PREGNANCY POLICE: THE HEALTH POLICY AND LEGAL IMPLICATIONS OF PUNISHING PREGNANT WOMEN FOR HARM TO THEIR FETUSES

INTRODUCTION

> *We are two-legged wombs, that's all; sacred vessels, ambulatory chalices.*[1]

The Handmaid's Tale, from which this quote is taken, describes a horrific future in which the decline of birthrates leads to the enslavement of women for use solely as propagators of the human species. Although the women are culturally glorified as "Handmaids," they effectively have been reduced to incubators, valued only for their wombs and subject to the punitive control of a patriarchal state.

Subordination of a mother's rights to the interest of the state in her fetus is a threat neither remote nor fictional. The case of *People v. Stewart*[2] demonstrates that a pregnant woman may be criminally prosecuted for conduct which may have endangered her fetus. In *Stewart*, the state attempted to prosecute a woman who allegedly took illegal drugs and failed to obtain adequate

1. M. ATWOOD, THE HANDMAID'S TALE 136 (1986). For a feminist review of *The Handmaid's Tale*, see Dahl, *Book Review*, 10 HARV. WOMEN'S L.J. 335 (1987).

2. People v. Stewart, No. M508097, slip op. (San Diego County Ct. Feb. 23, 1987). The *Stewart* case is discussed in detail *infra* notes 57-67 and accompanying text.

medical attention for her fetus.[3] *Stewart* was one of the first occasions in the United States in which a pregnant woman had been criminally charged for conduct that harmed her fetus prior to birth.[4] More recently, a Washington, D.C., judge jailed a pregnant woman convicted of second degree theft, Brenda Vaughn, who had traces of cocaine in her blood.[5] In justifying this action, the judge stated: "I'm going to keep her locked up until the baby is born because she's tested positive for cocaine when she came before me. . . . She's apparently an addictive personality and I'll be darned if I'm going to have a baby born that way."[6]

Medical and legal attempts to control or limit women's behavior during pregnancy are becoming more frequent. The combination of increased concern over the effects of drug use during pregnancy and the emerging legal concept of "fetal rights" have created a social climate that is leading to the suppression of women's civil rights and personal autonomy in the name of fetal well-being. The most extreme example of this trend is the increasing introduction of punitive legislation that seeks to punish women criminally for a variety of acts or omissions, including the failure to receive timely prenatal care, not complying with doctor's orders, and using drugs during pregnancy.

This Note will analyze the health policies and legal issues necessarily involved in any attempt to criminalize women's acts or omissions during pregnancy. It will demonstrate that any such laws would be inherently unfair since many women, particularly members of low-income and minority groups, lack meaningful access to adequate prenatal care or drug treatment. Furthermore, such laws would be ineffective: women would be deterred from seeking medical care for fear of being reported to the police, and the prenatal care of pregnant women imprisoned for violating these laws would actually be worsened, not bettered. Finally, the laws would be unconstitutional because they would violate prohibitions on vagueness, infringe upon the mother's rights to liberty and privacy, and deny equal protection.

Part I provides a background on the development of methods of intervention during pregnancy. Part II will provide a profile of the population at which proposed criminal sanctions are directed — those women whose inadequate prenatal care or substance abuse during pregnancy creates a risk of harm to their fetus. Part III will analyze two types of criminal statutes that legislators are likely to consider and will assess the effectiveness of these statutes from a health policy perspective. Part III concludes that, given the serious inequalities in our health care system, a statute would have to be very

3. *Id.* at 4.

4. *The Troubling Question of Fetal Rights*, NEWSWEEK, Dec. 8, 1986, at 87. Other attempts to punish women for prenatal conduct include the effort in Reyes v. California, 75 Cal. App. 3d 214, 141 Cal. Rptr. 912 (1977). *See also In re* Welfare of J.A., 417 N.W.2d 696 (Minn. App. 1988) (custody hearing because mother hostile to doctors and nurses who treated her during pregnancy); *In re* Ruiz, 27 Ohio Misc. 2d 31, 500 N.E.2d 935 (1986).

5. *D.C. Judge Jails Woman As Protection for Fetus*, Washington Post, July 23, 1988, at A1.

6. *Id.*

narrowly drawn to comport with principles of fairness and justice. A narrow statute, however, would fail to address public concern over the consequences of inadequate prenatal care and substance abuse. Part IV discusses additional constitutional concerns, including due process concerns of vagueness, deprivation of liberty, and equal protection which even the most carefully drawn statute would implicate. The Note concludes that, while theoretically possible, the problems inherent in criminalizing maternal conduct during pregnancy would unavoidably result in laws that are unfair to women who are members of low-income and minority groups, that are ineffective to improve prenatal care or deter drug use, and that are unconstitutional violations of due process, liberty, and equal protection guarantees. Finally, this Note suggests that legislatures should concentrate on improving maternal-child health care by increasing access to prenatal care and substance abuse treatment for all women, regardless of their ability to pay, rather than focusing on criminalization as a tool for encouraging healthy pregnancies.

I.
THE TREND TOWARD INTERVENTION

The *Stewart* case and the incarceration of Brenda Vaughn, far from being isolated, idiosyncratic episodes, represent part of a national trend toward expanding the scope of state intervention in a woman's pregnancy.[7] Through court-ordered surgery, deprivation of child custody, and incarceration, the government increasingly has used its coercive force to control a woman's actions during pregnancy.

A. Legal Changes

Until very recently, the precepts of Anglo-American common law did not recognize any assertable interest in the fetus.[8] The non-recognition of the fetus as a legal entity was embodied in the "born alive" rule, which stated that

7. For a discussion of: the development of the concept of feticide, see *infra* note 33 and accompanying text; wrongful life actions, see *infra* note 21 and accompanying text; wrongful death actions, see *infra* notes 17 and accompanying text; and forced treatment cases, see *infra* note 38 and accompanying text.

8. Roe v. Wade, 410 U.S. 113, 161-62 (1973) ("In areas other than criminal abortion, the law has been reluctant to endorse any theory that life, as we recognize it, begins before live birth or to accord legal rights to the unborn except in narrowly defined situations and except when the rights are contingent upon live birth. . . . In short, the unborn have never been recognized in the law as persons in the whole sense"). *Id. See* Commonwealth v. Cass, 392 Mass. 799, 467 N.E.2d 1324 (1984). *See also* Leelev v. Superior Court of Amador County, 2 Cal. 3d 619, 470 P.2d 617 (1970); People v. Grear, 79 Ill. 2d 103, 402 N.E.2d 203 (1980).

Exceptions were made solely for the purpose of protecting the inheritance rights of the subsequently born child and her parents. If a fetus existed at the time of death of the testator, the fetus, if subsequently born alive, was granted the status of a person. *See* Cowles v. Cowles, 56 Conn. 240, 13 A. 414 (1887); McLain v. Howard, 120 Mich. 274, 79 N.W. 152 (1899). Johnsen, *The Creation of Fetal Rights: Conflicts with Women's Constitutional Rights to Liberty, Privacy, and Equal Protection*, 95 YALE L.J. 599, 601-02 (1986).

the fetus had to be born alive as a precondition to legal personhood.[9] Underlying this rule was the assumption that the mother and the fetus constituted a unit whose legal interests were co-extensive. As the fetus has been increasingly endowed with the legal trappings of personhood, and the perception of mother and fetus as antagonistic entities has developed, the "born alive" rule increasingly has been eviscerated, in both civil and criminal law contexts. As a result, maternal and fetal rights are now perceived as conflicting interests that must be "balanced" against each other.[10] Increasingly, the balance is being struck for the fetus and against the mother's interests.[11]

In civil cases, tort actions were among the first to recognize a legally cognizable interest of the fetus. Prior to the middle of this century, courts had refused to recognize a cause of action for prenatal injuries.[12] Children were first given standing to sue for prenatal harm inflicted by third parties in *Bonbrest v. Kotz*,[13] in which the court permitted the parents of an infant to sue their physician for injuries sustained by the infant during delivery.[14] For the next several decades, cases involving fetal harm were limited to third party

9. At common law, the definition of "person" for purposes of the criminal law was one who had been "born alive." This definition was also incorporated into the Model Penal Code § 210.0(1). MODEL PENAL CODE OFFICIAL DRAFT AND EXPLANATORY NOTES § 210.0(1) and commentary at 119 (1985) [hereinafter MODEL PENAL CODE]. "Being 'born alive' required that the fetus be totally expelled from the mother and show a clear sign of independent vitality, such as respiration, although respiration was not strictly required." W. LAFAVE & A. SCOTT, CRIMINAL LAW, § 7.1(c) at 607 (1986).

10. For commentary on this phenomenon, see, e.g., Kahn, *Of Woman's First Disobedience: Forsaking a Duty of Care to Her Fetus — Is This a Mother's Crime?*, 53 BROOKLYN L. REV. 807 (Fall 1987); Note, *Maternal Substance Abuse: The Need to Provide Legal Protection for the Fetus*, 60 S. CAL. L. REV. 1209 (1987) [hereinafter *Maternal Substance Abuse*]; Gallagher, *Prenatal Invasions and Interventions: What's Wrong with Fetal Rights*, 10 HARV. WOMEN'S L.J. 9 (1987); Rush, *Prenatal Caretaking: Limits of State Intervention with and Without Roe*, 39 U. FLA. L. REV. 55 (1987); Stearns, *Maternal Duties During Pregnancy: Toward a Conceptual Framework*, 21 NEW ENG. L. REV. 595 (1986); Beal, *"Can I Sue Mommy?" An Analysis of a Woman's Tort Liability for Prenatal Injuries to Her Child Born Alive*, 21 SAN DIEGO L. REV. 325 (1984); Schott, *The Pamela Rae Stewart Case and Fetal Harm: Prosecution or Prevention?*, 11 HARV. WOMEN'S L.J. 227 (1988); Note, *Maternal Rights and Fetal Wrongs: The Case Against the Criminalization of "Fetal Abuse,"* 101 HARV. L. REV. 994 (1988) [hereinafter *Maternal Rights and Fetal Wrongs*]; Mathieu, *Respecting Liberty and Preventing Harm: Limits of State Intervention in Prenatal Choice*, 8 HARV. J.L. & PUB. POL'Y 19 (1985).

11. *See generally infra* notes 25-67 and accompanying text.

12. In refusing to recognize a cause of action for prenatal injuries, courts typically relied on the doctrine announced in Dietrich v. Northampton, 138 Mass. 14 (1884), which assumed that the fetus was a part of the mother and therefore had no independent legal rights in tort. *See, e.g.*, Stemmer v. Kline, 128 N.J.L. 455, 26 A.2d 489 (1942) (cause of action for medical malpractice dismissed). *See also supra* note 9 and accompanying text.

13. 65 F. Supp. 138 (D.D.C. 1946).

14. *Id.* at 139. The court relied on Canadian precedent in holding that " 'a child, if born alive and *viable* . . . should be allowed to maintain an action in the courts for injuries wrongfully committed upon its person while in the womb of its mother.' " *Id.* at 142 (quoting Montreal Tramways v. Leveille, [1933] 4 D.L.R. 337, 345 (emphasis in original)). The *Bonbrest* court distinguished earlier precedent that had barred recovery for prenatal harms by distinguishing the viability of the fetus at the time of its prenatal injuries. Furthermore, the *Bonbrest* court rejected the common law view that a fetus is so intimately united with its mother as to be part of her, observing that this argument was a "contradiction in terms." *Id.* at 140. The court finally

tort actions.[15]

In addition to new legal recognition of standing to sue for prenatal harm, the fetus has been recognized as a legal entity in contexts that are not contingent upon subsequent live birth.[16] For example, "wrongful death" actions, statutorily-created causes of action, allow representatives of a deceased person to sue the person who negligently caused the death.[17] A majority of states now consider fetuses that have died *in utero* to be "persons" under wrongful death statutes,[18] and therefore parents may sue people who harmed the fetus *in utero* causing its death.[19] These wrongful death actions are usually brought by parents against doctors or pharmaceutical companies.[20]

Courts have also recognized "wrongful life" actions, in which the parents of an unplanned child sue either the person who "caused" the life or the person who caused damage to the fetus affecting the quality of the child's life after birth.[21] The issue raised is "[w]hether it is better never to have been born at all than to have been born with even gross deficiencies."[22] Wrongful life claims have met with limited success because of the difficulty in quantifying

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held that the fact that allowance of this sort of cause of action "might represent insuperable difficulties of proof" was insufficient to defeat it. *Id.* at 142-43.

15. Initially, these tort actions did not confer rights upon the fetus *qua* fetus. Instead, they recognized the existence of the fetus as part of the pregnant woman as necessary ". . . to protect the interests of born persons, both the subsequently born child and his or her parents." Johnsen, *supra* note 8, at 602.

16. *Id.*

17. *See* W.P. KEETON, D. DOBBS, R. HEETON & D. OWEN, PROSSER AND KEETON ON THE LAW OF TORTS 368 (5th ed. 1984) [hereinafter PROSSER & KEETON].

18. *Id.*; Johnsen, *supra* note 8, at 602. *But see* Raymond v. Bartsch, 84 A.D.2d 60, 447 N.Y.S.2d 32 (1981); Hernandez v. Garwood, 390 So. 2d 357 (Fla. 1980); Olejniczak v. Whitten, 605 S.W.2d 142 (Mo. 1980); Justus v. Atchinson, 19 Cal. 3d 564, 565 P.2d 122, 138 Cal. Rptr. 97 (1977).

19. *See, e.g.*, Johnson v. Ruark Obstetrics and Gynecology Assocs., 365 S.E.2d 909 (N.C. App. 1988) (parents of stillborn fetus had claim against physicians who caused stillborn birth by failing to treat mother's diabetic condition); Werling v. Sandy, 17 Ohio St. 3d 45, 476 N.E.2d 1053 (1985); Volk v. Baldazo, 103 Idaho 570, 651 P.2d 11 (1982); Salazar v. St. Vincent Hospital, 619 P.2d 826 (N.M. App. 1980). A wrongful death action vindicates "the parents' interest and is thus consistent with the view that the fetus, at most, represents only the potentiality of life." Roe v. Wade, 410 U.S. 113, 162 (1973).

20. *See eg.*, Amadio v. Levin, 509 Pa. 199, 501 A.2d 1085 (1985) (parents of stillborn child maintain a cause of action for medical malpractice against mother's obstetrician); Presley v. Newport Hosp., 117 R.I. 177, 365 A.2d 748 (1976); Verhennese v. Cornled, 229 Minn. 365, 38 N.W.2d 838 (1968) (first court to allow a wrongful death recovery for viable but stillborn fetus where a negligently supervised delivery resulted in death).

21. *See, e.g.*, Renslow v. Mennonite Hosp., 67 Ill. 2d 348, 10 Ill. Dec. 484, 367 N.E.2d 1250 (1977) (mother had standing on behalf of fetus to sue for a foreseeable injury which the child sustained due to a negligently administered blood transfusion prior to conception). *See generally* PROSSER & KEETON, *supra* note 17, at 370-373.

22. *See* Becker v. Schwartz, 46 N.Y.2d 401, 411, 386 N.E.2d 807, 812, 413 N.Y.S.2d 895, 900 (1978). There has been extensive commentary on the implications of wrongful life actions. *See, e.g.*, Kashi, *The Case of the Unwanted Blessing: Wrongful Life*, 31 U. MIAMI L. REV. 1409 (1977); Robertson, *Toward Rational Boundaries of Tort Liability for Injury to the Unborn: Prenatal Injuries, Preconception Injuries and Wrongful Life*, 1978 DUKE L.J. 1401; Shaw, *Genetically Defective Children: Emerging Legal Consideration*, 3 AM. J.L. & MED. 333, 340 (1977).

the value of the lost quality of life.[23] One author has advocated adopting a cause of action for "diminished life" against both parents of substance-abused infants.[24]

In an extraordinary example of increased recognition of fetal rights in tort law, suits have been allowed by the child against the child's own parents. Recently, several courts have permitted a child to sue her own mother for tortious conduct during pregnancy that caused harm to the born child.[25] In *Stallman v. Youngquist*,[26] the court held that a child, who was a five-month fetus at the time of her prenatal injuries, was a legal person for purposes of maintaining a negligence action after birth against her mother.[27] In *Grodin v. Grodin*,[28] a Michigan court held that a child could sue her mother for taking tetracycline during her pregnancy, which allegedly resulted in the discoloration of the child's teeth. The *Grodin* court held that a pregnant woman's conduct would be measured against a standard of the "reasonable" pregnant woman.[29] Another court has even suggested that a woman may be sued by her child for not preventing its birth if she had prior knowledge of the probability of its being "defective."[30]

In criminal cases at common law, the termination of fetal life was not homicide because the fetus, not having been "born alive," was not considered a person.[31] Initially, judicial rather than legislative action overturned the

23. *See, e.g.*, Gleitman v. Cosgrove, 49 N.J. 22, 227 A.2d 689 (1967); Albala v. City of New York, 54 N.Y.2d 269, 429 N.E.2d 786, 445 N.Y.S.2d 108 (1981) (no cause of action for preconception tort).

24. *Maternal Substance Abuse*, *supra* note 10, at 1236.

25. *See generally* Note, *Parental Liability for Prenatal Injury*, 14 COLUM J.L. & SOC. PROB. 47 (1978) (whether and how a cause of action can be formulated by a child against its parents for negligent infliction of prenatal injuries); Note, *Recovery for Prenatal Injuries: The Right of a Child Against Its Mother*, 10 SUFFOLK W.L. REV. 582 (1976) (mother may be liable only when her conduct is shown to have been grossly negligent) [hereinafter *Recovery for Prenatal Injuries*]. *See also* Stallman v. Youngquist, 129 Ill. App. 3d 859, 473 N.E.2d 400 (1984); Grodin v. Grodin, 102 Mich. App. 396, 400-02, 301 N.W.2d 869, 970-71 (1980); Curlender v. Bio-Science Laboratories, 106 Cal. App. 3d 811, 829, 165 Cal. Rptr. 477, 488 (1980).

26. 129 Ill. App. 3d 859, 473 N.E.2d 400 (1984).

27. The *Stallman* decision was reversed by the Illinois Supreme Court on November 21, 1988. Stallman v. Youngquist, No. 64957 (Ill. Sup. Ct. Nov. 21, 1988), 57 U.S.L.W. 2341 (Dec. 13, 1988). The court found that holding a mother liable for negligent infliction of prenatal injuries infringes on her right to privacy and bodily autonomy. The court distinguished cases in which a third person may be held liable for prenatal injuries, noting that the relationship between a pregnant woman and her fetus is unlike that between any other plaintiff and defendant: "No other defendant must go through biological changes of the most profound type . . . in order to bring an adversary into the world." *Id.* at 2342. The court rejected the argument that there is a right to be born with a sound mind and body. Recognition of such a right, said the court, would in fact make a pregnant woman a guarantor of the mind and body of her child at birth — a legal duty to guarantee the mental and physical health of another that has never been recognized in law.

28. 102 Mich. App. 396, 301 N.W.2d 869 (1980).

29. *Id.*, at 400-02, 301 N.W.2d at 870-71.

30. Curlender v. Bio-Science Laboratories, 106 Cal. App. 3d 811, 819, 165 Cal. Rptr. 477, 488 (1980).

31. W. LAFAVE & A. SCOTT, *supra* note 9.

"born alive" rule. In *Commonwealth v. Cass*,[32] the court held that a viable fetus was a "person" within the protection of the state's vehicular homicide statute.[33] Other courts, however, have refused to adopt the feticide exception to the "born alive" rule, on the grounds that a fetus is not a person, and ought not to be granted legal rights.[34] Nonetheless, since *Cass*, several states have enacted "feticide" statutes.[35] The rationale for such statutes is that by enshrining the fetus as a person, criminal acts that destroy a fetus against the will of the pregnant woman are punished.

Judicial recognition that prenatal harms are cognizable at tort law, the development of causes of action for prenatal harms not requiring live birth, and the permission of suits against the plaintiff's parents for prenatal harms provide evidence of the growing legal status of the fetus. This legal development increasingly has been used in non-tort law contexts. Recently, the fetal rights doctrine has been given a punitive twist, having been used to justify forced treatment, civil commitment, custody deprivation, and even imprisonment of pregnant women whose acts or omissions were deemed to violate a fetus' rights.

In the name of fetal protection, courts increasingly are forcing pregnant women to undergo invasive medical treatment,[36] most often caesarian sec-

32. 467 N.E.2d 1324 (Mass. 1984).

33. The *Cass* court used two rationales in finding that a fetus is a person for the purposes of the vehicular homicide statute. First, the difficulty in proving causation in cases where the fetus was stillborn has been rendered obsolete by modern science. *Id.* at 1325, 1328. And second, previous precedent, which had held that a viable fetus is a "person" for the purposes of the state's wrongful death statute, put the state legislature on notice that the court considered a fetus to be a person. *Id.* at 1326. *See also* United States v. Spencer, 839 F.2d 1341 (9th Cir. 1988) (declaring feticide to be murder within the meaning of the federal statute); State v. Horne, 282 S.C. 444 (1984).

34. *See, e.g.*, Hollis v. Commonwealth, 652 S.W.2d 61, 65 (Ky. 1983) (legislature clearly intended that conduct directed to cause the unlawful abortion of a fetus, regardless of viability, be punished under the abortion statute rather than the criminal homicide statutes); State *ex rel.* Atkinson v. Wilson, 332 S.E.2d 807, 812 (W. Va. 1984) (neither statute nor common law authorized prosecution for killing unborn child, and issue was for legislature).

35. States codes containing feticide statutes include: CAL. PENAL CODE § 187 (West Supp. 1986)("Murder is the unlawful killing of a human being, *or a fetus*, with malice aforethought.") (emphasis added); ILL. ANN. STAT. ch. 38, § 9-1.1 (Smith-Hurd Supp. 1985); IOWA CODE ANN. § 707.7 (West 1979); MICH. COMP. LAWS ANN. § 750.322 (1968); MISS. CODE ANN. § 97-3-37 (1973); N.H. REV. STAT. ANN. § 585:13 (1974); OKLA. STAT. ANN. tit. 21, § 713 (West 1983); UTAH CODE ANN. § 76-5-201 (Supp. 1983); WASH. REV. CODE ANN. § 9A.32.060 (1977); WIS. STAT. ANN. § 940.04 (West 1982).

36. *Courts Acting to Force Care of the Unborn*, N.Y. Times, Nov. 23, 1987, at A1, col. 1; Bross, *Court-Ordered Intervention on Behalf of Unborn Children*, 7 CHILDREN'S LEGAL RTS. J. 11 (1986); Gallagher, *The Fetus and the Law — Whose Life Is It Anyway?*, MS. 62 (Sept. 1984); Kolder, *Court Ordered Obstetrical Interventions*, 316 NEW ENG. J. MED. 1192 (May 7, 1987); Note, *The Fetal Patient and the Unwilling Mother: A Standard for Judicial Intervention*, 14 PAC. L.J. 1065 (1983) [hereinafter *The Fetal Patient*]; Note, *Lifesaving Medical Treatment for the Nonviable Fetus: Limitations on State Authority Under Roe v. Wade*, 54 FORDHAM L. REV. 961 (1986) (arguing that state interference with a woman's freedom of bodily integrity by coercing treatment to save the "potentiality of human life" of a nonviable fetus is constitutionally prohibited).

tions[37] and blood transfusions. The intrusiveness of forced treatment falls most heavily upon low-income women and women with religious convictions different from those of the mainstream. In one case,[38] a hospital sought a court order to administer blood transfusions to a pregnant woman who did not wish to have the transfusions because they were contrary to her religious convictions as a Jehovah's Witness.[39] A more shocking case arose in Washington, D.C., in which a pregnant woman with terminal cancer was forced to submit to a Caesarean section against her will.[40] The D.C. court held that the woman forfeited her right to refuse treatment because she was about to die. As the attorney for the state argued: "All we are arguing is the state's obligation to rescue a potential life from a dying mother."[41]

The government has used the rationale underlying forced medical treatment to seek the involuntary civil committment of pregnant women.[42] For example, in *In re Steven S.*,[43] the Los Angeles Department of Social Services sought to have the fetus of a developmentally disabled woman declared a ward of the state on the ground that the mother's retardation might endanger the fetus. The juvenile court ordered the mother to a locked psychiatric facility. The Court of Appeals overturned the juvenile court decision, finding that an

37. *Court-Ordered Cesareans: A Growing Concern for Indigent Women*, 21 CLEARINGHOUSE REV. 1064 (1988); Rhoden, *The Judge in the Delivery Room: The Emergence of Court Ordered Cesareans*, 74 CALIF. L. REV. 1951 (1986); Annas, *Forced Cesareans: The Most Unkindest Cut of All*, 12 HASTINGS CENTER REP. 16 (1982); Guillemin, *Babies by Cesarean: Who Chooses, Who Controls*, 11 HASTINGS CENTER REP. 15 (1981).

38. Raleigh Fitkin-Paul Morgan Memorial Hosp. v. Anderson, 42 N.J. 421, 201 A.2d 537 (per curiam), *cert. denied*, 377 U.S. 985 (1964).

39. *Id.* at 538. The New Jersey Supreme Court granted the hospital's request, finding that "[w]e are satisfied that the unborn child is entitled to the law's protection." *Id.* at 537. The court found it "unnecessary" to decide under the facts presented "whether an adult may be compelled to submit to such medical procedures when necessary to save his life," because "the welfare of the child and the mother are so intertwined and inseparable that it would be impracticable to attempt to distinguish between them with respect to the sundry factual patterns which may develop." *Id.* at 538. The court authorized the blood transfusion, if necessary to save the life of the mother or child, as the physician in charge might determine.

40. *In re* A.C., 533 A.2d 611, 612 (D.C. 1987), *vacated, reh'g granted*, 539 A.2d 203 (D.C. 1988). The mother in this case had a history of bone cancer. At age twenty-seven, she believed that she was free of cancer and became pregnant. During her twenty-sixth week of pregnancy, she learned that her back pain and shortness of breath were due to a large tumor in her lung and that she had only days to live. Despite her objection to having a Caesarean section performed, the hospital obtained a court order to perform the Caesarean section. The baby, born at twenty-six weeks and thus not viable, died almost immediately. The mother died two days later. Greenhouse, *Appeals Court Vacates Forced-Caesarean Ruling*, N.Y. Times, Mar. 22, 1988, at A17, col. 1.

On March 21, 1988, the D.C. Court of Appeals set aside the ruling that a gravely ill pregnant woman could be forced to undergo a Caesarean section. 539 A.2d at 203. *Appeals Court Vacates Forced-Caesarean Ruling, supra*. Rehearing *en banc* was held on September 22, 1988, but no opinion has yet been rendered.

41. Goodman, *Pregnancy is No Excuse For Brutalizing Women*, Washington Post, Nov. 17, 1987, at A27, col.5 (quoting state's attorney).

42. *See* Soloff, Jewell & Roth, *Civil Commitment and the Rights of the Unborn*, 136 AM. J. PSYCHIATRY 114 (1979).

43. 126 Cal. App. 3d 23, 178 Cal. Rptr. 525 (1981).

unborn fetus was not a person within the meaning of the child abuse or neglect statutes.[44]

In another case, *In re Baby X*,[45] a court took temporary custody of a newborn who had exhibited symptoms of heroin withdrawal within twenty-four hours of his birth as a result of the mother's drug addiction during her pregnancy.[46] The court stated that

> [w]hile there is no wholesale recognition of fetuses as persons, . . . fetuses have been accorded rights under certain limited circumstances. . . . This limited recognition of a child *en ventre sa mere* as a child *in esse* is appropriate when it is for the child's best interest. . . . Since a child has a legal right to begin life with a sound mind and body, . . . we believe it is within this best interest to examine all prenatal conduct bearing on that right.[47]

Child custody regulations have also been used to seize custody of the fetus to control the woman's behavior. In *In re J. Jeffrey*,[48] a juvenile court filed a neglect petition alleging that a mother had, during the last few weeks of her pregnancy, taken four non-prescription Valium to relieve the pain from injuries she had sustained in an automobile accident. Her use of the Valium resulted in the child being born intoxicated but not addicted to the drug. The child was taken into temporary custody when the child was one month old. The mother argued that "non-narcotic prenatal drug ingestion [was] not neglect under Michigan law," and that the facts in her case do "not rise to the level of neglect in *Baby X*."[49] Similarly, the state of Iowa took custody of a newborn because "the mother paid no attention to the nutritional value of the food she ate during her pregnancy — she simply picked the foods that tasted good to her without considering whether they were good for her unborn child," smoked cigarettes and marijuana, used heroin, drank alcoholic beverages on a regular basis, and saw her obstetrician only once before her child was born.[50]

The removal of children from mothers' custody at birth where the infant

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44. In a similar case in Illinois, the court construed the Juvenile Court Act as extending jurisdiction to a fetus. The court declared that an 8-month old fetus was being abused by its mother because of her heroin habit and should therefore become a ward of the state. *'Addicted' Fetus Sparks Court Battle*, Chicago Tribune, Apr. 9, 1984, at 1, col. 4 [hereinafter *'Addicted' Fetus*].

45. *In re* Baby X, 97 Mich. App. 111, 293 N.W.2d 736 (1980).

46. The court held that a newborn suffering narcotics withdrawal symptoms was as a consequence of prenatal maternal drug addiction was probative of prenatal neglect and may properly be considered by a probate court. *Baby X*, 293 N.W.2d at 739.

47. *Id.* at 738-739 (citations omitted). *But see In re* Ernst, 130 Mich. App. 657, 344 N.W.2d 39 (1983) (adopting the alternative view that, in terminating parental rights, court may consider fitness of parent instead of best interests of child).

48. *In re* J. Jeffrey, No. 99851 (Mich. Ct. App. filed Apr. 9, 1987), *cited and discussed in* ACLU REPRODUCTIVE FREEDOM PROJECT, LEGAL DOCKET 140 (May 1987).

49. *Id.*

50. *Baby Placed in Foster Home; Doctor Claims Prenatal Abuse*, Des Moines Register, Apr. 3, 1980, at 11A.

has a positive toxicology is increasing. In California, a large percentage of these infants are removed from their mothers' custody at birth or placed under the supervision of the court or Department of Social Services.[51]

Finally, in the most drastic development of punitive sanctions, at least one state has attempted to prosecute a woman criminally for conduct during her pregnancy that may have harmed the fetus.[52] In *Reyes v. Superior Court*,[53] a pregnant woman addicted to heroin had been warned by a public health nurse "that, if she continued using heroin and failed to seek prenatal medical care, the health, and even the life, of any child born to her would be endangered."[54] Nonetheless, the mother continued using heroin and failed to seek prenatal medical care. As a result, her twins were born addicted to heroin and suffered withdrawal. Reyes was charged with two counts of felony child endangering.[55] The court found that the statute was not intended to apply to prenatal conduct, because "when the Legislature has intended to include a fetus or unborn child within the protection of a penal statute, it has done so expressly."[56]

In *Stewart*,[57] the state claimed that the mother's failure to follow medical direction and advice during her pregnancy caused the death of her baby shortly after its birth.[58] During her last month of pregnancy, after minor bleeding, and engaging in behavior contrary to medical instructions, Stewart

51. Statement of Xylina D. Bean, M.D., House Select Committee on Children, Youth, and Families, Field Hearing on "Young Children In Crises: Today's Problems, Tomorrow's Promises." (April 15, 1988) [hereinafter Statement of Xylina D. Bean] (on file with the New York University Review of Law & Social Change).

52. Butte County, California, has instituted a policy whereby the mother of a child born with a positive toxicology screen will be mandatorily reported not only to child protective services, but also to the district attorney's office. The toxicology screen will be used as evidence to prosecute the mother for use of illegal drugs. *Drug-Addicted Babies Problem*, Oroville (CA) Mercury-Register, October 28, 1988, at A1. The first charges brought under this policy against a mother with a drug abuse problem were dropped, when the prosecutor learned that the woman's effort to obtain treatment had been blocked by the lack of drug treatment services for poor pregnant women in her county. *Little Help Available for Addicted Poor*, Chico (CA) Enterprise-Record, Dec. 12, 1988, at A1.

53. 75 Cal. App. 3d 214, 41 Cal. Rptr. 912 (1977).

54. *Id.* at 216.

55. *See* CAL. PENAL CODE § 273a(1) (West 1986). The pertinent sections of the statute read:

> Any person who, under circumstances or conditions likely to produce great bodily harm or death, . . . having the care or custody of any child, . . . wilfully causes or permits such child to be placed in such situation that its person or health is endangered, is punishable by imprisonment in the county jail not exceeding 1 year, or in the state prison for not less than 1 year nor more than 10 years.

Id.

56. 75 Cal. App. 3d at 218.

57. *See* People v. Stewart, No. M508097, slip op. (San Diego County Ct. Feb. 23, 1987).

58. Chambers, *Dead Baby's Mother Faces Criminal Charge on Acts in Pregnancy*, N.Y. Times, Oct. 9, 1986, at A22, col. 1. Pamela Rae Stewart, the defendant, suffered from a pregnancy complication called *placenta previa*. *Id.* In *placenta previa*, rather than the placenta being normally attached to the upper part of the uterus, it is attached on the lower part of the uterus or across the cervical opening. D.N. DANFORTH, OBSTETRICS AND GYNECOLOGY 433 (5th ed. 1986). Any change in the condition of the cervix, such as the softening or dilating that

began heavy vaginal bleeding.[59] Several hours after she began to hemorrhage, she called the paramedics and was rushed to the hospital.[60] The baby was born with severe brain damage.[61] According to the police report, the delivering doctor identified traces of amphetamines in the baby's blood but concluded that these did "not cause the brain damage."[62] Eight months after the baby's death, Stewart was charged with "willful failure to provide medical attention to a minor child."[63] The charges in *Stewart* were dismissed because the statute under which the charges were brought was intended to apply only to financial child support obligations.[64]

Prosecutions based on maternal conduct during pregnancy that results in harm to the fetus have been initiated but dropped in Arizona[65] and New York.[66] Further, in the aftermath of *Stewart*, the California state legislature

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occurs toward the last six weeks of pregnancy, can cause the placenta to prematurely separate from the uterus and to bleed heavily. *Id.*

59. Chambers, *supra* note 58, at A22, col. 1.

60. *Id.*

61. *Id.*

62. Causes of death listed on coroner's report included bronchial pneumonia and a shriveled brain, . . . stemming from the placenta being suddenly detached from the uterine wall prior to birth. *Woman Charged in Fetal Neglect Did Not Abuse Drugs, Husband Says*, San Diego Union, Sept. 30, 1986, at B1. The doctor reported his discovery to the local Child Protective Services which notified the local police department. On January 1, 1986, the baby died. Chambers, *supra* note 58, at A22, col. 1.

63. California criminal law requires that a fetus be "born alive" before any murder charges may be brought on its behalf. *Id.* Since Stewart's child was born alive the prosecution against her was based on section 270 of the California Penal Code. Section 270 provides that:

> If a parent of a minor child willfully omits, without lawful excuse, to furnish necessary clothing, food, shelter, or medical attendance, or other remedial care for his or her child, he or she is guilty of a misdemeanor punishable by a fine not exceeding two thousand dollars, or by imprisonment [for one year] . . .
>
> A child conceived but not yet born is to be deemed an existing person insofar as this section is concerned.

CAL. PENAL CODE § 270 (West 1986).

64. People v. Stewart, No. M508097, slip op. at 10-11 (San Diego County Ct. Feb. 23, 1987). The legislative history of § 270 demonstrates that the original text was designed to create financial support obligations upon fathers to ensure that their children received "necessary clothing, food, shelter, or medical attendance." The statute was amended in 1926, providing that "a child conceived but not yet born is to be deemed an existing person insofar as this section is concerned." The purpose of this amendment was to force fathers to support the mothers of their illegitimate children. In 1974, § 270 again was amended to apply to mothers and fathers equally, at least to the extent of financial obligations.

65. In 1986, a Phoenix woman was arrested for investigation of child abuse for taking drugs during pregnancy. *Drug Use May Lead to Charge*, The Phoenix Gazette, Nov. 4, 1986, at B1. The District Attorney dropped the charges because, although traces of cocaine were found in the baby's blood at birth, there was no harm to the baby. *Mom Likely to Avoid Prenatal Child Abuse Charge*, The Phoenix Gazette, Nov. 21, 1986, at B7.

66. In a case in Yonkers, New York, a District Attorney initially brought manslaughter and criminally-negligent homicide charges against a woman following an attempted self-abortion during her ninth month of pregnancy. The baby was born alive but died shortly thereafter. The District Attorney argued that the indictment was proper, saying "that homicide charges can be brought against a woman if, while pregnant, she damages her fetus and if, after its birth, the infant survives for a time before succumbing to its injuries. He added that someone other

attempted to amend its child abuse laws to include fetuses.[67]

B. New Social Forces

Several social changes are fueling the trend toward punitive and coercive intervention in pregnancy. The current media and popular attention focused on drug abuse[68] and its potentially negative effects on newborns has generated more punitive attitudes toward addicted mothers than previously existed.[69] Medical knowledge about the harmful effects of drug use by pregnant women to their fetuses is growing,[70] and public awareness about these consequences has likewise increased.[71] This awareness is coupled with heavy media coverage of the growing number of addicted mothers.[72] As a result, involuntary treatment of pregnant women is now advocated as a "solution" to the problem of the adverse consequences of inadequate prenatal care.[73]

A second social force fueling the interventionist trend is the development of new bio-medical techniques that allow *in utero* treatment of fetuses. The availability of these techniques has created the perception that a fetus shares with the mother equal status as a patient. The advance of medical knowledge combined with new technologies has provided the means for diagnosing and

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than the mother can be charged with homicide under similar circumstances." *Abortion Case Raises New Issues*, The City Sun, Nov. 14-20, 1984, at 8.

67. *Bill Offered Based on Pamela Rae Stewart Baby Case*, San Diego Union, Mar. 7, 1987, at A3, col. 1.

68. *See generally*, Ehrenreich, *Drug Frenzy*, Ms. 20 (Nov. 1988); *Baby Death Case Attracts Interest*, San Diego Union, Oct. 8, 1986, A1 ("There is such a close tie between two situations going on right now, between drugs and abortion. . . . It smacks of the whole McCarthy era of the '50s. It's such a witch hunt. If you want to nail someone, just mention drugs."); *Washington Junkies in Need of a Fix (Drug Crusade and Politicians)*, L.A. Daily Journal, Sept. 29, 1986, at 2, col. 5; Bewley, *Over-Reaction to Drug Dependence — A Changing Menace*, 53 MEDICO-LEGAL J. 70, 70-86 (1985).

69. *See, e.g., This Is What You Thought: 46% Say Prenatal Abuse Should Be a Criminal Offense*, 86 GLAMOUR 109 (May 1988); *Maternal Substance Abuse, supra* note 10, at 1235 (advocating criminal penalties for women who use alcohol, drugs, or tobacco during pregnancy).

70. *See, e.g., 'Passive Smoking' Study Identifies Risks to Infants, Pregnant Women*, THE CHRONICLE OF HIGHER EDUC. 7 (1986) (study found that women whose husbands smoke may be more likely to give birth to smaller babies than those married to non-smokers).

71. THE GALLUP REPORTS, No. 260, *Alcohol Use Cause of Birth Defects?* (1987) (ninety percent of the population agree that use of alcohol by pregnant women can cause birth defects); THE GALLUP REPORTS, No. 242, *Awareness of the Effect of Alcohol Upon Pregnant Women* (1985) (awareness that alcohol may be a cause of birth defects has risen from fifty-four percent in 1984 to sixty-eight percent in 1985).

72. *See, e.g., Widespread Abuse of Drugs by Pregnant Women Is Found*, N.Y. Times, August 30, 1988, at A1, col. 1 [hereinafter *Widespread Abuse*]; *More Drug-Exposed Babies Being Born*, San Diego Union, Oct. 19, 1986, at A1, col. 3; *Help Is Hard to Find for Addict Mothers*, L.A. Times, Dec. 12, 1986, at J1; *Crack Addiction: The Tragic Toll on Women and Their Children*, N.Y. Times, Feb. 9, 1987, at B1, col. 1.

73. *Legal Issues In Prenatal Addiction*, in DRUG USE IN PREGNANCY 155 (1986); *see generally Maternal Substance Abuse, supra* note 10; *see also, Preventing Addict Babies*, San Diego Union, Oct. 26, 1986, at C2, col. 1 (editorial) ("Society cannot turn its back on the tragic national epidemic of 'cocaine babies' and other infants who begin life in an agonizing state of withdrawal from drug addiction. . . . Legal penalties would help deter fetal drug abuse in the same way that fear of arrest discourages drunk driving.").

treating fetuses as patients that are purportedly separate from their mothers.[74] "The new visual accessibility of the fetus through ultrasound and the emergence of new methods of prenatal diagnosis and treatment" are helping to transform popular perceptions of the fetus.[75] The concept of the fetus as a patient separate from the mother is reinforced by the

> medical model of pregnancy, as an essentially parasitic and vaguely pathological relationship, [which] encourages the physician to view the fetus and mother as two separate patients, and to see pregnancy as inherently a conflict of interests between the two. Where the fetus is highly valued, the effect is to reduce the woman to what current obstetrical language calls "the maternal environment."[76]

Another source of popular pressure upon the state to regulate conduct during pregnancy coercively is generated by the anti-abortion movement. Frustrated in its failed attempt to create fetal "personhood" by means of constitutional amendment,[77] the movement now urges the expansion of the concept of legal personhood to fetuses through judicial decisions and state legislation.[78] The creation of "fetal rights" buttresses their efforts. Abortion opponents have attempted to advance fetal rights as part of an argument against abortion, "claiming that it is inconsistent to acknowledge a right to sue but not a 'right to live.' "[79] Consequently, abortion foes also embrace the criminalization movement, recognizing its potential to eviscerate a woman's

74. *See generally, The Fetal Patient, supra* note 35 (the human fetus is no longer a "medical recluse" due to new techniques which enable doctors to make prenatal diagnoses and treatments).

75. Gallagher, *Fetal Personhood and Women's Policy*, 10 SAGE WOMEN'S POL'Y STUD. 91, 92 (1985).

76. Rothman, *Commentary*, 16 HASTINGS CENTER REP. 24, 25 (1986).

77. "The most consistent Right to Life effort has centered on passage of a constitutional amendment that would outlaw abortion by declaring the fetus a person." Gallagher, *supra* note 75, at 93 (citations omitted).

78. For example, a Connecticut judge denied a petition to authorize an abortion for a comatose woman, saying that the mother's doctors had advised him there was a ninety percent chance that she would bear a healthy baby. Instead, the judge appointed a guardian to represent the fetus. Representatives of "right-to-life" groups called the judge's action "extremely significant," saying that "court decisions in other states on the rights of a fetus have been 'all over the place' and [they hope] 'this one will be the precedent-setter.' " *Comatose Woman's Fetus Is Focus of Dispute*, N.Y. Times, Mar. 8, 1987, at A39, col. 1. Also, "[l]egislative reports indicate that feticide has become a standard part of "right-to-life" agendas .... With the failure of the Akron ordinance and the human life amendment right-to-lifers have increasingly focused on issues of state law. Feticide is one of them." Memorandum from Nan D. Hunter to American Civil Liberties Union, 2 (May 5, 1986).

79. Gallagher, *supra* note 75, at 103. Further, one "right-to-life" advocate has argued that "[i]t would be madness to rule that taking cocaine, for example, and then harming the infant is prosecutable but injecting salt to kill it (in an abortion) isn't." *Local Case Raises Unique Legal Questions*, Daily Californian, Oct. 5, 1986, at A1, col. 1 (quoting James Knoblock, president of the San Diego Right to Life Council). Nonetheless, some "right-to-lifers" have recognized that creating a criminal class of mothers might backfire because prosecuting drug addicted mothers could lead to an increase in abortions among patients who fear action after their babies are born. *Lords Consider Action Against Addict Mothers*, The [London] Observer, Oct. 5, 1986.

reproductive choice in the name of fetal rights.[80]

The combination of these new social forces has created a climate in which the fetus increasingly is perceived as a legal being which may be "protected" from its mother by the state, by force if necessary, at the expense of the mother's autonomy. The attempt to criminalize maternal conduct during pregnancy is an extreme extension of this pressure for coercive intervention by the state in a woman's pregnancy.

C. *Newly Perceived State Interests*

Changes in the social context have led to the assertion of newly perceived state interests. The interests asserted by the state in situations where the notion of "fetal rights" is invoked include: the protection of the potentiality of human life;[81] the protection of the fetus' right to be born with "sound mind and body";[82] and the enforcement of legal maternal duties toward "unborn children."

Criminalization advocates assert that the state has an "important and legitimate interest in protecting the potentiality of human life"[83] that justifies criminalizing maternal behavior that might harm the fetus.[84] These advocates claim that the state interest in protecting the fetus is not confined to the abortion context.[85] Instead, because the state interest in protecting fetal life can limit affirmative acts after viability — such as abortion — that are intended to terminate the life of the fetus, the state by logical extension has the power to proscribe and punish *failures* to act as well.[86] One criminalization

80. According to the general counsel of the National Right to Life Committee, *Stewart* stands for the principle that unborn children are entitled to legal protection. "Just as born children can be subject to abuse and neglect, so can unborn children. . . . They have a right to be protected from that." *Woman Contributing to Baby's Demise During Pregnancy*, L.A. Times, Oct. 1, 1986, at 1, col. 4.

See also, *Fetal Neglect Anxieties*, The Washington Times, Oct. 24, 1986, at E1 ("[I]f the prosecution [for fetal neglect] sticks, there will be at least one legal ruling which will slide us back toward re-establishing, in law, the fact that the unborn child is a human being with rights"); *Charges Against Mother in Death of Baby Are Thrown Out*, N.Y. Times, Feb. 27, 1987 at A25, col. 1 (the District Attorney in *Stewart* argued that "[f]etuses are people.").

81. *See, e.g.*, *Maternal Substance Abuse*, *supra* note 10, at 1221-29 (discussing state interest in reducing avoidable costs of care and protection of fetal life).

82. *See, e.g.*, Shaw, *The Potential Plaintiff: Preconception and Prenatal Torts*, 2 GENETICS & THE LAW 219, 228-29 (1980).

83. Roe v. Wade, 410 U.S. 113, 162 (1973). Although *Roe* initially appears to be the relevant constitutional precedent, it is inapplicable because the interests at stake are different, thus altering the balancing outcome. From the woman's perspective, the issue in *Roe* was whether a woman had the right to terminate her pregnancy. Her interest in the criminalization context is whether she, having decided to carry the fetus to term, can be compelled to refrain from certain conduct. From the state's perspective, the issue in *Roe* was whether the state had a sufficient interest in preserving maternal health or protecting potential life. In criminalization, the state's interest is in protecting the *quality* of the life that the child will live.

84. Myers, *Abuse & Neglect of the Unborn: Can the State Intervene?*, 23 DUQ. L. REV. 1, 18 (1984). *See also* Bross, *supra* note 35, at 14.

85. Myers, *supra* note 84, at 18.

86. "The freedom of choice, which I believe to be a woman's right for first-trimester abor-

advocate succinctly stated the argument:

> The state's interest in viable fetal life permits it to forbid abortion, an act designed to extinguish life. It follows from this that the state is empowered to proscribe other acts calculated or likely to lead to the same result. Furthermore, since the interest in preservation of fetal life authorizes intervention to prevent destructive acts, it should also authorize limited compulsion of action which is necessary to preserve fetal life. Since a failure to act can as surely lead to frustration of the state's interest as an affirmative act, the underlying interest must reach both cases.[87]

Based on this rationale, several courts have sustained intervention in a pregnancy.[88]

A second state interest frequently asserted is protection of the future child's "right to be born with a sound mind and body."[89] Courts that recognize this legal right "have permitted children to maintain actions against persons who negligently interfered with their right to commence life unhampered by disease or defects."[90]

The third perceived state interest commonly invoked to justify regulation or criminalization is enforcement of an alleged legal maternal duty to care for

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tions, is not applicable past the point of viability." Oppenheimer, *The Civil Liberties of the Unborn*, N.Y. Times, Oct. 23, 1986, at A26, col. 2.

87. Myers, *supra* note 84, at 18.

88. Another interest allegedly justifying state invervention in pregnancy is "paternal rights," raised in cases where fathers seek to prevent abortions by their wives or girlfriends. Though seemingly settled by Planned Parenthood v. Danforth, 428 U.S. 52 (1976), an Indiana court recently granted a court order to a boyfriend forbidding his girlfriend to have an abortion. *Woman Has Abortion, Violating Court's Order on Paternal Rights*, N.Y. Times, Apr. 14, 1988, at A26, col. 1. The court, in issuing the order, found that the woman would not be "stigmatized by unwed motherhood," that there was no evidence that maternity would force her into a distressful life or future, and that the only distress associated with continuing the pregnancy was her wish to look nice in a bathing suit this summer." *Id.* But the Supreme Court of Indiana denied the father's motion, finding the mother's interest outweighed the father's. Doe v. Smith, 527 N.E.2d 177 (1988) (per curiam). *See also*, Myers v. Lewis, 109 S. Ct. 494 (1988) (whether state's interest in protecting right of husband to care, custody, and companionship of his child can sustain trial court injunction preventing woman from obtaining abortion).

The notion of legally defensible paternal right to manage a woman's pregnancy raises the frightening prospect that men will be permitted to force the mothers of their children to conform to a lifestyle of men's choosing.

89. Shaw, *supra* note 82, at 228-229; Myers, *supra* note 84, at 60 ("the unborn child possesses a right to gestation undisturbed by wrongful injury, and a right to be born with a sound mind and body, free from parentally inflicted abuse or neglect."). *See also* Grodin v. Grodin, 102 Mich. App. 396, 301 N.W.2d 869 (1981); Womack v. Buchhorn, 384 Mich. 718, 187 N.W.2d 218 (1971); *In re* Sampson, 317 N.Y.S.2d 641 (N.Y. Fam. Ct. 1970); *In re* Clark, 185 N.E.2d 128 (Ct. Comm. Pleas Ohio 1962); Hoener v. Bertinato, 67 N.J. Super. 517, 171 A.2d 140 (Juv. & Dom. Rel. Ct. N.J. 1961); Smith v. Brennan, 31 N.J. 353, 157 A.2d 497 (1960). *But see* Stallman v. Youngquist, 102 Mich. App. 396, 301 N.W.2d 869 (1980) (there is no right to be born with a sound mind and body).

90. *Recovery for Prenatal Injuries, supra* note 25, at 589, 605.

her unborn child. According to this theory, if the mother conceives and "chooses" not to abort, she has a

> legal and moral duty to bring the child into the world as healthy as is reasonably possible. She has a duty to avoid actions or omissions that will damage the fetus and child, just as she has a duty to protect the child's welfare once it is born until she transfers this duty to another. . . . [O]nce the mother decides not to terminate the pregnancy, the viable fetus acquires rights to have the mother conduct her life in ways that will not injure it.[91]

Thus, once a woman "decides" not to abort her fetus, she waives her right to autonomy that is guaranteed to other patients and assumes a duty of self-care that is not required of other people.

These newly formulated state interests reflect an attempt by states to respond to popular pressure to improve the quality of prenatal care and to prevent prenatal harms. Because the interests in this context differ from the contexts in which existing legal tools were created, the emerging legal doctrine of "fetal rights" and the accompanying state interests fail to address effectively the true and legitimate concerns underlying the intervention trend — the concern with effective prenatal health care, and protection of the mother's liberty interests.

II.
PROFILE OF THE POPULATION

Three primary causes of infant mortality and birth defects include genetics,[92] lack of prenatal care,[93] and substance abuse during pregnancy. The question from a health policy perspective is whether criminalizing inadequate prenatal care or substance abuse during pregnancy will effectively lessen infant mortality and illness. The answer is that it will not.

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91. Robertson, *Procreative Liberty and the Control of Conception, Pregnancy and Childbirth*, 69 VA. L. REV. 405, 438 (1983); *see also*, Mathieu, *supra* note 10, at 49; *Recovery for Prenatal Injuries*, *supra* note 25, at 605 (pregnant woman has duty of care); Bross, *supra* note 35, at 14.

92. Ever since the rise and fall of the eugenics movement, which sought to improve the genetic make-up by sterilizing immigrants, racial minorities, and criminals, state control of the genetic pool has dramatically decreased. *See* D.J. KEVLES, IN THE NAME OF EUGENICS: GENETICS AND THE USES OF HUMAN HEREDITY (1985).

93. The terms "adequate, intermediate, and inadequate" prenatal care refer to the classification scheme developed by Kessner. D.M. KESSNER, J. SINGER, C.E. KALK, E.R. SCHLESINGER, INFANT DEATH: AN ANALYSIS FOR MATERNAL RISK AND HEALTH CARE, CONTRAST IN HEALTH STATUS (1973). The terms "early, delayed, and late" refer to prenatal care that begins in the first, second, and third trimesters of pregnancy, respectively. The term "insufficient prenatal care" is a general label used to describe care that is neither adequate nor begun early in pregnancy. INSTITUTE OF MEDICINE, PRENATAL CARE: REACHING MOTHERS, REACHING INFANTS 26-29 (1988).

A. Access to Prenatal Care

Prenatal care and appropriate delivery services are essential to healthy pregnancies and healthy babies.[94] The lack of care and services produce tragic consequences. For example, women who do not have access to these services are three times more likely than mothers who receive adequate care to have babies that will die within the first year of birth.[95] The results of inadequate prenatal care are costly as well. A study conducted by the National Academy of Sciences concluded that every additional dollar spent for prenatal care saved at least three dollars by reducing the need for intensive care and long-term institutional care of babies born with physical or mental defects.[96] Leading public health indicators of maternal and child health include the infant mortality rate,[97] the percentage of babies born with "low birthweight,"[98] and maternal mortality rates.

In recent years, access to prenatal care and delivery services appears to have diminished, particularly among poor women.[99] Evidence of this trend is shown by recent, distressing infant and maternal mortality and low

94. Hughes, Johnson, Rosenbaum & Simons, *The Health of America's Mothers and Children: Trends in Access to Care*, 20 CLEARINGHOUSE REV. 472, 473-474 (1986) [hereinafter *Trends in Access to Care*].

Services recommended during pregnancy to prevent infant and maternal morbidity and mortality include: health education, nutrition counselling; early physical examination; childbirth preparation training; psychosocial assessment and counselling; breastfeeding guidance; continuous, supportive care during labor and delivery; post-partum follow-up; and family planning to allow optimal spacing of births. RESEARCH AND SPECIAL PROJECTS UNIT, DIVISION OF CONSUMER SERVICES, CALIFORNIA STATE DEPARTMENT OF CONSUMER AFFAIRS, PREGNANT WOMEN AND NEWBORN INFANTS IN CALIFORNIA: A DEEPENING CRISIS IN HEALTH CARE iv-v (1982) [hereinafter PREGNANT WOMEN AND NEWBORN INFANTS IN CALIFORNIA].

95. U.S. DEP'T OF HEALTH, EDUC. & WELFARE, HEALTH PEOPLE: THE SURGEON GENERAL'S REPORT ON HEALTH PROMOTION AND DISEASE PREVENTION (1979), *cited in Trends in Access to Care*, *supra* note 94, at 473.

96. Pear, *States Act to Provide Health Care Benefits to Uninsured People*, N.Y. Times, Nov. 22, 1987, at A1, col. 6.

97. Infant mortality often reflects living conditions, quality of care for children, and medical care for treatable or controllable conditions, such as infection and accidents. THE NATIONAL COMMISSION TO PREVENT INFANT MORTALITY, DEATH BEFORE LIFE: THE TRAGEDY OF INFANT MORTALITY—APPENDIX 27-32 (1988) [hereinafter THE TRAGEDY OF INFANT MORTALITY].

98. Low birthweight refers to infants born weighing less than 5-1/2 pounds. This may result from a baby growing inadequately during the pregnancy or a baby being born too soon. The smaller the baby, the poorer the chances for survival. Low birthweight is a major factor in infant mortality — babies born weighing less than 5-1/2 pounds are forty times more likely to die in the first month of life than are babies who are born within a normal weight range. *Id.* at 23-26.

99. *Trends in Access to Care*, *supra* note 94, at 474. Recent definitive studies on the issue of access to maternity care include: CHILDREN'S DEFENSE FUND, THE HEALTH OF AMERICA'S CHILDREN: MATERNAL AND CHILD HEALTH DATA BOOK (1988); INSTITUTE OF MEDICINE, *supra* note 93; THE TRAGEDY OF INFANT MORTALITY *supra* note 97; NATIONAL GOVERNOR'S ASSOCIATION, REACHING WOMEN WHO NEED PRENATAL CARE (1988); THE ALAN GUTTMACHER INSTITUTE, BLESSED EVENTS AND THE BOTTOM LINE: FINANCING MATERNITY CARE IN THE UNITED STATES (1987).

birthweight statistics. A 1988 study by the Children's Defense Fund[100] published national findings on infant mortality rates. The study found that between 1984 and 1985, infant mortality increased nationwide by three percent among black infants and by one percent among all nonwhite infants.[101] Improvement in the infant mortality rate in the United States stopped in 1985.[102]

Low birthweight statistics also reflect declining maternal and child health. The Children's Defense Fund study found that the percentage of babies born at low birthweight increased in 1985 for the first time in twenty years.[103] The same study found that maternal mortality among black and all nonwhite women increased in 1985.[104] Three-quarters of the causes of these deaths are preventable, so this rate should be declining rather than increasing. Black women face a substantially higher risk of death.[105]

Statistics measuring rates of prenatal care indicate that between 1984 and 1985, the percentage of babies born to mothers who received late or no prenatal care increased; for the sixth consecutive year this key indicator either failed to improve or actually worsened.[106] In 1985, three out of every ten women of all races, and one out of every two black women, did not receive adequate prenatal care.[107] Use of prenatal care is especially low in certain states,[108] and wide disparities in the use of prenatal care continue to exist between white and black mothers.[109]

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100. CHILDREN'S DEFENSE FUND, *supra* note 99.

101. Not since 1964, just before the start of Medicaid and community health centers, have neonatal mortality rates among black and nonwhite infants increased. The year 1985 was also the first year since at least 1960 that overall neonatal mortality failed to decline. *Id.* at ix.

102. This halt followed the slowdown in progress in reducing infant mortality that has been occurring since 1981. Seventeen states experienced overall increases in infant mortality rates between 1984 and 1985. *Id.* at ix. The overall United States infant mortality rate placed it nineteenth in the world behind such countries as Spain and Singapore.

103. *Id.* at ix. "Simultaneously, the prematurity rate increased by 4 percent. While the percentage of babies born at low birthweight was virtually unchanged from 1980 to 1984, it had declined by 13 percent between 1970 and 1979. Now this modest progress is being reversed." *Id.*

Each low birthweight birth that could be averted would save the United States health care system between $14,000 and $30,000, estimated the National Commission on Infant Mortality. The lifetime costs of caring for a low birthweight infant can reach $400,000. The costs of prenatal care — care that might prevent the low birthweight condition — can be as little as $400. THE TRAGEDY OF INFANT MORTALITY, *supra* note 97, at 9.

104. CHILDREN'S DEFENSE FUND, *supra* note 99, at 10.

105. In 1985, black maternal mortality was almost four times as high as that of white mothers. This disparity can be explained largely by minority women's reduced access to adequate health care. *Id.* at ix.

106. *Id.* Although medical experts regard early care as critical to infant health, in 1985 nearly one-quarter of all infants were born to mothers who did not receive care during the important first trimester of pregnancy. *Id.*

107. The adequacy of care is determined by the time of the initiation of care and the number of visits received. While seventy-six percent of all infants in 1985 were born to mothers who received early care, only sixty-eight percent were born to mothers who received care that could be classified as adequate. *Id.* at 12-14.

108. *Trends in Access to Care*, *supra* note 94, at 473.

109. *Id.* at 474. In 1983, 79.4% of white mothers received prenatal care. By contrast, only 61.5% of black mothers received prenatal care that year. *Id.*

Several characteristics of the United States health care delivery system contribute to the recent decline in access to prenatal care and growing restrictions on hospital services for pregnant women. Financial barriers are substantial and have been exacerbated by an increase in the numbers of persons without health insurance.[110] Further, substantial reductions in federal funding for important maternal health programs impede access[111] as does inadequate state coverage of services vital to sound pregnancy management.[112] Other causes, including inadequate service providers and practical and cultural barriers, also have combined to prevent meaningful access to maternity care for women of all socioeconomic classes.

The primary barrier is, of course, financial. Having a baby is expensive. The average bill for having a baby hovers around $4,300 by recent estimates, approximately one-fifth of a typical young couple's annual income.[113] The health care system in the United States operates on the assumption that payment for necessary health care is achieved through private health insurance, usually provided for by employers. Yet for women, having private health insurance is no guarantee that pregnancy care will be paid for. In 1987, five million women of childbearing age had private health insurance that did not cover maternity care.[114] Most women are in plans that impose waiting periods; one-fifth are in plans that exclude those already pregnant.[115] Most policies do not pay the full medical bill, and half do not cover routine doctor care for the baby in the hospital.[116]

The rise in the uninsured population over the last decade also has contributed to the decline in access to adequate prenatal care. Between 1979 and 1983, the number of uninsured persons increased by more than twenty-two percent.[117] Poor women are disproportionately represented in the uninsured

110. *Id.* at 477. According to the Census Bureau, at least thirty-one million people and perhaps as many as thirty-seven million had no private or public health insurance in early 1986. *See* Pear, *supra* note 96.

111. *Trends in Access to Care*, *supra* note 94, at 477.

112. CHILDREN'S DEFENSE FUND, FINANCING MATERNITY CARE FOR LOW-INCOME WOMEN: RESULTS OF A NATIONWIDE MEDICAID SURVEY at 8 (1985) [hereinafter MEDICAID SURVEY].

113. THE ALAN GUTTMACHER INSTITUTE, *supra* note 99, at 18.

114. NATIONAL COMMISSION ON INFANT MORTALITY, *supra* note 97, at 16.

115. THE ALAN GUTTMACHER INSTITUTE, *supra* note 99, at 22.

116. *Id.* at 24.

117. The numbers increased from 28.7 million to 35.1 million. *Trends in Access to Care*, *supra* note 94, at 477, *citing* ROBERT WOOD JOHNSON FOUND., ENACTMENT OF INDIGENT HEALTH CARE ADMIN. PROGRAM (1985). This increase is due to several factors. First, in the four year period studied, the country experienced a sharp increase in poverty. Many Americans were left unemployed by the recession in the early 1980s. Even as these workers were reemployed, many returned to lower-paying jobs that do not include health insurance in their fringe benefits. Many employers curtailed fringe benefits to reduce costs and avoid loss of jobs. Finally, the large cuts in 1981 made in AFDC and Medicaid resulted in the loss of medical benefits to more than one million children and their caretakers losing medical benefits. *Trends in Access to Care*, *supra* note 94, at 478. In 1986, the Census Bureau estimated that perhaps as many as thirty-seven million people had no private or public health insurance. Pear, *supra* note 96, at A1, col. 6.

population.[118] Thirty-six percent of all poor women of child-bearing age are completely without insurance, compared to ten percent of all other women.[119] One factor contributing to the uninsured status of poor women is the lack of impact their employment status has upon their insurance status. Working women tend to be concentrated in industries that do not offer employer-purchased health insurance.[120] Second, many low-income women rely on the coverage plans of their spouses. The spouses of these poor women, however, tend to have poor or nonexistent dependent coverage because they themselves are low-income workers.[121] Poor women who are uninsured are often denied delivery care because they lack the resources to cover pre-admission deposits routinely required of uninsured people.[122] These women are already at high medical risk because they have been unable to obtain prenatal care or other needed health care. Thus, essential health services are unavailable to women who need them the most.[123]

Because of the large number of child-bearing women who are uninsured, public health programs are particularly critical in the area of prenatal health care. Unfortunately, neither federal nor state programs guarantee the prenatal care or the delivery services needed to ensure healthy babies. On the federal level, funding for important maternal health programs such as Medicaid,[124] Title V Maternal and Child Health Block Grant,[125] Community Migrant Health Centers,[126] the Women, Infants, and Children Food Supplement Program,[127] and Family Planning Programs have been severely cut back.[128]

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118. *Trends in Access to Care*, *supra* note 94, at 477.

119. *Id.*, citing Gold & Kenny, *Paying for Maternity Care*, 17 FAM. PLAN. PERSP. 103-11 (1985).

120. MEDICAID SURVEY, *supra* note 112, at 2; *see also* Pear, *Expanded Right to Medicaid Shatters the Link to Welfare*, N.Y. Times, March 6, 1988 at A1, col. 5, A32, col. 1 ("many employers have become less willing to pay health insurance premiums for coverage of their employees' dependents").

121. MEDICAID SURVEY, *supra* note 112, at 3.

122. *Trends in Access to Care*, *supra* note 94, at 474.

123. *Id.* at 475.

124. Medicaid is a program established by Title XIX of the Social Security Act, 42 U.S.C. § 1396 (1985), that sets out federal guidelines. Within these guidelines, states design their own programs. Although states must meet some minimum standards, they have numerous options to choose among in determining who is eligible and what services beneficiaries get. NATIONAL HEALTH LAW PROGRAM, BIRTH RIGHTS: AN ADVOCATE'S GUIDE TO ENDING INFANT MORTALITY 48 (1983) [hereinafter BIRTH RIGHTS].

125. "Title V Maternal and Child Health Block Grant provides states with funds to promote, develop, and deliver a range of health services to impoverished and medically underserved mothers and children." BIRTH RIGHTS, *supra* note 124, at 89.

126. "Community and Migrant Health Centers are community-based non-profit providers of primary medical care to indigents living in medically underserved areas." *Id.* at 120.

127. "Women, Infants, and Children Food Supplement program (WIC) provides access to nutritious foods to low income pregnant women, nursing mothers, infants, and children under five years of age. The funding for the WIC program is allocated by Congress. . . . The money goes to state health departments and is then distributed to local communities. Most local WIC agencies are non-profit private or public entities such as clinics, community centers, community action projects, etc." *Id.* at 105.

128. *Trends in Access to Care*, *supra* note 94, at 478.

Medicaid, the largest source of public funding of health care for pregnant women and infants, covers less than forty percent of the individuals in families with incomes below the federal poverty level — $9,690 per year for a family of three in 1988.[129] Although the federal Medicaid statute allows states to adopt many options favorable to pregnant women,[130] restrictive Medicaid eligibility standards nevertheless preclude poor women from receiving prenatal care and delivery services essential to healthy babies.[131] Seventeen states completely exclude pregnant women living in two-parent working families from their plans, no matter how poor the family.[132] Fourteen states currently exclude coverage of medically needy women.[133] Moreover, many state Medicaid programs place limits on coverage of services vital to sound pregnancy management, such as reimbursement for clinical services, preventive services, ultrasound, and risk assessment.[134] Often the limits are unrelated to medical necessity and even contradict recommended standards of practice by the Institute of Medicine.[135]

In addition to financial barriers, inadequate system capacity presents major barriers to prenatal services.[136] There are inadequate numbers of, as well as long waiting times for, appointments at community health centers and health department clinics.[137] Access to these services is essential for women who cannot participate in the private pay system of health care.[138] At the same time that the capacity of these clinics is declining and the demand for their services is increasing — as more women of reproductive age are without adequate private health insurance — the number of private providers who accept Medicaid payment continues to decrease.[139]

A critical problem for women enrolled in Medicaid is the lack of physicians who provide women's health care, mainly obstetricians and gynecologists.[140] A 1988 report shows that of all specialities, obstetricians had the

129. THE TRAGEDY OF INFANT MORTALITY, *supra* note 97, at 16.

130. The Omnibus Budget Reconciliation Act of 1987 allowed states to sever the traditional link between AFDC and Medicaid eligibility by extending Medicaid coverage to pregnant women and children with family incomes as high as the federal poverty level. New options beneficial to pregnant women include coverage up to 185 percent of the federal poverty level, waiver of the asset test in eligibility determinations, and presumptive eligibility for Medicaid for forty-five days. Act of Dec. 22, 1987, Pub. L. No. 100-203, § 4101(a), 1986 U.S. CODE CONG. & ADMIN. NEWS (100 Stat. 1330) 140 (to be codified at 42 U.S.C. §§ 1396a(1)(A)(2)(ii)).

131. Pear, *supra* note 120, at A32, col. 1.

132. MEDICAID SURVEY, *supra* note 112, at 6.

133. *Id.*

134. *Id.* at 8-16.

135. *Id.* at 8. The reason for restrictions that contravene medical standards is that Medicaid requires that services provided to one group of Medicaid recipients must be furnished to all recipients. States thus resist comprehensive benefit coverage to control costs.

136. INSTITUTE OF MEDICINE, *supra* note 93, at 63-69.

137. *Id.* at 64-66; *see also* Statement of Xylina D. Bean, *supra* note 50, at 3.

138. INSTITUTE OF MEDICINE, *supra* note 93, at 64-66.

139. *Id.*

140. Medicaid imposes no requirement upon health care providers to participate in the

second lowest rate of participation in Medicaid.[141] Several factors have had an adverse effect on obstetrician/gynecologist participation.[142] Common complaints cited by physicians include low reimbursement rates,[143] high malpractice premiums in conjunction with the erroneous belief that low-income patients sue more,[144] burdensome, prolonged battles with the Medicaid bureaucracy,[145] and simple prejudice toward low-income patients.[146] The lack of obstetric/gynecological providers has reached crisis proportions in some states.[147]

Practical difficulties also prevent poor women from obtaining adequate prenatal care, including inadequate coordination of services, problems in securing Medicaid, unpleasant surroundings, long waits for appointments,[148] and inadequate transportation.[149] Cultural and personal values can also limit

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program. Perkins, *Increasing Provider Participation in the Medicaid Program: Is There a Doctor in the House?*, 26 HOUSTON L. REV. 77, 78-99, 81-82 (1989).

141. CONGRESSIONAL RESEARCH SERVICE, MEDICAID SOURCE BOOK: BACKGROUND DATA AND ANALYSIS 446-47 (Nov. 1988) [hereinafter CONGRESSIONAL RESEARCH SERVICE]. Studies suggest that participation of providers of all reproductive health services has declined since 1977. *Id.* at 477.

See generally, Provider Participation Studies Reveal Inadequate Access to Maternity Care for More Low-Income Women, 156 HEALTH ADVOCATE 8 (1988); THE ALAN GUTTMACHER INSTITUTE, *supra* note 99, at 34; *New York Obstetricians Report a Crisis*, N.Y. Times, Oct. 6, 1988, at B1, col. 2; THE TRAGEDY OF INFANT MORTALITY, *supra* note 97, at 75-84; Mitchell & Cromwell, *Access to Private Physicians For Public Patients: Participation in Medicaid and Medicare*, in SECURING ACCESS TO HEALTH CARE: THE ETHICAL IMPLICATIONS OF DIFFERENCES IN THE AVAILABILITY OF HEALTH SERVICES (1982); Davidson, *Physician Participation in Medicaid: Background and Issues*, 6 J. HEALTH, POLITICS, POL'Y & L. 703 (1982).

142. AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS, OB/GYN SERVICES FOR INDIGENT WOMEN: ISSUES RAISED BY AN ACOG SURVEY (1988) [hereinafter AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS].

143. *Id.* at 4; THE ALAN GUTTMACHER INSTITUTE, *supra* note 99, at 34-35; INSTITUTE OF MEDICINE, *supra* note 93, at 67-68.

144. AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS, *supra* note 142, at 4; INSTITUTE OF MEDICINE, *supra* note 93, at 229-43; CONGRESSIONAL RESEARCH SERVICE, *supra* note 141, at 447-48.

145. AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS, *supra* note 142, at 4; INSTITUTE OF MEDICINE, *supra* note 93, at 67; CONGRESSIONAL RESEARCH SERVICE, *supra* note 141, at 448.

146. AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS, *supra* note 142, at 4; CONGRESSIONAL RESEARCH SERVICE, *supra* note 141, at 448-49; Parks & Ivie, *Low Provider Participation in Medicaid: A Surmountable Obstacle to Health Care Access*, 14 CLEARINGHOUSE REV. 415, 415 (1980).

147. *See, e.g., California Lawsuits Accuse State of Inadequate Health Care for the Poor*, 155 HEALTH ADVOCATE 1 (1988). For a discussion of legal remedies for low-income women harmed by the lack of obstetrician/gynecologist participation, *see* Perkins, *Medicaid Provider Participation: A Checklist of Claims*, 21 CLEARINGHOUSE REV. 347 (1987); Perkins, *supra* note 140.

148. INSTITUTE OF MEDICINE, *supra* note 93, at 69-76.

149. Low-income women must depend on public transportation to get to health clinics. Public transportation problems include high cost, long time period spent in transit, lack of coordination between public transit schedules and clinic hours, and lack of coordination between public transit routes and location of facilities. PREGNANT WOMEN AND NEWBORN INFANTS IN CALIFORNIA, *supra* note 94, at 32.

the use of prenatal care.[150]

In effect, "fetal neglect and abuse" statutes would require states to punish economically disadvantaged women for behavior imposed by the state itself through an inadequate patchwork of state health and welfare policies. Improving the currently inadequate maternal-child health care system would promote prenatal health to a far greater degree than would imposing punitive measures. For example, a criminal statute designed to punish drug-using pregnant women who willfully refuse treatment, with an awareness of its consequences, probably would capture only a very few women who had a treatment option. On the other hand, constructing a treatment facility specially designed to treat women would enormously help significant numbers of pregnant women and improve prenatal outcome.

A statute criminalizing the failure to obtain prenatal medical care would have deeply troubling consequences in our society, which suffers from a deficiency of prenatal health care. Most women do not obtain proper prenatal care because it is not available to them, rather than out of negligence or willful disregard for the health of their fetuses. Even if a woman *wanted* to conform to a state standard of prenatal care, in many cases it would be impossible for her to do so. The problem of inadequate prenatal care and its consequences cannot be addressed through the criminal law prism of individual culpability. Rather, the problem is a systemic one.[151] Resolution will require hard choices about the long-term allocation of scarce resources in society[152] — not token prosecutions that will prove ultimately to be ineffective methods of addressing the problem.

B. Pregnant Addicts

The women who seem to be of greatest public concern are pregnant drug addicts.[153] Understandably, society feels sympathy for children who are born damaged by alcohol or drugs. To punish the addict, however, for prenatal conduct which creates a substantial risk of harm to the fetus is deeply unjust because it punishes mothers for sustaining a status which most desperately

150. INSTITUTE OF MEDICINE, *supra* note 93, at 76-81.

151. As the president of the Children's Defense Fund wrote in 1988:

> A nation that cannot, or even worse, will not shield its defenseless babies from preventable death and sickness in the first year of life when it has the means at hand, forfeits its right to be called decent. Saving our babies' lives is not a budget issue. It is not a deficit issue. It is a moral issue. I hope we never have to report facts like these again. They are the harvest of seeds of child and maternal neglect sown in this decade of rising child poverty, rampant unemployment, loss of health insurance, greed run amok, and shortsighted and uncaring government and private sector leadership. It is time to change course.

CHILDREN'S DEFENSE FUND, *supra* note 99, at xi.

152. Comprehensive recommendations for change are available in several published studies. *See, e.g., id.* at 37-38; NATIONAL GOVERNOR'S ASSOCIATION, *supra* note 99, at 9-51; TRAGEDY OF INFANT MORTALITY, *supra* note 97; and THE INSTITUTE OF MEDICINE, *supra* note 93 (assessing the most effective delivery models of prenatal care).

153. *See supra* note 46 and accompanying text.

want to end but that may be impossible to overcome without medical supervision or treatment options.[154] A punitive statute would also conflict with the constitutional prohibition against "status crimes," the common law right to bodily integrity and the concomitant right to refuse invasive treatment.

A 1988 study[155] of the incidence of substance abuse during pregnancy found that the overall incidence of substance abuse in the hospitals studied was eleven percent, with a range of 0.4 percent to twenty-seven percent.[156] The high rate of pregnancies or births in which drugs were present was not confined to the largest urban areas; instead, the rate was similar in hospitals across the country.[157] Nor was the high rate confined to hospitals with high rates of low-income or public aid patients; hospitals with small or moderate numbers of public aid patients reported an incidence of substance abuse similar to that reported by hospitals where greater than half the patients received public aid.[158]

Who are the women substance-abusers? Although data is scarce, existing studies suggest that many are of childbearing age, including teenagers experimenting with drugs, habitual users of illegal drugs, and emotionally distraught individuals using psychotropic medications procured from legal sources.[159] In addition to the chaotic lifestyle and physical discomforts of addiction, addicted women frequently must also cope with single parenthood, poor housing, inadequate income, lack of education and emotional problems.[160] The lives of these women are profoundly affected by violence. Nineteen percent report being severely beaten as a child, and a staggering seventy percent report being beaten as adults, usually by husbands or partners.[161] Fifteen percent were raped as children,[162] and twenty-one percent were raped as adults.[163] For all these reasons, the physical and mental health of drug dependent wo-

154. In a truly novel approach to controlling women's alcohol intake during pregnancy, a fetal rights advocate said, "Pregnant women who drink, even in their own homes, are furnishing alcohol to minors, and giving alcohol to minors is already forbidden by the law." *Maternal v. Fetal Rights*, AT ISSUE 1, 6 (May 1986).

155. The study, conducted by the National Association of Perinatal Addiction, Research & Education and funded by grants from the Office of Substance Abuse Prevention and the March of Dimes Birth Defects Foundation, studied 36 hospitals across the country, accounting for 154,856 births. Substances included in the survey were heroin, methadone, cocaine, amphetamines, PCP, and marijuana. *Widespread Abuse*, *supra* note 72, at A1, col. 1.

156. *Id.* at C13, col. 1.

157. *Id.* at A1, col. 1.

158. *Id.* The incidence of substance abuse during pregnancy and the occurrence of children being born addicted reported by each hospital correlated with the thoroughness with which the hospital staff screened and/or tested pregnant women patients.

159. Ronkin, FitzSimmons, Wapnes & Finnegan, *Protecting Mother and Fetus from Narcotic Abuse*, CONTEMPORARY OB/GYN 178, 178 (March 1988).

160. Regan, Ehrlich & Finnegan, *Infants of Drug Addicts: At Risk for Child Abuse, Neglect, and Placement in Foster Care*, 9 NEUROTOXICOLOGY & TERATOLOGY 315, 315 (1987).

161. *Id.* at 317.

162. *Id.* The mean age of rape as a child was 12.8 years.

163. *Id.*

men is more fragile and at greater risk than that of their drug-free counterparts.

When pregnant addicts do receive proper prenatal care, neonatal problems can be significantly reduced.[164] Yet pregnant addicts face an almost complete lack of practical access to adequate health care.[165] The reasons are twofold. First, prenatal care centers often lack the capacity to diagnose or treat drug dependency.[166] Second, drug treatment centers routinely deny pregnant women admission for several reasons.[167] Centers fear that the withdrawal or treatment process might damage the fetus or end the pregnancy,[168] thus resulting in an obstetric malpractice case.[169] Also, most treatment centers were initially founded on a male-centered treatment model, and thus they have no provision for child care. Since most pregnant addicts seeking treatment already have children[170] for whom they are the primary care-takers, the lack of child care means that a pregnant, addicted mother is forced to choose between either surrendering her children to foster care as a prerequisite to admission in a residential treatment center or foregoing treatment, thereby placing her own health and that of her fetus at continued risk.[171] Moreover, the length of waiting lists for treatment centers frequently extends beyond the

164. Finnegan, Connaughton, Emich & Wieland, *Comprehensive Care of the Pregnant Addict and Its Effect on Maternal and Infant Outcome*, 1 CONTEMP. DRUG PROBS. 795 (1972).

165. Seventy five percent of addicted pregnant women never see a physician during their pregnancies. Finnegan & MacNew, *Care of the Addicted Infant*, 74 AM. J. OF NURSING 685 (1974).

166. In San Diego County, California, "[w]ith no organized efforts to reach out into high-risk communities and no room in state- and federally funded prenatal care programs, [the county] is virtually bereft of the preventative services health experts insist are essential to reducing the number of drug-exposed babies." *Help Is Hard to Find for Addict Mothers*, *supra* note 72.

167. The policy of drug treatment centers to categorically deny admission to pregnant women is widely known anecdotally among clinicians but is not yet documented. This exclusionary and discriminatory practice is open to legal challenge under state public accommodation statues, which typically prohibit discrimination on the basis of sex. Since discrimination based upon pregnancy is a form of sex discrimination (the Supreme Court notwithstanding), and since the exclusion of these women from treatment is based on their pregnancy, the exclusionary policy of drug centers constitutes illegal sex discrimination under state public accommodations statutes.

> Most centers worry about the liability, so as soon as they discover a woman is pregnant, they refuse her or throw her out of the program.... Even emergency detoxification programs don't want pregnant women.

See Widespread Abuse, *supra* note 155, at A1, col. 1 (quoting Dr. Janet Chandles, Northwestern University Perinatal Center for Chemical Dependence).

168. Detoxification before the fourteenth week of gestation is not advised because of the theoretical risk of inducing abortion, nor is it recommended after thirty-two weeks, since it might provoke preterm labor or fetal distress. Ronkin, *supra* note 159, at 183.

169. *See, e.g.*, Perkins & Stoll, *Medical Malpractice: A "Crisis" for Poor Women*, 20 CLEARINGHOUSE REV. 1277, 1278 (1987); Rosenbaum & Hughes, *The Medical Malpractice Crisis and Poor Women*, in THE INSTITUTE OF MEDICINE, *supra* note 93, at 229.

170. *See supra* note 46 and accompanying text.

171. *Addicts Say Child-Care Problems Keep Them from Detox Units*, Phila. Daily News, June 3, 1988, at 8; *Addicted Mothers Epidemic Probed*, Phila. Tribune, June 3, 1988.

pregnant woman's due date,[172] thus rendering the benefits of treatment meaningless for the purposes of fetal development. Funding inequities based on gender also exist.[173] Although addiction rates between men and women are equal,[174] most states — with the notable exception of Pennsylvania, which recently established a direct funding allocation to women's treatment centers[175] — lack adequate funding for treatment facilities to treat pregnant women with substance abuse problems.[176] As a result of these factors, only a handful of drug rehabilitation and substance abuse treatment centers nationwide offer treatment designed especially for expectant mothers.[177]

Addicts are, by definition, physically and psychologically dependent upon drugs or alcohol.[178] A female addict who discovers that she is pregnant has essentially two choices, assuming that she has decided not to abort: continue to use the addictive drug or go through withdrawal. Both choices put the fetus' health at risk. If the mother continues her addiction, the fetus may become addicted as well and may go through withdrawal at birth.[179] If the mother goes through withdrawal during pregnancy, the resulting distress may harm the fetus.[180] Thus, it is the mother's status as an addict that creates the

172. "[W]omen alcoholics and drug addicts can wait up to six months for a bed in a residential treatment center, and even longer if they want their children with them in a program that both combats addiction and teaches mothers to cope with the responsibilities of parenthood." *More Drug-Exposed Babies Being Born*, San Diego Union, Oct. 19, 1986, at A1, col. 1.

173. Feminists and advocates for low-income people can and should challenge this inequity in funding under state equal rights amendments.

174. *Supra* note 171.

175. On October 13, 1988, the Governor of Pennsylvania announced the creation of a one million dollar statewide network of substance abuse treatment centers for addicted women with small children, plans for a $300,000 facility to treat addicted Philadelphia mothers who have abused or neglected their children, and a $3.5 million project to convert an abandoned Philadelphia foundry into a showcase treatment facility for 125 hard-core addicted mothers and their children. *Press Release*, Commonwealth News Bureau, Office of the Governor, Commonwealth of Pennsylvania (Oct. 13, 1988).

176. NAT'L INSTITUTE OF STATE ALCOHOL AND DRUG ABUSE DIRECTORS, STATE RESOURCES AND SERVICES RELATED TO ALCOHOL AND DRUG ABUSE PROBLEMS: FISCAL YEAR 1987 52 (1988). Nine states specifically cited a need for services for women, and others emphasized the need for child care services.

177. *Detoxification Center Offers Care for Pregnant Women*, HEALTH AIMS 23 (Summer 1988).

178. Whatever arguably voluntary act may have led to their addictions, persons addicted to alcohol or drugs become psychologically or physically powerless to end the addiction themselves. An essay recently published in the Journal of the American Medical Association stated: "We recognize that the behavior of women who are abusers of alcohol or drugs poses significant potential for fetal harm. . . . However, there are solid reasons to doubt that a system of legal punishment or intervention would decrease the incidence of this behavior, as it is usually an addiction over which these women have little control." Nelson & Milliken, *Compelled Medical Treatment of Pregnant Women: Life Liberty and Law in Conflict*, 259 J.A.M.A. 1060, 1060-66 (1988), *reported in Essay Attacks Orders to Protect the Unborn*, N.Y. Times, Mar. 8, 1988, at C7, col. 1.

179. Finnegan, *Substance Abuse: Implications for the Newborn, reprinted in* CONTEMPORARY OB/GYN 182, 184 (Mar. 1988).

180. Ronkin, *supra* note 159, at 178.

danger to the health of the fetus, and if maternal conduct or omissions are subject to criminal sanction, she will face the risk of punishment whether or not she continues to use the harmful substance.[181] Thus, the criminal law would be used to punish a health status over which many women lack control. Just as attempts to use the criminal law to control public drunkenness were unsuccessful,[182] so too are criminal prosecutions of women likely to be ineffective to eradicate substance abuse during pregnancy.[183]

III.
ANALYSIS OF PROPOSED STATUTES FROM A HEALTH POLICY PERSPECTIVE

To date, there have been two reported cases of state attempts to prosecute women for the crime of "fetal abuse."[184] In both cases, the court threw out the prosecution because the statutes under which the women were prosecuted were not promulgated for punitive use against the mother. However, the decisions left open the possibility of allowing such prosecutions if the state legislature passed a criminal law specifically directed at prenatal harm to a fetus.[185] If a legislature were to pass such a criminal law, the principles of Anglo-American criminal law require that imposition of punishment be fair, be effec-

181. A punitive response to debilitating disease is wholly inappropriate. Like alcoholism, "Poverty, rootlessness, and personal inadequacy, which are at the bottom of [the drug dependency], are scarcely deterrable by the threat of human conviction. And rehabilitation in the human warehouses of our city jails is unthinkable." S. KADISH, BLAME AND PUNISHMENT: ESSAYS IN CRIMINAL LAW 29 (1987).

182. *Id.* The Court in Powell v. Texas, 392 U.S. 514 (1968), turned aside an attempt to have the enforcement of public intoxication laws against alcoholics declared unconstitutional. Efforts in other courts to establish a constitutional bar to the enforcement of narcotic laws against addicts have also been largely unsuccessful. *See, e.g.*, United States v. Moore, 486 F.2d 1139 (D.C. Cir. 1973); People v. Davis, 33 N.Y.2d 221, 306 N.E.2d 787 (1973).

183. There are other concerns beyond the scope of this Note, including potential violations of the fourth amendment, that are involved when courts order forced treatment of pregnant women with substance abuse problems. The right to bodily integrity is rooted in the fourth amendment "right of the people to be secure in their persons, houses, papers, and effects, against unreasonable searches and seizures." U.S. CONST. amend. IV; *see* Terry v. Ohio, 392 U.S. 1, 9 (1968) (quoting Union Pac. R.R. v. Botsford, 141 U.S. 250, 251 (1891)). *See also* Canterbury v. Spence, 464 F.2d 772, 780 (D.C.Cir. 1972), *cert. denied*, 409 U.S. 1064 (1972); Schmerber v. California, 384 U.S. 757, 767 (1966). When determining whether a person's constitutional right to bodily integrity has been violated, courts have applied a balancing test, weighing the invasion of the body against the state interest in taking the action that causes the invasion. *See, e.g.*, Winston v. Lee, 470 U.S. 753 (1985); Roe v. Wade, 410 U.S. 113, 154 (1973); Rennie v. Klein, 462 F. Supp. 1131, 1144 (D.N.J. 1978); Superintendent of Belchertown State School v. Saikewicz, 373 Mass. 728, 730 N.E.2d 417 (1977). *See also* Gallagher, *supra* note 10, at 9, 21-23 (pregnant women's fundamental rights to bodily integrity, self-determination, and privacy protect her against government intrusion into medical decisions). The biological reality of pregnancy is that, in order for the state and a doctor to reach the fetus, they must go through the woman's body. The state's coercive invasion of a woman's body in order to treat the fetus may violate the mother's fourth amendment rights. *Id.* at 23.

184. People v. Reyes, 75 Cal. App. 3d 214, 141 Cal. Rptr. 912 (1977); People v. Stewart, No. M508097, slip op. (San Diego County Ct. Feb. 23, 1987).

185. *See* People v. Stewart, No. M508097, slip op. (San Diego County Ct. Feb. 23, 1987).

tive to achieve state goals, and be constitutional. Any statute punishing pregnant women for harm to their fetuses that meets these requirements would necessarily be so narrow that it could not vindicate the newly articulated state interests that have been designed to reflect social concern about fetal well-being: the protection of potential life, the right to be born with a sound mind and body, or the enforcement of a particular standard of maternal care.[186] Not only would a narrow statute be ineffective to achieve these goals, it would also violate constitutional prohibitions on vagueness, a woman's rights to liberty, and guarantees of equal protection.

Theories of criminalization generally require that punishment be imposed only when there is both a criminal act and a culpable mental intent.[187] Recognized defenses to crimes exist when these two requirements are not met. For example, the requirement of culpable mental intent is not met when such defenses as duress or the lack of mental capacity are shown; and the requirement of a criminal act is not met when such defenses as impossibility are shown. Although the cases are limited to *physical* impossibility or a mental deficiency, nonetheless, these defenses were created to reflect the general concern that, in Anglo-American law, punishment is suitable only when the actor intended the harmful result. This principle has a religious basis in history.[188] The religious view at the conception of the common law was that human life is a testing ground for one's suitability for heaven or for hell.[189] The intent defenses were designed to ensure that only those who consciously chose to do evil would be punished.[190] The hope was that the human system of justice would mirror the system of divine justice.[191]

Thus, Anglo-American criminal law reflects the principle that it is unfair to punish people for evil actions that they have not chosen to do.[192] Because punishment in the absence of capacity is recognized to be fundamentally unjust, lack of capacity is recognized as justification for failure to conform to the law.[193] Women who harm their fetuses generally do so not because they intend to, but because they do not have a choice. Therefore, compliance with

186. *See supra* note 51 and accompanying text.

187. *See* MODEL PENAL CODE, *supra* note 9, at § 2.01 (voluntary act), § 2.02 (culpable mental state).

188. *See generally* J. MARSHALL, INTENTION IN LAW AND SOCIETY 14-19 (1968).

189. *Id.* at 15.

190. *Id.* at 14.

191. *Id.* at 15.

192. W. LAFAVE & A. SCOTT, *supra* note 9, at 208. The Model Penal Code uses the term "physically capable" to describe when a person is acting voluntarily and can be criminally punished. MODEL PENAL CODE, *supra* note 9, at §§ 2.01, 2.12. This phrase has been interpreted to refer to reflexes and convulsions, but the underlying principle is a concern with identifying those who consciously choose to rebel against the divine order. As LaFave states: "But impossibility means impossibility. Thus, though a poverty-stricken parent would not be criminally liable for his child's death resulting from the failure to provide food and shelter if it is impossible for him to obtain these necessities, he would be liable if he failed to go to an available welfare agency for help." W. LAFAVE & A. SCOTT, *supra* note 9, at 209.

193. W. LAFAVE & A. SCOTT, *supra* note 9, at 209.

this principle requires that pregnant women not be criminally punished for unintended harm to their fetuses.

A. The Unworkability of an Objective Standard

Generally, criminal liability requires mens rea, meaning an evil mind or a bad intent.[194] There are two general levels of intent used in criminal statutes[195] — an objective intent, requiring recklessness or negligence, and a subjective intent, requiring that the person act purposely or knowingly as a condition of criminal liability. This section focuses on the application of an objective standard of care during pregnancy to women who harm their fetuses.

It is not possible to create an objective standard of care by which to judge maternal conduct, for several reasons. By articulating such a standard of care, the state effectively punishes women whose negligent or reckless conduct during pregnancy harms their fetuses in a strict liability sense. Regardless of whether these women were financially or physically able to meet an objective standard of appropriate conduct for pregnant women, they will be deemed criminally liable. Second, the determination of the "reasonableness" of care will necessarily vary in specific circumstances. An example illustrating both of these points is the pregnant woman who is also the head of her household and who must work later into her pregnancy than may be established by the objective standard of care. Although her decision to continue working may be perceived as a violation for which she might be prosecuted, economic necessity makes the decision to work a reasonable one.

Furthermore, a "reasonable" standard of care must take into account not only the health requirements of the fetus, but the health requirements of the mother as well. It is entirely possible that different reasonable mothers may make different but equally reasonable choices when faced with the same health care decision.[196] Educating women about the potential dangers of their actions to the fetus is preferable to subjecting women to control by courts and physicians, particularly because medical science is fallible.

Lastly, an objective intent requirement is unworkable because reasonable people can and do differ as to the correct standard of care during pregnancy.[197] One commentator suggests a standard of the "reasonable" mother

194. "Actus non facit reum, nisi mens sit rea." (An unwarrantable act without a vicious will is no crime at all) Blackstone, cited in S. KADISH, *supra* note 181, at 65. *See, e.g.*, Morisette v. United States, 342 U.S. 246 (1952).

195. *See generally*, MODEL PENAL CODE, *supra* note 9, § 2.02. Intentional mens rea requires an intention or purpose to do the forbidden act or omission or to cause the forbidden result, and "knowledge" crimes require knowledge of the nature of act/omission or of the result which will follow from the circumstances.

196. *See infra* notes 200-02 and accompanying text.

197. Some criminalization advocates argue that mothers have a legal duty to their fetuses based upon voluntary assumption of care. Robertson, *supra* note 22, at 437. "Once [the mother] decides to forego abortion and the state chooses to protect the fetus, the woman loses the liberty to act in ways that would adversely affect the fetus." *Id. See also* Note, *Constitutional Limitations On State Intervention In Prenatal Care*, 67 VA. L. REV. 1051 (1981). Accord-

which includes the following characterization of "reasonable" maternal conduct: "prenatal duties . . . should include regular prenatal checkups, a balanced diet with vitamin, iron, and calcium supplementation, weight control, and judicious use of medications, tobacco and caffeine. Alcohol and narcotic use in pregnancy should be avoided entirely."[198] According to this standard, all reasonable pregnant women would also avoid "[n]egligent exposure to noxious chemicals and drugs" and would not refuse "to accept genetic counseling and prenatal diagnosis" or to "obtain prenatal therapy."[199] In contrast to this formulation of reasonable prenatal care, maternal health care choices that diverge from this standard may be reasonable. For example, when fetal and maternal health needs conflict,[200] a mother may reasonably elect to preserve her own health by *refusing* prenatal therapy. For example, treatments for maternal diabetes, epilepsy, and cancer[201] all have the potential to harm the fetus. Nonetheless, the mother's own life may be at risk if she foregoes the treatments. Having been fully apprised of the risks and benefits, a maternal patient may reasonably and ethically conclude that the treatments for her own health are necessary.[202]

On a deeper level, controversy exists as to whether the state should intrude at all into the "management" of pregnancy. Criminalizing conduct is

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ing to some commentators, once a woman decides to forego an abortion, "she places herself in a special relationship with her future child, a relationship that carries certain inherent obligations similar to those of any parent toward his or her child." Mathieu, *supra* note 10, at 37. "Having decided to use her body to procreate, she loses the bodily freedom during pregnancy to harm the child." Robertson, *supra* note 22, at 442. This "waiver" theory is flawed for two reasons. First, a woman who becomes pregnant, voluntarily or otherwise, never explicitly waives her right to bodily freedom. Second, a requirement that women surrender their basic rights of integrity and privacy creates a state-erected penalty on a woman's exercise of her right to bear children. Annas, *Pregnant Women As Fetal Containers*, 16 HASTINGS CENTER REPORT 13, 14 (Dec. 1986). Such a burden is unconstitutional. *See infra* note 258 and accompanying text.

198. Shaw, *supra* note 22, at 83.

199. *Id.* at 95.

200. "Two situations in which maternal and fetal interests can be potentially divergent are 1) the pregnant woman may refuse a diagnostic procedure, medical therapy, or a surgical procedure that may enhance or preserve fetal well-being, and if denied may produce fetal morbidity or mortality; and 2) the pregnant woman's behavior with respect to her health or life style may be deleterious to the fetus." AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS, PATIENT CHOICE: MATERNAL-FETAL CONFLICT, COMMITTEE OPINION NO. 55 (Oct. 1987) [hereinafter PATIENT CHOICE].

201. This conflict was present in *In re* A.C., 533 A.2d 611 (D.C. 1987), *vacated, reh'g granted*, 539 A.2d 203 (D.C. 1988). The mother had decided to forego caesarean delivery since the fetus was not viable, knowing that her own death was imminent and knowing a caesarean section would only cause her more pain before she died. Plaintiff's Memorandum in Response to the Court's Order to Be Informed of Further Developments in This Case at 4, *In re* A.C., 533 A.2d 611 (D.C. 1987) (No. 87-609), *vacated, reh'g granted*, 539 A.2d 203 (D.C. 1988). Many people would have made the same decision to minimize pain and surgical violation in their last few days of life. The state nonetheless overrode her decision. *See supra* note 40 and accompanying text.

202. Indeed, leaving the locus of choice with the patient, after education and counseling, is the recommended course of action of the American College of Obstetricians and Gynecologists. PATIENT CHOICE, *supra* note 200, at 1.

futile where there is no general consensus about the law.[203] For example, before abortion was made a constitutional right in *Roe v. Wade*,[204] "the primary force behind retention of the abortion laws [was the] belief that it is immoral. One of the serious moral objections is based on the view that the unborn fetus, even in its early stages of development, has an independent claim to life equivalent to that of a developed human being."[205] The identical assumption underlies attempts to criminalize neglect of a fetus. In the abortion context, the "coercive sanctions of the criminal law prove[d] unacceptable and unworkable as a means of settling clashes of sharply divided moralities."[206] Attempts to impose a uniform standard of care upon pregnant women would similarly result in widespread disobedience and lack of enforcement.

B. The Unworkability of a Subjective Standard

Given that an objective liability standard is not workable, an alternative statutory formulation might be to create a standard of prenatal care which

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203. The wisdom of using the criminal justice system to enforce private notions of morality has long been debated. For a summary of literature on moral legislation, *see* MODEL PENAL CODE, *supra* note 9, at 371, n.47 (vol. II commentary). Arguments in support of the validity of moral legislation argue that "society cannot ignore the morality of the individual any more than it can his loyalty; it flourishes on both and without either it dies." S. KADISH, *supra* note 181, at 22 (quoting) DEVLIN, THE ENFORCEMENT OF MORALS 23 (1959)). The contrary view, espoused by John Stuart Mill and H.L.A. Hart has been presented by the Wolfendon Report:

> Unless a deliberate attempt is to be made by society, acting through the agency of the law, to equate the sphere of crime with that of sin, there must remain a realm of private morality and immorality which is, in brief and crude terms, not the law's business.

Id. (quoting GREAT BRITAIN COMMITTEE ON HOMOSEXUAL OFFENSES AND PROSTITUTION, REPORT, COMMAND NO. 247 ¶¶ 61 & 62 (1957)).

Before incurring the costs of criminalizing behavior, it is vital to rationally assess the gains and losses of such a choice. Use of the criminal law to enforce conformity with private moral standards about what constitutes a "good mother" will have adverse consequences to effective law enforcement. S. KADISH, *supra* note 181, at 21. First, it incorporates a Western bias about conventional medical care that overlooks alternative methods of healing. Second, it imposes a religious assumption that underlies attempts to criminalize fetal neglect that the fetus is an independent being from its mother. Analogy to sex offense laws shows one undesirable consequence of criminalizing fetal neglect: it "will invite discriminatory enforcement against persons selected for prosecution on grounds unrelated to the evil against which these laws are purportedly addressed, whether those grounds be 'the prodding of some reform group, a newspaper-generated hysteria over some local sex crime.' " *Id.* at 23. Similarly, the criminalization effort here is an outgrowth of right-to-life groups and child advocacy groups prodding legislatures, and also the product of newspaper-generated hysteria over drug abuse.

204. 410 U.S. 113 (1973).

205. S. KADISH, *supra* note 181, at 25.

206. *Id.* at 26. "[E]stimates [of the number of illegal abortions] have ranged from a hundred thousand to a million and a half yearly. Among the factors responsible for this widespread nullification, two appear to predominate. The first is that there is no general consensus on the legitimacy of the moral claim on behalf of the fetus. While it is vigorously asserted by some portions of the community, it is as vigorously denied by others of equal honesty and respectability. . . . As with most moral offenses, therefore, sympathy for the offender combines with an unsettled moral climate to preclude any real possibility of enforcement." *Id.*

focuses on the subjective intent of the pregnant woman. A statute with a subjective standard might punish mothers who "intentionally, knowingly, or willfully create a substantial risk of serious injury to the fetus, without justification." Such a statute, however, will neither deter nor rehabilitate mothers whose behavior poses a risk of harm to their fetuses. The threat of punishment for violating the state-established code of prenatal conduct is unlikely to *encourage* this class of women to seek prenatal care. Indeed, the threat of punishment is more likely to have the exact opposite effect.[207] For example, a pregnant woman who smokes would be likely to conceal that information from her doctor and might even decrease her prenatal care visits for fear of being discovered and reported to the police. A pregnant woman who is a heroin addict would be less likely to seek treatment voluntarily for fear of incriminating herself.

Just as deterrence is a faulty justification for punishing a woman who knowingly harms her fetus, "rehabilitating" women to become state-approved mothers is highly improbable in our current penal system. Little attention is given to the needs and concerns of incarcerated mothers and their children, and even less is given to the specific needs of pregnant women in prison.[208] Indeed, "incarceration of a pregnant woman is a potential death sentence to her unborn child."[209]

Courts have found that the state frequently imposes upon its pregnant inmates the same quality of care for which the state of California attempted to punished Pamela Rae Stewart.[210] For example, in *Todaro v. Ward*,[211] the first suit in which incarcerated women challenged the adequacy of medical care delivered at a women's prison, the district court for the Southern District of New York held that some of the medical procedures at the Bedford Hills facility violated the eighth amendment prohibition against cruel and unusual punishment. Many of the medical procedures, which resulted in delayed access to

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207. The California Medical Association has stated:

> while unhealthy behavior cannot be condoned, to bring criminal charges against a pregnant woman for activities which may be harmful to her fetus is inappropriate and discriminatory. Such prosecution is counterproductive to the public interest as it may discourage a woman from seeking prenatal care or dissuade her from providing accurate information to health care providers out of fear of self-incrimination.

Letter to Lynn M. Paltrow from Gladden V. Elliott, President of the California Medical Association (Dec. 1, 1986) (on file with the New York University Review of Law & Social Change).

208. Barry, *Quality of Prenatal Care for Incarcerated Women Challenged*, 6 YOUTH L. NEWS 1, 2-3 (Nov.-Dec. 1985).

209. Stein & Mistiaen, *Pregnant in Prison*, THE PROGRESSIVE 18, 18 (Feb. 1988) (quoting Ellen Barry, director of San Francisco's Legal Services for Prisoners with Children). A recent study of three California prisons confirmed the inadequacy of prenatal care in state and county facilities. Barry, *supra* note 208, at 2-3. The study found that fewer than half (44.5 percent) of pregnant incarcerated women had pregnancies that resulted in live births and that the stages of pregnancy were not identified routinely. *Id.* at 3. The study also reported systemic problems in identifying and treating high-risk pregnancies, transporting pregnant women to outside hospitals for prenatal examination, and providing adequate prenatal nutrition. *Id.* at 2.

210. *See* People v. Stewart, No. M508097, slip op. (San Diego County Ct. Feb. 23, 1987).

211. 431 F. Supp. 1129 (S.D.N.Y.), *aff'd*, 565 F.2d 48 (2d Cir. 1977).

treatment and deficient follow-up care, significantly hurt the health of pregnant women.[212]

A statute drafted with a subjective standard of care will not encourage women to provide a state-imposed standard of care. Furthermore, punishing the pregnant woman by imprisoning her will only prevent her from conforming to the state-imposed standard of care toward her fetus.

In sum, a legislature that wants to enact legislation that will not only serve newly perceived state interests in the protection of fetal health,[213] but also will comport with basic principles of fairness and justice, must draft a limited statute that excludes punishment for conditions over which pregnant women have no practical control, such as lack of access to prenatal care or substance abuse treatment. A narrow statute would punish only intentional, knowing, or willful behavior that creates a substantial risk of serious injury to the fetus, without justification. Because only the rare pregnant woman would consciously harm her fetus, and the woman who does harm her fetus may do so because of her own personal medical necessity or lack of access to medical care, the only feasible statutory formulation will not cover the vast majority of women about whom the public seems most concerned. Therefore, a statute criminalizing maternal behavior that creates a risk of harm to the fetus will not improve the general status of neonatal health, and indeed may worsen it by deterring care.

IV.
CONSTITUTIONAL ISSUES

Even a narrowly drafted statute that would punish mothers who intentionally, knowingly or willfully create a substantial risk of harm to their fetus without a legally cognizable justification may nonetheless run afoul of constitutional requirements, including prohibitions on vagueness, guarantees of liberty and privacy, and rights of equal protection.[214]

212. Comment, *Women and Children First: An Examination of the Unique Needs of Women in Prison*, 16 GOLDEN GATE U.L. REV. 455, 461-62 (1986). In 1983, female inmates in Connecticut brought a class action suit, asserting claims similar to those at issue in Todero. West v. Manson, No. H83-366 (D. Conn. filed May 9, 1983), *cited and discussed in* Comment, *supra*, at 461-62. Prior to trial, *West* was settled. Comment, *supra*, at 461. According to the settlement agreement, the prison stated that it would supplement the dietary programs of the inmates and provide prenatal vitamins and access to prenatal classes. *Id.* at 462 & nn.66-67. Other challenges to prenatal care in prisons have been brought in Massachusetts, *see* Stein & Mistiaen, *supra* note 209, at 21, and in California. *See* Barry, *supra* note 208, at 3-4; Comment, *supra*, at 462-63.

213. State interests include the protection of potential life, or to guarantee the "right to be born with a sound mind and body," or to enforce a particular standard of maternal care. *See supra* note 47 and accompanying text.

214. For a comprehensive discussion of the constitutional issues at stake, see generally *Maternal Rights and Fetal Wrongs*, *supra* note 10, and Johnsen, *supra* note 8.

A. Prohibitions on Vagueness

A criminal statute must define its punishable offense in a sufficiently concrete manner to give adequate notice of what conduct is prohibited or required.[215] In addition, it must set standards to establish minimum guidelines to govern law enforcement so as not to prevent leaving an inherently legislative determination in the hands of the police.[216] To survive constitutional scrutiny, a criminal statute must be clear enough "to give a person of ordinary intelligence a reasonable opportunity to know what is prohibited, so that he may act accordingly."[217] A statute that imposes liability for "intentional, knowing, or willful behavior that creates a substantial risk of serious injury to the fetus, without justification" fails to give notice of the manner in which a pregnant woman must behave in order for her to comply with the statute. Would such a statute require a full course of prenatal care regardless of financial ability? Does it require medical care only when problems arise during pregnancy? Does it require that a woman merely seek advice? Does it require her to follow that advice regardless of the effect upon her own health?

In *In re Male R*, a New York court refused to find that a newborn with withdrawal symptoms had been "actually impaired" within the meaning of the child abuse statute, reasoning that

> [s]ince it is clear that a child in utero may be endangered or actually harmed by a broad range of conduct on the part of a pregnant woman, it would appear necessary to limit any application of the neglect statute to prenatal maternal conduct to a narrow and clearly defined class of cases. It may be possible to identify some cases in which it is common knowledge that the maternal conduct in question creates an unreasonable risk of harm to the fetus. However, even a "knew or should have known" standard may prove difficult to administer.[218]

Because of the potential for vagueness, a "fetal abuse" statute would probably suffer from the same constitutional infirmities which have rendered invalid the disorderly conduct and vagrancy laws of a number of jurisdictions.[219] At least one commentator has suggested that such laws "constitute,

215. *See, e.g.*, Kolender v. Lawson, 461 U.S. 352 (1983) (statute requiring loiterers to identify themselves at police request violative of due process because of failure to clarify "credible and reliable" identification); Colautti v. Franklin, 439 U.S. 379 (1979) (viability determination and standard of care provision of Pennsylvania Abortion Control Act struck down as void for vagueness); Palmer v. Euclid, 402 U.S. 544 (1971) (suspicious-person ordinance struck down because lacking in ascertainable standards of guilt).

216. *See, e.g.*, *Kolender*, 461 U.S. at 358.

217. United States v. Harris, 347 U.S. 612, 617 (1954).

218. *In re* Male R, 102 Misc. 2d 1, 10 n.18, 422 N.Y.S.2d 819 (Fam. Ct. 1979).

219. "Disorderly conduct statutes vary widely. They usually proscribe such conduct as riot, breach of the peace, unlawful assembly, disturbing the peace, and similar conduct in terms so general and imprecise as to offer the police a broad freedom to decide what conduct to treat as criminal." S. KADISH, *supra* note 181, at 31.

in effect, a grant of authority to the police to intervene in a great range of minor conduct, difficult or impossible legally to specify in advance, in which the police find it desirable to act."[220] A "fetal abuse" statute would give a police officer unlimited authority to decide when a pregnant-looking woman is doing something that in the officer's judgment might harm the fetus — perhaps smoking, drinking, running too fast, or declining surgery.

> The chief vice of these laws is that they constitute wholesale abandonment of the basic principle of legality upon which law enforcement in a democratic community must rest — close control over the exercise of the delegated authority to employ official force through the medium of carefully defined laws and judicial and administrative accountability.[221]

These types of vague statutes were severely limited by *Papachristou v. City of Jacksonville*,[222] in which the Supreme Court held unconstitutional Jacksonville's vagrancy ordinance. The Court reasoned that the extensive police discretion permitted by the ordinance violated democratic principles and served as a tool for discriminatory enforcement.[223] A "fetal neglect" law could easily result in similar discriminatory enforcement — most likely against the poor. Low-income women are in closer contact with the government through welfare agencies, public hospitals, and probation officers. As a result, they are much more likely to be reported for "fetal abuse" than are middle-class women who see private doctors and whose behavior is not supervised by the government.

The health policy effects of a vague "fetal neglect" statute would give the medical establishment wide-ranging authority to determine the mother's conduct in caring for her fetus.[224] Because nurses and doctors are more familiar with a pregnant woman's medical condition than are other members of society, criminal statutes would be enforcing their determinations.[225] This quasi-deputy role would undermine the doctor-patient privilege, eviscerate the in-

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220. *Id.*

221. *Id.* at 32.

222. 405 U.S. 156 (1972).

223. "The application of these laws often tends to discriminate against the poor and subcultural groups in the population." S. KADISH, *supra* note 181, at 32.

224. Doctors are likely to have great difficulties interpreting a legal question. Goodman, *When a Child Is Born Ill, Who Is Accountable?* L.A. Times, Oct. 7, 1986, at II5, col. 1 (" 'I have never heard of a vaguer crime than "fetal neglect," ' says George Annas, Boston University medical ethicist. 'It gives you a license to do whatever you want to a woman.' ").

225. "The use of the courts as 'enforcers' for doctors' orders or for the decision to do cesarean sections is especially startling because it flies in the face of a general legal trend toward honoring individual decision making in the area of medical care. It has long been recognized that touching someone without his or her consent can result in criminal charges or in a civil lawsuit. Doctors may not operate, or carry out medical procedures, without a patient's consent. A doctor who fails to obtain such informed consent can be sued." Gallagher, *supra* note 75, at 96-97 (citations omitted).

formed-consent model of treatment, and elevate medical advice to the status of law.

Traditionally, communication between a physician and her patient is privileged, and protected from disclosure.[226] Compulsory reporting of "fetal abuse" by all hospitals and clinics[227] and members of the medical profession would deter women from being frank with their physicians.[228] Inadequate information from the patient, in turn, would undermine the quality of the doctor's diagnosis and treatment during pregnancy, ultimately harming fetal health, rather than promoting it.

Placing the force of criminal sanction behind medical advice may also damage the informed-consent model of treatment. In this model, physicians inform patients of the risks of various medical procedures but are not empowered to make the final value choice for the patient.[229] A doctor who treats a patient without that patient's consent may face civil liability.[230] Requiring women to follow all medical advice obliterates this "consent" principle. Furthermore, imposition of a state-established preference for fetal health over that of the mother deprives members of the medical profession of their professional discretion as well.[231]

Medical advice also should not be given the force of law because medical science is fallible. For instance, twenty-five years ago medical advice to a pregnant diabetic would have included recommendations to take DES (to prevent miscarriage among diabetics), to limit weight gain during pregnancy to less than thirteen pounds, to take diuretics and to submit to X-rays.[232] Today, all of these procedures have been abandoned as dangerous.[233] Nonetheless, if the diabetic woman had not followed her doctor's advice at that time, she would have been subject to criminal prosecution under a statute that criminal-

226. United States v. Leon, 468 U.S. 897 (1984) (Brennan, J., dissenting); Grand Jury Proceeding of John Doe v. United States, 847 F.2d 744 (10th Cir. 1988); United States v. Byrd, 750 F.2d 585 (7th Cir. 1984). *See generally* MCCORMICK ON EVIDENCE 244 (3d ed. 1984).

227. *See, e.g., Maternal Substance Abuse, supra* note 10; Ament, *The Right to Be Well-Born*, J. LEGAL MED. 24, 28-9 (Nov.-Dec. 1974).

228. A California social worker reports that "I have women calling me up and asking me, 'Am I going to be put in jail because I have told you honestly about my drug problem?' " *Help Is Hard to Find for Addict Mothers*, L.A. Times, Dec. 12, 1986, at J4. Furthermore, doctors already have an inadequate ability to identify substance abuse during pregnancy. *See supra* note 158. Obstacles to confidentiality would only worsen the identification process.

229. Johnsen, *supra* note 8, at 609 n.47. *See also* Shultz, *From Informed Consent to Patient Choice: A New Protected Interest*, 95 YALE L.J. 219, 270-72 (1985).

230. *See generally*, PROSSER & KEETON, *supra* note 17, at 18.

231. For example, in *In re* A.C., 533 A.2d 611 (D.C. 1987), *vacated, reh'g granted*, 539 A.2d 203 (D.C. 1988), the "Hospital's Department of Obstetrics and Gynecology as a whole objected to carrying out the [forced Caesarean section]. As the Department's chairman, who was also one of the treating physicians, stated 'most of us will not do the procedures [ordered in this case] on the basis of our personal evaluation of the patient's wishes.' " Response to Petition for Rehearing or Rehearing en Banc at 2, *In re A.C.* (No. 87-609) (citation omitted) (App. D.C. 1988); *see supra* note 40 and accompanying text.

232. Rothman, *Commentary on When a Pregnant Woman Endangers Her Fetus*, 16 HASTINGS CENTER REP. 25 (1986).

233. *Id.*

izes fetal neglect. This example, which starkly illustrates the dangers of premising law on medical knowledge, is particulary relevant to punishing drug use during pregnancy because effective medical treatment for addition is not yet known.

Furthermore, individual doctors may make diagnostic errors.[234] Indeed, the medical judgments that form the basis for state intervention may later prove to be unsound.[235] A case frequently cited in support of forced medical treatment of the mother, when the treatment was deemed necessary for fetal well-being, was based on a medical diagnosis that turned out to be erroneous.[236] A blood transfusion was ordered over the mother's religiously-based objections. The mother left the hospital before the transfusion could be given. She subsequently delivered a healthy child without the transfusion.[237] Had the doctor's advice enjoyed the force of law, the maternal patient in that case would have been forced to violate her fundamental religious beliefs because of an erroneous medical diagnosis.

Women would not only lack notice of the conduct prohibited by the statute, but also, in many cases, they would be punished even where they lacked notice of their own pregnancy. The most severe harms to the fetus often occur early in pregnancy,[238] when many women may not know that they are pregnant.[239] Women may be unaware of their pregnancy for a variety of legitimate factors, including reliance upon failed contraception, lack of education and unfamiliarity with the signs of pregnancy, a history of irregular menstrual periods, and the psycho-biological processes of repression and denial.[240] One

234. Recognizing this, the American College of Obstetricians and Gynecologists Committee on Ethics recommends that "[o]bstetricians should refrain from performing procedures that are unwanted by a pregnant woman." PATIENT CHOICE, *supra* note 200, at 2. One of the Committee authors explained, "[W]hat we were trying to do was to get people to remember our fallibility in making these medical judgments, and become a little less cavalier about overriding what the woman wants." *Courts Acting to Force Care of the Unborn*, N.Y. Times, Nov. 23, 1987, at A1, col. 1, at B10, col. 3.

235. In a forced Caesarean section in Colorado, the doctor was surprised that the Caesarean section resulted in a healthy girl. The doctor said the case "underscores the limitations of continuous fetal heart monitoring as a means of predicting neonatal outcome." Annas, *supra* note 36, at 16.

236. *Id.*; Colloquium, *Legal Rights and Issues Surrounding Conception, Pregnancy, and Birth: Maternal Rights Versus Fetal Rights*, 39 VAND. L. REV. 819, 832 (1986).

237. *Id.* at 832.

238. *See* J.R. WILLSON & E.R. CARRINGTON, OBSTETRICS AND GYNECOLOGY 457 (8th ed. 1987).

239. Some women become pregnant despite contraceptive precautions; others bleed in early pregnancy and are mislead into thinking they are not pregnant; and others have abnormal menstrual cycles which cannot be relied upon to inform them whether they are pregnant. Some women, as a result of fear, youth, or circumstances making pregnancy unacceptable, engage in the psychological process of denial, thereby rejecting the possibility of pregnancy. Appendix to Defendant's Demurrer Without Leave to Amend and/or Motion to Dismiss, Appendix 8, at 7, People v. Stewart, No. M508097 (San Diego County Ct. Feb. 23, 1987).

240. *See generally*, Burr & Schulz, *Delayed Abortion in an Area of Easy Accessibility*, 244 J.A.M.A. 44 (1980); *Late Abortions Linked to Education, Age and Irregular Periods*, 13 FAMILY PLANNING PERSPECTIVES 86 (1981); G. MELTON, ADOLESCENT ABORTION: PSYCHOLOGICAL

commentator suggests that women should nonetheless be liable under a negligence standard for their actions or omissions even if they do not yet know they are pregnant. The argument is that if the mother "has reason to know she is pregnant — if, for example, she has been sexually active and has missed a period — but she has not yet had her pregnancy confirmed, it does not seem unreasonable to require her either to have a pregnancy test or to refrain from activities that would be hazardous to the fetus if she were pregnant."[241] If the state imposed liability before knowledge of pregnancy, women of childbearing age would have to conduct their lives as though they were perpetually pregnant.

B. The Right to Liberty

The constitutional right to liberty contains several guarantees that are relevant to women faced with punitive state action for harm to their fetus.[242] Guarantees of liberty include the fundamental right to privacy, which has been established firmly under the equal protection clause and the substantive component of the due process "liberty" guarantee of the federal Constitution. The right to privacy includes the right to bodily integrity,[243] the right of parental authority against the state,[244] and the right to make childbearing decisions.[245] Close regulation of a pregnant woman's behavior and moral decisions deprives her of the power to make choices essential to her personhood and to exercise her personal liberty.[246] "[I]n order to enforce fetal rights or state regulations dictating behavior during pregnancy, the state

AND LEGAL ISSUES 75-77 (1986); J.R. WILLSON & E.R. CARRINGTON, *supra* note 238, at 76, 97-109.

241. Robertson, *Procreative Liberty and the Control of Conception, Pregnancy and Childbirth*, 69 VA. L. REV. 405, 447 n.129 (1983). *See also* Shaw, *Conditional Prospective Rights of the Fetus*, 5 J. LEGAL MED. 63, 83-84 (1984).

242. For a discussion of how criminal statutes that punish women for negligent or reckless conduct that harms fetuses may violate maternal privacy rights, see Note, *supra* note 10. *See generally*, Johnsen, *supra* note 8 (comprehensive review of ways in which assertion of fetal rights in various contexts violate woman's constitutional rights).

243. *See* Roe v. Wade, 410 U.S. 113 (1973); *In re* Quinlan, 70 N.J. 10, 355 A.2d 647 (1976); *In re* Conroy, 98 N.J. 321, 360-61, 486 A.2d 1209, 1229 (1985); Sup't of Belchertown State School v. Saikewicz, 373 Mass. 728, 742, 370 N.E.2d 417, 426 (1977). *See also*, Stearns, *Maternal Duties During Pregnancy: Toward a Conceptual Framework*, 21 NEW ENG. L. REV. 593 (1985-86).

244. *See* Pierce v. Society of Sisters, 268 U.S. 510, 535 (1925); Meyer v. Nebraska, 262 U.S. 390, 399 (1923); Santosky v. Kramer, 455 U.S. 745 (1982).

245. *See* Roe v. Wade, 410 U.S. 113 (1973); Griswold v. Connecticut, 381 U.S. 479 (1965).

246. The Supreme Court has found that the constitutional guarantee of personal liberty:

> denotes not merely freedom from bodily restraint but also the right of the individual . . . to engage in any of the common occupations of life, to acquire useful knowledge, to marry, establish a home and bring up children, to worship God according to the dictates of his own conscience, and generally to enjoy those privileges long recognized at common law as essential to the orderly pursuit of happiness by free men.

Meyer v. Nebraska, 262 U.S. 390, 399 (1923).

would necessarily intrude in the most private areas of a woman's life."[247]

When a state law regulates the exercise of a fundamental right, the state has the burden of demonstrating that the law is necessary, is narrowly tailored, and will serve to promote a previously recognized compelling state interest.[248] Assessed against this standard, statutes criminalizing maternal failure to provide adequate prenatal care are unconstitutional.

Another liberty guarantee that may be violated by criminalizing maternal conduct during pregnancy is the right of parents to control the custody, care, and education of their children. This aspect of the right to privacy prohibits the state from unduly interfering with parental decisions, including decisions regarding the medical care of their children.[249] This natural right of parents to make decisions on behalf of their children was first recognized in a line of cases beginning in 1923 with *Meyer v. Nebraska*.[250] By 1965, the Court formally recognized a constitutional right of privacy in *Griswold v. Connecticut*.[251] This right was intended to shield the marriage relationship against state interference into a broad range of family decisions.[252] Parental autonomy applies to the expectant mother with as much force as it does to parents of children already born.[253] Thus, the United States Constitution guarantees a mother the autonomy to make decisions about her own health that incidentally may affect her fetus.

Closely linked to parental rights assertable against the state is the constitutional right of a woman to control her own childbearing decisions. Childbearing decisions are at the "very heart" of an individual's right to "independence in making certain kinds of important decisions."[254] The constitutional right to privacy therefore limits the State's power to substantively regulate conduct in matters relating to procreation and child rearing decisions.[255] Not surprisingly, the Supreme Court has struck down statutes that attempted to interfere in such matters.[256]

Likewise, a State may not penalize women who decide to bear a child. In

247. Johnsen, *supra* note 8, at 619.

248. City of Akron v. Akron Center for Reproductive Health, 462 U.S. 416, 427 (1983); *see also* H.L. v. Matheson, 450 U.S. 398, 413 (1981); Skinner v. Oklahoma, 316 U.S. 535, 540-41 (1942); United States v. Carolene Products Co., 304 U.S. 144, 152 n.4 (1938).

249. Parham v. J.R., 442 U.S. 584, 602-03 (1979).

250. 262 U.S. 390, 399-400 (1923); Pierce v. Society of Sisters, 268 U.S. 510, 534-35 (1925); Wisconsin v. Yoder, 406 U.S. 205, 213-14 (1972).

251. 381 U.S. 479 (1965).

252. *Id.* at 485-86.

253. Myers, *supra* note 84, at 59.

254. Carey v. Population Services International, 431 U.S. 678, 684-85 (1977).

255. *Id.*; Whalen v. Roe, 429 U.S. 589, 600 n.26 (1977) (quoting Paul v. David, 424 U.S. 693, 713 (1976)).

256. *See, e.g.*, Skinner v. Oklahoma, 316 U.S. 535 (1942) (compulsory sterilization of habitual criminals held unconstitutional because right to procreate is "one of the basic civil rights of man"); Thornburgh v. American College of Obstetricians and Gynecologists, 476 U.S. 747 (1986) (certain restrictions on abortion held unconstitutional because "few decisions are more personal and intimate, more properly private, or more basic to individual dignity and autonomy, than a woman's decision . . . whether to end her pregnancy.").

Cleveland Board of Education v. LaFleur,[257] the court struck down a rule that required pregnant school teachers to take unpaid maternity leave at a uniform time prior to childbirth.[258] Noting that "freedom of personal choice in matters of marriage and family life is one of the liberties protected by the Due Process Clause of the Fourteenth Amendment," the Court stated that "[b]y acting to penalize the pregnant teacher for deciding to bear a child, overly restrictive maternity leave regulations can constitute a heavy burden on the exercise of these protected freedoms."[259] By restricting a woman's right to control her actions because of the fetus she is carrying, the state appropriates a woman's right to control her actions and imposes a burden at least as great as that struck down in *LaFleur*.[260]

C. *Equal Protection of the Law*

In addition to violating women's right to liberty, criminal statutes proscribing certain maternal conduct during pregnancy may also violate women's right to equal protection of the laws.[261] Prosecuting women for failing to care for themselves during pregnancy revives damaging stereotypes which historically have undermined women's equality.[262]

Criminal statutes may result in attempts to exercise virtually complete control over the lives of pregnant women and potentially pregnant women in the name of "fetal protection."[263] Because the fetus is biologically dependent upon the mother at all stages of development, virtually every action by a pregnant woman could potentially affect her fetus. A statutory requirement that women resolve all health care decisions in favor of the fetus would hold women to a much higher standard of self-care than men and would infringe upon women's rights to autonomous decision-making in a manner not required of men.

Biological differences have long been used as justification for oppression of women.[264] "Protection" of women, supposedly required because of their

257. 414 U.S. 632 (1974).

258. *Id.* at 647-48.

259. *Id.* at 639-40 (citation omitted).

260. Johnsen, *supra* note 8, at 618.

261. U.S. CONST. amend. IV, § 1.

262. *See, e.g.*, Gallagher, *supra* note 75, at 104 (reviews "powerful and largely unacknowledged social attitudes in which pregnant women are viewed and treated as vessels"); Annas, *Protecting the Liberty of Pregnant Patients*, 316 NEW ENG. J. MED. 1213, 1214 ("Before birth, we can obtain access to the fetus only through its mother, and in the absence of her informed consent, can do so only by treating her as a fetal container, a nonperson without right to bodily integrity.").

263. Johnsen, *supra* note 8, at 605-09.

264. Johnsen, *supra* note 8, at 623.

> Our society seems on the verge of justifying enormous legal restrictions on women's behavior in the name of fetal rights. This is nothing new, of course. Historically, people have always used women's capacity for childbearing to support laws that treated women differently from men and that prevented their full and equal participation in this society.

J. Benshoof & L. Paltrow, *Letter to the Editor*, N.Y. Times, Nov. 10, 1986, at A22, col. 4.

reproductive capacity, has often been used throughout history to justify discrimination against women.[265] The motivation underlying protective restrictions is the same rationale underlying the prosecution of pregnant women — to enhance maternal and fetal health and to preserve the health of "the race:"

> [w]omen's physical structure, and the functions she performs in consequence thereof, justify special legislation restricting or qualifying the conditions under which she should be permitted to toil . . . [A]s healthy mothers are essential to vigorous offspring, the physical well-being of woman becomes an object of public interest and care in order to preserve the strength and vigor of the race.[266]

Under the banner of "protection," the law has justified a dual system of rights which has prevented women from equal access to and participation in the public sphere for the glorification of motherhood. The "protection of the race" argument also evokes the eugenics movement, the goal of which is to manipulate the human gene pool to eliminate undesirable traits. As Jeremy Rifkin pointed out during a recent forum on reproductive technology, "Meanwhile a new eugenics has quietly slipped in the back door. . . . We want perfect babies. . . . There's no evil intent here. The road to the Brave New World is paved with good intentions."[267]

The Supreme Court has announced that archaic rules and stereotypes may not be the basis for gender distinctions.[268] State policing of pregnancy rests on the implicit assumption that women are less than fully moral beings who have no independent judgment. When women are valued solely for their reproductive capacity, justifications of romantic, paternalistic state control of women are reinforced.[269] Romantic paternalism has historically damaged women, justifying their expulsion from the public sphere to that of the home and denigrating their worth as human beings. Romantic paternalism distorts the state's efforts to improve healthy fetal development by focusing on women's actions as the sole factor affecting fetal health. In fact, men can have a powerful effect on fetal development, and therefore nondiscriminatory efforts to improve fetal health would focus on both sexes.[270]

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265. Johnsen, *supra* note 8, at 623.

266. *See, e.g.*, Muller v. Oregon, 208 U.S. 412, 420-21 (1908). The need for a woman to "proper[ly] discharge her maternal function" justified the maximum hours statute in *Muller* and has been used to justify other laws "protecting" women by limiting their employment opportunities, access to the polls, and jury service.

267. *Ethics in Embryo*, HARPER'S MAGAZINE 37, 44 (Sept. 1987).

268. Mississippi University For Women v. Hogan, 458 U.S. 718, 723, 725 (1982) (a gender-based classification must be "applied free of fixed notions concerning the roles and abilities of males and females. Care must be taken in ascertaining whether the statutory objective itself reflects archaic and stereotypic notions.").

269. *See, e.g.*, Muller v. Oregon, 208 U.S. 412 (1908).

270. For example, pre-conception injury may cause genetic damage to the sperm. Bertin, *High Proof Paternity*, HEALTH 20 (June 1988) (father's drinking during conception affects baby's birthweight).

CONCLUSION

Society's decision to criminalize behavior is always a weighty one, because it tests our commitment to liberty, justice and fairness. Current pressures to criminalize the consequences of inadequate prenatal care and maternal substance abuse are fueled by a growing hysteria over the illegal drug "epidemic" in our society. However, implementing short-term punitive measures in response to popular pressure permits policy makers to avoid rationally considering long-term improvements to the health care delivery system. A long-term commitment to improving the maternity care system would help a greater number of women, and would have a more comprehensive beneficial effect on fetal health, than would criminal prosecution of a few women.

The population at which "fetal abuse" statutes and other punitive action are targeted tend to be the victims of neglect of our health care system, often on the fringes of society, beyond the reach of concerned health care workers. Access to prenatal care in America is poor and unequal, especially for low-income and minority women. Medicaid is inadequate to serve as a safety net for the growing number of women who lack private insurance because it covers only forty percent of women below poverty, because lack of obstetric participation in the program is reaching crisis proportions, and because burdensome paperwork and reimbursement delays continue to drive both physicians and patients away. With respect to the dilemma faced by drug dependent pregnant women, most prenatal care centers do not treat addiction, and most treatment centers do not treat pregnant patients because they lack child-care facilities and fear obstetric malpractice from "high-risk" pregnancies. In light of the declining availability of health care, a statute that punishes women for the consequences of inadequate prenatal care, such as *Stewart*, would be a bitter injustice. Prison is a wholly inadequate environment to teach women the proper standard of prenatal care.

A criminal statute designed to punish reckless or negligent behavior creating a substantial risk of harm to the fetus (an objective standard of care) effectively would result in a strict liability crime that would disregard a woman's economic situation, personal values, and individual health needs. Although a narrower statute targeting intentional or knowing imposition of harm (a subjective standard of care) might avoid the problems inherent in an objective standard, it nonetheless would deter women from seeking prenatal care or substance abuse treatment. Ironically, such a statute would be so narrow that it would not reach women who are the subject of public concern: those who use drugs during pregnancy because of addiction, rather than out of a desire to harm their fetuses.

Even a narrow statute that only punishes women who have been informed of the risks of drug use *and* who were offered a voluntary treatment option nonetheless raises serious constitutional questions about fair notice, liberty and equal protection. Acts potentially harmful to a fetus cannot be defined with sufficient precision to give notice to mothers of the legal behavioral

standard. The statute probably would be enforced only against poor mothers, because they often are in closer contact with governments monitors and generally are in poorer health. Further, such a vague statute would deputize the medical profession by imposing reporting requirements, undermining the patient-doctor privilage and deterring care, eviscerating the informed consent model of treatment, and giving fallible medical judgments the force of law. Finally, such a statute would punish women who lack notice of their own pregnancy, since the most serious prenatal harms often occur very early in pregnancy before women realize that they are pregnant.

Punishing women for harming their fetuses — intentionally or unintentionally — resurrects patriarchal stereotypes of women whose value is defined solely in terms of their reproductive capacity. A statute resting on paternalistic assumptions constitutes bad health policy. It distorts health policy by focusing only on maternal actions during pregnancy, when paternal actions can be equally harmful, and by focusing on individual behavior, when the problem is a systemic one.

In the best of worlds, all mothers would be healthy and would have healthy babies. A state-imposed standard of motherhood, however, would be ineffective unless enforced by the coercive power of the state. The use of coercion to enforce a governmental standard of motherhood necessarily would require fundamental negative changes in our health care delivery system that would fail to address the broad causes of inadequate access to prenatal care and substance abuse treatment. A coercive code of motherhood also would result in the restriction of liberty for all women of child-bearing age. Our society has elected not to live in such a society,[271] foreshadowed in Margaret Atwood's *The Handmaid's Tale*.[272] We value autonomy and freedom above perfection, and our criminal law must reflect that — by creating meaningful opportunity for access to health care and by leaving the locus of control over prenatal health care with the mother.

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271. "[P]reserving the rights of all competent adults to control their own bodies is preferable to living in a society that would would attempt to monitor every action of a pregnant women." Colloquium, *supra* note 236, at 849-50. The risk-balancing is a decision for the mother as patient. To place the locus of choice on the state would be to sacrifice our society's value on autonomy in exchange for a uniform standard of behavior.

272. M. ATWOOD, *supra* note 1.

* The author wishes to acknowledge gratefully the support and advice of Professor Sylvia A. Law, New York University Law School. Thanks are also owed to Lynn M. Paltrow, A.C.L.U. Reproductive Freedom Project, for her suggestions, and to the editors of the New York University Review of Law & Social Change for their moral support, honest criticism, and patience. Special thanks to Christopher D. Jagel, who provided invaluable editorial help, but prefers to be commended for the more difficult task of putting up with me throughout the course of this project.