APPENDIX

A

AMICI CURIAE STATEMENTS OF INTEREST

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Amicus Curiae **American Academy of Addiction Psychiatry (AAAP)** is an international professional membership organization made up of practicing psychiatrists, university faculty, medical students and other related professionals. Founded in 1985, it currently represents approximately 1,000 members in the United States and around the world. AAAP is devoted to promoting access to continuing education for addiction professionals, disseminating new information in the field of addiction psychiatry, and encouraging research on the etiology, prevention, identification, and treatment of addictions. AAAP opposes the prosecution of pregnant women based on the belief that the disclosure of personal drug use to law enforcement for use in criminal prosecutions will undermine prenatal care, discourage many women from seeking substance abuse treatment, and damage the medical provider-patient relationship that is founded on principles of confidentiality.

Amicus Curiae **American Medical Women's Association (AMWA)** is a national, non-profit organization of over 10,000 women physicians and physicians-in-training representing every medical specialty. Founded in 1915, AMWA is dedicated to promoting women in medicine and advocating for improved women's health policy. AMWA strongly supports treatment and rehabilitation of women who use alcohol and drugs during pregnancy, and opposes the arrest, jailing and/or prosecution of pregnant women as a method for preventing or punishing chemical dependency during pregnancy. AMWA encourages all pregnant women to seek prenatal care and believes that breaching the medical confidentiality of these women or otherwise hindering their ability to establish a relationship of trust with their treatment providers will deter women, especially those that may be at high risk for adverse pregnancy outcomes, from receiving prenatal care.

Amicus Curiae **American Public Health Association (APHA)** is a national organization devoted to the promotion and protection of personal and environmental health. Founded in 1872, APHA is the largest public health organization in the world, representing over 50,000 public health professionals. It represents all disciplines and specialties in public health, including maternal and child health and substance abuse. APHA strives to improve public health for everyone by proposing solutions based on research, helping to set public health practice standards, and working closely with national and international health agencies.

Amicus Curiae **American Society of Addiction Medicine (ASAM)** is devoted to increasing access to and improving the quality of addiction treatment. ASAM members are physicians from all medical specialties and subspecialties and are engaged in private practice, serve as corporate medical directors, work in group practice or other clinical settings, and are also involved in research and education. Through its conferences, continuing medical education courses, and publications (including the textbook,

Principles of Addiction Medicine (Third edition, 2002)), ASAM actively educates the medical community and the public about addiction disorders and diseases, treatment guidelines, and practice parameters in the field of addiction medicine. ASAM staunchly opposes policies that create obstacles to or deter persons from receiving substance treatment or counseling.

Amicus Curiae **Association of Reproductive Health Professionals (ARHP)** is a national non-profit, interdisciplinary medical association for leaders in the field of reproductive health. Founded in 1963 and comprised of physicians, nurse practitioners, other clinicians, pharmacists, and researchers, ARHP serves as an important source of reproductive health education and information for health care professionals, patients, legislators, other professionals, and the public at large. ARHP is concerned that the punitive response threatens to undermine the quality of care provided by physicians, nurse practitioners, and other clinicians who treat pregnant and parenting women in Texas by threatening prosecution, conviction, and incarceration - rather than treatment for their substance use during pregnancy.

Amicus Curiae **Center for Gender and Justice (CGJ)** seeks to develop gender - responsive policies and practices for women and girls who are under criminal justice supervision. The Center is committed to research and to the implementation of policies and programs that will encourage positive outcomes for this underserved population.

Amicus Curiae **Child Welfare Organizing Project (CWOP)** is a 14-year-old organization of New York City parents and professionals who seek reform of New York City child welfare practices through increased, meaningful parent/client involvement in child welfare decision-making at all levels, from case-planning to policy, budgets and legislation. CWOP has approximately 1,500 parent members. Most of CWOP's staff, and about half of CWOP's Board of Directors, are parents who have had direct, personal involvement with child welfare services. A significant percentage of CWOP members are mothers in recovery. A large part of CWOP's work involves debunking prevailing stereotypes about parents and families involved with child welfare services, putting a human face on parents who are often unfairly and inaccurately demonized, and bringing CWOP's unique insights into policy discussions. CWOP hopes this will result in more enlightened public policy that effectively identifies and addresses real problems and challenges to successful family life, ultimately protecting children by helping and strengthening their families and communities.

Amicus Curiae **Citizens for Midwifery (CfM)** is a national, non-profit, and consumer-based group that promotes maternal and child health through advocating the Midwives Model of Care and seeks to have these practices recognized as an accepted standard of care for childbearing mothers. In focusing on the normalcy of childbirth and the uniqueness of each childbearing woman and family, this model includes monitoring the physical, psychological, and social well-being of childbearing mothers, providing

pregnant women with individualized prenatal care and hands-on assistance during interventions, and identifying women who require obstetrical attention. As an organization CfM also provides information on midwifery and childbirth issues, encourages and provides guidance for midwifery and childbirth issues, and represents consumer interests regarding midwifery and maternity care.

Amicus Curiae **Drug Policy Alliance (The Alliance)** is the nation's leading advocacy organization dedicated to broadening the public debate over drug use and regulation and to advancing pragmatic drug laws and policies, grounded in science, compassion, public health and respect for human rights. The Alliance is a non-profit, non-partisan organization with more than 25,000 members and active supporters nationwide. The Alliance has actively taken part in cases in state and federal courts across the country in an effort to bring current scientific and public health data to bear on drug-related issues, and to combat irrational fears, prejudices and misconceptions about various drug-related matters that have, with regrettable frequency, distorted sound public policies regarding drug users and their families.

Amicus Curiae **Family Justice** is an organization that draws on the unique strengths of families and neighborhoods to break cycles of involvement with the criminal justice system. It works on engaging families in support of those released under community supervision and demonstrates the positive effect that families have on the reentry and rehabilitation process. In pursuing its mission, Family Justice assists government and communities by providing direct services, testing new methodology that promotes change, delivering training and consulting to encourage use of its methods, and serving as a resource for both the criminal justice field and the general public.

Amicus Curiae **Global Lawyers and Physicians (GLP)** is a non-profit non-governmental organization that focuses on health issues and human rights. Founded in 1996, GLP was formed to reinvigorate the collaboration of the legal, medical and public health professions in protecting the human rights and dignity of all persons. GLP's mission is to implement the health-related provisions of the Universal Declaration of Human Rights and the Covenants on Civil and Political Rights and Economic, Social, and Cultural Rights, with a focus on health and human rights, patient rights, and human experimentation.

Amicus Curiae **Harm Reduction Coalition (HRC)** is committed to reducing drug-related harm among individuals and communities by initiating and promoting local, regional, and national harm reduction education, interventions, and community organizing. HRC fosters alternative models to conventional health and human services and drug treatment; challenges traditional client/provider relationships; and provides resources and educational materials. HRC also supports health professionals and drug users in their communities to address drug-related harm. HRC believes in every

individual's right to health and well-being as well as in their competency to protect and help themselves, their loved ones, and their communities.

Amicus Curiae **Institute for Health and Recovery (IHR)** is a non-profit organization dedicated to developing a comprehensive continuum of care for families affected by substance abuse, especially women and their children. IHR focuses on the development of prevention, intervention, treatment services and the integration of gender-specific services within substance abuse prevention and treatment. IHR serves individual women and men, and families, with a continuing emphasis on pregnant and parenting women and their children. IHR members know firsthand the fears pregnant substance-abusing women have regarding prosecution, causing them to be reluctant to seek prenatal care and substance abuse treatment. With over 10 years of experience in working with pregnant women who use drugs, IHR rejects practices such as those used to punish Amber Lovill.

Amicus Curiae **Interfaith Drug Policy Initiative (IDPI)** has 5,000 members - clergy and other people of faith from dozens of denominations - who advocate that drug policies should be grounded in the universal religious values of compassion and justice. We are convinced by the overwhelming consensus of the health and medical community that incarceration of pregnant women who use drugs, rather than increasing access to and provision of health services, is detrimental to the health of pregnant women, mothers and children.

Amicus Curiae **The International Center for Advancement of Addiction Treatment's (ICAAT)** mission is to promote among medical professionals the humane treatment of people who are living with opioid addiction by making available to healthcare providers, policymakers, and members of the public, relevant medical, legal and policy information and by advocating for change in attitudes that constrain optimal treatment delivery. It strives to fulfill the mission through two main initiatives: 1) Collaborative research into the nature of chemical dependency and the experiences of different countries in responding to the need for treatment, particularly through care by community based medical practitioners; 2) Assistance to practitioners to facilitate the delivery of optimally effective medical care for addiction, including the creation and operation of an Internet website (OpiateAddictionRx.org) and to facilitate support, information flow and ongoing communication among treatment providers.

Amicus Curiae **Law Enforcement Against Prohibition (LEAP)** is a 10,000 member international non-profit educational organization, founded and run by police, judges, and prosecutors. LEAP was created to give voice to law-enforcers who believe the US war on drugs has failed and who wish to support alternative policies that will lower the incidence of death, disease, crime, and addiction, without destroying generations of our young by arrest and imprisonment. LEAP does not condone drug abuse but we know "Legalized Regulation of Drugs" will end the violent and property crime that are a result of prohibition of those drugs. We can then treat drug abuse as a health problem instead

of a crime problem and save the lives of our children, which we are now sacrificing at the altar of this terrible war.

Amicus Curiae **National Association of Nurse Practitioners in Women's Health (NPWH)**, formerly National Association of Nurse Practitioners in Reproductive Health, is a professional organization founded in 1980 that represents nurse practitioners who provide care to women in both the primary care setting and in women's health specialty practices. The U.S. Department of Education recognizes NPWH as the designated organization for the accreditation of women's health nurse practitioner programs. NPWH is committed to assuring access of quality health care to women of all ages by nurse practitioners, and to protecting a woman's right to determine the course of her own health care. NPWH programs and publications offer special expertise in reproductive health care and nurse practitioner issues.

Amicus Curiae **National Association of Social Workers (NASW)** is the world's largest association of professional social workers with 145,000 members in fifty-six chapters throughout the United States and abroad. Founded in 1955 from a merger of seven predecessor social work organizations, NASW is devoted to promoting the quality and effectiveness of social work practice, advancing the knowledge base of the social work profession, and improving the quality of life through utilization of social work knowledge and skills. NASW believes that criminal prosecution of women who use drugs during their pregnancy is inimical to family stability and counter to the best interests of the child. The needs of society are better served by treatment of addiction, not punishment of the addict. NASW's policy statement, Alcohol, Tobacco, and Other Drugs, supports "an approach to ATOD [alcohol, tobacco and other drug] problems that emphasizes prevention and treatment" and efforts to "eliminate health disparities that accrue from ATOD problems and discriminatory practices from the criminal justice system." (NASW, SOCIAL WORK SPEAKS, 7th ed., 2006).

Amicus Curiae **National Association of Social Workers – Texas (NASW-TX)** has 5,400 members and is particularly interested in this case due to its significant local impact.

Amicus Curiae **National Council on Alcoholism and Drug Dependence (NCADD),** with its nationwide network of affiliates, provides education, information, and hope in the fight against the chronic diseases of alcoholism and other drug addictions. Founded in 1944 and based in New York, NCADD historically has provided confidential assessment and referral services for alcoholics and other drug addicts seeking treatment. In 1990, the NCADD Board of Directors adopted a policy statement on "Women, Alcohol, Other Drugs and Pregnancy" recommending that "[s]tates should avoid measures which would define alcohol and other drug use during pregnancy as prenatal child abuse and should avoid prosecutions, jailing or other punitive measures which would serve to discourage women from seeking health care services."

Amicus Curiae **National Latina Institute for Reproductive Health (NLIRH)** wants to ensure the fundamental human right to reproductive health care for Latinas, their families and their communities through education, policy advocacy, and community mobilization. Through advocacy, community mobilization, and public education, NLIRH is shaping public policy, cultivating new Latina leadership, and broadening the reproductive health and rights movement to reflect the unique needs of Latinas. NLIRH believes that coercive, discriminatory and/or punitive policies and practices (such as the criminalization of pregnant substance users) are differentially impacting Latinas and other women of color.

Amicus Curiae **National Women's Health Network (NWHN)** improves the health of all women by developing and promoting a critical analysis of health issues in order to affect policy and support consumer decision-making. The NWHN aspires to a health care system that is guided by social justice and reflects the needs of diverse women. NWHN was founded in 1975 to give women a greater voice within the healthcare system. NWHN is a membership-based organization supported by 8,000 individuals and organizations nationwide. NWHN has established core values to guide us in our work as advocates for women's health: (1) We value women's descriptions of their own experiences and believe that health policy should reflect the diversity of women's experiences, (2) we believe that evidence rather than profit should drive the services offered and information that is made available to women to inform their health decision-making and practices, (3) we value analysis of science that takes into consideration systems of power and oppression, (4) we believe that the government has an obligation to safeguard the health of all people, (5) all women should have access to excellent health care and (6) women's normal physiological changes over a lifespan should not be unduly medicalized.

Amicus Curiae **Physicians for Reproductive Choice and Health (PRCH)** exists to ensure that all people have the knowledge, access to quality services, and freedom to make their own reproductive health decisions.

Amicus Curiae **Texas Civil Rights Project (TCRP)** promotes racial, social, and economic justice through education and litigation. TCRP strives to foster equality, secure justice, ensure diversity, and strengthen communities. TCRP uses education and litigation to make structural change in areas such as prison conditions, voting rights, police and border patrol misconduct, sex discrimination, employment bias, privacy, disability rights, grand jury discrimination, and traditional civil liberties. TCRP is very concerned with the conditions in Texas prisons and jails, and receives complaints about the poor quality of health care in Texas correctional facilities every week.

Amicus Curiae **Susan C. Boyd, Ph.D.**, is Associate Professor in the Studies in Policy and Practice Program at University of Victoria, and a Senior Research Fellow in the Centre

for Addictions Research of British Columbia. Her research is on gender and maternal drug use, women in conflict with the law, drug law and policy, and research methodology. Professor Boyd is author of *Mothers and Illicit Drugs: Transcending the Myths, From Witches to Crack Moms: Women, Drug Law, and Policy*, and co-author of *With Child, Substance Use During Pregnancy: a Woman-Centered Approach.*

Amicus Curiae **Wendy Chavkin, M.D., M.P.H.**, is a Professor of Clinical Public Health and Obstetrics/Gynecology at Columbia University, Mailman School of Public Health and College of Physicians and Surgeons in New York City. She is a 2004-2005 Fulbright New Century Scholar conducting research on policies relating to fertility decline. Dr. Chavkin currently serves as the director of the Soros Reproductive Health and Rights Fellowship. She has written extensively about women's reproductive health issues for over two decades. She has done extensive programmatic and policy research related to illegal drug use by pregnant women, punishment and lack of care.

Amicus Curiae **Stephanie S. Covington, Ph.D., L.C.S.W.,** has more than twenty-five years of experience in the design, development, and implementation of treatment services for women. She is recognized for her work on gender-responsive services in both the public and private sectors. Her fifteen years of experience in the criminal justice system include training, speaking, and writing, as well as consulting with varied national, state, and local corrections agencies in the United States and Canada. Dr. Covington has published extensively. She co-authored the multi-year National Institute of Corrections project report "Gender-Responsive Strategies: Research, Practice, and Guiding Principles for Women Offenders."

Amicus Curiae **Deborah A. Frank, M.D.**, is a Professor of Pediatrics at Boston University School of Medicine. Dr. Frank is also an Assistant Professor of Social and Behavioral Sciences at the Boston University School of Public Health. Since 1981 she has been the Director of the Failure to Thrive Program at the Boston Medical Center where she is also a staff physician in the Child Development Unit. In 1993 she was named a Fellow of the Society for Pediatric Research. Dr. Frank is a recognized expert on the effect of maternal substance abuse on fetal development and newborn behavior. She has published widely on these topics, including numerous articles concerning prenatal cocaine and methamphetamine exposure. In 2002, Dr. Frank testified before the United States Sentencing Commission concerning the effects of prenatal cocaine exposure. Dr. Frank comes to this Court in her capacity as *amicus curiae* in order to ensure that prevalent stigma and stereotypes about the nature of women who use drugs during pregnancy do not prevent the Court from understanding the medical issues in the case.

Amicus Curiae **Michael A. Grodin, M.D., F.A.A.P.**, is Director of the Bioethics and Human Rights Program and Professor of Health Law, Bioethics, Human Rights, Socio-Medical Sciences, and Community Medicine and Psychiatry at the Boston University Schools of Public Health and Medicine, where he is the recipient of the Norman A.

Scotch Award for Excellence in Teaching. In addition, Dr. Grodin is a Professor of Philosophy in the College of Arts and Sciences. Dr. Grodin has been on the faculty of Boston University for the past 26 years. Dr. Grodin is the Medical Ethicist at Boston Medical Center and for thirteen years served as the Human Studies Chairman for the Department of Health and Hospitals of the City of Boston. Dr. Grodin serves on the Ethics Committee of the Massachusetts Center for Organ Transplantation, is a consultant to the National Human Subjects Protection Review Panel of the National Institutes of Health AIDS Program Advisory Committee, and is a consultant on Ethics and Research with Human Subjects for the International Organizations of Medical Sciences and the World Health Organization. Dr. Grodin is the Co-Founder of Global Lawyers and Physicians.

B

CONSTITUTIONAL AND STATUTORY PROVISIONS

C

United States Code Annotated Currentness
Constitution of the United States
Annotated
Amendment XIV. Citizenship; Privileges and Immunities; Due Process; Equal Protection; Apportionment of Representation; Disqualification of Officers; Public Debt; Enforcement

➡AMENDMENT XIV. CITIZENSHIP; PRIVILEGES AND IMMUNITIES; DUE PROCESS; EQUAL PROTECTION; APPOINTMENT OF REPRESENTATION; DISQUALIFICATION OF OFFICERS; PUBLIC DEBT; ENFORCEMENT

Section 1. All persons born or naturalized in the United States, and subject to the jurisdiction thereof, are citizens of the United States and of the State wherein they reside. No State shall make or enforce any law which shall abridge the privileges or immunities of citizens of the United States; nor shall any State deprive any person of life, liberty, or property, without due process of law; nor deny to any person within its jurisdiction the equal protection of the laws.

Section 2. Representatives shall be apportioned among the several States according to their respective numbers, counting the whole number of persons in each State, excluding Indians not taxed. But when the right to vote at any election for the choice of electors for President and Vice President of the United States, Representatives in Congress, the Executive and Judicial officers of a State, or the members of the Legislature thereof, is denied to any of the male inhabitants of such State, being twenty-one years of age, and citizens of the United States, or in any way abridged, except for participation in rebellion, or other crime, the basis of representation therein shall be reduced in the proportion which the number of such male citizens shall bear to the whole number of male citizens twenty-one years of age in such State.

Section 3. No person shall be a Senator or Representative in Congress, or elector of President and Vice President, or hold any office, civil or military, under the United States, or under any State, who, having previously taken an oath, as a member of Congress, or as an officer of the United States, or as a member of any State legislature, or as an executive or judicial officer of any State, to support the Constitution of the United States, shall have engaged in insurrection or rebellion against the same, or given aid or comfort to the enemies thereof. But Congress may by a vote of two-thirds of each House, remove such disability.

Section 4. The validity of the public debt of the United States, authorized by law, including debts incurred for payment of pensions and bounties for services in suppressing insurrection or rebellion, shall not be questioned. But neither the United States nor any State shall assume or pay any debt or obligation incurred in aid of insurrection or rebellion against the United States, or any claim for the loss or emancipation of any slave; but all such debts, obligations and claims shall be held illegal and void.

Section 5. The Congress shall have power to enforce, by appropriate legislation, the provisions of this article.

END OF DOCUMENT

C

Effective: [See Text Amendments]

VERNON'S TEXAS STATUTES AND CODES ANNOTATED

CONSTITUTION
OF THE
STATE OF TEXAS 1876

ARTICLE I . BILL OF RIGHTS

➞ **§ 3a. Equality under the law**

Sec. 3a. Equality under the law shall not be denied or abridged because of sex, race, color, creed, or national origin. This amendment is self-operative.

Current through the end of the 2007 Regular Session of the 80th Legislature

END OF DOCUMENT

C

Effective: September 1, 2007

Vernon's Texas Statutes and Codes Annotated Currentness
Code of Criminal Procedure (Refs & Annos)
Title 1. Code of Criminal Procedure of 1965
Proceedings After Verdict
Chapter 42. Judgment and Sentence (Refs & Annos)
→ Art. 42.12. [781d] Community supervision

Purpose

Sec. 1. It is the purpose of this article to place wholly within the state courts the responsibility for determining when the imposition of sentence in certain cases shall be suspended, the conditions of community supervision, and the supervision of defendants placed on community supervision, in consonance with the powers assigned to the judicial branch of this government by the Constitution of Texas. It is the purpose of this article to remove from existing statutes the limitations, other than questions of constitutionality, that have acted as barriers to effective systems of community supervision in the public interest.

Definitions

Sec. 2. In this article:

(1) "Court" means a court of record having original criminal jurisdiction.

(2) "Community supervision" means the placement of a defendant by a court under a continuum of programs and sanctions, with conditions imposed by the court for a specified period during which:

(A) criminal proceedings are deferred without an adjudication of guilt; or

(B) a sentence of imprisonment or confinement, imprisonment and fine, or confinement and fine, is probated and the imposition of sentence is suspended in whole or in part.

(3) "Supervision officer" means a person appointed or employed under Section 76.004, Government Code, to supervise defendants placed on community supervision.

(4) "Electronic monitoring" includes voice tracking systems, position tracking systems, position location systems, biometric tracking systems, and any other electronic or telecommunications system that may be used to assist in the supervision of individuals under this article.

[Sections 3-10 Omitted]

Basic Conditions of Community Supervision

Sec. 11. (a) The judge of the court having jurisdiction of the case shall determine the conditions of community supervision and may, at any time, during the period of community supervision alter or modify the conditions. The judge may impose any reasonable condition that is designed to protect or restore the community, protect or restore the victim, or punish, rehabilitate, or reform the defendant. Conditions of community supervision may include, but shall not be limited to, the conditions that the defendant shall:

(1) Commit no offense against the laws of this State or of any other State or of the United States;

(2) Avoid injurious or vicious habits;

(3) Avoid persons or places of disreputable or harmful character;

(4) Report to the supervision officer as directed by the judge or supervision officer and obey all rules and regulations of the community supervision and corrections department;

(5) Permit the supervision officer to visit him at his home or elsewhere;

(6) Work faithfully at suitable employment as far as possible;

(7) Remain within a specified place;

(8) Pay his fine, if one be assessed, and all court costs whether a fine be assessed or not, in one or several sums;

(9) Support his dependents;

(10) Participate, for a time specified by the judge in any community-based program, including a community-service work program under Section 16 of this article;

(11) Reimburse the county in which the prosecution was instituted for compensation paid to appointed counsel for defending him in the case, if counsel was appointed, or if he was represented by a county-paid public defender, in an amount that would have been paid to an appointed attorney had the county not had a public defender;

(12) Remain under custodial supervision in a community corrections facility, obey all rules and regulations of such facility, and pay a percentage of his income to the facility for room and board;

(13) Pay a percentage of his income to his dependents for their support while under custodial supervision in a community corrections facility;

(14) Submit to testing for alcohol or controlled substances;

(15) Attend counseling sessions for substance abusers or participate in substance abuse treatment services in a program or facility approved or licensed by the Texas Commission on Alcohol and Drug Abuse;

(16) With the consent of the victim of a misdemeanor offense or of any offense under Title 7, [FN1] Penal Code, participate in victim-defendant mediation;

(17) Submit to electronic monitoring;

(18) Reimburse the general revenue fund for any amounts paid from that fund to a victim, as defined by Article 56.01 of this code, of the defendant's offense or if no reimbursement is required, make one payment to the fund in an amount not to exceed $50 if the offense is a misdemeanor or not to exceed $100 if the offense is a felony;

(19) Reimburse a law enforcement agency for the analysis, storage, or disposal of raw materials, controlled substances, chemical precursors, drug paraphernalia, or other materials seized in connection with the offense;

(20) Pay all or part of the reasonable and necessary costs incurred by the victim for psychological counseling made necessary by the offense or for counseling and education relating to acquired immune deficiency syndrome or human immunodeficiency virus made necessary by the offense;

(21) Make one payment in an amount not to exceed $50 to a crime stoppers organization as defined by Section 414.001, Government Code, and as certified by the Crime Stoppers Advisory Council;

<Text of § 11(22) as amended by Acts 2005, 79th Leg., ch. 956 § 2>

(22) Submit a blood sample or other specimen to the Department of Public Safety under Subchapter G, Chapter 411, Government Code, [FN2] for the purpose of creating a DNA record of the defendant;

<Text of § 11(22) as amended by Acts 2005, 79th Leg., ch. 1224 § 18>

(22) Submit a DNA sample to the Department of Public Safety under Subchapter G, Chapter 411, Government Code, [FN2] for the purpose of creating a DNA record of the defendant; and

(23) In any manner required by the judge, provide public notice of the offense for which the defendant was placed on community supervision in the county in which the offense was committed; and

(24) Reimburse the county in which the prosecution was instituted for compensation paid to any interpreter in the case.

(b) A judge may not order a defendant to make any payments as a term or condition of community supervision, except for fines, court costs, restitution to the victim, and other conditions related personally to the rehabilitation of the defendant or otherwise expressly authorized by law. The court shall consider the ability of the defendant to make

payments in ordering the defendant to make payments under this article.

(c) If the judge or jury places a defendant on community supervision, the judge shall require the defendant to demonstrate to the court whether the defendant has an educational skill level that is equal to or greater than the average skill level of students who have completed the sixth grade in public schools in this state. If the judge determines that the defendant has not attained that skill level, the judge shall require as a condition of community supervision that the defendant attain that level of educational skill, unless the judge determines that the defendant lacks the intellectual capacity or the learning ability to ever achieve that level of skill.

(d) If the judge places a defendant on community supervision and the defendant is determined to have a mental illness or be a person with mental retardation by an examining expert under Article 16.22 or Chapter 46B or in a psychological evaluation conducted under Section 9(i) of this article, the judge may require the defendant as a condition of community supervision to submit to outpatient or inpatient mental health or mental retardation treatment if the:

(1) defendant's:

(A) mental impairment is chronic in nature; or

(B) ability to function independently will continue to deteriorate if the defendant does not receive mental health or mental retardation services; and

(2) judge determines, in consultation with a local mental health or mental retardation services provider, that appropriate mental health or mental retardation services for the defendant are available through the Texas Department of Mental Health and Mental Retardation under Section 534.053, Health and Safety Code, or through another mental health or mental retardation services provider.

(e) A judge granting community supervision to a defendant required to register as a sex offender under Chapter 62 shall require that the defendant, as a condition of community supervision:

(1) register under that chapter; and

(2) submit a DNA sample to the Department of Public Safety under Subchapter G, Chapter 411, Government Code, for the purpose of creating a DNA record of the defendant, unless the defendant has already submitted the required sample under other state law.

(f) A judge may not require a defendant to undergo an orchiectomy as a condition of community supervision.

(g) A judge who grants community supervision to a person may require the person to make one payment in an amount not to exceed $50 to a children's advocacy center established under Subchapter E, Chapter 264, Family Code, if the person is charged with or convicted of an offense under Section 21.11 or 22.011(a)(2), Penal Code.

(h) If a judge grants community supervision to a person convicted of an offense under Title 5, Penal Code, that the court determines involves family violence, the judge may require the person to make one payment in an amount not to exceed $100 to a family violence shelter center that receives state or federal funds and that serves the county in which the court is located. In this subsection, "family violence" has the meaning assigned by Section 71.004, Family Code, and "family violence shelter center" has the meaning assigned by Section 51.002, Human Resources Code.

(i) A judge who grants community supervision to a sex offender evaluated under Section 9A may require the sex offender as a condition of community supervision to submit to treatment, specialized supervision, or rehabilitation

according to offense-specific standards of practice adopted by the Council on Sex Offender Treatment. On a finding that the defendant is financially able to make payment, the judge shall require the defendant to pay all or part of the reasonable and necessary costs of the treatment, supervision, or rehabilitation.

(j), (k) [Blank].

(l)(1) If the court grants community supervision to a person convicted of an offense under Section 42.072, Penal Code, the court may require as a condition of community supervision that the person may not:

(A) communicate directly or indirectly with the victim; or

(B) go to or near the residence, place of employment, or business of the victim or to or near a school, day-care facility, or similar facility where a dependent child of the victim is in attendance.

(2) If the court requires the prohibition contained in Subdivision (1)(B) of this subsection as a condition of community supervision, the court shall specifically describe the prohibited locations and the minimum distances, if any, that the person must maintain from the locations.

C

STATEMENTS OF MEDICAL & PUBLIC HEALTH GROUPS

Committee on Substance Abuse

Drug-Exposed Infants

Recent studies have documented that an increasing number of women of childbearing age are abusing licit and illicit substances. Although statistical data are insufficient, there are indications that approximately 1 in 10 infants may be exposed to illicit drugs during pregnancy. The National Institute on Drug Abuse 1988 National Household Survey[1] revealed that 8.8% of women of childbearing age admitted to having used an illicit drug in the month before questioning. A recent survey of 36 private and public hospitals[2] showed that approximately 11% of women delivering in these hospitals had used illegal drugs at some time during their pregnancies. A preliminary study in Pinellas County, Florida, demonstrated that cocaine and marijuana use during pregnancy were almost equally distributed across racial and socioeconomic lines.[3]

These incidence data parallel the increasing number of infants being admitted to special-care nurseries for complications caused by their intrauterine exposure to alcohol and other drugs. It is also important to consider that drug-exposed infants often go unrecognized and are discharged from the newborn nursery to homes where they are at increased risk for a complex of medical and social problems including abuse and neglect.

This statement addresses illicit substance use in pregnancy and its medical, social, mental health, and legal consequences for children and families. The Academy is developing a separate statement to address the issue of infants exposed to alcohol in utero.

THE PROBLEM

All illicit drugs reach the fetal circulation by crossing the placenta and can cause direct toxic effects on the fetus, as well as fetal and maternal dependency. For example, the opiate-exposed fetus may experience withdrawal in utero when drugs are withdrawn from a dependent mother or, after delivery, when the mother's use no longer directly affects her newborn. Although the incidence of breastfeeding by substance-abusing mothers is generally low, it is important to counsel nursing mothers about the hazards of drug use. See American Academy of Pediatrics policy statement "Transfer of Drugs and Other Chemicals into Human Milk."[4]

Symptoms of neonatal opiate withdrawal are often present at birth but may not reach a peak until 3 to 4 days or as late as 10 to 14 days after birth.[5] Evidence of withdrawal from narcotics can persist in a subacute form for 4 to 6 months after birth.[6] Common features of the neonatal abstinence syndrome mimic those of an adult's withdrawal from narcotics.[5] Significant signs and symptoms for the neonate include the high-pitched cry, sweating, tremulousness, excoriation of the extremities, and gastrointestinal disturbances. Although withdrawal from nonnarcotic substances, such as marijuana,[7] does not appear to result in as severe a syndrome of abstinence as withdrawal from narcotics, the newborn may exhibit irritability and restlessness, poor feeding, crying, and impaired neurobehavioral activity also seen in the neonatal narcotics abstinence syndrome. There is a need for increased research to define the degree of permanent residual in these infants.

A major problem confronting pediatricians today arises from the consequences of using cocaine during pregnancy. As in other substance-abusing populations, cocaine-dependent pregnant women have a high incidence of infectious diseases, especially hepatitis, acquired immunodeficiency syndrome, and other sexually transmitted diseases.[8] Other problems during pregnancy are anticipated in a population which underutilizes prenatal care. Even so, cocaine-using women often experience an uncomplicated labor and delivery, although they may be at increased risk of abruptio placentae.[9-11]

Cocaine-exposed infants have an increased incidence of premature birth, impaired fetal growth,[8-10] and neonatal seizures.[10] Although a specific co-

The recommendations in this statement do not indicate an exclusive course of treatment or procedure to be followed. Variations, taking into account individual circumstances, may be appropriate.

caine-withdrawal syndrome in the neonate has not been defined clearly, signs of irritability and tremulousness, lethargy, or an inability to respond appropriately to stimulation may occur. Many, however, seem to have no specific clinical manifestations in the early neonatal period.

Perinatal cerebral infarctions have occurred in infants whose mothers have used cocaine during the few days before delivery.[12] These perinatal cerebral infarctions exemplify the severe morbidity that may be associated with intrauterine exposure to cocaine. Issues of increased risk of malformations[11-13] and abnormalities of respiratory control[15] have been raised but await confirmatory studies. Because most published studies of cocaine's effect on pregnancies and infants have focused on recognized substance-abusing populations, little information is available regarding the effects of low doses of cocaine. In addition, interpretation of clinical studies is complicated by the fact that abuse of multiple drugs often occurs.

Environmental factors also place drug-exposed children at high risk for abuse, neglect, and developmental delay. The long-term effects on learning and school performance of children exposed to illicit drugs in utero have not been well documented. Although some research is in progress to study this issue, more emphasis is needed in this area.

IMPLICATIONS FOR THE PEDIATRICIAN

Universal neonatal screening for illicit drugs is not recommended. The long-term consequences, ie, the harms vs the benefits of "labeling" the infant and/or the mother, are not known. However, since there are well-documented and potential effects on children exposed to drugs in utero, it is essential that pediatricians recognize drug-exposed infants. Obtaining a thorough maternal history in a nonthreatening organized manner, from all women, is the key to diagnosis. Since many drug-exposed infants exhibit no specific signs or symptoms at birth, they may go unrecognized if pediatricians are not alert to the issue during or after the newborn period. Reliance on signs and symptoms is hampered by the increasing prevalence of early discharge from the nursery. Some drug-exposed infants will be missed if physicians rely solely on toxicology screens for diagnosis. Screens will surely be negative when drugs were used early in pregnancy and can be negative even when women have taken drugs during the 48 hours before delivery. Because urine toxicology screens may vary among laboratories, pediatricians should be aware that marijuana, its metabolites, and metabolites of cocaine may not be included unless requested specifically.

Infants and children of substance-abusing parents and/or guardians are at increased risk for physical, sexual, and emotional abuse. Although all states require physicians to report suspected child abuse or neglect, some states also mandate reporting to Child Protective Services infants with neonatal drug screens positive for illicit drugs. Many of these agencies are overburdened and unprepared to deal appropriately with the potential flood of babies born to substance-abusing mothers. Pediatricians should, therefore, work with their state social service agencies and state legislatures to extend the assistance now available through Child Protective Services. Until that is accomplished, pediatricians should consider recruiting the assistance of the local Child Protective Services agency to provide multidisciplinary treatment and support for the affected mother, child, and family. Chapters of the Academy and local pediatricians should discuss with all professionals and agencies involved how multifaceted problems resulting from drug exposure in utero might best be addressed in their communities. In general, a coordinated multidisciplinary approach in the development of a plan without criminal sanctions has the best chance of helping children and families.

IMPLICATIONS FOR HEALTH CARE POLICY

Far too little is known about how to best manage the problems posed by drug-exposed infants. There are virtually no data about which approaches are effective in decreasing the use of illegal drugs during pregnancy. Little is known about the difficulties faced by these infants, both in the newborn period and especially during their developmental years. It is imperative that efforts to alleviate serious problems include evaluation of the efficacy of interventions and ongoing observation and evaluation of drug-exposed infants and children. The following discussion of policy is necessitated by the critical need for more information.

Health policy issues posed by drug-exposed infants can be divided into two components. The first is how to prevent infants from being exposed to potentially harmful drugs before birth; the second is how to address the needs of drug-exposed infants and children.

Prevention of exposure before birth is a vexing problem that has defied solution. At the threshold is a need to explore more effective ways to help people resist the initial and subsequent use of drugs.

Even voluntary drug treatment programs, which probably are the most desirable means of approaching drug-using pregnant women, raise important policy concerns. The most basic problem is that

demand far exceeds supply. Meeting this need for effective therapy must be a major national priority. Moreover, although there is anecdotal evidence that the few community-based, multidisciplinary treatment programs currently available may help pregnant women to stop using drugs, there is a critical need to determine whether and which interventions within these programs actually work.

The Academy believes that the most appropriate way to prevent intrauterine drug exposure is to educate women of childbearing age about the hazards of drugs to the fetuses and to encourage drug avoidance. If this fails, effective drug treatment programs should be made readily available to pregnant women and to women anticipating and/or at risk for pregnancy. Punitive measures taken toward pregnant women, such as criminal prosecution and incarceration, have no proven benefits for infant health; although sanctions imposed by civil court involvement may be of benefit. The American Academy of Pediatrics is concerned that such involuntary measures may discourage mothers and their infants from receiving the very medical care and social support systems that are crucial to their treatment.

Forced intervention after the birth of the drug-exposed infant can occur in two different divisions of the legal system. Within the civil justice system, family or juvenile courts explicitly focus on the impact on children and families and attempt to protect children by soliciting Child Protective Services support for the family which sometimes entails placing children outside the home. There are few data about the effect of involvement in the civil justice system on child outcome. One study, however, did demonstrate better outcomes for physically abused children whose parents were ordered into therapy by a juvenile court than for children whose parents only signed voluntary treatment contracts.[16]

Intervention can also be enforced by criminal prosecution. Most states impose criminal sanctions against the perpetrators of child abuse and neglect, and recently a number of states have passed or are considering laws that impose criminal penalties on women who use drugs during pregnancy. There is no evidence that these latter sanctions prevent in utero drug exposure or help drug-exposed children after birth. Without strong evidence that involvement with the criminal justice system serves to prevent prenatal drug exposure or to improve children's health, such intervention is unjustifiable.

Until the issue of how to prevent drug exposure appropriately and effectively is resolved, we are left to deal with the second major health policy issue which is how to address the needs of drug-exposed infants and children. Although there are some data about the potential for illicit drugs to cause congenital malformations and other health problems in the infant and young child, little is known about subsequent problems confronting drug-exposed infants as they enter their school years and adolescence. Longitudinal studies of these children are crucial.

Prevention and/or treatment of women using illicit drugs during pregnancy is necessary to help ensure the health of newborn babies. Learning more about the problems to drug-exposed infants and children will require extensive research, and addressing the issues of prevention and remediation will require a societal commitment. Funds for research, prevention, and treatment must be made available, not only for the sake of these children, but also for the benefit of society.

RECOMMENDATIONS

1. Pediatricians can be involved in organizing community-based social service or child protective service systems, designed to provide essential services for drug-abusing women and their children.
2. A comprehensive medical and psychosocial history including specific inquiry regarding maternal drug use should be a part of every newborn evaluation.
3. Newborn urine toxicology should be regarded only as a potential adjunct to a thorough maternal drug history. Universal toxicologic screening is not recommended.
4. The pediatrician should include maternal drug use in the differential diagnosis of any neonate with suggestive symptomatology.
5. The pediatrician should be knowledgeable about state and local child protection reporting requirements.
6. In most circumstances, when a drug-exposed infant or drug-abusing mother is identified, the pediatrician should consider recruiting the assistance of local child protective services in order to provide multidisciplinary treatment and support for the affected mother, child, and family.
7. The pediatrician should evaluate the drug-exposed infant for other medical conditions associated with maternal drug use, including the possibility of concurrent sexually transmitted diseases in the mother and infant.
8. Since adverse effects of drug exposure may not be evident at birth, the pediatrician should be alert to potential long-term consequences which may become apparent during ongoing care.
9. The American Academy of Pediatrics supports the development and evaluation of models of coor-

dinated multidisciplinary prevention, intervention, and treatment services which improve access to early comprehensive care for all substance-abusing pregnant women and their children. Evaluation of current and new treatment modalities is imperative to determine their effectiveness.

10. Funds for research, prevention, and treatment should be made available to address issues of drug-exposed infants.

11. The public must be assured of nonpunitive access to comprehensive care which will meet the needs of the substance-abusing pregnant woman and her infant.

12. Pediatricians are encouraged to become actively involved in policy issues related to drug-exposed infants and children at the federal, state, and local levels.

REFERENCES

1. *NIDA Household Survey on Drug Abuse 1988, Population Estimates.* Rockville, MD: National Institute of Drug Abuse; 1989. Department of Health and Human Services ADM 89-1636
2. Chasnoff IJ. Drug use and women: establishing a standard of care. *Ann N Y Acad Sci.* 1989;562:208–210
3. Chasnoff IJ, Landress H, Barrett M. The prevalence of illicit-drug or alcohol use during pregnancy and discrepancies in mandatory reporting in Pinellas County, Florida. *N Engl J Med.* 1990:332:1202–1206
4. American Academy of Pediatrics, Committee on Drugs. Transfer of drugs and other chemicals into human milk. *Pediatrics.* 1989;84:924–936
5. Finnegan LP. Neonatal abstinence syndrome: assessment and pharmacotherapy. In: Rubaltelli FF, Granati B, eds. *Neonatal Therapy: An Update.* New York: Excerpta Medica; 1986:122–146
6. Chasnoff IJ, Hatcher RP, Burns WJ. Early growth patterns of methadone-addicted infants. *Am J Dis Child.* 1980;134: 1049–1051
7. Fried PA. Marihuana use by pregnant women: neurobehavioral effects in neonates. *Drug Alcohol Depend.* 1980;6:415–424
8. MacGregor S, Keith L, Chasnoff IJ, et al. Cocaine use during pregnancy: adverse perinatal outcome. *Am J Obstet Gynecol.* 1987;157:686–690
9. Chasnoff IJ, Burns WJ, Schnoll SH, Burns K. Cocaine use in pregnancy. *N Engl J Med.* 1985;313:666–669
10. Chasnoff IJ, Griffith DR, MacGregor SN, et al. Temporal patterns of cocaine use in pregnancy: perinatal outcome. *JAMA.* 1989;261:1741–1744
11. Bingol N, Fuchs M, Diaz V, et al. Teratogenicity of cocaine in humans. *J. Pediatr.* 1987;110:93–96
12. Chasnoff IJ, Bussey ME, Savich RE, Stack CM. Perinatal cerebral infarction and maternal cocaine use. *J Pediatr.* 1986;108:456–459
13. Chasnoff IJ, Chisum GM, Kaplan WE. Maternal cocaine use and genitourinary tract malformations. *Teratology.* 1988;37:201–204
14. Chavez GF, Mulnare J, Cordero JF. Maternal cocaine use during early pregnancy as a risk factor for congenital urogenital anomalies. *JAMA.* 1989;262:795–798
15. Chasnoff IJ, Hung CE, Kletter R, Kaplan D. Prenatal cocaine exposure is associated with respiratory pattern abnormalities. *Am J Dis Child.* 989;143:538–587
16. Wolfe DA, Aragona J, Kaufman K, Sandler J. The importance of adjudication in the treatment of child abusers: some preliminary findings. *Child Abuse Negl.* 1980;4:127–135

ACOG Committee Opinion

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Maternal Decision Making, Ethics, and the Law

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

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

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

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

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

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

Recent Cases

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

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

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

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

Ethical Considerations

Framing Ethics in Perinatal Medicine

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

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

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

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

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

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

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

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

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

Furthermore, many writers have noted a moral injury that arises from abstracting the fetus from the pregnant woman, in its failing to recognize the pregnant woman herself as a patient, person, and rights-bearer. This approach disregards a fundamental moral principle that persons never be treated solely as means to an end, but as ends in themselves. Within the rhetoric of conflict and fetal rights, the pregnant woman has at times been reduced to a vessel—even a "fortress" holding the fetus "prisoner" (16). As George Annas aptly described, "Before birth, we can obtain access to the fetus only through its mother, and in the absence of her informed consent, can do so only by treating her as a fetal container, a nonperson without rights to bodily integrity" (3).

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

Ethics Committee Opinions and the Maternal–Fetal Relationship

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Recommendations

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

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

References

1. In re A.C., 573 A.2d 1235 (D.C. 1990).
2. Annas GJ. Foreclosing the use of force: A.C. reversed. Hastings Cent Rep 1990;20(4):27–9.
3. Annas GJ. Protecting the liberty of pregnant patients [editorial]. N Engl J Med 1987;316:1213–4.
4. Rhoden NK. The judge in the delivery room: the emergence of court-ordered cesareans. Calif Law Rev 1986; 74:1951–2030.
5. Bianchi DW, Crombleholme TM, D'Alton ME. Fetology: diagnosis and management of the fetal patient. New York (NY): McGraw-Hill; 2000.
6. McCullough LB, Chervenak FA. Ethics in obstetrics and gynecology. New York (NY): Oxford University Press; 1994.
7. Harris LH. Rethinking maternal-fetal conflict: gender and equality in perinatal ethics. Obstet Gynecol 2000;96: 786–91.
8. Maternal and Child Health Bureau. Mission statement. Rockville (MD): MCHB; 2005. Available at: http://www.mchb.hrsa.gov/about/default.htm. Retrieved June 17, 2005.
9. Lyerly AD, Gates EA, Cefalo RC, Sugarman J. Toward the ethical evaluation and use of maternal-fetal surgery. Obstet Gynecol 2001;98:689–97.
10. State Children's Health Insurance Program; eligibility for prenatal care and other health services for unborn children. Final rule. Centers for Medicare & Medicaid Services (CMS), HHS. Fed Regist 2002;67:61955–74.
11. Steinbock B. Health care coverage for not-yet-born children. Hastings Cent Rep 2003;33(1):49.
12. Murray L, Cooper P. Effects of postnatal depression on infant development. Arch Dis Child 1997;77:99–101.
13. Murray L, Fiori-Cowley A, Hooper R, Cooper P. The impact of postnatal depression and associated adversity on early mother-infant interactions and later infant outcome. Child Dev 1996;67:2512–26.
14. Horon IL, Cheng D. Enhanced surveillance for pregnancy-associated mortality—Maryland, 1993–1998. JAMA 2001;285:1455–9.
15. Frye V. Examining homicide's contribution to pregnancy-associated deaths [editorial]. JAMA 2001;285:1510–1.
16. Phelan JP. The maternal abdominal wall: a fortress against fetal health care? South Calif Law Rev 1991;65:461–90.
17. Little MO. Abortion, intimacy, and the duty to gestate. Ethical Theory Moral Pract 1999;2:295–312.
18. Mattingly SS. The maternal-fetal dyad. Exploring the two-patient obstetric model. Hastings Cent Rep 1992;22: 13–8.
19. Informed consent. In: American College of Obstetricians and Gynecologists. Ethics in obstetrics and gynecology. 2nd ed. Washington, DC: ACOG; 2004. p. 9–17.
20. Patient choice in the maternal–fetal relationship. In: American College of Obstetricians and Gynecologists. Ethics in obstetrics and gynecology. 2nd ed. Washington, DC: ACOG; 2004. p. 34–6.
21. At-risk drinking and illicit drug use: ethical issues in obstetric and gynecologic practice. ACOG Committee Opinion No. 294. American College of Obstetricians and Gynecologists. Obstet Gynecol 2004;103:1021–31.
22. Ferguson v. City of Charleston, 532 U.S. 67 (2001).
23. Whitner v. State, 328 S.C. 1, 492 S.E.2n 777 (1997).
24. McFall v. Shimp, 10 Pa. D. & C.3d (C.P. 1978).
25. Rhoden NK. Informed consent in obstetrics: some special problems. West N Engl Law Rev 1987;9:67–88.
26. Nelson LJ, Milliken N. Compelled medical treatment of pregnant women. Life, liberty, and law in conflict. JAMA 1988;259:1060–6.
27. Kolder VE, Gallagher J, Parsons MT. Court-ordered obstetrical interventions. N Engl J Med 1987;316:1192–6.
28. Frank DA, Augustyn M, Knight WG, Pell T, Zuckerman B. Growth, development, and behavior in early childhood following prenatal cocaine exposure: a systematic review. JAMA 2001;285:1613–25.
29. Chavkin W. Cocaine and pregnancy—time to look at the evidence [editorial]. JAMA 2001;285:1626–8.
30. Marwick C. Physician leadership on National Drug Policy finds that addiction treatment works. JAMA 1998;279: 1149–50.
31. Murphy S, Rosenbaum M. Pregnant women on drugs: combating stereotypes and stigma. New Brunswick (NJ): Rutgers University Press; 1999.
32. Kearney MH, Murphy S, Rosenbaum M. Mothering on crack cocaine: a grounded theory analysis. Soc Sci Med 1994;38:351–61.
33. Harris LH, Paltrow L. MSJAMA. The status of pregnant women and fetuses in US criminal law. JAMA 2003; 289:1697–9.
34. Poland ML, Dombrowski MP, Ager JW, Sokol RJ. Punishing pregnant drug users: enhancing the flight from care. Drug Alcohol Depend 1993;31:199–203.
35. United States. General Accounting Office. Drug exposed infants: a generation at risk: report to the chairman, Committee on Finance, U.S. Senate. Washington, DC: U.S. General Accounting Office; 1990.
36. The Annie E. Casey Foundation. 2004 kids count data book: moving youth from risk to opportunity. Baltimore (MD): AECF; 2004. Available at: http://www.aecf.org/publications/data/kc2004_e.pdf. Retrieved June 17, 2005.
37. Haller DL, Knisely JS, Elswick RK Jr, Dawson KS, Schnoll SH. Perinatal substance abusers: factors influencing treatment retention. J Subst Abuse Treat 1997;14: 513–9.
38. Hohman MM, Shillington AM, Baxter HG. A comparison of pregnant women presenting for alcohol and other drug treatment by CPS status. Child Abuse Negl 2003;27: 303–17.
39. Kissin WB, Svikis DS, Morgan GD, Haug NA. Characterizing pregnant drug-dependent women in treatment and their children. J Subst Abuse Treat 2001;21: 27–34.
40. Nelson LJ, Marshall MF. Ethical and legal analyses of three coercive policies aimed at substance abuse by pregnant women. Charleston (SC): Medical University of South Carolina, Program in Bioethics; 1998.
41. Mathias R. NIDA survey provides first national data on drug use during pregnancy. NIDA Notes 1995;10(1). Available

at: http://www.nida.nih.gov/NIDA_Notes/NNVol10N1/NIDASurvey.html. Retrieved June 17, 2005.

42. Chasnoff IJ, Landress HJ, Barrett ME. The prevalence of illicit-drug or alcohol use during pregnancy and discrepancies in mandatory reporting in Pinellas County, Florida. N Engl J Med 1990;322:1202–6.
43. Cedergren MI. Maternal morbid obesity and the risk of adverse pregnancy outcome. Obstet Gynecol 2004;103:219–24.
44. Cnattingius S, Bergstrom R, Lipworth L, Kramer MS. Prepregnancy weight and the risk of adverse pregnancy outcomes. N Engl J Med 1998;338:147–52.

Information about
Methamphetamine Use in Pregnancy

Methamphetamine use has become widespread in the U.S., particularly in the western, mountain and central states and in rural areas. This stimulant (also known as meth, ice, and crystal meth) is inexpensive and readily available because of local clandestine laboratories and a recent supply of inexpensive and very pure methamphetamine from Mexico[1]. Methamphetamine can be smoked, sniffed, administered orally, or injected. During periods of repeated use, tolerance develops, enabling users to administer amounts that would be fatal under other circumstances. It can produce cardiovascular, neurological, digestive and psychiatric symptoms. Acute discontinuation of methamphetamine use can produce withdrawal symptoms such as depression, anxiety, fatigue, paranoia, and aggression.

The effects of maternal methamphetamine use can not be separated from other factors. As with drugs such as cocaine, pregnant methamphetamine users rarely use methamphetamine alone. Alcohol, cigarettes and marijuana are often used with methamphetamine. Pregnant methamphetamine users may also have poor diet and lack of adequate prenatal care. Therefore, even when poor birth outcome appears to be associated with methamphetamine exposure it may be due to these concurrent maternal health behaviors[2]. The National Toxicology Program, U.S. Department of Health and Human Services, Center for the Evaluation of Risks to Human Reproduction (CERHR), expert panel report on methamphetamine concluded that "in terms of the potential adverse reproductive and developmental effects of methamphetamine exposure, studies that focused upon humans were uninterpretable due to such factors as a lack of control of potential confounding factors and the issue of the purity and contaminants of the methamphetamine used by the drug abusers[3]."

There is no syndrome or disorder that can specifically be identified for babies who were exposed in utero to methamphetamine. The term "meth baby" or "ice baby" is stigmatizing and should not be used.

It is important for the clinician to remember that alcohol and cigarette use during pregnancy are the most prevalent and impacting substances of abuse on the fetus. Alcohol consumption during pregnancy is a leading preventable cause of mental retardation, developmental delay and birth defects in the fetus[4]. Smoking during pregnancy has been causally linked to premature rupture of membranes, low birth weight and perinatal mortality, including SIDS[5]. Therefore all pregnant women should be routinely asked and counseled about all substance use.

(continued)

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The role of the women's health clinician is to identify methamphetamine use as well as the use of other substances and to support the pregnant woman. Mandated reporting of pregnant women for substance use may endanger the relationship of trust between the physician and patient, placing the obstetrician in an adversarial relationship with the patient and possibly creating conflict with the therapeutic obligation[6]. If pregnant women become reluctant to seek medical care because they fear being reported for illegal drug use, these strategies will actually increase the risks to the woman and the fetus rather than reduce the consequences of substance abuse[7]. Seeking obstetric-gynecologic care should not expose a woman to criminal or civil penalties or the loss of custody of her children[8]. If methamphetamine use is suspected, the medical provider should discuss the suspicion with the patient and, if drug testing is to be carried out, to inform the patient about the nature and purpose of the test and how the test results will be used and to gain her consent for testing. Because of the possible implications of a positive drug screen, the rights of patients to autonomy and privacy are to be respected[9]. Methamphetamine has a strong addictive quality and referral to a substance abuse treatment program is encouraged.

References

[1] Zernike K. Potent Mexican meth floods in as states curb domestic variety. New York Times. January 23, 2006

[2] Wouldes T, LaGasse L, Sheridan J, Lester B. Maternal methamphetamine use during pregnancy and child outcome: what do we know? The New Zealand Medical Journal 2004;117:1180. Accessed at http://www.nzma.org.nz/journal/117-1206/1180/ on 1/27/06.

[3] Center for the Evaluation of Risks to Human Reproduction. NTP-CERHR Expert panel report on the reproductive and developmental toxicity of amphetamine and methamphetamine. National Toxicology Program. National Institute of Environmental Health Sciences. NIH Publication No. 05-4474, July 2005. Research Triangle Park, NC. pg. 191

[4] American College of Obstetricians and Gynecologists. Substance use: obstetric and gynecologic implications in Special Issues in Women's Health. Washington DC ACOG. 2005. Pg. 122

[5] American College of Obstetricians and Gynecologists. Committee Opinion No. 316: Smoking cessation during pregnancy. Washington DC. ACOG. 2005.

[6] American College of Obstetricians and Gynecologists. Substance use: obstetric and gynecologic implications in Special issues in Women's Health. Washington DC, ACOG. Pg. 120

[7] American College of Obstetricians and Gynecologists. Committee Opinion No. 294 At-risk drinking and illicit drug use: ethical issues in obstetric and gynecologic practice... Washington DC, ACOG. 2004

[8] American College of Obstetricians and Gynecologists. Substance use: obstetric and gynecologic implications. in Special issues in women's health. Washington DC, ACOG. Pg. 117

[9] American College of Obstetricians and Gynecologists. Substance use: obstetric and gynecologic implications in Special issues in women's health. Washington DC ACOG. 2005. Pg. 117.

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Law and Medicine/Board of Trustees Report

Helene M. Cole, MD, *Section Editor*

Legal Interventions During Pregnancy

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

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

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

SEEKING COURT ORDERS TO OVERRIDE THE MEDICAL PREFERENCES OF PREGNANT WOMEN

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

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

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

Questions and concerns over a pregnant woman's legal obligations to accept medical care are exacerbated by the unique physical relationship that exists between a pregnant woman and her fetus. Invariably, one cannot be treated without affecting the other. Performing medical procedures against the pregnant woman's will violates her right to informed consent and her constitutional right to bodily integrity.[3-6] These rights are among the most basic and are well established in both society and medicine. However, preservation of these rights may come at the risk of preventable fetal impairment or death.

Moral and Legal Responsibilities of the Pregnant Woman Toward Her Fetus

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

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

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Legal Precedent.—Several courts have considered the issue of legal interventions to impose medical treatments on pregnant women. However, few requests for court-ordered obstetrical interventions have been reviewed by appellate courts. Only two appellate courts have considered a decision to override a pregnant woman's refusal of a blood transfusion. In 1964, the New Jersey Supreme Court ordered a blood transfusion for a pregnant woman who refused the transfusion on religious grounds.[7] Also in 1964, an appeals court in the District of Columbia ruled that a pregnant woman could be forced to undergo a blood transfusion for the sake of her fetus.[8] However, both of these cases were decided in the early 1960s, before the current legal emphasis on the integrity of the individual and the right to refuse treatment.

Approximately two dozen courts have been asked to order cesarean sections.[9] Only two of these cases have reached the appellate level. In one, a trial court judge in the District of Columbia ordered a cesarean section on a woman who was terminally ill.[10] The woman's treatment desires and her competency were major points of controversy in this case. The District of Columbia Court of Appeals, en banc, ruled that the lower court was in error for ordering the cesarean section. The court of appeals ruled that rather than weighing the interests of the state (in protecting the potential life of the fetus) against the interests of the pregnant woman, the lower court should have used "substituted" judgment and proceeded according to what it could best ascertain the pregnant woman's wishes would have been.

In 1981, a trial court in Georgia ordered a cesarean section performed on a woman who had refused the operation for religious reasons. The physician involved diagnosed placenta previa, with a 99% to 100% chance of fetal demise if vaginal delivery occurred.[11] The Georgia Supreme Court, with minimal explanation or policy discussion, refused to stay the trial court's order. A few days after the court's denial of a stay, the woman had a safe vaginal delivery.

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

Distinctions Between Moral and Legal Responsibilities.—Society places a positive moral value on aiding those who may need help or be in danger, yet it does not ordinarily impose a legal duty on specific individuals to render that needed assistance.[12] This reluctance to impose a legal duty on the individual is especially strong where rendering aid would pose a risk to the health of the individual or would require an invasion of his or her bodily integrity.[4,12,13]

There is also no legal duty for an individual to render aid even if a life would be saved and the assistance rendered would incur minimal risk to the health of the person providing the aid. For example, a person need not donate bone marrow to a cousin who is dying of aplastic anemia.[12]

Yet the responsibility of a pregnant woman to her fetus is stronger than that of one individual to another. The duty of a pregnant woman to her fetus is more akin to the obligations of a parent to his or her child. And in fact, a parent's duty to his or her child is enforced with legal sanctions. The parent-child relationship is considered a "special relationship" under "Samaritan" law.[14] Samaritan law, which applies to duties to render aid, provides that those people who have a special relationship to another person, such as innkeeper to guest or common carrier to passenger, have a legal obligation to come to the aid of that person.[12]

Even in cases of special relationships, however, the obligation to render aid is minimal and cannot require the rescuer to endanger him or herself.[12] For example, if a child needed a bone marrow transplant, but the only compatible donor was the child's father, the father would not be legally required to donate his bone marrow to his child.

There are other situations in which a parent's obligation to his or her child is legally enforced. Parents clearly have both a moral and legal duty to provide reasonable medical care for their children. All states legally require parents to provide such care.[15] A pregnant woman who refuses a surgical intervention, treatment, or therapy that might benefit fetal health is, in practical terms, withholding medical care from her fetus. However, in the case of a pregnant woman, in order for her *not* to withhold medical treatment, she generally must accept a risk to her life or health, as well as bodily invasion of her person. Just as parental legal obligations to provide medical care to children do not include compelled acceptance of risk to life or health, neither should a pregnant woman's obligations to her fetus include the acceptance of such risk.

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

In addition, legally enforcing a pregnant woman's moral obligation to the fetus creates a burden or penalty on pregnancy itself.[17] The right to bear a child is constitutionally protected.[3] Forcing a pregnant woman to undertake a health risk or to accept an invasive procedure against her will burdens her decision to have a child.[3]

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

Ethical Obligations of the Physician in Instances of Treatment Refusal

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

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

The doctrine of informed consent also indicates that a pregnant woman's refusal of treatment should not be overridden for the benefit of the fetus. Principles of informed consent require a physician to respect the wishes of a mentally competent adult in situations of medical decision making.[1] These principles recognize that decisions that would result in health risks are properly made only by the individual who must bear the risk.[1,18] Considerable uncertainty can surround medical evaluations of the risks and benefits of obstetrical interventions.[19-22] Through a court-ordered intervention, a physician deprives a pregnant woman of her right to reject personal risk and replaces it with the physician's evaluation of the amount of risk that is properly acceptable.[1] This undermines the very concept of informed consent.

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

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

A Court Is an Inappropriate Forum for Resolving Treatment Disputes.—Courts are ill-equipped to resolve conflicts concerning obstetrical interventions. The judicial system ordinarily requires that court decisions be based on careful, focused deliberation and the cautious consideration of all facts and related legal concerns. In addition, there is always an opportunity for review on appeal. Court-ordered obstetrical interventions, on the other hand, are likely to be requested on extremely short notice and require immediate judicial action. A study done of court-ordered obstetrical interventions reported that in 70% of cases in which orders were considered, hospital administrators and attorneys were aware of the situation only a day or less before seeking a court order; 88% of the orders were obtained in less than 6 hours, and in 19%, less than an hour.[9] It is unlikely that most judges would already be familiar with the policy concerns or relevant legal precedents required to make a carefully considered decision on such short notice.[20] Decisions made under these immediate deadlines and intense pressures are likely to be hasty and lack well-reasoned conclusions. In the case of an improperly reached conclusion, there is no meaningful appeal available.[20]

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

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

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

A troubling fact is that court-ordered obstetrical interventions seem to be sought more often in cases where the woman is either a member of a minority group or of a lower economic background. According to an initial study,[9] in 81% of the instances in which a court-ordered intervention was sought, the woman belonged to a minority group. Every request for a court order involved a woman who had received care at a teaching hospital or who had received public assistance.

Women from lower socioeconomic groups and from differing ethnic backgounds may have religious and other personal beliefs or circumstances that vary greatly from those of their physicians or the judges who decide their cases.[20] A woman's reasons for refusing care may be misunderstood or disregarded by the physician seeking the court-ordered override of her decision or by the judge who decides the case.

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

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

Another consideration is the extent to which a physician would be required to participate in the practical aspects of enforcing an override of a pregnant woman's treatment decision.[23] In one case in which a court granted permission to a hospital to perform an unwanted cesarean section, the pregnant woman left the hospital before delivery.[7] Should a court choose to enforce an override by compelling the woman to accept treatment, severe methods of restraint may be required. A pregnant woman may have to be forcibly restrained to prevent her from leaving the hospital or physical force may have to be used in order to administer a particular medicine to her. Inviting the state to override a pregnant woman's decision legally may also be inviting government-mandated participation by physicians in administering the treatment. The

physician-patient relationship would certainly be damaged by physician participation in the forcible administration of medical care.[29]

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

Adverse Effects on the Physician-Patient Relationship.—Requests for court intervention may interfere with the physician-patient relationship in other ways. Physician willingness to override a pregnant woman's decision creates an adversarial relationship between physician and patient.[30] In a specific case, the damage to the physician-patient relationship may appear to be outweighed in relation to the benefit to the fetus. However, it may also precipitate general distrust of physicians on the part of pregnant women. Once it becomes known a particular physician or physicians in general are willing to override a pregnant woman's preferences, women may withhold information from the physician that they feel might lead the physician to seek judicial intervention. Or they may reject medical or prenatal care altogether,[7] seriously impairing a physician's ability to treat both the pregnant woman and her fetus. While the health of a few infants may be preserved by overriding a pregnant woman's decision, the health of a great many more may be sacrificed.

Conclusions

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

Physicians Should Not Have a Legal Duty to Seek Court-Ordered Obstetrical Interventions.—There may be no other case where patient rejection of medical advice is as frustrating as when a pregnant woman rejects a procedure designed to benefit her fetus.[5] Yet, physicians should refrain from using the courts to impose personal value judgments on a pregnant woman who refuses medical advice meant to benefit her fetus. As a corollary, a physician should not be liable for injuries sustained as a result of honoring a pregnant woman's informed refusal of treatment designed to benefit the fetus.

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

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

RESPONSES TO HARMFUL BEHAVIOR BY THE PREGNANT WOMAN

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

Currently, attention is increasingly being drawn to instances where the behavior of pregnant women is potentially harmful to fetal well-being. There has been particularly great concern with the incidence of babies born with cocaine in their systems as a result of cocaine use by pregnant women. Hospitals are reporting an alarming rise in the number of births of these drug-exposed infants.[31] The unprecedented rise in cocaine use among women of childbearing age is primarily due to the current popularity of the use of "crack," a concentrated, inexpensive, and highly addictive form of cocaine. Experts estimate that as many as 11% of pregnant women have used an illegal drug during pregnancy, and of those women, 75% have used cocaine.[32-37] The American Medical Association (AMA) Board of Trustees[37] profiled the current problem of substance abuse among pregnant women and discussed the clinical challenges involved in identifying and providing comprehensive treatment for these women.

The alarm with which these figures have been met is not unwarranted. The effects of cocaine use by a pregnant woman on her fetus and subsequently on her infant can be severe. Cocaine can cause in utero strokes, spontaneous abortion, and abruptio placentae.[32,38] It also results in increased infant mortality. On the average, cocaine-exposed babies have lower birth weights, shorter body lengths at birth, and smaller head circumferences than normal infants.[31] They also have a higher incidence of physical abnormalities, including deformed kidneys and neural tube defects.[32] Cocaine-exposed babies often experience withdrawal symptoms that make them more irritable and resistant to bonding than other babies.[32,34] Researchers believe that cocaine-exposed babies will be more likely to experience learning disabilities.[34]

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

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

pregnant women on their infants.[39-41] Babies born with fetal alcohol syndrome suffer from prenatal and postnatal growth retardation; cardiovascular, limb, skull, and facial defects; impaired fine- and gross-motor function; and impaired intellectual function.[27,28] Despite the serious health effects of alcohol consumption, the legal and social acceptance of alcohol make its use particularly difficult to prevent. Further, while excessive alcohol use during pregnancy *certainly* can cause serious fetal harm, no minimum level of alcohol use has yet been established as safe.[39-41] The AMA, former Surgeon General Koop, and a number of other experts have concluded that total abstinence is the only way to ensure no ill effects from alcohol consumption during pregnancy.[42]

Legal Penalties as a Response to Substance Abuse by Pregnant Women

The rising percentage of babies born with cocaine in their systems has been matched by the rising frustration of the health care and legal communities in finding ways to prevent the problem. A growing number of jurisdictions have tried to impose legal penalties, often criminal sanctions, in an attempt to deter drug use by pregnant women.[43] Women have been charged under statutes against child abuse and neglect and the delivery of a controlled substance to a minor,[44,45] or given special penalties for an unrelated conviction because they were pregnant and suspected of cocaine use.[46] Evidence of drug abuse by pregnant women is being used as grounds for the state's assuming immediate custody of newborns.[47] In addition, other legal interventions, such as civil detention, have been sought in order to monitor or control the behavior of a pregnant woman when her behavior was considered potentially dangerous to her fetus.[48,49] For the most part, these attempts to criminalize or legally penalize behavior by pregnant women have been unsuccessful. Several courts have ruled that existing statutes against child abuse and neglect cannot be applied to the fetus.[44,50]

Some public officials believe that imposing criminal sanctions will deter substance abuse by pregnant women. However, many health and social welfare experts feel that the problem is more effectively addressed as a health concern rather than as a legal problem.[51] They further maintain that criminal sanctions will not only fail to deter pregnant women from substance abuse, they will in fact prevent them from seeking prenatal care or medical help for their dependency.

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

Any attempt at detecting and managing the potentially harmful behavior of pregnant women through legal intervention is likely to require substantial participation on the part of the medical community. For instance, if a pregnant woman's actions are classified as child abuse, legal obligations are created for the physician. All states require physicians to report suspected abuse.[44] Most, in fact, hold health care personnel liable for failure to report, and some states even maintain liability for failure to diagnose child abuse properly.[51]

It is not unreasonable to assume that at-risk pregnant women would be deterred from seeking contact with those people or institutions who might take action leading to their incarceration. Pregnant women will be likely to avoid seeking prenatal or other medical care for fear that their physicians' knowledge of substance abuse or other potentially harmful behavior could result in a jail sentence rather than proper medical treatment. This fear is not unfounded; recently, a pregnant woman who sought medical care for injuries received as a result of a spousal beating was reported to the authorities, arrested, and charged with criminal child abuse for drinking during her pregnancy.[52] The case was subsequently dismissed. In addition, the number of women who are convicted and incarcerated for potentially harmful behavior is likely to be relatively small in comparison with the number of women who would be prompted to avoid medical care altogether. As a result, the potential well-being of many infants may be sacrificed in order to preserve the health of a few.

Imposing criminal or civil sanctions on pregnant women for potentially harmful behavior may also encourage women to seek abortions in order to avoid legal repercussions. In addition, incarceration would be of only limited value since a considerable amount of damage could be done to the fetus before a woman even realized she was pregnant.[53]

Further, while the incarceration of pregnant women would be intended to benefit the fetus, the reality of the environment in which pregnant women would be placed would do little to ensure fetal health. Prisons in general have inadequate health care resources. Moreover, prison health experts warn that prisons are "shockingly deficient" in attending to the health care needs of pregnant women.[54] Most prisons have inadequate protocol, staff, or training to properly attend to the special needs of pregnant prisoners. The result has been widespread deficiencies in prenatal diet, nutrition, and exercise and seriously inadequate, if any, prenatal care. Pregnant women in jail are routinely subject to conditions that are hazardous to fetal health, such as gross overcrowding,[55] 24-hour lock-up with no access to exercise or fresh air, exposure to tuberculosis, measles, and hepatitis, and a generally filthy and unsanitary enviroment. Additionally, it is unclear that incarceration would prevent drug use by pregnant women because drugs are readily available in prison.[46,54]

Legal Penalties Imposed After Birth.—*Criminal Sanctions.*—The most compelling reason that has been proposed for instituting postnatal criminal sanctions in cases of substance abuse by pregnant women is to prevent damage to fetal health. The actual efficacy of criminal sanctions as a method for preventing substance abuse is doubtful, however. Obviously, fetal harm caused by substance abuse is averted only by effecting abstinence from harmful substances by pregnant women. Punishing a person who abuses drugs or alcohol is not generally an effective way of curing their dependency or preventing future abuse. The AMA has stated that "it is clear that addiction is not simply the product of a failure of individual willpower."[56] Substance abuse is caused by complex hereditary, environmental, and social factors. Individuals who are substance dependent have impaired competence in making decisions about the use of that substance.

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

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

A woman's socioeconomic position may further affect her ability to carry out her moral responsibility to provide reasonable care in preserving fetal health. The women most likely to be prosecuted for exposing their fetuses to harmful substances are those from the lower economic levels.[46] These women are more likely to lack access to both prenatal care and substance abuse treatment because of financial barriers.[47] They are often uninsured or underinsured.[48] Even when Medicaid is available, women may still lack access to medical care because of inadequate system capacity.[49]

Access to care does not guarantee that pregnant women will receive drug treatment; one of the most commonly missed diagnoses in obstetric and pediatric medicine is drug abuse.[50] Additionally, many prenatal care facilities do not have the capacity to treat substance abuse.

Pregnant substance abusers also tend to have other severe life stresses that may contribute to their substance abuse. An AMA Board of Trustees[51] report states that female substance abusers tend to have more dysfunction in their families than nonabusers. They have high levels of depression, anxiety, sense of powerlessness, and low levels of self-esteem and self-confidence.[52] A study done by a center that treats female substance abusers found that 70% of them were sexually abused as children, as compared with 15% of nonsubstance abusers.[53] Eighty-three percent had had a chemically dependent parent, as opposed to 35% of the nonabusers.[51] Seventy percent of female substance abusers report being beaten.[54] Ten percent of female substance abusers in one study were homeless, while 50% had occasional housing problems.[51]

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

Civil Liability as a Remedy for Harmful Behavior by Pregnant Women.—Regardless of the inefficiency of criminal sanctions, a woman who uses harmful substances during her pregnancy often gives birth to a child who is either impaired or less healthy than the child would have been had the mother abstained from substance abuse. It is widely accepted that if a person other than the pregnant woman acts in such a way that fetal health, and consequently a child's health, is impaired, then that person can be held civilly liable for the impairment.[55] While recovery in such situations is meant to compensate the parents of the impaired child, it may also be used to compensate the subsequent child for injuries resulting from negligent actions during the prenatal period.[56]

The consequences of harm may be similar regardless of whether the responsible party is the pregnant woman herself or another person (a third party). Some commentators have stated that to punish third parties but not pregnant women for actions that result in harm to the fetus would be inconsistent.[57] However, a pregnant woman and her fetus share a physical interdependency that a third-party tort-feasor and the fetus do not. The nature of the relationship between the pregnant woman and her fetus makes problematic tort liability against the mother for prenatal injuries.

Third-party liability protects both the pregnant woman and her fetus from behavior that is normally unacceptable under any circumstances.[57] For instance, a drunk driver is liable for his or her actions because they are a menance to all, the born and unborn alike. However, *every* action on the part of a pregnant woman can have substantial impact on fetal health. Maternal liability would severely restrict a pregnant woman's freedom to act in even normally innocuous ways.

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

Even if it could be proven that a pregnant woman's behavior caused infant impairment, intense scrutiny of the most intimate details of a pregnant woman's life would be required to evaluate the extent to which she could be held responsible for her actions.[57] A judicial investigation to determine which action caused the harm and its reasonableness would have to include a determination of whether the harm was caused before or after the woman realized she was pregnant and whether she realized the behavior could affect fetal health. The court would also have to determine whether she could have reasonably prevented the harm or whether the action taken was reasonable in the context of other circumstances. Even the most insignificant decision on the part of the pregnant woman could be subsequently called into question.

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

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

Many health and public welfare officials feel that the most effective way of preventing substance abuse in pregnant women is through education about potential harms and the provision of comprehensive treatment for their abuse.[51,58] Important methods for preventing or minimizing fetal harm due to substance abuse by pregnant women include identification of women who are at high risk for being substance abusers, early medical and psychotherapeutic intervention in the pregnancies of substance-abusing women, and access to programs that address the full range of social and health care needs associated with substance abuse.[51] The National Association for Perinatal Addiction Education and Research has docu-

mented the efficacy of programs that follow these methods.[82]

In contrast, criminal penalties may exacerbate the harm done to fetal health by deterring pregnant substance abusers from obtaining help or care from either the health or public welfare professions, the very people who are best able to prevent future abuse. The California Medical Association[82] has noted:

> While unhealthy behavior cannot be condoned, to bring criminal charges against a pregnant woman for activities which may be harmful to her fetus is inappropriate. Such prosecution is counterproductive to the public interest as it may discourage a woman from seeking prenatal care or dissuade her from providing accurate information to health care providers out of fear of self-incrimination. This failure to seek proper care or to withhold vital information concerning her health could increase the risks to herself and her baby.

Florida's secretary of Health and Rehabilitative Services has also observed that potential prosecution under existing child abuse or drug use statutes already "makes many potential reporters reluctant to identify women as substance abusers."[83]

It may seem that a pregnant substance abuser has an obligation to obtain treatment for her dependence. However, obtaining treatment is not currently a practical alternative for pregnant substance abusers. Even the most persistent woman is likely to fail to find a treatment program for her substance dependency. Rehabilitative centers for substance abusers are in short supply.[84] The majority of those facilities that do treat substance abuse refuse to accept pregnant women, in part due to concerns over liability.[85] Of the few centers that do treat pregnant women, most have long waiting lists.

Further, the majority of substance abuse treatment facilities operate on an adult-male centered model.[86] They are not designed to address problems specific to women's psychological or physiological needs. Nor are they equipped to handle other problems that substance-dependent women often have, such as how to arrange day-care for older children or counseling for a woman who is abused by a spouse or partner. It would be an injustice to punish a pregnant women for not receiving treatment for her substance abuse when treatment is not an available option to her.

Finally, societal efforts to educate pregnant women and provide accessible treatment for those who may be substance abusers promote relationships and attitudes that are beneficial to fetal health in general. Criminal penalties levied against pregnant women for their actions would posit physicians as government agents with enforcement responsibilities rather than as concerned patient advocates.[87] Criminal penalties would also emphasize conflict between the pregnant woman and her fetus, which does not encourage a healthy relationship between the pregnant woman and her future child. On the other hand, providing education and treatment emphasizes cooperation and trust between the pregnant woman and her physician and facilitates a more emotionally positive relationship after birth.[88]

State-Assumed Custody of Exposed Infants

Another response to harmful behavior by pregnant women is taking the woman's baby into state custody after birth. Probably the most widely accepted action for preterm substance abuse is state-assumed custody of infants who show signs of prenatal exposure to harmful substances.[89] Legal penalties for behavior while pregnant are problematic because a pregnant woman and her fetus cannot practically be treated as separate entities. Once an infant is born, this is not a consideration. In addition, evidence shows that parental substance abuse and child abuse are highly correlated.[90] Children who have been impaired due to in utero exposure to harmful substances are likely to be especially difficult to care for, requiring above normal parenting skills.[20,21] Courts have ruled that the potential for abuse implied by substance abuse by a woman while pregnant is adequate justification for allowing the state to assume at least temporary custody of these infants.[14]

Ordinarily, the state cannot impose punishment for potential, rather than actual, actions. Presumably, the termination or suspension of parental rights is an exception because it is primarily a protection for the child and not a penalty directed at the parent.[91] In the interest of preserving family unity wherever reasonably possible, courts should be careful to ensure that such actions are actually protective of the child.

Consideration of Criminal or Civil Sanctions In Exceptional Cases

Some commentators have argued that legal penalties or state intrusion into the lives of pregnant women are legally justifiable because once a pregnant woman forgoes her right to have an abortion she has a "legal . . . duty to bring the child into the world as healthy as is reasonably possible."[77,80] This duty includes restrictions that "may significantly limit a woman's freedom of action and even lead to forcible bodily intrusion."[80] The implication is that once a woman has become pregnant and does not take affirmative steps to terminate her pregnancy, then she has forfeited her constitutional rights to bodily integrity and privacy.

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

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

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

RECOMMENDATIONS

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

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

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

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

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

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

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

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

References

1. Nelson LJ, Milliken NM. Compelled medical treatment of pregnant women. *JAMA*. 1988;259:1060-1066.
2. Annas GJ. The impact of medical technology on the pregnant woman's right to privacy. *Am J Law Med*. 1989;13:213-232.
3. Council on Ethical and Judicial Affairs. *Current Opinions*. Chicago, Ill: American Medical Association; 1989. Opinion 8.08, Informed Consent.
4. *Winston v Lee*, 470 US 753 (1985).
5. *Skinner v Railway Labor Executives' Ass'n*, 109 SCt 1402 (1989).
6. *Schmerber v California*, 384 US 757 (1966).
7. *Raleigh Fitkin-Paul Morgan Memorial Hospital v Anderson*, 201 A2d 537, *cert denied*, 377 US 985 (1964).
8. *Application of President and Director's of Georgetown College*, 331 F2d 1000 (App DC 1964).
9. Kolder VE, Gallagher J, Parsons MT. Court-ordered obstetrical interventions. *N Engl J Med*. 1987;316:1192-1196.
10. *In re A.C.*, 573 A2d 1235 (DC 1990).
11. *Jefferson v Griffin Spalding County Hospital Authority*, 274 SE2d 457 (1981).
12. Keeton W, Dobbs D, Keeton R, Owen D, eds. *Prosser and Keeton on Torts*. St Paul, Minn: West Publishing Co; 1984: sect 56.
13. *McFall v Shimp*, 10 Pa D&C 3d 90 (1978).
14. Reporting child abuse and neglect: state laws. In: Sloan IJ, ed. *Protection for Abused Victims: State Laws and Decisions*. New York, NY: Oceana Publications; 1982:19.
15. *Roe v Wade*, 410 US 113 (1973).
16. *Thornburgh v American College of Obstetricians and Gynecologists*, 476 US 747 (1986).
17. Johnsen D. The creation of fetal rights: conflicts with women's constitutional rights to liberty, privacy, and equal protection. *Yale Law J*. 1986;95:599-625.
18. Murray TH. Moral obligations to the not-yet-born: the fetus as patient. *Clin Perinatol*. 1987;14:329-343.
19. Committee on Ethics. *Patient Choice: Maternal/Fetal Conflict*. Washington, DC: American College of Obstetricians and Gynecologists; 1987.
20. Annas GJ. Protecting the liberty of pregnant patients. *N Engl J Med*. 1987;316:1213-1214.
21. Kirkwood KS, Luthy DA, Bennett FC, et al. Effects of electronic fetal-heart-rate monitoring, as compared with periodic auscultation, on the neurologic development of premature infants. *N Engl J Med*. 1990;322:588-593.
22. Freeman R. Intrapartum fetal monitoring: a disappointing story. *N Engl J Med*. 1990;322:624-625.
23. Annas GJ. Forced cesareans: the most unkindest cut of all. *Hastings Cent Rep*. June 1982;12:16-17, 45.
24. Field MA. Controlling the woman to protect the fetus. *Law Med Health Care*. 1989;17:114-129.
25. Chasnoff IJ. Drug use and women: establishing a standard of care. *Ann NY Acad Sci*. 1989;562:208-210.
26. Cocaine babies: issue for the courts? *Am Med News*. 1989;3:41.
27. American Medical Association Board of Trustees Report. *Drug Abuse in the United States: The Next Generation*. Interim 1989.
28. Chasnoff IJ, Burns WJ, Schnoff SH, et al. Cocaine use in pregnancy. *N Engl J Med*. 1985;313:666.
29. Acker D, Sachs BP, Tracey KJ, Wise WE. Abruptio placentae associated with cocaine use. *Am J Obstet Gynecol*. 1988;146:220-221.
30. Revkin AC. Crack in the cradle. *Discover*. September 1989;10:63-69.
31. Zuckerman B, Frank DA, Hingson R, et al. Effects of maternal marijuana and cocaine use on fetal growth. *N Engl J Med*. 1989;320:762-768.
32. Chasnoff IJ, Griffith DR, MacGregor S, et al. Temporal patterns of cocaine use in pregnancy. *JAMA*. 1989;261:1741-1744.
33. Dixon SD. Effects of transplacental exposure to cocaine and methamphetamine on the neonate. *West J Med*. 1989;150:436-442. Specialty Conference.
34. Chasnoff IJ. Drug use in pregnancy: parameters of risk. *Pediatr Clin North Am*. 1988;35:1403-1412.
35. Pritchard J, MacDonald P, Gant N, eds. *Williams Obstetrics*. Norwalk, Conn: Appleton-Century-Crofts; 1985.
36. Sachs BP. Sharing the cigarette: the effects of smoking in pregnancy. In: Rosenberg MJ, ed. *Smoking and Reproductive Health*. Littleton, Mass: PSG Publishing Co; 1985:144.
37. Murphy JF, Mulcahy R. Cigarette smoking and spontaneous abortion. *BMJ*. 1978;1:1968.
38. Shaw MW. Conditional prospective rights of the fetus. *J Leg Med*. 1984;5:63-116.
39. Colsher PL, Wallace RB. Is modest alcohol consumption better than none at all? *Ann Rev Public Health*. 1989;10:208-221.
40. Streissguth AP, Landesman-Dwyer S, Martin JC, et al. Teratogenic effects of alcohol in humans and laboratory animals. *Science*. 1980;209:353.
41. Hadi HA, Hill JA, Castillo RA. Alcohol and reproduction: a review. *Obstet Gynecol Surv*. 1987;42:69.
42. Council on Scientific Affairs. Fetal Effects of Maternal Alcohol Abuse. Chicago, Ill: American Medical Association; 1989.
43. American Civil Liberties Union. Criminal prosecutions for fetal abuse increasing at alarming rate. *Reprod Rights Update*. September 1, 1989;1:2.
44. *California v Stewart*, Civ No. 575396 (Mun Ct, Calif, San Diego County, 1987).
45. *Florida v Johnson*, Case No. E89-890-CFA (Seminole County Cir Ct, July 13, 1989).
46. Moss DC. Pregnant? go directly to jail. *ABA J*. November 1, 1988;74:20.
47. *New York Times*. January 9, 1989;col 1:A1.
48. Nurmi J, LeClair V. Fetal rights prompts judge's decision. *Potomac Gazette*. February 14, 1990 sect A:2.
49. *Matter of Steven S.*, 126 Cal App 3d 23, 178 Cal Rptr 525 (1981).
50. *Reyes v Superior Court of California*, 75 Cal App 3d 214, 141 Cal Rptr 912 (Cal Ct App 1977).
51. Coordinating Federal and Drug Policy for Women, Infants, and Children. Hearings before the Senate Committee on Governmental Affairs, 101st Cong, 1st Sess (1989).
52. American Civil Liberties Union. *Reproduct Rights Update*. February 3, 1990; 2 (no. 3).
53. Barry EM. Pregnant prisoners. *Harvard Women's Law J*. 1989;12:189-205.
54. Drug use at Lorton 'disturbing': increased demand by prisoners feared. *Wash Post*, July 3, 1989; sect B:1.
55. Drug Abuse in the United States: a policy report. In: Proceedings of the House of Delegates, 137th annual meeting of the Board of Trustees of the American Medical Association; June 26-30, 1988;
56. Chasnoff IJ, Landress HJ, Barrett ME. The prevalence of illicit drug use during pregnancy and discrepancies in mandatory reporting in Pinellas County, Florida. *N Engl J Med*. 1990;322:1202-1206.
57. Hughes D, Johnson K, Rosenbaum S, Simons J. The health of America's mothers: trends in access to care. *Clearinghouse Rev*. 1988;20:472.
58. Gold K. Paying for maternity care. *Fam Plann Perspect*. 1985;17:103-111.
59. Pregnancy police: the health policy and legal implications of punishing pregnant women for harm to their fetuses. *Rev Law Soc Change*. 1987-1988;16:277-319. Note.
60. Robertson JA. Procreative liberty and the control of contraception, pregnancy, and childbirth. *Va Law Rev*. 1983;69:405-464.
61. Baby's drug death stirs mothers' rights flap. *Chicago Tribune*. May 10, 1989; sect 1:1.
62. *California v Stewart*, Civ No. 575396 (Mun Ct Calif, San Diego County, 1987). Testimony of Gladden V. Elliott, MD, president, California Medical Association. (This statement constitutes the public policy position of CMA on the propriety of using criminal law to enforce a prenatal duty of care.)
63. Note. Maternal rights and fetal wrongs: the case against the criminalization of 'fetal abuse.' *Harv L Rev*. 1988;101:994.
64. Regan DO, Ehrlich SM, Finnegan LP. Infants of drug addicts: at risk for child abuse, neglect, and placement in foster care. *Neurotoxicol Teratol*. 1987;9:315-317.

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Position Statements

Opposition to Criminal Prosecution of Women for Use of Drugs While Pregnant

Summary: Perinatal alcohol and other drug abuse has serious consequences for mothers and children. ANA supports treatment services for women of childbearing age that are alcohol and drug-dependent and is in opposition to criminal prosecution and punishment of these women.

Perinatal alcohol and other drug abuse is a major societal problem with serious consequences for the nation's mothers and children. Addiction is primary disease requiring specialized treatment to achieve a process of long-term behavior change known as recovery. ANA is also opposed to the application of current laws for criminal prosecution of alcohol and drug dependent women solely because they were pregnant when they used alcohol or other drugs and opposes any legislation that focuses on the criminal punishment of the mothers of drug-exposed infants. ANA recognizes alcohol and other drug problems as treatable illnesses. The threat of criminal prosecution is counterproductive in that it prevents many women from seeking prenatal care and treatment for their alcohol and other drug problems. There are presently few alcohol and other drug abuse treatment services available for pregnant women and few programs designed specifically for women of childbearing age, and due to perceived risk of liabilities of care for the unborn child and/or regulations at state levels of care. ANA supports a marked increase in funding at federal, state and local levels for development and expansion of alcohol and other drug abuse treatment services tailored to meet the special needs of women of childbearing age.

ANA is committed to prevention and treatment as primary solutions to perinatal substance abuse and addiction. There is an urgent need for nursing and other research designed to improve the knowledge base upon which prevention and treatment efforts are based and to test innovative interventions tailored to women of childbearing age.

The Coalition on Alcohol and Drug Dependent Women and Their Children reports that an increasing number of women are being arrested and prosecuted solely because they used drugs while they were pregnant. Laws are being applied that were never intended to pertain to the behavior of pregnant women. Pregnant women also find themselves receiving stiffer sentences than those being imposed on men and women who are not pregnant. Some states are considering

new laws to make drug use during pregnancy a felony subject to a punishment of imprisonment. ANA joins the Coalition on Alcohol and Drug Dependent Women and their Children in opposing these trends toward criminalization of drug use during pregnancy as constituting extreme, inappropriate, and ineffective responses to health problems. In order for pregnant women to receive health care that is sensitive to potential or existing drug problems, women must feel that they can seek care and give information regarding their drug use or other problematic behavior without fear or punishment.

Rationale

Government surveys of hospital discharges show a range of 13 drug exposed births per thousand to 181 per thousand births. Recent studies show that early identification of pregnant women at risk, anticipatory guidance and rapid initiation of treatment can prevent birth defects, developmental disabilities and provide significant positive effects in the health of the infant. Perinatal alcohol and drug abuse are currently responded to with punitive measures and incarceration. These approaches to problems constitute extreme, inappropriate, and infective responses to health problems.

Effective date: April 5, 1991
Status: New Position Statement
Originated by: Task Force on Drug and Alcohol Abuse/Addictions
Adopted by: ANA Board of Directors
Replaces: This position statement was combined with the Position on Support for Treatment Services for Alcohol and Drug Dependent Women of Childbearing Age and became the Position Statement on Opposition to Criminal Prosecution of Women for Use of Drugs While Pregnant and support for Treatment Services for Alcohol and Drug Dependent Women of Childbearing Age

Related past action:

1. Resolution on Drug Abuse, ANA House of Delegates, 1970
2. Resolution on Alcohol Abuse and Alcoholism, ANA House of Delegates, 1974
3. Resolution on United States Dumping of Unsafe Drugs and Devices on Third World Countries, ANA House of Delegates, 1980
4. Resolution of Action on Alcohol and Drug Misuse and Psychological Dysfunctions Among Nurses, ANA House of Delegates, 1982
5. Resolution of Action on Smoking Issues, ANA House of Delegates, 1984
6. Action report of Resources for the Treatment of Drug Addiction, ANA House of Delegates, 1990

Return to the position statement index list.

Return to the Reading Room.

Care of Pregnant and Newly Delivered Women Addicts
POSITION STATEMENT

Approved by the Board of Trustees, March 2001

"Policy documents are approved by the APA Assembly and Board of Trustees...These are ... position statements that define APA official policy on specific subjects..." -- *APA Operations Manual.*

This policy updates the 1991 position statement.

Rationale

Alcohol and other drug abuse and dependence affect many women of childbearing age. These psychiatric disorders produce harm to the health and social functioning of the individual and may also affect the health and well-being of her children. Substance abuse and dependence are often accompanied by other comorbid psychiatric disorders. In addition, many of the women who become dependent on substances are also victims of abuse and deprivation. Women living in poverty and members of minority groups may be disproportionately affected.3

Children of these mothers are at risk for growth retardation, facial abnormalities, and developmental deficiencies, arousal and affective regulatory problems, language disorders, and impulsive and hyperactive behavioral difficulties that require psychiatric assessment and intervention.

During the 1980s and 1990s, several jurisdictions initiated policies of prosecuting pregnant and/or postpartum women who have used either alcohol or illegal substances during pregnancy, on grounds of "prenatal child abuse". Subsequent incarceration, either in jails, prisons or in locked psychiatric units both deprives the mother of her liberty and seriously disrupts the incipient or nascent maternal-infant bond. One state's highest court has upheld this practice. Several states have also established involuntary commitment laws applying solely to pregnant women in ways that are not applied to men or non-pregnant women. Such policies are likely to deter pregnant addicts from seeking either prenatal care or addiction treatment, because of fear of prosecution and/or civil commitment.

The most effective way to prevent harm to both mothers and infants is to make available accessible, culturally appropriate prevention and treatment services designed specifically for adolescent girls and women. Adequate screening for substance-related disorders in all obstetric practices, with referral for treatment and careful follow-up, are also necessary parts of the continuum of care. Screening instruments are available for this purpose. In many or most geographic areas, there are few voluntary addiction treatment services willing to accept pregnant women, and few or no residential services in which a mother may bring her children. This is unfortunate, as during pregnancy and the two years postpartum, women are particularly open to treatment and treatment can be highly effective.

ACTIONS

The APA Board of Trustees intends to take a leadership role in advocating on behalf of both these mothers and their children with departments of social services or their agencies that are legally responsible for the safety of these children. This advocacy will serve to enhance these mothers' parenting, to preserve the integrity of their families whenever possible, and to ensure the safety of their children. APA also takes the following specific positions.

The American Psychiatric Association is a national medical specialty society, founded in 1844, whose 40,000 physician members specialize in the diagnosis and treatment of mental and emotional illnesses and substance use disorders.

The American Psychiatric Association
1400 K Street NW • Washington, D.C. 20005
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1. APA opposes the criminal prosecution and incarceration of pregnant and/or newly delivered women on child abuse charges based solely on the use of substances during pregnancy. (Child abuse charges may be appropriate if positive evidence of abuse or neglect is found following the birth of a child.) The best way to prevent abuse and neglect in this situation is adequate treatment for the mother and family.

2. APA advocates that adequate prenatal care be available to all pregnant women, including pregnant addicts, irrespective of ability to pay and without fear of punitive consequences.

3. APA urges that societal resources be directed not to punitive actions but to adequate preventive and treatment services for these women and children. APA strongly advocates the development and funding of the necessary inpatient, outpatient, and residential programs for mothers with their children. Services should address and foster the parental functions, as well as the care of individual mother and child.

APA opposes involuntary commitment laws that are applied only to pregnant women in ways that do not apply to men or women who are not pregnant.

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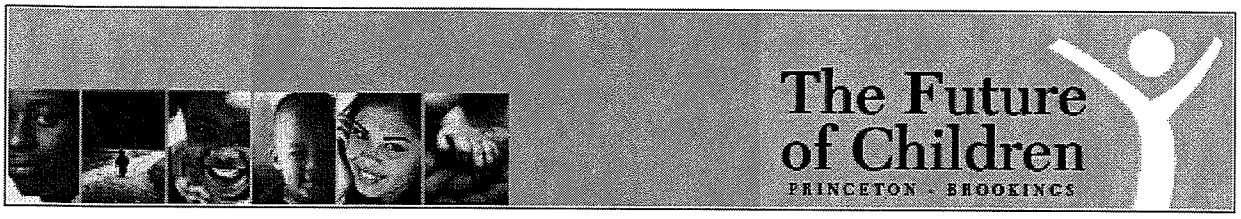

PRINT PAGE

FULL JOURNAL ISSUE: Drug-Exposed Infants

Drug-Exposed Infants: Recommendations

Center for the Future of Children staff

The following are the Center for the Future of Children staff recommendations for policy in response to the problem of drug-exposed infants. An analysis discussing these recommendations follows.

1. Pregnant women should receive prenatal care and education about the risks of using drugs, alcohol, and/or tobacco during pregnancy.
2. Drug treatment programs should be available for all drug-abusing pregnant women and parents of infants, and these programs should be responsive to other related needs of these families.
3. An infant should be considered drug-exposed and in need of some level of intervention if the mother states she has used illegal drugs during pregnancy or if drug exposure is shown through urine or blood tests of the infant. Such tests should be administered only if there is a recent history of maternal drug use and/or medical conditions of the mother or infant indicate that testing is needed for diagnostic or treatment purposes.
4. When an infant is identified as drug-exposed, the infant and his/her family should be assessed by health providers (with assistance when necessary from developmental, drug treatment, and other specialists) to determine what intervention, if any, is needed.
5. Health and developmental services should be available to all identified drug-exposed infants as needed. Parenting education and other support services should be available to their parents as needed.
6. An identified drug-exposed infant should be reported to child protective services only if factors in addition to prenatal drug exposure show that the infant is at risk for abuse or neglect.
7. Barriers to child protective services' capacity to meet the requirements of current child welfare laws should be identified and removed. These barriers might include high caseloads, lack of drug treatment and support services for the families, backlogs in

the courts, and inadequate numbers of foster or adoptive homes.

8. A drug-exposed infant should be removed from the custody of his/her parent(s) only if the parent(s) are unable to protect and care for the infant and either support services are not sufficient to manage this risk or the parent(s) have refused such services. If the parent(s) are not capable of resuming custody of the infant within 12–18 months, despite receiving services to make reunification possible, a permanent, alternative placement should be promptly provided for the infant.
9. A woman who uses illegal drugs during pregnancy should not be subject to special criminal prosecution on the basis of allegations that her illegal drug use harms the fetus. Nor should states adopt special civil commitment provisions for pregnant women who use drugs.
10. Research should be supported to determine (a) the prevalence of illegal drug use among pregnant women, (b) the relationship between such use and birth and developmental outcomes, and (c) the effectiveness of drug treatment and intervention programs. Special focus should be given to evaluating drug treatment programs for pregnant women and parents with infants for their effectiveness in enabling participants to function as adequate caretakers of their children.

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Recommendations (186K)
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MORE ABOUT THE AUTHORS

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MARCH OF DIMES
STATEMENT ON
MATERNAL SUBSTANCE ABUSE

The March of Dimes is committed to improving the health of babies. We strongly support the full range of health programs and policies that assist pregnant women in receiving appropriate comprehensive health care. The interests of mothers and their babies are interdependent and similar, and health policies should serve to strengthen the health of mother and child. Medical conditions that threaten the health of either a mother or her baby demand and deserve to be addressed expeditiously by professionals and by society with compassion for both mother and child.

Drug abuse and addiction, and the use of drugs by pregnant women, has recently increased at an alarming rate. The pervasive and seriously harmful effects of substance abuse during pregnancy for both a mother and her infant are well documented by scientific studies. Increasingly state legislatures are enacting or considering legislation which criminalizes substance abuse during pregnancy. The March of Dimes is concerned that legal action, which makes a pregnant woman criminally liable solely based on the use of drugs during pregnancy, is potentially harmful to the mother and to her unborn child. While it is important that society express concern with the increase in maternal substance abuse, we believe that criminalization of substance-abusing pregnant women may be inappropriate for a number of reasons:

- Addiction is an illness and there is no evidence currently available to demonstrate that the threat of criminalization will deter addictive behavior.

- We believe that the proper treatment of drug addiction requires comprehensive medical, educational and psychological and social intervention to address the etiology of the problem and to support recovery from addiction.

- Punitive approaches to drug addiction may be harmful to pregnant women because they interfere with access to appropriate health care. Fear of punishment may cause women most in need of prenatal services to avoid health care professionals.

- Drug abuse treatment programs are largely unavailable to women, and especially are in short supply for pregnant women. Many programs are designed to serve men and many refuse to treat drug dependent women or are not able to provide women with essential services they need during pregnancy. Few accept women without private insurance coverage.

For these reasons the March of Dimes strongly recommends action which will result in appropriate rehabilitative services for drug dependent women. Further, we call upon the American people to work together to support efforts that will:

1) Harness and coordinate community and governmental resources necessary to eliminate the social dynamics that spawn and contribute to the abuse of substances by women of childbearing age.

2) Assist the pregnant woman in making the appropriate behavioral choices that are consistent with her best health and that of her developing child.

3) Make available upon demand the comprehensive therapeutic interventions which meet the specific needs of the pregnant woman suffering from the disease of addiction.

4) Develop model treatment environments that provide the best opportunities for successful outcomes and that support the best interests of the entire family.

5) Advance the level of scientific and clinical knowledge in the medical management of this disease and the special considerations of its management during pregnancy.

In summary, in the absence of evidence to the contrary, it is obvious to us that criminal sanctions will serve as a significant barrier and disincentive to pregnant women seeking care. The March of Dimes is opposed to the use of such sanctions as a method of facilitating good pregnancy outcomes and generally considers such approaches to be contrary to the best interests of the mother and child.

NATIONAL ASSOCIATION OF PUBLIC CHILD WELFARE ADMINISTRATORS

GUIDING PRINCIPLES FOR WORKING WITH SUBSTANCE-ABUSING FAMILIES AND DRUG-EXPOSED CHILDREN: THE CHILD WELFARE RESPONSE

Background

The plight of children of substance-abusing parents demands increasing attention from policy makers at all levels of government. As administrators of our nation's public child welfare agencies, we are deeply concerned that too many of our nation's children are growing up in families that are unsafe because of a parent's abuse of or addiction to drugs or alcohol.

Parents have the primary responsibility for assuring that their children are raised in a safe, nurturing environment. When parents are unable or unwilling to care for their children, society must intervene. Society has created many mechanisms for such intervention including child protective services (CPS), law enforcement, public health services, financial assistance programs, and educational services. Society has established CPS specifically to intervene in cases of abuse and neglect occurring within the family.

CPS services are provided to children and their families by public agencies mandated to protect children from abuse or neglect. Services are provided to strengthen families; to enable children to remain safe in the home; to temporarily remove a child who is at imminent risk from parental custody; or to pursue termination of parental rights and assure the child permanency in a substitute family if the birth family cannot be preserved without serious risk to the child. These services are provided as an integral component of a larger child welfare system to enhance the well-being of the child.

The dramatic increase in the number of substance-abusing families with children threatens the ability of the child welfare system to protect children. In California, the number of children involved in CPS whose parents are alcohol or drug dependent increased by 82.8% in three years. In Illinois between FY 86 and FY 88 the number of "substance affected infants" increased by 403%. The severity of these cases has sharpened the debate over how society should protect children in danger: remove them from their families or work with families to keep them intact.

Child welfare agencies are established to support families as they carry out their parental responsibilities. Nonetheless, the safety of the child is the primary responsibility of CPS. Consequently, in all CPS cases, including those in which substance abuse is a factor, it is necessary to assess risk to the child and determine whether the child can remain safely in the home while treatment and services are provided to alleviate the conditions causing child maltreatment.

The following was approved by the NAPCWA members present at the December meeting in Tempe and the executive committee of the National Council of State Human Service Administrators.

Guiding Principles for Working with Substance-Abusing Families and Drug-Exposed Children: The Child Welfare Response

Background

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In responding to complaints in which parental substance abuse is a factor, it is essential that CPS agencies recognize that substance abuse or the addiction of the parent to alcohol and drugs in itself does not constitute abuse or neglect* of the child. Parents abuse substances to varying degrees. When substance abuse significantly interferes with parental responsibility and causes harm to the child, these failures of parental duty provide the basis for substantiating a finding of abuse or neglect.

The response of the administration and Congress to the nation's drug crisis equally divides spending between enforcement and treatment. Nevertheless, discussion of this problem has focused overwhelmingly on enforcement, in spite of the fact that addiction is not a crime. This creates an assumption that the many causes of substance abuse can be remedied through law enforcement. This scenario is evident in states that have passed or are considering legislation requiring the selective testing of pregnant women for illicit drug use, with results used for punitive action. This places physicians and CPS workers in the role of law enforcement officials.

Principles

The National Association of Public Child Welfare Administrators and the National Council of State Human Service Administrators of the American Public Welfare Association therefore propose that policies and programs follow these principles:

- The mission of child welfare is to protect children and help ensure their healthy development. Since

children grow and develop best in families that provide safe, nurturing environments, child welfare agencies work with families in times of need to strengthen their ability to provide safe homes. When families refuse or are unable to safely care for a child, however, child protective services must and will intervene and provide a safe living environment.

- A comprehensive child and family service system, not CPS alone, should be developed to take the lead, in collaboration with health, mental health, and substance abuse systems, in identifying and providing follow-up services for drug-dependent infants, and their siblings and parents.

- Comprehensive substance abuse treatment programs that meet the unique needs of families and pregnant women must be made available. Substance abuse programs must be community based, culturally appropriate, and family focused.

- If a jurisdiction elects to mandate drug testing of pregnant women and newborns, such testing must be universal (i.e., testing would be conducted on all pregnant women and newborns at all medical facilities and not targeted at specific populations.) Test results should be used only to identify families in need of treatment and make referrals. Positive test results should not be used for punitive action.

- A positive drug test of a newborn or the child's mother will precipitate a report to the public CPS agency to determine if the child is at risk of harm or in need of protection. A positive drug test is a factor in such an investigation, but should not be used in and of itself as the sole basis for court action or the involuntary removal of the child.

- Laws, regulations, or policies that respond to addiction in a primarily punitive nature, requiring human service workers and physicians to function as law enforcement agents, are inappropriate.

- Families and children are best served when treatment and family preservation services are central and medical, education, mental health, and social work services are provided. Laws, regulations, or policies should strengthen, not hinder, families in need of help.

- As in all cases, the family's prognosis should determine the length of treatment. Laws, regulations, or policies that set unique time frames on decisions related to the termination of parental rights solely because of substance abuse are inappropriate.

- When children must be removed from their birth parents, relative (kinship) care should be used whenever possible, unless the agency determines that the relatives are not suitable caretakers.

- Substance-abusing families need support to regain their well-being and adequately care for their children. Society should seek the removal of children from their families only when there is serious risk to their well-being, and not as an automatic response when parents are substance abusers.

- Medical, mental health, juvenile justice, education, and social service systems, in addition to child welfare, should dedicate a portion of their resources to provide services to this specialized population.

- Staff of all courts, and human service and law enforcement agencies should be jointly trained in identification of substance-abusing parents and drug-exposed children and the appropriate interventions.

**As defined by the model guidelines developed by NAPCWA, child abuse and neglect is "any recent act or failure to act on the part of the parent, which results in death or serious physical, sexual or emotional harm, or presents an imminent risk of serious harm to a person under age 18."*

Approved January 1991 by the Executive Committee of the National Council of State Human Service Administrators

The National Council on Alcoholism and Drug Dependence fights the stigma and the disease of alcoholism and other drug addictions.

Policy Statement:

Women, Alcohol, Other Drugs and Pregnancy

Summary of the Issue

There has been a great deal of denial about the extent to which women experience alcohol and other drug problems. This denial is even more profound when considering pregnant women. While we have made progress in expanding prevention and treatment efforts to include women, our social and medical institutions have not responded effectively to the needs of pregnant alcoholic and other drug-dependent women. Specific emphasis needs to be given to the development of specialized prevention and treatment for alcoholic and other drug-dependent women of child-bearing age.

Background

There is growing concern throughout our nation about the problems associated with alcohol and other drug use by pregnant women. The advent of crack, a highly and quickly addictive cocaine derivative, has brought these problems into sharp focus and stimulated public debate and discussion about how to respond to the needs of alcoholic and other drug-dependent women and their children. Alcoholic and other drug-dependent pregnant women have become subject to charges of child abuse and prosecution rather than to the support of the health care system. This punitive approach is fundamentally unfair to women suffering from addictive diseases and serves to drive them away from seeking both prenatal care and treatment for their alcoholism and other drug addictions. It thus works against the best interests of infants and children by involving the sanctions of the criminal law in the case of a health and medical problem. Moreover, there is increasing evidence of disparities regarding the screening and reporting of positive toxicologies of newborns, with women of color, poor women and women receiving care in public hospitals having the greatest likelihood of being subject to drug testing and subsequent reporting to legal authorities.

The National Council on Alcoholism and Drug Dependence supports efforts to educate women and their partners about specific risks associated with drug use, including alcohol, tobacco, prescription and over-the-counter

medications as well as illegal drugs, during pregnancy. NCADD supports the development of prevention and treatment efforts for pregnant alcoholic and other drug-dependent women and urges policy makers to support measures which will increase access to care and decriminalize the governmental response.

Alcohol- and Other Drug-Related Birth Defects

A great deal is known about the effects of drinking on fetal development. **Fetal alcohol syndrome (FAS)**, the most severe constellation of alcohol-related birth defects, was identified by a team of health professionals in Seattle, Washington in 1973. FAS is a cluster of symptoms including malformations of the face and skull, growth retardation either before or after birth, central nervous system problems and mental retardation. ***Fetal alcohol effects (FAE)*** are a range of birth defects which fall short of meeting the criteria for the full blown syndrome. Children with FAS and FAE are born to mothers who drank during pregnancy. It is unclear how much alcohol at what time during pregnancy causes the range of problems. NCADD perceives any alcohol consumption during pregnancy as high-risk drinking and supports a clear no-alcohol-use message as the only responsible public health message.

Cocaine use during pregnancy can cause multiple and complex problems in utero and after birth. These problems may include physical anomalies, inadequate development and dysfunction of the body's major organs and systems, including the cardiovascular, neurological and excretory systems. Infants can experience withdrawal systems if mothers have used cocaine shortly before delivery. Cocaine use may also cause precipitous delivery resulting in premature birth and problems associated with low birth weight. Sudden infant death syndrome (SIDS) occurs at a higher rate among babies exposed to cocaine.

Babies exposed prenatally to heroin tend to be low in birth weight, short for their age, and have a small head circumference. There is no evidence that opiate drug use by the mother causes malformations like those seen in FAS. Research is continuing in this area. The developing fetus does experience withdrawal as the mother goes through withdrawal. Some postnatal problems of these infants may be due to repeated withdrawals before birth. Newborn infants of opiate-dependent mothers can experience opiate withdrawal symptoms after birth.

Tobacco use during pregnancy can also interfere with healthy fetal development. Babies born to smokers are more likely to be low in birth weight, born prematurely, have lower scores on a standard test of physical functions, and die within the first year of life. It is not known exactly how the ingredients in tobacco smoke affect fetal development. It is known that tobacco smoke reduces oxygen flow to the fetus. It is clear that cessation of smoking during pregnancy will contribute to a positive pregnancy outcome.

There are risks associated with the use of other drugs during pregnancy such as **PCP, barbiturates and other prescription medications.** These risks vary depending on the extent and time of use. In general, all drugs are contraindicated during pregnancy unless deemed absolutely necessary and administered under the supervision of a trained health professional.

Although different drugs have different prenatal effects, the drugs discussed above have some similar effects when they are used during pregnancy. They all tend to contribute to low birth weight. They all may influence the way in which children are able to learn and interact socially. Some cause

severe damage, including mental retardation and physical deformities. All contribute to heightened nervousness and irritability in newborns which may impede parent-child bonding and exacerbate post-partum stress for mothers.

It is well-known that the United States has an extraordinarily high rate of infant mortality--one of the highest in the western world. Efforts to reduce the incidence of alcohol and other drug use during pregnancy would undoubtedly contribute to a reduction in infant mortality in the nation.

Treatment for Alcoholic and Other Drug-Dependent Women

A great deal of progress has been made in the United States in our approaches to preventing and treating alcoholism and other drug addictions among women. Prior to the 1970s there were virtually no treatment options for women with alcoholism and other drug addictions. Women rarely came into treatment and when they did, the treatment that they received was based on the male experiences of alcoholism with no adjustments for the fact that a woman's life experience and physiology are different from a man's.

The 1970s was a time of dramatic change for women in need of treatment for alcoholism and other drug addictions. The National Institute on Alcohol Abuse and Alcoholism (NIAAA) funded the first wave of women's treatment programs across the nation. Later, in 1984, the women's set-aside of the Alcohol, Drug Abuse and Mental Health Services (ADMS) block grant required that states spend 5% of their block grant award on new prevention and treatment efforts designated for women. The set-aside requirement was raised in 1988 to 10%.

Only a few prevention and treatment efforts have focused specifically on pregnant alcoholic and other drug-dependent women. There are tremendous fears among service providers about liability problems associated with treating pregnant, addicted women. There is also a great need for additional training of treatment providers about how to proceed with safe detoxification and treatment. To date, much of the reaction to treating pregnant alcoholic and other drug-dependent women has been guided by fear, lack of knowledge and lack of experience. The sad irony is that pregnancy offers an opportunity to intervene and provide treatment, yet it is at this very time that the least amount of treatment is available.

The Anti-Drug Abuse Act of 1988 included a provision to establish prevention, education, intervention and treatment demonstration projects administered through the Center for Substance Abuse Prevention (CSAP) for pregnant and postpartum alcohol- and other drug-dependent women. This program has stimulated the development of some of the first programs in the nation to address the needs of pregnant women.

Services for Children

Children born to alcoholic and other drug-dependent women and children living in homes where parents and family members are alcoholic and dependent on other drugs deserve special mention. Children born with

alcohol- and other drug-related birth defects often go unrecognized. We need to improve identification and intervention services for these children. They must have access to services for ongoing treatment and special education. Children growing up in alcoholic and other drug-dependent families also need a range of prevention, intervention and treatment services. Intervention and treatment can be powerful tools in preventing future problems for these children. Child welfare services should be enhanced so that alternative living situations are available for children who need temporary foster care and permanent placement. In all cases, efforts should be made to intervene and treat families with the goal of keeping them together if appropriate and possible.

Proposed Policy Recommendations

NCADD supports the development of comprehensive efforts to address the needs of women of child-bearing age and their children. NCADD recommends the enactment of comprehensive policies at the national, state and community levels to improve prevention, education, treatment and research efforts for women. Prevention and treatment programs for women and their children should be sensitive to ethnic and cultural differences among women and employ approaches which reflect sensitivity to the particular needs of the population of women being served. Finally, enhancement of research, prevention, education and treatment initiatives tailored to address the needs of women generally, will undoubtedly reduce the numbers of alcoholic and drug-dependent pregnant women in need of services and ultimately, the number of children born with alcohol- and other drug-related birth defects.

The NCADD Board of Directors, Affiliates and Staff will work towards the enactment and implementation of the following recommendations:

Congress

- Congress should closely monitor the states' use of the 10% women's set-aside of the ADMS block grant and insist that this money be spent consistent with the legislation (i.e., new and expanded prevention and treatment services for alcoholic and other drug-dependent women).
- Congress should appropriate additional funds to support the Model Projects for Pregnant and Post-partum Women and Their Infants administered by the CSAP.
- Congress should direct NIAAA and the National Institute on Drug Abuse (NIDA) to establish a join research center for alcohol and other drug problems of women.

Executive Branch

- CSAP should convene a task force on women, alcohol, drugs and pregnancy with representatives from NIAAA, NIDA, the National Institute of Child Health and Human Development, the Office of Minority Health Affairs, the Office of Adolescent Pregnancy

Programs, and lay field representation to coordinate a comprehensive federal response to the health and social services needs of pregnant alcoholic and other drug-dependent women and their children.

- CSAP and the National Clearinghouse for Alcohol and Drug Information (NCADI) should develop materials on alcohol and other drug use during pregnancy. Campagins to disseminate this information to various professional medical and social service professionals should be established.

- NCADI should increase efforts to develop culturally and linguistically appropriate materials on alcohol, other drugs and pregnancy for specific underserved groups of women.

- NIAAA and NIDA should support and encourage studies which focus on alcohol, other drugs and pregnancy. Both Institutes should support longitudinal studies on children with alcohol- and other drug-related birth defects. Such defects should be made reportable to establish a data base.

- CSAP should convene a national meeting of experts on women, alcohol, other drugs and pregnancy. One outcome of this meeting should be a monograph on state-of-the-art prevention, treatment and research efforts addressing women, alcohol, other drugs and pregnancy.

- SAP should develop written materials and posters which address HIV infection, alcohol, other drugs and pregnancy.

- CSAP should develop and disseminate model training programs about identification and referral of women with alcoholism and other drug dependence for health professionals, including nurses and social workers and others who interact with pregnant women.

- The Substance Abuse and Mental Health Services Administration should require that states report on the number of pregnant women being served in publicly-funded prevention and treatment programs as part of their routine data collection efforts. Alcohol- and other drug-related birth defects should be made reportable to establish a data base.

- The Bureau of Alcohol, Tobacco and Firearms should require that mandated health warning labels on alcoholic beverage containers regarding the risks of drinking during pregnancy be clearly legible to alcoholic beverage consumers.

- The Children's Bureau housed in the Office of Human Development Services of the Department of Health and Human Services should fund grants and contracts that address the issues of foster care placement for children of alcoholic and drug-dependent women.

- The Justice Department, in collaboration with the Department of Health and Human Services, should be required to develop and fund training programs for police and other law enforcement officers on the nature of alcoholism and other drug dependence, intervention processes, treatment principles, and the availability of local treatment resources.

State Legislative and Executive Bodies

- States should mandate coordination of available health and social service resources to include but not be limited to: Alcoholism and Drug Treatment Programs, especially those agencies which provide services to women and their children; Crippled Children's Services; Early Periodic Screening Diagnosis and Treatment Programs; Developmental Disabilities services; Special Education programs; Family Planning; Aid to Families with Dependent Children; and Women, Infants and Children.

- State agencies which manage publicly-funded alcohol and drug addiction programs should offer funding for up to three years for demonstration projects which provide services to women and their children with sufficient funds to entice providers to initiate such programs and to allow for adequate start-up time.

- Each state should develop a task force of state executive branch agencies to coordinate provision of alcohol and drug prevention and treatment services, maternal and child health care, and child welfare services and training to health and social service professionals who serve as gatekeepers to women and their children.

- States should avoid measures which would define alcohol and other drug use during pregnancy as prenatal child abuse and should avoid prosecutions, jailing or other punitive measures which would serve to discourage women from seeking health care services and which might be offered as a substitute for health care services.

- States should resist the enactment of laws which identify alcoholism or other drug dependency or alcohol and other drug use as prima facie evidence of child abuse or neglect.

- States should resist the enactment of laws or regulation which require the automatic removal of an infant from the mother solely on the basis of a positive toxicology screen of the infant.

- States should appropriate additional funds for the development of comprehensive, multidisciplinary prenatal care and alcoholism and other drug addictions treatment services to pregnant women with alcohol and other drug problems. The continuum of services should include prenatal care, alcoholism and other drug addictions treatment, housing, job training, educational and support services.

- States should encourage linkages between alcoholism and drug treatment programs and the criminal justice system so that alcoholic and drug-dependent women who enter the criminal justice system can receive appropriate identification, referral and treatment services.

- States should enact legislation requiring the posting of warning signs at points of purchase of alcoholic beverages alerting the public to the dangers of drinking during pregnancy. These signs should be available in other languages, if appropriate, to meet the needs of ethnic populations.

Research

- Research is needed on the long-term impact of drug exposure on the health and development of children; comparisons between children raised in foster care to those supported in their biological homes; cost/benefit analyses of the efficacy of various prevention strategies on health and social welfare costs.

- Research is needed on the male contribution to birth abnormalities related to alcohol and other drug use.

Prevention

- Schools should offer age-appropriate alcohol and other drug education programs which include specific information on the dangers associated with drinking alcohol, smoking cigarettes, and using other drugs during pregnancy. Appropriate programming for pregnant teens should also be made available in schools.

- Local governing bodies should offer educational materials on the dangers associated with drinking alcohol, smoking cigarettes, and using other drugs during pregnancy when individuals apply for marriage licenses. These materials should be made available, if appropriate, in languages suitable to other ethnic populations.

- Schools providing education for health professionals should include education and requirements for continuing education on alcohol- and other drug-related birth defects and identification and treatment of alcoholic and other drug-dependent women.

- State agencies should offer training on innovative methods to prevent and identify high-risk alcohol and other drug use among women.

- Health professionals and agencies which provide family planning services should also provide educational materials about alcohol and drug use during pregnancy. Plans for referral to treatment, when needed, should be established.

- All local health officers who issue marriage licenses should be educated on the subjects of alcoholism and other addictions, and alcohol and other drug use during pregnancy. They should also be provided with educational materials to be distributed to marriage license applicants.

Treatment

- State and local agencies with responsibility for managing publicly funded alcoholism and other drug addictions programs should offer training for treatment providers on intervening and treating pregnant alcoholic and other drug-dependent women.

- State and local agencies with responsibility for managing publicly funded alcoholism and other drug addictions programs should ensure that there are an adequate number of residential and outpatient treatment programs with comprehensive childcare components. Treatment programs serving women and their children should be prepared to offer services to the significant others of alcoholic and drug-dependent women, including their male partners.

- State and local agencies should ensure that physicians and other health professionals providing services to pregnant alcoholic and other drug-dependent pregnant women offer their clients strict confidentiality protections within the confines of existing law.

- States should resist efforts to weaken confidentiality protections for pregnant alcoholic and other drug-dependent women seeking prenatal care or alcoholism and/or drug treatment services.

- Whenever possible, individuals including women of child-bearing age and pregnant women, should have the opportunity to receive an evaluation and assessment from an independent community-based referral agency capable of directing them to the most appropriate program.

- States should utilize mandated prevention funding from their allotment of the ADMS block grant to support prevention, education and intervention aimed at reducing alcohol and other drug problems among women of child-bearing age and at facilitating early intervention for women already dependent on alcohol and other drugs.

- State and local agencies with responsibility for managing publicly funded alcoholism and other drug addictions programs should withdraw funds from programs which refuse admission to pregnant women.

Child Welfare

- States should support the development of adequate child protection services to provide alternative placements for infants and children who need to be removed from the care of their parents.

- Federal and state governments should support the provision of comprehensive health and social services to alcohol- and other drug-affected infants and children, as well as children living in homes with alcoholism and other drug addictions.

- State alcohol and drug agencies should fund or co-fund staff positions within the child welfare system designated to identify and intervene with pregnant women and parents who are alcoholic and/or drug dependent as well as to educate the child welfare personnel about alcoholism and drug addiction.

Approved by the Delegate Assembly (April 28, 1990) and adopted by the

Board of Directors of the National Council on Alcoholism and Drug Dependence, Inc. (April 29, 1990).

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Position Paper

SUBSTANCE ABUSE AMONG WOMEN

THE NATIONAL PERINATAL ASSOCIATION IS DEDICATED TO PROMOTING THE HEALTH AND WELL BEING OF MOTHERS AND BABIES, ENRICHING FAMILIES, COMMUNITIES AND OUR WORLD. NPA ENGAGES A BROAD COALITION TO IMPROVE SOCIAL, CULTURAL, AND ECONOMIC ENVIRONMENTS.

Substance abuse is epidemic in the United States. It involves not only illicit drugs but also many products easily and legally available--beer, wine, whiskey, and prescription drugs. This addictive behavior affects all socio-economic groups. It is often accompanied by the use of tobacco.

Many substance abusers are pregnant women or women of childbearing age. The adverse effects on both the mother and the infant are well documented. Such addiction is an illness widely recognized by medical and health professionals as a public health problem. However, in some communities, the response has been to bring criminal charges against the pregnant woman for abuse of the fetus.

The National Perinatal Association opposes criminal prosecution of women solely because they are pregnant when they used alcohol or drugs. The threat of such prosecution is both inappropriate and counterproductive. No evidence exists to show that it either prevents prenatal drug or alcohol exposure or improves the infant's health. Such a threat prevents many women from seeking prenatal care and early intervention for their alcohol or drug dependency. It undermines the relationship between the health care providers and their patients and may keep women from giving accurate and essential information vital to their care.

NPA supports a comprehensive program that embodies the following principles:

Education on the effects of substance abuse must begin before use and/or abuse is probable.

Pregnant women and women of childbearing age must be given priority in medical substance treatment programs. Such programs must be based on a therapeutic model of care.

Substance treatment programs must include comprehensive services for the addicted and her family as addictive behavior arises from a complex set of social and psychological factors that affect all family members.

All children impacted by alcohol or drug dependence must have access to comprehensive, family-centered health and social services.

NPA also recognizes the debilitating effects that smoking has on the fetus. Since smoking is an addictive behavior often associated with drug or alcohol dependency, NPA urge that dependency treatment programs include smoking cessation. NPA also believe such cessation programs should be available to all pregnant women without charge.

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