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PRENATAL SUBSTANCE ABUSE: A CALL FOR LEGISLATIVE ACTION IN MARYLAND

I. INTRODUCTION

The alarming increase in chemical substance abuse in recent history has left no segment of the population untouched. Even the unborn are affected. In 1988, at least one thousand babies a day were born to women who used illegal drugs during pregnancy.[1] The future costs, both economic and emotional, of caring for these damaged children will be significant, particularly because the problem is increasing.[2] Unfortunately, the status of the fetus as a legal entity that may be legally shielded from the untoward effects of drug and alcohol abuse is questionable.

This Comment first reviews the medical effects of prenatal substance abuse and related social issues. Second, this Comment outlines the relevant legal implications, including constitutional considerations and various state treatments of the problem. Third, it discusses the current status of Maryland law in this arena. Fourth, it critiques and analyzes various approaches. Finally, it offers possible alternatives to the Maryland approach.

II. MEDICAL AND SOCIAL ISSUES

Exact statistics on the number of infants exposed to drugs in utero are lacking.[3] A major difficulty in obtaining this statistical data is the lack of uniformity in testing and screening for prenatal substance abuse.[4] Many hospitals have no formal procedures for prenatal substance abuse screening.[5] As a result, there is significant undercounting in any numbers that have been compiled.[6] Research indicates that when screening and testing are uniformly applied, a much higher incidence of drug-exposed infants are identified.[7] In one study, hos-

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1. Michelle D. Wilkins, Comment, *Solving the Problem of Prenatal Substance Abuse: An Analysis of Punitive and Rehabilitative Approaches*, 39 EMORY L.J. 1401, 1401 (1990).
2. *Id.*
3. DRUG EXPOSED INFANTS: A GENERATION AT RISK, REPORT TO THE CHAIRMAN, SENATE COMMITTEE ON FINANCE, U.S. SENATE, 4 (U.S. General Accounting Office ed., 1990) [hereinafter GAO REPORT].
4. *Id.*
5. *Id.* at 5.
6. *Id.* at 4.
7. *Id.*

pitals with rigorous detection procedures designed to identify maternal drug exposure had an incidence rate three to five times greater than that of hospitals without such screening procedures.[8] Detecting maternal drug exposure is further complicated by the apparent bias in testing.[9] While much of the public's attention has focused upon the "crack cocaine" problems of poor inner city women, evidence from blind studies suggests that the problem of prenatal drug use may be similar to that of middle class America.[10]

Although exact numbers are difficult to obtain, estimates indicate that drug abuse in its many forms is a significant public health problem. The National Institute on Drug Abuse (NIDA) estimates that "in 1988, five million women of childbearing age used illicit drugs."[11] The greatest increase in drug use since the 1970s has been among young adults of child-bearing age who use cocaine.[12] Experts attribute this increase to the ready availability and low cost of crack cocaine.[13] As a result, "cocaine babies" now comprise 10-15% of the populations of urban neonatal nurseries and intensive care units in major cities within the United States.[14]

Unfortunately, this 10-15% figure does not represent the entire universe of prenatal drug exposure. Maternal prenatal ingestion of alcohol, cigarettes, methadone, heroin, and other legal and street drugs significantly contributes to this epidemic of "fetal abuse."[15] Fetal alcohol syndrome is now the leading known cause of mental retardation and birth defects.[16] Cigarette smoking is estimated to account for 20-40% of the prevalence of below normal birth weight babies.[17] Maternal heroin and methadone addiction, among other

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8. *Id.*
9. *See* Ira J. Chasnoff et al., *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, 1205-06 (1990).
10. *Id.* at 1205. Some researchers studying prenatal drug use state the following: "First, the overall prevalence of drug or alcohol use . . . was similar among women who received care from private physicians and those cared for at public health clinics. Second, the rate of substance use by pregnant women, as documented at the first prenatal visit, was similar for whites and blacks." *Id.*
11. GAO REPORT, *supra* note 3, at 1.
12. Lynn Singer et al., *Childhood Medical and Behavioral Consequences of Maternal Cocaine Use*, 17 J. PEDIATRIC PSYCHOL. 389, 390 (1992).
13. GAO REPORT, *supra* note 3, at 1.
14. *See* Singer et al., *supra* note 12, at 390.
15. *See generally* Ira J. Chasnoff, *Drug Use in Pregnancy: Parameters of Risk*, 35 PEDIATRIC CLINICS N. AM. 1403 (1988) [hereinafter Chasnoff, *Parameters*] (discussing the types and consequences of various forms of prenatal substance use).
16. LAWRENCE S. WISSOW, CHILD ADVOCACY FOR THE CLINICIAN: AN APPROACH TO CHILD ABUSE AND NEGLECT 186 (1990).
17. *Id.*

drugs, is responsible for prenatal growth retardation[18] and neonatal drug withdrawal syndromes.[19] Actual injury to the infant resulting from fetal drug exposure may be substantial. In addition to the damaging intrauterine effects of drugs and alcohol, there is clear evidence of long term sequelae (*i.e.*, after-effects). Fetal alcohol syndrome is manifested by intrauterine and postnatal growth deficiency, microcephaly (small head and brain size), and facial anomalies.[20] Additionally, mild to moderate mental retardation is common.[21] Many children born with fetal alcohol syndrome are later diagnosed with hyperactivity and other emotional and behavioral disorders.[22]

Maternal cocaine use reduces the supply of oxygen to the fetus, causing the potential for later problems in neurological and cognitive-behavioral development.[23] For example, "[i]ntrauterine growth retardation, also known to be associated with later child development problems, has been found in almost all studies comparing cocaine-exposed to cocaine-free infants."[24] Cocaine-exposed infants suffer an increased incidence of prematurity and its attendant complications.[25] Of particular concern in cocaine exposure are the concomitant high rates of infection, particularly from sexually transmitted diseases such as syphilis and the human immunodeficiency virus[26]—diseases which themselves have devastating consequences. These high rates of exposure to sexually transmitted diseases are attributed to the fact that cocaine, and crack cocaine in particular, is a stimulant often used communally, resulting in an increased frequency of sexual activity.[27]

Studies of the development and behavior of cocaine-exposed infants beyond three years of age are lacking.[28] According to studies of young children who were exposed to cocaine as infants, early treatment intervention aids both developmental lags and behavioral problems.[29] However, it is clear that these children required some

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18. Chasnoff, *Parameters*, *supra* note 15, at 1406.
19. *Id.*
20. PRINCIPLES AND PRACTICE OF PEDIATRICS 1995 (Frank A. Oski et al., eds., 1990).
21. *Id.* at 1996.
22. *Id.*
23. Singer et al., *supra* note 12, at 391.
24. *Id.* at 391-92.
25. Ira J. Chasnoff, *Newborn Infants With Drug Withdrawal Symptoms*, 9 PEDIATRICS IN REV. 273, 275 (1988).
26. WISSOW, *supra* note 16, at 186.
27. *Id.*
28. Singer et al., *supra* note 12, at 394.
29. *Individuals with Disabilities Education Act Amendments of 1991: Hearings on P.L. 102-119 Before the Select Subcomm. on Educ. of the House Comm. on Educ. and Labor*, 102d Cong., 1st Sess. 73 (1991) (statement of Dan R. Griffith, Ph.D, National Association for Prenatal Addiction and Research (NAPRE)).

type of rehabilitative or remedial services to make any progress at all.[30] Additionally, the research suggests that early intervention is necessary.[31] Without early intervention, it is conceivable that many of these children would suffer more serious long term consequences.

In addition to medical intervention, many drug-exposed infants require special education later on in life to address developmental, learning, emotional and behavioral problems resulting from their drug exposure in utero.[32] In 1975, Congress enacted Public Law 94-142, known as the "Education for All Handicapped Children Act,"[33] which is currently referred to as the "Individuals with Disabilities Education Act."[34] The Act mandates that all children receive free public education appropriate to meet their particular learning needs, regardless of their handicapping or disabling conditions.[35] The Act defines "children with disabilities" as those suffering from mental retardation, serious emotional disturbances, and specific learning disabilities, among other things,[36] and those "who, by reason thereof need special education and related services."[37] Clearly, this definition encompasses children suffering from the mental retardation and cognitive disturbance effects of drug exposure in utero.

The Individuals with Disabilities Education Act makes the provision of special education to these and other disabled children a requirement, not a luxury. Thus, the fiscal responsibility to provide the services is inherent, whether the cost is small or large, as it undoubtedly will be if more children require special services.[38] For example, during the 1990-1991 school year, the State of Maryland

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30. *Id.*
31. *Id.*
32. GAO REPORT, *supra* note 3, at 34. Some clinical reports indicate that cocaine-exposed children exhibit patterns of behavioral problems similar to those seen in emotionally disturbed children. Singer et al., *supra* note 12, at 402.
33. Education for All Handicapped Children Act of 1975, Pub. L. No. 94-142, 89 Stat. 773 (1975).
34. 20 U.S.C. § 1400(a) (1988 & Supp. II 1990), *amended by* Pub. L. 101-476 (1990) (amended to affect terminology change).
35. *Id.* § 1400(c).
36. *Id.* § 1401(a)(1)(A). Children with specific learning disabilities are further defined as

    [c]hildren who have a disorder in one or more of the basic psychological processes involved in understanding or in using language, spoken or written, which disorder may manifest itself in imperfect ability to listen, think, speak, read, write, spell, or do mathematical calculations. Such disorders include such conditions as perceptual disabilities, brain injury, minimal brain dysfunction, dyslexia, and developmental aphasia.

    Id. § 1401(a)(15).
37. *Id.* § 1401(a)(1)(B).
38. *See* GAO REPORT, *supra* note 3, at 34-35.

had a total of 88,024 children from the ages of three to twenty-one participating in some type of special education,[39] at a cost in excess of 406.5 million dollars.[40] Because children receiving special education are categorized by their handicapping condition, rather than by its cause,[41] it is impossible to tell how many children are educationally disabled as a result of prenatal drug exposure. However, many of the handicapping conditions identified are those associated with fetal exposure to drugs and/or alcohol.[42]

The federal law authorizes the appropriation of federal funds to assist the states in educating children with special needs.[43] The total amount that a state spends is augmented by federal money pursuant to a percentage scheme.[44] A finite amount of money, however, can go only so far. Significant increases in the number of children receiving special educational services will unduly burden an already costly system. As more students require special education, this finite amount of money must be more broadly disbursed.

Compounding the problem is the fact that substance abuse is strongly associated with other health and social risks.[45] In addition to requiring a greater amount and costlier measure of educational and medical care,[46] those children and their families who reside in homes where drug use and abuse is present are more likely to become the needy recipients of social service assistance programs.[47] Nationwide, the demand for foster care placements rose 29% from 1986 to 1989: Much of this increase was attributable to substance abuse in general.[48]

The likelihood of an individual having criminal involvement with the legal system seems greater when drug abuse is dominant in family life. Crack cocaine, in particular, is associated with increases in

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39. MARYLAND STATE DEP'T OF EDUC., THE FACT BOOK 28 (1992).
40. *Id.* at 21.
41. *Id.* at 30.
42. *Id.* (discussing specifically mental retardation, emotional disturbance and specific learning disabilities as handicapping conditions).
43. 20 U.S.C. § 1412 (1988 & Supp. II 1990).
44. *Id.* § 1411.
45. WISSOW, *supra* note 16, at 186.
46. GAO REPORT, *supra* note 3, at 6. Hospitals surveyed for the GAO REPORT indicated that hospital charges for drug-exposed infants were at least four times higher than charges for non-exposed infants. *Id.*
47. *Id.* at 30. In cities that require the reporting of drug-exposed infants to child welfare authorities, there has been a dramatic increase in the number of such reports from 1986 to 1989. In New York, Los Angeles, and Chicago, these reports increased by 268%, 342%, and 1735%, respectively. *Id.*
48. *Id.* at 33. The increase in foster care placements for children under two years of age rose even more dramatically. For example, in Illinois the number of infants in foster care who were younger than one year old increased by 284% from 1985 to 1989. *Id.*

interpersonal violence and increases in the proportion of fatal child abuse and neglect cases associated with drug use.[49] Although the number of arrests for the sale and possession of illegal drugs in Maryland declined somewhat during 1989-1991,[50] possession and sales account for only a small portion of drug-related activity.[51] Other drug-related crimes include those committed under the influence of drugs, those committed to obtain money to buy drugs, and those associated with drug distribution.[52]

In general, the use of secondary drugs such as alcohol, marijuana and cigarettes is common among those who abuse other drugs.[53] This secondary drug use phenomenon further complicates the evaluation of the infant exposed in utero to narcotics or cocaine.[54] Alcohol intoxication is highly correlated with criminal behavior: More than half of all murderers and their victims are believed to have been intoxicated at the time of the murder.[55] Additionally, the percentage of women who are assessed for driving while intoxicated has increased.[56]

III. LEGAL ISSUES

While the need to control prenatal substance abuse is obvious, a dilemma arises concerning the reconciliation of maternal and fetal rights. Although there are no reported Maryland cases specifically addressing the issue of fetal abuse due to maternal drug use, a number of other states have decided the legal rights of the unborn in such a situation. Some of these states have criminally prosecuted

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49. Wissow, *supra* note 16, at 187.
50. Maryland Alcohol and Drug Abuse Admin., Trends and Patterns in Alcohol and Drug Abuse in Maryland 96 (1991) [hereinafter Trends and Patterns].
51. *Id.* at 105.
52. *Id.*
53. Chasnoff, *Parameters*, *supra* note 15, at 1408.
54. Wissow, *supra* note 16, at 186. In addition to the problems created by known drugs, street drugs may be adulterated with other substances, such as phencyclidine, chalk, sugar, or talc, that may have untoward effects on the fetus. *Id.*
55. The American Psychiatric Ass'n, Diagnostic and Statistical Manual of Mental Disorders 128 (3d ed. rev. 1987).
56. Trends and Patterns, *supra* note 50, at 83. Driving while intoxicated (DWI) assessments are conducted as soon as possible after an individual has been charged with a drinking and driving offense. Referrals for assessment are usually generated through the courts. The purpose of the assessments is to determine both the severity of the drinking problem and the most appropriate rehabilitative service for the offender. *Id.* at 79.

mothers under existing child abuse or drug-related statutes.[57] Other states have considered the use of civil commitment penalties[58] or tort liability.[59] A threshold issue in decision-making arises in all cases because state intervention in pregnancy poses problems of constitutional dimensions.

A. *Constitutional Considerations*

The constraints to governmental intervention in a woman's decisions about her pregnancy emanate from the interest in protecting her privacy rights. Since *Griswold v. Connecticut*,[60] where the Supreme Court held that the right of a married couple to use contraceptives fell within a general right of privacy,[61] women have been entitled to certain freedoms regarding the management of their reproductive interests. Following the *Griswold* decision, the Court in *Eisenstadt v. Baird*[62] soundly endorsed the privacy right in procreative interests when it extended the right to contraception to unmarried individuals. The Court firmly stated that "[i]f the right of privacy means anything, it is the right of the *individual*, married or single, to be free from unwarranted governmental intrusion into matters so fundamentally affecting a person as the decision whether to bear or beget a child."[63]

Under *Roe v. Wade*,[64] the right of women to control their pregnancy was firmly established. The Supreme Court made clear in *Roe* that, within certain parameters, it is within a woman's fundamental right of privacy to make decisions affecting her own pregnancy. The Court, however, limited that right based upon the state's compelling interest in maternal health during the second trimester, and in the potential life of a viable fetus.[65] The *Roe* decision held that a woman's right to terminate her pregnancy until the second

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57. Reyes v. Superior Court, 141 Cal. Rptr. 912 (Cal. Ct. App. 1977); Johnson v. State, 602 So. 2d 1288 (Fla. 1992); State v. Gethers, 585 So. 2d 1140 (Fla. Dist. Ct. App. 1991); People v. Hardy, 469 N.W.2d 50 (Mich. Ct. App.), *cert. denied*, 471 N.W.2d 619 (Mich. 1991); State v. Gray, 584 N.E.2d 710 (Ohio 1992).
58. Troy D. v. Kelly D., 263 Cal. Rptr. 869 (Cal. Ct. App. 1989); *In re* Baby X, 293 N.W.2d 736 (Mich. Ct. App. 1980); *In re* Fathima Ashanti K.J., 558 N.Y.S.2d 447 (N.Y. Fam. Ct. 1990); *In re* Ruiz, 500 N.E.2d 935 (Ohio Misc. 2d 1986).
59. Grodin v. Grodin, 301 N.W.2d 869 (Mich. Ct. App. 1980).
60. 381 U.S. 479 (1965).
61. *Id.* at 485-86.
62. 405 U.S. 438 (1972).
63. *Id.* at 453.
64. 410 U.S. 113 (1973).
65. *Id.* at 150.

trimester virtually precludes any state intervention prior to this time.[66] If early prenatal drug abuse constituted actionable behavior, the "rather absurd result would be that endangering a fetus [would be] more severely punished than aborting it."[67]

Under the standards set forth in *Roe*, a fetus is not a "person" for purposes of the Fourteenth Amendment equal protection analysis.[68] Once a fetus is viable, however, the state has a compelling interest in its protection.[69] The Court based its decision on a "trimester framework" to determine that crucial time.[70] The third trimester in a pregnancy signaled a point when the state's interest was activated because that was deemed about the time when a fetus has the capability of "meaningful life outside the mother's womb."[71] At viability, the fetus may indeed have some limited legal status. The *Roe* decision may be interpreted as holding that, although it is clear that prenatal substance abuse may cause fetal harm long before viability,[72] the problem may not be considered a state problem until that point of viability.[73] Under *Roe*, any legal recourse that might be available to the viable fetus would be absent for the nonviable fetus.

The parameters set forth in *Roe*, however, are currently not as clear. In 1989 the Supreme Court, in *Webster v. Reproductive Health Services*,[74] expanded the constitutionally permissible scope of state regulation of reproduction. While the Court did not explicitly overrule the abortion right in *Roe*, it refused to strike down the preamble to a Missouri statute which states that life begins at conception and that the unborn have some protectable interests.[75] The Court further set the stage for dismantling the trimester framework by stating that it "[does] not see why the State's interest in protecting potential human life should come into existence only at the point of viability, and that there should therefore be a rigid line allowing state regulation after viability but prohibiting it before viability."[76]

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66. *Id.* at 163.
67. Reyes v. Superior Court, 141 Cal. Rptr. 912, 914 (Cal. Ct. App. 1977).
68. 410 U.S. at 158.
69. *Id.* at 163.
70. *Id.* at 164-65.
71. *Id.* at 163.
72. Ira J. Chasnoff et al., *Temporal Patterns of Cocaine Use in Pregnancy*, 261 JAMA 1741, 1744 (1989). The author states that "[i]t appears . . . that cocaine exposure in only the first trimester does place the newborn at risk for neurobehavioral deficiencies compared with drug-free infants." *Id.*
73. 410 U.S. at 163.
74. 492 U.S. 490 (1989).
75. *Id.* at 506-07.
76. *Id.* at 519.

The conflict between maternal and fetal rights pits the woman's constitutional fundamental "right(s) to religious free exercise, physical autonomy, and privacy [against] the fetus' right to freedom from physical harm."[77] State intervention in areas of fundamental rights requires a compelling state interest, and any restrictive action undertaken by the state must be narrowly tailored to meet that interest.[78] Those advocating state intervention argue that there is no fundamental right to illegal drug use.[79] These advocates further argue that the fetus "has a protectable legal right to be free from harm resulting from maternal conduct."[80] These arguments are premised upon the theory that a woman's right of privacy related to her pregnancy extends only to her decision to have an abortion within the given parameters: Once she has decided to carry her pregnancy to term, the state has a compelling interest in the health of the fetus.[81] One obstacle to state intervention aimed at protecting the fetus from harm lies in reconciling the language of statutes. In order for advocates to successfully urge state intervention, the language of the statutes must be interpreted so as to include the fetus within their scope. A number of courts have grappled with this statutory obstacle.

B. *State Treatment of Prenatal Substance Abuse*

1. Criminal Liability of the Mother

In *Reyes v. Superior Court*,[82] a pregnant heroin addict was warned by a public health nurse about the dangers of drug use in pregnancy and the problems associated with the failure to seek prenatal medical care.[83] Despite this warning, the woman continued

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77. Note, *Rethinking (M)otherhood: Feminist Theory and State Regulation of Pregnancy*, 103 HARV. L. REV. 1325, 1331 (1990) [hereinafter *Rethinking Motherhood*].

78. Roe v. Wade, 410 U.S. 113, 155 (1973).

79. State v. Gray, 584 N.E.2d 710 (Ohio 1992) (Wright, J., dissenting). The dissent quotes the Ohio Prosecuting Attorneys Association as *amicus* as follows:

> [I]n the case at bar, the use of the test set out in *Roe v. Wade* and its prodigy [*sic*] to balance the privacy rights of a woman against the compelling interest the State possesses in the life and well-being of the unborn child is inappropriate. For here, we are not dealing with a fundamental right. There is no fundamental right to abuse cocaine. The act of using cocaine is not an act relating to a right connected with marriage, procreation, contraception, family relations, or child bearing. * * * No special protection is afforded the cocaine abuser just because she is pregnant.

Id. at 714 (second alteration in original) (omissions in original).

80. *Rethinking Motherhood*, *supra* note 77, at 1331.

81. *See id.* at 1331-32 for a general discussion of the arguments for state regulation.

82. 141 Cal. Rptr. 912 (Cal. Ct. App. 1977).

83. *Id.* at 912-13.

to use drugs and to abstain from receiving prenatal care.[84] When the woman later gave birth to twin boys who were addicted to heroin and suffering from withdrawal, felony child endangerment charges were filed against her.[85] The Court of Appeal of California held that the statute was not intended to apply to prenatal conduct.[86] The court stated that if "the Legislature determines to confer legal personality on unborn fetuses for certain limited purposes, it expresses that intent in specific and appropriate terms."[87] The court further noted the mandate to strictly construe penal statutes in favor of the defendant.[88]

Shortly after the *Reyes* decision, the Court of Appeals of Michigan reached a seemingly different conclusion. The court in *In re Baby X*[89] held that a newborn suffering from narcotics withdrawal because of prenatal maternal drug addiction may properly be considered a neglected child.[90] The real difference between these two cases is the type of proceeding that was brought. In *Reyes*, the mother was prosecuted under a felony criminal statute.[91] In contrast, *Baby X* involved a civil neglect suit[92]—a distinctly different type of proceeding where the aim is to protect rather than punish. Like the *Reyes* court, the *Baby X* court declined to give "wholesale recognition of fetuses as persons."[93] However, the *Baby X* court adopted a limited recognition of the rights of the child in utero when it is in the child's best interest: The court opined that "since a child has legal right to begin life with a sound mind and body, it is within

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84. *Id.* at 913.
85. *Id.*
86. *Id.*
87. *Id.* at 914.
88. *Id.*
89. 293 N.W.2d 736 (Mich. Ct. App. 1980).
90. *Id.* at 739.
91. *Reyes*, 141 Cal. Rptr. at 913. Reyes was charged with two counts of felony child endangering in violation of Cal. Penal Code § 273a(1), which at the time read in part:

> "Any person who, under circumstances or conditions likely to produce great bodily harm or death, . . . having the care or custody of any child, . . . willfully causes or permits such child to be placed in such situation that its person or health is endangered, is punishable by imprisonment in the county jail not exceeding 1 year, or in the state prison for not less than 1 year nor more than 10 years."

Id. (alterations in original) (quoting CAL. PENAL CODE § 273(a)(1)).
92. *Baby X*, 293 N.W.2d. at 736. A petition was filed against Mother X in the Oakland County Probate Court alleging that she had "so neglected her child that the court should assert jurisdiction." *Id.* at 738. The probate court is a court given jurisdiction over such juvenile matters under MICH. COMP. LAWS ANN. § 712A.2 and MICH. STAT. ANN. § 27.3178(598.2). *Id.*
93. *Id.*

this best interest to examine all prenatal conduct bearing on that right."[94] The court further stated that "[s]ince prior treatment of one child can support neglect allegations regarding another child, . . . prenatal treatment can be considered probative of a child's neglect as well."[95]

Other courts have taken similar positions, reflecting the differences in a punitive versus protective approach to this dilemma. In another California case, *Troy D. v. Kelly D.*,[96] because an infant was born under the influence of drugs, the juvenile court's jurisdiction was considered sufficient.[97] While the Court of Appeal of California only cursorily noted the *Reyes* decision, it lent credibility to the idea that "[a] fetus is accorded variable legal treatment due to social policies underlying different areas of the law. For example, an unborn fetus is not considered to be a child within California's felony child abuse statute . . . ."[98] Nonetheless, the court cited *Baby X* with approval in deciding that prenatal use of dangerous drugs by a mother is probative of future child neglect.[99] The Family Court of New York has established similar standards.[100]

In keeping with this trend, in *People v. Hardy*,[101] the Court of Appeals of Michigan held that a woman could not be criminally prosecuted for either child abuse or delivery of cocaine to her baby via the umbilical cord.[102] While the court made no mention of the *Baby X* case and its civil rationale for fetal rights, it did identify problems associated with applying a criminal law to a situation of this nature. In *Hardy*, a mother was charged with child abuse following allegations that she ingested cocaine while pregnant, thereby causing serious physical harm to her infant.[103] The mother was also

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94. *Id.* at 739 (citations omitted).
95. *Id.*
96. 263 Cal. Rptr. 869 (Cal. Ct. App. 1989).
97. *Id.* at 874.
98. *Id.* at 873.
99. *Id.* at 874. The court pointed out that "[w]hile jurisdiction must be asserted on the basis of conditions which exist at the time of the jurisdictional hearing, the court is not required to disregard the mother's prior conduct." *Id.*
100. *In re* Fathima Ashanti K.J., 558 N.Y.S.2d 447 (N.Y. Fam. Ct. 1990). In this case, where the father was also a respondent, the court recognized that the mother's drug use was responsible for the newborn's positive urine toxicology screen at birth. *Id.* at 447. However, the court also placed blame upon the father for dissuading the mother from participating in a drug treatment program. *Id.* Additionally, the court heard the father's arguments 1) that he did not pass cocaine to the fetus; and 2) that he never had care of the child. *Id.* at 448. The court identified the child's condition at birth as the precipitating event warranting judicial intervention, and based jurisdiction on the potential danger to the child. *Id.* at 449.
101. 469 N.W.2d 50 (Mich. Ct. App.), *cert. denied*, 471 N.W.2d 619 (Mich. 1991).
102. *Id.* at 52-53.
103. *Id.* at 51.

charged with the delivery of cocaine to the infant, because at the baby's birth, when the umbilical cord was still attached to both mother and baby, cocaine was being delivered from the mother to her child.[104] The court again highlighted the mandate to strictly construe penal statutes, and determined that the legislature did not intend for this statute to cover the offense charged.[105] Additionally, the court emphasized that a criminal statute must be sufficiently definite and explicit to put an individual on notice as to what behavior might be proscribed.[106]

This reluctance to broaden the scope of criminal statutes has been echoed in other jurisdictions. In *State v. Gray*,[107] the Supreme Court of Ohio declined to sustain the child endangerment conviction of a mother who had allegedly ingested cocaine during the third trimester of her pregnancy, thereby causing serious physical harm, cocaine withdrawal, to her infant.[108] The court again called attention to the need to strictly construe criminal statutes against the State and liberally construe them in favor of the accused.[109] In addition, the court refused to broadly read the word "child" in the statute to encompass a fetus when the legislature had declined to adopt such a broad interpretation.[110] Furthermore, the court pointed out that the legislature was indeed undertaking an investigation of prenatal neglect.[111]

In a compelling dissent, Judge Wright insisted that the "[l]aws of Ohio do protect the unborn child who is subsequently born alive."[112] His dissent observed that the Ohio courts have determined that a viable fetus is a "child" for purposes of the child abuse statute, and that a cause of action exists when a viable fetus is negligently injured in utero and is subsequently stillborn.[113] Addi-

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104. *Id.* at 51-52.
105. *Id.* at 52-53.
106. *Id.* at 52.
107. 584 N.E.2d 710 (Ohio 1992).
108. *Id.* at 710.
109. *Id.* at 711.
110. *Id.*
111. *Id.* at 712-13. At the time of this decision, the Ohio legislature had a pending bill which, if passed, would create a new crime of prenatal child neglect in an effort to address the issue of prenatal substance abuse and subsequent fetus/infant exposure. *Id.* at 712.
112. *Id.* at 714 n.5 (Wright, J., dissenting).
113. *Id.* Judge Wright's dissent cited *In re* Ruiz, 500 N.E.2d 935 (Ohio Misc. 2d 1986), for the proposition that a viable fetus is a "child" for purposes of the child abuse statute. *Gray*, 500 N.E.2d at 714. His dissent appeared to overlook that the *Ruiz* court was construing a civil child abuse statute rather than a criminal child abuse statute. The *Ruiz* court specifically distinguished between civil and criminal child abuse statutes:

    Such a holding does not conflict with the . . . general principle that

tionally, his dissent cited with approval the brief of the Ohio Prosecuting Attorneys Association as *amicus*:

> A pregnant woman is not, due to her maternity, immune from the consequences of her illegal acts. This case is not about a woman's choice to conceive or carry a child. This is about the right of a child to be born healthy, free of injuries inflicted by the illegal acts of another.[114]

The dissent, however, apparently failed to consider the distinction between the civil and criminal approaches to the problem—a distinction recognized by other courts. In addition, the dissent also neglected to address whether recourse is available to a drug-exposed nonviable fetus that is subsequently born with defects resulting from that exposure.

Florida courts have also declined to allow convictions of substance abusing mothers.[115] As in the other criminal prosecution cases, the courts cite legislative intent for their justification.[116] Moreover, in *Johnson v. State*,[117] the Supreme Court of Florida indicated that it understood the relevant statutes to address the problem of drug dependent mothers and newborns as a public health problem rather than as a criminal problem.[118] In *Johnson*, a case similar to *People*

> criminal statutes must be construed strictly. [The child abuse statute] is not a criminal statute. And the child endangerment provision specifies that there need not be a conviction under [the statute] in order to find that a child is abused.

Ruiz, 500 N.E.2d at 938.

114. *Gray*, 584 N.E.2d at 714.

115. Johnson v. State, 602 So. 2d 1288, (Fla. 1992); State v. Gethers, 585 So. 2d 1140 (Fla. Dist. Ct. App. 1991).

116. In *Gethers*, the District Court of Appeal of Florida quoted with approval the following portion of Judge Sharp's dissent in *Johnson*:

> "From this legislative history, it is clear that the Legislature *considered* and *rejected* a specific statutory provision authorizing criminal penalties against mothers for delivering drug-affected children who received transfer of an illegal drug derivative metabolized by the mother's body, *in utero*. In light of this express legislative statement, I conclude that the Legislature never intended for the general drug delivery statute to authorize prosecutions . . . ."

Gethers, 585 So. 2d at 1142 (quoting *Johnson*, 578 So. 2d at 422-23 (Sharp, J., dissenting)).

Judge Sharp's analysis was also adopted by the Florida Supreme Court, which reversed the district court of appeal's decision in *Johnson*. Johnson v. State, 602 So. 2d 1288 (Fla. 1992), *rev'g* 578 So. 2d 419 (Fla. Dist. Ct. App. 1991).

117. 602 So. 2d 1288 (Fla. 1992).

118. *Id.* at 1293. The court again adopted the language of the lower court's dissent: "[T]he legislature expressly chose to treat the problem of drug dependent mothers and newborns as a public health problem and that it considered but rejected imposing criminal sanctions via section 893.13(1)(c)(1)." *Id.*

v. Hardy,[119] a woman was charged with delivery of a controlled dangerous substance to her newborn infant during the thirty to ninety seconds following the infant's birth, but before the umbilical cord was cut.[120] In refusing to uphold a lower court conviction, the court opined that prosecuting mothers for drug use and "delivery" to their newborns may be the least effective means of addressing prenatal drug abuse.[121] The court contended that the fear of prosecution may have the effect of increasing the incidence of abortion, causing substance-abusing pregnant women to avoid prenatal care, or causing reluctance in health care workers to identify substance abusers.[122] Any one of these negative effects, resulting from the fear of prosecution, would certainly undermine compelling state interests in preventing harm to the child or the mother.

2. Tort Liability of the Mother

One commentator has suggested that "criminalization fails to strike at the heart of the issue. Because criminalization does not attempt to cure the addictions which cause fetal harm, it fails to protect the fetuses from the dangers of gestational substance abuse."[123] In addition to the described civil and criminal treatments of the fetal abuse problem, state intervention to prevent such abuse has been analyzed under a maternal duty of care theory.[124] While a fundamental right to privacy protects a woman's right to an abortion within certain limits, no similar protection of the right to abuse harmful substances exists. Therefore, under a duty of care theory, once a woman has decided to carry her pregnancy to term she assumes the duty to use reasonable care in ensuring the safety of the fetus.[125] Although it is a universal principle that a child may have a cause of action against a third party for injuries sustained in utero,[126] parent-child immunity doctrines prevail in many jurisdictions, and may prevent a negligence claim by the drug-exposed child.[127]

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119. 469 N.W.2d 50 (Mich. Ct. App.), *cert. denied*, 471 N.W.2d 619 (Mich. 1991).
120. *Id.* at 1290-91.
121. *Id.* at 1295-96.
122. *Id.*
123. Kristen R. Lichtenberg, *Gestational Substance Abuse: A Call for a Thoughtful Legislative Response*, 65 WASH. L. REV. 377, 393 (1990).
124. *See id.* at 383-84 (discussing Stallman v. Youngquist, 531 N.E.2d 355 (Ill. 1988); Grodin v. Grodin, 301 N.W.2d 869 (Mich. Ct. App. 1980)).
125. *Id.* at 388-89.
126. *E.g.*, W. PAGE KEETON ET AL., PROSSER AND KEATON ON TORTS § 55 (5th ed. 1984).
127. *See, e.g.*, Smith v. Gross, 319 Md. 138, 571 A.2d 1219 (1990) (holding that parent-child immunity doctrines apply to wrongful death and survival actions); Frye v. Frye, 305 Md. 542, 505 A.2d 826 (1986) (refusing to abrogate parent-child immunity doctrines).

In *Grodin v. Grodin*,[128] however, the Court of Appeals of Michigan upheld the ability of a child to maintain a negligence suit against his mother for the injury he sustained from his mother's use of tetracycline during her pregnancy.[129] Even though the actual injury, discolored teeth, was not manifested until some time after the mother took the drug, the court held that "the litigating child's mother would bear the same liability for injurious, negligent conduct as would a third person."[130] In so holding, the court applied the principles of *Plumley v. Klein*,[131] which abrogated intra-family tort immunity.[132]

The danger with an approach allowing the child to sue the mother in negligence for prenatal injuries lies in its tendency to place the mother in the position of the guarantor of the health of the fetus.[133] The ramifications of such a maternal responsibility are enormous. Imposing such a duty on the mother may not only create an adversarial relationship between mother and fetus, but also may effectively handcuff the mother from undertaking any activity that may have a potentially adverse effect on the child. Any realistic remedy for this type of tort action would be difficult to identify, and even more difficult to enforce.

In contrast, *Stallman v. Youngquist*[134] did not involve the use of illegal, or even prescription drugs by a pregnant woman. The Supreme Court of Illinois, in *Stallman*, took a definitive stand on the issue of tort actions between mother and fetus. The court addressed whether a pregnant woman should be liable to her unborn child for negligent driving.[135] The court held that for purposes of tort liability, any recognition of a legal duty from mother to fetus must emanate from the legislature.[136] The court criticized *Grodin* for creating a legal fiction by "[treating] a pregnant woman as a stranger

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128. 301 N.W.2d 869 (Mich. Ct. App. 1980).
129. *Id.* at 869-70.
130. *Id.* at 870.
131. 199 N.W.2d 169 (Mich. 1972).
132. *Grodin*, 301 N.W.2d at 870. The court remanded the case to determine whether the mother, in her decision to continue using the drug during pregnancy, had used a "reasonable exercise of parental discretion." *Id.* at 871. The court emphasized that any intra-family tort immunity was abrogated, except where 1) the alleged negligent act involves an exercise of reasonable parental authority over the child; and 2) the alleged negligent act involves an exercise of reasonable parental discretion with respect to the provisions of food, clothing, housing, medical and dental services and other care. *Id.* at 870.
133. Lichtenberg, *supra* note 123, at 389.
134. 531 N.E.2d 355 (Ill. 1988).
135. *Id.* at 355-56.
136. *Id.* at 361.

to her developing fetus for purposes of tort liability."[137] The court pointedly questioned as follows:

> By what judicially defined standard would a mother have her every act or omission while pregnant subjected to State scrutiny? By what objective standard could a jury be guided in determining whether a pregnant woman did all that was necessary in order not to breach a legal duty to not interfere with her fetus' separate and independent right to be born whole? In what way would prejudicial and stereotypical beliefs about the reproductive abilities of women be kept from interfering with a jury's determination of whether a particular woman was negligent at any point during her pregnancy?[138]

3. State and Federal Statutory Responses

In response to maternal liability for prenatal substance abuse, a number of states have attempted to enact or modify laws that specifically address substance-related injury to the fetus. Aligned with related case law, prenatal substance abuse laws have been incorporated into statutes geared toward child protection or rehabilitation: No state has yet enacted criminal laws specific to this purpose.[139]

Several states have identified children born with fetal alcohol syndrome or drug withdrawal symptoms as falling within the purview of child neglect statutes. In some of these states, a medical diagnosis of fetal alcohol syndrome or drug withdrawal symptoms at birth is prima facie evidence of neglect.[140] In other states, similar statutes require a reporting of prenatal substance abuse situations, triggering investigation but not necessarily a finding of neglect.[141]

Other states have approached prenatal substance abuse differently. Colorado requires that pregnant women who receive medical assistance benefits be assessed for the risk of a poor birth outcome due to substance abuse; where the risk is high, special assistance may be provided to reduce such risk.[142]

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137. *Id.* at 358.
138. *Id.* at 360.
139. *Rethinking Motherhood*, *supra* note 77, at 1329.
140. Ill. Ann. Stat. ch. 37, para. 802-18(2)(c)-(d) (Smith-Hurd 1990); Ind. Code Ann. § 31-6-4-3.1(1) (Burns 1987 & Supp. 1992); Nev. Rev. Stat. Ann. § 432B.330.1(b) (Michie 1991).
141. Mass. Gen. Laws Ann. ch. 119, § 51A (West 1969 & Supp. 1993); Utah Code Ann. §§ 62A-4-504, 62A-4-509(1) (1989).
142. Colo. Rev. Stat. Ann. § 26-4-508.2(1) (West Supp. 1992).

A number of other states tap into existing laws related to alcohol and drug abuse prevention,[143] or health generally,[144] where provisions specifically target drug use in pregnancy as an area properly addressed through education and intervention. Statutory provisions of this nature provide for the establishment of screening, educational and treatment services for pregnant substance abusers and their children. One such statute in Wisconsin mandates the allocation of funds to provide these services within local public health agencies.[145] These laws are valuable because they directly address the problem without affixing blame or discouraging prenatal care.

Although no specifically relevant federal legislation exists, Congress has indicated an interest in the problem through proposed legislation to establish a program of grants for children exposed perinatally to drugs.[146] Through the Senate Committee on Finance, the federal government has also requested a special report on the subject from the General Accounting Office.[147] Existing federal legislation related to the issues of child abuse/neglect[148] and drug/alcohol abuse[149] only peripherally address the problem. None of this federal legislation, however, specifically addresses drug-exposed infants.

IV. MARYLAND'S TREATMENT OF PRENATAL SUBSTANCE ABUSE

Once born, an infant in Maryland is safeguarded by laws seeking to protect "children who have been the subject of abuse or neglect."[150] Maryland also has enacted criminal laws prohibiting child abuse,[151] the furnishing of alcohol to minors,[152] the possession[153] and

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143. CONN. GEN. STAT. ANN. § 17a-644(a) (West 1992); OHIO REV. CODE ANN. § 3793.15 (Baldwin 1993); OR. REV. STAT. § 430.955 (1991).
144. WIS. STAT. ANN. § 146.183 (West Supp. 1992).
145. *Id.* The statute allocates $250,000 in each of fiscal years 1989-90 and 1990-91. However, the grant is apparently time limited, as the statute specifically states that "[t]his section does not apply after June 30, 1993." *Id.* § 146.183(2).
146. H.R. 3832, 102d Cong., 1st Sess. (1991). One purpose of this bill was to amend the "Individuals with Disabilities Education Act," 20 U.S.C. § 1400 (1988 & Supp. II 1990), to identify drug-exposed children as a discrete group falling under the purview of the Act, thus requiring grant funding to address the issue. *Id.* § 1400(c). The bill was sent to various committees and apparently never resurfaced.
147. GAO REPORT, *supra* note 3, at 1.
148. 42 U.S.C. § 5101 (1988 & Supp. II 1990). The Child Abuse Prevention and Treatment and Adoption Reform Act sets guidelines for the management of these matters.
149. *Id.*
150. MD. CODE ANN., FAM. LAW § 5-702 (1991).
151. MD. ANN. CODE art. 27, § 35A (1992).
152. *Id.* § 401A. However, § 401A(b) provides an exception if alcohol is provided by an immediate family member and consumed in a private residence. *Id.* § 401A(b).
153. *Id.* § 286 (1992 & Supp. 1993).

distribution of controlled dangerous substances,[154] and the battering of family members.[155] Currently, no counterpart statutory provisions specifically address the interests of the unborn. Maryland law clearly identifies a child as "any individual under the age of eighteen years."[156] Consequently, what may not be administered to an infant who has just emerged from the womb may apparently be freely administered to a fetus with impunity. Although the devastating effects of fetal abuse are well-documented,[157] Maryland has yet to adopt any legal provisions to protect the fetus from such abuse when it is caused by the mother.

Notably, Maryland courts have identified some legal rights for the unborn when injury or death results from the behavior of a third party. The Court of Appeals of Maryland first addressed injury inflicted to a fetus in *Damasiewicz v. Gorsuch*,[158] where an infant born prematurely suffered injuries resulting in blindness after an automobile accident in which the infant's pregnant mother was a passenger.[159] In a scholarly opinion, the court presented an exhaustive historical accounting of the law as it relates to the unborn.[160] Absent any applicable statutes, the court's holding reflected its understanding of the common law as it should be applied in Maryland.[161] Utilizing this common law application, the court held that the infant was entitled to recover against the defendant drivers for injuries sustained in utero.[162]

The court of appeals reached a similar conclusion in *Odham v. Sherman*,[163] where a full-term viable fetus was delivered stillborn following the mother's involvement in an automobile accident caused by the defendant's negligence.[164] While the court viewed *Gorsuch* as controlling for the proposition that a viable child born dead is a

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154. *Id.* § 287 (1992).
155. MD. CODE ANN., FAM. LAW §§ 4-504 to 509 (1991 & Supp. 1993). These sections do not actually prohibit domestic violence as a criminal activity; more precisely, they serve to identify the available recourse to a victim of domestic violence, and authorize the court, upon clear and convincing evidence of abuse, to issue protective orders. Section 4-508 provides for the protective order to be backed by punitive sanctions for violations. Section 4-509 provides for penalties for failure to comply with court orders.
156. *Id.* § 5-701(d).
157. *See supra* notes 16-31 and accompanying text.
158. 197 Md. 417, 79 A.2d 550 (1951).
159. *Id.* at 418-19, 79 A.2d at 550.
160. *Id.* at 419-37, 79 A.2d at 550-59.
161. *See* MD. CODE ANN., CONST. art. 5(a) (Supp. 1993) (stating in part that "the Inhabitants of Maryland are entitled to the Common Law of England").
162. *Gorsuch*, 197 Md. at 440-41, 79 A.2d at 560-61.
163. 234 Md. 179, 198 A.2d 71 (1964).
164. *Id.* at 182, 198 A.2d at 72.

"person" for purposes of Lord Campbell's Act,[165] it acknowledged that *Gorsuch* dealt with an infant born alive.[166] Nonetheless, the court did not think that the language of *Gorsuch* was "intended to impose a limitation or condition of birth."[167] Therefore, the *Odham* court limited its holding to infants viable at the time of the wrong, stating that "[w]e think the weight of present authority draws the line at least at a point where the common law concept of viability is in effect."[168]

Maryland courts did not confront the issue of a nonviable fetus until almost twenty years later. In *Group Health Ass'n v. Blumenthal*,[169] the court of appeals made it clear that viability at the time of injury is not required to uphold an infant's cause of action if the infant is born alive.[170] In *Blumenthal*, an infant born alive subsequently died because of an obstetrician's negligence in failing to address the mother's problem of an incompetent cervix early in her pregnancy.[171] Because the doctor had failed to perform the necessary minor surgery during the early months of pregnancy, the infant was born premature and was unable to survive.[172] The court upheld the wrongful death action, notwithstanding that the actual injury occurred during a period of fetal nonviability.[173]

More recently, Maryland courts have determined the status of a fetus in a criminal context. In *Williams v. State*,[174] a defendant's homicide conviction was upheld when an infant born alive died soon thereafter from injuries received in utero when the defendant shot

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165. *Id.* at 183, 198 A.2d at 72. At that time Lord Campbell's Act was codified as MD. CODE ANN. art. 67, §§ 1, 4 (1957) and stated the following:

> Whenever the death of a person shall be caused by a wrongful act, neglect or default, and the act, neglect or default is such as would (if death had not ensued) have entitled the party injured to maintain an action and recover damages in respect thereof, the . . . person who would have been liable if death had not ensued . . . shall be liable to an action for damages, notwithstanding the death of the person injured.

Id. at 181, 198 A.2d at 71 (omissions in original).

166. *Id.* at 183, 198 A.2d 72-73.

167. *Id.* at 184, 198 A.2d at 73.

168. *Id.* at 185, 198 A.2d at 73. The common law understanding of viability referred to "quickening," the time when a mother first begins to feel fetal movement. *See* Damasiewicz v. Gorsuch, 197 Md. 417, 420, 79 A.2d 550, 550-51 (1951).

169. 295 Md. 104, 453 A.2d 1198 (1983).

170. *Id.* at 116, 453 A.2d at 1206.

171. *Id.* at 107, 453 A.2d at 1201. An incompetent cervix is defective in its musculature and thus is prone to dilation too early in the pregnancy: Without corrective surgery, the condition will result in premature delivery of the fetus. *Id.* n.2.

172. *Id.* at 108, 453 A.2d at 1201.

173. *Id.* at 118-19, 453 A.2d at 1206-07.

174. 316 Md. 677, 561 A.2d 216 (1989).

the mother with a bow and arrow.[175] The infant in utero was necessarily deemed a "person" for purposes of the homicide conviction. Although the infant in *Williams* had reached the point of viability,[176] the question remains whether the same result would have occurred had the fetus been nonviable.

As these cases make clear, a third party is liable to a viable fetus for injuries caused by that party, regardless of the infant's status upon emerging from the womb. However, liability does not result when the third party is a parent of that fetus/infant. Since 1930, Maryland has subscribed to the parent-child immunity doctrine elucidated in *Schneider v. Schneider*,[177] where the court held that a mother could not sue her minor child for injuries received as a result of the child's negligent driving.[178] In reaching its decision, the court utilized the reasoning of other jurisdictions which have held that a child could not sue his parent.[179] The *Schneider* court, therefore, applied the parent-child immunity against both the parent and the child seeking to bring suit and, as a result, has clearly established the policy in Maryland.

Since *Schneider*, Maryland has steadfastly refused to abrogate the parent-child immunity doctrine as applied to minor children.[180] In *Frye v. Frye*,[181] the court of appeals discussed the policy reasons for the maintenance of the parent-child immunity doctrine in the past, declaring the following:

> [T]his Court has had an abiding belief that the parent-child immunity rule enhances the public policy in that it subserves the repose of families and the best interests of society by preserving the peace and harmony of society and of the families composing society. Therefore, the inquiry now turns

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175. *Id.* at 679, 561 A.2d at 217.
176. The mother was nine months pregnant at the time of the shooting. *Id.* at 679, 561 A.2d at 217.
177. 160 Md. 18, 152 A. 498 (1930).
178. *Id.* at 19, 152 A. at 498.
179. *Id.* at 22, 152 A. at 499.
180. *See* Smith v. Gross, 319 Md. 138, 571 A.2d 1219 (1990) (applying parent-child immunity to children born out of wedlock); Frye v. Frye, 305 Md. 542, 505 A.2d 826 (1986) (applying parent-child immunity to son suing father for injuries sustained in automobile accident); Yost v. Yost, 172 Md. 128, 190 A. 753 (1937) (applying parent-child immunity to divorced parent living apart from child); Sanford v. Sanford, 15 Md. App. 390, 290 A.2d 812 (1972) (applying parent-child immunity to child suing father for personal injuries arising out of automobile accident); Latz v. Latz, 10 Md. App. 720, 272 A.2d 435 (holding that parent-child immunity is constitutional and does not violate equal protection guarantees), *cert. denied*, 261 Md. 726 (1971).
181. 305 Md. 542, 505 A.2d 826 (1986).

> to the validity of that belief under present day mores and in light of the current status of the law . . . .[182]

The court maintained that the preservation of parental authority and family unity was a policy as strongly held today as in the past, and that "[i]t is clear that today's parent-child relationship, as recognized by this Court and the legislature, furnishes no compelling reason to abrogate the rule."[183] Thus, until this doctrine is either overturned by the courts or abrogated by statute, parent-child immunity remains the rule in Maryland, and thus precludes any action by or on behalf of an infant for damages arising from fetal abuse.

The absence of Maryland statutes acknowledging the existence of fetal abuse compounds the problem. Although several attempts have been made to introduce bills into the legislature which would amend the existing family law article to include laws related to prenatal use of controlled dangerous substances and subsequent infant harm, these bills have failed to gain the requisite approval of both the House and the Senate. The most recent Bill, which passed in the Senate but received an unfavorable review in the House Judiciary Committee, where it subsequently died, has not been substantially changed from previous bills.[184] The Bill sought to expand the current statutory definition of neglect as follows:

> "Neglect" includes use of a controlled dangerous substance, as defined under article 27, § 277 of the code, by a woman:
> 1. resulting in an infant's addiction to or dependence on a controlled dangerous substance; or
> 2. resulting in the presence of a controlled dangerous substance in an infant evidenced by toxicology or other appropriate tests.[185]

The proposed amendment further identifies that an investigation shall include what is required in other neglect cases and

> (3) [i]f the suspected abuse or neglect of an infant involves possible use of a controlled dangerous substance, as defined under article 27, § 277 of the code, by the infant's mother:
> (I) a toxicology or other appropriate chemical test of the infant; and
> (II) a report to the appropriate division of the local Department of Social Services on the mother's use of a controlled dangerous substance.[186]

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182. *Id.* at 552, 505 A.2d at 831.
183. *Id.* at 561, 505 A.2d at 836.
184. S. 660, Reg. Sess. (1992) (originally introduced as S. 657 (1991)).
185. *Id.*
186. *Id.*

Although the Maryland General Assembly has not passed a prenatal abuse statute, it has established an Alcohol and Drug Abuse Administration[187] to "[p]romote, develop, establish, conduct, certify, and monitor programs for the prevention, treatment, and rehabilitation related to the misuse of alcohol and drugs; [and] [p]romote and conduct training and research related to the misuse of alcohol and drugs."[188] The authority to develop programs which specifically address the needs of pregnant women clearly lies within the domain of the Alcohol and Drug Abuse Administration.[189] However, because the enabling statute does not identify the different types of programs to be generated, there is no mandate to address the substance abuse problems of certain discrete risk groups.

Another attempt to legislate on the subject of prenatal substance abuse came in 1992 with the introduction of House Bill 1459.[190] The purpose of this Bill was to require the state Alcohol and Drug Abuse Administration to establish referral procedures to address the problem of prenatal substance abuse.[191] The Bill sought to require health care practitioners to report pregnant women suspected of being chemically dependent to the Alcohol and Drug Abuse Administration for referral to treatment services.[192] This Bill also died in committee without ever being passed in either house. Thus, the Maryland General Assembly has yet to pass any relevant legislation to address the problem.[193]

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187. MD. CODE ANN., HEALTH-GEN. § 8-201 (1990).
188. *Id.* § 8-401.
189. *See id.*
190. H.D. 1459, Reg. Sess. (1992).
191. *Id.*
192. *Id.*
193. The Department of Health and Mental Hygiene, pursuant to §§ 2-104(b), 15-103, and 15-105 of the Health-General Article of the Annotated Code of Maryland, established a case management program designed to

> demonstrate the costs and effectiveness of two innovative outreach strategies for pregnant, Medicaid-eligible substance abusers. Specifically, the demonstration project will compare the effectiveness of case management and support groups in motivating use of prenatal care and drug treatment and in improving maternal and infant health.

COMAR 10.09.31.04B. This demonstration project, however, is only intended to last for three years, effective September 1, 1992, and cover a narrow group of pregnant women having substance-abuse problems. *Id.* 10.09.31.02, 10.09.31.04, 10.09.31.13. Only pregnant women meeting the following characteristics are eligible to participate in the program: (1) Women in a "federal categorically needy eligibility category . . . because the recipient is receiving Aid to Families with Dependent Children," *id.* 10.09.31.02A; (2) Women electing to participate "before the 28th week of . . . pregnancy and ending the 7th month following delivery or termination of pregnancy," *id.* 10.09.31.02B; (3) Women between the ages of 18 and 45, *id.* 10.09.31.02C; (4) Women "diagnosed with illicit psychoactive substance abuse or dependence," *id.* 10.09.31.02C; (5) Women residing within various zip codes located in Baltimore

V. ANALYSIS

Resolution of the prenatal substance abuse problem will obviously be difficult. In creating appropriate legislation to address this problem, consideration must be given to a number of factors. While attempts have been made in other jurisdictions to impose criminal liability upon the mother,[194] to date, no jurisdiction has upheld a mother's conviction for passing illicit drugs to her fetus in utero.[195] The use of a statutory construction analysis, strictly construing criminal laws,[196] evidences an awareness that criminal laws were not designed to address public health issues. Furthermore, criminal prosecution following the birth of an exposed infant does nothing to further the goal of ensuring healthy children. Rather than providing a vehicle for treatment of substance abuse problems in pregnancy, the fear of prosecution may have a chilling effect on a mother's decision to seek any prenatal care.

Civil commitment proceedings, which identify infant drug exposure as a prima facie case of neglect, would have similar results. In many cases, a finding of abuse or neglect results in removal of the child from the home. Removing a child from the home does nothing to promote the "preservation of parental authority and the family unity" that the court of appeals held so dear in *Frye v. Frye*.[197] Additionally, drug or alcohol dependence is not dispositive of neglectful parenting. In contrast, drug or alcohol dependency does indicate the need for educational and rehabilitative intervention for both mother and child. Likewise, other civil remedies do not provide a ready solution to the problem of prenatal substance abuse. Given the status of the parent-child immunity doctrine in Maryland[198] and

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City, *id.* 10.09.31.02E; and (6) Women "not enrolled in a drug abuse treatment program at the time of entry into the demonstration project," *id.* 10.09.31.02F. Obviously, this type of response by an administrative agency will hardly address the problem of substance abuse among pregnant women since it is limited both in duration and scope.

194. *See supra* notes 82-121 and accompanying text.

195. *See* Johnson v. State, 602 So. 2d 1288, 1297 (Fla. 1992).

196. *See, e.g.*, People v. Hardy, 469 N.W.2d 50 (Mich. Ct. App.), *cert. denied*, 471 N.W.2d 619 (Mich. 1991). The language of *Hardy* typifies the sentiments of other jurisdictions regarding the construction of criminal statutes to include prenatal substance abuse conduct. The *Hardy* court stated:

> We are not persuaded that a pregnant woman's use of cocaine, which might result in the postpartum transfer of cocaine metabolites . . . is the type of conduct that the Legislature intended to be prosecuted under the delivery-of-cocaine statute . . . . This, in our opinion, would not be a reasonable construction of the statute.

Id. at 53.

197. 305 Md. 542, 561, 505 A.2d 826, 836 (1986).

198. *See supra* notes 176-82 and accompanying text.

in other jurisdictions, it is unlikely that relief will come in the form of tort liability.

Attempts at legislation have also proved unfruitful, perhaps because the proposed laws have failed to consider the potential consequences of both the civil and criminal approaches to the problem. Senate Bill 660 and others like it are flawed for several reasons. Bills like Senate Bill 660 importantly fail to address prenatal substance abuse as the real problem—these bills do not mention how drug use by the "woman" might result in an infant's addiction. Prenatal drug use is not identified as the culprit. The plain language of bills singling out the mother pose a potential equal protection problem if a drug-using father is not similarly identified as neglectful. A law solely applicable to women will not withstand strict scrutiny.[199] Furthermore, if a drug-exposed infant *automatically* triggers a neglect report, this report may have the same chilling effect on pregnant women seeking prenatal care as would a criminal statute. Practically speaking, opposition to the enactment of legislation addressing prenatal substance abuse stems from the potentially enormous fiscal responsibility that would attach to its enforcement.[200] Already overburdened local departments of social service and protective service units would be additionally burdened in an effort to accommodate prenatal substance abuse legislation.[201]

House Bill 1459 was another attempt to incorporate some of the relevant prenatal substance abuse language into existing legislation related to alcohol and drug abuse prevention and treatment.[202] However, House Bill 1459 is too vague because it does not specify how the recommended program might be implemented. In contrast, the Bill is too narrow because it would limit the types of chemical

199. *See, e.g.*, MD. CODE ANN., CONST. art. 46, (1981) ("Equality of rights under the law shall not be abridged or denied because of sex.").

200. Telephone interview with Carla Simon, LCSW, Program Specialist, Maryland Dept. of Human Resources in Baltimore, Md. (Oct. 3, 1992).

201. *Id.*

202. H.D. 1459, Reg. Sess. (1992). The Bill's proposed amendment to MD. CODE ANN., HEALTH-GEN. § 8-402 states that "the Administration shall establish a referral procedure to link chemically dependent women referred to the Administrator under the provisions of § 1-207 of the Health Occupations article with an appropriate facility or services for the treatment of drug abuse." *Id.* The proposed amendment to the health occupations article reads in pertinent part:

> A health care practitioner who is providing health care services to a pregnant woman and who suspects that the woman is chemically dependent shall refer that woman to the Administrator of the Alcohol and Drug Abuse Administration in the Department of Health and Mental Hygiene for referral to an appropriate facility or services for the treatment of drug abuse.

Id.

dependence which trigger action.[203] As a result, while a pregnant cocaine addict may be appropriately referred for assistance under the statute, a pregnant alcoholic may not be referred.[204]

Finally, although the Maryland courts have not grappled with the problem of prenatal substance abuse, Maryland residents are not immune to this problem. Estimates indicate that approximately 7440 drug affected newborns were born in Maryland in 1990 at a total cost of 387 million dollars.[205] Efforts to enact prenatal substance abuse legislation indicate that there is a growing awareness of the effects of prenatal substance abuse: It may only be a matter of time before prenatal substance abuse is challenged in a Maryland court. Because prenatal substance abuse is bound to enter the courts, the Maryland General Assembly should assume a proactive stance, and adopt a cogent plan for addressing fetal substance exposure, which respects the rights of both mother and fetus.

VI. RECOMMENDATIONS FOR LEGISLATION

Maryland has enacted many laws providing for comprehensive health services for singular problems. Similar laws would be appropriate to address the concerns of substance abuse in pregnancy. One such law requires the establishment of a program for early identification and treatment of infants at risk for developing a hearing impairment.[206] Similar statutes related to Acquired Immune Deficiency Syndrome explicitly detail the State's expectation in the facilitation of the treatment of this illness.[207] Laws are also in place providing for the testing and education of those pregnant women at risk for having children with sickle cell disease.[208] Similar legislation established a kidney disease program with attendant services[209] and an advisory council on arthritis and related diseases.[210] These "health promotion" laws provide guidelines and definitively establish programs for the evaluation and treatment of specific medical conditions. They also provide education and direction for health care practitioners.

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203. *Id.* The proposed bill identifies "chemically dependent" as "engaging in the habitual or excessive use for a nonmedical purpose of any of the following controlled substances or their derivatives: (I) amphetamine; (II) cocaine; (III) heroin; (IV) methamphetamine; or (V) phencyclidine." *Id.*
204. *Id.*
205. *Cocaine Babies' Cost: $504 Million Study Calls for Drug Treatment of Moms-To-Be*, BALTIMORE EVENING SUN, Sept. 18, 1991, at A3.
206. MD. CODE ANN., HEALTH-GEN. § 13-602(a) (1990).
207. *Id.* § 18-333.
208. *Id.* § 18-502.
209. *Id.* § 13-301 (1990 & Supp. 1993).
210. *Id.* § 13-502.

The legislature has also explicitly directed medical practitioners to provide specific interventions under certain circumstances. For example, those who provide primary care to pregnant women are mandated to perform blood sampling for syphilis at least twice during the woman's pregnancy.[211] Another law requires that the physician or midwife attending the birth to administer certain prophylactic medication to the infant immediately thereafter.[212] Clearly, the General Assembly is not adverse to legislating matters of far reaching public health policy. Creating free-standing statutes to address particular health issues is not without precedent.

The Maryland legislature should craft prenatal substance abuse laws which reflect the thoughtfulness of the statutes just discussed. A realistic law would call for the establishment of an advisory council to address the needs of high risk pregnant women. The law should include provisions for mandatory prenatal substance abuse screening; a method of educating both patients and health care practitioners; authority to develop treatment programs geared to the peculiar needs of the pregnant addict; and infant intervention programs for those born exposed. Although the cost of such a comprehensive program may initially be substantial, failure to act may result in even higher costs in social services, education and medical care. Research suggests that the costs of crime and other economic consequences of drug abuse are actually lowered after treatment.[213] Rather than focusing upon a mother's failures, such laws may prevent negative results by directing medical practitioners to intervene early and follow through with necessary treatment. Explicit language within an existing statute would ensure that the issues of pregnant women with substance abuse problems are addressed.

VII. CONCLUSION

Prenatal substance abuse is a serious problem which can result in potentially devastating effects to a fetus. Nevertheless, the right of a fetus to be born healthy and free from injury, when weighed against a mother's right to privacy and autonomy, is limited by constitutional parameters and statutory construction. Unless laws explicitly contemplate the fetus as a legal entity, criminal sanctions against a mother will not be upheld. Although civil definitions of neglect or abuse have been construed to protect the fetus, this approach does not address the heart of the problem. Remedies which

211. *Id.* § 18-307 (1990).
212. *Id.* § 18-308.
213. National Association of State Alcohol and Drug Abuse Directors, Treatment Works: The Tragic Cost of Undervaluing Treatment in the "Drug War," 24 (1990).

serve only to protect the child do nothing to curb the problem of maternal substance abuse. A comprehensive approach to prevention and treatment for mother and child must be instituted. The Maryland General Assembly should enact a statute designed specifically to address the problem of prenatal substance abuse. Until either the Maryland General Assembly or the Maryland courts address prenatal substance abuse, the citizens of Maryland will continue to bear the long-term costs associated with infants who are born exposed to alcohol and drugs.

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