

## MORAL AND SOCIAL ISSUES REGARDING PREGNANT WOMEN WHO USE AND ABUSE DRUGS

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How should society respond to pregnant women using recreational or addictive drugs that may harm their future children? During the past three decades, medical science has become increasingly aware of the potential impact of maternal lifestyle choices on fetal well-being. Beginning in the early 1980s, a series of studies regarding fetal health and substance use and abuse surfaced and helped to inspire the unprecedented attempt to improve fetal outcomes by monitoring, controlling, and sanctioning the actions of pregnant women. In 1988 a national study found that 5 million women confirmed the use of an illegal substance in the month before they delivered a child.<sup>4, 20</sup> The following year, researchers found that 11% of the women who delivered infants in the hospital in the study had used illegal drugs sometime during their pregnancy. Moreover, evidence is accumulating that fetuses may be damaged by maternal use of a variety of substances, including heroin, methadone, amphetamines, prescription and over-the-counter drugs, tobacco, marijuana, cocaine, and alcohol; but the evidence for each substance varies in reliability and relevance. For example, marijuana use during pregnancy, although almost certainly unwise, is incompletely studied and has not been correlated definitively with fetal growth retardation or neurologic behavioral changes in infants.<sup>2</sup>

The pregnant woman's use of cocaine generates the most attention

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and concern. Such use has been linked to somewhat increased risk of a variety of fetal teratogenic effects, including intestinal atresia, cardiac malformations, genitourinary anomalies, limb defects, and brain and skull deformations.<sup>2</sup> One study found that 16% of newborns who had been exposed to cocaine during pregnancy sustained microcephaly in comparison with 6% of the controls. Similarly, maternal cocaine use has been correlated with low birth weight, small-for-gestational age and premature birth,<sup>46</sup> tremors, seizures, irritability, hypertension, abnormal reflex behavior, depressed interactive abilities, sudden infant death syndrome, and slow development in the first 6 months to 2 years of life.<sup>18, 19</sup> However, methodologic difficulties plague demonstrations of direct causal links between cocaine and some of these observed effects. One study identified cognitive and behavioral delays in 40% of children who had been exposed to drugs in utero, but a similar percentage of delays was observed in children with no drug exposure who lived in underprivileged environments.<sup>25</sup> Moreover, neonatal neurologic syndrome may be temporary, with only a minority of cocaine-exposed neonates sustaining significant injury.<sup>46</sup> Maternal cocaine use is potentially destructive and represents a documented danger to fetuses, but the nature of that risk is unclear.<sup>32</sup> Limited data outline the impact of low doses of maternal cocaine use.

Despite the public attention focused on cocaine use, the damaging effects of alcohol taken during pregnancy are better documented and more dramatic.<sup>2</sup> Fetal alcohol syndrome is the most common recognizable cause of mental retardation. Alcohol consumption has been correlated with an increase in spontaneous abortion, fetal growth retardation, premature delivery, abruption placentae, and breech presentations. Alcohol is also a proven teratogen, and heavy maternal use has been associated with a variety of congenital defects including microcephaly and other cerebral and craniofacial abnormalities. Some studies have found such defects present in as many as 80% of the children of heavy drinkers. Typically, heavy alcohol use in the first trimester is associated with morphologic defects, whereas alcohol use later in the pregnancy is accompanied by growth retardation and neurobehavioral disturbances. Moderate amounts of alcohol use during pregnancy have been correlated with behavioral features such as distractibility, excitability, and disciplinary problems, as well as autism, learning disabilities, and lowered intellectual capabilities. Although the neurobehavioral effects of lower levels of prenatal alcohol exposure seem to dissipate slowly as the child develops, the impact of moderate and high alcohol use may last much longer and even into adulthood.<sup>2</sup>

Although many tragic cases associated with substance use during pregnancy are preventable, most of the data on this problem remain equivocal and are rendered problematic by several confounding factors. Polydrug and multiple substance use may make it difficult to delineate with precision the fetal toxic affects of each discrete substance. In addition, it is difficult for investigators to determine both the amount of the substance or substances ingested and when in the course of the preg-

nancy they were used. Other factors, such as socioeconomic status, the availability of prenatal care, and individual patient pathophysiology, frequently have an important role in suboptimal fetal outcomes.<sup>2</sup> The public, clinicians, and policy makers sometimes unconsciously inflate the degree and certitude of risk represented by maternal substance use or tend to direct the focus of their attention and efforts to one substance to the exclusion of other equally hazardous toxins.

## **PUNITIVE OR COERCIVE STATE INTERVENTIONS**

Social responses to prevent substance abuse damage to the future child fall into two general classes. One group of responses is voluntary and nonpunitive, such as educational and drug treatment programs; the other actions are coercive and punitive. In an attempt to decrease fetal injury as the result of substance use during pregnancy, physicians, prosecuting attorneys, judges, and legislatures have employed a wide range of interventions that may intrude on the pregnant woman's rights in a variety of ways.<sup>35</sup> This section describes punitive or coercive state interventions designed to stop pregnant women from taking recreational or addictive drugs that may harm their future children. In subsequent sections it is argued that such actions raise serious moral and social problems.

One type of intervention represents an attempt to prevent damage or further damage from occurring to a fetus while it is still in utero. A judge in Washington, DC, sentenced a pregnant, drug-using woman to jail for the duration of her pregnancy, presumably to protect the fetus from drug-induced damage.<sup>35</sup> A New York hospital petitioned a court to commit civilly a pregnant woman under the state mental health law for mandatory substance abuse treatment because she was 8 months pregnant and known to have used crack cocaine.<sup>12</sup> Frequently, even when the request for a legal detention order is ultimately denied or overturned, the woman has already been held against her will during the course of the legal proceedings. For example, a Wisconsin court used the state's existing child abuse statute to rule that a pregnant woman who had tested positive for drugs could be held against her will and treated for substance abuse. The court justified the action as an attempt to take the fetus into protective custody.<sup>41</sup> Although the state supreme court ultimately condemned such use of the statute, the woman was successfully detained for the duration of her pregnancy.

A second type of intervention attempts to invoke criminal sanctions for women who give birth to injured infants or who have used substances during pregnancy.<sup>35</sup> These interventions are typically punitive in nature and are motivated by the hope that such punishments, if publicized, will deter future substance abuse during pregnancy. In 1993 an Indiana woman was arrested, jailed, and charged with reckless homicide after she reportedly used drugs and gave birth to a 22-week-old baby who died after 4 days.<sup>9</sup> Similarly, prosecutors in California, New Jersey,

and other jurisdictions have attempted to use their states' homicide statutes to prosecute women who deliver stillborn and mortally injured infants prematurely after using illegal substances, usually cocaine.<sup>17</sup> Women who have used cocaine, alcohol, and other substances have been charged with criminal mistreatment of a child,<sup>16</sup> reckless endangerment,<sup>10</sup> child abuse,<sup>6, 7</sup> and child neglect.<sup>13</sup> In an especially innovative series of cases, prosecutors have charged pregnant women who use drugs with the delivery or distribution of drugs to a minor, in some instances, through the medium of the umbilicus during the instant after delivery but before the cord was severed by the physician.

For the most part, these prosecutions have failed. Most courts have dismissed or overturned fetal protection prosecutions not on constitutional grounds (although such a defense may be viable) but rather on the statutory construction of words such as "delivery" and "distribution" in the controlled substances prosecutions, and of "child," "human being," and "person" in the abuse and homicide prosecutions. In refusing to interpret these terms broadly, courts have typically concluded that current statutes were not intended by the legislature to apply to fetuses.<sup>22, 23, 28, 36, 37, 42</sup> That conclusion, however, is not foreordained. The Supreme Court of South Carolina, for example, recently affirmed the child abuse conviction of a woman who tested positive for cocaine during a prenatal care visit and whose child was later born unharmed but with cocaine metabolites in his blood stream. The woman was sentenced to 8 years in prison.<sup>48</sup>

Despite the court decision in South Carolina, it seems likely that most state court judges will refuse to allow prosecutors to pursue pregnant women who use or abuse drugs and alcohol through existing homicide, controlled substance, and child abuse statutes. The failure of these prosecutions under existing remedies has been followed by the introduction of scores of fetal protection bills in state legislatures. These bills take on a variety of forms but typically include proposed legislation to permit explicitly the prosecution of women for child abuse if they test positive for a controlled substance. Other bills would create the legal presumption that a woman who uses drugs while pregnant is likely to abuse her child in the future, thereby justifying state custody proceedings or expanding the definition of the terms *child* and *human being* in abuse and homicide statutes in an attempt to hold pregnant women who use drugs and alcohol criminally liable.<sup>11, 14, 15</sup>

Fetal protection initiatives have had limited success, and none have become law in any state. If legislation specifically tailored for fetal protection prosecution passes in any state, it would be vulnerable to a range of state and federal constitutional challenges, including equal protection, privacy, and reproductive liberty claims. Despite these observations, it is conceivable that one or more state legislatures may be successful in drafting and enacting into law fetal protection policies in such a way as to pass constitutional muster. Consequently, although constitutional challenges to fetal protection legislation are viable and will continue, it is important to determine whether those policies are

just, wise, practical, and morally sound, regardless of their ultimate legal and constitutional status, and whether they should be pursued at all.

## MORAL STATUS OF THE FETUS

The morality of maternal actions during pregnancy and the ethical legitimacy of socially mandated fetal protection policies depend, in part, upon the moral status of the fetus. There is profound dispute over when and why a fetus acquires moral standing. Some commentators believe that full moral consideration is warranted early in a pregnancy at conception or implantation.<sup>34</sup> Persons who subscribe to such a position might also believe that a pregnant woman owes the conceptus and subsequent fetus virtually the same duty as she owes a child who has already been born. Similarly, if full moral standing accompanies conception, fairly vigorous fetal protection policies might be justified. However, other scholars believe that a fetus acquires moral standing only at later points in the pregnancy, for example, with the appearance of brain waves at 8 to 10 weeks.<sup>3</sup> Other commentators contend that, whereas the conceptus is worthy of some respect early in its existence, substantial moral significance or personhood does not attach until the fetus attains sentience, that is, until the fetus possesses brain life sufficient to feel pain, experience pleasure, and sustain consciousness at roughly 20 to 24 weeks.<sup>43</sup> Still other scholars hold that viability, birth, or an even later period, may be the only defensible and workable benchmark for awarding full moral standing to fetuses.<sup>45, 47</sup>

The difficult issue of the moral status or personhood of the fetus is largely irrelevant to this debate, because regardless of the view held, the same conclusion is reached as long as the woman decides to deliver an infant. Consider those persons who believe that a conceptus possesses nearly full moral standing throughout pregnancy. Such persons would almost certainly argue that substance abuse-induced injury to a conceptus or fetus is harming another person. Thus, it is a moral wrong whenever it occurs and regardless of whether the fetus is brought to term. In contrast, persons who believe that the fetus does not possess morally significant standing until it reaches some stage of fetal development<sup>38, 43</sup> would almost certainly still see great wrong with injuring the fetus in the early stages of a pregnancy if the intention is to bring the fetus to term. The salient issue is whether the woman intends to give birth to an infant who might be harmed by her behavior. The focus should then be on the possible harms to the future child rather than on tying moral duties regarding prenatal substance abuse to the quagmire of problems associated with determining the moral status of the fetus at the time of the chemical insult.

The relevant harm is sustained by the child who is ultimately born, hence, it is unnecessary to come to terms with the moral status of the

fetus. The child to be delivered clearly has an interest and perhaps the right not to be injured unnecessarily. The central moral consideration is framed by the woman's decision to carry the fetus to term. As Steinbock<sup>43</sup> has noted, "once this decision is made, the fetus is not simply a potential child, but a child-who-will-be born" who has interests that should be recognized and given weight. Such children have an interest in a healthy existence and a right not to be injured unreasonably. Recognition of the interests of the child-who-will-be born does not affect a woman's right to procreative liberty because it arises with the decision to carry the fetus to term. As a practical matter, most real-life cases involving maternal duties during pregnancy relate to situations in which the woman voluntarily foregoes abortion, is unable to secure abortion services within the legally circumscribed time period, or is unable to obtain an abortion as a consequence of the advanced state of the pregnancy. Although these contingencies raise other questions regarding the nature of women's health care in the United States, the fact that a living child with legitimate interests will probably be the product of the pregnancy remains relevant.

Thus, the maternal substance abuse debate can be separated from the daunting tasks of reaching a consensus on the moral status of the fetus' personhood or the contentious debate over abortion. Despite the broad range of positions regarding the moral status of the fetus, virtually all disputants hold similar positions regarding the importance of protecting children from harm and the child's claim for an undamaged existence. The next section proposes that the woman who has decided to carry her fetus to term has a moral duty to give due consideration to the interests and claims of her future child.

## **MATERNAL RIGHTS, INTERESTS, AND DUTIES**

The duty of the pregnant woman to give due consideration to the interests and claims of the child-who-will-be-born derives, in part, from the general moral obligation to avoid harming any other person regardless of one's personal, familial, or social relationship to that person. Parents are generally under a greater obligation to protect their children from harm than would be a stranger.<sup>29</sup> Parents are expected to consider the best interests of their children and to make compromises regarding their own interests to increase the welfare of their children. Therefore, a woman who purposefully becomes pregnant and who decides to carry the fetus to term has a moral duty to consider the best interests of her future child and some duty to circumscribe her own desires and interests to prevent harm and increase benefit for the future child. Most women recognize such duties to their offspring and do everything that they can to optimize their health and well-being.

Moral duties to future children are not absolute. People have a variety of obligations, and no one is expected to set aside all other duties and interests for any one else, even a future child. Women may have

duties to themselves, relating to their jobs or health, that may override benefits to someone else or a future child. A woman may decide to undergo cancer treatments that could harm the child-who-will-be-born after giving due consideration to the risks posed to the fetus. A woman may also have duties to other persons that may override her future child's best interest. A pregnant mother may rush into a fire to save another child, placing herself and the fetus at risk. In balancing these various interests and duties, however, the future child should receive due consideration based on general duties to avoid harming others and parental duties to help children flourish.

Thus, even when there is a moral duty to the future child, pregnant women are not required to subrogate all other duties or interests during pregnancy to prevent harm to the child. Moral obligations of the pregnant woman in regards to her future child do not demand that she subject herself to great personal risks, ignore all other duties, or forgo all pleasures to do what is absolutely best for the fetus. Rather, the woman is morally obligated to give due consideration to the future child's interests in balancing the child's claims with other duties and interests.<sup>43</sup> What is an unreasonable harm depends upon (1) the likelihood the harm will occur; (2) the gravity of the harm to the future child if it materializes; and (3) the degree and importance of the interests and pleasures that the woman must compromise to prevent that harm.

In egregious cases of substance abuse, the moral analysis offers clear and uncontroversial examples of violations of the pregnant woman's moral duty to give due consideration the interests of her future child. The scientific evidence regarding the impact of heavy smoking, heavy drinking, and habitual use of cocaine on the fetus represents potential harms of significant probability and magnitude. Therefore, the pregnant woman who has decided to carry to term has a moral duty to avoid egregious abuse of substances during the course of her pregnancy.<sup>31</sup> Indeed, she and other family members may have similar duties even after the child is delivered.

A woman who did not intend to become pregnant and who is denied access to abortion by legal restrictions or financial or other limitations still has a moral obligation to consider the claims of her offspring. Some scholars, however, argue that this obligation has less moral force when a woman involuntarily carries the fetus to term.<sup>24</sup> The moral duties of the woman who is bearing a child against her will might more closely resemble those of the third-party stranger who has a generalized duty not to harm others, rather than the greater duty of a parent. Although this suggestion is controversial, it underscores the difficulty in evaluating precisely the nature of a pregnant woman's moral duty toward her future child and highlights one of the many difficulties inherent in any attempt to enshrine moral duty into law and policy.

The authors have argued that the pregnant woman who decides to carry a fetus to term has a moral duty to give due consideration to the interests and claims of the child-who-will-be-born. In the next section, it

is questioned whether these duties justify coercive or punitive social policies on the part of the state to force such women to refrain from illegal or addictive drugs that might harm their offspring.

## **FAIRNESS, SOCIAL POLICY, AND THE LIMITS OF LIBERTY**

Given that pregnant women have some moral duty to protect the children they intend to deliver, and that they have interests in avoiding harm, what is the status of current fetal protection policies in terms of prudence, fairness, justice, and morality? Society clearly possesses some duties and rights to promote the health and flourishing of its future citizens, for example, by providing prenatal programs and removing environmental hazards causing birth defects. Is it a natural extension of those commitments to frame laws and adopt policies that force pregnant women to refrain from the use of recreational or addictive drugs that may harm the conceptus or fetus or to punish them for such behavior?

A comprehensive moral assessment of a fetal protection policy must take into account the interests of future children and the interests of society in protecting its members. It must also include, however, a full appreciation and respect of the rights and interests of pregnant women as well as an assessment of whether such policies are effective. In Western society, individuals are presumed to possess rights to liberty and autonomy—the right to be left alone. Moreover, the pregnant woman is typically considered the presumptive decision maker for her child-who-will-be-born. Women are entitled to privacy and a secure and trusting relationship with their physician and other health care providers. The most reasonable and morally legitimate social policies are those that accomplish the desired social goal, in this case, the birth of healthy children, but that are the least restrictive. Given these interlocking moral considerations, there are several fundamental difficulties with current punitive or coercive fetal protection policies.

### **Harm Principle**

John Stuart Mill proposed what is probably the most widely accepted principle for limiting the liberty of others—the harm principle. It draws its name from Mill's contention that competent adults should not be restrained, compelled, or coerced against their will except to prevent harm to other persons.<sup>33</sup> The harm principle is employed to justify state intervention when parents abuse or neglect their children. The central issue in the analysis of coercive and punitive fetal protection policies is whether and when it is legitimate to apply the harm principle to the unborn to limit the pregnant woman's liberty to stop her in exactly the same way we restrain parents who abuse their children. Those who favor such policies argue that the claims of the future child and the

interests of society justify interfering with the liberty of the pregnant woman who abuses drugs or punishing her after the delivery of the infant. Potential harm to the conceptus or fetus, they reason, vindicates coercive or punitive measures.

Interference with the liberty of competent adults, however, requires the satisfaction of a heavy burden of proof in regards to the magnitude of the harm threatened and the probability that it will occur. Some individuals, perhaps most, may understand their moral duties as requiring a total abstinence of substances during pregnancy. The question, however, is whether there should be punitive or coercive state measures to enforce what most pregnant women recognize as a moral duty to prevent harm. The case for coercive state measures is strongest when serious injury is most likely to befall the child-who-will-be-born. However, as the probability and magnitude of these harms diminish, it becomes increasingly difficult to justify punitive or coercive state measures. The moderate or high use of alcohol, tobacco, and narcotics has been correlated with lower intelligence quotients, fetal immaturity, and lower birth rates, and thus a case may be made in regards to such use. These types of injuries, however, occur less frequently with moderate-to-low use, can often be overcome as the child ages, and may be attributable to other causal factors. Some maternal behavior is linked to great fetal injury, but most substance use probably falls into the class of low-to-moderate use that poses possible but uncertain or low risk to the fetus.

A morally justifiable fetal protection policy would have to resolve the profoundly difficult issue of setting the threshold of probability and magnitude of harm that is sufficient to outweigh the other interests and duties of the expectant mother. Such a determination is made more problematic by the fact that, as the result of biologic variability, virtually identical behavior by pregnant women will result in different fetal outcomes. The calculus that is required to determine the magnitude of a pregnant woman's duty to her child-who-will-be-born is complex, uncertain, and value-laden. Striking a balance between duties and interests is complicated furthermore because not all pregnant women choose pregnancy and consciously and voluntarily eliminate abortion as an option. Indeed, it would be an ironic twist if a policy intended to protect the health and well-being of future children scared targeted women into terminating their pregnancies by abortion because they feared punitive or coercive state action. Therefore, there are well-established moral and parental duties to refrain from behavior that will cause the child-who-will-be-born harm and a limited societal duty to prevent such harm. It is questionable whether these duties justify broad coercive or punitive social policies of detention, forced treatment, or criminal sanctions to protect the fetus.

### **Fairness and Gender Bias**

In an effort to protect children from prenatal harm, public concern, proposed fetal protection policies, and enforcement efforts currently

focus predominantly on the actions and lifestyle choices of the pregnant woman. Equality before the law, however, is a fundamental political and a constitutional principle in democratic societies.<sup>26</sup> As a result, the public, policy makers, enforcement agents, and physicians should be inherently skeptical of any approach that reserves restrictive and punitive measures for one segment of society while neglecting analogous wrongs perpetrated by another segment of society. Irresponsible actions on the part of men can have a significant impact on the health of the fetus and the well-being of the resulting child. Although the literature is not as fully developed as that regarding substance abuse and the pregnant woman, preliminary evidence suggests that male abuse of alcohol, tobacco, and illegal drugs may damage the sperm in ways that might lead to fetal abnormalities. Similarly, exposure to toxic materials in the workplace can damage the sperm prior to fertilization.<sup>39</sup> Yet, little societal concern and virtually no official action are directed at the potential impact of male substance abuse on the health of future children.

It is possible to distinguish the case of the substance-abusing pregnant woman from the substance-abusing man. Whereas the man is potentially damaging sperm that could harm the resulting child, the woman is potentially damaging a fetus that could result in a damaged child. Much of this discussion on the moral status of substance abuse and reproduction has been based on the notion that the relevant moral wrong is committed against the child-who-will-be-born rather than against the fetus. Damage to sperm may injure a future child just as much as an injury to a fetus. In this respect, the actions of both male and female partners could lead to the birth of an injured or affected child.

Society and public policy have failed in other ways to appreciate fully and regulate male responsibilities during pregnancy. For example, there is growing evidence, statistical and anecdotal, that pregnant women are at a greater risk for physical abuse than are other women,<sup>5</sup> and that domestic violence remains a highly underreported and under-prosecuted phenomenon. Physical assaults pose a danger not only to the female and pregnant victim but also to her future child. Future fathers also have a duty to safeguard the interests of the child-to-be-born. The often cited case of Pamela Rae Stewart is instructive. Stewart was charged with child neglect after she reportedly, and against the advice of physicians, eschewed bed rest and prescribed medication, engaged in sexual intercourse, used marijuana and amphetamines, and did not contact her physician when she began bleeding. It is often overlooked that Stewart's husband also had a duty to their future child and also heard the physician's advice. He reportedly used drugs with her, had sex with her, assaulted her, and failed to call physicians when she began bleeding yet, unlike his wife, was never charged with child neglect.<sup>40</sup> Fathers and other men can have a central role in encouraging drug or alcohol use by pregnant women and are arguably culpable in any damage caused to future children. In addition, second-hand exposure to crack, marijuana, and tobacco smoke may present at least marginal potential dangers to pregnant women and their fetuses.<sup>40</sup>

Despite the variety of ways in which the actions of the male partner during pregnancy can wrong the child-who-will-be-born, public scrutiny remains focused on the pregnant woman. Although the pregnant woman's actions frequently pose a greater immediate risk of harm, in some instances this is not true. It is likely that the issues of fetal protection focus on women because our culture still views child-bearing and child-rearing as largely female responsibilities.<sup>39</sup> Even if these cultural expectations underlie current fetal protection efforts, they are insufficient justification in a society based on the aspiration that all citizens should be treated equally by law.

### **Fairness and Racial Bias**

Similarly, fetal protection policies have disproportionately focused on poor women, especially those of color. Although studies have suggested that the rate of alcohol and drug use among white and black pregnant women is comparable, reporting and enforcement practices have the effect of singling out women of color. In one institution, black women who used alcohol or illegal drugs during pregnancy were 10 times as likely to be reported to child protection services and law enforcement agencies in comparison with white women who used such substances during pregnancy.<sup>20</sup> Virtually all of the women arrested for child abuse under South Carolina's maternal drug prevention program have been African-American.<sup>8</sup> Other studies reveal similar figures.<sup>27</sup> This disparity may be explained in a variety of ways, including thinly veiled racism. Fetal protection, reporting, and enforcement policies typically focus on public clinics and prenatal cocaine use, especially crack use, making poor women of color the more likely target of enforcement efforts. Such highly selective enforcement policies make women of a particular ethnic and socioeconomic identity the more likely targets of fetal protection policies. Upper and middle class women are more likely to receive their prenatal care from a private physician than from a clinic and may be less likely to abuse cocaine during their pregnancies. They are, however, equally likely to abuse other potentially harmful drugs such as tobacco and alcohol during pregnancy. Such practices probably account for as much or more fetal injury than does cocaine. Even if a draconian fetal protection policy could be defended in the abstract, it would still be suspect. Current attempts to protect fetuses from maternal lifestyle choices reflect stark racial and socioeconomic disparities. Such policies are also antithetical to the constitutional and political ethos that all persons be treated equally under the law. Universal and broad enforcement of fetal protection policies without regard to race or economic status might be one way to meet this criticism. Given the existing social biases, such a color-blind, class-neutral policy would probably be politically tricky, difficult to craft, and objectionable on other grounds.

## Evaluating Detention, Monitoring, and Forced Treatment

The most egregious cases of maternal irresponsibility and the tragic plight and prospects of the newborn seriously injured by prenatal substance abuse seem to cry out for action. The state has an interest in promoting and protecting the health of future citizens. Children who have been injured or disadvantaged by prenatal substance abuse represent an unnecessary burden on society's medical, educational, and social services. The economic costs of fetal alcohol syndrome in the United States have been estimated to be \$321 million each year for all affected children less than 21 years of age. The lifetime societal costs of a permanently disabled citizen may be even higher.<sup>44</sup> Individuals in society have a duty to prevent unnecessary harm to others, including children-who-will-be-born; a woman who decides to carry a fetus to term may have a heightened duty of care. Although most women who abuse substances during pregnancy may acknowledge and accept this duty, they may be unable to help themselves because of the realities of substance addiction or social and economic dependency.

Despite the foregoing arguments, these policies remain problematic. Unless such measures can be justified, jail detention or hospital commitment of a pregnant woman who is using or abusing substances intrudes upon the most revered and protected right in Western culture—the right to liberty and the freedom from bodily restraint. Although the state may sometimes infringe upon the rights of individuals, it may only justifiably do so in highly circumscribed situations, such as when great public harm is threatened, when other less onerous alternatives are unavailable, or when the risk of harm to other individuals is both severe and likely.

In most cases, the confinement and treatment of pregnant women who use substances does not meet these standards for limiting liberty. In most cases, other less coercive means exist. Voluntary outpatient substance abuse education, counseling, and treatment do not infringe on the pregnant woman's right of liberty, are profoundly less restrictive, and would most likely be more successful in reducing drug and alcohol use during pregnancy.<sup>21</sup> Individuals who voluntarily submit to substance abuse treatment are likely to be more committed and to be faithful to a substance-free lifestyle and pregnancy and thus are more responsive to therapy. In general, mandated substance abuse programs are less successful than voluntary ones. The fear of detention, if drug use is admitted during the pregnancy, may discourage women from seeking help voluntarily, thus increasing the danger that the fetus will sustain unhealthy exposures in utero. If applied equally and without prejudice to all substance abusers, confinement and mandated treatment would be impractical. To be effective, some women would have to be confined for much of the duration of the pregnancy. Various types of fetal damage can occur at broadly divergent periods of gestation. Moreover, to be fairly and efficiently administered, a fetal protection policy should in-

volve the detention of women who use not only crack cocaine but also tobacco, alcohol, and a relatively large number of known fetal toxins both legal and illegal. Thus far in public policy the focus has been on maternal cocaine use, but other substances represent an equal or greater risk of harm to the fetus. Therefore, as a matter of pure pragmatism, society does not have the resources, penal or medical, to pursue such a course.

It is also illegitimate to limit an individual's liberty without substantial evidence concerning the nature, probability, and magnitude of the harm to be avoided. Even though substance abuse poses a risk of fetal harm, *that risk and its intensity are highly unpredictable*. Heavy alcohol use throughout pregnancy yields clear and significant fetal damage in a high percentage of, but not all, resulting births. The results of lower levels of usage are more ambiguous, as is the relative impact of alcohol use at differing points during pregnancy. The evidence involving cocaine, marijuana, and other controlled substances is even more equivocal. A vast majority of children born to women who use or abuse controlled substances during pregnancy sustain little or no long-term injury. Thus, the endemic uncertainty of maternal alcohol and drug use on the health of newborns makes it a slender reed upon which to justify the profound intrusion on individual liberty that is represented by confinement and mandatory treatment.

The relevant liberty in this instance is not the right to use illegal substances or abuse alcohol, rather, it is the right to move about freely in the world as one wishes and to refuse treatment that one does not desire. Although it may be irresponsible and even immoral to abuse substances when one is pregnant, a just public policy should intervene only in important individual liberties when there is a clear risk of serious harm to third parties or society. Confinement during pregnancy and mandatory treatment do not meet this standard. Although such policies may prevent serious damage to newborns in some cases, they unnecessarily and unjustifiably violate the almost transcendent liberties of women in many others.

In addition, fetal protection strategies must not offend or undermine the professional ethos of the physicians and health care professionals who are, by necessity, integrally involved in the implementation of the various policies. Thus, even when there is a moral duty for women to avoid the use of substances that pose a risk to the child-who-will-be-born, there may be no legal policy devised that is morally justifiable, clinically and socially efficacious, and nondiscriminatory.

### **Evaluating Punishments After Delivery**

During the past decade, many women have been charged with child abuse, manslaughter, and the delivery of drugs to minors. In some

jurisdictions, evidence of drug use during pregnancy has served as a justification for the initiation of child custody actions directed at the newborn and, in some cases, the woman's other children. As noted earlier, although virtually all such attempts have been rebuffed by judges, hundreds of bills have been submitted to state legislatures proposing to rewrite criminal statutes to sanction these actions. It is intended, presumably, that these bills will punish women who have subjected their children to a risk of harm before they were born, and that this threat will deter other pregnant women from acting in a similar way. Advocates of such legislation typically argue that women have no intrinsic right to use illegal drugs. Postbirth prosecutions are justified on the grounds that newborn infants do not deserve to be burdened for life by the irresponsible behavior of others, especially their mothers. Society, they assert, should not be forced to bear the economic and social burdens represented by the child who is unnecessarily injured prenatally. Such supporters contend that women who continue to abuse drugs and alcohol during pregnancy are obviously not responding to available education and counseling and thereby should be subject to stronger, punitive measures.

Despite these arguments forwarded by fetal-protection advocates, sanctions applied after delivery are probably unjust, unwarranted, and unlikely to accomplish any goal beyond the punishment of women who have used illegal substances during their pregnancies. Moreover, the argument for such sanctions does not apply to other more dangerous behaviors such as alcohol consumption. The focus on punitive measures for using illegal substances does nothing to stop or assuage the damage that has already occurred to children exposed during gestation or to help the mother gain control of her life. The proposed role of these sanctions in preventing harm to children born and unborn is also only speculative. It is unclear that the prosecution and imprisonment of women is the most effective means to bring maternal drug and alcohol use to a halt. Substance abusers are not likely to calculate rationally the cost and benefits of their behaviors. More likely, the prospect of prosecution may encourage women to bypass vital prenatal care and available counseling in an attempt to evade potential detection of maternal drug use. Such a course of action is more likely to lead to higher levels of neonatal morbidity rather than lower, as the proposed legislation presumably intends. Some studies have suggested that voluntary education and counseling tend to have a more lasting benefit in comparison with coercive programs.<sup>21</sup>

Imposing criminal sanctions for prenatal drug use following a positive urine test during pregnancy or the discovery of cocaine metabolites in cord blood represents an unjust use of criminal law. Even though substance abuse during pregnancy represents a known and preventable risk of harm to the child-who-will-be-born, such use results in injury to the child in a minority of cases only. Law, both criminal and civil, typically imposes sanctions on individuals for wrongs and harms, and

not for creating the risk of wrongs and harms. Negligent behavior does not generate civil damages unless damage results. Individuals with criminal intent are not prosecuted and punished until that intent results in a socially defined injury. The woman who uses drugs or alcohol during pregnancy may risk harming her child-to-be-born, but that harm does not always come to fruition.

Criminal fetal protection sanctions, however, penalize women regardless of the resulting harm. The woman in South Carolina who received an 8-year sentence for child abuse after repeat positive tests for cocaine gave birth to an uninjured, healthy child.<sup>46</sup> Newly framed child abuse, drug delivery, and homicide statutes that apply to fetuses, if they are confirmed by legislatures, will punish many, even most, women for behavior that results in no harm to the newborn child. In what other context does society punish individuals criminally with potential imprisonment merely for creating a risk of harm? Individuals receive criminal traffic citations for speeding, which represents a risk of harm but causes no damage. Such speeding violations do not result in imprisonment or in the loss of custody of one's child. Driving while intoxicated sometimes results in imprisonment even where it has resulted in no injury or damage. However, drunk driving represents a serious and unambiguous risk to other drivers, being implicated in a large percentage of serious traffic-related injuries. The percentage of birth injuries clearly connected to substance use during pregnancy is much smaller. Indeed, criminal fetal protection statutes, if enacted, stand almost alone in Anglo-American law as examples of serious punishment meted out even in the absence of showing harm to the putative victim.

Punishment in the form of imprisonment or automatic loss of child custody may be difficult to justify even when injury has occurred. In some cases, it is relatively easy to determine that conscious, prenatal abuse of substances has caused a particular injury or deficiency in a newborn. However, those cases are probably in the minority. In most instances, any number of potential comorbidity factors ranging from congenital to economic to environmental blur the causal link between the maternal use of substances and the deficiency or harm sustained by the infant. Typically, proposed fetal protection statutes ignore this murky causal link between maternal action and fetal injury. The criminal punishment of individuals is usually justified by society's interest in deterrence, restraint, rehabilitation, education, and retribution.<sup>30</sup>

As discussed earlier, little evidence suggests that any of these objectives, except retribution, are better served by punitive measures than they would be by less expensive and less intrusive voluntary education, treatment, and counseling opportunities.<sup>1</sup> It is also troubling that certain racial and socioeconomic groups seem targeted by these prosecutions. As a result, these actions are inconsistent with the traditions and aims of criminal law, further undermining the proposed sanctions' moral legitimacy.

## CONCLUSIONS

Most state courts have refused to apply existing statutes against women who use drugs or alcohol during pregnancy. Similarly, although many legislators have tried, no state has passed a law that criminalizes maternal use of substances during pregnancy. There is a range of available constitutional challenges to such statutes but no guarantee that courts would overturn these laws.<sup>40</sup> In the contemporary US environment, criminal fetal protection policies seem unwise and unjust, even if they may ultimately be found constitutional, and should not be enacted.

In the vast majority of cases, the pregnant woman, more than anyone else, wishes to give birth to a healthy child and will conform her behavior in an attempt to further that result. The pregnant woman has a moral duty to give due consideration to the claims and best interests of the child-who-will-be-born. This is not an absolute duty, however, because the woman is not obligated to subrogate totally all other interests or duties to herself or others. Diverse values in regard to individual maternal obligation make it difficult to translate the pregnant woman's moral duties toward her child-who-will-be-born into just policies. This is especially true given the uncertainty and limited evidence available regarding substance use and abuse during pregnancy and the likelihood of its occurrence in a predictable range of cases. An attempt to balance the interests of the child-who-will-be-born against the interests, comfort, liberty, and pleasures of the pregnant woman becomes a highly speculative endeavor. Given the serious intrusion into the pregnant woman's privacy, her relationship with the medical community, her bodily autonomy, and her very liberty of movement, this is not the type of moral obligation that can justifiably be enshrined in law. The liberties at stake are too dear and the moral obligation too ambiguous and individualistic. In deciding how society should respond when pregnant women use drugs, the most morally defensible social policies are those that are least restrictive and necessary to achieve the desired effect, in this case, healthy children. Until such policies are shown to be significantly less effective than punitive or coercive programs, the preferable responses are voluntary and nonpunitive. Such policies are not only less restrictive but are more likely to empower and secure the cooperation of those who participate. Voluntary programs also avoid the tangle of serious problems arising from programs that, by design or effect, focus prejudicially on a particular gender, ethnic group, or economic class. Moreover, expanded voluntary education, counseling, and treatment services are less controversial. They escape the irrational bias reflected in the focus on the uncertain effects of illegal drugs while ignoring the threat of more dangerous, legal, and popular drugs, such as alcohol.

The evaluation of fetal protection policies is inescapably a discussion involving individual liberty and the degree to which it should be limited. It is also an issue of pragmatism. The most successful approach to the problem of substance use and abuse during pregnancy recognizes that

the woman's, the child's, and society's interests are usually consonant. All would be better served by a comprehensive approach to the challenge of fetal health that would respect not only individual liberty but also recognize and address the social and economic context within which disadvantaged children are born.

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