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Shifting our Focus from Retribution to Social Justice: An Alternative Vision for the Treatment of Pregnant Women Who Harm Their Fetuses

April L. Cherry
Cleveland-Marshall College of Law, Cleveland State University, a.cherry@csuohio.edu

SHIFTING OUR FOCUS FROM RETRIBUTION TO SOCIAL JUSTICE: AN ALTERNATIVE VISION FOR THE TREATMENT OF PREGNANT WOMEN WHO HARM THEIR FETUSES

APRIL L. CHERRY*

* Professor of Law, Cleveland-Marshall College of Law, Cleveland State University. A.B., Vassar College; J.D., Yale Law School. Thanks to colleagues Patricia J. Falk, Marnie S. Rodriquez, and the participants of the Journal of Law & Health Symposium, *Issues of Reproductive Rights*, for their many helpful comments and observations. Thanks also to Anne Seese and Bethany Strickradt for their invaluable research. Research for this article was completed, in part, with a grant from the Cleveland-Marshall Fund, Cleveland-Marshall College of Law.

I. INTRODUCTION

I long have been interested in the legal and social treatment of pregnant women whose behavior is thought to damage fetal health, and I have thought about the issue from a variety of vantage points. In previous articles I have written about the free exercise of religion of pregnant women who refuse medical treatment;[1] the right to be free from physical restraint during pregnancy, including freedom from unwarranted detention, confinement and incarceration;[2] and reproductive rights, namely rights to privacy, bodily integrity, and freedom from unduly burdensome government regulation.[3] In this essay my focus is a bit different. Here, I argue that we can and should approach the issue of pregnant women whose behavior may harm their fetuses, not from the vantage point of fetal harm, but rather from the vantage point of pregnant women's social location. That location often includes poverty, violence, need, and despair. Placing blame and exacting retribution on an individual woman, absent an understanding of the social context, makes the provision of justice in these cases difficult if not impossible. Moreover, attempts to enhance fetal health by assigning criminal liability in such cases are destined to fail in light of the significant contribution that negative social and economic conditions have on fetal health, and over which pregnant women have little or no control.[4]

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[1] April L. Cherry, *The Free Exercise Rights of Pregnant Women Who Refuse Medical Treatment*, 69 TENN. L. REV. 563 (2002).

[2] April L. Cherry, *The Detention, Confinement, and Incarceration of Pregnant Women for the Benefit of Fetal Health*, 16 COLUM. J. GENDER & L. 147 (2007) [hereinafter Cherry, *The Detention, Confinement, and Incarceration*].

[3] April L. Cherry, *Roe's Legacy: The Non-Consensual Medical Treatment of Pregnant Women and Implications for Female Citizenship*, 6 U. PA. J. CONST. L. 723 (2004) [hereinafter Cherry, *Roe's Legacy*].

[4] *See, e.g.*, Jean Ruth Schroedel & Pamela Fiber, *Punitive Versus Public Health Oriented Responses to Drug Use by Pregnant Women*, 1 YALE J. HEALTH POL'Y L. & ETHICS 217, 218 (2001); Seema Mohapatra, *Unshackling Addiction: A Public Health Approach to Drug Use During Pregnancy*, 26 WISC. J. L. GENDER & SOC'Y 241 (2011); Linda C. Fentiman, *Rethinking Addiction: Drugs Deterrence, and the Neuroscience Revolution*, 12 U. PA. J.L. & SOC. CHANGE 233 (2011); Jeanne Flavin & Lynn M. Paltrow, *Punishing Pregnant Drug-using*

Instead of viewing maternal behaviors that are harmful or fatal to fetuses as criminal, we should view them as a function of the myriad social and economic deprivations suffered by some women.[5] I believe that if we explore the problem from this viewpoint, focusing not solely on the fetus or fetal harm, but rather on the life and health of the pregnant woman, we might be willing to bring an end to punitive measures and construct more intelligent, effective, and socially just policies that will more positively affect both maternal and fetal health.

To this end, this essay is divided into four sections. In section I, I detail three archetypal scenarios of the criminal prosecution of pregnant women for behaviors resulting in harm to, or the death of, their fetuses: (1) cases concerning depression and attempted suicide, illustrated by the prosecution of Bei Bei Shuai;[6] (2) cases involving drug and alcohol use and abuse, illustrated by the prosecution of Rennie Gibbs;[7] and (3) prosecutions relating to self-induced abortion, illustrated by the prosecution of Kawana Ashley.[8] These cases demonstrate typical legal responses to fetal harm caused by pregnant women. They also demonstrate the social and economic context in which that harm occurs.

In sections II and III, I explore two contemporary rhetorical devices, arguments regarding fetal personhood and maternal deviance. Both of these discourses have significantly influenced society's expectations of how a pregnant woman ought to behave and the appropriate social and legal responses to any "misbehavior." With regard to the rhetoric of fetal personhood, I discuss the values articulated by its proponents through consideration of the underlying philosophical and religious arguments. I also consider how these values have been codified into law via state and federal feticide statutes. I then discuss the rhetoric of maternal deviance and address the ways in which the social construction of women as mothers, the good mother/bad mother dichotomy, and the use of "choice," influence that rhetoric. In these sections I also demonstrate how fetal personhood and maternal deviance rhetoric marginalizes pregnant women by encouraging the view of pregnant women as fetal containers, rather than as self-governing beings. The invisibility of pregnant women as self-governing persons sanctions the treatment, as criminal, of behaviors that are

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Women: Defying Law, Medicine, and Common Sense, 29 J. ADDICTIVE DISEASES 231 (2010); Julie B. Ehrlich, *Breaking the Law by Giving Birth*, 32 N.Y.U. REV. L. & SOC. CHANGE 381 (2008); Barry M. Lester, Lynne Andreozzi & Lindsey Appiah, *Substance Use During Pregnancy: Time for Policy to Catchup with Research*, 1 HARM REDUCTION J. 5 (2004).

[5] *See* Schroedel & Fiber, *supra* note 4, at 218.

[6] Shuai v. State, 966 N.E.2d 619, 622 (Ind. Ct. App. 2012).

[7] During the pendency of this essay, the State of Tennessee passed legislation criminalizing illicit drug use during pregnancy. *See* TENN. CODE § 39-13-107 (2014). Tennessee has also prosecuted the first person under this statute, Mallory Loyola. Ms. Loyola was arrested and charged with assault two days after giving birth. Her newborn had allegedly tested positive for methamphetamines. *See* Sydney Lupkin, *Why Some Doctors Object to Tennessee Law that Criminalizes Drug Use During Pregnancy: Experts Weigh In on Law that Led to New Mom's Arrest*, ABC NEWS, July 14, 2014, *available at* http://abcnews.go.com/Health/doctors-object-tennessee-law-criminalizes-drug-pregnancy/story?id=24557525; Nina Martin, *A Stillborn Child, A Charge of Murder and the Disputed Case Law on 'Fetal Harm'*, PROPUBLICA, Mar. 8, 2014, http://www.propublica.org/article/stillborn-child-charge-of-murder-and-disputed-case-law-on-fetal-harm.

[8] State v. Ashley, 701 So. 2d 338 (Fla. Dist. Ct. App. 1997).

primarily self-harming, and in the end work to criminalize "bad" mothering.[9] Both the fetal rights rhetoric and the rhetoric of maternal deviance effectively work to control women's behavior by objectifying women and viewing their primary purpose as ensuring the health of the child. Such a conception of women operates to the detriment of women's dignity. And as such, it operates to the detriment of social justice.

Finally in section IV, I propose that both the law and society shift focus: Rather than continuing to criminalize women's behavior when they fall short of society's expectation that they privilege the life and health of their fetuses above all else, this essay suggests that society's interests in healthier women, babies, and communities would be better served through a more serious consideration of social context. Society should focus on the lives of pregnant women, not to chastise, destroy, or incarcerate them; but instead to see pregnant women in a more holistic way, and to understand the social and economic conditions that may lead to adverse behaviors.[10] This shift in focus will show that most adverse prenatal behaviors are not exclusively or primarily directed at the fetus.

Focusing on the social context also illuminates the fact that destructive behavior is injurious to the pregnant women herself, in addition to her fetus. By articulating the issue as one of self-harm, we may be able to develop policies that more

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[9] Dorothy Roberts has written extensively on the criminalization of the "bad" mother. *See, e.g.*, DOROTHY E. ROBERTS, KILLING THE BLACK BODY: RACE, REPRODUCTION, AND THE MEANING OF LIBERTY 8–21 (1998) [hereinafter ROBERTS, KILLING THE BLACK BODY] (detailing stereotypes of Black women as bad mothers, including as mothers who damage their children during pregnancy); Dorothy E. Roberts, *Motherhood and Crime*, 79 IOWA L. REV. 95, 97–98 (1993) [hereinafter Roberts, *Motherhood and Crime*] ("The law compels and legitimizes prevailing relationships of power. Criminal law not only defines and mandates socially acceptable behavior, it also shapes the way we perceive ourselves and our relationships to others. Legal rules reward conduct that fulfills a woman's maternal role and punish conduct that conflicts with mothering. Society's construction of mother, its image of what constitutes a good mother and what constitutes a bad mother, facilitates its continuing control of women. Society considers women who fail to meet the ideal of motherhood deviant or criminal. It stigmatizes unwed mothers, unfit mothers, and women who do not become mothers for violating the dominant norm. Considering our society's general neglect of children, it is probable that laws which punish mothers' conduct do so just as much to enforce gender roles as to protect children."). *See also* Dorothy E. Roberts, *Punishing Drug Addicts Who Have Babies: Women of Color, Equality, and the Right of Privacy*, 104 HARV. L. REV. 1419, 1436 (1991) [hereinafter Roberts, *Punishing Drug Addicts*] ("[T]he prosecution of crack-addicted mothers diverts public attention from social ills such as poverty, racism, and a misguided national health policy and implies instead that shamefully high Black infant death rates are caused by the bad acts of individual mothers").

[10] *See* Amy J. Schultz, et al., *Discrimination, Symptoms of Depression, and Self-Rated Health Among African American Women in Detroit: Results from a Longitudinal Analysis*, 96 RES. & PRAC. 1265, 1265–70 (2006) (everyday discrimination is associated with poor physical and mental health); C. Anne Broussard, Alfred L. Joseph & Marco Thompson, *Stressors and Coping Strategies Used by Single Mothers Living in Poverty*, 27 J. WOMEN & SOC. WORK 190, 190–204 (2012). ("[Societal stigma diminishes] educational access and employment opportunities, which combine to limit socioeconomic mobility and access to good-quality health care. Also, research has shown that stigmatized individuals perceive stigma differently and use different coping mechanisms than do non-stigmatized individuals . . . [Stigma and] shame [are] related to depression . . . lower levels of self-esteem, [and] the . . . perception of the [lack] of social support, and . . . to a greater fear of rejection for requested support.").

effectively ensure that pregnant women are able to lead healthier lives, and as a result, deliver healthier babies. As bioethist George Annas has said: "If the state really wants to protect fetuses it should do so by improving the welfare of pregnant women – not by oppressing them."[11] To this end, I suggest looking to public health law as a way to shape potential mechanisms to serve pregnant women (and by extension, their fetuses) in more just and compassionate ways.[12]

II. THREE ACCOUNTS OF SELF-HARMING BEHAVIOR AMONG PREGNANT WOMEN

Self-harming behavior is not unique to pregnant women. People across racial, social, and economic boundaries engage in it. As a society, we understand self-harming behavior in markedly different ways: as a symptom of individual illness, as a social problem or group pathology,[13] or as no problem at all.[14] How we

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[11] George J. Annas, *At Law: Pregnant Women as Fetal Containers*, 16 HASTINGS CTR. RPT. 13, 14 (1986).

[12] The specific type of justice referred to in this context is social justice. Implicit in this argument is the notion that social justice is a state concern, and as such, the state has an obligation to promote and foster it. *See, e.g.*, MARTHA C. NUSSBAUM, SEX & SOCIAL JUSTICE 41–42 (1999) (Citizens should have control over both their material and physical environments, including bodily health, bodily integrity, thought, imagination, and affiliation); JOHN RAWLS, A THEORY OF JUSTICE 3 (1971) (justice is "the first virtue of social institutions"); JOHN RAWLS, POLITICAL LIBERALISM 110–113 (1993) ("justice as fairness" as a political concern). Health is widely viewed as a social justice concern. *See, e.g.*, MADISON POWERS & RUTH FADEN, SOCIAL JUSTICE: THE MORAL FOUNDATIONS OF PUBLIC HEALTH AND HEALTH POLICY 5 (2006) ("Social justice is concerned with human well-being"); LAWRENCE O. GOSTIN, PUBLIC HEALTH LAW: POWER, DUTY, RESTRAINT 16 (2d ed. 2008) (hereinafter PUBLIC HEALTH LAW) (social justice is a widely appreciated aspect of public health ethics). The concept of health as a political right can be found in the United Nation's Universal Declaration of Human Rights. UNITED NATIONS GENERAL ASSEMBLY, UNIVERSAL DECLARATION OF HUMAN RIGHTS. G.A. Res. 217A (III), at 71, U.N. Doc A/810, (Dec. 10, 1948).

[13] "Social pathology" refers to a problem or behavior that is caused by a conflict of values rather than as a problem of individual behavior. *See* Edwin H. Sutherland, *Social Pathology*, 50 J. OF SOCIOLOGY 429, 431 (1945). By labeling any behavior as part of a social pathology, we can blame not just the actor, but the community from which they come. Pathologizing the behavior also permits us to "hide the effects of power and privilege," and to "stifle recognition of a need to address social problems through sociopolitical change." *Judith Goode, Pathology, Social*, INT'L ENCYCLOPEDIA OF THE SOC. SCI. (2008), *available at* http://www.encyclopedia.com/topic/Social_Pathology.aspx). *See also* Monica T. Williams, *African Americans and Pathological Stereotypes: Assumptions about Race Can Lead to Wrong Conclusions and Prejudice*, PSYCHOLOGY TODAY (Dec. 26, 2011), http://www.psychologytoday.com/blog/colorblind/201112/african-americans-and-pathological-stereotypes ("Pathological stereotypes are ideas about groups of people that exist to explain and justify inequalities"). Thus, it is not surprising that the behavior of poor minorities are pathologized in mainstream American culture.

[14] For example, libertarians are likely to view solely self-harming behavior as a protected liberty where no state or community solution is warranted. *Cf.* LIBERTARIAN PARTY PLATFORM, http://www.lp.org/platform (As adopted in Convention, June 2014, Columbus, Ohio) ("Government exists to protect the rights of every individual including life, liberty and property. Criminal laws should be limited to violation of the rights of others through force or fraud, or deliberate actions that place others involuntarily at significant risk of harm. We favor the repeal of all laws creating "crimes" without victims, such as the use of drugs for medicinal

characterize such behavior often depends in large part on the actor and whether the behavior harms innocent third parties.[15] The self-harming behavior of pregnant women is pathologizied and punished because it is seen as being potentially harmful to a third party, the fetus. Below, I discuss three accounts of self-harming behavior as a way to "de-pathologize" the behavior by exposing the effects of inequality.

A. Depression and Attempted Suicide: The Story of Bei Bei Shuai

In December 2010, a woman in Indiana named Bei Bei Shuai attempted suicide by eating rat poison while eight months pregnant.[16] Her attempt failed because she was rushed to the hospital by friends.[17] Eight days after the suicide attempt, her fetus was delivered by emergency caesarian section.[18] The child died a few days later.[19] Notwithstanding Shuai's admitted suicide attempt, Shuai was arrested and charged with murder and attempted feticide.[20] If found guilty, Shuai would face a prison sentence of up to sixty-five years for, in essence, attempting to commit suicide while pregnant.[21]

Moving to dismiss the charges, Shuai argued that the state's murder and feticide statutes did not apply to pregnant women who harm their fetuses and that the application of these laws would violate both state and federal constitutional protections.[22] The trial court denied her motion.[23] The appellate court affirmed the

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or recreational purposes, since only actions that infringe on the rights of others can properly be termed crimes. Individuals retain the right to voluntarily assume risk of harm to themselves.").

[15] For example, when poor black and brown peoples engage in self-harming behaviors society often considers it pathological, but when young, middle and upper class whites engage in similarly self-harming behaviors, society is more likely to view that behavior as symptom of mental illness or as an individual social problem. *See, e.g.,* Ishmael Reed, *The Black Pathology Biz,* THE NATION (Feb. 12, 2002) *available at* http://www.thenation.com/article/black-pathology-biz# ("Black pathology is big business. Two-thirds of teenage mothers are white, two-thirds of welfare recipients are white and white youth commit most of the crime in this country . . . . Yet in the popular imagination blacks are blamed for all these activities"); *see also* Williams, *supra* note 13 (Although African Americans are less likely to use alcohol or drugs than whites or Latinos, stereotypes of Black pathology are used to rationalize the disproportionate targeting of Black people for drug related crimes).

[16] Shuai v. State, 966 N.E.2d 619, 622 (Ind. Ct. App. 2012).

[17] *Id*.

[18] *Id*.

[19] *Id*. at 624.

[20] *Id.* at 623 ("Shuai was released from the Methodist Psychiatric Unit on February 4, 2011. . . . On March 14, the State charged Shuai with murder, a felony, and Class B felony attempted feticide, and Shuai turned herself in on the same day.").

[21] Robin Marty & Jessica Mason Pieklo, *Criminalized Pregnancies: When One Woman's Suicide Attempt Becomes Murder*, RH REALITY CHECK (May 16, 2013, 11:44 AM), http://rhrealitycheck.org/article/2013/05/06/criminalized-pregnancies-when-one-womans-suicide-attempt-becomes-murder.

[22] Brief of Appellant, Shuai v. State, 966 N.E.2d 619, 622 (Ind. Ct. App. 2012) (No. 49G09-1103-MR-014478).

trial court decision, holding that pregnant women were not immune from prosecution by any common law doctrine, state, or federal law.[24] After a legal battle lasting two-and-a-half years, Shuai was allowed to plead guilty to the misdemeanor of criminal recklessness and was sentenced to 178 days in jail.[25] Dissenting from the appellate court decision refusing to find abuse of discretion in the denial of bail, Judge Patricia Riley stated that "it was never the intention of the legislature that the feticide statute should be used to criminalize prenatal conduct of pregnant women."[26] Moreover, Judge Riley also expressed her concern that the court's interpretation of the feticide statute, in recognizing criminal liability for the pregnant women's behavior, "might lead to a slippery slope whereby the feticide statute could be construed as covering a full range of a pregnant woman's behavior."[27]

What is most surprising about this case is that the *context*, specifically, mental illness and despair, was apparently deemed unimportant, irrelevant, and erased from view, even though depression and suicide attempts generally are treated medically, as a disease or mental disorder and not subjected to criminal law sanction.[28] Even where a third party is injured or killed as a result of attempted suicide, our understanding of mental health usually proscribes prosecution of the battery or homicide; the person attempting suicide is usually deemed as not having the requisite mental intent to commit the crime.[29]

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[23] Shuai v. State, 2012 Ind. LEXIS 408 (Ind. May 11, 2012).

[24] Shuai, 966 N.E. 2d at 628–29.

[25] By this point Shuai had been imprisoned, without the possibility of bail, for more than one year. She also spent more than a year on bail, but with severe limitations on her freedom (including subjection to surveillance and supervision). *See* Dave Stafford, *Shuai Case Resolved: Thorny Legal Issues Remain*, IND. LAWYER (Aug. 14, 2013), http://www.the indianalawyer.com/shuai-case-resolved-thorny-legal-issues-remain/PARAMS/article/32121.

[26] Shuai, 966 N.E.2d at 635-36 (Riley, J. concurring in part and dissenting in part).

[27] *Id*. at 636.

[28] In the United States, many early statutes viewed attempted suicide as a crime, usually a misdemeanor. Donald W. Grieshober, *Suicide – Criminal Aspects*, 1 VILL. L. REV. 316, 318 (1956). At common law, suicide and attempted suicide were criminalized, viewing suicide as immoral, and as a criminal offense against God and the Crown. Nevertheless, laws prohibiting suicide were rarely enforced or were considered "a crime or unlawful act, although not a punishable offense . . . . [Though] none of the modern codifications treats attempted suicide as a crime." WAYNE R. LAFAVE, CRIMINAL LAW 853 (5th ed. 2010) (citing MODEL PENAL CODE § 210.5 cmt., n.10 (1980)). Instead, those who have attempted suicide or are believed to be suicidal are generally subject to involuntary commitment to a medical facility for evaluation and treatment. *See e.g.*, ARIZ. REV. STAT. §§ 36-540 (A), 36-501(6); FLA. STAT. § 394.467(1) ; OHIO REV. CODE §§ 5122.15(C), 5122.01(B).

[29] For example, of attempted suicide, the Model Penal Code states that "[i]ntrusion of the criminal law into such tragedies is an abuse. There is a certain moral extravagance in imposing criminal punishment on a person who has sought his own self-destruction . . . and who more properly requires medical or psychiatric attention." Model Penal Code §210.5, cmt. (1980). LaFave notes that presently, criminalization of suicide and attempted suicide is limited to situations where "one whose unsuccessful attempt kills or injures someone else – a would be rescuer or innocent bystander" or when the suicide is the result of persuasion, assistance, or force from another person – that person is subjected to criminal liability. LAFAVE, *supra* note 28, at 853–54; *see also* Grieshober, *supra* note 28, at 317, 321–22 (acknowledging the

Depression, suicide, attempted suicide, and suicidal ideation are not uncommon among pregnant women. In fact, some studies indicate that one in eight, or 12.5% of pregnant women, report suffering from depression.[30] Other studies put that number higher, estimating that 14-23 % of pregnant women experience depression.[31] But even these estimates may be low as they include only reported cases.[32] Indeed, researchers in Great Britain have found that in the United Kingdom, suicide is the leading cause of maternal death.[33] In the United States, suicide is the second leading cause of maternal death; the leading cause of maternal death is murder.[34] Further, in the United States maternal suicide is often related to domestic violence.[35] A study using data from the National Violent Death Reporting System found that "54.3% of pregnancy-associated suicides involved intimate partner conflict that appeared to contribute to the suicide."[36] In light of this reality, suicide and attempted suicide

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exception to this general rule when acts of attempted suicide amount to criminal negligence, e.g., attempting suicide with a gun in a crowed area and with knowledge of the danger to the public).

[30] Pam Belluck, '*Thinking of Ways to Harm Her': New Findings on Timing and Range of Maternal Mental Illness*, N.Y. TIMES (June 15, 2014), http://www.nytimes.com/2014/06/16/health/thinking-of-ways-to-harmher.html?hp&_r=0.

[31] Josie Pickens, *Pregnancy and Suicide*, EBONY, Aug. 2012, *available at* http://www.ebony.com/wellness-empowerment/pregnancy-and-suicide-799#axzz39QwmJdGs. Depression among women is quite prevalent in the general population: approximately 20% of women in the general population experience major depressive disorder in their lifetimes. *See* Samantha L. Illangasekare, et al., *The Impact of Intimate Partner Violence, Substance Use, and HIV on Depressive Symptoms Among Abused Low-Income Urban Women*, 28 J. INTERPERSONAL VIOLENCE, 2831, 2832–33 (2013) (citing Ellen L. Bassuk, et al., *Prevalence of Mental Health and Substance Use Disorders Among Homeless and Low-Income Housed Mothers*, 155 AM. J. PSYCHIATRY 1561 (1998) (finding that poor women had a higher level of mental health disorders which resulted from trauma than other women, and that social programs and policies for poor women should include mental health treatment). Among low-income women the percentages of women who experience a major depressive disorder during their lifetimes range from 43.8% to 45%. *Id.*

[32] Pickens, *supra* note 31.

[33] Margaret Oates, *Suicide: The Leading Cause of Maternal Death*, 183 BRIT. J. PSYCHIATRY 279, 279 (2002).

[34] *See* Christie Lancaster Palladino et al., *Homicide and Suicide During the Perinatal Period: Findings From the National Violent Death Reporting System*, 118 OBSTETRICS & GYNECOLOGY 1056–63 (2011) (Studies show that about three out of every 100,000 women who are pregnant or have a child less than one year old are murdered, and two out of every 100,000 kill themselves.). Pregnancy-associated homicide victims were significantly more likely to be at the extremes of the age range and African American; and 45.3% of pregnancy-associated homicides were associated with intimate-partner violence. *Id*.; s*ee also* Kerry Grens, *Murder, Suicide Top Medical Deaths in* Pregnancy, REUTERS (Oct. 26, 2011, 6:17 PM), http://www.reuters.com/article/2011/10/26/us-deaths-pregnancy-idUSTRE79P7OK20111026.

[35] *See* Palladino, *supra* note 34, at 1056–63.

[36] *Id*.; *see also,* Lynn M. Paltrow & Jeanne Flavin, *Arrest of and Forced Interventions on Pregnant Women in the United States, 1973–2005: Implications for Women's Legal Status*

among pregnant women should be seen not as a "choice" made in an attempt to harm her fetus, but rather as a consequence of mental illness or domestic violence. Thus we might better describe a pregnant woman who attempts suicide and harms her fetus as a *victim* of mental illness or crime, rather than as a perpetrator of criminal activity. Hence, instead of responding to attempted suicide among pregnant women as a criminal law issue, we should respond to these issues using medical and public health frameworks. To the extent that the criminal law is implicated, it should be used to eliminate domestic violence perpetrated against pregnant women.

B. A Story about Drug and Alcohol Use: The Story of Rennie Gibbs

In 2006, a sixteen-year-old, crack-addicted, young woman named Rennie Gibbs delivered a thirty-six-week-old stillborn baby.[37] Although there was no evidence that her drug use or addiction caused the stillbirth, Ms. Gibbs was arrested and charged with depraved heart murder.[38] Amici from physician and public health organizations, including the American Medical Association, the American College of Obstetricians and Gynecologists, the American Academy of Pediatrics, the American Public Health Association, and the American Academy of Family Physicians, argued that the charges against Ms. Gibbs should be dropped due to a multiplicity of medical and public health concerns, including:

1. The problem of drug and alcohol abuse during pregnancy is a health issue best addressed through education and community-based treatment, not through the criminal justice system.
2. Drug and alcohol dependency is a medical condition, as such pregnant women do not experience drug and alcohol addiction because they want to harm their fetuses and children or because they don't care about their children.
3. Because drug and alcohol dependency is an addiction, the majority of people who experience them cannot simply stop their drug and alcohol use on the threat of arrest, prison, or other negative consequences.
4. Threats of criminal (or civil) prosecution have been shown to harm women and children because it deters pregnant and parenting women from seeking prenatal care and drug and alcohol treatment.[39]

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and Public Health, 38 J. OF HEALTH, POL. POL'Y & L. 299, 309–311 (2013) (finding that in 9% of arrests and forced interventions, domestic violence was mentioned).

[37] Brief of Appellant at 1, Gibbs v. Mississippi, 2010-M-S19-SCT (Miss. 2010); Martin, *supra* note 7.

[38] Ed Pilkington, *Outcry in America as Pregnant Women who Lose Babies Face Murder Charges*, THE GUARDIAN, (June 24, 2011), www.guardian.co.uk/world/2011/jun/24/america-pregnant-women-murder-charges. One category of murder under the Mississippi statue is "depraved heart" murder. Miss. Code Ann. § 97-3-19(1)(b) (2000). Depraved heart is a category of second degree murder. It occurs "where an individual under 'circumstances evidencing a depraved indifference to human life, he recklessly engaged in conduct which creates a grave risk of death to another and thereby caused the death of another . . .'" Clayton v. State, 652 So.2d 720, 731-32 (Miss. 1995) (quoting State v. Nicholson, 585 P.2d 60 (Utah 1978)); *see also* LaFave, *supra* note 28, at 779–85 (addressing "depraved heart murder").

[39] Letter to Att'y Gen. of State of Tex., Press release, Nat'l Advoc. for Pregnant Women, *Over 70 Child Welfare and Public Health Organizations, Experts, and Advocates Condemn The Prosecution of Pregnant Women in Texas*, *available at*

Perhaps most importantly, Amici noted the difficulty in determining the cause of stillbirth.[40] Even where a woman tests positively for cocaine during labor or immediately post-partum, it is extremely difficult to establish that cocaine use was the cause of death because a large variety of factors contribute to stillbirth.[41]

On April 3, 2014, a Mississippi judge ruled that the state's murder case against Ms. Gibbs was prohibited and dismissed the indictment.[42] Nevertheless, the district attorney reported that the state would indict Ms. Gibbs again, presumably this time under the state's abortion statute, which prohibits self-induced abortion, or alternatively under the state's feticide statute.[43]

Ms. Gibbs's prosecution, like the criminal prosecution of other women who use drugs while pregnant, is perplexing because much of it belies what researchers know (and do not know) about the effects of illicit drug use on the developing fetus.[44] Undeniably some fetuses are harmed by in utero exposure to alcohol, illicit drugs, and other substances.[45] Babies born to drug-dependent women can suffer from a host of medical, developmental, and behavioral problems.[46] However, not all children born to women who used illicit drugs during their pregnancies are permanently affected by that exposure.[47] Not only is the presence and severity of these problems

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http://www.advocatesforpregnantwomen.org/issues/texasprosecute.htm [hereinafter Letter to Att'y Gen.]; Brief for Nat'l Ass'n. of Social Workers, et al. as Amicus Curiae Supporting Petitioner, Gibbs v. State, No. 2010-M-819-SCT (Miss.2010).

[40] *Id.*

[41] *Id.; see also* Mohapatra, *supra* note 4, at 242.

[42] Order, State vs. Gibbs, No. 2007-0031-CR1, slip op. at 1 (Cir. Ct. Lowndes County 2014), *available at* http://www.*cdispatch*.com/news/article.asp?aid=32344. In *Buckhalter v. State*, the Mississippi Supreme Court upheld the lower court's dismissal of indictment for manslaughter under similar circumstances, but noted that the pregnant women could be prosecuted under another section of the statute that criminalized abortions save those performed by a licensed physician, or under the state's feticide statute. Buckhalter v. State, 119 So. 3d 1015, 1018 (Miss. 2013).

[43] Sarah Fowler, *Judge Dismisses Rennie Gibbs' Depraved Heart Murder Case*, COLUMBUS DISPATCH (Apr. 3, 2014), www.cdispatch.com/news/article.asp?aid=32344.

[44] NAT'L INST. ON DRUG ABUSE, TOPICS IN BRIEF: PRENATAL EXPOSURE TO DRUGS OF ABUSE (2011), http://www.drugabuse.gov/sites/default/files/prenatal.pdf.

[45] Michelle Ungerer et al., *In Utero Alcohol Exposure, Epigenetic Changes, and Their Consequences*, 35 ALCOHOL RESEARCH 37, 37 (2013); Sonia Minnes et al., *Prenatal Tobacco, Marijuana, Stimulant, and Opiate Exposure: Outcomes and Practice Implications*. 6 ADDICTION SCI. & CLINICAL PRAC. 57, 57 (2011).

[46] Victoria J. Swenson & Cheryl Crabbe, *Pregnant Substance Abusers: A Problem That Won't Go Away*, 25 ST. MARY'S L.J. 623, 626 (1994).

[47] Marylou Behnke & Vincent Smith, Am. Acad. of Pediatrics, *Prenatal Substance Abuse: Short- and Long-term Effects on the Exposed Fetus,* 131 PEDIATRICS, 1009, 1016 (2013); Gideon Koren, et al., *Bias Against the Null Hypothesis: The Reproductive Hazards of Cocaine*, 8677 LANCET 1440, 1440 (1989) (bias against studies finding no fetal harm with maternal cocaine use may lead to a "distorted estimation of the teratogenic risk of cocaine"); AM. COL. OF OBSTETRICIANS AND GYNECOLOGISTS, OPIOID ABUSE, DEPENDENCE, AND ADDICTION IN PREGNANCY, 2 (2012), http://www.acog.org/-/media/Committee-Opinions/Committee-on-Health-Care-for-Underserved-Women/co524.pdf [hereinafter *AM.*

dependent upon the nature of their mother's drug use,[48] there is evidence that demonstrates that the link is itself uncertain.[49]

The harmful effect of alcohol on a developing fetus is much better understood. Alcohol is a teratogen, an agent that causes malformation of the developing embryo.[50] Maternal alcohol consumption can result in developmental disabilities and other disabling conditions in the resulting child. [51] But again, the gravity of these problems is dependent on the nature of pregnant women's alcohol consumption.[52] Nevertheless, women who consume or are addicted to alcohol are less likely to be subject to criminal prosecution.[53]

COL. OF OBGYN], (Concluding at with regard to opioid use, "[t]he observed birth defects remain rare with a minute increase in absolute risk").

[48] *See* Swenson & Crabbe, *supra* note 46, at 628; *see also* AM. COL. OF OBGYN, *supra* note 47, at 2 (providing studies indicating that while "chronic *untreated* heroin use is associated with an increased risk to fetal growth restriction, abruption placentae, fetal death, [and] preterm labor," these effects may also be associated with "lifestyle issues." (emphasis added).

[49] AM. COL. OF OBGYN, *supra* note 47, at 2 (discussing that case-control and prospective studies have not confirmed association between maternal methamphetamine use and fetal defects); Kenneth A. De Ville & Loretta M. Kopelman, *Fetal Protection in Wisconsin's Revised Child Abuse Law: Right Goal, Wrong Remedy*, 27 J.L. MED. & ETHICS 332, 336 (1999); *see* Kenneth A. DeVille and Loretta Kopelman, *Moral and Social Issues Regarding Pregnant Women Who Use and Abuse Drugs*, 25 OBSTETRICS AND GYNECOLOGY CLINIC OF NORTH AMERICA 237, 237–54 (1998); *see* Lester et al., *supra* note 4; see LAURA E. GOMEZ, MISCONCEIVING MOTHERS: LEGISLATORS, PROSECUTORS, AND THE POLITICS OF PRENATAL DRUG EXPOSURE 23–24 (1997). Initial Studies by Dr. Ira Chasnoff and his colleagues suggested a correlation between the use of cocaine during pregnancy and instances of premature birth, low birth weight, and higher rates of physical, mental, and emotional problems. These claims have been refuted by many other scientists. *See, e.g.*, Jennifer Havens et al., *Factors Associated With Substance Use During Pregnancy: Results From a National Sample*, 99 DRUG ALCOHOL DEPENDENCE 89, 89–90 (2009); John P. Ackerman et al., *A Review of the Effects of Prenatal Cocaine Exposure Among School-Aged Children*, 125 PEDIATRICS 554, 554 (2010); Stacy Buckingham-Howes et al., *Systematic Review of Prenatal Cocaine Exposure and Adolescent Development*, 131 PEDIATRICS 1917, 1917 (2013).

[50] *See* Claire E. Dineen, *Fetal Alcohol Syndrome: The Legal and Social Responses to Its Impact on Native Americans*, 70 N.D. L. REV. 1, 3–4 (1994).

[51] *Id.* at 4 ("Fetal alcohol syndrome (or FAS) is the name given to a pattern of major and minor physical malformations, growth deficiencies, and central nervous system abnormalities caused by maternal alcohol use during pregnancy. FAS is well defined for the children most severely affected by prenatal alcohol exposure." Fetal alcohol effects or FAE is a milder or more subtle form of FAS.). *See also* Karen K. Howell et al., *Prenatal Alcohol Exposure and Ability, Academic Achievement, and School Functioning in Adolescence: A Longitudinal Follow-up*, 31 J. PEDIATRIC PSYCHOLOGY 116, 116–21 (2006).

[52] Claire E. Dineen, *Fetal Alcohol Syndrome: The Legal and Social Responses to Its Impact on Native Americans*, 70 N.D. L. REV. 1, 19–21 (1994); Colleen O'Leary et al., *Prenatal Alcohol Exposure and Educational Achievement in Children Aged 8–9 Years*, 132 PEDIATRICS 468, 471–72 (2013).

[53] *See* Paltrow & Flavin, *supra* note 36, at 310 (finding that only 10% of arrests and forced interventions mentioned pregnant woman's use of alcohol).

Since the effects of alcohol and drug abuse on the fetus can vary widely, the state's actions regarding pregnant abusers are difficult to defend on a scientific basis. Moreover, prosecution for drug addiction runs counter to the contemporary understanding of the nature of addiction, particularly maternal drug addiction.[54] Most physicians understand drug addiction as an illness, one causing changes in the structure and function of the brain.[55] These changes are responsible for the cognitive and emotional impairments suffered by those who are addicted to drugs and alcohol, including the overwhelming drive to use these substances despite the medical, social, and economic costs.[56] Because addiction is as an illness, it cannot be simply ignored or wished away,[57] and even where treatment programs are available, rates of recidivism remain high, even in the most promising cases.[58] Moreover, relying on a criminal law solution presumes that effective treatment is available and that the pregnant woman willfully refuses to avail herself of it. This belief (in the widespread

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[54] Lester et al., *supra* note 4.

[55] *See* NAT'L INST. OF HEALTH, NAT'L INST. ON DRUG ABUSE, DRUGS, BRAINS, AND BEHAVIOR: THE SCIENCE OF ADDICTION 5 (2007), http://www.drugabuse.gov/sites/default/files/soa_2014.pdf [hereinafter NAT'L INST. OF HEALTH] (defining drug addiction as a brain disease); A.T. McLellan, et al., *Drug Dependence, A Chronic Medical Illness: Implications for Treatment, Insurance, and Outcomes Evaluation*, 284 J. AMER. MED. ASS'N 1689, 1689 (2000) (acknowledging that, although often treated as an acute disease, drug addiction is better understood as a chronic disease in need of long-term strategies of medication management and monitoring); Ellen M. Weber, *Bridging the Barriers: Public Health Strategies for Expanding Drug Treatment in Communities*, 57 RUTGERS L. REV. 631, 638–39 (2005) (majority of medical community considers addiction a disease of the brain). Moreover, both the World Health Organization and the American Psychiatric Association classify drug and alcohol addiction as disease/disorder. *See* AM. PSYCHIATRIC ASS'N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS 483 (5th ed. 2013) [hereinafter DSM-5] ("The essential feature of a substance abuse disorder is a cluster of cognitive, behavioral, and physiological symptoms indicating that the individual continues using the substance despite significant substance abuse-related problems"); WORLD HEALTH ORG., THE INTERNATIONAL CLASSIFICATION OF DISEASES 57 (10th ed.1994) [hereinafter ICD-10].

[56] Alan I. Leshner, *Addiction Is A Brain Disease*, ISSUES SCI. & TECH. 75, 75 (2001), http://www.issues.org/17.3/leshner.htm; *see also* NAT'L INST. OF HEALTH, *supra* note 55 at 5 (defining drug addiction as a brain disease).

[57] McLellan et al., *supra* note 55, at 1689 (treatment entails the implementation of long-term strategies of management and monitoring); Weber, *supra* note 55, at 638–39 (showing that a majority of medical the community considers addiction a disease of the brain that requires treatment for improvement of symptoms).

[58] *See* B. Douglas Bernheim & Antonio Rangel, *Addiction and Cue-Triggered Decision Processes*, 94 AM. ECON. REV. 1558, 1560 (2004) ("Addicts often express a desire to stop using a substance permanently and unconditionally but are unable to follow through. Short-term abstention is common while long-term recidivism rates are high."); *see also* NAT'L INST. OF HEALTH, *supra* note 55, at 26 (treatment does not cure all patients, but it does reduce drug use by 40–60 percent); McLellan, *supra* note 55 (Although drug addiction is often treated as an acute disease, it is better understood as a chronic disease in need of long-term strategies of medication management and monitoring).

availability of drug treatment programs for pregnant women) is inaccurate.[59] As of 2007, only 14.1% of the mental health and substance abuse facilities in the United States offered treatment programs specifically designed for pregnant and post-partum women. In real numbers, this amounts to only 1,926 out of a total of 13,648 facilities offering programs for pregnant addicts.[60] Moreover, as of August 2014, only nineteen states have at least one drug treatment program available to pregnant women.[61] And among those states, only eleven give priority admission to pregnant women.[62] Indeed, in at least two states, New York and Pennsylvania, pregnant women have initiated class action lawsuits to gain access to treatment programs near their residences.[63]

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[59] SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMIN., OFFICE OF APPLIED STUDIES, U.S. DEP'T OF HEALTH & HUMAN SERV., NATIONAL SURVEY OF SUBSTANCE ABUSE TREATMENT SERVICES 56 (2007), http://wwwdasis.samhsa.gov/07nssats/nssats2k7web.pdf.

[60] *Id*.

[61] GUTTMACHER INST., STATE POLICIES IN BRIEF AS OF OCTOBER 1, 2014: SUBSTANCE ABUSE DURING PREGNANCY (2014), http://www.guttmacher.org/statecenter/spibs/spib_SADP.pdf; *see also* Janet W. Steverson & Traci Rieckmann, *Legislating for the Provision of Comprehensive Substance Abuse Treatment Programs* 16 DUKE J. GENDER L. & POL'Y 315 (2009).

[62] GUTTMACHER INST., *supra* note 61. Eligibility for Medicaid benefits provides some benefits to pregnant women. U.S. Dep't of Health and Human Servs., *Health Coverage Options for Pregnant or Soon to Be Pregnant Women* (last visited Sept. 26, 2014), https://www.healthcare.gov/how-does-the-health-care-law-protect-me/summary-of-benefits-and-coverage; *see also* CTRS. FOR MEDICARE AND MEDICAID SERVS., GLOSSARY OF HEALTH COVERAGE AND MEDICAL TERMS https://www.cms.gov/CCIIO/Resources/Files/Downloads/uniform-glossary-final.pdf; Eligibility for Medicaid benefits provides some benefits to pregnant women; U.S. Dep't of Health and Human Servs, *Essential Health Benefits* (last visited Sept. 26, 2014), https://www.healthcare.gov/glossary/essential-health-benefits/ ("States expanding their Medicaid programs must provide these benefits [essential benefits, which include drug treatment and prenatal, postpartum, and postnatal care for mother and child] to people newly eligible for Medicaid."). Medicaid coverage does not guarantee pregnant women access to treatment programs:

> Given that Medicaid is one of the largest sources of funding for indigent women, one would logically look to Medicaid to provide payment for treatment services. Unfortunately, there are a variety of barriers to a woman in seeking payment for treatment services through Medicaid. For example, Medicaid coverage for substance abuse treatment is not mandated by federal law, thus, the states may choose to not provide reimbursement for such services. Further, even if a state chooses to provide reimbursement for treatment services, it will only receive federal reimbursement if the patient is Medicaid-eligible and the treatment is provided under 'a Medicaid service category that qualifies for matching funds.' Thus, a treatment might not be reimbursable because the service was social rather than medical treatment; the client was too old or too young to qualify; the provider was not Medicaid-qualified because it did not meet the definition of medical practitioner; the facility provided room and board, which may not be reimbursed if provided in certain types of facilities; or the facility was too large.

Steverson & Rieckmann, *supra* note 61, at 331–32.

[63] *See* RACHEL ROTH, MAKING WOMEN PAY: THE HIDDEN COSTS OF FETAL RIGHTS, 139–40 (2003).

Even where treatment is available, programs are poorly equipped to deal with the needs of many pregnant women, particularly pregnant women who are poor.[64] The costs and the lack of availability of childcare are prohibitive for many women.[65] Moreover, a few drug treatment facilities are unwilling to treat pregnant women for fear of tort liability.[66] It cannot be assumed, therefore, that pregnant drug and alcohol users who do not receive treatment have rejected medical assistance.[67] Thus, criminal penalties are utilized in this context, despite the limited availability of treatment that could have ameliorated harm to the pregnant woman and her fetus.[68]

Perhaps, the use of criminal law sanctions in the United States to punish pregnant women who use drugs is inevitable in light of the dominant social construction of addiction. This construction stigmatizes the afflicted as weak, while at the same time holding them responsible and consequently blameworthy.[69] In other words, addicted pregnant women are viewed as having a moral character too weak to halt their addiction, but nevertheless are culpable for their addiction and the related consequences of that addiction.[70] Stigmatization is also severe for women because

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[64] AM. COL. OF OBGYN, *supra* note 47, at 2 ("The few drug treatment facilities in the United States accepting pregnant women often do not provide child care, account for the woman's family responsibilities, or provide treatment that is affordable.").

[65] Steverson & Rieckmann, *supra* note 61, at 326, 334 (noting the lack of funding to create the programs for women, the lack of funding for those women unable to pay for treatment, and that the lack of childcare facilities within programs limit poor women's access to treatment); *see also* ROTH, *supra* note 63, at 139, 140 (noting in a previous study, in New York City, 87% of drug treatment programs rejected Medicaid patients who were pregnant and addicted to crack); *see also* Dennis Andrulis & Sarah Hopkins, *Public Hospitals and Substance Abuse Services for Pregnant Women and Mothers: Implications for Managed-Care Programs and Medicaid*, 78 J. URBAN HEALTH, 181, 181–82 (2001).

[66] Lester et al., *supra* note 4, at 22; *see also* Schroedel & Fiber, *supra* note 4, at 225 ("Fears of insurance liability for drug-affected children are an important reason why many treatment providers refuse to accept pregnant women in their programs."). *See also* Carol Jean Sovinski, *The Criminalization of Maternal Substance Abuse: A Quick Fix to a Complex Problem,* 25 PEPP. L. REV. 107, 135 (1997).

[67] Flavin & Paltrow, *supra* note 4, at 237 ("Along similar lines, women who do not receive treatment for drug dependence cannot be assumed to have rejected treatment.").

[68] *Id*. at 226 (citing Illinois as an exception to this pattern). Neither the federal or state governments have meaningfully increased the number of treatment spaces available to pregnant women despite widespread acknowledgement of the need. *See* Schroedel & Fiber, *supra* note 4, at 225.

[69] *See* Michael Salter & Jan Breckenridge, *Women, Trauma and Substance Abuse: Understanding the Experiences of Female Survivors of Childhood Abuse in Alcohol and Drug Treatment*, 23 INT'L. J. SOC. WELFARE 165, 167 (2014) (Drug treatment programs offer "punitive institutional cultures characterized by significant power differentials between workers and clients." This structure, with the client portrayed as weak and irresponsible, along with the expectation that she remain "deferential, penitent and apologetic" or suffer punishment, "provoked fear among women whose abuse histories gave them reason to be distrustful of regimes of control and discipline.").

[70] Lester et al., *supra* note 4.

the status of "female addict" represents "an array of derelictions from (female) gender norms."[71]

Stigmatization of the pregnant drug user is also an important step toward legitimizing punitive sanctions.[72] It does so by masking the circumstances under which drug abuse occurs. As Seema Mohapatra notes, "women do not abuse drugs in a vacuum. There are a variety of societal factors, such as poverty, domestic violence, lack of social support and education, which relate to drug use."[73] The failure of the criminal legal system to address these factors means that it cannot effectively prevent harms that result from a pregnant woman's drug use. Instead of helping women who use drugs and alcohol while pregnant and their fetuses, the criminal legal system simply targets these women for prosecution.[74]

Finally, punitive treatment of pregnant women who use or who are addicted to drugs or alcohol is inappropriate because it harms both pregnant women and their babies.[75] Even those who subordinate the rights of women to those of the fetus should be concerned with the costs to fetal health exacted by the punitive measures of the criminal law. Professional medical and public health organizations have long opposed the use of the criminal law against pregnant women who use drugs due to possible adverse consequences for fetal health.[76] For instance, the American Medical Association, the American College of Obstetricians and Gynecologists, the American Academy of Pediatrics, and the American Public Health Association have all assailed the use of criminal law as a response to maternal drug use and addiction.[77] In public statements, each of these organizations has noted that criminalization of maternal drug use and addiction leads to poor fetal outcomes –[78]

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[71] Salter & Breckenridge, *supra* note 69, at 171; *see infra* note 227 (providing text regarding hegemonic gender norms); *see also* Elizabeth Ettorre, *Revisioning Women and Drug Use: Gender Sensitivity, Embodiment and Reducing Harm*, Int'l J. of Drug Pol'y 327, 327–35 (2004); and *infra* Section III.

[72] Salter & Breckenridge, *supra* note 69, at 165.

[73] *See, e.g.*, Mohapatra, *supra* note 4, at 253.

[74] *See* ROTH, *supra* note 63, at 139.

[75] *See* Doug McVay et al., Justice Policy Institute, *Treatment or Incarceration? National and State Findings on the Efficacy and Cost Savings of Drug treatment versus Imprisonment* 4 (2004), http://www.justicepolicy.org/uploads/justicepolicy/documents/04-01_rep_md treatmentorincarceration_ac-dp.pdf (punishment is also inappropriate because it is ineffective and costs more than would treatment).

[76] Lester at al., *supra* note 4; *see* Ernest L. Abel, & Michael Kruger, *Physician Attitudes Concerning Legal Coercion of Pregnant Alcohol and Drug Abusers*, 186 AM. J. OBSTETRICS GYNECOLOGY 768, 768 (2002); *see* Letter to Att'y Gen., *supra* note 39.

[77] Kristin Pulatie, *The Legality of Drug-Testing Procedures for Pregnant Women*, 10 AM. MED. ASS'N J. OF ETHICS 41, 42 (2008); AM. COL. OF OBGYN, *supra* note 47, at 2; *see also* NATIONAL ASSOCIATION OF SOCIAL WORKERS, DESCRIPTION OF AMICI CURIAE, https://www.socialworkers.org/assets/secured/documents/ldf/briefDocuments/Aiowhi%20Appendix.pdf.

[78] *See* Am. Med. Ass'n Bd.Trustees, *Legal Interventions During Pregnancy*, 264 J. AM. MED. ASS'N, 2663 (1990); Comm. on Substance Abuse, Am. Acad. of Pediatrics, *Drug Exposed Infants*, 86 PEDIATRICS 639 (1990); Am. Pub. Health Ass'n, Policy Statement No. 9020, *Illicit Drug Use by Pregnant Women*, (1990); Comm. on Ethics, Am. College of

often by discouraging these women from seeking treatment because they fear legal retribution.[79] In the alternative, the aforementioned organizations recommend education[80] and referrals to voluntary treatment as a way of improving fetal outcomes for pregnant women who use or who are addicted to drugs.[81]

C. Self-Induced Abortion: The Story of Kawana Ashley

While incidents of attempted suicide and drug use among pregnant women are intended primarily to affect the pregnant woman, cases involving self-induced abortion are different. In these cases, the pregnant woman's behavior is aimed more directly toward the fetus – the purpose of the woman's action is destruction of the fetus. Nevertheless, there are important similarities to the cases outlined above. Like the pregnant women who attempt suicide and those who use drugs and alcohol, women who induce their own abortions are acting in response to similar social pressures, such as shame and despair. As a result, these women are willing to risk grievous bodily harm to avoid the social stigma that may accompany an unintended pregnancy.[82] Thus, even in cases involving self-induced abortion, our attention

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Obstetricians & Gynecologists, Committee Opinion No. 321, *Maternal Decision Making, Ethics and Law*, 106 OBSTETRICS & GYNECOLOGY 1127 (2005).

The American College of Obstetricians and Gynecologists have issued several critical statements of the current approach of the criminal legal system to maternal drug and alcohol use. *See, e.g*., Comm. on Health Care for Underserved Women, Am. College of Obstetricians & Gynecologists, Committee Opinion No. 473, *Substance Abuse Reporting and Pregnancy: The Role of the Obstetrician-Gynecologists* (2001) ("Drug enforcement policies that deter women from seeking prenatal care are contrary to the welfare of the mother and fetus. Incarceration and the threat of incarceration have proved to be ineffective in reducing the incidence of alcohol or drug use.").

[79] Cynthia Dailard & Elizabeth Nash, *State Responses to Substance Abuse Among Pregnant Women*, 3 GUTTMACHER REPORT ON PUBLIC POLICY, no. 6, Dec. 2010 (noting South Carolina experienced an 80% reduction of pregnant women admissions into drug treatment programs after aggressive prosecution of pregnant drug users in the state); Mohapatra, *supra* note 4, at 254.

[80] *See, e.g*., American Academy of Pediatrics, *How Pediatricians Can Help Babies Exposed to Drugs* (Aug. 7, 2014), http://www.aap.org/en-us/about-the-aap/aap-press-room/Pages/How-Pediatricians-Can-Help-Babies-Exposed-to-Drugs.aspx. (recommending partnering with government and other health care providers to educate women and providers regarding problem and treatment); Am. Pub. Health Ass'n, *supra* note 78 (encouraging educational programs, community outreach, and availability of drug treatment facilities).

[81] *See, e.g.*, Am. Pub. Health Ass'n, *supra* note 78; Comm. on Ethics, Am. College of Obstetricians & Gynecologists, Committee Opinion No. 422, *At-Risk Drinking and Illicit Drug Use: Ethical Issues in Obstetric and Gynecologic Practice* (Dec. 2008), http://www.acog.org/Resources-And-Publications/Committee-Opinions/Committee-on-Ethics/At-Risk-Drinking-and-Illicit-Drug-Use-Ethical-Issues-in-Obstetric-and-Gynecologic-Practice; Comm. on Health Care for Underserved Women, Am. College of Obstetricians & Gynecologists, Committee Opinion No. 479, *Methamphetamine Abuse in Women of Reproductive Age* (2011); Comm. on Health Care for Underserved Women, Am. College of Obstetricians & Gynecologists, Committee Opinion No. 524, *Opioid Abuse, Dependence, and Addiction in Pregnancy* (2012).

[82] Letter to Att'y Gen., *supra* note 39. In can be argued that they are making double-bind choices – choices that exposes a person to "[s]ituations in which options are reduced to a very

would be better focused on viewing the behavior of the pregnant woman as self-harming, rather than behavior primarily designed to harm the fetus. Not only would such a focus increase the quality of women's health, it would also decrease the number of situations in which fetuses are subject to harmful prenatal maternal behavior.

The 1997 Florida case of a young, unmarried teenager named Kawana Ashley provides an example of circumstances that may lead to incidents of self-induced abortion.[83] Ms. Ashley shot herself in the abdomen with a .22 caliber gun when she was twenty-five weeks pregnant.[84] The gunshot injured her fetus in the wrist, and forced delivery of the fetus via an emergency caesarian section.[85] Fifteen days later, the child died as a result of its premature birth.[86]

Unlike Ms. Shuai, Ms. Ashley did not try to kill herself.[87] She shot herself in an attempt to terminate her pregnancy, believing that her pregnancy had advanced beyond the time frame in which she could obtain a legal abortion.[88] Ms. Ashley was arrested and charged with a violation of the state's criminal abortion statute "by performing a third-trimester abortion on herself with a .22 caliber firearm without certification of necessity by two physicians,"[89] felony murder, and manslaughter.[90]

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few and all of them expose one to penalty, censure, or deprivation," and as such, are emblematic of oppression. MARILYN FRYE, *Oppression*, *in* THE POLITICS OF REALITY: ESSAYS IN FEMINIST THEORY 1, 2 (1983).

[83] State v. Ashley, 701 So. 2d 338, (Fla.1997) (per curiam). The case of a pregnant seventeen-year-old, who desperately wanted to end her pregnancy, hired a man to beat her in an attempt to terminate the pregnancy represents a similar approach to self-induced abortion. The young woman allegedly hired the man after her boyfriend told her that he would leave her if she did not "get rid of the baby." She paid the man $150 and he kicked her in the stomach 5 times (he also bit her on the neck – I'm unsure what that had to do with ending the pregnancy). Both the pregnant teenager and the fetus survived, but teenager was charged with 2nd degree felony criminal solicitation to commit murder. She pled no contest to the charges and was initially placed in confinement until the age of 21. The Utah State Attorney General actually appealed the Juvenile Court Judge's opinion – and the judge reversed himself, and released the young woman after being convinced that under Utah law pregnant women cannot be held criminally liable for seeking to obtain an abortion for herself. *See*, National Advocates for Pregnant Women, *Utah Bill Creating the Crime of Criminal Homicide of an Unborn Child will Affect all Pregnant Women*, (Jan. 12, 2010), http://advocatesforpregnantwomen.org/main/publications/fact_sheets/utah_bill_creating_the_crime_of_criminal_homicide_of_an_unborn_child_will_affect_all_pregnant_women.php.

[84] State v. Ashley, 701 So. 2d at 339.

[85] *Id*.

[86] *Id*.

[87] Shuai v. State, 966 N.E.2d 619 (Ind. Ct. App. 2012).

[88] Lynn M. Paltrow, *Punishment and Prejudice: Judging Drug-Using Pregnant Women*, *in* MOTHER TROUBLES: RETHINKING CONTEMPORARY MATERNAL DILEMMAS 59 (Julia E. Hanigsgerg & Sara Ruddick eds., 1999).

[89] State v. Ashley, 701 So. 2d 340.

[90] *Id*. at 341–42.

Although the trial court dismissed the murder charge against the teenager, it proceeded with the manslaughter charge.[91]

The court of appeals affirmed the trial court's decision to allow a manslaughter charge to go forward, but it certified two questions to the Florida Supreme Court for its review, namely: (1) "may an expectant mother be criminally charged with the death of her born alive child resulting from self-inflicted injuries during the third trimester of pregnancy"; and (2) "[i]f so, may she be charged with manslaughter or third-degree murder, the underlying predicate felony being abortion or attempted abortion?"[92] Reasoning that the criminal law regarding abortion was "intended to protect, not punish" pregnant women, the Florida Supreme Court answered the first question in the negative.[93] The second question was thus rendered moot.[94] As a result of the Florida Supreme Court decision, Ms. Ashley was not prosecuted for her attempted self-induced abortion. Nevertheless, her arrest and indictment are illustrative of how some prosecutors approach the issue of self-induced abortion.[95] Prosecutions for self-induced abortion continue where criminal statutes do not expressly exempt women from criminal liability.[96]

The issue of self-induced abortion[97] has not garnered much attention since the landmark Supreme Court decision of *Roe v. Wade*.[98] Perhaps we have assumed that

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[91] *Id*. at 341.

[92] *Id.* at 340.

[93] *Id*.

[94] *Id.*

[95] "Self-induced abortion," also called "self-abortion," is an abortion performed without the assistance of medical professionals. The term does not include medical abortions, where abortion is achieved with the use of the lawfully prescribed drug mifepristone, which is also known as "RU-486." Self-induced abortion does not include the use of "emergency contraception," commonly known as the "morning after pill." Methods of self-induced abortion include the ingestion of drugs and other substances; insertion of implements into the uterine cavity; and infliction of physical trauma, including blows to the abdomen. *See* Daniel Grossman, et al., *Self-Induction of Abortion Among Women in the United States,* 18 REPRODUCTIVE HEALTH MATTERS 136, 138–40 (2010); *see also* Erica Hellerstein, *The Rise of the DIY Abortion in Texas*, THE ATLANTIC, (Jun. 27, 2014), http://www.theatlantic.com/health/archive/2014/06/the-rise-of-the-diy-abortion-in-texas/373240/ (Texas experiences a rise in self-induced abortion with the closing of abortion clinics); *see also* Teresa A. Saultes, Diane Devita, & Jason D. Heiner, *The Back Alley Revisited: Sepsis After Attempted Self-Induced Abortion*, 10 WESTERN J. OF EMERGENCY MED. 278 (2009) (looking at a case study of patient who self-aborted).

[96] Arrest and prosecution for self-induced abortion continues to be a possibility in the thirty-nine states that require an abortion to be performed by a licensed physician. *See* GUTTMACHER INST., STATE POLICIES IN BRIEF AS OF OCTOBER 1, 2014: AN OVERVIEW OF ABORTION LAWS (2014), http://www.guttmacher.org/statecenter/spibs/spib_OAL.pdf. Alabama, Arizona, and Delaware statutes are examples of statutes that on their face prohibit self-induced abortion. ALA. CODE §13A-13-7 (1975); ARIZ. REV. STAT. ANN. § 13-3603 (1978); DEL. CODE ANN. TIT. 11, § 652 (1995). *See also* McCormack v. Hiedeman, 694 F.3d 1004, 1011 (9th Cir. 2012).

[97] Self-induced abortion continues to be practiced worldwide where abortion is criminalized or access to abortion services is restricted by age, status, or by economic circumstances. *See* M.S. Coles, & L.P. Koenigs, *Self-Induced Medical Abortion in an*

self-induced abortion itself was a thing of the past,[99] only necessary in the pre-*Roe* era when most abortions were criminalized.[100] On the contrary, self-induced abortions continue to occur in the United States.[101] These abortions often occur among women who are unable to afford or access legal abortions.[102]

Self-induced abortions are gravely dangerous to the women who attempt them. Women who attempt self-induced abortion risk serious health complications, including infection and infertility.[103] They also face an increased risk of death from hemorrhage, infection, embolism, septic shock, and sepsis.[104] Moreover, criminalization of self-induced abortion may lead to increased maternal mortality because women who find that they need medical help after attempting to self-abort may be hesitant to seek assistance – they may fear that hospitals will turn them over to the police.[105]

Adolescent, 20 J. PED. ADOLESCENT GYNECOLOGY 93, 93 (2007); Jane Parker Smith, *Risky Choices: The Dangers of Teens Using Self-Induced Abortion Attempts*, 12 J. PEDIATRIC HEALTH CARE 147 (1998); Benjamin Honigman, Guillermo Davila, & Janice Petersen, *Reemergence of Self-Induced Abortion*, 11 J. EMERGENCY MED. 105 (1993).

[98] Roe v. Wade, 410 U.S. 113 (1973).

[99] Saultes et al., *supra* note 95, at 279 (suggesting that the rate of mortality due to sepsis in patients that self-abort is as high as 20–50%).

[100] Although *Roe v. Wade* is often thought to stand for the proposition of that abortion was legalized in the United States, in fact the Court in *Roe* decriminalized only abortions performed by licensed medical professionals, and then only those performed during the first and second trimesters. Roe v. Wade, 410 U.S. 113, 163–64 (1973).

[101] Grossman et al., *supra* note 95, at 140–42.

[102] *Id*. (noting that the women interviewed cited avoidance of abortion clinic, obstacles to accessing clinic services caused by age and finances, as well as a preference for self-induction as reasons for self-induced abortion).

[103] Honigman et al., *supra* note 97, at 108.

[104] *Id*. Fetal harm may also result even if the abortion is unsuccessful. *See,* Helen C. Pymar & Mitchell D. Creinin, *Alternatives to Mifepristone regimes for Medical Abortion*, 183 AM. J. OBSTET. GYNECOL. 54 (2000) (While some data suggests an increase in limb reduction abnormalities among fetuses examined after failed abortion with the drugs methotrexate and misoprostol. Other studies have found no significant differences in the rates of major or minor abnormalities in misoprostol-exposed and unexposed newborns).

[105] As of the time of the writing of this essay, the State of Indiana has charged a thirty-three year-old woman, Purvi Patel, with feticide, a class B felony that carries a prison sentence of 8 to 20 years. She was also charged with criminal child neglect, Indiana Code 35-46-1-4(b) (3), a class A felony that carries a potential prison sentence of up to fifty years. Information for Neglect of a Dependent at 1, State v. Patel, No. 71 D08-1307-FA-000017, (Sup. Ct. St. Joseph County 2013 (*available at* https://www.documentcloud.org/documents/1280086-patelpcaffidavit.html). The state alleges that Patel took several drugs in an attempt to terminate her pregnancy and in doing so either killed her at least 28 week-old fetus, or that the child was born alive and was then neglected causing its death. This case came to the attention of law enforcement after Patel, bleeding from her vagina, went to an emergency room for treatment. Supplemental Affidavit in Support of Probable Cause at 1, State v. Patel, No. 71 D08-1307-FA-000017, (Sup. Ct. St. Joseph County 2013) (Available at https://www.documentcloud.org/documents/1280086-patelpcaffidavit.html). *See also* Ed Pilkington, *Indiana Woman Charged with Feticide after Unborn Child's Death,* THE

Although fetal rights rhetoric insists that cases of self-induced abortion be punished because of the fetal harm or death that results, there is an alternative to this approach. Instead of viewing cases involving self-induced abortion as being primarily about fetal harm, they may be better understood as being a result of the inaccessibility of legal abortion in the United States despite the decriminalization of early abortion in *Roe*.[106] Cases of self-induced abortion demonstrate the difficulty that some women have in accessing safe and legal abortion because of social, economic, and legal constraints. The social weight of shame prevents some women from seeking legal abortion.[107] Economic constraints caused by poverty also prevent some women from accessing legal abortions.[108] Finally, some women may resort to

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GUARDIAN, Aug. 26, 2014, http://www.theguardian.com/world/2014/aug/26/indiana-woman-feticide-charge.

[106] Roe v. Wade, 410 U.S. 113 (1973).

[107] "Sidewalk Counseling" is a common tactic among anti-choice activists. These activists talk to and yell at clients are entering or trying to enter an abortion clinic, in an effort to persuade them not to have an abortion. Although anti-choice organizations often assert that such "counseling" is done in a "quiet and friendly manner." *See* Judith Fetrow, *The Sidewalk Counselor's Guidebook,* AM. LIFE LEAGUE (Aug. 30, 2014), http://www.all.org/article/index/id/MjM4OA. During oral arguments before the Supreme Court in McCullen v. Coakley, Justice Scalia described anti-choice sidewalk counseling: "[W]hat these people want to do is to speak quietly and in a friendly manner, not in a hostile manner, because that would frustrate their purpose, with the people going into the clinic." Transcript of Oral Argument at 32, McCullen v. Coakley, 134 S.Ct. 2518 (2014) (No. 12–1168 Justice Scalia's description of the practice belies the reality. Anti-choice activists are often angry, shouting, and accusing. Their purpose is to shame women and stop them from accessing abortion services. *See* Dean Obeidallah, *The Loud Truth Abort Abortion Protestors*, DAILY BEAST, (Jan. 22, 2014), http://www.thedailybeast.com/articles/2014/01/22/the-loud-truth-about-abortion-protesters .html.Anti-choice activists are also known to engage in physical violence. The National Abortion Federation complies statistics on acts of violence toward abortion clinics and abortion providers including murder, attempted murder, bombing, arson, assault and battery, hate mail, and bomb threats. *See* National Abortion Federation, NAF VIOLENCE AND DISRUPTION STATISTICS: INCIDENTS OF VIOLENCE & DISRUPTION AGAINST ABORTION PROVIDERS IN THE U.S. & CANADA (2009), http://prochoice.org/wp-content/uploads/violence_stats.pdf.

[108] To the extent that the poorest women receive health care, that health care is funded by a joint federal-state program: Medicaid. More than seven million women of reproductive age, approximately 12% of all American women of reproductive age, are enrolled in the Medicaid program. Heather D. Boonstra, *The Heart of the Matter: Public Funding of Abortion for Poor Women in the United States,* 10 GUTTMACHER POL'Y REV., no 1, Winter 2007,, 12 . Under this program, federal law severely restricts the use of federal funds for the provision of abortion services. The Hyde Amendment, initially passed in 1976, limited federal funding for abortions except for cases in which the pregnant woman's life was threatened by the continuation of the pregnancy. Pub.L.96-123, §109, 93, Stat. 926 (1976). Since then, the Hyde Amendment, with small modifications, has been renewed every year. The current version of the Amendment forbids the use of federal funds for abortions except for cases of life in which the pregnant woman's life is endangered by a continuation of the pregnancy, or where the pregnancy was the result of rape or incest. With regard to life endangering conditions, the current statute permits payment with federal funds only when the pregnant woman's life is threatened by a "physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself." Departments of Labor, Health and Human Services, and Education, and Related Agencies Appropriations Act of 2009, Pub. L.

self-induced abortion because of burdensome state regulation.[109] Many abortion regulations deemed constitutional, including mandatory waiting periods, counseling requirements, and "TRAP" laws,[110] constitute significant barriers to safe, legal, and early abortion for poor and low income women.[111] Thus, stories about self-induced abortion should be more readily understood as resulting from the lack of comprehensive health care, including reproductive healthcare, for women across the socio-economic spectrum.

The preceding cases of Shuai, Gibbs, and Ashley provide a good opportunity to consider why pregnant women lack adequate access to healthcare, including mental healthcare, substance abuse treatment, and reproductive healthcare. I believe that the influences of the fetal personhood rhetoric and maternal deviance rhetoric both play a part in this deprivation.

III. THE RHETORIC OF FETAL PERSONHOOD AND THE USE OF FETAL PROTECTION MEASURES AGAINST PREGNANT WOMEN

There is much debate in contemporary society about the status of the human embryo and fetus. In large part, this debate revolves around questions of personhood

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No. 111-8, § 507(b), 123 Stat. 524, 802. *See also*, Harris v. McRae, 448 U.S. 297 (1980) (upholding constitutionality of the Hyde Amendment).

[109] *See, e.g.*, Planned Parenthood of SE. Pennsylvania v. Casey, 505 U.S. 833, 878 (1992) (permitting state regulations so long as regulation purpose or effect is not to place a "substantial obstacle in the path of a woman seeking an abortion before the fetus attains viability"); Gonzales v. Carhart, 550 U.S. 127 (2007) (upholding constitutionality of state ban on so called "partial birth abortion"). *But see* Jackson Women's Health Org. v. Currier, No. 13-60599, 2014 WL 3730467, at *10 (5th Cir. July 29, 2014) (holding that regulations which will cause the closure of Mississippi's only abortion clinic comprise "an undue burden on a woman's right to choose an abortion in Mississippi, and is therefore unconstitutional as applied to the plaintiffs in this case.").

[110] A recent trend amongst state legislatures is the passage of targeted regulation of abortion providers, or "TRAP" laws. These laws single out the medical practices of doctors who provide abortions, and impose different and more burdensome regulations on them than those imposed on other physicians and medical practices.; CENTER FOR REPRODUCTIVE RIGHTS, BRIEFING PAPER, TARGETED REGULATION OF ABORTION PROVIDERS: AVOIDING THE "TRAP" 1 (2003), http://http://reproductiverights.org/sites/crr.civicactions.net/files/documents/pub_bp_avoidingthetrap.pdf; Carol M. Sanger, *Seeing and Believing: Mandatory Ultrasound and the Path to a Protected Choice*, 56 UCLA L. REV. 408 (2008) *See generally* SARA DUBOW, OURSELVES UNBORN: A HISTORY OF THE FETUS IN MODERN AMERICA (2011) (providing a detailed account of this trend in legislation). An example of a particularly egregious piece of TRAP legislation was Virginia's pre-abortion ultrasound statutory proposal which required women to whose pregnancies were less than 8 weeks to undergo a highly invasive transvaginal ultrasound before an abortion could be performed, even though ultrasounds under these conditions have not been deemed medically necessary and are contrary to guidelines published by the American College of Obstetricians and Gynecologists. *See* Rick Ungar, *Virginia's Pre-Abortion Ultrasound Law Medically Unsound-Violates Guideline of American College of Obstetricians and Gynecologists*, FORBES MAG. Forbes.com, Mar. 8, 2012. http://www.forbes.com/sites/rickungar/2012/03/08/virginias-pre-abortion-ultrasound-law-medically -unsound-violates-guidelines-of-american-college-of-obstetricians-and-gynecologists/.

[111] *See* Kate Gerasley, *The Pearl of the 'Pro-Life' Movement? Reflections on the Kermit Grisnell Controversy*, 40 J. MED. ETHICS 419, 420–21 (2014).

and resulting legal and moral rights.[112] Although much of the rhetoric regarding embryonic and fetal personhood can be found in debates about abortion, human cloning, and embryo experimentation,[113] it also underlies the use of fetal protection measures against pregnant women, including charges of fetal neglect and fetal homicide.[114] In this section, I analyze contemporary fetal personhood rhetoric and the ways in which this rhetoric, despite its limitations, has been translated into the law, specifically fetal homicide statutes.

A. Fetal Personhood Rhetoric and Critique

While a comprehensive review and analysis of the philosophical and ethical literature examining moral personhood is beyond the scope of this essay, it is important to note that within that literature, much debate exists regarding the appropriate basis for recognizing moral and legal personhood status. These debates include: debates centered on religious and ethical views;[115] scientific explanations;[116]

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[112] *See generally* Jessica Berg, *Of Elephants and Embryos: A Proposed Framework for Legal Personhood*, 59 HASTINGS L.J. 369 (2007); *see generally* ABORTION RIGHTS AND FETAL "PERSONHOOD" (Edd Doerr & James W. Prescott eds., 2nd. ed. 1990).

[113] *See, e.g.*, Janet L. Dolgin, *Embryonic Discourse: Abortion, Stem Cells, and Cloning*, 31 FLA. ST. U. L. REV 101, 101–02 (2003) ("Two debates, one about abortion and the other about embryonic stem cell research and therapeutic cloning, are being conflated in social and legal discourse.").

[114] *See, e.g.*, Margaret Kelly, *Increasing Victimization Through Fetal Abuse Redefinition*, 20 WM. & MARY J. WOMEN & L. 685 (2014) (examining the ways in which women are held accountable for their failure to protect their fetuses from domestic violence and how women have been prosecuted for legal behavior during pregnancy, such as drinking alcohol, by the same officers summoned to the home for a domestic violence situation); Juliana Vines Crist, *The Myth of Fetal Personhood: Reconciling Roe and Fetal Homicide Laws*, 60 CASE W. RES. L. REV. 851 (2010) (arguing that fetal homicide laws do not undermine boundaries of the fetus as a juridical person, and thus they do not subordinate to the pregnant woman).

[115] *See, e.g.*, *Catechism of the Catholic Church, Abortion* § 2270 ("Human life must be respected and protected absolutely from the moment of conception. From the first moment of his existence, a human being must be recognized as having the rights of a person - among which is the inviolable right of every innocent being to life.); John Noonan, *Abortion and the Catholic Church: A Summary History*, 12 NAT. L. F. 5, 126 (1967) (addressing moral personhood; arguing that since the embryo and fetus is conceived by human beings, it is a human being); *see, e.g.*, ROBERT P. GEORGE & CHRISTOPHER TOLLEFSEN, EMBRYO: A DEFENSE OF HUMAN LIFE 50, 123 (2008) ("Since human beings are intrinsically valuable and deserving of full moral respect by virtue of what they are, it follows that they are intrinsically valuable from the point at which they come into being.").

[116] For example, neuroscientist Michael Bennett argues that "[f]rom a neuroscientific and behavioral point of view, personhood develops over the months or year or two when the baby is beginning to recognize its parents, feel fear, joy and anger, and to put its feelings into words." Michael V.L. Bennett *Personhood From a Neuroscientific Perspective*, *in* ABORTION RIGHTS AND FETAL "PERSONHOOD" 78, 78–79 (Edd Doerr & James W. Prescott eds., 2nd. ed., 1990).

One the other hand, psychologist Paul Bloom argues that the question, 'when does life begin', is not relevant to what people think of as personhood. Rather, Bloom believes that the question is a spiritual question that science cannot answer. Paul Bloom, *The Duel Between Body and Soul*, N.Y. TIMES, Sept. 10, 2004, http://www.nytimes.com/2004/09/10/opinion/

functional views such as that moral personhood can be defined by a collection of functions or abilities,[117] or the potential capacity to attain those functions or abilities;[118] and debates incorporating some amalgamation of the preceding bases.[119] Where the basis for moral personhood has a religious underpinning, the fetus is often viewed as having the status of moral personhood.[120] On the other hand, where the basis of personhood is scientific or functional, the fetus is not normally imbued with personhood status.[121]

Outside of the academy, much of the contemporary rhetoric regarding fetal personhood combines a call in favor of the recognition of moral personhood with a recognition of legal personhood, including legal rights for the fetus.[122] Much of this rhetoric and activism can be found under the banner of the "right to life" or "pro-

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[117] *See, e.g.*, Mary Anne Warren, *On the Moral and Legal Status of Abortion*, 57 The Monist 4, 5 (1973) (arguing there are five indicia of personhood: consciousness, reasoning, self-motivated activity, capacity to communicate, and presence of self-concepts and self-awareness); Joseph Fletcher, *Indicators of Humanhood: A Tentative Profile of Man*, Hastings Center Rep., at 1–2 (1972) (arguing that there are four indicia of personhood: minimum intelligence, self-awareness, sense of time, and the ability to relate to others); Joseph Fletcher, *Four Indicators of Humanhood – The Enquiry Matures*, 4(6) HASTINGS CENTER REP. 4–7 (arguing that higher brain or neocortical function – that is required for volition – is the most important indicia of personhood).

[118] *See, e.g.*, Lawrence Becker, *Human Being: The Boundaries of the Concept*, 4 PHIL. & PUB. AFF. 334, 352 (Summer, 1975).

[119] Scholar Ronald Green may be an example of this approach. In his book, Green argues that judgments regarding personhood status are "the outcome of complex moral choice involving many competing considerations. Sometimes these consideration have less to do with the nature of the entity than with the implications of a boundary maker itself." RONALD M. GREEN, THE HUMAN EMBRYO RESEARCH DEBATES: BIOETHICS IN THE VORTEX OF CONTROVERSY 49 (2001).

[120] *See, e.g.*, *id*, at 31 ("Roman Catholic theorists are particularly sensitive to [the appearance of the embryo at fertilization marking the beginning of a new human individual that merits some degree of moral protection]. Catholic theology defines the human soul as 'an individual substance of a rational nature.' The soul is an individual reality, and every human individual can have only one soul . . . This is a metaphysical question pertaining to religious faith, not something that can be determined by the means available to those who must form public policy.").

[121] *See, e.g.*, *id.* at 25 (Personhood is a legal status given by "a pluralistic society in which people hold very different views."); *see also* GREEN, *supra* note 119, at 49 ("[There is, among both conservatives and liberals, a] failure to realize that the judgments of 'humanity,' 'personhood,' or any similar determination of moral protectedness are not a matter of definition, of finding the intrinsic biological property of an entity that makes it morally protectable, but are instead the outcome of a complex moral choice involving many competing considerations.").

[122] Mary Jo Neitz, *Family, State, and God: Ideologies of the Right-to-Life Movement*, 42 Sociological Analysis 265, 265 (1981).

life" movement.[123] By and large, the right to life movement is both a social and political movement. It bases its fetal personhood and fetal rights stance on a conservative religious doctrine, which posits that the fetus is a moral person and as such is entitled to legal personhood with its concomitant legal rights and protections, including protections from physical harm by its mother.[124]

Many aspects of the fetal personhood rhetoric are troubling. For example, the contemporary fetal personhood rhetoric fails to consider that there may be a difference between legal and moral personhood. It is not self-evident that they are equivalents. In other words, the fetal personhood rhetoric conflates the two concepts, or at the very least glosses over important distinctions between them. Further, this analysis fails to consider why a fetus might be accorded moral personhood status but not imbued with legal rights.[125]

Moreover, much of the fetal rights rhetoric ignores the differences between the two types of legal persons – natural persons (generally a function of live human birth) and juridical persons (entities given some of the characteristics and rights of personhood due to their legal interests, such as corporations). [126] This demarcation

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[123] In this section I am referring to the American pro-life/right to life movement as both a social and political movement. Although the movement consists of various pro-life organizations that hold diverse rationales for their right to life position, their common goal has been to oppose abortion on moral or religious grounds. *Id*. (arguing that there are two different conceptual frameworks in the right to life movement: a "pro-life" contingent, and a "pro-family contingent). Nevertheless, members of the right to life movement seem to share three central beliefs (which are often conflated): 1) that human life begins at conception; 2) that the human fetus (and in most cases the embryo) is a person; and 3) that because the fetus is a person, it has both a moral and legal right to life. Right to life organizations include organizations such as Operation Rescue, http://www.operationrescue.org/; Americans United for Life, http://www.aul.org; The National Right to Life Convention, http://nrlconvention.com/; The National Right to Life Committee, http://www.nrlc.org/; The United States Conference of Catholic Bishops, http://www.usccb.org/; Focus on the Family, http://www.focusonthefamily.com/; Concerned Women of America, http://www.focusonthefamily.com/; and Feminists for Life, http://www.feministsforlife.org/.

[124] *See, e.g.*, GREEN, *supra* note 119, at 37 ("If, from fertilization onward, the embryo inside a woman's womb were regarded as her moral equivalent, every conflict between the fetus and pregnant woman would require careful determination of whose health and survival should take precedence. If a woman's other interests clashed with the moral claims of the embryo or fetus, those interests could be overridden.").

[125] For example, the Supreme Court has held that the fetus, regardless of its stage of development, is not a legal person with legal rights. Roe v. Wade, 410 U.S. 113, 158–59 (1973) ("the word 'person' as used in the Fourteenth Amendment, does not include the unborn"). *See also* LAURENCE B. MCCULLOUGH & FRANK A CHERVENAK, ETHICS IN OBSTETRICS AND GYNECOLOGY 105 (1994) ("There is no compelling reason in bioethics, as a philosophical intellectual undertaking, for the physician, the pregnant woman, or anyone else—the male gamete donor, family members, or the state, in particular—to regard the previable fetus as independently possessing, lacking, or possessing only to some degree, the moral status of being a patient.").

[126] In American law legal "personhood" is understood and conveyed by the doctrines of "natural" personhood or "juridical" personhood. Natural personhood is limited to people and is conferred upon birth. Berg, *supra* note 112, at 372–73 (2007). By contrast, juridical personhood is a legal mechanism by which a state may give limited rights (such as the right to sue and be sued) to entities that are not natural persons. Crist, *supra* note 114, at 864 ("They

between natural and juridical persons is critical because where an entity is deemed a juridical person, its rights are generally understood to be subordinate to the rights of natural persons.[127] Under this framework, the fetus that the state seeks to protect via fetal endangerment and homicide laws is not a natural person.[128] It may, arguably, be a juridical person; but, even then, its rights should be limited, as "natural persons are entitled to priority over juridical persons in a hierarchy of rights."[129] Indeed, one commentator, Juliana Crist, argues that the law should recognize juridical personhood in the fetus as a way of protecting the pregnant woman's interests in her fetus, stating:

> The fetus, like the corporation, is not entitled to protections because of what it is innately. Instead, the law recognizes that there is a natural person, the mother, who has fundamental interests at stake. Her rights are invested in another entity, the fetus. The law gives that entity juridical personhood to ensure that the rights of the mother may be secured, just as the law gives the corporation juridical personhood to protect the rights of shareholders.[130]

Within Crist's understanding of fetal personhood, fetal homicide laws can exist only to protect the pregnant woman's interest in her pregnancy as against outsiders, and thus cannot be used against her for any damage done to the fetus by her own behavior.

B. Translating Fetal Personhood Values into the Law: Feticide/Fetal Homicide Laws

Despite the absence of legal personhood status in the fetus, both civil and criminal penalties have been exacted against women who have used drugs or alcohol

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are creatures of the state, and as such are limited to whatever rights the state chooses to give or not give them."). Corporations are entities that operate in this latter category.

[127] Generally, the rights conveyed through a recognition of juridical personhood are inferior (or fewer) than those rights conveyed by natural personhood. However, there are circumstances in which the rights accorded by juridical personhood are equivalent/equal to those convey to natural persons – when the according equal rights are justified by the nature of their interests. Berg, *supra* note 112, at 374. As Berg notes:

> This is not to say that juridical persons might not be granted equal rights with natural persons, but that such allocation of rights would have to be justified by the interests involved. In other words, natural persons function as the baseline against which other rights allocations are judged. Our society was developed by and for natural persons, and thus legal rights focus on this group.

Id.

Moreover, the distinction between natural persons and juridical persons is important because even if the fetus is not deemed a natural person (because it has not yet been born live), the fetus might be deemed a juridical person and if the state deems appropriate, imbued with limited legal rights and obligations. *Id.* at 391–92.

[128] *See* Wade, 410 U.S. at 158.

[129] Berg, *supra* note 112, at 372–73.

[130] Crist, *supra* note 114, at 858.

during their pregnancies. Where the civil penalties have been imposed, they have been severe.[131] Sanctions have included civil commitment and incarceration during pregnancy for the benefit of fetal health, and civil orders requiring submission to a physician's orders.[132] In the family law context, the punishment of women for their behavior while pregnant is frequently manifested by removal of the child (directly after its birth) from its mother.[133] In this context, the fetus is constructed either as a child who has been abused and neglected, or the prenatal maternal behavior is used as proof of the likelihood of child abuse or neglect if the newborn is permitted to remain with its mother.[134] Women of color are more vulnerable to this sort of state action than white women.[135] In fact, a 1990 study found that while white and black women have similar rates of illicit drug use during pregnancy, black women were ten times more likely to be reported to county child protection authorities.[136]

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[131] LYNN M. PALTROW, DAVID S. COHEN & CORINNE A. CAREY, YEAR 2000 OVERVIEW: GOVERNMENTAL RESPONSES TO PREGNANT WOMEN WHO USE ALCOHOL OR OTHER DRUGS 4 (2000), *available at* http://www.advocatesforpregnantwomen.org/articles/gov_response_review.pdf.

[132] *See* Cherry, *The Detention*, *supra* note 2, at 159.

[133] Eighteen states (Alabama, Arkansas, Colorado, Florida, Illinois, Indiana, Iowa, Louisiana, Minnesota, Nevada, Oklahoma, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Virginia, and Wisconsin) have deemed drug use during pregnancy as child abuse under their civil child abuse and neglect statutes. GUTTMACHER INST., *supra* note 61. Others, namely Minnesota, South Dakota, and Wisconsin also have specific statutes permitting civil commitment of pregnant women who used drugs. *See* Dailard & Nash, *supra* note 79, at 2, 4–5.

[134] The South Dakota and Illinois child abuse and neglect statutes are examples of this approach. In the South Dakota statute, the term "abused or neglected child," includes a newborn "[w]ho was subject to prenatal exposure to abusive use of alcohol, marijuana, or any controlled drug or substance not lawfully prescribed by a practitioner." S.D. CODIFIED LAWS § 26-8A-2(9) (West 1998). In Illinois, under 705 ILCS 405/2-3(1)(c), a neglected minor includes:

> any newborn infant whose blood, urine, or meconium contains any amount of a controlled substance as defined in subsection (f) of Section 102 of the Illinois Controlled Substances Act, as now or hereafter amended, or a metabolite of a controlled substance, with the exception of controlled substances or metabolites of such substances, the presence of which in the newborn infant is the result of medical treatment administered to the mother or the newborn infant.

See also In re Baby Boy Blackshear, 736 N.E.2d 462, 464–65 (Ohio 2000) (Although court found "that the issue is not whether a fetus is a child but rather whether the plain language of" the statute applies to newborns, it nevertheless held that when newborn toxicology yields a positive result for illicit drug, the newborn is *per se* an abused child); Dailiard & Nash, *supra* note 79, at 3.

[135] *See generally* Ira J. Chasnoff, Harvey J. Landress & Mark E. Barrett, *The Prevalence of Illicit-Drug or Alcohol Use During Pregnancy and Discrepancies in Mandatory Reporting in Pinellas County, Florida,* 322 NEW ENG. J.MED. 1202, 1205 (1990).

[136] *Id.* Of the 715 women enrolled for prenatal care at the five public health clinics and twelve private obstetrical offices in Pinellas County, 15.4% of white women and 14.1% of African-American women showed positive toxicological results for the presence of alcohol, cannabinoids, cocaine, or opiates. Nevertheless, only1.1% of white women were tested, as

As the cases of Shuai, Gibbs, and Ashley demonstrate, pregnant women accused of endangering the life or health of their fetuses also have been punished via the criminal law.[137] Although presently only one jurisdiction, the state of Tennessee, has enacted a statute that directly and explicitly criminalizes illicit drug use during pregnancy,[138] many other states have used the criminal law as a way to criminalize drug and alcohol use by pregnant women.[139] For example, pregnant women who use illicit substances during pregnancy have been prosecuted for delivery of drugs to a minor, corruption of a minor, criminal child abuse, assault with a deadly weapon, and as the case against Ms. Gibbs demonstrates, women have also been prosecuted for manslaughter and murder.[140] Like in the civil law context, criminal law prosecutions have depended upon the construction of the fetus as a legal person, thus a proper target of the state's protection.[141] And like in the civil law context, race

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compared to 10.7% of Black women tested, were reported to county welfare authorities. *Id.* at 1203–04.

[137] *See supra* section I.

[138] TENN. CODE ANN. § 39-13-107 (West 2014). The statute is extensive and encompassing on many fronts. For example in its definition of "person" includes "a human embryo or fetus at any stage of gestation in utero, when any such term refers to the victim of any act made criminal by this part." § 39-13-107 (a) And although it precludes the prosecution of women for any "lawful act or lawful omission" during pregnancy, including any lawful medical or surgical procedure . . . performed by a health care professional." § 39-13-107 (c) (1), the statute explicitly permits the prosecution of women who use drugs while pregnant. The statute reads:

> Notwithstanding subdivision (c) (1), nothing in this section shall preclude prosecution of a woman for assault under § 39-13-101 for the illegal use of a narcotic drug, as defined in § 39-17-402, while pregnant, if her child is born addicted to or harmed by the narcotic drug and the addiction or harm is a result of her illegal use of a narcotic drug taken while pregnant.

§ 39-13-107 (c) (2). *See also* Sydney Lupkin, *Why Some Doctors Object to Tennessee Law that Criminalizes Drug Use During Pregnancy: Experts Weigh In on Law that Led to New Mom's Arrest*, ABC NEWS, July 14, 2014; CTR. FOR REPRODUCTIVE RIGHTS, PUNISHING WOMEN FOR THEIR BEHAVIOR DURING PREGNANCY 2 (2013), http://reproductiverights.org/sites/default/files/documents/pub_bp_punishingwomen.pdf. Last accessed Sept. 25, 2014.

[139] GUTTMACHER INST., *supra* note 61.

[140] *See supra*, section I.B.; *see also*, Whitner v. State, 492 S.E.2d 777, 779 (S.C. 1997) (upholding conviction for criminal child neglect after birth of newborn testing positive for cocaine metabolites); Johnson v. Florida, 602 So. 2d 1288, 1297 (Fl.1992) (overturning conviction for delivery of controlled substance through the umbilical cord); State v. McKnight, 576 S.E.2d 168, 179 (S.C. 2003) (affirming twenty-year sentence for felony murder based on child endangerment), *vacated,* 661 S.E.2d 354 (2008) (overturning conviction on grounds of ineffective assistance of counsel); *see also* Dailard & Nash, *supra* note 79, 4–5; PALTROW, COHEN & CAREY, *supra* 131.

[141] The Unborn Victims of Violence Act of 2004 (also known as Laci and Connor's Law) is an example of the construction of the fetus as a legal person. The statute provides that one who injures or kills "an unborn child" is guilty of an offense that is separate from the crime committed against the pregnant woman; § 1841(d) defines the term "unborn child" to mean "'a child in utero' and the term 'child in utero' or 'child, who is in utero' means a member of

plays a part in these prosecutions as women of color are more likely to be held criminally liable for any alleged harm to their fetuses.[142] As a result, fetal protection and the moral values of fetal personhood have not only become integral parts of the law, but they also contribute to the disproportionate characterization of women of color as bad mothers. Feticide statutes exacerbate this disproportionate treatment by the creation of a new crime of fetal homicide and the recognition of the fetus *qua* fetus as a proper entity for the protection of the criminal law.

In the remainder of this section, I outline the varied ways that the criminal law has viewed the killing of a fetus, including the prosecution of pregnant and post-partum women for self-harming activities that result in fetal death. Examination of the common law, the federal law, and state statutes also demonstrate the development of a criminal law paradigm that punishes women without any corresponding benefit to fetuses and infants.[143]

1. The Common Law: Born Alive Rule

The crime of feticide, or fetal homicide, was unknown at common law.[144] Because the fetus was not deemed to be a legal person, it could not be murdered.[145] This does not mean that the common law did not punish the destruction of any and all fetuses.[146] The destruction of a "quick" fetus[147] was sometimes deemed a misdemeanor.[148] The injury of a fetus in utero was only actionable as murder if the

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the species homo sapiens, at any stage of development, who is carried in the womb." 18 U.S.C.A. § 1841 (West 2014) (Pub. L. No. 108–212—Apr. 1, 2004) (§1841 (a)(1).

[142] Paltrow & Flavin, *supra* note 36, at 310–11; *see also id*, at 322. (finding that 52% of arrests and interventions were of Black women; 41% of the women were white); Roberts, *Motherhood and Crime*, *supra* note 9, at 97–98; Roberts, *Punishing Drug Addicts, supra* note 9, at 1424.

[143] *See*, *e.g.*, *supra* section I (providing discussion & analysis of three cases).

[144] Dietrich v. Inhabitants of Northampton, 138 Mass. 14, 17 (1884) (establishing that a fetus has "no separate existence" from the pregnant woman and therefore cannot seek damages for injuries sustained in utero).

[145] For example, during the sixteenth century, the common view held if a man killed a fetus in utero, it was neither actionable at law nor subject him to forfeiture of any rights because "the thing killed had no baptismal name." Jennifer A. Brobst, *The Prospect of Enacting an Unborn Victims of Violence Act in North Carolina*, 28 N.C. CENT. L.J. 127, 133 (2006). However, in some instances the viable fetus was recognized as having an interest in tort law, in wrongful death actions. *See generally* Roe v. Wade, 410 U.S. 113 (1973).

[146] *See* Michael P. McCready, *Recovery for the Wrongful Death of a Fetus*, 25 U. Rich. L. Rev. 391, 391–92 (1995).

[147] "Quickening" refers to the moment in a pregnancy when the pregnant woman feels, for the first time, the movement of her baby in utero. It usually occurring between 16 and 20 weeks of gestation. MOSBY'S MEDICAL DICTIONARY, 8th ed. (2009). Thus a "quick fetus' refers to a fetus that has reached this point of development.

[148] In certain criminal cases, there was potential for recovery for the wrongful death of a fetus if that fetus were born alive. The same was not true for tort cases. *Id*.

fetus was born alive but then died of injuries sustained in utero.[149] This policy is expressed by the "born alive" rule.

The "born alive" rule provided criminal penalties for infant death resulting from harm in utero where the infant was (1) ultimately born alive, (2) had injuries inflicted upon it by another person, and (3) died as a result of the injuries inflicted.[150] The difficulty of the rule lay in knowing whether or not the fetus was actually alive when the accused was alleged to have caused the fetal death.[151] The common law born alive approach is a "single entity approach," an approach that treats the fetus and the pregnant woman as a single entity, and thus holds that a person cannot be charged with the murder of an entity that is not legally alive.[152]

The common law view prevailed in the United States and was accepted by every court that considered the issue of whether or not the killing of a fetus should be deemed murder; that is until 1984 when the Supreme Court of Massachusetts, in the case *Commonwealth v. Cass*, held that modern medical knowledge undermined the primary rationale in support of the born alive rule.[153] The court noted: "Medical science now may provide competent proof as to whether the fetus was alive at the time of a defendant's conduct and whether his conduct was the cause of death."[154] Thus the court held that third-party violence against a pregnant woman that destroyed her viable fetus was punishable as a homicide.[155]

Since the Massachusetts Supreme Court ruling in *Cass*, there has been a tremendous decline in courts acceptance and use of the born alive rule.[156] As of February 2013, at least 38 states have fetal homicide laws,[157] and in twenty-three of

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[149] *Id*. at 391.

[150] *See* Bonbrest v. Kotz, 65 F. Supp. 138, 139 (D.D.C. 1946); *see also* Tara Kole & Laura Kadetsky, *Recent Development: The Unborn Victims of Violence Act*, 39 HARV. J. ON LEGIS. 215, 216 (2002).

[151] Commonwealth v. Cass, 467 N.E.2d 1324, 1328 (1984).

[152] *See e.g.,* Dietrich v. Inhabitants of Northampton, 138 Mass. 14, 17 (1884).

[153] Commonwealth v. Cass, 467 N.E.2d 1324, 1328 (1984).

[154] *Id.*

[155] *Id.* at 1329. A footnote, citing to the U.S. Supreme Court abortion jurisprudence, suggests that the Massachusetts court limited fetal homicide to the killing of viable fetuses in order not to conflict with constitutional protections for abortion. *See* 467 N.E.2d at 1329 n.11.

[156] Other courts rejecting the born alive rule include: Keeler v. Superior Court, 2 Cal. 3d 619, 628 (1970) (rejecting the born alive rule and protecting a fetus under the California murder statute); State v. Horne, 319 S.E.2d 703, 704 (S.C. 1984); Hughes v. State, 868 P. 2d 730, 735 (Okla. Crim. App. 1994); State ex.rel. Angela M.W. v. Kruzicki, 541 N.W.2d 482, 484 (Wis. Ct. App. 1995).

[157] Nat'l Conference of State Legislatures. *Fetal Homicide Laws* (Updated Feb. 2013) http://www.ncsl.org/research/health/fetal-homicide-state-laws.aspx (Accessed on Mar. 4, 2014). ALA. CODE § 13A-6-1 (2009); ALASKA STAT. § 11.41.150 (2009); ARIZ. REV. STAT. ANN. § 13-1102 (2009) (West); ARK. CODE ANN. § 5-1-102(13) (B)(i)(a)-(b) (2009) (LexisNexis); CAL. PENAL CODE § 187(a) (West 2009); COLO. REV. STAT. ANN. § 18-1.3-401(13) (West 2009); FLA. STAT. ANN. § 782.09 (West 2009); GA. CODE ANN. § 16-5-80 (West 2009); IDAHO CODE ANN. § 18-4001 (West 2009); 720 ILL. COMP. STAT. ANN. § 5/9-1.2 (West 2009); IND. CODE ANN. § 35-42-2-1.5 (West 2009); IOWA CODE ANN. § 707.8 (West

these jurisdictions the fetal homicide laws apply to embryos and fetuses in the earliest stages of pregnancy.[158] Some states define homicide as the killing of an embryo or fetus in "any state of gestation," including "conception," "fertilization," and "post-fertilization."[159] Other state legislatures have created a new crime of fetal homicide.[160]

2. The Federal Law: The Unborn Victims of Violence Act

In 2004, Congress passed the Unborn Victims of Violence Act.[161] This statute was the first federal statute imposing a separate criminal penalty for causing the death or injury of a fetus at any stage of development.[162] It provides that one who injures or kills a fetus during the commission of certain enumerated federal crimes is guilty of an offense that is separate from the crime committed against the pregnant woman.[163] Moreover, the federal statute explicitly provides that the killing or injuring of a fetus (both viable and nonviable) is subject to the same punishment as

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2009); KY. REV. STAT. § 507A.010 (West 2009); LA. REV. STAT. ANN. § 14:32.5 (2009); ME. REV. STAT. ANN. tit. 17-A, § 208-C (2009); MD. CODE ANN., Crim. Law § 2-103 (West 2009); MICH. COMP. LAWS ANN. § 750.323 (West 2009); MINN. STAT. ANN. § 609.205 (West 2009); MISS. CODE ANN. § 11-7-13 (West 2009); NEB. REV. STAT. ANN. § 28-388 (West 2009); NEV. REV. STAT. § 200.210 (West 2009); N.D. CENT. CODE ANN. § 12.1-17.1-01 (West 2009); OHIO REV. CODE ANN. § 2901.01 (West 2009); OKLA. STAT. ANN. tit. 21, § 691 (West 2009); 18 PA. CONS. STAT. ANN. § 2603 (West 2009); R.I. GEN. LAWS ANN. § 11-23-5 (West 2009); S.C. CODE ANN. § 16-3-1083 (2009); S.D. CODIFIED LAWS § 22-16-41 (2009); TENN. CODE ANN. § 39-13-214 (West 2009); UTAH CODE ANN. § 76-5-201 (West 2009); VA. CODE ANN. § 18.2-32.2 (West 2009); WASH. REV. CODE ANN. § 9A.32.060 (West 2009); W. VA. CODE ANN. § 61-2-30 (West 2009); WIS. STAT. ANN. § 940.04(2) (West 2009).

[158] Feticide statutes punishing feticide at all stages include: Alabama, Arizona, Georgia, Idaho, Illinois, Kansas, Kentucky, Louisiana, Minnesota, Mississippi, Nebraska, North Carolina, North Dakota, Ohio, Oklahoma, Pennsylvania, South Carolina, South Dakota, Tennessee, Texas, Utah, West Virginia, and Wisconsin. *See Id.*

[159] *Id* (Examples include Alabama, Arizona, Arkansas, Idaho, Illinois, Florida, and Kansas).

[160] *Id* (Examples include Alaska, Colorado, Georgia, Indiana, Iowa, Kentucky, and Louisiana).

[161] Unborn Victims of Violence Act of 2004, Pub. L. No. 108-212, 118 Stat. 568 (codified as amended at 18 U.S.C. § 1841, and 10 U.S.C. §919a (2012)) (also known as Laci and Connor's Law). The statute amends both the United States Code and the Uniform Code of Military Justice.

[162] *See* 18 U.S.C.A. § 1841(d) (defining "unborn child" as "a member of the species homo sapiens, at any stage of development, who is carried in the womb").

[163] The Unborn Victims of Violence Act of 2004, 18 U.S.C.A. § 1841 (West 2014) (Pub. L. No. 108–212—Apr. 1, 2004) (§ 1841 (a)(1) provides that one who injures or kills "an unborn child" is guilty of an offense that is separate from the crime committed against the pregnant woman; § 1841(d) defines the term "unborn child" to mean "'a child in utero' and the term 'child in utero' or 'child, who is in utero' means a member of the species homo sapiens, at any stage of development, who is carried in the womb.").

would be the case if that injury or death had occurred to the fetus's mother.[164] As legal scholar Deborah Tuerkheimer notes, the statute:

> does not create any new crimes or enhanced sentences with respect to pregnant victims of violence, nor does it recognize that the harm of violence may be distinct when experienced by a woman during pregnancy. Rather, the (Unborn Victims of Violence Act) supplements existing law only insofar as it makes fetuses a new class of crime victims.[165]

Curiously, in portions of the statute, the pregnant woman is largely absent from view. For instance, at one point in the statue the pregnant woman upon whom the violence is initiated is referred to as "the unborn child's mother."[166] The woman is "disappeared" by, or made invisible by, the language of the statute.[167] This erasure is irrational, because it could hardly be said that violence that affects the fetus does not affect or harm the pregnant woman.

Despite the erasure of the pregnant woman in portions of the statute, the pregnant woman's behavior is exempted from sanction under the federal statute, which states

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[164] 18 U.S.C.A. § 1841 (2) (A) (West 2014) ("Except as otherwise provided in this paragraph, the punishment for that separate offense is the same as the punishment provided under Federal law for that conduct had that injury or death occurred to the unborn child's mother.").

[165] Deborah Tuerkheimer, *Conceptualizing Violence Against Pregnant Women*, 81 IND. L.J. 667, 696 (2006).

[166] Unborn Victims of Violence Act of 2004, Pub. L. No. 108-212, 118 Stat. 568 (codified as amended at 18 U.S.C. § 1841, and 10 U.S.C. §919a (2012)).

[167] I wonder if this is, at least in part, a function of technology. Ultrasounds, often performed during pregnancy, give the physician and the pregnant women a view of the fetus that is in many ways false. On the computer monitor and on the photo offered to the pregnant woman, the fetus is unconnected to its mother – it is free-floating. Thus the fetus can be visually seen as a singular entity – an autonomous being that can then be imbued with both legal and moral rights. It can then more easily be seem as a being in need of an advocate to protect it from a potential enemy. From the vantage point of the technology, the fetus can be imagined to be a separate person and a separate patient. I surmise that all of this talk of fetal personhood and the fetus as a separate person becomes possible because the technology, by allowing us a peek inside pregnant women's bodies, the technology has allowed our cultural imagination to perceive separateness where many women experience unity. *See, e.g.*, Patricia Williams, *Fetal Fictions: An Exploration of Property Archetypes in Racial and Gendered Contexts*, 42 FLA. L. REV. 81, 92 (1990) (discussing pregnancy as a unitary experience rather than an experience where the woman and fetus are separate beings); Carole Stabile, *Shooting the Mother: Fetal Photography and the Politics of Disappearance*, 28 CAMERA OBSCURA 179, 179–85 (1992); Rosalind Pollack Petchesky, *Fetal Images: The Power of Visual Culture in the Politics of Reproduction*, 13 FEMINIST STUD. 263 (1987) (ability to see the fetus in utero through the use of ultrasound technology has promoted the view of the fetus as a separate individual, and as a separate patient); *see also* Susan Marken, *Feeding the Fetus: On Interrogating the Notion of Maternal-Fetal Conflicts*, 23 FEMINIST STUD. 351 (1997) (arguing that emergence of fetal rights discourse is not solely attributable to technological innovation; it is also a result of anti-abortion rhetoric); LISA M. MITCHELL, BABY'S FIRST PICTURE: ULTRASOUND & THE POLITICS OF FETAL SUBJECTS (2001); JANELLE S. TAYLOR, THE PUBLIC LIFE OF THE FETAL SONOGRAM: TECHNOLOGY, CONSUMPTION & THE POLITICS OF REPRODUCTION (2008).

"[n]othing in [this statute] shall be construed to permit the prosecution . . . of any woman with respect to her unborn child."[168] In this way the federal statute can be understood as protecting the pregnant woman's interest in her fetus, and providing added protection to pregnant women from the harms of third parties.[169] Even so, the federal statute has caused concern among those who advocate on behalf of women because it is premised on the idea of fetal rights and similar statutes at the state level have been used to prosecute pregnant women for prenatal harms.[170] These women's rights advocates are thus concerned that the federal statute will be used to punish pregnant women "for behaviors and conditions that are not criminally sanctioned for other members of society."[171]

Due to some of these concerns, in 2003, Senator Diane Feinstein and Representative Zoe Lofgren introduced the Motherhood Protection Act.[172] Their proposed statute would have enhanced the penalties for certain violent crimes against pregnant women when those crimes resulted in "an interruption in the normal course of their pregnancies."[173] Instead of focusing on the fetus, this proposed statute focused on the harm to pregnant women and pregnant women's interest in their fetuses that are the result of third-party violence.[174] The Motherhood Protection Act was not enacted, but the Unborn Victims of Violence Act became law. Implicit in these Congressional actions is that Congress prefers to focus on fetal life as an independent interest rather than focus on the lives of pregnant women and interests of pregnant women in the lives of their fetuses.

3. State Feticide Statutes –Where the Action Is

As noted earlier, the addition of the fetus as a potential victim in traditional homicide statutes, as well as the creation of new fetal homicide statutes represent a fairly new political and legislative strategy. Nevertheless, as of February of 2013, at least 38 states have fetal homicide laws.[175] Like the federal statute, these state

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[168] 18 U.S.C. § 1841(c) (3). Pregnant women are exempted from prosecution in at least 18 state statutes as well. *See* Nat'l Conference of State Legislatures, *supra* note 157.

[169] Crist, *supra* note 114, at 858.

[170] The National Advocates for Pregnant Women issued a statement which reads:

> The Unborn Victims of Violence Act creates a federal law making it a crime to cause harm to a "child in utero," recognizing everything from a zygote to a fetus as an independent "victim," with legal rights distinct from the woman who has been attacked. More than 30 states already have similar laws on the books. In practice, these laws treat the pregnant woman as little more than collateral damage in an attack portrayed to the public as one directed against the fetus. Moreover, pregnant women in states with such laws are more likely to be punished for behaviors and conditions that are not criminally sanctioned for other members of society.

National Advocates for Pregnant Women, *available at* http://advocatesfor pregnantwomen.org/issues/unborn_victims_of_violence_act.php.

[171] *Id.*

[172] The Motherhood Protection Act of 2003, H.R. 2247, 108th Cong. §1 (2003).

[173] *Id.*

[174] *Id.*

[175] Nat'l Conference of State Legislatures, *supra* 157.

statutes primarily target fetal harm, by constructing and delineating the fetus as the victim,[176] and many explicitly exempt pregnant women from prosecution.[177] Twenty-three of these jurisdictions, however, apply their fetal homicide laws to embryos and fetuses in the earliest stages of pregnancy.[178]

Although these statutes' coverage of both viable and nonviable fetuses may seem inconsistent with constitutional law, given that the Constitution protects women's right to abortion until viability,[179] the inclusion of nonviable fetuses for protection nevertheless can make sense *if* the fact that "abortion is . . . legal indicates that in this area of the law, the interests, choices, and wishes of pregnant women are the overriding concern, rather than any attempt at a consistent definition of 'when life begins."[180] This means that while state feticide statutes could be understood as protecting the interests of pregnant women in the lives of their fetuses instead of protecting the fetus *qua* fetus, often they are not. The difficulty is that prosecutors do not always understand feticide statutes as protecting the interest of pregnant women. Because many of the feticide statutes do not explicitly preclude the operation of the statues when the behavior of the pregnant woman has caused the death of the fetus, many prosecutors construe feticide statutes as requiring the punishment of pregnant women for prenatal behavior that is deleterious to the fetus. In fact, only twelve of the thirty-eight states with fetal homicide laws explicitly preclude the punishment of abortion under the state fetal homicide laws.[181]

In practice, these statutes do little to protect the fetus or pregnant women from harm done by third parties. Nor do these statutes vindicate any interest that the pregnant woman might have in the life of her fetus. Instead, what these statutes do is grant rights to the fetus, create an adversarial relationship between the fetus and the pregnant woman, and criminalize the behavior of the pregnant woman when that behavior is believed to result in miscarriages, stillbirths, or other fetal harm.[182]

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[176] *See* Nat'l Conference of State Legislatures, *supra* note 157.

[177] *Id.*

[178] Feticide statutes punishing feticide at all stages include: Alabama, Arizona, Georgia, Idaho, Illinois, Kansas, Kentucky, Louisiana, Minnesota, Mississippi, Nebraska, North Carolina, North Dakota, Ohio, Oklahoma, Pennsylvania, South Carolina, South Dakota, Tennessee, Texas, Utah, West Virginia, and Wisconsin. *See Id.*

[179] *See, e.g.*, Roe v. Wade, 410 U.S. 113 (1973); Planned Parenthood of SE Pennsylvania v. Casey, 505 U.S. 833, 878 (1992) (permitting state regulations so long as regulation does not have as "its purpose or effect is to place a substantial obstacle in the path of a woman seeking an abortion before the fetus attains viability").

[180] Benjamin Wolf, *New York's Fetal Homicide Law & Legal Abortion – The Common Denominator*, ELIOT SCHLISSEL N.Y. L. BLOG (Apr. 20, 2009), http://schissellaw.wordpress.com/2009/04/20/new-yok-will-soon-classify-killing-a-fetus-at -any-stage-of-gestation-as-homicide/.

[181] Alabama, Alaska, Arkansas, Idaho, Illinois, Indiana, Kentucky, Louisiana, Maine, North Carolina, Oklahoma, and South Carolina. Nat'l Conference of State Legislatures, *supra* note 157.

[182] Another problem here is that while the statutes nominally protect the fetus from the harm of third parties – they miss the bigger point – the protection of women from the harm of third parties, particularly, domestic violence.

Deborah Tuerkheimer makes a similar argument in the context of domestic violence against pregnant women. She states:

> By granting fetuses victim status, the (Unborn Victim of Violence) and similar state laws sever the interests of fetus and pregnant woman, ultimately furthering an agenda of control over women's bodies and lives. Redefining the fetus as a victim – to the exclusion of the pregnant woman – the law obscures the injury that has been inflicted on the woman. It does so in a manner that, by removing her from consideration altogether, effectively precludes an account of the nature of her suffering, or even her existence as a person who has been harmed.[183]

The same can be said in the context of maternal self-harm. When feticide statutes are used to prosecute pregnant women for self-harming behaviors that also harm their fetuses, the law acts in such a way as to obscure the injuries and suffering of pregnant women. The lives of pregnant women become secondary to the life of the fetus. Moreover, the fetal protection narrative works to enforce gender norms via the law, by punishing women who do not comply with the state's construction of the "good" mother. The purported state interest in the fetus seems to preclude actions by the state in support of these pregnant women.

IV. THE IDEOLOGY OF MOTHERHOOD, MATERNAL DEVIANCE DISCOURSES AND THE CRIMINALIZATION OF THE BAD MOTHER

Motherhood is a hegemonic ideology. An ideology is a network of ideas and images that endeavor to explain or justify the status quo; and as such, ideology reflects the preferences of, and operates to serve the interests of, a particular group.[184] A hegemonic ideology, then, is one that reflects the biases of and serves to protect the advantages had by the dominant political or cultural group.[185] Ideology enables dominant groups to justify their control over subordinated groups, "often by making existing order seem inevitable."[186] When considered in these terms, it becomes clear that motherhood is not simply a biological status. Motherhood is an ideology, and in American culture it is one that has been shaped by prevailing patriarchal norms.[187] As a hegemonic ideology, motherhood is reinforced by at least

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[183] Tuerkheimer, *supra* note 165, at 696–97.

[184] JOHN T. JOST, AARON C. KAY & HILDA THORISDOTTIR, SOCIAL & PSYCHOLOGICAL BASES OF IDEOLOGY & SYSTEM JUSTIFICATION 4-5 (2009) (defining the concept of ideology).

[185] JOHN STOREY, CULTURE & POWER IN CULTURAL STUDIES: THE POLITICS OF SIGNIFICATION 6-7 (2010) (discussing the concept of hegemony).

[186] Evelyn Nakano Glenn, *Social Construction of Mothering: A Thematic Overview*, *in* MOTHERING: IDEOLOGY, EXPERIENCE, AND AGENCY 1–29 (Evelyn Nakano Glenn, Grace Change & Linda Rennie Forcey eds., 1994).

[187] Institutions support hegemonic ideologies and motherhood can also be understood as an institution. Emile Durkheim defined a social institution as follows:

> An institution is any structure or mechanism of social order governing the behavior of a set of individuals within a given community; may it be human or a specific animal one. Institutions are identified with a social purpose, transcending individuals and intentions by mediating the rules that govern living behavior.

three core beliefs and expectations: (1) that motherhood for women is normal, natural, and desired; (2) that good mothers are altruistic and intensive, which includes the assumption of primary responsibility for the care of their children; and (3) that the women who put their own needs and desires before those of their children are bad mothers who need to be regulated and controlled.[188] Thus maternal altruism is an essential characteristic of the "good" mother.[189] Indeed, altruism is often viewed as women's defining moral characteristic.[190] In social discourses on motherhood, altruism is an essential characteristic of women, and motherhood is their essential purpose.[191] As mothers, women are expected to be completely self-sacrificing and selfless. The aforementioned cases demonstrate that when pregnant

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See generally Émile DURKHEIM, THE RULES OF SOCIOLOGICAL METHOD, 45 (George E. G. Catlin ed., Sarah A. Solovay & John M. Mueller trans., 8th ed., 1938, 1964). Adrienne Rich is one social commentator that discusses motherhood as a hegemonic institution. *See generally* ADRIENNE RICH, OF WOMAN BORN: MOTHERHOOD AS EXPERIENCE AND INSTITUTION (1976).

[188] *See* ROBERTS, KILLING THE BLACK BODY, *supra* note 9, at 8–21 (detailing how Black women are deemed bad mothers in need of social control).

[189] *See* JANICE G. RAYMOND, WOMEN AS WOMBS 9 (1993). As sociologist Janice Raymond notes:

> For women, gift-giving is a source of identity, status, and relieffrom guilt. Women who don't give time, energy, care, sex . . . are exposed to disapproval or penalty. But the more importantelement here is that on a cultural level women *are expected* todonate themselves in the form of time, energy and body, particularly mothers.

Id.

[190] *See* CAROL GILLIGAN, IN A DIFFERENCE VOICE: PSYCHOLOGICAL THEORY AND WOMEN'S DEVELOPMENT 24–63, 159–60 (1982); *see also* NANCY CHODOROW, THE REPRODUCTION OF MOTHERING: PSYCHOANALYSIS AND THE SOCIOLOGY OF GENDER 178 (1978) (describing "[w]oman's roles [as] basically familial, and concerned with personal, affective ties."); ROSALIND PETCHESKY, ABORTION AND WOMAN'S CHOICE: THE STATE, SEXUALITY, AND REPRODUCTIVE FREEDOM 328 (1994) (explaining the modern definition of motherhood as a "total and selfless devotion to one's biological children"); PATRICE DIQUINZIO, THE IMPOSSIBILITY OF MOTHERHOOD: FEMINISM, INDIVIDUALISM, AND THE PROBLEM OF MOTHERING xiii (1999) (examining the conflicted relationship of feminism and individualism).

For example, according to psychologist Carol Gilligan, the socialization of women and girls focuses on their relationships with others, exercising care and concern for others, and nurturing others. GILLIGAN, *supra* note 190; *see also* Nel Noddings, *Ethics from the Standpoint of Women*, *in* THEORETICAL PERSPECTIVES ON SEXUAL DIFFERENCE 160 (Deborah L. Rhode ed., 1990) (defending the construction of female ethics based on women's traditional role as nurturer).

[191] *See* SUSAN MOLLER OKIN, WOMEN IN WESTERN POLITICAL THOUGHT 238 (1979) (citing psychologist Bruno Bettelheim who asserted that women "'want first and foremost . . . to be mothers.'"). These social norms regarding who women are, and their proper role, have been enforced throughout our nation's history by the power of law. The constitutionality of the denial of women's admission to the bar, and of protective labor legislation for women has been predicated on these social roles and enforced by law. The law has enforced these state sanctioned roles even in the face of one of the primary obligations of citizenship: jury service. Women were initially excluded from jury service and then excused from such service on account of these social norms regarding the altruistic mother. *See*, Cherry, *Roe's Legacy*, *supra* note 3, at 740–44.

women violate these social norms they are often subject to criminal sanction.[192] For those who advance the notion of the propriety of the criminal law in these circumstances, the use of criminal sanctions make sense – one purpose of the criminal law is to safeguard social norms, not to examine them.[193]

A. Motherhood as the Normal, Natural, and Desired Status of Women

A core attribute of the hegemonic ideology of motherhood is that women naturally desire to be mothers.[194] Sociologist Evelyn Nakano Glenn suggests that motherhood may be seen as a normal and expected role for women because it appears unavoidable, a status springing from women's reproductive capacity.[195] These ideas receive support from others in the culture, including scientists, psychologists, and psychoanalysts, who argue that women are called to mother and must do so in order to lead healthy and fulfilling lives.[196] Motherhood is viewed not just as natural and instinctive, but as required – consider, for instance, the "maternal instinct." The notion that women have, or should have, a "maternal instinct" reinforces the belief that all women should be and desire to be mothers.[197] Thus "by depicting motherhood as natural, a patriarchal ideology of mothering locks women into biological reproduction and denies them identities and selfhood outside of mothering."[198] Moreover, not to mother is evidence of failure, or worse, deviance.[199] As Sociologist Martha Gimenez states:

> To be childless becomes synonymous with failure, and those feelings are reinforced by cultural and social pressures which condemn childlessness. The equation of motherhood with self-realization, in conjunction with the lack of desirable [or socially acceptable] alternatives . . . make women's

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[192] *Supra* section I; *see also* Cherry, *Roe's Legacy*, *supra* note 3, at 740.

[193] Thanks to my colleague Patricia J. Falk for this observation.

[194] Glenn, *supra* note 186, at 3.

[195] *Id.*

[196] RICH, *supra* note 187, at 265–66; *see also* ELAINE TYLER MAY, BARREN IN THE PROMISED LAND: CHILDLESS AMERICANS AND PURSUIT OF HAPPINESS 129 (1995); Benjamin Spock, *Should Mothers Work?* LADIES' HOME J., Feb. 1963, *quoted in* Sandra L. Bern & Daryl J. Bem, *Homogenizing the American Woman: The Power of an Unconscious Ideology*, *in* FEMINIST FRAMEWORKS ALTERNATIVE THEORETICAL ACCOUNTS OF RELATIONS BETWEEN WOMEN AND MEN, 10 (Alison Jaggar & Paula Rothenberg eds., 1978).

[197] ANN OAKLEY, WOMAN'S WORK: THE HOUSEWIFE, PAST AND PRESENT 186 (1974); J. SWIGART, THE MYTH OF THE BAD MOTHER: THE EMOTIONAL REALITIES OF MOTHERING 8 (1991).

[198] Glenn, *supra* note 186, at 9.

[199] Martha E. Gimenez, *Feminism, Pronatalism, and Motherhood*, *in* MOTHERING: ESSAYS IN FEMINIST THEORY 287–90, 297 (Joyce Trebilcot ed., 1983) (agreeing with the arguments developed by sociologist Judith Blake). As a corollary, motherhood is often understood as a prerequisite for women's adult status. It is viewed as an indicia of adult status, and a condition for all socially acceptable female adult roles. *See also* Maya Angelou, *Forward*, to DOUBLE STITCH: BLACK WOMEN WRITE ABOUT MOTHERS AND DAUGHTERS, xi-xii (Patricia Bell-Scott, et al., eds 1991); B. WEARING, THE IDEOLOGY OF MOTHERHOOD: A STUDY OF SYDNEY SUBURBAN MOTHERS 72 (1984).

> attainment of reproductive freedom structurally impossible. "Self-determination cannot exist if none of the options is attractive."[200]

Naturalizing motherhood is a way of essentializing motherhood. Because "mother" is an abstract sort of character, individual women, the contexts of their lives, and the contexts in which they actually mother become immaterial. Women as mothers tend to be divided into two groups: the good, altruistic mother, or the bad, selfish mother whose care and concern is not for her children, but only for herself.[201]

B. "Intensive Mothering": Good Mothering is Altruistic and All-Consuming

A second attribute of the hegemonic ideology of motherhood is that good mothers are altruistic, and that good mothering practice is intensive.[202] Although intensive mothering practices began with the advent of the industrial revolution, [203] it was not until the 1960s that "child development researchers 'discovered' maternal bonding" as necessary to the proper development of infants and children.[204] The idea of maternal bonding "was used to argue that the infant need a single caretaking figure, preferably the biological mother, to develop a healthy sense of self and the ability to relate to others."[205] It was argued that in order for children to thrive, mothers need to be physically available at home.[206] Women who worked outside of the home could be seen as deviant, shirking their maternal duties to the detriment of their children.[207] In fact, contemporary proponents of this ideology assert that "less

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[200] Gimenez, *supra* note 199, at 297 (quoting LINDA GORDON, WOMAN'S BODY, WOMAN'S RIGHT 408 (1976)).

[201] *Id.*

[202] *Id.*

[203] *See* ALICE KESSLER-HARRIS, WOMEN HAVE ALWAYS WORKED: AN HISTORICAL OVERVIEW 33–35 (1981). With the nineteenth century industrial revolution came the idealized form of motherhood under the auspices of the cult of domesticity. The role of women ascribed to women was that of the stay at home mother whose primary duty was to birth, rear, and mold her children. *Id.* By the turn of the twentieth century this ideal was well cemented. *Id.*

[204] Glenn, *supra* note 186, at 9–10.

[205] *Id.*

[206] *Id.*

[207] Self-sacrifice is not just a virtue for mothers, it is a condition of good motherhood. The importance of women's physical availability can be seen in the present day hegemonic ideology of motherhood which preferences practices sociologist Sharon Hays has labeled "intensive mothering." *See* SHARON HAYS, THE CULTURAL CONTRADICTIONS OF MOTHERHOOD 4 (1998). According to Hays, intensive mothering is not just a practice, it is an ideology that obliges that each individual mother to be primarily responsible for raising her children. It requires child rearing be "child-centered" and directed by "experts." And finally, it requires that child rearing be time consuming, emotionally absorbing, and expensive. *Id.* at 69. Hays notes that under intensive mothering ideology, mothers are responsible for the health and character of their children from conception through adulthood. *Id.* at 108. In order to meet these responsibilities, the good mother must be self-sacrificing. Indeed, in intensive mothering discourse, the good mother "is not subject to her own needs and interests" D. Bassin, M. Honey, & M.M. Kaplan. *Introduction*, *in* REPRESENTATIONS OF MOTHERHOOD 2 (D. Bassin, M. Honey, & M.M. Kaplan, eds., 1994). "Attachment parenting" is one version of how intensive parenting is performed. A 2012 *Time Magazine* article on attachment parenthood noted:

sensitive and emotionally unavailable parenting" is akin to neglecting the child's needs and may result in mental health problems in children, including depression, anxiety, and eating disorders.[208] Good mothering then, requires maternal altruism. It requires mothers to be physically available to their children in all circumstances; it requires maternal sacrifice.[209]

Maternal altruism is not simply an expectation. It is reified and enforced by prevailing social and legal norms. Under this ideology, pregnant women who engage in self-harming behaviors that result in, or have the potential to result in, fetal harm are viewed as selfish and not selfless in complete opposition to the prototypical "good" mother. One way that this component of the hegemonic motherhood ideology, and hence, control of women's reproductive and maternal behavior, is enforced by shaming.[210] The cultural myth is that if women wanted to be "good

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> While the concept sounds simple, the practicalities of attachment parenting ask a great deal of mothers. The three basic tenets are breast-feeding (sometimes into toddlerhood), co-sleeping (inviting babies into the parental bed or pulling a bassinet alongside it) and "baby wearing," in which infants are literally attached to their mothers via slings. Attachment-parenting dogma also says that every baby's whimper is a plea for help and that no infant should ever be left to cry.

Kate Pickert, *The Man Who Remade Motherhood*, TIME MAG. May 21, 2012.

[208] Pickert, *supra* note 207.

[209] Part of maternal altruism is the willingness of a pregnant woman to sacrifice her life for the life or health of her fetus. The strict anti-abortion policies of Catholic hospitals to refuse abortion or referral for abortion even where the pregnant woman's life is at risk, is an example of the requirement of maternal altruism in practice. *See* U.S. Conf. of Bishops, *Ethical and Religious Directives for Catholic Health Care Services* 26 (5th ed. 2009) *available at* www.usccb.org.

Many physicians believe that by not permitting abortions or abortion referral, these hospitals are neglecting their pregnant patients, constituting medical malpractice. *See* Erik Eckholm, *Bishops Sued Over Anti-Abortion Policies at Catholic Hospitals*, N.Y. TIMES, Dec. 2, 2013, *available at* http://www.nytimes.com/2013/12/03/us/lawsuit-challenges-anti-abortion-policies-at-catholic-hospitals.html?_r=0; Molly M. Ginty, *Treatment Denied*, MS. MAGAZINE, Spring 2011, *available at* http://www.msmagazine.com/spring2011/treatmentdenied.asp (discussing near death incidents of pregnant women at Catholic hospitals); PETCHESKY, *supra* note 190, at 328 (explaining that modern definition of motherhood entails "total and selfless devotion to one's biological children."). Post mortem obstetrical intervention is another example. *See* JANICE G. RAYMOND, WOMEN AS WOMBS 47, 52 (1993) (discussing post-mortem obstetrical interventions).

[210] *See* Miriam Liss, et al., *Maternal Guilt and Shame: The Role of Self-discrepancy and Fear of Negative Evaluation*, 22 J. CHILD & FAM. STUD. 1112, 1116 (2012) ("Mothers who internalize the cultural standards of motherhood (Rizzo et al. 2012), as well as experience shame about their inability to meet those standards. . . . may be particularly prone to depression.") (citations omitted). The article further explains:

> Theorists and researchers have expressed concerns over the high standards for being a perfect mother that have become the dominant discourse for motherhood. . . . Our data suggest that the internalization of these high standards for ideal motherhood and the perception that one does not meet these standards is detrimental to mothers of young children. Internalization of the motherhood myth has been implicated as a source of guilt for mothers . . . and our data confirm this idea and expand it to the feeling of shame. Furthermore, fear of being judged by others exacerbates the impact of feeling

mothers" they could be, if only they made better choices. Concepts like autonomy and choice are used to construct the myth that pregnant women have the power to overcome mental illness, addiction, and despair, without resources and without treatment.[211] The problem is that such a mythos ignores the context in which women mother; it disregards the ways in which social and economic conditions affect behavior and possibilities. Women who deviate from the dictates of hegemonic motherhood, those who make "bad" choices, are constructed as bad mothers and subject to both social regulation through shaming and through legal regulation through fetal rights' mechanisms.[212]

C. Deviancy Discourses: Maternal Deviance and the Pregnant Woman

Pregnant women whose behavior does, or has the potential to, negatively affect their fetuses are often characterized as deviant,[213] and deviant mothers are treated with derision and potentially subject to legal repercussions. Historians Molly Ladd-Taylor and Lauri Umansky have argued that for at least 100 years, "bad" mothers have been categorized in one of three ways: (1) those who mother outside of the "traditional" nuclear family; (2) those who could not protect their children from harm, including harms caused by third parties or by disease; and (3) those who did not mother well – those whose children grew up to be disreputable adults.[214] As Ladd-Taylor and Umansky note:

> that one is not living up to the internalized societal standards of motherhood. Women who have more realistic expectations for what it means to be a good mother may be protected from the potential detrimental effects of guilt and shame. Therefore, adjusting both societal and individual expectations for the standards of motherhood might benefit women's mental health.

Id. at 1117 (citations omitted).

[211] *See* Cherry, *The Detention, Confinement, and Incarceration*, *supra* note 2; Cherry, *Roe's Legacy, supra* note 3; DOROTHY E. ROBERTS, SHATTERED BONDS: THE COLOR OF CHILD WELFARE (2002) [hereinafter ROBERTS, SHATTERED BONDS].

[212] Ann Phoenix & Anne Woollett, *Motherhood: Social Construction, Politics and Psychology*, MOTHERHOOD: MEANINGS, PRACTICES AND IDEOLOGIES 13, 18–19 (Ann Phoenix, Anne Woollett & Eva Lloyd., eds., 1991). The hegemonic ideology of motherhood is also used to limit women's participation in the labor market on equal terms with men and to devalue both women's paid labor and women's affective labor in the home. *See* Natalie J. Sokoloff, *Motherwork and Working Mothers*, FEMINIST FRAMEWORKS: ALTERNATIVE THEORETICAL ACCOUNTS OF RELATIONS BETWEEN WOMEN AND MEN 259–66 (Alison M. Jaggar & Paula S. Rothenberg, eds.,1984); Paula England, *Gender Inequality in Labor Markets: The Role of Motherhood and Segregation*, 12 SOC. POL. 264, 278–80 (2005); Arlene Kaplan Daniels, *Invisible Work*, 34 SOC. PROBS. 403, 405–06 (1987).

[213] MOLLY LADD-TAYLOR & LAURI UMANSKY, "BAD" MOTHERS: THE POLITICS OF BLAME IN TWENTIETH-CENTURY AMERICA. 3–4 (1998). Sociologists understand deviance as behavior that is disapproved of by the larger culture, and as such, is socially constructed. Whether behavior is approved or disapproved – that is whether any behavior is deviant – depends on who is behaving and who is defining the behavior. Thus, deviance must be understood as behavior that is located in a social context.

[214] *Id.*

> Women who did not fit the middle-class family ideal of breadwinning father and stay-at-home mother have born (sic) the brunt of mother-blaming throughout most of American history. Wage-earning mothers, single mothers, slave mothers – in short, everyone except middle-class whites – fall outside the narrow good-mother ideal.[215]

Pregnant women who engage in behavior that may, or is believed to, negatively affect their fetuses, often fall into all three of Ladd-Taylor and Umansky "bad" mother classifications. They are often single, poor, and uneducated and participate in behaviors thought to produce sub-standard children.[216] Moreover, female gender norms are heightened with regard to pregnant women.[217] Pregnant women are expected to be all-sacrificing toward their fetuses.[218] Not only are they are expected to give up their lives for their fetuses, they are expected, after death, to continue their sacrifice. Pregnancy exceptions in living will statutes, which make void the living will of pregnant women, are illustrative of this expectation.[219] Perhaps these statutes

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[215] *Id.* Black mothers have long been held as deviant and dangerous. Dangerous to their own children and dangerous to the culture at large – that is social problems in the Black community, as well as in the larger culture have been blamed on Black mothers. Contemporary stereotypes about Black women as mothers has reinforced the view that Black families are dysfunctional; and that they are so on account of the Black mother who is describing as domineering and lacking maternal instincts. *See, e.g.*, DANIEL P. MOYNIHAN, OFFICE OF POLICY PLANNING & RESEARCH, U.S. DEP'T OF LABOR. THE NEGRO FAMILY: THE CASE FOR NATIONAL ACTION 29–34 (1965). Under this discourse, Black children are viewed in either one of two ways. At times black children are viewed as victims of Black mothers – they are viewed as not receiving any benefit from the care of Black mothers, or as being harmed by it. Indeed, African-American mothers have been found guilty of both neglecting their children and disciplining too harshly, ROBERTS, SHATTERED BONDS, *supra* note 211, at 32–34, and emasculating their sons and defeminizing their daughters. MOYNIHAN, *supra* note 215, at 29–34.

[216] Pamela J. Smith has noted that in American culture, as a result of racism, "Black children are more likely to be deemed mentally retarded, more likely to be deemed seriously emotionally disturbed, more likely to be deemed to have a specific learning disability, and are more likely to be educationally tracked into lower ability groups." *Our Children's Burden: The Many-Headed Hydra of the Educational Disenfranchisement of Black Children*, 42 HOW. L.J., 133, 190 (1998). Smith also notes that the majority of "the tests used to assess whether a child has a disability, are subject to abuse and racial bias." *Id.* (citing Peter Breggin & Ginger Ross Breggin, THE WAR ON CHILDREN 77, 170–71 (1993)). *See also* GOMEZ, *supra* note 49.

[217] LADD-TAYLOR & UMANSKY, *supra* note 213, at 3–4.

[218] *Id.*

[219] Several jurisdictions have living will statutes that make the living will of a pregnant woman void. For example Ohio's pregnancy exception is contained in R.C. § 2133.06(B) which provides:

> Life-sustaining treatment shall not be withheld or withdrawn from a declarant pursuant to a declaration if the declarant is pregnant and if the withholding or withdrawal of life support would terminate the pregnancy, unless the declarant's attending physician and one other physician who has examined the declarant determine, to a reasonable degree of medical certainty and accordance with reasonable medical standards, that the fetus would not be born alive.

serve as proof that as a culture, we do not value women for their own sake.[220] Rather, we value women only to the extent that they serve the needs of others.[221]

Women who are deemed deviant mothers "plac[e] [themselves] outside of female nature and culture"[222] and risk placing themselves outside of the law's protection as the force of law continues to be used to ensure women's compliance with female social norms.[223] It is only when pregnant women make altruistic "choices" on behalf of their fetuses, often notwithstanding social and economic forces, that these choices and women's liberty are certain to be protected by the state.[224] In the alternative,

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OHIO REV. CODE ANN. § 2133.06(B) (West 2014). *See also* Katherine Taylor, *The Pregnancy Exclusions: Respect for Women Requires Repeal*, 14 AMER. J. OF BIOETHICS 50 (2014); Katherine Taylor, *Compelling Pregnancy at Death's Door*, 7 COLUM. J. OF GENDER & L. 85 (1997); Megan Greene & Leslie Wolfe, *Pregnancy Exclusion in State Living Will and Medical Proxy Statutes* (2012), *available at* http://www.centerwomenpolicy.org/programs/health/statepolicy/default.asp.

A November 2013 case in Texas is instructive. Marlise Munoz was declared brain dead. At the time she was 14 weeks pregnant (and hence the fetus was not yet viable) and had previously expressed her desire to have ventilation removed in the case brain death. *Id.* The Texas statute, however, prohibited removal of "life sustaining" treatment from pregnant women on the fetal protection grounds. TEX. HEALTH & SAFETY CODE ANN. § 166.049 (West 2014) ("A person may not withdraw or withhold life-sustaining treatment under this subchapter from a pregnant patient."). Ultimately, in January of 2014, Mrs. Munoz's family was permitted to remove her from life support after a successful federal suit alleging that the Texas statute was unconstitutional because it impinged on women's right to make their own decisions regarding medical treatment and because the statute violated the equal protection clause by treating women differently from men. Judgment, *Munoz v. John Peter Smith Hospital*, No. 096-270080-14, 96th Judicial District, Tarrant County, Texas (Jan. 24, 2014), available at: http://thaddeuspope.com/images/MUNOZ_202053415-Judges-Order-on-Munoz-Matter.pdf. *See also*, Plaintiff's First Amended Motion to Compel Defendants to Remove Marlise Munoz From "Life Sustaining" Measures and Application For Unopposed Expedited Relief; *see also*, Manny Fernandez, *Suing to End Life Support for Woman and Fetus*, N.Y. TIMES, Jan. 15, 2014, A1.

[220] *See e.g.*, Lucinda J. Peach, *From Spiritual Descriptions to Legal Prescriptions: Religious Imagery of Woman as "Fetal Container,"* 10 J. L. & RELIGION 73 (1993); Laura M. Purdy, *Are Pregnant Women Fetal Containers?* 4 BIOETHICS 273 (1990); George J. Annas, *At Law: Pregnant Women as Fetal Containers*, 16 HASTINGS CTR. REP. 13 (Dec. 1986), Stable URL: http://www.jstor.org/stable/3562083. Last Accessed Aug.t 8, 2014.

In THE HANDMAID'S TALE (1985), Margaret Atwood creates a dystopian society in which women are treated merely as both sex slaves and as fetal containers (and thereby offers a critique of our own society). The protagonist, Offred (literally Of "Fred," the name of her owner) understands her objectification—she describes herself not as a concubine or as a slave, but rather as a tool, a 'two legged womb'—just something to be used. *Id.* at 136.

[221] Peach, *supra* note 220, at 73.

[222] Janice G. Raymond, *Reproductive Gifts and Gift Giving: The Altruistic Woman*, *in* LIFE CHOICES: A HASTINGS CENTER INTRODUCTION TO BIOETHICS 395, 399 (Joseph H. Howell & William Frederick Sale eds., 2d ed. 2000).

[223] *See* Marken, *supra* note 167, at 257 (explaining that once women are described as deviant from social norms, they become subject to physician and judicial control).

[224] *See* Cherry, *The Detention, Confinement, and Incarceration*, *supra* note 2.

pregnant women risk punishment via the criminal law. Under this rhetoric, pregnant women whose behaviors harm or potentially harm their fetuses are by definition "bad mothers" – in need of punishment and control.

V. A PARADIGMATIC SHIFT? SHIFTING OUR FOCUS FROM SOCIAL CONTROL AND RETRIBUTION TO SOCIAL JUSTICE

The fetal personhood and maternal deviance discourses that are the integral background principles of fetal homicide statutes also have the purpose and effect of enforcing the gender norms of motherhood. Feticide statutes, particularly those that do not exclude behaviors by pregnant women that might cause fetal harm, accomplish this by first treating the pregnant woman as a mother and next by subjecting her to maternal norms.[225] These statutes tell us that pregnant women are expected to act not just as mothers, but as good mothers; and when they fail, the maternal deviance discourse inherent in these statutes, justifies punishment. As Tuerkheimer notes:

> Although a pregnant woman is not yet a mother (unless she already has a child), she is expected to possess the same characteristics that are associated with idealized motherhood. The paradigmatic woman is selfless, sacrificing, willing, and able to put the interests of her unborn children ahead of her own needs and desires, and fully committed to- and capable of- providing a uterine environment that is nothing short of perfection. Deviation from this archetype threatens social norms; fetal rights provide the justification from punishing any such deviation.[226]

The statutes further enforce gender norms by their focus on fetal harm (as opposed to focusing on the harm done to the pregnant woman) and by making the pregnant woman, and her interests, invisible.[227] Once the acceptance of fetal rights is established in this way, the rights of pregnant women become constricted by the rights of the fetus and these women consequently become the target of state intervention on behalf of the fetus.[228]

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[225] *Id*.

[226] Tuerkheimer, *supra* note 165, at 692–93.

[227] Tuerkheimer has also made similar observations with respect to the recognition of fetal rights in feticide statutes and the enforcement of gender norms. She states:

> Legal recognition of fetal rights can best be understood as a powerful mechanism for enforcing societal notions of maternity and womanhood. . . . As the notion of fetal personhood becomes 'not merely acceptable' but 'increasingly . . . unchallengeable,' fetal protective legislation may now be justified without reference to status-enforcing norms, and even without reference to women.

Tuerkheimer, *supra* note 165, at 687–88 (quoting Reva Siegel, *Reasoning from the Body: A Historical Perspective on Abortion Regulation and Questions of Equal Protection*, 44 STAN. L. REV. 261, 330 (1992)).

[228] For example, at the time of this writing, non-consensual and court ordered obstetrical interventions, detention and confinement of pregnant women, and the criminal prosecution of pregnant women, including those whose behavior is self-harming is occurring all over the country in the name of fetal rights. I am not just worried about some slippery slope. Non-consensual and court ordered obstetrical interventions, detention and confinement of pregnant

Fetal rights, fetal personhood, and maternal deviance are not the only ways to think about pregnant women who engage in risky prenatal behavior. We can instead attend to the issue of self-harming behaviors by pregnant women (and fetal harm) by engaging in a public health model of problem solving. This mode of analysis and problem solving allows us to focus on harm prevention and reduction strategies, and social justice.[229] Harm reduction and prevention strategies work to actually increase the health of pregnant women, and as a result, their fetuses. Social justice is important because it demands that we treat pregnant women as if their own lives were meaningful, rather than treat pregnant women as means to effectuate other social goals.

A. A Promising Shift of Focus: Using Public Health Law Principles to Address Maternal and Fetal Harm

Despite the contemporary rhetoric of fetal personhood, maternal deviance, and our penchant for punitive responses, several jurisdictions have instead opted for a public health response to the self-harming and fetal-harming behavior of pregnant women – specifically when that behavior involves maternal drug use.[230] The Guttmacher Institute reports that as many as twenty-five states have created or funded additional treatment opportunities for pregnant women, or have given priority access to pregnant women, in existing programs.[231] A few jurisdictions have worked to provide pregnant users with additional social services in order to ameliorate any negative effects that drug and alcohol use might have on the developing fetus.[232] The

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women, and the criminal prosecution of pregnant women, including those whose behavior is self-harming is occurring right now – all over the country – all in the name of fetal rights. For accounts s*ee* JEANNE FLAVIN, OUR BODIES, OUR CRIMES: THE POLICING OF WOMEN'S REPRODUCTION IN AMERICA (2009); Cherry, *The Detention, Confinement, and Incarceration*, *supra* note 2; Cherry, *Roe's Legacy*, supra note 3; Tuerkheimer, *supra* note 165, at 694 ("Once fetuses are granted status as persons/children/victims, pregnant women become subject to control by the full panoply of laws already in place to protect the rights of persons/children/victims. Women who fail to conform to the maternal ideal typically, the most marginalized members of society – have been the primary targets of state intervention on behalf of the fetus.").

[229] The idea of "social justice" emanates from a broader theory of justice, and includes access to the public goods necessary for achieving a "good" life. *See*, POWERS & FADEN, *supra* note 12, at 16 (social justice includes concerns for well-being in the "six core dimensions: health, personal security, reasoning, respect, attachment, and self-determination"); Amartya Sen, *Capability and Well-Being*, in WORLD INSTITUTE FOR DEVELOPMENT ECONOMICS RESEARCH (WIDER) OF THE UNITED NATIONS UNIVERSITY, CAPABILITY AND WELL-BEING 30-31 (Martha C. Nussbaum et al. eds.) 1993 ("The functionings relevant for well-being vary from such elementary ones as escaping morbidity and mortality, being adequately nourished, having mobility, etc., to complex ones such as being happy, achieving self-respect, taking part in the life of the community, [and] appearing in public without shame."); NUSSBAUM, *supra* note 12, at 41-42 ("All citizens should have these capabilities . . . life . . . bodily health and integrity . . . bodily integrity . . . senses, imagination [and] thought . . . emotions . . . practical reason . . . affiliation . . . [and] control over one's environment, both political and material.").

[230] Dailard & Nash, *supra* note 79.

[231] *Id.* at 5.

[232] *Id.* (noting that Colorado, Kansas, and California have used this model).

focus of these strategies is largely on the health and well-being of the fetus. The health and well-being of the pregnant woman is secondary; simply instrumental to the health of the fetus.[233] Nevertheless, these public health models seem promising for women. By making treatment or nutritional supplementation available, pregnant women are given the opportunity to improve their own health and thereby increase the possibilities and prospects for their own lives.

Legal scholars have begun to address these issues from a public health approach.[234] Here, too, the focus of the scholarship seems to be primarily on the prevention of fetal harm rather than on the promotion of women's health more generally.[235] While the recent work of public health law scholar Seema Mohapatra challenges this focus, she nevertheless concludes that the ultimate public health concern is fetal health. In her article *Unshackling Addiction: A Public Health Approach to Drug Use During Pregnancy*, Mohapatra argues against the use of the criminal law, and in favor of a public health law approach to the problems caused by pregnant women who use drugs.[236] Mohapatra argues that:

> [p]unishment alone does nothing to further the goal of reducing such drug use. It also ignores the reality that women do not abuse drugs in a vacuum. There are a variety of societal factors, such as poverty, domestic violence, lack of social support and education, related to drug use. Additionally, after a woman is already addicted to drugs, she may not just will herself to stop even if she is pregnant. Women need access to effective treatment options to properly overcome their addictions. Without addressing these societal factors, a criminal model fails in helping the woman or her baby. A public health model is broader in scope and addresses these concerns.[237]

In the end, Mohapatra's analysis suggests two things: that the criminal law may not have a place in solving the problem of prenatal maternal drug use; and, that the focus on prenatal maternal drug use is primarily to address the harm done to the developing fetus.[238]

Mohapatra's primary task is to outline the scope of public health methodologies and to demonstrate how a public health approach would differ from the current use

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[233] *Id.*

[234] *See*, *e.g.*, Mohapatra, *supra* note 4; Linda C. Fentiman, *supra* note 4, at 269–70 (2011); Flavin & Paltrow, *supra* note 4, 237–38 (2010).

[235] Dailard, *supra* note 79.

[236] Mohapatra, *supra* note 4.

[237] *Id.* at 253; *see also* Peter Old & Jonathan Montgomery, *Law, Coercion, and the Public Health*, 304 Brit. Med. J. 891 (1992).

[238] Mohapatra, *supra* note 4, at 254. ("Additionally, the punitive approach is not grounded in science. Legal drugs, such as tobacco and alcohol have been shown to have much greater risk to the fetus than illegal drugs such as cocaine.") (citing Deborah A. Frank, et al., Growth, Development, and Behavior in Early Childhood Following Prenatal Cocaine Exposure, 285 J. AM. MED. ASS'N 1613, 1621–24 (2001).

of the criminal law.[239] Specifically, she addresses how an application of the public health objectives of harm prevention and harm reduction[240] would change our approach to pregnant women who are drug or alcohol dependent.[241] While her analysis has merit, I believe that an even greater shift is necessary. By focusing so exclusively on potential harms to the fetus that result from the pregnant woman's behavior, we risk treating pregnant women merely as channels for fetal life. In other words, I am suggesting that our focus – the public health focus – should be on the health and welfare of the pregnant woman for her own sake rather than viewing her instrumentally – that is, as a vehicle to ensure better fetal health.

The public health framework is especially attractive for thinking about issues confronted by pregnant women because it is both pragmatic and consequentialist.[242] Accordingly, public health frameworks demand the consideration of the socio-economic conditions in which negative and potentially negative health behaviors occur, and judges its success by determining whether the interventions actually create better health outcomes.[243] In other words, social and economic "stratification, social networks and support, discrimination, work demands, and control" are focused upon as a way to increase wellness and produce more positive outcomes among populations, on the belief that "disease and other health outcomes . . . are affected by the social world surrounding us all."[244]

Using a public health policy framework, also demands consideration of the social epidemiologist insight that social context (or "environments") "place constraints on

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[239] Mohapatra, *supra* note 4, at 259–71 (discussing the need for a population-based and evidence-based legal theory, the use of social epidemiology, and the public health values of prevention of harm and harm reduction).

[240] Harm prevention and the reduction of harm are two emphases of field of public health. *See* GOSTIN, *supra* note 12, at 19–20 (2d ed. 2008) (focus of public health is prevention of disease, but prevention and amelioration are not mutually exclusive).

[241] Mohapatra, *supra* note 4, at 264–70.

[242] As a philosophy, pragmatism attempts to assess the truth or meaning of an approach, theory, or belief system, by through the success or failure of its practical application. *See*, Raymond S. Pfeiffer, *American Pragmatism: An Introduction to Classic American Pragmatism*, PHILOSOPHY NOW (July/Aug 2014) https://philosophynow.org/issues/43/An_Introduction_to_Classic_American_Pragmatism. Consequentialist philosophy also looks at the effect of an action or rule to determine its moral or ethical value. Robert M. Veatch, et al., CASE STUDIES IN BIOMEDICAL ETHICS 10–11 (2010); *see also,* James F. Childress et al., *Public Health Ethics: Mapping the Terrain*, 30 J. L. MED. & ETHICS 169 (2002) ("public health activities are generally understood to be teleological (end-oriented) and consequentialist – the health of the public is the primary end that is sought and the primary outcome for measuring success.").

[243] Social epidemiology is a branch of epidemiology which "studies the social distribution and social determinants of states of health." Lisa E. Beckman & Ichiro Kawachi, *A Historical Framework for Social Epidemiology*, *in* SOCIAL EPIDEMIOLOGY 3-12, at 6 (Lisa E. Beckman & Ichiro Kawachi, eds., 2000). As an important component of public health policy, social epidemiology considers the ways in which social conditions or context influence health and healthcare decision-making. *See id.* at 7–8.

[244] *Id.* at 6.

individual choice."[245] Considering context also facilitates social justice because it allows us to more effectively respond to the needs of the community. As a consequence, the public health model can shift attention away from blame and punishment as a response to poor fetal outcomes among self-harming pregnant women, and instead focus attention and efforts on transforming the context that produces the self-harming (and fetal-harming) behavior among pregnant women.

The public health framework thus allows us to consider the values of harm prevention and reduction as a pragmatic way to produce a more useful, and compassionate response to pregnant women who engage in self-harming behaviors. Similarly, it also allows us to consider social justice in our response, including a call to treat pregnant women primarily as an end onto themselves rather than as conduits for healthy fetuses.[246]

B. Harm Reduction and Prevention

Harm reduction and prevention are goal of both the criminal law[247] and public health policy.[248] But for the criminal law, the reduction and prevention of harm are not generally considered the primary mission. Rather, the primary purpose of the criminal law is the punishment of the guilty—retribution or retaliation.[249] Deterrence or prevention of future harm, either by the subject herself, or by others, is a

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[245] *Id.* at 7–8; *See also* Childress, et al., *supra* note 242, at 169 ("social injustice expressed in poverty, racism, and sexism have long been implicated in conditions of poor health.").

[246] Philosopher Immanuel Kant argued that human beings should be treated with dignity and respect. By this he meant that human beings should not be treated as a means to another individual's ends, but rather as their own ends. IMMANUEL KANT, GROUNDWORK OF THE METAPHYSICS OF MORALS §§ 4:412, 4:440 (Mary Gregor ed. & trans., 1998) [hereinafter KANT, GROUNDWORK]; IMMANUEL KANT, GROUNDING FOR THE METAPHYSICS OF MORALS: ON A SUPPOSED RIGHT TO LIE BECAUSE OF PHILANTHROPIC CONCERNS § 436 (James W. Ellington trans., 2d ed. 1983) [hereinafter KANT, ON A SUPPOSED RIGHT TO LIE]. *See also* JAMES RACHELS, THE ELEMENTS OF MORAL PHILOSOPHY 114-124 (1986); Adam Schulman, *Bioethics and the Question of Human Dignity*, *in* HUMAN DIGNITY AND BIOETHICS: ESSAYS COMMISSIONED BY THE PRESIDENT'S COUNCIL ON BIOETHICS, 3, 6, 8, 10-11, 13 (2008) available at https://bioethicsarchive.georgetown.edu/pcbe/reports/human_dignity /human_dignity_and_bioethics.pdf; Jacob Dahl Rendtorff, *Basic Ethical Principles in European Bioethics and Biolaw: Autonomy, Dignity, Integrity, and Vulnerability – Towards a Foundation of Bioethics and Biolaw*, 5 MED. HEALTH CARE & PHIL. 235, 237 (2002) (detailing the components of dignity).

[247] JOEL FEINBERG, HARM TO OTHERS: THE MORAL LIMITS OF CRIMINAL LAW 11 (1984) (prevention of harm to third parties is a legitimate purpose of criminal legislation).

[248] Lawrence O. Gostin, *Mapping the Issues: Public Health, Law and Ethics*, *in* PUBLIC HEALTH LAW & ETHICS: A READER 1, 3–4 (Lawrence O. Gostin, 2ND ED., 2010).

[249] Retribution is the oldest theory of criminal punishment and continues to have substantial support in legal and lay communities. Aaron Xavier Fellmeth, *Civil and Criminal Sanctions in the Constitution and Courts*, 94 GEO. L.J. 1, 19 (2005) (retributive justice for punishment is glorified in American Culture); *But see*, *id*. at 22–23 (popularity of revenge as a motive for criminal punishment); LAFAVE, *supra* note 28, at 26–36 (detailing seven theories of punishment).

secondary consideration.[250] In fact, many cases go so far as to assume deterrence is achieved through punishment without any empirical proof in support.[251] We see these principles in action in the context of pregnant women whose behaviors harm their fetuses. Laws regarding maternal behavior are increasingly punitive in nature, culminating in fetal homicide laws that fail to protect pregnant women from prosecution.[252] At the same time, these punitive measures fail to prevent or reduce fetal harm, the purpose for which they are, at least rhetorically, designed.[253] The number of fetuses and infants exposed to drugs is increasing despite the use of criminal sanctions for drug use during pregnancy.[254] Punishment and fear also can cause harm to pregnant women and their fetuses because it discourages women from accessing needed services.[255] For example, women using drugs or alcohol sometimes lie about their drug use or avoid prenatal medical care altogether for fear of legal sanctions.[256] Some women also forgo needed mental health or other medical treatment for fear of criminal sanctions.[257]

The cases of Bei Bei Shuai, Rennie Gibbs, and Kawana Ashley also demonstrate the criminal law's difficulty in changing the behavior of pregnant women or

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[250] LAFAVE, *supra* note 28 (Prevention as a goal of criminal law is aimed at dissuading "the criminal himself . . . from committing further crimes," while deterrence is aimed at discouraging others from committing future crimes).

[251] This is indeed the situation with regard to punishment of pregnant women. Cherry, *The Detention, Confinement, and Incarceration*, *supra* note 2. Although states have increasingly punished pregnant women for damage done to their fetuses, there is no proof that suicidal ideation, suicide attempts, or drug and alcohol use among pregnant women have decreased. *Id.* Indeed, with respect to illicit drug use, some studies of pregnant women show that use has been relatively stable. *See*, *e.g.*, Behnke & Smith, *supra* note 47. Substance abuse treatment admissions for pregnant women have also been stable. Substance Abuse and Mental Health Services Administration (SAMHSA), *Trends in Substance Abuse among Pregnant Women and Women of Childbearing Age in Treatment* (July 25, 2013), http://www.samhsa.gov/data/spotlight/spot110-trends-pregnant-women-2013.pdf (proportion of pregnant women entering substance abuse treatment relatively stable between 2000 and 2010).

[252] *See supra*, section II (discussion regarding fetal personhood or fetal homicide laws).

[253] The American College of Obstetricians and Gynecologists has recognized that even though "legal action against women who abuse drugs prenatally is taken with the intent to produce healthy birth outcomes, negative results are frequently cited." Comm. on Health Care for Underserved Women, Am. Col. of Obstetricians and Gynecologists, Committee Opinion No. 473, *Substance Abuse Reporting and Pregnancy: The Role of the Obstetrician-Gynecologists* (2001; reaffirmed 2014). *See also*, Fentiman, *supra* note 4, at 239.

[254] Mohapatra, *supra* note 4, at 264 (citing Fentiman, *supra* note 4, at 239).

[255] Fentiman, *supra* note 4.

[256] For example, Lester, et al., noted that women avoided prenatal care for fear that their children would be removed for their care on account of their substance use. Lester et al., *supra* note 4.

[257] *See*, Sally Kohn, *Indiana 'Feticide' Charge is the Latest Fallout from States' Strict Anti-bortion Laws*, DAILY BEAST (August 27, 2014) http://www.thedailybeast.com/articles/2014/08/27/indiana-feticide-charge-is-the-latest-fallout-from-states-strict-anti-abortion-laws.html.

protecting their fetuses from prenatal harm.[258] These cases demonstrate that the criminal law can only punish the outcome of the potentially deleterious behavior of pregnant women. The criminal law has not been, or perhaps cannot be, effectively used to combat the problem of fetal harm for two reasons. First, it does not take into account the context in which the harm occurs. Understanding the context is crucial for harm reduction and prevention, for misunderstood needs cannot be met. Second, the criminal law presumes that the simple presence of criminal sanctions will prevent or ameliorate harm. This has proven not to be the case.[259] Ultimately, these shortcomings in the criminal law signify that the criminal law cannot effectively achieve the goals of harm reduction and prevention.

Conversely, a public health paradigm focuses primarily on the question of what strategies will actually prevent the harm from occurring or reduce the potential for harm. In order to make that assessment, public health policymakers cannot only look at the resulting harm – the consequence of any behavior – they must likewise consider the context (or social environments) in which the harm occurs. Looking at the context is what permits the formulation of workable, practical, and pragmatic solutions.

Mohapatra's analysis makes this suggestion by looking at harm prevention strategies for prenatal drug and alcohol exposure.[260] When looking at the context in which prenatal drug and alcohol exposure occurs, Mohapatra cites poverty, lack of education, and the lack of mentoring programs that might offer social support to women in need.[261] She suggests early education and mentoring as a key component of a public health prevention program, including drug and alcohol prevention education, education about the criminal consequences of illicit drug use, and mentoring programs for high-risk populations.[262] Mohapatra notes that early education (during middle and high school years) is essential because it gives young women information regarding the effects of drug and alcohol use on the human fetus before they get pregnant.[263] Conversely, education provided during the prenatal period is of little use for prevention as pregnant drug and alcohol users often do not receive prenatal care, and harm to the fetus may have occurred before the woman receives the information, and where pregnant women are drug or alcohol addicted,[264] they may be unable to simply stop their use in light of the information.[265] By focusing on prevention education, "the hope is that fewer individuals begin to use

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[258] *Supra* section I.

[259] *See supra* note 251.

[260] Mohapatra, *supra* note 4.

[261] *Id.* at 264–65.

[262] *Id.* at 265.

[263] *Id.* at 266; *see also* Schroedel & Fiber, *supra* note 4 at 224; Lester et al., *supra* note 4.

[264] Mohapatra, *supra* note 4, at 266.

[265] McLellan, *supra* note 55, at 1689 (treatment entails the implementation of long-term strategies of management and monitoring); Weber, *supra* note 55, at 638–39 (showing that a majority of medical the community considers addiction a disease of the brain that requires treatment for improvement of symptoms).

drugs and therefore, fewer need to face the criminal justice system."[266] Mohapatra's suggestions seem helpful because there is a close relationship between the proposals and the harms she identifies – primarily harm to the fetus. But her suggestions do not address harm prevention and reduction strategies directed toward harms to the woman herself.

Similarly, with regard to harm reduction, in public health approaches, the focus is principally on fetal health.[267] For example, Mohapatra defines her "public health approach to drug use during pregnancy . . . refers to reacting to the problem (drug use) once it has occurred and trying to minimize the effects as much as possible."[268] Harm reduction for Mohapatra and others,[269] is twofold. It consists of social support and family friendly drug treatment programs for pregnant users instead of criminal sanctions,[270] and the "availability of appropriate and comprehensive drug treatment."[271] Social supports include halting the removal of newborns and other children on account of maternal drug and alcohol use absent other evidence of abuse or neglect,[272] and nutritional support for pregnant women.[273] By discontinuing child removal policies, the state can encourage pregnant women who use drugs or alcohol to obtain prenatal treatment and to be more honest with their health care providers so providers can offer appropriate care. Nutritional support as a harm reduction measure should also be effective, as studies indicate that an improved nutrition status of a pregnant woman improves the health status of the fetus.[274] Finally, by making appropriate and comprehensive treatment available, the state increases the chances that the treatment will be effective.[275] While all of these recommendations are laudable, my concern is twofold. First I am concerned that at the core of these

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[266] Mohapatra, *supra* note 4, at 265.

[267] *Id.*

[268] *Id.* at 266; *see al*so Steverson & Rieckman, *supra* note 61, at 317 (arguing that availability of drug and alcohol treatment programs to pregnant and mothering women is necessary in order to protect children from prenatal drug and alcohol exposure).

[269] *See, e.g*., Dailard & Nash, *supra* note 79; Lester et al., *supra* note 4; Schroedel & Fiber, *supra* note 4.

[270] *See* Mohapatra, *supra* note 4, at 267 (citing David C. Brody & Heidee McMillian, *Combating Fetal Substance Abuse and Governmental Foolhardiness Through Collaborative Linkages, Therapeutic Jurisprudence and Common Sense: Helping Women Help Themselves*, 12 HASTINGS WOMEN'S L.J. 243, 266 (2001).

[271] Mohapatra, *supra* note 4, at 267.

[272] *See* Mohapatra, *supra* note 4, at 267 (citing David C. Brody & Heidee McMillian, *Combating Fetal Substance Abuse and Governmental Foolhardiness Through Collaborative Linages, Therapeutic Jurisprudence and Common Sense: Helping Women Help Themselves*, 12 HASTINGS WOMEN'S L.J. 243, 266 (2001); Lester et al., *supra* note 4.

[273] *See* Mohapatra, *supra* note 4, at 268–69.

[274] *Id.* at 268.

[275] For example, studies indicate that drug and alcohol treatment programs aimed at the needs of women, particularly women-only programs, are more likely to be effective than mixed-gender programs. National Abandoned Infants Assistance Resource Center, *Fact Sheet: Prenatal Substance Exposure* 8-10 (March 2012) (Available at http://aia.berkeley.edu). *See also*, Mohapatra, *supra* note 4, at 267; Steverson & Rieckman, *supra* note 61, at 316.

suggestions is the belief that *fetal* harm reduction through drug treatment is possible even though the scientific evidence on fetal harm is, in many cases, inconclusive.[276] My second concern is that while all of the foregoing strategies are important in order to decrease fetal harm, we should also be mindful that strategies need to, first and foremost, reduce or prevent harm to the pregnant woman herself. Without such an inquiry, we risk obscuring the importance of women as women, and risk treating women without the dignity and respect they are owed as human beings because we continue to treat pregnant women primarily as fetal containers.

C. Social Justice

Public health law and policy scholar Lawrence Gostin has written that "[t]he prime objective of public health law is to pursue the highest level of physical and mental health in the population, consistent with the values of social justice."[277] As such, the value of social justice – directing our attention to the deprivations of the most disadvantaged in society – is a critical element of a public health analysis and has been described as one of the core values of public health law and policy.[278] Social justice is important in the context of public health, because without this value, the needs of the most vulnerable would be neglected, resulting in the destruction of public trust and social cohesion. Gostin argues:

> Neglecting the needs of the vulnerable predictably harms the whole community by eroding public trust and undermining social cohesion. It signals to those affected and to everyone else that the basic human needs of some matter less than those of others, and thereby it fails to show the respect due to all members of the community. Social justice thus not only encompasses a core commitment to fair distribution of resources, but also calls for policies of action that are consistent with the preservation of human dignity and showing of equal respect for the interests of all members of the community.[279]

Accordingly, the social justice mission of public health is not solely for the benefit of the disadvantaged; rather, it benefits the entire community. Moreover, social justice is not solely a consideration of how social groups are treated, it also entails a consideration of how individuals (as members of social groups) are treated. Thus, social justice requires that individuals as well as social groups be treated with dignity and respect.[280] As a consequence, social justice in the public health context requires us both "to engage in systematic action to ensure the conditions for improved health for all members of the populations," and to "identify[] and

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[276] *See* discussion *supra* pp.11–12.

[277] GOSTIN, *supra* note 12, at 4.

[278] *Id*. at 21–22.

[279] *Id*. at 23.

[280] *See* Marc J. Roberts & Michael R. Reich, *Ethical Analysis in Public Health*, 359 LANCET 1055, 1056 (2002); Childress et al., *supra* note 242, at 170.

ameliorat[e] patterns of systematic disadvantage that profoundly and pervasively undermine the prospects for well-being of oppressed and subordinated groups."[281]

1. Access to Resources

Social justice in the context of public health requires that policymakers look at the context, or environment in which harm occurs.[282] Context allows policymakers to determine which populations are subject to systemic hardships and what response would work to ameliorate these hardships. Amelioration often involves the resources of state actors.[283] Thus, social justice also requires an active state – one that has a duty to ensure the access to the resources needed for good health for the right to good health is meaningless without access to sufficient resources.[284] Access to

[281] GOSTIN, *supra* note 12, at 22. Gostin argues that in the context of public health, social justice is a form of distributive justice – requiring the state "to act to limit the extent to which the burden of disease falls unfairly upon the least advantaged and to ensure that the burden of the interventions themselves is distributed equitably. Distributive justice also requires fair allocation of public health benefits."). *Id.*

[282] In this way social justice may be congruent with the aims and approach of "reproductive justice." Reproductive justice as an ethic and as a movement, developed by women of color involved in social justice and women's health care movements. It is designed to look at the social context in which reproductive health is created and maintained. *See* REPRODUCTIVE JUSTICE BRIEFING BOOK: A PRIMER ON REPRODUCTIVE JUSTICE AND SOCIAL CHANGE (available athttp://protectchoice.org/downloads/Reproductive%20Justice%20Briefing%20Book.pdf); *see also* Kimala Price, *What Is Reproductive Justice? How Women of Color Activists Are Redefining the Pro-Choice Paradigm*, 10 MERIDIANS, 42 (2010) (describing the history and content of the reproductive justice movement); Sarah London, *Reproductive Justice: Developing a Lawyering Model*, 13 BERKELEY J. AFRICAN-AMERICAN L. & POL'Y 71 (2011) (describing the history and content of the reproductive justice movement as well as lawyering strategies); Zakiya Luna & Kristen Luker, *Reproductive Justice*, 9 ANN. REV. L. & SOC. SCI. 327 (2013) (highlighting the intertwining histories of the reproductive health, reproductive rights, and reproductive justice movements, and the relationships between scholarship and activism in these areas); Zakiya Luna, *From Rights to Justice: Women of Color Changing the Face of US Reproductive Rights Organizing*, 4 SOCIETIES WITHOUT BORDERS 343 (2009) (reproductive justice integrates a human rights analysis into domestic reproductive rights law and policy).

[283] Loretta Ross, *What is Reproductive Justice?*, *in* REPRODUCTIVE JUSTICE BRIEFING BOOK: A PRIMER ON REPRODUCTIVE JUSTICE AND SOCIAL CHANGE 4, 4 (available at http://protectchoice.org/downloads/Reproductive%20Justice%20Briefing%20Book.pdf).

[284] Roberts & Reich, *Ethical Analysis in Public Health*, *supra* note 280, at 1056–57. Roberts and Reich note that public health includes a more political or civic component as well. They note "that a minimum level of health is necessary for people to have a reasonable range of opportunity when they make life choices. In this view, health is a component of each citizen's opportunity – like such basic liberties as free speech and political participation."). *Id.* at 1057. Loretta Ross, one of the reproductive justice movement's founders argues that reproductive justice also requires positive state action on behalf of those with the fewest choices and opportunities. She notes that at its core, the reproductive justice framework:

> addresses the social reality of inequality, specifically, the inequality of opportunities that we have to control our reproductive destiny. Moving beyond a demand for privacy and respect for individual decision making to include the social supports necessary for our individual decisions to be optimally realized, this framework also includes obligations from our government for protecting women's human rights.

resources requires that we look at the context in which the harm occurs (i.e. poverty, racism, systemic deprivation) in order to determine what resources are necessary to improve conditions and abate the harm. Pregnant women who are depressed and suicidal, who are addicted to drugs and alcohol, and those who lack the resources to procure a legal abortion, like Ms. Shuai, Ms. Gibbs, and Ms. Ashley, are among the most vulnerable in American society. Not only are they female, and hence subject to a culture that devalues them as women and demonizes them as bad mothers,[285] but they also are often poor and undereducated, and as a result, have few social resources available to them.[286] When we consider the context in which the harms arise, it is evident that these women are part of a population that is subject to multiple patterns of systematic disadvantage, and that their health might be considerably improved if they had access to additional public resources.

As noted previously, in their assessments of public health strategies for pregnant women who are drug or alcohol addicted, many scholars have suggested that early drug and alcohol education, access to drug and alcohol treatment, and nutritional supplementation are approaches that could potentially enhance fetal outcomes.[287] Each of these approaches also provides access to resources for women to improve their own health. Similar resources can be brought to bear for women who are depressed and suicidal. Like alcohol and drug abuse, depression is a chronic illness that benefits from medical treatment. Making psychological and medical treatment more available to pregnant women would help in improving the health and well-being of pregnant women (and in turn, their fetuses). Finally, better access to contraception and abortion resources for all women as a positive right, regardless of socio-economic status and age,[288] would help to stem the problems of self-induced

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Loretta Ross, *What is Reproductive Justice? in* REPRODUCTIVE JUSTICE BRIEFING BOOK: A PRIMER ON REPRODUCTIVE JUSTICE AND SOCIAL CHANGE 4, 4 (available at http://protectchoice.org/downloads/Reproductive%20Justice%20Briefing%20Book.pdf).

[285] *See* discussion *supra* section II.

[286] *See*, Rebecca Joyce Kissane, et al., *Social Ties, Social Support, and Collective Efficacy among Families from Public Housing in Chicago and Baltimore*, J. OF SOCIOLOGY AND SOC. WELFARE 157, 159 (2012) ("neighborhood disadvantage results in individual disadvantage, as residents of high-poverty neighborhoods are socially isolated from the mainstream world of educational and job opportunities").

[287] See discussion *supra* p. 62.

[288] Under current privacy jurisprudence, the rights to contraception and abortion are construed as negative rights, thus solely limiting state interference. As Robin West notes:

> The constitutional preference for negative over positive liberty is captured by the oft-made claim that the Constitution itself is a negative one. The Constitution, it is said, protects our negative rights to be free from intrusion instead of our positive rights to a positively free, active, involved, civic, or healthy existence. The Constitution at least according to its modern interpreters, is a shield of protection; it is not a sword of entitlement.

Robin West, *Reconstructing Liberty*, 59 TENN. L. REV. 441, 448 (1992).

A positive right would require state intervention in order to ensure access to these services. Recent developments in the law, including The Patient Protection and Affordable Care Act of 2010 (often referred to as the "Affordable Care Act" or "Obamacare"), with its contraceptive mandate, moves toward viewing access to family planning services as a positive

abortion and illegal abortion, both of which endanger the lives of women.[289] This would entail substantive legislation, such as overturning the Hyde Amendment[290] – so as to permit the use of federal funds for abortions for poor women who want them; and enacting legislation to ensure access to contraception to all women of childbearing age, possibly through Medicaid, Title X programs,[291] and private insurance.

In order to safeguard social justice for women who engage in behaviors while pregnant that may pose risks to their fetuses, we need to consider what resources these women need to ensure better health outcomes for themselves. Safeguarding the health of women necessarily results in safeguarding the health of fetuses. By putting the health needs of women first, fetuses will also benefit. However, this is not the end of the social justice inquiry because social justice also requires treating both individuals and communities with dignity and respect.

2. Dignity and Social Justice

The social justice potential of public health policy is that, at the end of the day, the dignity of the community and the individual will be respected and indeed, promoted. To approach the social justice aspect of public health policy, policymakers must determine what populations are most vulnerable in society and at the greatest risk for poor health. They must also evaluate how those vulnerabilities can be reduced or prevented, and how to do so in a fair and respectful manner. [292] If

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right. Patient Protection & Affordable Care Act (PPACA), Pub. L. No. 111-148, 124 Stat. 119 (2010); *see also* Press Release, Kathleen Sebelius, Sec'y, U.S. Dep't of Health & Human Servs. (Jan. 20, 2012), *available at* http://www.hhs.gov/news/press/2012pres/01/20120120a.html (explaining contraception mandate).

[289] *See* text *supra* at p. 23.

[290] Beginning in 1976, Congress passed a number of versions of the "Hyde Amendment." These amendments to the Social Security Act prohibited the use of federal funds for the reimbursement of the costs of non-medically necessary abortions and strictly limit the use of federal funds for the reimbursement of the costs of medically necessary abortions under the Medicaid program. Pub.L. 96-123, § 109, 93 Stat. 926; see also Harris v. McRae, 448 U.S. 297, note 2 (1980); Maher v. Roe, 432 U.S. 464, 466 (1977).

[291] Title X of the Social Security Act includes funding for family planning. The purpose of Title X is to ensure "access to a broad range of family planning and related preventive health services for millions of low-income or uninsured individuals and others" through low cost family planning clinics. Title X Family Planning, http://www.hhs.gov/opa/title-x-family-planning/.

[292] *See* GOSTIN, *supra* note 12, at 11; Lawrence O. Gostin, *Public Health Law in a New Century: Part I: Law as a Tool to Advance the Community's Health*, 283 J. AM. MED. ASS'N 2837, 2840 (2000). There may sometimes be a conflict between the state's duty to prevent harm and the individual's right to autonomy and liberty. In those cases, Gostin suggests that public health law requires that certain questions be asked:

> Does the coercive intervention truly reduce aggregate health risks, and what, if any, less intrusive interventions might reduce those risks as well or better? Respect for the rights of individuals and fairness toward groups of all races, religions, and cultures remain at the heart of public interest law.

GOSTIN, *supra* note 12, at 12.

social justice means anything, it means that the dignity of the individual and of communities are to be respected. In the context of public health, dignity and respect is Kantian.[293] This means that individuals and groups are to be treated as an end in themselves and not as a means to the ends of others.[294] Dignity means that individual autonomy is respected,[295] and modern notions of autonomy require "freedom from coercion, manipulation, and temporary distortion of judgment," and the availability of "an adequate set of options."[296]

In the public health realm, this value is often expressed in the pragmatic preference of permitting access to health care measures on a voluntary basis, rather than enforcing health through the coercive action of the state.[297] As British public health scholars Peter Old and Jonathan Montgomery argue, "enforcing social responsibility through the threat of punishment is . . . probably counterproductive. It alienates those with disease and discourages them from seeking medical help. Effective disease control must depend primarily on working with those who are infected, not characterising them as the enemy."[298]

Consequently, in the instant case, the value of dignity should be articulated by voluntariness, offering assistance and access to resources on a non-compulsory basis, not through the coercion of the criminal law. Dignity also requires that we treat pregnant women as individuals first, instead of defaulting to concerns about fetal

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[293] *See,* KANT, GROUNDWORK, *supra* note 246; KANT, ON A SUPPOSED RIGHT TO LIE, *supra* note 246.

[294] Roberts & Reich, *supra* note 306, at 1056; RACHELS, *supra* note 246, at114–24.

[295] Autonomy, which includes notions of choice, which I define here as the right to assert one's own interest without abuse and exploitation from others. Choice, defined in this manner, is central to dignity and respect. *See* Old & Montgomery, *supra* note 237, at 892 (underlying assumption in public health law is that "individuals are best placed to judge their own interests.").

Under these liberal conceptions of autonomy, found in public health, bioethics, and liberalism scholarship, autonomy is "self-defining, self-interested, and self-protecting," and any interference in an individual's autonomy must be justified, if it can be justified, by extreme circumstances. SUSAN SHERWIN, THE POLITICS OF WOMEN'S HEALTH: EXPLORING AGENCY AND AUTONOMY 34, 22 (1998) (autonomy is "a fundamental moral precept for health care."). The right to refuse medical treatment is a right based on the notion that the autonomy of an individual, including to make decisions that might harm him, can be outweighed only by four countervailing state interests: (1) the preservation of life, (2) the prevention of suicide, (3) the ethical integrity of the medical profession, and (4) the protection of innocent third parties. *See, e.g.*, In re Fetus of Brown, 689 N.E.2d 397, 402 (Ill. 1997).

[296] Richard H. Fallon, Jr., *Two Senses of Autonomy*, 46 STAN. L. REV. 875, 877 (1994) (citations omitted); *see also* JOSEPH RAZ, THE MORALITY OF FREEDOM 373–77 (1986).

[297] GOSTIN, *supra* note 12, at 113 (Although the state has the power to coerce behavior in the name of public health (to protect the community interest in health), the state's power to coerce is limited by the individual's right to autonomy, liberty, and other constitutionally protected rights and interests. *See* Gostin, *supra* note 292, at 2840. Gostin also argues that coercion is constitutionally permissible only where five conditions are met: public health necessity, reasonable means, proportionality, harm avoidance, and fairness. GOSTIN, *supra* note 12, at 126–28.

[298] Old & Montgomery, *supra* note 237, at 891.

welfare. If we rely too heavily on fetal welfare concerns, we risk treating pregnant women solely as a means to fetal health and, thus not with dignity.

VI. CONCLUSION

I began this essay by setting forth examples of women who are depressed, suicidal, drug addicted and simply desperate, and who consequently engaged in behavior that caused harm to their fetuses. These examples are illustrative of the fact that pregnant women who engage in behaviors that harm their fetuses are not animated by malice. Rather, these behaviors are the result of illness, desperation, the lack of social safety nets, health care, and economic resources. Many argue in favor of imposing criminal law sanctions in these cases. The substance of their argument is that the fetus has an interest that must be vindicated by the criminal law. Beneath this principle, hegemonic notions of women in general, pregnant women, and women of color in particular, motivate the arguments. Hegemonic motherhood is white, middle class, and requires altruism. Women who are sanctioned for prenatal behavior that harms their fetuses are often non-white,[299] poor,[300] and through their self-harming behaviors (suicidal, drug using, desperate) are not acting in an altruistic manner. In short, they are seen as "bad mothers" and are, therefore properly subject to sanctions by the community, including criminal punishment.

Others argue that where prenatal maternal behavior has harmed the fetus, criminal sanctions are inappropriate and counterproductive. These scholars suggest that the problem should not be individualized, as it is in the criminal law, but should instead be viewed through a public health lens. Public health frameworks are useful for many reasons, including the ability to consider the social environment that produces the health problem. Additionally, they are pragmatic in that they look for a solution to the problem in terms of harm prevention and reduction. These frameworks are useful because they look to achieve justice for both individuals and communities. In the case of prenatal maternal behavior, a public health approach allows a solution to be fashioned that takes into account pregnant women's social location and the effects of poverty, discrimination, violence, need, and despair. The public health framework, as it has been envisioned, turns away from a retributive solution, instead focusing on preventing and abating fetal harm.

Finally, the public health framework tries to ensure some measure of social justice. Social justice is difficult to achieve where there are social factors outside of the pregnant woman's control for which she is held responsible. By looking at the social environment, the public health framework allows us to reduce our emphasis on individual personal responsibility, and focus more appropriately on changing the conditions in which the harm occurs.

While there is much to commend in a public health approach, I have nevertheless argued that scholars suggesting it have mistakenly focused on the wrong actor. In this essay I have argued that the focus of the public health inquiry should be on the woman, not the fetus. The proper vantage point from which to view the problem of prenatal fetal harm is actually the harm experienced by the pregnant woman, rather than any injury experienced by the fetus. In essence, I am arguing that any fetal harm

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[299] *See* Paltrow & Flavin, *supra* note 36, at 311 (finding that 52% of arrests and interventions were of Black women; 41% of the women were white).

[300] *See id.* (finding that 71% of pregnant women subject to forced intervention or arrest were represented by indigent defense counsel).

that has occurred has only occurred because the pregnant woman has herself been harmed, even when the harm has been self-inflicted. As a result, it is only by focusing on the social needs of women that fetuses such as the ones mentioned in the aforementioned cases will have a better chance of good health.

Moreover, securing the social justice promise of public health is only possible if the pregnant woman and her interests are primary. When we give the fetus a legally cognizable interest and make those interests primary, we do a grave injustice to the dignity of the pregnant woman. Fetal rights rhetoric in this context does not help prevent harm to the fetus. All the rhetoric does is make the pregnant woman's pain invisible. It tells us that women are primarily incubators for the fetus and that women are merely instrumental in fetal health. My hope is that using a public health framework will lead to an approach that prevents women from being objectified in this manner, while recognizing their dignity, and giving them the social resources they need to lead healthier lives.