Compelled Medical Treatment of Pregnant Women

To the Editor.—I wish to correct the statement that "the criminal law historically did not recognize the killing of an unborn fetus as a homicide unless it was born alive," contained in the article entitled "Compelled Medical Treatment of Pregnant Women." The common law was summarized by Judge Boggs, with suitable citation of authority, in his dissenting opinion in *Abortion v. St. Luke's Hospital*, 56 NE 638, 641 (III 1900), as follows:

A child in ventre sanguineo was regarded at the common law as in esse from the time of its conception for the purpose of taking any estate, whether by descent or devise, or under the statute of distribution, if the infant was born alive after such a period of fetal existence that its continuance in life was or might be reasonably expected. 10 Am. & Eng. Enc. Law 624; Co. Litt. 36. Blackstone, after declaring the right of personal security to be an absolute right, says: "The right of personal security consists in a personal liberty and uninterrupted enjoyment of his life, his health, his body, his health, and his reputation. Life is the immediate gift of God,—a right inherent in nature in every individual; and it begins, in contemplation of law, as soon as an infant is able to sit in the mother's womb. For, if a woman is quick with child, she being a proper reason of her pregnancy, or if one beat her, whereby the child dies in her body, and she is delivered of a dead child, that, though not murder, was, by the ancient law, homicide or manslaughter." Though it was the rule of the common law if one should unlawfully beat a woman pregnant with child, and thereby cause the child to die in the body of the mother, the crime was deemed to be murder, but the ancient crime of homicide or manslaughter, still the doctrine of the common law was, if the child should not die in the womb of the mother, but should be born alive, and should afterwards die in consequence of the assault while in the womb of the mother, the offense was deemed to be murder. 3 Co. Inst. 56; 1 P. Wms. 345.


To the Editor.—In a recent article published in the *Journal of the American Medical Association* (JAMA), Nelson and Milliken*state that the California Appellate Court case People v. Smith* "decided that a child after birth has a right to recover damages for injuries wrongfully inflicted by a third party prior to birth." Would or should the child have a right to recover damages from the mother's willfulness to fulfill her ethical obligation to accept reasonable, nonexperimental medical treatment for the sake of her fetus and to behave otherwise in a manner intended to benefit and not harm her fetus? Would or should these damages resulting from third-party or malformations inflicted injuries include lifelong costs for physical damage resulting directly or secondarily from the above situations, damages for emotional suffering, and costs for necessary psychiatric care? If the mother or the third party is not liable for any of these costs or cannot pay, then who is liable and who will pay? Society in the shape of the government? Insurance companies? The obstetrician? Will the father of the child, who has no legal say in the mother's prenatal care and treatment decisions, be legally obligated to absorb the costs of physical and mental treatment for the affected child?

Nelson and Milliken also state that "California law provides that the death of a viable fetus is not murder if the act of killing is solicited, aided, abetted, or consented to by the mother of the fetus." Assume that the attempted killing of the fetus is unsuccessful (or, that an abortion attempted by the mother herself or by a qualified third party is unsuccessful) and damage to the fetus occurs, resulting in morbidity in the child after birth. Would or should these injuries be considered "wrongfully inflicted?" Who is liable for the medical care of the child and any emotional damages?

Have any other court cases or articles addressed these controversial issues?

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In Reply.—Mr Ruley takes exception to our statement that the criminal law historically did not recognize the killing of a fetus in utero as homicide. We cited three modern (ie, since 1980) appellate court opinions for this proposition. One of these opinions clearly stated that this rule "has been accepted as the established law in every American jurisdiction that has considered the question" and cited no fewer than ten recent appell...
Blow-Blow-Blow
To the Editor.—During my 35 years of serving on various labor decks, I have noted relatively consistent commands given by labor nurses to prevent the parturient from pushing and delivering in what to them appears to be an important place or time. Depending on the hospital, these commands have been “blow-blow-blow,” in another delivery room “breathe-breathe-breathe,” and in still another “exhale-exhale-exhale." Each institution seems to have its own favorite phrase, but generally the sequences are three or four words, spoken in a monotonous manner and in a repetitive manner. Invariably, the care givers themselves act out their own instruction, such as blowing with each command to blow. I know of no studies that indicate which labor-reductionental or palsy techniques are the most effective in preventing bearing down.

I have wondered about the reasons for these stereotyped labor room verbal and note commands. In my experience, no delivery room attunates what was described in the first nine editions of DeLee’s *Principles and Practices of Obstetrics* as required to accomplish a successful delivery. He recommended the frequent nailing of the maternal perineum and vagina with disinfectant and frequent changing of the obstetrician’s gloves and of the dress around the patient. Even with all these delivery room efforts, DeLee himself noted that a truly sterile delivery was a “rarely". This is even more true today with the widespread use of the fetal scalp electrode, which drenches over the membranes' peritoneum throughout her labor and often deliver. Other reasons given for delayed delivery are the absence of skilled personnel for the newborn immediate care, that the patient might "near" or on the occasion, difficulty in collection of fees if the patient doesn’t give birth in the previously planned manner.

Largely that parturient should be allowed to deliver when they feel like it, whether it be in the hospital bed or on the stretcher on the way to the delivery room. One reason is that the mother-to-be is often frightened and anxious under these circumstances and will be relieved only by immediate delivery. This maternal stress may adversely affect her fetus by decreasing uterine blood flow. If the expert personnel aren’t immediately available when she delivers the newborn, it can usually be managed by the less skilled or the newborn can be whisked to the nursery. Having been associated with more than 500 deliveries in a birthing room, I no longer believe what I was taught or have taught—that vaginal tears are much more painful post partum than are episiotomies. Furthermore, I have been depressed newborns after delayed delivery and have recently reviewed two cases of alleged malpractice in which the infant has cerebral dysfunction. In these particular cases, the mother was instructed or encouraged to “blow" away her impending delivery.

Except with the tight breech or perhaps the very tiny newborn, all labor room personnel are capable of2 catching babies safely and satisfactorily no matter where they choose to be born. In these days of superspecialization and expensive delivery equipment, we should be willing to return to the past in some areas and let women deliver when they feel like it. So, in times of impending birth, instead of "blow-blow-blow" we should be saying “good good—good" or perhaps “swell—swell—swell.”

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Long Hours and Risk to and From Residents
To the Editor.—Three cheers for Dr. Garard for his response to the letter by Drs. Wexler and Yon about house staff moonlighting. He has addressed the concerns of many residents, recent graduates, and patients. The current method of residency training is antiquated. As technology has advanced and malpractice liability has demanded increased documentation in medical settings, the modern-day resident struggles with rapidly increasing responsibilities.

Is the residency training program adhering to its goals? Dr. Garard’s arguments might be pushed one step further to define those goals and shed light on