help us keep our thinking clear as the investigation of HIV infection proceeds.

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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."[1] The common law was summarized by Judge Boggs, with suitable citation of authority, in his didactic dissenting opinion in *Allaire v St Luke's Hospital*, 56 NE 638, 641 (Ill 1900), as follows:

> A child in ventre sa mere was regarded at the common law as in esse from the time of 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 foetal 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 person's legal and uninterrupted enjoyment of his life, his limbs, his body, his health, and his reputation. Life is the immediate gift of God,—a right inherent by nature in every individual; and it begins, in contemplation of law, as soon as an infant is able to stir in the mother's womb. For, if a woman is quick with child, and by a potion or otherwise killeth it in her womb, or if any one beat her, whereby the child dieth in her body, and she is delivered of a dead child, this, 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 not 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. 50; 1 P. Wms. 345.

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1. Nelson LJ, Milliken N: Compelled medical treatment of pregnant women: Life, liberty, and law in conflict. *JAMA* 1988;259:1060-1066.

To the Editor.—In a recent article published in THE JOURNAL, Nelson and Milliken[1] state that the California Appellate Court case *People v Smith*[2] "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 unwillingness 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 maternally inflicted injuries include lifelong costs for physical damage resulting directly and 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[3] 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 nonqualified 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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1. Nelson LJ, Milliken N: Compelled medical treatment of pregnant women: Life, liberty, and law in conflict. *JAMA* 1988;259:1060-1066.
2. *People v Smith*, 59 Cal App 3d 751 (Cal App 1976).
3. Cal Penal Code §187(b)(3).

To the Editor.—I was profoundly distressed with the ethical reasoning expressed in Nelson and Milliken's article.[1] The authors correctly state that the issues of fetal rights, legal and ethical, are hotly debated. It is understandable that physicians would seek the help of the courts to judge what is the just course of action when a fetus' health or life is jeopardized by its mother's behavior.

The authors' contention that to seek a court ruling on life and death issues is unethical because it invades the mother's privacy is a gross distortion of ethical reasoning. Any issue brought to judicial review, whether criminal or civil, involves a discovery process that invades one's privacy. Certainly the mother might be psychologically ill-disposed to defend her choices while pregnant, but the psychological states of a person standing trial in a criminal action or of the parties in a contested divorce are no less vulnerable, and it would be absurd to suggest that it is unethical to involve the courts in these situations.

Most physicians are not adequately trained in the difficult ethical and legal reasoning involved in these cases. The only two options that exist to provide help in making a decision are the ethics committee of the hospital involved (if a hospital is involved) and the courts. I would rather trust the court's decision as to what is ethically or legally correct to do than accept the guilt stemming from failure to seek to protect the fetus by accepting a mother's irresponsible decisions and actions. The lack of legal precedent for civil damages for a physician not seeking judicial review is slim comfort considering the increasingly broad liability to which physicians have been exposed, as well as the long period before the statute of limitations would apply in the case of a person seeking compensation for a prenatal injury.

I hope that Nelson and Milliken's article sparks a debate on the issues involved. If it does, it will have served a useful purpose.

Stephen E. Whitney, MD
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1. Nelson LJ, Milliken N: Compelled medical treatment of pregnant women: Life, liberty, and law in conflict. *JAMA* 1988;259:1060-1066.

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[1] 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 appel-

late cases to this effect. Another stated that at common law "the killing of a fetus was not murder unless the child was born alive and then expired as a result of the injuries . . . sustained." We find these modern appellate authorities to be much more persuasive than Justice Boggs writing a dissenting opinion almost 90 years ago.

We assume Mr Donohoe is referring to *Smith v Brennan* rather than *People v Smith* for the proposition that a live-born child may recover civil damages from a third-party wrongdoer. Currently, third-party strangers uniformly are held legally responsible to a live-born child for prenatally inflicted harm. There is scant legal precedent holding a woman civilly liable for harm inflicted to her child prenatally. We believe there are good reasons not to allow tort actions between parent and child, which would introduce destructive adversarial conflict into this important, nurturing, intimate, and sometimes delicate human relationship. Furthermore, allowing such suits would seriously limit a pregnant woman's freedom of action and thus undermine a value that we argued in our article is fundamental. We believe that mothers should be immune from civil damage actions brought by their children based on their prenatal conduct, with the possible exception of a woman who knowingly, maliciously, and affirmatively acts in a manner directly intending to cause harm to her fetus.

Dr Whitney expects far too much from courts. He is looking to the courts to tell physicians (to use his words) "what is ethically or legally correct to do." Courts are not experts on ethical right and wrong, nor would they be able to give consistent ethical "rulings." If each of us ran to a judge before we made any serious ethical choice in our professional and personal lives, the courts would be busy indeed. After engaging in careful ethical reflection and using sound legal advice and information, physicians need to assume professional responsibility for the medical decisions they and their patients (not judges) are best suited to make.

Our article gave numerous reasons why the courts should not get involved in maternal-fetal conflict and why the Constitution may actually bar such involvement. Dr Whitney does not dispute any of these reasons directly, but he plainly is worried about "the increasingly broad liability to which physicians have been exposed." We understand physicians' fears of liability, but we gave substantial reasons and legal authority for our claim that these fears are largely unwarranted. Dr Whitney provides no argument or authority to the contrary except his own free-floating anxiety about legal liability.

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Nancy Milliken, MD
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1. *Commonwealth v Case*, 467 NE2d 1324 (Mass 1984).
2. *People v Greer*, 402 NE2d 203 (Ill 1980).

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 room staff to prevent the parturients from pushing and delivering in what to them appears to be an inopportune 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 monotone and in a repetitive manner. Invariably, the care givers themselves act out their own instructions, such as blowing with each command to blow. I know of no studies that indicate which labor coach's verbal or body techniques are the most effective in preventing bearing down.

I have wondered about the reasons for these stereotyped labor room verbal and body commands. Sometimes the goal appears to be to achieve a sterile vaginal delivery, which is probably nonsense. In my experience, no delivery room attempts what was described in the first nine editions of DeLee's[1] *The Principles and Practices of Obstetrics* as required to accomplish a sterile delivery. He recommended the frequent bathing of the maternal perineum and vagina with disinfectant and frequent changing of the obstetrician's gloves and of the drapes around the patient. Even with all these delivery room efforts, DeLee himself noted that a truly sterile delivery was a "fallacy." This is even more true today with the widespread use of the fetal scalp electrode, which dangles over the mother's perineum throughout her labor and often delivery. Other reasons given for delaying delivery are the absence of skilled personnel for the newborn's immediate care, that the patient might "tear," or the occasional difficulty in collection of fees if the patient doesn't give birth in the previously planned manner.

I argue that parturients should be allowed to deliver when they feel like it, whether it be in the unsterile labor 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.[2] 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 750 deliveries in a birthing room, I no longer believe what I was taught or have taught—that vaginal tears are more painful post partum than are episiotomies.[3-5] Furthermore, I have seen 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 of catching babies safely and satisfactorily no matter where they choose to be born. In these days of superspecialization and expensive fetal monitoring 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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1. DeLee JB. *The Principles and Practices of Obstetrics*. Philadelphia, WB Saunders Co, 1913, pp 301-303.
2. Pritchard JA, MacDonald PC, Gant NF: *Williams Obstetrics*, ed 17. East Norwalk, Conn, Appleton-Century-Crofts, 1985, p 184.
3. Goodlin RC: Low risk obstetric care for low risk mothers. *Lancet* 1980;1:1017-1019.
4. Goodlin RC: On protection of the maternal perineum during birth. *Obstet Gynecol* 1983;62:263-264.
5. Hoffman K, Lorkovic M, Rayburn W, et al: Alternative birth centers. A four year experience at the University of Nebraska Medical Center. *Ariz Med J* 1987;72:296-298.

Long Hours and Risks to and From Residents

To the Editor.—Three cheers for Dr Giardino[1] for his response to the letter by Drs Wendt and Yen[2] 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 increasing documentation in medical settings, the modern-day resident struggles with rapidly increasing responsibilities.

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