IN THE DISTRICT COURT OF APPEAL
FIRST DISTRICT, STATE OF FLORIDA

Samantha Burton, Appellant,

v.

State of Florida, Appellee.

CASE NO: ID09-1958
L.T. No.: 2009 CA 1167

BRIEF OF *AMICI CURIAE* AMERICAN CIVIL LIBERTIES UNION, AMERICAN CIVIL LIBERTIES UNION OF FLORIDA, AND AMERICAN MEDICAL WOMEN'S ASSOCIATION IN SUPPORT OF APPELLANT

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AMICI STATEMENT OF INTEREST

The American Civil Liberties Union ("ACLU"), the ACLU of Florida, and the American Medical Women's Association ("AMWA") (collectively "*Amici*"), submit this brief in support of Appellant Samantha Burton's appeal from the Leon County Court order that she be confined to a hospital and submit to medical treatment, all against her will, for the duration of her pregnancy. Each of the *Amici* is committed to advancing and protecting women's rights to health, privacy, and autonomy, particularly with respect to a woman's decisions affecting her pregnancy.

The ACLU and its state affiliate, the ACLU of Florida, have long been dedicated to the principles of liberty and equality embodied in the United States and Florida Constitutions and to protecting the constitutional rights of privacy and reproductive choice. AMWA, an organization of women physicians and medical students dedicated to women's health and the advancement of women in medicine, supports the right of women to make choices, without governmental interference, when it comes to their medical care. Thus, the proper resolution of this case is a matter of substantial concern to *Amici*. In addition, it is respectfully submitted that *Amici*'s analysis of the important constitutional question raised by this appeal may assist this Court in resolving this case.

SUMMARY OF THE ARGUMENT

At stake in this case are two related components of the fundamental constitutional right of privacy guaranteed by the Florida Constitution: the right of every adult person to make an informed decision to refuse medical treatment, and the right of women to continue their pregnancies without fear of state intrusion on their bodily integrity and autonomy. In violation of these rights, in March 2009, the State succeeded in completely depriving Samantha Burton, a mother of two who was suffering pregnancy complications in her 25th week of pregnancy, of her physical liberty and medical decision-making authority for the remainder of her pregnancy.

At the State's request, the Circuit Court, Leon County, ordered Ms. Burton to be indefinitely confined, which had her pregnancy gone to term would have been up to fifteen weeks, to Tallahassee Memorial Hospital and to submit, against her will, to any and all medical treatments, restrictions to bed rest, and other interventions, including cesarean section delivery, that in the words of the court, "the unborn child's attending physician," deemed necessary to "preserve the life and health of Samantha Burton's unborn child." (Appellant's Ex. D, at 1-2.) The court further ordered that "Ms. Burton's request to change hospitals is denied as such a change is not in the child's best interest at this time." (*Id.* at 3.) The court approved the State's

wholesale control over Ms. Burton's liberty and medical care during pregnancy on the erroneous legal premise that the "ultimate welfare" of the fetus is the "controlling factor" and was sufficient to override her constitutional rights to liberty, privacy, and autonomy. (*Id.* at 1.) After at least three days of this state-compelled confinement and management of Ms. Burton's pregnancy, doctors performed an emergency cesarean section on Ms. Burton and discovered that her fetus had already died in utero. Thereafter, she was released from the hospital. (Appellant's Ex. E, at 1; Ex. F, at 1.)

As addressed fully below, first, the court erred as a matter of law by failing to give any real consideration to the liberty and privacy rights of Ms. Burton and instead applying what amounted to a "best interest of the fetus" standard. Such an approach turns on its head well-established standards protecting the right of every adult to make private decisions about their own medical care. Second, the court erred in equating the asserted interest in protecting fetal life to the State's "*parens patriae* authority to ensure that children receive medical treatment which is necessary for the preservation of their life and health," (*see* Appellant's Ex. D, at 1), and in holding that the interest in fetal life justified confining Ms. Burton to a hospital bed and overriding her right to refuse medical treatment. Finally, applying the

correct constitutional analysis, and looking to appropriate medical standards of care, it is evident that the State did not demonstrate the type of compelling interest necessary to justify the extraordinary use of involuntary confinement and forced medical treatment in this case.

STANDARD OF REVIEW

On this appeal, the threshold issue is whether the court below applied the correct constitutional analysis for determining whether the State carried its burden of demonstrating that absolutely depriving Appellant of her fundamental constitutional rights of privacy, medical autonomy, and liberty, was necessary to achieve a compelling state interest. Because the appropriate constitutional analysis is a question of law, review on appeal is *de novo*. *See Armstrong v. Harris*, 773 So.2d 7, 11 (Fla. 2000); *see also Davis v. Bruhaspati, Inc.*, 917 So.2d 350, 351 (Fla. 1st DCA 2005); *Wagner v. Wagner*, 885 So.2d 488 (Fla. 1st DCA 2004).[1]

[1] Although the present case is now moot, this Court can accept jurisdiction because, as the Florida Supreme Court has held in another case of forced medical treatment, "the issue is one of great public importance, is capable of repetition, and otherwise might evade review." *In re Dubreuil*, 629 So.2d 819, 822 (Fla. 1993) (accepting jurisdiction and reversing decision below after patient's right to refuse treatment had already been violated), *reh'g denied*, 629 So.2d 819 (Fla. Jan. 20, 1994) (No. 80311).

ARGUMENT

I. The Constitutional Standard for Authorizing Forced Medical Treatment Requires the State to Prove that its Action is Narrowly Tailored to Advance a Compelling State Interest.

It is firmly established that under the Florida Constitution's expressly enumerated right of privacy, article I, section 23, "everyone has a fundamental right to the sole control of his or her person," which includes the "integral . . . right to make choices pertaining to one's health, including the right to refuse unwanted medical treatment." *In re Guardianship of Browning*, 568 So.2d 4, 10 (Fla. 1990). This "inherent right to make choices about medical treatment . . . encompasses all medical choices." *Id.*[2] Thus, the right, which extends to "everyone" and "all medical choices," of course, necessarily encompasses the right of a pregnant woman to refuse medical treatment recommended to preserve her own health or the health of her fetus.[3]

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[2] While the federal Constitution also protects the right to refuse medical treatment, *see, e.g.*, *Cruzan ex rel. Cruzan v. Director*, 497 U.S. 261 (1990), the greater protections afforded under the Florida constitutional right to privacy control this case. *See, e.g.*, *In re T.W.*, 551 So.2d 1186, 1192 (Fla. 1989) (holding Florida Constitution's express right of privacy "embraces more privacy interests, and extends more protection to the individual in those interests, than does the federal Constitution").

[3] Indeed, *In re Guardianship of Browning*, 568 So.2d at 10, and *In re Dubreuil*, 629 So.2d at 822, two seminal Florida Supreme Court cases addressing the right to refuse medical treatment, repeatedly draw and quote

The Florida Supreme Court has repeatedly made clear the rigorous standard of review that courts must apply to any infringement of this right:

> The State has a duty to assure that a person's wishes regarding medical treatment are respected. That obligation serves to protect the rights of individuals from intrusion by the state unless the state has a compelling interest great enough to override this constitutional right. The means to carry out any such compelling state interest must be narrowly tailored in the least intrusive manner possible to safeguard the rights of the individual.

Id. at 13-14; *see In re Dubreuil*, 629 So.2d 819, 822 (Fla. 1993), *reh'g denied*, 629 So.2d 819 (Fla. Jan. 20, 1994) (No. 80311) (quoting same).

There is no "'bright-line test'" for determining what constitutes a sufficiently compelling interest to override a patient's refusal of medical treatment. *In re Guardianship of Browning*, 568 So.2d at 14 (quoting *Pub. Health Trust v. Wons*, 541 So.2d 96, 97 (Fla. 1989)). Rather, each case "'demand[s] individual attention.'" *In re Dubreuil*, 629 So.2d at 827 (quoting *Wons*, 541 So.2d at 98). However, it is clear that even if a compelling interest is shown, the State must put forth "sufficient evidence" to "satisfy the heavy burden" of demonstrating the necessity of "overrid[ing] the patient's constitutional right to refuse medical treatment." *Id.* at 828.

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from the Florida Supreme Court's decision in *In re T.W.*, 551 So.2d 1186, a case delineating the fundamental privacy rights of pregnant women.

As discussed below, the trial court wholly failed to apply this strict scrutiny standard, which places the "heavy burden" of proof squarely on the State. Rather, it improperly assumed that the State's *parens patriae* authority – which permits the State, in exceptional cases, to order medical treatment for a *child* over a parent's religious objections – permitted the State to confine Ms. Burton and force *her* to undergo medical treatment for the benefit of her fetus. *See infra* Part II. In so doing, the court overrode Ms. Burton's fundamental rights without requiring the State to establish a compelling need that justified the extreme deprivation imposed.

II. The State's Interest in Protecting Fetal Life is not Equivalent to its Interest in Protecting Children and was not Sufficient to Override Appellant's Liberty and Privacy Rights.

The State argued, and the trial court incorrectly found, that this case involved the State's "*parens patriae* authority to ensure that children receive medical treatment which is necessary for the preservation of life and health," and therefore applied the rule that "as between parent and child, the ultimate welfare of the child is the controlling factor." (Appellant's Ex. D, at 1.) But cases recognizing the *parens patriae* authority of the State to, in exceptional circumstances, override a parent's refusal to allow their *children* to receive life-saving medical care, *see., e.g., M.N. v. Southern Baptist Hosp. of Florida*, 648 So.2d 769 (Fla. 1st DCA 1994) (involving parents' refusal for

religious reasons to consent to blood transfusion for minor child); *ex rel. J.V. v. State*, 516 So.2d 1133 (Fla. 1st DCA 1987) (same); *ex rel. Ivey*, 319 So.2d 53, 58 (Fla. 1st DCA 1975) (same), have no application to this case, in which the State forced a *woman* to be confined and undergo unwanted medical treatment for the benefit of her fetus.

Indeed, no Florida court has applied these principles to the State's interest in potential fetal life. This is unsurprising, as the courts of this state – including the Florida Supreme Court – have time and again refused to extend the meaning of laws protecting children or persons to include fetuses. For example, the Florida Supreme Court has held that a statute criminalizing the distribution of a controlled substance to children was not intended to apply to transmission during birth. *See Johnson v. Florida*, 602 So.2d 1288 (Fla. 1992). And, in *In re Guardianship of J.D.S.*, 864 So.2d 534, 538 (Fla. 5th DCA 2004),[4] the Fifth District Court of Appeal cited numerous Florida

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[4] The Fifth District Court of Appeal relied on the weight of Florida statutes and court cases, while also pointing to "persuasive … holdings from other jurisdictions which have concluded that a fetus is not a 'person.'" *In re Guardianship of J.D.S.*, 864 So.2d at 538. Specifically:

> [T]he Florida Supreme Court declined to rule that a fetus is a "person" within the meaning of the Florida Wrongful Death Act, *Young v. St. Vincent's Med. Ctr., Inc.*, 673 So.2d 482 (Fla. 1996), and the Fourth District declined to apply a child abuse statute in a case involving a fetus, *State v. Gethers*, 585 So.2d 1140 (Fla. 4th DCA 1991). *See also Roe v. Wade*, 410 U.S.

cases in support of its holding that the protections of the state guardianship laws "[do] not extend to fetuses."

Nor can such an extension be permitted in this case without creating an impermissible constitutional conflict. By equating the State's interest in fetal health with its very different obligation to protect children, and ordering Ms. Burton to be confined and undergo unwanted invasive medical procedures for the benefit of her fetus, the trial court contravened decisions of the United States and Florida Supreme Courts.[5] These decisions recognize that because a fetus is inextricably part of, and physiologically dependent on, the pregnant woman who carries it, a state interest in fetal life,

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> 113, 158 (1973) ("the word 'person,' as used in the Fourteenth Amendment, does not include the unborn"); . . . *In re Fetus Brown*, 294 Ill. App. 3d 159 (Ill. App. Ct. 1997) (holding trial court erred in appointing guardian for fetus in case involving mother's right to refuse medical treatment versus state's interest in viable fetus).

Id. at 538-39 (additional supporting citations omitted).

[5] Indeed, although the Florida Supreme Court "has declined at this time to rule out the possibility that some case not yet before us may present a compelling interest" to require a patient to undergo forced medical treatment for the benefit of a child or other third party, *see In re Dubreuil*, 629 So.2d at 827, *Amici* are unaware of any case decided under the Florida Constitution that actually approves of such forced treatment. This case should not be first.

even a viable fetus,[6] does not ultimately "control" the privacy and autonomy rights of a pregnant woman.

Since its decision in *Roe v. Wade*, 410 U.S. 113 (1973), the United States Supreme Court has repeatedly protected a woman's constitutional right to make independent medical decisions related to her pregnancy, including, ultimately, the choice whether to continue a pregnancy. *See, e.g.*, *Ayotte v. Planned Parenthood of Northern New England*, 546 U.S. 320, 327-28 (2006) (describing *Roe* and *Casey* as controlling); *Stenberg v. Carhart*, 530 U.S. 914, 920 (2000) (reaffirming *Roe*); *Planned Parenthood v. Casey*, 505 U.S. 833, 860 (1992) (same). This stems from the Court's recognition that decisions related to pregnancy involve personal considerations that are central to a woman's dignity, autonomy, and health. As the Court has explained:

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[6] The United States Supreme Court has held that a "viable" fetus is one that is capable of sustained life outside the womb and has recognized that this point is different for every pregnancy: "Viability is reached when, in the judgment of the attending physician . . . there is a reasonable likelihood of the fetus' sustained survival outside the woman." *Colautti v. Franklin*, 439 U.S. 379, 388-89 (1979); *see also* Fla. Stat. § 390.0111(4) (1999) ("'Viability' means that stage of fetal development when the life of the unborn child may with a reasonable degree of medical probability be continued indefinitely outside the womb."). Although Ms. Burton's pregnancy was at 25 weeks, right around the earliest time when a healthy fetus might be able to survive outside the womb, not all fetuses are viable at this time. And, indeed, despite the fact that she was confined to the hospital, her fetus was not able to survive even *inside* the womb. (Appellants Ex. E, at 1.)

> [T]he liberty of the [pregnant] woman is at stake in a sense unique to the human condition and so unique to the law. The mother who carries a child to full term is subject to anxieties, to physical constraints, to pain that only she must bear.

Casey, 505 U.S. at 852.

These principles apply even more strongly in Florida, where state interference with the exercise of a person's right to privacy – including decisions about reproductive health – must further a compelling state interest by the least intrusive means. The Florida Constitution contains an explicit right to individual privacy that has no parallel in the United States Constitution. Article I, section 23 of the Florida Constitution provides that "[e]very natural person has the right to be let alone and free from governmental intrusion into the person's private life . . . ." Fla. Const. art.1 § 23. The Florida Supreme Court has repeatedly held that this provision provides more protection for the right of individual privacy, including the right to make decisions about reproductive health care, than does the federal Constitution. *See, e.g.*, *Beagle v. Beagle*, 678 So.2d 1271, 1276 (Fla. 1996); *B.B. v. State*, 659 So.2d 256, 259 (Fla. 1995); *In re T.W.*, 551 So.2d 1186, 1192, 1195 (Fla. 1989) (holding "the Florida constitution requires a 'compelling' state interest in all cases where the right to privacy is implicated").

Applying these fundamental guarantees of liberty, privacy and bodily integrity, courts have held unconstitutional forced interventions on behalf of a viable fetus in medical circumstances more dire than those here. For example, an Illinois appellate court held that the prospect of state control over the medical decisions and bodily integrity of a pregnant woman could not be constitutionally tolerated and refused to force her to receive medical treatment on behalf of her fetus. In *In re Fetus Brown*, 689 N.E.2d 397, 399 (Ill. App. Ct. 1997), *appeal denied*, 698 N.E.2d 543 (Ill. 1998), a decision cited with approval by the Fifth District Court of Appeal in *In re Guardianship of J.D.S.*, 864 So.2d at 539, Darlene Brown, who was over 34 weeks pregnant and experiencing blood-loss that was life-threatening to both herself and her fetus, refused blood transfusions for religious reasons. The court, applying virtually the same constitutional standard for refusing medical treatment as is applied in Florida, held that "balancing the mother's right to refuse medical treatment against the State's substantial interest in the viable fetus, we hold that the State may not override a pregnant woman's competent decision, including refusal of recommended invasive medical procedures, to potentially save the life of the viable fetus." *In re Fetus Brown*, 689 N.E.2d at 403.

Likewise, in a case involving a court-ordered cesarean section to be performed on a terminally ill woman who was "twenty-six and one-half weeks pregnant with a viable fetus," the District of Columbia Court of Appeals reversed, holding: "We do not quite foreclose the possibility that a conflicting state interest may be so compelling that the patient's wishes must yield, but we anticipate that such cases will be extremely rare and truly exceptional. This is not such a case." *In re A.C.*, 573 A.2d 1235, 1252 (D.C. Ct. App. 1990) (emphasizing that pregnant patient's wishes "must be followed in virtually all cases, unless there are truly extraordinary or compelling reasons to override them") (internal citations omitted).[7]

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[7] For reasons discussed *infra* Part III, this is not an otherwise "exceptional" case, and thus is completely distinguishable from *Pemberton v. Tallahassee Mem'l Reg'l Med. Ctr., Inc.*, 66 F. Supp.2d 1247, 1249 (N.D. Fla. 1999), in which a federal district court held that a court-ordered cesarean section did not violate the federal Constitution. In that case, the patient was "at full term and actively in labor [for more than a full day]". *Id.* "[And i]t was clear that one way or the other, a baby would be born (or stillborn) very soon, certainly within hours." *Id.* at 1249, 1251. Indeed, in *Pemberton*, the court echoed the analysis in *In re A.C.*, cautioning: "Medicine is not an exact science. . . . In anything other than an extraordinary and overwhelming case, the right to decide [on the course of medical treatment] would surely rest with the mother, not with the state." *Id.* at 1254. Based on the unique and exigent facts and "clear and uncontradicted evidence," it ultimately held that Ms. Pemberton's case was "thus markedly different" from the situation in *In re A.C.*, and thus extraordinary. *Id.* However, because the federal court did not consider Ms. Pemberton's right to refuse medical treatment under the Florida Constitution and because the facts of Ms. Burton's case do not even begin to approach the facts in *Pemberton*, that decision does not support, let alone require, a similar determination in this case.

As these cases demonstrate, while the State may seek to advance a "substantial interest in potential fetal life throughout pregnancy," *Casey*, 505 U.S. at 876, and while the weight of that interest increases after viability, *id.* at 870, a fetus is not, physiologically or legally, an independent person with equivalent, let alone greater, constitutional status than the pregnant woman herself. *Roe*, 410 U.S. at 156-59. Moreover, to ignore this fundamental constitutional distinction between the State interest in protecting fetal life and its interest in the protecting the lives and health of people is to risk virtually unfettered intrusion into the lives of pregnant women. As Justice Orfinger presciently cautioned in his concurrence in *In re Guardianship of J.D.S.*:

> While the debate is typically framed in the context of the State's right to interfere with a woman's decision regarding an abortion, taking control of a woman's body and supervising her conduct or lifestyle during pregnancy or forcing her to undergo medical treatment in order to protect the health of the fetus creates its own universe of troubling questions. Should the State have the authority to prohibit a pregnant woman from smoking cigarettes or drinking alcohol, both legal activities with recognized health risks to the unborn? Could the Legislature do so constitutionally given our supreme court's broad interpretation of Florida's constitutional right of privacy and the limitations placed on the State's ability to act by *Roe*?

In re Guardianship of J.D.S., 864 So.2d at 540-41 (Orfinger, J. concurring and concurring specially).

Thus, the overwhelming weight of federal and Florida precedent required the circuit court to apply the strictest level of constitutional scrutiny by giving full weight to Ms. Burton's fundamental rights of liberty, bodily integrity, and medical autonomy and requiring the State to carry its heavy burden of demonstrating an overwhelming interest in fetal health that justified the extreme liberty deprivation in this case. However, as is evident from the lower court's incorrect weighing of the State interest in fetal life as equivalent to its *parens patriae* authority, from the outset the court erroneously presumed that Ms. Burton's fundamental constitutional rights were inferior to the state's interest in fetal life. (Appellant's Ex. B, at 2.) In so doing, as discussed *infra* Part III, it authorized an unwarranted intrusion on her liberty, bodily integrity, and medical autonomy.

III. The Liberty Deprivation was not Justified in this Case and, if Approved, will Invite State Interventions that Only Serve to Undermine Maternal and Fetal Health.

By essentially removing Ms. Burton's personal and medical autonomy from the equation, the State pursued a course that was antithetical to constitutional limits and to expert recommendations for providing appropriate and effective care when a pregnant patient disagrees with medical recommendations to improve fetal health. Indeed, the medical-ethical recommendations of the American College of Obstetricians and

Gynecologists (ACOG) and the American Medical Association (AMA) not only vigorously discourage the approach taken in this case, they demonstrate why court-ordered interventions undermine, rather than advance, fetal health.

In the ACOG Committee Opinion, *Maternal Decision Making, Ethics, and the Law*, the ACOG Committee on Ethics addresses the medical, ethical, and legal "dilemmas when [pregnant] patients reject medical recommendations," or otherwise engage in behaviors "that have the potential to cause fetal harm." ACOG Committee Opinion No. 321 1-2 (Nov. 2005) (App. A) ("ACOG Opinion"). The Committee elaborates on six reasons why "restricting patients' liberty . . . . for their actions during pregnancy that may affect their fetus is neither wise nor justifiable." *Id.* at 6.

At least three of those reasons are especially instructive in this case. First, "[c]oercive and punitive legal approaches to pregnant women who refuse medical advice fail to recognize that all competent adults are entitled to informed consent and bodily integrity." *Id.* Second, "[f]allibility . . . is sufficiently high in obstetric decision making . . . that [l]evels of certainty underlying medical recommendations to pregnant women are unlikely to be adequate to justify legal coercion and the tremendous impact . . . that such intervention would entail." *Id.* at 7. And third, coercive treatment is

"potentially counterproductive in that [it is] likely to discourage prenatal care." *Id.* at 8. Thus, "court-ordered interventions and other coercive measures may result in fear . . . and ultimately could discourage pregnant patients from seeking care." ACOG Opinion at 8. In contrast, as ACOG advises, "[e]ncouraging prenatal care and treatment in a supportive environment will advance maternal and child health most effectively." *Id.*

For these reasons, ACOG recommends:

> In caring for pregnant women, practitioners should recognize that *in the majority of cases, the interests of the pregnant woman and her fetus converge rather than diverge*.
>
> ….
>
> Pregnant women's autonomous decisions should be respected. . . . *In the absence of extraordinary circumstances, circumstances that, in fact, the Committee on Ethics cannot currently imagine,* judicial authority should not be used to implement treatment regimens aimed at protecting the fetus, for such actions violate the pregnant woman's autonomy.

Id. at 9 (emphasis added). Consistent with these recommendations, *Amici* American Medical Women's Association promotes the standard that a "physician shall recognize and respect the rights of all patients, female and male, *regardless of reproductive status*, to receive the same standard of care." AMWA, *Principles of Ethical Conduct* (rev. 2000), *available at*

http://www.amwa-doc.org/index.cfm?objectId=243A88E4-D567-0B25-5C4EBCA9757330EF (last visited July 30, 2009) (App. B) (emphasis added).

Likewise, the AMA Board of Trustees advises:

> Judicial intervention is inappropriate when a woman has made an informed refusal of a medical treatment designed to benefit her fetus.
>
> *If an exceptional circumstance could be found* in which a medical treatment poses an insignificant or no health risk to the woman, entails a minimal invasion of her bodily integrity, and would clearly prevent substantial and irreversible harm to her fetus, *it might* be appropriate for a physician to seek judicial intervention. *However, the fundamental principle against compelled medical procedures should control in all cases that do not present such exceptional circumstances*.

AMA Board of Trustees Report, *Legal Interventions During Pregnancy: Court-Ordered Medical Treatments and Legal Penalties for Potentially Harmful Behavior by Pregnant Women*, 264 JAMA 2663, 2670 (Nov. 1990) (Report adopted by the House of Delegates of the AMA at the Annual Meeting, June 1990) (emphasis added) (App. C). The AMA Board of Trustees Report reaches this recommendation on many of the same grounds as discussed in the ACOG Committee Report. In addition, it emphasizes that "[c]ourts are ill-equipped to resolve conflicts concerning obstetrical

interventions," and cautions that the use of courts is likely to do more harm than good in such cases: "When a decision must be rendered almost immediately, there will be little or no time to obtain the full range of medical opinions or facts. The inability of a court to understand the full range of the relevant medical evidence may lead to error with serious and irreversible consequences." *Id.* at 2665.

In contrast to these uniform recommendations, it is evident from the proceedings below that Ms. Burton's bodily integrity, privacy, and autonomous decision-making were given no consideration, let alone respected; and that the State failed to consider the fallibility of the single medical opinion presented in this case or the reality, unfortunately demonstrated in this case, that forced medical interventions cannot guarantee the preservation of fetal life. (Appellant's Ex. E at 1; Ex. F at 1.)

Additionally, the reported conflict with fetal health in this case – that Ms. Burton did not agree to comply fully with recommendations regarding bedrest and smoking cessation – was not "extraordinary." To the contrary, it is hard to imagine anything more commonplace than the inability of a mother of two to remain on continuous bed rest, or the well-documented difficulty in quitting smoking. Thus, this was not the type of "extraordinary" or "exceptional" case that medical experts like ACOG and

AMA, or other courts, have contemplated as potentially falling within that rarity of "justified" court intervention.

Moreover, if the decision below stands, it invites State requests for court intervention in nearly all aspects of pregnant women's behavior and medical judgments. In turn, some women will be discouraged from coming to a hospital for pregnancy care if they know that any disagreement may lead to forced medical treatment. Such a result does not advance maternal or fetal health by any measure and is not constitutionally permissible.

CONCLUSION

For all of the foregoing reasons, *Amici* urge this Court to hold that the order below violated Ms. Burton's constitutional right to refuse medical treatment and constituted an unauthorized intrusion into her fundamental rights of privacy, liberty, and bodily integrity.

Respectfully submitted,

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Certificate of Compliance

I hereby certify that the foregoing brief is submitted in Times New Roman 14 point font, pursuant to Fla. R. App. P. 9.210(a)(2).

/s Randall C. Marshall

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Certificate of Service

I certify that a true and accurate copy of this motion has been sent by Federal Express, and by e-mail, on July 31, 2009, to the following counsel of record:

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APPENDIX

A. American College of Obstetricians and Gynecologists Committee Opinion No. 321

B. American Medical Women's Association, *Principles of Ethical Conduct*

C. American Medical Association Board of Trustees Report, *Legal Interventions During Pregnancy: Court-Ordered Medical Treatments and Legal Penalties for Potentially Harmful Behavior by Pregnant Women*

APPENDIX

A. American College of Obstetricians and Gynecologists Committee Opinion No. 321

B. American Medical Women's Association, *Principles of Ethical Conduct*

C. American Medical Association Board of Trustees Report, *Legal Interventions During Pregnancy: Court-Ordered Medical Treatments and Legal Penalties for Potentially Harmful Behavior by Pregnant Women*

Appendix A

American College of Obstetricians and Gynecologists Committee Opinion No. 321

ACOG

Committee on Ethics

Committee Opinion

Number 321, November 2005

Maternal Decision Making, Ethics, and the Law

ABSTRACT: Recent legal actions and policies aimed at protecting the fetus as an entity separate from the woman have challenged the rights of pregnant women to make decisions about medical interventions and have criminalized maternal behavior that is believed to be associated with fetal harm or adverse perinatal outcomes. This opinion summarizes recent, notable legal cases; reviews the underlying, established ethical principles relevant to the highlighted issues; and considers six objections to punitive and coercive legal approaches to maternal decision making. These approaches 1) fail to recognize that pregnant women are entitled to informed consent and bodily integrity, 2) fail to recognize that medical knowledge and predictions of outcomes in obstetrics have limitations, 3) treat addiction and psychiatric illness as if they were moral failings, 4) threaten to dissuade women from prenatal care, 5) unjustly single out the most vulnerable women, and 6) create the potential for criminalization of otherwise legal maternal behavior. Efforts to use the legal system to protect the fetus by constraining pregnant women's decision making or punishing them erode a woman's basic rights to privacy and bodily integrity and are not justified. Physicians and policy makers should promote the health of women and their fetuses through advocacy of healthy behavior; referral for substance abuse treatment and mental health services when indicated; and development of safe, available, and efficacious services for women and families.

Ethical issues that arise in the care of pregnant women are challenging to physicians, politicians, lawyers, and ethicists alike. One of the fundamental goals of medicine and society is to optimize the outcome of pregnancy. Recently, some apparent attempts to foster this goal have been characterized by legal action and policies aimed at specifically protecting the fetus as an entity separate from the woman. These actions and policies have challenged the rights of pregnant women to make decisions about medical interventions and have criminalized maternal behavior that is believed to be associated with fetal harm or adverse perinatal outcomes.

Practitioners who care for pregnant women face particularly difficult dilemmas when their patients reject medical recommendations, use illegal

ISSN 1074-861X

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drugs, or engage in a range of other behaviors that have the potential to cause fetal harm. In such situations, physicians, hospital representatives, and others have at times resorted to legal actions to impose their views about what these pregnant patients ought to do or to effect particular interventions or outcomes. Appellate courts have held, however, that a pregnant woman's decisions regarding medical treatment should take precedence regardless of the presumed fetal consequences of those decisions. In one notable 1990 decision, a District of Columbia appellate court vacated a lower court's decision to compel cesarean delivery in a critically ill woman at 26 weeks of gestation against her wishes, stating in its opinion that "in virtually all cases the question of what is to be done is to be decided by the patient—the pregnant woman—on behalf of herself and the fetus" (1). Furthermore, the court stated that it could think of no "extremely rare and truly exceptional" case in which the state might have an interest sufficiently compelling to override a pregnant patient's wishes (2). Amid often vigorous debate, most ethicists also agree that a pregnant woman's informed refusal of medical intervention ought to prevail as long as she has the ability to make medical decisions (3, 4).

Recent legislation, criminal prosecutions, and legal cases much discussed in both courtrooms and newsrooms have challenged these precedents, raising the question of whether there are circumstances in which a woman who has become pregnant may have her rights to bodily integrity and informed consent overridden to protect her fetus. In Utah, a woman who had used cocaine was charged with homicide for refusing cesarean delivery of a fetus that was ultimately stillborn. In Pennsylvania, physicians obtained a court order for cesarean delivery in a patient with suspected fetal macrosomia. Across the country, pregnant women have been arrested and prosecuted for being pregnant and using drugs or alcohol. These cases and the publicity they have engendered suggest that it is time to revisit the ethical issues involved.

The ethics of caring for pregnant women and an approach to decision making in the context of the maternal–fetal relationship have been discussed in previous statements by the American College of Obstetricians and Gynecologists (ACOG) Committee on Ethics. After briefly reiterating those discussions, this opinion will summarize recent, notable cases; review the underlying, established ethical principles relevant to the highlighted issues; consider objections to punitive and coercive legal approaches to maternal decision making; and summarize recommendations for attending to future ethical matters that may arise.

Recent Cases

In March 2004, a 28-year-old woman was charged with first-degree murder for refusing to undergo an immediate cesarean delivery because of concerns about fetal well-being and later giving birth to a girl who tested positive for cocaine and a stillborn boy. According to press reports, the woman was mentally ill and intermittently homeless and had been brought to Utah by a Florida adoption agency to give birth to the infants and give them up. She ultimately pled guilty to two counts of child endangerment.

In January 2004, a woman who previously had given birth vaginally to six infants, some of whom weighed close to 12 pounds, refused a cesarean delivery that was recommended because of presumed macrosomia. A Pennsylvania hospital obtained a court order to perform the cesarean delivery and gain custody of the fetus before and after delivery, but the woman and her husband fled to another hospital, where she reportedly had an uncomplicated vaginal delivery of a healthy 11-pound infant.

In September 2003, a 22-year-old woman was prosecuted after her son tested positive for alcohol when he was born in Glens Falls, New York. A few days after the birth, the woman was arrested and charged with two counts of child endangerment for "knowingly feeding her blood," containing alcohol, to her fetus via the umbilical cord. Several months later, her lawyers successfully appealed her conviction.

In May 1999, a 22-year-old woman who was homeless regularly used cocaine while pregnant and gave birth to a stillborn infant in South Carolina. She became the first woman in the United States to be tried and convicted of homicide by child abuse based on her behavior during pregnancy and was given a 12-year prison sentence. The conviction was upheld in the South Carolina Supreme Court, and the U.S. Supreme Court recently refused to hear her appeal. At a postconviction relief hearing, expert testimony supported arguments that the woman had had inadequate representation, but the court held that there was no ineffective assistance of counsel and that she is not entitled to a new trial. This decision is being appealed.

Ethical Considerations

Framing Ethics in Perinatal Medicine

It is likely that the interventions described in the preceding cases were motivated by a shared concept—that a fetus can and should be treated as separable and legally, philosophically, and practically independent from the pregnant woman within whom it resides. This common method of framing ethical issues in perinatal medicine is not surprising given a number of developments in the past several decades. First, since the 1970s, the development of techniques for imaging, testing, and treating fetuses has led to the widespread endorsement of the notion that fetuses are independent patients, treatable apart from the pregnant women upon whom their existence depends (5). Similarly, some bioethical models now assert that physicians have moral obligations to fetal "patients" that are separate from their obligations to pregnant women (6). Finally, a number of civil laws, discussed later in this section, aim to create fetal rights separate from a pregnant woman's rights.

Although frameworks that treat the woman and fetus as separable and independent are meant to simplify and clarify complex issues that arise in obstetrics, many writers have noted that such frameworks tend to distort, rather than illuminate, ethical and policy debates (7). In particular, these approaches have been criticized for their tendency to emphasize the divergent rather than shared interests of the pregnant woman and fetus. This emphasis results in a view of the maternal–fetal relationship as paradigmatically adversarial, when in fact in the vast majority of cases, the interests of the pregnant woman and fetus actually converge.

In addition, these approaches tend to ignore the moral relevance of relationships, including the physically and emotionally intimate relationship between the woman and her fetus, as well as the relationships of the pregnant woman within her broader social and cultural networks. The cultural and policy context, for example, suggests a predominantly child-centered approach to maternal and child health, which has influenced current perspectives on the fetus. The prototype for the federal Maternal and Child Health Bureau dates back to 1912, when the first organization was called into existence by reformers such as Florence Kelley, who stated that "the U.S. should have a bureau to look after the child crop," and Julia Lathrop, who said that "the final purpose of the Bureau is to serve all children, to try to work out standards of care and protection which shall give to every child his fair chance in the world." The current home page of the Maternal and Child Health Bureau web site cites as its "vision" an equally child-centered goal (8).

At times, in the current clinical and policy contexts, when the woman and fetus are treated as separate individuals, the woman and her medical interests, health needs, and rights as moral agent, patient, and research subject fade from view. Consider, first, women's medical interests as patients. Researchers performing "fetal surgery"—novel interventions to correct fetal anatomic abnormalities—have been criticized recently not only for their tendency to exaggerate claims of success with regard to fetal and neonatal health, but also for their failure to assess the impact of surgery on pregnant women, who also undertake the risks of the major surgical procedures (9). As a result, several centers performing these techniques now use the term "maternal–fetal surgery" to explicitly recognize the fact that a woman's bodily integrity and health are at stake whenever interventions directed at her fetus are performed. Furthermore, a study sponsored by the National Institute of Child Health and Human Development comparing maternal–fetal surgery with postnatal repair of myelomeningocele (the Management of Myelomeningocele Study) is now assessing maternal as well as fetal outcomes, including measurement of reproductive and health outcomes, depression testing, and economic and family health outcomes in women who participate in the clinical trial.

Similarly, new civil laws that aim to treat the fetus as separate and independent have been criticized for their failure both to address the health needs of the woman within whose body the fetus resides and to recognize the converging interests of the woman and fetus. In November 2002, a revision of the state child health insurance program (sCHIP) that expanded coverage to "individual(s) under the age of 19 including the period from conception until birth" was signed into law. The program does not cover pregnant women older than 18 years except when medical interventions could directly affect the well-being of their fetuses. For example, under sCHIP, intrapartum anesthesia is covered, according to the U.S. Department of Health and Human Services, only because "if a woman's pain during a labor and delivery is not reduced or properly

relieved, adverse and sometimes disastrous effects can occur for the unborn child" (10).

Furthermore, for beneficiaries of sCHIP, many significant women's health issues, even those that are precipitated by pregnancy (eg, molar gestation, postpartum depression, or traumatic injury from intimate partner violence not impacting the fetus), are not covered as a part of routine antenatal care (11). This approach has been criticized not only for its failure to address the health needs of women, but also for its failure to achieve the narrow goal of improving child health because it ignores the fact that maternal and neonatal interests converge. For instance, postpartum depression is associated with adverse effects in infants, including impaired maternal–infant interaction, delayed cognitive and emotional development, increased anxiety, and decreased self-esteem (12, 13). Thus, the law ignores the fact that a critical component of ensuring the health of newborns is the provision of comprehensive care for their mothers.

Likewise, in April 2004, the Unborn Victims of Violence Act was signed into law, creating a separate federal offense if, during the commission of certain federal crimes, an individual causes the death of, or bodily injury to, a fetus at any stage of pregnancy. The law, however, does not categorize the death of or injury to a pregnant woman as a separate federal offense, or create sentence enhancement for those who assault or murder a woman while pregnant. The statute's sponsors explicitly rejected proposals that had virtually identical criminal penalties but recognized the pregnant woman as the victim, despite the fact that murder is responsible for more pregnancy-associated deaths in the United States than any other cause, including hemorrhage and thromboembolic events (14, 15).

Beyond its impact on maternal and child health, a failure to recognize the interconnectedness of the pregnant woman and fetus has important ethical and legal implications. Because an intervention on a fetus must be performed through the body of a pregnant woman, an assertion of fetal rights must be reconciled with the ethical and legal obligations toward pregnant women *as women*, persons in their own right. Discussions about rights of the unborn often have failed to address these obligations. Regardless of what is believed about fetal personhood, claims about fetal rights require an assessment of the rights of pregnant women, whose personhood within the legal and moral community is indisputable.

Furthermore, many writers have noted a moral injury that arises from abstracting the fetus from the pregnant woman, in its failing to recognize the pregnant woman herself as a patient, person, and rights-bearer. This approach disregards a fundamental moral principle that persons never be treated solely as means to an end, but as ends in themselves. Within the rhetoric of conflict and fetal rights, the pregnant woman has at times been reduced to a vessel—even a "fortress" holding the fetus "prisoner" (16). As George Annas aptly described, "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 rights to bodily integrity" (3).

Some writers have argued that at the heart of the distorting influence of the "two-patient" model of the maternal–fetal dyad is the fact that, according to traditional theories that undergird medical ethics, the very notion of a person or a patient is someone who is physically separate from others. Pregnancy, however, is marked by a "particular and particularly thoroughgoing kind of intertwinement" (17). Thus, the pregnant woman and fetus fit awkwardly at best into what the term "patient" is understood to mean. They are neither physically separate, as persons are understood to be, nor indistinguishably fused. A framework that instead defines the professional ethical obligations with a deep sensitivity to relationships of interdependency may help to avoid the distorting influence of the two-patient model as traditionally understood (18). Although this opinion does not specifically articulate a novel comprehensive conceptual model for perinatal ethics, in the discussion that follows, the Committee on Ethics takes as morally central the essential connection between the pregnant woman and fetus.

Ethics Committee Opinions and the Maternal–Fetal Relationship

In the context of a framework that recognizes the interconnectedness of the pregnant woman and fetus and emphasizes their shared interests, certain opinions previously published by the ACOG Committee on Ethics are particularly relevant. These include:

- "Informed Consent" (19)
- "Patient Choice in the Maternal–Fetal Relationship" (20)
- "At-Risk Drinking and Illicit Drug Use: Ethical Issues in Obstetric and Gynecologic Practice" (21)

One fundamental ethical obligation of health care professionals is to respect patients' autonomous decision making and to adhere to the requirement for informed consent for medical intervention. In January 2004, the Committee on Ethics published a revised edition of "Informed Consent" in which the following points are defended:

- "Requiring informed consent is an expression of respect for the patient as a person; it particularly respects a patient's moral right to bodily integrity, to self-determination regarding sexuality and reproductive capacities, and to the support of the patient's freedom within caring relationships."
- "The ethical requirement for informed consent need not conflict with physicians' overall ethical obligation to a principle of beneficence; that is, every effort should be made to incorporate a commitment to informed consent within a commitment to provide medical benefit to patients and thus respect them as whole and embodied persons."

Pregnancy does not obviate or limit the requirement to obtain informed consent. Intervention on behalf of the fetus must be undertaken through the body and within the context of the life of the pregnant woman, and therefore her consent for medical treatment is required, regardless of the treatment indication. However, pregnancy presents a special set of issues. The issues associated with informed refusal of care by pregnant women are addressed in the January 2004 opinion "Patient Choice in the Maternal–Fetal Relationship" (20). This opinion states that in cases of maternal refusal of treatment for the sake of the fetus, "court-ordered intervention against the wishes of a pregnant woman is rarely if ever acceptable." The document presents a review of general ethical considerations applicable to pregnant women who do not follow the advice of their physicians or do not seem to make decisions in the best interest of their fetuses. Although the possibility of a justifiable court-ordered intervention is not completely ruled out, the document presents several recommendations that strongly discourage coercive measures:

- "The obstetrician's response to a patient's unwillingness to cooperate with medical advice . . . should be to convey clearly the reasons for the recommendations to the pregnant woman, examine the barriers to change along with her, and encourage the development of health-promoting behavior."
- "[Even if] a woman's autonomous decision [seems] not to promote beneficence-based obligations (of the woman or the physician) to the fetus, . . . the obstetrician must respect the patient's autonomy, continue to care for the pregnant woman, and not intervene against the patient's wishes, regardless of the consequences."
- "The obstetrician must keep in mind that medical knowledge has limitations and medical judgment is fallible" and should therefore take great care "to present a balanced evaluation of expected outcomes for both [the woman and the fetus]."
- "Obstetricians should consider the social and cultural context in which these decisions are made and question whether their ethical judgments reinforce gender, class, or racial inequality."

In addition to revisiting questions of how practitioners should address refusal of treatment in the clinic and delivery room, the four cases outlined previously illustrate punitive and coercive policies aimed at pregnant women who engage in behaviors that may adversely affect fetal well-being. The 2004 opinion "At-Risk Drinking and Illicit Drug Use: Ethical Issues in Obstetric and Gynecologic Practice" (21) specifically addresses addiction and the prosecution of women who use drugs and alcohol during pregnancy and recommends strongly against punitive policies:

- "Addiction is not primarily a moral weakness, as it has been viewed in the past, but a 'brain disease' that should be included in a review of systems just like any other biologic disease process."
- "Recommended screening . . . connected with legally mandated testing or reporting . . . endanger[s] the relationship of trust between physician and patient, place[s] the obstetrician in an adversarial relationship with the patient, and possibly conflict[s] with the therapeutic obligation."
- Punitive policies "are unjust in that they indict the woman for failing to seek treatment that actually may not be available to her" and in that they "are not applied evenly across sex, race, and socioeconomic status."

- Physicians must make a substantial effort to "treat the patient with a substance abuse problem with dignity and respect in order to form a therapeutic alliance."

Finally, recent legal decisions affirm that physicians have neither an obligation nor a right to perform prenatal testing for alcohol or drug use without a pregnant woman's consent (22, 23). This includes consent to testing of the woman that could lead to any form of reporting, both to legal authorities for purposes of criminal prosecution and to civil child welfare authorities.

Against Coercive and Punitive Legal Approaches to the Maternal–Fetal Relationship

This section addresses specifically the ethical issues associated with the cases outlined previously and delineates six reasons why restricting patients' liberty and punishing pregnant women for their actions during pregnancy that may affect their fetuses is neither wise nor justifiable. Each raises important objections to punishing pregnant women for actions during pregnancy; together they provide an overwhelming rationale for avoiding such approaches.

1. *Coercive and punitive legal approaches to pregnant women who refuse medical advice fail to recognize that all competent adults are entitled to informed consent and bodily integrity.*

A fundamental tenet of contemporary medical ethics is the requirement for informed consent, including the right of competent adults to refuse medical intervention. The Committee on Ethics affirms that informed consent for medical treatment is an ethical requirement and is an expression of respect for the patient as a person with a moral right to bodily integrity (19).

The crucial difference between pregnant and nonpregnant individuals, though, is that a fetus is involved whose health interests could arguably be served by overriding the pregnant woman's wishes. However, in the United States, even in the case of two completely separate individuals, constitutional law and common law have historically recognized the rights of all adults, pregnant or not, to informed consent and bodily integrity, *regardless of the impact of that person's decision on others*. For instance, in 1978, a man suffering from aplastic anemia sought a court order to force his cousin, who was the only compatible donor available, to submit to bone marrow harvest. The court declined, explaining in its opinion:

> For our law to compel the Defendant to submit to an intrusion of his body would change every concept and principle upon which our society is founded. To do so would defeat the sanctity of the individual and would impose a rule which would know no limits. . . . For a society that respects the rights of one individual, to sink its teeth into the jugular vein or neck of its members and suck from it sustenance for another member, is revolting to our hard-wrought concepts of jurisprudence. Forcible extraction of living body tissues causes revulsion to the judicial mind. Such would raise the specter of the swastika and the Inquisition, reminiscent of the horrors this portends. (24)

Justice requires that a pregnant woman, like any other individual, retain the basic right to refuse medical intervention, even if the intervention is in the best interest of her fetus. This principle was challenged unsuccessfully in June 1987 with the case of a 27-year-old woman who was at 25 weeks of gestation when she became critically ill with cancer. Against the wishes of the woman, her family, and her physicians, the hospital obtained a court order for a cesarean delivery, claiming independent rights of the fetus. Both mother and infant died shortly after the cesarean delivery was performed. Three years later, the District of Columbia Court of Appeals vacated the court-ordered cesarean delivery and held that the woman had the right to make health care decisions for herself and her fetus, arguing that the lower court had "erred in subordinating her right to bodily integrity in favor of the state's interest in potential life" (1).

2. *Court-ordered interventions in cases of informed refusal, as well as punishment of pregnant women for their behavior that may put a fetus at risk, neglect the fact that medical knowledge and predictions of outcomes in obstetrics have limitations.*

Beyond its importance as a means to protect the right of individuals to bodily integrity, the doctrine of informed consent recognizes the right of individuals to weigh risks and benefits for themselves. Women almost always are best situated to understand the importance of risks and benefits in the context of their own values, circumstances, and concerns. Furthermore, medical judgment in obstetrics itself has limitations in its ability to predict outcomes. In this document, the Committee on Ethics has argued that overriding a woman's autonomous choice, whatever its potential consequences, is neither ethi-

cally nor legally justified, given her fundamental rights to bodily integrity. Even those who challenge these fundamental rights in favor of protecting the fetus, however, must recognize and communicate that medical judgments in obstetrics are fallible (25). And fallibility—present to various degrees in all medical encounters—is sufficiently high in obstetric decision making to warrant wariness in imposing legal coercion. Levels of certainty underlying medical recommendations to pregnant women are unlikely to be adequate to justify legal coercion and the tremendous impact on the lives and civil liberties of pregnant women that such intervention would entail (26). Some have argued that court-ordered intervention might plausibly be justified only when certainty is especially robust and the stakes are especially high. However, in many cases of court-ordered obstetric intervention, the latter criterion has been met but not the former. Furthermore, evidence-based medicine has revealed limitations in the ability to concretely describe the relationship of maternal behavior to perinatal outcome. Criminalizing women in the face of such scientific and clinical uncertainty is morally dubious. Not only do these approaches fail to take into account the standards of evidence-based medical practice, but they are also unjust, and their application is likely to be informed by bias and opinion rather than objective assessment of risk.

Consider, first, the limitations of medical judgment in predicting birth outcomes based on mode of childbirth. A study of court-ordered obstetric interventions suggested that in almost one third of cases in which court orders were sought, the medical judgment was incorrect in retrospect (27). One clear example of the challenges of predicting outcome is in the management of risk associated with shoulder dystocia in the setting of fetal macrosomia—which is, and should be, of great concern for all practitioners. When making recommendations to patients, however, practitioners have an ethical obligation to recognize and communicate that accurate diagnosis of macrosomia is imprecise (20). Furthermore, although macrosomia increases the risk of shoulder dystocia, it is certainly not absolutely predictive; in fact, most cases of shoulder dystocia occur unpredictably among infants of normal birthweight. Given this uncertainty, ACOG makes recommendations about when cesarean delivery may be considered, not about when it is absolutely indicated. Because of the inability to determine with certainty when a situation is harmful to the fetus or pregnant woman and the inability to guarantee that the pregnant woman will not be harmed by the medical intervention, great care should be exercised to present a balanced evaluation of expected outcomes for both parties (20). The decision about weighing risks and benefits in the setting of uncertainty should remain the pregnant woman's to make in the setting of supportive, informative medical care.

Medical judgment also has limitations in that the relationship of maternal behavior to pregnancy outcome is poorly understood and may be exaggerated in realms often mistaken to be of moral rather than medical concern, such as drug use. For instance, recent child development research has not found the effects of prenatal cocaine exposure that earlier uncontrolled studies reported (28). It is now understood that poverty and its concomitants—poor nutrition and inadequate health care—can account for many of the effects popularly attributed to cocaine. Before these data emerged, the criminal justice approach to drug addiction during pregnancy was fueled to a great degree by what is now understood to be the distorting image of the "crack baby." Such an image served as a "convenient symbol for an aggressive war on drug users [that] makes it easier to advocate a simplistic punitive response than to address the complex causes of drug use" (29). The findings questioning the impact of cocaine on perinatal outcome are among many considerations that bring sharply into question any possible justification for a criminal justice approach, rather than a public health approach, to drug use during pregnancy. Given the incomplete understanding of factors underlying perinatal outcomes in general and the contribution of individual behavioral and socioeconomic factors in particular, to identify homeless and addicted women as personally, morally, and legally culpable for perinatal outcomes is inaccurate, misleading, and unjust.

3. Coercive and punitive policies treat medical problems such as addiction and psychiatric illness as if they were moral failings.

Regardless of the strength of the link between an individual's behaviors and pregnancy outcome, punitive policies directed at women who use drugs are not justified, because these policies are, in effect, punishing women for having a medical problem. Although once considered a sign of moral weakness, addiction is now, according to evidence-based medicine, considered a disease—a compulsive disorder

requiring medical attention (30). Pregnancy should not change how clinicians understand the medical nature of addictive behavior. In fact, studies overwhelmingly show that pregnant drug users are very concerned about the consequences of their drug use for their fetuses and are particularly eager to obtain treatment once they find out they are pregnant (31, 32). Despite evidence-based medical recommendations that support treatment approaches to drug use and addiction (21), appropriate treatment is particularly difficult to obtain for pregnant and parenting women and the incarcerated (29). Thus, a disease process exacerbated by social circumstance—not personal, legal, or moral culpability—is at the heart of substance abuse and pregnancy. Punitive policies unfairly make pregnant women scapegoats for medical problems whose cause is often beyond their control.

In most states, governmental responses to pregnant women who use drugs have upheld medical characterizations of addiction. Consistent with longstanding U.S. Supreme Court decisions recognizing that addiction is an illness and that criminalizing it violates the Constitution's Eighth Amendment prohibitions against cruel and unusual punishment, no state has adopted a law that specifically creates unique criminal penalties for pregnant women who use drugs (33). However, in South Carolina, using drugs or being addicted to drugs was *effectively* criminalized when the state supreme court interpreted the word "child" in the state's criminal child endangerment statute to include viable fetuses, making the child endangerment statute applicable to pregnant women whose actions risk harm to a viable fetus (23). In all states, women retain their Fourth Amendment freedom from unreasonable searches, so that pregnant women may not be subject to nonconsensual drug testing for the purpose of criminal prosecution.

Partly on the basis of the understanding of addiction as a compulsive disorder requiring medical attention, medical professionals, U.S. state laws, and the vast majority of courts do not support unique criminal penalties for pregnant women who use drugs.

4. *Coercive and punitive policies are potentially counterproductive in that they are likely to discourage prenatal care and successful treatment, adversely affect infant mortality rates, and undermine the physician–patient relationship.*

Even if the aforementioned ethical concerns could be addressed, punitive policies would not be justifiable on utilitarian grounds, because they would likely result in more harm than good for maternal and child health, broadly construed. Various studies have suggested that attempts to criminalize pregnant women's behavior discourage women from seeking prenatal care (34, 35). Furthermore, an increased infant mortality rate was observed in South Carolina in the years following the *Whitner v State* decision (36), in which the state supreme court concluded that *anything* a pregnant woman does that might endanger a viable fetus (including, but not limited to, drug use) could result in either charges of child abuse and a jail sentence of up to 10 years or homicide and a 20-year sentence if a stillbirth coincides with a positive drug test (23). As documented previously (21), threats and incarceration have been ineffective in reducing the incidence of alcohol and drug abuse among pregnant women, and removing children from the home of an addicted mother may subject them to worse risks in the foster care system. In fact, women who have custody of their children complete substance abuse treatment at a higher rate (37–39).

These data suggest that punishment of pregnant women might not result in women receiving the desired message about the dangers of prenatal substance abuse; such measures might instead send an unintended message about the dangers of prenatal care. Ultimately, fear surrounding prenatal care would likely undermine, rather than enhance, maternal and child health. Likewise, court-ordered interventions and other coercive measures may result in fear about whether one's wishes in the delivery room will be respected and ultimately could discourage pregnant patients from seeking care. Encouraging prenatal care and treatment in a supportive environment will advance maternal and child health most effectively.

5. *Coercive and punitive policies directed toward pregnant women unjustly single out the most vulnerable women.*

Evidence suggests that punitive and coercive policies not only are ethically problematic in and of themselves, but also unfairly burden the most vulnerable women. In cases of court-ordered cesarean deliveries, for instance, the vast majority of court orders have been obtained against poor women of color (27, 40).

Similarly, decisions about detection and management of substance abuse in pregnancy are fraught

with bias, unfairly burdening the most vulnerable despite the fact that addiction occurs consistently across race and socioeconomic status (41). In the landmark case of *Ferguson v City of Charleston*, which involved selective screening and arrest of pregnant women who tested positive for drugs, 29 of 30 women arrested were African American. Studies suggest that affluent women are less likely to be tested for use of illicit drugs than poor women of color, perhaps because of stereotyped but demonstrably inaccurate assumptions about drug use. One study found that despite similar rates of substance abuse across racial and socioeconomic status, African–American women were 10 times more likely than white women to be reported to public health authorities for substance abuse during pregnancy (42). These data suggest that, as implemented, many punitive policies centered on maternal behaviors, including substance use, are deeply unjust in that they reinforce social and racial inequality.

6. Coercive and punitive policies create the potential for criminalization of many types of otherwise legal maternal behavior.

In addition to raising concerns about race and socioeconomic status, punitive and coercive policies may have even broader implications for justice for women. Because many maternal behaviors are associated with adverse pregnancy outcome, these policies could result in a society in which simply being a woman of reproductive potential could put an individual at risk for criminal prosecution. For instance, poorly controlled diabetes is associated with numerous congenital malformations and an excessive rate of fetal death. Periconceptional folic acid deficiency is associated with an increased risk of neural tube defects. Obesity has been associated in recent studies with adverse pregnancy outcomes, including preeclampsia, shoulder dystocia, and antepartum stillbirth (43, 44). Prenatal exposure to certain medications that may be essential to maintaining a pregnant woman's health status is associated with congenital abnormalities. If states were to consistently adopt policies of punishing women whose behavior (ranging from substance abuse to poor nutrition to informed decisions about prescription drugs) has the potential to lead to adverse perinatal outcomes, at what point would they draw the line? Punitive policies, therefore, threaten the privacy and autonomy not only of all pregnant women, but also of all women of reproductive potential.

Recommendations

In light of these six considerations, the Committee on Ethics strongly opposes the criminal prosecution of pregnant women whose activities may appear to cause harm to their fetuses. Efforts to use the legal system specifically to protect the fetus by constraining women's decision making or punishing them for their behavior erode a woman's basic rights to privacy and bodily integrity and are neither legally nor morally justified. The ACOG Committee on Ethics therefore makes the following recommendations:

- In caring for pregnant women, practitioners should recognize that in the majority of cases, the interests of the pregnant woman and her fetus converge rather than diverge. Promoting pregnant women's health through advocacy of healthy behavior, referral for substance abuse treatment and mental health services when necessary, and maintenance of a good physician–patient relationship is always in the best interest of both the woman and her fetus.
- Pregnant women's autonomous decisions should be respected. Concerns about the impact of maternal decisions on fetal well-being should be discussed in the context of medical evidence and understood within the context of each woman's broad social network, cultural beliefs, and values. In the absence of extraordinary circumstances, circumstances that, in fact, the Committee on Ethics cannot currently imagine, judicial authority should not be used to implement treatment regimens aimed at protecting the fetus, for such actions violate the pregnant woman's autonomy.
- Pregnant women should not be punished for adverse perinatal outcomes. The relationship between maternal behavior and perinatal outcome is not fully understood, and punitive approaches threaten to dissuade pregnant women from seeking health care and ultimately undermine the health of pregnant women and their fetuses.
- Policy makers, legislators, and physicians should work together to find constructive and evidence-based ways to address the needs of women with alcohol and other substance abuse problems. This should include the development of safe, available, and efficacious services for women and families.

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Appendix B

American Medical Women's Association, *Principles of Ethical Conduct*

Principles of Ethical Conduct

The American Medical Women's Association supports a body of ethical statements developed primary for the benefit of the patient. As a member of the medical profession, a physician must recognize responsibility not only to patients, but also to society, to other health professionals, and so self. The following Principals of Ethical Conduct are not laws, but standards of conduct which define the essentials of appropriate behavior for the physician.

•A physician shall be dedicated to provide competent medical service with compassion and respect for human dignity.
•A physician will deal honestly with patients and colleagues.
•A physician will recognize the right of all patients to receive the same quality of care regardless of gender, race, marital status, sexual orientation, religious preference, diagnosis, or age.
•A physician shall recognize and respect the rights of all patients, female and male, regardless of reproductive status, to receive the same standard of care.
•A physician shall respect the rights of patients, colleagues, and of other health professionals, and shall safeguard patient confidences within the constraints of the law.
•A physician shall continue to study, apply and advance scientific knowledge; make relevant information available to patients and colleagues and the public; obtain consultation; and use the talents of other health professional when indicated.
•A physician shall, in the provision of appropriate patient care, except in emergencies, be free to choose whom so serve, with whom to associate, and the environment in which to provide medical services.
•A physician shall recognize a responsibility to participate in activities contributing to an improved community.
•A physician shall respect the law and also recognize a responsibility to seek changes in those requirements which are contrary to the best interest of the patient.
•A physician shall notify, in a timely and clinically appropriate manner, an appropriate authority regarding those physicians whose conduct the reporting physician believes illegal, unethical, or incompetent or who engages in fraud or deception.

Adapted, in part, from AMA and AOA codes of medial ethics by AMWA medical ethics committee in 1989;

Adopted by the House of Delegate
October 1990
Revised 2000

http://www.amwa-doc.org/index.cfm?objectId=243A88E4-D567-0B25-5C4EBCA9757330EF

Appendix C

American Medical Association Board of Trustees Report, *Legal Interventions During Pregnancy: Court-Ordered Medical Treatments and Legal Penalties for Potentially Harmful Behavior by Pregnant Women*

Helene M. Cole, MD, *Section Editor*

Legal Interventions During Pregnancy

Court-Ordered Medical Treatments and Legal Penalties for Potentially Harmful Behavior by Pregnant Women

ORDINARILY, the pregnant woman, in consultation with her physician, acts in all reasonable ways to enhance the health of her fetus. Indeed, clinicians are frequently impressed with the amount of personal health risk undertaken and voluntary self-restraint exhibited by the pregnant woman for the sake of her fetus and to help ensure that her child will be as healthy as possible.[1] In a limited number of situations, however, a pregnant woman may reject a medical treatment or procedure that her physician believes would benefit the health of her fetus. For instance, she may refuse to submit to a cesarean section when her physician believes that a cesarean section is in the best interests of the fetus. Or a pregnant woman may behave in ways that are potentially detrimental to fetal well-being, for example, taking illegal drugs while pregnant.

Increasingly, legal interventions are being sought in cases in which the decisions or actions of pregnant women do not accord with medical recommendations that could benefit fetal health. Physicians have sought, and some courts have granted, permission to override refusals of pregnant women to submit to medical procedures. Public officials have tried to impose legal penalties on women whose behavior is not in the best interest of the fetus. This report, which is based on the deliberations of the Committee of Medicolegal Problems, discusses the various legal and policy concerns and makes recommendations regarding legal interventions in pregnancy.

SEEKING COURT ORDERS TO OVERRIDE THE MEDICAL PREFERENCES OF PREGNANT WOMEN

Recent Medical Advances Enable Physicians to Address the Health of the Fetus More Directly

Until recently, promoting fetal well-being was generally not a separate endeavor from promoting the health of the pregnant woman. Advances in medicine and surgery, however, have increased the ability of physicians to direct medical procedures specifically at the fetus. Diagnostic tools, such as ultrasonography, amniocentesis, or chorionic villus sampling, can be used to detect fetal abnormalities that, in some cases, may be treated through prenatal therapy or fetal surgery.[2]

The ability to treat the fetus more directly than in the past has given rise to the question of whether a pregnant woman has a legal obligation to undergo medical treatments that could benefit the fetus. When a pregnant woman refuses treatment or procedures that could benefit fetal health, a conflict arises between her right to make medical decisions that affect the health of her fetus and herself and the state's desire to intervene on behalf of the fetus.

Questions and concerns over a pregnant woman's legal obligations to accept medical care are exacerbated by the unique physical relationship that exists between a pregnant woman and her fetus. Invariably, one cannot be treated without affecting the other. Performing medical procedures against the pregnant woman's will violates her right to informed consent and her constitutional right to bodily integrity.[3-4] These rights are among the most basic and are well established in both society and medicine. However, preservation of these rights may come at the risk of preventable fetal impairment or death.

Moral and Legal Responsibilities of the Pregnant Woman Toward Her Fetus

A woman who chooses to carry her pregnancy to term has a moral responsibility to make reasonable efforts toward preserving fetal health. This moral responsibility, however, does not necessarily imply a legal duty to accept medical procedures or treatments in order to benefit the fetus.

From the Board of Trustees, American Medical Association, Chicago, Ill.

This report was adopted as Report DD by the House of Delegates of the American Medical Association at the Annual Meeting, June 1990.

Reprint requests to the Board of Trustees, American Medical Association, 515 N State St, Chicago, IL 60610 (Dr Orentlicher).

Legal Precedent.—Several courts have considered the issue of legal interventions to impose medical treatments on pregnant women. However, few requests for court-ordered obstetrical interventions have been reviewed by appellate courts. Only two appellate courts have considered a decision to override a pregnant woman's refusal of a blood transfusion. In 1964, the New Jersey Supreme Court ordered a blood transfusion for a pregnant woman who refused the transfusion on religious grounds.[3] Also in 1964, an appeals court in the District of Columbia ruled that a pregnant woman could be forced to undergo a blood transfusion for the sake of her fetus.[4] However, both of these cases were decided in the early 1960s, before the current legal emphasis on the integrity of the individual and the right to refuse treatment.

Approximately two dozen courts have been asked to order cesarean sections.[5] Only two of these cases have reached the appellate level. In one, a trial court judge in the District of Columbia ordered a cesarean section on a woman who was terminally ill.[6] The woman's treatment desires and her competency were major points of controversy in this case. The District of Columbia Court of Appeals, en banc, ruled that the lower court was in error for ordering the cesarean section. The court of appeals ruled that rather than weighing the interests of the state (in protecting the potential life of the fetus) against the interests of the pregnant woman, the lower court should have used "substituted" judgment and proceeded according to what it could best ascertain the pregnant woman's wishes would have been.

In 1981, a trial court in Georgia ordered a cesarean section performed on a woman who had refused the operation for religious reasons. The physician involved diagnosed placenta previa, with a 99% to 100% chance of fetal demise if vaginal delivery occurred.[7] The Georgia Supreme Court, with minimal explanation or policy discussion, refused to stay the trial court's order. A few days after the court's denial of a stay, the woman had a safe vaginal delivery.

The remainder of this section of the report provides an analysis of relevant law and policy considerations and recommends guidelines on the extent to which a pregnant woman's moral duties toward the fetus should be legally enforced.

Distinctions Between Moral and Legal Responsibilities.—Society places a positive moral value on aiding those who may need help or be in danger, yet it does not ordinarily impose a legal duty on specific individuals to render that needed assistance.[8] This reluctance to impose a legal duty on the individual is especially strong where rendering aid would pose a risk to the health of the individual or would require an invasion of his or her bodily integrity.[9,10,11]

There is also no legal duty for an individual to render aid even if a life would be saved and the assistance rendered would incur minimal risk to the health of the person providing the aid. For example, a person need not donate bone marrow to a cousin who is dying of aplastic anemia.[9]

Yet the responsibility of a pregnant woman to her fetus is stronger than that of one individual to another. The duty of a pregnant woman to her fetus is more akin to the obligations of a parent to his or her child. And in fact, a parent's duty to his or her child is enforced with legal sanctions. The parent-child relationship is considered a "special relationship" under "Samaritan" law.[9] Samaritan law, which applies to duties to render aid, provides that those people who have a special relationship to another person, such as innkeeper to guest or common carrier to passenger, have a legal obligation to come to the aid of that person.[12]

Even in cases of special relationships, however, the obligation to render aid is minimal and cannot require the rescuer to endanger him or herself.[13] For example, if a child needed a bone marrow transplant, but the only compatible donor was the child's father, the father would not be legally required to donate his bone marrow to his child.

There are other situations in which a parent's obligation to his or her child is legally enforced. Parents clearly have both a moral and legal duty to provide reasonable medical care for their children. All states legally require parents to provide such care.[14] A pregnant woman who refuses a surgical intervention, treatment, or therapy that might benefit fetal health is, in practical terms, withholding medical care from her fetus. However, in the case of a pregnant woman, in order for her *not* to withhold medical treatment, she generally must accept a risk to her life or health, as well as bodily invasion of her person. Just as parental legal obligations to provide medical care to children do not include compelled acceptance of risk to life or health, neither should a pregnant woman's obligations to her fetus include the acceptance of such risk.

Current procreative law reflects this principle. Under *Roe v Wade*, the state's interest in potential life becomes compelling at the point of viability.[15] It is at that point, therefore, that the state may prevent a woman from having an abortion. Nevertheless, the state may not adopt postviability abortion regulations that trade off risks to the health of the pregnant woman against benefits to the health of her fetus.[16]

In addition, legally enforcing a pregnant woman's moral obligation to the fetus creates a burden or penalty on pregnancy itself.[17] The right to bear a child is constitutionally protected.[2] Forcing a pregnant woman to undertake a health risk or to accept an invasive procedure against her will burdens her decision to have a child.[2]

Even a viable fetus does not generally receive the same legal recognition as a child. Consequently, the legal enforcement of a pregnant woman's moral responsibility to her fetus should not exceed the legal enforcement of a parent's moral duty to his or her child.[18] Society does not legally require parents to undergo a risk of life, health, or bodily invasion in order to carry out their moral obligations to provide medical care for their children. Few, if any, medical procedures meant to benefit the fetus would entail no risk to a pregnant woman's health. Thus, while a pregnant woman should be resolutely encouraged to fulfill her moral responsibilities to her fetus, a legal duty to accept medical procedures meant to benefit her fetus generally should not be imposed.

Ethical Obligations of the Physician in Instances of Treatment Refusal

A physician's ethical duty toward the pregnant woman clearly requires the physician to act in the interest of the fetus as well as the woman. Arguably, adherence to a pregnant woman's refusal of treatment that is intended to benefit the fetus would violate that ethical obligation, particularly when the physician believes that the potential benefit to the fetus outweighs the health risk to the mother. While some physicians find adherence to a pregnant woman's wishes morally untenable in situations of fetal endangerment,[1] the duty to protect the health of both the pregnant woman and the fetus precludes balancing one against the other. The physician's

responsibilities in other settings provide a useful analogy, eg, there is no situation (other than perhaps the case of conjoint twins) when it is appropriate for a physician to impose a medical risk on one patient in order to preserve the health of another. A physician cannot force one patient to donate blood to another patient, even if the donation would save the second patient's life. Similarly, such a balancing should generally not be undertaken in the context of pregnancy.

The doctrine of informed consent also indicates that a pregnant woman's refusal of treatment should not be overridden for the benefit of the fetus. Principles of informed consent require a physician to respect the wishes of a mentally competent adult in situations of medical decision making.[3] These principles recognize that decisions that would result in health risks are properly made only by the individual who must bear the risk.[4,5] Considerable uncertainty can surround medical evaluations of the risks and benefits of obstetrical interventions.[6-8] Through a court-ordered intervention, a physician deprives a pregnant woman of her right to reject personal risk and replaces it with the physician's evaluation of the amount of risk that is properly acceptable.[1] This undermines the very concept of informed consent.

Adverse Consequences of Seeking Court-Ordered Obstetrical Interventions in Instances of Treatment Refusal

There are additional reasons why seeking a court order is not necessarily an appropriate response to a pregnant woman's treatment refusal.

A Court Is an Inappropriate Forum for Resolving Treatment Disputes.—Courts are ill-equipped to resolve conflicts concerning obstetrical interventions. The judicial system ordinarily requires that court decisions be based on careful, focused deliberation and the cautious consideration of all facts and related legal concerns. In addition, there is always an opportunity for review on appeal. Court-ordered obstetrical interventions, on the other hand, are likely to be requested on extremely short notice and require immediate judicial action. A study done of court-ordered obstetrical interventions reported that in 70% of cases in which orders were considered, hospital administrators and attorneys were aware of the situation only a day or less before seeking a court order; 88% of the orders were obtained in less than 6 hours, and in 19%, less than an hour.[1] It is unlikely that most judges would already be familiar with the policy concerns or relevant legal precedents required to make a carefully considered decision on such short notice.[9] Decisions made under these immediate deadlines and intense pressures are likely to be hasty and lack well-reasoned conclusions. In the case of an improperly reached conclusion, there is no meaningful appeal available.[9]

In addition, such court proceedings may be unfairly weighted against the pregnant woman. A woman in such a situation is probably under considerable psychological stress and may be suffering from substantial physical pain as well. Her ability to articulate her interests may be seriously impaired. It is further unlikely that the woman will be able to find adequate counsel on such short notice, and it is even more unlikely that counsel will have time to prepare properly for the hearing.

When a decision must be rendered almost immediately, there will be little or no time to obtain the full range of medical opinions or facts. The inability of a court to understand the full range of the relevant medical evidence may lead to error with serious and irreversible consequences.

The Bases for Selecting Cases for a Court Order May Result in the Inconsistent Application of Compelled Treatment.—A physician's decision to pursue a court order reflects his or her personal evaluation of the importance of a pregnant woman's autonomy vis-à-vis the importance of fetal health. Accordingly, whether a woman must undergo judicial review of her decision regarding medical care will vary from physician to physician.

A troubling fact is that court-ordered obstetrical interventions seem to be sought more often in cases where the woman is either a member of a minority group or of a lower economic background. According to an initial study,[1] in 81% of the instances in which a court-ordered intervention was sought, the woman belonged to a minority group. Every request for a court order involved a woman who had received care at a teaching hospital or who had received public assistance.

Women from lower socioeconomic groups and from differing ethnic backgounds may have religious and other personal beliefs or circumstances that vary greatly from those of their physicians or the judges who decide their cases.[9] A woman's reasons for refusing care may be misunderstood or disregarded by the physician seeking the court-ordered override of her decision or by the judge who decides the case.

Creating Impermissible Legal Obligations for the Physician.—An important consideration for physicians is the extent to which they should encourage or contribute to state or court intervention in the medical decision-making process in general. Physicians have traditionally rejected outside intrusion into the physician-patient relationship. Imposing legal duties to accept medical care on pregnant women may result in concomitant legal duties for the physician. Such duties may require the physician to act as an agent of the state rather than as an independent patient counselor.

Judicial intervention is often sought in part to minimize either physician or hospital liability. However, seeking such interventions could ultimately serve to expand rather than limit liability.[1] The tendency to resort to judicial intervention in cases of treatment refusal may create an obligation for the physician to obtain a court order in any situation in which a pregnant woman's preference does not accord with the physician's evaluation of the fetus' needs. If a pregnant woman's obligations to the fetus become legally enforceable, then it is up to the physician to decide in which situations a woman is shirking her legal obligations by rejecting proposed care. Courts may therefore consider a physician negligent for not seeking a court order in situations where a pregnant woman's decision led to fetal impairment.

Another consideration is the extent to which a physician would be required to participate in the practical aspects of enforcing an override of a pregnant woman's treatment decision.[5] In one case in which a court granted permission to a hospital to perform an unwanted cesarean section, the pregnant woman left the hospital before delivery.[7] Should a court choose to enforce an override by compelling the woman to accept treatment, severe methods of restraint may be required. A pregnant woman may have to be forcibly restrained to prevent her from leaving the hospital or physical force may have to be used in order to administer a particular medicine to her. Inviting the state to override a pregnant woman's decision legally may also be inviting government-mandated participation by physicians in administering the treatment. The

physician-patient relationship would certainly be damaged by physician participation in the forcible administration of medical care.[28]

A physician's role is as a medical adviser and counselor. Physicians should not be responsible for policing the decisions that a pregnant woman makes that affect the health of herself and her fetus, nor should they be liable for respecting an informed, competent refusal of medical care. In the interest of preserving fetal health, the physician must ensure that a pregnant woman's decision is a fully informed, competent, and considered decision. A physician should make sure that the pregnant woman understands the nature of the proposed treatment and the implications of treatment and nontreatment for both herself and her fetus. A physician may encourage the pregnant woman to consult other sources, such as family members, health professionals, social welfare workers, or the clergy, to provide her with additional information regarding her decision. When a pregnant woman makes an informed refusal of a procedure meant to benefit fetal health, the physician cannot be held morally responsible for the consequences of the pregnant woman's decision.

Adverse Effects on the Physician-Patient Relationship.—Requests for court intervention may interfere with the physician-patient relationship in other ways. Physician willingness to override a pregnant woman's decision creates an adversarial relationship between physician and patient.[17] In a specific case, the damage to the physician-patient relationship may appear to be outweighed in relation to the benefit to the fetus. However, it may also precipitate general distrust of physicians on the part of pregnant women. Once it becomes known a particular physician or physicians in general are willing to override a pregnant woman's preferences, women may withhold information from the physician that they feel might lead the physician to seek judicial intervention. Or they may reject medical or prenatal care altogether,[1] seriously impairing a physician's ability to treat both the pregnant woman and her fetus. While the health of a few infants may be preserved by overriding a pregnant woman's decision, the health of a great many more may be sacrificed.

Conclusions

The Physician's Professional Duty.—The physician's duty is to ensure that the pregnant woman makes an informed and thoughtful decision, not to dictate the woman's decision.

Physicians Should Not Have a Legal Duty to Seek Court-Ordered Obstetrical Interventions.—There may be no other case where patient rejection of medical advice is as frustrating as when a pregnant woman rejects a procedure designed to benefit her fetus.[1] Yet, physicians should refrain from using the courts to impose personal value judgments on a pregnant woman who refuses medical advice meant to benefit her fetus. As a corollary, a physician should not be liable for injuries sustained as a result of honoring a pregnant woman's informed refusal of treatment designed to benefit the fetus.

Justification for Seeking Court-Ordered Interventions May Be Permissible Only in Exceptional Circumstances.—An absolute rule that a pregnant woman has no legal duty to accept any medical treatment that would substantially benefit her fetus would be problematic. For example, a woman conceivably could refuse oral administration of a drug that would cause no ill effects in her own body but would almost certainly prevent a substantial and irreversible injury to her fetus. Given the current state of medical technology, it is unlikely that such a situation would occur. In addition, as a practical matter, it is unlikely that a woman would refuse treatment in that situation.

If an exceptional circumstance could be found in which a medical treatment poses an insignificant—or no—health risk to the woman, entails a minimal invasion of her bodily integrity, and would clearly prevent substantial and irreversible harm to her fetus, it might be appropriate for a physician to seek judicial intervention. However, the fundamental principle against compelled medical procedures should be a control in all cases that do not present such exceptional circumstances.

RESPONSES TO HARMFUL BEHAVIOR BY THE PREGNANT WOMAN

Alarm at the Rising Percentages of Infants Exposed to Harmful Substances In Utero

Currently, attention is increasingly being drawn to instances where the behavior of pregnant women is potentially harmful to fetal well-being. There has been particularly great concern with the incidence of babies born with cocaine in their systems as a result of cocaine use by pregnant women. Hospitals are reporting an alarming rise in the number of births of these drug-exposed infants.[29] The unprecedented rise in cocaine use among women of childbearing age is primarily due to the current popularity of the use of "crack," a concentrated, inexpensive, and highly addictive form of cocaine. Experts estimate that as many as 11% of pregnant women have used an illegal drug during pregnancy, and of those women, 75% have used cocaine.[30-32] The American Medical Association (AMA) Board of Trustees[33] profiled the current problem of substance abuse among pregnant women and discussed the clinical challenges involved in identifying and providing comprehensive treatment for these women.

The alarm with which these figures have been met is not unwarranted. The effects of cocaine use by a pregnant woman on her fetus and subsequently on her infant can be severe. Cocaine can cause in utero strokes, spontaneous abortion, and abruptio placentae.[34-36] It also results in increased infant mortality. On the average, cocaine-exposed babies have lower birth weights, shorter body lengths at birth, and smaller head circumferences than normal infants.[31] They also have a higher incidence of physical abnormalities, including deformed kidneys and neural tube defects.[32] Cocaine-exposed babies often experience withdrawal symptoms that make them more irritable and resistant to bonding than other babies.[33,34] Researchers believe that cocaine-exposed babies will be more likely to experience learning disabilities.[34]

Although drug and other substance abuse by the pregnant woman attracts intense media attention, there are actually a large variety of behaviors that can adversely affect the fetus. Cigarette smoking by pregnant women results in higher rates of spontaneous abortion, premature birth, increased perinatal mortality, low birth weight, and negative effects on later growth and development in infants.[35-37] Many prescription or over-the-counter medicines will cross the placenta and affect fetal health.[38] Exposure to hazardous chemicals heightens the risk for spontaneous abortion, premature birth, stillbirth, low birth weight, and birth defects.[38]

Special mention should be made of alcohol use. Many studies have confirmed the dangerous effects of alcohol use by

pregnant women on their infants.[8-11] Babies born with fetal alcohol syndrome suffer from prenatal and postnatal growth retardation; cardiovascular, limb, skull, and facial defects; impaired fine- and gross-motor function; and impaired intellectual function.[8,12] Despite the serious health effects of alcohol consumption, the legal and social acceptance of alcohol make its use particularly difficult to prevent. Further, while excessive alcohol use during pregnancy *certainly* can cause serious fetal harm, no minimum level of alcohol use has yet been established as safe.[8-11] The AMA, former Surgeon General Koop, and a number of other experts have concluded that total abstinence is the only way to ensure no ill effects from alcohol consumption during pregnancy.[8]

Legal Penalties as a Response to Substance Abuse by Pregnant Women

The rising percentage of babies born with cocaine in their systems has been matched by the rising frustration of the health care and legal communities in finding ways to prevent the problem. A growing number of jurisdictions have tried to impose legal penalties, often criminal sanctions, in an attempt to deter drug use by pregnant women.[4] Women have been charged under statutes against child abuse and neglect and the delivery of a controlled substance to a minor,[4-6] or given special penalties for an unrelated conviction because they were pregnant and suspected of cocaine use.[4] Evidence of drug abuse by pregnant women is being used as grounds for the state's assuming immediate custody of newborns.[7] In addition, other legal interventions, such as civil detention, have been sought in order to monitor or control the behavior of a pregnant woman when her behavior was considered potentially dangerous to her fetus.[4,6] For the most part, these attempts to criminalize or legally penalize behavior by pregnant women have been unsuccessful. Several courts have ruled that existing statutes against child abuse and neglect cannot be applied to the fetus.[4,6]

Some public officials believe that imposing criminal sanctions will deter substance abuse by pregnant women. However, many health and social welfare experts feel that the problem is more effectively addressed as a health concern rather than as a legal problem.[3] They further maintain that criminal sanctions will not only fail to deter pregnant women from substance abuse, they will in fact prevent them from seeking prenatal care or medical help for their dependency.

Incarceration or Detention During Pregnancy.—Incarceration or detention might seem to be the most effective means of preventing a specific harmful behavior. Ostensibly, the state could force an incarcerated or detained woman to adopt behavior that would promote the health of her fetus. However, incarcerating pregnant women in order to preserve fetal health may prove counterproductive.

Any attempt at detecting and managing the potentially harmful behavior of pregnant women through legal intervention is likely to require substantial participation on the part of the medical community. For instance, if a pregnant woman's actions are classified as child abuse, legal obligations are created for the physician. All states require physicians to report suspected abuse.[4] Most, in fact, hold health care personnel liable for failure to report, and some states even maintain liability for failure to diagnose child abuse properly.[4]

It is not unreasonable to assume that at-risk pregnant women would be deterred from seeking contact with those people or institutions who might take action leading to their incarceration. Pregnant women will be likely to avoid seeking prenatal or other medical care for fear that their physicians' knowledge of substance abuse or other potentially harmful behavior could result in a jail sentence rather than proper medical treatment. This fear is not unfounded; recently, a pregnant woman who sought medical care for injuries received as a result of a spousal beating was reported to the authorities, arrested, and charged with criminal child abuse for drinking during her pregnancy.[4] The case was subsequently dismissed. In addition, the number of women who are convicted and incarcerated for potentially harmful behavior is likely to be relatively small in comparison with the number of women who would be prompted to avoid medical care altogether. As a result, the potential well-being of many infants may be sacrificed in order to preserve the health of a few.

Imposing criminal or civil sanctions on pregnant women for potentially harmful behavior may also encourage women to seek abortions in order to avoid legal repercussions. In addition, incarceration would be of only limited value since a considerable amount of damage could be done to the fetus before a woman even realized she was pregnant.[3]

Further, while the incarceration of pregnant women would be intended to benefit the fetus, the reality of the environment in which pregnant women would be placed would do little to ensure fetal health. Prisons in general have inadequate health care resources. Moreover, prison health experts warn that prisons are "shockingly deficient" in attending to the health care needs of pregnant women.[3] Most prisons have inadequate protocol, staff, or training to properly attend to the special needs of pregnant prisoners. The result has been widespread deficiencies in prenatal diet, nutrition, and exercise and seriously inadequate, if any, prenatal care. Pregnant women in jail are routinely subject to conditions that are hazardous to fetal health, such as gross overcrowding,[3] 24-hour lock-up with no access to exercise or fresh air, exposure to tuberculosis, measles, and hepatitis, and a generally filthy and unsanitary enviroment. Additionally, it is unclear that incarceration would prevent drug use by pregnant women because drugs are readily available in prison.[4,14]

Legal Penalties Imposed After Birth.—*Criminal Sanctions.*—The most compelling reason that has been proposed for instituting postnatal criminal sanctions in cases of substance abuse by pregnant women is to prevent damage to fetal health. The actual efficacy of criminal sanctions as a method for preventing substance abuse is doubtful, however. Obviously, fetal harm caused by substance abuse is averted only by effecting abstinence from harmful substances by pregnant women. Punishing a person who abuses drugs or alcohol is not generally an effective way of curing their dependency or preventing future abuse. The AMA has stated that "it is clear that addiction is not simply the product of a failure of individual willpower."[8] Substance abuse is caused by complex hereditary, environmental, and social factors. Individuals who are substance dependent have impaired competence in making decisions about the use of that substance.

Punishing a person for substance abuse is generally ineffective because it ignores the impaired capacity of substance-abusing individuals to make decisions for themselves. In all but a few cases, taking a harmful substance such as cocaine is not meant to harm the fetus but to satisfy an acute psychological and physical need for that particular substance. If a preg-

nant woman suffers from a substance dependency, it is the physical impossibility of avoiding an impact on fetal health that causes severe damage to the fetus, not an intentional or malicious wish to cause harm.

A woman's socioeconomic position may further affect her ability to carry out her moral responsibility to provide reasonable care in preserving fetal health. The women most likely to be prosecuted for exposing their fetuses to harmful substances are those from the lower economic levels.[56] These women are more likely to lack access to both prenatal care and substance abuse treatment because of financial barriers.[57] They are often uninsured or underinsured.[58] Even when Medicaid is available, women may still lack access to medical care because of inadequate system capacity.[59]

Access to care does not guarantee that pregnant women will receive drug treatment; one of the most commonly missed diagnoses in obstetric and pediatric medicine is drug abuse.[51] Additionally, many prenatal care facilities do not have the capacity to treat substance abuse.

Pregnant substance abusers also tend to have other severe life stresses that may contribute to their substance abuse. An AMA Board of Trustees[57] report states that female substance abusers tend to have more dysfunction in their families than nonabusers. They have high levels of depression, anxiety, sense of powerlessness, and low levels of self-esteem and self-confidence.[51] A study done by a center that treats female substance abusers found that 70% of them were sexually abused as children, as compared with 15% of nonsubstance abusers.[51] Eighty-three percent had had a chemically dependent parent, as opposed to 35% of the nonabusers.[51] Seventy percent of female substance abusers report being beaten.[51] Ten percent of female substance abusers in one study were homeless, while 50% had occasional housing problems.[51]

Substance dependence and contributing factors cannot be used as an excuse for disregarding the consequences of dependent behavior on fetal and infant health. However, the magnitude of the problem and the influence of aggravating factors may preclude criminal sanctions from being an effective deterrent. For example, the use of illegal substances already incurs criminal penalties. Pregnant women who use illegal substances are obviously not deterred by existing sanctions; the reasons that prompt them to ignore existing penalties might also prompt disregard for any additional penalties. Furthermore, in ordinary instances, concern for fetal health prompts the great majority of women to refrain from potentially harmful behavior. If that concern, generally a strong impetus for avoiding certain actions, is not sufficient to prevent harmful behavior, then it is questionable that criminal sanctions would provide the additional motivation needed to avoid behaviors that may cause fetal harm.

Civil Liability as a Remedy for Harmful Behavior by Pregnant Women.—Regardless of the inefficiency of criminal sanctions, a woman who uses harmful substances during her pregnancy often gives birth to a child who is either impaired or less healthy than the child would have been had the mother abstained from substance abuse. It is widely accepted that if a person other than the pregnant woman acts in such a way that fetal health, and consequently a child's health, is impaired, then that person can be held civilly liable for the impairment.[52] While recovery in such situations is meant to compensate the parents of the impaired child, it may also be used to compensate the subsequent child for injuries resulting from negligent actions during the prenatal period.[53]

The consequences of harm may be similar regardless of whether the responsible party is the pregnant woman herself or another person (a third party). Some commentators have stated that to punish third parties but not pregnant women for actions that result in harm to the fetus would be inconsistent.[60] However, a pregnant woman and her fetus share a physical interdependency that a third-party tort-feasor and the fetus do not. The nature of the relationship between the pregnant woman and her fetus makes problematic tort liability against the mother for prenatal injuries.

Third-party liability protects both the pregnant woman and her fetus from behavior that is normally unacceptable under any circumstances.[17] For instance, a drunk driver is liable for his or her actions because they are a menance to all, the born and unborn alike. However, *every* action on the part of a pregnant woman can have substantial impact on fetal health. Maternal liability would severely restrict a pregnant woman's freedom to act in even normally innocuous ways.

Causes of action would arise much more frequently than instances where the mother would actually be at fault. The difficulty in determining the cause of infant impairment could give rise to numerous unfounded claims of maternal liability. Many women who behaved in an acceptable manner during pregnancy would be unfairly subjected to liability proceedings, just as presently many physicians who practice good obstetrical medicine are subjected to unfounded liability claims.

Even if it could be proven that a pregnant woman's behavior caused infant impairment, intense scrutiny of the most intimate details of a pregnant woman's life would be required to evaluate the extent to which she could be held responsible for her actions.[17] A judicial investigation to determine which action caused the harm and its reasonableness would have to include a determination of whether the harm was caused before or after the woman realized she was pregnant and whether she realized the behavior could affect fetal health. The court would also have to determine whether she could have reasonably prevented the harm or whether the action taken was reasonable in the context of other circumstances. Even the most insignificant decision on the part of the pregnant woman could be subsequently called into question.

The imposition of civil liability on women whose infants are born impaired would pose too great a burden and too great an intrusion into the lives of innocent women to justify it as a remedy to harmful behavior by the pregnant woman.

The Most Effective Method of Preventing Harmful Behavior by Pregnant Women Is Through Treatment and Education

Many health and public welfare officials feel that the most effective way of preventing substance abuse in pregnant women is through education about potential harms and the provision of comprehensive treatment for their abuse.[51,61] Important methods for preventing or minimizing fetal harm due to substance abuse by pregnant women include identification of women who are at high risk for being substance abusers, early medical and psychotherapeutic intervention in the pregnancies of substance-abusing women, and access to programs that address the full range of social and health care needs associated with substance abuse.[51] The National Association for Perinatal Addiction Education and Research has docu-

mented the efficacy of programs that follow these methods.[71]

In contrast, criminal penalties may exacerbate the harm done to fetal health by deterring pregnant substance abusers from obtaining help or care from either the health or public welfare professions, the very people who are best able to prevent future abuse. The California Medical Association[72] has noted:

> 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. 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. This failure to seek proper care or to withhold vital information concerning her health could increase the risks to herself and her baby.

Florida's secretary of Health and Rehabilitative Services has also observed that potential prosecution under existing child abuse or drug use statutes already "makes many potential reporters reluctant to identify women as substance abusers."[73]

It may seem that a pregnant substance abuser has an obligation to obtain treatment for her dependence. However, obtaining treatment is not currently a practical alternative for pregnant substance abusers. Even the most persistent woman is likely to fail to find a treatment program for her substance dependency. Rehabilitative centers for substance abusers are in short supply.[74] The majority of those facilities that do treat substance abuse refuse to accept pregnant women, in part due to concerns over liability.[75] Of the few centers that do treat pregnant women, most have long waiting lists.

Further, the majority of substance abuse treatment facilities operate on an adult-male centered model.[76] They are not designed to address problems specific to women's psychological or physiological needs. Nor are they equipped to handle other problems that substance-dependent women often have, such as how to arrange day-care for older children or counseling for a woman who is abused by a spouse or partner. It would be an injustice to punish a pregnant women for not receiving treatment for her substance abuse when treatment is not an available option to her.

Finally, societal efforts to educate pregnant women and provide accessible treatment for those who may be substance abusers promote relationships and attitudes that are beneficial to fetal health in general. Criminal penalties levied against pregnant women for their actions would posit physicians as government agents with enforcement responsibilities rather than as concerned patient advocates.[77] Criminal penalties would also emphasize conflict between the pregnant woman and her fetus, which does not encourage a healthy relationship between the pregnant woman and her future child. On the other hand, providing education and treatment emphasizes cooperation and trust between the pregnant woman and her physician and facilitates a more emotionally positive relationship after birth.[78]

State-Assumed Custody of Exposed Infants

Another response to harmful behavior by pregnant women is taking the woman's baby into state custody after birth. Probably the most widely accepted action for preterm substance abuse is state-assumed custody of infants who show signs of prenatal exposure to harmful substances.[79] Legal penalties for behavior while pregnant are problematic because a pregnant woman and her fetus cannot practically be treated as separate entities. Once an infant is born, this is not a consideration. In addition, evidence shows that parental substance abuse and child abuse are highly correlated.[80] Children who have been impaired due to in utero exposure to harmful substances are likely to be especially difficult to care for, requiring above normal parenting skills.[80,81] Courts have ruled that the potential for abuse implied by substance abuse by a woman while pregnant is adequate justification for allowing the state to assume at least temporary custody of these infants.[14]

Ordinarily, the state cannot impose punishment for potential, rather than actual, actions. Presumably, the termination or suspension of parental rights is an exception because it is primarily a protection for the child and not a penalty directed at the parent.[14] In the interest of preserving family unity wherever reasonably possible, courts should be careful to ensure that such actions are actually protective of the child.

Consideration of Criminal or Civil Sanctions in Exceptional Cases

Some commentators have argued that legal penalties or state intrusion into the lives of pregnant women are legally justifiable because once a pregnant woman forgoes her right to have an abortion she has a "legal . . . duty to bring the child into the world as healthy as is reasonably possible."[82] This duty includes restrictions that "may significantly limit a woman's freedom of action and even lead to forcible bodily intrusion."[82] The implication is that once a woman has become pregnant and does not take affirmative steps to terminate her pregnancy, then she has forfeited her constitutional rights to bodily integrity and privacy.

However, this legal argument has been criticized as misplaced.[2] One commentator notes that such a waiver of constitutional rights never actually takes place because "women do not appear before judges to waive their rights at any time during pregnancy."[2] The fact that a woman does not abort her fetus cannot be construed as the willing forfeiture of her constitutional rights. Further, if the decision to have a child automatically precipitates a waiver of constitutional rights, then the state has created a penalty for choosing to bear a child.[2] The right to procreate is constitutionally protected and its exercise cannot be penalized.[2] In addition, state-imposed penalties upon the decision to bear children would be troubling as a policy matter.

Absolutely prohibiting legal penalties for all potentially harmful actions by a pregnant woman may seem extreme. For instance, if a situation arose in which a woman willingly engaged in an elective behavior that would clearly cause severe and irreparable injury to the future child, it seems incongruous to suggest that society should have no legal recourse for such behavior.

Yet, it is difficult to imagine that such circumstances might occur in significant numbers, if at all. More important, the conscious infliction of certain and severe harm to the fetus would generally pose a serious risk of harm to the pregnant woman as well. Therefore, counseling, psychiatric treatment, or other support services would probably be a more appropriate response than criminal punishment. In addition, it is difficult to imagine a situation in which legal rules would be the best policy choice as legal penalties or liability may be ultimately detrimental, rather than beneficial, to fetal health.

RECOMMENDATIONS

The AMA Board of Trustees recommends adoption of the following statement:

1. Judicial intervention is inappropriate when a woman has made an informed refusal of a medical treatment designed to benefit her fetus.

If an exceptional circumstance could be found in which a medical treatment poses an insignificant or no health risk to the woman, entails a minimal invasion of her bodily integrity, and would clearly prevent substantial and irreversible harm to her fetus, it might be appropriate for a physician to seek judicial intervention. However, the fundamental principle against compelled medical procedures should control in all cases that do not present such exceptional circumstances.

2. The physician's duty is to provide appropriate information, such that the pregnant woman may make an informed and thoughtful decision, not to dictate the woman's decision.

3. A physician should not be liable for honoring a pregnant woman's informed refusal of medical treatment designed to benefit the fetus.

4. Criminal sanctions or civil liability for harmful behavior by the pregnant woman toward her fetus are inappropriate.

5. Pregnant substance abusers should be provided with rehabilitative treatment appropriate to their specific physiological and psychological needs.

6. To minimize the risk of legal action by a pregnant patient or an injured child or fetus, the physician should document medical recommendations made including the consequences of failure to comply with the physician's recommendations.

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