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**The New Fetal Protection: The Wrong Answer to the Crisis of Inadequate Health Care for Women and Children**

## THE NEW “FETAL PROTECTION”: THE WRONG ANSWER TO THE CRISIS OF INADEQUATE HEALTH CARE FOR WOMEN AND CHILDREN

LINDA C. FENTIMAN<sup>†</sup>

*In 1999, Regina McKnight, a homeless, mentally retarded woman who was pregnant and addicted to cocaine, was charged with murder when her child was stillborn. The South Carolina Supreme Court affirmed her murder conviction and upheld the twenty-year sentence imposed.*<sup>1</sup>

*In 2002, a severely mentally disabled woman became pregnant after being raped by the owner of the group home where she lived. The wife of a Florida prosecutor sought to be appointed “guardian of the fetus” in order to prevent the woman from taking prescription drugs necessary to maintain her physical health and mental stability and to prevent the woman from having an abortion. Ultimately, the Florida courts rejected these efforts.*<sup>2</sup>

*In 2004, Melissa Rowland, a pregnant woman with a long history of mental illness, sought assistance at a hospital because she noticed a decrease in fetal movements. Doctors recommended a Caesarean delivery, but Rowland declined, and the hospital offered no other help. When one of the twins she was carrying was stillborn, Rowland was charged with murder, with prosecutors asserting that she had acted with depraved indifference to the value of human life.*<sup>3</sup>

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1. State v. McKnight, 576 S.E.2d 168, 171 (S.C. 2003).

2. *In re Guardianship of J.D.S.*, 864 So. 2d 534, 536 (Fla. Dist. Ct. App. 2004); Bob Mahlborg, *Senate Chief Wary of Fetus Guardian Bill; Governor Finds House Support, Won't Back Down on Legislation*, ORLANDO SENTINEL, Jan. 28, 2004, at B1.

3. Pamela Manson, *Mother is Charged in Stillborn Son's Death; Criminal Homicide: Prosecutors Say the West Jordan Woman Ignored Numerous Warnings from Doctors and Refused a Surgery that Could Have Saved the Boy's Life; Prosecutors Say Mom Guilty in Baby's Death*, SALT LAKE TRIBUNE, Mar. 12, 2004, at A1; Linda Thomson, *Rowland Case Is Called 'Political,'*

*In roughly two-thirds of the states, women who write advance directives to guide their medical care should they become incompetent may have their directives rendered unenforceable if they become pregnant.*<sup>4</sup>

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DESERET MORNING NEWS March 13, 2004; Linda Thomson & Pat Reavy, *Rowland’s Out of Jail, Heading to Indiana*, DESERET MORNING NEWS, Apr. 30, 2004.

4. See Amy Lynn Jerdee, Note, *Breaking Through the Silence: Minnesota’s Pregnancy Presumption and the Right to Refuse Medical Treatment*, 84 MINN. L. REV. 971, 977 (2000).

## INTRODUCTION

The last few years have witnessed an astonishing array of intrusive and punitive government actions against pregnant women. These government interventions, ranging from criminal prosecutions and fetal "guardianship" proceedings to statutes safeguarding "the unborn" and new "regulatory interpretations" of existing law, are touted as necessary to protect fetuses from harm, particularly harm from their own mothers, and are framed as a response to a new public health crisis.<sup>5</sup> While these government actions vary in the extent to which they threaten women's physical liberty and decision-making autonomy,<sup>6</sup> they share a common view of pregnant women as vessels for the developing fetus, with both the potential, and the obligation, to protect that fetus at all costs.

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5. See Ziba Kashef, *The Fetal Position: Federal and State Dollars Are Subsidizing a Boom in Antiabortion 'Crisis Pregnancy Centers'*, MOTHER JONES, Jan./Feb. 2003, available at [http://www.motherjones.com/news/outfront/2003/01/ma\\_218\\_01.html](http://www.motherjones.com/news/outfront/2003/01/ma_218_01.html). Other government activities support the position that embryos and fetuses are full human beings, as the Bush Administration has funded so-called "Snowflake Adoptions" (the directed donation of embryos to infertile couples) and fetal imaging technology for "pregnancy crisis centers," whose *raison d'être* is to discourage women from choosing abortions. See Elissa K. Zirinsky, *Adoption's New Frontier*, CBS News, July 28, 2005, <http://www.cbsnews.com/stories/2005/07/28/national/printable712541.shtml>; Anna Mulrine, *A Home for Frozen Embryos*, USNEWS.COM, Sept. 27, 2004, <http://www.usnews.com/usnews/health/articles/040927/27babies.b1.htm> (discussing the \$1 million federal grant to two "embryo adoption" organizations to promote public awareness of these programs). The Department of Health and Human Services has funded so-called "crisis pregnancy centers" since 1996. See Kashef *supra*; see also The Abortion Access Project, *Impeding the Right to Choose: Crisis Pregnancy Centers*, and sources cited therein (on file with Author); Informed Choice Act, S.755.1S, 109th Cong. § 2(a) (providing for additional funding for ultrasound equipment to be used to provide pregnant women with a visual image of the fetus).

6. One might distinguish, for example, between prosecuting a woman for homicide because she used drugs while pregnant and a law that requires that pregnant women be told of the possibility of fetal pain before having an abortion. My point is not that all government "fetal protection" initiatives are equivalent, but that they each diminish the ability of a competent adult to make choices about her life and her body, and does so based upon the actor's status as a *pregnant woman*.

Current “fetal protection”<sup>7</sup> efforts pack a triple whammy: they undermine women’s health, limit women’s ability to fully participate in the economic life of the nation, and disproportionately affect the indigent and racial minorities. First, the new “fetal protection” threatens to limit women’s ability to participate in the workforce and control their reproductive capability by raising the specter of civil or criminal liability if they engage in potentially risky activities before or during pregnancy. Second, many “fetal protection” initiatives seek to redefine the fetus as a person, with rights fully equal to those of a born human being, in a thinly disguised effort to limit abortion access.<sup>8</sup> Finally, efforts to constrain women’s actions for the benefit of their fetuses frequently reflect racial, gender, and class stereotypes about how women in general, or certain groups of women, do or should behave.<sup>9</sup> It does not appear coincidental that poor women and women of color are the main targets of “fetal protection” efforts.<sup>10</sup>

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7. The term “fetal protection” was apparently first used by legal commentators in the early 1980’s, referring to employers’ policies that excluded fertile women from the workplace, or at least better-paying jobs within the workplace. The ostensible purpose of these “fetal protection” policies was to ensure that children born to their female employees would not be injured by their mothers’ on-the-job exposure to toxic chemicals, but the goal of protecting employers against tort liability was also important. See, e.g., Wendy Williams, *Firing the Woman to Protect the Fetus: The Reconciliation of Fetal Protection with Employment Opportunity Goals Under Title VII*, 69 GEO. L.J. 641 (1981). In the mid-1980s the use of the term was broadened to include state laws prohibiting the experimentation on, and transfer of, embryos and fetuses, the fore-runner of today’s controversy over stem cell research. See, e.g., Note, *Reproductive Technology and the Procreation Rights of the Unmarried*, 98 HARV. L. REV. 669 (1985). In the late 1980s, courts and commentators began to use the term “fetal protection” to encompass tort actions and criminal prosecutions of women based on their conduct during pregnancy, as well as broader questions about how to consider the interests of women and their fetuses in the abortion context. See, e.g., George Annas, *The Impact of Medical Technology on the Pregnant Woman’s Right to Privacy*, 13 AM. J.L. & MED. 213, 229 (1987); John A. Robertson, *Gestational Burdens and Fetal Status: Justifying Roe v. Wade*, 13 AM. J.L. & MED. 189, 202 (1987); Dawn Johnsen, *From Driving to Drugs: Government Regulation of Pregnant Women’s Lives After Webster*, 138 U. PA. L. REV. 179, 187-89 (1989). What I call the “new ‘fetal protection’” is the increased range of government actions, beginning in the late 1990s and continuing through the present, taken against, or about, pregnant women, encompassing health care access and decisionmaking, civil commitment, and criminal and tort actions.

8. Julia L. Ernst, Laura Katzive, & Erica Smock, *The Global Pattern of U.S. Initiative Curtailing Women’s Reproductive Rights: A Perspective on the Increasingly Anti-Choice Mosaic*, 6 U. PA. J. CONST. L. 752, 781 (2004); see also *infra* text accompanying notes 41-47, (discussing in detail the debate surrounding Unborn Victims of Violence Act, Pub. L. 108-212, 118 Stat. 568 (2004)).

9. Indeed, some of the most aggressive criminal prosecutions of pregnant women brought in the name of fetal protection have been brought in the former slave states of Florida, Missouri, South Carolina, and Texas; although these states are not the only locus of prosecution. See *infra* note 66; see, e.g., Dorothy E. Roberts, *Punishing Drug Addicts Who Have Babies: Women of Color, Equality, and the Right of Privacy*, in CRITICAL RACE FEMINISM, A READER 127, 128-31 (Adrien Katherine Wing ed., New York University Press 2d ed. 1997) [hereinafter Roberts, *Punishing Drug Addicts Who Have Babies*] (suggesting that the “devaluation of [black women] as mothers . . . has its roots in the unique experience of slavery”); Dorothy E. Roberts, *Unshackling Black Motherhood*, 95 MICH. L. REV. 938, 939 (1997) [hereinafter Roberts, *Unshackling Black Motherhood*].

10. See Ira J. Chasnoff, *The Prevalence of Illicit-Drug or Alcohol Use During Pregnancy and Discrepancies in Mandatory Reporting in Pinellas County, Florida*, 322 NEW ENG. J. MED. 1202, 1206 (1990) (observing that black women were ten times as likely as white women to be reported by their physicians for using drugs, despite equal rates of drug use); LAURA E. GÓMEZ, MISCONCEIVING MOTHERS: LEGISLATORS, PROSECUTORS AND THE POLITICS OF PRENATAL DRUG EXPOSURE 118 (1997). Of course, one could observe that the poor and the people of color are disproportionately repre-

Strikingly, the new "fetal protection" crusades have failed utterly to deliver more health care to poor children or women or to improve the health status of at-risk children. Rather, they are potent symbolic gestures, offering a quick fix to complex social, medical, and economic problems. By blaming individual women for conduct which is often not freely chosen,<sup>11</sup> government avoids taking responsibility for its continuing failure to meaningfully address the reality that many poor and low-income Americans lack access to health care or acknowledge the special problems faced by women who are victims of domestic violence, suffering from mental illness, and/or addicted to drugs and alcohol.<sup>12</sup> Effective health policy requires the provision of adequate health care services for all, including reproductive health care across the life span and targeted services addressing our most vulnerable women and children.

This article will expand upon the feminist critique by focusing on children's health as well as the health and liberty interests of their mothers. In the first part of this article, I examine the legal and cultural underpinnings of "fetal protection" and explore its current manifestations. In the second part, I place "fetal protection" in a broader context, documenting the ways in which American law currently promotes fetal life, while simultaneously neglecting the lives and health of born children. The third part of the article offers concrete recommendations about how government, both state and federal, can actually achieve the goal of bringing healthy children into the world and enabling them to live healthy lives, paying particular attention to the problems of children who are born into domestic violence and/or poverty and are therefore at high risk for poor educational and health care outcomes.<sup>13</sup> If we are to truly

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sented in the criminal justice system, in both the courts and prisons. See, e.g., William H. Edmonson, Note, *A "New" No-Contact Rule: Proposing an Addition to the No-Contact Rule to Address Questioning of Suspects After Unreasonable Charging Delays*, 80 N.Y.U. L. REV. 1773, 1785 (2005). However, this does not explain the extraordinary frequency and ferocity of criminal prosecutions against women of color, particularly when one considers that it is alcohol, not crack cocaine (stereotypically connected with African-Americans), that is the drug most clearly shown to cause long-term developmental harm. See *infra* notes 14-22 and discussion in accompanying text.

11. The theme of "choice" is frequently raised by proponents of "fetal protection," ignoring the reality that for many poor women, the systemic lack of health care, education, and employment denies them the ability to make optimal choices for themselves or their children. See, e.g., Erin Nelson, *Reconceiving Pregnancy: Expressive Choice and Legal Reasoning*, 49 MCGILL L.J. 593, 623, 624 (2004).

12. There is a significant link between a woman's experiencing domestic violence (physical or sexual abuse) as a child or an adult and her subsequent development of mental illness and/or substance abuse problems. WOMEN'S LAW PROJECT, RESPONDING TO THE NEEDS OF PREGNANT AND PARENTING WOMEN WITH SUBSTANCE USE DISORDERS IN PHILADELPHIA 4, 6 (Sept. 2002), available at [http://www.womenslawproject.org/reports/Pregnant\\_parenting\\_PVS.pdf](http://www.womenslawproject.org/reports/Pregnant_parenting_PVS.pdf); Lynn M. Paltrow, *Pregnancy, Domestic Violence, and the Law: The Interface of Medicine, Public Health, and the Law: Governmental Responses to Pregnant Women Who Use Alcohol or Other Drugs*, 8 DEPAUL J. HEALTH CARE L. 461, 477 (2005).

13. Poverty is a major contributor to poor birth outcomes and later childhood health problems. See Charles Oberly, *The Impact of Childhood Poverty on Health and Development*, HEALTHY GENERATIONS, May 2003, at 2-3, available at [http://www.epi.umn.edu/mch/resources/hg/hg\\_childpoverty.pdf](http://www.epi.umn.edu/mch/resources/hg/hg_childpoverty.pdf); Jane D. McLeod & Michael J. Shanahan, *Trajectories of Poverty and Children's Mental Health*, 37 J. HEALTH & SOCIAL BEHAVIOR 207, 207 (1996).

become a society in which “no child [is] left behind,” we must implement a comprehensive public health strategy to promote women’s and children’s health across the lifespan, not just during the few months in which women are pregnant.

*What’s “New” About the “New Fetal Protection?”*

At the outset, one might be tempted to ask, “What’s all the fuss about? Are these government actions so different from those taken before?” Women’s use of alcohol, tobacco, and other drugs during pregnancy has long been controversial,<sup>14</sup> and there has been significant debate over whether criminal prosecutions and involuntary civil commitment are an appropriate or effective way to ensure that children are born healthy and drug-free.<sup>15</sup>

Virtually all observers agree that drug use, broadly defined, during pregnancy is harmful to the newborn child, although there is disagreement about the extent, and permanence, of the harm.<sup>16</sup> Research shows that 5-6% of women use illegal drugs during pregnancy, while 25% used alcohol, and maternal alcohol use is the leading cause of mental retardation.<sup>17</sup> Some researchers have concluded that maternal cocaine use may lead to subtle, long-lasting neurological deficits, including “the ability to habituate or self-regulate” and small but statistically significant deficits

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14. Currently, there is increasing attention paid to methamphetamine, which, like cocaine in its day, is giving rise to media stories about the grave risks of in utero drug exposure for the long-term development of children. See, e.g., Katie Zernike, *A Drug Scourge Creates its Own Form of Orphan*, N.Y. TIMES, July 11, 2005, at A1; *U.S. Warns of ‘Global Meth Threat,’* BBC News, <http://news.bbc.co.uk/1/hi/world/americas/4757179.stm>. Others have criticized this media coverage as sensational and poorly informed. See, e.g., *Meth and Myth: Top Doctors, Scientists and Specialists Warn Mass Media on “Meth Baby” Stories*, July 29, 2005, <http://stopthedrugwar.org/chronicle/397/methandmyth.shtml>; see also RYAN S. KING, THE SENTENCING PROJECT, THE NEXT BIG THING? METHAMPHETAMINE IN THE UNITED STATES 16 (June 2006) (asserting that the media have failed utterly to accurately predict the science and epidemiological data surrounding methamphetamine addiction).

15. See, e.g., Sarah Childress, *Justice: A New Controversy in the Fetal-Rights Wars*, NEWSWEEK, March 29, 2004, at 7; Lynn Paltrow, *Pregnant Drug Abusers, Fetal Persons, and the Threat to Roe v. Wade*, 62 ALB. L. REV. 999, 1008, 1009 (1999); Brian Maffly, *‘Fetal Abuse’ Charges Give Rise to Debate; Mothers-to-Be Need Help, Not Fear, Critics Say*, SALT LAKE TRIBUNE, Dec. 1, 1997, at D1; Wendy Chavkin, Vicki Breitbart, & Paul H. Wise, *Finding Common Ground: The Necessity of an Integrated Agenda for Women’s and Children’s Health*, 22 J.L. MED. & ETHICS 262, 263 (1994) (arguing that choosing to reduce infant mortality, HIV transmission, and drug exposure only by reducing harm to the fetus (and thus intervening through the body of the pregnant woman) ignores data showing that provision of quality health care across a woman’s life is the best guarantee of ensuring healthy babies).

16. See, e.g., DAN STEINBERG & SHELLY GEHSAN, NATIONAL CONFERENCE OF STATE LEGISLATURES, STATES RESPONSES TO MATERNAL DRUG AND ALCOHOL USE: AN UPDATE (Jan. 2000), [www.ncsl.org/programs/health/forum/maternalabuse.htm](http://www.ncsl.org/programs/health/forum/maternalabuse.htm); JANET R. HANKIN, NATIONAL INSTITUTE ON ALCOHOL ABUSE AND ALCOHOLISM, FETAL ALCOHOL SYNDROME PREVENTION RESEARCH (Aug. 2002), <http://pubs.niaaa.nih.gov/publications/arh26-1/58-65.htm>.

17. *Addiction Medicine: Psychopathology of Pregnant Women with Alcohol and Drug Dependencies Examined*, WOMEN’S HEALTH WEEKLY, August 23, 2001, at 8 [hereinafter *Addiction Medicine*].



in IQ and language ability,<sup>18</sup> but others have found that most infants exposed in utero to cocaine "catch up to their peers in physical size and health status by age 2."<sup>19</sup> In contrast, maternal alcohol use during pregnancy is known to cause serious harm to children with significant in utero exposure, and infants born to mothers who drank moderately while pregnant may still experience deficits in IQ, learning, and attention.<sup>20</sup> Using tobacco during pregnancy poses risks similar in type to those of cocaine.<sup>21</sup> Most recent research emphasizes the multiple factors leading to poor birth outcomes, including maternal poverty, homelessness, a history of domestic violence, and lack of prenatal care, undermining the argument that drug use, whether legal or illegal, is the primary cause of children being born with deficits.<sup>22</sup>

Recent "fetal protection" efforts have been most aggressive in the criminal arena. In an unprecedented use of criminal law's heaviest artillery, prosecutors in two instances filed murder charges against women who delivered stillborn infants, based, respectively, on the woman's drug use while pregnant<sup>23</sup> or her refusal to have a Caesarean section.<sup>24</sup> The result was a murder conviction in the first instance and a conviction for felony child endangerment in the second.<sup>25</sup> Women have also been charged with other types of homicide<sup>26</sup> and with child abuse or reckless

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18. Steven J. Ondersma et al., *Prenatal Drug Exposure and Social Policy: The Search for an Appropriate Response*, 5 CHILD MALTREATMENT 93, 95 (2000), available at <http://cmx.sagepub.com/cgi/reprint/5/2/93>.

19. STEINBERG & GEHSAN, *supra* note 16.

20. Ondersma et al., *supra* note 18, at 96.

21. N. Kistin, A. Handler, F. Davis, & C. Ferre, *Cocaine and Cigarettes: a Comparison of Risks*, 10 PEDIATRIC PERINATAL EPIDEMIOLOGY 269 (1996) (noting that while children exposed to cocaine in utero were more likely to have adverse birth outcomes than children whose pregnant mothers consumed no drugs, children whose mothers used tobacco products while pregnant were at risk for the same adverse outcomes as children whose mothers used cocaine, although the magnitude of the risk was lower. "[G]iven the greater number of cigarette smokers than cocaine users in the population . . . [there are likely to be more children harmed by their mothers' smoking than by their mothers' cocaine use during pregnancy]").

22. See, e.g., Ondersma et al., *supra* note 18, at 95; Deborah A. Frank et al., *Growth, Development, and Behavior in Early Childhood Following Prenatal Cocaine Exposure*, 285 JAMA 1613, 1615 (2001). Because some women who use illegal drugs also abuse alcohol, researchers recognize the need for comprehensive and intensive drug treatment programs that take into account the complex needs of this population, which has high "[r]ates of homelessness, poverty, unemployment, and prostitution . . . [and] histories of emotional, physical, and sexual abuse." See *Addiction Medicine*, *supra* note 17.

23. *McKnight*, 576 S.E.2d at 171.

24. *Mom in Caesarean Case Gets Probation*, CHI. TRIB., April 30, 2004, at 18; see also Linda Thomson, *Mother is Charged in Stillbirth of a Twin*, DESERET MORNING NEWS, March 12, 2004; Linda Thomson, *Rowland Airs Her Case on Cable TV*, DESERET MORNING NEWS, May 13, 2004.

25. See *McKnight*, 576 S.E.2d at 171; Jacob Santini, *Stillborn Twin Case Fades, Issues Stay*, THE SALT LAKE TRIBUNE, April 16, 2004, at B4. Criminal prosecutions against women who used alcohol or other drugs while pregnant began in the late 1980's. See *infra* note 66. However, in only one state, South Carolina, were these prosecutions and convictions ultimately sustained by the courts. See *Whitner v. State*, 492 S.E.2d 777, 778-79, 786 (S.C. 1997) (upholding conviction under child endangerment statute for drug use during pregnancy because viable fetus is a "child" under the statute); *McKnight*, 576 S.E.2d at 171.

26. *State v. Deborah J.Z.*, 596 N.W.2d 490, 491 (Wis. Ct. App. 1999); *State v. Aiwohi*, 123 P.3d 1210, 1210-11 (Haw. 2005).

endangerment based on their alcohol and drug use while pregnant,<sup>27</sup> relying on reports from physicians or newborn toxicology testing. Yet the unanimous judgment of medical and public health groups is that such prosecutions will only drive a wedge between pregnant women and their physicians, and render it less, not more, likely that the women will seek appropriate pre- and post-natal care, including substance abuse treatment.<sup>28</sup>

In addition to criminal prosecutions, in the last several years, a breathtaking array of civil suits and statutory and regulatory initiatives has sought to treat fetuses as entirely separate from the pregnant women whose bodies sustain them. In 2002, the federal Department of Health and Human Services (HHS) issued regulations “clarify[ing] and expand[ing]” the statutory definition of “child” in the State Children’s Health Insurance Program (SCHIP), a program which provides health care to low-income children.<sup>29</sup> The regulations redefined “child,” from “an individual under 19 years of age”<sup>30</sup> to “an individual under the age of 19 including the period from conception to birth.”<sup>31</sup> Critics asserted that this recasting of fetuses as “children” was both unnecessary and ineffective if, as HHS claimed, its goal was to provide pregnant women with

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27. See *infra* discussion in text accompanying notes 112-15 (discussing recent prosecutions initiated in Maryland, Missouri, Texas, and Wyoming).

28. See *Ferguson v. City of Charleston*, 532 U.S. 67, 85-86 (2001) (holding that public hospital’s policy of testing pregnant women for drug use, developed in conjunction with local prosecutors and police, and turning drug results over to authorities for criminal prosecution, did not come within the “special needs” exception to the Fourth Amendment). The Court observed that “an intrusion on . . . [a patient’s] expectation of privacy in regard to diagnostic medical tests] may have adverse consequences because it may deter patients from receiving needed medical care.” *Id.* at 78 n.14. In a separate article, I will explore in greater depth the anti-deterrent impact of criminal prosecutions on women seeking prenatal care and substance abuse treatment.

29. SCHIP was established in 1997 under Title XXI of the Social Security Act, 42 U.S.C. §§ 1397aa-1397jj (2000), and gives states the opportunity to provide additional health insurance coverage to children whose parents are too “wealthy” to qualify for Medicaid. Medicaid, which was enacted in 1965 and is authorized by Title XIX of the Social Security Act, 42 U.S.C. §§ 1396v et seq., provides health care insurance for the very poorest of American children. BARRY R. FURROW ET AL., *THE LAW OF HEALTH CARE ORGANIZATION AND FINANCE* 420-21 (4th ed. 2001). Both Medicaid and SCHIP are federal/state partnerships, with the federal and state governments sharing in both the financing and administration of the two programs. However, there are important differences. Medicaid is an entitlement program, in which all eligible persons must receive the same benefits. SCHIP gives states much more flexibility in terms of the services that a particular state may choose to provide. FURROW ET AL., *supra*, at 418-21, 438-39; see also Sara Rosenbaum, Anne Markus, & Colleen Sonosky, *Public Health Insurance Design for Children: The Evolution from Medicaid to SCHIP*, 1 J. HEALTH & BIOMED. L. 1, 3-12 (2004) (arguing that Medicaid, because it provides a more comprehensive set of benefits, including Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) is a superior program). Children who receive Medicaid “are more likely than uninsured children and as likely as privately insured children to receive well-child visits and to visit the doctor in a given year. KAISER COMMISSION ON MEDICAID AND THE UNINSURED, *MEDICAID FACTS, EARLY AND PERIODIC SCREENING, DIAGNOSTIC, AND TREATMENT SERVICES* (Oct. 2005) [hereinafter *MEDICAID FACTS*], available at <http://www.kff.org/medicaid/upload/Early-and-Periodic-Screening-Diagnostic-and-Treatment-Services-Fact-Sheet.pdf>.

30. 42 U.S.C. § 1397jj(c)(1) (2000).

31. 42 C.F.R. § 457.10 (2006).

prenatal care.<sup>32</sup> Instead, it appears that the real purpose of the regulation was to establish the legal principle that fetuses are children, with all the rights that accrue to that status.<sup>33</sup>

Government lawyers have also sought the involuntary civil commitment of pregnant women, in order to impose "treatment" on the women and their fetuses,<sup>34</sup> as well as court orders mandating Caesarean sections.<sup>35</sup> While the avowed goal of these actions is to ensure the birth of healthy children, here too the consensus among medical professionals is that such interventions are unjustified.<sup>36</sup> More than thirty states' laws permit civil commitment based on the use of alcohol and other drugs,<sup>37</sup>

32. ROBERT WOOD JOHNSON FOUNDATION, *THE MEDICAID EXPANSIONS FOR PREGNANT WOMEN AND CHILDREN* (1995).

33. For example, in the Omnibus Budget Reconciliation Act (OBRA) of 1986 Congress expanded Medicaid to permit states to enroll all pregnant women with incomes up to 100% of the Federal Poverty Level and adopted procedural changes that made enrollment easier, thus significantly increasing the number of pregnant women eligible to receive pre- and post-natal care as a means of ensuring better birth outcomes. *See, e.g.*, Omnibus Budget Reconciliation Act of 1986, Pub. L. No. 99-509, § 9401(b)(2), 100 Stat. 1874 (1986); GENERAL ACCOUNTING OFFICE, *PRENATAL CARE: EARLY SUCCESS IN ENROLLING WOMEN MADE ELIGIBLE BY MEDICAID EXPANSIONS 7* (February 1991), available at <http://archive.gao.gov/d21t9/143346.pdf>. While these changes in the Medicaid program were not totally effective in achieving the birth of healthier children, ROBERT WOOD JOHNSON FOUNDATION, *supra* note 32, at 1-2, no one had ever suggested that the result would be better if the fetuses were enrolled rather than the women in whose bodies they were developing.

34. These include the case of *State ex rel. Angela M.W. v Kruzicki*, 561 N.W.2d 729, 732 (Wis. 1997) and Rebecca Corneau, a pregnant woman who belonged to a religious sect that did not believe in Western medicine, who was confined in a "secure hospital facility for pregnant prison inmates" by a Massachusetts juvenile court judge until she agreed to medical examination and treatment. *See* Marilyn L. Miller, Note, *Fetal Neglect and State Intervention: Preventing Another Attleboro Cult Baby Death*, 8 CARDOZO WOMEN'S L. J. 71, 71 (2001). These cases will be discussed in more detail in Part I. C., *infra*.

35. *News . . . Husband to Challenge Court Order in Lawsuit over Wife's Refusal of Caesarean Section*, PENN. LAW WEEKLY, Jan. 26, 2004, at 9; Associated Press, *New Questions about Childbirth Rights*, May 19, 2004, [http://keytv.com/health/health\\_story\\_140110423.html](http://keytv.com/health/health_story_140110423.html) (discussing the case of Amber Marlowe, who was the subject of an ex parte order to have a Caesarean section because her fetus weighed 11 pounds, despite her having delivered 6 very large children previously).

36. *See, e.g.*, AMERICAN MEDICAL ASSOCIATION, POLICY H-420.969: LEGAL INTERVENTIONS DURING PREGNANCY, available at <http://www.ama-assn.org/ama/noindex/category/11760.html>, (click "accept," search "420.969") (propounding a general rule that "[j]udicial intervention is inappropriate when a woman has made an informed refusal of a medical treatment designed to benefit her fetus" and specifically recognizing the need for rehabilitative treatment for pregnant substance abusers); AMERICAN COLLEGE OF OBSTETRICS AND GYNECOLOGY, *Patient Choice in the Maternal-Fetal Relationship*, in *ETHICS IN OBSTETRICS AND GYNECOLOGY* (2d ed. 2004), available at [http://www.acog.org/from\\_home/publications/ethics/ethics034.pdf](http://www.acog.org/from_home/publications/ethics/ethics034.pdf) (stating that "court-ordered intervention against the wishes of a pregnant woman is rarely if ever acceptable"); American Academy of Pediatrics, Committee on Bioethics, *Fetal Therapy - Ethical Considerations*, 103 PEDIATRICS 1061, 1062 (May 1999) (after discussing the range of medical interventions to promote fetal health and the legal-ethical issues involved, concluding that "Under no circumstances should a physician physically intervene [to insist on medical treatment] without the explicit consent of the pregnant woman without judicial review . . .").

37. ALA. CODE § 22-52-1.2 (LexisNexis 2006); ALASKA STAT. § 47.37.190 (2006); ARK. CODE ANN. § 20-64-815 (2006); CAL. WEL & INST CODE § 3050 (Deering 2006); COLO. REV. STAT. § 25-1-1107 (2006); CONN. GEN. STAT. § 17a-685 (2006); DEL. CODE ANN. tit. 16, § 2212 (2006); D.C. CODE ANN. §7-1303.04 (LexisNexis 2006); FLA. STAT. ANN. § 397.675 (LexisNexis 2006); GA. CODE ANN. § 37-7-41 (2006); HAW. REV. STAT. ANN. § 334.60.2 (LexisNexis 2006); IDAHO CODE ANN. § 66-329 (2006); IND. CODE ANN. § 12-23-11-1 (LexisNexis 2006); IOWA CODE §

and several states have recently enacted laws specifically authorizing the civil commitment of pregnant women based on substance abuse.<sup>38</sup> Further, a majority of states which authorize the use of advance medical directives to govern the medical care of mentally incompetent individuals suspend the operation of these directives if the patient is pregnant.<sup>39</sup>

In June 2003, the wife of a Florida prosecutor sought to be appointed “guardian” of the fetus of a mentally disabled patient who lived in a group home in order to prevent the woman from having an abortion.<sup>40</sup> Although the Florida courts ultimately rejected the suit, the case became a cause célèbre in Florida.

In March 2004, Congress enacted the Unborn Victims of Violence Act (the UVVA or Act),<sup>41</sup> which made it a crime to injure or cause the death of a fetus while committing another federal offense.<sup>42</sup> Both supporters and opponents of the Act acknowledged the significant problem of violence against pregnant women;<sup>43</sup> however, opponents objected to the Act’s solution. Rather than focusing on the injury suffered by the pregnant woman herself and providing that a person who harms a pregnant woman who in the process injures or kills the fetus should receive

125.75 (2006); KAN. STAT. ANN. § 59-29b54 (2006); LA. REV. STAT. ANN. § 28:54 (2006); MASS. ANN. LAWS ch. 123, § 35 (LexisNexis 2006); MISS. CODE ANN. § 41-30-27 (2004); NEB. REV. STAT. ANN. § 71-919 (LexisNexis 2006), see also NEB. REV. STAT. ANN. § 71-908 (LexisNexis 2006); N.H. REV. STAT. ANN. § 135-C:27 (2006); N.M. STAT. ANN. § 43-2-8 (LexisNexis 2006); N.D. CENT. CODE § 12.1-04.1-22 (2006); R.I. GEN. LAWS § 21-28.2-3 (2006); S.C. CODE ANN. § 44-52-50 (2005); S.D. CODIFIED LAWS § 29A-5-311 (2006); TEXAS HEALTH & SAFETY CODE ANN. § 574.034 (Vernon 2006); VA. CODE ANN § 37.2-809 (2006); WASH. REV. CODE ANN. § 70.96A.140 (LexisNexis 2006); W. VA. CODE ANN. § 27-5-2 (LexisNexis 2006); WIS. STAT. § 51.15 (2006); WYO. STAT. ANN. § 25-10-110 (2006). Minnesota, Oklahoma, and South Dakota have involuntary commitment laws specifically for pregnant women who use drugs. MINN. STAT. § 626.5561 (2006); OKLA. STAT. tit. 43A, § 5-410 (2005); see also OKL. STAT. tit. 63 § 1-546.5 (2005); S.D. CODIFIED LAWS § 34-20A-70 (2006).

38. See, e.g., WIS. STAT. §§ 48.205 (2006) (permitting the civil commitment of pregnant girls and women, dubbed “The Cocaine Mom law”); see also Tom Kertscher, ‘Cocaine Mom’ Law Invoked in Attempt to Detain Woman, Racine Case Thought to Be First Time Law is Used Without Other Crime, MILWAUKEE JOURNAL SENTINEL, Nov. 5, 1999, at 1.

39. See discussion *infra* Part I.D.

40. This attempt was rejected by the Florida District Court of Appeal in *In re Guardianship of J.D.S.*, 864 So. 2d 534, 535 (Fla. Dist. Ct. App. 2004), which held that under the Florida guardianship statute, a guardian can be appointed only for a “person,” and that fetuses were not “persons” under Florida law. *Id.* at 538.

41. Pub. L. 108-212, 118 Stat. 568 (2004).

42. 18 U.S.C.A. § 1841 (West 2006). The Act enumerated a lengthy list of federal offenses, including drive-by shootings in connection with drug offenses (18 U.S.C.A. § 36), violence at international airports (18 U.S.C.S. § 37), and assault on a federal officer or employee (18 U.S.C.A. § 111). See 18 U.S.C.A. § 1841(b)(1).

43. H.R. REP. NO. 108-420, Pt. 1, at 4 n.2 (2004) (Conf. Rep.) (citing Victoria Frey, *Examining Homicide’s Contribution to Pregnancy-Associated Deaths*, 285 JAMA 1510 (2001) (summarizing the various studies)); Isabelle L. Horon & Diana Cheng, *Enhanced Surveillance for Pregnancy-Associated Mortality—Maryland, 1993-1998*, 285 JAMA 1455 (2001); Linn H. Parsons & Margaret A. Harper, *Violent Maternal Deaths in North Carolina*, 94 OBSTET. GYNECOL. 990, 991 (1999); Dannenberg et al., *Homicide and Other Injuries as Causes of Maternal Death in New York City, 1987 through 1991*, 172 AM. J. OBSTET. GYNECOL. 1557 (1995); Fildes et al., *Trauma: The Leading Cause of Maternal Mortality*, 32 J. TRAUMA 643-45 (1992).

an enhanced penalty for that harm,<sup>44</sup> the UVVA makes such an attack or injury a separate crime.<sup>45</sup> To do so, the UVVA defines "unborn child" broadly, as "a member of the species homo sapiens, at any stage of development . . . ."<sup>46</sup> Like the SCHIP regulation, this language raises concern that the statute's real goal is to limit women's ability to obtain an abortion.<sup>47</sup>

Most recently, laws have been proposed which emphasize fetal "personhood" in new ways. These include laws requiring women seeking abortion to be told about fetal pain,<sup>48</sup> to be informed of the need to prepare a fetal death certificate, or to be given the opportunity to view a sonogram or listen to the heartbeat of their fetus prior to deciding to have an abortion.<sup>49</sup> Supporters of these statutes justify them as providing "informed consent," but the statutes are unusual in mandating the substantive details of what patients contemplating a medical procedure must be told. In contrast, most American informed consent<sup>50</sup> law focuses on the *process* of ensuring full communication between patients and their health care providers rather than on the *content* of the physician-patient dialogue,<sup>51</sup> relying on the health care professional to determine what information to convey to a particular patient based on her individual needs.

44. Senator Dianne Feinstein proposed an amendment to the Senate bill to accomplish this, which was defeated by a vote of 50-49, largely along party lines. A similar amendment offered by Representative Zoe Lofgren was also defeated in the House of Representatives, by a 229-186 vote. Edward Epstein, *Bill to Make Harming Fetus a Crime is Passed by Senate; Assailant of a Pregnant Woman Could be Charged with 2 Separate Federal Offenses*, S. F. CHRON., March 26, 2004, at A1; see also H.R. REP. NO. 108-420, Pt. 1, at 86.

45. 18 U.S.C.A. § 1841 (West 2006).

46. 18 U.S.C.A. § 1841(d). Under the law, "the term unborn child means a child in utero, and the term "child in utero" or "child, who is in utero" means a member of the species homo sapiens, at any stage of development, who is carried in the womb." See also 10 U.S.C.A. § 919a(d) (West 2006).

47. Senator Feinstein argued that the UVVA was a deliberate effort to undermine abortion rights, by "set[ting] . . . the stage for a jurist to rule that a human being at any stage of development deserves . . . rights under the law' . . ." Epstein, *supra* note 46.

48. See S.51, 109th Cong. § 2902 (2005) (proposed by Senator Sam Brownback of Kansas, a fierce abortion opponent); H.B. 238, 59th Leg., Reg. Sess. (Mont. 2005). Both bills are discussed *infra* in text accompanying notes 244-252.

49. See discussion *infra* in Section I.D. The way for these laws has been paved by federal funding of fetal imaging machinery, through federal and state grants that are given to organizations that promote "abstinence only" sex education. The so-called "pregnancy crisis centers" have been a major beneficiary of such grants. Kashef, *supra* note 5; The Abortion Access Project, *supra* note 5.

50. Informed consent doctrine has roots in both the common law tort of battery and in negligence. It protects a patient's interest in choosing when to be touched (a battery is an unwanted touching and includes medical treatment which the patient did not agree to). See, e.g., Schloendorff v. The Society of New York Hospital, 105 N.E. 92, 93 (N.Y. 1914). It also ensures that a patient receives medical treatment from a physician who has explained to the patient those risks and benefits of treatment that a reasonable patient would wish to know. See, e.g., Canterbury v. Spence, 464 F.2d 772, 787 (D.C. Cir. 1972); N.Y. PUB. HEALTH LAW § 2805-d (McKinney 2001).

51. For example, some abortion statutes require that the pregnant woman be told certain details about the fetus, such as its gestational age and its potential to survive outside the womb, and be informed of the availability of medical assistance for prenatal care, childbirth, and neonatal care, as well as options for child support and adoption. See, e.g., LA. REV. STAT. ANN § 40:1299.35.6 (2006); TEX. HEALTH & SAFETY CODE ANN §171.012 (Vernon 2003); Planned Parenthood v. Casey, 505 U.S. 833, 881 (1992). In addition, there are other areas of health care in which state laws

In sum, the mounting numbers of civil and criminal actions against pregnant women, along with statutes and regulations equating fetuses with born children, mean that the new “fetal protection” crusade can no longer be ignored. These government initiatives are particularly disturbing because their focus on the harm that could be caused by a woman’s behavior during pregnancy ignores the widespread failings of the American health care system, which does not promote women’s and children’s health.

The United States falls far short of other developed countries in objective indicators of health status,<sup>52</sup> and indeed, American infant mortality rates have risen in recent years.<sup>53</sup> Two-thirds of American infants who die in their first year of life suffer from low birthweight, attributable in part to their mothers’ lack of prenatal care and long-standing health problems, as well as to multiple births.<sup>54</sup> One-eighth of American children are born pre-term, at an estimated cost of \$26 billion per year.<sup>55</sup> There are significant racial disparities in birth outcomes and other measures of children’s health, which reflect major problems of health care access, including the lack of a primary care physician and the lack of health insurance.<sup>56</sup> More than ten million American children have no

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mandate that patients (usually women) be told of alternative medical or surgical options. *See, e.g.*, CAL. HEALTH & SAFETY CODE § 1690 (West 2006) (sterilization); OR. REV. STAT. ANN. § 436.225 (West 2003) (sterilization); S.G. Nayfield et al., *Statutory Requirements for Disclosure of Breast Cancer Treatment Alternatives*, 86 J. NAT’L CANCER INST. 1202 (1994); ARK. CODE ANN. § 6-18-702 (West 2006) (childhood vaccination). Medical procedures that are less politically charged rarely have such “informed consent” requirements.

52. *See, e.g.*, ASSOCIATION OF MATERNAL AND CHILD HEALTH PROGRAMS, PLANNING FOR HEALTHY FAMILIES (June 2004), available at <http://amchp.org/aboutamchp/publications/familyplanning2004.pdf> (noting that the United States ranks 29th in the world in infant mortality and arguing that more attention should be devoted to encouraging family planning as a way of ensuring good birth outcomes, as data show that when pregnancies are intended children are less likely to be born premature and with health problems); Margaret A. Harper et al., *Pregnancy-Related Death and Health Care Services*, 102 OBSTETRICS & GYNECOLOGY 273, 273, 275, 276 (Aug. 2003), available at <http://www.greenjournal.org/cgi/reprint/102/2/273> (noting that “[m]aternal mortality statistics for the United States have shown little improvement for 2 decades, and 20 countries have lower rates,” and concluding in a study of North Carolina maternal pregnancy deaths that lacking access to prenatal care made maternal death slightly more likely and having a Caesarean section made maternal death nearly four times as likely). *See also* detailed discussion in Part II.B, *infra*.

53. T.J. Matthews, *Racial/Ethnic Disparities in Infant Mortality- United States, 1995-2002*, MORBIDITY AND MORTALITY WEEKLY REPORT, June 10, 2005.

54. *Id.* *See also* ANNIE E. CASEY FOUNDATION, 2004 KIDS COUNT DATA BOOK, 34 (2005), available at [www.kidscount.org](http://www.kidscount.org) [hereinafter CASEY FOUNDATION, KIDS COUNT]. Low birthweight is also linked significantly to being born as a twin or other multiple births. *Id.* at 34; Tarun Jain et al., *Trends in Embryo-Transfer Practice and in Outcomes of the Use of Assisted Reproductive Technology in the United States*, 350 N. E. J. MED. 1639, 1640 (2004).

55. Press Release, Institute of Medicine, *Preterm Births Cost U.S. \$26 Billion a Year; Multidisciplinary Research Effort Needed to Prevent Early Births* (July 13, 2006), available at <http://www8.nationalacademies.org/onpinews/newsitem.aspx?RecordID=11622> [hereinafter IOM Report]. The Report defines “preterm” as any birth that occurs at less than 37 weeks of pregnancy (a full-term pregnancy is 38-42 weeks post-conception) and notes that the rate of pre-term births has risen 30% since 1981. *Id.*

56. IOM Report, *supra* note 55; Matthews, *supra* note 53 (noting significant racial disparities in infant mortality rates within and across states); Kenneth E. Thorpe, Jennifer Flome & Peter Joski, *The Distribution of Health Insurance Coverage Among Pregnant Women, 1999* (Emory University

health insurance at all,<sup>57</sup> even though at least 70% live in families where at least one parent works full time.<sup>58</sup>

If the goal of government policymakers and prosecutors were actually to ensure that more children are born healthy and have the opportunity to stay that way, the United States would adopt radically different policies. In addition to the lack of health care access, two notable omissions from the rhetoric of fetal protection are the harms posed to children by assisted reproductive technology (ART), used largely by the middle and upper classes,<sup>59</sup> and the risk to all children posed by environmental

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April 2001) (identifying disparities in health insurance coverage along racial, employment status, and income lines) (paper prepared for the March of Dimes, on file with the author).

57. KAISER COMMISSION ON MEDICAID AND THE UNINSURED, MEDICAID FACTS, ENROLLING UNINSURED LOW-INCOME CHILDREN IN MEDICAID AND SCHIP (March 2005) (summarizing 2002 data), available at <http://www.kff.org/medicaid/2177-04.cfm> [hereinafter KAISER, ENROLLING CHILDREN]. In 2005, more than 12% of children under age 18 lacked health insurance for at least part of the previous year. ROBIN A. COHEN & MICHAEL E. MARTINEZ, CENTERS FOR DISEASE CONTROL, HEALTH INSURANCE COVERAGE: ESTIMATES FROM THE NATIONAL HEALTH INTERVIEW SURVEY, JANUARY–SEPTEMBER 2005, 3 (Mar. 20, 2006), available at <http://www.cdc.gov/nchs/data/nhis/earlyrelease/insur200603.pdf>. “[U]ninsured but Medicaid-eligible children are twice as likely as those enrolled in Medicaid to have an unmet medical need, to have not seen a doctor, and to have substantial family out-of-pocket spending on health care.” KAISER, ENROLLING CHILDREN, *supra*.

58. Associated Press, *Most Uninsured Children Have Parents with Jobs*, Sept. 28, 2006, [http://www.foxnews.com/printer\\_friendly\\_story/0,3566,216338,00.html](http://www.foxnews.com/printer_friendly_story/0,3566,216338,00.html).

59. What has been absent from the government initiatives described above are any efforts to regulate the new assisted reproductive technologies (ARTs) designed to address problems of infertility, which increase the risk of adverse birth outcomes, but which are used primarily by middle- and upper-income Americans. See, e.g., Jain, *supra* note 54, at 1640 (noting the continuing high rate of multiple births in the United States and their adverse consequences, but observing that the United States, in contrast to many other countries, has not regulated ART practices, “in part because of the basic belief that such decisions should be left to couples and their physicians”); Liza Mundy, *A Special Kind of Poverty: The Poor Get Used to Going Without, but Going Without a Baby is Hard to Get Used to*, WASH. POST, Apr. 20, 2003, at W08 (describing costs of infertility treatments and how poor men and women seek subsidized or alternative access to fertility treatment). People who use ART are much more likely than the rest of the population to have twins or other multiple births, which in turn dramatically increases the chances of having a low birthweight infant (one who weighs less than 2500 grams, or about 5.5 pounds), from 6% to 57%. See CASEY FOUNDATION, KIDS COUNT, *supra* note 54, at 34. Low birth weight is a major contributor to infant mortality and developmental defects. *Id.* Yet even singleton births achieved through ART are at risk for harm. Jennifer L. Rosato, *The Children of ART (Assisted Reproductive Technology): Should the Law Protect Them From Harm?*, 2004 UTAH L. REV. 57, 60, 62-66, 69-70, 77-80 (summarizing the data showing that up to 10% of children born using ART suffer some adverse consequences and criticizing the regulatory hands-off position of states and the federal government); see also John A. Robertson, *Procreative Liberty and Harm to Offspring in Assisted Reproduction*, 30 AM. J. L. & MED. 7, 9 (2004) (noting that intracytoplasmic sperm injection (ICSI), which is used in nearly half of American in vitro fertilization (IVF) treatments, may cause a higher incidence of rare birth defects as well as low birth weight). But see Anja Pinborg et al., *Neurological Sequelae in Twins Born After Assisted Conception: Controlled National Cohort Study*, 329 BRIT. MED. J. 311 (July 15 2004) (finding no difference in adverse birth outcomes between infants conceived through ICSI and IVF, but noting that children born through ART methods have higher rates of stillbirths and neurological problems). See also PHILIP G. PETERS, JR., HOW SAFE IS SAFE ENOUGH? OBLIGATIONS TO THE CHILDREN OF REPRODUCTIVE TECHNOLOGY (2004). Similarly, the bioethics issues raised by particular uses of IVF are generally ignored. Arlene Judith Klotzko, *Medical Miracle or Medical Mischief? The Saga of the McCaughley Septuplets*, Hastings Center Report 5 (May 1998); Susan M. Wolf, Jeffrey P. Kahn, & John E. Wagner, *Using Preimplantation Genetic Diagnosis to Create a Stem Cell Donor: Issues, Guidelines & Limits*, 31 J.L. MED. & ETHICS 327, 331 (2003) (arguing that the combination of IVF technology with preimplantation genetic diagnosis in order to produce a child who is a poten-

hazards, including mercury in fish<sup>60</sup> and the forests<sup>61</sup> to pesticides<sup>62</sup> to lead from older buildings and manufacturing.<sup>63</sup> The United States has also failed to promote fetal and children's health and development by providing paid parenting leaves.<sup>64</sup> When compared to other developed nations where universal health care and subsidized parenting leave are the norm,<sup>65</sup> the approach of the United States is both seriously out of step and actively unhelpful in promoting childhood health.

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tial organ donor for a sibling with a rare genetic disorder is so ethically questionable that it should only take place under human subject research protocols which have been thoroughly reviewed by institutional review boards). Only recently have suggestions been made that ART should be monitored and regulated. THE PRESIDENT'S COUNCIL ON BIOETHICS, REPRODUCTION AND RESPONSIBILITY: THE REGULATION OF NEW BIOTECHNOLOGIES, EXECUTIVE SUMMARY 2-9 (March 2004), available at [www.bioethics.gov](http://www.bioethics.gov). Due to the volatile politics evoked by discussions of fetal and embryonic life, little regulation is likely to occur anytime soon. Rosato, *supra*, at 74, 75. In July 2006 the Institute of Medicine issued a report noting the 30% increase in pre-term labor over the last 25 years, and urging further study of the contribution of ART to this growth. IOM Report, *supra* note 55.

60. Many species of fish pose risks to adults, children, and fetuses, primarily through exposure to mercury and polychlorinated biphenyls (PCB). "Children born to women exposed to high levels of methylmercury [the organic form of mercury found naturally in the environment] during or before pregnancy may face numerous health problems, including brain damage, mental retardation, blindness, and seizures. Lower levels of methylmercury exposure in the womb have caused subtle but irreversible deficits in learning ability." Jennifer Fisher Wilson, *Balancing the Risks and Benefits of Fish Consumption*, 141 ANNALS INT. MED. 977, 978 (2004). PCBs are a probable carcinogen. In addition, "[i]n children, PCB exposure in utero and from breast milk consumption has been linked with neurodevelopmental delays, impaired cognition, immune problems, and alterations in male reproductive organs." *Id.* at 979.

61. Anthony DePalma, *Study of Songbirds Finds High Levels of Mercury*, N.Y. TIMES, Jul. 25, 2006, at B1.

62. A number of widely-used pesticides are suspected of being endocrine disrupters, which affect both male and female reproductive systems and increase the chances of infertility and other reproductive harms. SHARON L. DROZDOWSKI & STEPHEN G. WHITTAKER, WASHINGTON STATE DEPARTMENT OF LABOR & INDUSTRIES' SAFETY & HEALTH ASSESSMENT & RESEARCH FOR PREVENTION PROGRAM, WORKPLACE HAZARDS TO REPRODUCTION AND DEVELOPMENT: A RESOURCE FOR WORKERS, EMPLOYERS, HEALTH CARE PROVIDERS, AND HEALTH & SAFETY PERSONNEL 48, 49 (Aug. 1999).

63. Lead poses risks to male and female workers, as well as their children. In men, lead exposure leads to lowered sperm counts, abnormal sperm shapes, altered sperm transfer, and altered hormone levels. The results can be sterility and infertility. In women, lead can cause miscarriages, stillbirths, and infertility, as well as developmental disorders in children exposed in utero. NATIONAL INSTITUTE FOR OCCUPATIONAL SAFETY AND HEALTH, THE EFFECTS OF WORKPLACE HAZARDS ON FEMALE REPRODUCTIVE HEALTH 2-3 (Feb. 1999), available at <http://www.cdc.gov/niosh/99-104.html>. Lead that workers bring home on their skin, hair, clothes, tool box or car can cause severe lead poisoning for everyone who comes into contact with it, and can lead to neurobehavioral and growth effects in a fetus. NATIONAL INSTITUTE FOR OCCUPATIONAL SAFETY AND HEALTH, THE EFFECTS OF WORKPLACE HAZARDS ON MALE REPRODUCTIVE HEALTH (1997), <http://www.cdc.gov/niosh/malrepro.html>.

64. The Family and Medical Leave Act of 1993, Pub. L. No. 103-3, 107 Stat. 6 (1993), discussed *infra* in text accompanying notes 329-44, requires employers of more than fifty employees to permit employees to take an unpaid leave for their own illness or a family member's birth, adoption, or illness. However, in contrast to almost all developed countries, the United States does not mandate paid leave. KURT H. DECKER, FAMILY AND MEDICAL LEAVE IN A NUTSHELL 9-14 (2000).

65. Sakiko Tanaka, *Parental Leave and Child Health Across OECD Countries*, 115 THE ECON. J. F7, F8, F9 (Royal Economic Society 2005).



## I. THE NEW "FETAL PROTECTION"

A. *Criminal Prosecutions*

Criminal actions against pregnant women have risen sharply in the last decade. Although women have been prosecuted for drug and alcohol use during pregnancy in more than half the states since the 1970s, courts have quashed prosecutions or overturned convictions in all but one state, South Carolina.<sup>66</sup> There the courts have upheld women's convictions for homicide and child abuse based on their conduct during pregnancy.<sup>67</sup> Virtually all the women who faced these criminal charges were living at the very margins of society, suffering from poverty, substance abuse, and often, mental disability.<sup>68</sup> Frequently they were sexually abused as children, and often they are current victims of domestic violence.<sup>69</sup>

In 1996, Deborah J.Z. was charged with attempted first-degree intentional homicide<sup>70</sup> and first-degree reckless injury,<sup>71</sup> after she went into labor while at a tavern and said that she would drink herself and her fetus to death.<sup>72</sup> Her child was born with a high blood alcohol level and physical features showing fetal alcohol effects.<sup>73</sup> Although the Wisconsin Supreme Court condemned her conduct, it barred criminal prosecution because under Wisconsin's "born alive" rule, a fetus was not a hu-

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66. The first reported effort at prosecution was in 1977, when a California prosecutor indicted Margaret Reyes on two counts of felony child endangering based on her heroin use while pregnant, which allegedly caused her twin sons to be born addicted to heroin. The California Court of Appeal issued a writ or prohibition, enjoining further prosecution of the case. *Reyes v. Superior Court*, 141 Cal. Rptr. 912 (Cal. Ct. App. 1977). A rash of prosecutions began in the late 1980s, beginning with the 1987 prosecution of Pamela Rae Stewart, who had intercourse with her husband and used amphetamines, both against medical advice. See George Annas, *The Impact of Medical Technology on the Pregnant Woman's Right to Privacy*, 13 AM J. L. & MED. 213, 229 (1987). Since then, at least 30 states have prosecuted women for manslaughter, child abuse or endangerment, or drug delivery to a minor. See CENTER FOR REPRODUCTIVE RIGHTS, PUNISHING PREGNANT WOMEN FOR THEIR BEHAVIOR DURING PREGNANCY: AN APPROACH THAT UNDERMINES WOMEN'S HEALTH AND CHILDREN'S INTERESTS 2 [hereinafter CTR. FOR REPRODUCTIVE RIGHTS, PUNISHING PREGNANT WOMEN], available at [http://www.reproductiverights.org/pdf/pub\\_bp\\_punishingwomen.pdf](http://www.reproductiverights.org/pdf/pub_bp_punishingwomen.pdf) (listing cases wherein women have been prosecuted for behavior during pregnancy).

67. See *Whitner v. State*, 492 S.E.2d 777, 778 (S.C. 1997) (upholding conviction under child endangerment statute for drug use during pregnancy because viable fetus is a "child" under the statute); see also *State v. McKnight*, 576 S.E.2d 168, 171 (S.C. 2003) (upholding conviction for homicide by child abuse).

68. See CTR. FOR REPRODUCTIVE RIGHTS, PUNISHING PREGNANT WOMEN, *supra* note 66, at 2.

69. See WOMEN'S LAW PROJECT, *supra* note 12, at 7; see also Paltrow, *supra* note 12, at 477.

70. WIS. STAT. ANN. § 940.01 (West 2005) ("[F]irst-degree intentional homicide" [provides that:] "(a) . . . whoever causes the death of another human being with intent to kill that person or another is guilty of a Class A felony.").

71. § 940.23 ("[R]eckless injury" [provides that:] "(a) Whoever recklessly causes great bodily harm to another human being under circumstances which show utter disregard for human life is guilty of a Class D felony.").

72. Deborah J.Z. "allegedly told a nurse that 'if you don't keep me here, I'm just going to go home and keep drinking and drink myself to death and I'm going to kill this thing because I don't want it anyways.'" Deborah J.Z. also expressed fear about the pain of giving birth and the baby's race. *State v. Deborah J.Z.*, 596 N.W.2d 490, 491 (Wis. Ct. App. 1999).

73. *Deborah J.Z.*, 569 N.W.2d at 491. The baby's blood alcohol level at birth was 0.199%.

man being.<sup>74</sup> The court cited the ongoing debate over whether substance abuse should be addressed through treatment or punishment, noting the concern that threatening criminal prosecution could deter women from seeking prenatal care.<sup>75</sup> The court held that to permit prosecution of Deborah Z. would mean that “a woman could risk criminal charges for any perceived self-destructive behavior during her pregnancy that may result in injuries to her unborn child . . . [including] smoking or abusing legal medications . . . [or] ‘the failure to secure adequate prenatal medical care and overzealous behavior, such as excessive exercising or dieting.’”<sup>76</sup>

In 1999, Regina McKnight, a homeless African-American woman with an IQ of 72 and an addiction to crack cocaine, delivered a stillborn child.<sup>77</sup> When she and the child tested positive for cocaine metabolites, she was charged with homicide by child abuse.<sup>78</sup> McKnight was convicted and sentenced to twenty years in prison.<sup>79</sup> The South Carolina Supreme Court upheld her conviction, rejecting McKnight’s arguments that there was insufficient evidence to show causation or mens rea.<sup>80</sup> The court also rebuffed her argument that she was denied due process by being prosecuted for homicide when the South Carolina legislature had not enacted a statute declaring that a fetus was a child. The court relied on its prior decisions upholding convictions for felony child abuse based

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74. *Id.* at 496. Wisconsin law defines a “human being” as “one who has been born alive.” WIS. STAT. ANN. § 939.22 (16). The court explained its decision as required by the rule of strict construction of penal laws and by deference to the legislature in a complex public policy area. *Deborah J.Z.*, 596 N.W.2d at 494-95.

75. *Deborah J.Z.*, 596 N.W.2d at 495. The court’s concern is supported by a study of low-income women who delivered their babies at an inner city hospital in Detroit, who stated their belief that if Michigan adopted a law mandating that women whose babies tested positive for drugs would be sent to jail, substance-abusing women would be less likely to seek prenatal care, drug testing, or drug treatment. When the study’s authors attempted to interview women in a state with a law that threatened incarceration, all known drug users refused to participate in the study out of fear of self-incrimination. See Marilyn L. Poland et al., *Punishing Pregnant Drug Users: Enhancing the Flight from Care*, 31 DRUG & ALCOHOL DEPENDENCE 199, 201-02 (1993).

76. *Deborah J.Z.*, 596 N.W.2d at 494-95 (citing *Hillman v. Georgia*, 503 S.E.2d 610, 613 (Ga. Ct. App. 1998)).

77. Robyn E. Blummer, *Moralists’ New Target: Pregnant Women*, ST. PETERSBURG TIMES, Aug. 10, 2003, at 7D; *McKnight*, 576 S.E.2d at 171, 173 (S.C. 2003).

78. *McKnight*, 576 S.E.2d at 171, 173. Under title 16, article 3, section 85 of the South Carolina Code, a person may be found guilty of “homicide by child abuse” if he “causes the death of a child under the age of eleven while committing child abuse or neglect, and the death occurs under circumstances manifesting an extreme indifference to human life.” S.C. CODE ANN. § 16-3-85 (2005).

79. See *McKnight*, 576 S.E.2d at 171. The court suspended the sentence upon service of twelve years in prison.

80. The court rejected Ms. McKnight’s argument that the evidence was insufficient to survive her motion for a directed verdict of acquittal, finding that there was evidence of her “extreme indifference to human life” based on her use of cocaine during pregnancy in light of South Carolina precedents which upheld felony child abuse convictions based on a woman’s drug use while pregnant, holding that both she and women in South Carolina generally were on ample notice that the use of cocaine while pregnant causes fetal harm. The court also found sufficient evidence to send the case to the jury on the causation question, despite evidence that in approximately 40% of stillbirths it is impossible to make a medical judgment about the cause of death. *Id.* at 172, 73.

on a woman's drug use while pregnant as providing sufficient notice,<sup>81</sup> effectively ignoring her argument that her crime could not be homicide, because a fetus cannot be treated as a child under criminal law unless the legislature expressly declares it to be so.<sup>82</sup> The court also spurned McKnight's argument that the homicide prosecution violated her right to privacy and autonomy.<sup>83</sup> Further, the court rejected her argument that a twenty-year prison term for the stillbirth of a child was unconstitutional under the Eight Amendment, insisting that the proper comparison was to criminal abortion,<sup>84</sup> rather than to other murders.<sup>85</sup>

The *McKnight* decision was condemned around the nation, as unfairly singling out a poor, African-American woman for unprecedented criminal punishment, while failing to address the underlying problems of addiction and lack of health care access. Critics charged that threatening drug-abusing pregnant women with criminal prosecution, rather than providing them with social and economic support and effective drug rehabilitation, would drive women away from treatment, out of fear that they would lose their babies or be imprisoned.<sup>86</sup>

Similar concern was expressed when, in 2003, a Hawaii prosecutor charged Tayshea Aiwohi with manslaughter based on her use of methamphetamine while pregnant, which caused the death of her infant two days after birth.<sup>87</sup> Ms. Aiwohi was not charged until two years after her child's death, when she had successfully completed a drug treatment program.<sup>88</sup> Both the prosecutor and the trial judge spoke of the need to hold her accountable and to send a message to prevent other mothers from using drugs while pregnant.<sup>89</sup> The trial judge also rejected any suggestion that Aiwohi's addiction might be a mitigating factor, declaring that,

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81. *Id.* at 176 (citing *Whitner v. State*, 492 S.E.2d 777 (S.C. 1997)).

82. The maximum sentence for a woman who procures an abortion in South Carolina is two years and the crime is a misdemeanor. S.C. CODE ANN. § 44-41-80(b) (2002).

83. *McKnight*, 576 S.E.2d at 176-77.

84. *Id.* at 174, 177. The court declined to address McKnight's contention that the abortion statute was applicable, saying that she had not preserved the issue for appellate review. *Id.* at 174.

85. *Id.* at 174, 177. The court compared McKnight's sentence to the sentence received by other convicted murderers in South Carolina, and murderers of children in other states. *Id.*

86. See, e.g., Kirsten Scharnberg, *Prosecutors Targeting Pregnant Drug Users; Some Fear Women Will Shun Treatment*, CHI. TRIB., Nov. 23, 2003, at C1; Patrik Jonsson, *South Carolina Tests the Bounds of a Fetus's Rights*, CHRISTIAN SCIENCE MONITOR, Jun. 28, 2001, USA Section at 1.

87. See *State v. Aiwohi*, 123 P.3d 1210, 1210-13 (Haw. 2005).

88. See *id.*; see also *State v. Aiwohi*, FCCR03-1-0036 (Haw. Aug. 25, 2004), available at <http://www.courts.state.hi.us> (use search function with the name "Aiwohi" and then use the hyperlink for the case file FCCR03-1-0036).

89. See *id.* The trial judge ruled that "the State, with good reason, has served clear notice that such conduct can and will result in serious felony charges brought where the child is born alive and later dies or suffers injury due to knowing, intentional or reckless drug use." The prosecutor "hailed the judge's remarks" finding the indictment was necessary "to get justice for the baby" and to hold the mother accountable. Ken Kobayashi, *Mother Gets Probation in Ice Death*, HONOLULU ADVERTISER, Aug. 26, 2004, at 1B.

[D]rug usage, including the use of crystal methamphetamine is a matter of choice and not an illness. Certainly it is a conscious choice to obtain and use the drug initially and worse yet, while pregnant . . . . If drug usage were an illness from the get go, we would today be in [a] medical center with a physician present in a diagnosis, treatment mode.<sup>90</sup>

Ms. Aiwahi pleaded no contest in order to appeal the denial of her motion to dismiss, and received a twenty-year prison sentence, which was suspended on condition that she comply with the terms of probation for the next ten years.<sup>91</sup> The Supreme Court of Hawaii overturned the conviction, holding that one of the elements of manslaughter was the attendant circumstance that the victim be a person at the time of the defendant's conduct.<sup>92</sup>

Yet even after *McKnight* and *Aiwahi*, few observers were prepared for the 2004 prosecution of Melissa Rowland for capital murder in Utah after she declined to have a recommended Caesarean section and her son was stillborn.<sup>93</sup> Like Ms. McKnight, Ms. Rowland was a vulnerable woman with few resources. Her own mother died shortly after birth, and Melissa Rowland had a history of serious mental illness dating from childhood, as well as substance abuse problems.<sup>94</sup> Ms. Rowland moved to Utah to deliver her children at the request of the adoption agency that was handling their adoption because Utah's loose adoption laws made adoption easier.<sup>95</sup> In Utah, she lived on Social Security disability payments and a \$100 weekly stipend from the adoption agency; she also used cocaine and tobacco.<sup>96</sup> Ms. Rowland sought help at three hospitals because she could not feel fetal movements, but rejected their advice to have a Caesarean section (C-section).<sup>97</sup> None of the hospitals sought a court order requiring a C-section or made any other effort to provide Ms. Rowland with medical treatment.<sup>98</sup> However, after Ms. Rowland delivered a stillborn son and a living daughter, she was arrested and charged with murder.<sup>99</sup> After spending more than three months in jail, Rowland

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90. See *State v. Aiwahi*, FCCR03-1-0036 (Haw. Aug. 25, 2004), available at <http://www.courts.state.hi.us> (use search function with the name "Aiwahi" and then use the hyperlink for the case file FCCR03-1-0036).

91. See *id.*

92. See *State v. Aiwahi*, 123 P.3d 1210, 1223 (Haw. 2005).

93. Linda Thomson & Pat Reavy, *Rowland's Out of Jail, Heading to Indiana*, DESERET MORNING NEWS, Apr. 30, 2004.

94. See *id.*

95. See Katha Pollitt, *Pregnant and Dangerous*, 278 (#16) THE NATION 9, Apr. 26, 2004.

96. See *id.*; see also Pamela Manson, *Mother is Charged in Stillborn Son's Death . . .*, SALT LAKE TRIBUNE, Mar. 12, 2004, at A1.

97. Thomson & Reavy, *supra* note 93; see also Manson, *supra* note 96. Prosecutors charged that she refused to have a Caesarean section because of cosmetic concerns that the operation would disfigure her. See *id.* But Rowland stated that she never would have said that because she had already delivered two children by Caesarean. See Pollitt, *supra* note 95.

98. See, e.g., Thomson & Reavy, *supra* note 93; see also Manson, *supra* note 96.

99. See Manson, *supra* note 96.

pleaded guilty to two counts of felony child endangerment based on her drug use during pregnancy pursuant to a plea bargain.<sup>100</sup>

The Rowland case aroused a storm of controversy.<sup>101</sup> Prosecutors argued that Rowland's failure to undergo a C-section when she was warned that the fetuses might be harmed by a delay in their birth was a culpable omission, demonstrating the "depraved indifference to human life" necessary for a murder charge.<sup>102</sup> The indictment was expressly predicated on a theory of maternal "selfishness," as prosecutors argued that Ms. Rowland had refused the surgical procedure solely out of vanity.<sup>103</sup> The prosecutors suggested, contrary to established tort law principles of informed consent,<sup>104</sup> that Ms. Rowland did not have a right to decline medical treatment, but was required to "choose among alternative treatments available," rather than electing the option of no treatment.<sup>105</sup>

Virtually all other observers condemned the prosecution as unwarranted and legally unsound.<sup>106</sup> In part, they argued that it was improper and dangerous to subject anyone to the risk of criminal prosecution based on a decision to forego a potentially dangerous surgical procedure, particularly when there had been no effort to seek a court order mandating medical treatment.<sup>107</sup> Commentators also asserted that criminal prosecution was not the way to handle potentially risky pregnancies, as it would drive vulnerable women away from medical treatment due to fear that they would face criminal charges if they admitted to having a drug or mental health problem.<sup>108</sup> Similarly, vulnerable women may fear criminal charges if they underwent drug testing while receiving prenatal care or delivering the baby.<sup>109</sup> Further, some writers cautioned that prosecuting pregnant women under these circumstances would lead to a slippery

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100. See Santini, *supra* note 25; see also Doug Smith & Linda Thomson, *Rowland in New Trouble*, DESERET MORNING NEWS May 27, 2004. Ms. Rowland was sentenced to two concurrent five year prison terms, with sentence suspended while on "good behavior" probation for eighteen months, requiring her to complete mental health and substance abuse treatment as well as a "parenting skills" course. See *id.* Ms. Rowland went directly from jail to a rehabilitation facility in Indiana, but left it after a month. See *id.*

101. See Thomson & Reavy, *supra* note 93.

102. Thomson, *Rowland Case Is Called 'Political,'* DESERET MORNING NEWS Mar. 13, 2004.

103. Associated Press, *Mother Accused of Murder of Unborn Child Pleads Not Guilty*, Mar. 15, 2004, available at <http://www.signonsandiego.com/news/nation/20040315-1529-wst-mother-charged.html>.

104. See discussion *infra* in Part II. Utah Code Ann. § 78-14-5 codifies the common law of informed consent, although it presumes that "when a person submits to health care rendered by a health care provider ... that what the health care provider did was [ ] expressly or impliedly authorized" by the patient. UTAH CODE ANN. § 78-14-5(1) (2006). However, patients may still have a cause of action for battery without meeting the requirements of § 78-14-5 if they allege that they did not consent at all to medical treatment. *Lounsbury v. Capel*, 836 P.2d 188 (Utah Ct. App. 1992).

105. Linda Thomson, *Mother Is Charged in Stillbirth of a Twin*, DESERET MORNING NEWS (Salt Lake City, Utah), Mar. 12, 2004.

106. See, e.g., Thomson & Reavy, *supra* note 93; Matt Canham, *Proposed Law Targets Pregnant Drug Users . . .*, SALT LAKE TRIBUNE, Apr. 10, 2004, at A1.

107. See Thomson & Reavy, *supra* note 93; see also Manson, *supra* note 96.

108. See, e.g., Thomson & Reavy, *supra* note 93; see also Canham, *supra* note 106.

109. See, e.g., Thomson & Reavy, *supra* note 93; see also Canham, *supra* note 106.

slope: there was no principled way to distinguish the prosecution in that case from prosecution of pregnant women who smoke or who do not follow their physicians' recommendations about healthy eating.<sup>110</sup> Finally, observers again noted the problem of selective prosecution, since almost all those facing such criminal charges are poor and women of color.<sup>111</sup>

Nonetheless, prosecutors continue to bring criminal charges against women who have used drugs while pregnant, most recently in Maryland,<sup>112</sup> Missouri,<sup>113</sup> Texas,<sup>114</sup> and Wyoming.<sup>115</sup> It appears that prosecutors are more interested in scoring points with the public or in pushing the legislature to expand criminal sanctions against pregnant women who use drugs than in addressing the underlying causes of substance abuse. For example, a Wyoming prosecutor who lost his case declared, "We

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110. Associated Press, *Arrest in C-Section Case Alarms Women's Groups*, THE HOLLAND SENTINEL, available at <http://hollandsentinel.com> (use search function and type in name of article).

111. See, e.g., Roberts, *Unshackling Black Motherhood*, *supra* note 9, at 938; Chasnoff et al., *supra* note 10, at 1206.

112. See generally *Kilmon v. State*, 905 A.2d 306 (Md. 2006). The Maryland Court of Appeals has recently invalidated the prosecution of two women for reckless endangerment based on their use of cocaine while pregnant. *Id.*

113. A Missouri prosecutor charged Keila Lewis with first degree felony child endangerment, based on her newborn baby's positive test for marijuana and Lewis' admission that she smoked marijuana once while pregnant. Brief of Amici Curiae in *State v. Lewis*, Case 03CR113048, Chariton County, Missouri Circuit Ct. (on file with author) Ms. Lewis was charged with violating section 568.045, which provides *inter alia* that "A person commits the crime of endangering the welfare of a child in the first degree if . . . [t]he person knowingly acts in a manner that creates a substantial risk to the life, body, or health of a child less than seventeen years old . . ." MO. ANN. STAT. § 568.045 (West 2006). The case was dismissed in 2005 because the infant's toxicology test was inadmissible under Missouri law. Personal communications with Jane Aiken, Professor, Washington University School of Law, March 7, 2005, and Jenean Thompson, Counsel for Keila Lewis, June 21, 2005.

114. In September 2003, an Amarillo, Texas prosecutor invoked a newly enacted state law when she asked local physicians to report all women who used illegal drugs while pregnant, so that they could be prosecuted for child abuse. The new law, redefined the term "individual" in certain statutes to mean "a human being who is alive, including an unborn child at very stage of gestation from fertilization until birth." S. 319, 78th Leg., Reg. Sess. (Tex. 2003). The law also redefined death to "include... for an individual who is an unborn child, the failure to be born alive." Tex. Atty. Gen. Opinion No. GA-0291, January 5, 2005, available at <http://http://www.oag.state.tx.us/opinions/GA/GA0291.pdf>. See Letter from Rebecca King, 47<sup>th</sup> District Attorney to all Physicians Practicing in Potter County, Texas (Sept. 22, 2003) (on file with author). The prosecutor charged at least eighteen women with crimes before the Texas Attorney General issued an Opinion concluding that the new law neither authorized prosecution for maternal drug use under the Controlled Substances Act nor required physicians to report such drug use. News from Lynn Paltrow, Executive Director of National Advocates for Pregnant Women, <http://realcostofprisons.org/blog>. The convictions of two women for delivery of a controlled substance to a fetus were overturned by the Texas Court of Appeals, on the ground that the prosecution did not show that the fetus possessed the drug as required by Texas law. *Ward v. State*, 188 S.W.3d 874 (Tex. Ct. App. 2006) and *Rhonda Tulane Smith v. State*, No. 07-04-0490, 2006 Tex. App. LEXIS 2370 (Tex. Ct. App. Mar. 29, 2006) (unpublished opinion).

115. See Associated Press, *Judge Drops 'Meth Baby' Charge*, CASPER STAR-TRIBUNE, Sept. 29, 2005, available at <http://www.casperstartribune.com> (use search function). In 2004, a Wyoming prosecutor charged Michelle Foust with causing a child to ingest methamphetamine based on blood tests of Foust and her newborn child. See *id.* The case was dismissed on the ground that the law encompassed conduct taken in regard to a "child," ... not a 'fetus' or 'unborn child.'" *Id.*; see also Associated Press, *Woman Charged with Using Meth While Pregnant Arrested Again*, May 2, 2005, available at <http://www.billingsgazette.com> (use search function).

stuck our toe in the water on this thing . . . . People need to understand there's a big hole in the law that needs to be filled."<sup>116</sup> It has been left to the judiciary to restrain overzealous prosecutors, through the application of the fundamental principle that legislative intent to criminalize certain behavior must be clear, and in recognition of the multiple policy considerations that argue against punishing pregnant women rather than offering them treatment.<sup>117</sup>

### B. New Criminal Statutes: Changing the Born-Alive Rule

While the prosecutions of pregnant women for murder in *McKnight* and *Rowland* made headlines, the trend toward third party criminal liability for causing the death of a fetus has been underway for more than thirty years.<sup>118</sup> This change has been accomplished primarily by legislative action, as courts have been reluctant to overturn the common law "born-alive rule" without explicit legislative authorization.<sup>119</sup> Under the "born-alive rule," the fetus was not seen as a legal person, separate from its mother, and a homicide prosecution could not be brought.<sup>120</sup> Criminal

116. Associated Press, *Judge Drops 'Meth Baby' Charge*, *supra* note 115.

117. See *Kilmon v. State*, 905 A.2d 306 (Md. 2006). As the Maryland Court of Appeals explained in *State v. Kilmon*, to accept the prosecutor's argument to construe the reckless endangerment statute to apply to pregnant women who used drugs could mean the criminalization of:

[N]ot just the ingestion of unlawful controlled substances but a whole host of intentional and conceivably reckless activity . . . [including] everything from becoming (or remaining) pregnant with knowledge that the child likely will have a genetic disorder that may cause serious disability or death . . . to smoking, to not maintaining a proper and sufficient diet . . . to exercising too much or too little . . . .

*Id.* at 311-12. The court also noted that the Maryland Legislature had considered but a penal approach to pregnant women's drug use, choosing instead to provide drug treatment for pregnant women and to consider a woman's drug use while pregnant, if she subsequently refused to enter a treatment program, as evidence supporting the termination of her parental rights. *Id.* at 312.

118. See generally *Keeler v. Superior Court of Amador County*, 470 P.2d 617 (Cal. 1970).

119. See, e.g., *id.* The "born alive" rule is of very long standing. See *id.* Lord Coke is frequently cited for his articulation of the rule:

If a woman be quick with childe, and by a potion or otherwise killeth it in her wombe, or if a man beat her, whereby the child dyeth in her body, and she is delivered of a dead childe, this is great misprision, and no murder; but if he childe be born alive and dyeth of the potion, battery, or other cause, this is murder; for in law it is accounted a reasonable creature, *in rerum natura*, when it is born alive.

*State v. Dickinson*, 275 N.E.2d 599, 601 (Ohio 1971) (citing 3 Coke, Institutes 58 [1648]). Coke was followed by other British jurists, including Blackstone, Hale, Hawkins, and Sir James Stephen, and the rule passed into American common law. *Keeler*, 470 P.2d at 620.

120. See, e.g., *Commonwealth v. Morris*, 142 S.W. 3d 654, 657 (Ky. 2004). In part this was due to difficulties in proof, because in the case of a stillbirth it could not be established beyond a reasonable doubt that the fetus had been alive when injured or that the defendant's conduct was the proximate cause of death. See *id.* (citing Clarke D. Forsythe, *Homicide of the Unborn Child: The Born Alive Rule and Other Legal Anachronisms*, 21 VAL. L. REV. 563, 575 (1987)). At the same time, the born alive rule reflected the essential unity of the pregnant woman and her fetus, and the latter's absolute dependence on her for existence. Cf. *Dobson v. Dobson*, [1999] 2 S.C.R. 753, ¶¶ 95-96 (Can.) (explaining, in the context of deciding not to impose maternal tort liability on the basis of prenatal harm, that "a pregnant woman cannot have a duty of care to her own foetus, which is at law but a part of herself . . . . [T]he physical unity of pregnant woman and foetus means that the imposition of a duty of care would amount to a profound compromise of her privacy and autonomy.").

statutes were interpreted in light of that rule, unless the statute specifically included fetuses within the class of victims.<sup>121</sup>

In the last few years, there has been an expanded push to characterize the harm caused by battering a pregnant woman solely as harm to the fetus, effectively erasing the woman herself.<sup>122</sup> New criminal laws directed at fetal harm ignore the psychic injuries imposed on the woman by such attacks. These include the fear of future domestic violence and subjugation by an intimate partner, the loss of self-determination, and the harm to the woman's interest in carrying her pregnancy to term.<sup>123</sup> At least nineteen states have enacted statutes authorizing a homicide prosecution for causing the death of a fetus,<sup>124</sup> and Congress accomplished this via the Unborn Victims of Violence Act.<sup>125</sup> Several states have enacted separate feticide statutes or other statutes focusing on fetal harm.<sup>126</sup> Some state courts have achieved the same result through judicial interpretation, rejecting the common law "born alive" rule as outmoded.<sup>127</sup> However, with the exception of South Carolina, each court has been

121. See, e.g., *Dickinson*, 275 N.E.2d at 600-02. The same approach was taken with tort suits for prenatal injury and wrongful death, and inheritance proceedings. See *id.* (citing *Robbins v. State*, 8 Ohio St. 131 (1857)); see also *Keeler*, 470 P.2d at 627 (citing *State v. McKee*, 1 Add. 1 (Pa. 1797)); see also *Tucker v. Carmichael & Sons, Inc.*, 65 S.E.2d 909, 910 (Ga. 1951) (citing Blackstone's Commentary on the Laws of England and the common law rule that an infant "in the mother's womb . . . is capable of having a legacy . . . made to it."). See generally *Remy v. MacDonald*, 801 N.E.2d 260 (Mass. 2004) (discussing common law cases permitting a born child to sue a third party for causing prenatal injuries and the Massachusetts wrongful death statute's applicability to a viable stillborn fetus).

122. See Deborah Tuerkheimer, *Conceptualizing Violence Against Pregnant Women*, 81 IND. L. J. 667, 694-97 (2006).

123. *Id.* at 669, 677-85.

124. See ARIZ. REV. STAT. § 13-1103(A)(5) (2006); CAL. PENAL CODE § 187(a) (West 2006); FLA. STAT. ANN. §§ 782.071, 782.09 (West 2006); 720 ILL. COMP. STAT. ANN. 5/9-1.2, 5/9-2.1, 5/9-3.2 (West 2006); MINN. STAT. ANN. §§ 609.266, 609.2661-65 (West 2006); MISS. CODE ANN. § 97-3-37 (West 2006); MO. ANN. STAT. §§ 1.205, 565.024, 565.020 (West 2006); NEV. REV. STAT. ANN. § 200.210 (West 2006); N.Y. PENAL LAW § 125.00 (McKinney 2006); N.D. CENT. CODE §§ 12.1-01-04, 17.1-01-04 (2006); OHIO REV. CODE ANN. §§ 2903.01-2903.07, 2903.09 (West 2006); 18 PA. CONS. STAT. ANN. § 2601-09 (West 2006); S.D. CODIFIED LAWS §§ 22-16-1, 22-16-15, 22-16-20, 22-16-41 (2006) (including definitions: 22-1-2(31), 22-1-(50A)); TENN. CODE ANN. §§ 39-13-201, 39-13-202, 39-13-210 (amended 2006), 39-13-211, 39-13-213 to 215 (West 2006); UTAH CODE ANN. § 76-5-201 (West 2006); VA. CODE ANN. § 18.2-31 (West 2006); WASH. REV. CODE ANN. § 9A.32.060(1)(b) (West 2006); WIS. STAT. ANN. §§ 939.75, 940.01-.02, 940.05-.06, 940.08-.10 (West 2006).

125. Pub. L. 108-212, 118 Stat. 568 (2004).

126. GA. CODE ANN. §§ 16-5-80, 40-6-393.1, 52-7-12.3 (West 2006); IND. CODE ANN. § 35-42-1-6 (West 2006); IOWA CODE ANN. § 707.8 (West 2006); KAN. STAT. ANN. § 21-3440 (West 2006); H. 108, 2004 Gen. Assem., Reg. Sess. (Ky. 2004); LA. REV. STAT. ANN. §§ 14:32.5-32.8 (2006); N.H. REV. STAT. ANN. §§ 631:1-631:2 (2006); N.M. STAT. ANN. § 30-3-7 (West 2006); N.C. GEN. STAT. ANN. § 14-18.2 (West 2006). In Virginia, killing a pregnant woman with the intent to terminate her pregnancy is capital murder. VA. CODE ANN. § 18.2-31 (West 2006).

127. See, e.g., *Commonwealth v. Morris*, 142 S.W.3d 654 (Ky. 2004) (holding that born alive rule should be eliminated through a reinterpretation of the term "human being"); *Hughes v. State*, 868 P.2d 730 (Okla. Crim. App. 1994) (holding in a vehicular manslaughter case that born alive rule should be abandoned, but only prospectively); *Commonwealth v. Cass*, 467 N.E.2d 1324, 1326-27 (Mass. 1984) (holding that a viable fetus is a "person" within the meaning of the vehicular homicide statute, but applying it prospectively only "in order to ensure fairness to the defendant and . . . [others] who did not have the benefit of the warning provided by our construction").



careful to apply its rule prospectively only, recognizing the due process "legality" problem that would arise if a court were to change the common law and apply it to the case before it.<sup>128</sup>

### C. Regulatory Redefinition: SCHIP—Turning the Fetus into a Child

At the same time that criminal initiatives which treat the fetus as a legally separate person have increased, the Bush Administration has adopted regulatory policies with the same goal. In 2002, the Department of Health and Services (HHS) promulgated a regulation purporting to "clarify and expand"<sup>129</sup> the definition of "child" under the State Child Health Insurance Program<sup>130</sup> by redefining "child" from "an individual under 19 years of age"<sup>131</sup> to "an individual under the age of 19 including the period from conception to birth."<sup>132</sup> The Bush Administration offered two justifications for this change. The first was to promote the birth of healthy children by expanding government coverage of prenatal care, fetal surgery, and other medical interventions which it asserted would provide "continuity of care," benefit children after birth, and ultimately save the SCHIP program money.<sup>133</sup> The second goal was to maximize states' "regulatory flexibility,"<sup>134</sup> permitting them to cover "unborn children," including those of immigrant women, who would otherwise be excluded from federal health care programs under the provisions of the

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128. See, e.g., *Morris*, 142 S.W.3d at 654; see also *Hughes*, 868 P.2d at 730; see also *Cass*, 467 N.E.2d at 1326-27.

129. State Children's Health Insurance Program; Eligibility for Prenatal Care for Unborn Children, 67 Fed. Reg. 9936, 9937 (proposed Mar. 5, 2002) (to be codified at 42 C.F.R. 457) [hereinafter SCHIP Proposed Rule].

130. The State Children's Health Insurance Program, or SCHIP, as it is popularly known, is a joint federal state program which, for ten years beginning in 1997, provides coverage for many poor children whose parents earn too much money to qualify for Medicaid. See 42 U.S.C. §§ 1397aa-jj. SCHIP is authorized under Title XXI of the Social Security Act, 42 U.S.C. 1397aa-jj. Many applaud SCHIP because it gives as an expansion of health care services for poor children and does so by providing states with 70% of its costs. See HHS News, *States May Provide SCHIP Coverage for Prenatal Care, New Rule to Expand Health Care Coverage for Babies, Mothers*, Sept. 27, 2002, available at [www.hhs.gov/news](http://www.hhs.gov/news) [hereinafter HHS News]. However, SCHIP is also frequently criticized as providing a much more meager package of health benefits than Medicaid, particularly those comprehensive Early and Periodic Screening Diagnostic and Treatment (EPSTD) benefits that are especially important for children with disabilities. See, e.g., Rosenbaum, Markus & Sonosky, *supra* note 29, at 1, 3-12. Medicaid and SCHIP are both faulted, for having administrative barriers that make it difficult for enrollees to maintain eligibility. See *id.* at 10; Wendy Chavkin & Paul H. Wise, *The Data Are In: Health Matters in Welfare Policy*, 92 AM J. PUB. HEALTH 1392, 1393-94 (2002).

131. Section 2110 of SCHIP; 42 U.S.C. 1397jj(c)(1) (2006) (defining "child" as "an individual under 19 years of age").

132. State Children's Health Insurance Program; Eligibility for Prenatal Care and Other Health Services for Unborn Children, 67 Fed. Reg. 61956 (Oct. 2, 2002) (to be codified at 42 C.F.R. 457) (discussing the procedural history of the regulation, which was subsequently codified at 42 C.F.R. § 457.10) [hereinafter SCHIP Final Rule].

133. SCHIP Proposed Rule, *supra* note 129, at 9937.

134. This "state choice" mantra was evident throughout the Federal Register notice promulgating the final regulations, with the Department of Health and Services reiterating its view "that States should have the option to include unborn children as eligible targeted low income children. We are therefore retaining a revised definition [of child] . . . that permits States maximum flexibility in extending SCHIP eligibility." SCHIP Final Rule, *supra* note 132, at 61960.

Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA).<sup>135</sup>

Critics of the proposed regulation responded with several arguments. First, the most fundamental objection to the new SCHIP regulations was that they constituted an *ultra vires* action by HHS, since nothing in the SCHIP statute or its legislative history suggested that Congress intended “child” to have anything other than its common, everyday meaning, as one who had been born. Critics noted that Congress knew how to use the term “unborn child,” as it had in the Medicare and Medicaid statutes, and that all the services covered under SCHIP, such as “well-baby and well-child care,” were manifestly applicable only to born children.<sup>136</sup> Critics asserted that Congressional silence about “unborn children” in enacting SCHIP meant that Congress had not intended them to be covered by the SCHIP program.<sup>137</sup> HHS responded that the silence meant only that Congress had not “directly spoke[n] to . . . whether the term ‘child’ could include unborn children.”<sup>138</sup>

Second, critics noted that when the regulations were proposed, a bipartisan coalition in Congress was already working to amend SCHIP to provide prenatal and postpartum care to pregnant women. The critics asserted that the regulatory change to include “unborn children” was unnecessary if in truth HHS’ goal was simply to provide the needed care.<sup>139</sup>

Third, many objected to the regulation’s blatant politicization of maternal and children’s health.<sup>140</sup> By adopting a definition of “child” which was *not* in the statute and *was* inconsistent with long-standing Supreme Court precedent that a fetus was not a child,<sup>141</sup> the HHS regula-

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135. Personal Responsibility and Work Opportunity Reconciliation Act of 1996, Pub. Law No. 104-193 (codified at 42 U.S.C. §§ 601-19).

136. SCHIP Final Rule, *supra* note 132, at 61961-62.

137. *See id.* at 61962.

138. *Id.*

139. Cynthia Dailard, *New SCHIP Prenatal Care Rule Advances Fetal Rights At Low-Income Women’s Expense*, THE GUTTMACHER REPORT ON PUBLIC POLICY, Dec. 2002, at 3. Among the bills pending were the Mothers and Newborns Health Insurance Act of 2001, S. 724, 107th Cong. (2002); the Start Healthy/Stay Healthy Act of 2001, S. 1016, 107th Cong. (2001) and the Start Healthy/Stay Healthy Act of 2001, H.R. 3729, 107th Cong. (2002); the Immigrant Children’s Health Improvement Act of 2001, S. 582, 107th Cong. (2001) and the Legal Immigrant Children’s Health Improvement Act of 2001, H.R. 1143, 107th Cong. (2001), all of which proposed to amend Medicaid and SCHIP to permit states to offer health care to more infants and pregnant women, including immigrant women who were excluded from eligibility under the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, 42 U.S.C. §§601 *et seq.*

140. SCHIP Final Rule, *supra* note 132, at 61957; Editorial, *A Cynical Political Act*, WASH. POST, Feb. 3, 2002, at B06; AMERICAN CIVIL LIBERTIES UNION, COMMENTS ON STATE CHILDREN’S HEALTH PROGRAM: ELIGIBILITY FOR PRENATAL CARE FOR UNBORN CHILDREN, May 6, 2002, <http://www.aclu.org/reproductiverights/fetalrights/16400leg20020506.html> [hereinafter ACLU COMMENTS]; Dailard, *supra* note 139, at 5.

141. In *Roe v. Wade*, the Court held that the fetus was not a person within the meaning of the Fourteenth Amendment. 410 U.S. 113, 158 (1973). In *Burns v. Alcala*, the Court held, in a case challenging the denial of welfare benefits to pregnant women under the Aid to Families with De-

tions were part of a strategy to undermine access to abortion.<sup>142</sup> It surely was not coincidental that HHS Secretary Tommy Thompson announced the new regulations at the Conservative Political Action Committee Conference, touting the Bush Administration's "commitment to the unborn."<sup>143</sup>

Fourth, critics charged that the regulations violated the First Amendment in imposing a particular theological viewpoint on the American public, i.e., that life begins at conception.<sup>144</sup> The critics asserted that poor pregnant women who did not believe that a fetus was a child would be forced to choose between acting in conformity with their beliefs and accepting a government benefit enshrining a different religious belief, and that this violated the Supreme Court's Free Exercise of Religion cases.<sup>145</sup> HHS rejected this concern, stating that "[i]f a woman has a religious objection, she simply would not accept SCHIP benefits,"<sup>146</sup> ignoring the reality that many poor women need these health care services.

Fifth, critics contended that the regulation was bad health policy, as it provided continuity of care for the fetus but not for the woman, who would not be entitled to post-partum care because it was her "child," and not she, who was the patient under SCHIP.<sup>147</sup> Not only did this devalue women by treating them as mere "vessels" for the fetus, but the regula-

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pendent Children (AFDC) program, that pregnant women were not entitled to receive AFDC benefits because "dependent child" does not include an unborn child. 420 U.S. 575, 580 (1975). The *Burns* court stated:

Following the axiom that words used in a statute are to be given their ordinary meaning in the absence of persuasive reasons to the contrary . . . and reading the definition "dependent child" in its statutory context, we conclude that Congress used the word "child" to refer to an individual already born, with an existence separate from its mother.

*Id.* at 580-81.

142. See Elisabeth H. Sperow, *Redefining Child Under the State Children's Health Insurance Program: Capable of Repetition, Yet Evading Results*, 12 AM. U. J. GENDER SOC. POL'Y & L. 137, 143-44 (2003).

143. *Id.* at 156-57 (citing Tommy G. Thompson, Sec'y Health & Human Servs., Compassionate Conservatism and Health Care Policy, Remarks at the Conservative Political Action Committee Conference (Jan. 31, 2002) (transcript available at <http://www.hhs.gov/news/speech/2002>)).

144. SCHIP Final Rule, *supra* note 132, at 61963.

145. *Id.* In *Sherbert v. Verner*, 374 U.S. 398 (1963), the Supreme Court held that a state could not deny unemployment insurance benefits to a person fired for refusing to work on her Sabbath without running afoul of the First Amendment's guarantee of the free exercise of religion. *Id.* at 410. This ruling has been undercut to some extent by the Court's decision in *Employment Div. of Oregon v. Smith*, 494 U.S. 872, 878-79 890, which held that Oregon could deny unemployment benefits on the ground of work-related misconduct, when Smith, a drug counselor, used peyote (a controlled substance whose use was prohibited by Oregon criminal law) during a Native American Church ceremony.

146. SCHIP Final Rule, *supra* note 132, at 61963. However, in *Sherbert*, the Supreme Court emphasized that the exercise of religious freedom could not be predicated on a right/privilege distinction. 374 U.S. at 404-05 (citing *American Commc'ns Ass'n v. Douds*, 339 U.S. 382, 390 (1950); *Speiser v. Randall*, 357 U.S. 513 (1958)).

147. SCHIP Final Rule, *supra* note 132, at 61960, 61967-70. Further, as HHS conceded, although covering the "unborn child" meant continuity of coverage after birth, this did not change the state's normal "redetermination of eligibility" period, which could, depending on state rules, fall shortly after the child was born. See *id.* at 61964.

tion was also contrary to accepted medical practice and counter-productive for the newly born child, who depended on care from a healthy mother.<sup>148</sup> These critics noted that a wide range of medical conditions could affect the mother without directly affecting her fetus or newborn,<sup>149</sup> and that these might not be covered under the HHS regulation.<sup>150</sup> HHS conceded the point, declaring that “care after delivery, such as postpartum services could not be covered as part of the Title XXI [SCHIP] State Plan, . . . because they are not services for an eligible child.”<sup>151</sup> Further, HHS informed state SCHIP administrators that states could cover “at least one postnatal visit” only if they used a “bundled fee payment” or “global fee method” in paying for pregnancy and delivery services.<sup>152</sup> Since only twenty-eight states use this billing method, there was concern that many new mothers would have serious gaps in their health care.<sup>153</sup> There were also fears that some health care providers would choose not to treat pregnant women under SCHIP at all, to avoid the ethical and malpractice issues raised by having the fetus, and not the woman, as their patient.<sup>154</sup>

The sixth concern was that the SCHIP change would not deliver more care to pregnant immigrant women.<sup>155</sup> Commentators asserted that because the new regulation did not exempt the states from their reporting obligations to the Immigration and Naturalization Service, many immigrant women would still be afraid to request services.<sup>156</sup>

148. *Id.* at 61968-70; *see also Impact on Infant and Maternal Mortality: Hearings on Uninsured Pregnant Women Before the S. Comm. on Health, Education, Labor & Pensions*, 107th Cong. 747 (2002) (statement of Senator Jeff Bingaman); *see also* ACLU COMMENTS, *supra* note 140.

149. These included “breast masses, influenza . . . vaccination, . . . peptic ulcer disease, . . . postpartum treatment of hemorrhage, infection, episiotomy repair, and postpartum depression.” MARCH OF DIMES COMMENTS ON PROPOSED RULE TO REDEFINE CHILD UNDER SCHIP, May 6, 2002, <http://www.marchofdimes.com> (use search function).

150. *See, e.g., id.*

151. SCHIP Final Rule, *supra* note 132, at 61969.

152. Letter from Dennis G. Smith, Dir., Center for Medicaid and State Operations of Centers for Medicare and Medicaid Services, to State Health Officials (Nov. 12, 2002) (on file with author).

153. Dailard, *supra* note 139, at 5.

154. *Id.* at 4.

155. HHS asserted that “the new regulation makes sure that all low-income immigrants have access to important prenatal care for their babies.” HHS News, *supra* note 130.

156. Dailard, *supra* note 139, at 5; SCHIP Final Rule, *supra* note 132, at 61965-66. Many immigrants continue to be deterred from seeking government supported health care for which they and/or their children are eligible, due to confusion about eligibility requirements and fear that health care providers or government insurance programs will report illegal immigrants to the federal enforcement authorities. *See* URBAN INSTITUTE, IMMIGRANT FAMILIES AND WORKERS, THE HEALTH AND WELL-BEING OF YOUNG CHILDREN OF IMMIGRANTS, Brief No. 5, Feb. 2005, at 3, *available at* <http://www.urban.org/publications/310584.html>; KAISER COMMISSION ON MEDICAID AND THE UNINSURED, IMMIGRANTS’ HEALTH CARE COVERAGE AND ACCESS, Aug. 2003, at 2, *available at* <http://www.kff.org/medicaid/2241-index.cfm>; NATIONAL IMMIGRATION LAW CENTER, IMMIGRATION-FRIENDLY HEALTH COVERAGE OUTREACH AND ENROLLMENT, June 2002, at 1, *available at* [http://www.nilc.org/immspbs/health/Issue\\_Briefs/Immigrant-Friendly\\_App\\_Enrllmnt.PDF](http://www.nilc.org/immspbs/health/Issue_Briefs/Immigrant-Friendly_App_Enrllmnt.PDF). Indeed, some legal immigrants are denied care; *see also* Julia Preston, *Texas Hospitals’ Separate Paths Reflect the Debate on Immigration*, N.Y. TIMES, July 18, 2006, at A1, A18. When the SCHIP rule was proposed, and the final rule promulgated, enforcement authority was held in the Immigration and Naturalization Service. On November 25, 2002 President Bush signed the Home-

Finally, critics argued that justifying the regulation as a means of expanding health care access<sup>157</sup> was disingenuous and contrary to the fiscal structure of SCHIP. Because the regulation did not (and could not) authorize additional funding for SCHIP, it could not lead to any more health care being delivered.<sup>158</sup> Further, because SCHIP is optional both with regard to states' decision to participate and the range of services they offer,<sup>159</sup> states had no incentive to add "unborn children" to their programs. In practice, these predictions have been fulfilled. Only nine states decided to cover "unborn children" under SCHIP,<sup>160</sup> and one of these—Rhode Island—had already included pregnant women under an HHS-approved waiver.<sup>161</sup> Because total SCHIP funds are capped, and many states are struggling to handle mounting Medicaid and SCHIP costs in a time of budget shortfalls,<sup>162</sup> they are unlikely to expand SCHIP programs.<sup>163</sup> Indeed, many states have been cutting or redesigning SCHIP to limit costs.

#### *D. Compelled Medical Treatment, Civil Commitment, and Fetal Guardianships*

In recent years, other efforts to "protect" fetuses from their mothers' actions during pregnancy have increased,<sup>164</sup> limiting women's autonomy to make medical decisions for themselves. Two-thirds of states either preclude or limit the enforcement of a woman's previously expressed wishes about foregoing medical treatment from being implemented while she is pregnant.<sup>165</sup> In addition, many states authorize the civil commit-

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land Security Act of 2002, Pub. L. No. 107-296, 116 Stat. 2135, which transferred immigration enforcement authority to the Directorate of Border and Transportation Security, within the Department of Homeland Security.

157. HHS News, *supra* note 130.

158. ACLU COMMENTS, *supra* note 140; *see also* KAISER COMMISSION ON MEDICAID AND THE UNINSURED, ASSESSING THE ROLE OF RECENT WAIVERS IN PROVIDING NEW COVERAGE, Dec. 2003, at iii, *available at* <http://www.kff.org/medicaid/4158.cfm> [hereinafter KAISER, ASSESSING WAIVERS] (noting that SCHIP funds are capped nationally, and that "[n]ot all states have available funds to redirect toward coverage").

159. Rosenbaum, Markus & Sonosky, *supra* note 29, at 1, 17-21.

160. KAISER COMMISSION ON MEDICAID AND THE UNINSURED, IN A TIME OF GROWING NEED: STATE CHOICES INFLUENCE HEALTH COVERAGE ACCESS FOR CHILDREN AND FAMILIES, Oct. 2005, at 19, *available at* <http://www.kff.org/medicaid/7393.cfm> [hereinafter KAISER, IN A TIME OF GROWING NEED].

161. HHS News, *supra* note 130 (noting that Rhode Island, Colorado and New Jersey had previously obtained waivers to include pregnant women in their SCHIP programs).

162. KAISER, ASSESSING WAIVERS, *supra* note 158, at iv (observing that Medicaid and SCHIP enrollment grew by about 3.2 million people in 2002, largely "because more people became eligible for Medicaid due to the downturn in the economy").

163. Many states have cut or redesigned their SCHIP programs to limit costs. JOHN HOLAHAN ET AL., STATE RESPONSES TO 2004 BUDGET CRISES: A LOOK AT TEN STATES, URBAN INSTITUTE, Feb. 2004, at 1-2, 7-8, *available at* [http://www.urban.org/UploadedPDF/410946\\_StateBudgetCrises.pdf](http://www.urban.org/UploadedPDF/410946_StateBudgetCrises.pdf); IAN HILL, HOLLY STOCKDALE & BRIGETTE COURTOT, SQUEEZING SCHIP: STATES USE FLEXIBILITY TO RESPOND TO THE ONGOING BUDGET CRISIS, URBAN INSTITUTE, June 2004, at 1-2, *available at* <http://www.urban.org/url.cfm?ID=311015>.

164. *See generally* Jerdee, *supra* note 4.

165. *See generally id.*

ment of pregnant women for substance abuse treatment,<sup>166</sup> as well as court orders that compel women to accept medical attendants at labor and delivery, or mandate particular forms of care such as Caesarean sections.

### 1. The Pregnancy Exception from Advanced Medical Directives

Women have regularly been denied the right to self-determination and bodily integrity by state laws that, in the name of “fetal protection,” automatically invalidate advance health care directives when a woman is pregnant. Advance directives are widely seen as an important and binding vehicle that enable competent individuals to indicate the kinds of health care treatment they want should they become terminally ill, suffer a stroke or other neurological injury, or are in a persistent vegetative state, and, due to mental incapacity, can no longer make treatment decisions.<sup>167</sup> Advance directives are particularly important for women, because of judicial gender bias in many cases in which men, but not women, have been deemed strong, self-reliant, and courageous enough to choose death rather than a lifetime spent in a persistent vegetative state or other mentally compromised condition.<sup>168</sup>

Yet two-thirds of states either limit absolutely or make it more difficult to enforce women’s advance directives when they become pregnant. Seventeen states provide statutory exceptions to their “living will” or health care proxy statutes which render advance directions automatically ineffective if the patient is pregnant.<sup>169</sup> Another sixteen states render the living will or health care proxy inapplicable in a variety of circumstances, ranging from a possibility to a probability that the fetus will “develop to a live birth.”<sup>170</sup> Minnesota gives a slight bow to women’s autonomy by establishing a rebuttable presumption that a pregnant woman would want health care to be provided if there is a “real possibility [that] . . . the fetus could survive to the point of life birth,” even if “the withholding or withdrawal of such health care would be authorized were she not pregnant.”<sup>171</sup> The presumption can be rebutted by an ex-

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166. See, e.g., WIS. STAT. §§ 48.205 (2006) (permitting the civil commitment of pregnant girls and women, dubbed “The Cocaine Mom law”); see also Tom Kertscher, ‘Cocaine Mom’ Law Invoked in Attempt to Detain Woman, *Racine Case Thought to Be First Time Law is Used Without Other Crime*, MILWAUKEE JOURNAL SENTINEL, Nov. 5, 1999, at 1.

167. See Linda C. Fentiman, *Privacy and Personhood Revisited: Substitute Decisionmaking for the Incompetent Incurably Ill Adult*, 57 GEO. WASH. L. REV. 801, 818-828 (1989) (discussing living wills and documents designating a medical treatment agent); see also BARRY R. FURROW ET AL., *supra* note 29, at 842.

168. See generally Steven H. Miles & Allison August, *Courts, Gender, and “The Right to Die,”* 18 L. MED. & HEALTH CARE 85 (1990).

169. Jerdee, *supra* note 4, at 978 n.35.

170. *Id.* at 978-79 nn.36-44. The Alaska statute cited in n.37, ALASKA STAT § 18.12.040, was repealed in 2004.

171. The Minnesota law states in pertinent part:

When a patient lacks decision-making capacity and is pregnant, and in reasonable Medical judgment there is a real possibility that if health care to sustain her life and the life of

PLICIT statement to the contrary in the advance directive itself, or by clear and convincing evidence presented at a hearing.<sup>172</sup> While Minnesota's law endeavors to strike a balance between the woman's interest in autonomy and the provision of a living maternal body in which the fetus can continue to develop, it still enshrines a normative view of women—that any "reasonable" woman would choose to continue on life-support if it meant that her fetus would survive until birth.

The potential impact of these statutes is substantial. In *University Health Services v. Piazzi*,<sup>173</sup> a Georgia trial court granted a hospital's petition to continue life support for a brain-dead pregnant woman over the objections of the woman's husband and other family members,<sup>174</sup> so that a fetus could be delivered. Although Ms. Piazzi had not executed an advance directive, the court reached out to decide the case based on the Georgia Natural Death Act, which rendered a pregnant woman's advance directive inoperable if the fetus was viable.<sup>175</sup> The court declared that because Ms. Piazzi was brain dead, she no longer had a constitutionally protected right to privacy,<sup>176</sup> but implied that even if she did, any interest she had would be rendered irrelevant by the Georgia living will statute.<sup>177</sup>

In contrast to the *Piazzi* court's expansive interpretation, two other courts have rebuffed constitutional challenges to state advance directive statutes, dismissing the cases for lack of justiciability. In *DiNino v. Gorton*,<sup>178</sup> a woman alleged that the Washington Model Health Care Directive Act was unconstitutional because it made advance directives ineffective during pregnancy.<sup>179</sup> DiNino drafted an advance directive contrary to Washington law, and her physician refused to place it in her medical file, asserting fears of potential liability.<sup>180</sup> DeNino sought a declaratory judgment that her advance directive was valid and enforce-

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the fetus is provided the fetus could survive to the point of live birth, the health care provider shall presume that the patient would have wanted such health care to be provided, even if the withholding or withdrawal of such health care would be authorized were she not pregnant. This presumption is negated by health care directive provisions described in section 145C.05, subdivision 2, paragraph (a), clause (10), that are to the contrary, or, in the absence of such provisions, by clear and convincing evidence that the patient's wishes, while competent, were to the contrary.

MINN. STAT. § 145C.10 (g) (2006).

172. *Id.*

173. This unreported case, No. CV86-RCCV-464, was cited in Daniel Sperling, *Maternal Brain Death*, 30 AM. J. L. & MED. 453, 494-95 (2004) and Molly C. Dyke, *A Matter of Life and Death: Pregnancy Clauses in Living Will Statutes*, 70 B.U. L. REV. 867, 871-72 (1990).

174. Daniel Sperling, *Panel Discussion American Association of Law Schools Panel: Panel on the Use of Patients for Teaching Purposes Without Their Knowledge or Consent: Article: Do Pregnant Women Have (Living) Will?*, 8 J. HEALTH CARE L. & POL'Y 331, 336 (2005).

175. GA. CODE ANN. § 31-32-3(b) (2006).

176. Sperling, *supra* note 173, at 336-37.

177. *Id.* at 337.

178. 684 P.2d 1297 (Wash. 1984) (en banc).

179. *DiNino*, 684 P.2d at 1299.

180. *Id.* at 1298-99.

able, and that her physician would not be held liable if he acted in accordance with its provisions. In the alternative, she argued the statute violated her Fourteenth Amendment rights to privacy, which encompassed her right to seek abortion and to forego medical treatment.<sup>181</sup> Her suit was dismissed as presenting a “purely hypothetical and speculative controversy.”<sup>182</sup> In *Gabrynowicz v. Heitkamp*,<sup>183</sup> the plaintiffs challenged the constitutionality of two North Dakota statutes which rendered a woman’s advance directive inoperable while she was pregnant, and further mandated that pregnant women receive medical treatment to permit the “continuing development and live birth of the unborn child.”<sup>184</sup> While the United States District Court for North Dakota acknowledged the statutes’ potential constitutional problems, it ruled that because the plaintiff was neither pregnant nor in a terminal condition, her case was non-justiciable.<sup>185</sup> What both *DiNino* and *Gabrynowicz* overlook, of course, is that the entire point of a living will or advance directive statute is to permit competent adults to announce their wishes for treatment prior to becoming incapacitated, when they are able to think through their choices. Denying a woman the opportunity to bring a constitutional challenge while healthy and non-pregnant will mean, in practical terms, that she will never be able to challenge the law.

## 2. Civil Commitment for Substance Abuse and Other Treatment

Thirty-four states and the District of Columbia currently permit pregnant women to be civilly committed for alcohol and other drug abuse.<sup>186</sup> Most of these state statutes address substance abuse in the same way that statutes authorize the civil commitment of the mentally ill when the mental illness poses danger to “self or others.”<sup>187</sup> Three states’ statutes specifically target pregnant women.<sup>188</sup> For example, the Minnesota statute requires physicians to report pregnant patients’ use of alcohol and controlled substances during pregnancy and mandates toxicology

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181. *Id.* at 1299.

182. *Id.* at 1300.

183. 904 F. Supp. 1061 (N.D. 1995).

184. *Gabrynowicz*, 904 F. Supp. at 1062. One of the statutes being challenged stated: Notwithstanding a declaration executed under this chapter, medical treatment must be provided to a pregnant patient with a terminal condition unless . . . such medical treatment will not maintain the patient in such a way as to permit the continuing development and live birth of the unborn child or will be physically harmful or unreasonably painful to the patient or will prolong severe pain that cannot be alleviated by medication.

N. D. CENT. CODE § 23-06.4-07(3) (repealed 2005)

185. *Gabrynowicz*, 904 F. Supp. at 1063-64.

186. *See supra* note 37 and statutes cited therein.

187. *See, e.g.*, IOWA CODE § 125.81 (2005) (authorizing the immediate custody of a chronic substance abuser, defined in § 125.2 (2005) as a person who “[h]abitually lacks self control as to the use of chemical substances to the extent that the person is likely to endanger the person’s health, or to physically injure the person’s self or others, if allowed to remain at liberty without treatment” and “[i]acks sufficient judgment to make responsible decisions with respect to the person’s hospitalization or treatment”).

188. MINN. STAT. § 626.5561-63 (2005); OKL. STAT. tit. 63 § 1-546.5 (2005); S.D. CODIFIED LAWS § 34-20A-70 (2006).



testing of mothers and newborns shortly after delivery if there is reason to believe that a mother has used controlled substances.<sup>189</sup> At least one other state, Wisconsin, has amended its child abuse law to permit the involuntary commitment of pregnant women who are abusing alcohol or controlled substances throughout pregnancy to the extent constitutionally permissible.<sup>190</sup>

The Wisconsin law, popularly dubbed the "Cocaine Mom Bill," was a reaction to the Wisconsin Supreme Court's decision in *State ex rel. Angela M.W. v. Kruicki*.<sup>191</sup> When Angela M.W. was pregnant, her physician reported her to child welfare authorities after she tested positive for drugs and failed to show up for an appointment.<sup>192</sup> The court held that Ms. M.W. could not be compelled to participate in in-patient drug treatment through a "child custody" proceeding, concluding that the legislature had not intended the term "child" in the child neglect statute to include children not yet born.<sup>193</sup>

The Arkansas Supreme Court relied on *Angela M.W.* in *Arkansas Dep't of Human Services v. Collier*,<sup>194</sup> a case which challenged a family court judge's authority to declare that the fetus of a pregnant woman who was using methamphetamines was a dependent-neglected child.<sup>195</sup> Acting *sua sponte*, the trial judge ordered the "child" to be taken into custody, by holding the woman at a county detention center until she went into labor.<sup>196</sup> The Arkansas Supreme Court held that the judge's actions exceeded her statutory authority.<sup>197</sup>

In sharp contrast to these two decisions, in 2000 a Massachusetts family court judge ordered the involuntary medical treatment of Rebecca Corneau, a pregnant woman who rejected all medical care and was suspected of membership in a religious cult that denied children adequate nutrition and medical care.<sup>198</sup> The court ordered Ms. Corneau to be taken to a prison hospital and compelled to submit to a medical examination to determine her health, pregnancy status, and the anticipated birth date of her "unborn child," so that the court could determine what prena-

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189. MINN. STAT. § 626.5561 (2005).

190. WIS. STAT. § 48.01(1) (2006).

191. 561 N.W.2d 729 (Wis. 1997).

192. *State ex rel. Angela M.W.*, 561 N.W.2d at 732-33.

193. *Id.* at 737.

194. 95 S.W.3d 772 (2003).

195. *Collier*, 95 S.W.3d at 773.

196. *Id.* at 773; see also *Bennett v. Collier*, 95 S.W.3d 782, 785 (2003) (holding in a related civil contempt proceeding that the trial judge lacked authority to hold the pregnant woman in contempt of court once the judge terminated her parental rights in a different case).

197. *Collier*, 95 S.W.3d at 781 (rejecting arguments that the term "child" in the child neglect statute should be construed to include a fetus even though other areas of Arkansas law authorized actions to be brought on behalf of a fetus).

198. Dave Wedge & Edwin Molina, *Experts: Ruling May Just Open Up Floodgates*, BOSTON HERALD, Sept. 1, 2000, at 4.

tal treatment should be ordered.<sup>199</sup> Ms. Corneau did not appeal the judge's ruling and she was imprisoned until after her child's birth, when the child was declared neglected and Corneau's parental rights were terminated.<sup>200</sup>

### 3. Compelled Caesarean Sections

Women continue to be forced to have Caesarean sections over their objections.<sup>201</sup> In *Jefferson v. Griffin Spaulding County Hospital*,<sup>202</sup> the Supreme Court of Georgia upheld a trial judge's decision to order a woman who was close to her delivery date to undergo a Caesarean section, based on hospital physicians' concern that because the fetus was in a breech position, it was likely to die in childbirth.<sup>203</sup> The court rejected Ms. Jefferson's religious objections to the procedure, but before the order could be enforced, she gave birth to a healthy child.<sup>204</sup> In the landmark case of *In re A.C.*,<sup>205</sup> the District of Columbia Court of Appeals took a different view, declaring that pregnant women had the right to control their medical treatment, even when it could affect the health of the fetus.<sup>206</sup> The court stated, "[s]urely, . . . a fetus cannot have rights in this respect superior to those of a person who has already been born."<sup>207</sup>

In 1996, a Florida trial court held an *ex parte* hearing concerning Laura Pemberton, a pregnant woman who refused medical advice to deliver by Caesarean section because it was feared that her previous cae-

199. See *Barbara F. v. Bristol Div. of Juvenile Court*, 735 N.E. 2d 357 (Mass. 2000) (discussing the juvenile court's order in the course of rejecting a challenge to that court's decision brought by another pregnant woman, who asserted that the juvenile court's order had a chilling effect on her own conduct). See also *Wedge & Molina*, *supra* note 198, at 4; Dave Wedge, *Appeal Cites Abortion Ruling in Bid to Free Pregnant Cultist*, BOSTON HERALD, Sept. 6, 2000, at 10; Michael Paulson, *Fetus Dispute Brings Wider Issues to Fore*, BOSTON GLOBE, Sept. 10, 2000, at B5; Miller, *supra* note 34, at 71-74.

200. Miller, *supra* note 34, at 73-74 nn. 31 & 34.

201. For illuminating analyses of the issues raised by these cases, see Nancy K. Rhoden, *The Judge in the Delivery Room: The Emergence of Court-Ordered Cesareans*, 74 CAL. L. REV. 1951 (1986); Roberts, *Punishing Addicts Who Have Babies*, *supra* note 9, at 964. Women of color have borne the brunt of these interventions. *Id.* at 939.

202. 274 S.E.2d 457 (Ga. 1981).

203. *Jefferson*, 274 S.E.2d at 458.

204. *Id.* at 459. See also Alicia Ouellette, *New Medical Technology: A Chance to Reexamine Court-Ordered Medical Procedures During Pregnancy*, 57 ALB. L. REV. 927, 940 (1994).

205. 573 A.2d 1235 (D.C. 1990).

206. See *In re A.C.*, 573 A.2d at 1252.

207. *Id.* at 1244. The case arose out of tragic circumstances. In 1987, Angela Carder, a twenty-seven year old woman who had survived cancer as a teenager, became pregnant. At twenty-five weeks of pregnancy, she was found to be suffering from cancer again. *Id.* Her condition deteriorated rapidly, and at twenty-six weeks, she was hospitalized and expected to die shortly. When the hospital sought a court order to perform a Caesarean section, a trial court held a hearing, and ordered a Caesarean section to be performed. The baby died within two hours, and Carder died two days later. *Id.* at 1238. On appeal, the District of Columbia Court of Appeal declared first that the pregnant woman had the right to self-determination, which included the right to refuse a Caesarean section. The court further held that in cases such as this one, where it was difficult to ascertain the pregnant woman's wishes because she was close to death, under the influence of medication, and suffering extreme emotional distress, the trial court should undertake a substituted judgment analysis, so that it could decide what the patient would have chosen if she were competent. *Id.* at 1247-49.

sarean section put her at higher risk for uterine rupture.<sup>208</sup> The court ordered Ms. Pemberton to be transported to the hospital via ambulance against her will, and then continued the hearing in her presence, ultimately ordering the Caesarean section to be performed.<sup>209</sup> When Ms. Pemberton subsequently brought a section 1983 civil rights action an action in federal court, the court held that Ms. Pemberton's constitutional rights "did not outweigh Florida's interest in preserving the life of the unborn child."<sup>210</sup>

In a less dramatic case, in 2004 a Pennsylvania woman, Amber Marlowe, who had previously given birth to six children, each weighing more than eleven pounds, went to deliver her seventh child, only to be told that the fetus was so large that it was not safe to deliver vaginally.<sup>211</sup> When Marlowe declined the hospital's advice to have a Caesarean section, the hospital obtained an *ex parte* order compelling her to have the surgery.<sup>212</sup> Marlowe and her husband did not learn of the order until after she had safely delivered her baby at another hospital.<sup>213</sup>

These court-ordered detentions and medical interventions are contrary to the prevailing view of medical professionals that medical treatment against the pregnant woman's wishes is rarely, if ever, appropriate.<sup>214</sup> The American College of Obstetrics and Gynecology (ACOG), for example, emphasizes that medical judgment is limited and fallible, that pregnant women do not lose their rights to autonomy merely by becoming pregnant, and, most importantly, that doctors who believe that a medical intervention will benefit the fetus and/or the mother should exhaust all possible avenues of explanation and persuasion before seeking a court order, including consultation with an institutional ethics committee.<sup>215</sup>

Significantly, medical groups recognize the need to view pregnant women's decisionmaking in its full social and economic context. ACOG alerts physicians to the risk that "clinicians' conclusions reinforce exist-

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208. *Pemberton v. Tallahassee Mem'l Reg'l Med. Ctr., Inc.*, 66 F. Supp. 2d 1247 (N.D. Fla. 1999). At the hearing, five physicians testified that the risk of uterine rupture during vaginal delivery was too high (from "four to six percent"), and that if there was rupture, the fetus was likely to die during delivery. *Pemberton*, 66 F. Supp. at 1252-53. Neither the state nor federal court addressed the question of informed consent, that is, who was entitled to make the fetal risk assessment. See generally *id.* at 1251-57 (discussing only the issues of substantive due process, procedural due process, professional negligence, and false imprisonment).

209. *Id.* at 1250.

210. *Id.* at 1251.

211. David Weiss, *Court Delivers Controversy, Mom Rejects C-Sections; Gives Birth on Own Terms*, TIMES LEADER Jan. 16, 2004; Associated Press, *New Questions about Childbirth Rights*, May 19, 2004, available at [http://keyetv.com/health/health\\_story\\_140110423.html](http://keyetv.com/health/health_story_140110423.html).

212. Weiss, *supra* note 211.

213. *Id.*

214. See AMERICAN MEDICAL ASSOCIATION, *supra* note 36; AMERICAN COLLEGE OF OBSTETRICS & GYNECOLOGY, *supra* note 36, at 35; American Academy of Pediatrics, *supra* note 36.

215. AMERICAN COLLEGE OF OBSTETRICS & GYNECOLOGY, *supra* note 36, at 34-35.

ing gender, class, or racial inequality.”<sup>216</sup> The American Medical Association (AMA) agrees that legal interventions during pregnancy are seldom, if ever, proper,<sup>217</sup> and emphatically rejects “criminal sanctions or civil liability” for pregnant women based on their conduct “toward [their] . . . fetus.”<sup>218</sup> Instead, the AMA endorses a comprehensive, long-term approach to substance abuse, to begin in adolescence and continue through pregnancy and beyond, in recognition of the fact that addiction to alcohol and other drugs is a disease.<sup>219</sup>

Many physicians believe that seeking judicial intervention to compel women to accept treatment during pregnancy is counter-productive, not only leading to a loss of trust in the health care system on the part of the particular woman who is the object of the intervention, but also deterring other women from seeking care.<sup>220</sup> This problem is compounded when women are forcibly restrained while an unwanted medical procedure is performed,<sup>221</sup> or when pregnant women are confined in prison hospitals, which often meet only the most minimal standards of health care and, at the same time, make it possible for a woman to have access to drugs.<sup>222</sup>

#### 4. Fetal Guardians

Another way that courts have separated pregnant women from their fetuses, undermining women’s right to self-determination, is through the appointment of fetal guardians. Sometimes such appointments are the means used to compel women to accept medical treatment to benefit the

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216. *Id.* at 35.

217. AMERICAN MEDICAL ASSOCIATION, *supra* note 36 (stating that a physician might seek judicial action to override a woman’s informed treatment refusal only “[i]f 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”).

218. *Id.*

219. AMERICAN MEDICAL ASSOCIATION, POLICY H-420.976: ALCOHOL AND OTHER SUBSTANCE ABUSE DURING PREGNANCY, *available at* <http://www.ama-assn.org/ama/noindex/category/11760.html> (click “accept”; search “420.976”); AMERICAN MEDICAL ASSOCIATION, POLICY H-95.976: DRUG ABUSE IN THE UNITED STATES – THE NEXT GENERATION, *available at* <http://www.ama-assn.org/ama/noindex/category/11760.html> (click “accept”; search “95.976”).

220. Helene Cole, *Legal Interventions During Pregnancy*, 264 J.A.M.A. 2663, 2667 (1990); AMERICAN COLLEGE OF OBSTETRICS & GYNECOLOGY, *supra* note 36, at 36. Similar concerns have been raised about mandatory maternal HIV testing in order to reduce maternal-fetal transmission of the virus. *See, e.g.*, Comm. on HIV Prenatal/Newborn Testing, *Prenatal/Newborn HIV Testing*, 49 THE RECORD OF THE ASS’N OF THE BAR OF THE CITY OF NEW YORK 420 (1994).

221. *See, e.g.*, *In re Fetus Brown*, 689 N.E.2d 397, 400 (Ill. App. 1997) (reversing a trial court’s decision to appoint a hospital the “temporary custodian of Fetus Brown, with the right to consent to one or more blood transfusions for [his mother] when advised of such necessity by any attending physician”).

222. Cole, *supra* note 220.

fetus.<sup>223</sup> More frequently, they are a direct challenge to a pregnant woman's right to have an abortion.<sup>224</sup>

In Alabama, trial judges have appointed fetal "guardians" as part of their procedures for determining whether pregnant teenagers can obtain an abortion without parental consent, a practice whose legality the Alabama Supreme Court has declined to address.<sup>225</sup> Such fetal guardianships turn what may already be an intimidating but parentalistic proceeding into an adversarial one, effectively changing the burden of proof established by the legislature in authorizing a judicial bypass proceeding.<sup>226</sup> For example, in one case, the trial court appointed a guardian ad litem for the fetus, whom the court denominated "Baby Teresa."<sup>227</sup> The guardian ad litem called three witnesses who worked at organizations opposed to abortion, "Sav-A-Life" and the "COPE Crisis Pregnancy Center," and cross-examined the minor about whether she had consulted these or other anti-abortion groups in making her decision.<sup>228</sup> In another case, a judge (perhaps the same one) declared,

I have . . . as has been my practice for five years now, appointed a lawyer to represent *your unborn child*, because I do not feel that the court should be placed in the position of being a cross-examiner, an advocate for one side or the other, so I've appointed someone to represent *the silent voice* in this case.<sup>229</sup>

In 2003, the wife of a Florida prosecutor petitioned to be appointed guardian of the fetus in the case of a severely retarded woman who had been raped at the group home where she resided, in order to prevent the woman from having an abortion.<sup>230</sup> The rape victim suffered from autism, cerebral palsy, and a seizure disorder, in addition to her retardation,

223. See, e.g., *In re Fetus Brown*, 689 N.E.2d at 400, 406 (reversing a trial court's decision to appoint a hospital the "temporary custodian of Fetus Brown" and appointing the Cook County, Illinois Public Guardian as the "guardian ad litem" for Fetus Brown in order to override the pregnant woman's refusal of blood transfusions, based on her religious beliefs).

224. See *Benten v. Kessler*, 1192 U.S. Dist. LEXIS 14747 (E.D.N.Y. 1992) (holding in a pregnant woman's class action suit to enjoin the Food and Drug Administration's ban on the importation of RU-486, an abortifacient drug, that an attorney could not intervene on behalf of the woman's non-viable fetus, declaring that "[t]he Federal Rules of Civil Procedure make no provision for appointing a guardian ad litem for a fetus"). See also *In re Nancy Klein*, 1989 N.Y. App. Div. LEXIS 1613 (N.Y. App. Div. 1989) (holding, in the case of a comatose woman injured in an accident, that her husband should be appointed guardian with authority to terminate her pregnancy, and that a stranger could not be appointed guardian of her fetus, since a non-viable fetus was not "a legally recognized 'person,'" (citing *Roe v. Wade*, 410 U.S. 113 (1973))).

225. *In re Anonymous*, 810 So. 2d 786, 795 (Ala. 2001).

226. As one trial judge explained, "it has been my practice for three years now when I'm faced with these cases to not only have a lawyer for you but to have a lawyer to represent the interest of the unborn child." *Id.* at 789. See also *In re Anonymous*, 889 So. 2d 525, 525 (Ala. 2003) (Johnstone, J., dissenting, in discussing evidence of the trial court's bias against abortion).

227. *In re Anonymous*, 733 So. 2d 429, 429-30 (Ala. Civ. App. 1999).

228. *In re Anonymous*, 733 So. 2d at 429-30.

229. *In re Anonymous*, 889 So. 2d at 527 (Johnstone, J., dissenting, in discussing evidence of the trial court's bias against abortion) (emphasis added).

230. *In re J.D.S.*, 864 So. 2d 534, 536 (Fla. Dist. Ct. App. 2004).

but the putative guardian only expressed concern that the woman was taking medications which could injure the fetus.<sup>231</sup> Both the trial judge and the mid-level appellate court rebuffed the request for guardianship, holding that Florida law did not authorize such an appointment.<sup>232</sup> They noted that Florida law instead authorized guardians to be appointed for mentally incompetent women to protect *their* interests, with the guardian to consider whether an abortion was appropriate as “necessary to save the life or preserve the health of the pregnant woman,” subject to court approval.<sup>233</sup> In response to the decision in *J.D.S.*, Governor Jeb Bush announced his intention to seek a change in Florida law, but these efforts have been unsuccessful so far.<sup>234</sup>

### E. New Abortion Laws

New laws seeking to limit abortions reflect new fetal protection in two different ways. First, in addition to the federal Partial Birth Abortion Act,<sup>235</sup> a number of states, as well as Congress, have enacted laws which seek to limit women’s access to necessary health care by prohibiting so-called “partial birth” abortions, a term which suggests that the fetus in such cases is fully formed or capable of being born.<sup>236</sup> Second, laws have been proposed in Congress and state legislatures which, in the name of requiring “informed consent,” make the fetus more vivid and alive, with the goal of discouraging women from choosing abortion.

So-called “partial birth” abortion laws are criticized on four major grounds.<sup>237</sup> First, and foremost, these statutes do not acknowledge that most “partial birth” abortions take place under urgent or even emergent medical circumstances. These include the discovery that the fetus is anencephalic, hydrocephalic, or suffers from a fatal genetic defect, or the determination that an alternative abortion procedure would put the mother’s health at risk.<sup>238</sup> If “partial birth” abortions are prohibited,

231. *In re J.D.S.*, 864 So. 2d at 536.

232. *Id.*

233. *Id.* at 539 (discussing the requirements of FLA. STAT. ANN. 390.0111(1) and (3) (West 2006)).

234. Bob Mahlburg, *Senate Chief Wary of Fetus Guardian Bill [-] Governor Finds House Support, Won't Back Down on Legislation*, ORLANDO SENTINEL, Jan. 28, 2004, at B1.

235. 18 U.S.C.A. § 1531 (West 2006).

236. The Virginia law, for example, refers to the types of abortion prohibited as “partial-birth infanticide.” VA. CODE ANN. § 18.2-71.1 (West 2006).

237. A full discussion of “partial-birth” abortion bans is beyond the scope of this article; in any case, the Supreme Court will consider the constitutionality of the federal law next term. *Carhart v. Gonzales*, 413 F.3d 791 (8th Cir. 2005), *aff'g* *Carhart v. Ashcroft*, 331 F. Supp. 2d 805 (D. Neb. 2004), *cert. granted sub nom.* *Gonzales v. Carhart*, 126 S. Ct. 1314 (2006).

238. PLANNED PARENTHOOD, ABORTION AFTER THE FIRST TRIMESTER, *available at* <http://www.plannedparenthood.org/news-articles-press/politics-policy-issues/abortion-access/trimester-abortion-6140.htm> (citing SHELDON CHERRY & IRWIN MERKATZ, *COMPLICATIONS OF PREGNANCY: MEDICAL, SURGICAL, GYNECOLOGIC, PSYCHOSOCIAL, AND PERINATAL* (4th ed. 1991) and MAUREEN PAUL, *A CLINICIAN'S GUIDE TO MEDICAL AND SURGICAL ABORTION* (1999)). Medical complications for the woman include infections, heart failure, malignant hypertension, uncontrolled diabetes, renal disease, depression and suicidal tendencies. *Id.* In addition, many

women may be rendered sterile or otherwise unable to have other children, suggesting that "partial birth" abortion bans are not only anti-female, but also "anti-life" in practice.<sup>239</sup> Second, these "partial birth" laws describe abortion procedures using language inconsistent with medical parlance, making it impossible for a physician to know whether the technique used in a particular case is proscribed and thus rendering the law unconstitutionally vague.<sup>240</sup> Third, the laws' lack of an exemption for the mother's health is incompatible with prior decisions of the Supreme Court, which has held repeatedly that the state's interest in protecting the potential life of a fetus cannot supersede its interest in protecting the health and life of the pregnant woman.<sup>241</sup> Finally, these laws are not limited to "late" or third trimester abortions, but could apply as early as twelve weeks, when a fetus would clearly not be viable, and thus are incompatible with *Roe v. Wade*<sup>242</sup> and *Planned Parenthood of Southeastern Pennsylvania v. Casey*.<sup>243</sup>

Recently, proposals have been offered which, while nominally permitting abortion, conceptualize the fetus as a child in order to encourage women not to have abortions. The Unborn Child Pain Awareness Act of 2005 would require that abortion providers inform all women seeking abortion that Congress has determined that an "unborn child" may experience pain at twenty weeks or more after fertilization,<sup>244</sup> give each

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women face barriers that delay their access to abortion until the second trimester, including poverty, partner abuse, geographic difficulty in finding an abortion provider, and teenage status. See Brief for Seventy-Five Organizations Committed to Women's Equality as Amici Curiae Supporting Respondents, *Stenberg v. Carhart*, 530 U.S. 914 (2000) (No. 99-830), 2000 WL 340122.

239. Forcing physicians to use other, older abortion techniques increases the risk of infection and laceration as an option increases the chance of uterine perforations, cervical lacerations, hemorrhaging, and infection, all of which can lead to sterility. See *Women's Med. Prof'l Corp. v. Voinovich*, 911 F. Supp. 1051, 1069-70, *aff'd* 130 F.3d 187 (1997).

240. *Stenberg v. Carhart*, 530 U.S. 914, 939-46 (2000); see also *Carhart v. Gonzales*, 413 F.3d 791 (8th Cir. 2005), *aff'g* *Carhart v. Ashcroft*, 331 F. Supp. 2d 805 (D. Neb. 2004), *cert. granted sub nom. Gonzales v. Carhart*, 126 S. Ct. 1314 (2006).

241. *Stenberg*, 530 U.S. at 930-31; *Thornburgh v. Am. Coll. of Obstetricians & Gynecologists*, 476 U.S. 747, 768-69 (1986); *Richmond Med. Ctr. for Women v. Hicks*, 409 F.3d 619 (4th Cir. 2005).

242. 410 U.S. 113, 165-66 (1973).

243. 505 U.S. 833, 879 (1992).

244. Before an abortion could be performed, the woman would have to be told the following:

You are considering having an abortion of an unborn child who will have developed, at the time of the abortion, approximately XX weeks after fertilization. The Congress of the United States has determined that at this stage of development, an unborn child has the physical structures necessary to experience pain. There is substantial evidence that by this point, unborn children draw away from surgical instruments in a manner which in an infant or an adult would be interpreted as a response to pain. Congress finds that there is substantial evidence that the process of being killed in an abortion will cause the unborn child pain, even though you receive a pain-reducing drug or drugs. Under the Federal Unborn Child Pain Awareness Act of 2005, you have the option of choosing to have anesthesia or other pain-reducing drug or drugs administered directly to the pain-capable unborn child if you so desire. The purpose of administering such drug or drugs would be to reduce or eliminate the capacity of the unborn child to experience pain during the abortion procedure. In some cases, there may be some additional risk to you associated with administering such a drug.

S. 46, 109th Cong. §2902 (2005).

woman an Unborn Child Pain Awareness Brochure,<sup>245</sup> and require her to sign an Unborn Child Pain Awareness Decision Form, indicating whether or not she wishes to have her “pain-capable unborn child” to receive anesthesia.<sup>246</sup> Other proposals would set an even earlier date for a woman contemplating abortion to be told about the fetus’ potential to experience pain.<sup>247</sup> At least one law would impose a twenty-four hour waiting period in which the pregnant woman is to consider the information regarding fetal pain prior to having the abortion,<sup>248</sup> exacerbating the pressure on women not to have an abortion.<sup>249</sup>

Although legislative mandating of explicit informed consent requirements is not unprecedented,<sup>250</sup> the Unborn Child Pain Awareness Act of 2005 is unusual in its detailed explanation of the procedure contemplated.<sup>251</sup> All other laws mandating the specifics of the informed consent dialogue require informing the patient of the consequences of the contemplated medical procedure *to her*, not a third party. Imagine, for example, a statute requiring a prospective kidney donor be told about the impact of the decision to donate on the donor’s child, because of the risk that the donor might die after donating the kidney. Courts have increasingly recognized that as competent adults, parents are able to accept or reject medical treatment based on their personal views of what is best for them, and have not required them to take their children’s interests into account.<sup>252</sup>

245. This Brochure would be developed by the Department of Health and Human Services, and include: “the same information as required under the statement under subsection (b)(2)(A)(i), including greater detail on her option of having a pain-reducing drug or drugs administered to the unborn child to reduce the experience of pain by the unborn child during the abortion.” S. 46, 109th Cong. §2902 (2005).

246. The law would require that the woman sign an Unborn Child Pain Awareness Decision Form, which shall:

(A) with respect to the pregnant woman—

(i) contain a statement that affirms that the woman has received or been offered all of the information required in subsection (b);

(ii) require the woman to explicitly either request or refuse the administration of pain-reducing drugs to the unborn child; and

(iii) be signed by a pregnant woman prior to the performance of an abortion involving a pain-capable unborn child.

S. 46, 109th Cong. §2902 (2005).

247. Under the Montana Unborn Child Pain Prevention Act, all women contemplating abortion at 16 weeks or later would have to be informed that the fetus could feel pain. H.B. 238, 59th Leg., Reg. Sess. (Mont. 2005).

248. H.B. 238, 59th Leg., Reg. Sess. (Mont. 2005).

249. Imposing a waiting period is believed to add a significant barrier to abortion access. PLANNED PARENTHOOD, *supra* note 228.

250. See, e.g., S.G. Nayfield et al., *Statutory Requirements for Disclosure of Breast Cancer Treatment Alternatives*, 86 J. NAT’L CANCER INST. 1202 (1994) (discussing state laws that require that women contemplating mastectomy be told of the range of treatment options available); and similar laws governing hysterectomy (CAL. HEALTH & SAFETY CODE § 1690 (West 2006)) and sterilization (OR. REV. STAT. ANN. § 436.225 (West 2006)).

251. Cf. OR. REV. STAT. §§ 127.800–.897 (1998) (popularly known as Oregon’s Death with Dignity Law).

252. See, e.g., *Norwood Hospital v. Munoz*, 564 N.E.2d 1017, 1024 (Mass. 1991) (holding that a mother who was a Jehovah’s Witness could decline to receive a medically recommended blood



Several legislators have introduced laws which compel women to contemplate their fetuses as "unborn" children in other ways. These include laws that require that women be given the opportunity to visualize their fetus in a sonogram and to hear the fetus' heartbeat, as a precondition to the "informed consent" necessary to receive an abortion,<sup>253</sup> as well as laws that provide federal funding to purchase sonogram equipment for this purpose.<sup>254</sup> These laws increase government involvement in a heretofore private trend: the use of sonogram technology by anti-abortion groups,<sup>255</sup> which have found that women are less likely to choose abortion if they see a sonographic image of their fetus.<sup>256</sup>

## II. THE FETUS AND CHILD IN AMERICAN LAW AND SOCIETY

### A. *The Status of the Fetus in American Law*

To put current "fetal protection" law in context, it is necessary to trace briefly the common law and statutory trend toward recognition of the fetus as a legal entity, although in most instances this recognition arises after a child has been born.<sup>257</sup> At common law the fetus was not considered a legal person, and it was only after birth that a child had legal rights. The "born alive" rule governed criminal,<sup>258</sup> tort,<sup>259</sup> and inheritance<sup>260</sup> law.

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transfusion, even though doctors testified that without it she was likely to die, leaving her young son with only one parent).

253. See, e.g., S.B. 76, 2005 Reg. Sess. (Ind. 2005) (amending title 28, article 34, chapter 2, section 1.1 of the Indiana Code to require that at least eighteen hours prior to abortion, a woman be told of the "availability of fetal ultrasound imaging and auscultation of fetal heart tone services to enable the pregnant woman to view the image and hear the heartbeat of the fetus and how to obtain access to those services").

254. The proposed Informed Choice Act would authorize the Department of Health and Human Services to make grants to tax-exempt "community based pregnancy help medical clinic[s]" to provide ultrasound equipment to be used to give the woman a "visual image of the fetus," information about its probable gestational age, and information on abortion and its alternatives. H.R. Con. 216, 109th Cong. (2005).

255. Since 2001, the Department of Health and Human Services has been funding crisis pregnancy centers because they support President Bush's "abstinence-only" position on premarital sex education. See Kashef, *supra* note 5.

256. Neela Banerjee, *Church Groups Turn to Sonogram to Turn Women from Abortions*, N.Y. TIMES, Feb. 2, 2005, at A1.

257. See *infra* notes 260-273. But see *Mone v. Greyhound Lines, Inc.*, 331 N.E.2d 916, at 920 (Mass. 1975) (permitting parents to recover under a wrongful death theory due to bus company's negligence that caused the stillbirth of a viable fetus).

258. See *supra* text accompanying notes 113-121 (noting the born-alive rule precluded prosecution for homicide for causing the death of a fetus); See also *Commonwealth v. Morris*, 142 S.W.3d 654, 655-57 (Ky. 2004) (discussing the history of the rule).

259. See, e.g., Sheldon R. Shapiro, Annotation, *Right to Maintain Action or to Recover Damages for Death of Unborn Child*, 84 A.L.R. 3d 411 (2004).

260. See, e.g., *Tucker v. Carmichael & Sons, Inc.*, 65 S.E.2d 909, 910 (Ga. 1951) (discussing common law rules on inheritance, permitting children to sue after birth for interests that came into being while they were in utero); see also UNIF. PROBATE CODE § 2-109 (amended 2005) (permitting children conceived before an individual's death but born thereafter to inherit). See also David E. Koropp, Note, *Setting the Standard: A Mother's Duty During the Prenatal Period*, 1989 ILL. L. REV. 493, 495, n.13.

## 1. Tort Liability

The first case to apply the “born alive” rule in American tort law was *Dietrich v. Inhabitants of Northampton*.<sup>261</sup> In *Dietrich*, a pregnant woman slipped and fell and suffered a miscarriage, with her four or five month old fetus living only for a few minutes. Mr. Justice Holmes, then sitting on the Massachusetts Supreme Judicial Court, observed that “no case . . . has ever decided that, if the infant survived, it could maintain an action for injuries received by it while in its mother’s womb.” In his view, this was wholly appropriate, since “*the unborn child was a part of the mother at the time of the injury.*”<sup>262</sup>

*Dietrich* was followed for seventy-five years, until the 1946 decision in *Bonbrest v. Kotz*.<sup>263</sup> In *Bonbrest*, the United States District Court for the District of Columbia held that a viable fetus, injured through medical malpractice, had a cause of action against the physician who negligently delivered him. The decision spawned a rapid retreat from the born alive rule, accomplished by both statutory and case law. Today, every state allows a suit for prenatal injuries if the infant is born alive,<sup>264</sup> and most states permit a wrongful death suit to be brought on behalf of a viable fetus who succumbs prior to birth due to prenatal injury.<sup>265</sup> A minority of states also permits suit on behalf of a non-viable fetus.<sup>266</sup> Other states have recognized causes of action for loss of consortium on the part of parents whose fetus has been killed due to the tortious acts by others.<sup>267</sup>

261. 138 Mass. 14 (1884).

262. *Dietrich*, 138 Mass. at 17 (emphasis added).

263. 65 F. Supp. 138 (D.D.C. 1946).

264. *Farley v. Sartin*, 466 S.E.2d 522, 528 (W.Va. 1995).

265. See Michael P. Penick, *Wrongful Death of a Fetus*, 19 AM. JUR. 3D *Proof of Facts* 107 (2004); Jill D. Washburn Helbling, Symposium, *To Recover or Not to Recover: A State by State Survey of Fetal Wrongful Death Law*, 99 W. VA. L. REV. 363 (1996). See also *Meyer v. Burger King Corp.*, 26 P.3d 925, 928-30 (Wash. 2001) (holding that the Washington worker’s compensation statute did not bar a suit brought by a child allegedly deprived of oxygen in utero due to his mother’s employer negligence). Indeed, employers’ fear of tort liability for causing harm to the fetuses of their female employees is a major rationale of fetal protection policies in the workplace, which exclude some women from high-paying but hazardous positions. See Elaine Draper, *Reproductive Hazards and Fetal Exclusion Policies after Johnson Controls*, 12 STAN. L. & POL’Y REV. 117, 118, 121 (2001). For a fuller discussion of the gendered nature of the construction of workplace risks, see *id.* and discussion *infra* at text accompanying notes 323-344. Nine states (California, Florida, Iowa, Maine, Nebraska, New Jersey, New York, Texas, and Virginia) require that a child be born alive before a suit for prenatal injuries can be brought. See Penick, *supra*; Helbling, *supra*.

266. See, e.g., *Wiersma v. Maple Leaf Farms*, 543 N.W.2d 787 (S.D. 1996) (holding that the South Dakota wrongful death statute should be interpreted to authorize a cause of action for wrongful death for non-viable fetuses, and surveying the law in other jurisdictions in the process); *Connor v. Monkem Co., Inc.*, 898 S.W.2d 89, 91-93 (Mo. 1995) (construing Missouri’s wrongful death statute to permit a cause of action for a non-viable fetus in light of a Missouri statute of general applicability that declares that “[t]he life of each human being begins at conception....”).

267. See, e.g., *Broadnax v. Gonzales*, 809 N.E.2d 645 (N.Y. 2004) (permitting a woman to recover for emotional injury for a miscarriage or stillbirth due to medical malpractice, even if she herself does not suffer physical injury); *Dunn v. Rose Way, Inc.*, 333 N.W.2d 830, 832 (Iowa 1983) (holding that a parent could recover for loss of consortium even though Iowa does not recognize a cause of action for wrongful fetal death, because a loss of consortium action is based on parental,

Only a handful of American courts have addressed the question of whether tort liability can be imposed on pregnant women based on their conduct during pregnancy. Three courts have upheld such liability, while three courts have rejected it. These cases are important in addressing the normative question of who *is* the reasonable pregnant woman, as well as the related question of who gets to evaluate her conduct.

*Grodin v. Grodin*<sup>268</sup> was the first case to permit a woman to be sued for her actions while pregnant.<sup>269</sup> The Michigan Court of Appeals allowed the father of a child born with discolored teeth to sue the child's mother (and his wife) for these injuries, allegedly caused by the woman's taking Tetracycline® while pregnant. Without analyzing the consequences of its decision for pregnant women, the court framed the question as a simple one of fact: did the woman's use of Tetracycline® constitute a "reasonable exercise of parental discretion?" If it did, this conduct would fall within an exception to the general abrogation of parental-child tort immunity under Michigan law, and the woman could not be sued.<sup>270</sup>

Two other cases, *Bonte v. Bonte*,<sup>271</sup> and *National Casualty Co. v. Northern Trust Bank of Florida, N.A.*,<sup>272</sup> also permitted suit to be brought on behalf of children who were injured due to their mothers' alleged negligence while pregnant. In *Bonte*, the mother was struck by a car while crossing the street and her child was born with severe brain damage and cerebral palsy.<sup>273</sup> The New Hampshire Supreme Court held that a suit could go forward, relying on the abrogation of parent-child tort immunity (in part in recognition of the availability of insurance as a source of recovery) and the law that a child born alive can bring a cause of action for injuries suffered in utero against a third party.<sup>274</sup> The court rejected the argument that either the unique relationship between a pregnant woman and her fetus or the potential deprivation of a woman's right to control her life during pregnancy should preclude liability.<sup>275</sup> The court held that a pregnant woman was "required to act with . . . the same standard of care as that required of her once the child is born."<sup>276</sup>

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rather than fetal, loss). Loss of consortium has been recognized as a cause of action at least since the time of Hammurabi, although his code explicitly calculated damages based on the social class of the pregnant woman. The Code of Hammurabi, §§ 209 and 213 (L.W.King trans.), available at <http://www.leb.net/~farras/history/hammurabi.htm> (declaring that a free born woman was entitled to receive ten shekels for her loss while a maid-servant was entitled to receive two shekels).

268. 301 N.W.2d 869 (Mich. Ct. App. 1981).

269. *Grodin*, 310 N.W.2d 869.

270. The court remanded the matter to the trial court to determine the "'reasonableness' of the [mother's] alleged negligent conduct." *Id.* at 871.

271. 616 A.2d 464 (N.H. 1992).

272. 807 So. 2d 86 (Fla. Dist. Ct. App. 2001).

273. *Bonte*, 616 A.2d at 464.

274. *Id.* at 465-66.

275. *Id.* at 466.

276. *Id.*

A similar result was reached by a Florida appellate court in *National Casualty Co.*, which ruled that a child could sue its mother for injuries allegedly caused by her negligent driving while pregnant, up to the amount of her automobile insurance coverage.<sup>277</sup> The court's brief opinion held that there was no reason to "den[y] . . . recovery merely because of the identity of the tortfeasor,"<sup>278</sup> rejecting concerns about the impact of its decision on the mother's privacy and personal health, and distinguishing *State v. Ashley*, in which the Florida Supreme Court held a pregnant woman who shot herself and caused the death of her fetus could not be charged criminally.<sup>279</sup>

In contrast, three courts have adamantly rebuffed suits brought by children against their mothers for injuries suffered in utero. In *Stallman v. Youngquist*,<sup>280</sup> the Illinois Supreme Court held that a child who suffered prenatal injuries in a car accident in which her mother was driving could not sue her mother for negligence.<sup>281</sup> The court first criticized the *Grodin* decision, suggesting that the Michigan court had confused the question of whether parental tort immunity should be abrogated with the different issue of whether a pregnant woman owed a tort duty to her fetus.<sup>282</sup> The *Stallman* court confronted the latter issue directly. It emphasized that the relationship between a pregnant woman and the fetus she was carrying was unique and "unlike the relationship between any other plaintiff and defendant,"<sup>283</sup> and thus could not be analogized to other negligence situations. The Illinois Supreme Court held that in view of the "fact of life" that a pregnant woman's "every waking and sleeping moment . . . shapes the prenatal environment which forms the world for the developing fetus,"<sup>284</sup> it was impermissible to impose a duty of care on a pregnant woman.<sup>285</sup>

The court asserted four grounds for its decision. First, it would be impossible to either limit or define the duty of a pregnant woman toward her fetus, since many actions taken in a woman's life, even prior to conception, could affect a fetus.<sup>286</sup> Second, it would be impossible to develop an objective standard applicable to women from diverse socio-economic backgrounds, whose access to health care differed, and who might or might not know whether they were pregnant.<sup>287</sup> Third, the court recognized that creating a common law cause of action had the potential

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277. *National Casualty*, 807 So. 2d 86.

278. *Id.* at 87.

279. *Id.* at 87-88 (citing *State v. Ashley*, 701 So. 2d 338 (Fla. 1997)).

280. 531 N.E.2d 355 (Ill. 1988).

281. *Stallman*, 531 N.E.2d at 361.

282. *Id.* at 358.

283. *Id.* at 360.

284. *Id.*

285. *Id.* at 359-61.

286. *Id.* at 360.

287. *Id.*

for "unprecedented intrusion into the privacy and autonomy of the [female] citizens of this State."<sup>288</sup> It held that if a duty was to be recognized, it must be by the legislature, "only after thorough investigation, study, and debate."<sup>289</sup> Finally, the court urged that "[t]he way to effectuate the birth of healthy babies is not . . . through after-the-fact civil liability in tort for individual mothers, but rather through before-the-fact education of all women and families about prenatal development."<sup>290</sup>

*Chenault v. Huie*<sup>291</sup> addressed the more difficult factual circumstances in which Huie, a pregnant woman (and her boyfriend) abused alcohol and other drugs while she was pregnant, and she gave birth to a child with developmental problems and cerebral palsy.<sup>292</sup> Huie's sister sued on behalf of the child, seeking compensatory and punitive damages for Huie's alleged negligence and gross negligence.<sup>293</sup> The Texas Court of Appeals declined to recognize a child's common law cause of action against its mother for prenatally-caused injuries. The court declared that while "the law wisely no longer treats a fetus as only a part of the mother, the law would ignore the equally important physical realities of pregnancy if it treated the fetus as an individual entirely separate from his mother."<sup>294</sup> The court pointed to the difficulty of establishing an objective, uniform standard of care for pregnant and potentially pregnant women, noting the inevitable subjectivity of after-the-fact jury decision-making, which would lead to inconsistent and unpredictable jury verdicts, as well as the invasion of women's autonomy and right to control their daily lives.<sup>295</sup> The court declared that recognizing a duty of women toward their fetuses was the province of the legislature, which alone could conduct the necessary "research and analysis of scientific and medical data . . . [and] evaluat[e] . . . broad matters of public policy."<sup>296</sup> Finally, the court expressed the concern that imposing civil liability might be counterproductive, because women who feared civil liability might not be candid with their physicians, and thus would receive less than adequate prenatal care.<sup>297</sup>

In 2004, in *Remy v. MacDonald*,<sup>298</sup> the Massachusetts Supreme Judicial Court declined to permit a child to sue its mother for prenatal harm.<sup>299</sup> In *Remy*, the plaintiff alleged that her mother drove negligently while pregnant, causing the plaintiff to be born prematurely with adverse

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288. *Id.* at 361.

289. *Id.*

290. *Id.*

291. 989 S.W.2d 474 (Tex. Ct. App. 1999).

292. *Chenault*, 989 S.W.2d at 475.

293. *Id.*

294. *Id.* at 475-76.

295. *Id.* at 477-78.

296. *Id.* at 478.

297. *Id.*

298. 801 N.E.2d 260 (Mass. 2004).

299. *Remy*, 801 N.E.2d at 266.

health consequences. The court followed *Stallman* and *Chenault*, emphasizing the substantial disagreement about whether pregnant women should be held liable for causing fetal harm, observing that there were virtually unlimited circumstances in which a woman could be sued, and declaring that there was no principled way to limit the liability of pregnant women for causing fetal harm to the motor vehicle context.<sup>300</sup> The court explicitly rejected the reasoning of *Grodin*, *Bonte*, and *National Casualty Co.*, and found that courts should recognize “that there are inherent and important differences between a fetus, in utero, and a child already born, that permits [sic] a bright line to be drawn around the zone of potential tort liability of one who is still biologically joined to an injured plaintiff.”<sup>301</sup>

The approach of *Remy*, *Stallman*, and *Chenault* is similar to that set forth by the Supreme Court of Canada, whose reasoning is instructive. The Court has held consistently over the last fifteen years that a pregnant woman and her fetus share a unique relationship, in which there is only one legal person, rather than two persons with potentially adverse positions.<sup>302</sup> In *Winnipeg Child & Family Services (Northwest Area) v. G. (D.F.)*, the Court noted, “[T]he law has always treated the mother and unborn child as one. To sue a pregnant woman on behalf of her unborn fetus therefore posits the anomaly of one part of a legal and physical entity suing itself.”<sup>303</sup> In *Dobson v. Dobson*, the Court explained that there was no principled way to limit the circumstances under which the woman could be held liable, due to the extraordinarily close physical proximity between the woman and her fetus, and the enormous range of actions which the woman could take which could have a detrimental effect on fetal development.<sup>304</sup> “Everything the pregnant woman eats or drinks, and every physical action she takes, may affect the foetus.”<sup>305</sup> The Court further identified two important public policy concerns “militat[ing] against the imposition of maternal tort liability for prenatal negligence[:] . . . the privacy and autonomy rights of women and . . . the difficulties inherent in articulating a judicial standard of conduct for pregnant women.”<sup>306</sup> The Court emphasized that simply because a woman is pregnant, she does not lose “the right to make personal decisions, to control [her] . . . bodily integrity, and to refuse unwanted medi-

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300. *Id.* at 264-66.

301. *Id.* at 267.

302. *Winnipeg Child & Family Services (Northwest Area) v. G. (D.F.)*, [1997] 3 S.C.R. 925 ¶¶ 27-29 (holding that a pregnant woman addicted to solvents could not be civilly committed for treatment) and *Dobson v. Dobson*, [1999] 174 D.L.R. (4th) ¶ 1 (rejecting tort liability for a pregnant woman who allegedly drove negligently, causing injury to her fetus and declaring that, “[t]he relationship between a pregnant woman and her foetus is unique and innately recognized as one of great and special importance to society”).

303. *Winnipeg Child & Family Services*, 3 S.C.R. at ¶ 27.

304. *See Dobson* 174 D.L.R. at ¶ 20.

305. *Id.* at ¶ 27.

306. *Id.* at ¶ 21.

cal treatment."<sup>307</sup> The Court finally noted the difficulty in developing a workable judicial standard of conduct for pregnant women, stating it would be impossible to articulate an objective standard because the context of every pregnant woman's life is different, with women who are well-educated and ignorant, rich and poor, with and without access to good health care and good prenatal care.<sup>308</sup> The court observed that "the reasonable pregnant woman" standard would inevitably be interpreted in light of the trier of fact's prejudices about the proper conduct of pregnant women.<sup>309</sup>

## 2. Child Neglect and Proceedings to Terminate Parental Rights

In contrast to the split over whether pregnant women should be liable for prenatal torts, all states agree that a woman's use of alcohol or other drugs while pregnant is a proper trigger for taking custody of a child as "neglected," and may be the basis for terminating her parental rights.<sup>310</sup> The jurisprudence in this area can be succinctly summarized: "Courts rarely side with drug abusing parents where children are concerned."<sup>311</sup> Courts do differ, however, over the jurisdictional question of whether a fetus may be considered a child and the further question of whether a woman's substance abuse during pregnancy is in itself sufficient to justify the loss of parental rights.<sup>312</sup>

307. *Id.* at ¶ 32 (citing the ROYAL COMMISSION ON NEW REPRODUCTIVE TECHNOLOGIES, PROCEED WITH CARE: FINAL REPORT ON NEW REPRODUCTIVE TECHNOLOGIES 955-56 (1993)).

308. *Id.* at ¶ 54.

309. *Id.* at ¶ 53.

310. Some states statutes explicitly authorize courts to consider prenatal substance abuse. *See, e.g.,* COLO. REV. STAT. ANN §§ 19-3-102(1)(g) (West 2005) (declaring that a child is neglected or dependent if it is born with controlled substances in its system); OKLA. STAT. ANN. tit. 10, § 7001-1.3(14)(c) (West 2006) (declaring that a child born dependent on controlled substance is a "deprived child"). Other states have achieved the same result through judicial interpretation of more general child neglect criteria. *See, e.g., In re Troy D.*, 263 Cal. Rptr. 869 (Cal. Ct. App. 1989) (applying CAL. WELF. & INST. CODE § 300 (a) (West 2006) to a child born to a mother who ingested drugs during pregnancy); *In re Baby Boy Blackshear*, 736 N.E.2d 462 (Ohio 2000) (holding that a newborn with a positive toxicology screen is *per se* an abused child under the Ohio civil child abuse statute); *see also In re Stefanel Tyesha C.*, 556 N.Y.S.2d 280 (N.Y. App. Div. 1990) (quoting N.Y. FAM. CT. ACT § 1046 (a) (iii) (1981)) (holding that allegations that a mother admitted drug use while pregnant and that her infant had a positive toxicology test are sufficient to permit a child neglect proceeding to go forward).

311. Mary E. Taylor, Annotation, *Parent's Use of Drugs as Factor in Award of Custody of Children, Visitation Rights, or Termination of Parental Rights*, 20 A.L.R. 5th 534, §2 [b] (2005).

312. In *In re Valerie D.*, the Supreme Court of Connecticut held that a woman's use of drugs while pregnant could not, standing alone, justify the termination of her parental rights, and also found that by taking the child away immediately after birth, the state made it impossible for the mother to establish that she had an appropriate and ongoing relationship with her child. 613 A.2d 748, 752-53 (Conn. 1992). *See also In re Appeal in Pima County Juvenile Severance Action No. S-120171*, 905 P.2d 555, 558 (Ariz. Ct. App. 1995) (holding that "while chronic use of drugs or alcohol by either parent during the mother's pregnancy may reflect a pattern of substance abuse and may be so telling of the kind of environment to which the child will be born as to justify the child's immediate removal from the parents at birth, chronic substance abuse during pregnancy in and of itself does not reflect an inability to parent that would justify severance of a parent's fundamental rights"); *see also supra* text accompanying notes 201-13 (regarding the jurisdiction of juvenile and family courts over fetuses, as opposed to children). Other courts have come to a different conclusion, *cf. In*

As always in child abuse and neglect cases, there are competing goals and strategies, which are magnified in the case of parents<sup>313</sup> who use alcohol and other drugs. The law's basic premise is that it is the child's, rather than the parent's, best interests, which are paramount. This leads to early intervention by child welfare authorities to protect a child at risk,<sup>314</sup> and means in practice that many courts have ruled that children born with positive toxicology screens for illegal drugs and/or other evidence of prenatal drug exposure may be temporarily removed from their parents' custody.<sup>315</sup> On the other hand, parental advocates may urge a watchful waiting period and argue that more family support services and drug treatment should be provided, in order to make it more likely that children may remain with their parents, whose interest in the enjoyment of a relationship with their children is constitutionally protected.<sup>316</sup> The Adoption and Safe Families Act of 1997 (AFSA)<sup>317</sup> gives states financial incentives to expeditiously terminate parental rights, with the laudable goal of not leaving children in foster care limbo while their parents struggle to get their lives in order.<sup>318</sup> Since the law translates "the best interests of the child" as "less time spent in foster care," the result has been faster termination of parental rights.<sup>319</sup> Many commentators have asserted that "the 12-month permanency clock for children ignores the clock of treatment for addiction, which is at best 24 months," and that the statute operates in a draconian and counter-productive manner in the

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*re* Baby Blackshear, 736 N.E.2d 462, 464 (Ohio 2000), but in most cases there are factors in addition to the mother's prenatal drug use that are cited in support of the decision to terminate parental rights. See, e.g., *In re* W.A.B., 979 S.W.2d 804, 808 (Tex. Ct. App. 1999).

313. It is important to remember that there are often two parents involved, and frequently that the father is also a drug user or the one whose physical and emotional abuse exacerbates the mother's vulnerability to drug use. See *Francisco G. v. Superior Court*, 110 Cal. Rptr. 2d 679 (Cal. Ct. App. 2001) (upholding the termination of a father's parental rights where his alcohol abuse and domestic violence had not been addressed and he supported the mother's assertion that she did not have a drug problem when there was overwhelming evidence to the contrary).

314. See, e.g., *In re* Stefanel Tyesha C., 556 N.Y.S.2d at 284 ("[A] court cannot and should not 'await broken bone or shattered psyche before extending its protective cloak around [a] child pursuant to . . . article 10 of the Family Court Act . . .'" (citations omitted)). Courts have justified their decision by citing the child's "right to begin life with a sound mind and body." *Stallman*, 531 N.E.2d at 358 (citations omitted).

315. See, e.g., *In re* Troy D., 263 Cal. Rptr. at 877 (holding that there was substantial evidence to support the juvenile court's finding that a newborn was "in need of proper and effective parental care or control" in light of the infant's positive toxicology results for opiates and amphetamines, post-birth behavior which suggested prenatal drug exposure, and the mother's continued drug use after losing custody of another child due to her drug use).

316. See *Stanley v. Illinois*, 405 U.S. 645 (1972); *Santosky v. Kramer*, 455 U.S. 745 (1982); *In re* Guardianship of K.H.O., 736 A.2d 1246, 1251 (N.J. 1999).

317. Pub. L. No. 105-89, 111 Stat. 2115 (1997) (codified as amended in scattered sections in 42 U.S.C.A.).

318. 42 U.S.C.A. § 671(a)(15) (West 2006).

319. See *Laureen D'Ambra, Terminating the Parental Rights of the Mentally Disabled*, 49 R. I. BAR. J. 5, 7 (2001) (discussing the law's shorter time frames for children to remain in foster care, with the goal of promoting permanent placement for children); *Dorothy Roberts, The Challenge of Substance Abuse for Family Preservation Policy*, 3 J. HEALTH CARE L. & POL'Y 72, 73-76 (1999).



case of drug-abusing women.<sup>320</sup> The AFSA's push for a quick decision about termination of parental rights is also problematic in view of most states' inadequate drug treatment resources.<sup>321</sup> Many drug treatment programs are simply not tailored to mothers, who need both child care and a treatment philosophy different from the "confrontational" and individually focused style typical of drug treatment programs designed with the male drug addict in mind.<sup>322</sup>

### *B. The Failure to Protect Fetuses and Children from Work-Related Harms*

In contrast to the emphasis of prosecutors, child abuse agencies, and some tort plaintiffs on the mother's body and behavior as the locus of both fetal harm and protection, government and private actors have largely been silent about systemic deficits in the American workplace that place parents and their offspring at risk. Two aspects of workplace life bear special scrutiny: the dangers to fetal and childhood development posed by male and female workers' exposure to toxic substances, and the lack of economically viable parental leave policies, which prevent many parents from adequately addressing the health and emotional needs of their newborns and young children.

#### 1. Workplace Exposure to Hazardous Substances

Employers have responded to the risk that workplace exposure to toxins and other dangerous substances will injure future children by en-

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320. See Roberts, *supra* note 319, at 77, 86 (quoting Cornelia Grunman, *Parents Give Advice on Reforming DCFS: Agency Criticized at Panel Hearings*, CHI. TRIB., Apr. 13, 1999, at Metro Chicago 3).

321. Federal law requires 5% of its Substance Abuse Prevention and Treatment (SAPT) Block Grant program to improve drug treatment access for pregnant women, but states may seek a waiver of this requirement if they can show that there are no access problems. See 45 C.F.R. § 96.124 (1993)(c)-(d). Only 14% of the drug treatment facilities in the United States have program specifically designed to treat pregnant and postpartum women. OFFICE OF APPLIED STUDIES, SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMIN., DEP'T OF HEALTH AND HUMAN SERVICES, NATIONAL SURVEY OF SUBSTANCE ABUSE TREATMENT SERVICES (N-SSATS): 2003, DATA ON SUBSTANCE ABUSE TREATMENT FACILITIES 38 (Sept. 2004), [http://www.dasis.samhsa.gov/04nssats/nssats\\_rpt\\_04.pdf](http://www.dasis.samhsa.gov/04nssats/nssats_rpt_04.pdf). Compounding the lack of adequate treatment facilities for pregnant women, only 35% of the facilities had programs for persons needing treatment for both substance abuse and mental illness. *Id.* at 37. Such individuals are especially likely to fall through the cracks of government sponsored program, as legislation is usually targeted at one, but not the other, of these illnesses. Georganne Chapin, *Sanctioning Substance-Abusing Home Relief Clients with the Loss of Medical Benefits—Legal and Policy Concerns*, 7 N.Y.S. BAR ASS'N HEALTH L. J. 35, 39 (Spring 2002).

322. See Roberts, *supra* note 319, at 78; Mary O'Flynn, *The Adoption and Safe Families Act of 1997: Changing Child Welfare Policy Without Addressing Parental Substance Abuse*, 16 J. CONTEMP. HEALTH L. & POL'Y 243, 262 (1999); Kathryn T. Jones, *Prenatal Substance Abuse: Oregon's Progressive Approach to Treatment and Child Protection Can Support Children, Women and Families*, 35 WILLAMETTE L. REV. 797 (1999); Holly A. Hills, Deborah Rugs & M. Scott Young, *Justice, Ethics, and Interdisciplinary Teaching and Practice: The Impact of Substance Abuse Disorders on Women Involved in Dependency Court*, 14 WASH. U. J.L. & POL'Y 359 (2004); Jane C. Murphy & Margaret J. Potthast, *Domestic Violence, Substance Abuse and Child Welfare: The Legal System's Response*, 3 J. HEALTH CARE L. & POL'Y 88 (1999).

acting "fetal protection" policies limiting the exposure of women of child-bearing age to such substances.<sup>323</sup> The Supreme Court ruled in 1991 in *International Union, UAW v. Johnson Controls*<sup>324</sup> that a fetal protection policy which excludes women from the workplace as a means of reducing the risk that a child will be harmed by prenatal toxic exposure constituted sex discrimination in violation of Title VII of the Civil Rights Act of 1964.<sup>325</sup> The employer's actions will be illegal unless the employer can demonstrate that its policy is a bona fide occupational qualification, that is, "reasonably necessary to the normal operation of the particular business."<sup>326</sup> However, many employers still implement "fetal protection" policies, admitting in effect that they would rather be sued for sex discrimination than for damages for causing prenatal injury.<sup>327</sup> These employers continue to focus exclusively on the risks of harm to future children posed via the female body (including harm to the woman's reproductive system and to the fetus) rather than acknowledge the harm that many substances pose to the male reproductive system. However, when studies show that a substance poses harm to the male reproductive system, industry and government frequently have acted to ban the substance entirely.<sup>328</sup>

## 2. Parenting Leaves

American law has also failed to mandate paid parenting leaves, which would permit parents to take care of newborns, as well as older children who become ill. Although the Family and Medical Leave Act (FMLA)<sup>329</sup> requires employers of more than fifty employees to grant

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323. Although the Occupational Safety and Health Act, 29 U.S.C.A. §§ 651-678 (West 2006), and the Toxic Substances Control Act, 15 U.S.C.A. §§ 2601-2692 (West 2006), both mandate that the government set safe levels of workplace exposure to many dangerous substances, both acts have been weakened by court rulings about the level of scientific proof required for the government to demonstrate "significant risk." See, e.g., *Industrial Union Dep't., AFL-CIO v. American Petroleum Institute*, 448 U.S. 607, 642 (1980) (plurality opinion) (holding that before promulgating any occupational safety and health standard, the Secretary of Labor must find that there are "significant risks" in a workplace which can be eliminated or decreased by a change in the standard).

324. 499 U.S. 187 (1991).

325. *Johnson Controls*, 499 U.S. at 207.

326. *Id.* at 200 (quoting 42 U.S.C.A. § 2000(e)(1)). In *Johnson Controls*, the defendant company manufactured batteries, in which lead was a major ingredient. Although the company initially permitted pregnant women to work in the manufacturing process, informing them of the dangers of lead exposure, after eight women tested with higher blood lead levels than recommended by OSHA, the company issued a "fetal protection" policy. This policy excluded "all women except those whose inability to bear children is medically documented," but it made no provision for men to lower their lead exposure, which has also been shown to pose a risk of fetal harm. *Id.* at 190-92.

327. Draper, *supra* note 265, at 121.

328. The pesticide ethylene dibromide (EDB), for example, was cancelled because of its oncogenic and mutagenic risks, as well as reproductive risks to male workers. See EPA Limitation on Ethylene Dibromide, 48 Fed. Reg. 46,234 (Oct. 11, 1983); see also OSHA Limitation on Levels of Occupational Exposure to Ethylene Dibromide, 48 Fed. Reg. 45,956 (Department of Labor document regarding EDB's effects on male reproductive capacity); cf. *Johnson Controls*, 499 U.S. 187 (1991).

329. Pub. L. No. 103-3, 107 Stat. 6 (1993) (codified in scattered sections of 2 U.S.C.A., 5 U.S.C.A., 29 U.S.C.A.).

employees up to twelve weeks a year of unpaid leave for the birth or adoption of a child or for reasons related to illness,<sup>330</sup> many critics assert that this is insufficient to support vulnerable children in need of parental attention and that the unpaid character of such parental leave means that existing race and class hierarchies are not remedied.<sup>331</sup> The United States' policy stands in marked contrast to those of other developed nations, which give much more generous leaves to working parents.<sup>332</sup> Almost half of American workers are not covered by the FMLA,<sup>333</sup> and even among those who are, only a fraction avail themselves of its leave provisions, because they cannot afford not to work.<sup>334</sup> No federal law mandates paid parental leave for the period connected with pregnancy, childbirth, and the early stages of infancy,<sup>335</sup> and California and Ohio are the only two states to mandate any form of paid parental leave.<sup>336</sup> In contrast, other developed nations either mandate or offer paid parenting leave, at least for some portion of this critical stage of fetal and childhood health and development,<sup>337</sup> and many countries offer additional financial or child-care support to single parents, those who are most likely to need leave from work to care for a newborn or ill child and are simultaneously the least likely to be able to afford to do so.<sup>338</sup>

America's failure to provide paid leave for child-bearing and parenting is both physically and socially harmful to children, as well as economically short-sighted. Many studies indicate that breast-feeding provides important health benefits to newborns,<sup>339</sup> and it is certainly much

330. See 29 U.S.C.A. § 2611(4)(a)(i) (West 2006) (defining "Employer" as any person employing more than 50 people); 29 U.S.C.A. § 2612(a)(1)(B), (C) (entitling an employee to 12 weeks leave for the birth or adoption of a child).

331. Nancy E. Dowd, *The Family and Medical Leave Act of 1993: Ten Years of Experience: Race, Gender, and Work/Family Policy*, 15 WASH. U. J.L. & POL'Y 219, 222-31 (2004) [hereinafter *Ten Years of Experience*].

332. *Id.* at 231-36.

333. Erin Gielow, Note, *Equality in the Workplace: Why Family Leave Does Not Work*, 75 S. CAL. L. REV. 1529, 1539 (2002)

334. *Id.* at 1546.

335. In April 2006, Representative Caroline Maloney introduced HR 5148, the Federal Employees Paid Parental Leave Act. The Act would ensure paid leave for 6 of the 12 weeks that federal employees are authorized to take parental leave. H.R. 5148, 109th Cong. (2006) (referred to H. Comm. on Gov't Reform), available at <http://thomas.loc.gov/cgi-bin/query/z?c109:H.R.5148>.

336. CAL. UNEMP. INS. CODE § 3300 (West 2006); OHIO REV. CODE ANN. § 124.136 (West 2006) (providing that permanent government employees shall receive 70% of their salary for four of the six weeks in which they are authorized to take parental leave).

337. Dowd, *supra* note 331 at 233-36 (summarizing European Union law, and comparing, *inter alia*, the approach of France, which mandates maternity leave and provides much more generous paid leaves to mothers than to fathers, and Sweden, which is gender-neutral in its paid parenting leave policies); see also Naomi S. Stern, *The Challenges of Parental Leave Reforms for French and American Women: A Call for a Revived Feminist-Social Theory*, 28 VT. L. REV. 321, 324-25 (2004) (describing the French statutory scheme).

338. Gielow, *supra* note 333, at 1547.

339. American Academy of Pediatrics, *Policy Statement: Breast Feeding and the Use of Human Milk*, 115 PEDIATRICS 496, 496-97 (2005); see also Shana M. Christup, *Breastfeeding in the American Workplace*, 9 AM. U.J. GENDER SOC. POL'Y & L. 471, 474-76 (2001); Judy Heymann, Editorial, *We Can Afford to Give Parents a Break*, WASH. POST, May 14, 2006, at B07.

easier to breastfeed when not working full-time.<sup>340</sup> Both newborns and older children whose health needs are not met promptly are likely to be sicker for longer periods of time, adding to state and federal health care expenditures.<sup>341</sup> In addition, parents who are distracted by ill children left at home may be less productive workers.<sup>342</sup> Studies of parental leave practices in other countries show that parents who are given generous paid leaves to care for their children rarely abuse it,<sup>343</sup> and that children, parents, and employers benefit when the law provides a framework for parents to care for their children's health without jeopardizing the familial economy.<sup>344</sup>

### C. Environmental Exposures

Children and fetuses are exposed to an astounding number of toxins, teratogens, mutagens, and carcinogens in the environment.<sup>345</sup> While the full effects of these exposures are not yet known,<sup>346</sup> and a comprehensive discussion of environmental hazards is beyond the scope of this paper, one recent example of government actions putting children at risk is instructive. In March 2005 the Environmental Protection Agency (EPA) promulgated the so-called Clean Air Mercury Rule,<sup>347</sup> which reversed a 2000 EPA rule and substantially expanded the ability of American power plants to continue to emit mercury and other toxic air pollutants. The EPA announced that coal- and oil-burning power plants were not subject to the requirements of §112 of the Clean Air Act, which would have required them to install new equipment to reduce mercury emissions. Instead, the new rule created a complicated system of "cap-and-trade" pol-

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340. American Academy of Pediatrics, *supra* note 339 at 498; Christrup, *supra* note 339, at 480-81.

341. Cf. KAISER, IN A TIME OF GROWING NEED, *supra* note 160, at 12 (citing a study in Washington State showing that children who lack health care insurance were less likely than those who do to have had a clinic or physician visit within six months and are twice as likely to have received care at an emergency room during the same period).

342. See Gielow, *supra* note 333, at 1541-43.

343. DECKER, *supra* note 64, at 10 ("Contrary to the widely held belief that employees would abuse a liberal leave policy, the average usage rate of [Sweden's generous leave policy, which is 90 days per year to care for a sick child] . . . is seven days a year.").

344. See Gielow, *supra* note 333, at 1540-42.

345. In recognition of the risks posed by these exposures, in 1997 President Clinton formed a Task Force on Environmental Health and Safety Risks to Children, to improve inter-agency cooperation within the federal government to provide greater protections for children's health. Exec. Order No. 13,045, 62 Fed. Reg. 19,885 (April 23, 1997).

346. Robert L. Brent & Michael Weitzman, *The Current State of Knowledge About the Effects, Risks, and Science of Children's Environmental Exposures*, 113 PEDIATRICS 1158, 1159, 1164-65 (2004), available at <http://pediatrics.aappublications.org/cgi/reprint/113/4/S1/1158> (noting the wide range of conclusions reached about the risk that pesticides and other environmental toxicants pose to children, urging that more, carefully controlled, studies be undertaken to evaluate issues such as the susceptibility of children compared with adults, the impact of exposure to multiple environmental hazards, and observing that where there is sufficient data to act, as in the case of lead, there is no reason to delay).

347. Mark D. Sullivan & Christine A. Fazio, *The EPA's New Clean Air Rules: Mixed Results for Air Quality*, N.Y. ST. B.J. 11, 15 (Jan. 2006); 70 Fed. Reg. 15,994 (Mar. 29, 2005) (to be codified at 40 C.F.R. pt. 63).

lution allowances which permitted the power plants to increase their mercury pollution by purchasing emissions allowances from other facilities.<sup>348</sup> Since half of all Americans live within thirty miles of a coal-burning power plant, children and their families living near a power plant were likely to be exposed to substantially more mercury emissions than they are now.<sup>349</sup> Eleven states filed suit to invalidate the new Rule.<sup>350</sup>

Congressional critics also sought to overturn the Rule, citing the significant risks that mercury poses to fetuses and children. They noted that mercury was a recognized neurotoxin, which causes devastating effects on fetuses and young children because it interferes with normal brain development. They further noted that 4.9 million women of child-bearing age have elevated levels of mercury, 630,000 infants are born with elevated mercury levels, and 1,500 children are born each year with mental retardation due to in utero exposure to mercury.<sup>351</sup> Ultimately, this Congressional effort was defeated. Although EPA agreed to reconsider the rule,<sup>352</sup> in May 2006 the agency reaffirmed its original position.<sup>353</sup>

#### *D. Lack of Health Care Access in the United States and Its Consequences*

##### 1. Uninsured Children and Adults

Americans continue to lack health insurance coverage in record numbers. In 2005, 51.4 million Americans (almost 18%) were uninsured for at least some part of the previous year, and 29.3 million (more than 10%) had been uninsured for more than a year.<sup>354</sup> Although children were more likely than adults to have health insurance, 9.2 million chil-

348. Sullivan & Fazio, *supra* note 347, at 15-16; Kim McGuire, *New Mercury Rules Decried, Environmental Coalition Plans Lawsuits over EPA Changes, Activists Say the New Limits Will Allow More Mercury Pollution from Coal-Burning Power Plants-Which They Say Violates the Clean Air Act*, DENVER POST, May 18, 2005, at B-02.

349. Mark Clayton, *In Bid to Cut Mercury, US Lets Other Toxins Through*, CHRISTIAN SCIENCE MONITOR, Mar. 31, 2005, at 13, available at <http://www.csmonitor.com/2005/0331/p13s01-sten.html> (noting also that coal-fired power plants also emit many other serious pollutants, including "vanadium, barium, zinc, nickel, hydrogen fluoride, hydrochloric acid, ammonia, and selenium").

350. Don Hopey, *11 States Sue EPA on Mercury Rules: Pennsylvania Joins suit Saying Emission Standards Inadequate*, PITTSBURGH POST-GAZETTE, May 19, 2005, available at <http://www.post-gazette.com/pg/05139/507051.stm>.

351. Senate Debate on Disapproval of EPA Rule Promulgation, 151 CONG. REC. S9912, S9913-14 (2005).

352. Sullivan & Fazio, *supra* note 347, at 16.

353. EPA, FINAL RULE RECONSIDERING TWO MERCURY ACTIONS: (1) RECONSIDERATION OF RULE REVISING EARLIER REGULATORY FINDING AND REMOVING CERTAIN ELECTRIC STEAM GENERATING UNITS FROM THE LIST OF SOURCE CATEGORIES; AND (2) RECONSIDERATION OF THE CLEAN AIR MERCURY RULE FACT SHEET 1, 2 (May 31, 2006), <http://www.epa.gov/air/mercuryrule/pdfs/fs20060531.pdf>.

354. ROBIN A. COHEN & MICHAEL E. MARTINEZ, HEALTH INSURANCE COVERAGE: ESTIMATES FROM THE NATIONAL HEALTH INTERVIEW SURVEY, JANUARY-SEPTEMBER 2005 1 (Mar. 2006), <http://www.cdc.gov/nchs/data/nhis/earlyrelease/insur200603.pdf>.

dren (more than 12%) lacked health insurance for some portion of the year and an additional 3.9 million (more than 5%) had been without health care coverage for more than a year.<sup>355</sup> There are also substantial racial and ethnic disparities in insurance status, with Hispanics suffering the greatest access problems, although African-Americans also lagged behind their white counterparts. One-third of all Hispanics were uninsured for at least part of the previous year and one-quarter lacked health care coverage for more than a year.<sup>356</sup> About 13% of pregnant women lack health insurance coverage,<sup>357</sup> despite efforts to expand Medicaid during the last two decades.<sup>358</sup> Medicaid does insure a greater proportion of pregnant than non-pregnant women,<sup>359</sup> and pays for a third of all American births.<sup>360</sup>

The consequences of lack of health insurance for adults and children are profound. While prenatal care is seen as an important factor in leading to good birth-outcomes,<sup>361</sup> many poor and low-income American women continue to lack prenatal care,<sup>362</sup> and those who receive some prenatal care often receive it late in pregnancy, when it is less effective.<sup>363</sup> Similarly, while pediatricians and health policymakers agree that well-child visits are essential to providing necessary screening and other preventative care,<sup>364</sup> half of uninsured children fail to have even one well-child visit a year.<sup>365</sup> Children with private health insurance coverage are much more likely to have received all necessary immunizations than those who are uninsured or have government health insurance.<sup>366</sup>

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355. *Id.* at 8. This percentage that has not changed since 2002. *Id.* at 2-3.

356. *Id.* at 4. See also URBAN INSTITUTE, HEALTH INSURANCE TRENDS (2005), available at <http://www.urban.org/toolkit/issues/healthinsurance.cfm?renderforprint=1>.

357. KENNETH E. THORPE, JENNIFER FLOME & PETER JOSKI, THE DISTRIBUTION OF HEALTH INSURANCE COVERAGE AMONG PREGNANT WOMEN, 1999 5-6 (2001), available at <http://www.marchofdimes.com/files/2001FinalThorpeReport.pdf>. Forty-seven percent of poor pregnant women lacked Medicaid coverage in 1999. *Id.* at 10.

358. ROBERT WOOD JOHNSON FOUNDATION, *supra* note 32, at 5; U.S. GEN. ACCOUNTING OFFICE, GAO/PEMD-91-10: PRENATAL CARE: EARLY SUCCESS IN ENROLLING WOMEN MADE ELIGIBLE BY MEDICAID EXPANSIONS 7-8 (Feb. 1991), available at <http://archive.gao.gov/d21t9/143346.pdf> (describing legislative changes).

359. ROBERT WOOD JOHNSON FOUNDATION, *supra* note 32.

360. NATIONAL GOVERNORS ASSOCIATION CENTER FOR BEST PRACTICES, MATERNAL AND CHILD HEALTH UPDATE 2002: STATE HEALTH COVERAGE FOR LOW-INCOME PREGNANT WOMEN, CHILDREN, AND PARENTS I (June 10, 2003), <http://www.nga.org/Files/pdf/MCHUPDATE02.pdf>.

361. ROBERT WOOD JOHNSON FOUNDATION, *supra* note 32.

362. *Id.*

363. *Id.* at 8-9 (analyzing results of Medicaid expansions of the 1980's and early 1990's).

364. See, e.g., MEDICAID FACTS, *supra* note 29, at 1. The American Academy of Pediatrics recommends that children receive 10-11 well-child visits before the age of three, in order for pediatricians to monitor child behavior and development and prevent illness and behavioral and educational problems in the future. Steven Blumberg, Neal Halfon, & Lynn M. Olson, National Survey of Early Childhood Health, *National Survey of Early Childhood Health: Parents' Views on Preventive Care for Infants and Toddlers*, 113 PEDIATRICS 1899 (2004), available at <http://pediatrics.aappublications.org/cgi/reprint/113/6/S1/1899>.

365. URBAN INSTITUTE, *supra* note 356.

366. National Survey of Early Childhood Health, *National Survey of Early Childhood Health: Parents' Views on Preventive Care for Infants and Toddlers*, *supra* note 364, at 6.

## 2. Medicaid and SCHIP Need Improvement

Medicaid is a partnership between state and federal governments, which provides health insurance to the very poorest of American children and adults, persons with disabilities, and elderly needing long-term care.<sup>367</sup> All states participating in Medicaid agree to provide the same set of federally mandated services for children,<sup>368</sup> which are known as Early and Periodic Screening, Diagnostic, and Treatment Services (EPSDT).<sup>369</sup> These provide essential care for children, particularly those with disabilities and other special needs.<sup>370</sup> However, many children have not received the mandated EPSDT benefits, either because they cannot find a physician willing to accept the low Medicaid reimbursement rates,<sup>371</sup> or because some states have failed to adequately define the EPSDT services in their managed care contracts.<sup>372</sup> Several suits have been brought by groups of parents challenging the denial of benefits,<sup>373</sup> but it has been an uphill struggle to ensure that children enrolled in Medicaid receive all the

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367. For a good overview of the Medicaid program, see U.S. GEN. ACCOUNTING OFFICE, GAO-01-749, MEDICAID: STRONGER EFFORTS NEEDED TO ENSURE CHILDREN'S ACCESS TO HEALTH SCREENING SERVICES 1-8 (July 2001) [hereinafter GAO, MEDICAID REPORT].

368. States differ in the extent to which they provide covered services to the near-poor, as well as the desperately poor. For example, all states provide coverage to parents who earn no more than the Federal Poverty Level, which is \$16,600 for a family of three in the Lower Forty-Eight states. Only 14 states have raised their eligibility levels about the Federal Poverty Level. NATIONAL WOMEN'S LAW CENTER, POOR PARENTS ON MEDICAID TARGETED FOR CUTS 1-2 & 3 n.8 (Feb. 2006), available at [http://www.nwlc.org/pdf/FSPoorParentsTargeted\\_06.06.pdf](http://www.nwlc.org/pdf/FSPoorParentsTargeted_06.06.pdf).

369. Some state variation is permitted in what services are covered under the rubric of "family planning," which includes birth control, treatment of sexually transmitted diseases, and sterilization, NATIONAL WOMEN'S LAW CENTER, MEDICAID, BIRTH CONTROL AND WOMEN'S HEALTH 1 & 2 n.2 (Mar. 10, 2006), available at [http://www.nwlc.org/pdf/FSMedicaidBirthControlandWomensHealth\\_05.31.06.pdf](http://www.nwlc.org/pdf/FSMedicaidBirthControlandWomensHealth_05.31.06.pdf), thus risking reversal of recent gains in health outcomes for children and their parents, including the decrease in the rate of teenage pregnancy. ANNIE E. CASEY FOUNDATION, 2005 KIDS COUNT POCKET GUIDE 7 (2005), available at [http://www.aecf.org/kidscount/sld/db05\\_pdfs/entire\\_db.pdf](http://www.aecf.org/kidscount/sld/db05_pdfs/entire_db.pdf) (noting that the teen birth rate has steadily declined since 1991, reaching its lowest level ever, 43 births per 1,000, in 2002). Medicaid provides two-thirds of all federal and state family planning funding. NATIONAL WOMEN'S LAW CENTER, MEDICAID, BIRTH CONTROL AND WOMEN'S HEALTH, *supra* at 1.

370. See MEDICAID FACTS, *supra* note 29, at 1. EPSDT services provide all necessary preventative, diagnostic, and screening care necessary to prevent and treat acute and chronic health conditions, including both physical and mental ailments. Medicaid's goal in insisting that they be provided is not only to ameliorate individual patient suffering, but also to prevent the development of more serious health problems, which are both expensive and debilitating. *Id.*

371. *Id.* at 2.

372. *Id.* Some contend that the increased enrollment of Medicaid beneficiaries into managed care is the source of this failure, *id.*, while others assert that managed care enhances access to health care services, because Medicaid beneficiaries now have a medical home, rather than being forced to hunt for a provider willing to accept the historically low Medicaid fees. See Vernon Smith & Linda Hamacher, *The "Good Olde Days" of Fee-for-Service Were Not So Good After All: Managed Care Has Made Things Better* 3, 6-8 (Ass'n of Health Ctr. Affiliated Health Plans, Working Paper, May 2003), available at <http://www.ahcaph.org/publications/Working%20Papers/ffs%20is%20bad.pdf>.

373. Suits have been brought in at least 28 states. See GAO, MEDICAID REPORT, *supra* note 367, at 9; see, e.g., *Westside Mothers v. Haveman*, 289 F.3d 852, 863 (6th Cir. 2002) (holding that parents could seek injunctive relief against Michigan and managed care organizations with which Michigan had contracted to enforce the children's rights to receive EPSDT services); see also *Frew v. Hawkins*, 540 U.S. 431 (2004) (upholding a federal court consent decree in which Texas health officials agreed to provide EPSDT services to the more than one million child beneficiaries of the Texas Medicaid program, many of whom received services via managed care).

services to which they are entitled.<sup>374</sup> Other barriers to health care access under Medicaid are discussed below.

The State Child Health Insurance Program (SCHIP) was inaugurated in 1997, with the goal of giving states additional options in addressing the health care needs of children. In contrast to Medicaid, whose recipients are entitled to receive all mandated EPSDT services, SCHIP permits states to offer a less generous package of benefits, with the goal of reaching a larger group of enrollees.<sup>375</sup> SCHIP also authorizes states to provide services to the low-income parents of eligible children, and this opportunity for parental enrollment has increased the number of children who receive health care services.<sup>376</sup> However, children's health advocates, notably Sara Rosenbaum, have strongly criticized the SCHIP program for promising more than it actually delivers in terms of services to children.<sup>377</sup>

Unlike Medicaid,<sup>378</sup> the SCHIP program can be curtailed if states decide it is too generous or that they cannot afford it.<sup>379</sup> In the late 1990s, when the economy was strong, many states engaged in significant outreach activities, and Medicaid and SCHIP enrollments boomed, even though many eligible children and families were still not enrolled in the programs.<sup>380</sup> But as the economy faltered in the early twenty-first century, many states began to face large budget deficits. They scrambled to limit enrollment in SCHIP, either by freezing enrollment numbers, increasing procedural obstacles to enrollment, imposing cost-sharing measures, or limiting outreach activities.<sup>381</sup> As a result, SCHIP enrollment has fallen dramatically in many states.<sup>382</sup>

Further, as a result of the enactment of the Deficit Reduction Act of 2005,<sup>383</sup> federal and state spending on Medicaid will be significantly curtailed,<sup>384</sup> and some Medicaid enrollees will have to spend much more

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374. GAO, MEDICAID REPORT, *supra* note 367, at 1-2, 7-8.

375. Rosenbaum, Markus & Sonosky, *supra* note 29, at 18-21.

376. KAISER, IN A TIME OF GROWING NEED, *supra* note 160, at 9-10.

377. Rosenbaum, Markus & Sonosky, *supra* note 29, at 18-21.

378. Medicaid provides states with some flexibility in provision of services through its waiver procedures, but historically it has been difficult for states to make major cuts in services. However, the Deficit Reduction Act of 2005, Pub. L. 109-171, has made significant changes in Medicaid. See discussion *infra* in text accompanying notes 384-388. KAISER COMMISSION ON MEDICAID AND THE UNINSURED, DEFICIT REDUCTION ACT OF 2005: IMPLICATIONS FOR MEDICAID 1-3 (Feb. 2006), [hereinafter KAISER, DEFICIT REDUCTION ACT], available at <http://www.kff.org/medicaid/upload/7465.pdf>.

379. KAISER, ENROLLING CHILDREN, *supra* note 57, at 2.

380. KAISER, IN A TIME OF GROWING NEED, *supra* note 160, at 2, 4.

381. KAISER, ENROLLING CHILDREN, *supra* note 57, at 1-2.

382. *Id.*; see also KAISER, IN A TIME OF GROWING NEED, *supra* note 160, 1-4.

383. Pub. L. 109-171, 120 Stat. 4 (signed by President Bush Feb. 8, 2006).

384. The Congressional Budget Office estimates \$4.8 billion in reductions over the period 2006 - 2010 and \$26.1 billion over the next ten years. See KAISER, DEFICIT REDUCTION ACT, *supra* note 379, at 1.



out of pocket for their health care.<sup>385</sup> Congress made major changes in Medicaid, permitting states to charge families with incomes greater than 150% of the federal poverty level (\$24,900 for a family of three in 2006) premiums and cost-sharing (co-pays, etc.) for health care services, although these cost-sharing requirements are not to be applied to pregnant women and certain eligible children.<sup>386</sup> In addition, the law makes it harder for certain groups of children to receive the preventative EPSDT services previously mandated.<sup>387</sup>

### 3. Insurance Alone is Not the Answer

Two decades of research on Medicaid and SCHIP have shown that merely making government insurance available is insufficient to ensure adequate care, for a number of reasons.<sup>388</sup> First, because Medicaid was originally conceived of as part of the welfare system, it lacks necessary political support,<sup>389</sup> and many health care professionals choose not to participate because of the very low reimbursement rates.<sup>390</sup> Medicaid recipients often feel stigmatized, and many eligible families are discouraged from enrolling.<sup>391</sup> As noted, in some states, the shift of poor children and families into Medicaid and SCHIP managed care programs has created access and service problems which parallel those of middle class families in managed care,<sup>392</sup> with children failing to receive preventative screenings or other mandated services.<sup>393</sup> In other states, however, Medicaid managed care delivers better health care services to its enrol-

385. Although it appears that the primary impact of the Deficit Reduction Act of 2005 (DRA) will be to curtail government spending on behalf of elderly and disabled adults, the DRA will also affect some children and their families. *Id.* at 1-6.

386. *Id.* at 1-3.

387. *Id.* at 3.

388. ROBERT WOOD JOHNSON FOUNDATION, *supra* note 32, at 5.

389. John K. Iglehart, *The American Health Care System: Medicaid*, 340 N. E. J. MED. 403, 407 (1999) (noting that "Medicaid underscores the ambivalence of a society that continually struggles with the question of which citizens deserve access to publicly financed medical care, and under what conditions").

390. GAO, MEDICAID REPORT, *supra* note 367, at 13-14.

391. Alexandra Marks, *Healthcare 'Crisis' Grows for Middle Class*, CHRISTIAN SCIENCE MONITOR, Apr. 3, 2002, at USA 3; Lauren Terrazzano, *More Kids Uninsured; L.I. Is One of the Nation's Richest Areas But Its Children Are Insurance-Poor in Greater Numbers*, NEWSDAY, Aug. 20, 2005, at A08.

392. Some access problems are inevitable in a system which provides disincentives to treat. See *Pegram v. Herdrich*, 530 U.S. 211 (2000) (describing the incentives inherent in both managed care and fee-for-service medicine). For a fuller discussion of the problems of managed care, see CLARK C. HAVIGHURST, JAMES F. BLUMSTEIN, & TROYEN A. BRENNAN, *HEALTH CARE LAW AND POLICY* 1180-1298 (2d ed. 1998). Of course, one should be cautious in bashing managed care, since the fee-for-service health care system also has undesirable incentives, particularly to over-treat, which can be equally bad for patient well-being. *Id.* at 160-83.

393. GAO, MEDICAID REPORT, *supra* note 367, at 9-10, 12-13. For example, only 19% of Medicaid enrolled children five and under had been screened for lead poisoning, even though this group of children is "almost five times more likely than others to have a harmful blood lead level." *Id.* at 12. Only a fifth of eligible children aged two to five had visited a dentist within the previous year. *Id.*

les than the traditional fee-for-service model.<sup>394</sup> In any case, since Medicaid and SCHIP enrollees are frequently less well-educated, lack child care and convenient transportation, and are not native English speakers, it may be difficult for them to receive all of the care to which they are entitled.<sup>395</sup>

Further, either by design or inadvertence, Medicaid and SCHIP have substantial barriers to enrollment and utilization. These include complex eligibility rules (including in many states, denial of eligibility if the parents have even limited assets), cumbersome forms to fill out at inconvenient locations, and requirements of frequent reenrollment, as often as every six months.<sup>396</sup> SCHIP permits enrollees to be charged premiums or co-payments.<sup>397</sup> This can be a significant burden for low-income families enrolled in SCHIP.<sup>398</sup> Although it is necessary to ensure that enrollees meet the statutory means tests, and to acknowledge the possibility of "crowd-out" (the phenomenon by which consumers shift from privately funded health insurance to public programs),<sup>399</sup> if concerns about fraud or crowd-out become a major focus, many children will not have access to health care.<sup>400</sup>

#### 4. Inadequate Substance Abuse Programs

The resources presently available to treat women who abuse alcohol and other drugs are woefully inadequate. There are three major problems with most substance abuse programs: 1) they fail to recognize the significant relationship between domestic violence and women's mental illness and substance abuse;<sup>401</sup> 2) they do not take into account the differing treatment needs of men and women;<sup>402</sup> and 3) they do not provide the complementary support necessary for pregnant women and mothers to succeed in beating their addiction.<sup>403</sup> Only 14% of the drug treatment

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394. See, e.g., Patrick J. Roohan et al., *Quality Measurement in Medicaid Managed Care and Fee-for-Service, the New York State Experience*, 21 AM. J. MED. QUALITY 185 (2006); Smith & Hamacher, *supra* note 372.

395. GAO, MEDICAID REPORT, *supra* note 367, at 14.

396. KAISER, IN A TIME OF GROWING NEED, *supra* note 160, at 4-10 (summarizing recent changes made by states in Medicaid and SCHIP and their impact on enrollment).

397. *Id.* at 7, 13.

398. *Id.* at 6-8.

399. *Id.* at 14-15. For a general discussion of the crowd-out phenomenon, see John V. Jacobi, *Government Reinsurance Programs and Consumer-Driven Care*, 53 BUFF. L. REV. 537, 571-73 (2005).

400. See URBAN INSTITUTE, *supra* note 356.

401. Only 35% of drug treatment facilities in the United States have programs for persons needing treatment for both substance abuse and mental illness. See SUBSTANCE ABUSE & MENTAL HEALTH SERVICES ADMIN. OFFICE OF APPLIED STUDIES, DEP'T OF HEALTH & HUMAN SERVICES, NATIONAL SURVEY OF SUBSTANCE ABUSE TREATMENT SERVICES (N-SSATS): 2003, DATA ON SUBSTANCE ABUSE TREATMENT FACILITIES 4 (Sept. 2004), available at [http://www.dasis.samhsa.gov/03nssats/nssats\\_rpt\\_03.pdf](http://www.dasis.samhsa.gov/03nssats/nssats_rpt_03.pdf).

402. See *id.*

403. See *id.*

facilities in the United States have programs specifically designed to treat pregnant and postpartum women.<sup>404</sup>

Many women who abuse alcohol and other drugs were sexually abused or beaten as children and have significant mental health and self-esteem issues, which make it much more likely that they will misuse drugs.<sup>405</sup> Without acknowledgement of the causal connections between domestic violence, substance abuse, and mental illness and active intervention to prevent current domestic violence from continuing, women will not receive the support necessary to recover from addiction and mental illness.<sup>406</sup> Those who work in the government agencies that deal with domestic violence victims, including police, hospital staff, and social workers need more training in understanding the broad context of domestic violence, in order for their interventions to be appropriate and effective.<sup>407</sup>

Many drug treatment programs are not designed with the needs of women in mind. For example, traditional confrontational approaches, effective with male drug addicts, do not work well with women,<sup>408</sup> and women also have better treatment outcomes in programs that are for women only.<sup>409</sup> For women who are long-term abusers, residential programs are most effective,<sup>410</sup> but these programs must take into account the needs of women with children.<sup>411</sup> Child care, housing, health care, job training, and other vital supports are necessary if women are to stay "clean" and become self-sufficient.<sup>412</sup> Further, the Adoption and Safe Families Act should be amended to provide an exemption from its strict time limits, to acknowledge that addiction recovery does not fit neatly into the statutory timetable.<sup>413</sup> Finally, more programs must emphasize prevention, to treat addicted women before they become pregnant.<sup>414</sup>

##### 5. The Consequences of America's Inadequate Health Care System

Research over the last several decades has made clear the consequences of inadequate health care for America's women and children. Both maternal and infant mortality are higher in the United States than in

404. *Id.*

405. Paltrow, *supra* note 12, at 477; WOMEN'S LAW PROJECT, *supra* note 12, at 1.

406. WOMEN'S LAW PROJECT, *supra* note 12, at 3.

407. *Id.*

408. SANDRA L. BLOOM, *THE PVS DISASTER: POVERTY, VIOLENCE, AND SUBSTANCE ABUSE IN THE LIVES OF WOMEN AND CHILDREN* 165 (2002).

409. *Id.* at 164; WOMEN'S LAW PROJECT, *supra* note 12, at 5, 23.

410. BLOOM, *supra* note 408, at 108 (citing M. Daley et al., *The Impact of Substance Abuse Treatment Modality on Birth Weight and Health Care Expenditures*, 33 J. PSYCHOACTIVE DRUGS 57-66 (2001)).

411. BLOOM, *supra* note 408, at 164.

412. *Id.* (citing NAT'L INST. OF DRUG ADDICTION, *TREATMENT METHODS FOR WOMEN* 13652 (1999)).

413. See generally Roberts, *Punishing Drug Addicts Who Have Babies*, *supra* note 9.

414. See generally WOMEN'S LAW PROJECT, *supra* note 12.

many other nations.<sup>415</sup> American children are more likely to be born pre-term and at low or very low birthweight,<sup>416</sup> and are less likely to have preventative doctors' visits, obtain necessary immunizations, and access necessary reproductive and mental health care.<sup>417</sup> Study after study has shown that a focus on pregnant women as a vehicle for ensuring healthy children is too little, too late. Instead, comprehensive solutions, which address the systemic failure to take care of America's children, must be developed.

### III. CONCLUSIONS AND RECOMMENDATIONS

If we are to truly assist children to become healthy adults who are able to embrace life's opportunities, we must explore new ways of thinking about the health of children and the women who bear and raise them. There are six areas where change is crucial: ending poverty, providing universal health care, expanding substance abuse prevention and treatment programs, enhancing environmental and workplace protections, instituting no-fault compensation for children who are harmed in utero, and ending criminal and civil actions against pregnant women who may be placing their fetuses at risk.

#### *End Poverty*

Even making this recommendation seems both naïve and incredibly ambitious; yet it is an inescapable fact that being poor has serious adverse consequences for children's health and development. Children living in poverty (who are also more likely to be malnourished and homeless) have more learning disabilities and mental retardation, lower IQs, and higher rates of mental illness, behavioral problems, and greater physical health problems, than middle-income children.<sup>418</sup> The effects of childhood poverty continue through adulthood, perpetuating the cyclical connection between inadequate parental income and childhood disease and dysfunction.<sup>419</sup> With twelve million American children living in families with incomes less than the federal poverty level (and five mil-

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415. See *supra* text accompanying notes 52-59.

416. IOM Report, *supra* note 55.

417. KAISER, ENROLLING CHILDREN, *supra* note 57, at 1; GAO, MEDICAID REPORT, *supra* note 367, at 9, 12-13.

418. Charles Oberg, Maternal & Child Health Program, School of Public Health, University of Minnesota, *The Impact of Childhood Poverty on Health and Development*, HEALTHY GENERATIONS, May 2003, at 2 & 3 nn.7-10; See also Jane D. McLeod & Michael J. Shanahan, *Trajectories of Poverty and Children's Mental Health*, 37 J. HEALTH & SOCIAL BEHAVIOR 207, 207 (1996).

419. Anne Case, Darren Lubotsky & Christina Paxson, *Economic Status and Health in Childhood: The Origins of the Gradient*, 92 AM. ECON. REVIEW 1308, 1308-09 (2002). Studies indicate that malnutrition in utero has significant life-time consequences, which actually are more pronounced as people age. See Gina Kolata, *So Big and Healthy Nowadays, Grandpa Wouldn't Know You*, N.Y. TIMES, July 30, 2006, at A1.

lion of those children living on less than half that amount),<sup>420</sup> intervention is critical.

### *Provide Universal Health Care*

Universal health care coverage is essential if we are to provide children with the health care services necessary for them to grow, learn, and develop into healthy and productive adults, who in turn will have healthy children of their own. While there are many historical and philosophical reasons for America's reliance on the market to provide health care for its citizens,<sup>421</sup> we can no longer afford to ignore the health care needs of the one-sixth of the population who lack health insurance of any kind.<sup>422</sup> Estimates of the cost of providing health care coverage for all Americans range from thirty-three to sixty-nine billion dollars annually,<sup>423</sup> potentially less than the amount the American government currently spends on the war in Iraq.<sup>424</sup> While several states have recently enacted laws expanding health care coverage<sup>425</sup> a comprehensive solution requires a federal effort.

At the very least, a uniform federal health care program for children with a comprehensive set of benefits and services should be established.<sup>426</sup> This would avoid the cyclical contractions and expansions of state Medicaid and SCHIP programs which presently accompany economic upswings and downturns and make it difficult for states to pay for

420. NATIONAL CENTER FOR CHILDHOOD POVERTY, MAILMAN SCHOOL OF PUBLIC HEALTH, COLUMBIA UNIVERSITY, WHO ARE AMERICA'S POOR CHILDREN 1, available at [http://www.nccp.org/pub\\_cpt05b.html](http://www.nccp.org/pub_cpt05b.html).

421. See, e.g., Timothy S. Jost, *Why Can't We Do What They Do? National Health Reform Abroad*, 32 J. L. MED. & ETHICS 433 (2004).

422. URBAN INSTITUTE, *supra* note 356 (finding that 46.6 million Americans did not have insurance in 2005). As a practical matter, the uninsured do receive some health care through emergency room visits. Such care is expensive and often time-consuming. It is estimated that one-third of the care provided at hospital emergency departments is inappropriate. Ceci Connolly, *Some Finding No Room at the ER; Screening Out Non-Urgent Cases Stirs Controversy*, WASH. POST, Apr. 26, 2004, at A01. The high costs of providing emergency room care required under EMTALA, the Emergency Medical Treatment and Active Labor Act, and state anti-dumping laws are borne by hospitals and ultimately, the tax-payer. See *Aliessa v. Novello*, 754 N.E.2d 1085, 1093 (N.Y. 2001) (discussing the problem of immigrants who are denied care until their medical situation becomes an emergency).

423. URBAN INSTITUTE, *supra* note 356. These estimates appear to be in 2004 dollars. If it is not possible to establish health care for the entire population immediately, then, at a minimum, full coverage for children's health care should be established now, before the mass of Baby Boomers age into retirement, Medicare, and the need for long-term care.

424. In February, 2006, the Department of Defense stated that it was spending \$4.5 billion a month (or \$54 billion a year) on the Iraq war. Mark Mazetti & Joel Haveman, *Iraq War is Costing \$100,000 per Minute*, SEATTLE TIMES, Feb. 3, 2006; Mark Silva, *\$70 Billion Sought for War Costs; White House Says Another \$50 Billion Needed for 2007*, CHI. TRIB., Feb. 3, 2006, at C1.

425. The most notable are the Massachusetts Health Care Access and Affordability Act, ch. 58 (2006), available at <http://www.mass.gov/legis/laws/seslaw06/sl060058.htm>, and the Maryland Fair Share Health Care Fund Act, MD. CODE ANN., LAB. & EMPL. § 8.5-101 *et. seq.*, partially invalidated by *Retail Indus. Leaders Ass'n v. Fielder*, 435 F. Supp. 2d 481 (D. Md. 2006) (finding the act preempted by the Employment Retirement Income Security Act of 1974).

426. The Medicaid EPSDT program should be seen as a floor, not a ceiling. See Rosenbaum, Markus & Sonosky, *supra* note 29, at 43; see also *supra* text accompanying notes 370-401.

adequate health care in times of fiscal exigency.<sup>427</sup> With national universal coverage, children will not lose access to vital health services because their parents move or change jobs, fail to fill out cumbersome paperwork, earn slightly more or less income, or are unable to afford premiums and co-payments.<sup>428</sup> Further, boys and girls who receive good health care will become adults who are more likely to bear healthy children.

Ultimately, however, if we want to meet the goal of having more American children in good health, it will be necessary to provide health care for all adults as well. Issues of nutrition, infertility, sterility, sexually transmitted diseases, and reproductive problems must be addressed in the adult population if we are to achieve better birth outcomes.

*Provide Expanded and Targeted Substance Abuse Programs for Pregnant Women and Addicts Who Are Likely to Become Pregnant*

As noted above, substance abuse education and treatment programs must be expanded and improved in order to serve both addicted women and the children they bear. Treatment which takes into account the special needs of women with drug and alcohol problems has been shown to be effective and to save money over the long run.<sup>429</sup>

*Improve Environmental, Workplace, and Public Health Protections*

At the same time, medical treatment alone is insufficient to ensure children's health. Environmental, workplace, and other public health laws must be strengthened to protect children from exposure to toxic substances, whether exposure is in utero or after birth. In addition, the government should mandate paid parental leave so that parents will be able to care for their children when they are infants or ill.

*Establish a No-Fault Program to Compensate Children Who Suffer Prenatal Harm*

One way that the government can respect the autonomy of pregnant women, compensate children who are harmed due to prenatal injury or exposure to toxic substances, and respond to the fears of employers and others about tort liability is to establish a national prenatal injury compensation program. Such a program could be funded by modest contributions by employers and manufacturers of toxic substances, including alcohol. Such a program could be modeled on the National Childhood Vaccine Injury (NCVI) program,<sup>430</sup> enacted in 1986 to encourage vac-

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427. Smith & Hamacher, *supra* note 372, at 12-13.

428. See generally KAISER, IN A TIME OF GROWING NEED, *supra* note 160.

429. BLOOM, *supra* note 408, at 163-75.

430. The National Childhood Vaccine Injury Act of 1986, 42 U.S.C. §§ 300aa-1-33, created a program to provide compensation children injured by state-mandated vaccines, as a means of ensuring that children who suffer injury from vaccination will be compensated, that parents will be en-

cine manufacturers to continue producing vaccines for childhood diseases while simultaneously compensating the small number of children who were injured as a result of vaccination, and thus reassure parents who might otherwise decide not to vaccinate their children. The NCVI has proved extraordinarily successful in meeting all three of its goals, and has been touted as a model for other tort-based consumer protection problems.<sup>431</sup>

The program I propose acknowledges that women, men, and children face risks from the food and drink they consume, the environment, and the workplace, and that manufacturers of dangerous substances should be held responsible for the harm caused by in utero exposure, even when they try to minimize those risks. Children who suffer harm from an otherwise socially desired or valued product must be compensated, just as they are under the National Childhood Vaccine Injury Program. The proposed program would involve a compromise, limiting liability of manufacturers and employers in exchange for guaranteeing compensation to prenatally injured children. These trade-offs are superior to the current approach of excluding women from the workplace or otherwise penalizing women for their conduct during pregnancy. Manufacturers would have an incentive to minimize the exposure to the toxic substances they use and produce, whether it is lead used to make batteries, mercury and other environmental contaminants, nicotine and tar in cigarettes, or alcohol in wine, beer, and liquor.<sup>432</sup> Even sellers and distributors of illegal drugs could be made to contribute to the PIC fund, by requiring monetary victim restitution as part of their criminal sentences.<sup>433</sup>

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courage to vaccinate their children, and that manufacturers will not be discouraged from entering and participating in the vaccine market because of fears of liability for products that are "unavoidably unsafe." Theodore H. Davis, Jr. & Catherine B. Bowman, *No-Fault Compensation for Unavoidable Injuries: Evaluating the National Childhood Vaccine Injury Compensation Program*, 16 U. DAYTON L. REV. 277, 279 (1991).

431. Derry Ridgway, *No-Fault Vaccine Insurance, Lessons from the National Vaccine Injury Compensation Program*, 24 J. HEALTH POL. POL'Y & LAW 59, 76-88 (1999); Geoffrey Evans, *Update on Vaccine Liability in the United States: Presentation at the National Vaccine Program Office Workshop on Strengthening the Supply of Routinely Recommended Vaccines in the United States*, 12 February 2002, 42 CLINICAL INFECTIOUS DISEASES S130-S137 (Mar. 1, 2006), abstract available at <http://www.journals.uchicago.edu/cgi-bin/resolve?id=doi:10.1086/499592&erFrom=7871817745696282041> Guest. Under the National Vaccine Injury Compensation Program, manufacturers pay a tax of \$0.75 per dose of vaccine administered. Ridgway, *supra* at 62, <http://content.nejm.org/cgi/reprint/340/5/403.pdf>.

432. Thus, for example, alcohol manufacturers and distributors would have an economic incentive to make warning labels about the effects of alcohol during pregnancy clearer, more conspicuous, and more explicit. Press Release, Center for Science in the Public Interest, Alcohol Warning Labels Go Unnoticed, Poll Finds (Aug. 20, 200), available at [http://www.cspinet.org/booze/batf\\_labels2001\\_press.htm](http://www.cspinet.org/booze/batf_labels2001_press.htm).

433. Cf. U.S. SENTENCING GUIDELINES MANUAL §§ 5E1.1, 8B1.1 (2005), available at [http://www.ussc.gov/2005guid/5e1\\_1.htm](http://www.ussc.gov/2005guid/5e1_1.htm) and [http://www.ussc.gov/2005guid/8b1\\_1.htm](http://www.ussc.gov/2005guid/8b1_1.htm) (requiring individual and organizational defendants to pay restitution to their victims).

*End Civil Commitment and Involuntary Medical Treatment of Pregnant Women*

The involuntary restraint and compulsory medical treatment of pregnant women is counterproductive, deterring women from seeking medical and psychological help. Physicians and hospitals are fallible. They do a profound disservice to those whom they wish to help when they rely on court orders rather than trying to advise and persuade pregnant patients about what is in their (and their fetuses') best interest. There is substantial evidence that health care providers are relying on racial and class stereotypes when they decide when to seek judicial intervention.<sup>434</sup> Similarly, there is no reason for legislatures to disable women from exercising the right to self-determination when pregnant, by rendering their advance medical directives invalid.

*End Civil and Criminal Liability of Pregnant Women for Causing Prenatal Harm*

The thesis of this article is that holding women civilly or criminally liable for their actions while pregnant is bad public policy. Imposing criminal or civil liability deters women from seeking medical care, including treatment for drug and alcohol addiction, leading to worse, rather than better, birth outcomes, and raises significant normative questions about who is the reasonable pregnant woman.<sup>435</sup> Some American courts,<sup>436</sup> as well as those in other countries,<sup>437</sup> have acknowledged that there is no way to prescribe the standard of appropriate behavior while pregnant with any certainty, that making a judgment about recklessness or negligence is inevitably subjective, and thus is freighted with the possibility of prejudice and bias. Further, most efforts at criminal prosecution or civil commitment have focused on poor women and women of color,<sup>438</sup> despite evidence that drug usage during pregnancy is equivalent across racial and economic lines, with the only difference being that white and middle-class women tend to use alcohol, a legal drug, rather than cocaine.<sup>439</sup>

Attacking pregnant women provides a simplistic solution to a complex problem. Courts and legislatures should avoid this meretricious solution, recognizing the unique relationship between pregnant woman

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434. See generally Chasnoff, *supra* note 10; Roberts, *Unshackling Black Motherhood*, *supra* note 9.

435. *Chenault v. Huie*, 989 S.W.2d 474, 477-78 (Tex. App. 1999).

436. *Chenault*, 989 S.W.2d at 477-78; *Stallman v. Youngquist*, 531 N.E.2d 355, 360 (Ill. 1988); *Kilmon v. State*, 905 A.2d 306, 310-15 (Md. 2006).

437. *Dobson v. Dobson*, 2 S.C.R. 753 (Can. 1999); *Winnipeg Child & Family Services (Northwest Area) v. G. (D.F.)*, 3 S.C.R. 925 (Can. 1997); *Paton v. United Kingdom*, App. No. 8416/78, 3 Eur. H.R. Rep. 408, 415 (1980).

438. BLOOM, *supra* note 408, at 109; Chasnoff, *supra* note 10; Roberts, *Unshackling Black Motherhood*, *supra* note 9.

439. BLOOM, *supra* note 408, at 109-10.



and the fetus.<sup>440</sup> Government policymakers should acknowledge that the vast majority of pregnant women want only the best for the fetus whom they are nourishing, and that in almost all cases women who are not acting in the best interests of their fetus are facing heavy burdens of poverty, addiction, lack of access to quality health care, and domestic abuse. The way to help such women, and the children they will bear, is to change the system in which they are now struggling, not to make pregnant women the scapegoat for that system's failures.

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440. *Stallman*, 531 N.E.2d at 360.

