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COURT-ORDERED PRENATAL INTERVENTION: A FINAL MEANS TO THE END OF GESTATIONAL SUBSTANCE ABUSE

Michael T. Flannery*

They served their idols, which became a snare for them. They sacrificed their sons and daughters to demons.

Psalms 106:36-37

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Valerie M. is the victim of an epidemic. She was born addicted to cocaine on July 26, 1989, as a result of her mother's drug abuse during the pregnancy. Upon her delivery, she trembled violently and bellowed a piercing scream throughout the intensive care unit of the hospital—a scream easily distinguishable from those of the healthy newborns. Valerie's skin was pale and her eyes darted back and forth in her head. Because of her mother's drug abuse, during her birth Valerie had inhaled meconium, the stool of an unborn child. This inhalation would have been fatal had doctors not suctioned her air passages vigorously prior to her delivery and on an hourly basis thereafter. She required continuous personal attention and had to be separated from all external stimuli. She suffers from severe low birth weight and, if she even survives, will most likely sustain some degree of neurological, intellectual and emotional damage.[1]

[1] This scenario is based on the case of *In re* Valerie M. (Conn. Super. Ct. July 24, 1990) (LEXIS 529, States library, Conn. file), *aff'd sub nom. In re* Valerie D., 25 Conn. App. 586, 595 A.2d 922 (1991); *see also* Brower, *Children in Peril*, PEOPLE, Apr. 16, 1990, at 82; King, *Centers Will Care for Drug Babies*, Seattle Times, Oct. 7, 1990, News Section, at A15 (final ed.). For a more extensive review of the effects of prenatal drug abuse on infants, see *Born Hooked:*

However, Valerie will not suffer alone. By Valerie's first birthday, between 500 and 3,000 other drug-addicted newborns will endure the same symptoms. These children, however, will not represent the number of drug-addicted newborns born each year in the United States; they will not represent a year's total of drug-addicted newborns in Valerie's state of Connecticut; nor will they even represent the number in Valerie's hometown. Rather, these 500 to 3,000 addicted newborns represent the number who will suffer similar symptoms in the same intensive care unit of the *same hospital* as Valerie.[2] Multiplied by the number of hospitals and health services in Valerie's town, then multiplied by the number of towns in Valerie's state, then multiplied by the fifty states in this country, Valerie's story becomes commonplace.[3]

Confronting the Impact of Perinatal Substance Abuse: Hearing Before the Select Comm. on Children, Youth, and Families, House of Representatives, 101st Cong., 1st Sess. 58-60 (1989) (prepared statement by Neal Halfon, Director, Center for the Vulnerable Child, Oakland Children's Hospital, Oakland, Cal.) [hereinafter *Children, Youth, and Families*]; Rosenstein, Wheeler & Heid, *Fetal Protection: Drugs and Pregnancy The Medical Impact*, 23 MD. B.J. 23, 24-25 (May/June 1990) [hereinafter Rosenstein]; McClain, *Study Confirms to Moms: Cocaine Cripples Babies*, Gannett News Service, Oct. 16, 1990 (describing a study of ten cocaine-addicted babies in Arizona, Iowa and New York); Melvin, *When Mothers and Infants Are Addicts*, N.Y. Times, Sept. 23, 1990, § 12WC, at 1, col. 1 (discussing a new treatment program in White Plains, New York); Blakeslee, *Crack's Toll Among Babies: A Joyless View, Even of Toys*, N.Y. Times, Sept. 17, 1989, § 1, at 1, col. 2 (late ed.); Fulroth, Phillips & Durand, *Perinatal Outcome of Infants Exposed to Cocaine and/or Heroin in Utero*, 143 AM. J. DISEASES CHILDREN 905, 910 (Aug. 1989) [hereinafter Fulroth] (describing effects of prenatal cocaine and heroin exposure); Chasnoff, Hunt, Kletter & Kaplan, *Prenatal Cocaine Exposure Is Associated With Respiratory Pattern Abnormalities*, 143 AM. J. DISEASES CHILDREN 583-87 (May 1989) (concluding that prenatal exposure to cocaine has a greater effect on cardiorespiratory abnormalities than nonexposure); Fackelmann, *Cocaine Mothers Imperil Babies' Brains*, 135 SCI. NEWS 198 (Apr. 1, 1989); Langone, *Crack Comes to the Nursery*, TIME, Sept. 19, 1988, at 85 (stating that "[f]etal growth, including head and brain size, may be impaired, strokes and seizures may occur, and malformations of the kidneys, genitals, intestines and spinal cord may develop"). The length and intensity of these symptoms will vary according to the type of drug the mother has abused. *See* Rosenstein, *supra*, at 24-25 (comparing the effects of opiates, cocaine, marijuana, alcohol and tobacco on newborns exposed in utero). The effects of the drugs on the baby last much longer than with the mother. For every 20 minutes of "high" for the mother, the baby suffers for 72 hours. *See* Trost, *Born to Lose*, Wall St. J., July 18, 1989, at A1, col. 1.

[2] For a sampling of the trends in various cities, see *Children, Youth, and Families*, *supra* note 1, at 5-6 (survey requested by George Miller, Chairman, Select Committee on Children, Youth, and Families).

[3] The most recent report of the number of drug-exposed infants born in the United States every year estimates the number to be as high as 430,000. Adirim & Gupta, *A National Survey of State Maternal and Newborn Drug Testing and Reporting Policies*, 106 PUB. HEALTH REP. 292, 293 (May-June, 1991). Most previous reports estimate that 375,000 newborns, or 11% a year, are prenatally exposed to drugs. Gittler & McPherson, *Prenatal Substance Abuse: An Overview of the Problem*, CHILDREN TODAY, July-Aug. 1990, at 3; McNamara, *Snared by Drugs, Haunted by Loss; Birth in the "Death Zones,"* Boston Globe, Sept. 12, 1990, Metro/Region section, at 1. This is a 1988 figure, however, and is most likely a gross underestimate due to the

I. INTRODUCTION

As more and more children like Valerie are born each year and the numbers of those similarly situated grow at a staggering rate throughout the country,[4] courts increasingly are ordering criminal prosecution,[5] civil commitment[6] and even major surgery[7] as a means of pro-

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slipshod detection methods used by most hospitals. *See* U.S. GEN. ACCOUNTING OFFICE, REPORT TO THE CHAIRMAN, COMMITTEE ON FINANCE, U.S. SENATE, DRUG-EXPOSED INFANTS: A GENERATION AT RISK, June 28, 1990, at 18-21 [hereinafter COMMITTEE ON FINANCE]. *But see* Besharov, *Crack Children in Foster Care*, CHILDREN TODAY, July-Aug. 1990, at 21-22 (stating that 375,000 addicted newborns a year is much too high an estimate and that 40,000 to 80,000 babies a year is a more accurate figure). The percentage of children born addicted to drugs has increased each year from 1985 to 1988, *id.*, and the figure no doubt continued to increase between 1988 and 1991. *See* Gittler & McPherson, *supra*, at 4.

It is estimated that by the year 2000, the number of drug-exposed babies in the United States will be between one and four million. Cornelius, *D.C. Unit Given Help for Babies of Addicts*, Wash. Times, Sept. 18, 1990, at B1 (final ed.) (interviewing Dr. J. Ferman, executive medical director of the D.C. Institute for Mental Health). Also increasing is the 1988 estimate offered by The National Institute on Drug Abuse that five million women of childbearing age have used illicit drugs. COMMITTEE ON FINANCE, *supra*, at 1. Hospitals in Dallas, San Francisco and Florida report that 10% of all births are cocaine-related, and national figures are not very different. Revkin, *Crack in the Cradle*, DISCOVER, Sept. 1989, at 62, 64; *see also* Toufexis, *Innocent Victims*, TIME, May 13, 1991, at 56-57 (according to the National Association for Perinatal Addiction Research and Education statistics, one out of every 10 newborns is exposed in utero to illicit drugs). In Philadelphia one out of every six newborns is addicted to crack. Zucchino, *Preparing Crack-Exposed Children for the Difficult Times They Face*, Phila. Inquirer, June 2, 1991, at B1, col. 2; Cowley, *Children in Peril*, NEWSWEEK, Summer, 1991, at 18, 20 (special ed.). Some hospitals in major cities like New York and Los Angeles report figures above 20%. Toufexis, *supra*, at 45.

[4] *See* COMMITTEE ON FINANCE, *supra* note 3, at 18-19. As of 1989, over five million women of childbearing age (15-44) were users of illicit drugs, including almost one million who used cocaine and 3.8 million who used marijuana. *See Women, Addiction, and Perinatal Substance Abuse (a fact sheet): Select Comm. on Children, Youth, and Families, House of Representatives*, 101st Cong., 2d Sess., 4 (Apr. 19, 1990) (statement by George Miller, representative from California) [hereinafter *Women, Addiction, and Perinatal Substance Abuse*]; *see also* Snow, *Cocaine Babies: How Many Is Anybody's Guess*, Chicago Tribune, July 8, 1990, Tempo-DuPage section, at 3 (final ed.), which offers similar estimates but suggests that accurate statistics on drug-addicted newborns and substance abuse by pregnant mothers are hard to calculate, partly because of the difficulty in diagnosing neonatal addictions. Accurate statistics are also elusive because many pregnant women are not likely to report their substance abuse, or even seek prenatal care, out of fear of prosecution or other consequences now possible through court mandates. *See* McNamara, *supra* note 3. Unfortunately, without accurate statistics, health care facilities designed to service the epidemic are unable to plan effectively for the wave of addicted children yet to be born.

[5] *See* cases cited *infra* note 278; Sachs, *Here Come the Pregnancy Police*, TIME, May 22, 1989, at 104 (discussing various criminal prosecutions).

[6] *See infra* notes 302-17 and accompanying text.

[7] *See infra* notes 381-422 and accompanying text.

tecting the unborn from the abusive actions of the pregnant mother.[8] The questions of when, under what circumstances and even whether or not to intervene are widely contested. The effect these questions have on both the mother and the fetus will depend on the legal standard applied by the courts in answering them. Some commentators advocate applying the *Roe v. Wade*[9] standard.[10] Others prefer applying a neglected child standard.[11] Still others support a reasonable pregnant mother standard.[12]

This Article will examine the advantages and disadvantages of the various standards available to the courts in deciding when, to what degree and even whether to intervene on behalf of drug-addicted babies. It will also discuss the recent decisions reflecting the judicial view of

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[8] The effects of prenatal substance abuse extend well beyond the scope of just addicted babies. Between 40 and 50% of mothers who have gone without prenatal care will be afflicted with the AIDS virus and 30 to 50% of their babies will contract the disease. Revkin, *supra* note 3, at 66; *see also* Gittler & McPherson, *supra* note 3, at 4. According to recent statistics, women accounted for 11.5% of the AIDS cases reported in 1990. In 1981 there were six reported cases of women with AIDS; in 1990 this figure jumped to almost 5,000. Of all the women with AIDS, 29% contracted the disease through sex, while 51% were infected through intravenous drug use. Puerto Rico and New Jersey have the highest rates of women with AIDS—71 and 63 per 100,000 women, respectively. Tofani, *AIDS' Rise in Women Foreshadows Its Spread*, Phila. Inquirer, June 12, 1991, at A1, A18, col. 1. The New Jersey Department of Health reports that there were 438 cases of AIDS reported in March and April of 1991 alone. New Jersey ranks fifth in the nation in number of AIDS cases overall, behind New York, California, Florida and Texas. *438 Cases of AIDS Reported in 2-Month Period in N.J.*, Phila. Inquirer, July 8, 1991, at B2, col. 3. A separate study conducted in Philadelphia revealed that cases of women with AIDS have increased from 2% in 1984 to 12% in 1990. Tofani, *supra*, at A1, A18, col. 1. Notwithstanding the AIDS virus, an increase in syphilis among female crack users has occurred since women are "selling sex" in order to support their drug habit. *See* Gittler & McPherson, *supra* note 3, at 4. Researchers also suggest that because of the effects of cocaine addiction in newborns, addicted mothers, incapable of dealing with an addicted child, will resort to child abuse. *See* Revkin, *supra* note 3, at 66-67. "[A]ddiction to crack may substantially impair a mother's ability and willingness to provide even minimal care to her baby." Gittler & McPherson, *supra* note 3, at 5.

[9] 410 U.S. 113 (1973).

[10] *See, e.g.*, Comment, *Gestational Substance Abuse: A Call for a Thoughtful Legislative Response*, 65 WASH. L. REV. 377 (1990) (advocating that gestational drug use should be treated similarly to alcohol abuse).

[11] *See, e.g.*, Note, *The Problem of the Drug-Exposed Newborn: A Return to Principled Intervention*, 42 STAN. L. REV. 745, 773-76 (1990) (arguing that drug users do not necessarily display a predilection for neglect).

[12] *See, e.g.*, Note, *Setting the Standard: A Mother's Duty During the Prenatal Period*, 1989 U. ILL. L. REV. 493, 511 (1989) (discussing the mother's duty of care toward the child); *see also* Grodin v. Grodin, 102 Mich. App. 396, 400, 301 N.W.2d 869, 870 (1980) (holding that a child could sue a mother for the discoloration of his teeth as a result of the mother's use of tetracycline during pregnancy).

the relationship between the substance-abusing mother and the addicted, unborn child.

Part II of this Article will address the issue of fetal rights: what is the legal status of the fetus? How is the status of the fetus determined? In addition, Part II analyzes the relationship between the status given to the fetus and its effect on abortion laws, abuse and neglect laws and tort laws.

The other side of the spectrum—the maternal rights and their limits—are the subject of Part III.[13] When juxtaposed with the protection of the fetus, these rights include the right to privacy, the right to refuse medical treatment and the right to withhold treatment. These maternal rights, however, create an inherent duty of reasonableness owed to the fetus. How courts balance these rights will determine when the state may intervene.

Part IV of this Article explores the state's interests. These interests are balanced against the maternal interests in privacy and autonomy, which are rooted in the Constitution. How firmly they are rooted, however, is a question that may be unanswerable because the standard used to balance these interests is perpetually changing. This changing standard will also be examined in Part V. Whatever standard the courts choose will necessarily have a substantial effect on both the mother and the fetus.

Part VI will discuss the intervention options available to courts in determining a disposition for both the mother and the child. Choosing the intervention necessary to achieve a proper balance will necessarily require deference to the state's interest in protecting children.

This Article proposes that the state must be permitted to protect those who are unable to protect themselves—particularly, unborn children, who are entitled to and deserving of a gestation and a life that is free of the effects of gestational substance abuse. The courts should therefore apply a strict standard of care when confronted with prima facie evidence of maternal gestational substance abuse. If the mother demands the rights bestowed on those deciding to take on the status of motherhood, then she must also assume the responsibilities inherent in motherhood, including those duties that are mandated by the elected

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[13] This is not to suggest that maternal rights and fetal rights are always diametrically opposed. For purposes of this Article, however, the conflict arises when the courts must determine whose rights take priority.

representatives of the state. Furthermore, as medical technology continues to develop, the degree of intrusiveness into women's rights that is necessary to protect the fetus is minimized, and intervention on behalf of abused children becomes a mandate. However, what constitutes abuse must be statutorily, and very narrowly, construed if a strict standard is to be applied.

II. Fetal Rights: Legal Status of the Fetus

Before the courts, or anyone else, can determine the appropriate circumstances in which to intervene during a pregnancy,[14] and thereby to violate a woman's right to privacy or right to refuse medical treatment,[15] the legal status of the fetus must be defined.[16] The rights of the fetus will vary according to the legal circumstances. For example, the restricted legal status of the fetus in the context of abortion laws[17] may be different from the fetal status under state abuse and neglect law or tort law, under which the fetus may take on an entirely different penumbra of rights.

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[14] Intervention may include mandating toxicological screening of pregnant mothers and newborns, *infra* notes 248-72 and accompanying text; criminalization of specifically defined conduct, *infra* notes 273-301 and accompanying text; civil commitment in order to promote treatment, *infra* notes 302-17 and accompanying text; and various medical interventions ranging from cesarean section orders, *infra* notes 380-422 and accompanying text, to sterilization, *infra* notes 423-48 and accompanying text.

[15] *See infra* text accompanying notes 122-40.

[16] *See generally* Murray, *Moral Obligations to the Not-Yet Born: The Fetus as Patient*, 14:2 CLINICS IN PERINATOLOGY 329 (1987) (discussing fetal intervention implications of advancements in the status of the fetus). For a very brief discussion of the status of the fetus under property and inheritance law, which is not discussed here, see Rickhoff & Cukjati, *Protecting the Fetus From Maternal Drug and Alcohol Abuse: A Proposal for Texas*, 21 ST. MARY'S L.J. 259, 276 (1989).

Much of the abortion debate turns on whether the fetus is a person. As a result, the abortion debate unfolds on two levels. The first level deals strictly with the issue of "personhood." There are those who advocate that the fetus is not a person and therefore never reach the second level of the debate. This second level revolves around the presumed status of the fetus as a person. In order to debate on the second level, both advocates must acknowledge the status of the fetus as a person.

This Article will not argue the merits of "personhood" or the "potentiality of being," which are encompassed within the first level of debate. However, in terms of the abortion discussion, this Article will argue from the perspective of the second level of debate—that the fetus is a person. The term "status," for purposes of this Article, will refer to the disposition of having or acquiring legal rights.

[17] An argument is made in Myers, *Abuse and Neglect of the Unborn: Can the State Intervene?*, 23 DUQ. L. REV. 1, 15-17 (1984), that *Roe v. Wade* restricts fetal rights only in the fourteenth amendment arena. *Id.* (citing *Roe*, 410 U.S. 113 (1973)).

A. Abortion Law

Any action taken under color of state abortion law will naturally affect the rights of both the mother and the fetus. If abortion laws are liberalized, the rights of the mother broaden, while fetal rights become limited. As legislatures adopt more restrictive abortion laws, the rights of the fetus may expand at the expense of the mother's rights.

Of course, *Roe v. Wade*[18] has become the high water mark for the rights of the pregnant woman.[19] In *Roe* the Supreme Court found that a woman's right to terminate pregnancy was encompassed within her right to privacy.[20] Although the state may interfere with that right in order to protect its interest in the potentiality of human life, this interest only becomes compelling at viability, which the Court found begins at the third trimester.[21] The Court permitted the state to interfere during the second trimester only to protect the mother's health.[22] The Court allowed no interference during the first trimester.[23]

The trimester theory was labeled "rigid" in *Webster v. Reproductive Health Services*,[24] which upheld a state statute requiring viability tests to be performed prior to abortions of fetuses twenty weeks or older in order to ensure that a viable fetus was not aborted.[25] The Court in *Webster* recognized the need for a modification of *Roe* in order to effectuate its holding.[26] Thus, the Court refused to restrict the compelling interest of the state to the third trimester, as in *Roe*.[27] Rather, the pinpoint for viability will be only as limited as the advances in medical technology proscribe.[28]

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[18] 410 U.S. 113 (1973).

[19] *See infra* notes 122-45 and accompanying text.

[20] *Roe*, 410 U.S. at 153.

[21] *Id.* at 163.

[22] *Id.*

[23] *Id.* at 163-64.

[24] 492 U.S. 490, 515-17 (1989).

[25] *Id.* at 515.

[26] *Id.* at 518.

[27] *See Roe*, 410 U.S. at 163-64.

[28] *See* Murray, *supra* note 16, at 332-34 (discussing the relevancy of viability); Rickhoff & Cukjati, *supra* note 16, at 264-65 (arguing that advances in medical technology will continually push back in gestation the point of viability); *see also infra* text accompanying notes 323-79. In *Colautti v. Franklin*, 439 U.S. 379, 388-89, 396 (1979), the Court noted that the determination of the viability of a fetus must be left to the discretion of a physician and should not be temporally fixed in gestation by any individual factor. *Id.*

Advances in ultrasound and fiber-optic cameras have opened up the frontier for the development of in-utero technology. Consequently, scientists are uncovering ground breaking information

Although *Roe* seems to pit the mother and the fetus against each other with respect to the acquisition or protection of rights,[29] commentators generally agree that the restrictive scope of *Roe* does not reach so far into the realm of fetal rights as to deny a wrongful death action for a pre-viable fetus.[30] However, the dilemma for courts preparing to force medical treatment on a substance-abusing mother becomes most apparent when the court is faced with the resulting curtailment of the maternal rights as granted in *Roe*. How can a court order a drug-addicted mother to undergo major surgery, and indeed even prosecute her criminally for neglect or abuse, while also granting her the right to extinguish the life of the fetus prior to viability? Seemingly, this is a non sequitur. Unfortunately, the option to abort offered in *Roe* does not render the choice a difficult one for a substance-abusing woman since

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about the development of the fetus. For example, scientists have discovered signs of consciousness in fetuses only seven months old. Brain waves that assimilate dreaming have been recorded in eight-month-old fetuses, and sentience has been pushed back in gestation to the second trimester. It is now known that after 28 weeks of gestation, the fetus is able to hear and respond to sound. Scientists are continually finding that their earlier estimates of the time during gestation when the fetus naturally develops certain organs were too conservative. At *four weeks*, the fetus has a pulsing heartbeat. At *eight weeks*, the fetus is no longer termed an "embryo" as it now has all of its organs in place—limbs, hands and feet have taken shape and the fetus now begins to move; neural cells in the brain are now functioning. The fetus is able to open and close its mouth by the *eleventh week*. By the *fourth month*, the fetus can visibly move its lips and display facial expressions; it is able to turn its head to the side, grasp with its hands and kick with its feet; hair begins to develop and at this point, all 5 million ova have formed in the female fetus. The nervous system is connected by the *sixth month*. During the *seventh month*, the fetus opens its eyes and is able to react to light and sound; it can now distinguish between new and old and is able to pay attention. It will sleep and wake as a normal child; the fetus is now able to survive a premature birth. At the *eighth month*, the fetus has developed as many brain cells as it will have at birth. By the *ninth month*, brain waves are fully functioning; a healthy fetus now produces the hormone ACTH, which will stimulate the uterus and contract labor. Begley, *Do You Hear What I Hear?*, NEWSWEEK, Summer, 1991, at 12-14 (special ed.).

[29] *See* Note, *Rethinking (M)otherhood: Feminist Theory and State Regulation of Pregnancy*, 103 HARV. L. REV. 1325, 1326, 1335-37 (1990) (suggesting that legal analysis must not focus on the conflict between the mother and the fetus, but rather on the interdependence of each). The commentator, suggesting that state intervention is a tool for subordination of the woman's familial role, in effect subordinates fetal dependence for life to the maternal desire for autonomy. *Id.* at 1337. Similarly, other commentators argue that the holding in *Webster*, through an expansive characterization of fetal rights, served to undermine the rights of women by distinguishing the mother and the fetus as two separate entities, thereby creating a legal conflict and furthering restrictions on abortions. *See* Johnsen, *From Driving to Drugs: Governmental Regulation of Pregnant Women's Lives After Webster*, 138 U. PA. L. REV. 179, 179-81 (1989).

[30] *See generally* Kadar, *The Law of Tortious Prenatal Death Since Roe v. Wade*, 45 MO. L. REV. 639 (1980); *see also infra* text accompanying notes 101-21.

by opting to abort the baby she is abusing, she also aborts potential criminal prosecution.[31]

However, the influence of *Roe v. Wade* and its effect on other areas of law is questionable.[32] Conceivably, the issue of a mother's right to bring the fetus to term stands completely apart from the mother's right to act contrary to the well-being of the fetus while carrying it to term.[33] Whereas *Roe* addresses the woman's right to *have* a child, the issue in prenatal abuse cases is distinctive and turns on the mother's right to *mistreat* the fetus commissively while exercising her right to carry it to term.[34] Whereas *Webster* uses viability to draw the line for a woman's right to privacy or autonomy, a woman's freedom to commit acts resulting in harm to the fetus is not dependent on any qualifying terms, such as "personhood" or "viability."[35] Therefore, the legal and

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[31] Many commentators point to the potential for increased abortions as an escape from criminal prosecution for gestational substance abuse. One commentator, who opposes the criminalization of maternal substance abuse, recognizes: "An addict who discovers that she is pregnant cannot definitely avoid this added punishment unless she aborts the fetus." Roberts, *Drug-Addicted Women Who Have Babies*, TRIAL, Apr. 1990, at 56, 58.

[32] Simon, *Parental Liability for Prenatal Injuries*, 14 COLUM. J. L. & SOC. PROBS. 47, 84-86 (1978) (suggesting that *Roe* has little relevance in cases involving medical treatment). *But see* Wallace v. Wallace, 120 N.H. 675, ____, 421 A.2d 134, 137 (1980) (relying on *Roe* to deny liability for negligently committed acts that harm the fetus).

[33] *See* Robertson, *Procreative Liberty and the Control of Conception, Pregnancy, and Childbirth*, 69 VA. L. REV. 405, 438 (1983) (supporting the argument that this distinction provides the fetus with a right to be free from harmful maternal conduct during gestation).

[34] For a view acknowledging, yet rejecting, this distinction as violative of *Roe v. Wade*, see Johnsen, *The Creation of Fetal Rights: Conflicts with Women's Constitutional Rights to Liberty, Privacy, and Equal Protection*, 95 YALE L.J. 599, 611-13 (1986) (supporting the position that restrictions by the state on the mother's sphere of appropriate acts during pregnancy will violate women's rights by the self-authorization of courts to define socially acceptable behavior). *But see* Mainor, *Fetal Protection: Drugs & Pregnancy*, 23 MD. B.J. May-June 1990, at 23, 26 (stating that this distinction may withstand arguments to the contrary). Supporting the distinction, Mainor writes: "[E]ven if a fetus does not have a right to be brought to term, it has rights if it will be brought to term—if the mother is not going to have an abortion, she owes an obligation to the fetus not to harm it." *Id.*

[35] Some states maintain abortion statutes making it a crime for a woman to take drugs in order to induce a miscarriage or abortion. *See, e.g.*, WASH. REV. CODE ANN. § 9.02.020 (1988), which states:

> Every pregnant woman who shall take any medicine, drug or substance, or use or submit to the use of any instrument or other means, with intent thereby to produce her own miscarriage, unless the same is necessary to preserve her life or that of the child whereof she is pregnant, shall be punished by imprisonment in the state penitentiary for not more than five years or by a fine of not more than one thousand dollars.

North Carolina maintains a similar statute criminalizing the administration of drugs to a woman with the intent of destroying the child. The language of the statute would include the woman herself:

ethical dilemmas surrounding the problem of fetal abuse can be discussed outside the restrictions of abortion standards.[36] Nevertheless, this distinction, which limits the mother's constitutionally protected right of privacy to the decision of whether to terminate her pregnancy, will be crucial as state abortion laws are enacted and interpreted.[37]

B. *Abuse and Neglect Law*

Presently, at least ten states and the District of Columbia have statutorily addressed the issue of gestational substance abuse.[38] The most comprehensive approach by a state legislature in addressing the problem is Minnesota's. The Minnesota statute includes prenatal exposure to drugs in its definition of neglect;[39] it mandates reporting[40] and

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> If any person shall willfully administer to any woman, either pregnant or quick with child, or prescribe for any such woman, or advise or procure any such woman to take any medicine, drug or other substance whatever, or shall use or employ any instrument or other means with intent thereby to destroy such child, he shall be punished as a Class H felon.

N.C. GEN. STAT. § 14-44 (1986).

[36] *See* Murray, *supra* note 16, at 330-31; Lisman, *Substance Abuse During Pregnancy: A Case for State Intervention to Protect Children from Prenatally Caused Harm*, B. B.J., July/Aug. 1990, at 26. *But see* Johnsen, *supra* note 29, at 180, 215 (asserting that the fetus is mistakenly endowed with rights within the abortion context that affect the legal debate concerning women's rights within the maternal substance abuse context).

[37] Some feel that criminalizing gestational substance abuse (*see infra* notes 273-301 and accompanying text) based on this distinction is a means of attacking the holding in *Roe v. Wade*. *See* Sachs, *supra* note 5, at 105.

[38] The ten states other than the District of Columbia include: California, Florida, Illinois, Indiana, Massachusetts, Minnesota, Nevada, Oklahoma, South Dakota and Utah. *See* DeBettencourt, *The Wisdom of Solomon: Cutting the Cord That Harms*, CHILDREN TODAY, July-Aug. 1990, at 17, 18 (discussing state statutes); Adirim & Gupta, *supra* note 3, at 293 (reporting that ten states categorize their reports of gestational substance abuse as child abuse or neglect).

[39] See MINN. STAT. ANN. § 626.556(2)(c) (West Supp. 1991), which provides:

> Neglect includes prenatal exposure to a controlled substance, as defined in section 253B.02, subdivision 2, used by the mother for a nonmedical purpose, as evidenced by withdrawal symptoms in the child at birth, results of a toxicology test performed on the mother at delivery or the child at birth, or medical effects or developmental delays during the child's first year of life that medically indicate prenatal exposure to a controlled substance.

[40] Specific persons would be required to report incidents of gestational drug abuse pursuant to the normal requirements for reporting any form of abuse or neglect. *See id.* § 626.556(3), which states in part:

> (a) A person who knows or has reason to believe a child is being neglected . . . as defined in subdivision 2, . . . shall immediately report the information to the local welfare agency, police department, or the county sheriff if the person is:
>
> (1) a professional or professional's delegate who is engaged in the practice of the healing arts, social services, hospital administration, psychological or psychiatric treatment, child care, education, or law enforcement; or

it requires toxicological screening.[41] Wisconsin also requires toxicological screening of newborns.[42] Reporting of gestational substance abuse is

> (2) employed as a member of the clergy . . . .
> (b) Any person may voluntarily report to the local welfare agency, police department, or the county sheriff if the person knows, has reason to believe, or suspects a child is being or has been neglected . . . .

The same people will also be required to report pursuant to § 626.5561, which specifically requires reporting of prenatal exposure to controlled substances:

> A person mandated to report under section 626.556, subdivision 3, shall immediately report to the local welfare agency if the person knows or has reason to believe that a woman is pregnant and has used a controlled substance for a nonmedical purpose during the pregnancy. Any person may make a voluntary report . . . . Any report shall be of sufficient content to identify the pregnant woman, the nature and extent of the use, if known, and the name and address of the reporter.

Id. § 626.5561(1).

[41] The Minnesota statute requires toxicology tests from both the mother and the child. Subdivision 1 of § 626.5562, requiring tests from the mother, states in part:

> A physician shall administer a toxicology test to a pregnant woman under the physician's care or to a woman under the physician's care within eight hours after delivery to determine whether there is evidence that she has ingested a controlled substance, if the woman has obstetrical complications that are a medical indication of possible use of a controlled substance for a nonmedical purpose. If the test results are positive, the physician shall report the results . . . . A negative test result does not eliminate the obligation to report . . . if other evidence gives the physician reason to believe the patient has used a controlled substance for a nonmedical purpose.

Id. § 626.5562(1).

Subdivison 2 of § 626.5562, requiring tests from the child, states in part:

> A physician shall administer to each newborn infant born under the physician's care a toxicology test to determine whether there is evidence of prenatal exposure to a controlled substance, if the physician has reason to believe based on a medical assessment of the mother or the infant that the mother used a controlled substance for a nonmedical purpose during the pregnancy. If the test results are positive, the physician shall report the results as neglect . . . . A negative test result does not eliminate the obligation to report . . . if other medical evidence of prenatal exposure to a controlled substance is present.

Id. § 626.5562(2); *see* Horowitz, *Perinatal Substance Abuse*, CHILDREN TODAY, July-Aug. 1990, at 8, 9 (discussing various reporting requirements).

[42] *See* WISC. STAT. ANN. § 146.0255(2) (West Supp. 1991), which provides:

> Any hospital employe [sic] who provides health care, social worker or foster care intake worker may refer an infant to a physician for testing of the infant's bodily fluids for controlled substances if the hospital employe [sic] who provides health care, social worker or foster care intake worker suspects that the infant has controlled substances in * * * *the infant's* bodily fluids because of * * * *the* mother's ingestion of controlled substances while she was pregnant with the infant. The physician may test the infant to ascertain whether or not the infant has controlled substances in * * * *the infant's* bodily fluids, if the * * * parent or guardian * * * *consents* to the testing * * * *and* if * * * *the physician* determines that there is a serious risk that there are controlled substances in the infant's bodily fluids because of * * * *the* mother's ingestion of controlled substances while she was pregnant with the infant. If the results of the test indicate that the infant does have controlled substances in * * * *the infant's* bodily fluids, the physician shall make a report . . . .

expressly mandated by other states,[43] including, for example, Massachusetts,[44] Oklahoma,[45] Illinois[46] and Utah.[47] California, however, spe-

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[43] A 1991 report of a national survey of testing and reporting policies indicates that thirteen states have mandatory reporting requirements to either social service agencies, child protection services or criminal justice agencies. These include: the District of Columbia, Florida, Georgia, Indiana, Kansas, Massachusetts, Minnesota, New York, Oklahoma, Rhode Island, Utah, Washington and Wisconsin. Adirim & Gupta, *supra* note 3, at 293-94.

[44] MASS. GEN. LAWS ANN. ch. 119, § 51A (West Supp. 1991) states in pertinent part:

> Any physician, medical intern, hospital personnel engaged in the examination, care or treatment of persons, medical examiner . . . or any person paid to care for or work with a child in any public or private facility . . . who, in his professional capacity shall have reasonable cause to believe that a child . . . is determined to be physically dependent upon an addictive drug at birth, shall immediately report such condition to the department by oral communication and by making a written report within forty-eight hours after such oral communication . . . .

[45] OKLA. STAT. ANN. tit. 21, § 846(A) (West Supp. 1992) states in part:

> Every physician or surgeon, including doctors of medicine, licensed osteopathic physicians, residents and interns, or any other health care professional attending the birth of a child who appears to be a child born in a condition of dependence on a controlled dangerous substance shall promptly report the matter to the county office of the Department of Human Services in the county in which such birth occurred.

[46] The Illinois law states:

> Any physician, resident, intern, hospital, hospital administrator and personnel engaged in examination, care and treatment of persons, . . . having reasonable cause to believe a child known to them in their professional or official capacity may be an abused child or a neglected child shall immediately report or cause a report to be made to the Department.

ILL. ANN. STAT. ch. 23, para. 2054, § 4 (Smith-Hurd 1988 & Supp. 1991) (requiring reporting).

Paragraph 2057.3b *permits* referrals of addicted pregnant women for services by those required to report under § 4 above: "All persons required to report under Section 4 may refer to the Department of Public Health any pregnant person . . . who is addicted as defined in the Illinois Alcoholism and Other Drug Dependency Act. . . ." *Id.* para. 2057.3b, § 7.3b (addressing permissive referrals).

[47] UTAH CODE ANN. § 62A-4-504 (1987 & Supp. 1990) states:

> When any person, including a licensee under the Medical Practice Act or the Nurse Practice Act, attends the birth of a child or cares for a child, and determines that the child, at the time of birth, has fetal alcohol syndrome or fetal drug dependency, he shall report that determination to the division as soon as possible.

The Pennsylvania Senate is now in the process of legislating Senate Bill No. 1197, known as the Substance-Exposed Infant Identification, Intervention and Prevention Act, which also mandates reporting by doctors to private social service agencies of newborns who test positive for drugs or who show signs of withdrawal. The bill also provides for voluntary services for addicted women. *See* S.B. 1197, Pa. Gen. Assembly (1991). For views both for and against S.B. 1197, compare Frietsche, *Why Hurt Drug-Addicted Mothers?*, Phila. Inquirer, Aug. 11, 1991, at F7 (advocating the elimination of mandatory reporting of "drug babies" but supporting voluntary services) with Greenwood, *Society's Obligations to Helpless Children Come First*, Phila. Inquirer, Aug. 11, 1991, at F7 (supporting S.B. 1197).

cifically states that a positive toxicological screen is not, alone, sufficient to mandate reporting.[48]

In Minnesota and Kansas, positive drug tests are indicated on the infants' birth certificates.[49] Florida qualifies maternal substance abuse as "abuse and neglect" under its definition of "harm"[50] and statutorily provides for appointments of "guardian advocates"[51] on behalf of the child.[52] Indiana makes a finding of gestational substance abuse suffi-

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[48] *See* CAL. PENAL CODE § 11165.13 (West Supp. 1991) (operative July 1, 1991), which states in part:

> [A] positive toxicology screen at the time of the delivery of an infant is not in and of itself a sufficient basis for reporting child abuse or neglect. However, any indication of maternal substance abuse shall lead to an assessment of the needs of the mother and child . . . . If other factors are present that indicate risk to a child, then a report shall be made. However, a report based on risk to a child which relates solely to the inability of the parent to provide the child with regular care due to the parent's substance abuse shall be made only to county welfare departments and not to law enforcement agencies.

Aside from the reporting requirement, if gestational drug abuse becomes a prosecutorial offense, "[t]he role of the doctor would be as judge, jury, and prosecutor. . . . Every obstetrician and gynecologist will be in court testifying." Marcotte, *Crime & Pregnancy*, A.B.A. J., Aug. 1989, at 16 (quoting Walter Connolly, Jr., a Detroit lawyer who represents hospitals).

[49] Adirim & Gupta, *supra* note 3, at 293.

[50] Under FLA. STAT. ANN. § 415.503(3) (West Supp. 1991), "child abuse or neglect" is defined as "harm or threatened harm to a child's physical or mental health or welfare by the acts or omissions of the parent or other person responsible for the child's welfare."

> "Harm" to a child's health or welfare can occur when the parent or other person responsible for the child's welfare:
>
> (a) Inflicts, or allows to be inflicted, upon the child physical or mental injury. Such injury includes, but is not limited to:
>
> 2. Physical dependency of a newborn infant upon any drug . . . with the exception of drugs administered in conjunction with a detoxification program . . . , or upon drugs administered in conjunction with medically approved treatment procedures; provided that no parent of such a newborn infant shall be subject to criminal investigation solely on the basis of such infant's drug dependency . . . .

Id. § 415.503(9)(a).

[51] " 'Guardian advocate' means a person appointed by the court to act on behalf of a drug dependent newborn . . . ." *Id.* § 415.503(4).

[52] *See id.* § 415.5082, which states:

> The Legislature finds that increasing numbers of drug dependent children are born in this state. Because of the parents' continued dependence upon drugs, the parents may temporarily leave their child with a relative or other adult or may have agreed to voluntary family services . . . . The relative or other adult may be left with a child who is likely to require medical treatment but for whom they are unable to obtain medical treatment. The purpose of this section is to provide an expeditious method for such relatives or other responsible adults to obtain a court order which allows them to provide consent for medical treatment and otherwise advocate for the needs of the child and to provide court review of such authorization.

See also Comment, *Legal Representation of a Fetus: The Mother and Child Disunion?*, 18 CAP. U.L. REV. 591, 591-92 (1989) (briefly commenting that appointments of guardians *ad litem* for the fetus is further indication of the advancing legal status of the fetus).

cient to categorize the newborns as "children in need of services."[53] Similarly, Nevada determines these children to be "in need of protection."[54] Utah[55] and Illinois[56] also explicitly include the newborn infant within their definitions of "child abuse or neglect."[57] By doing so, these states free prosecutors from the statutory limitations faced by many frustrated law enforcement officials in other states.[58]

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[53] IND. STAT. ANN. § 31-6-4-3.1 (Burns Supp. 1991), which states, in part:

> A child is a child in need of services if:
>
> (1) The child is born with:
>
> (A) Fetal alcohol syndrome; or
>
> (B) An addiction to a controlled substance or a legend drug; or
>
> . . .
>
> (C) Is at a substantial risk of a life threatening condition; that arises or is substantially aggravated because the child's mother used alcohol, a controlled substance, or a legend drug during pregnancy; and needs care, treatment, or rehabilitation that the child is not receiving, or that is unlikely to be provided or accepted without the coercive intervention of the court.

[54] NEV. REV. STAT. ANN. § 432B.330(1)(b) (Michie 1986 & Supp. 1989), which states in part: "A child is in need of protection if: . . . [h]e is suffering from congenital drug addiction or the fetal alcohol syndrome, because of the faults or habits of a person responsible for his welfare. . . ."

[55] *See* UTAH CODE ANN. § 62A-4-504 (1989 & Supp. 1991).

[56] ILL. ANN. STAT. ch. 23, para. 2053, § 3 (Smith-Hurd 1988 & Supp. 1991) states in part:

> "Neglected Child" means any child . . . who is a newborn infant whose blood or urine contains any amount of a controlled substance . . . or a metabolite thereof, with the exception of a controlled substance or metabolite thereof whose presence in the newborn infant is the result of medical treatment administered to the mother or the newborn infant.

[57] *But cf.* Burns v. Alcala, 420 U.S. 575, 580-81 (1975) (holding that "child" does not include the unborn); Reyes v. Superior Court, 75 Cal. App. 3d 214, 141 Cal. Rptr. 912, 913-15 (1977).

[58] Maryland, for example, like most other states, does not explicitly include the fetus within its definition of "child." Some feel, however, that this omission is not a complete barrier to successful prosecution and that broad interpretations of other statutes will serve the prosecutor's purpose. *See* Mainor, *supra* note 34, at 26-27 (1990) (discussing possible statutory manipulations of the Maryland Code).

Were Maryland's statutory definition of "child" to include the newborn fetus, as in Utah, *see* UTAH CODE ANN. § 62A-4-504, and Illinois, *see* ILL. ANN. STAT. ch. 23, para. 2053, § 3, then § 35A would create felony liability for harm done to the child as a result of maternal drug abuse. *See* Mainor, *supra* note 34, at 26. Section 35A(2) states in part: "'Abuse' means: . . . [t]he sustaining of physical injury by a child as a result of cruel or inhumane treatment or as a result of a malicious act by any parent . . . under circumstances that indicate that the child's health or welfare is harmed or threatened thereby; . . . ." MD. ANN. CODE art. 27, § 35A(a)(2)(i) (Supp. 1991). Similarly, if the fetus were statutorily defined as a "person," then § 120(a), which states: "Any person who recklessly engages in conduct that creates a substantial risk of death or serious physical injury to another person is guilty of the misdemeanor of reckless endangerment and on conviction is subject to a fine not exceeding $5,000 or imprisonment not exceeding 5 years or both," would apply. *Id.* § 120(a).

Although South Dakota does not expressly include the fetus within its statutory definition of abuse or neglect, it impliedly does so within the context of another statute.[59] Section 26-1-2 of South Dakota Codified Laws holds a fetus to be an existing person for purposes of its interests subsequent to birth.[60] Therefore, when there is harm to the child as a result of the mother's abusive actions while pregnant, the fetus will qualify under the definition of neglect.[61] Likewise, the District of Columbia Code does not contain express language including the fetus; however, the language of the Code may be construed as qualifying gestational substance abuse as "abuse." Under section 6-2101, " '[A]buse[],' when used in reference to a child, means a child whose

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The Code need not be read to include the fetus within the definition of "child" in order that § 3-831 apply. Section 3-831(a) makes it "unlawful for an adult willfully to contribute to, encourage, cause or tend to cause any act, omission, or condition which results in a violation, renders a child delinquent, in need of supervision, or in need of assistance." MD. CTS. & JUD. PROC. CODE ANN. § 3-831(a) (1989 & Supp. 1991). Because the statute addresses a child who *has been caused* to be in need of supervision, or the like, the statute must be read to include the *act* and not the victim or its qualification.

Finally, § 286 and § 287, read in accordance with § 277, would make it a crime to "dispense" or "administer" a controlled dangerous substance. MD. ANN. CODE art. 27, § 277(i) (1988 & Supp. 1991), defines "delivery" as "attempted transfer, exchange, or delivering . . . from one person to another." "Administer" is defined as "introduc[ing] . . . substance[s] into the system of a human being." *Id.* § 277(a). Thus, the fetus, upon birth and prior to the severance of the umbilical cord, may qualify as a "person" or "human being" under these statutes. *See* Mainor, *supra* note 34, at 26. As in the Jennifer Johnson case, however, the applicability of these types of statutes depends upon successfully proving that the drug or drugs passed through the umbilical cord during the moments immediately following birth. *See* Florida v. Johnson, 578 So. 2d 419 (Fla. Dist. Ct. App. 1991).

[59] *See* S.D. CODIFIED LAWS ANN. § 26-1-2 (1984 & Supp. 1991), which states: "A child conceived, but not born, is to be deemed an existing person so far as may be necessary for its interests in the event of its subsequent birth."

[60] *See id.*

[61] The South Dakota statute defines a "neglected child" as a child:

(1) Whose parent, guardian, or custodian has abandoned him or has subjected him to mistreatment or abuse;

(2) Who lacks proper parental care through the actions or omissions of the parent, guardian, or custodian;

(3) Whose environment is injurious to his welfare;

(4) Whose parent, guardian, or custodian fails or refuses to provide proper or necessary subsistence, supervision, education, medical care or any other care necessary for the child's health, guidance, or well-being;

. . .

(6) Who is threatened with substantial harm;

(7) Who has sustained emotional harm or mental injury as indicated by an injury to the child's intellectual or psychological capacity evidenced by an observable and substantial impairment in the child's ability to function within the child's normal range of performance and behavior . . . .

S.D. CODIFIED LAWS ANN. § 86-8A-2 (Supp. 1991).

parent . . . inflicts or fails to make reasonable efforts to prevent the infliction of physical . . . injury upon the child, including . . . an injury that results from exposure to drug related activity."[62]

Gestational substance abuse has qualified as abuse and neglect without express statutory language in other states as well. For example, in *In re Valerie M.*,[63] the Connecticut Superior Court held that a child could be characterized as abused[64] and neglected[65] as a result of the physical injuries inflicted by the mother's substance abuse during pregnancy. Other jurisdictions have upheld similar claims of neglect.[66] Although the action in *In re Valerie M.* was brought on behalf of a child presently neglected, the court did not necessarily reject cases holding that fetal injuries sustained in utero are actionable upon birth. In es-

[62] D.C. CODE ANN. § 6-2101 (1989 & Supp. 1990) (defining abuse).

[63] (Conn. Super. Ct. July 24, 1990) (LEXIS 529, States library, Conn. file), *aff'd sub nom. In re* Valerie D., 25 Conn. App. 586, 595 A.2d 922 (1991). On appeal, the Connecticut Appellate Court held that the termination of parental rights may be based solely on the mother's prenatal conduct. *In re* Valerie D., 25 Conn. App. 586, 593, 595 A.2d 922, 925-26 (1991). The court stated that the state's compelling interest in protecting the well-being of children is not "diluted" because of the prenatal causation of the injuries. *Id.* at 593, 595 A.2d at 925.

[64] (Conn. Super. Ct. Mar. 28, 1990) (LEXIS 529, States library, Conn. file at 23). The court stated:

> The fact that Jean injected cocaine eight hours before her birth rather than eight hours after is irrelevant; her act in introducing cocaine into the bloodstream of an infant about to be born is just as much abuse as if she had done so immediately after birth. Valerie's condition at the moment of birth was the direct result of maltreatment.

Id.

[65] *Id.*, stating:

> Failure of the parents to seek and pursue prenatal care, ignoring repeated warnings as to the detriment to the unborn of maternal drug abuse, the continued use of injected cocaine throughout the pregnancy, and, finally, the intravenous injection of cocaine into the bloodstream of the mother . . . after initiation of labor, resulted in a tangible denial of proper care and attention physically and, projected into the future, educationally and emotionally as well.

[66] *See, e.g., In re* Troy D., 215 Cal. App. 3d 889, 263 Cal. Rptr. 869 (1990); *In re* Baby X., 97 Mich. App. 111, 293 N.W.2d 736 (1980); Department of Social Servs. v. Felicia B., 144 Misc. 2d 169, 543 N.Y.S.2d 637 (Fam. Ct. 1989); *In re* Danielle Smith, 128 Misc. 2d 976, 492 N.Y.S.2d 331 (Fam. Ct. 1985); *In re* Ruiz, 27 Ohio Misc. 2d 31, 500 N.E.2d 935 (Com. Pl., 1986). *But see In re* Steven S., 126 Cal. App. 3d 23, 178 Cal. Rptr. 525 (1981) (unborn child did not qualify as a dependent minor under CAL. WELF. & INST. CODE, § 300(a) (1984 & Supp. 1992)); *In re* Dittrick Infant, 80 Mich. App. 219, 263 N.W.2d 37 (1977) (although unborn child could qualify as "child," legislature did not intend such use regarding child custody in probate court); Cox v. Court of Common Pleas, 42 Ohio App. 3d 171, 537 N.E.2d 721 (1988) (juvenile court lacked jurisdiction to regulate conduct of pregnant woman in order to protect the fetus).

sence, the court provided the fetus with the legal rights traditionally associated with an abused or neglected, but viable, child.[67]

The court in *In re Valerie M.* also addressed the issue of prospective neglect resulting from drug abuse during pregnancy.[68] Prospective neglect occurs when a court can clearly and certainly predict that the child will be adversely affected by similar parental behavior in the future.[69] To establish prospective neglect, it appears that Florida courts must find that no reasonable basis exists for improvement.[70] In another case addressing this issue,[71] a New York Appellate Division court reversed the trial court's dismissal of a neglect petition based on gestational substance abuse by the mother. The trial court dismissed on the ground that an adjudication of neglect could not result from prenatal conduct.[72] The appellate court reversed, holding that because the mother admitted to drug use during pregnancy, because there was a positive toxicology for cocaine in the child at birth and because the mother was not enrolled in any rehabilitative program that would offer some reasonable basis for improvement, there was a sufficient cause of action for prospective neglect.[73]

In addition, a court may find prima facie evidence of neglect and abuse sufficient to terminate parental rights.[74] In doing so, a court may

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[67] *See* Murray, *supra* note 16, at 331 (supporting the theory that the time at which the harm is caused to the child is morally irrelevant).

[68] *See In re* Valerie M., (Conn. Sup. Ct. Mar. 28, 1990) (LEXIS 529, States library, Conn. file); *see also In re* Troy D., 215 Cal. App. 3d 889, 263 Cal. Rptr. 869 (1989); *In re* Baby X., 97 Mich. App. 111, 293 N.W.2d 736 (1980)); *In re* Ruiz, 27 Ohio Misc. 2d 31, 500 N.E.2d 935 (Ct. Comm. Pl. 1986); DeBettencourt, *supra* note 38, at 19 (discussing *In re* Troy D. and *In re* Baby X.).

[69] Palmer v. Department of Human and Rehab. Servs., 547 So. 2d 981 (Fla. Dist. Ct. App. 1989). For a discussion of prospective abuse and neglect, see generally Note, *Prospective Abuse and Neglect — The Termination of Parental Rights*, 14 NOVA L. REV. 1171 (1990).

[70] Note, *supra* note 69, at 1190.

[71] *In re* Stefanel Tyesha C., 157 A.D.2d 322, 556 N.Y.S.2d 280 (App. Div. 1990).

[72] *Id.*

[73] *Id.*

[74] *In re* Valerie M., (Conn. Super. Ct. Mar. 28, 1990) (LEXIS 529, States library, Conn. file at 25-26); *see* Horowitz, *supra* note 41, at 12 (describing the changing standards for terminating parental rights in various state laws); Jost, *Mother Versus Child*, A.B.A. J., Apr. 1989, at 84, 88 (reporting that in one six-month period in 1988, the Nassau County Department of Social Services had obtained 33 removal orders resulting from positive toxicology exams).

One effect of terminating parental rights is that these children will then be placed in the already overcrowded foster care system. *See infra* notes 363-69 and accompanying text. "If we took every child who came out with a positive tox screen, it would overwhelm the system." Willwerth, *Should We Take Away Their Kids?*, TIME, May 13, 1991, at 62, 63 (quoting Gerhard Moland, a children's services administrator in Los Angeles). One way of eliminating, or at least

use the same standard for a fetus as for a finding of abuse of a child; that is, the injection of cocaine into the bloodstream of a fetus should have no different legal consequences than the act of injecting it into a newborn.[75] Thus, although the *Valerie M.* court did not speak directly to the issue, it points to the conclusion that prenatal substance abuse may be prima facie evidence sufficient to terminate the parental rights of the mother in her fetus since the fetus is given the status of a neglected child.[76] Therefore, the state, instituting its *parens patriae* power over the fetus, may intervene on the fetus' behalf.[77] Consistent with this line of reasoning is the proposition that the state should prosecute similarly those giving drugs to a child and those giving drugs to a fetus.[78] If a mother who gives her child drugs may be prosecuted,[79] and if the act of injecting cocaine into the bloodstream of a fetus has the same legal consequences as injecting it into a newborn, then the mother should be prosecuted accordingly for causing harm to the fetus.

In *In re Stefanel Tyesha C.*,[80] neglect proceedings were instituted pursuant to Article 10 of the New York Family Court Act,[81] alleging

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minimizing, this effect is to amend state laws to encourage adoption. Besharov, *supra* note 3, at 24-25.

[75] *In re* Valerie M., (Conn. Super. Ct. Mar. 28, 1990) (LEXIS 529, States library, Conn. file at 27). Although the court found this requirement inadvertently placed, it held that if the best interest of the child is to be promoted, the court must waive the requirement that the claim exist for 12 months before termination of parental rights may be instituted. *Id.*

[76] Although terminating parental custody is one means of intervention, social workers and courts are now considering the potential for rehabilitation and the health of the child before resorting to this method. The biggest factor in this consideration seems to be the availability of a sober grandmother. In one Los Angeles county, grandmothers care for more than half of the "high-risk" babies. Willwerth, *supra* note 74, at 63.

[77] *See In re* Fathima Ashanti K. J., 147 Misc. 2d 551, 558 N.Y.S.2d 447 (Fam. Ct. 1990); *see also* U. Press Int'l, *Sullivan Calls for Moral Response to Drug Problem of Mothers*, Nov. 1, 1990 [hereinafter *Call for Moral Response*] (justifying harsher responses by governments, even if it means placing the children with single parents).

Despite these cases and others with similar holdings, New York has shifted its strategy in recent years in terminating the parental rights of drug-addicted mothers. Under the Koch administration in the mid-1980s, parental rights could be terminated after a single, positive toxicological screen. However, the Dinkins administration has altered the parental rights policy after a series of mistaken abuse cases that resulted from false positive toxicological screens on the newborns due to medications used by doctors during caesarean deliveries. Now, a single positive result will usually not suffice to immediately take the child away from the parent. Willwerth, *supra* note 74, at 63.

[78] *See infra* notes 275-79 and accompanying text.

[79] *See, e.g.*, *Sitter's Kin Ruled Negligent in Infant's Death*, Wash. Post, Nov. 30, 1990, at B6, col. 1 (discussing the case of Martha Guba, who was convicted of felony neglect in the fatal drug poisoning of a 10-month-old child and is now serving a 10-year sentence).

[80] 157 A.D.2d 322, 556 N.Y.S.2d 280 (1990).

[81] The New York Family Court Act defines a neglected child as follows:

that Sebastian M., whose mother smoked marijuana on a daily basis during pregnancy and used cocaine during the fifth month of pregnancy and two days before delivery, was a neglected child.[82] Stefanel Tyesha C. also was declared neglected under the statute as a result of similar conditions.[83] The court found both children to be "child[ren] under 18 years of age whose physical, mental and emotional condition [had] been impaired or [was] in imminent danger of becoming impaired as a result of the failure of [their] parent . . . to exercise a minimum degree of care by misusing a drug or drugs . . . ."[84] The court further held that a single act of misconduct may support a finding of neglect.[85]

The petition in *Stefanel Tyesha C.* sought relief for the neglect of "children" born with a positive toxicology for cocaine, and not "fetuses."[86] However, the court did address the maternal reliance on *Roe v. Wade*[87] to defend her prenatal conduct. The court rejected this defense because of the distinction between a woman's privacy right (electing to terminate her pregnancy) and protecting a child from the acts of the mother who elects to carry the fetus to term.[88] The Court in *Roe v. Wade* specifically recognized the state's interest in this protection.[89] In addition, the New York Family Court Act was designed to allow the state to intervene and protect a child under otherwise unconstitutional

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"Neglected child" means a child . . . whose physical, mental or emotional condition has been impaired or is in imminent danger of becoming impaired as the result of the failure of his parent or other person legally responsible for his care to exercise a minimum degree of care . . . in providing the child with proper supervision or guardianship, by unreasonably inflicting or allowing to be inflicted harm, or a substantial risk thereof, . . . by misusing a drug or drugs; . . . or by any other acts of a similarly serious nature requiring the aid of the court; provided, however, that where the respondent is voluntarily and regularly participating in a rehabilitative program, evidence that the respondent has repeatedly misused a drug or drugs or alcoholic beverages to the extent that he loses self-control of his actions shall not establish that the child is a neglected child in the absence of evidence establishing that the child's physical, mental or emotional condition has been impaired or is in imminent danger of becoming impaired . . ..

N.Y. FAM. CT. ACT § 1012 (f)(i)(B) (McKinney 1987 & Supp. 1991).

[82] *Stefanel Tyesha C.*, 157 A.D.2d at 324.

[83] *Id.*

[84] *Id.* at 325-26.

[85] *Id.* (citing *In re* Coleen P., 148 A.D.2d 782, 538 N.Y.S.2d 361 (1988)).

[86] Presently, the only state to equate "fetal" abuse and "child" abuse is New Jersey. *Cocaine Babies: The Littlest Victims*, NEWSWEEK, Oct. 2, 1989, at 55.

[87] 410 U.S. 113 (1973).

[88] *Stefanel Tyesha C.*, 157 A.D.2d at 330, 556 N.Y.S.2d at 285; *see also supra* notes 33-34 and accompanying text.

[89] *Roe*, 410 U.S. at 162.

circumstances.[90] Recognizing this purpose, the court concluded that the unborn came within the scope of Article 10 of the Family Court Act.[91] The court suggested that failure to so hold would render the Act unenforceable and meaningless.[92]

In light of the protections demanded by the New York Family Court Act,[93] judicial intervention is mandated.[94] The court, in *In re Fathima Ashanti K. J.*,[95] stated that "the unborn child possess[es] a right to a gestation undisturbed by wrongful injury and the right to be born with a sound mind and body free from parentally inflicted abuse or neglect."[96] The court also specifically stated that the parents' constitutional rights to privacy, freedom of religion and bodily integrity must yield to the compelling state interest of protecting the unborn.[97] This reasoning allows the court to look solely within the four corners of the Family Court Act to justify intervention.

Beyond the abuse and neglect that arises from the mother's prenatal conduct, studies show that children who are prenatally exposed to drugs and sent home to a mother who continues to abuse drugs are more likely to suffer from physical abuse and neglect in the future.[98] Because drug-exposed infants are irritable, cry continually and resist bonding with the parent,[99] many drug-abusing mothers are unable to understand and cope with the child's needs. When combined with the emotional and physical instability of the mother, a high risk of abuse

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[90] N.Y. FAM. CT. ACT § 1011.

[91] *Stefanel Tyesha C.*, 157 A.D.2d at 326, 556 N.Y.S.2d at 282-83.

[92] *Id.* at 330-31, 556 N.Y.S.2d at 285; *see also In re* Fathima Ashanti K. J., 147 Misc.2d 551, 558 N.Y.S.2d 447, 449 (Fam. Ct. 1990) (suggesting that including the unborn within the scope of the protections of abuse and neglect statutes is consistent with medical and scientific advances in treating the fetus in the womb); Anderson, *Fetal Operation Opens up Legal Controversy*, NEW SCI., Oct. 16, 1986, at 20.

[93] N.Y. FAM. CT. ACT (McKinney 1987 & Supp. 1991).

[94] *See Stefanel Tyesha C.*, 157 A.D.2d at 330, 556 N.Y.S.2d at 285.

[95] 147 Misc. 2d 551, 558 N.Y.S.2d 447.

[96] *Id.* at 555, 558 N.Y.S.2d at 449 (quoting Myers, *supra* note 17, at 60).

[97] *Id.*; *see also* Crouse-Irving Memorial Hosp. v. Paddock, 127 Misc. 2d 101, 485 N.Y.S.2d 443 (1985).

[98] *See* COMMITTEE ON FINANCE, *supra* note 3, at 31-32; Gittler & McPherson, *supra* note 3, at 5. A study conducted by the Massachusetts Department of Social Services revealed that drug or alcohol use was prevalent in 64% of child abuse or neglect investigations. *Id.*

[99] The reason for the lack of bonding with the mother is not only the child's abhorrence of external stimuli—being held, caressed, hugged and the like—but the child's simple inability to distinguish between its own mother and complete strangers. *See* Toufexis, *supra* note 3, at 60.

results.[100] For these reasons, legislative interpretations of existing abuse and neglect statutes, as well as abuse and neglect statutes that address gestational substance abuse expressly, are more readily available as a source of protection for the fetus.

C. *Tort Law*

Another means of recovery for prenatal injury to the fetus is tort law. Prior to 1946, a child born alive could not recover damages for prenatal injuries inflicted by third party tortfeasors.[101] Also, until recently, the doctrine of parental immunity protected mothers from the legal consequences of the harms caused by such actions.[102] Now, every state recognizes claims for prenatal injuries.[103] Although the issue becomes more complicated, claims brought on behalf of children for the infliction of prenatal injuries by the mother herself are also actionable.[104] This is largely because of the progress in medical knowledge concerning the effects of maternal actions on fetal development.[105]

Some courts will deny a child's recovery against the mother based on the constitutional privacy protections of *Roe v. Wade*. These courts are reluctant to provide constitutional protection for the mother on one hand and declare liability on the other.[106] This inconsistency is invalid,

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[100] *Id.* Commenting on the neglect and violence that occurs after crack kids are born, Dr. Barry Zuckerman, head of the division of developmental and behavioral pediatrics at Boston City College, states: "I sometimes believe that babies are better protected before they are born than they are after." *See id.* at 58.

[101] *See* Bonbrest v. Kotz, 65 F. Supp. 138, 142 (D.D.C. 1946) (rejecting Justice Holmes' decision in Dietrich v. Northampton, 138 Mass. 14 (1884), which set the standard in the United States denying recovery for the negligent infliction of prenatal injuries).

[102] *See generally* Smith, *Fetal Abuse: Culpable Behavior by Pregnant Women or Parental Immunity?* 3 J.L. & HEALTH 223 (1988-1989) (advocating tort and criminal liability for substance-abusing pregnant women).

[103] Marcotte, *supra* note 48, at 14 (commenting on the appropriateness of criminal sanctions).

[104] *See generally* Beal, *"Can I Sue Mommy?" An Analysis of a Woman's Tort Liability for Prenatal Injuries to Her Child Born Alive*, 21 SAN DIEGO L. REV. 325, 327 (1984) (discussing recovery for negligent prenatal care).

[105] *See, e.g.*, sources cited *supra* note 1.

[106] *See, e.g.*, Wallace v. Wallace, 421 A.2d 134, 136 (N.H. Sup. Ct. 1980); Toth v. Goree, 65 Mich. App. 296, 237 N.W.2d 297 (1975) (denying recovery against a third party for the wrongful death of a nonviable fetus).

In *Toth v. Goree*, the court offers the following *Roe v. Wade* reasoning:

> If the mother can intentionally terminate the pregnancy at three months, without regard to the rights of the fetus, it becomes increasingly difficult to justify holding a third person liable to the fetus for unknowingly and unintentionally, but negligently, causing the pregnancy to end at the same stage.

however, if a distinction is made between the mother's right to terminate pregnancy and her obligation to prevent fetal harm after deciding to carry the fetus to term.[107]

The leading case affirming a child's legal right to recover for prenatal injuries is *Grodin v. Grodin*.[108] There, the Michigan appellate court reversed the trial court's ruling in favor of the mother and allowed recovery for the child as a result of the mother's continued use of the drug tetracycline during pregnancy.[109] The court held:

> [R]egardless of analogies to other areas of the law, justice requires that the principle be recognized that a child has a legal right to begin life with a sound mind and body. If the wrongful conduct of another interferes with that right, and it can be established by competent proof that there is a causal connection between the wrongful interference and the harm suffered by the child when born, damages for such harm should be recoverable by the child.[110]

The court further reasoned that the mother may be liable without limitation for the tortious infliction of prenatal injuries.[111]

On the other hand, the court in *Stallman v. Youngquist*[112] held that there is no cause of action against the mother for prenatal injuries that are not intentionally inflicted.[113] The court grounded its decision on the theory that holding the mother liable for the unintentional infliction of injuries would permit excessive state scrutiny in an area replete with privacy and autonomy concerns.[114] The court suggested that this level of scrutiny would necessarily put the mother and the fetus on legally adverse grounds throughout gestation.[115] However, this adversarial concept, though logically sound, may not always apply. First, the

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Id. at 301, 237 N.W.2d at 301.

[107] *See supra* notes 33-34 and accompanying text.

[108] 102 Mich. App. 396, 301 N.W.2d 869 (1980).

[109] *Id.*

[110] *Id.* at 400, 301 N.W.2d at 870 (quoting Smith v. Brennan, 31 N.J. 353, 364-65, 157 A.2d 497, 503 (1960)).

[111] *Id.*

[112] 125 Ill. 2d 267, 531 N.E.2d 355 (1988) (involving the mother's negligent operation of an automobile).

[113] *Id.* at 280, 531 N.E.2d at 361. Some commentators suggest that there should be a rebuttable presumption against state intervention, but "when the conduct of the mother borders on the intentional infliction of harm," intervention will be warranted if the intrusion is minimal and the good to be achieved is great. Allegretti, *Delicate Balance: The Emerging Issue of Maternal-Fetal Conflict*, 164 AMERICA 238, 238, 250 (1991).

[114] *Stallman*, 125 Ill. 2d at 279-80, 531 N.E.2d at 361.

[115] *Id.* at 276, 531 N.E.2d at 359; *but cf.* Note, *supra* note 29, at 1326 (suggesting that the court should look to the interdependence between the mother and the fetus instead of the conflicting rights between the two).

mother and fetus are not adversarial opponents in every case.[116] Most often, the best interest of the mother will coincide with the best interest of the fetus, and detriment to the fetus' health will harm the mother as well. Second, there is no legally recognized right that the mother may assert in cases in which she purposefully injects illegal substances into her system, and hence the system of the fetus. Without any such right, the mother has no legally cognizable position from which to assert a claim.

Further, *Stallman* is limited to the *unintentional* infliction of injury on the fetus.[117] Maternal ingestion of cocaine, or any other drug, during gestation can be nothing but intentional. Arguably, the mother may be unaware that the abuse of illegal substances will negatively affect the fetus, as when the mother is indigent and cannot afford adequate prenatal care and advice. Under such circumstances, the court will need to decide whether these issues are relevant.[118] However, the reasoning of *Stallman* is misplaced in cases when the mother purposefully, willfully and intentionally disregards the advice of her doctor or prenatal caretaker and internalizes[119] substances that she knows, or should know, will harm her fetus.

In support of the position against such state scrutiny, the *Stallman* court concluded that any duty on the part of the pregnant woman to her fetus must be legislatively created.[120] The broadening of abuse and neglect statutes to include the unborn[121] and recognition of the developing status of the fetus conforms with that proposal.

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[116] *See, e.g., infra* notes 419-21 (describing situations when the mother struggles to prevent premature delivery in order to protect the baby).

[117] "[T]his court does not recognize a cause of action brought by or on behalf of a fetus, subsequently born alive, against its mother *for the unintentional infliction of prenatal injuries*." *Stallman*, 125 Ill. 2d at 268, 531 N.E.2d at 355 (emphasis added).

[118] Without proper prenatal care, the mother may be ignorant of the effects of drugs on a fetus or may even be unaware that she is pregnant when using drugs.

[119] Internalization of substances may occur intravenously, through ingestion or even epidermally.

[120] *Stallman*, 125 Ill. 2d at 280, 531 N.E.2d at 361.

[121] *See supra* notes 38-100 and accompanying text.

III. Maternal Rights

A. Right to Privacy

The due process clause of the fourteenth amendment grants a right to privacy in a number of areas, including reproduction,[122] contraception,[123] marriage[124] and abortion.[125] Included within the right to privacy is an individual's right to maintain his or her own bodily integrity,[126] a right that may also envelop the first amendment right to freedom of religion.[127] The state may not intrude into areas that involve a woman's right to privacy without a compelling interest. In *Roe*[128] and *Webster*,[129] the Court found that an interest in the potentiality of human life was not compelling, for state intervention purposes, until fetal viability. Thus, a woman's privacy interest remained intact at least until that point. Fetal viability, however, may fluctuate with the development of medical technology. Therefore, although a woman's right over her fetus is rooted in the privacy right afforded by the Constitution, it is not an intransigent right that is free from being uprooted and resecured at a different point in gestation.[130]

Arguably, the right to privacy affords a woman freedom of choice, including the right to choose whether to follow her doctor's orders in caring for and sensibly maintaining the proper development of her fetus.[131] Although such a freedom of choice premise may be legally defensible in cases involving routine practices during the course of a woman's existence as an individual, it does not extend with such assurance when the woman is pregnant. For example, a woman should not be allowed to abuse her freedom of choice by engaging in practices that

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[122] Skinner v. Oklahoma, 316 U.S. 535 (1942) (invalidating state statute authorizing sterilization of persons convicted of two or more felonies involving moral turpitude).

[123] Griswold v. Connecticut, 381 U.S. 479 (1965) (striking down state statute forbidding use of contraceptives by married couples); Eisenstadt v. Baird, 405 U.S. 438 (1972).

[124] Loving v. Virginia, 388 U.S. 1 (1967) (invalidating state statute forbidding interracial marriage).

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

[126] *See, e.g., In re* Conroy, 98 N.J. 321, 486 A.2d 1209 (1985) (state's interest in preserving life does not outweigh woman's interest in freedom from invasion of her person).

[127] *See, e.g.,* St. Mary's Hosp. v. Ramsey, 465 So.2d 666 (Fla. Dist. Ct. App. 1985) (patient may refuse blood transfusion on grounds of religious belief). *But see* Raleigh Fitkin-Paul Morgan Memorial Hosp. v. Anderson, 42 N.J. 421, 201 A.2d 537, *cert. denied,* 377 U.S. 985 (1964).

[128] 410 U.S. 113 (1973).

[129] 492 U.S. 490 (1989).

[130] *See supra* notes 18-28 and accompanying text.

[131] Comment, *A New Crime, Fetal Neglect: State Intervention to Protect the Unborn—Protection at What Cost?*, 24 CAL. W.L. REV. 161, 177 (1988).

are normally harmful and illegal, both outside and within the scope of the right to privacy, and contrary to what a doctor prescribes as being most conducive to the protection of potential human life. This protection is an interest that the state finds compelling. The blatant disregard for such an interest, via the abuse of illegal substances, justifies mandating interference with the woman's right to disregard what is not in *her* best interest.[132]

B. *Right to Refuse Medical Treatment*

Inherent in the woman's right to privacy is the woman's right to control her own body. Since 1891 the Supreme Court has recognized the refusal of medical treatment as part of that right.[133] However, this right is not absolute.[134] Just as an individual's other privacy rights are subject to some compelling governmental interest, the liberty to refuse medical treatment may also be qualified.[135] One qualification involves

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[132] *See* Taft v. Taft, 388 Mass. 331, 334, 446 N.E.2d 395, 397 (1983) (refusing to affirm an order by the lower court compelling a woman to submit to an operation for the benefit of the fetus). Nevertheless, the court stated:

> We do not decide whether, in some situations, there would be justification for ordering a wife to submit to medical treatment in order to assist in carrying a child to term. Perhaps the state's interest, in some circumstances might be sufficiently compelling . . . to justify such a restriction on a person's constitutional right of privacy.

Id.

[133] *See* Union Pac. Ry. Co. v. Botsford, 141 U.S. 250, 251 (1891), in which the Court did not compel the plaintiff to undergo a medical examination. In *Union Pacific*, the Court stated: "No right is held more sacred, or is more carefully guarded by the common law, than the right of every individual to the possession and control of his own person, free from all restraint and interference of others. . . ." *Id.*; *see also* Schloendorff v. Society of New York Hosp., 211 N.Y. 125, 105 N.E. 92 (1914) (asserting an interest in the right to bodily integrity). For a discussion of available remedies for the violation of the right to refuse medical treatment, see Comment, *Patient Autonomy and the Right to Refuse Treatment: Available Remedies*, 33 St. Louis U.L.J. 711 (1989).

[134] *See In re* A.C., 573 A.2d 1235, 1245-46 (D.C. 1990) (citing a series of other cases that support this proposition).

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> [T]here are five reasons that states claim a basis to override the right to refuse treatment:
> "(1) preservation of life when the patient's condition is curable; (2) protection of the patient's dependents, especially minor children; (3) prevention of irrational self-destruction; (4) preservation of the ethical integrity of health care providers; (5) protection of the public health and other interests."

Moody, *The Right to Refuse Medical Treatment*, 36 Hosp. & Health Serv. Admin. 147, 148 (Spring 1991) (quoting R. Miller, Problems in Hospital Law (1983)).

the protection of potential human life,[136] even over the mother's religious objections.[137] "[A]t stake is whether . . . [the mother] can be branded a criminal for not following a doctor's orders despite court rulings that patients have the right to refuse medical care."[138] Of course, the courts must conduct a delicate balancing of interests in deciding when to subordinate the mother's right to refuse treatment in order to protect the child. Given the progressive status of the fetus,[139] the scales will tend to tip in favor of the interest of the state in protecting the child, especially as medical technology advances and the intrusiveness of the intervention diminishes.[140]

C. *Right to Withhold Treatment*

In California a parent's willful omission, without legal excuse, "to furnish necessary . . . medical attendance, or other remedial care for his or her child" is a misdemeanor.[141] This provision of the penal code defines a child conceived but not yet born as an existing person within the provision.[142] Additionally, the Florida Supreme Court has held that the biological father can lose parental rights in his child for nonsupport.[143] Legislative and judicial maneuvers such as these have imposed a greater duty on parents to properly care for their children. When that duty is neglected, the state, through its *parens patriae* power, may intervene to assume that duty.[144] Again, the amount of harm caused to the fetus by not intervening and the extent of intrusion into the mother's privacy caused by intervention will weigh in the balance.[145]

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[136] *See, e.g.*, Raleigh Fitkin-Paul Morgan Memorial Hosp. v. Anderson, 42 N.J. 421, 201 A.2d 537, *cert. denied*, 377 U.S. 985 (1964) (court ordered mother to undergo blood transfusion in order to protect her child).

[137] *See, e.g.*, Application of President & Directors of Georgetown College, 331 F.2d 1000 (D.C. Cir.), *cert. denied*, 377 U.S. 978 (1964) (mother ordered to undergo blood transfusion over religious objections due to civic duty to care for her infant).

[138] LaCroix, *Jailing Mothers for Drug Abuse*, THE NATION, May 1, 1989, at 585 (discussing tactics used by prosecutors to avoid the limited scope of most child abuse statutes).

[139] *See supra* text accompanying notes 14-121.

[140] *See* sources cited *infra* note 421.

[141] CAL. PENAL CODE § 270 (West 1988).

[142] *See Children, Youth, and Families*, *supra* note 1, at 107 (prepared statement of Jeffrey A. Parness).

[143] Andrews v. Walton, 428 So. 2d 663 (Fla. 1983).

[144] *See, e.g.*, *In re* Jensen, 54 Or. App. 1, 633 P.2d 1302 (1981) (court ordered surgery on 15-month-old child who, if untreated, would suffer severe disabilities).

[145] *See generally* Strong, *Ethical Conflicts Between Mother and Fetus in Obstetrics*, 14 CLINICS IN PERINATOLOGY 313 (1987) (discussing the dilemma between mother and obstetrician).

IV. State Interests

A. Protecting the Child's Interest

In *Maryland v. Craig*,[146] the Supreme Court of the United States held that certain constitutional rights[147] may be dispensed with when it is "necessary to further an important public policy."[148] The Court recognized the "State's interest in the physical and psychological well-being of child abuse victims" as an important public policy, and therefore, "sufficiently important to outweigh . . . a defendant's right."[149] Following the reasoning of *Craig*, dispensing with a woman's privacy right is justified when necessary to further the important public policy of protecting the well-being of children.[150]

More recently, the Supreme Court has subordinated other constitutional protections in favor of the interest in protecting children.[151] For example, *Baltimore City Department of Social Service v. Bouknight*[152] balances the interest of the child against the parent's fifth amendment privilege against self-incrimination.[153] In *Bouknight* the Supreme Court held that a mother could not invoke the privilege against self-incrimination to resist a juvenile court order to produce a

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[146] 110 S. Ct. 3157 (1990).

[147] *Id. Craig* involved the sixth amendment right to confrontation, which states in pertinent part: "In all criminal prosecutions, the accused shall enjoy the right to . . . be confronted with the witnesses against him . . . ." U.S. CONST. amend. VI.

[148] *Craig*, 110 S. Ct. at 3166. Sandra Ann Craig was charged with various sexual offenses committed against Brook Etza, a six-year-old child. The issue was whether use of a one-way closed circuit television camera during the child's testimony was necessary to further the state's interest in protecting children. In the majority opinion, Justice O'Connor stated that general rules of law that grant protections such as those offered by the sixth amendment, "however beneficent in their operation and valuable to the accused, must occasionally give way to considerations of public policy and the necessities of the case." *Id.* at 3165 (quoting Mattox v. United States, 156 U.S. 237, 243 (1895) (confrontation clause intended to prevent conviction by affidavit)).

[149] *Id.* at 3167.

[150] *See id.*; *see also* Roe v. Wade, 410 U.S. 113, 150 (1973) in which Justice Blackmun wrote: "In assessing the State's interest, recognition may be given to the less rigid claim that as long as at least *potential* life is involved, the State may assert interests beyond the protection of the pregnant woman alone."

[151] These include the fifth amendment privilege against self-incrimination, *see* Baltimore City Dept. of Social Serv. v. Bouknight, 493 U.S. 549 (1990), and the privacy rights protected by the first amendment, *see* Osborne v. Ohio, 495 U.S. 103 (1990).

[152] 493 U.S. 549 (1990).

[153] *See* U.S. CONST. amend. V, which states in part: "No person . . . shall be compelled in any criminal case to be a witness against himself. . . ."

child suspected of being abused.[154] The Department of Social Service suspected that Jacqueline Bouknight was abusing her child, Maurice M. A juvenile court order was obtained to remove Maurice from Bouknight's control. Bouknight violated the order and was held in contempt. Bouknight claimed that the order unconstitutionally compelled her to testify, through production of the child, that she had continuing control over the boy under circumstances of abuse, testimony she reasonably suspected would result in her prosecution. The Court rejected this claim, reasoning that the interest in protecting the child falls within a "regulatory regime constructed to effectuate the State's public purposes unrelated to the enforcement of its criminal laws."[155]

Statutes requiring toxicological screening[156] or criminal prosecution[157] would likewise fall under "a regulatory regime constructed to effectuate the state's public purpose" in protecting children and therefore should be enforced. Although such statutes may be related to the enforcement of criminal laws,[158] the Court in *Bouknight* suggests that even when criminal conduct may exist, the court may enforce its request "for reasons related entirely to the child's well-being."[159]

Finally, in *Osborne v. Ohio*,[160] the Supreme Court upheld a state statute that proscribed the possession and viewing of child pornography by placing its interest in the protection of children above the first amendment interest in privacy.[161] The Court held that the state's justification for the law—the protection of children—is distinct from other reasons for state restrictions[162] and therefore is sufficient to outweigh the protected interest. Given the conclusion in *Craig*, *Bouknight* and

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[154] *Bouknight*, 493 U.S. at 551 (subordinating woman's right against self-incrimination to child's interest).

[155] *Id.* at 556.

[156] *See infra* notes 248-72 and accompanying text.

[157] *See infra* notes 273-301 and accompanying text.

[158] *See Bouknight*, 493 U.S. at 569-70 (Marshall, J., dissenting).

[159] *Id.*

[160] 110 S. Ct. 1691 (1990).

[161] *Id.* at 1694. In *Osborne* the petitioner possessed pictures in his home of a nude male adolescent in sexually explicit positions. The state statute prohibited any person from possessing or viewing any material or performance showing a minor who is not his child or ward in a state of nudity, unless, "(a) [t]he material or performance is . . . presented for a bona fide . . . purpose, by or to . . . [a] person having a proper interest . . . [therein], [or] (b) [t]he person knows that the [minor's] parents, [or] guardian . . . has consented in writing to the photographing or use of the minor . . . ." OHIO REV. CODE ANN. § 2907.323(A)(3) (Baldwin 1991).

[162] *See, e.g.*, Stanley v. Georgia, 394 U.S. 557 (1969) (striking down a Georgia law outlawing the private possession of obscene material on the paternalistic ground that the obscenity would poison the minds of its viewers). In *Osborne* the Court held that "the interest underlying child

Osborne that the best interest of the child may sometimes outweigh constitutional guarantees, the state's interest in protecting children from the horrible effects of their mothers' drug abuse (to which the mothers have no constitutionally protected right) should prevail. Even under a test that balances the state's interest against a woman's privacy right, given the holding in *Craig* and cases similar to it, the state's interest in the protection of the child should outweigh this privacy right.

B. Drug Prohibition

The problem of gestational substance abuse extends into many areas and raises state concerns beyond just immediate treatment of addicted children.[163] Aside from the treatment and counseling needed to care for the substance-abusing mother and her addicted child, services are also needed to care for the mother's other children who will be left alone while the mother receives therapy or possibly serves a prison sentence.[164] The costs of providing these services are very high.[165] These are state concerns that arise after the child has been born. However, even before the child is born, there is a continual state concern in controlling what causes the problem, namely, drugs.[166] Although casual drug use has decreased,[167] the overall "war on drugs" has had little or

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pornography prohibitions far exceed the interests justifying the Georgia law at issue in *Stanley*." *Osborne*, 110 S. Ct. at 1695.

[163] *See* Note, *A Proposal to Illinois Legislators: Revise the Illinois Criminal Code to Include Criminal Sanctions Against Prenatal Substance Abusers*, 23 J. MARSHALL L. REV. 393, 395-402 (1990) (describing detailed effects of cocaine use on the fetus, the mother and public health and welfare in general).

[164] *See* COMMITTEE ON FINANCE, *supra* note 3, at 9.

[165] *See infra* notes 355-62 and accompanying text.

[166] Although "drugs" are a direct cause of the problem of gestational substance abuse, they are not the *sole* problem. The problem stems from a combination of factors ignited by a mother's lack of concern.

[167] Green, *U.S. Reports Sharp Drop in Casual Drug Use*, Phila. Inquirer, Dec. 20, 1990, at A1, col. 3. The number of people who use drugs at least once a month has reportedly dropped from 23 million to 13 million since 1985. Meddis, *USA on a See-Saw of Victories and Defeats*, USA Today, June 18, 1991, at A7, col. 1. The number of teenagers who reported using cocaine during their senior year in school has dropped from 13% to 5% since 1986. *Id.* "Cocaine arrests, child-abuse reports and the number of babies abandoned in hospitals—statistics used to estimate the rate of drug use—have all decreased in recent months." *Turning A Corner on Crack*, Newsday, Oct. 11, 1990, at 3 (city ed.). Reports show that emergency room cases involving cocaine have decreased by 28% from 1989 to 1990 and 14% for drug abuse cases overall. Anderson, *Emergency Room Drug-Abuse Cases Fell 14%, U.S. Says*, Phila. Inquirer, July 3, 1991, at A10, col. 1. Except for Baltimore, which showed an overall increase, 17 of 21 metropolitan areas had comparable statistics. *Id.* Further evidence of a decrease in drug use, at least in New York City, is

no impact on addiction or violent crime.[168] "Crack" has become the drug of the future,[169] and its effects on pregnant women and their fetuses are more devastating than any other drug.[170] Many say increased federal spending is not the solution to the problem.[171] Others, insisting that the strategies used in the past have stimulated positive results,[172]

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the dramatic drop in the number of positive urine tests for cocaine in male felony suspects. According to the Drug Use Forecasting Program of the National Institute of Justice, 83% tested positive in June 1988, while only 58% tested positive in April, 1990. *Id.* Tests on female felony suspects did not indicate the same decline and were positive more often than the tests on males—66% tested positive in April 1990. *Id.*

[168] According to the National Institute of Drug Addiction, 37 million people 12 years of age or older have used illicit drugs. Rosenstein, *supra* note 1, at 23. The number of those using cocaine on a daily basis has doubled between 1985 and 1990. Meddis, *supra* note 167, at A7. Although the overall crack addiction has decreased, drug addicts are still resorting to other drugs. For example, although the crack use declined in New York City in the beginning months of 1990, heroin arrests increased 19%. Coincidentally, violent crimes have risen by 10% because of the smaller crack market in which drug dealers must fight for profits. *Turning A Corner on Crack*, *supra* note 167, at 3; *see also* Meddis, *supra* note 167, at A7; Shannon, *A Losing Battle*, TIME, Dec. 3, 1990, at 44 (describing the failed efforts of the war on drugs during the past two years in various cities). Shannon states:

> If Washington were really serious about alleviating the drug problem, state and local governments would establish urgent projects to find and deal with addicted mothers of young children and pregnant drug users . . . [but] [s]uch steps would cost additional tens of billions of dollars and take many years to achieve significant results.

Id. at 48.

[169] *See Children, Youth, and Families*, *supra* note 1, at 29-31 (containing article from Psychiatric Inst. of Wash., D.C., *Crack: Cocaine in New Clothes* (1986)[hereinafter Psychiatric Inst.]).

[170]
> The mother will excrete cocaine crack into her urine but the baby does the same thing and the baby then will excrete the crack into the amniotic fluid. For the mother the high is finished in 20 minutes. But, the baby keeps drinking the amniotic fluid containing the crack so the baby's high lasts for days. So there's a big difference. Babies are being born, because of the constant high that they live with, having had strokes. In some cases the constriction of blood vessels has cut off circulation to limbs and babies have been born without fingers, toes, that kind of thing.

Children, Youth, and Families, *supra* note 1, at 16 (statement by Margaret Gallen).

[171] President Bush recently announced an 11% increase in spending on the war on drugs for fiscal year 1992. Marcus, *Bush Proposes 11% Increase in Drug War Spending*, Wash. Post, Feb. 1, 1991, at A6, col. 1. This is an increase of $1.2 billion to the current budget. *Id.* The proposed $11.7 billion budget for anti-drug spending is a dramatic increase since 1986, when the budget was about $2.7 billion. Meddis, *supra* note 167, at A7. Although this may be a step in the right direction, it "falls far short of what must be done to combat the drug epidemic." Marcus, *supra*, at A6 (quoting Senate Judiciary Committee Chairman Joseph R. Biden Jr.). *But cf.* COMMITTEE ON FINANCE, *supra* note 3, at 11 (supporting the proposition that federal funding will continue to minimize the disparity between women in need of treatment and treatment facilities available).

[172] The first national drug control strategy was announced in 1989 and consisted of nine goals. Each of the nine goals was "either met or exceeded" in 1990. COMMITTEE ON FINANCE, *supra* note 3, at 11 (referring to comments by John P. Walters, director of the Drug Policy Office).

support expanded efforts in the war on drugs as one means of fulfilling the state's interest in protecting addicted newborns.[173]

C. Balancing the Interests

The determination of when, under what circumstances and even whether or not to intervene on behalf of a fetus suffering the effects of its mother's drug abuse will depend on how the courts balance the individual interests involved. The state may only interfere with the woman's right to privacy by showing a compelling interest.[174] The extent to which this interest must be compelling will be directly proportional to the degree of intrusion on the woman's rights. For example, for a court to require a woman to undergo a simple inoculation, the state interest may not need to possess a high degree of compulsion.[175] However, for a court to require a woman to undergo major surgery, the state interest to be protected must be quite compelling.[176] The crucial task for the court in deciding to intervene is to determine where the interest in potential human life fits in terms of degrees of compulsion.[177] How compelling a court finds the interest in potential human

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[173] *See* Note, *supra* note 163, at 417-20 (discussing the state's interest in drug control).

The increased budget proposal announced by President Bush would channel 70% of the money to the reduction of drug supplies and 30% to drug abuse prevention and treatment. Marcus, *supra* note 171, at A6. A total of $1.5 billion would be used for prevention education efforts and $1.7 billion would finance drug treatment programs—an increase of 10%. *Id. See Children, Youth and Families*, *supra* note 1, at 94-99 (prepared statement of Congressman Charles B. Rangel calling for a comprehensive, national anti-drug strategy that includes more treatment facilities); *see also Kicking Addiction With Acupuncture*, Newsday, Oct. 7, 1990, at 1 (Queens ed.), which describes the efforts of some to promote acupuncture detoxification treatment centers as a means of stamping out the drug epidemic. The establishment of the original center for the program, Lincoln Hospital's Substance Abuse Division, has led to the development of 100 other clinics throughout the country. Approximately 200 to 230 patients a day receive acupuncture treatment at Lincoln Hospital. *Id.*

[174] Roe v. Wade, 410 U.S. 113, 163 (1973).

[175] In *In re* Jamaica Hosp., 128 Misc. 2d 1006, 491 N.Y.S.2d 898 (Sup. Ct. 1985), the court's interest in protecting the as yet unborn fetus justified the intrusion of a blood transfusion against the mother's will. A less intrusive inoculation would not require as great a compelling interest.

[176] "[T]he state's interest in preserving life must be truly compelling to justify overriding a competent person's right to refuse medical treatment." *In re* A.C., 573 A.2d 1235, 1246 (D.C. 1990).

[177] According to Murray, determinations to intervene on behalf of the fetus should include the following factors:

1. How certain is the benefit to the fetus? (Is the intervention experimental? Is it well established? Does it carry substantial risks to the fetus?)
2. How great are the benefits? (Will a successful intervention make a large or small difference in the fetus' prognosis?)

life will determine how the interests are balanced. The following facts may cause the balance to favor state intervention:[178] (1) The fetus has developed, in numerous areas of law, a legal status equivalent to that of a child.[179] (2) The fetus has been recognized as possessing rights that mandate state protection.[180] (3) The rights of the mother are not necessarily guaranteed and may be subordinated to other interests.[181] (4) The mother has no constitutional right to abuse drugs and therefore no protected interest concerning her actions.[182] (5) The state has declared the interest in children to be compelling.[183] (6) Finally, medical technology is continually advancing, allowing for less intrusive measures to protect the fetus.[184] Perhaps the Supreme Court of Massachusetts was considering gestational substance abuse when it stated in 1983:

> We do not decide whether, in some situations, there would be justification for ordering a wife to submit to medical treatment in order to assist carrying a child to term. Perhaps, the State's interest, in some cases, might be sufficiently compelling . . . to justify such a restriction on a person's constitutional right of privacy.[185]

V. When to Intervene: Standards of Care

Commentators have proposed various standards of care for determining the liability of a mother who gives birth to an addicted child. Which standard to use will be determined by the relationship between the status accorded the fetus and the rights prescribed to the mother; it will also decide the duty the mother owes the fetus. Whatever standard is used and whatever duty is assigned to the mother, this duty of care will be the only means by which the courts, the medical profession and society as a whole may confront gestational abuse. The standard used,

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3. How intrusive, coercive, or harmful will it be to the mother?
4. Will anything be lost or gained by waiting until after the child is born?

Murray, *supra* note 28, at 339.

[178] The imposition of criminal statutes and civil liabilities will be limited by the equities involved in the balancing between the interests of the mother and the fetus.

[179] *See supra* notes 14-121 and accompanying text.

[180] *See supra* notes 14-121 and accompanying text.

[181] *See supra* notes 122-40 and accompanying text.

[182] "I feel sympathetic toward the defendant, but her behavior is proscribed criminal behavior. And you don't excuse it by saying she's disadvantaged or a mother." Hoffman, *Pregnant, Addicted—and Guilty?*, N.Y. Times, Aug. 19, 1990, § 6 (Magazine), at 44 (quoting Judge Frederic Grimm, Jr., of the district court of Muskegon County, Michigan).

[183] *See supra* notes 146-62 and accompanying text.

[184] *See infra* notes 248-72, 323-52 and accompanying text.

[185] *Children, Youth, and Families*, *supra* note 1, at 108.

therefore, should be strict. Certain primary rights may temporarily become secondary as a result; however, if the numbers increase at the current rate, the few protections now available will inevitably give way under the weight of this massive problem. A strict standard is a reasonable and resourceful means to begin managing what is becoming unmanageable. It may also be a less intrusive, if not the only, way to protect the youth of the twenty-first century.

A. Roe v. Wade Standard

Roe v. Wade[186] produced far reaching effects well beyond the scope of abortion.[187] Because of the privacy rights recognized in *Roe*, it surges immediately to the forefront in the search for a standard for any issue concerning the rights of women. It is certainly available as a possible standard in dealing with the issue of gestational substance abuse.[188]

As the main premise of her article dealing with gestational substance abuse, Kristen Rochelle Lichtenberg suggests that civil commitment will most effectively prevent gestational substance abuse.[189] To effectuate this method, she proposes using the *Roe v. Wade* standard.[190] She claims that a *Roe* standard would not prohibit state intervention in the first trimester in substance abuse cases, but that for reasons of public policy, the state should avoid such early intervention.[191] Lichtenberg calls for a compromise between state intervention and existing abortion laws.[192] Unfortunately, the issue of gestational substance abuse is not conducive to compromise. Lichtenberg proposes to equip *Roe v. Wade* with strength it does not possess by allowing states to intervene after the first trimester, but by doing so, qualifies the state's interest in potential human life by limiting it to the period after the first trimester. Although such a position does address the heart of the matter, it does so hesitantly. For the state to effectively treat the real problem and

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[186] 410 U.S. 113 (1973).

[187] *See supra* notes 18-37 and accompanying text.

[188] *See* Comment, *supra* note 10.

[189] *Id.* at 377-78, 396. Author Lichtenberg proposes effective intervention by legislatively adopting the UNIFORM ALCOHOLISM AND INTOXICATION TREATMENT ACT, 9(1) U.L.A. 79 (1988), and amending it to include gestational substance abuse.

[190] Comment, *supra* note 10, at 377.

[191] *Id.*

[192] *Id.* at 377-78.

intervene in a timely manner,[193] it must apply a stricter standard since the effects of drugs are most serious in the first trimester.[194]

Lichtenberg acknowledges the state's interest in protecting the fetus from the effects of gestational substance abuse but argues that the state should limit its intervention to civil commitment.[195] Criminalization may be beyond the scope of what is constitutionally permissible.[196] Because "prosecuting the mother fails to protect fetuses from harm," she urges more state funding for health services, tending to the special needs of both the mother and the child born addicted.[197] Unfortunately, while treatment centers with these goals in mind are to be commended,[198] their success rate is very often disappointingly low.[199]

Adopting the *Roe v. Wade* standard will necessarily require overlooking the distinction between the right of the woman to abort and the duty of the mother to provide care.[200] Lichtenberg specifically rejects any such maternal duty.[201] One reason for this rejection is that "[a] maternal duty renders a woman the guarantor of the mental and physical health of her fetus."[202] This may not be true. The maternal duty to her fetus would comprise obligations not only to avoid illegalities, like every other citizen, but to avoid commissive acts that she knows or should know will have direct and serious adverse effects on the health

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[193] *See infra* notes 247, 270-72 and accompanying text.

[194] *Id.*

[195] Comment, *supra* note 10, at 387.

[196] *Id.* at 387-88, 391.

[197] *Id.* at 388; *see also* Hill, *When Addiction Hurts the Young*, Wash. Post, Sept. 20, 1990, at B5, col. 1 (discussing the Center for Addiction and Pregnancy, which is a Baltimore center, and its approach to addressing the needs of the escalating problem of gestational substance abuse).

[198] This coordinating approach is "critical in encouraging pregnant abusers or women with young children to end drug use." Hill, *supra* note 197. In addition to the drug treatment for the child, the type of care needed for the mother includes specialized obstetrical care, educational and career planning and psychiatric counseling. In-patient facilities that treat regardless of ability to pay are rare, but are important if treatment programs are to succeed. The increase in drug-exposed infants has placed a high demand on federal funding for such facilities. One study in Baltimore reveals that if comprehensive care is available, the time the baby is required to spend in neonatal intensive care drops from an average of 21 days to 24 hours. *Id.*

[199] *See id.* at B5, col. 3 (reports from the Center for Prenatal Addiction at the Medical College of Virginia show that within two years, only 18 out of hundreds of women who enrolled in the program stayed there — 17 of whom delivered drug free babies).

[200] *See* Comment, *supra* note 10, at 388.

[201] *Id.* at 388-89: "The maternal duty theory presents an undesirable departure from *Roe's* analysis because it conflicts with first-trimester abortion rights."

[202] *Id.* at 389.

of her child.[203] Very simply, Lichtenberg contends that it is illogical to depart from *Roe* because to do so would be inconsistent with abortion law. This premise, however, denies the developing status of the fetus in abortion law[204] and ignores the flexible opportunities available under *Webster*[205] and through advancements in medical technology. A *Roe v. Wade* standard is only part of the answer. Limiting the courts to such a standard avoids the real issue of how to *prevent* acts that cause harm, rather than merely treating the subsequent effects. Nevertheless, Lichtenberg's push for civil commitment should not be discredited.[206] Civil commitment does address part of the problem, despite the limitations of her standard of implementation.

Lichtenberg further proposes that each state utilize the Uniform Alcoholism and Intoxification Treatment Act[207] and apply it to drug addicts as well as alcoholics.[208] With its individually responsive substantive and procedural safeguards, the uniform act would serve the health concerns of the mother and the fetus (the primary concern),[209] while systematically avoiding what are termed "slippery slope" problems.[210] However, such a proposal offers no recourse against the casual abuser, equally capable of causing harm to the fetus.[211]

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[203] Lichtenberg rejects this theory because of its direct opposition to the policy drawn out of *Roe v. Wade*, and therefore would not allow intervention in the first trimester. Lichtenberg reasons, "[i]f the state lacks a compelling interest in first-trimester fetal *life*, then it lacks a compelling interest in first-trimester fetal *health*." *Id.* at 390 (emphasis in original).

[204] *See supra* notes 18-37 and accompanying text.

[205] Webster v. Reproductive Health Servs., 492 U.S. 490, 515-17 (1989).

[206] Lichtenberg does not advocate criminalization because it does not address the issue of providing care for the fetus. Rather, she suggests, it focuses on punitive sanctions for the mother. Lichtenberg states that "because criminalization fails to address the essential problem of maternal addiction, it fails to accomplish the intended purpose of protecting fetuses." Comment, *supra* note 10, at 391. Arguably, however, criminalization is not to be so quickly overlooked when considering its coercive power to prevent substance abuse. *See infra* notes 273-301 and accompanying text.

[207] UNIF. ALCOHOLISM AND INTOXIFICATION TREATMENT ACT, 9(1) U.L.A. 79 (1988).

[208] *See* Comment, *supra* note 10, at 393-95.

[209] Lichtenberg's primary concern is the addiction of the woman. *Id.* at 395.

[210] *Id.* at 394. Here, Lichtenberg refers to arbitrary commitments of women who pose a threat to the fetus by, for example, eating improperly. Such situations would not qualify for civil commitment under the narrow definitions of the amended act. University of Texas law professor John Robertson asserts that "the police and courts will deal with 'the slippery slope' of prenatal conduct just as they have with other forms of child abuse." Curriden, *Holding Mom Accountable*, 76 A.B.A. J., Mar. 1990, at 52. "When the evidence is clear that some activity is very harmful to the health of the child-to-be, then that should be prosecuted . . . . When the evidence is not as clear or the risks are not as dramatic, then law enforcement should lay off." *Id.* (quoting John Robertson).

[211] Curriden, *supra* note 210, at 52. The most recent government survey by the National Institute of Drug Abuse reveals that casual drug use has decreased considerably in the past five

Civil commitment, in both the short and long run, has its advantages.[212] Using the *Roe v. Wade* standard to determine when to enforce civil commitment, however, limits its scope and effectiveness by exempting abusers in their first trimester of gestation.

B. Neglected Child Standard

Under a neglected child standard, courts may decide whether to intervene on behalf of the drug-exposed child[213] by weighing the same factors considered when intervening on behalf of *any* neglected child.[214] The standard calls for a determination of whether the drug-exposed infant is in imminent danger of future harm.[215]

Although this standard is beneficial in treating the symptoms of addicted infants born to addicted mothers, the test is narrowly directed toward children already born and therefore does not address the cause of the problem. Further, it cannot prevent harm at the early stages of fetal development, when the greatest amount of damage occurs.[216] Nevertheless, the standard partially addresses the problem and may lead to some preventive protection for the fetus and treatment for the mother.

In her article supporting the application of the neglected child standard, author Bonnie I. Robin-Vergeer first calls for legislative action providing toxicological screens for all newborn infants who are either demonstrably symptomatic or are born to mothers who have either

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years. Casual drug use is defined as less than once a month. Since 1985 more than 10 million people have discontinued occasional use of illicit drugs. This statistic represents a 44% decrease in occasional illicit drug use. A 72% decrease was reported for casual cocaine users. Overall, the report estimated that 1.6 million people were classified as "occasional" users this year, compared to 5.8 million users in 1985. Since 1988 the number of weekly cocaine users has declined by 200,000. Daily cocaine users have increased by 44,000, however, during the same two year period. Marijuana remained the most commonly used illicit drug. An estimated 10.2 million people are casual marijuana smokers. Despite the overall decrease in drug use, the results of the study are considered misleading by some, who suggest that despite the statistics for casual users, cocaine and crack addictions are still a very serious problem for babies in major urban communities. Green, *supra* note 167, at 1-A.

[212] *See infra* notes 302-17 and accompanying text.

[213] *See* Note, *supra* note 11, at 745, in which the author proposes that the neglected child standard apply only to the drug-exposed "infant." The author does not apply the standard to drug-exposed fetuses. *Id.* at 749.

[214] *See id.*

[215] *Id.* at 746.

[216] *See infra* notes 247 & 272 and accompanying text.

had a recent history of drug use or ignored prenatal care.[217] Positive results of such screens could lead to an investigation. Other factors must supplement a positive toxicological screen, however, before a full investigation is initiated.[218] Regardless of the results of the screen or the amount of evident risk factors, drug-exposed infants will be removed from the mother prior to full investigation and determination of parental fitness only under the most threatening circumstances.[219] The mother would be legally required to participate in a service plan designed to assist in development of parenting skills and to evaluate the child's susceptibility to future neglect.[220] The neglected child standard is purely prospective in nature and addresses the issue of caring for the fetus, already affected, and treating the woman, already addicted. This standard, however, when strictly limited to newborn infants, includes no preventive or precautionary efforts to limit the harm suffered by the fetus. A more effective means of preventing the harm would be to adopt a quasi-neglected child standard, applicable to the fetus, that would call for preventive measures in utero.

C. *Reasonable Mother Standard*

The "reasonable mother" standard is a position advocated by some commentators[221] and applied by some courts.[222] This standard predomi-

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[217] Note, *supra* note 11, at 749-50.

[218] The author lists three categories of supplemental risk factors to be considered:

> These risk factors can be categorized as maternal, infant, and interactional factors. Maternal risk factors include neglect of other children, prior child protective services history, failure to seek drug treatment, facts suggesting that the mother lives a "street" life, and lack of a social or economic support system. The fragility of the newborn infant's health as a result of withdrawal symptoms, low birth weight, or other drug-related problems constitutes an infant risk factor to be considered. Finally, an interactional risk factor may be present if the mother ignores her infant or if there is a clear lack of bonding between mother and child.

Id. at 750 n.17. Not all factors are equally important, however. *Id.* at 750.

[219] *Id.* at 750 n.181:

> Child welfare agencies should place a drug-exposed infant in protective custody without first conducting a preliminary investigation only if the mother exhibits an extreme and *clear* indifference to her child, if the mother cannot provide an address or phone number at which she and the baby can be found over the following few weeks, if the infant is severely medically fragile and will be released to the mother before the appropriate agency has had the opportunity to verify parental fitness, or if the mother appears to be completely "out of touch" with reality and is the sole care-taker of the child.

Id. (emphasis in original).

[220] *Id.* at 750-51.

[221] *See* Note, *supra* note 12.

[222] *See, e.g.*, Grodin v. Grodin, 102 Mich. App. 396, 301 N.W.2d 869 (1980).

nantly relates to a mother's duty to protect against risk to the child. Other commentators suggest that a reasonable mother standard is not a suitable guideline for the mother's duty toward her child because it unfairly ignores the implications of the mother's privacy rights.[223]

In his article addressing the mother's duty toward the fetus during pregnancy, David Koropp suggests that a mere negligence standard is insufficient to reconcile the rights of the fetus with the privacy rights of the mother.[224] Rather, he proposes a gross negligence standard that would hold the mother liable for harm done to the fetus "only if she acts with knowledge of, or with reckless indifference to, the life or health of her fetus."[225] Koropp also advocates a per se rule barring actions for prenatal negligence for a mother's refusal to submit to medical procedures of a physically invasive nature designed solely to protect or preserve the fetus.[226]

These two proposals are independently tenable, but to combine the two is incongruous. The two are mutually exclusive when a mother's unreasonable refusal to submit to medical procedures to protect the fetus constitutes reckless indifference to the health of the fetus. Koropp's position is that medical procedures of a physically invasive nature are not a reasonable means of securing the health of the fetus. One would have to question where Koropp draws the line on the scale of medical procedures. Certainly a woman would not be expected to submit to any and all procedures to protect the fetus. One could imagine intolerable situations in which medical technology was not able to determine accurately the chance of success or risks of harm to the mother and the fetus for a certain procedure, such as vaginal delivery,[227] or situations assuring the death of the mother and only a possibility of survival for the fetus. Forcing treatment under such situations would be unacceptable. Similarly, invasive procedures performed when nothing indicates that the child or the mother is at risk by natural delivery would unreasonably violate the mother's rights and would be the type of physically invasive procedure Koropp proposes should be avoided. However, con-

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[223] *See generally* Note, *supra* note 12. Koropp suggests adopting a "stringent standard for maternal liability that requires gross negligence and precludes liability for failure to submit to [physically invasive] medical procedures designed solely to benefit the fetus." *Id.* at 493.

[224] *Id.* at 512.

[225] *Id.*

[226] *Id.*

[227] *See In re* A.C., 533 A.2d 611 (D.C. 1987), *reh'g granted*, 539 A.2d 203 (D.C. 1988) (en banc), *later proceeding*, 573 A.2d 1235 (D.C. App. 1990) (en banc).

sidering the advanced medical technology now available, the accuracy with which fetal and maternal health can be predicted and the developing status of the fetus, certain invasive procedures, like cesarean sections[228] and fetal surgery,[229] now fall outside the scope of what is an unreasonable, physically invasive procedure.[230]

In Koropp's first proposal, a gross negligence standard would include four elements: (1) "that the [mother] knew, or that it would have been obvious to a reasonable person in her situation, that she was pregnant at the time of the negligent act," (2) "that at the time of the negligent act, the [mother] knew, or it would have been obvious to a reasonable person, that her action posed a serious threat to the life or health of her fetus," (3) "that the [mother's] acts were the cause-in-fact of the injuries sustained" by the fetus and (4) that the mother's acts were the proximate cause of the fetus' injuries.[231]

Koropp suggests that a reasonable pregnant mother standard is too harsh on the mother because it "allows juries to dictate, according to their own notions of proper maternal behavior, how a mother should act during pregnancy."[232] Koropp also restates the argument that the threat of liability will only deter women from seeking prenatal care.[233] In defense of this deterrence position, however, Koropp offers an example suggesting that women should be free to make "highly personal decisions" regarding childbirth, even if it means posing a risk of injury to the child:

> Under the reasonable standard, a jury could simply conclude that a reasonable mother would not take even the slightest risk during delivery. Under the gross negligence standard, a woman would still be free to decide for herself whether to have her child at home, as long as it was not obvious that to do so would greatly endanger her unborn child. Thus, this highly personal decision relating to childbearing would be left to the mother and not a sympathetic jury eager to come to the aid of an injured child-plaintiff.[234]

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[228] *See infra* notes 380-422 and accompanying text.

[229] *See infra* notes 323-52 and accompanying text.

[230] Although Koropp does not qualify his second proposal as a barring of all "unreasonable" physically invasive medical procedures, a qualification will be inferred. Without such an inference, *all* procedures within prenatal care involving the refusal to submit to the least physical intrusion, including taking prescription medicine, would be physically invasive, and therefore barred as an actionable claim.

[231] Note, *supra* note 12, at 512.

[232] *Id.* at 513.

[233] *Id.*

[234] *Id.*

This premise, however, is not altogether persuasive. By calling for a gross negligence standard, Koropp would allow the mother freedom to make unreasonable decisions concerning the health of the fetus. Such a standard permits generous maternal discretion. Furthermore, the issue is not whether the act manifesting the harm is an intimate, private or personal one, like the present status of the decision to bear a child. Rather, the issue is simply whether the mother's actions causing the harm were negligent. This is a question that a jury is legally capable of deciding. The fact that the action of the mother would strike the jury as particularly heinous or unreasonable, thereby making jurors more sympathetic to the victim, should not take the question out of their hands. It is simply not logical to suggest that a higher standard be required so that a mother, as opposed to a court of law, may decide what is negligent action concerning the health of her child. This controversy only reaffirms the importance of distinguishing between the mother's right and the mother's duty.[235] Although a gross negligence standard offers protection for the right, it limits enforcement of the duty.

A gross negligence standard would, however, offer limited protection for a fetus suffering the effects of its mother's substance abuse. That such a gross negligence standard allows room for possible harm by overly narrowing its scope presents a problem. Yet it is also true that a mere negligence standard will, in certain situations, be overly broad because it includes situations that will infringe a woman's rights by holding the woman responsible for *all* possible injury to the fetus.[236] An over-inclusive negligence standard would include acts such as smoking[237] and drinking,[238] both of which can have substantial deleterious

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[235] *See supra* notes 33-37 and accompanying text.

[236] For example, a woman may be liable under a mere negligence standard for the common usage of an electric blanket while pregnant. A study conducted by one epidemiologist revealed that children whose mothers had used the blankets while pregnant had a 30% greater chance of developing cancer by the age of 15 than those whose mothers did not use the blankets. The greatest effect was present during the first trimester, which is consistent with the effects of drugs and other illicit substances. *Blanket Warning*, IN HEALTH, July-Aug., 1990, at 11.

[237] Nearly 24% of American women smoke, and it is estimated that 2,000 women start smoking every day. Of the women who smoke before pregnancy, 25% continue to smoke while pregnant. Zamula, *Drugs and Pregnancy: Often the Two Don't Mix*, 23 FDA CONSUMER 7, 10 (1989). A study of pregnant smokers in Missouri reveals that, although there was an overall drop in smoking rates from 1978 to 1988, the highest smoking rates were among unmarried women and those between the ages of 20 and 24. Stockbauer & Land, *Changes in Characteristics of Women Who Smoke During Pregnancy: Missouri, 1978-88*, 106 PUB. HEALTH REP. 52, 52 (Jan.-Feb. 1991). The federal Centers for Disease Control estimate that more than 434,000 Americans died in 1988 from health problems related to smoking, which includes infant deaths caused by mater-

nal smoking during pregnancy. Okie, *Smoking-Related Deaths Up 11% to 434,000 Yearly, CDC Reports*, Wash. Post, Feb. 1, 1991, at A1, col. 4. Although other studies have shown significantly higher figures, the report estimates that 3,825 of those deaths were caused by "passive smoking." *Id.*; *see also* Bateman & Heagarty, *Passive Freebase Cocaine ('Crack') Inhalation by Infants and Toddlers*, 143 AM. J. DISEASES CHILDREN 25, 25-27 (Jan. 1989) (concluding that passive cocaine inhalation may contribute to neurological damage). Infant mortality figures show that if all women refrain from smoking during pregnancy and in the presence of infants, 10% of the deaths of children under one year old could be prevented. Okie, *supra*, at A1. Currently, cigarette smoking causes one fourth of all low birth weights and is a major cause of disability in children who breathe the smoke as they grow up. *See* Cowley, *supra* note 3, at 20. It is interesting to note that despite these statistics the Department of Health and Human Services perceives cigarette export issues to be "a trade rather than a health matter." *See* U.S. GEN. ACCOUNTING OFFICE, REPORT TO CONGRESSIONAL REQUESTERS, NATIONAL SECURITY AND INTERNATIONAL AFFAIRS DIVISION, TRADE AND HEALTH ISSUES: DICHOTOMY BETWEEN U.S. TOBACCO EXPORT POLICY AND ANTI-SMOKING INITIATIVES, May 15, 1990, at 6.

[238] About 60% of all women and teenage girls drink alcohol. Between 20% and 35% drink regularly. Six million women are alcoholic. In 1989 these women gave birth to 8,000 babies who now suffer from Fetal Alcohol Syndrome (FAS)—reportedly the leading cause of mental retardation. Zamula, *supra* note 237, at 9; *see also* Dorris, *A Desperate Crack Legacy*, NEWSWEEK, June 25, 1990, at 8; Rosenthal, *When a Pregnant Woman Drinks*, N.Y. Times, Feb. 4, 1990, Magazine section, at 49; Cowley, *supra* note 3, at 20. Up to 10,000 children a year are born with complete fetal alcohol syndrome, and almost 100,000 a year are born with fetal alcohol effect (FAE), a less severe form of affliction. Cowley, *supra* note 3, at 20. Many adults and teenagers who actually suffer some form of FAS go undiagnosed because, unless the victim is grossly dysmorphic, the disease is usually not detected in newborns. *See* Rosenthal, *supra*, at 30, 49. Undetected cases account for approximately two-thirds of actual cases. *Id.* at 49.

Although not conclusive, it has been reported that paternal alcohol use, especially that occurring one month before conception, may be strongly related to the infant's birth weight. *Compare* Little & Sing, *Association of Father's Drinking and Infant's Birth Weight*, 314 NEW ENG. J. MED. 1644, 1644 (1986) (supporting a relationship between fathers' drinking and infants' birth weights) *with* Rubin, Leventhal, Krasilnikoff, Weile & Berget, *Fathers' Drinking (and Smoking) and Infants' Birth Weight*, 315 NEW ENG. J. MED. 1551, 1551 (1986) (discrediting a relationship between fathers' drinking and infants' birth weights but supporting the theory that there is an association between infants' birth weights and fathers' smoking).

A study on the effect of alcohol ingested by breast-fed infants reinforces the hypothesis that alcohol has immediate and long term effects on the development and behavior in newborns. Mennella & Beauchamp, *The Transfer of Alcohol to Human Milk: Effects on Flavor and the Infant's Behavior*, 325 NEW ENG. J. MED. 981 (1991); *see also* Fitzgerald, *Study Contradicts View on Breast-Feeding: Mother's Alcohol Use Found Not to Help in Nursing*, Phila. Inquirer, Oct. 3, 1991, at A3 (discussing the effect the study has had on the debate between advocates of breast-feeding and those who oppose *any* alcohol consumption during periods of lactation). For a discussion of a comprehensive approach to preventing FAS and FAE, see Masis & May, *A Comprehensive Local Program for the Prevention of Fetal Alcohol Syndrome*, 106 PUB. HEALTH REP. 484 (1991).

Researchers at the Temple University School of Medicine have recently discovered that effects of cocaine use may also have paternal origins. By combining fresh semen from nonusers of cocaine with doses of cocaine equivalent to what would normally be present in the bloodstream of drug users, researchers discovered that the cocaine attached to the sperm without affecting the mobility of the sperm. Yazigi, Odem & Polakoski, *Demonstration of Specific Binding of Cocaine to Human Spermatozoa*, 266 J.A.M.A. 1956 (1991); Fitzgerald, *Study: A Father's Use of Cocaine May Harm Fetus*, Phila. Inquirer, Oct. 9, 1991, at A1. Although the results are inconclusive

effects on the fetus,[239] but neither of which are prohibited by statute or common law.[240]

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as to whether abnormal development of the fetus resulting from exposure to drugs occurs only during gestational development or may occur within the genetic makeup of the sperm, the study does invite a whole new spectrum of legal debate as to the appropriatenesss of the criminalization of gestational substance abuse.

[239] FAS is believed to be the leading cause of mental retardation for children. *See* Toufexis, *supra* note 3, at 58. Children born with FAS usually suffer from abnormally small head size, narrowness of the eyes, drooping eyelids, short upturned noses and very wide upper lips with no center groove. Some suffer heart, genital and urinary defects. Zamula, *supra* note 237, at 10; *see* Dorris, *supra* note 238, at 8 (stating that FAS victims are likely to demonstrate "poor judgment, impulsiveness, persistent confusion over handling money, telling time and distinguishing right from wrong); Rosenthal, *supra* note 238, at 30 (describing the impact of FAS); *see generally* Smith, Lancaster, Moss-Wells, Coles & Falek, *Identifying High Risk Pregnant Drinkers: Biological and Behavioral Correlates of Continuous Heavy Drinking During Pregnancy*, 48 J. STUD. ALCOHOL 304 (1987) (suggesting that "women who continue to drink during pregnancy may be experiencing more chronic and severe alcohol-related problems than women who discontinue alcohol use and may thus be identified and targeted for intensive prevention effects"). Mothers who drink very heavily (three ounces of pure alcohol daily—six average drinks) frequently give birth to babies who suffer a full range of fetal alcohol symptoms; those who drink less heavily (two to six drinks a day) may give birth to babies suffering some, but not all, symptoms of fetal alcohol syndrome. Zamula, *supra* note 237, at 10. Some reports suggest that although the blood alcohol level of the fetus will equal that of the mother, the effects of alcohol on the fetus will depend on the type of drinking that is conducted by the mother. For example, "binge" drinking is more likely to have harmful effects on the fetus than having one drink every night. Rosenthal, *supra* note 238, at 49. Also, the type of damage caused to the fetus will depend on the stage of development of the fetus when the drinking occurs. *Id.*

Smoking during pregnancy creates a higher likelihood of prematurity or low birth weight. Passive exposure to smoke also creates a greater chance of lung disease in children and sudden infant death syndrome. *See* Okie, *supra* note 237, at A7. Babies born to mothers who smoke during pregnancy are also more likely to suffer physical, mental and even linguistic developmental problems by the age of three. *See* Rovner, *Smoking During Pregnancy Affects Child Development*, Wash. Post, Sept. 4, 1990, Health, at 25, col. 3. A 1988 study concentrating on passive smoke exposure of children under five years old revealed that 4.1% of children who lived in households with active smokers were in fair to poor health; 3.5% of those who lived with smokers who had quit were in fair to poor health and 2.4% were similarly healthy who were never exposed to tobacco smoke. Jaffe, *Children's Health, Parents' Smoking Linked in Study*, Phila. Inquirer, June 19, 1991, at A2, col. 1.

[240] Recently, however, as part of her sentencing for her conviction of child abuse, Darlene Johnson was ordered by Judge Howard R. Broadman to quit smoking during her pregnancy.

> I told her that since she was pregnant, if she got caught smoking, I was going to send her to prison and take away the baby. . . . "If you can't quit smoking for the betterment of your baby, how are you ever going to get your act together not to beat your children?"

Judge: Birth Control Implant Ruling Stands, Chicago Tribune, Jan. 11, 1991, at 4; *see also* Note, *Prenatal Injuries from Passive Tobacco Smoke: Establishing a Cause of Action for Negligence*, 78 KY. L.J. 865 (1989-1990) (arguing that a cause of action does exist for prenatal injuries caused by passive tobacco smoke). For the argument that some protective intervention by the state is required in cases in which the mother abuses even legal substances that have serious adverse postnatal effects, see Lisman, *supra* note 36, at 26. *But see* Gertner, *Women v. Fetus*, B.B.J.,

D. Independent Strict Liability Standard.

The various standards discussed above are problematic because they attempt to pigeonhole substance abuse into one of the already existing legal definitions of abuse. For example, gestational substance abuse may qualify as grossly negligent under certain definitions, but may only qualify as mere negligence under others. However one qualifies the act of abusing substances during pregnancy, there will always be other acts that fall under that categorization if it is too broad.[241] Conversely, however narrowly one describes acts that constitute unreasonable risks of harm to the fetus, there will be some categories that exclude the act of abusing substances during pregnancy.[242]

To ensure that women's privacy rights remain intact in areas beyond the scope of the state's compelling interest, yet still assure effective and timely protection for the fetus, there must be a separate and specific standard for gestational substance abuse outside the qualifying scope of negligence, reasonableness and viability. In essence, gestational substance abuse must have its own strictly applied standard, independent of the flexible interpretations of abuse and neglect statutes.[243] A strict substance abuse standard would guarantee the protections offered by other standards, yet separate the specific act so as not to include more innocent acts, which would unreasonably burden the mother. Overly narrow restrictions that limit the compelling interests of the state would also be avoided. As a result, an independent standard would overcome the shortcomings of the other tests, which fail to fully protect the fetus from gestational substance abuse.

Concerning viability, an independent strict standard would afford timely protection to the fetus by avoiding the strictures of the *Roe v. Wade* standard. Because an applied maternal duty would extend to the

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July/Aug. 1990, at 27 (arguing that maternal substance abuse is a socially-oriented problem that, because of the "slippery-slope" argument, should not be criminally penalized).

[241] For example, smoking, drinking or standing for extended periods of time.

[242] For example, substance abuse may not qualify as grossly negligent when the actions are proscribed for medical reasons.

[243] Because no state has specifically criminalized harmful conduct of the mother, *see* Note, *supra* note 29, at 1329, and therefore all depend on narrow interpretations of child abuse and neglect laws, restrictions on substance abuse during pregnancy must be applied independent of other restrictions. *See* Note, *Solving the Problem of Prenatal Substance Abuse: An Analysis of Punitive and Rehabilitative Approaches*, 39 EMORY L.J. 1401 (1990) (supporting separate and narrowly drawn statutory impositions, yet diverging on the punitive approach as an effective option for the courts).

fetus prior to viability, as distinguished from the right of the mother to decide whether or not to carry the fetus to term, the state may intervene at a time sufficient to take preventive measures.

On the question of reasonableness, the independent standard would allow the state to intervene when diagnosis demonstrates a need for intervention and when commissive acts threatening the health of the fetus are evident.[244] Such acts would be unreasonable per se.[245] Evidence of the acts would have to be gathered by screening of mothers as a part of prenatal care. Any recent history of drug abuse would provoke some form of intervention by the state. What form this intervention would take would depend on the point at which the potential harm was detected.[246] Although it is in the mother's best interest to encourage early detection and intervention,[247] a woman is more apt to

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[244] Certain omissions, even though they may be beneficial for the fetus, would not be unreasonable. For example, there is now debate between researchers at the American Association of Public Health Dentistry, who have found that prenatal fluoride supplements are effective in preventing tooth decay in children up to age five, and anti-fluoride groups, who assert that such supplements may result in birth defects. In tests conducted on 1,100 children, half of whose mothers took prenatal fluoride supplements beginning at four months of pregnancy, there were positive results for the prevention of tooth decay by age four and no increase in the reported cases of premature births, birth defects or fluorosis, the discoloration of the teeth. Although the use of prenatal fluoride supplements may effectively aid in the prevention of tooth decay, failure to use such supplements would not necessarily be "unreasonable." Similarly, researchers have found that low doses of aspirin taken by pregnant women during the second and third trimesters may reduce the risks of a low-birth-weight infant by as much as 44%. It also reduced hypertension (pregnancy-induced high blood pressure), which may be fatal to the fetus, by 65%. Reuters, *Aspirin May Cut Risk During Pregnancy*, Phila. Inquirer, July 11, 1991, at A14, col. 1. However, failing to take aspirin during pregnancy may not necessarily be "unreasonable."

Studies have also shown that daily doses of the vitamin folic acid during pregnancy may reduce the chances of birth defects such as anencephaly and spina bifida by as much as 72%. Wald et al., *Prevention of Neural Tube Defects: Results of the Medical Research Council Vitamin Study*, 338 LANCET 131 (1991). It is suspected that folic acid plays an important part in the neural development of the fetus from the time of conception. The study invites debate as to whether failure to take the drug—once proven effective—may be considered legally "unreasonable."

[245] There are acts of omission that will be unreasonable and threaten the health of the fetus, yet would not fall within this strict standard because the standard is an independent one, inclusive of only commissive acts of substance abuse. That is not to say, however, that certain acts of omission would not demand intervention; the response would have to be authorized by qualification under another standard.

[246] *See infra* text accompanying notes 248-448 (discussing various options available to the courts).

[247] "[W]hen early interventions [are] mounted, and the crack cocaine use [is] stopped during the first trimester of pregnancy, . . . the risk of prematurity and intrauterine growth retardation [is reduced. This] tells us that prenatal care and early interventions have an effect." *Children, Youth, and Families*, *supra* note 1, at 47 (statement of Neal Halfon, Director, Center for the Vulnerable Child, Oakland Children's Hospital, Oakland, California).

know in the later stages of pregnancy whether she has created the potential for harm by taking drugs. Therefore, the strict standard could be the test not only for civil liability but also for deciding when to intervene and what type of intervention to employ, including criminal liability.

VI. What Type of Intervention: Options for the Courts

A. *Mandatory Toxicological Screening*

The first step in treating drug-addicted babies is to require toxicological screening that would indicate substance abuse by the mother.[248] Mandatory screening of pregnant women should take place when they enroll in prenatal care programs and similar treatment facilities.[249]

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[248] Some states have implemented mandatory screening of newborns simply in an effort to obtain a more accurate determination of the number of drug-related pregnancies in the state. *See* U. Press Int'l, *Cocaine Babies: Growing Problem in North Carolina*, Nov. 16, 1989 (regional news) (stating that North Carolina faces a growing problem of cocaine-addicted babies and plans to begin screening programs in major hospitals in order to assemble an estimate on the growing figures). Unfortunately, national screening and testing regulations are unlikely, simply due to the high cost, which could reach $100 million every year. Adirim & Gupta, *supra* note 3, at 295. Some commentators argue that mandatory screening is a coercive and discriminatory measure that will only serve to drive women away from proper health care and cause distrust between patient and doctor. *See* Moss, *Legal Issues: Drug Testing of Postpartum Women and Newborns as the Basis for Civil and Criminal Proceedings*, 1990 CLEARINGHOUSE REV. 1406, 1406-07.

[249] At the Neonatal Nursery and Obstetrics/Gynecology wards that took part in a recent study by Osterloh & Lee, drug screening was not mandatory. Rather, the house staff ordered diagnostic drug screening according to various factors.

> Urine drug screens for mothers had been ordered on the basis of (1) a history of drug abuse, (2) signs and symptoms of drug use (track marks, skin abscesses, nasal mucosal ulceration), or (3) signs of pharmacologic effect (eg, elevated blood pressure due to cocaine vs pregnancy or disease). In the newborns, urine drug screens were ordered when there was (1) suspicion of drug effect (eg, opiate-induced respiratory depression or cocaine-induced irritability), (2) drug withdrawal (irritability, failure to feed, vascular instability, poor motor performance, wakefulness, tremulousness, hyperactivity, or hyperreflexia), or (3) a history of drug abuse or positive urine drug screen in the mother.

Osterloh & Lee, *Urine Drug Screening in Mothers and Newborns*, 143 AM. J. DISEASES CHILDREN 791, 791 (July 1989). In a study of 18 hospitals by the Select Committee on Children, Youth, and Families, none reported routine screening of all newborns and pregnant women. Fifteen of the 18 hospitals screened newborns if there was a reasonable suspicion of drug exposure based on either medical history or clinical signs. Only eight of the 18 hospitals screened the mother if there was reason to suspect drug abuse. *Children, Youth, and Families*, *supra* note 1, at 9. One clinical sign that now arouses suspicion of drug abuse is *abruptio placenta*, in which the afterbirth comes off the wall of the uterus before delivery, causing hemorrhage. This condition may be caused by irritation from crack cocaine. Because this condition is much more prevalent today than it once was, a toxicological screen should be conducted when this condition occurs. *See id.* at 16-17, 23 (statement by Margaret Gallen).

"The perfect prenatal test would be safe, painless, and precise, but unfortunately none meet all three criteria."[250] Nevertheless, because of technological advances in the past twenty years, more sophisticated and accurate options are available in prenatal testing.[251] Such options include ultrasound;[252] maternal serum alpha-fetoprotein (MSAFP), which is a simple blood test;[253] amniocentesis;[254] Chorionic-villus sampling (CVS);[255] percutaneous umbilical blood sampling (PUBS), or

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[250] Haupt, *Prenatal Purgatory*, CHILD, June/July 1991, at 72 (quoting Timothy R.B. Johnson, M.D., director of the Division of Maternal-fetal Medicine at Johns Hopkins Hospital and University School of Medicine in Baltimore).

[251] *See* Kaplan, *Prenatal Testing: The Newest Options*, WORKING WOMAN, Jan. 1990, at 134-35.

[252] Physicians utilize ultrasound most often to detect fetal anatomical anomalies, to date the pregnancy and simply to make sure that the fetus is alive and developing normally. The technique uses high frequency sound waves to produce a picture of the fetus; however, the test is painless and there has been no evidence of any harm to the fetus or the mother. The sound waves are transmitted by a transducer, which the doctor moves across the abdomen, and are translated by computer on a TV screen. *See* Kaplan, *supra* note 251, at 136. An even newer technique—transvaginal ultrasound—allows the doctor to view the fetus even more closely via a probe, which is inserted into the vagina. Ultrasound can be performed at any stage of the pregnancy. *See* Haupt, *supra* note 250, at 74. For a discussion of the effects of the advancements in ultrasonography, see Chervenak, Isaacson & Mahoney, *Advances in the Diagnosis of Fetal Defects*, 315 NEW ENG. J. MED. 305 (1986).

[253] Physicians now require a MSAFP on virtually all pregnant women. The test is used to determine unnatural levels of protein in the blood (usually in the liver of the fetus), which is sometimes indicative of a neural-tube defect (NTD). The test is most often used for genetic determinations. Because alpha-fetoprotein tests cannot be performed until the 16th or 18th week of pregnancy, they usually do not offer evidence of abnormalities until after the woman is into her fourth month of pregnancy. No state actually mandates the test; however, California requires all physicians to offer the test to all pregnant patients. One risk with the test is that it has a high rate of false-positive results—suggesting a fetal anomaly when there in fact is none. The test is 80% successful, however, in detecting abnormalities. *See* Haupt, *supra* note 250, at 74; Kaplan, *supra* note 251, at 136.

[254] Amniocentesis, like MSAFP, is most useful in determining genetic defects but can also determine the sex of the child. Physicians administer the test between the 16th and 18th weeks of pregnancy, after viewing the fetus by ultrasound. It uses a needle to remove small amounts of amniotic fluid containing cells from the fetus from the woman's womb. The cells are grown in the laboratory and evidence genetic abnormalities within three weeks. Amniocentesis increases the risk of miscarriage by one percent. There is also a one percent failure rate. *See* Haupt, *supra* note 250, at 74, 76; Kaplan, *supra* note 251, at 136.

[255] CVS has only been in the United States for six years and is only available in 80 medical centers in the United States. It carries up to a 10% increased risk of miscarriage, and its success is dependent on the physician's experience. During the procedure, which may be conducted during the first trimester as early as nine weeks gestation, doctors remove and test a small portion of the placenta, called the chorionic villi, which is a small, hairlike projection that covers the gestational sac. Presently there are two types of CVS. The standard CVS involves the insertion of a plastic tube, through which the villi is suctioned out, through the cervix. Similarly, a transabdominal CVS is available. Although the patient may experience minimal cramping and bleeding, the pro-

cordocentesis;[256] fetal tissue sampling[257] and cell sorting.[258] Although these options are mostly used for detecting genetic disorders, advances in each have led to increased availability.[259]

One Canadian research group has developed a method of detecting cocaine in both the mother and the newborn through analysis of hair samples.[260] Other hospitals incorporate meconium testing that is more sensitive and designed specifically for drug testing. These two methods of screening are more accurate than simple urinalysis and are temporally more advantageous.[261] Other promising techniques in the prenatal field are presently being tested and researched. For example, researchers have known since the early 1970s that at or about the eighth week of pregnancy, fetal cells begin to leak into the mother's bloodstream; however, the fetal cells were never distinguishable from those of past pregnancies. In 1989, however, a team of English scientists developed an entirely new technique to isolate the fetal cells from the blood of the

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cedure is, at most, slightly uncomfortable. *See* Haupt, *supra* note 250, at 76; Kaplan, *supra* note 251, at 136-38.

[256] This four-year-old procedure is used for detecting genetic abnormalities and infections. It can only be performed after the 17th week of pregnancy and is available at about 25 medical centers in the country. Here, doctors remove a sample of the fetus's red blood cells from the umbilical cord. Kaplan, *supra* note 251, at 138.

[257] Doctors employ this procedure to determine fatal hereditary skin disorders. The procedure is performed so rarely that its risks and long term effects are uncertain. *Id.*

[258] Cell sorting is a less invasive procedure, requiring only a blood sample from the mother. Since between the 8th and 10th weeks of pregnancy a few fetal cells leak into the bloodstream of the mother, doctors are able to isolate, extract and then genetically test a fetal cell with a simple blood sample from the mother. The test is highly experimental and extremely difficult to perform. However, the benefits of a risk-free genetic test make it a valuable tool. *Id.*

[259] For example, the use of ultrasound more than doubled between 1980 and 1987. Its use during the first trimester increased from 6.9% (in 1980) to 10.1% (in 1987). The use of external electronic fetal monitoring devices during delivery also more than doubled during this time period. Moore, Jeng, Kaczmarek & Placek, *Use of Diagnostic Imaging Procedures and Fetal Monitoring Devices in the Care of Pregnant Women*, 105 PUB. HEALTH REP. 471 (1990).

[260] *See Sizing Up the Hazards of Cocaine Use*, SCI. NEWS, Jan. 6, 1990, at 13 (reporting the findings of the Canadian group). In order for this technique to be effective, the baby's hair must be tested within the first few months since newborns lose their fetal hair after this period and the new hair will not show traces of cocaine. Likewise, the neonatal hair will not reveal exposure occurring immediately before birth as there is not enough time for the drugs to enter the hair. Despite its proven accuracy, however, it is doubtful that this technique will ever become standard procedure for most United States hospitals because of the extensive time involved. *See* Graham, Koren, Klein, Schneiderman & Greenwald, *Determination of Gestational Cocaine Exposure by Hair Analysis*, 262 J. A.M.A. 3328-30 (1989); Bailey, *Drug Screening in an Unconventional Matrix: Hair Analysis*, 262 J.A.M.A. 3331 (1989) (expressing doubt about the future use of the technique).

[261] In one Detroit study, meconium testing revealed 42% of drug-exposed infants while self-reporting of the mother revealed only 8%. COMMITTEE ON FINANCE, *supra* note 3, at 20.

mother. By multiplying the genes within the cells, they were able to determine the sex of the babies. In furtherance of this process, American researchers are now able to use advanced DNA techniques to diagnose chromosomal abnormalities in the fetal cells within the mother's blood. Scientists hope a fully effective diagnostic blood test will be available by 1996.[262]

Currently, if a woman simply tests positive for drugs in prenatal screening, some steps should be taken then to protect the fetus from future abuse.[263] Similarly, if the newborn shows clinical signs of addiction and withdrawal, screening should be performed by testing the urine of the mother and the child for drugs.[264] Studies show that clinical urine testing for drugs yields more positive screens than do history screens of mothers admitted for delivery.[265] Understandably, the incidence of drug-exposed babies is higher when drug testing is performed than when the identifying factor is the mere self-reporting of the mother.[266]

Unfortunately, on a number of occasions, the newborn may suffer delayed withdrawal signs, resulting in a delay in the triggering of the toxicological screen. Because the screen is not conducted immediately, there is a late collection of urine. Consequently, a majority of drug screens performed on newborns show negative results and detection becomes inadequate.[267] No state has a statewide regulation for testing,[268]

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[262] *See* Haupt, *supra* note 250, at 77.

[263] Such a strategy would also be applicable to women who are in treatment programs. For example, the Women and Infants Clinic at Boston City Hospital follows a procedure in which the women must submit to random urine tests every week. If the women are absent for two screens in a row, an immediate investigation for child neglect is conducted. Willwerth, *supra* note 74, at 63.

[264] In cases in which either the mother or the newborn is tested, clinical suspicions of drug abuse are confirmed in two-thirds of the cases, leading to the conclusion that "testing both mothers and newborns . . . appear[s] to yield greater confirmation of clinical suspicion." Osterloh & Lee, *supra* note 249, at 792. Other researchers also recommend testing both the mother and the fetus when signs of gestational substance abuse first appear. *See* Fulroth, *supra* note 1, at 910.

[265] Fulroth, *supra* note 1, at 908.

[266] A study involving a large Detroit hospital showed that under testing circumstances, 42% of the births, or nearly 3,000 infants, were recorded as drug-exposed, while simply relying on the mothers' reports of drug use revealed that only 8%, or 600 infants, were drug-exposed. COMMITTEE ON FINANCE, *supra* note 3, at 4-5, 18-19.

[267] Osterloh & Lee, *supra* note 249, at 793. Research has shown that urine tests prove unreliable in about 50% of all cases. *See Sizing Up the Hazards of Cocaine Use*, *supra* note 260, at 13. Some newborns are given the Neonatal Behavioral Assessment scale, which is a test designed to identify neurologically related behavioral difficulties. *See* Fackelmann, *supra* note 1, at 198. Diagnostic tests such as these are useful when urine sampling is inadequate. "Research has found that when screening and testing is uniformly applied, a much higher number of drug-exposed infants are identified." COMMITTEE ON FINANCE, *supra* note 3, at 4.

and some hospitals do not even have a protocol for the screening or testing of pregnant women. This accounts for many undetected cases of drug-exposed infants and certainly increases the national incidence.[269]

Because the most damaging effects are suffered by the fetus in the first trimester,[270] and because early clinical screening results in a greater diagnostic yield of positive screens, toxicological tests should be performed at the earliest stage possible. The most practicable point would be when the mother first becomes aware of her pregnancy and seeks prenatal care.[271] Many women, however, may refrain from seeking proper prenatal care for fear of drug detection upon screening.[272] While this is an unfortunate situation, the fact that *some* women will *possibly* avoid seeking care should not negate efforts to detect abuse by those who do seek care for themselves and their babies.

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[268] Adirim & Gupta, *supra* note 3, at 293.

[269] *See* COMMITTEE ON FINANCE, *supra* note 3, at 5, 19. In addition to the already poor rate of screening in most hospitals, many pregnancies of white upper and middle class women go unscreened because they take place in private hospitals, in which mothers are seldom asked about drug use or screened for illegal chemicals in their system. One 1989 Florida study revealed that drug use by pregnant white and black women of similar socioeconomic background was rated equally; however, only 1% of the white women were reported to authorities, while 11% of the black abusers were reported. Toufexis, *supra* note 3, at 58; Willwerth, *supra* note 86, at 63.

[270] *See* Chasnoff, Griffith, MacGregor, Dirkes & Burns, *Temporal Patterns of Cocaine Use in Pregnancy*, 261 J. A.M.A. 1741-44 (Mar. 1989) (although damage occurs at any time during gestation, certain perinatal outcomes, such as low birth weight and intrauterine growth retardation, are greater during the first trimester). Harm to the normal embryonic development is most likely to occur between the third and eighth weeks. Zamula, *supra* note 237, at 8 (suggesting that the effects of drugs during the first few months of pregnancy have been known for 2,500 years, since the time of Hippocrates); *see also* Fackelmann, *supra* note 1, at 198. "If a teratogenic drug—a chemical that can produce birth deformities—is taken in the earliest part of pregnancy (from conception until about 20 days), it will either cause the death of the embryo and subsequent miscarriage, or not affect it at all." Zamula, *supra* note 237, at 9. Teratogenic drugs taken after the eighth week of pregnancy may cause little structural damage, but may have a large effect on growth and organ function, particularly the nervous system. *Id.* Similarly, when a baby is finally born and is addicted, the most serious effects of the addiction are prevalent during the first four months of life—exactly when the baby and the mother would normally begin to interact and establish a bonding relationship. This leads to psychological and emotional damage during developmental years. *See* Revkin, *supra* note 3, at 66.

[271] Of course, many women who cannot afford prenatal care are therefore not going to be screened. The most that could be hoped for is that screening take place early enough in the pregnancy to be able to minimize the damage to the baby.

[272] *See* Benderly, *Saving the Children*, HEALTH, Dec. 1989, at 74-75 (suggesting that any type of screening and criminalization would be impracticable as well as unconstitutional; the only preventive means available would be education).

B. Criminalization

Michael Brown Jr., a fourteen-month-old boy, lies in a Florida hospital bed in a potentially fatal coma as a result of crack cocaine.[273] His eighteen-year-old mother, LaShella Lanett Allen, now faces criminal prosecution. However, LaShella's son did not ingest the crack as a result of substance abuse during pregnancy. Rather, the boy swallowed and ingested the crack when his mother left twenty-one pieces of the drug lying on the coffee table in their home. Although the ingestion was accidental, the mother was charged with child abuse.[274]

It was no accident, however, in the case of five-year-old Raymond "Tinkie" Griffin, who died in February 1990. His mother, Patricia Griffin, urged him to drink ten ounces of bourbon at a party.[275] Aside from criminal charges stemming from that incident, state officials have taken custody of Patricia Griffin's newborn baby girl, who demonstrated signs of cocaine withdrawal.[276] It would be an outrage if authorities were to forego criminal charges of these women and instead, institute civil commitment proceedings to assure that the mother at least receives some treatment before she returns to what is left of her family. The children in these cases are victims of child abuse. Whether the drugs or alcohol pass through the placenta or a pacifier, the mother is abusing the child and child abusers must be held accountable for their crimes.[277]

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[273] *See* Wash. Post, Oct. 20, 1990, at A6, col. 4; *Tot in Coma After Eating Crack*, Chicago Tribune, Oct. 19, 1990, § 1, at 8.

[274] Despite her knowledge of the ingestion, the mother did not call emergency workers until the following day after the child began to convulse. *See* Wash. Post, *supra* note 275, at A6; *Tot in Coma After Eating Crack*, *supra* note 273, at 8.

[275] *Texas Officials Seize Newborn from Mom*, Wash. Times, Oct. 12, 1990, § B, at 5 (final ed.).

[276] *Id.*

[277] In support of criminalization for fetal abuse, John Robertson, University of Texas law professor, writes: "All persons have obligations to refrain from harming children after birth. Similarly, they have obligations to refrain from harming children by prenatal actions. The timing of the conduct does not affect the duty to avoid harm." Robertson & Paltrow, *Fetal Abuse: Should We Recognize It as a Crime?*, 75 A.B.A. J., Aug. 1989, note 178, at 38; *see also* Lisman, *supra* note 36, at 26 (arguing that because maternal substance abuse results in harm to the "child," criminalization for fetal abuse should be valid, just as criminalization of the abuse of children is valid).

For a discussion of the need for courts to re-evaluate the way the justice system as a whole deals with the criminalization of child abuse crimes, see National CASA Association, *Arresting Family Violence*, 6 THE CONNECTION 1 (Fall 1990).

There have been criminal prosecutions against pregnant women in nineteen states and the District of Columbia relating to substance abuse by the mother.[278] Jennifer Johnson of Florida was the first to be

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[278] Alaska: *See* Alaska v. Grubbs, No. 4FA S89 415 Criminal (Sup. Ct. Aug. 25, 1989) (woman sentenced to six months in jail and five years probation for criminally negligent homicide for the death of her two-week-old son). California: Reyes v. Superior Ct., 75 Cal. App. 3d 214, 141 Cal. Rptr. 912 (1977) (prosecution of woman under the felony child endangerment statute, which the appeals court later held did not apply to prenatal conduct); California v. Stewart, No. M508197 (San Diego Mun. Ct., Feb. 26, 1987) (case dismissed when court found that the criminal child support statute did not apply to pregnant women and did not impose a duty of care on the mother for the fetus). Colorado: six women have been charged with use of a controlled substance and misdemeanor child abuse as a result of newborn toxicology tests; Goldsmith, *Prosecution to Enhance Treatment*, CHILDREN TODAY, July-Aug. 1990, at 13. Connecticut: Connecticut v. Baez, No. CR089-010-4414 (Super. Ct. of Middletown, filed July 31, 1989) (charge of "risk of injury to a child" for swallowing a quarter ounce of cocaine was later dropped). District of Columbia: United States v. Vaughan, No. F-2172-88B (Super. Ct. of D.C., Aug. 23, 1988) (pregnant woman, who tested positive for cocaine, was given prison term rather than usual sentence of probation for second degree theft in order to prevent her from taking drugs until her pregnancy was over); Moss, *Pregnant? Go Directly to Jail*, A.B.A. J., Nov. 1, 1988, at 20 (discussing criminal sentences and their effect on pregnant inmates).

Florida: Florida v. Jerez, No. K89-16257 (Cir./County Ct. of Monroe County, warrant issued Jan. 11, 1990) (arrest warrant issued for woman charged with child abuse for cocaine use during pregnancy); Florida v. Black, No. 89-5325 (Cir. Ct. for Escambia County, Jan. 3, 1990) (woman imprisoned for 18 months and three years probation for "passing cocaine to her baby through the umbilical cord"); Florida v. Carter, No. 89-6274-D (Cir. Ct. for Escambia County, filed Nov. 20, 1989) (case has been moved for dismissal); charges have been dropped against Frances Arlene Nelson, who gave birth to an addicted baby in 1989; prosecutions are pending for two other Florida women, Sheila Dawson and Rhonda Maxwell; Denise Lee, who is in jail, is awaiting trial; Florida v. Gethers, No. 89-4454 CF10A (Cir. Ct. for Broward County, Nov. 6, 1989) (criminal charges dismissed for a woman whose daughter tested positive for cocaine, because the fetus did not qualify under the child abuse statute as a legal person); Florida v. Hudson, No. K88-3435-CFA (Cir. Ct. July 26, 1989) (distribution to a minor and child endangerment charges dropped against woman whose baby tested positive for cocaine); Florida v. Johnson, No. E89-890-CFA (Cir. Ct. July 13, 1989), *appeal docketed*, No. 89-1765 (Dist. Ct. App. Aug. 31, 1989) (woman guilty of two counts of "delivery of a controlled substance to a minor" was sentenced to 15 years probation).

Georgia: Georgia v. Coney, No. 14/403-404 (Super. Ct. of Crisp County, filed Nov. 6, 1989) (woman indicted for "distribution of cocaine to her fetus"). Hawaii: a prostitute from Honolulu who was four months pregnant was sentenced in August 1990 to six months in a halfway house; USA Today, Oct. 23, 1990, § A, at 10. Illinois: Illinois v. Green, No. 88-CM-8256 (Cir. Ct., filed May 8, 1989) (charges of involuntary manslaughter and delivery of a controlled substance to a minor were dropped when grand jury refused to indict woman whose baby died due to cocaine use during pregnancy); Walsh, *infra* note 285, at A3. Indiana: Indiana v. Yurchak, No. 64D01-8901-CF-181B (Super. Ct. of Porter County, filed Oct. 2, 1989) (woman charged with possession of cocaine based on evidence of her baby's addiction).

Kentucky: a woman who gave birth to three children over a 17-year span was sentenced to five years in prison for criminal child abuse as a result of her addiction to pills and intravenous drugs; Hoffman, *supra* note 182, at 35; another woman was sentenced to eight years for "placing a child in a situation of risk of death or serious injury after birth"; Goldsmith, *supra*, at 14. Massachusetts: Commonwealth of Mass. v. Levey, No. 89-2725-2729 (Super. Ct., Dec. 4, 1989)

convicted for delivering drugs to her baby[279] despite Florida precedent holding that the fetus is not a person for purposes of the state statute.[280] Before being convicted, Johnson had given birth to three other cocaine-affected children.[281] Maria Reyes, a twenty-three-year-old mother of five, was likewise convicted of felony injury to a child when

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(woman, who suffered miscarriage at eight months and two weeks of pregnancy, was charged with the motor vehicle homicide of her fetus as the result of her drunk driving); Commonwealth of Mass. v. Pellegrini, No. 87970 (Super. Ct. filed Aug. 21, 1989) (woman charged with "distributing cocaine to her fetus" after baby tested positive for cocaine). Michigan: Michigan v. Hardy, No. 89-2931-FY (60th Dist. Ct. for Muskegon County, filed Dec. 5, 1989) (woman charged with delivery of controlled substance and child abuse; she now faces 20 years in prison); Michigan v. Cox, No. 9053545FH (Cir. Ct. for Jackson County filed Jan. 30, 1990) (charges of child abuse and delivery of drugs during pregnancy were dropped; however, woman is being charged for delivery of cocaine to her fetus on theory that delivery took place after birth but before cutting of umbilical cord).

Nevada: Nevada v. Bloxham, No. RJC-36887 (Reno J. Ct., filed Feb. 2, 1990) (woman charged with child abuse); Nevada v. Peters, No. 90-241 (Sparks J. Ct., filed Feb. 2, 1990) (child abuse charges). North Carolina: North Carolina v. Inzar, No. 90 CRS 6960, 6961 (Super. Ct. of Robeson County, filed Apr. 16, 1990) (woman who smoked crack one day before delivery was charged with assault with a deadly weapon and distributing cocaine to a minor after child suffered brain damage). Ohio: Cox v. Court of Common Pleas, No. 88AP 856 (Ct. App. for Franklin County Dec. 13, 1988) (juvenile court order placing woman in drug treatment facility was overturned for lack of jurisdiction over an adult woman to control her conduct while pregnant); Ohio v. Andrews, No. JU 68459 (Ct. C.P. of Stark County, June 19, 1989) (charges of child endangerment, dismissed by trial court because of limited scope of statute); Ohio v. Gray, No. CR88-7406 (Ct. C.P. of Lucas County, July 13, 1989) (charges of child endangerment, dismissed by trial court because statute inapplicable to fetus).

South Carolina: eight Greenville women have been charged with criminal neglect of a child, one of whose parents have also been charged with criminal neglect as a result of their five-day-old granddaughter's positive drug test; Curriden, *supra* note 210, at 51. South Dakota: South Dakota v. Christenson, No. CRI. 90 (Cir. Ct. Mar. 12, 1990) (woman charged with contributing to the dependency of a minor and ingestion of a toxic substance was sentenced to six months in jail for giving birth to baby addicted to cocaine). Texas: Texas v. Rodden, No. 0373625R (Dist. Ct. for Tarrant County, filed June 1, 1989) (felony charges dismissed against woman whose baby was born addicted to cocaine). Wyoming: Wyoming v. Pfannenstiel, No. 1-90-8CR (Laramie County Ct., filed Jan. 5, 1990) (while waiting in hospital room to be treated for beating sustained by her husband, woman was tested for alcohol, arrested, jailed and charged with criminal child abuse for endangering her fetus; the court discontinued the case after finding no probable cause).

[279] Florida v. Johnson, No. E89-890-CFA (Cir. Ct. July 13, 1989); Curriden, *supra* note 210, at 51; Roberts, *supra* note 31, at 56.

[280] Love v. State, 450 So. 2d 1191 (Fla. Dist. Ct. App. 1984). Johnson was convicted for the delivery of drugs to her child, which occurred during the minutes after birth and prior to the severance of the umbilical cord. Also of significance in the case was the fact that a cocaine derivative, called benzoylecgonine, remains in the bloodstream for up to 72 hours after ingestion, especially since Johnson had ingested cocaine just hours before her delivery. Florida v. Johnson, No. E89-890-CFA (Cir. Ct. July 13, 1989).

[281] Curriden, *supra* note 210, at 51.

her infant son died of an overdose.[282] Doctors originally diagnosed the boy, two-month-old Fabian, as a victim of sudden infant death syndrome but later found he had suffered from a massive cocaine overdose. The boy had so much cocaine in his blood that it overloaded the laboratory equipment. The mother faces a maximum of ten years in prison.[283]

Most recently, Illinois Judge Harris Agnew of the Winnebago County Circuit Court ordered twenty-five-year-old LeeAnn Moore to twenty-four-hour supervision at a drug treatment center.[284] Moore, an alleged cocaine addict and prostitute, was eight months pregnant and had violated the conditions under which she was free without bond just one week before for disorderly conduct. Judge Agnew did not mention the woman's pregnancy or protection of the child in his order; however, State's Attorney Paul Logli had indicated that he sought a court order to protect the child.[285]

In light of the fact that approximately 375,000 children a year are born addicted to drugs, one must question why so few women have been charged with any crime.[286] The answer to this devastating imbalance of statistics is that most child abuse statutes do not cover fetuses.[287] In order to bring successful criminal charges against mothers

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[282] *Mom Found Guilty in Coke Baby's Death*, Gannett News Service, Oct. 17, 1990. This was the first case in the state of Idaho to relate the charge of felony injury to a child to gestational substance abuse.

[283] The prosecutor in the case suggested to the jury in closing arguments that the mother may have mixed cocaine with some other liquids and fed it to the boy in an effort to minimize the symptoms of withdrawal the boy was suffering. The cocaine metabolite that showed up in massive quantities in the boy's blood was barely detectible in the urine, an effect of the rapid death and the failure of the kidneys to function completely, *id.*, proving, therefore, that urinalysis may prove to be a misleading toxicological screen for children who suffer from gestational substance abuse.

[284] For a proposal for the revision of the Illinois Criminal Code to accommodate prenatal substance abuse, see Note, *supra* note 163, at 393.

[285] Walsh, *Illinois Court Orders Pregnant Woman Confined to Drug Treatment Center*, Wash. Post, Apr. 12, 1991, at A3, col. 4.

[286] For an account of the method used by prosecutors to develop cases against two Michigan women for delivering drugs to their infants, see Hoffman, *supra* note 182, at 35, 44.

[287] *See supra* notes 38-62 and accompanying text; Moss, *Substance Abuse During Pregnancy*, 13 HARV. WOMEN'S L.J. 278, 285-86 (1990) (arguing that the statutes used to prosecute pregnant drug abusers were not intended to protect fetuses, nor do they meet due process requirements in their application). In the case of California v. Stewart, No. M508197 (San Diego Mun. Ct., Feb. 26, 1987), although the 1925 California statute that made it a crime for a parent to willfully withhold medical care from his or her child *did* include the fetus within its definition of the word "child," the court dismissed the case against Pamela Rae Stewart, holding that the statute was designed for pregnant women seeking support payments from their husbands. LaCroix, *supra* note 138, at 585. Many social workers feel that they are limited in the amount of help they can provide because of outdated local laws. As a result, social workers often overstep the

who abuse their fetuses with drugs, legislators must either reconstruct the legal definitions of child neglect and child abuse to include the fetus[288] or create a new criminal statute that is narrowly tailored toward gestational substance abuse and that will enable courts to apply an independent strict liability standard.[289]

Many are opposed to prosecuting women for the harm done to the baby and advocate that state governments direct their efforts toward prevention instead of punishment.[290] Although there has been no docu-

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bounds of legally appropriate responses to reports of this type of child abuse. *See* Thomas, *Stronger Net of Protection Sought for Babies Born to Addicts*, Wash. Post, Dec. 3, 1990, at D1.

[288] Presently, only eight states include fetal drug exposure in their definition of child abuse and neglect. Hoffman, *supra* note 182, at 35; *see also* DeBettencourt, *supra* note 38, at 18 (discussing amended state statutes that now include the fetus within their definitions of abuse and neglect).

[289]

> [The] policy of state custody over the drug-exposed child . . . is inadequate in several respects. First, . . . our child welfare system is too over-burdened to handle the rising number of cases. Second, state intervention comes too late. The physiological damage done to the baby occurs *in utero* when the pregnant mother uses the cocaine. Third, custody is not a sufficiently coercive factor to compel many of these women to comply with court-ordered rehabilitation. As a result, the state simply has one more foster child, no rehabilitated mother, and, most likely, more drug-exposed offspring in the future.

Note, *supra* note 163, at 404 (italics in original text) (footnotes omitted) (arguing for criminal statutory enforcement instead of innovative yet limited uses of already existing abuse and neglect statutes). *But see* Note, *Fetus vs. Mother: Criminal Liability for Maternal Substance Abuse During Pregnancy*, 36 WAYNE L. REV. 1285, 1290, 1317-18 (1990) (arguing that statutes which criminalize maternal substance abuse, include substance abuse as per se abuse and neglect and even those that mandate reporting are all counterproductive to the health and well-being of the substance abuser).

Virginia legislators are now debating a proposal that would require pregnant drug abusers either to receive treatment or face charges of child abuse. Thomas, *supra* note 289, at D1. Recently, in such states as Florida, Minnesota and Massachusetts, legislatures have mandated that doctors, nurses and hospitals report cases of addicted newborns to social workers. *See, e.g.*, UTAH CODE ANN. § 62A-4-504 (1989 & Supp. 1990), which states:

> When any person, including a licensee under the Medical Practice Act or the Nurse Practice Act, attends the birth of a child or cares for a child, and determines that the child, at the time of birth, has fetal alcohol syndrome or fetal drug dependency, he shall report that determination to the division as soon as possible.

Presently, six other states are considering similar mandates. Thomas, *supra* note 289, at D1. There are more than 12 different bills relating to gestational substance abuse before the California legislature alone. The main proposal would make it manslaughter to cause the death of a baby by illicit drugs, would require reporting of infants who test positive for drugs and would include fetuses within the California child abuse laws. Roberts, *supra* note 31, at 56.

[290] *See* Kimmins, *"Crack Baby" Report Stresses Education, Treatment, Not Tests*, Gannett News Service, May 9, 1990 (discussing the Ohio Governor's Task Force Report on Drug-Exposed Infants). The report recommends a policy of prevention and intervention, yet stresses that "the state should not require women to be tested for illegal drugs during pregnancy or after delivery."

mentation supporting the contention that the punitive approach will deter women from seeking proper care,[291] this seems to be the strongest argument for decriminalization.[292] However, "[w]arnings from public health officials that criminalizing addictive behavior will drive pregnant women from prenatal care are no match for public sympathy for 'crack babies' and anger at their mothers."[293] Furthermore, as evidenced by the escalating number of babies born addicted to drugs, there is already little incentive for drug addicted mothers to seek proper treatment for their babies. Instructions on proper care and pleadings that such actions will harm the baby are of little value to the mothers who continue to disregard the advice of their doctors.[294] In response to the negative acceptance of the punitive approach, others argue that prosecution is in fact an effective motivational tool for seeking proper care and is essential to the protection of the children.[295] If substance abuse during pregnancy is prosecuted, society sends out a clear message that

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Id.; McGinnis, *Prosecution of Mothers of Drug-Exposed Babies: Constitutional and Criminal Theory*, 139 U. PA. L. REV. 505, 539 (1990) (concluding that additional educational programs and reductions in drug supplies—not criminalization—will quell the rise in maternal substance abuse); Note, *supra* note 289, at 1317-18. *But see* Note, *supra* note 163, at 402-03 (arguing that although prevention campaigns and voluntary treatment programs are essential to a comprehensive approach to the problem, they have proven unsuccessful, and therefore, criminal sanctions are warranted). For arguments for and against the criminalization of gestational substance abuse, see Robertson & Paltrow, *supra* note 277, at 38-39 (Robertson, supporting post-birth sanctions in egregious cases, and Paltrow, arguing that neither pre- nor post-birth sanctions are justifiable).

[291] *See* Goldsmith, *supra* note 278, at 16.

[292] *See generally* Note, *Maternal Rights and Fetal Wrongs: The Case Against the Criminalization of "Fetal Abuse"*, 101 HARV. L. REV. 994 (1988); *see also* Kimmins, *supra* note 290; Sachs, *supra* note 5, at 107. *Contra Children, Youth, and Families*, *supra* note 1, at 134 (supporting the punitive effectiveness of criminalization).

[293] McNamara, *supra* note 3, at 1. Hippocrates Magazine published a gallop poll in 1988, finding that 48% of those participating in the poll agreed that women should be legally liable for damage to their newborns. Sachs, *supra* note 5, at 107; *see also* LaCroix, *supra* note 138, at 586. A 15-state survey by The Atlanta Constitution revealed a much higher percentage—71%—who favored criminal penalties for fetal injury. Hoffman, *supra* note 182, at 34; Curriden, *supra* note 210, at 51. Forty-five percent of those in the same survey approved of prosecutions for women who harm their children by smoking or consuming alcohol while pregnant. The survey also showed that more women than men favored criminal prosecution. *Id.*

[294] *See generally* Chavez, *Face-off: Mothers of "Cocaine Babies"*, USA Today, May 17, 1989, at A12 (final ed.). Dr. Stephen Kandall, chief of neonatology at New York's Beth Israel Medical Center, was quoted as saying, "If I were a woman about to have a baby, and if I knew that if the baby had drugs in the urine I could be prosecuted, I would probably have my baby in a back alley." *Cocaine Babies: The Littlest Victims*, *supra* note 86, at 55.

[295] *See* Note, *supra* note 163, at 395 (supporting the constitutionality of criminal sanctions for prenatal substance abuse); Chavez, *supra* note 296, at A12; Thomas, *supra* note 289, at D5; *see also* Goldsmith, *supra* note 280, at 14 (suggesting that "the stigma from illegality still effects usage" and that the value of this stigma is usually underestimated). Commenting on the effectiveness of criminal sanctions, prosecutor Jeff Deen, who prosecuted Jennifer Johnson, said, "She

it will condemn and punish those responsible for the harms caused by the substance abuse.[296] Therefore, prospective jail terms will motivate drug-addicted women either to seek treatment prior to becoming pregnant, or if already pregnant, to obtain what treatment is still available to them before giving birth and to continue treatment for future pregnancies after delivery.[297]

Treatment of the mother's addiction is a critical factor in preventing child abuse. Criminalization for the resulting harm is not necessarily insensitive to that need.[298] However, the importance of treatment does not justify overlooking the fact that the woman must be held accountable for her actions, just the same as any criminal facing incarceration might also need some form of treatment.[299] Although

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wasn't doing anything to help herself. The arrest is what motivated her to get help that she wasn't getting on her own." *Id.*

Likewise, some commentators and experts say that many addicted mothers see termination of parental rights as an effective motivational tool for treatment. "[I]f it were not for the threat of losing legal custody, [they] would not have sought treatment for [their] drug habit[s]." Willwerth, *supra* note 74, at 63.

[296] *See Children, Youth, and Families, supra* note 1, at 134 (statement by Jeffrey Parness in support of criminal sanctions).

[297] *See* Mainor, *supra* note 34, at 27. Mainor suggests that if prosecution results in mandatory treatment and not simply a jail term, then criminalization may be appropriate and effective. Coercive techniques are pointless, however, if there are not enough treatment facilities available to serve the needs of both the mother and the child. *Id.* at 27-28. Sadly, in Maryland there are "76 residential and 63 outpatient drug treatment facilities . . . [but] only four are dedicated to women [and] [o]nly one facility treats indigent cocaine-addicted women." *Id.* at 27. Given these statistics, prosecutions in Maryland resulting in convictions and sentences of mandatory treatment are futile, if not unlikely.

[298] One commentator suggests that "criminalizing maternal conduct [and] increasing awareness about, and the quality of, prenatal care . . . are essentially incompatible." Note, *supra* note 292, at 1011. The author argues that criminalizing maternal conduct undermines the doctor-patient relationship, and the trust therein, by requiring doctors to "report disobedient patients." *Id.* The author misconstrues the nature of the relationship, however, in that regardless of by what method the courts choose to intervene, the children are still being abused and the doctors are legally responsible for reporting suspected cases of child abuse, whether it will result in criminal prosecution or not. Moreover, sentences received by convicted women may be conducive to treatment and preventative incentives, as is evident by the sentence received by Jennifer Johnson. *See* Florida v. Johnson, No. E89-890-CFA (Cir. Ct. July 13, 1989). Florida Circuit Judge O. H. Heaton, Jr., instead of sentencing Johnson to a possible 30 years in prison, sentenced her to 15 years probation, including one year of strict supervision and drug rehabilitation, one year of monthly drug testing, educational and vocational programs and extensive prenatal care programs. *See* Curriden, *supra* note 210, at 51; *see also* Goldsmith, *supra* note 278, at 15-16, 36 (refuting the argument that treatment resulting from prosecution would be ineffective because it is involuntary).

[299] "The choice to use or not to use cocaine is just that—a choice. . . . Once the defendant made that choice she assumed responsibility for the natural consequences of it. Children, like all persons, have the right to be free from having cocaine introduced into their systems by others."

criminalization is rooted in a punitive foundation, it does still offer another means of change for the problem of child abuse and family violence.[300] Thus, both legislative and judicial initiatives are needed if criminalization of gestational substance abuse is to be effective.[301]

C. *Civil Commitment*

1. *The Standard*

One common criticism of criminalization is that prosecuting women for giving birth to addicted babies does nothing to prevent the harm to the baby.[302] Others charge that criminalization is too intrusive into the woman's rights and raises due process questions.[303] To implement a nonintrusive solution that is also preventive, Lichtenberg, who advocates the *Roe v. Wade* standard for deciding when a state should intervene on behalf of the addicted fetus, suggests this standard be used also to impose civil commitment after the first trimester.[304] Presently, only Minnesota has a civil commitment law specifically designed to address pregnant substance abusers.[305] Although civil commitment may be a less intrusive means of achieving the state's interest, using the *Roe v. Wade* standard to implement it still limits the preventive effect.[306] Therefore, adherence to the strict confines of *Roe v. Wade* and abortion law is an inadequate means of achieving the state's end since it limits the means to do so.

Curriden, *supra* note 210, at 51 (quoting Judge Heaton on the Jennifer Johnson case). Adopting a similar position, Stephen Goldsmith asks, "[W]hat is so extraordinary about the presence of a fetus that it should allow an otherwise illegal act to become legal?" Goldsmith, *supra* note 280, at 14.

[300] "There's an aggressive movement taking shape in the U.S. legal system to bring family violence out of the shadows and into the courtroom—to arrest, prosecute and punish offenders for their violent acts in order to help break the generational cycle of abuse." National CASA Association, *supra* note 277, at 1.

[301] *See* Note, *supra* note 292, at 1010 (discussing the undesirability of the legislative and judicial movement toward fetal abuse statutes). The author suggests that criminalization is only one solution of many and may not be the most effective option: "[i]n the final analysis, these negative effects may not be sufficient to preclude enacting fetal abuse statutes if such statutes are truly effective and if no better approach is available." *Id.* at 1010. For the argument that statutes criminalizing gestational substance abuse may be constitutional but are counterproductive and economically unfeasible, see generally Note, *supra* note 289.

[302] *See* Comment, *supra* note 10, at 391-93.

[303] *Id.* at 391.

[304] *Id.* at 387-95.

[305] *See* Horowitz, *supra* note 41, at 10.

[306] *See supra* notes 186-212 and accompanying text.

Lichtenberg recognizes the necessary distinction between a woman's right to abort and her right to decide to abuse substances during her pregnancy.[307] This distinction must be made under any standard calling for a maternal duty of care. Lichtenberg therefore rejects any maternal duty of care because such a standard, relying on the above distinction, would permit state intervention during the first trimester.[308] However, the first trimester is when the most harmful effects of a pregnant woman's abuse will occur.[309] If one acknowledges the distinction between the mother's abortion rights and maternal duty, the only logical standard with preventive effects would be one that allows intervention during the first trimester since "[p]ost-viability intervention may fail to prevent fetal harm."[310] Therefore, whatever the advantages and disadvantages of civil commitment as a means of protecting the fetus, such protection will not be afforded by applying a *Roe v. Wade* standard. Regardless of the type of intervention used, an independent strict liability standard should apply for determining *when* to intervene since it secures the most protection for the child.[311]

2. *An Effective Means of Protection for the Fetus*

When applied under a strict liability standard, civil commitment may be an effective means of protection, on a temporary basis and in limited circumstances.[312] Of course, the statute defining "a gestational substance abuser" would have to be very narrowly drawn in order to trigger any civil commitment proceedings. Ideally, civil commitment would offer the opportunity for the addicted mother to take part in a treatment program, the most successful of which offer detoxification, pediatric services for the child, psychological and job counseling and extensive classes in parenting.[313]

Once civil commitment proceedings are instituted, the length of the commitment becomes a controversy. Because the purpose of com-

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[307] *See* Comment, *supra* note 10, at 388; *supra* notes 33-37 and accompanying text.

[308] First trimester intervention is inconsistent with the abortion rights and restrictive boundaries of *Roe v. Wade*.

[309] *See supra* notes 247, 272 and accompanying text.

[310] Comment, *supra* note 10, at 391.

[311] *See supra* notes 241-47 and accompanying text.

[312] When implementing civil commitment, Lichtenberg proposes that states use THE UNIF. ALCOHOLISM AND INTOXICATION TREATMENT ACT, 9(1) U.L.A. 79 (1988) by amending it to include gestational substance abuse. Unamended, the Uniform Act allows the state to commit alcoholics to a facility offering treatment. *See* Comment, *supra* note 10, at 385, 393-94.

[313] *See* Willwerth, *supra* note 74, at 63.

mitment is to protect the fetus from further harm, the maximum period of commitment would be until the baby is born, thus assuring that the baby is not subject to any further substance abuse during gestation. Alternatively, the time of commitment may be adjusted if the abusive mother no longer presents a threat to the baby. Should treatment of the mother's addiction prove successful prior to delivery of the baby, commitment may not be necessary throughout the pregnancy. If the addiction reoccurs, recommitment would be necessary. However, this process risks further harm to the fetus by allowing the opportunity for abuse prior to birth. If civil commitment is used, the court would seek a medical opinion[314] on the length of commitment necessary for protection of the fetus.

Civil commitment is highly favored because it both protects the fetus and treats the mother's addiction. Penal incarceration may not serve both of these needs simultaneously because treatment in prison may be inadequate or unavailable.[315] Civil commitment also protects the fetus in a more timely fashion than would the criminal process.[316] These advantages, however, must be weighed against the high cost of treatment involved with each civilly committed mother and child.[317]

D. *Medical Intervention*

Civil commitment as a final resolution focuses on the treatment of the mother.[318] Criminalization as a resolution would serve to hold the abuser accountable for her actions.[319] Both would protect fetuses from future gestational abuse by dissuading the woman from using drugs during subsequent pregnancies. To whatever extent possible, each would also protect the fetus from additional harm. However, neither one applies protection to the fetus directly. In most, if not all, cases of gestational substance abuse, the baby will suffer the effects of whatever degree of harm the mother has already induced by her use of drugs until birth. Once delivered, the baby could receive medical attention

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[314] A medical determination of how long to commit the mother should consider factors such as her prior drug abuse, the extent that she may have already injured the baby, the degree to which she is presently addicted and the likelihood of future abuse.

[315] *See* Comment, *supra* note 10, at 394.

[316] Statutes such as the Uniform Act would require civil commitment hearings within a certain time period, for example, 10 days, thereby interjecting protection for the fetus much sooner than under the criminal process.

[317] *See infra* notes 353-62 and accompanying text.

[318] *See supra* notes 302-17 and accompanying text.

[319] *See supra* notes 273-301 and accompanying text.

directly to stem the effects of the damage already done.[320] There have been cases, however, when the protection of the fetus has demanded medical intervention in utero.[321] Therefore, in addition to the aforementioned options available to the courts, in utero medical intervention on behalf of the child is a preventive option available to address the physical needs of the fetus directly.[322]

1. *Technological Developments*

As medical technology advances, fetal surgery becomes more readily available to correct more complicated conditions.[323] Since the 1960s,[324] the fetus as a patient has become commonplace,[325] and the types of procedures available to the fetus have advanced in turn.[326]

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[320] Although very expensive and extensive care is necessary to treat drug-exposed infants, medical technology is continually advancing in treatment developments as well. For example, one study concludes that the use of waterbeds has proven to be an inexpensive, yet effective, method for supplementing therapy for drug-exposed newborns. Oro & Dixon, *Waterbed Care of Narcotic-Exposed Neonates: A Useful Adjunct to Supportive Care*, 142 AM. J. DISEASES CHILDREN 186-88 (Feb. 1988).

[321] *See, e.g., In re* A.C., 573 A.2d 1235 (D.C. 1990).

[322] Medical intervention would only be preventive to the extent that it would intervene in order to protect the fetus from further harm caused by the pregnant mother. The only complete preventive tool is the moral integrity of the mother.

[323] *See generally* Evans, Drugan, Manning & Harrison, *Fetal Surgery in the 1990s*, 143 AM. J. DISEASES CHILDREN 1431 (1989) [hereinafter Evans].

[324] There had been 40 unsuccessful open-womb operations during the 1960s, which had caused most surgeons to shy away from further attempts at that time. Ohlendorf-Moffat, *Surgery Before Birth*, DISCOVER, Feb. 1991, at 60.

[325] Amniocentesis, a means of evaluating the health of the fetus, advanced in the 1960s and is now used to conclusively check for over 200 birth defects. Haupt, *supra* note 250, at 72. As a result of this technique, prenatal treatment became possible using fetal transfusion. *See* Evans, *supra* note 323, at 1431; Note, *Developments in the Law: Medical Technology and the Law*, 103 HARV. L. REV. 1519, 1556-57 (1990); *see also* American Academy of Pediatrics, Committee on Bioethics, *Fetal Therapy: Ethical Considerations*, 81 PEDIATRICS 898 (1988)[hereinafter Committee on Bioethics](stating that the relationship between the doctor and the mother has become complicated by the new focus on the health of the fetus).

[326] At first, doctors attempted intrauterine procedures, such as exchange transfusions, by opening the abdomen or by incising the uterus. These "open" procedures were abandoned, however, because of a high maternal morbidity. As less invasive techniques were developed, such as catheterizations and placement of needles for transfusions, in utero transfusions became available. The development of ultrasonography in the 1970s made possible the visualization of the structure and the function of the fetus. When combined with the form of screening known as maternal serum alpha-fetoprotein, *see supra* note 253, ultrasonography allows for prenatal diagnosis of various fetal anomalies. *See* Evans, *supra* note 323, at 1431, 1434; *see also* Anderson & Strong, *The Premature Breech: Caesarean Section or Trial of Labour?*, 14 J. MED. ETHICS 18, 18, 22 (1988); Rhoden, *Cesareans and Samaritans*, 15 L. MED. & HEALTH CARE 118, 118 (1987) (referring to cesarean sections).

These in utero procedures may diagnose various fetal anomalies and offer parents the option of aborting the fetus prior to viability or preparing for an "affected child."

Because of technological progress, however, these procedures now serve more than simply diagnostic needs. In a limited number of cases, the option of corrective surgical intervention before birth is available.[327] Such in utero intervention is only considered, however, "if the natural history of the anomaly is associated frequently with neonatal severe handicap or early death, if there is evidence (from animal models) that the natural history of the anomaly can be altered by the surgical procedure, and if the risk to the mother is relatively small . . . ."[328] The effects of gestational substance abuse on the fetus may be considered an anomalous condition triggering the consideration of these factors.

Open fetal surgery was developed in the late 1970s and early 1980s.[329] Because this type of surgery is so invasive to both the mother and the fetus, it is justified only when a stricter set of criteria are met.[330] Although no doctor to date has performed open fetal surgery to correct gestational substance abuse, the "first [medical] cases of open fetal surgery represent a steep learning curve . . . ,"[331] and while still highly experimental, this option may become a more reasonable means toward fetal protection as advances in medical technology and fetal surgery continue.[332]

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[327] *See* Evans, *supra* note 323, at 1431.

[328] *Id.* Evans states that after diagnosing a potentially treatable fetal anomaly, there are certain factors to be considered, for example:

> 1. What is the natural outcome of [the] anomaly? Will additional or irreversible damage be caused to the fetus if repair procedures are delayed until after birth?
> 2. Is it possible to correct the anomaly or its consequences in utero? Will the procedure change the natural outcome?
> 3. What is the risk to the mother and the fetus?

Id.

[329] *Id.* at 1434.

[330] *See id.*, stating the criteria for justifying open fetal surgery as follows:

> 1. The natural history of the human fetal disorder is defined and selection of only those fetuses with the disorder who are likely to benefit from intervention is possible.
> 2. The pathophysiologic structure of the disorder and the efficacy of in utero correction were established in animal models.
> 3. The proposed procedure was proved feasible and safe for both fetus and mother in a rigorous, nonhuman primate model.

Id.

[331] *Id.* at 1435.

[332] A number of commentators have addressed the effects of the advancements in medical technology in the field of fetal rights. *See, e.g.*, Stearns, *Maternal Duties During Pregnancy: Toward a Conceptual Framework*, 21 NEW ENG. L. REV. 595, 595 (1985-86) (questioning whether

The fact that fetal surgery is an option available to protect the fetus adds fuel to the controversy over whether the rights of the fetus should supersede the rights of the mother. In 1986 a team of San Francisco doctors performed a successful operation on a 23-week-old fetus by extracting it from the womb, surgically correcting a life-threatening blocked urinary tract and replacing the fetus in the mother's womb.[333] Baby Mitchell was born nine weeks after the operation by cesarean section and was healthy.[334] The operation was significant not only because of its ground breaking contribution to the development of the neonatal field, but because it had tremendous legal significance for the treatment of injured fetuses.[335]

The first major surgery on a fetus, however, was performed on Blake Schultz, who is now a healthy baby.[336] Dr. Michael Harrison performed the operation at the University of California in 1989, when the child was a 24-week-old fetus—seven weeks before his birth. During the fifty-four-minute operation, physicians repaired a hole in the

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the fetus is an individual patient—separate from the mother); Gallagher, *Prenatal v. Parental Rights: What a Difference an "A" Makes*, 21 ST. MARY'S L.J. 301, 303-04, 323-24 (1989) (stating that medical advancements designed to protect the fetus are not alone sufficient to outweigh the rights of women); Note, *Constitutional Limitations on State Intervention in Prenatal Care*, 67 VA. L. REV. 1051, 1051 (1981) (observing that the ability to prevent prenatal injuries raises questions of how the law should treat inadequate care of the unborn child by the parents); Comment, *Unborn Child: Can You Be Protected?*, 22 U. RICH. L. REV. 285, 285 (1988) (raising question of state intervention). The short- and long-term advantages and disadvantages of fetal surgery require extensive research and documentation before such techniques become state-of-the-art. While it is clear that fetal surgery is in a formative stage, "[i]ntrauterine fetal surgery is here to stay. . . . If properly applied, fetal surgery could improve the length and quality of life of some fetuses that otherwise would have lost the race even before reaching the starting line." *Id.* Michael Harrison, the physician who conducted the first major surgery on a fetus, notes, however, that "[f]etal surgery will never affect large numbers of babies, because [the] defects are rare. But we've shown that you can perform open-womb surgery with great benefit to the fetus and without harm to the mom." Ohlendorf-Moffat, *supra* note 324, at 60.

[333] *See* Anderson, *supra* note 92, at 20. The fetus was outside the mother's womb for three minutes during the operation. *Id.*

[334] *Id.*

[335] Although in the case of Baby Mitchell the mother sanctioned the operation, the fact that the operation proved successful was enough to create pressure for future mothers who may not consent. "The more medicine can do for the fetus, the more pressure will be brought to bear on the woman." *Id.* (quoting Lawrence Nelson, a San Francisco lawyer who specializes in medical ethics).

[336] Six prior attempts were made at a similar surgery but failed. Since the birth of Blake Schultz, another similar operation has succeeded. Although approximately 150 babies each year would benefit from this type of operation, it will not be available to more than a few. *See A Fetal Feat That Is a First*, U.S. NEWS & WORLD REP., June 11, 1990, at 16.

boy's diaphragm and rearranged his vital organs.[337] In doing so, they corrected what is known as a diaphragmatic hernia, which affects one in 2,200 babies.[338] The procedure had developed from what was originally used to correct blocked bladders in the fetus—a procedure known as closed-womb shunting.[339] Since 1982 Harrison has performed eight shunting operations, and over 100 have been completed worldwide. Because of the success of the shunting procedure, many doctors now consider it to be an established intervention that does not require approval by an ethics committee.[340]

Although fetal therapy has developed slowly during recent years compared to other procedures, such as heart transplants and bypass surgery, its success in correlation with the risks involved[341] has surpassed the success of these other methods when they were at the same "pioneering" stage. Most importantly, with each successful operation, researchers and physicians are continually developing more advanced techniques that will further protect the fetus in the future. Some of the most promising advances most recently tested are: hydrocephalus shunts,[342] treatment for premature labor,[343] cosmetic fetal surgery,[344]

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[337] *Id.*; Ohlendorf-Moffat, *supra* note 326, at 59; *see also* Purvis, *Major Surgery Before Birth*, TIME, June 11, 1990, at 55 (discussing the operation and optimism for future success); Begley, *The Tiniest Patients*, NEWSWEEK, June 11, 1990, at 56 (diagramming the operation).

[338] Ohlendorf-Moffat, *supra* note 326, at 59.

[339] In a closed-womb shunting operation, the surgeon inserts a large needle through the mother's abdomen and womb and places a catheter into the fetus's enlarged bladder enabling it to drain into the amniotic sac. The shunt is then removed after birth. The procedure takes approximately 10 to 15 minutes. The shunting procedure was further developed in 1986, when Mark Evans, director of reproductive genetics at Hutzel Hospital in Detroit, successfully performed the shunt operation on a 14-week-old fetus who was only four inches long. *Id.* at 61.

[340] *Id.*

[341] Harrison points out that with each fetal surgery there is a 200% chance of mortality because both the fetus and the mother are at risk. *Id.* at 61-62.

[342] In 1979 the first attempt at a closed-womb shunt of a fetus with hydrocephalus, which is the accumulation of fluid around the brain, was a horrible failure in that although the therapy was effective in draining the fluid from the brain, the neurological damage remained, and the child's agony was only prolonged. Of the first 45 attempts, only 34 of the babies survived, 24 of whom suffered further neurological damage. This led doctors to question not only, " 'Can we do procedure X?' [but also] . . . 'Should we be doing procedure X?' " *Id.* at 62. Since then, there have been no attempts at hydrocephalus shunting, although Michael Harrison feels that with proper diagnostic techniques, the procedure will prove effective. *Id.*

[343] One problem physicians are facing is the post-operative trauma that induces premature labor. Michael Harrison has recently combined the newest obstetric drugs with advanced monitoring devices, however, and successfully brought 20 women far enough through gestation after surgery for the baby to be viable. The technique has proven effective for hundreds of pregnant monkeys and promises to be worth future efforts to advance the technique. *Id.*; *see also infra* notes

stem cell transplantation[345] and gene transplantation.[346] Future possible treatments include fetal open-heart surgery and the implantation of cardiac pacemakers.[347]

Depending on the efficiency of fetal intervention operations, and of course, the degree of maternal risk involved, doctors should recommend such operations for the protection of the fetus and even stress that the mother has a responsibility to accept *some* risk in the advancement of the health of the fetus.[348] Generally, a refusal to consent should be respected; however, as one commentator suggests, there may be circumstances in which a physician might oppose the mother's refusal to undergo surgery on behalf of the fetus. Such circumstances might arise

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419-21 and accompanying text (describing the situations in which pregnant women freely choose to medically obstruct their premature labor to keep from giving birth until the fetus is viable).

[344] Studies on both humans and animals have revealed that the fetus is able to heal itself after surgery without scarring through a unique chemical process in which the fetus produces collagen, a form of connective tissue. There is evidence to suggest that the younger the fetus is, the more collagen that is produced and the more perfectly the fetus is able to heal. Scientists are now experimenting to isolate the collagen-producing agent in order to perfect the healing process in adults and even to cosmetically alter other serious fetal anomalies. While this procedure is still years away, it nonetheless offers insight into other reconstructive techniques like stem cell transplantation. *See infra* note 345, *see also* Ohlendorf-Moffat, *supra* note 345, at 62-63.

[345] The highly reconstructive fetal tissue, collagen, is also receptive in other fetuses. Therefore, scientists hope to transplant fetal cells from one fetus to the system of another fetal donee. Fetal cell transplantation research is just now moving from animal laboratories to human operating rooms and will have serious clinical ramifications for the field of immunology. Michael Harrison feels that this work may supercede all other developments in the field of fetal therapy. With such a fetal cell transplant procedure, researchers believe the dangers of bone marrow transplantation would become obsolete and the 25% mortality rate for bone marrow recipients would be minimized.

Closed-womb stem cell transplantation, if successful, may cost $2,000, as opposed to the cost of a bone marrow transplantation after birth, which may cost as much as $100,000. However, treatment of this sort is not economically supported by the federal government due to a ban on the use of federal funding for procedures involving aborted fetal tissue for human therapy. Consequently, 1.5 million aborted fetuses are simply discarded every year. Esmail Zanjani argues that because the tissue of one aborted fetus can be used in treating up to six donee fetuses, the procedure could ultimately prevent six more abortions by healing defective fetuses who would otherwise have been aborted. *See* Ohlendorf-Moffat, *supra* note 324, at 63-65.

[346] Gene transplantation would involve the same procedure as stem cell transplantation, *see supra* note 345, except instead of transplanting entire cells containing healthy genes, doctors would transplant actual genes by treating the defective cells. The first gene transplantation has already been conducted on a four-year-old girl. Because this procedure proved so hopeful, and because of less regulatory restrictions, it has become the procedure pursued most by present researchers. *See* Ohlendorf-Moffat, *supra* note 324, at 65.

[347] "Right now fetal therapy is still a demanding new specialty that works miracles on a precious few. Soon it could be a powerful branch of medicine that nips genetic diseases in the bud—routinely." Ohlendorf-Moffat, *supra* note 324, at 65.

[348] *See* Committee on Bioethics, *supra* note 325, at 899.

when: "(1) there is substantial likelihood that the fetus will suffer irrevocable harm without the intervention, (2) the intervention is clearly appropriate and will likely be efficacious, and (3) the risk to the woman is low."[349] A physician who opposes a mother's decision under these circumstances should seek court intervention only as a last resort.[350]

Ideally, the decision to employ surgical intervention would become less controversial if physicians could perfect the medical procedures and prove their success, could minimize the risks to the woman and could clarify the responsibilities of the doctor to the two patients.[351] Realistically, however, the procedures are currently experimental in certain respects, the risks to the woman are occasionally uncertain, and the doctor-patient relationship remains clouded with constitutional issues such as privacy and autonomy.[352]

Another unavoidable consideration in fetal intervention determinations is cost, both financial and consequential. Financially, the annual cost of care to the public and private sectors for just very-low-birth-weight infants alone is approximately $250 million.[353] Some reports estimate hospital care costs as high as $2 billion.[354] It is estimated that for every low-birth-weight birth that can be avoided by early and frequent prenatal care, between $14,000 and $30,000 is saved in short and long term health care costs.[355] But when only one third of these infants survive,[356] the value of investing in neonatal care is questionable.[357] In

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[349] *Id.*

[350] *Id.*

[351] *Id.*

[352] *Id.*

[353] *See* Storch, *The Unkindest Cut*, 144 AM. J. DISEASES CHILDREN 533 (1990) (commenting on the argument that because of limited funding, access to health care resources should be restricted to those who could pay back society).

[354] Diamond, *Babies in Jeopardy*, Chicago Tribune, Nov. 4, 1990, § C6, at 1 (final ed.).

[355] COMMITTEE ON FINANCE, *supra* note 3, at 38. This figure is substantial in light of the growing number of low-birth-weight infants. For example, in Philadelphia, the number of low-birth-weight infants born in 1986 was 3045, which was 10% of all births in Philadelphia that year. By 1988 this figure jumped to 11.8% of all births. PHILADELPHIA CITIZENS FOR CHILDREN AND YOUTH, THE HEALTH STATUS OF PHILADELPHIA'S CHILDREN: REACHING OUT FOR CHILDREN'S HEALTH (1990) [hereinafter PCCY].

[356] An estimated seven percent of all babies—250,000 per year--are low-birth-weight babies, having a 40 times greater chance of dying within the first month of life. Cowley, *supra* note 3, at 20; *see* Diamond, *supra* note 354, at 1 (reporting that women and children suffer from a lack of commitment regarding this nation's health care provisions). These same children, should they survive the first month, are 20 times more likely to die before they reach age one. Cowley, *supra* note 3, at 20. Approximately 1 out of 14 babies is born weighing under 5.5 pounds. One in 100 weigh less than 3.3 pounds. Scott, *The Legacy of Low Birthweight; Respiratory and Learning Problems are Common*, Wash. Post, Apr. 2, 1991, Health, at 10. Between 10 and 20% of babies weighing

"erring on the side of life . . . we do immediate harm to and inflict long term suffering on many who survive; and we expend an enormous amount of money on neonatal intensive care."[358] Notwithstanding the ability to save children who were once unsavable, "[o]ne of the most difficult tasks is telling parents that despite all the innovations in medical treatment, their infant is going to die or they are going to have a damaged child."[359] Furthermore, if such an investment is demonstrably valuable, proper funding is still scarce. Only twenty-one of the fifty states and the District of Columbia specifically allocate funds for programs directed toward the problem of gestational substance abuse.[360] Because of minimal funding, hospital resources are strained.[361] But

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under 3.5 pounds at birth will have major disabilities, some of which will be caused by the very technology needed to keep them alive. *Id.* at 11. Still, one third of all low-birth-weight infants could survive with proper attention given to the social and economic factors that contribute to their plight. *Id.* at 10.

Washington, Detroit and Philadelphia have infant death rates among the highest in the country. Cowley, *supra* note 3, at 18. The state of Georgia, reporting on data collected over the past 10 years by the March of Dimes Birth Defects Foundation, has announced that low birth weight is the leading cause of infant death in that state. Although the report commented on data collected on the prevalence of alcohol and tobacco use during pregnancy, it also stated that "no scientific data currently exists in Georgia about substance abuse during pregnancy." *March of Dimes Reveals Leading Causes of Infant Death in Georgia*, PR Newswire, Oct. 5, 1990 (quoting Reed Tuckson, M.D., senior vice president for programs for the March of Dimes). As a result, the March of Dimes has planned to undertake a statewide study of the prevalence of substance abuse during pregnancy. The task will be one of the first in the nation to offer statewide data; the preliminary results will be available in January 1992. *Id.*

[357] The modern medical ethos is to treat handicapped and disabled children more aggressively than has been done in the last twenty years. However, some medical ethicists feel that this trend may be not only medically futile, but morally flawed, because of the enormous costs involved in treating and caring for the children and the added pain and suffering that the children inevitably face in the future. Nevertheless, studies reveal that most doctors overwhelmingly approve of aggressively treating very-low-birth-weight newborns because of their growing probability of survival. For example, in the early 1970s, less than 20% of newborns with birth-weights under 2 lbs. 3 oz. survived. By the mid-1980s over 50% survived. *See* Glazer, *Born Too Soon, Too Small, Too Sick; Whatever Happened to Baby Doe?*, Wash. Post, Apr. 2, 1991, Health, at 8, 12.

[358] *Id.* at 8 (quoting ethicist Ernle W.D. Young and pediatrician David K. Stevenson of Stanford University).

[359] Trafford, *Scenes from an Intensive Care Nursery*, Wash. Post, Apr. 2, 1991, Health, at 9.

[360] *See* Adirim & Gupta, *supra* note 3, at 294. Researchers have recently reported that new methods of estimating the need for subsidized prenatal care are necessary in order to effectively allocate resources. *See* Buescher, Peoples-Sheps, Guild & Siegel, *Problems in Estimating the Number of Women in Need of Subsidized Prenatal Care*, 106 PUB. HEALTH REP. 333, 333 (May-June 1991).

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> While the Title XIX Medical Assistance Program (Medicaid) has become a prime source of payments to hospitals for their care [of drug-exposed newborns], a substantial percentage of the costs of their hospital care are not compensated by Medicaid or other third party payors and has had to be absorbed by hospitals.

"[h]ospitals are not altruistic institutions, and [these] costs have to be passed on to the public. It's a dramatic money drain on this country."[362]

Also under considerable strain is the foster care system.[363] Approximately 360,000 children nationwide, known as "boarder babies," were placed in foster care in 1989.[364] Because of the increase in drug-exposed babies, the number of babies entering the foster care system in

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Gittler & McPherson, *supra* note 3, at 5; *see also Children, Youth, and Families*, *supra* note 1, at 66.

Hospital bills for drug-exposed infants can be up to four times as great as those for normal infants. In California the cost of initial hospital treatment for newborns suffering from drug withdrawal is about $6,000 per child. For the one third of these babies who enter intensive care, costs will rise to $60,000 per child. The costs for these children who are also born premature will rise to $250,000 per child because of prolonged hospital stays. Goldsmith, *supra* note 278, at 13. Officials in Pennsylvania estimate that the added costs of caring for an addicted child is $225,000 from birth until first grade. Roche, *For Pregnant Mothers, a Place to Kick Crack*, Phila. Inquirer, May 21, 1991, at B4, col. 4.

In one study of four major hospitals, charges for drug-exposed infants ranged from $455 to $65,325; the median charge was $5,500. COMMITTEE ON FINANCE, *supra* note 3, at 6. One baby at Grady Memorial, an inner-city hospital in Atlanta, had run up a bill of $450,000 in a six-month period—a bill that taxpayers will ultimately pay. *Call for Moral Response*, *supra* note 77. At Hutzel Hospital in Detroit a crack addict's 17-month-old baby has accumulated hospital expenses totalling $1.05 million and the bills are still growing. This bill is one of the most expensive in the history of the Michigan Medicaid program. *Crack Addict's Baby Costs State $1.05 Million*, Chicago Tribune, Oct. 3, 1990, at 3 (final ed.). As a result of a 3,000% increase in drug-abusing mothers over the past 10 years, New York City has spent $300 million on neonatal intensive care. *See* Goldsmith, *supra* note 280, at 13.

[362] Diamond, *supra*, note 354 at _____ (quoting Dr. Rae Grad, executive director of the National Commission to Prevent Infant Mortality). When confronted with the fact that each infant death costs an estimated $380,000 in lost productivity, Dr. Grad answered, "[p]eople don't seem to understand the relationship of healthy children to a healthy nation." *Id.* According to a White House Task Force on Infant Mortality report in November 1989, of which findings were suppressed, every dollar invested in prevention could save three dollars in intensive care costs. *Id.* Costs continue as the child grows older. A conservative estimate places the costs of caring for the drug-affected children born in Maryland in 1989 alone at $387 million. Mainor, *supra* note 34, at 26 (1990) (advocating criminalization under certain circumstances).

[363] *See* COMMITTEE ON FINANCE, *supra* note 3, at 30-31 (stating that more babies are left in the hospital for nonmedical reasons because either the parent is not willing to care for an addicted baby or social services have declared the home environments unacceptable for the infants); *Children, Youth, and Families*, *supra* note 1, at 63-65 (offering statistics on the increase in drug-exposed children entering the foster care system); *see generally* Besharov, *supra* note 3 (expressing concerns that until there is an effective treatment for heavily addicted parents, the foster care system will be seiged with unwanted and neglected children).

[364] *See* COMMITTEE ON FINANCE, *supra* note 3, at 33; Cornelius, *supra* note 3, at B1 (discussing a pilot program, The National Family-Centered Health Model Program, which assists in identifying, treating and rehabilitating cocaine-addicted women). Between 1986 and 1989, the national demand for foster care has increased by 29%. COMMITTEE ON FINANCE, *supra* note 3, at 33.

New York City has doubled between 1987 and 1989, bringing the total to more than 50,000.[365] The number of Massachusetts children under two years old who have entered the foster system has increased by 73% between 1988 and 1990.[366] From 1985 to 1989 Illinois saw its admission of children under one year old into the foster system multiply by 284%.[367] Los Angeles County has reported an 1100% increase between 1981 and 1987.[368] At this rate, it is unlikely that the foster care system will be able to maintain adequate services.[369]

The public school system is also just beginning to face the consequences of this epidemic and must provide special education programs for these children.[370] Thus, as the first wave of addicted children

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[365] Approximately 30 to 50% of identified crack-exposed babies wind up in the foster care system. Gittler & McPherson, *supra* note 3, at 5. In one 1989 study of 10 hospitals, 1,200 of the 4,000 babies born addicted to drugs were placed in foster care. The cost for foster care for these 1,200 children is approximately $7.2 million a year. COMMITTEE ON FINANCE, *supra* note 3, at 7. For the 3,500 drug-affected children placed in foster care every year in New York City, total costs will be as high as $795 million. In the next 10 years, the city will spend another $765 million on special education for these children. Toufexis, *supra* note 3, at 57-58.

[366] COMMITTEE ON FINANCE, *supra* note 3, at 33.

[367] *Id.*

[368] *Children, Youth, and Families*, *supra* note 1, at 51 (prepared statement by Neal Halfon).

[369] There are a limited number of foster parents who are willing to take care of children who have been exposed to drugs. For the few that are willing, there is minimum financial support. *See* COMMITTEE ON FINANCE, *supra* note 3, at 7; King, *supra* note 1, at A15 (commenting on the lack of training for foster care parents and lack of facilities for children awaiting to enter the system). Most importantly, despite the fact that the children often receive substantially better care in foster homes than they would from their parents, the emotional harm caused by the foster care process is at times irreversible. "[T]he emotional limbo of foster care can be as harmful to these children as living at home with their drug-using parents." Besharov, *supra* note 3, at 24. For a discussion of how the foster system can cause more damage than good, see Woodall, *Suffering the Child: Lost in Foster Care*, Phila. Inquirer, June 24, 1991, at 1A, col. 5 (describing one case of a child in the Philadelphia foster care system and asserting that the system is unfairly geared toward the exclusion of foster parents' participation in disposition proceedings); Thompson, *Lawsuit Shows the Catch-22 in D.C. Foster Care System; Adoption Limbo Said to Damage Children*, Wash. Post, Feb. 20, 1991, at B1, col. 2 (describing an impasse between social workers and attorneys that results in extended adoption proceedings). A lawsuit filed by the American Civil Liberties Union asserts that the District of Columbia has failed to place over 2,200 abused and neglected children who are now within the child welfare system. *Id.*

[370] According to the Florida Department of Human Resources, the cost of preparing a crack-exposed child for school will be close to $40,000 annually. COMMITTEE ON FINANCE, *supra* note 3, at 34. In Boston, special education for one year will cost almost three times as much as a normal education. Toufexis, *supra* note 3, at 59. Service costs to age 18 could total $750,000. COMMITTEE ON FINANCE, *supra* note 3, at 8. "[M]any drug-exposed infants may have long-term learning and developmental deficiencies that could result in underachievement and excessive school dropout rates leading to adult illiteracy and unemployment." *Id.* at 7-8.

Presently, Los Angeles has one of the only public school systems designed for these children. *See* Hamilton, *Crack's Children Grow Up*, L.A. Times, Aug. 24, 1990, at A1, col. 1 (home ed.)

reaches school age, the school system and society are beginning to see the importance not only of prenatal intervention, but of postnatal treatment as well.

Consequently, there is a threefold barrier for pregnant mothers to overcome in trying to obtain treatment for themselves and proper care for their addicted babies: first, there must be facilities available;[371] sec-

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(discussing the effects of drug-exposed children on the education system). For a description of the problems faced by teachers and program directors who deal on a daily basis with the first wave of "crack kids" to reach school age, see generally Toufexis, *supra* note 3. A leading Los Angeles organization that directs its program toward helping older children is the Salvin Special Education Center. A leading pilot project in Boston, designed to both care for the child and treat the mother, is Zuckerman's Women and Infant Clinic at Boston City Hospital. Toufexis, *supra* note 3, at 60. Unfortunately, many state special education programs are undergoing a crisis because of cutbacks in federal funding. Pennsylvania is especially underfinanced in the special education field. The costs of special education programs in Pennsylvania have increased from $389.5 million in 1981 to $770 million in 1991, yet the federal government has reduced its contributions from 12% to 7% since 1985.

Furthermore, the government has restructured its contribution scheme so as to no longer make payments in advance, adopting, instead, a reimbursement scheme. Consequently, special education programs in Pennsylvania have been deprived of the advanced federal contributions during the 1990-1991 adjustment. Parents and critics of the change are most fearful that as a result of the severe cutbacks children either will be mainstreamed into regular classroom settings for which they are unprepared or will suffer the effects of layoffs of quality caretakers and teachers. *See* Matza, *Pa.'s Crisis in Special Education*, Phila. Inquirer, June 17, 1991, at B1, col. 2. Florida and New York have expanded their preschool and special education programs and Congress has authorized pilot programs designed to study the developmental needs of school aged "crack babies," but funding for such programs remains limited. *See* Anderson, *Schools Brace for Crack Children*, Phila. Inquirer, Aug. 7, 1991, at A4.

In an effort to address this crisis, the Bush administration has proposed a five-year budget consisting of $800,000 a year for an Early Childhood Research Institute to coordinate studies on the effects of the "crack babies" on the school system. *See* Anderson, *supra* at A4. The Senate Labor and Human Resource Committee has also passed the Children of Substance Abusers (COSA) Act, which will provide $100 million a year to help train teachers and treat drug-addicted women. *Id.*

[371] Inadequate or unavailable prenatal care is not just a national problem. More than one million women die annually from childbirth and complications during pregnancy; over 100 million suffer serious illness. These numbers are expected to double in the next nine years without dramatic reformation of maternal health care and family planning. Mesce, *Study: Poor Maternal Care Kills Millions*, Phila. Inquirer, June 9, 1991, at A3, col. 5. A recent report by the National Commission on Children states that children today are generally less socially, economically and familially secure than they were 20 years ago and includes maternal substance abuse as a concern. Zaldivar & Spears, *Report: Children Worse Off Than in 1970*, Phila. Inquirer, June 25, 1991, at A3, col. 2; *see also* Rich & Spolar, *1980s 'Terrible' for American Children*, Wash. Post, Feb. 1, 1991, at A3, col. 1 (offering statistics showing that the social and economic conditions are steadily growing worse for American children, with the District of Columbia having the worst composite score).

Even in the United States there are a limited number of treatment facilities equipped to meet the needs of pregnant, addicted mothers. Those facilities that are available have long waiting lists. Of the 280,000 women who needed treatment in 1990, less than 11% ever received it. COMMITTEE

ond, if there are treatment facilities, the pregnant addicted mother must qualify for care;[372] third, there must be adequate funding for the special educational needs that will be required when the child reaches school age.[373] The response to this is that funding for neonatal care would be available with proper pressure on the federal government.[374] However, while the problem of addicted babies increases, federal spending to correct the problem decreases.[375] In light of the depletion

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ON FINANCE, *supra* note 3, at 8-9; *see* Toufexis, *supra* note 3, at 59; Besharov, *supra* note 3, at 22; McNamara, *Birth In The Death Zones*, Boston Globe, Sept. 11, 1990, Metro section, at 1 (city ed.) (explaining the shortage of doctors as a typical reason for denying prenatal care). Those treatment facilities that are available and do not have waiting lists are usually not affordable. *See Crack Addict's Baby Costs State $1.05 Million*, *supra* note 361, at 3. Some commentators feel that the only way to effectively attack the problem is for state agencies to collaborate their prevention efforts. *See* Durfee & Tilton-Durfee, *Interagency Intervention With Perinatal Substance Abuse*, CHILDREN TODAY, July-Aug. 1990, at 30 (listing 14 available services for pregnant, addicted mothers); Reider, *Perinatal Substance Abuse and Public Health Nursing Intervention*, CHILDREN TODAY, July-Aug. 1990, at 33 (advocating Public Health Nursing as a necessary service for the prevention of prenatal substance abuse).

The U.S. Health Care Financing Administration (HCFA) is presently reviewing a proposal by the state of Pennsylvania for a residential treatment program, called the New Life Program, which will be located at Episcopal Hospital in Philadelphia. Officials supporting the program have transformed an abandoned dormitory into a home where up to 24 pregnant, addicted mothers can stay for up to one year. The facility will also house up to two children (under 12 years of age) per resident. The Philadelphia program is only one of more than a dozen similar programs now under review. The HCFA is expected to choose five of these programs for demonstration by September 1991. *See* Roche, *supra* note 361, at B4. Of the 28,723 babies born in Philadelphia in 1986, 14.7% were born to mothers with inadequate prenatal care. PCCY, *supra* note 355, at 1, 3. For a discussion of a comprehensive prenatal health care model that has proven successful for low-income pregnant women, see Machala & Miner, *Piecing Together the Crazy Quilt of Prenatal Care*, 106 PUB. HEALTH REP. 353 (1991).

[372] Those publicly funded facilities that are available have very long waiting lists; the few openings that are available are often denied to pregnant women. For example, of 78 drug treatment programs in New York City, 54% refused treatment to pregnant women, mostly out of fear of legal liability. Pregnant women on Medicaid were denied treatment by 67% of the facilities; 87% of the facilities denied treatment to addicted pregnant women who qualified for Medicaid. Gittler & McPherson, *supra* note 3, at 6; *see* COMMITTEE ON FINANCE, *supra* note 3, at 9; DeBettencourt, *supra* note 38, at 17; *Crack Addict's Baby Costs State $1.05 Million*, *supra* note 361, at 3; *see generally* U.S. GEN. ACCOUNTING OFFICE, REPORT TO THE HONORABLE RONNIE G. FLIPPO, HOUSE OF REPRESENTATIVES, MEDICAID: STATES EXPAND COVERAGE FOR PREGNANT WOMEN, INFANTS AND CHILDREN, Aug. 16, 1989 [hereinafter REPORT TO FLIPPO](discussing the extent to which states have expanded Medicaid eligibility through the Omnibus Budget Reconciliation Acts of 1986 and 1987).

[373] *See* sources cited *supra* note 372.

[374] "The current failure of public funding to keep pace with the costs of neonatal intensive care is a problem that can be solved. The sacrifice of VLBW infants should be a last resort—not a first step." Storch, *supra* note 353, at 533.

[375] David S. Liederman, Executive Director of the Child Welfare League of America, states that "[b]illions of dollars for children's services are being lost." Gilliam, *Putting Our Children First*, Wash. Post, Sept. 20, 1990, at B3 (discussing the need for more funding and public aware-

of financial resources for treatment programs, Harvard pediatrician T. Berry Brazelton notes the economic importance of early intervention: "If we worked with these infants from the first, it would cost us one-tenth or one-hundredth as much as it will cost us later. To educate them, to keep them off the streets, to keep them in prisons will cost us billions."[376]

Tied very closely to the financial costs are the consequential costs, which include the cost of the experimental means of achieving an end. The utility of medical intervention is directly proportional to the success of its long term outcome.[377] Advances in the neonatal field have resulted in a greater number of successful procedures and surviving infants. However, as the success rate enlarges and medical technology continues to save smaller and more severely handicapped infants, the need for ongoing and specialized care grows proportionately and the quality of life diminishes.[378] When confronted with this unfortunate cause and effect, the medical, legal and political fields must somehow factor the financial and consequential costs into any intervention decision.[379]

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ness); *see* Besharov, *Crack and Kids*, SOCIETY, July-Aug., 1990, at 25-26 (calling for private philanthropy to supplement funding by the federal government). In fiscal year 1987, the federal government distributed $497 million to the states out of the federal maternal and child health services block grant. U.S. GEN. ACCOUNTING OFFICE, REPORT TO THE CHAIRMAN, COMMITTEE ON FINANCE, U.S. SENATE: HEALTH CARE, CHILDREN'S MEDICAL SERVICES PROGRAMS IN 10 STATES 1 (July 1989). However, in many cases, federal funding is withheld until state legislatures approve adequate treatment programs and also provide matching funds. *See* Shannon, *supra* note 168, at 47 (stating that despite a $10.4 billion federal anti-drug program, proper facilities are still scarce). Nevertheless, the 1990 National Drug Control Strategy estimates that $10.6 billion will be spent in 1991—29% of which will go toward reducing the demand for drugs and 71% toward drug supply reduction strategies. Grants similar to the aforementioned federal block grants to the states will account for half of the $1.5 billion spent on drug treatment. *See* COMMITTEE ON FINANCE, *supra* note 3, at 2.

[376] Toufexis, *supra* note 3, at 59.

[377] *See* Bedrick, *Neonatal Intensive Care: At What Price?*, 143 AM. J. DISEASES CHILDREN 451 (1989).

[378] *Id.*

[379]

> The prematurely born infant emerges into a hectic, cold, noisy, and bright environment filled with mysterious equipment and masked strangers who try to help. Almost everything done to or for the infant is painful and that pain can certainly be felt. . . . The infant who must have an endotracheal tube cannot cry and may not be fed by mouth for weeks. His or her feet are slashed periodically for blood samples. The infant's respirator whirrs away night and day keeping his or her lungs inflated and sustaining life—but at what price?

Id. (quoting Lucey, *Foreword* to INFANT STRESS UNDER INTENSIVE CARE at ix. (A. Gottfried & J. Gaiter eds. 1985)).

2. *Cesarean Sections*

A thirty-eight-year-old woman was admitted to D.C. General Hospital in Washington, D.C. She was semi-comatose, suffered from seizures and was about to give birth. As she was brought into the hospital, she clutched a container of crack cocaine that had to be forcibly removed from her hand. The woman died in the delivery room, but the doctors were able to perform a cesarean section and deliver a live baby.[380] In deciding whether to compel a woman to undergo surgery to protect the fetus from the effects of gestational substance abuse, courts confront issues similar to those considered in deciding whether to compel a woman to undergo a cesarean section to avoid fetal harm caused by complications in vaginal delivery.[381] Two examples of such warranted cesareans are when the fetus is in a premature breech position or when the fetus suffers low birth weight.[382] While cesarean sections would avoid the risks inherent in the vaginal delivery of these fetuses,[383] the procedure also involves risks to the mother, including in-

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[380] *Children, Youth, and Families*, *supra* note 1, at 16 (statement by Margaret Gallen, Director of Nurse Midwifery, Department of Obstetrics and Gynecology). Two other D.C. hospitals reported that identical situations had occurred on two other occasions within a six month period. *Id.* at 20-21.

[381] It is not specifically argued here that cesarean sections would be necessary, or even effective, as a means of intervention in protecting the fetus from further damages caused by the mother's drug abuse. The argument is applicable to "fetal intervention," however, in that the same principles and analysis apply to both situations. Also, should cesarean sections prove effective in limiting the effects of substance abuse on the fetus, or necessary to save the life of an addicted baby, the "cesarean section" analysis would become applicable. In any case, cesarean sections are not unforeseeable as a result not of the drug abuse directly, but of the effects of the drug abuse, such as low birth weight. *See* Anderson & Strong, *supra* note 326, at 21 (concluding that a routine cesarean section is recommended for breech fetuses of 1000-2000 grams).

[382] *See id.* A premature breech position occurs when the baby is situated with feet or buttocks presenting and premature delivery cannot be stopped with drugs. Vaginal delivery of the breech fetus increases the risk of brain damage and other serious effects. There are approximately 100,000 breech deliveries a year, accounting for 10% of all cesarean sections. Allen, *The Incision Decision*, PARENTING, Dec.-Jan. 1991, at 63.

[383] Routinely, women who have given birth by cesarean section have been advised to attempt their next delivery by vaginal delivery—what physicians term VBAC (vaginal births after cesareans). However, two recent studies have revealed that subsequent vaginal deliveries may lead to rupture of the woman's uterus and death of the child. The rupture occurs along the scar tissue from the previous cesarean incision and causes suffocation to the child. *See* Vrazo, *Caution Advised for Vaginal Births After Caesareans*, Phila. Inquirer, June 1, 1991, at A6, col. 1. In 1986, 8.5% of all women who had delivered previously by cesarean sections were able to have a subsequent vaginal birth. Scott, *After 5-Fold Rise, Rate of Caesarean Sections in U.S. Leveling Off*, Phila. Inquirer, July 12, 1991, at A2, col. 1. By 1987 this figure had increased to 10%. Vrazo, *supra* note 385, at A6. By 1988 it was up to 13%. Scott, *supra*, at A2. The National Center for Health Statistics recently reported that this figure leveled off at 18.5% in 1989. *Id.* In 1965, the

fection, hemorrhage, injury to the urinary tract and sometimes death.[384] The cesarean section procedure may also take on the added risk of futility depending on the prematurity of the fetus.[385] Thus, the decision whether to order a cesarean section involves weighing the interests of the mother against those of the fetus.[386] An argument may also be made that the court may, and should, take into account the interests of the biological father in determining whether to intervene on behalf of the fetus against the wishes of the mother.[387]

Anderson and Strong[388] make an important point in support of balancing these interests in favor of the fetus[389] by suggesting that "the mother usually is emotionally attached to the fetus, so that her interests are promoted in doing what is best for the fetus."[390] This observation lends support to the argument that the mother should be held responsible for assuming *some* risk in promoting the health of the fetus since she probably has an interest in doing so.[391] Anderson and Strong

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overall cesarean rate was 4.5 per 100 births. Today, the United States maintains the highest cesarean rate in the western industrialized world with a rate of 23.8 per 100 births. *Id.*; Vrazo, *supra* note 383, at A6.

[384] Anderson & Strong, *supra* note 326, at 18, reports that from 1968 to 1978 there were no maternal deaths following 10,231 cesarean sections performed at the Boston Hospital for women. These results are atypical, however, and reports vary as to the morbidity rates associated with cesarean sections. *Id.*

[385] *Id.* at 19.

[386] The balancing test was applied in *Jefferson v. Griffin Spalding County Hosp. Auth.*, 247 Ga. 86, 274 S.E.2d 457 (1981), which is the only appellate court decision to rule on the issue of the rights of a viable unborn child against the mother who refuses a cesarean section. *See In re* A.C., 573 A.2d 1235 (D.C. 1990) (Belson, J., dissenting). *But cf.* Rhoden, *supra* note 340, at 121-23 (arguing the invalidity of a simple, risk-benefit balance of interests).

[387] *See generally* Note, *The Biological Father's Right to Require a Pregnant Woman to Undergo Medical Treatment Necessary to Sustain Fetal Life*, 94 DICK. L. REV. 199 (1989) (arguing that refusal by the mother to submit to medical intervention to protect the fetus may be outweighed by the interests of the biological father).

[388] *See* Anderson & Strong, *supra* note 326, at 21.

[389] Anderson and Strong find no morally relevant difference between newborns and fetuses in the respective birth weights involved in their study. *Id.*

[390] *Id.*

[391] The fact that the woman has carried the fetus to term—or at least to the point at which intervention is considered—is evidence that the mother has an interest in seeing the child born and born free of injury. In a dissenting opinion, Judge Belson found this point worthy of comment: "The vast majority of women will accept significant risk, pain, and inconvenience to give their babies the best chance possible. One obstetrician who performs innovative fetal surgery stated that most of the women he sees 'would cut off their heads to save their babies.'" *In re* A.C., 573 A.2d 1235, 1257 n.7 (1990) (Belson, J., dissenting) (quoting Rhoden, *The Judge in the Delivery Room: The Emergence of Court-Ordered Cesareans*, 74 CALIF. L. REV. 1951, 1959 (1986)). Even the majority in *In re* A.C. recognized that "[w]hen the patient is pregnant, . . . she may not be concerned exclusively with her own welfare." *Id.* at 1251.

conclude that the trial-of-labour (vaginal delivery) "would have a less favorable balance of risks and benefits for women who want to do what is best for their fetus."[392] Their conclusions, however, are based on the assumption that the woman is informed of the risks and validly consents.[393] But what should be the result of the cases in which the mother does not consent?

In *Jefferson v. Griffin Spalding County Hospital Authority*,[394] Jessie Mae Jefferson suffered placenta previa, which carried with it a ninety-nine percent certainty that her baby would not survive vaginal delivery and a fifty percent chance that she herself would not survive. Nevertheless, Ms. Jefferson refused to consent to a cesarean section and blood transfusions on religious grounds. Consequently, the hospital sought a court order to authorize the cesarean section. The court reasoned that the state's duty in protecting the child outweighed the intrusion and granted the order.[395] The mother never returned to the hospital, however, and delivered a healthy child naturally.[396] The New Jersey Supreme Court used similar reasoning to support an order for

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[392] Anderson & Strong, *supra* note 326, at 22-23. The authors conclude that a cesarean section should not be recommended when the survival rate for the fetus is approximately 10% or less, which leads to three categories of conclusion:

> First, when the estimated fetal weight is approximately 1000 to 2000 grams, caesarean section appears to be in the fetus's interests. . . . Second, for smaller fetuses (approximately 600-1000 grams) there is genuine controversy due to uncertainty concerning the usefulness of caesarean delivery. . . . Third, for the most premature fetuses (less than approximately 600 grams) the survival rate is too low to justify a recommendation for caesarean section.

Id. at 23.

[393] *Id.* at 22. "A higher degree of competence to give consent should be required when patients take risks for the sake of research, compared to situations in which patients consent to therapy having a favourable balance of benefits and risks." *Id.* at 23. Of the four million babies born in 1988 in this country, one million were delivered by cesarean section—500,000 of which were unnecessary, according to many critics. Allen, *supra* note 382, at 62 (debating whether women are making truly informed decisions about undergoing cesarean section or if doctors are performing the operation simply because of higher insurance coverage); Scott, *supra* note 385, at A2. Consistent with the theory that insurance coverage is a factor is a study showing that hospitals serving primarily non-Medicaid patients had a lower incidence of screening for drug exposure. *See* COMMITTEE ON FINANCE, *supra* note 3, at 5. The New England Journal of Medicine reports that another factor that may play a role in determining whether a woman undergoes cesarean delivery is whether the woman received care from a private physician or through a hospital clinic. De Regt, Minkoff, Feldman & Schwarz, *Relation of Private or Clinic Care to the Cesarean Birth Rate*, 315 NEW ENG. J. MED. 619, 619 (1986).

[394] 247 Ga. 86, 274 S.E.2d 457 (1981).

[395] *Id.*; *see also* Jost, *supra* note 74, at 84 (discussing the case of Ayesha Madyun, who was forced to undergo cesarean section despite her objections).

[396] There are at least five other reported cases in which the child was born naturally despite assurances of the need for cesarean delivery. *See* Jost, *supra* note 74, at 86.

blood transfusions for a Jehovah's Witness who objected to the procedure.[397] Of course, a cesarean section is a much more invasive procedure than a blood transfusion, but the significance of the cases is the same—the unborn children were entitled to protection.

Many commentators argue that such protection from the court is unjustified.[398] Despite this avid opposition, many more courts support fetal protection than is apparent because of the number of unreported cases.[399] In fact, as of 1987, of all the applications for court-ordered cesarean sections, only one judge had ever denied the order.[400] Ironically, justification for these orders is most often embedded in the reasoning of *Roe v. Wade*.[401] Because of the compelling interest in the life and health of the post-viable fetus,[402] states are justified in preventing vaginal delivery of the post-viable fetus when its effect is the same as abortion.[403]

The most widely contested case regarding this issue is *In re A.C.*[404] There the District of Columbia Court of Appeals held that the trial judge did not err in interpreting the reasoning of *Roe v. Wade*[405] to subordinate the privacy rights of Angela C. to the interest of her un-

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[397] Raleigh Fitkin-Paul Morgan Memorial Hosp. v. Anderson, 42 N.J. 421, 201 A.2d 537, *cert. denied*, 377 U.S. 985 (1964).

[398] *See generally* Annas, *Forced Cesareans: The Most Unkindest Cut of All*, HASTINGS CENTER REP., June 1982, at 16 (suggesting that these cases are of limited value concerning the balancing of interests due to the lack of reflection demanded by exigency of the decisionmaking process); Rhoden, *supra* note 307, at 118. A 1986 study published in the New England Journal of Medicine revealed that in 88% of the documented cases of court-ordered cesareans, decisions were made within six hours. Kolder, Gallagher & Parsons, *Court-Ordered Obstetrical Interventions*, 316 NEW ENG. J. MED. 1192, 1193 (1987) (survey revealing that as of 1987, courts in ten states had ordered cesarean sections).

[399] *See* Kolder, Gallagher & Parsons, *supra* note 398, at 1193; Rhoden, *supra* note 326, at 118 (citing North Central Bronx Hosp. Auth. v. Headley, No. 1992-85 (N.Y. Sup. Ct. Jan. 6, 1986), as one example).

[400] Although there is no written decision of the refusal to order the cesarean section, the 1982 case involved New York City Family Court Judge Margaret Taylor's denial of a request by St. Vincent's Hospital. *See* Rhoden, *supra* note 328, at 124 n.5.

[401] 410 U.S. 113 (1973). One of the first cases dealing with the issue of court-ordered cesarean sections that used the reasoning of *Roe v. Wade* was a 1979 Colorado case filed by the University of Colorado Hospital (juvenile court file #79-JN83). Jost, *supra* note 74, at 85.

[402] *See* Jost, *supra* note 74, at 85.

[403] *But cf.* Rhoden, *supra* note 326, at 119 (citing Colautti v. Franklin, 439 U.S. 379 (1979), which invalidated a statute that supported the contention that maternal health should come before fetal survival by requiring doctors to use the least harmful technique in performing post-viability abortions).

[404] 533 A.2d 611 (D.C. 1987), *reh'g granted (en banc)*, 539 A.2d 203 (D.C. 1988), *later proceeding (en banc)*, 573 A.2d 1235 (D.C. App. 1990).

[405] 410 U.S. 113 (1973).

born child.[406] After twenty-five weeks of pregnancy, Angela C. became terminally ill. The best chance of survival for her fetus was delivery at twenty-eight weeks. However, at twenty-six weeks, Angela's condition deteriorated, and despite controversy as to her consent, the court issued an order authorizing a cesarean section. Doctors performed the operation, but both the mother and the child died shortly thereafter.[407] *In re A.C.* opened the door to the question of whether the court may intervene by ordering a cesarean section to protect the baby when doing so offers no health benefit to the mother.[408]

In April 1990, the court of appeals, addressing this issue, vacated and remanded the initial decision and held that

> without a competent refusal from A.C. to go forward with the surgery, and without a finding through substituted judgment that A.C. would not have consented to the surgery, it was error for the trial court to proceed to a balancing analysis, weighing the rights of A.C. against the interests of the state.[409]

In holding the balancing test inapplicable, the court decided that in almost all cases the woman cannot be forced to undergo a cesarean section against her will unless there is a compelling state interest.[410] The court then argued in dictum that the protection of the fetus is not a sufficiently compelling interest to allow intervention since the operation held no redeeming value for the health of the mother.[411] However,

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[406] *In re* A.C., 533 A.2d at 612, *vacated and reh'g granted*, 539 A.2d 203 (D.C. 1988).

[407] *Id.*; *see also* Di Somma, *In re A.C.*, 4 ISSUES IN L. & MED. 249 (1988) (discussing the case).

[408] *See generally* Annas, *She's Going to Die: The Case of Angela C.*, HASTINGS CENTER REP., Feb.-Mar. 1988, at 23 (arguing that the decision was brutal and unprincipled); Note, *Terminally Ill and Pregnant: State Denial of a Woman's Right to Refuse a Cesarean Section*, 38 BUFFALO L. REV. 619 (1990) (discussing the history of *In re A.C.* and arguing that there should be a stronger emphasis on women's rights).

[409] *In re* A.C., 573 A.2d at 1247.

[410] *Id.* at 1237. Because the dissent holds that the potentiality of human life is a sufficiently compelling interest, it also holds that

> in those instances, fortunately rare, in which the viable unborn child's interest in living and the state's parallel interest in protecting human life come into conflict with the mother's decision to forgo [sic] a procedure such as a caesarean section, a balancing should be struck in which the unborn child's and the state's interests are entitled to substantial weight.

Id. at 1254 (Belson, J., dissenting).

[411] *Id.* at 1247. The fetus in *In re* A.C. had only a 50 to 60% chance of survival, and, if it was delivered promptly, the risk of substantial impairment was less than 20%. *Id.* at 1239. The court also concluded that a cesarean section would hasten the death of the mother. *Id.* at 1243. In doing so, the court arguably distinguished *Jefferson v. Griffin Spalding Co. Hosp. Auth.*, 247 Ga. 86, 274 S.E.2d 457 (1981), and *In re Madyun*, 114 Daily Wash. L. Rptr. 2233 (D.C. Super. Ct. 1986), in which the cesarean section was in the interest of both the mother and the fetus. *Id.*

the court did not find this to be the case in all circumstances; it left open the possibility, albeit remote, for intervention when it is in the interest of both the mother and the fetus.[412] The court stated: "We express no opinion with regard to the circumstances, if any, in which lesser invasions might be permitted, or where the line should be drawn between major and minor surgery."[413] However, as Judge Belson correctly responded in dissent, cesarean deliveries are quite common and

> [w]ithout detracting from the seriousness of the caesarean procedure, its invasiveness, and the somewhat greater risk it entails, it seems reasonable to consider the fact that nearly a quarter of all births are caesarean not only in the substituted judgment analysis but also in the balancing analysis that should resolve a conflict between mother and unborn child.[414]

Therefore, the court's holding does not disqualify cesarean intervention in cases in which the intervention is beneficial to the fetus and reasonably safe for the mother,[415] such as in many cases of gestational substance abuse. Also, the court only presupposes that the procedure is medically considered a "major" one. Regarding the issue of gestational substance abuse specifically, the court stated that subjecting a woman to unwanted surgery against her will would "give one pause . . . especially when [the woman] ha[s] done no wrong."[416] It may be inferred from this decision that when the mother *is* at fault—for example, when the mother knowingly and willingly ingests illegal substances during pregnancy—court intervention is justifiable. In light of this distinguishing factor and the relevance of the dissent in *In re A.C.*, the cesarean section remains an option for the court wishing to intervene on behalf of the addicted fetus.

Proponents and opponents of court-ordered deliveries may gain insight into the debate by considering the exact opposite situation—may women be forcibly *prevented* from delivering their babies?[417] Terri

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However, the dissent states: "That some of the circumstances were different from those in the case before us does not alter [the] most salient feature of the case . . . [the] balanc[ing] of the interest of the unborn child in living against a competent mother's refusal to undergo a cesarean section . . . ." *Id.* at 1256 n.6.

[412] *See id.* at 1252 n.23.

[413] *Id.* at 1246 n.10.

[414] *Id.* at 1259 n.14 (Belson, J., concurring in part and dissenting in part).

[415] "We do not quite foreclose the possibility that a conflicting state interest may be so compelling that the patient's wishes must yield . . . ." *Id.* at 1252.

[416] *Id.* at 1244 n.8.

[417] This type of situation involves women who go into labor prematurely, resulting in delivery (sometimes up to 21 weeks before their due date) that would harm or kill the baby. Most likely,

Davitch was one of many women who freely decided to forestall a premature delivery by staying in bed for months, with pumps in her legs for a continuous supply of medication to stop contractions.[418] But what if Terri Davitch was unwilling to undergo these restrictions to increase the likelihood of a healthy baby?[419] Would a court be able to issue an order requiring the pregnant woman to remain in bed for thirteen weeks until it was safe to deliver the baby? Application of a *Roe v. Wade* standard would allow for intervention only after the fetus becomes viable, which in this case renders the point moot. In situations in which the interest of the fetus in preventing delivery must be weighed against the privacy rights of the mother, extension of the *Roe v. Wade* standard would become more plausible as the predictability of success becomes greater and the intrusiveness of the procedures is minimized.

Regardless of the means required in each situation, some commentators suggest that *In re A.C.* and cases like it have only served to further the intrusion into a woman's right to privacy.[420] The balance of interests will no doubt continue to tip in favor of the fetus, however, as medical technology advances and the potential risks to the mother diminish.[421] Using the cesarean section as an intervention for the protection of children facing the effects of the mother's drug abuse is now a possible option and will become a more probable one as the procedure becomes safer and the problem of gestational substance abuse grows worse.[422]

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these situations are caused by diethylstilbestrol (DES), taken in the 1940s and 1950s by the mothers of the pregnant women to prevent miscarriage. *See generally* Nussbaum, *Women in Waiting*, Phila. Inquirer, Nov. 4, 1990, at 12 (magazine section) (discussing the ordeal of preventing birth); *see also* Note, *Court-Ordered Confinement of Pregnant Women*, 15 CRIM. & CIV. CONFINEMENT 203 (1989) (discussing circumstances when a court would have the right to confine a woman in the hospital for the sake of the fetus when a doctor disagrees with the choices of the woman regarding the best interest of her child).

[418] The antepartum unit in Philadelphia's Pennsylvania Hospital alone faces 500 cases similar to that of Terri Davitch every year. Nussbaum, *supra* note 417, at 12.

[419] A full term pregnancy is 40 weeks. Babies born under 37 weeks are defined as "premature." Babies born between 24 and 26 weeks of gestation usually suffer from very low birth weight and severely underdeveloped lungs, and will probably not survive. It is unlikely that any baby born at or before 23 weeks will survive. *See id.* at 13.

[420] *See, e.g.*, Note, *Mother v. Fetus—The Case of "Do or Die": In re A.C.*, 5 J. CONTEMP. HEALTH L. & POL'Y 319 (1989).

[421] *See supra* notes 323-79 and accompanying text; *see also* Jost, *supra* note 74, at 87 (recognizing that developments in fetal medicine offer more accurate diagnoses of fetal disorders, and therefore, more successful intervention); *see generally* Note, *supra* note 325, at 1519 (discussing the implications of medical technological developments on legal issues).

[422] According to the Ethics Committee of the American College of Obstetricians and Gynecologists, court intervention is never warranted because of the uncertainty of the medical proce-

3. *Sterilization*

Sterilization[423] is yet another alternative according to some commentators[424] and courts.[425] Recently, California Judge Howard Broadman ordered Darlene Johnson, who was five months pregnant with her fifth child, to undergo surgical implantation of Norplant[426] to

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dures that the courts are ordering. *See* Jost, *supra* note 74, at 86, 87. There is much debate as to whether cesarean sections are actually becoming increasingly safer and more effective. Infant mortality rates have not actually been lowered as a direct result of improved cesarean technology. Rather, the improvement is a result of high-tech prenatal care. *See* Allen, *supra* note 324, at 63. According to some studies, cesarean sections present a greater risk to the mother and more oppressive symptoms than vaginal deliveries. These risks and symptoms are created by the anesthesia involved, a 50% increase in blood loss, a longer recovery period, a 40% rate of infectious development, an increased risk of harm to other organs and even emotional complications. *Id.*; *see also* Rhoden, *supra* note 326, at 119 (arguing that surgical delivery methods offer substantial risks to the mother and are therefore unjustified).

[423] Technically, an argument may be made for the proposition that the use of Norplant is not sterilization per se, but rather a form of birth control since it is reversible. *See* Lieb, *Judge Orders Contraception*, L.A. Times, Mar. 15, 1991, at B6, col. 4.

[424] *See* Smith, *supra* note 102, at 234-35 (advocating sterilization for women who show a reasonable expectation of future repeated abuse). *But see* Coyle, *Sterilization: A "Remedy for the Malady" of Child Abuse?*, 5 J. CONTEMP. HEALTH L. & POL'Y 245 (1989) (arguing that sterilization is an ineffective tool that only treats the symptoms of abuse).

[425] People v. Blankenship, 161 Cal. 2d 606, 61 P.2d 352 (1936) (affirming trial court decision to suspend sentence provided appellant submitted to sterilization); Buck v. Bell, 274 U.S. 200, 206 (1927) (upholding statute authorizing sterilization of institutionalized patients with "hereditary forms of insanity, imbecility, etc."). *But cf.* Smith v. Superior Court, 151 Ariz. 67, 725 P.2d 1101 (1986) (en banc) (holding that although submission to sterilization may influence a reduction of sentence, sterilization could not be mandated absent legislative authority). A 21-year-old Nebraska woman, Michelle Carlton, was also sentenced to be implanted with Norplant after being convicted of child abuse by Lincoln County Judge James O'Rourke. USA Today, Apr. 23, 1991, at 6A.

[426] Norplant, which has been in development since 1966 and is presently being used by 1,000,000 women in 19 countries, was approved on Dec. 10, 1990, by the Food and Drug Administration. Vrazo, *Implant Gets Few Takers: Norplant Finds Slow Acceptance*, Phila. Inquirer, June 17, 1991, at A8, col. 1. The birth control drug is now available for sale in the United States for $350 to $500, for an amount that will cover five years, as compared to $235 per year for birth control pills. The 15-minute procedure involves the insertion of six small rods in the woman's arm. The rods release nomegestol acetate, which reduces cervical mucus, thereby suspending menstruation over a period of five years. Booth, *Updating a Revolution; 5-Year Birth Control Implant Offers Reliability, but With Side Effects*, Wash. Post, Jan. 7, 1991, at A3; Lewin, *Implanted Birth Control Device Renews Debate Over Forced Contraception*, N.Y. Times, Jan. 10, 1991, at A20, col. 1; Rubin, *Birth Control Breakthrough*, San Francisco Chronicle, Jan. 28, 1991, at B3 (final ed.).

effectuate sterilization.[427] An appeal was filed, however, with the Fifth District Court of Appeals.[428]

Medical ethicists predict that because it is so simple to use, Norplant will become a popular choice in court orders affecting women who are demonstrably unfit parents.[429] Kansas state representative Kerry Patrick has introduced a bill requiring all convicted female addicts to either receive Norplant or serve their jail term. The law would require that the state pay for the implantation of the Norplant sticks[430] and for their removal if the woman remains drug-free for at least a

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[427] Booth, *Judge Orders Birth Control Implant in Defendant*, Wash. Post, Jan. 5, 1991, at A1. Johnson was found guilty of beating her children with a belt and was sentenced to one year in jail and three years probation. *Id.* Johnson was also ordered to quit smoking during her pregnancy and to take parenting classes. *See* Stein, *Judge Stirs Debate with Ordering of Birth Control*, L.A. Times, Jan. 10, 1991, at A3, col. 1. Judge Broadman had previously tried to impose Norplant on a drug-addicted woman, Linda Zaring, as a condition for probation but he revoked his offer when she showed up late for her hearing and sentenced her to jail instead. *See* Ainsworth, *"I Take Away People's Rights All the Time,"* Legal Times, Apr. 8, 1991, at 10; Stein, *supra* note 429, at 3.

Judge Broadman has had a history of imposing unorthodox sentences. Broadman once ordered a felon to wear a T-shirt that had his crime—theft—and the fact that he was on felony probation printed on the back. Police subsequently arrested the man for another theft after a witness had identified him by the T-shirt. *See* Moss, *Court-Ordered Birth Control Draws Fire*, USA Today, Jan. 10, 1991, at 2A (final ed.); Lev, *Judge Is Firm on Forced Contraception, but Welcomes an Appeal*, N.Y. Times, Jan. 11, 1991, at A17, col. 1 (late ed.). Other innovative sentences imposed by Broadman include ordering an alcoholic to swallow, in court, the drug Antabuse, which makes a person violently ill upon drinking alcohol and ordering a man who stole a boat to relinquish his car to see how it feels to lose a valuable possession. Stein, *supra* note 429, at 3.

[428] *Birth Control Implant Order Is Appealed*, L.A. Times, Feb. 2, 1991, at B18, col. 1.

[429] "Norplant presents a special temptation to judges because it's so long lasting and doesn't require any cooperation after it's implanted, and can be monitored by a parole officer just by looking at the woman's arm." Lewin, *supra* note 426, at 1 (quoting Dr. George Annas, director of the program on law, medicine and ethics at the Boston University School of Medicine).

Judge Broadman's order also stimulated antagonistic reactions. Two months after ordering Darlene Johnson to undergo the implantation, Broadman was shot at while in his courtroom by a gunman who was reported to have targeted the judge because of his personal view on abortion. *Gunshot Fired at Judge Is Tied to Norplant Case*, N.Y. Times, Mar. 6, 1991, at A20, col. 1. Broadman has filed a civil suit against the gunman, Harry Raymond Bodine, for mental, physical and nervous pain, *see Judge Who Was Shot at in Courtroom Files Suit Against Alleged Assailant*, L.A. Times, Mar. 9, 1991, at A23, col. 5, and has also removed himself from the case. *See Controversial Judge Quits Abuse Case*, L.A. Times, Apr. 14, 1991, at A30, col. 1.

[430] As of March 1991, Medicaid programs in twelve states had agreed to pay for Norplant. These states include: Delaware, Maryland, Michigan, Montana, New Hampshire, New York, North Dakota, Pennsylvania, Washington, Wyoming, Utah and Alaska. Rovner, *Norplant Medicaid Payments Approved in 12 States*, Wash. Post, Mar. 19, 1991, Health, at 5, col. 2 (final ed.). Only three months later, in June 1991, 33 states were reported to have offered to fund the drug. *See* Vrazo, *supra* note 426, at A8, col. 1.

year.[431] Arthur Caplan, director of the University of Minnesota's Center for Biomedical Ethics, feels that "[t]here's definitely a trend toward third-party involvement in reproductive decisions, including all the attempts to put women in jail for taking drugs that can affect the fetus."[432] Some medical experts feel, however, that it would be illegal for any doctor to administer Norplant without voluntary and informed consent by the patient, despite any order by the court.[433] Furthermore, recent studies have shown that despite Norplant's seemingly high rate of success, many women are hesitant to try it,[434] many insurance companies refuse to cover it and it has proven to be unobtainable by most poor women[435] and undesirable by most teenagers.[436]

Those who support the judicially imposed use of Norplant as a tool for sterilization and child protection do so in the hope of avoiding situations similar to Ruby Pointer's. In 1981 Pointer was ordered by a Santa Cruz County Superior Court judge not to conceive any more children after authorities discovered her ten-month-old son nearly starved to death, weighing only eight pounds.[437] The California Supreme Court overturned the decision. In June 1991, police found Pointer's three daughters, ages two, four and six, huddled in their

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[431] *See* Willwerth, *supra* note 74, at 62; Goodman, *Norplant: Birth Control—Or Woman Control?*, Newsday, Feb. 19, 1991, at 38.

[432] Goodman, *supra* note 431, at 38.

[433] *See Judge Refuses to Lift Birth Control Implant Order*, U. Press Int'l, Jan. 11, 1991 (reporting comments by Dr. Philip Darney from the University of California). Nationwide, there are approximately 12,000 doctors who have been trained in the procedure for the implantation of Norplant. Vrazo, *supra* note 426, at A1.

[434] At one Chicago clinic where Gerald Zatuchni, one of the Norplant developers, practices, only four women have had Norplant inserted in two months. At the University of Pennsylvania Hospital, there have been 15 implantations in three months—most of which were performed at no cost as part of the training for the doctors. Vrazo, *supra* note 426, at A1.

[435] Wyeth-Ayerst, producer of Norplant, has reported that as of June 1991, 33 states have offered to fund the sale of the device through state Medicaid programs. New Jersey plans to institute a program that will cover the cost of both Norplant and the doctors' fees. However, for many women, especially those who are not covered by Medicaid, the cost of the device plus the implantation puts Norplant out of reach. In April 1991, Wyeth-Ayerst promised a $2.8 million contribution from a company foundation; however, as of June 1991, there had been no donation. Until the foundation does contribute funds, Wyeth-Ayerst has donated over 20,000 Norplant kits to various clinics throughout the country. *Id.* at A8, col. 1.

[436] Most teenagers are unwilling to take advantage of the device because they are unsure of its effectiveness and side effects and because the procedure is not completely concealable from parents. *See id.*

[437] Rogers, *Calif. Suspect Was Once Ordered Not to Have Children*, Phila. Inquirer, June 23, 1991, at A4, col. 5.

house in piles of garbage and urine, unable to communicate except for mere grunting. Ruby Pointer was again charged with child abuse.[438]

Those who oppose stricter sentences for child abuse and support the abusing woman's right to privacy contend that Norplant does nothing to protect the children who are already being abused and that "the *system* has failed the children."[439] The fact remains, however, that no one other than the abuser has "failed" the child, and the "system" is only obligated to hold the abuser responsible for the crime. The female abuser inevitably relies on a right of reproductive freedom—a freedom that she assumes should never be restricted or forfeited. However, no fundamental right should outweigh another when the right being claimed is abused and demonstrably unappreciated.

The ineffectiveness of Norplant as a tool to prevent the abuse of children already born, as with other options, may be balanced by its effectiveness in preventing future abusive pregnancies and its limited intrusiveness to the mother.[440] Although Norplant does have side effects in some situations,[441] these effects are minimal and would not be considered at all intrusive in comparison to major surgical intervention, which has already been justified in certain situations.[442]

Its effectiveness in preventing child abuse, however, is where Norplant receives the most criticism as a tool for courts. Aside from the fact that Norplant is not perfectly effective[443] and may not be medically suitable for all women,[444] most commentators who oppose its

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[438] *Id.* People v. Pointer, 151 Cal. App. 3d 1128, 199 Cal. Rptr. 357 (1984).

[439] Neuborne, *In the Norplant Case, Good Intentions Make Bad Law*, L.A. Times, Mar. 3, 1991, at M1, col. 1.

[440] *See supra* notes 323-79 and accompanying text.

[441] For most women now using Norplant, the most common side effect has been sporadic bleeding caused by alterations in the menstrual cycle, at least during the first year of use. Other side effects experienced by some users have been those commonly suffered by birth control pill users: headaches, nausea, dizziness, acne, fluctuation in weight, tenderness of the breast, noticeable hirsutism and mood swings. The implantation is practically painless and its effects are reversible upon removal. *See Appraising New Birth Control*, Chicago Tribune, Jan. 20, 1991, § 6, at 7, col. 5 (final ed.); Booth, *supra* note 426, at A3; *Rubin*, *supra* note 439, at B3; Gelernter, *New Contraceptive Holds Promise*, Chicago Tribune, Jan. 20, 1991, § 6, at 7, col. 1 (final ed.).

[442] *See supra* notes 380-422 and accompanying text.

[443] Reports show that Norplant has an effective rate of about 99.8%. *Appraising New Birth Control*, *supra* note 443, at 7. It is expected, therefore, that over a three-year period, one out of 100 Norplant users will still become pregnant. Over a five-year period, three to four users will become pregnant. Booth, *supra* note 426, at A3.

[444] Women with heart problems, liver disease, diabetes or blood deficiencies will not be good candidates for Norplant. *See* Gelernter, *supra* note 441, at 7; Rubin, *supra* note 426, at B3; Booth, *supra* note 426, at A3. Darlene Johnson will argue on appeal that because of her diabetes

court-ordered use claim that it does nothing to prevent abuse.[445] However, opponents of sterilization confine their argument to the children who have already been abused. Such a narrow view does not consider the legitimate interest of the state in preventing *prospective* abuse and fails to acknowledge the full spectrum of compelling interests. What Norplant does not do, however, is offer women an incentive to stop taking drugs, which is also an interest of the state. According to California Judge Broadman, however, "[t]he compelling state interest in the protection of the children of the state . . . supersedes this particular individual's right to procreate and does not interfere with her right of sexual expression."[446] Judge Broadman remarked that the state's compelling interest in protecting children included the protection of any children Darlene Johnson had not yet conceived.[447] Therefore, sterilization, at least temporarily imposed with the use of Norplant,[448] is also an option for the courts in preventing future harm to children from maternal abuse.

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and high blood pressure, she is not an acceptable candidate for Norplant implantation. Lev, *supra* note 429, at 17.

[445] "The conditions of probation have to be related in some way to rehabilitation. . . . Preventing someone from having a child really doesn't have anything to do with the crime of child abuse. Case law says child abuse is remedied by removing the child." Lev, *supra* note 427, at 17 (quoting Charles Rothbaum, attorney for Darlene Johnson).

> "Voluntary" sterilization under these conditions is a punitive measure, regardless of how one who advocates it chooses to describe it. Sterilization is not a remedy for the malady of child abuse. . . . Sterilization does not cure the deeply rooted psychological problems of . . . [child abusers]: psychotherapy does. . . . [Child abusers] could be helped if the government would renew and strengthen its commitment to finding (and funding) a workable cure for the disease instead of merely treating its symptoms.

Coyle, *supra* note 424, at 262 (referring to sterilization as a plea bargaining tool).

[446] Lev, *supra* note 427, at 17 (quoting Judge Howard Broadman).

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> [Ms. Johnson] has been convicted of brutally beating her children. It is in the defendant's best interest and certainly in any unconceived child's best interest that she not have any more children until she is mentally and emotionally prepared to do so. . . . The birth of additional children until after she has successfully completed the court-ordered mental health counseling and parenting classes dooms both her and any subsequent children to repeat this vicious cycle. This is unconscionable.

Id.

[448] Because over 640,000 women a year resort to sterilization, officials at Wyeth-Ayerst are hopeful that Norplant would be used as an alternative to sterilization. Vrazo, *supra* note 426, at A8, col. 5.

VII. CONCLUSION

President Bush, in his address before the General Assembly at the World Summit for Children, said that "children are a mirror, an honest reflection of their parents and their world."[449] Sadly, this statement rings especially true for the 375,000 children a year who are born addicted to drugs and forced to suffer the consequences of their mothers' illegalities. Finally, courts are beginning to take advantage of the opportunity to become a means of intervention.

To intervene on behalf of the child, the state necessarily violates a woman's right to privacy. But developments in the law illustrate that, given the interest to be protected, this intrusion is legally tolerable. The severity of the problem demonstrates that this intrusion is necessary. However, only its implementation will prove whether the intrusion is effective. How a court intervenes will be an ad hoc determination according to what is most protective of the child and least intrusive to the mother. Because medical technology is continually advancing, the intrusiveness necessary for protection eventually becomes minimal and earlier intervention becomes possible. Legally, interventions ranging from civil commitment to medical surgery are feasible options. However, the value of each must be carefully considered.

The decisions whether to intervene and what type of intervention is appropriate are not solely legal determinations. There are medical, social, financial and even psychological factors to consider. The legal contribution to the effort to end gestational substance abuse, regardless of what form the intervention takes, must manifest itself in the standard that is used to implement intervention. This standard must be strictly and independently applied if the court is to effectively take a preventive role. The conflict in the application of a strict standard of redress occurs in the balancing of maternal and fetal rights. However, developments in the status of the fetus and advances in neonatal medicine give added force to the interest of the fetus in a healthy and drug-free gestation.

"To get off drugs one must be motivated by love or dedication to something greater than personal pleasure or pain."[450] If this statement

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[449] *World Summit for Children*, N.Y. Times, Oct. 1, 1990, at A13, col. 4 (late ed.) (containing excerpts from remarks by world leaders at the World Summit for Children).

[450] Besharov, *supra* note 3, at 22 (quoting Edwin Delattre of Boston University).

is true, perhaps in the end the only truly effective means of prevention is a mother's love for her child.