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INTRODUCTION

Imagine a time when fetal protection legislation emboldens a state’s attorney to prosecute a pregnant woman for smoking a cigarette. On the one hand, cigarette smoking is a rigorously defended legal activity. Indeed, states persistently choose not to ban cigarette smoking, despite concerns for public health and safety and their ongoing civil litigation against tobacco companies. On the other hand, inhaling nicotine and carcinogens risks both pregnant women’s health and that of their fetuses. Increasingly, state statutes are the primary means in which constitutional norms relating to women’s pregnancies are introduced and shaped. Nurses, doctors, police, and prosecutors are key players in helping to enforce and entrench these

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3 See, e.g., Michelle Goldberg, Policing Pregnancy, THE NATION, May 9, 2011, available at (discussing the recent trend of “women in several states ... fac[ing] arrest and imprisonment for the crime of ending their pregnancies, or merely attempting to do so.”), available at http://www.thenation.com/article/160092/policing-pregnancy.
norms. And yet, in review of legal scholarship, no theory has been offered to explain the recent emergence of fetal protection laws or provide any meaningful account of their constitutional legitimacy or to interrogate the way in which national values are formed and entrenched by enactment of these laws.

Fetal protection efforts are on the rise, driving the creation, enactment, and enforcement of statutes authorizing criminal intervention in women’s pregnancies. Referenda in Mississippi, Colorado, and petitions in Florida, Georgia, Nevada, Ohio, Montana, California, Kansas, Virginia, Alabama and other states to redefine “personhood” mark the most recent manifestations of fetal protection legislative efforts. On the ground level, arrests, prosecutions, and involuntary “maternity rest” restraining orders evidence fetal protection efforts as more than an isolated, fringe legislative movement. Instead, robust, on-the-ground fetal protection efforts reveal another important story. Judges, prosecutors, police, and even medical personnel play an increasingly central role in implementing and enforcing fetal protection laws at the front end, often using discretion in the interpretation of state statutory law. As a result, this

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5 See Linda C. Fentiman, In the Name of Fetal Protection: Why American Prosecutors Pursue Pregnant Drug Users (And Other Countries Don’t), 18 COLUM. J. GENDER & L. 647, 669 (2009) (“The criminal prosecution of pregnant women for causing fetal harm exemplifies the . . . dangers of the American system of autonomous state prosecutors. Locally elected, politically ambitious, and largely unsupervised, individual prosecutors have wide discretion in deciding whether, when, and whom to prosecute.”).
recent era of maternal policing reshapes police interaction with pregnant women accused of crime, inspires (and sometimes demands) medical officials to breach confidentiality in the treatment of pregnant women, motivates selective prosecution, and obligates, if not emboldens judges to make “bad judgment” calls. A range of fetal protection laws are implemented and variously enforced in thirty-eight states.

For all the recent attention to abortion in constitutional doctrine and legal theory related to women and pornography, work, capacity, assisted reproduction, literature, domestic labor, and

6 See Angell & Greene, supra note 4 (stating that recent legislative restrictions on reproductive freedoms work “mainly by intruding on the relationship between doctor and patient”).

7 See Fentiman, supra note 5, at 669.


9 Compare ANDREA DWORIN, PORNOGRAPHY: MEN POSSESSING WOMEN (1980) (discussing the damaging effects of pornography on women and society), and Catharine A. MacKinnon, Pornography, Civil Rights, and Speech, 20 HARV. C.R.-C.L. L. REV. 1, 1 (1995) (defining “pornography as a civil rights violation”), with ALAN SOBLE, PORNOGRAPHY, SEX, AND FEMINISM (2002) (defending pornography, suggesting that MacKinnon’s and Dworkin’s views as paternalistic and flawed), and Steven G. Gey, The Apologetics of Suppression: The Regulation of Pornography as Act and Idea, 86 MICH. L. REV. 1564, 1566 (1988) (“[T]he anti-porn forces have fundamentally misconstrued the nature of pornography, and . . . only by accepting their cropped view of communication and ideas can their repressive goals be justified.”).


marriage, scholars have yet to articulate doctrines and theories that recognize—much less provide an answer for—the emergence of this new constitutional battlefront, despite a spate of cases involving state encroachment on constitutional rights. There is also no doctrine that connects this modern maternal policing (fetal protection laws) to the old reproductive policing (eugenics), now revisited by legislatures in Georgia, California, and North Carolina in their attempt to


account for thousands of forced-sterilizations carried out in their states in the name of promoting racial purity and intellectual “fitness.” Neither is there a narrative account that bridges the gap between gender and status to illustrate a more dynamic and accurate story of fetal protection law implementation. Indeed, states increasingly rely on non-legal actors, particularly nurses and doctors to implement fetal protection laws, which leads to judgment calls that color who becomes the subject of maternal policing and who is exempted. A random, but telling sampling of recent cases illustrates this latter point.

In 2010, Christine Taylor was arrested for falling down steps in her Iowa home.\textsuperscript{19} Hospital staff reported the case to police after interpreting the fall to fit within the state statute criminalizing attempted feticide, resulting in police interrogation and Taylor’s arrest.\textsuperscript{20} Refusal to submit to an immediate cesarean section prompted doctors in another case to urge the arrest of Melissa Rowland.\textsuperscript{21} She was subsequently charged with manslaughter for the still-birth of one of her fetuses.\textsuperscript{22} In Florida, a state court authorized involuntary confinement of Samantha Burton because she refused bed rest against her physician’s recommendation.\textsuperscript{23} Several days after her hospital incarceration, she suffered a miscarriage, alone in a dreary, gray hospital room that according to her lawyer resembled a jail cell.\textsuperscript{24} Increasingly, nurses and doctors act as front-end interpreters of state law in these cases and frame the described events as volitional acts against developing fetuses, and therefore the broader community and state.\textsuperscript{25}


\textsuperscript{20} Id.


\textsuperscript{22} Id.


\textsuperscript{24} Id.
State legislation criminalizing pregnant women’s unhealthy—but legal—conduct reinvigorates old, but clearly unsettled reproductive policy debates. Proponents of fetal protection laws point to unsympathetic, pregnant drug addicts as the main targets of their legislative efforts; other pregnant women are simply collateral damage. Yet the symbolic walls proponents erect, distinguishing the illicit drug user from all other pregnant women deserves scrutiny, because on inspection some of the distinctions between the cohorts are quite fluid and arbitrary. For example, wealthier, educated white women are more likely to seek and acquire multiple prescription medications, including Xanax, Oxycontin, Demerol, Ritalin, and Tylenol with codeine to ease and erase their stress during pregnancies, substantially increasing risks of fetal impact.\footnote{Allen A. Mitchell et al., Medication Use During Pregnancy, with Particular Focus on Prescription Drugs: 1976-2008, 205 AM. J. OBSTETRICS & GYNECOLOGY 51.e1 (2011); Abusing Prescription Drugs During Pregnancy, AM. PREGNANCY ASS’N, http://www.americanpregnancy.org/pregnancyhealth/abusingprescriptiondrugs.html (last visited Oct. 19, 2012) (noting that such drugs adversely “affect the function of the placenta . . . which can affect the blood supply to the baby or cause preterm labor and birth).}

Fetal protection laws, which can be categorized by their focus—fetal drug laws (FDLs) and maternal conduct laws (MCLs)—represent the new battlefronts in constitutional reproductive law. The former category is clear and narrow, seeking to punish women for conduct (illegal drug use) that tramples the criminal law in a manner that presumes an injury to fetuses; the latter potentially envelopes any maternal conduct that risks some (at times unavoidable) harm to fetuses, including the cases mentioned above. Its contours are largely defined by those who implement the legislation at the ground level. Legislation targeting pregnant women for criminal prosecution implicates not only the historic privacy rights concerns, but also other constitutional law concerns.

That states incur a duty to protect the health and safety of its citizens, including the unborn, provides a weak and unsatisfying

\footnote{See Charles Condon, Clinton’s Cocaine Babies: Why Won’t the Administration Let Us Save Our Children, 72 POL’Y REV. 12 (1995) (arguing that in his former capacity as circuit solicitor of South Carolina, “[w]e needed a program that used not only a carrot, but a real and very firm stick.”), http://www.hoover.org/publications/policy-review/article/6853; Dorothy E. Roberts, Unshackling Black Motherhood, 95 MICH. L. REV. 938, 941 (1997).}
defense of these laws. Equally uninspiring are the moral justifications on which these prosecutions rest. Prior scholarship illuminates the selective deployment of parens patriae interest in protecting fetuses. Assisted reproduction, an unregulated set of “family creation,” tools provides a provocative counterpoint. Despite startling outcomes: 65% of the procedures fail; fetal crowding often results, contributing to low birth weight infants, miscarriages and still births, cerebral palsy, and higher incidences of cognitive delays, hearing impairment and chromosomal abnormalities in infants, legislators turn a blind eye.

As a normative matter, fetal protection laws promote externalities that we should be concerned about. Not only are the statutory provisions inconsistently and disparately enforced by gender, class and race, but they significantly factor into the increased shackling of pregnant women during labor and birth; clandestine, nonconsensual drug-screening of infants; coercive police interrogation of pregnant women; and selective prosecution of pregnant women, all of which raise questions about the constitutionality of the tools deployed to enforce the statutes.

However, what has not been asked or substantively captured in doctrine or theory is why recent statutory provisions to protect fetal health focus almost exclusively on criminal punishment of pregnant women. The fetal protection movement exemplifies “the manifold ways” that morality influences the rule of law, determining its course, implementation, enforcement, and entrenchment. In other words, statutory efforts to protect fetal health derive from moral commitments, rather than pure public health concerns, which helps to explain selective enforcement of fetal protection laws: why some

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27 Michele Goodwin, A View From The Cradle: Tort Law and The Private Regulation of Assisted Reproduction, 59 E MORY L.J. 1040 (2010) [hereinafter View From the Cradle].

28 See, e.g., Connie Cho, Regulating Assisted Reproductive Technology, VII Y ALE M ED. & L. (Oct. 20, 2010), http://www.yalemedlaw.com/2010/10/regulating-assisted-reproductive-technology/ (noting the lack of regulation and it can “lead to medical irresponsibility, even jeopardizing maternal health). Neither current legislation nor law enforcement reconciles the disparate prosecutorial and legislative interests in “policing” some pregnant women and not others. To date, neither federal nor state laws regulate this often-used, but medically risky form of reproduction. Examination of this important legal contradiction has not been taken up in legal scholarship, nor given consideration in judicial jurisprudence or legislative interpretation. This Article fills that gap.
pregnant women are targets of enforcement (smokers, women who refuse bed-rest, drinkers, and illegal drug users) and women who use assisted reproductive technology or expose their pregnancies to risk through “morally neutral” activities are not.

This Article posits that there is more to be said about criminally regulating pregnancy, including its faulty reliance on moral norms and justifications. Fetal protection laws are not unique in this regard; other examples of moral legislation can be traced over time: criminal prohibitions against interracial marriage, homosexual intimacy, interracial intimacy, alcohol consumption, adultery, pornography, and gambling to name but a few. Moral legislation related to public health and safety further substantiates my argument: segregated swimming pools that banned African Americans from swimming with whites; state prohibitions on oral sex; segregated water fountains, restricting all “colored” persons from drinking at spigots reserved for whites; regulations criminalizing spitting on streets, suicide, euthanasia, and physician assisted suicide; and a broad spectrum of accommodation restrictions have all been deployed as public health measures. In reality, these laws served as proxies for promoting and preserving “decency” norms and traditions. Fetal protection laws, however, are an alarming, under-explored contemporary example of moral legislation.

Fifty years ago, in his magnum opus, Law, Liberty, and Morality,29 H.L.A. Hart questioned whether law is open to moral criticism or whether “the admission that a rule is a valid legal rule preclude moral criticism…?”30 Inherent in this question is the recognition of contradiction, that laws which form the basis for criminal punishment are often motivated by a collective moral ethic and yet the enforcement of the community’s ethic might be its moral undoing. Importantly, located within that question are many others that relate to the legal enforcement of morality, and specifically to the subject of this Article. If my intuition is correct, “is the fact that certain conduct is by common standards immoral sufficient to justify making that conduct punishable by law?”31 In other words, is it morally or legally acceptable to “enforce morality as such?”32


30 Id. at 4.

31 Id.
immoral, but otherwise legal conduct, during pregnancy, be a crime?\textsuperscript{33}

Historically, proponents of maternal regulation\textsuperscript{34} point to moral concerns to justify criminal punishment and state encroachments, such as compelled, non-consensual sterilization, and court-sanctioned medical or psychiatric incarceration. Sometimes these concerns are wedded with utilitarian, social welfare interests. For example, Justice Oliver Wendell Holmes famously extolled:

\begin{quote}
It is better for all the world, if instead of waiting to execute degenerate offspring for crime, or to let them starve for their imbecility, society can prevent those who are manifestly unfit from continuing their kind. The principle that sustains compulsory vaccination is broad enough to cover cutting the Fallopian tubes.\textsuperscript{35}
\end{quote}

In recent years, legislators and prosecutors deploy similarly potent moral and social welfare arguments, including saving “our babies,” to justify criminal prosecution of pregnant women. In Utah, for example, Governor Gary Herbert recently signed into law the Criminal Homicide and Abortion Revisions Act,\textsuperscript{36} which specifically applies to miscarriages and other fetal harms that result from “knowing acts” committed by women.\textsuperscript{37} A prior version of the bill drafted by state

\textsuperscript{32} Id.

\textsuperscript{33} JOHN STUART MILL, ON LIBERTY 68 (1859). Mill answers this question in the negative, pointing out the inherent injustice and fallibility in organizing criminal laws on such principles. He said, “[an individual] cannot rightfully be compelled to do or forbear because it will be better for him to do so, because it will make him happier, because in the opinions of others, to do so would be wise or even right.”

\textsuperscript{34} In this Article, “maternity” or “maternal” conduct refers to pregnant women’s behaviors or actions. It does not take up the conduct of women who are mothers, though certainly these categories may overlap.

\textsuperscript{35} Buck v. Bell, 274 U.S. 200, 207 (1927).

\textsuperscript{36} UTAH CODE ANN. § 76-5-201(4) (2010).

\textsuperscript{37} Id.; Rose Aguilar, Utah Governor Signs Controversial Law Charging Women and Girls with Murder for Miscarriages, ALTERNET (Mar. 9, 2010),
legislator Carl Wimmer authorized life imprisonment for pregnant women who engage in reckless behavior during pregnancy that could result in miscarriage and stillbirth. Even where such laws do not exist State Attorneys and courts act on moral urgency to override pregnant women’s constitutional interests.

Moral arguments suggest that “no woman is an island;” and that it is impractical and unfeasible to disentangle actions that harm only the pregnant woman. Thus the line countenanced by Hart and John Stuart Mill, that “the only purpose for which power can rightfully be exercised over any member of a civilized community against [her] will is to prevent harms to others,” is framed by fetal protection proponents as illusory, because fetuses have taken on the status of persons. Even if a distinction in conduct (harm to self versus harm to others) can be made, legislators and prosecutors claim there are social and health reasons to compel moral conduct even when the behaviors of pregnant women do not harm others. Yet, when exposed to critical scrutiny, prosecuting pregnant women for immoral conduct loses its moral authority and can be exposed for reliance on stereotypes, inconsistent application, ambiguity, inaccuracy, and fallibility.

This Article critiques the moral assertions implicit in state criminal regulation of pregnancy. It argues that fetal protection laws fall short of protecting fetal health, while selectively and unconstitutionally burdening the interests of pregnant women. Indeed, states subvert their purported moral and legislative interests in

http://www.alternet.org/rights/145956/utah_governor_signs_controversial_law_charging_women_and_girls_with_murder_for_miscarriages.

38 Aguilar, supra note 37.

39 A trial court in Florida compelled a pregnant mother of two children to bed rest against her will, reasoning that “as between parent and child, the ultimate welfare of the child is the controlling factor,” and as such “override[s] Ms. Burton’s privacy interests at this time.” In that case, the court would not allow the woman to return home to care for her children, but forced her to stay at the hospital. Burton v. Florida, 49 So.3d 263, 265 (Fla. Dist. Ct. App. 2010).

40 MILL, supra note 33. See also HART, supra note 29, at 4. Hart explains that “I myself think there may be grounds justifying the legal coercion of the individual other than the prevention of harm to others,” but agrees with Mill on the “narrower issue relevant to the enforcement of morality.” Id. at 5. Here Hart reminds us that “Mill seems to me to be right.” Id.
promoting fetal health by “chilling” proactive maternal prenatal care as clinics and hospitals (under legislative pressure) cooperate and disclose pregnant patients’ prenatal conduct to law authorities.\textsuperscript{41} Thus, the means by which states increasingly attempt to protect fetal health by exercising \textit{parens patriae} interest invites moral and legal scrutiny because the enforcement norms are neither constitutionally neutral nor non-discriminatory.

This Article develops in four parts. Part I takes up my claim that states’ increasing turn to fetal protection efforts to create, implement, and enforce statutes authorizing criminal intervention in women’s pregnancies entrenches problematic norms. This process reveals that states necessarily (and problematically) turn to nurses, doctors and police, granting them formidable discretionary power to interpret state statutory law and make ground calls about constitutional rights and fetal health. Reliance on these actors, however, is neither neutral nor unencumbered. As a normative matter, substantiating nurses and doctors as lead interpreters of state statutory law colors how fetal protection provisions are interpreted and who becomes the subject of statutory enforcement efforts. In this way, moralist laws become further defined by subjective “decency” standards and interpretations at the ground level, including reliance on stereotype, and importantly prove fallible.

Part II, then, turns from instantiating my claims to unpacking the second part of its critique: that fetal protection laws are premised on faulty and reductive—but seductive—logic that the criminal law provides useful leverage in achieving medical utility or welfare in select prenatal cases. However, the question remains: do fetal protection laws achieve states’ purported goals? This Part explains why fetal protection laws are unlikely to achieve medical utility. If my claims are correct, fetal protection laws function as powerful, unchecked tools in states’ arsenals.

Part III advances a theory to explain why states leverage fetal protection laws as a criminal law “stick” to regulate prenatal conduct. In an era of federal statutes creating and protecting women’s rights and decades-recent constitutional protections, it might seem counterintuitive that women’s reproduction remains entrenched in what I describe as a “moral property” framework at the state level.

Part III unpacks this theory of women’s reproduction as “moral property” of the state. It explains that fetal protection laws seek to selectively promote virtue, prevent vice, and to some degree restrain sex among a discreet class of women. Indeed, recent state statutes give evidence of a trend that even learning about sex is a bad thing. More specifically then, fetal protection laws promote a principle of punishing wicked behavior rather than preventing harmful acts.

Part IV weighs the constitutionality of fetal protection laws. It considers whether such legislative efforts, despite burdening women’s medical and reproductive liberty, pass constitutional muster. Thus, even if fetal protection laws emanate from moral paternalism, such laws may be constitutionally neutral, falling within permissible state regulatory discretion. Part IV analyzes why such laws operate at odds with Fourteenth Amendment Equal Protection values. I argue that fetal protection laws arbitrarily focus on some classes of pregnant women and not others; meanwhile, prosecutors wield “a real and very strong stick” in selectively choosing whom and how they enforce FDLs and MCLs. Selective prosecutions function to discourage and punish some conduct that might threaten fetal health while bypassing other fetal-endangering behavior without medical or legal justification. Part IV argues that even if states possess a important interest in regulating pregnant women’s reproductive conduct, the means by which states enforce the legislation may not be substantially related to the states ultimate goal in protecting fetal health. Part V concludes.

PART I: IMPLEMENTATION OF STATE LAW: THE SHIFTING ROLE OF MEDICAL PERSONNEL IN FETAL PROTECTION LAW CASES

Protecting fetal health is a national concern often expressed in disjointed ways. On the one hand, the rapid expansion of neonate wards results in these medical departments becoming the most
profitable and dynamic centers of research and treatment at hospitals. One explanation for this is the rise in preterm infants born through assisted reproductive technologies (ART), which enhances the probability of multiple gestations and womb crowding in a single pregnancy, resulting in twins, triplets, quadruplets and higher order births. To sustain these births, ventilation, intubation, and other high tech, sophisticated medical treatments are deployed, often at great cost to the individual, insurance companies, hospitals, and sometimes the state. These births generally escape public and legislative scrutiny, despite largely being responsible for the rise in costs and end-of-life care associated with ART newborns. Indeed, ART remains unregulated for the most part at state and federal levels.

On the other hand, the rise in fetal protection laws, and the “stick” approach that attend their enforcement, marks the resurgence of women and their poverty and illnesses as permissible, unrelenting public theatre. Shackling, handcuffing during delivery, and giving


47 Goodwin, Precarious Moorings, supra note 45 at 682.

48 Movies such as BLACK STORK (Sheriott Pictures Corp. 1917) captured the nation’s fascination with proper “breeding” and the dangers of marriage and reproduction with persons from genetically “unfit” lower-classes. Directed by Leopold and Theodore Wharton, this movie invites the public into literal and figurative theatre—an intimate, delicate matter—should a couple marry that
birth on toilets in jails and prisons represent the new punitive norm shaping the underbelly of criminal law enforcement against poor pregnant women at hospitals. Noticeably, poor women’s pregnancies acquire not only a different rank and regard among medical professionals, but also a different legal status than other gestations fraught by risks and uncertainty. For example, Dorothy Roberts’ ground breaking research on race and reproduction theorizes that during the post-antebellum period, states eschewed black women reproducing at all.

Key to these evolving criminal law norms, however, is the increased reliance on medical personnel to assist states in interpreting and implementing fetal protection laws. In their expanded roles, physicians and nurses become key statutory interpreters and law enforcement authorities. Section A explains how physicians and nurses are increasingly relied upon to implement and interpret fetal protection laws. Section B critiques this reliance as a problematic delegation of formidable discretionary power.

A. Reliance on Medical Personnel to Interpret State Statutes

State fetal protection laws along with federal legislation, such as The Keeping Children and Families Safe Act of 2003, 42 U.S.C. §5106a increasingly and necessarily turn to nurses and doctors to interpret and implement key statutory provisions. For example, in states that collect federal funds for child abuse and neglect services, the Act indicates that health care providers involved in the delivery or care of infants identified as being affected by illegal substance abuse or withdrawal symptoms resulting from prenatal drug exposure must

might produce a “defective” child? In the film, a doctor warns the happy groom not to marry a beautiful woman who happens to be his genetic inferior; they fail to heed the doctor’s prescient warning. To emphasize the point of the film, and its broader warning—or perhaps reflection of the times—the fated child is born with a terrible disability and dies. See generally MARTIN S. PERNICK, THE BLACK STORK: EUGENICS AND THE DEATH OF “DEFECTIVE” BABIES IN AMERICAN MEDICINE AND MOTION PICTURES SINCE 1915 (1996).

49 Such dynamics are discussed in more depth in prior literature. See, e.g., KHIARA BRIDGES, REPRODUCING RACE (2011); DOROTHY ROBERTS, KILLING THE BLACK BODY (1997); Goodwin, Precarious Moorings, supra note 45.

50 ROBERTS, KILLING THE BLACK BODY (1997), supra note 49.
notify the child protective services system of the exposure. This is often the first step in police notification.

Two recent cases in Florida and Iowa illustrate how physicians and hospital staff operate not only as caretakers to their patients, but also interpreters of state statutes. The cases described below are not unique and could easily be substituted by other examples in Indiana, South Carolina, Maryland, and others discussed infra and found in the appendix. However, like similar cases, they call our attention to hard realities: obtaining appropriate prenatal care can be subject to state (political) rather than medical (patient) considerations.

In their politicized roles as deputized law interpreters, physicians and nurses may make wrong legal calls or prioritize legal calls over medical calls. To explicate, physicians and nurses are called upon to wear two hats: that of healthcare provider and the other of legal enforcer. In this dual role, conflicts of interests arise, where a) patients’ needs or interests become subordinate to physicians’ interests in accommodating or promoting state interests; b) physicians’ legal duties to comply with law enforcement protocols conflict with their ethical duties to the patient; c) physicians’ obligations to the profession conflict with obligations to law enforcement. All of these may be at odds with patient priorities and their constitutional rights. Samantha Burton’s lawsuit against government officials in Florida heightens this concern.

1. Florida

In 2010, during a routine prenatal medical visit, Samantha’s physician ordered bed rest at the hospital for the duration of her pregnancy—roughly fifteen weeks. Recommending bed rest to a patient is not unusual. However, seeking a court order to enforce it is another matter. Indeed, Burton’s doctor set into action a plan to obtain a court order for involuntary confinement.51 In the process, the physician overruled Burton’s protestations for a second opinion, desire to return home to her two kids, or to switch hospitals if bed rest was unavoidable, given the distance from her home.52

51 See James, supra note 23.

On petition by the State Attorney, the order was granted. According to the circuit court judge, John Cooper, Burton’s physician deemed it “necessary to ‘preserve the life and health of Samantha Burton’s unborn child.’” In accommodating medical staff’s requests, the Leon County Circuit Court ordered Burton’s indefinite confinement at the Tallahassee Memorial Hospital. In addition, the court granted Burton’s physicians the authority to take whatever medical course of action necessary to achieve their goals, even if against the patient’s will, including performing a cesarean delivery.

Problematically, law and medicine intersected in this case in pernicious ways, extending beyond Burton’s physician seeking an order to confine her. For example, Burton was not provided any legal representation at her hearing, despite the significant liberty interests at stake. These liberty interests included freedom from unwanted medical intervention, the unconstitutional search of her body, and subsequent seizure of her fetus. Burton’s doctors and hospital medical staff interpreted state law to provide that fetal protection interests trump the liberty interest of their pregnant patient.

The question remains: are health care providers in the best position to make legal determinations that contravene liberty interests and permit unlawful searches and seizures? And, while prosecutors and even courts may be perceived as appropriate checks on medical staff interpreting state laws to protect fetuses, their judgment is neither immune to the influence of medical urgency, moral panic, nor


55 Id. at 267 (Van Nortwick, J., concurring).

56 Id. at 265.

57 This also implicates the right to privacy; all competent individuals have the constitutional right to accept or refuse medical care and to make all decisions concerning their health. Id.

the perception that medicine and science are infallible.\textsuperscript{59} Indeed, the judge denied Ms. Burton’s request to switch hospitals because “such a change is not in the child’s best interest at this time.”\textsuperscript{60} Burton’s case ultimately came to light through the American Civil Liberties Union’s (ACLU) advocacy on her behalf, but only after three days of involuntary confinement and a forced cesarean section.\textsuperscript{61} The order was overturned on appeal,\textsuperscript{62} providing a symbolic victory on the constitutional merits of Burton’s claims that her autonomy and bodily integrity were unconstitutionally violated by the state.

Yet, the problem inherent in cases like Burton’s or the treatment of pregnant patients is that the cases are prone to repetition. Burton was “treated” at the eighth largest hospital in Florida.\textsuperscript{63} And judgment calls are not without serious constitutional consequences. Indeed, such instances are “capable of repetition yet evading review,”\textsuperscript{64}

\textsuperscript{59} See Condon, \textit{supra} note 6. \textit{See also} Pemberton v. Tallahassee Mem’l Reg’l Med. Ctr., 66 F. Supp.2d 1247, 1252–53 (N.D. Fla. 1999) (“The medical evidence belies Ms. Pemberton’s bravado. . . . [T]here is a very substantial risk of uterine rupture and resulting death of the baby (as well as serious injury to the mother);

“I am interested in providing additional safety and it must happen now. . . . The Texas Legislature can no longer sit idly by while its next generation is born addicted to illegal drugs, born with physical and mental abnormalities, set up for education hardship, and destined to be on Social Security Benefits. Parents must be responsible for their actions.”


\textsuperscript{60} Belkin, \textit{supra} note 52.

\textsuperscript{61} James, \textit{supra} note 23.


\textsuperscript{63}TALLAHASSEE MEM. HEALTHCARE, http://www.tmh.org/AboutUsPressRoomTallahasseeMemorialHealthCare (last visited Aug. 6, 2012).

\textsuperscript{64} Burton, 49 So.3d at 264.
because of the unending number of women who will become pregnant and undoubtedly experience sickness, anxiety, depression, or risk during their gestations. As a policy matter then, such instances are never purely isolated and likely to impact more than a few; obstetricians treat multiple patients, and that figure can be multiplied by the number of pregnant patients treated at a given hospital under the supervision of other medical staff trained to interpret the law in similar, but flawed ways.

2. Iowa

On one hand, fetal protection cases illuminate the great heights medical staff and prosecutors will scale in the name of protecting fetal interests. On the other hand, the subordination of women’s rights, reducing expectations of privacy, and scaling back constitutional protections appear concomitant with furthering those goals.

In Christine Taylor’s case, she fell down steps, during her pregnancy. After receiving treatment by emergency medical technicians, she decided to voluntarily seek medical care at a hospital. At interviews with a nurse and doctor Taylor confided that because she was single, she considered both adoption and abortion during the early stages of her pregnancy. Thereafter, medical staff alerted police, because they interpreted Taylor’s case to fit within the feticide statute. That is, they found her case to meet the law’s criminal prohibition against “intentionally terminat[ing] a human pregnancy . . . after the end of the second trimester of the pregnancy.”

In this case, medical staff determined that even considering an abortion during the first trimester of a pregnancy violated the state’s feticide law.

Taylor’s pregnancy survived her fall. Nevertheless, she was arrested at the hospital and incarcerating at the local jail for two days, while police launched an investigation to determine whether Taylor meant to kill her fetus when she tripped. For three weeks, local

65 IOWA CODE ANN. § 707.7 (West 2011).


67 Id.
prosecutors pursued their investigation against her until the case was dismissed—perhaps as a response to public pressure or because assembling the type of evidence necessary to establish Taylor’s intention to kill her fetus proved difficult.

Importantly, both the Taylor and Burton cases demonstrate legislatures’ reliance on medical staff to police at the front end in risky pregnancy cases. Nurses and doctors serve as more than the eyes and ears for the state. Rather, as a formal matter, these cases illustrate that at the ground level, medical staff operate as the interpreters and implementers of state fetal protection statutes, often with the support and cooperation of police, prosecutors, and even judges. For many reasons, we should be concerned about medical staff serving as interpreters and implementers of fetal protection laws, particularly as 38 states have adopted feticide legislation of some sort.

What makes these cases problematic is that medical staff and law enforcement take up a joint enterprise in efforts to change pregnant patients’ behavior. Often, their medical diagnosis objectives are subordinate to criminal law enforcement purposes, which introduce problematic norms into the physician-patient relationship. As described below, to more appropriately concentrate their efforts, these alliances may rely on stereotypes and cultural biases to determine which women deserve state intervention. Indeed, in some instances, the primary goal is law enforcement.

At the state level, fetal protection laws are intended to promote the health and safety of fetuses by criminalizing actual or intended harm to fetuses. On one hand the laws create a bright line rule that

68 Doctors and other health care providers are in a better position to identify which women are high-risk and thus become the interpreters of various fetal protection laws. See Goodwin, Precarious Moorings, supra note 45, at 684.

69 Id. at 684–85.


71 According to Solicitor Condon, a primary purpose of the task force established to address the issue of drug use during pregnancy was “to consider possible prosecution of the mothers of drug affected babies.” Reply Brief of Appellant-Petitioner at 9, Ferguson v. City of Charleston, 532 U.S. 67 (2001) (No.99-936).
although broad, place fetus abusers on notice. Historically, the common law required an actual birth and “childhood” status (i.e. the child born alive and living) in order for an individual to be convicted under state law for harming a child.\footnote{The “born alive rule” allows the death of a fetus to “stand as a basis for murder as long as the fetus was born alive . . . .” State v. Courchesne, 998 A.2d 1, 35 (Conn. 2010) (quoting State v. Courchesne, 757 A.2d 699, 703 (Conn. Super. Ct. 1999)).} However, the advent and revision of fetal protection laws introduce new standards and definitions that affect not only the interpretations of the legal status of fetuses for purposes of child protection, but also for criminal prosecution.\footnote{Under fetal protection laws, if interpreted broadly, “a woman could be subject to criminal penalties for failure to provide adequate water, nourishment or a healthy environment to a developing fetus or for attempting to save her life at a risk to the fetus.” Goodwin, supra note 21, at 686.} In other words, a common law conviction for harming a child no longer requires that a child is born alive and living independent of its mother under state fetal protection law statutes.\footnote{States frequently use language that assigns “legal rights to fetuses ‘at any gestational age.’” Christine Vestal & Elizabeth Wilkerson, States Expand Fetal Homicide Laws, STATELINE, Aug. 22, 2006, http://www.pewstates.org/projects/stateline/headlines/states-expand-fetal-homicide-laws-85899390068.} This element of fetal protection statutes introduces ambiguity, complexity, and complication regarding interpretation and implementation at the ground level and without training in constitutional or tort law, medical personnel may not understand competing legal interests or the primacy of pregnant women’s rights to privacy and bodily integrity.

\section*{B. Formidable Discretionary Power}

Noticeably absent in the operation of contemporary fetal protection efforts are these foundational bioethics principles: informed consent, autonomy, social justice, and voluntary participation.\footnote{2 Trials of War Criminals Before the Nuremberg Tribunals Under Control Council Law No. 10, at 189, 237 (U.S. Gov't Printing Office, 1946-1949) [hereinafter Nuremberg Code]; 18th World Medical Association General}
fiduciaries to their pregnant patients to donning new roles as *quasi* agents of the state, symbolic and substantive reallocations of *power* and *decision-making* have resulted. To be clear, part of this new role is not new: the collection of important medical data in the provision of medical care comports with an age-old standard. However, the means and type of medical information collected by medical practitioners in the service of pregnant women has realigned, implicating constitutional rights (discussed *infra*). Additionally, the purpose and function of collecting sensitive medical data from pregnant women (and their fetuses and newborns), increasingly surreptitiously, serves a criminal state interest rather than that of the patient.

*Ferguson v. City of Charleston* points to this shift in the role of medical staff from serving the needs of patients to donning the role of interagency participant whose function is to gather medical evidence against patients. In that case, ten women initiated §1983 litigation against the Medical University of South Carolina (MUSC) and local government officials, claiming that they were the victims of warrantless and nonconsensual searches initiated and performed by medical staff. In this matter, medical officials volunteered to serve as informants against their patients, initiating contact with the

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76 “The nine criteria for identifying which obstetrical patients to search for cocaine allowed physicians to exercise virtually unbridled discretion . . . .” Brief for Petitioners, *supra* note 58, at 11.

77 *Ferguson v. City of Charleston*, 532 U.S. 67 (2001) (holding that the hospital’s performance of drug tests on pregnant women’s urine to obtain evidence of drug use for law enforcement purposes was an unreasonable search in violation of the Fourth Amendment); *Bearder v. State*, 806 N.W.2d 766 (Minn. 2011) (concluding that the state’s usage, storage, and dissemination of newborn blood samples without informed consent violated the genetic privacy act.).

78 *Ferguson*, 532 U.S.

79 *Id.* at 73.

80 *Id.* at 70–71.
Charleston County Solicitor (local prosecutor), Charles Condon, upon learning that he campaigned to extend child abuse laws to the use of drugs by pregnant women.  

Consequently, Condon established an interagency task-force, which included police, the prosecutor’s office, and hospital staff, and together they created what plaintiffs called the “Search Policy.”  

In a series of memoranda and meetings, Condon and his team informed medical personnel how to collect urine samples for use in criminal investigations, protect a chain of custody, and the method by which MUSC staff should report to police.  

Law enforcement staff trained doctors and nurses, and Condon provided written guidance “listing criminal charges that could apply to women coming under the Search Policy.”  

The collaboration between MUSC medical staff and law enforcement to obtain incriminating evidence against pregnant women seeking prenatal care exposes a provocative, but not unusual example of physicians using formidable discretionary power in the furtherance of a criminal law purpose rather than patient interest.  

The American Medical Association, the American Public Health Association, and the Association of Maternal and Child Health have each issued amicus briefs in high profile pregnancy prosecution cases making clear that the role of doctors and nurses must be first and primarily to the service of patients and not law enforcement.  

Despite their efforts and the filings of persuasive amicus briefs, fetal protection efforts amplified over the past year, leading to the arrests

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81 Id. at 71–72.

82 Brief for Petitioners supra note 58, at 2.

83 Id. at 11–12.

84 Id. at 12.

85 “As the Medical Director of the Neonatal Intensive Care Unit testified, testing was not being done for medical reasons, but solely for purposes of the Search Policy.” Brief for Petitioners, supra note 58, at 12.

and imprisonment of a broad spectrum of pregnant woman and new mothers. In one case, a woman was arrested and now faces up to forty-five years in prison for attempting suicide while pregnant. In another case, a member of fundamentalist Christian group was arrested for refusing medical care during her pregnancy. The threats of law enforcement and civil confinement now extend to women who refuse cesarean birth, preferring natural births instead. Medical personnel play key roles in making judgment calls about these arrests. The discretionary power described above, much like that afforded prosecutors or police officers, can be corruptible and vulnerable to selective enforcement, social bias, political ideology, and prejudice. Indeed, the only women whose urine samples became the subject of the MUSC Search Policy were African American, with the exception of one white patient. In the latter’s case, Nurse Shirley Brown—a member of the interagency taskforce—made a point of notating the patient’s chart with the following information: “patient live[s] with her boyfriend who is a Negro.” This notation did not serve a medically relevant purpose, but it revealed an extra-legal consideration: race in the implementation and enforcement of South Carolina’s fetal protection law.


88 Rebecca Corneau was taken into custody and confined to a secure hospital after she refused to submit to a court-ordered medical exam to evaluate the health or her and her fetus. See Dave Wedge, Judge Confines Cult Mom to Secure Hospital, BOS. HERALD, Sept. 1, 2000, available at 2000 WLNR 227248.

89 See Brief of the NARAL Foundation et al. as Amici Curiae in Support of Petitioners, Ferguson v. City of Charleston, 532 U.S. 67 (2001) (No. 99-936) 200 WL 1506972, at *23-*26 for a discussion about how discretionary power can be abused and subjectively applied. See also Dwight L. Green, Abusive Prosecutors: Gender, Race & Class Discretion and the Prosecution of Drug-Addicted Mothers, 39 BUFF. L. REV. 737, 738 (stating that prosecutorial discretion can lead to biased law enforcement because “[p]rosecutors reflect the unstated but operative norms in American courtrooms which are predominantly affluent, white, usually male, and often Protestant perspectives.”).

90 Brief for Petitioners, supra note 58, at 12.

91 Id. at n.10.
Importantly, these institutional shifts that imbed doctors as criminal law gatekeepers cannot be described as episodic or rare. These shifts represent the institutionalization of changing ideologies and the reprioritization of legal values, particularly fiduciary duties. Black’s Law Dictionary defines the fiduciary’s obligation as the highest standard of care and “duty to act with the highest degree of honesty and loyalty toward another person and in the best interests of the other person.” Legal and medical scholars have long recognized the physician’s duty “to give the well-being of their patients the highest priority.” Trust remains central to the physician-patient relationship—prioritizing the principal (or patient) above all else. Relevantly, courts enumerate these fiduciary duties in a line of cases dating back to *Canterbury v. Spence*. These duties include maintaining confidentiality and withholding information from third parties, obtaining the patient’s informed consent for medical treatments and procedures, making decisions based on the patient’s best interest, and disclosing potential conflicts of interest, including with the state.


94 464 F.2d 772 (D.C. Cir. 1972). This is a classic case that, among other things, established that physician has a duty to obtain a patient’s informed consent prior to beginning treatment.

95 See, e.g., MacDonald v. Clinger, 446 N.Y.S.2d 801, 802 (N.Y. App. Div. 1993) (stating that “the confidentiality of the relationship is a cardinal rule of the medical profession . . . [it] is contractual in nature, whereby the physician . . . impliedly covenants that the disclosures necessary to diagnosis and treatment of the patient’s . . . condition will be kept in confidence.”).

96 See *Canterbury*, 464 F.2d (establishing that patients have a right to give their informed consent prior to receiving any treatment). See also Matthies v. Mastromonaco, 733 A.2d 456, 463 (N.J. 1999) (recognizing that “[l]ike the deviation from a standard of care, the physician’s failure to obtain informed consent is a form of medical negligence.”).

The Fourth Circuit Court of Appeals reasoned quite emphatically: “We reiterate: …a fiduciary laboring under a conflict of interest ‘must act as if he is ‘free’ of such a conflict.’” The court underlined, “‘free’ is an absolute. There is no balancing of [the beneficiaries’ and either the fiduciary’s or a third party’s] interests,” even when the other interest belongs to the government.

More than an ethical duty, the fiduciary responsibility physicians owe patients is contractual. Arguably, it is the strictest standard of duty agents owe their principles or that physicians owe their patients. Succinctly put, the duty requires “undivided loyalty.” The U.S. Supreme Court emphasizes that the fiduciary standard imposes the requirement of “an eye single” toward beneficiaries’ interests. The historic—indeed ancient—origins can be traced to the Hippocratic Oath, a pledge sworn by doctors at their graduation from medical school. In pertinent part, the oath states, “[w]hatever I see or hear in the lives of my patients, whether in connection with my have an ethical duty and a professional responsibility to act in the best interests of their patients . . . .”


100 Id.


103 Id.

professional practice or not, which ought not to be spoken of outside, I will keep secret, as considering all such things to be private.”105 The consensus among courts emphasizes that “a fiduciary relationship exists between the patient and the physician”106 and that this fiduciary relationship requires the physician “to disclose all information material to the patient’s decision.”107

If dutifully exercised the fiduciary duty is “especially arduous.”108 According to the Fourth Circuit, “that is because it is.”109 The duties of medical fiduciaries require a very high, demanding threshold of integrity, loyalty, and trust to patients. This level of care and integrity is “among the highest, if not the very highest, known to the common law.”110 Justice Cardozo’s articulation of this duty is iconic:


107 Moore, 793 P.2d at 483. See also Canterbury v. Spence, 464 F.2d 772, 786 (D.C. Cir. 1972) (stating that “the physician’s communications to the patient . . . must be measured by the patient’s need, and that need is the information material to the [patient’s] decision.”); Small v. Gifford Mem’l Hosp., 349 A.2d 703, 706 (Vt. 1975) (“[I]t is the duty of the physician, in terms of informed consent, to give a patient . . . all information material to the decision to undergo the proposed treatment.”).


109 Id.

110 Id.
Many forms of conduct permissible in a workaday world for those acting at arm's length, are forbidden to those bound by fiduciary ties. A trustee is held to something stricter than the morals of the market place. Not honesty alone, but the punctilio of an honor the most sensitive, is then the standard of behavior. As to this there has developed a tradition that is unbending and inveterate. Uncompromising rigidity has been the attitude of courts of equity when petitioned to undermine the rule of undivided loyalty by the "disintegrating erosion" of particular exceptions. Only thus has the level of conduct for fiduciaries been kept at a level higher than that trodden by the crowd. It will not consciously be lowered by any judgment of this court.111

Contemporary fetal protection cases demonstrate a bold abrogation of the fiduciary standard established by courts and the medical profession. More perniciously, in fetal protection cases involving pregnant women like the Ferguson plaintiffs, medical staff lure them into a symbolic lair under the pretense of providing medical services. Ferguson court documents, including memoranda, briefs,112 and court transcripts,113 plaintiff exhibits,114 joint exhibits, and the briefs’ appendices115 illuminate the program’s goal to facilitate the arrests and criminal prosecutions of pregnant African American patients who participated in illegal drug use during their gestations. Nor is there any law that prohibits doctors from subordinating their medical obligations to patients for their criminal informant role for the state. The U.S. Supreme Court116 found the MUSC program to


116 Ferguson, 532 U.S. at 86.
violate the pregnant women’s Fourth Amendment interests, because the program authorized nonconsensual searches and seizures without a valid warrant. What the Court did not address, nor has contemporary legal scholarship accounted for, is how the physician patient relationship becomes corrupted by doctors and nurses implementation of FPLs.

Part II. Criminal Leverage, Medical Utility and the Fiduciary Relationship

As described in Part I, contemporary fetal protection efforts involve multiple layers of criminal law enforcement and policing. In deploying new criminal law strategies to curb abuse against fetuses, one key, increasingly important effort is the reliance on medical personnel to serve as the interpreters of state feticide statutes. In that capacity, the locus or front end of law enforcement occurs at hospitals and clinics at a time when pregnant women anticipate treatment and medical assistance. Functionally, medically trained care providers step in to interpret broad, vaguely written legal statutes intended to protect fetuses and children from third party harm.

In their new roles as criminal law statute interpreters, medical personnel wield significant legal authority and considerable discretionary power. This power is exercised in multiple ways through the guise and facility of medical priority and care to encourage prenatal screenings; initiate and perform selective test on patients, their fetuses, and their babies that may not otherwise have been performed at a particular time; to initiate particular tests for certain patients and not others based on profiling; to maintain a chain of custody on tests such as urinalyses; to report medical results to police; and to assist law enforcement in the detainment, shackling, and arrests of patients. Professor Paul Butler, a criminal law expert and former federal prosecutor, refers to this type of law enforcement as “snitching” on patients.117 In the process of revealing patient “secrets” and medical information, doctors and nurses abrogate their duty of confidentiality,118 well-established common law principles,119

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118 See, e.g., MacDonald v. Clinger, 446 N.Y.S.2d 801, 802 (N.Y. App. Div. 1993) (stating that “the confidentiality of the relationship is a cardinal rule of the medical profession . . . . [it] is contractual in nature, whereby the physician . . .
and very likely the Health Insurance Portability and Accountability Act.\(^{120}\)

Part A argues that in assessing maternal fetal conflict—or women’s intent to harm their fetuses, medical personnel may—and frequently do—make wrong legal calls. To comply with state statutes that encroach and burden pregnant women’s constitutional rights, doctors increasingly prioritize punitive legal calls over beneficent medical calls in maternal conduct cases. Part B examines and conjectures why this happens. On one hand, it is not surprising that medical personnel are poor interpreters of state law; they are neither elected or appointed, nor trained or studied in the law and legislative processes. On the other hand, fetal protection laws’ coercive effects and absurd outcomes impact not only pregnant women, but also the medical personnel who serve them.

A. Wrong Calls & Corruption of the Physician Patient Relationship

The Burton\(^{121}\) and Ferguson\(^{122}\) cases as well as Taylor’s story\(^{123}\) demonstrate the corruptibility of medical discretion and the physician-patient relationship in fetal protection cases. For pregnant women, detecting (and guarding against) the dual role of medical staff as healthcare providers and state criminal informants can be virtually impossible, as long as patients receive a modicum of medical service. Patients assume that interactions with physicians will promote their health and that in-confidence sharing of social and medical histories

\(^{119}\) Id.


\(^{121}\) Burton v. Florida, 49 So.3d 263 (Fla. Dist. Ct. App. 2010).


will achieve that goal. Historically, confidentiality norms in the physician-patient relationship rival only that of the lawyer and her client or clergy and parishioners.

However, fetal protection laws impose responsibilities on doctors that conflict with well-established common law duties to maintain confidence and advocate for their patients as described above. Indeed, such laws introduce problematic norms, which turn prior medical and legal expectations and practices on their head. As demonstrated in the above cases, increasingly pregnant women enjoy reduced expectations of confidentiality, privacy, and autonomy in their medical treatments. Arguably, this recent phenomenon is not completely new to American politics or medicine. Consider the pervasive eugenics laws enacted a century ago and for which there is complicated legal precedent.

On the one hand, the Supreme Court in *Skinner v. Oklahoma* made clear that criminal laws calling for the sterilization of petty thieves, but not white collar embezzlers violated equal protection. In other words, state laws that might require the castration of the modern day chicken thief while sparing sophisticated Ponzi schemers the same fate cannot stand. On the other hand, *Buck v. Bell*, a 1927 eugenics case, permitting the non-consensual sterilization of a young woman considered in Justice Oliver Wendell Holmes’ opinion to be degenerate and an “imbecile” has never been overturned.

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124 See, e.g., Cynthia M.A. Geppart & Laura Weiss Roberts, *Protecting Patient Confidentiality in Primary Care*, 3 SEMINARS IN MED. PRAC. 7, 7 (2000) (“Many patients assume that physician-patient confidentiality is an absolute.”).

125 MODEL RULES OF PROF’L CONDUCT R. 1.6 (2012).

126 Ezra E.H. Griffith & John L. Young, *Clergy Counselors and Confidentiality: A Case for Scrutiny*, 32 J. AM. ACAD. PSYCHIATRY L. 43, 44 (2004) (“There is a basic societal expectation that clergy will respect the confidences of their charges.”)


129 Id.

1. Disparate Calls

Importantly, the modern fetal protection cases described here, as well as others, demonstrate the fallibility of legal calls made by medical staff. The cases highlight how non-legal actors, donning legal roles to interpret and implement law can be problematic. After all, falling down stairs, even while pregnant is not illegal, nor is refusing bed rest. In many such cases, pregnant women ultimately legally prevail, demonstrating how doctors and nurses frequently make wrong legal calls. However, these moments of ex post legal success occur subsequent to invasive searches, humiliation, arrest, sometimes shackling, and incarceration (even if temporary). Thus, if pregnant women are spared extended

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131 See Ferguson v. City of Charleston, 532 U.S. 67 (2001); State v. Martinez, 137 P.3d 1195 (holding that the state could not prosecute Martinez for child abuse because she used cocaine during pregnancy); McKnight v. State, 661 S.E.2d 354 (S.C. 2008) (overturning McKnight’s conviction for homicide by child abuse after she gave birth to a stillborn and admitted to using cocaine during pregnancy); Alexandria Sage, Utah C-Section Mom Gets Probation, CBS News (May 7, 2009, 1:34 PM), http://www.cbsnews.com/2100-201_162-605537.html (discussing how prosecutors dropped their capital murder charge against Rowland, instead sentencing her to 18 months’ probation for child endangerment).

132 Lori Griffin’s urine, for example, was searched “with her knowledge of consent” when she went to the hospital for prenatal care. Brief for Petitioners, supra note 58 at 7.

133 Griffin was removed from the hospital, in front of others, in handcuffs and shackles. Id. Another plaintiff, Sandra Powell, was arrested after giving birth, “while she was still in pain and bleeding from childbirth.” Id. at 8. She was transported to the city jail “handcuffed and wearing only a hospital gown.” Id.

134 After her urine was searched and tested for drugs, police entered into Lori Griffin’s hospital room, informing her that “she was under arrest for distribution of cocaine to a minor and removed her in handcuffs and shackles to a waiting police car.” Id. at 7.

135 Id.

136 “Griffin spent three weeks in jail in an unsanitary cell with only a metal table and cushion to serve as a bed.” Id.
incarceration, their victories appear very local, symbolic, and at great personal, reputational, and financial expense.\textsuperscript{137}

That men and women (and even patients with serious medical concerns) place their health at risk by engaging in perilous activities is nothing new. So it should be a matter of concern that pregnant patients risk differential, extra-legal, unequal treatment, specifically, criminal arrests for engaging in similar activities to that of others that do not result in criminal investigations nor arrests. Even pregnant patients’ illegal activity, such as the use of illicit drugs, is treated disproportionately by physicians within and outside of their gender. For example, a woman whose drug use is incidental to her medical treatment or condition does not risk physician disclosure of that information to police. Why is this? Why are fathers or soon to be fathers who smoke, drink excessively, or use illegal drugs not surrendered to law enforcement by medical personnel based on the theory that their behavior poses risk to the health of children or fetuses? The questions and their answers point—in part—to institutional biases.

2. Racial Calls

The questions above cannot be evaluated in isolation.\textsuperscript{138} My prior work explains that doctors may respond to their personal intuitions rather than professional standards when treating pregnant patients.\textsuperscript{139} In these contexts, race and class may consciously or unconsciously figure into their decision-making, such as in the Medical University of South Carolina cases,\textsuperscript{140} where it appears Black women were the near-exclusive targets of a plan to arrest pregnant drug users. Indeed,

\textsuperscript{137} See \textit{id.} for additional information about the plaintiffs’ experiences.


\textsuperscript{139} Goodwin, \textit{Precarious Moorings}, supra note 45.

\textsuperscript{140} Of the thirty women arrested under South Carolina’s Search Policy, 29 were African American. Brief for Petitioners, \textit{supra} note 58 at 13. In regard to the one white patient who was arrested, the nurse had indicated on her chart that she lived “with her boyfriend who is a Negro.” \textit{id.} at n. 9.
empirical studies demonstrate that Black women are ten times more likely to be reported to child-welfare organizations than their white counterparts for similar behavior (drug and alcohol use). 141

3. Responding To Legislative Pressure

So, one explanation might be that doctors are more inclined to be punitive with pregnant patients than other persons receiving medical services, because they are biased. Another plausible, rational explanation is that legislators and their conduits—prosecutors—pressure doctors to act outside of their patients interests through the passage and enforcement of fetal protection legislation. In other words, legislators’ political agendas may undermine and pervert the physician-patient relationship, burdening doctors to identify and initiate various legal proceedings against pregnant patients whose conduct fails to conform to new legal and medical standards. This includes physician-initiated court ordered, involuntary cesarean surgical operations for pregnancies that involve low or high birth-weight fetuses, twins, or at risk pregnancies. 142

4. Wrong Calls Involving Courts


142 See, e.g., Pemberton v. Tallahassee Mem’l Reg’l Med. Ctr., 66 F. Supp.2d 1247, 1254 (N.D. Fla. 1999) (holding that a judge’s order that a caesarean section be performed did not violate Pemberton’s constitutional rights “because of the very substantial risk that the course Ms. Pemberton was attempting to pursue would result in the death of her baby.”); Jefferson v. Griffin Spalding Cnty. Hosp. Auth., 274 S.E.2d 457 (Ga. 1981) (upholding the Superior Court’s grant of the county hospital’s petition authorizing it to perform a caesarean section upon a woman in the event she came to the hospital for delivery). A County Court Judge in Luzerne County, Pennsylvania, approved the request of doctors at Wilkes-Barre General Hospital for legal permission to perform a C-section on Amber Marlowe. Marlowe was told she should have a C-section because her baby was large, expected to weigh around 13 pounds. Marlowe left the hospital and did not return. She gave birth to a healthy baby girl. David Weiss, Court Delivers Controversy, TIMES LEADER (Wilkes-Barre, PA), Jan. 16, 2004, available at http://www.uchastings.edu/faculty-administration/faculty/adjuncts/class-websites/dunn/Westlaw_Document_12_40_12.pdf
There are medical reasons for which pregnant patients are often concerned regarding cesarean births. Indeed, perverse medical consequences can result from the very medical procedures imposed to save fetuses or mother. Consider the deaths of Angela Carder and her fetus; her medical treatment and ultimate death following a court-ordered cesarean provide an instructive lesson. Carder, a leukemia survivor, developed a tumor and sought chemotherapy and radiation treatment at the George Washington University Hospital. Carder was close to death and chemotherapy provided a slight hope for survival, although it posed medical risk to her 26 week old fetus. According to the D.C. Court of Appeals, “there was no evidence before the court showing that A.C. consented to, or even contemplated, a caesarean section before her twenty-eighth week of pregnancy.” Despite this and her family’s opposition, doctors and


144 BeiBei Shua’s prosecution involves a question of medical evidence. Prosecutors claim that the rat poison Shua consumed caused the medical condition that resulted in the baby’s death. However, doctors presented compelling evidence that the treatments provided to save the baby’s life could have caused the condition from which the daughter died. See Charles Wilson, Ind. Mom’s Lawyer: Cause of Baby’s Death Unproven, ABC NEWS, Oct. 10, 2012, http://abcnews.go.com/US/wireStory/ind-moms-lawyer-babys-death-unproven-17446585#.UIGZrMU1-Mo.

145 See In Re A.C., 573 A.2d 1235 (D.C. 1990) (holding that when a pregnant patient is near death and her fetus is viable, the decision of what is to be done is to be decided by the patient, unless incompetent).

146 Id. at 1238.

147 Testimony from Dr. Alan Weingold makes clear that Carder opposed the surgery:

THE COURT: You could hear what the parties were saying to one another?

DR. WEINGOLD: She does not make sound because of the tube in her windpipe. She nods and she mouths words. One can see what she’s saying rather readily. She asked whether she would survive the operation. She asked [Dr.] Hamner if he would
hospital officials intubated Carder and petitioned a court to authorize an immediate cesarean operation. After adopting the hospital’s recommendation, the “court ordered that a caesarean section be performed on Carder to deliver the fetus.” 148 Notwithstanding Carder’s counsel immediate request for a stay, “a hastily assembled” panel consisting of three D.C. Court of Appeals judges denied the proposed injunction. 149

Following Angela Carder’s court-ordered caesarean operation, her baby survived for two hours and Carder died two days later, never receiving cancer treatment she sought. 150 On appeal after her death, however, the D.C. Court of Appeals held that “in virtually all cases the question of what is to be done is to be decided by the patient on behalf of herself and the fetus.” 151 What went wrong then in that case and other more recent cases like that of Amber Marlow?

In 2004, Pennsylvania doctors obtained a court order to force Amber Marlow to deliver by cesarean section, because ultrasound imaging indicated that her baby might weigh as much as thirteen pounds. 152 The court order granted Marlow’s doctors and the hospital

perform the operation. He told her he would only perform it if she authorized it but it would be done in any case. She understood that. She then seemed to pause for a few moments and then very clearly mouthed words several times, I don’t want it done. I don’t want it done. Quite clear to me.

Id. at 1240–41.

148 Id. at 1240.

149 Id. at 1238.

150 Id.


the authority to perform a non-consensual cesarean operation.\footnote{Id.} Marlow, the mother of six—all big babies—fled the hospital and later delivered a healthy eleven pound baby girl at another hospital. In a subsequent interview, Marlow confided “when I found out about the court order, I couldn’t believe the hospital would do something like that. It was scary and very shocking.”\footnote{Lisa Collier Cool, \textit{Could You Be Forced To Have A C-Section}, \textsc{Advocates for Pregnant Women}, at http://advocatesforpregnantwomen.org/articles/forced_c-section.htm.}

The scope of the problems identified here—physicians prioritizing fetal health over maternal health and decision-making because of legislative, law enforcement, activists pressure—are difficult to track as not all cases of compelled cesarean operations, shackling, or arrest are afforded judicial review or a written opinion when a court has been involved. Nevertheless, the collateral consequences that flow from even the national sample of cases illuminated here should cause serious alarm. The cases described herein indicate the necessity for urgent legal review. Indeed, each unchecked case is capable of repetition, yet evading review.\footnote{South Carolina Senator Charles Condon, for example, has stated: “Nothing could be more heart-breaking than the sight of a baby born with an addiction to cocaine. There is very little doctors and nurses can do to ease the pain of these innocent newborns, whose mothers’ use of hard, illegal drugs during pregnancy constitutes nothing less than blatant child abuse.” Charles Charles Molony Condon, \textit{Clinton’s Cocaine Babies}, 72 Pol.’y Rev. 12 (1995),} What these cases illume, however, is a serious corruption of the physician-patient relationship.

\section*{B. Matters of Scope: The Benefit & The Harm(s)}

Who benefits from the modern corruption of the physician-patient relationship? Is there a medical benefit to the pregnant patient or the fetus that would otherwise not be realized without the imposition of civil commitment, forced cesarean operations, or criminal sanction? Empirical data examining rehabilitation versus incarceration for drug use provides more reliable answers than tough on crime anecdotes from political campaigns.\footnote{To measure success rates in treatment}
versus incarceration, studies track recidivism, arrest rates, and the reduction of illicit drug and alcohol use. Few studies comprehensively measure each of these factors collectively. However, tracking multiple studies provides sturdy evidence that drug treatment programs are far more health and cost effective than prison. Maryland’s Alcohol and Drug Abuse Administration reports that patients in treatment were less likely to be rearrested and more likely to maintain employment. Patients who completed treatment were less likely to be readmitted to treatment. Some of the findings include:

- Among a sample of patients attending treatment in Baltimore City, treatment completion was associated with a 54% decrease in the likelihood of being arrested post-discharge, after adjustment for individual characteristics.
- In Baltimore City, treatment completion was associated with both increased wages following treatment and a 28% increase in the likelihood of becoming employed post-discharge, after adjustment for individual characteristics.

Available at http://www.hoover.org/publications/policy-review/article/6853 (emphasis added). Similarly, Chief Reuben of the Charleston, South Carolina Police Department said, in regard to drug-addicted pregnant women, that “[u]nless you have sanctions in place, unless you understand the basic irresponsibility of these drug-addicted women, it won’t work.” Id. Studies, however, suggest that rehabilitation may be more successful than incarceration of drug users. See, e.g., Doug McVay, et al., Treatment or Incarceration?: National and State Findings on the Efficacy and Cost Savings of Drug Treatment Versus Imprisonment, JUST. POL’Y INST. (2004) (discussing numerous studies that have looked at the success rates of treatment versus incarceration).

157 See, e.g., INST. OF MED., PATHWAYS OF ADDICTION: OPPORTUNITIES IN DRUG ABUSE RESEARCH 192–215 (1996); McVay, et al., supra note 156; Substance Abuse Treatment and Public Safety, JUST. POL’Y INST. (2008), http://www.justicepolicy.org/images/upload/08_01_REP_DrugTx_AC-PS.pdf (discussing studies that have shown that drug treatment within the community is “more cost-effective than prison or other punitive measures”).


159 Id.
In Oregon, treatment completion “is associated with substantially fewer incarcerations in the state prison system and with fewer days of incarceration.”161 A study sponsored by the Oregon Office of Alcohol and Drug Abuse Programs examining data from that state discovered “residential treatment completers were incarcerated at a rate of 70% lower than the matched group.”162 In the period following treatment, patients who completed the treatment, “received 65% higher wages than those who didn't complete treatment.”163 In addition, “the use of food stamps was reduced significantly for clients who completed treatment compared with those who were non-completers.”164 The study also found that patients who completed treatment programs were much less likely to use medical emergency rooms, indicating that preventative services were more likely to be utilized and perhaps less risky activities became the norm among the population completing treatment.

The positive correlations associated with drug treatment,165 which depend on doctors focusing on reducing their patients’ addiction to illegal drugs and alcohol along with providing mental health services, are in stark contrast to the outcomes associated with incarceration,

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160 Id.


162 Id.

163 Id.

164 Id.

165 Amelia M. Arria et. al., Drug Treatment Completion And Post-Discharge Employment In The TOPPS-II Interstate Cooperative Study Treatment, 25 J. SUBSTANCE ABUSE TREATMENT 9 (2003). This multi-state empirical study found “completers were 22% to 49% more likely than non-completers to be employed and to earn higher wages in the year following treatment, holding other variables constant.” Moreover, authors confirmed that patients who remain in treatment more than 90 days are more likely to be employed in the year following treatment. The findings are “consistent across the three state project with different client populations, treatment delivery systems, and labor markets.” Id. at 13–14.
including negative externalities for children of incarcerated parents,\textsuperscript{166} recidivism,\textsuperscript{167} and abuse while in prison.\textsuperscript{168} For example, the Beckley Foundation reports that, “there is little evidence that large scale imprisonment of drug offenders has had the desired results in deterring drug use or reducing drug problems.”\textsuperscript{169} In a very sophisticated research study, engaging analysis across multiple countries, including the U.S., researchers found that incarcerated drug users are likely to continue to use drugs while in prison. Moreover, those who previously were not drug users are more likely to begin using drugs during their incarceration.\textsuperscript{170} In other words, prison is a high risk, low social benefit environment for pregnant patients. More troubling, fetal health is not improved by exposing pregnant women to prison.

Importantly, physicians’ decision-making as to whom they will or should profile or report is influenced by social factors and remains vulnerable to stereotyping. For these reasons, they are more likely to under-police and under-report white women because cognitive bias\textsuperscript{171}


\textsuperscript{168} Data examined by the Bureau of Justice Statistics found that 9.6% of prisoners is sexually victimized during incarceration. Terry Frieden, \textit{Study Finds Nearly 1 in 10 State Prisoners is Sexually Abused While Incarcerated}, CNN (May 17, 2012), http://articles.cnn.com/2012-05-17/us/us-state-prisons-abuse_1_sexual-abuse-staff-sexual-misconduct-prisoners?_s=PM:US.


\textsuperscript{170} \textit{Id.} at 2.

\textsuperscript{171} Michele Goodwin and Naomi Duke, Health Law: Cognitive Bias in Medical Decision-Making, \textit{in IMPLICIT RACIAL BIAS ACROSS THE LAW} 95 (Justin D. Levinson & Robert J. Smith eds., 2012); Justin D. Levinson et al., Implicit Racial Bias: A Social Science Overview, \textit{in IMPLICIT RACIAL BIAS
leads to fallible, unreliable, and incorrect conclusions and assumptions.\textsuperscript{172} White women’s use of drugs occurs at a rate higher than that of black women.\textsuperscript{173} However, “black women are three times more likely than white women to be incarcerated for drug offenses.”\textsuperscript{174} Indeed, a study in the New England Journal of Medicine highlights the racial disparities in the reporting of illicit drug or alcohol use among pregnant women.\textsuperscript{175} Research reveals that the frequency of reporting black women to child welfare agencies is ten times greater than that of reporting white female drug abusers.\textsuperscript{176} How should we read this?

On one hand, this empirical data exposes that black women are more likely to be “over-policed” or targeted for urine and blood searches. That is an obvious, though no less real observation. However, it is worth thinking about the function and capacity of front line interpreters to execute the legislature’s agenda, including the alignment of incentives and burdens and to situate those responsibilities alongside maximizing welfare, including that of

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\textsuperscript{172} See sources cited supra note 171.
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\textsuperscript{175} D.R. Neuspiel, Racism and Prenatal Addiction, 6 ETHNICITY & DISEASE 47; I.J. Chasnoff et al., supra note 141.
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\textsuperscript{176} Chasnoff, supra note 141 at 1204.
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pregnant patients. Ultimately, these dynamics demand thinking about who should make these decisions.

Patients and their fetuses are the least likely to benefit from criminal responses to their health care crises, even in cases of drug addiction. However, medicine suffers too. At the ground level, fetal protection laws destabilize the care-giving roles of nurses and doctors, casting a shadow on the integrity of one of the few fiduciary relationships understood to prioritize the interest of the individual seeking services above all else, including the state. As well, the introduction of criminal sanctions and court orders for bed rest and cesarean operations may drive women away from seeking the care that only medical staff can provide. Driving pregnant patients away from medical care is a form of punishment that harms not only women but undermines the purported state interest in nurturing fetal development. George Annas explains quite succinctly:

[M]arriage of the state and medicine is likely to harm more fetuses than it helps, since many women will quite reasonably avoid physicians altogether during pregnancy if failure to follow medical advice can result in . . . involuntary confinement, or criminal charges. By protecting . . . the integrity of a voluntary doctor-patient relationship, we not only promote autonomy; we also promote the well-being of the vast majority of fetuses.\footnote{George Annas, Protecting the Liberty of Pregnant Patients, 316 \textit{N. ENG. J. MED.} 1213, 1214 (1987).}

A fractured physician-patient relationship reduces trust and manufactures the types of externalities difficult for patients to overcome, including fear, suspicion, and anxiety of doctors and nurses, while introducing coercion into a once venerable space.

Finally, because FPLs and their statutory language are not explicit, much is left to the discretion of the laws’ implementers to determine those harms that fall within the perimeters of the laws. Legislatures ostensibly rely on medical personnel to interpret statutes criminalizing feticide although the laws are vaguely written and most medical personal lack legal training to interpret statutes. This process reveals that States necessarily (and problematically) turn to nurses and doctors, granting formidable discretionary power to interpret state statutory law and make ground calls about constitutional rights and
fetal health, even when medical personnel are not professionally trained to do so and even though doing so violates the common law and their ethical obligations. Reliance on doctors and nurses, however, is neither neutral nor unencumbered. As a normative matter, substantiating nurses and doctors as lead interpreters of state statutory law colors how fetal protection provisions are interpreted and who becomes the subject of statutory enforcement efforts.

Part III. The Moral Stick

What helps to explain why prenatal conduct dominates political discourse and legislative action? Over time, credible theories have been proffered. Dorothy Roberts presents one of the most articulate and compelling cases to explain and account for the racialized roots of American concern over reproduction. As she explains across a series of articles and books, Black women’s status as slave chattel necessarily generated ownership interests on the part of the men and women who owned them.178 This interest was largely a property interest as the children borne from these women were as much property of the owners as they were the off-spring of the women who birthed them.

That said, other interests in Black women’s reproduction proliferated during the Antebellum period, as Roberts explains, whether to thwart infanticide, to maximize profits through forced breeding,179 or harness the economics of childrearing,180 which included balancing the interests in women’s labor and also child bearing.181

Contemporary, legislative interests in women’s reproduction date back at least one century, to the modern eugenics movement, which is best remembered by the German platform euphemistically known as “The Final Solution.” However, American roots in eugenics were deeply entrenched throughout the first half of the twentieth century and continued well into the 1970s under the guise of health care platforms. Some scholars underestimate the scope of that movement,

178 DOROTHY ROBERTS, KILLING THE BLACK BODY (1997)
179 Id. at 27–28.
180 Id. at 24–28.
narrowly framing it as a campaign against American Black women. Yet, such a view of the scope of eugenics underestimates its scale and class dimensions. In other words, it misreads and misrepresents the story.

Part III advances the story of eugenics and by doing so, offers a theory to explain why states leverage fetal protection laws as a criminal law “stick” to regulate prenatal conduct. Part III makes the case, that in an era of federal statutes creating and protecting women’s rights and decades-recent constitutional protections, it might seem counterintuitive that women’s reproduction remains entrenched in a “moral property” framework at the state level. Part III unpacks this theory of women’s reproduction as “moral property” of the state. It explains that fetal protection laws seek to selectively promote virtue, prevent vice, and to some degree restrain sex among a discreet class of women. In other words, fetal protection laws promote a principle of punishing wicked behavior rather preventing harmful acts.

A. Women’s Reproduction as Physical Property

Two American periods help to anchor my theories on reproduction as physical and moral property. The first, human slavery is briefly discussed as “nobody doubts that human beings were a form of capital in slave society.” My point in that section is to recognize the historic roots of property and reproduction as intertwined, interdependent social, political, and economic vehicles in the U.S. Indeed, state regulation of pregnant women’s behavior can only be justified if it has some legitimate interest in the health and safety of the unborn. But what is that legitimate interest, and to the extent that it exists, why is it selectively enforced only against women and not other harmful forces, including abusive domestic partners or factories that pollute the environment?

1. Human Capital, Title, & Slavery

The hypothesis that slave women were property is not new. Indeed, it is incontrovertible. Nor is this Article the first to contribute on that point. What is novel is the point about the structure and practice of reproduction being a propertyed space. As Fogel and

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183 FOGEL & ENGERMAN, *supra* note 181 at 233.
Engerman write, “slaves who were traded commanded prices as specific and well-defined as those on land, buildings, or machines.”184 When viewed through this lens, the critical distinction between enslaved women’s reproduction and that of free women rested not “on the existence of property rights” in women, but who held title to those property rights.185 Clearly black women and to indentured white women’s did not hold title to themselves—and by extension—their offspring. In other words, in slave societies, Black women “were permanently deprived of title to their own human capital” and reproduction. But if they did not hold capital, who did? And what might that have to do with the State?

Masters, whether plantation farmers or the wealthy elite in northern and southern cities “were virtually unrestricted by law” in the ability harness, sell, destroy, breed, punish, and barter slave women and their offspring. Indeed, “ownership of a female slave brought with it title, in perpetuity, to all her descendants.”186 This point is quite relevant as Conrad and Meyer found higher profits on women than men in the Old South.187 In other words, there was a significant incentive to control the reproduction of slave women, which included monitoring and breeding and high rates of return based on continued breeding. Conrad and Meyer referred to this as “systematic breeding for the market,” which involved: a) intruding upon the ordinary sexual practices of female slaves to exploit fertility through such devises as forcing women to copulate. The authors compared this type of breeding to that common for livestock, and b) grooming women’s offspring with profit by means of sale, labor, or breeding, as the main objective. Again, the authors compared this to the formula used in the production for market of cattle or horses.188

However, it is important to observe that such transactions were not exclusively private to the extent that they fostered social norms, were buttressed by legal protection and enforcement by the state, and affected the economic behavior of whole regions of American society. Legislators enacted regulations to protect slave owners property interests, including the Fugitive Slave Act; courts aided in this process

184 Id.
185 Id.
186 Id. at 234
188 Alfred Conrad & John Meyer, The Economics of Slavery in the Antebellum South, 66 J. Pol. Econ. 95 (1958)
by allocating slaves like chattel in various court proceedings from bankruptcy and contracts to contestations about freedom.\(^{189}\) Indeed a special economic advantage was gained by this formula that provided property title to women and their offspring. Cliometricians offer a very important insight on this matter: “economies of scale in southern agriculture were achieved exclusively with slave labor.” In other words there was a societal advantage to the slave enterprise—and for propagating the system. Women and their reproduction was an intrinsic part of that system.

2. Eugenics

Eugenics serves as a second example of a turn to reproductive property. If the reproductive liberties (or lack thereof) of enslaved women can be characterized in terms of others’ property interests, eugenics involved moral concerns over the use of the body. That is to say, state intervention and interference in poor women’s pregnancies was justified based on moral arguments about the moral fitness and character of adolescent, poor girls.

In other words, socio-economics matter in reproduction as much today as a century ago when the nation’s first eugenics laws were introduced. In our society, there is an enduring belief about the moral fiber or character of our country being defined by the masses and not the wealthy elites. Nowhere was that more clearly expressed than by the American eugenics movement.\(^{190}\) Class struggles and the tensions about reproduction, in part, form the basis of Professor Paul Lombardo’s enlightening investigations\(^{191}\) into the American obsession with moral purity and psychological fitness.\(^{192}\)


\(^{190}\) This concept is age old and was also prevalent during the earliest American periods, such Antebellum. See Peter Shrag, Unwanted: Immigration and Nativism in America, http://mfs.uchicago.edu/institutes/migration/prereadings/Immigration_and_Nativism.pdf


\(^{192}\) Paul A. Lombardo, Medicine, Eugenics, and the Supreme Court, From Coercive Sterilization to Reproductive Freedom, 13 J. Contemp. Health L. Pol’y 1, 5 (1996).
offers a stunning indictment of the U.S. legal system’s complicity in perpetuating constitutional violations against poor, uneducated women and girls.\textsuperscript{193} Indeed, eugenicists of the early twentieth century advanced an ideological platform that successfully manipulated public opinion and spurred public unrest against poor, “socially inadequate” fertile women and girls.\textsuperscript{194} Poverty, addiction, homelessness, and promiscuousness chiefly represented categories of impurity and “unfitness.” Placement into one of these categories frequently led to criminal incarceration or psychiatric institutionalization in state-run asylums. Carrie Buck, the unsuccessful petitioner in \textit{Buck v. Bell}, lived in such an institution.

States justified incarcerations and the forced sterilizations practiced on these women as a means of protecting the welfare of its citizens from the degeneracy rampant among the lower classes.

The theory put forth in this Article is that the vestiges of that legacy survive or at least its moral intuitions and foundations. Moreover, these intuitions may not be cognitively understood. That is, the “moral property” foundations of contemporary reproductive policing may be cognitively unavailable to a significant cohort of Americans. On inspection, this may not be surprising given the American passivity toward eugenics, despite its brutal practices.

Let me explain. \textit{Buck v. Bell},\textsuperscript{195} the landmark decision affirming a state’s right to compel sterilization against a non-consenting woman (or man), has never been overturned. The eugenic era’s powerful legacy proves instructive — and foreboding — in current debates about the capacity of Fourteenth Amendment jurisprudence in the twin domains of Equal Protection and Due Process to afford justice to women caught in state raids of maternity wards. At best, \textit{Buck} exemplifies a cautionary tale; in less than ten days (between oral arguments and issuing a written opinion) the U.S. Supreme Court swiftly and decisively dismantled decades of more nuanced jurisprudence on the Fourteenth Amendment,\textsuperscript{196} spurring the rapid

\textsuperscript{193} See \textit{id.} at 1. Lombardo suggests that an evaluation of eugenicists legislative accomplishments and an evaluation of those affected by “eugenical” laws, would demonstrate how extraordinarily successful these people were.


\textsuperscript{195} Buck v. Bell, 274 U.S. 200 (1927).

\textsuperscript{196} \textit{Id.} at 200; but see generally Plessy v. Ferguson, 163 U.S. 537 (1896).
expansion of eugenics legislation throughout the United States and culminating in tens of thousands of men and women being sterilized.\textsuperscript{197} In a near-unanimous opinion,\textsuperscript{198} Justice Holmes reminded the nation that “the public welfare may call upon the best citizens for their lives.”\textsuperscript{199} So, according to the Justice, it would be unusual, if not “strange if [states] could not call upon those who already sap the strength of [government] for these lesser sacrifices . . . in order to prevent our being swamped with incompetence.”\textsuperscript{200} He continues:

“It is better for all the world, if instead of waiting to execute degenerate offspring for crime, or to let them starve for their imbecility, society can prevent those who are manifestly unfit from continuing their kind. The principle that sustains compulsory vaccination is broad enough to cover cutting the Fallopian tubes.”\textsuperscript{201}

Holmes articulates an incontrovertibly clear position; class and status matter in reproductive decision-making, and that states occupy an important decision-making role in monitoring community health through women’s reproduction.\textsuperscript{202} In fact, reproduction becomes legitimately ensconced as a state matter — with the best interests of the state displacing autonomy. The Court, however, merely reflected


\textsuperscript{198} Justice Butler, the lone dissenter, did not issue a written dissent. Buck v. Bell, 274 US 200, 208 (1927).

\textsuperscript{199} Id. at 207.

\textsuperscript{200} Id.

\textsuperscript{201} Id.

\textsuperscript{202} According to Holmes, “Carrie Buck is a feeble-minded white woman who was committed to the State Colony above mentioned in due form. She is the daughter of a feeble-minded mother in the same institution, and the mother of an illegitimate feeble minded child. . . . Three generations of imbeciles are enough.” Id. at 205, 207.
growing sentiment among the public. Turn of the century newspapers provide a compelling glimpse of a nation comforted by the notion of “breeding out” degeneracy, low IQ, criminality, and poverty through artful, strategic marriages and science.

In 1909, two years after the passage of the first state eugenics legislation, Dr. Eugene Davenport, dean and director of the College of Agriculture at the University of Illinois, presented a paper to an elite audience of physicians in Chicago. In the paper, he advocated the application of eugenics, applying theories from his research with cows and livestock to that of people. According to the Chicago Daily Tribune, “his chief proposal was that all the ‘culls’ or ‘scalawags’ of the human race should be taken before the courts, scientifically investigated, and if found unworthy, colonized and allowed to die off.” Davenport explained that to breed out degeneracy, “let Mr. Jones be taken into court and his ancestry record be investigated. If we find his parents were dominantly bad it means that he is 50 per cent bad...When he gets to 90 per cent bad, it is certain he must be colonized. . . . There is a strict mathematical law that runs through it all.”

Thus, FPLs do not represent a new form of monitoring and prosecuting women’s reproductive conduct or gendered public punishment and theatre, because roots of this type of legislative interest and extra-legal force in the reproductive realm can be traced to eugenic laws in the early twentieth century and the infamous Buck v. Bell case.

Montague Crackenthorpe, Parents May Improve the Race, CHI. DAILY TRIB. (1872–1922); July 5, 1908, at G5 (noting that “well established facts show that all who are likely to become parents should take far more care than they do at the present when choosing their partners for life—say, a tenth part of the care they take when selecting their horses or their dogs.”)

Why Not Improve the Human Race? CHI. DAILY TRIB. (1872–1922); Jan. 26, 1908, at E3; Bell’s Plan for Uplift of Race, CHI. DAILY TRIB. (1872–1922); Jan. 30, 1908, at 5.


Id.

A Perfect Race of Men: According to Prof. Kellar the Success of Eugenics Depends on Rules Made by Custom, N.Y. TIMES, Sept. 27, 1908
incarceration, were not esteemed among the “inmates.” Their reputations among the incarcerated were characterized by fear and loathing for sterilizing inmates as young as ten year old and delivering babies, but leaving them to expire in trashcans. This type of public theatre — then and now (figuratively if not substantively for some women) — resituates important legal principles as mere common terms; privacy, reproductive freedom, and reproductive autonomy lose their resonance and power in these contexts, casting doubt on the viability of poor women to utilize legislative and judicial tools to gain healthy footings in reproductive matters.

Yet, it is not enough to make the case that women’s reproduction at times has been subject to the property interest of others, including the state. For example, that alone does not satisfy my inquiry here nor explain why contemporary wars are waged about women and their prenatal conduct. What story can be told to explain why doctors, judges, legislators, and prosecutors police women’s reproduction?

B. Women’s Reproduction: Moral Property of the State


208 See THE LYNCHBURG STORY (Worldview Pictures 1993), a documentary that includes interviews with former Lynchburg inmates, an instructor, and tours of the now defunct facility.

209 Michel Foucault’s portrayal of prisons and asylums as places of public theatre for mass consumption and entertainment resonates in the cases of poor women. According to Foucault, the public gains satisfaction and takes pleasure from witnessing punishment of its less desired citizens. MICHEL FOUCAULT, MADNESS AND CIVILIZATION, A HISTORY OF INSANITY IN THE AGE OF REASON (1965); MICHEL FOUCAULT, DISCIPLINE AND PUNISH: THE BIRTH OF THE PRISON (1975). See also James Allen et al., WITHOUT SANCTUARY: LYNCHING PHOTOGRAPHY IN AMERICA 8–9 (2000), which temporally situates the public theatre of lynching in the same time frame of eugenics and mass sterilization. In both cases, punishment and sanctioning the poor and undesirable facilitate public engagement and theatre. The images reveal parents bringing little children to view lynchings and setting up picnics alongside hanging bodies.
In earlier work, I have offered observations about the role of communitarianism in the production, monitoring, and enforcement of reproduction norms.\(^{210}\) When women are punished for clumsy (or illegal) prenatal acts, the punishment is framed one way: to prevent harms that are dangerous to the fetus. However, two other considerations are at play. First, such punishment is to prevent acts deemed “dangerous to society” but also to persecute (and prosecute) vice. Second, retribution and denunciation motivate public sentiment, including legal punishment against pregnant women perceived to intentionally or recklessly threaten harm to their fetuses.

1. Threat To Fetus
First it is important to comprehend the important role granted to fetuses in American society. Texas Representative, Doug Miller explained it this way to the American Independent Newspaper, “I am interested in providing additional safety and protection for our next generation, and it must happen now . . .[t]he Texas Legislature can no longer sit idly by while its next generation is born addicted to illegal drugs, born with physical and mental abnormalities, set up for educational hardship, and destined to be on Social Security benefits. Parents must be responsible for their actions.”\(^{211}\)

Jocelyn Elders, the former Secretary of Health and Human Services described passionate platforms about fetuses as the “love affair” with the fetus. Her off-the-cuff comment attracted strident criticism and she exited her position without completed the expected term. Elders painted a contrast between the activism surrounding the health of fetuses, mainly anti-abortion protests, coinciding in the 1990s with aggressive welfare reform efforts to reduce the benefits provided to mothers and children surviving below the poverty level.

Legislators across the country emphasize the importance of fetal health and develop. That practice is laudable, indeed commendable. Yet, an internecine conflict has come into sharp view with the advent of personhood legislation and a movement to legislate abortion based on whether fetuses feel “pain.” These recent efforts reflect a new ideology that grants fetuses legal statuses and rights where previously none existed.


For example, in the case of Bei Bei Shua, a Chinese immigrant prosecuted for attempting to kill herself while pregnant, faces 45 years to life in prison, if convicted.212 This type of prosecution is the first in Indiana’s nearly two hundred year history. In other words, it’s been over two hundred years since a woman in that state has been prosecuted for the murder of a child for conduct that happened during the time of her pregnancy. If she is convicted, it will be the first time in the state’s history that a woman is criminally punished after attempting a suicide.213

2. Promoting Virtue and Preventing Vice

A contemporary effort to promote virtue and prevent vice helps to account for the contemporary trend in policing women’s prenatal conduct. In other words, moral judgments about sex and reproduction matter and they long have. Hart reflected on American sexuality and the criminal law in *Law, Liberty and Morality*:

In America a glance at the penal statutes of the various states of the Union reveals something quite astonishing to English eyes...there seems to be no sexual practice, except “normal” relations between husband and wife...In a very large number of states adultery, which has not been criminally punishable in England since Cromwell’s time, is a crime...fornication is not a criminal offence in England or in most countries...but only a minority of American states do not have statutes making fornication...punishable.214

In addition, anti-miscegenation laws, anti-sodomy laws, and even statutory rape laws to the extent they are enforced against consenting minors all represent legal enforcement of sexual morality. Interracial sex was previously considered morally wicked in the United States.

212 Pilkington, *supra* note 87.


214 HART, *supra* note 29 at 26
State statutes codified these moral precepts and courts enforced the criminal prosecution of men and women who violated those laws. Not until 1967 with the *Loving v. Virginia* case did the U.S. Supreme Court finally strike down such legislation as unconstitutional. Legislators employed public health and safety arguments to justify anti-miscegenation rules. Yet, such propositions served as pretext, not simply to cover racism, but to police an offensive form of sex. That is, sex between different “races” of people. As startling and dated as that fairly recent era may seem, associating moral vice with sex is not uncommon nor unusual.\(^{215}\)

Contemporary moral judgments translate in medical terms that relate to the health of pregnant women, the prenatal health of fetuses, and the anticipated health of newborns. However, moral judgments also carry political weight and force, and clearly the power and authority to punish. For example, although laws can be about protecting fetuses and not simply punishing women, recent prosecutions of pregnant women emphasize the moral gradation of punishment. In other words, a non-moralist law seeks to protect the fetus without using a stick approach to punish the mother more severely than had she unwittingly committed those acts against children.

FPLs are deployed to enforce moral principles rather than protecting fetal health. What else can explain several disparate views of risk and motherhood: a) the health outcomes in utero and after birth for some children born through assisted reproductive technology, include extreme low birthweight, cognitive delays, hearing impairment, cerebral palsy, and other dangers—to name a few, but is never regulated or punished; b) prescription drug users risk harm to their fetuses at high rates but with no regard from the state. In both instances named above, the “users” are more often wealthy, educated, elites.

Indeed, what appears clear is that legislators have conceded that harming or threatening to harm fetuses is an immoral act, not deserving fact based inquiry if the women are poor, and particularly of color. Maternal harms to fetuses, they conclude, demonstrate a lack of moral character and must be understood as acts of depravity. As such, those immoral acts must be punished according to their gravity. In the case of fetal injury, the acts are deemed grave; legislators find few other offenses as morally wicked. As a pragmatic matter,\(^ {215}\)

Anti-sodomy statutes, now rendered moot by *Lawrence v. Texas* provide yet another example. 539 U.S. 558 (2003).
prosecutors and courts may be inclined to treat morally similar crimes alike, thereby establishing precedents that extend beyond the confines of their states.

3. Retribution and Denunciation

Another way to view the trend toward criminal punishment of pregnant women is that it serves to persecute the grosser forms of vice. 216 Stephen articulated a “healthiness” for a society to generate resentment or even hatred for those who breach moral codes in society. He acknowledged the human desire for revenge—even if one is not harmed by the act he seeks to avenge. It is enough that the act was immoral and threatens harm to the moral fabric and values of a society. Hart reflected on Stephen’s theory as a crude form of retribution theory. Yet, Stephen’s view of crime and punishment resonates with the punishment of pregnant women in the U.S. Stephens wrote, criminal punishment can be rationalized because, “the feeling of hatred and the desire of vengeance are important elements in human nature which out in such cases to be satisfied in a regular public and legal manner.” 217

This view on hatred and the legitimacy of revenge can explain some of the aggressive efforts to punish and publicly humiliate pregnant patients. Indeed, Stephens recognized that the criminal law gives “distinct shape to the feeling of anger” and “distinct satisfaction to the desire for vengeance.” 218 Thus punishment is not simply about deterrence. Rather, it is the emphatic denunciation by the community and State of the threat posed to fetuses. What distinguishes this passionate form of denunciation is that it has no rehabilitative aspect. It is by its nature a moral condemnation that justifies extreme punishment.

Thus, as a society, we have advanced beyond the point of inquiring what sort of conduct may justifiably be punished when the harm appears targeted at fetuses. The question that remains open asks “How severely should we punish different offenses?” Is the fact that certain conduct is by common standards immoral, sufficient to justify

216 JAMES STEPHEN, LIBERTY, EQUALITY, FRATERNITY at 162 (1873)

217 Id.

218 Id. at 165.
making that conduct punishable by law?’” Stated differently, is the fact that some poor women conduct their prenatal experiences in ways that by common standards are immoral, sufficient to justify making that conduct punishable by law?219

Part IV: The Equal Protection Conundrum

In Parts I–III, this Article exposed the imperfections of contemporary criminal law approaches to protect fetal health. As analyzed, the approaches impose conflicting duties on physicians; at one turn requiring that they serve as vigilant gatekeepers of patients’ secrets and on the other, interlopers and informants for government. The approaches to fetal protection also tend to create hierarchies, ranking the legal and health interests of fetuses above that of pregnant patients. These imperfections produce externalities and introduce constitutionally problematic legal, social, and medical norms.

Part IV weighs the constitutionality of fetal protection laws. It considers whether such legislative efforts, despite burdening women’s medical and reproductive liberty, pass constitutional muster. Thus even if fetal protection laws emanate from moral paternalism, such laws may be constitutionally neutral, falling within permissible state regulatory discretion. Part IV considers whether FPLs conflict with Fourteenth Amendment values. For example, it examines whether fetal protection laws arbitrarily focus on some classes of pregnant women and not others. It takes up that issue against a legal realism backdrop, observing that prosecutors wield “a real and very strong stick” in selectively choosing whom and how they enforce FDLs and MCLs.220

As a secondary, but not less important matter, selective prosecutions of pregnant women function to discourage and punish some conduct that might threaten fetal health while bypassing other fetal-endangering behavior without medical or legal justification. Part IV argues that even if states possess a legitimate interest in

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219 HLA Hart, posed a similar question fifty years ago. “Is the fact that certain conduct is by common standards immoral sufficient to justify making it punishable by law?” HART, supra note 29.

220 See Condon, supra note 25.
regulating pregnant women’s reproductive conduct, the means by which states enforce the legislation is not rationally related to governments’ ultimate goal in protecting fetal health.

A. The Empirical Problem

Part A considers whether the constitutional costs associated with contemporary fetal protection efforts extend beyond the traditional privacy arguments commonly evoked in reproductive health matters to encompass other liberty interests. It posits that among the constitutional interests at stake are the Fourteenth Amendment Equal Protection interests of pregnant women, which become burdened by the criminal policing of their conduct during gestation. For example, prosecuting pregnant women for violating fetal protection laws creates an equal protection problem in that it holds women to a different standard than men who engage in the same conduct. Indeed, fetal protection laws tend to hold women responsible for all fetal health outcomes. The risk is that women who cannot guarantee a healthy birth may be prosecuted.

Consider once more Representative Doug Miller’s urgent appeal to his colleagues and the Texas Governor: “The Texas Legislature can no longer sit idly by while its next generation is born addicted to illegal drugs, born with physical and mental abnormalities, set up for educational hardship, and destined to be on Social Security benefits. Parents must be responsible for their actions.”  The bill he introduced in 2011, HB 1243, would amend the Texas penal and family codes to make it a felony offense for a woman to ingest “a controlled substance while pregnant.”  The logic behind this

221 Resnick, supra note 59.

222 See TEX. LEGISLATURE ONLINE, History, HB 1243 at http://www.legis.state.tx.us/BillLookup/History.aspx?LegSess=82R&Bill=HB1243 (last searched November 25, 2012). Importantly, Representative Miller is not alone in his concern for “the next generation.” On one hand, this is a good thing; promoting fetal health is a timely and worthy agenda. The problem is that such broad sweeping assumptions and the legislation, upon which those perspectives are framed, bear minimal if any relationship to the sturdy empirical data that frames a more accurate picture of what causes fetal health harms. Moreover, even with a better understanding of what brings about fetal health harms, using criminal law mechanisms as the primary feature for maternal health reform is an ineffective and costly.
legislation and similar bills is that it is pregnant women who negatively “affect[] the parent-child relationship.” The penalty proposed by Miller could result in a maximum fine of $10,000 and a state felony conviction, punishable by 180 days to two years in prison for women who violate the law.

Yet, women are not solely responsible for the type of fetal health outcomes—such as “physical and mental abnormalities”—that legislatures in Utah, Texas, Indiana, Ohio, Mississippi and a host of other states seek to reduce or eliminate. Empirical data underscore this point. Recent longitudinal studies focusing on fathers conclude that factors such as paternal age influence fetal health outcomes. This branch of research offers important insights, particularly as research on fetal health outcomes primarily focus on women.

For example, a study conducted by Dr. Harry Fisch, a Weill Medical College professor, and a team of researchers highlights a paternal age “effect” in birth outcomes. Their study, published in the peer-reviewed Journal of Urology in 2003, concluded that advanced paternal age influences the incidence of Down syndrome.

223 Id.

224 Indeed, the FPLs are somewhat vague in terms of what they specifically desire to achieve other than fetal wellness. Reducing low fetal birth weight and miscarriages are laudable social policy goals, however, incarcerating pregnant women or those formerly pregnant has very little rational connection to that goal as many factors contribute to low birth weight and miscarriage other than drug use, falling down steps, or failure to bed rest.

225 Harry Fisch et al., The Influence of Paternal Age on Down Syndrome, 169 J. UROLOGY 2275 (2003).

226 Researchers note, “[t]he association between maternal age and risk of Down syndrome has been repeatedly shown in various populations. However, the effect of paternal age and education of parents has not been frequently studied.” Dagmara Dzurova & Hynek Pikhart, Down Syndrome, Paternal Age and Education: Comparison of California and the Czech Republic, 5 BIOMEDCENTRAL PUB. HEALTH, available at http://www.biomedcentral.com/content/pdf/1471-2458-5-69.pdf.

227 Fisch et al., supra note 225, at 2275. Relevantly, maternal age may also influence the incidence of chromosomal “abnormalities” in genetic offspring.

228 Id. Down syndrome is noted in 1 in every 750 births. The health risks associated with Down syndrome include severe cognitive impairment, speech and developmental delay, hearing loss, and chronic ear infections. Other
Fisch’s study was based on data collected between 1983 and 1997 (3,419 cases) by the New York State Department of Health congenital malformations registry. These paternal-related effects, the researchers noted, “may represent a paradigm for other genetic abnormalities in children of older fathers.”

These insights and others counter the notion that fetal health outcomes rest exclusively with mothers. Recent peer-reviewed findings offer a compelling counter-narrative to political and social presumption that fetal health disabilities and risks are directly and exclusively linked to maternal behavior. In fact, from achondroplasia—a condition that can lead to obesity, curvature of the spine, spinal compression, hydrocephalus, and brain abnormalities—to schizophrenia, “common mental disorders,”

conditions associated with Down syndrome include congenital heart disease (40–50%), increased risk in the fourth decade for Alzheimer disease and leukemia. Santhosh Girirajan, Parental Age Effects in Down Syndrome, 88 J. GENETICS 1, 1 (2009).

Fisch et al., supra note 225, at 2278.

Achondroplasia is defined as a “hereditary condition in which the growth of long bones by ossification of cartilage is retarded, resulting in very short limbs and sometimes a face that is small in relation to the (normal-sized) skull. THE NEW OXFORD AMERICAN DICTIONARY (2001). This condition is commonly associated with severe dwarfism and is primarily connected with advanced paternal age.


Vivek Phutane et al., Are Advanced Paternal Age and Point Mutation at Chromosome 4 Associated With Schizophrenia?, 12 PRIMARY CARE COMPANION J CLINICAL PSYCHIATRY (2010) (noting that “Achondroplasia and schizophrenia are genetic conditions known to occur as a result of mutations consequent to advanced paternal age”), at http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3026002/ (last visited November 24, 2012).

S. Krishnaswamy S, et al., Paternal Age and Common Mental Disorders, WORLD J. BIOLOGICAL PSYCHIATRY 518 (2009) (finding that “[p]rogenies of fathers under 20 and over 50 had higher risk for mental disorders. Factors such as immaturity in sperm of teenage fathers and mutation in germ line of older fathers...could have contributed to increased prevalence of common mental
and autism, paternal age is a significant if not dominant factor. More recent findings published this year in *Nature* provide the most conclusive evidence yet linking paternal age to the autism. According to the researchers, “[w]hen we looked at the variation in the …mutation rate, 97 percent of it is explained by the age of the father.” The conclusions are quite relevant given the dramatic rise in diagnosed cases of autism. A third of the cases are now believed to be linked to paternal age. The researchers emphasize that their “observations shed light on the importance of the father’s age on the risk of diseases such as schizophrenia and autism.” As one reporter noted, “when it comes to some complex developmental and psychiatric problems, the lion’s share of the genetic risk originates in the sperm, not the egg.”

In *International Union v. Johnson Controls,* the Supreme Court opined that male health may have as much bearing on fetal outcomes as women’s health. In that case, Johnson Controls barred all women, disorders in the progeny.” Researchers also note that environmental factors may also influence fetal health outcomes.


236 Id.; see also Benedict Carey, *Fathers Age is Linked to Increased Risk of Autism and Schizophrenia*, NY TIMES, Aug. 22, 2012, at A1 (commenting that this study “provides support for the argument that the surging rate of autism diagnoses over recent decades is attributable in part to the increasing average age of fathers, which could account for as many as 20 to 30 percent of cases”).

237 Id.

except those who could prove infertility, from holding certain jobs that could expose them to lead. The company took such steps after learning that eight of its female employees who became pregnant continued to test high for lead exposure. However, the company did not bar all men, “except those whose infertility was medically documented, from jobs involving actual or potential lead exposure exceeding the OSHA standard.”\footnote{Id.} The company justified its policy based on concerns for fetal health outcomes. The Court ruled that the policy was discriminatory under the Pregnancy Discrimination Act of Title VII.\footnote{Title VII of the Civil Rights Act of 1964, 42 USC § 2000e(k).} The Court held that Title VII as amended by the Pregnancy Discrimination Act forbids “sex-specific fetal-protection policies.”\footnote{International Union, 499 U.S. at 189.} According to the Court, “[d]espite evidence in the record about the debilitating effect of lead exposure on the male reproductive system, Johnson Controls is concerned only with the harms that may befall the unborn offspring of its female employees.”\footnote{Id. at 198.} That type of explicit discrimination cannot survive judicial scrutiny, because the company “chose[] to treat all its female employees as potentially pregnant,” and that policy evinces a form of unjustifiable sex discrimination.\footnote{Id.}

The empirical record linking paternal age and reproduction decision-making suggests the importance of rethinking our understanding of fetal health risks and outcomes, because this emerging data exposes the fallibility in locating gestation outcomes solely within the control of women. When states make this mistake, their error rises to the risk of unequally burdening women, particularly as fetal protection prosecutions almost exclusively target women for prosecution.

B. Means & Ends

Indeed, prosecuting women for violating fetal protection statutes discriminates against women because men are not prosecuted for engaging in the same conduct as women. Simply stated, the means
and ends do not fit. At best, locating fetal harms as the exclusive control of women “must be considered an unduly tenuous ‘fit.’”

Dating back to Reed v. Reed and Frontiero, the Court has found that “statutory classifications that distinguish between males and females are ‘subject to scrutiny under the Equal Protection Clause.’” To withstand constitutional scrutiny, discrimination based on gender must serve important government objectives and be substantially related to achievement of those objectives.

In Craig v. Boren, the Supreme Court carved out an intermediary level of scrutiny for sex-based discrimination. In that case, the Court struck down an Oklahoma law that prohibited alcohol sales to adult males. The Court held that law discriminated against young males, but not females, because it prohibited sales of a non-intoxicating beer to males under 21 and to females under the age of 18. The Court found that the means-discriminating against young men by denying them the right to purchase beer—was not substantially related to Oklahoma’s purported ends: promoting traffic


245 Reed v. Reed, 404 US 71 (1971). In a unanimous decision, the Court invalidated a law permitting preferences of men over women in the appointment of estate administrators.

246 Frontiero v. Richardson 411 U.S. 677 (1973). In a plurality decision, the Court opined that laws granting male members of the armed forces an automatic dependency allowance for their wives, but denying the same for women and their husbands violated the Equal Protection Clause. According to Justice Brennan, “classifications based upon sex, like…race, alienage, and national origin, are inherently suspect and must therefore be subjected to close judicial scrutiny.” Id. at 688.

247 Reed, 404 U.S. at 75. In Geduldig v. Aiello, 417 U.S. 484 (1974), an early equal protection case, Justices Brennan, Marshall, and Douglas surmised that “by singling out [pregnant women] for less favorable treatment a gender-linked disability peculiar to women, the State…create[] a double standard.” In other words, when “one set of rules is applied to females and another to males… on the basis of physical characteristics inextricably linked to one sex, inevitably constitutes sex discrimination.” (dissenting).


249 Id.
The Court acknowledged the importance of traffic safety although perhaps not to the degree of Justice Rehnquist in his dissent. The majority reasoned that even though “arrest statistics assembled in 1973 indicated that males in the 18-20 age group were arrested for ‘driving under the influence’ almost 18 times as often as their female counterparts, and for ‘drunkenness’ in a ratio of almost 10 to 1,” singling out the one sex for gender discrimination was impermissible where the means of reducing traffic deaths and injuries was tenuously connected to the ends—even if the ends were socially important.

The justices were unpersuaded by data showing that “over three-fourths of the drivers under 20 in the Oklahoma City area [were] males, and that each of them, on average, drives…many [more] miles per year as their female counterparts; [and] that four-fifths of male drivers under 20 in the Oklahoma City area state a drink preference for beer, while about three-fifths of female drivers state the same preference.” Neither was the Court persuaded that the law could withstand intermediate scrutiny despite the fact that “93% of all persons arrested for drunken driving were male” between 1967 and 1972.

In a footnote, Justice Brennan, who delivered the opinion for the Court, cautioned that social stereotypes were reflected in the Oklahoma law and the stereotypes were likely to distort how legislators and even police officers interpreted traffic violations. Brennan cautioned that “social stereotypes” that make their way into legislation “are likely substantially to distort the accuracy of…comparative statistics.” As an example, Brennan pointed to common social stereotypes as possibly influencing law enforcement.

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250 The statute under review contained two sections that prohibited the sale of “‘nonintoxicating’ 3.2% beer to males under the age of 21 and to females under the age of 18.” Id. at 190.

251 See id. at 224 (Rehnquist, J., dissenting).

252 Id. at 223.

253 Id. at 224.

254 Id. at 223.

255 Id. at 203 n 14.
For example, if police perceive young men as “reckless” drinkers who drive, that presumption may lead to or be “transformed into arrest statistics.” On the other hand, young women may slide under the radar, including those who are “reckless” or “drunk drivers” based on other stereotypes and entrenched views about women’s femininity and temperance. As to the latter, Brennan cautioned that young women may be under-policied or not policed for drunk driving. Rather than ticketing or arresting young women, Brennan surmised that officers “chivalrously escorted [them] home” for the same type of offenses that might have landed young men in jail.

Thus, when states single out one sex for discriminatory purposes, including prosecution, they must show an exceedingly persuasive justification. This is a demanding burden to meet, because states must show that singling out women for prosecution serves “important governmental objectives and that the discriminatory means employed are substantially related to the achievement of those objectives.”

Whether the means in selective reproduction prosecutions serve or justify the ultimate governmental goal—to reduce the incidence of childhood disabilities and miscarriages—deserves heightened scrutiny. In other words, prosecuting pregnant women patients rather than men (or along with men who father) for the fetal risks associated with reproduction must be substantially related to achieving an important government objective. This type of discrimination may be hard to justify in light of empirical evidence demonstrating negative fetal health outcomes related not only to

256 Id.
257 Id.
258 Brennan offered no statistical analysis to support this theory. However, a well-developed feminist jurisprudence and critical race theory dossier adds further heft to the assertion that gender-based stereotypes influence law enforcement decisions. See L. Song Richardson, Arrest Efficiency and the Fourth Amendment, 95 MINN. L. REV. 2035 (2011)


paternal age, but also conduct—choosing to father children at ages that pose fetal health risks, exposing pregnant partners and fetuses to second-hand smoke, severe stress or anxiety, or engaging in domestic violence against a partner during her pregnancy.\footnote{PAN AM. HEALTH ORG., Domestic Partner Violence During Pregnancy, PAHO.ORG, http://www.paho.org/english/ad/ge/vawpregnancy.pdf (last visited Dec. 17, 2012).}

Consider that among the many ways that men influence fetal health outcomes, domestic violence and battery against pregnant women rank high.\footnote{The Centers for Disease Control defines intimate partner or domestic violence during pregnancy as “physical, sexual, or psychological/emotional violence or threats of physical or sexual violence that are inflicted on a pregnant woman.” \textit{Id}.} Domestic violence is one of the leading threats to fetal health and development in developed as well as developing nations. According to the World Health Organization (WHO), pregnant women are “60% more likely to be beaten than women who are not pregnant.”\footnote{\textit{Id}.} The risk of domestic violence against a pregnant woman increases by 400% if her pregnancy is unintended or unwanted.\footnote{\textit{Id}.} Medical surveys and empirical studies explain that prenatal domestic violence specifically targets the breasts, abdomen, and genitals, dramatically increasing the risk of fetal death due to trauma.\footnote{Jacquelyn C. Campbell, \textit{Health Consequences of Intimate Partner Violence}, 359 LANCET 1331, 1331–36 (2002); see also Julie A. Gazmararian et al., \textit{Prevalence of Violence Against Pregnant Women: A Review of the Literature}, 275 JAMA 1915, 1915–20 (1996).}

The consequences of domestic violence, during pregnancy include, hemorrhage, miscarriage, abruption placenta, fetal bruising, fractures, and hematomas, and death.\footnote{PAN AM. HEALTH ORG., supra note 262.}

In a telling example of disparate criminal policing involving “violence” against fetuses, the state of Indiana has charged Bei Bei Shuai, a Chinese immigrant with attempted murder of her fetus.\footnote{Pilkington, supra note 87.}
Shuai ate several packets of rat poison in an attempt to end her life, following a break-up with her boyfriend. 269 Importantly, in Indiana attempting suicide is not a crime, however it has now become a crime but only if the person is pregnant.

In Shuai’s case, she was rushed to the hospital, where doctors performed emergency procedures to save her life and that of the fetus (although after birth, the child died). 270 Within weeks of the baby’s death on March 14, 2011, Shuai was charged with murder and attempted feticide and incarcerated. 271 Shuai, who was released on bail after enduring more than a year in prison, faces up to 45 years in prison if convicted. After two extensions, her case will go to trial in September of 2013. 272

Another Indiana case, Perigo v. State, (1989) highlights an important distinction between Shuai’s arrest and prosecution and prior prosecutions of men who harm fetuses. In that case, James Perigo confronted his former girlfriend, Kathy Evans, who was pregnant with a fetus both believed were his. According to the Indiana Supreme Court, “Perigo trapped Evans and beat her head and abdomen with a baseball bat. Evans died and her fetus was terminated.” 273 Perigo was convicted and among other charges, was sentenced to five years in prison for the death of the fetus. In another case, on April 22, 2008, a bank robber shot a young, pregnant teller at a bank; she was five months pregnant with twins. The shooting was intentional; Kendrick stormed the bank, jumping over the counter because he could not unlatch the gate. Unprovoked, Kendrick shot Shuffield in the abdomen, grabbing cash from her drawer and that of several others before fleeing. Visibly pregnant, Shuffield was the only targeted shooting victim; she was the only wounded person in the robbery. She survived. However, two days later, after premature contractions her fetuses were delivered; one was stillborn and the other survived less than a few hours. Eventually Kendrick was convicted on several counts, including feticide—to serve four years

269 Id.

270 Id.

271 Id.

272 Id.

for each death. If convicted, Bei Bei Shuai faces more years in prison than Perigo and Kendricks combined.

C. State Action & Stereotypes

Selective prosecution of pregnant women patients but not men who father children or men who harm children in utero, unfairly burdens the liberty interests of those women in a manner that is virtually impossible to justify. However, the state action described in this Article happens not in a vacuum, but is conditioned, if not directed by law. The right questions to ask then relate to states’ justifications for FPLs and whether those justifications substantially relate to achieving those objectives.

As discussed above, a bounty of empirical evidence indicates that fetal health is not controlled exclusively by pregnant women. Scholars have acknowledged this much for some time, but so have courts.274 Some scholars and advocates for pregnant women, including Lynn Paltrow, the Executive Director of the National Advocates for Pregnant Women, caution that stereotypes often influence state prosecution of pregnant women. Paltrow argues that the prosecutions of women for causing fetal harm are overwhelmingly of poor, women of color. Dorothy Roberts expresses a similar sentiment, when she analyzes the historical record of reproduction in the U.S. across race lines, “white childbearing is generally thought to be a beneficial activity; it brings personal joy and allows the nation to flourish. Black reproduction, on the other hand, is treated as a form of degeneracy.”275 Recent cases of disparate state efforts to prosecute primarily or only women of color for violating FPLs provide support for such conclusions.276


Just as the Supreme Court has rejected administrative convenience as a sufficiently important justification for gender discrimination, so too are sex-based stereotypes impermissible reasons, because they are “outdated conceptions” concerning the role of pregnant women. The Court makes clear that “increasingly outdated misconceptions concerning the role of females...[are] rejected as loose-fitting characterizations incapable of supporting state statutory schemes that were premised upon their accuracy.”

In Frontiero (striking down a federal law that demanded "dissimilar treatment for men and women who are similarly situated"), Justice Brennan urged the adoption of a strict scrutiny standard of review because “our Nation has had a long and unfortunate history of sex discrimination. Traditionally, such discrimination was rationalized by an attitude of ‘romantic paternalism’ which, in practical effect, put women, not on a pedestal, but in a cage.”

The aftermath of generations of legally and socially permissible sex discrimination, according to Brennan, results in legislation “laden with gross, stereotyped distinctions between sexes and, indeed, throughout much of the 19th century the position of women in our society was, in many respects, comparable to that of blacks under the pre-Civil War slave codes.” The sex-based stereotyping Brennan critiqued four decades ago in Frontiero and Craig, persists in state enactment of FPLs to criminalize breaches in the maternal fetal relationship. Recent scholarly works offer a sturdy critique of the negative externalities of associating fetal health outcomes with stereotypes and social profiling of pregnant women generally, and pregnant women of color specifically.

For example, poor pregnant women and women of color are criminally hyper-policed during pregnancy to reduce the incidence of

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277 See Reed v. Reed, 404 U.S. 71 (1971).


280 Id.

281 Goodwin, Precarious Moorings, supra note 45.
low birth weight and miscarriage in ways that neither men, nor wealthier, white women experience. Class based distinctions can be ferreted out based on what the state chooses to regulate as achieving the state’s goals.

Dr. Allen A. Mitchell’s research on prescription drug dependency during pregnancy provides empirical heft to buttress intuitions that stereotyping occurs in the drafting and enforcement of FPLs. Mitchell, who serves as Director of the Slone Epidemiology Center, debunks commonly held presumptions about drug use during pregnancy, which likely drive the enactment and enforcement of FDLs.282 Longitudinal studies conducted by Mitchell and other scientists find that educated white women are more likely to rely on prescription medications during pregnancy and their dependency on these medications increases by age.283 His research findings demonstrate that during the first trimester of pregnancy, over seventy percent of women reported taking at least one medication that was not a vitamin or mineral and that drug use increased with age, and also by race. Here is the relevant part: Mitchell and his colleagues surmise that educated, white women are more likely to take prescription medications during pregnancy generally, and use more prescription medications during pregnancy as they age.284

Despite sturdy evidence demonstrating a risk of fetal harm based on prescription drug use, states ignore that cohort of gestating mothers. Instead, they target poor users of illicit substances. In other words, despite the dramatic rise in prescription pain relief during pregnancy, which is directly linked to wealth and race, states rely on stereotypes, targeting poor women primarily. For example, Tylenol with codeine, Xanax, Demerol, Ritalin, and Oxycontin are among the prescription pain medications that wealthier women ingest (including concurrently) during pregnancy, and these drugs “affect the function of the placenta . . . which can affect the blood supply to the baby or cause preterm labor and birth.”285


283 Id. at 51.e4–e5

284 Id.

285 Abusing Prescription Drugs During Pregnancy, AM. PREGNANCY ASS’N http://www.americanpregnancy.org/pregnancyhealth/abusingprescriptiondrugs.h
Other stereotypes plague state criminal monitoring of women’s reproduction, including selective attention to what drugs to police and what types of pregnancies to police. Legislators tend to ignore fetal health risks caused by luxury reproductive services, such as assisted reproductive technology, which fails at a rate of over 65%, with pregnancies terminating in miscarriage or after preterm birth.\footnote{According to the CDC’s 2010 Artificial Reproductive Technology Success Rates, 147,260 ART cycles were performed in the U.S. during 2010, resulting in 47,090 live births. \textit{What is Assisted Reproductive Technology?}, CDC (last updated Aug. 1, 2012), http://www.cdc.gov/art.} A report published in the \textit{Journal of Morbidity and Mortality} frames the concerns about ART related pregnancies in this way: “ART-related multiple births are an increasingly important public health problem nationally and in many states.”\footnote{Laura A. Schieve et al., \textit{Use of Assisted Reproductive Technology—United States, 1996 and 1998}, 51 MORBIDITY & MORTALITY WKLY. REP. 97 (2002), available at http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5105a2.htm (noting that multiple births increase the risk of low birthweight babies).} And perhaps state inattention to the risks associated with these technologies is also based on stereotypes of the kind that Dorothy Roberts, Khiara Bridges, Patricia Williams, Kimberle Crenshaw and others speak to, where the social preferences based on race impact reproductive policy more broadly.

The known risks associated with reproductive technologies include high rates of low birth weight in babies, fetal crowding,\footnote{Increasingly, those who rely on the sophisticated medical technologies found in U.S. neonatology hospital wards are older, more educated parents who, through aggressive hormone therapies and in vitro fertilization birth premature, low-birthweight twins, triplets, quadruplets, and even higher order births. \textit{See id.}} subsequent visual and hearing impairment, cognitive delays and cerebral palsy.\footnote{Valentine Akande & Deirdre J Murphy, \textit{Neurological Sequelae in In-Vitro Fertilisation Babies}, 359 LANCET 717 (2002); Meredith A. Reynolds et al., \textit{Trends in Multiple Births Conceived Using Assisted Reproductive Technology, United States, 1997-2000}, 111 PEDIATRICS 1159, (2003); Robert M.L. Winston & Kate Hardy, \textit{Are We Ignoring Potential Dangers Of In Vitro Fertilization And Related Treatments?} 4 NATURE CELL BIOLOGY & NATURE MED. s14 (2002).} Based on medical evidence, researchers in the field...
posit that “increases in maternal age and greater use of in vitro fertilization, combined with remarkable medical advances, are leading not only to increases in preterm births, but also to medical complications and associated costs.” The average medical cost associated with preterm ART births is one thousand per cent more than that for a full-term infant. And while not all ART offspring will be born with such challenges, the point of the comparison is to bring attention to states’ arbitrary and selective interests in reducing fetal health risks.

In *Mississippi University for Women v. Hogan*, the Court cautioned that the test for determining the validity of gender based discrimination is “straightforward,” and must be applied free of fixed notions concerning the roles and abilities of males and females. Again, the Court cautioned against discrimination based on archaic stereotypes. Archaic stereotypes in these contexts include the assumption that pregnant women hold exclusive control over fetal health outcomes and that women of color are more likely to engage in fetal-risky behavior during gestation than other pregnant women—hence the persistent policing.

However, the Supreme Court emphasizes that states cannot craft laws that spare some members of the class indignities and yet subject others to surreptitious law-enforcement dragnets when they seek prenatal care. Can states make a case that is exceedingly persuasive...

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291 *Id.* (noting that “the average medical costs through the first year of life are approximately $32,000 for preterm infants vs. $3,000 for a full-term infant”).


293 Since August 2012, at least two dozen poor women in Alabama have been arrested based on violation of FPLs [and to confirm almost all of them were women of color]; *See* Ferguson v. City of Charleston, 532 U.S. 67 (2001).

why some women, particularly poor women, are singled out to birth the healthiest babies when others are not? In *United States v. Virginia*, Justice Ginsburg opined that “[t]he burden of justification is demanding and it rests entirely on the State.” Inherent differences between men and women or different categories of women pose “artificial constraints on an individual’s opportunity,” and cannot be used as they were in prior generations to “create or perpetuate the legal, social,” and reproductive “inferiority” of women.

D. Chilling Prenatal and Medical Care

Women alone cannot ensure healthy pregnancies. However, the best fetal protection efforts on their part, during pregnancy, will involve seeking prenatal services. Prenatal care provides the opportunity for information sharing between doctors and patients, since patients raise health and emotional concerns about the pregnancy, receive counsel on managing diet, and when appropriate for the use of technology, such as ultrasounds to monitor the health and development of the fetus. Health care providers consider prenatal care to be an essential component of gestation.

Yet, a series of cases documented by the National Advocates for Pregnant Women and law review articles, reveal that the overwhelming majority of intrusive state interventions, including arrests and confinement, take place during prenatal or medical visits at hospitals and clinics. Ultimately, locating the selective punishment of gestating women at prenatal appointments may chill the very behavior that government desires to promote or erode the best avenue for achieving the healthiest outcomes for babies. One researcher warns that the “[u]ncomfortable relationships with health care providers and fear of reprisal on the part of pregnant women who are addicted make women four times less likely to receive adequate care, thereby creating health risks for women who are addicted, their unborn fetuses, and their other children.”

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296 Id.

297 Id. at 534.

Law Center echoes these concerns as have the American Medical Association, the Center for Reproductive Rights, and The National Partnership for Women & Families and other advocacy groups.

If using prenatal services is one of the best ways to promote fetal health, chilling that conduct will not achieve government interests. Instead, it may very well undermine child and maternal welfare by creating an “unsafe” harbor around clinics and hospitals. Some scholars predict that women who can afford to end their pregnancies may seek abortions to avoid hospital “dragnets” all together. Others suggest that pregnant women will simply avoid medical screenings. In either case, the state encroachments of the type described in this Article are far too deep and wide.

Part V: Conclusion

The important question for policy makers is whether the criminal law approach to protecting fetal health achieves that goal. This Article posits that it does not. Whether the criminal law approach can ever be justified in such contexts seems unlikely as these cases at their worst fail to demonstrate intent to harm. Dr. David Orentlicher, former Director of the Division of Medical Ethics at the AMA, who oversaw the drafting and adoption of the medical organization’s platform on maternal-fetal conflict, frames the organization’s response to that question in this way, “I was concerned because…these were counterproductive legal responses that weren’t good for the mother or the child.” Orentlicher’s colleagues agreed and for that reason, the AMA developed a policy statement condemning maternal arrest policies.

This Article emphasizes that criminal law approaches to fetal health protection undermine rather than promote the public health and welfare of fetuses and pregnant women. Scientific studies


300 See, e.g., Elizabeth L. Thompson, The Criminalization of Maternal Conduct During Pregnancy: A Decisionmaking Model for Lawyers, 64 IND. L. J. 357, 370 (1989) (“Perhaps the greatest danger in adopting a statutory scheme of fetal neglect or endangerment laws is that it will, in fact, deter women from seeking prenatal care for fear of being “turned-in” by their doctors.”).

301 Interview with David Orentlicher, February 20, 2013.
highlighted in this project, data on rehabilitation outcomes versus prison incarceration, interviews with physicians, and the AMA’s platform on maternal arrests collectively emphasize this point. When states choose arrest and incarceration of pregnant women as a means of improving health outcomes for fetuses, families suffer and the consequences extend beyond pregnancy. That states choose criminal law mechanisms to incentivize healthy maternal conduct over other alternatives reflects entrenched biases exemplified by who becomes the subject of criminal prosecutions for harming fetuses and the types of approaches utilized by the State. One former AMA official explained to me, “I suppose this kind of illustrates …we are discounting [pregnant women’s] humanity… we don’t think about the dignity of [these women]… we think they are bad people who should be in prison.”

States are more likely to maximize public welfare and promote better fetal health outcomes by rethinking and realigning their approaches to promoting fetal health. Recent efforts that call upon doctors to represent states’ criminal law enforcement interests necessarily compete with and conflict with fiduciary obligations physicians owe to their patients in unjustifiable ways. The law enforcement policies described in this Article fall short of promoting fetal health, because they do not actively place fetuses in better health conditions nor do they promote better post-natal outcomes for children. Instead, FPLs rely on faulty stereotypes and myths.

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302 Interview with David Orentlicher, February 20, 2013.