abstracted from medical reality—including the risks and potential benefits of the intervention itself. Seemingly no amount of counseling by physicians and psychologists, weeks or even months before the surrogate is confronted with the choice, could prepare her to make a meaningful choice, even before she has become pregnant. As the President’s Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research has noted, advance consent is “lacking in one important attribute: active, contemporaneous personal choice.”

A physician who ignores the contemporaneous personal choices of a patient denies her autonomy, precludes her active participation in her own health care, denies her the medical benefits that may result from that active participation, and, as Professor Katz has asserted, may also commit an act of psychological abandonment of the patient. The common wisdom that we cannot know how we would respond to a difficult choice until we actually are faced with the need to choose deserves to be respected in the context of surrogacy.

103. 1 President’s Comm’n for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, Making Health Care Decisions 50 (1982). The Commission limits its approval of such advance consents to those that are made by the patient in anticipation of her incapacitation because of disease or the use of a general anesthetic. Id. at 49.

104. Refer to notes 95-101 supra and accompanying text.

105. Katz, supra note 1, at 208-12.

106. The New Jersey Supreme Court’s opinion in Baby M recognizes this principle. The court criticized the surrogate’s contractual consent to surrender custody in terms that are equally applicable to the consent to medical treatment:

Under the contract, the natural mother is irrevocably committed before she knows the strength of her bond with her child. She never makes a totally voluntary, informed decision, for quite clearly any decision prior to the baby’s birth is, in the most important sense, uninformed, and any decision after that, compelled
Even if the surrogate mother's contractual consent is deemed to be effective consent at the time it is given, her later objection to a particular intervention can only be seen as a withdrawal of that consent. And once consent has been revoked, it may no longer be relied upon by the treating physician. Thus, the consent found in the surrogate contract is a fiction in every sense, if not at the time it is made then at least once the surrogate mother states her objection to the proposed diagnostic procedure or course of treatment.

Any argument that the surrogate mother has contractually waived her right to informed consent is also flawed. Although it is sometimes observed that patients may waive their right to informed consent, at least in some jurisdictions, what patients actually waive is their right to be informed or, as Professor Hagman put it, "the right to know the truth." In such a situation, the patient gives her physician "carte blanche by saying, 'You are the doctor, do anything that needs doing and tell me only what you want to.' This sort of statement contains two separate propositions: a waiver of the right to know, and a consent to treatment that "needs" to be done. Just as that consent should not be construed as permission to perform an unnecessary or unreasonably dangerous intervention, it should also not be treated as irrevocable. Once the patient makes it clear that she has taken back the blank check and does not consent to a particular intervention, the waiver...

by a pre-existing contractual commitment, the threat of a lawsuit, and the inducement of a $10,000 payment, is less than totally voluntary.


111. Id.
(if any) can provide the physician no basis for proceeding.\textsuperscript{112}

Despite these objections to relying upon the surrogate's supposed consent to future obstetrical interventions, a physician (or court) might be persuaded that the surrogate had nonetheless sold her right to object as part of her bartered-for exchange with the biological father. In addition to obvious concerns that judicial enforcement of such a contractual arrangement would violate the thirteenth amendment's prohibition of all forms of forced servitude,\textsuperscript{113} attempts to give effect to the medical care provisions would also present great practical difficulties of interpretation. Even more significantly, these difficulties are also present when neither physician nor biological father seeks to compel the surrogate mother to accept medical treatment, but the father merely

\textsuperscript{112} Cf. Note, supra note 35, at 1941 (an effective waiver is produced only "when the permission and the infringement occur at the same time"). Professor Katz' position on patient waivers lends some support to the suggestion in the text. In his view, "[a] patient's waiver of the physician's obligation to disclose and obtain the patient's consent should be accepted only after a committed effort has been made to explore the underlying reasons for the patient's abdication of decision-making responsibility." J. Katz, supra note 1, at 125. The patient's abdication is not to be accepted at face value, but instead is a problem to be worked through to help the patient regain her role as an active participant in the decisions concerning her health care.

The relatively vague and potentially unbounded consent form that is presented to surgical patients as part of their admission to the hospital provides a serviceable analogy. A standard admissions form propounded by the American Medical Association in 1961 read as follows: "I consent to the performance of operations and procedures in addition to or different from those now contemplated, whether or not arising from presently unforeseen conditions, which the above-named doctor or his associates or assistants may consider necessary or advisable in the course of the operation." Hagman, supra note 110, at 786 (quoting A.M.A., LAW DEP'T, MEDICOLEGAL FORMS, FORM 16 (1961)). The form raises questions concerning the kinds of information that should be communicated to a patient before she signs it. Even assuming, however, that the form was presented under circumstances that would render it a valid consent, the A.M.A. itself recognized that the consent did not authorize procedures as to which the patient has stated her "clearly specific prohibitions." Id. (quoting A.M.A., LAW DEP'T, MEDICOLEGAL FORMS, FORM 22 (1961)).

\textsuperscript{113} See U.S. CONST. amend. XIII ("Neither slavery nor involuntary servitude, except as a punishment for crime whereof the party shall have been duly convicted, shall exist within the United States, or any place subject to their jurisdiction."). See Peonage Abolition Act, 42 U.S.C. § 1994 (1982). The fact that a servitude began voluntarily and by contract does not save it from invalidity. See United States v. Reynolds, 235 U.S. 133, 149-50 (1914); State v. Oliva, 144 La. 51, 52-53, 80 So. 195, 196 (1918). This argument has been advanced as a ground for invalidating the abortion provisions of surrogacy arrangements. See Comment, Surrogate Mother Agreements: Contemporary Legal Aspects of a Biblical Notion, 16 U. Rich. L. Rev. 467, 476-77 (1982).

One student commentator, however, has questioned the applicability of the thirteenth amendment to an essentially, although artificially, familial relationship such as surrogacy, and has argued that the constitutionally protected right to privacy provides a more appropriate analytical frame. See Note, supra note 35, at 1937-38, 1946-49.
seeks to determine whether the surrogate's refusal to submit to a particular treatment constitutes a violation of the contract.

One problem is that the lack of precision in the surrogate contract's medical care provisions makes the surrogate's consent to treatment vague and indeterminate and, thus, potentially very broad. The range of tests and interventions includes Cesarean sections, cerclage, blood transfusions to the mother, maternal drug therapy, *in utero* diagnostic techniques (such as ultrasonography and amniocentesis), intra-amniotic instillation of drugs, blood transfusions into the peritoneal cavity of the fetus, fetal blood transfusions, and fetal surgery. The language of the contract provides no basis for distinguishing among the many forms of obstetrical diagnosis and treatment.

This lack of precision invites disputes over interpretation. What is a "medically reasonable" instruction or intervention? If an instruction or proposed intervention is "unreasonable," it presumably need not be followed, and if the surrogate refuses she will not be in breach, but how is the surrogate to know?

If these concerns involved difficulties of "mere" interpretation, they might not be seen as all that serious. The issues of appropriate treatment and the scope of consent may well arise, however, more often than will the dispute over custody that was at the heart of the *Baby M* case. Objections to medical advice, treatment or intervention can foreseeably be made by surrogate mothers who intend to go ahead with the arrangement and deliver the child to the biological father, as well as by surrogate mothers who decide during gestation that they want to cancel the contract and keep the

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114. Cesarean sections involve significant risk of mortality or morbidity to the mother, because they are major surgery and require anesthesia (most often general, although spinal and epidural anesthesia may also be used). Although surgery on the fetus *in utero* presents comparable risks to the mother, Cesarean sections are indicated much more frequently than fetal surgery. For a helpful discussion of the medical aspects of the Cesarean section see Rhoden, *The Judge in the Delivery Room: The Emergence of Court-Ordered Cesareans*, 74 CALIF. L. REV. 1951, 1954-58 (1986)[hereinafter Rhoden, *Judge in Delivery Room*]. For useful discussions of the procedures mentioned in the text, see the discussion in Blank, *Emerging Notions of Women's Rights and Responsibilities During Gestation*, 7 J. LEGAL MED. 441, 452-64 (1986); Nelson, Buggy & Weil, *Forced Medical Treatment of Pregnant Women: "Compelling Each to Live as Seems Good to the Rest,"* 37 HASTINGS L.J. 703, 706-11 (1986); Comment, *A Maternal Duty to Protect Fetal Health?*, 58 IND. L.J. 531, 531-34 (1983).

115. Chances are the surrogate's decision whether to submit to an intervention or follow an instruction will be based on factors other than her interpretation of the contract—her own weighing of the risks and benefits (to herself and the child), religious convictions, her possibly changing feelings about the surrogacy arrangement, and the like.
Moreover, the problem of interpreting the contract language is not a simple matter of divining the parties’ intent or arriving at a position that is consistent with the purposes of the agreement. The interpretive problem is complicated because the meaning of the surrogacy contract’s terms will be determined simultaneously from three perspectives: the surrogate mother, the biological father, and the attending physician.

It is not difficult to see that the surrogate and the father could well have very different perspectives as to the appropriateness of medical advice, treatment, or interventions. The father’s interest is principally, if not exclusively, in the well-being of the child and in maximizing the prospects for the delivery of a healthy baby. The child’s health is, of course, a function of the mother’s well-being; the contract itself recognizes that fact by requiring the surrogate to maintain a healthy lifestyle. Yet the surrogate’s health is simply the means to the end desired by the biological father, not an independent goal the father can be expected to value for its own sake. He will be likely to view the risks that an intervention poses to the mother’s health in a far different light than the mother herself will.

By contrast, the surrogate’s perspective is, at first glance, the same as for any pregnant woman: a difficult mixture of altruistic concern for the child she is carrying and concern for her own well-being. But the nature of surrogacy may also complicate the picture for her because, while the child is genetically related to her, the child is also one whom the surrogate is contractually obligated to surrender—that is, one whom the surrogate has agreed never to see again. Suppose the surrogate mother’s choice is between risking her own life by submitting to an aggressive and risky intervention to save the fetus, on the one hand, and refusing to submit to it on the other hand, thereby increasing the chances of mortality or morbidity for the child at birth. A difficult decision for many pregnant women faced with that choice could be even more so for a surrogate.

The third perspective from which the contract language will be viewed is, of course, that of the surrogate mother’s obstetrician.
As Professor Nancy Rhoden and others have persuasively argued, the obstetrician's situation embodies its own set of conflicts, because the obstetrician arguably has two separate patients: the mother and the child. When the mother defines her own self-interest in terms of bringing a healthy baby to full term, the potential for conflict is academic. When, on the other hand, the welfare of the fetus can be advanced only at some risk to the mother, the obstetrician's dilemma becomes apparent, especially when the mother is not ill and the medical condition for which treatment is proposed is the fetus's alone. A third source of conflict for obstetricians is their own self-interest as it is manifested in a fear of legal liability for failing to do everything possible to prevent injury to or the death of the child.

The conflict for the obstetrician with two patients, and the barriers to achieving empathy with the pregnant woman, are well illustrated by a recent national survey of the heads of all fellowship programs in maternal-fetal medicine and directors of maternal-fetal medicine divisions in residency programs in obstetrics and gynecology. Nearly half of the responding physicians believed "that mothers who refused medical advice and thereby endangered the life of the fetus should be detained in hospitals or other facilities so that compliance could be ensured." The survey results provide a chilling example of a sort of double effect that

116. Rhoden, Consent in Obstetrics, supra note 102, at 76; Rhoden, Judge in Delivery Room, supra note 114, at 1972.
118. See Kolder, Gallagher & Parsons, Court-Ordered Obstetrical Interventions, 316 NEW ENGL. J. MED. 1192, 1195 (1987) [hereinafter Court Ordered Interventions]; Rhoden, Judge in Delivery Room, supra note 114, at 2021.
119. See Court-Ordered Interventions, supra note 118. The net response rate of the two groups to the authors' questionnaire was 83%. The respondents represented 45 states and the District of Columbia. Id. at 1192.
120. Id. at 1193 (46% supported involuntary detention).
121. The term "double effect" is used here not so much in its technical sense as to suggest the ethical problem of consciously permitting an evil effect (i.e., negating the pregnant woman's autonomous right to self-determination) in order to achieve a good effect (promoting the health or preserving the life of a fetus). This formulation conceded makes some key, and debatable, assumptions. Among them are: (1) that the mother's autonomy is or should be unbounded, or at least that it includes the right to make a medical decision for herself that precludes an intervention needed for the fetus, and (2) that preserving fetal life is a good effect or, more to the point, that exposing a fetus to a higher risk of mortality or morbidity by withholding treatment rises to a level of gravity that is proportionate to the denial of the mother's autonomy. A useful survey of the principle of double effect is May,
can begin to operate on the obstetrician's two-patient dilemma. Once the physician views the fetus as a patient, it becomes easier to treat the mother as if she were a child. This transformation of the obstetrician's relationship with both patients is encapsulated by this article's introductory quotation from William Carlos Williams. The obstetrician's role is redefined as one of protecting the pregnant woman, her child, and society from the woman's "idiocy."

Professor Rhoden has observed that "no doctor can fully embrace and accept a patient's feelings. . . . the barriers to achieving at least empathy are higher than usual in obstetrics."122 The potential for conflict is significant "even if the doctor and the woman share similar values."123 The barriers to achieving empathy are undoubtedly even more significant when the mother is a surrogate, someone whose motivations and decisions are likely to be at least unfamiliar, and perhaps even distasteful, to the obstetrician.124 Moreover, the ethical bind in which the surrogate's obstetrician is placed is made particularly acute because a third person, the natural father, is paying the obstetrician's fee, receiving information about the medical condition of the surrogate and the fetus, and claiming a right under the contract to participate in and even control the medical decision making of the surrogate and her physician. If there is, as Professor Rhoden concludes, "reason to be profoundly pessimistic about the chances for shared decision-making in obstetrics,"125 the pessimism should be even darker for the prospects of shared decision making during a surrogate pregnancy.

To some, these concerns may seem a bit overdrawn. After all, when confronted with a stark conflict between the welfare of a fe-

122. Rhoden, Consent in Obstetrics, supra note 102, at 77.
123. Id. at 79. In Professor Rhoden's view, doctors are more likely than mothers to be influenced by their view of medical uncertainty (i.e., the possibility that "the baby will be fine, or at least do better than expected"), the availability of technology that they have been trained (through education and socialization) to use, and the specter of legal liability for failing to use all available means to lessen or avoid the impairment of the child. Id.
124. The "Recommendations of the American College of Obstetricians and Gynecologists Concerning Surrogate Mothering" states that "a woman [who] seeks medical care for an established pregnancy, regardless of the method of conception . . . should be cared for as any other obstetric patient or referred to a qualified physician who will provide that care." Smith, supra note 35, at 665. The statement implicitly recognizes that not all obstetricians will be able to overcome their personal feelings toward a surrogate mother, but it perhaps too naively suggests that obstetricians with those feelings will recognize them and take corrective action.
125. Rhoden, Consent in Obstetrics, supra note 102, at 87.
tus and the objections of the mother to a proposed intervention, most physicians are unlikely to risk incurring tort liability by performing the unconsented-to procedure. Further, Professor Rhoden has opined "that a physician is relatively unlikely to go to court to attempt to force treatment in a crisis situation where the fetus' chances, even with treatment, appear seriously compromised," although "[i]f [they] believe that with the treatment the child can be fine, they are increasingly apt to challenge the woman's decision in court." Short of either of these alternatives, however, physicians may significantly affect their patients' choice of health care options by the manner in which the options are presented and explained.

A patient's resistance, and even objections, to a diagnostic procedure or course of treatment can be influenced or silenced by subtle shadings of a physician's intonation, volume, and facial expressions, to say nothing of the way the physician expresses the alternative outcomes and risks. Within the "silent world of doctor and patient," this unspoken and sometimes subconscious attempt to overcome the will of the patient is as much a threat to professional values as overtly disregarding the patient's objections. This is perhaps the most invidious response to the surrogate's refusal to consent to an intervention for the benefit of the fetus: "invidious" because it is shrouded in secrecy and may not be detectable to the patient whose attention and emotions interfere with any objective assessment of the physician's demeanor. An application to a court for an injunction may not produce a proceeding, opinion, or order that is a model of analytical clarity, but at least

126. Id. at 81.
127. Id. at 82. Professor Rhoden's conclusions concerning the unwillingness of obstetricians to incur tort liability or to seek a court order against a resistant mother seem intuitively correct. If the survey results discussed in text accompanying notes 119-20 supra are any indication, obstetricians' attitudes may be changing, and the change could make them more willing in the future to challenge the medical decisions of pregnant women.
128. The phrase, of course, is from the title of Professor Katz' classic study, in which the nuances of the doctor-patient relationship are played out against the backdrop of informed consent. J. Katz, supra note 1.
129. Deliberation and reasoned elaboration are admittedly not the norm in these cases. In most cases in which a court order to compel an obstetrical intervention is sought, "hospital administrators and lawyers often have little forewarning of impending conflicts" and "[j]udges, unfortunately, have even less time for deliberation." Court-Ordered Interventions, supra note 118, at 1195. The two reported cases in which court-ordered Cesareans have been upheld on appeal illustrate the speed with which such cases go through the judicial system. See In re A.C., 533 A.2d 611 (D.C. 1987) (application to trial court for declaratory order on June 16; telephonic hearing in Court of Appeals conducted and motion for
the legal proceeding provides a forum and an opportunity for the interests of the mother to be heard and evaluated, and for the conflicting values to be aired and resolved. This is not to say that the involvement of the courts is particularly to be welcomed when a conflict surfaces between the surrogate and her physician. But, unlike the private decisions and actions of a physician, a court's reasoning and result can be subjected to the scrutiny of the patient, her family, and the medical and legal communities. The more subtle control of the patient's will that can be exercised in a hospital room or doctor's office is not nearly as public, nor is it subject to the moderating influences of the requirement of reasoned elaboration.

C. The Surrogate and the Courts

A surrogate mother's refusal to follow her obstetrician's recommendations, or refusal to consent to a diagnostic test or other intervention that her doctor deems "reasonable" for the preservation of fetal health or life, would raise a host of difficult legal issues. If the surrogate's refusal can be shown to have proximately caused a miscarriage, stillbirth, or birth defect, the principal legal issues concern: (1) the surrogate's liability to the father for his unfulfilled expectations; (2) the placement of the child (with the surrogate? the father and his wife? a third party or agency?); and (3) responsibility for the child's support, including special medical care needs. Recent commentators have remarked that these "concerns [are] difficult to resolve" and that "[e]xisting law does not address the issues of the surrogate's liability or acceptable reme-

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dies."\textsuperscript{131} Most of the proposed answers to these questions have assumed the existence of valid claims in tort or for breach of contract, with damages assessed to compensate the father for expenditures made pursuant to contract or to compensate the social parents for the additional expenditures that will be required to care for the child in the future.\textsuperscript{132}

The ex post facto legal remedy, however, does not provide a truly adequate remedy for the damage to the interests of the biological father and his wife, to say nothing of the injury to the child\textsuperscript{133} and to society's interest in the birth of live, healthy babies. Moreover, the damages sought by the natural father may not be collectible if the surrogate is judgment-proof. Further, a tort action for damages simply may not be a realistic possibility, given the difficulty one would expect in many cases of showing that the surrogate's breach was the cause of the child's condition. Consequently, the search for appropriate mechanisms to prevent avoidable miscarriages, stillbirths, and birth defects has begun in earnest. Some commentators have viewed the contract itself as an appropriate means of avoiding a bad outcome, suggesting that "when there is potential harm to the child and small burden to the surrogate, a court might enforce this [medical care] provision."\textsuperscript{134}

Another form this search has taken is legislation. Following the New Jersey trial court's decision in Baby M, at least seventy bills addressing the practice of surrogacy were introduced in state

\textsuperscript{131} Comment, supra note 24, at 421.

\textsuperscript{132} See, e.g., Brophy, supra note 12, at 279; Capron, supra note 3, at 698; Comment, supra note 130, at 634.

\textsuperscript{133} Few jurisdictions have recognized the existence of a child's cause of action in tort against his mother for negligent failure to provide an adequate level of prenatal care. In one of the few reported cases in which such a cause of action has been recognized, a boy sued his mother for failing to inform her physician that she was taking the antibiotic tetracycline. As a consequence of her ingestion of that drug, he was born with permanently discolored teeth. See Grodin v. Grodin, 102 Mich. App. 396, 301 N.W.2d 869, 870 (1980). In addition, the application of criminal child abuse laws to "fetal abuse" by a pregnant woman has been endorsed by some writers and unsuccessfully attempted in a widely reported California prosecution. No state has yet enacted a statute that explicitly criminalizes fetal abuse. See Note, Maternal Rights and Fetal Wrongs: The Case Against the Criminalization of "Fetal Abuse," 101 HARV. L. REV. 994, 995 (1988).

\textsuperscript{134} Coleman, Surrogate Motherhood: Analysis of the Problems and Suggestions for Solutions, 50 TENN. L. REV. 71, 86 (1982). See also Eaton, Comparative Responses to Surrogate Motherhood, 65 NEB. L. REV. 686, 720 (1986) ("If the provision protects a child late in the pregnancy, specific performance would be consistent with the best interests of the child.").
legislatures around the country.\textsuperscript{135} While a majority of the pending bills recognize the surrogate mother's right to decide whether to have an abortion and to make health care decisions as she sees fit,\textsuperscript{136} others would impose a statutory obligation on the surrogate mother to have regularly scheduled medical examinations, to follow medical instructions to protect maternal and fetal health, or to submit to the reasonable medical requests of the natural father and his wife.\textsuperscript{137} The passage of these bills would provide statutory support for the notion that the medical care provisions in surrogacy contracts should be subject to court ordered performance.

A third basis for judicially compelled obstetrical interventions exists quite apart from legislative innovations and the surrogate contract itself. Increasingly, state courts have been asked to order pregnant women to submit to medical treatment, and in the majority of cases, the courts have granted the request.\textsuperscript{138} A recent survey in the \textit{New England Journal of Medicine} reported that between 1981 and 1986, medical institutions filed thirty-six applications for court orders in eighteen states and the District of Columbia. Excluding the fifteen requests to compel maternal transfusions after birth, seventeen of the remaining twenty-one requests were

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\item 136. See Andrews, \textit{Proposed State Laws}, supra note 9, at 37.
\item 137. Id. (describing bills pending in the District of Columbia, Maryland, New Jersey, New York, and South Carolina).
\item 138. The trend toward greater state intervention, in the form of prenatal interventions and the imposition of postbirth criminal or civil sanctions for exposing the child to unreasonable prenatal risks, has been described in the recent literature. See, e.g., Blank, \textit{supra} note 114 (discussing tendency in tort law to view fetus as person); Johnsen, \textit{A New Threat to Pregnant Women's Autonomy}, HASTINGS CENTER REP., Aug./Sept. 1987, at 33 [hereinafter Johnsen, \textit{New Threat}] (criticizing recent court and legislative decisions requiring women to take certain actions in pregnancy); Rhoden, \textit{Judge in Delivery Room}, \textit{supra} note 114, at 1951, 1986-89 (discussing implications of judge-ordered Ceasarean sections); Lewin, \textit{Courts Acting To Force Care Of the Unborn}, N.Y. Times, Nov. 23, 1987, § 1, at 1, col. 1.
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Although this article discusses the power of the states to compel a mother to submit to undesired medical treatment for the benefit of the fetus, the less direct forms of coercion (post-birth civil and criminal sanctions against the mother for unreasonably refusing a beneficial fetal therapy, for example) may influence her choice as well. See, e.g., Shaw, \textit{Conditional Prospective Rights of the Fetus}, 5 J. LEGAL MED. 63, 83-104 (1984); Robertson, \textit{Procreative Liberty and the Control of Conception, Pregnancy, and Childbirth}, 69 VA. L. REV. 405, 437-42 (1983) [hereinafter Robertson, \textit{Procreative Liberty}]. Postbirth sanctions have been criticized as "suffer[ing] from largely the same shortcomings as prebirth seizures." Kolder, Gallagher & Parsons, \textit{Correspondence to the Editor}, 317 NEW ENG. J. MED. 1224 (1987).
granted by judges in ten states. The orders were for involuntary Cesarean sections (fifteen requests; thirteen orders granted in ten states), hospital detentions (three requests; two orders in two states), and intra-uterine transfusions (three requests; two orders).

The figures reported in this survey offer dramatic evidence of a growing willingness of state courts to grant requests for compulsory obstetrical interventions. The survey also showed that obstetricians themselves are similarly inclined: nearly half of the responding physicians agreed that potentially life-saving procedures, such as intra-uterine transfusions, should be compelled by court order when the mother did not consent. The significance of these figures cannot be underestimated. The legal and medical professions are experiencing a marked shift in the way they view the status of pregnant women, "a shift away from the traditional notion of the fetus as an integral part of the pregnant woman, with the woman controlling the decisions concerning her own and her fetus's well-being" to a view "that treat[s] the maternal-fetal relationship as it does the conflicts between two distinct and independent entities."

139. See Court-Ordered Interventions, supra note 118, at 1192-93. The ten states were Colorado, Hawaii, Illinois, Michigan, Minnesota, Ohio, Pennsylvania, South Carolina, Tennessee, and Texas. The requests for court orders were reported by respondents to a nation-wide survey of leading obstetricians. Id. In addition to the requests reported by the obstetricians, at least three other requests were made during the survey period, one of which was granted and affirmed on appeal. See Jefferson v. Griffin Spalding County Hosp. Auth., 247 Ga. 86, 274 S.E.2d 457, 460 (1981) (Cesarean section ordered by trial court, affirmed by the Georgia Supreme Court); Taft v. Taft, 388 Mass. 331, 446 N.E.2d 395, 397 (1983) (probate and family court judge ordered a woman to submit to a "purse string" operation in order "to hold [her] pregnancy," vacated by the Massachusetts Supreme Judicial Court); Kolder, Gallagher & Parsons, supra note 138, at 1196 n.23 (citing Gallagher, The Fetus and the Law—Whose Life Is It Anyway?, Ms., Sept. 1984, at 62).

More recently, the District of Columbia became the twelfth jurisdiction to grant an order compelling a woman to undergo an unwanted Cesarean section, which it did on two occasions in 1987. See In re A.C., 533 A.2d 611, 613 (D.C. 1987) (terminally ill cancer patient in 26th week of pregnancy ordered to undergo Cesarean; affirmed by Court of Appeals); id. at 613 & n.1 (abnormally long labor at the end of full-term pregnancy; Court of Appeals affirmed trial court's order directing "hospital [to] take steps to 'protect the birth and safety of the fetus,' including a Caesarean section if necessary").

140. See Court-Ordered Interventions, supra note 118, at 1192-93.

141. See id. at 1192 (47% favored court-ordered obstetrical interventions when the life of the fetus is endangered). The attitudes surveyed in the article are more crudely revealed in the telling title of a recent article. See Feldman, Leading Them to Water and Making Them Drink, 13 LEGAL ASPECTS OF MED. PRAC. 1 (1985).


143. Id.
Ironically, the fetal rights doctrine has an ambiguous, even inconsistent, relationship with the practice of surrogacy. Even if surrogacy arrangements do not violate existing prohibitions against baby selling, they cannot entirely escape the charge of womb leasing and, perhaps more seriously, of treating babies as commodities. Nothing could be more antithetical to the notion of fetal rights than a practice that treats fetuses and infants as the proper objects of commerce and trade. At the same time, the notion that the fetus has a right to life and to medical treatment provides the justification for compelled obstetrical interventions and is entirely consistent with the contractual waiver or assignment of a surrogate mother's right to object to medical treatment for the fetus she carries.

The increasingly accepted shift in values toward a recognition of fetal rights asks physicians and courts to weigh the pregnant woman's rights of autonomous self-determination against the state's interest in preserving fetal life. For example, while Professor John Robertson believes that "pre-birth seizures rarely are [justifiable]," he does not rule them out. Professor Robertson has argued that the appropriateness of compulsory obstetrical interventions should depend upon three factors: the risk to the mother's health (or, the degree of intrusiveness, which should be comparable to the risk in most cases); whether the intervention benefits only the fetus or the mother as well; and the viability of the fetus. He states that before the fetus reaches viability, "a court should not order . . . more than minimal bodily intrusions for the unborn child's sake," while after viability "more intrusive

144. Robertson, Correspondence to the Editor, Court-Ordered Obstetrical Interventions, 317 New Eng. J. Med. 1223 (1987) [hereinafter Robertson, Correspondence].
145. Professor Robertson has also argued in favor of indirect limits on maternal decision making by imposing postnatal civil sanctions against the mother who fails to take reasonable steps to ensure the health of the newborn:

The mother has, if she conceives and chooses not to abort, a legal and moral duty to bring the child into the world as healthy as is reasonably possible. She has a duty to avoid actions or omissions that will damage the fetus and child, just as she has a duty to protect the child's welfare once it is born until she transfers this duty to another. In terms of fetal rights, a fetus has no right to be conceived—or, once conceived, to be carried to viability. But once the mother decides not to terminate the pregnancy, the viable fetus acquires rights to have the mother conduct her life in ways that will not injure it.

Robertson, Procreative Liberty, supra note 138, at 438.
146. Id. at 443-47.
147. Id. at 447.
or risky interventions could be justified.\textsuperscript{148} Commentators who are not categorically opposed to all court-ordered interventions generally favor a similar balancing test,\textsuperscript{149} and the reasoning of the few court decisions on the subject is consistent with this approach.\textsuperscript{150} On the other hand, those who do categorically oppose all court-ordered obstetrical interventions reject any balancing test that would allow the mother's rights of autonomy and self-determina-

\textsuperscript{148} Id.

\textsuperscript{149} See, e.g., Blank, supra note 114, at 468-69; Shaw, supra note 138, at 83-89; Mathieu, Respecting Liberty and Preventing Harm: Limits of State Intervention in Prenatal Choice, 8 HARV. J.L. & PUB. POL'Y 19, 50-54 (1985).

\textsuperscript{150} In Jefferson v. Griffin Spalding County Hosp. Auth., 247 Ga. 186, 274 S.E.2d 457, 460 (1981), the Georgia Supreme Court affirmed a lower court order directing that a Cesarean section be performed on an unwilling mother. While the proposed intervention was undeniably major surgery, the chances of fetal death without the Cesarean were said to be 99\% and the chances of maternal death were placed at 50\%. Id. at 458-59. The Cesarean was said to offer a nearly 100\% chance of survival of both mother and child, and the mother was in her 39th week of pregnancy. Id.

In Taft v. Taft, 388 Mass. 331, 446 N.E.2d 395 (1983), the Massachusetts Supreme Judicial Court vacated a lower court order directing a woman to submit to a "purse string" operation in order "to hold [her] pregnancy." Id. Its ruling, however, was consistent with Professor Robertson's analysis. The court focused on the lack of expert testimony concerning the nature of the operation, the nature of the risks to the mother and to the unborn child, and the nature of the benefits of the procedure. Id. at 397.

In re A.C., 533 A.2d 611 (D.C. 1987), presented a more enigmatic fact situation. The mother was terminally ill with cancer; thus, not only was the intervention not for her benefit, the Court of Appeals admitted that the Cesarean section probably hastened her death by a few hours. Id. at 612-14. At the same time, the Cesarean posed virtually no risk to the mother's physical health, because she was already dying, and the procedure offered the only hope for saving the infant, who died after delivery. Id. at 612. While arguably consistent with Professor Robertson's proposed analysis of such cases, A.C. is a disturbing case. With a gestational age of 26 weeks, the fetus' chances of survival were described by hospital officials as "grim." Id. at 612. Moreover, the mother's deteriorating physical condition had produced oxygen starvation in the fetus, with an increased risk that the child would be born with cerebral palsy, neurological defects, deafness, or blindness. Id. at 613. In addition, medications the mother had been taking throughout her pregnancy increased the risk of poor fetal health. Id. The intervention, therefore, seems to have been one that increased the fetus' chances of survival only marginally and with questionable benefits for the newborn's quality of life. Even more disturbing was the court's willingness to discount the express wishes of the mother, apparently in the belief that she would not have to live with the physical and psychological consequences of the compelled intervention for very long, or that she was entitled to less say in the medical decisionmaking for her fetus because of her impending death. Id. at 617. It has been reported that the baby "lived for two hours" and that the mother "regained consciousness and cried when she learned that her baby died. She died two days later." Greenhouse, On Legal Call to Meet Medical Emergencies, N.Y. Times, Jan. 15, 1988, at 10, col. 3. See also Annas, supra note 129, at 25 (characterizing the result as forcing the patient to undergo an unwanted abortion and criticizing the opinion as "cavalierly lawless and unprincipled").
tion to be overridden for the benefit of the fetus. While a detailed discussion of the arguments for and against judicially compelled obstetrical interventions is beyond the scope of this article, a brief summary of the competing positions will illuminate the position in which surrogates may find themselves if a court order is sought.

Both the Georgia Supreme Court and the District of Columbia Court of Appeals have upheld lower court orders directing that a pregnant woman submit to a Cesarean section against her will. The courts proceeded from their belief that a viable fetus has a right to live and the state has an interest in protecting fetal life. The Georgia court based its ruling on Roe v. Wade, in which the Supreme Court stated that the state’s compelling interest in the preservation of fetal life would justify the imposition of limitations on the ability of a pregnant woman to choose to abort her fetus in the third trimester of pregnancy, including a ban on abortions except when necessary to save the mother’s life. The District of Columbia Court of Appeals, however, did not read Roe as broadly as the Georgia Supreme Court:

There is a significant difference, however, between a court authorizing medical treatment for a child already born and a child who is yet unborn, although the state has compelling interests in protecting the life and health of both children and viable unborn

151. See, e.g., Annas, Protecting Liberty, supra note 5; Johnsen, New Threat, supra note 138; Court-Ordered Interventions, supra note 118; Nelson, Buggy & Weil, supra note 114; Nelson & Milliken, supra note 117; Rhoden, Judge in Delivery Room, supra note 114; Note, The Creation of Fetal Rights: Conflicts with Women’s Constitutional Rights to Liberty, Privacy, & Equal Protection, 95 YALE L.J. 599, 624-25 (1986). Nancy Gallagher, one of the co-authors of the New England Journal of Medicine article cited above, probably belongs on this list in her own right. Her article in the Harvard Women’s Law Journal argues persuasively against court-ordered interventions and the notion of fetal rights. Although it concludes with a proposed balancing test, under her test a compelled Cesarean section would be “as constitutionally impermissible as a state-compelled organ or tissue transplant.” Gallagher, Prenatal Invasions & Interventions: What’s Wrong With Fetal Rights, 10 HARV. WOMEN’S L.J. 9, 55 (1987).
154. See id. at 617 (holding the trial court properly subordinated the mother’s “right against bodily intrusion to the interests of the unborn child and the state”) (emphasis added); Jefferson v. Griffin Spalding County Hosp. Auth., 247 Ga. 86, 274 S.E.2d 457, 460 (1981) (denying motion for stay of lower court’s order with citation to Roe v. Wade) (Hill, P.J., concurring) (recognizing the “unborn child’s right to live”); id. at 461 (Smith, J., concurring) (relying on “the state’s compelling interest in preserving the life of [the] fetus”).
children. Where birth has occurred, the medical treatment does not infringe on the mother's right to bodily integrity. With an unborn child, the state's interest in preserving the health of the child may run squarely against the mother's interest in her bodily integrity.\footnote{156}

The District of Columbia panel tentatively concluded that the state has the power to "infringe upon the mother's right to bodily integrity to protect the life or health of her unborn child [if] to do so will not significantly affect the health of the mother and . . . the child has a significant chance of being born alive."\footnote{157} It retreated from this position, however, in the case of forced Cesarean sections, because of the risks of complications, discomfort, and death. The court then concluded that the exception for Cesareans (and, presumably, other interventions posing comparable risks to the mother's health) did not apply to the case at hand, because the pregnant woman was a terminal cancer patient with "at best, two days left of sedated life."\footnote{158}

Academic commentary against forced obstetrical interventions denies that a fetal right to receive in utero therapy or to birth by Cesarean section can be justified by the Supreme Court's recognition in \textit{Roe v. Wade} of a strong state interest in the preservation of fetal life.\footnote{159} The principal argument against a broad reading of \textit{Roe} rests upon the Supreme Court's decision to limit the state's power to prohibit even postviability abortions when an abortion is necessary to protect the pregnant woman's health and life.

The Court recently demonstrated that its holding in \textit{Roe} was intended to prevent states from legislating a maternal-fetal trade-off when to do so would increase the risks to the mother's health. In \textit{Thornburgh v. American College of Obstetricians & Gynecologists},\footnote{160} the Supreme Court struck down significant provisions of Pennsylvania's Abortion Control Act of 1982 on the ground that the Act's required disclosures, reporting requirements, and medical choices as to the method by which viable fetuses should be aborted

\begin{itemize}
  \item \textit{In re A.C.}, 533 A.2d 611, 616-17 (D.C. 1987).
  \item Id. at 617.
  \item \textit{Id.}
  \item 106 S. Ct. 2169 (1986).
\end{itemize}
unconstitutionally interfered with the decision making process of pregnant women and their physicians. One provision that was struck down, for example, required that obstetricians aborting a viable fetus should use "'the abortion technique . . . which would provide the best opportunity for the unborn child to be aborted alive unless,' in the physician’s good-faith judgment, that technique 'would present a significantly greater medical risk to the life or health of the pregnant woman.'” In the view of the majority, the imposition by the state of a “significant” medical risk on the pregnant woman rendered the statute “facially invalid.”

The disagreement over the meaning of the Supreme Court’s abortion decisions crystallizes the essence of the debate over forced obstetrical interventions. The clear message of Thornburgh, as well as the Supreme Court’s other abortion decisions, is that the mother’s interests in making her own health decisions must take precedence over the state’s interest in preserving fetal health and life when those interests conflict, at least when the mother still has the right to have an abortion. What must await future decisions, however, is whether the Court would give added weight to the

161. Id. at 2182-83 (quoting § 3210(b) of the Act).
162. Id. See also Kennedy & Nicolazzo, Abortion: Toward a Standard Based Upon Clinical Medical Signs of Life and Death, 23 J. Fam. L. 545, 559 (1984-1985) (under a proposed abortion standard based upon the fetus’ vital signs, “[i]n the final trimester, as now, the viability of the fetus would still establish the state’s compelling interest in potential human life and would override the woman’s interest in privacy, but could not override her interest in her own life or health”) (emphasis added).

Three of the four dissenting justices in Thornburgh appeared to disagree with the notion that the state’s interest in preserving fetal life should be subordinated to the pregnant woman’s health and safety interests. See, e.g., Thornburgh, 106 S. Ct. at 2191 (Burger, C.J., dissenting) (“No governmental power exists to say that a viable fetus should not have every protection required to preserve its life.”) (emphasis added); id. at 2204 (White & Rehnquist, JJ., dissenting) (“If . . . a compelling state interest may justify the imposition of some physical danger upon an individual, and if, as the Court has held, the State has a compelling interest in the preservation of the life of a viable fetus, I find the majority’s unwillingness to tolerate the imposition of any nonnegligible risk of injury to a pregnant woman in order to protect the life of her viable fetus in the course of an abortion baffling.”) (emphasis in original). With respect to § 3510(b), Justice O’Connor would have adopted a construction of the statute, rejected by the majority, that equated “significantly greater risk” to maternal life or health with “real and identifiable” risk, resulting in “little possibility that a woman’s abortion decision will be unduly burdened by risks falling below that threshold.” Id. at 2216 (O’Connor, J., dissenting).

163. See generally Colautti v. Franklin, 439 U.S. 379, 400 (1979) (Pennsylvania statute held invalid because, among other things, it did not “clearly specify . . . that the woman’s life and health must always prevail over the fetus’ life and health when they conflict”); Planned Parenthood Ass’n v. Ashcroft, 462 U.S. 476, 482 (1983) (abortion statute must be interpreted so as to avoid increasing the risks to the health of the mother).
states' interest in preserving fetal life and promoting fetal health where the mother has made the decision not to have an abortion.

In Professor Robertson's view, such a change in the mother's intention would be critical: the decision to give up one's right to abort the fetus and, instead, to carry the child to term, imposes serious moral and legal obligations on the mother to take all reasonable steps to ensure the child's health. 164 Under this view, the surrogate with a viable fetus might be regarded as doubly obligated, both as a matter of the state's law regarding postviability abortions and as a result of her contractual obligations. The risk is that a judge might be influenced by the existence of the contract more readily to authorize an unwanted medical procedure. Whether or not the jurisdiction is one in which such authorizations have been granted, the use of the surrogate's prior agreement as an additional basis for granting the request of a hospital or natural father would be an unwarranted extension of the contract.

There is a risk, however, that the surrogate arrangement will have a subtle influence on the outlook of a judge presented with a surrogate mother who refuses to consent to a particular treatment or invasive diagnostic procedure and a request for an order to compel the intervention. To the extent courts are increasingly willing to order obstetrical interventions for the fetus' benefit, a judge may be inclined to view the surrogate mother as a "fetal container" 165 who is contractually obligated to accept the label and the consequences that flow from it. Ironically, to avoid charges of baby selling, the proponents of surrogacy have urged the public to accept their characterization of the practice as "womb leasing," or the mere provision of gestational services. These characterizations, however, carry additional rhetorical and emotional baggage by fostering an image of the surrogate mother as simply the means by which an infertile couple can achieve their desired ends. The image that is thus created may well diminish a judge's receptiveness to a defense that is based upon the surrogate's personal rights of privacy, autonomy, and self-determination.

164. Robertson, Procreative Liberty, supra note 138, at 437-38. In his view, the difficult question of the state's power to compel interventions involves a practice of "dubious public policy," Robertson, Correspondence, supra note 144, but a permissible one in certain circumstances. Robertson, Procreative Liberty, supra note 138, at 437.

165. The phrase is from Professor Annas, one of the most perceptive and vocal opponents of compelled obstetrical interventions. See Annas, Fetal Containers, supra note 5, at 13. See also Annas, Protecting Liberty, supra note 5, at 1213.
The surrogate who insists on her right to be free from nonconsensual interventions could well encounter subtle forms of discrimination. As the authors of the *New England Journal of Medicine* survey pointed out, most of the women who have been ordered to submit to obstetrical interventions were Black, Asian, or Hispanic, and all were either being treated at teaching hospital clinics or were receiving some form of public assistance. The strong inference from these data is that a factor that may have influenced the hospitals to seek a court order and the judges to issue one was the economic status, race, or ethnicity of the mothers, which may have made it more difficult for the physicians and judges involved to be empathetic with the women's refusals. Similarly, a nonconsenting surrogate mother—whose motivations to be a surrogate may seem mysterious and whose decision to bear a child and surrender it to a stranger unfathomable—may run the risk that her refusal to consent to a Cesarean section or to fetal surgery will be given shorter shrift than the refusal of a woman whose pregnancy is in their view more "normal."

A surrogate mother's objections to a form of treatment or diagnostic test, however, should be evaluated in the same manner and against the same norms as a nonsurrogate's. Both are free, autonomous individuals with the same rights of privacy and self-determination. The "fetal container" label is equally inapt for both surrogate and nonsurrogate pregnant women whether the controversy concerns custody of the child or the mother's right to refuse to consent to an unwanted medical intervention.

In jurisdictions that have recognized the courts' power to order such interventions, no different treatment should be accorded the surrogate simply on the basis that she is a surrogate. For example, the issue of the competency of the mother is latent in any refusal to consent case, and the courts have the power to order an examination to determine the mother's competency. The courts should not presume that the surrogate is incompetent from the sole fact that she is a surrogate any more than they would presume incompetency in any other case. Most especially, the surrogate should not be deemed to have waived or contracted away her personal right to object to a proposed intervention. To do so would raise a most chilling prospect. If courts were to allow a pregnant woman to be depersonalized on the basis of a contract, the next

166. *See Court-Ordered Interventions, supra* note 118, at 1193.
and all too easy step would be to regard all pregnant women as “fetal containers” on the basis of their status as pregnant women. Even in jurisdictions rejecting an absolutist view of a woman’s rights, the balancing test for determining the appropriateness of compelling a medical intervention requires that a woman’s rights of privacy and autonomous self-determination be seriously considered. The first step toward regarding the rights of all pregnant women less seriously should not be taken by treating the rights of surrogate women less seriously.

III. Conclusion

Surrogate motherhood provides an alternative method of reproduction for infertile couples, but it is a method that contains great risks. As the Baby M case illustrates, the parties do not necessarily know what they are setting themselves up for when they begin their partnership. The contract itself is an imperfect device for protecting the parties against untoward developments, and as courts and legislatures take a closer look at the practice, the parties may find, as they did in the Baby M case, that the contract provides no protection at all.

As surrogate contracts are currently being written, it is the surrogate mother who gives up the most. She promises to give up the child at the end of the pregnancy, and she also promises to surrender her rights of autonomy and self-determination during the pregnancy. While the father’s desire to protect himself against foreseeable risks is understandable, the potential impact of abortion and medical care provisions on the surrogate mother is extreme.

This article has considered the nature of the surrogate mother’s promises—not to have an abortion except if the natural father insists, to consent to all recommended medical treatments for the benefit of the fetus and herself—and the difficulties they raise both for the principals and for the legal and medical professions. This article proposes to make specific performance of the abortion provisions impossible to obtain and specific performance of the medical care provisions no more obtainable than would otherwise be the case if there were no surrogate contract at all. If phy-

sicians and judges resist the temptation to depersonalize the surrogate, at least she will not have given up her most fundamental rights of privacy and autonomy.

According the surrogate her full measure of autonomy, however, does not mean that she is fully protected from the consequences of her original promises. Although she should not be subjected to medical treatment against her will, or restrained from having an abortion if she would otherwise have that right, neither should she be able to walk away from her agreement with impunity. The probability that many of the provisions are void, unenforceable by injunction, or not subject to damages, does not mean that there is no obligation. The challenge that surrogacy presents to both the legal and the medical professions is to achieve some measure of justice in balancing contract rights without doing damage to the human rights that are involved.