Smoke-Filled Wombs and Fragile Fetuses:  
The Social Politics of Fetal Representation

It does not seem too much to claim that the biomedical, public fetus—given flesh by the high technology of visualization—is a sacred-secular incarnation, the material realization of the promise of life itself. Here is the fusion of art, science, and creation. No wonder we look.
—Haraway 1997, 179

Despite the multiple meanings associated with the public fetus, fetal images are often presented in ways that specify and limit interpretations of them. In this article, I explore the use of fetal imagery in two seemingly separate areas of current social and political contest in the United States: antismoking education and antiabortion activism. Health education campaigns to convince pregnant women to quit smoking cigarettes and antiabortion drives to criminalize abortion, I argue, reinforce fetal-centric medical, social, and moral expectations of women's reproductive responsibilities. Antismoking messages often draw on the widespread emotional appeal of the public fetus, depicting fetuses as vulnerable individuals who demand maternal protection and care. This has serious implications for public health policy, medical practice, cultural politics, and women's experiences of pregnancy and motherhood.

Feminist scholars have explored the politics of pregnancy and reproductive health in response to intensified cultural, medical, and legal trends in the United States over the past three decades that emphasize pregnant women's “separateness” from their fetuses and also constrain their choices, rights, and actions. Images of the fetus as autonomous threaten to overshadow the significance of pregnant women’s bodies in the reproductive process, devalue the relationship between pregnant women and their

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fetuses, and represent women as adversaries of their babies-to-be.\(^1\) Of pressing concern is the proliferation of fetal representations that establish the fetus as an actor who lives beyond the boundaries of a pregnant woman's body and inhabits a privileged place in the public imagination. Rosalind Petchesky (1987), Valerie Hartouni (1991), Janelle Taylor (1992, 1998), and others have analyzed and criticized fetal images in public culture, from those sponsored by antiabortion organizations to those in Hollywood films, news stories, and Volvo ads that are not necessarily directly related to, but invoke, antiabortion ideologies. Although such fetal representations may not explicitly support the antiabortion cause, fetuses are gaining symbolic status as persons in the United States. The question of how fetuses should be defined is hotly contested in medicine, law, and popular culture, and as anthropologist Lynn Morgan writes, “the more we puzzle over fetuses, the more we legitimate the subject, and, by extension, the subjectivity, of the ‘fetal person’” (1997, 324). I argue that a particular type of fetal person—coded as a vulnerable agent in need of, if not demanding, vigilant protection—is at the center of health-policy, legal, and social debates. Feminists must seriously consider whether representations of the fetus as a fragile individual necessarily strengthen moral judgments of and limitations on women's agency.

The construction of the fetal person as a subject has coincided with increased attention to how pregnant women's practices, such as cigarette smoking, alcohol consumption, and drug use, negatively affect fetal health. Framing pregnancy as a potential conflict (in which a woman's rights, needs, or desires clash with those of her fetus) has opened the so-called maternal-fetal relationship to public surveillance, regulation, and intervention. The omnipresence of fetal protection messages—from anti-smoking and antialcohol warnings on posters at grocery and convenience stores and stickers in restaurant bathrooms to health warning labels on product containers and advertisements—produces and reinforces “pregnancy rules.”

In addition to receiving medical recommendations through public warnings, pregnancy advice books, parenting magazines, prenatal health classes, and doctor visits, many pregnant women find themselves surrounded by well-meaning but often intrusive “lay experts” in their day-to-day lives. The Girlfriends’ Guide to Pregnancy: Or, Everything Your Doctor Won’t Tell You warns, “The world is filled with people who feel it is their responsibility to monitor your performance ... the Pregnancy Police”

\(^1\) These points are analyzed in depth by Petchesky 1987; Rothman 1989; Pollitt 1990; Hartouni 1991; Duden 1993; Stabile 1994; Morgan 1996; Morgan and Michaels 1999.
(Iovine 1995, 64). All pregnant women are subject to “pregnancy policing,” or others’ judgment, criticism, and advice about what is “best for the baby.”

In some cases, women face not only medical and social scrutiny but also legal censure. Since the late 1980s, more than two hundred women in more than thirty states have been prosecuted for health practices that medical and legal experts deemed dangerous to their fetuses, mainly through extensions of child abuse or neglect and drug laws (Terry 1996). Legal charges have not been brought against pregnant women who smoke cigarettes; however, some antismoking advocates and health professionals have labeled smoking during pregnancy as “child abuse.” Further, parental smoking has been cited in a number of child custody suits since the 1980s (Action on Smoking and Health 1995). Given the increasing stigma attached to smoking and calls for the regulation of nicotine as a drug, it is possible that pregnant women who smoke will be charged with “fetal abuse.”

The expanding recognition of and concern for fetal persons, the unrelenting antiabortion drive to impose limits on legal abortion, and the threat of fetal abuse charges raise several urgent questions about feminist politics: What position(s) on fetal health can feminists hold? Do arguments that pregnant women ought to change some practices to benefit their babies-to-be undermine a belief in women’s moral and legal rights to choose how to treat their bodies? Are there ways to discuss fetal health without buttressing the antiabortion movement’s constructions of fetal personhood and fetal rights? Cigarette smoking during pregnancy—formerly tolerated by medical experts and still legal—offers a complex case through which to consider these questions.

My analysis is based on research that explored health professionals’ and

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2 For feminist analyses of such cases, see Gallagher 1987; Moss 1990; Roberts 1991, 1997; Daniels 1993; Roth 1993; Center for Reproductive Law and Policy 1996a, 1996b.

3 Although drug, alcohol, and tobacco use are often categorized together in prenatal advice literature as fetal dangers, there are significant differences in medical and legal approaches to each. Despite the rise in concern in the 1980s about cigarette smoking by pregnant women, labels paralleling the well-publicized terms crack babies and fetal alcohol syndrome, such as nicotine babies or fetal tobacco syndrome, are not used. Why not? As one obstetrician explained to me, determining which newborns have health problems related to smoking during pregnancy is simply not as easy as identifying those exposed to drugs or alcohol. Moreover, there are no legal limits on the amount of cigarette consumption, whereas all drug use and certain levels of drinking are illegal. If in the future nicotine is regulated by the Food and Drug Administration (or another governmental agency), however, cigarette smoking may be classified as drug use and pregnant women who smoke penalized on these grounds. Finally, and related to these medical and legal distinctions, from a social perspective cigarette smoking may be viewed as the least of these three evils and thus be more tolerated.
“everyday” or “lay” women’s perceptions of prenatal health risks, with an emphasis on cigarette smoking during pregnancy. Research was carried out in 1995–96 in the Baltimore-Washington, D.C., area. I conducted open-ended interviews with more than thirty health professionals, including health educators, obstetricians, a maternal-fetal health specialist, nurse-midwives, antitobacco policy advocates, and prenatal clinic directors; all but three were women, and all but one were Euro-American. Access to these professionals was aided by my status as a researcher affiliated with a well-known university. Through social networks of friends, family, and coworkers, I also contacted lay women who were currently pregnant or who had children. I talked to these women in their homes, workplaces, or other agreed-on locations. To gain insight into a range of women's health experiences during pregnancy, feelings about health risks, and opinions on smoking during pregnancy, I interviewed a cross section of women with diverse characteristics (including age, race, ethnicity, smoking status, marital status, and socioeconomic status). I also analyzed public health, medical, and media reports on smoking; pregnancy advice literature; antiabortion literature; and antismoking publications produced by national and local nongovernmental health advocacy organizations and governmental health agencies.

This article contributes to feminist research on women’s and pregnant women’s cigarette smoking and to feminist scholarship on the politics of fetal imagery by analyzing how antismoking and antiabortion messages reveal mutually supporting depictions of fetuses and fetal life. First, I dis-

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4 For an extended analysis and details of the research, see Oaks (in press).
5 In this article, my definition of health educator goes beyond those professionally trained in health education, a public health subfield, to include a broader range of health professionals who engage in health educating and with whom most pregnant women consult as a part of their prenatal health care.
6 At the end of an interview, I usually asked the participant if she knew of other women I might talk to, a “snowball sampling” method of identifying interviewees.
7 Fourteen African-American and thirty-two Euro-American women (the dominant demographic racial/ethnic groups in the region) participated. Of the African-American women interviewed, ranging in age from twenty to sixty, six were never regular smokers, two smoked during pregnancy, six were former smokers, and two were current smokers. Of the Euro-American women, ages sixteen to forty-four, thirteen were never regular smokers, eight smoked during pregnancy, seven were former smokers, and twelve were current smokers. The majority of participants, both health professionals and everyday women, were Euro-American. This situation reflects the study design (everyday men were not sought as interviewees, and a representative sample was not a goal), the disproportionate representation of Euro-American women in the health education and reproductive health fields, and my own social identity as a middle-class, Euro-American woman.
8 For feminist analyses of smoking, see Oakley 1989; Graham 1993; Condit 1996; Greaves 1996.
Discuss the construction of smoking during pregnancy as not only a health problem but also a social problem. Next, I explore two overlapping visual and discursive strategies adopted by antismoking and antiabortion advocates: emotional appeals that urge the protection of the fetus-as-person and scientific appeals that attempt to demonstrate what happens to the fetus when a woman smokes cigarettes. Both themes promote specific moral expectations about “maternal bonding,” fetal care, and the responsibilities of motherhood. Finally, I address feminists’ participation in fetal politics and discuss how health education on smoking during pregnancy might be redesigned. Representations of fetuses as persons and patients are unlikely to fade given legal attempts to recognize fetal rights, the development of medical treatments for fetuses, and the fact that many women experience and think of their babies-to-be as specific individuals. It is imperative that feminist scholars and health advocates produce ways to recognize fetuses as subjects without ceding women’s reproductive options, agency, and rights.

Smoking during pregnancy as a health and social problem

Like other issues that are perceived as both health and social problems, such as teen pregnancy, drug and alcohol use, and HIV/AIDS, the case of smoking during pregnancy reveals that the public health agenda is driven not only by medical evidence about health risks but also by social and political trends. A combination of factors have sparked public health campaigns and social concerns over pregnant women’s smoking in the United States over the past twenty-five years: increased research on the health effects of smoking, antismoking campaigns, the antiabortion movement’s efforts to define the fetus as a person with rights, the medical treatment of the fetus as a patient, and changing expectations about pregnancy and mothering. To provide some social and medical background to health campaigns against smoking during pregnancy, I explore how health professionals and everyday women define it as a health risk and a social risk.

Despite scientific findings published in 1957 showing a link between smoking and low birth weight (Simpson 1957) and the Surgeon General’s 1964 report calling attention to the health risks associated with tobacco use (U.S. DHEW 1964), smoking during pregnancy did not gain status as a visible public health problem until the late 1970s and 1980s, when government health agencies and large health organizations (such as the

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American Cancer Society, American Lung Association, and American Heart Association) initiated nationwide health education and smoking cessation campaigns focusing on the fetal health risks of smoking during pregnancy. In 1984, Congress mandated that health warnings about smoking during pregnancy appear on cigarette packs and in ads. Attention to pregnant women's smoking as a problem peaked in the mid-1980s, coincident with the period in which obstetric advances created the fetal patient (Kolata 1990; Casper 1998) and antiabortion activists intensified their campaign for legal rights for fetuses (Luker 1984; Petchesky 1984; Ginsburg 1989).

Currently, cigarettes are vilified by medical professionals, antismoking activists, and many nonsmokers, who regard smoking during pregnancy as a wholly unacceptable and "preventable" practice. Pregnant women's cigarette smoking is "one of the most-studied risk factors in contemporary obstetrics" (Floyd et al. 1993, 379), and the medical literature routinely refers to its association with increased risks of miscarriage, preterm delivery, stillbirths, sudden infant death syndrome, and respiratory and ear diseases (see U.S. DHHS 1990; Charlton 1994; DiFranza and Lew 1995). Other, "suggestive" studies point to links between smoking during pregnancy and childhood cancers (New York Times 1996b; Sasco and Vainio 1999), cleft palate (Lieff et al. 1999), mental retardation (New York Times 1996a), hyperactivity (Action on Smoking and Health 1998), the transmission of HIV during delivery (Action on Smoking and Health 1997), and the increased probability that the daughters of pregnant smokers will smoke when they are teens (Kandel, Wu, and Davies 1994). In fact, some researchers contend that smoking carries more serious fetal health risks than cocaine use (Cotton 1994), a claim that strengthens proscriptions against pregnant women's cigarette use by symbolically placing cigarettes in the same category as illicit drugs.

Indeed, health professionals categorize pregnant smokers as a "special population target" or a "high-risk group" (U.S. DHHS 1991, 95–96). Rates of pregnant women's smoking have declined over several decades, likely because of the numerous warnings against smoking in pregnancy advice literature and the growing social stigma against smoking in general. While studies from the 1980s reported that 25–30 percent of pregnant women smoked cigarettes, the most recent estimate, from 1997 data, indicates that only 13 percent did so (Ventura et al. 1999, 10). Health research-

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ers believe, however, that national statistics underrepresent the actual number of pregnant smokers, for pregnant women are increasingly unwilling to identify themselves as smokers (Ventura et al. 1999).

The transformation of pregnant women’s cigarette smoking from socially acceptable and medically approved to unconditionally wrong was repeatedly commented on by the pregnant women I interviewed. Jennifer Montelli, a nonsmoking, middle-class, Euro-American woman in her thirties said that her mother smoked cigarettes during all four of her pregnancies: “My impression is that they assumed everything would be fine. She thinks we’re all crazy, we worry so much. They just had babies back then.”

April McGough, a Euro-American communications director in her early thirties, commented with an incredulous tone, “Things were so different then! My mother didn’t smoke or anything, but I have a friend about my age and her mother, she smoked during her whole pregnancy. And her doctor said it was okay.” Today, women who smoke when pregnant are subject to negative judgment on health and moral grounds, and smoking during pregnancy is discussed not only as a personal, individual failing but also as a social problem.

Increasingly, smoking, particularly during pregnancy and near young children, serves as a marker of lower socioeconomic status, and public health professionals identify the problem of smoking as existing mainly in “low-income communities” and among youths. Statistical analyses, which use educational attainment as a measure of socioeconomic status, show that when women’s cigarette use peaked in the 1960s, those with a high school education or less had higher smoking rates than those with more education; however, the gap has widened greatly, primarily because of a steeper decline in smoking by the latter group. In 1997, the percentage of pregnant women smokers was highest among those who had not completed high school (26 percent), followed by high school graduates (17 percent), those with some college (10 percent), and college graduates (2 percent; Ventura et al. 1999, 11).

Further, pregnant women’s smoking patterns differ significantly by race/
ethnicity and age. For women under age thirty, smoking rates during pregnancy are much higher among Euro-American women than among African-American or Chicana/Latina women, but at age thirty and over, the rates of smoking during pregnancy are highest among African-American women (13–16 percent). Low smoking rates (3–5 percent) are recorded for pregnant Chicana/Latina women regardless of age (Ventura et al. 1999, 57). The highest smoking rate of any age group, 29 percent, is documented among pregnant Euro-American women ages fifteen to twenty. This rate is drastically higher than that among African-American (7 percent) and Latina (4 percent) teenagers (Ventura et al. 1999, 57). Teenage women are the subjects of public health campaigns against both teen pregnancy and teen smoking and therefore are open to exceptionally negative stigmatization as irresponsible transgressors of middle-class health and social norms.

In fact, pregnant women who smoke have been held responsible for a "cycle of deprivation" that results in teenage pregnancy and other health-related social problems that figure prominently on the public health agenda (Charlton 1996). A pregnant woman who smokes activates the cycle: smoking during pregnancy results in the child's delayed physical and social development, repeated childhood illness, low self-esteem, poor school performance, dropping out of school, teen smoking, and teen pregnancy. Framed this way, cigarette use is not simply a personal health risk; it is a social risk. According to some health advocates, smoking by pregnant women represents a threat to "healthy families" and even to a "healthy society" (Reid 1997).

An overwhelming number of nonsmokers with whom I spoke also

14 The most recent data, from 1997, show the highest smoking rates for pregnant women for American Indian, white, and Hawaiian women (17–21 percent) and lowest among Mexican, Cuban, Central and South American, and Asian or Pacific Islander (except Hawaiian) women (1–5 percent; Ventura et al. 1999, 10). Although not specific to pregnancy, new data reveal that teenage smoking rates are rising among young African-American and Chicana/Latina women (Centers for Disease Control and Prevention 1998; Stolberg 1998).

15 While I interviewed women who seem to fit Charlton's pattern, I take issue with the discourse she promotes and with the narrowness of her theory. The label cycle of deprivation suggests that children of smokers are denied normal lives and that women who smoke are responsible for perpetuating an unhealthy underclass. Her doomed-before-birth argument is grounded in biological determinism, allows little agency on the part of individuals, and endorses the idea that smoking alone is the root cause of a variety of "social ills." Charlton disregards the experience of previous generations, in which women smoked during pregnancy without knowledge of risks to fetal health. She also fails to account for past generations of smokers, many of whom had professional and middle-class status, who did not exhibit this pattern.
harshly judged pregnant smokers. Nearly every woman interviewed agreed that all pregnant women are aware of health warnings against smoking during pregnancy, which suggests that warnings about the fetal health risks of smoking are remarkably widespread. Therefore, “not knowing the risks” is not viewed as a valid explanation for the behavior. Pregnant women who smoke are perceived most often as poor or working class, uncaring, and/or victims of addiction. This perception arises from the stigma around smoking, the strength of women’s feelings about following health advice for the good of the baby-to-be, and the identification of “unhealthy” and “irresponsible” behaviors with women of lower-class status. The antismoking position also contains a broader, middle- and upper-class “healthist” discourse that equates good health with morality (see Crawford 1980). Judy Levine, an antitobacco advocate I interviewed, agreed that strong feelings about health norms underlie middle-class hostility toward mothers and all child-care providers who smoke: “My daughter had a very nice lady nursery school teacher who had a couple children and got pregnant the year she taught my daughter. And she was a smoker. I knew it... but she was hiding it. I’m sure she was very ashamed of it. She was a nice middle-class teacher, and, who knows, it might have even jeopardized her job. It’s not impossible that they’d think ‘if she’ll take a chance with her own baby, what kind of nursery school teacher can she be?’ It’s not that farfetched.” The main problem is not that children will see their teacher, a role model, smoking and emulate her behavior or that they will be exposed to the health risk of secondhand smoke. Rather, it is that she is of questionable character and lacks the ability to act responsibly. Her identity as a middle-class teacher and mother clashes with her identity as a smoker.

Predictably, health professionals’ and nonsmokers’ assessments of pregnant women who smoke, regardless of class position or racial/ethnic identity, focus on the idea that every woman should assume responsibility for the health of her baby-to-be. Two main reasons are offered to explain pregnant women’s smoking: that they do not care about their babies-to-be or that, despite their caring, they are powerless nicotine addicts. Joselyn Behm, a suburban Euro-American woman in her early thirties, told me that she fairly often sees pregnant women smoking, “especially—I don’t want to make it sound bad, but—at country fairs and things like that, where there’s a whole different social-economic group.” When I asked why she thinks that these women are smokers, she stated, “Well, I assume they just can’t quit. Either they’re addicted to it or they aren’t concerned. I assume they are aware it isn’t good.” Speaking about a friend who smoked when pregnant, Martha Voss, another Euro-American middle-class nonsmoker, identifies the problem as a habit and a lack of self-sacrifice: “It's
such a strong thing in her life, and just a habit she won't give up. I mean for nobody will she give it up. . . . I just, I don't know what she was thinking, but you'd think she would know better. Thank God her babies turned out fine—I mean they really didn't have any problems. But I still worry about it because she smokes in the house and has three kids, and putting them through that, it's just sorta a terrible, selfish kind of thing, you know."

The two main assumptions about the reasons pregnant women do not quit smoking—a selfish, uncaring attitude and an addiction or habit—do not leave room for women's conscious, reasoned resistance to antismoking messages. Smoking during pregnancy is represented as either a bad choice or not a choice at all; however, some pregnant women who smoke reject antismoking advice on the grounds that health warnings are too extreme and not fully justified. Smoking, they argue, does not always cause fetal or infant health problems. While health educators want women to take action to prevent babies-to-be from being harmed by smoking, some smokers optimistically focus on a positive outcome: that the baby-to-be could be healthy. The statement "my mother/friend/relative never quit smoking, and all her babies were big and healthy" challenges health professionals' authority. Nearly every health educator I interviewed stated that this argument was the most difficult "smoker's excuse" to which they had to respond because, indeed, scientific evidence shows that smoking during pregnancy does not always impair fetal health.

In the face of such opposition to their warnings, health educators often resort to telling women that it is irresponsible to "take a chance." In doing so, they mobilize a moral discourse in which pregnant women ought to follow strict antismoking recommendations even if experience indicates that it is unnecessary. From an antismoking perspective, all women who smoke are irrational risk takers. A second rebuttal used by health educators, and repeated to me by a number of everyday women, is that new medical evidence about the risks of smoking simply confers more stringent responsibilities on pregnant women.16 Meredith Rodgers, a nurse-midwife, believes that it is irresponsible to assess the risks of smoking on the basis of past experience instead of on current scientific medical knowledge: "Then there's the old argument that 'My mother smoked when she was pregnant, and it made no

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16 Given the high visibility of antitobacco advocates' attacks on the tobacco industry for luring smokers through slick advertising campaigns, it is notable that health advice targeting pregnant women does not place greater stress on urging women to fight the tobacco industry by not consuming cigarettes. In part, I believe this reflects that "stop smoking during pregnancy" campaigns continue to rely on the behavior modification model of health education despite the public health paradigm shift away from attempting to change individuals' use of cigarettes and toward trying to regulate tobacco marketing and distribution (see Oaks, in press).
difference. . . . Saying that makes it very much a question of 'If she could
get away with it, so can I,' rather than what we know now.' At the most
resistant extreme, reported to me by smokers and health professionals
alike, some women, in an attempt to evade antismoking advice or judg-
ment, lie to their health-care providers about whether they smoke.

In my interviews, a few smokers' reactions to health warnings and poli-
cies focused on the social meaning of attacks on smoking. In the 1980s,
scientific studies citing the dangers of secondhand smoke undermined the
argument that a smoker harms only herself or himself when smoking. This
finding advanced the antismoking movement's goal of making cigarette
use socially unacceptable (see Nathanson 1999). Smokers are increasingly
socially marginalized, perhaps best symbolized in the physical separation
of smokers from nonsmokers in "smoke-free" public spaces. But not every-
one—particularly smokers—agrees with the sentiment behind these regu-
lations. Defining cigarette smoking as a social threat erodes respect for each
smoker's choice to use cigarettes. Indeed, some see health-promotion mes-
sages and policies as ways for the more powerful to morally judge and
dictate the everyday behavior of others (see Balshem 1993). In opposition
to Maryland's "smoke-free" public spaces policy, one low-income Euro-
American woman I interviewed, who is a smoker and smoked during preg-
nancy, commented, "What're they gonna do next? Tell ya 'you can sit in
that chair, but not that one'?

The interviews I conducted suggest that antismoking actions are most
strongly resented by smokers who deal closely with state authorities, such
as those who receive government financial assistance and state-funded
health care and those who have had disputes with public school adminis-
trators, child protective service agents, and police officers regarding paren-
tal methods of child discipline. Antismoking attitudes and policies can be
perceived as an extension of social and legal control over private actions.
Tobacco companies and their "grassroots organizations" adopt and fuel
this critique in media campaigns designed to incite "the public" to protect
"smokers' rights" and freedom in America.17

But health professionals contend that smoking is a public health problem
and therefore should be restricted. Further, smoking during pregnancy, for

17 The National Smokers Alliance, which claims to represent "America's 50 Million Adult
Smokers," is "dedicated to protecting individual freedoms" (http://www.speakup.org), and
FORCES (Fight Ordinances and Restrictions to Control and Eliminate Smoking) declares,
"Better America Free than America Smoke-Free!" (http://forces.com). The smokers' rights
message does not, however, extend to underage smokers. That tobacco companies must spon-
sor antismoking advertising aimed at youths is a provision of the 1998 multistate settlement
between forty-six state attorneys general and the tobacco industry.
some, is not simply an issue of “individual freedom and choice,” as suggested by smokers’ rights advocates, because pregnant women represent more than one “individual” and hold responsibility for the health of future generations. Pregnant women’s smoking is, then, a “problem” with negative consequences for fetal health and for the health of society. A number of antismoking campaigns emphasize these messages by drawing on dominant, “traditional” (white, middle-class) ideas about motherhood and by relying on fetal images to persuade women to protect their babies-to-be.

**Smoking during pregnancy as a threat to fetal life:**

**Visual appeals to emotion**

While antismoking materials aimed at pregnant women do not all use the same methods to persuade women to stop smoking, fetal health is routinely presented as the ultimate reason women should quit. Public health professionals use professional jargon to refer to programs that promote health behavior change as “interventions.” Through smoking cessation campaigns, health educators attempt to intervene in the relationship between the pregnant woman and her fetus on behalf of the fetus’s health.

The “don’t smoke when you’re pregnant” message must be read within a cultural-political context in which the threat of so-called maternal-fetal conflict is a public concern. Most health education campaigns are designed with the sincere intent to help women and babies. However, the ways women are directed to quit smoking expose the micropower of health policy and education and reveal moral discourses that label mothers “good” and “bad” in health campaigns. Antismoking and antiabortion campaigns draw on the concepts of rights, health, and maternal nurturance to produce the powerful message that fetuses are unique individuals who have rights to life and health and that pregnant women are morally responsible for making “healthy choices” and must devote themselves to responding to the needs of their babies-to-be.

The use of fetal images in prenatal health and antiabortion campaigns supports specific expectations about women’s pregnancy practices and their perceptions of fetal life. Despite their differences, both campaigns rely on a combination of scientific and emotional arguments to demonstrate that fetuses are unique individuals who should have their rights to life and health protected. Ultrasound imaging, “lifelike” models, and photography are employed to depict the “biological realities” of fetal life, and drawings, cartoons, and narrative descriptions are presented to associate fetuses emotionally with infants. These strategies promote specific ways of seeing fetuses and of defining how pregnant women should feel about and act to-
ward them. As I suggest later in this article, feminists can and should move beyond such limited views of fetal life to offer greater recognition of women's diverse ways of understanding and caring for their babies-to-be.

The ability of health educators to capitalize on the antiabortion ideology of fetal personhood and to invoke fetal images as emotional symbols increases the power of warnings against smoking during pregnancy. Drawing on emotional rather than scientific appeals, pregnant women are often urged by health educators to visualize their babies-to-be, no matter what developmental stage, as miniature infants. One pregnancy book, for example, engages women in a mental dialogue: "Would you blow a puff of smoke directly into your child's face? Would you deliberately surround your baby with carbon monoxide or cut off your child's oxygen supply? Of course you wouldn't. But every time you smoke . . . you could be exposing your fetus . . . to danger" (Herman and Perry 1997, 48). This warning offers strong social and moral messages but provides scant health information. Blowing smoke in anyone's face is a sign of disrespect and aggression, and exposing a baby to carbon monoxide or cutting off its oxygen supply suggests an intent to kill. Thus, the author asks the pregnant reader whether she intends to be a "bad" or even murderous mother. If not, she must quit smoking.

Other antismoking advocates use upbeat language and imagery, but the argument remains fundamentally the same: the fetus is an individual person in need of protection from its mother. An American Lung Association (ALA) antismoking pamphlet presents fetal life as a "struggle" that requires a pregnant woman's assistance: "Your baby-to-be, snuggled inside your womb, is silently engaged in a wonder-filled adventure: the struggle toward life. Your unborn baby needs all the help it can get in that struggle. Especially from you" (1980). The ALA further suggests, "When you quit smoking this minute, you'll be giving your unborn baby the smoke-free environment both of you need to be healthy. It's more than a gift. It's a matter of life and breath." The assertion that a smoke-free womb is "more than a gift" indicates that not smoking is a moral responsibility (a woman's on behalf of her fetus) and that being born "smoke-free" is an entitlement, not simply a privilege.¹⁸

In other literature, the phrase smoke-filled womb, a play on smoke-filled room, is frequently used to conjure up the image of a baby trapped in a smoky environment. The popular What to Expect When You're Expecting intones, "In effect, when you smoke, your baby is confined in a smoke-filled

¹⁸See Layne 1999b for ethnographic approaches to the study of "the gift" and mothering.
womb. His heartbeat speeds, he coughs and sputters, and worst of all, due to insufficient oxygen, he can’t grow and thrive as he should” (Eisenberg, Murkhoff, and Hathaway 1991, 56). This description works from the specific (what happens when a pregnant woman smokes) to the general (the risk of low birth weight). The scientific content of the warning—that lack of oxygen inhibits fetal growth—is overshadowed by the emotional image. The reader is invited to imagine an infant’s reactions to being imprisoned in a smoky place and to envision the uterus as actually polluted with cigarette smoke (which cannot physically happen). In fact, some health education tactics instruct women that this is what “really” happens when a pregnant woman smokes.

Warnings against smoking during pregnancy often personify fetuses by featuring illustrations of thinking and talking fetuses that look, unrealistically, like infants. This representation elides the differences between fetuses and infants, attributing feelings and thought processes to fetuses. One theme emphasizes how a fetus attempts to communicate with its “pregnant mother,” as seen in a series of cartoons in an American Cancer Society smoking cessation workbook that asks, “What Would Your Baby Say?” (1988, 5). One cartoon illustrates the warning “if you smoke, there is more of a chance that your baby will be born too soon” with a drawing of an in utero infant who “wants” to be born. A smiling, Euro-American woman holds a lit cigarette in one hand and her pregnant belly in the other. Her fetus screams, “Get me out of here, quick!” This cartoon portrays an adversarial relationship between the woman and fetus. While she experiences pleasure from smoking, she is oblivious to her fetus’s feelings and attempts to communicate with her. Not only does she engage in an unhealthy practice, she is self-absorbed and self-centered, qualities associated with neglectful mothering. The fetus’s demand is the result of both the “womb pollution” caused by smoking and a lack of emotional care.

The health education strategy of explaining to women what their babies-to-be are thinking, feeling, and even saying is jarringly similar to that advanced by antiabortion activists. Ellen Curro, a “pro-life crisis pregnancy counselor,” writes about trying to dissuade a woman from having an abortion: “Even though I’m sitting listening and talking to this woman, it’s as if I can ‘see’ the tiny baby inside her! The baby is facing me with a smile on its face, waving its arms as if cheering me on. The little one is saying to me, ‘Keep talking to Mom, don’t give up!’” (Curro 1990, 18). Curro sees her job as some health educators see theirs: to inform the pregnant woman that she is ignoring her baby’s attempt to communicate its

19 The fetus is coded predominantly as male in prenatal health materials.
needs. Similar advocacy on behalf of the fetus is demonstrated in a prenatal health pamphlet that instructs pregnant women to listen to an imaginary antismoking message from their babies-to-be: "Mommy, please don't smoke!" That's what your unborn baby would say, if he or she could talk" (Pennsylvania Department of Health 1994, 2).

While antiabortion activists attempt to convince women to continue their pregnancies on behalf of their fetus's life, antismoking advocates work to persuade women to quit smoking on behalf of their fetus's life and health. Women who do not follow these admonitions are subject to moral judgment and are explicitly or implicitly labeled self-centered, uncaring, "bad" mothers. From a feminist perspective, the similar judgments of anti-abortion and antismoking advocates raise the question of whether there are positive ways to recognize the concerns that pregnant women have for their fetus's health even when they do not (or cannot) follow all health directives. I return to this issue in my conclusion.

In many antismoking campaigns, quitting smoking is a symbol of maternal love. The moral message of the health slogan publicized by the ALA between 1983 and 1988, "Because You Love Your Baby . . . There's Never Been a Better Time to Quit," implies that women who do not quit smoking do not love their babies-to-be and that only nonsmokers are loving mothers. In 1986, the ALA launched a new campaign but retained the earlier fetal-centered theme: "I Quit Smoking . . . because I Love My Baby." The ALA urges women to use concern for their babies' health as justification for quitting and offers this slogan (on stickers and stand-up cards to replace ashtrays) as a way for women to announce that they have adopted proper mothering practices. In effect, the former smoker mimics the health professionals' message, renounces her former "bad mother" identity, and declares she has reformed to follow the medical and moral imperative to guard fetal health because that is what a "good mother" does. These and other antismoking materials construct and support an ideal type of mother, one who is self-sacrificing, nurturing, and compliant with medical advice about how to care for the baby-to-be.

By contrast, fathers-to-be who smoke are not always perceived as "bad fathers." Some health professionals' messages about men's smoking and fetal health are far less strict or didactic than those directed at pregnant women. For example, in an advice column in American Baby magazine, advice-giver Ellen Sue Stern expresses great sympathy for a father-to-be who smokes:

Q: My baby is due in three weeks, and my husband and I have one big problem we can't seem to resolve. He's a smoker, and I
desperately want him to quit before the baby’s born. After all I’ve read about second-hand smoke, it seems like a reasonable request. Am I wrong?

A: This isn’t a matter of right and wrong. But, hard as it is to fathom, it isn’t a choice either. Your husband is addicted to cigarettes—and it’s one of the toughest of all addictions to break. You might believe that if he cared enough about becoming a father and about you and your baby’s health, he would quit (Stern 1995, 16).

The reasoning offered here, that smoking due to addiction is neither right nor wrong, is not extended to pregnant women. Women’s smoking during pregnancy, for any reason, is considered wrong and, by some, even a form of child abuse. Stern’s answer continues, “Smokers smoke as a way to relieve stress, and becoming a father rates high on the stress scale. In other words his smoking is not a reflection of his commitment to you or the baby” (16; emphasis added). The assumptions that mothers should do everything they can to influence fetal health positively and that their health practices symbolize their commitment to and love for the baby-to-be do not also apply to men. The implication is that men’s reproductive nature allows them to be less accountable for fetal health.20

Relying on conventional addiction recovery discourse, Stern tells the reader that she must express her desire “gently and compassionately” and then wait for her husband to want to quit: “Let him know that he has your complete support if and when he’s ready” (1995, 16). Stern undercuts the “stop smoking” strategies relied on by health educators when she contends that criticism, scare tactics, or ALA pamphlets will not lead a father-to-be to give up smoking. Ironically, many of these strategies have been and still are used to encourage pregnant women to quit. Finally, Stern tells the concerned woman that she is powerless over her husband’s behavior and advises her, “Remember, he’s a good person with a bad habit that need not poison your joy and excitement about the new family you’re about to be-

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20 My research supports Cynthia Daniels’s observations that media coverage of men’s reproductive health studies does not represent men as fully responsible for fetal harm, is couched in language that highlights the uncertainties and limits of scientific knowledge, and avoids stigmatizing male behaviors (1997, 601-5). In contrast, the popular media often represent scientific evidence about women’s reproductive health as factual and certain, thereby easily pinpointing mothers as fully to blame for fetal health. Given that research on—and theories of—men’s reproductive health corresponds with cultural notions about women’s and men’s reproductive responsibilities and roles, broader social changes must accompany new medical knowledge before the emphasis on the causes of smoking-related fetal health defects is shifted from solely the biological mother to both biological parents or to those who smoke near a pregnant woman.
come" (16). This advice provides instructions about not only health but also gender and marital roles. The pregnant woman is instructed to be a compassionate empathizer, gentle supporter, and patient and non-demanding wife.

There are, however, multiple discourses about the responsibilities of fathers-to-be for fetal health, and not all antismoking campaigns treat fathers-to-be sympathetically. Roddey Reid's analysis of the California Department of Health Services-sponsored television ads in the 1990s against secondhand smoke demonstrates that male smokers of varied racial/ethnic groups and class status are represented as callously threatening the health and lives of their family members (Reid 1997). Men are portrayed as aggressors, and women, children, and fetuses as victims. One ad features an Asian-American husband who smokes at the kitchen table as his pregnant wife sets it. To illustrate how she is affected by his smoke, she coughs violently and smoke pours from her mouth and nose. In Reid's analysis, this ad also holds the pregnant woman accountable for endangering their baby-to-be: she acts irresponsibly by failing to avoid her husband's smoke and is too subservient to her husband. She neither instructs her husband to smoke elsewhere nor leaves the room; thus, "she puts her husband's pleasure and comfort before her health and that of her fetus" (Reid 1997, 561).

A significant difference between the two depictions of these husbands and wives—the couple in the parenting magazine and the other in the television ad—lies in the representation of the "health consciousness" of each person. The husband described in the advice column apparently rejects warnings about the risks of secondhand smoke, while the husband

21 Several studies have explored the effect that husbands' smoking has on fetal health as a result of their pregnant wives' exposure to secondhand smoke, but researchers have not reached uniform conclusions (see Chen and Petitti 1995; Eskenazi, Prehn, and Christianson 1995; Sadler et al. 1999). Scientific research also remains inconclusive on the effects of men's smoking on fetal health or on men's reproductive health, such as decreased sperm quality, impaired sperm motility, and impotence (see U.S. DHHS 1990, 404–9; Vine 1996).

22 Whereas the East Coast and national antismoking materials I gathered portray mainly Euro-Americans, African Americans, and Latinos/Chicanos, the California campaign is remarkably more multicultural in scope. Slogans were publicized in six languages (English, Spanish, Mandarin, Cantonese, Vietnamese, and Korean), and African-American, Asian-American, and Chicano/Latino audiences were specifically targeted. Reid suggests that this campaign reflects California's demographics, its racial/ethnic and immigrant politics, and a symbolic "othering of people of color as unhealthy" (1997, 551).

23 Reid analyzes the racist theme reproduced in this portrayal of Asian Americans: the husband represents the domineering patriarch, while the wife is the overly submissive, "non-modern" woman (1997, 561).
portrayed in the TV ad either does not know he should not smoke around his pregnant wife or chooses to disregard this health advice. The woman who wrote to the magazine was aware that she should avoid being around her husband when he smoked; the Asian-American woman appears oblivious to this idea, or she is culturally trapped and helpless. The bottom line is the same in both cases: husbands should “help” their wives protect their fetuses by not smoking, but, ultimately, women must reduce fetal health risks by avoiding their husbands’ smoke. Even though there are dramatic contrasts between the two messages, similar disciplinary (in a Foucauldian sense) discourses are at work, reinscribing and producing gendered expectations of mothers- and fathers-to-be, wherein women must assume primary practical, emotional, and moral responsibility for fetal care.

Demonstrating the need for fetal protection:
Visual appeals to scientific authority
In addition to cartoonlike drawings and narrative descriptions, real-time fetal images and “lifelike” fetal models are used in antismoking campaigns. Visual access to fetal life through obstetric imaging technologies has been crucial to social and medical definitions of the fetus as a patient and a person.24 Antismoking educators support their claims about the effects of smoking on fetal life through scientific displays, drawing on the cultural association of science and medicine with “truth” or “reality” and the construction of the fetus as a vulnerable individual. These representations also parallel antiabortion depictions of fetuses as seen in the video The Silent Scream, Lennart Nilsson’s photographs, fetal models, and preserved fetuses.25

A 1977 film sponsored by the American Cancer Society (ACS) uses fetal sonogram images to reinforce the message that pregnant women who smoke endanger fetal health.26 The title of the film, The Feminine Mistake, is an obvious play on Betty Friedan’s title The Feminine Mystique (1963).


25 The introduction of fetal images to the U.S. public is often traced to a 1965 Life magazine cover story, the “Drama of Life before Birth,” which carried a series of photographs of developing fetuses taken by Lennart Nilsson. These and later photos by Nilsson have been publicized by the antiabortion movement in its literature, posters, and educational materials since the 1970s (see Franklin 1991, 195–96; Stabile 1994, 74–83; Newman 1996, 10–18; Rapp 1997). For analyses of The Silent Scream, the video—produced by the National Right-to-Life Committee and aired on network television—that claims to show an abortion in progress, see Petchesky 1987; Hartouni 1992.

26 I have chosen to analyze the films of the ACS because it is a national organization with a highly visible, reputable, and authoritative stature.
While the book describes how middle-class, college-educated, suburban mothers who identified as housewives were dissatisfied with their everyday lives and with their position in society, the film suggests that women have adopted the dangerous “male” practice of smoking in an attempt to be equal with men. Sitcom actress Bonnie Franklin, who hosts the film, announces, “The social equality women are achieving extends, it seems, all the way to self-destruction.” In the film’s conclusion, Franklin returns to this theme to inform women that if they quit, they will “feel more independent” and “in control” of their lives. Indeed, the film both critiques and appropriates ideas about “women’s liberation.” It warns women against “false equality,” attempts to raise women’s consciousness about how cigarettes oppress them, and urges women’s “independence” from smoking. By framing women’s smoking this way, the ACS works to reverse a set of cultural symbols attached to women’s smoking since the 1920s, when legal and social prohibitions against women’s cigarette smoking in public began to erode and some women’s rights advocates and cigarette advertisers considered women’s cigarette use to be a positive symbol of their new social status (Brandt 1996). Decades later, in 1968, Philip Morris’s Virginia Slims slogan, “You’ve Come a Long Way, Baby!” linked smoking with social advances brought by the women’s liberation movement (see O’Keefe and Pollay 1996).

The ACS’s message is that not only is smoking self-destructive, it is also harmful to “unborn children” and infants. One segment of the ACS film is devoted specifically to smoking during pregnancy and begins with the image of a woman, presumably a new mother, pushing a baby carriage down a busy city sidewalk. As the mother lights a cigarette, Franklin intones, “One of the least publicized, but most insidious effects of cigarette smoke is upon the unborn child of a pregnant woman.” The only health statistic cited warns of a 30–60 percent increased risk of fetal and newborn

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27 Sex-specific regulations were not passed at the national level, but by 1921 statutes against tobacco manufacturers or smokers were established in twenty-eight states (Goodman 1993, 119). These laws were aimed mainly at minors but also included local ordinances limiting women’s smoking in public. In the 1920s, cigarette smoking was perceived by some as “a symbol of new roles and expectations of women’s behavior” that were ushered in with women’s suffrage and provided a public forum for contests over changing gender ideologies (Brandt 1996, 64). Helen Lowry, writing in the New York Times in 1921, attacked a congressional bill that stipulated stiff fines against “female persons” witnessed smoking in public in Washington, D.C. She charged that male policy makers were unfairly attempting to impose different social standards on women and men and contended that the bill represented “the outworn fallacy that woman is a ward of the State and not a citizen” (2).

28 The effect of the woman smoking near her infant is not a concern because the film predates the publicity surrounding early research findings on secondhand and environmental tobacco smoke.
death, and the remainder of the segment illustrates this risk through use of ultrasound technology. The central health education message is that the “unborn child” is “affected by each and every cigarette.”

The scene cuts from the city street to a hospital, and the film introduces Dr. Frank Manning, who wears a white lab coat (and who had published research on smoking and fetal activity just before the film was made [Manning and Feyerabend 1976]). The camera focuses on an ultrasound monitor displaying vigorous pulses on the screen, which, the viewer is told, proves that the fetus is “breathing.” Manning explains that the fetus is “immersed in fluid but exercising the muscles it will depend on to survive.” A pregnant woman, identified as “Mrs. Delores Arrojo,” lies in a hospital bed with her shiny belly exposed, as a laboratory technician performs an ultrasound. The viewer is informed that she has smoked one pack of cigarettes a day throughout pregnancy. To demonstrate the effect of smoking on fetal movement, she smokes a cigarette. Manning then describes the change in the sonogram image after thirty minutes elapse: “No movements of the chest wall at all. This fetus is not breathing at all.” Manning addresses Arrojo: “We’ve seen before your baby was breathing about 60 percent of the time. Now we see not at all. How do you feel about that?” Her eyes widen, and she smiles slightly and opens her mouth to speak when a voice-over preempts her response to announce, “Delores Arrojo has stopped smoking.” The unanswered question, “How do you feel about that?” lingers, as if directed to the audience in order to elicit an emotional response. The viewer is left with the impression that the experience of seeing her baby-to-be and receiving health warnings persuaded Arrojo to quit. Her own reasons for quitting are silenced, and she is portrayed as a compliant, reformed mother-to-be.

The antismoking argument here relies on the power associated with medical authority and with the demonstration of scientific facts. The film attempts to establish as a “universal fact” that all fetuses will react to smoking in the way Delores Arrojo’s did. In medical-statistical language, Manning points out that the fetus had been “breathing” 60 percent of the time, but the viewer has nothing to measure this information against. Should fetuses, like infants, breathe 100 percent of the time?29 Manning explains that by “breathing” he means that a fetus is exercising the muscles that later will be used to breathe. But does a fetus take rests or stop “exercising” when sleeping? The scene strategically evades such questions, and the strength of the message relies on the (inaccurate) assumption that not “breathing” threatens a fetus’s life, just as it would an infant’s.

29 Oakley cites research that found fetal breathing movements a mean of 31 percent of the time in fetuses of women without known pregnancy complications (1984, 167).
This demonstration was evidently judged effective by the ACS; it was revised and included in a second version of the film produced twelve years later. The 1989 update, *The Feminine Mistake: The Next Generation*, extends the section on smoking and pregnancy (and is hosted by a different “TV mom,” Meredith Baxter Birney). The subject of smoking and pregnancy is first alluded to by a blond teenager who ruminates about how smoking might influence her life plans. She explains that she wants to have children one day but worries that “you can develop a really major addiction, like having three or four packs a day, and you become pregnant, and you’re gonna have a kid and its gonna affect your kids, and that’s really scary.” Smoking represents a dangerous threat to a “normal” woman’s life course and to the health of her future imagined fetuses and children. Expanding the addiction theme, the statement “cigarettes can be as addictive as cocaine,” from the 1988 Surgeon General’s annual report on smoking and health, is the lead-in to the revised ultrasound segment (see U.S. DHHS 1998). The film goes on to categorize pregnant women who smoke cigarettes as powerless addicts: “For people like Emma Parra, the craving is overwhelming even when another life is at stake.” But Emma Parra not only represents the addicted pregnant smoker. She also stands for the stereotypical less-educated Latina woman, as does Delores Arrojo in the first film. This characterization is misleading since Latina women have significantly lower rates of smoking than women of other racial/ethnic backgrounds. The films (like the California ad featuring an Asian-American couple) suggest that nonwhite women are more likely to resist Euro-American, middle-class health norms and that they therefore deserve strict surveillance. Thus, these antismoking messages underwrite the historical trend of disproportionate social and medical control over the reproductive experiences of low-income women and women of color.30

The ultrasound scene begins as Dr. Andrew Chow of the University of California, Los Angeles Medical Center identifies parts of Parra’s “baby,” six weeks from its due date, on a sonogram screen. Baxter narrates: “[Dr. Chow] provides Emma a glimpse of her unborn child and cautions her against the danger of smoking.” In contrast to the earlier film, the woman is in the foreground, and the doctor himself moves the transducer around her abdomen. While Delores Arrojo was passive and stared at the ceiling, Emma Parra holds herself up with one arm behind her head and watches the fetal image on the screen. However, the most striking difference is that while Arrojo’s reaction to the sonogram image was edited out of the film, the audience listens in as Parra, who speaks English with a Spanish accent, engages Chow in conversation: “I’m hooked on cigarettes. Does it go into

the baby like it [goes] into my lungs?” Chow’s reply, “Whatever enters your bloodstream does reach the baby to some degree,” does not truly answer her question, and he fails to elaborate on what health dangers face the fetus. Thus, little medical information is transmitted beyond the general idea that smoking is bad for the “baby.”

Suddenly, the scene changes from the medical setting to a park, and the camera zooms in on Parra, who rests her hand on her pregnant belly while holding a cigarette. She comments, “It's a nice feeling when your baby moves. You’ll feel it, but then I'll sit up there and I'll pick up a cigarette and then I won't feel it move for a while.” The scene immediately shifts back to the hospital, where Parra’s observations about her bodily sensations are demonstrated by the ultrasound. Chow now warns her about the fetal and infant risks of smoking, including low birth weight, impaired reading and writing abilities, and poorer “performance in social relationships.” Parra props herself up on her arms in the bed, nodding and biting her lip. She listens intently as the doctor delivers the most powerful message: “You're, in effect, with every cigarette you take, strangling and suffocating the baby for a little while.” Chow’s use of everyday language, “strangling and suffocating,” instead of scientific language, such as “causing reduced blood-oxygen flow,” more readily conjures the image of intentional murder. As in the earlier film, the woman does not describe her reactions on hearing this warning and seeing it demonstrated.

But the film cuts back to the outdoor shot of Parra’s hand on her belly, holding a cigarette. Outside the hospital and away from medical authority, she confesses that, even having seen the sonogram, she continues to smoke. The spatial proximity of her cigarette and her baby-to-be in this shot signals the constant peril of fetal strangulation and suffocation and suggests that she will smoke near her infant after it is born. In contrast to the 1977 film, in which Arrojo quits smoking, Parra stammers as she explains, “If anything ever happened to, my, my, my kid, I think I would really, really hate myself. But here I will not quit. ... And it’s a scary feeling wondering if this baby’s gonna be affected by it.” She admits that she is addicted to cigarettes and accepts the lack of control and guilt associated with being a pregnant smoker.

A later segment indicates that her problem is not addiction but “attitude.” A Euro-American health educator leading an ACS-sponsored “Fresh Start” smoking cessation class (which Parra does not attend) declares, “You can totally adjust your attitude. It's a total choice on your part. . . . [It's an] empowering feeling, not letting that little cigarette run your life.” For pregnant women, though, as argued in both ACS films, the “little fetus,” not the “little cigarette,” should run their lives. This argument implies that
the two compete for the woman's attention: if a woman smokes, her fetus loses.

In their sonogram demonstrations, the ACS films depict smoking during pregnancy as a serious threat to fetal health and exploit ultrasound technology to present this problem as a "scientific reality." Notably, while the ultrasound images construct the fetus as a patient and a person who needs protection, the blame for women's fetus-threatening smoking is placed differently in the two films. The 1977 version blames women, who willingly participate in "self-destruction," whereas the 1989 film points an accusing finger at the tobacco industry for "hooking" women on nicotine through slick advertising. Antitobacco advocate Virginia Ernster presents a critical analysis of cigarette ads to a high school audience in the 1989 film, stating, "I started getting really angry, not at women who smoke but at what it was that was inducing women to smoke." This redirection of blame follows a paradigm shift in the public health approach to cigarette use, from antismoking activism to antitobacco advocacy. In the new framework, the smoker is a victim of the tobacco industry's advertising and marketing and thus deserves help (such as smoking cessation counseling or nicotine replacement therapy).31 But in either approach, messages about smoking during pregnancy remain fetal-centered, and women are represented either as poor decision makers because they choose to smoke or as helpless addicts because they cannot quit.

The films also contain specific ideas about women's feelings toward their fetuses. The assumption behind the 1977 film is that if a woman sees her fetus stop "breathing" when she smokes, she will quit. This logic parallels that of antiabortion activists who argue that "if there were a window on a pregnant woman's stomach, there would be no more abortions" (quoted in Ginsburg 1989, 104) and that of some health professionals who show sonogram images to women to dissuade them from having abortions (Rapp 1990, 35; 1997, 47). Such visual tactics not only invoke assumptions about how women "bond" with the baby-to-be but also point to how publicized visualization of fetal life can incite public protection of all "unborn babies." The 1989 film, however, confounds the bonding hypothesis because it portrays a woman who is worried about her baby's health but does not quit smoking. While some viewers may be sympathetic to her plight, others likely are motivated by the idea that something must be done to stop nicotine addicts from smoking when pregnant (or, perhaps even

31 Pregnancy is not listed by the Food and Drug Administration as a contraindication for nicotine replacement therapy, but there are no guidelines for evaluating the risks and benefits to the fetus of pregnant women's use of nicotine replacement therapy (see Zapka et al. 2000).
to stop them from becoming pregnant). In contrast to the 1977 film, in which the pregnant smoker complies with medical advice, the 1989 version portrays a noncompliant patient, thus inviting the audience to conclude that medical advice alone is not sufficient and that smoking during pregnancy is a social problem that everyone should do something about. In essence, this logic gives viewers license to intervene on behalf of the fetus. In fact, many of the women I talked to had been told by family, friends, coworkers, and even strangers to quit smoking when they were pregnant. Anastasia Powers, a twenty-year-old Euro-American who receives government assistance, reported, “At the mall once, a woman said, ‘You shouldn’t smoke, it’ll harm the baby.’ I say, ‘God created it [cigarette smoking], so it can’t hurt.’ People shouldn’t be ignorant with me.” Leslie Hollins, a Euro-American executive assistant and writer, painfully recalled that when she was pregnant in the early 1980s, “all the men I worked with would yell at me” for smoking because it was bad for the baby. Once she even burst into tears and left the office. At this point in the interview, Leslie leaned into the table, clearly still angry about the incident: “It was none of their damn business!” Her feelings directly contradict the films’ message that smoking during pregnancy is everyone’s business.

Although the modified and expanded version of the ACS’s film is more than ten years old, some health educators still find it a powerful educational tool. Maria Baker shows *The Feminine Mistake* in the smoking cessation classes she runs and feels that the scene with the fetal monitor and the ultrasound that shows how “the baby stops moving” is effective “even with low-education audiences.” This comment reveals that smokers who have “low education” or lower-class status are considered by public-health professionals to be particularly resistant to antismoking messages. The strength of the film is that the audience, in Baker’s words, “gets to see reality.” But while the ACS films back their antismoking position with scientific evidence that smoking influences fetal activity, there is little evidence that women will react to this information by quitting smoking. Two recent clinical studies have tested the effectiveness of presenting a personalized fetal ultrasound image to pregnant smokers in order to reduce their smoking (Newnham et al. 1993; LeFevre, Evans, and Ewigman 1995). The first concluded that there was no decrease in smoking by women who underwent ultrasounds, while the second found not only that women in intervention groups did not decrease smoking more than women in the control group, but that they in fact smoked a higher mean number of cigarettes

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32 I did not specifically ask the everyday women I interviewed whether they had seen the ACS films, and none mentioned a film as a source of health information.
per day. The authors of these studies offer no insight into why these experiments did not lead women to “bond” with the fetus in a way that would result in quitting or reducing smoking.

The absence of the association between seeing a fetal sonogram and adopting “protective” health practices points to the diversity of ways women experience and think about pregnancy. Despite social and medical constructions of the fetus as a person and a patient, women’s practices during pregnancy are not solely fetus-centered. Emma Parra’s statements stress that she does indeed worry about her “baby’s” health, but other reasons cause her to continue smoking. Contradicting the presumption made by some health professionals, a pregnant woman can both disregard medical recommendations and care about her baby-to-be. The simplistic formulations about smokers’ feelings that are carried in antismoking materials do not consider the complexities of women’s experiences.

While the ultrasound demonstrations described above rely on real-time fetal imagery, other health education tools feature “lifelike” fetuses. Health educators and antiabortion activists present fetal models to mobilize the authority of science and to advance their cause. An ACS public service announcement and two health education models marketed by Health Edco represent fetuses in ways that are nearly indistinguishable from the fetal images used by antiabortion advocates. The “scientific,” “factual” aspect of these images is complemented by an emotional and moral component that invokes the argument that fetuses are unique individuals who should have their rights to life and health protected.

In 1985, the ACS sponsored a thirty-second television public service announcement that stunningly, and intentionally, exploits the fetal image produced by antiabortion advocates that some feminist scholars refer to as the “astronaut floating in space” (Oakley 1984, 174–75; Rothman 1986, 114). The spot opens with a close-up of the forehead of a baby-like fetus (actually a puppet moved by invisible strings). A calm, warm ambience is created as the fetus is bathed in yellow light against a black background and soothing synthesizer music plays. The sound of a heartbeat joins the music as the head of the fetus floats into the picture from the left side of the screen. It sucks its thumb. The camera pans back to show the whole body of the fetus, now in a sitting position, grasping a cigarette in its fist. It takes its thumb out of its mouth and slowly raises the cigarette as a woman’s voice-over asks, “Would you give a cigarette to your unborn child?” As she speaks, the cigarette reaches the fetus’s mouth: “You do, every time you smoke while you’re pregnant. Pregnant mothers, please, don’t smoke.” The camera retreats, and the fetus sits in a transparent bubble, an umbilical cord resting neatly at its feet. It exhales a stream of smoke
The ACS’s use of this fetal imagery sparked controversy. Two major television networks, CBS and NBC, rejected it because it might “offend viewers” (Broadcasting Magazine 1985, 190). Antismoking advocate Bobbie Jacobson noted that the antiabortion lobby “loved” the spot, while women’s movement activists were “outraged” because it seemed to be part of an “anti-abortionist conspiracy” (Jacobson 1986, 125). Jacobson criticizes the ACS, charging, “It is hard to see how such a deliberately emotion-ridden and uninformative manoeuvre could have achieved anything other than alienating the women it sought to influence” (1986, 125). I argue, however, that the ACS’s target population was not solely pregnant mothers but the public in general. All viewers are implicitly urged to increase social pressure on pregnant women not to smoke. The ACS’s vice president for public affairs claimed that the announcement did not indicate an antiabortion position on the part of the ACS but was strictly “opportunistic advertising” (Jacobson 1986, 125). However, the ACS’s fetal-centric themes certainly supported antiabortion ideologies. William Cahan, a surgeon who worked with the ACS throughout the 1980s by giving lectures and television and radio interviews, wrote that his “Abusing Children by Smoking” op-ed piece in the New York Times in March 1985 “served as a complement to [the] dramatic TV spot” (Cahan 1992, 336). The spot, Cahan’s piece, and other ACS materials all play on antiabortion and child abuse prevention discourses in the service of the “stop smoking during pregnancy” imperative. For example, a 1986 ACS poster (one I saw displayed on the wall of a state prenatal clinic waiting room ten years after its production) shows the shadowy profile of a woman’s midsection; one raised hand holds a cigarette, and the other covers her very pregnant belly. The message reads, “Some people commit child abuse before the child is even born. According to the Surgeon General, smoking by a pregnant woman may result in a child’s premature birth, low birthweight, and fetal injury. If that’s not child abuse, then what is?”
In equating fetus with child, this message shares the logic that underlies the antiabortion slogan "Abortion: The Ultimate Child Abuse." The poster reproduces the health warning that is printed on cigarette packs and ads and plays on the phrase "fetal injury" to introduce the concept of prenatal child abuse. Providing women with health education alone is apparently deemed ineffective; the warning label is transformed into a moral statement about the (anti)social meaning of smoking during pregnancy. The connection that the ACS and others make between smoking and child abuse also implicitly condones legal prosecution of women who smoke when pregnant. Laws mandate that action must be taken against those who abuse children; therefore, if pregnant women "abuse" their fetuses by smoking, intervention is called for. Public health and antiabortion discourses are launched out of concern for fetal life, with the intent of changing not only women's actions during pregnancy but also the ways they think about and experience their "maternal" responsibilities. That these discourses are so easily transformed into a child abuse prevention discourse reveals the extent to which the distinction between the fetal person and the infant or child has been erased.

While the ACS's smoking fetus spot and references to smoking as child abuse represent the most explicit and conscious instances of the exploitation of antiabortion fetal imagery, another health education tactic is remarkably similar to that employed by antiabortion activists: the production of fetal models for health educators to use in their smoking cessation and prevention classes. One model invokes the image of antiabortion activists carrying preserved fetuses in jars to clinic demonstrations to show that fetuses are "preborn children." The "Smokey Sue Smokes for Two" doll is featured in a health education catalog with other models under the headline "Aversion Therapy Works! Nothing Is as Gross as the Deadly

33 The calming effect that some women experience from smoking a cigarette complicates the claim that smoking is fetal or child abuse. Women may defuse tense situations—often associated with the burden of caring for others with limited material resources—by smoking, thus preventing themselves from becoming angry or abusive. A woman interviewed as part of a British study on low-income women smokers reported that she most wants to smoke "when I'm tired and worn out or when the children get a bit stroppy. When I'm violently mad and about to throttle them" (quoted in Graham 1993, 86). Of course, women who use smoking to dispel anger could turn to other outlets. My point is that the possible positive aspects of women's smoking should not be totally ignored in the rush to stigmatize smoking as indicative of poor mothering.

34 This use of models showing fetal development is remarkable given that they were first used in medical settings to demonstrate "scientific facts" and later appropriated by antiabortion lobbyists to advance their political claims (see Newman 1996).
Effects of a Cigarette” (Health Edco 1996, 4). Smokey Sue is a Raggedy Ann–or Orphan Annie–looking doll that “smokes” cigarettes (fig. 1). From the neck down, her body is a clear plastic jug with liquid and a model fetus. The sales pitch explains, “This graphic demonstration should be seen by all women of childbearing age. As Sue smokes, tars and nicotine pass through the water around the life-like model of a seven-month fetus, mimicking the placenta. Collecting along the surface and in the darkened water, the tars and nicotine graphically show the pollutants reaching the developing baby” (Health Edco 1996, 4). The assumption backing this health education strategy is that women will associate the “lifelike” fetus floating in brown, polluted “amniotic fluid” with what happens when they smoke and then decide to quit smoking. The doll’s educational power lies in this imaginative leap. Smokey Sue may succeed in shocking smokers, but it does not impart biologically accurate information.

Health Edco offered a new antismoking model, the “Itty Bitty Smoker,” in 1997. The model was so popular that my purchase request was back ordered. The fetal model is the size of an adult thumb and is made of pale-colored “BIOLIKE synthetic tissue.” Not endearing but ugly, its arms and legs are wrapped around its body in a protective pose, and it has a scowling facial expression. What sets it apart from other fetal models is the itty-bitty (but not realistic) plastic cigarette stuck in its mouth. The promotional catalog text reads, “Show who really winds up puffing on the 4,000-plus toxins in tobacco smoke. The model of a 10-week-old fetus, made of soft, realistic BIOLIKE, is a hard-hitting reminder that pregnant mothers have special responsibilities. Hand them out as a pregnancy health promotion, at health fairs, in smoking cessation classes—anywhere you need to get your health message across” (Health Edco 1997, 10). Like the ACS public service announcement and Smokey Sue, the smoking fetus model provides women with a tangible visual image that symbolizes the effect of smoking during pregnancy and pregnant mothers’ “special responsibilities.” This model can even be kept in a pocket, perhaps in place of cigarettes!

An instruction card carries the Itty Bitty Smoker’s purpose statement: “To demonstrate the fact that when a pregnant mother lights up, her baby also smokes. The harmful pollutants of cigarette smoke are absorbed by the infant.” The card explains how to care diligently for the fetal model: “It can be damaged like real tissue. To ensure maximum life for the model, observe the following instructions carefully: 1. Wash gently with soap and

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35 I was made aware of Smokey Sue by Erma Jean Lawson’s dissertation (1990), which describes using the model in an antismoking intervention with low-income pregnant teens (see also Lawson 1994).
Figure 1  Smokey Sue Smokes for Two®. Reprinted with permission of Health Edco.
water; pat dry. 2. Treat as sensitively as human flesh . . . [and] keep model in bag when not in use." The Itty Bitty Smoker combines an appeal to scientific reality by emphasizing its "lifelike flesh" with an appeal to emotion based on the shock value of imagining a fetus with a cigarette in its mouth. Further, antiabortion discourse (whether intentional or not) is mimicked: the fetus is referred to as a baby and an infant, and correct care extends the fetal model's "life." In fact, the Itty Bitty Smoker is much like fetal models marketed and distributed by antiabortion activists, such as Baby Hope, Young One, and Precious Preborn.36

By pointing out the parallels between health educators’ and antiabortion advocates’ use of fetal images and models, I do not mean to imply a conscious collusion of political efforts. But given the current cultural-political status accorded to fetuses, largely the result of the antiabortion movement’s publicization of fetal images, health education models cannot stand outside antiabortion discourses on fetal life and gender roles.37 The health education tactic of combining emotional and scientific appeals to persuade pregnant women to stop smoking draws on the antiabortion construction of the fetus as a vulnerable, baby-like individual. Further, the emphasis in antismoking messages on "good" mothers as self-sacrificing, nurturing, and caring relies on the traditional American ideology of maternal nature that is supported by antiabortion advocates (see Luker 1984; Petchesky 1984; Ginsburg 1989). Within this framework, pregnancy confers motherhood and naturally carries the responsibility to protect and to love one's baby-to-be unconditionally.

Quitting, antismoking messages announce, is a necessary part of fulfilling the role of the "good" mother. This prescription holds across racial/ethnic and class categories. Any pregnant woman, even one who, for example, attends prenatal health visits, "eats right," exercises moderately, and does not drink or take drugs, transgresses expectations about proper pregnancy behavior and is vulnerable to social reprimands if she smokes cigarettes. However, pregnant low-income women and women of color may

36 In her book on crisis pregnancy counseling, Ellen Curro tells of sitting next to a "proabortion" judge on an airplane: "[He] didn't figure out I was a pro-lifer until three-and-a-half hours into the discussion. That happened . . . when I reached into my purse for a tissue and accidentally pulled our 'Precious Preborn' (a model of a ten-to-twelve-week-old preborn child). Jack had seen those models in a courtroom, and his immediate association was 'crazy, radical pro-lifer'" (1990, 12).

37 Fetal models, however, may be used in ways that directly contradict antiabortion aims, such as to explain an abortion procedure to a woman before surgery, or in ways that cannot be interpreted as supporting antiabortion politics, such as to memorialize a miscarried fetus (see Layne 1990).
face harsher moral judgment from health professionals and others because they do not fully embody middle-class, Euro-American, and medicalized ideals of motherhood. Quitting smoking, then, is a necessary but not a sufficient step toward becoming a good mother-to-be. Antismoking campaigns represent just one strand of a larger web of discourses that shape medical, social, and political expectations and norms about women's reproductive practices.

**Creating feminist responses to the fetus-as-subject**

In this article, I have charted the ways antismoking and antiabortion visual and discursive tactics support mutually reinforcing messages about fetal personhood and women's reproductive responsibilities. My analysis of how antismoking and antiabortion campaigns direct us to see certain things in fetal images reveals how pervasive the idea of fetal abuse has become and calls for a bolder feminist engagement with fetal-centric arguments in the field of reproductive health care and, more generally, in popular culture. Feminist scholars and health advocates should continue to be critically attentive to what such fetal constructions say about pregnant women's agency and should also turn more attention to how greater recognition of alternative social constructions might undermine the fetus as a moral symbol (see Morgan and Michaels 1999).

Like other prenatal health issues, smoking during pregnancy raises complicated questions for feminist politics and health advocacy. Smoking is a health risk for pregnant women and their fetuses. But feminists' opposition to pregnant women's smoking entails political and social risks. Politically, how can a feminist argument support fetal health without giving power to antiabortion "fetal rights" ideology? Should pregnant women's choice to smoke be respected? Socially, can (and should) feminists hold an antismoking position without stigmatizing smokers as "bad mothers"? Closer scrutiny of feminists' understandings of fetal identity involves addressing these subjects.

Antismoking advocates have criticized both pro-choice and antiabortion organizations for not taking on smoking as an important political issue.38 One antitobacco activist and pro-choice supporter pointedly asks,

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38 Criticism of pro-choice advocates has been voiced by feminists (Jacobson 1981, 1986; Shear 1985; Lerner 1995, 1996), public health officials (Terry 1981), and doctors (Cromer 1983). The antiabortion movement's leadership has been denounced within and beyond the movement on the grounds that it is not committed to saving fetuses that might be spontaneously aborted or miscarried as a result of cigarette smoking (see Estrich 1996; Saletan 1996, 1997).
“Shouldn’t pro-choice people be concerned about the wanted babies that are being hurt by tobacco smoke? . . . This is a pro-choice and a pro-life issue” (Bill Godshall, quoted in Saletan 1996, 61). But there are serious problems with Godshall’s call for collaboration. One reason that feminist support for antismoking campaigns is problematic is that it contradicts the idea that women, as adult, rational actors, should have their “choice” to smoke respected. But even if those on opposing sides of the abortion issue came together to support antitobacco politics, their strategies to prevent smoking during pregnancy would be predictably different. Antiabortion advocates likely would favor fetal-centric approaches to antismoking messages and the characterization of the pregnant woman who smokes as a “fetal abuser.” Pro-choice supporters might call for the redesign of antismoking messages with a stronger emphasis on women’s perspectives on fetal health and avoidance of the implication that pregnant women who smoke are “bad mothers.”

Pro-choice feminist advocates have reacted to the antiabortion movement’s mobilization of the fetus as its primary symbol by refusing to recognize the fetus as a subject or agent. This approach leaves pro-choice advocates vulnerable to the charge that they do not recognize or care about fetuses in any circumstance, including in the case of women’s smoking during pregnancy. With the advent of criminal charges of fetal abuse and neglect, this position is increasingly problematic; reproductive rights arguments now pertain not only to abortion decisions but also to actions that influence fetal health. This expansion raises questions about the desirability of promoting pro-choice language and avoiding reference to “the fetus.” Katha Pollitt warns, “As the ‘rights’ of the fetus grow and respect for the capacities and rights of women declines, it becomes harder and harder to explain why drug addiction is a crime if it produces an addicted baby, but not if it produces a miscarriage, and why a woman can choose abortion but not vodka [or cigarettes]. And that is just what the ‘pro-lifers’ want” (1990, 414). Pollitt points to the dangers of framing the abortion debate as an opposition between fetal rights and women’s rights, a formulation that can lead to charges of hypocrisy if, for example, feminists argue that women should back the right to choose abortion but disagree with pregnant women’s choices to smoke or to drink. As antiabortion lobbyists would have it, this stance is contradictory because respect for abortion

39 Some would argue that wanted versus unwanted pregnancy is a highly salient distinction in terms of pregnant women’s health practices, including smoking. However, I have found overly simplistic the stereotype that women who disregard pregnancy advice do so because their pregnancies are unwanted.
rights is anti-fetus, while attention to fetal health is pro-fetus: the recognition of fetal health is the same as the identification of the fetus as a person that supports an antiabortion position. As Pollitt indicates, "what the 'pro-lifers' want" is to force feminists—indeed, the public—to regard fetuses as subjects.

But feminists can both recognize fetuses as subjects and challenge anti-abortion ideologies. There is a great need to move beyond static, polarized pro-choice and antiabortion arguments about whether fetuses are persons. In her critique of feminist philosophers' theories of fetal personhood, Morgan (1996) urges a move beyond arguments about fetal consciousness, sentience, and the ethics of dependency in the maternal-fetal relationship. Morgan asserts that the search for a stable definition of fetal personhood is misdirected and contends, "We cannot talk about 'the' fetus but rather need to talk about a diversity of situations and perspectives which carry with them many different meanings" (1996, 60). This approach pertains both to fetuses represented in public culture and to particular women's fetuses.

Feminists should step up efforts to expose the "pro-life" fetus as just one of many versions of fetuses, while remaining vigilant in our attention to how some fetal subjects undermine efforts to secure and maintain women's reproductive rights. The use of fetal imagery and the portrayal of fetuses as subjects in contexts not intended to be related directly to abortion politics (including prenatal health education, Hollywood films, television and magazine ads, and memorials for miscarried fetuses) invite analysis of the multiple social and cultural constructions that "give life" to fetuses. A growing number of feminist scholars are responding by exploring the diverse ways fetal subjects are understood and by demonstrating how constructions of fetal identity are contingent on women's historical, sociocultural, economic, political, and health-care contexts (see Morgan and Michaels 1999).

Pregnant women, their partners and families, health care providers and insurance companies, and health policy makers hold flexible, and at times conflicting, ideas about the conditions that constitute fetal personhood and motherhood. Rayna Rapp, in her research on women's, men's, and genetic counselors' interpretations of fetal life in the context of amniocen-

40 The pro-choice slogan "Pro-Family, Pro-Child, Pro-Choice" is one response to anti-abortion rights advocates' charges that an abortion rights stand contradicts concern for the well-being of children and families. But this declaration skirts the question of fetal identity: pro-child is not the same as pro-fetus.

41 See contributions in Morgan and Michaels 1999 for feminist explications of this argument.
tesis testing, reports the words of one woman: “When we walked into the doctor’s office, both my husband and I were crying. He looked up and said, ‘What’s wrong? Why are you in tears?’ ‘It’s the baby, the baby is going to die,’ I said. ‘That isn’t a baby,’ he said firmly. ‘It’s a collection of cells that made a mistake’” (Leah Rubinstein, quoted in Rapp 1990, 28). Rapp (1990, 1999) also has identified different patterns in the ways Hispanic, African-American, and white women of varied class backgrounds in New York City feel about prenatal testing, fetal identity, abortion, and disability.42 Linda Layne’s (1990, 1997, 1999a, in press) work on the “cultural denial of pregnancy loss” in the United States describes how the “realness” of a baby—felt by a pregnant woman when she abstains from coffee and wine, attends prenatal visits, and buys and receives gifts for the baby-to-be—is erased when a woman miscarries. These examples reveal that in some instances women feel that there is too little, not too much, emphasis on fetal personhood.

Despite the high visibility of the public fetus, ongoing debates over abortion and fetal personhood, and the widespread use of fetal sonograms, accumulating evidence clearly shows that in the United States pregnant women (and others) do not all think about or see fetuses in the same way. Women’s feelings toward their fetuses have been explored in relation to coping with infertility (Sandelowski 1993), experiencing pregnancy as a surrogate mother (Ragoné 1994, 1998), choosing experimental fetal surgery to correct a fetal health problem (Casper 1998), and viewing fetal sonogram images (Rapp 1997; Taylor 1998). Indeed, although sonogram images reassured some women that their babies-to-be were real and healthy, the women I interviewed did not all identify fetal images as infantlike, independent “babies.” Lena Ferro, a Euro-American executive assistant in her thirties who had difficulty becoming pregnant, said that her best memory of pregnancy was “just feeling the baby’s moving, and the sonograms—seeing it’s for real.” But others interpreted the image as monstrous or could not think of the fetus as “really a baby” until after it was born. Johnna Miles, a forty-year-old African-American nursing assistant, remembered that her fetus looked “like a big-headed monster” in the ultrasound picture. Christina Lee, a working-class, Euro-American woman in her early twenties, explained, “I didn’t have that bond, really. I couldn’t think of it as a baby. I couldn’t get the concept in my head ‘I’m havin’ a

42 However, research conducted with a relatively homogeneous group of California women who attend an HMO found no significant differences by race/ethnicity or social class in women’s attitudes or practices toward prenatal care or testing, respectively (see Browner and Press 1995; Markens, Browner, and Press 1997). Further comparative research on social differences and prenatal experiences is needed.
baby. . . . You can't see it, so it's not really a baby, I thought. I had two sonograms and have the pictures still, but because I didn't see it all the time, you know, it wasn't really real." Like these examples, the comparative literature demonstrates that fetal identity is open to a variety of interpretations at the personal and the social, cultural, and political levels.43

These sorts of insights can translate into effective political positions, health policy actions, and stronger critical, social analyses of reproductive and fetal politics. Feminists face an enormous challenge: we must work to gain respect for women's agency in a sociocultural context within which agency and reproductive options are limited and are granted on the basis of racial/ethnic identity, social class position, marital status, age, and so on. Borrowing from the pro-choice position, women's health advocates can promote a fetal politics by asserting that, in disputes over the fetus-as-subject, the pregnant woman's judgment is to be respected. This support would entail a steadfast foregrounding of women's agency by privileging their notions of their fetuses. In her ethnography of a feminist abortion clinic, Wendy Simonds suggests that this strategy is already in place: "The anti-abortionists have chosen to make fetuses central: take notice, they say, fetuses look like babies; hence, they are babies. Center workers replied that there is a difference between looking like a baby and being a baby. Fetuses get to be babies only if women choose motherhood" (1996, 101). This stance echoes Barbara Katz Rothman's call for feminists to focus attention less on the fetus itself and more on the relationship between a pregnant woman and her fetus (1989, 86). Feminists should work to ensure that the power over definition of "the baby" and of motherhood resides with each pregnant woman and that medical, legal, and political institutions formally recognize this right.

**Implications of rethinking fetal identity for antismoking advocacy**

In keeping with this position, I suggest that feminists support the elimination of narrow, absolutist antismoking messages so that a broader range of women's health choices can be respected even if they do not fully reduce risks to fetal health. Greater respect can be paid to the "fluidity" of the

43 Not only are there personal differences in ways of seeing and thinking about babies-to-be, but feminist research also documents variation within and between cultures. Cross-cultural analyses reveal that the primacy of the "biological reality" of the fetus that is voiced in U.S. debates over fetal life is not universal: in some cultures, ideas about fetuses are not solely or primarily mediated by biotechnology and draw on wider cultural and religious traditions. See Morgan 1989, 1996; Inhorn 1994; Oaks 1994, 1998, 1999; Conklin and Morgan 1996; Renne 1996; Hardacre 1997.
maternal-fetal relationship, as suggested by Susan Markens, C. H. Browner, and Nancy Press in their study of how pregnant women choose what they eat: “It is incorrect to envision the fetus in conflict with its mother or with complementary interests—women experience it as both” (1997, 368). Pregnant women negotiate their needs or desires with the perceived needs of their fetuses in a variety of ways.

When a “conflict of interests” such as a woman’s smoking cigarettes arises, some women “quit cold turkey” before trying to become pregnant or upon confirming a pregnancy, while others decide not to or feel that they cannot quit. Women’s smoking decisions take into consideration their own perceptions of fetal health risks, the effects of a partner’s or family member’s smoking on their ability to quit, stress levels, biochemical addiction, and personal enjoyment of smoking. Still other women “compromise” on behalf of fetal health without totally forgoing their own desires. Angela Perry, a Euro-American part-time housekeeper in her mid-thirties, smoking as we spoke, said that she changed her smoking practices when pregnant but did not quit:

AP: It was back in the ’80s, ya know. They’s sayin’ stuff . . . said it’s dangerous, low birth weight and all that. And I understand, but I needed that cigarette! It calms my nerves. I went from Kools to Lights though.

Author: How’d you feel about people sayin’ what you should or shouldn’t do when pregnant then? Did it bother you?

AP: They’re worryin’ about my unborn child and my health. So I didn’t mind much.

Angela argues that she did not reject the antismoking message entirely, nor did she fully accept it. She compromised by switching to a light brand, which was her way of balancing care for her “unborn child” with care for her own needs.44 This sort of negotiated fetal care deserves positive attention. Although Angela’s decision did not follow strict antismoking messages, she ought not be considered an uncaring mother-to-be.

In fact, although the types of fetal-centric smoking campaigns I have discussed have not disappeared, some antismoking advocates recently have voiced support for a move away from fetal health as the main “selling point” to convince pregnant women to quit smoking. Rethinking strategies directed at women is, in part, a result of smoking cessation programs’ lack of success. According to one review, “even with the best results, the

44 Health educators caution, however, that light cigarettes—those with lower nicotine or tar levels—do not reduce the risks to fetal health and that “there is no safe cigarette” (Maryland Department of Health and Mental Hygiene—Centers for Disease Control n.d., ix).
vast majority of women continue to smoke throughout pregnancy despite
their knowledge of the increased risks of adverse consequences to them-
selves and to the developing fetus" (Floyd et al. 1993, 406).

In response to such findings, some antismoking campaigns for pregnant
women are being rethought and redesigned. For example, public health
nurse and antitobacco advocate Trish Jackson suggested to me that the best
way to approach pregnant women who smoke is to “keep reminding them
of the benefits of smoking cessation, not just for the baby, but for their
health. Many interventions have an emphasis on the baby, but then we see
that after the baby is born, women go back to smoking to deal with the
stress.” She believes that advice needs to be tailored to each woman because
the reasons women smoke and the reasons they quit vary. Other antismok-
ing advocates, such as members of the International Network of Women
against Tobacco, take a broader perspective, focusing less on smoking ces-
sation and more on prevention and the social reasons women smoke.45
Antitobacco advocate and feminist scholar Lorraine Greaves argues that,
to end women’s smoking, community-based action and social change are
necessary: “The solution to women’s smoking will require nothing less
than an improvement in women’s lot” (1996, 126, 135). Alleviating the
conditions that create the need or desire for women to smoke places blame
less on individuals and more on sociocultural, economic, or biochemical
influences in women’s lives. This approach is in line with that of feminist
health care advocates, who attend not only to the specific details of wom-
en’s bodies, health, and lives but equally to promoting changes in the soci-
ocultural, economic, and political contexts in which women are embedded
(see Boston Women’s Health Book Collective 1998).

The goal, then, is to reach a balance between recognizing women’s
agency (including women’s choice to smoke when pregnant) and empha-
sizing the larger forces that shape women’s health choices (e.g., a social
network of smokers, the pleasure of smoking, stressful living conditions, a
desire to minimize weight gain, savvy cigarette advertising, biochemical
predispositions, etc.). With input from feminist health advocates and
women who smoke, health education campaigns can be strengthened.
Antismoking messages should not prescribe certain ways of thinking about
fetuses and fetal life and ought to make room for valuing the varied ways
that women care for their babies-to-be. Further, such messages must put
greater emphasis on pregnant women and their babies-to-be as parts of

45 The range of issues they call attention to includes the particularly stressful effects of
low-income and poverty status on women’s lives, the strains of motherhood, women’s social
support networks, government policies, images of women in tobacco industry advertising,
niche marketing techniques, and nicotine addiction.
complex social networks and place responsibility for fetal health not only on women but on all members of the social and political institutions that influence women’s lives.46

The types of antismoking messages that I have analyzed, which portray fetuses as independent agents and women who smoke as bad mothers, pose more harm to pregnant women than good to their babies-to-be. Mixing health advice with moral judgments against smoking supports the perception that public intervention into the maternal-fetal relationship on behalf of the fetus is socially, medically, and legally justified. But the solution to preventing fetal health risks does not lie in better surveillance, harsher moral judgment, or greater punishment of pregnant and parenting women. Rather, it requires turning concerted attention toward women’s perceptions of their babies-to-be, creating positive health education messages, and devoting resources to broadscale social change.

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46 It has been argued that women have a moral obligation to follow medical recommendations about fetal health once they decide to carry a pregnancy to term. John Robertson, writing in the Virginia Law Review, contends that “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... The viable fetus acquires rights to have the mother conduct her life in ways that will not injure it” (1983, 405). But this position too easily assumes that women have a true choice about whether to have an abortion. Many lack access to abortion because of financial constraints, minor status, religious prohibition, social stigma, distance to clinics, familial opposition, etc. (see Scales and Chavkin 1996). I agree with Cynthia Daniels that assigning women “individual moral obligations” for fetal care would be feasible only if these barriers did not exist and if women had full control over the conditions of their pregnancies (1993, 138).


