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COERCIVE INTERVENTIONS IN PREGNANCY: LAW AND ETHICS⁺

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Women¹ experience tremendous pressure to protect fetuses from risk during pregnancy.

The dominant idea of a ‘good mother’ in North America requires that women abjure personal gain, comfort, leisure, time, income, and even fulfillment; paradoxically, during pregnancy, when the woman is not yet a mother, this expectation of self-sacrifice can be even more stringently applied. The idea of imposing any risk on the fetus, however small or theoretical, for the benefit of a pregnant woman’s interest has become anathema.²

While this pressure to avoid fetal risk pervades women’s day-to-day choices during pregnancy, this discussion focuses on coercive interventions in pregnancy, including forced cesarean sections and penalties for exposing fetuses to risk.

Based on “systematic searches of legal, medical, news, and other periodical databases” with review of police and court records for identified cases, Paltrow and Flavin document 413 cases of arrests, detentions, and forced interventions in pregnancy in 44 states, the District of Columbia, and federal jurisdictions from 1973 (the year of the *Roe v. Wade*³ ruling) to 2005 (the latest date for which there were records of cases that had reached their legal conclusion at the time the

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1. It should be noted that persons who do not identify as women can become pregnant, such as transgender men or non-binary or gender nonconforming individuals. The analysis herein will be framed in terms of the experience of cisgender women, because to date the documented cases of coercive interventions have involved pregnant cisgender women. Moreover, given the significance of gender to societal norms and expectations regarding pregnancy, unique pressures and challenges may affect transgender, non-binary and gender nonconforming individuals. While those issues extend beyond the more limited scope of this paper, it bears noting that these gender differences should in no way be understood to diminish the equal moral significance of the rights and well-being of these individuals.

2. Anne Drapkin Lyerly et al., *Risk and the Pregnant Body*, 39 HASTINGS CTR. REP. 34, 40 (2009).

3. 410 U.S. 113 (1973).

article was published).⁴ These cases include coerced medical interventions (e.g., cesarean sections) as well as arrests and detentions for allegations of behaviors posing harms to fetuses. Given barriers to identifying cases – e.g., difficulties with identifying such cases in searches of legal databases and lack of reporting on forced interventions—the actual number is likely greater.⁵ Amnesty International has found that, between 2005 and 2017, approximately 700 women have been charged with crimes related to fetal neglect, “chemical endangerment” or “fetal assault” in Alabama, Tennessee, and South Carolina alone.⁶ Beyond these three states, “hundreds of others across the country have also been charged.”⁷ Note that the more recent data focus on arrests and detentions, as opposed to coerced medical interventions, which are also ongoing.⁸

We will consider legal and ethical responses to such coercion, exploring the ways in which ethical approaches overlap with, supplement, or diverge from legal ones. We will begin by focusing on coercive medical interventions because the moral commitment to patient autonomy and the fiduciary duties of practitioners are so firmly established in this context. We will then consider to what extent such considerations apply to arrests or detentions of women for exposing their fetuses to risk.⁹ We will argue that, contrary to common assumptions, assigning personhood to fetuses does not undermine the arguments against coercion. Finally, we will consider recommendations for bringing medical and legal practice in line with ethical obligations.

I. COERCIVE MEDICAL INTERVENTIONS

Coercive medical interventions involve overriding pregnant women’s autonomous choices to impose therapeutic intervention such as cesarean sections, intrauterine transfusions, or enforced bed rest in an effort to shield fetuses from risk. Consider the following two cases in which women were subjected to cesarean sections against their will, when they sought a trial of labor to attempt vaginal birth after previously having a cesarean delivery.¹⁰ In Laura

4. Lynn M. Paltrow & Jeanne Flavin, *Arrests of and Forced Interventions on Pregnant Women in the United States, 1973-2005: Implications for Women’s Legal Status and Public Health*, J. HEALTH POL. POL’Y L., 299, 302-09 (2013).

5. *See id.* at 300-02.

6. *Criminalizing Pregnancy: Policing Pregnant Women Who Use Drugs in the USA*, AMNESTY INTERNATIONAL 7, 8 (2017), <https://www.amnesty.org/download/Documents/AMR5162032017ENGLISH.pdf>.

7. *Id.*

8. *See, e.g.*, Thaddeus Mason Pope, *Legal Briefing: Unwanted Cesareans and Obstetric Violence*, 28 J. CLINICAL ETHICS 163, 163-64 (2017).

9. Beyond these broad categories, we will not attempt to produce a taxonomy of types of coercive interventions used in pregnancy in this analysis. We recognize that the categories we employ here are themselves diverse. Fully identifying and analyzing that diversity is a task for another project.

10. *Pemberton v. Tallahassee Mem. Regional Med. Ctr.*, 66 F. Supp.2d 1247, 1250 (N.D. Fla. 1999); *Dray v. Staten Is. Univ. Hosp.*, 160 A.D.3d 614, 616 (N.Y. App. Div. 2018).

Pemberton's case, "a sheriff went to [her] home, took her into custody, strapped her legs together, and forced her to go to a hospital in an ambulance," where the court-ordered cesarean was performed.¹¹ Ms. Pemberton successfully delivered subsequent pregnancies vaginally, raising significant questions about the risk assessment prompting the court order,¹² which stated "vaginal birth would pose a substantial risk of uterine rupture and resulting death of the baby."¹³ In Rinat Dray's case, the clinical team overrode her express objections and performed a cesarean section, without first seeking a court order. Her bladder was lacerated during the procedure, which required follow up surgery to repair.¹⁴ As Kolder *et al.* maintain, cases such as these "force women to assume medical risks and forfeit their legal autonomy in a manner not required of competent men or non-pregnant women. Thus, basic constitutional and common-law rights are at issue."¹⁵

Pope argues that "[e]very fully briefed appellate case has held that clinicians may not override a woman's right to refuse [a cesarean section] . . . even when they have serious concerns about the fetus."¹⁶ His review acknowledges the precedent set by *In re A.C.*, which he contends has been followed by all appellate courts faced with cases involving coerced cesarean sections.¹⁷ In that case, Angela Carder was 26-1/2 weeks pregnant and near death from cancer.¹⁸ Clinicians advocated for a cesarean section in an effort to save the fetus, but Ms. Carder repeatedly stated "I don't want it done," and her husband and parents supported her refusal.¹⁹ The hospital secured an emergency court order and performed the operation, but both Ms. Carder and her baby died.²⁰ The surgery was determined to have been a contributing cause of Ms. Carder's death.²¹ The District of Columbia Court of Appeals vacated the court order that had authorized the forced cesarean section, holding that "in virtually all cases the question of what is to be done is to be decided by the patient - the pregnant

11. Paltrow & Flavin, *supra* note 4, at 306-07; *cf.* *Pemberton*, 66 F. Supp.2d at 1250.

12. Paltrow & Flavin, *supra* note 4, at 306-07.

13. *Pemberton*, 66 F. Supp. 2d at 1249.

14. *Dray*, 160 A.D.3d at 616.

15. Veronica E. B. Kolder, Janet Gallagher & Michael T Parsons, *Court-Ordered Obstetrical Interventions*, 316 NEW ENG. J. MED. 1192, 1195 (1987);

16. Pope, *supra* note 8, at 164.

17. Pope, *supra* note 8, at 165.

18. *In re A.C.*, 573 A.2d 1235, 1240 (D.C. 1990); *see, e.g. Coercive and Punitive Governmental Responses to Women's Conduct During Pregnancy*, AMERICAN CIVIL LIBERTIES UNION (ACLU) [hereinafter *Coercive and Punitive Governmental Responses*] <https://www.aclu.org/other/coercive-and-punitive-governmental-responses-womens-conduct-during-pregnancy> (last visited Jan. 12, 2020).

19. *See In re A.C.*, 573 A.2d at 1243; *see also Coercive and Punitive Governmental Responses*.

20. *Id.* at 1238; *see Pope, supra* note 8, at 165; *see also Coercive and Punitive Governmental Responses, supra* note 18.

21. *Id.*; *see Coercive and Punitive Governmental Responses, supra* note 18.

woman - on behalf of herself and the fetus.”²² In support of this decision, the appellate court offered three arguments focusing on rights of self-determination and bodily integrity, due process rights, and the consequences of permitting coercive interventions.²³ We have previously summarized these arguments, with the aim of arguing that they must be supplemented with considerations of social justice that tend not to be recognized in analyses of coercion in pregnancy.²⁴ Here, we delve more deeply into the arguments offered by the District of Columbia Court of Appeals, to investigate the ways in which ethical considerations relate to legal ones and to consider recommendations for bringing medical and legal practice in line with ethical obligations.

The first argument is based on the court’s review of case law which affirms that “every person has the right, under the common law and the Constitution, to accept or refuse medical treatment.”²⁵ The court highlights the precedent set by *McFall v. Shimp* to establish that concerns about fetal protection do not justify overriding the pregnant woman’s decision.²⁶ In that case, the court ruled against forcing Shimp to donate bone marrow for a transplant that could save the life of his cousin, McFall.²⁷ The court explained:

The common law has consistently held to a rule which provides that one human being is under no legal compulsion to give aid or to take action to save another human being or to rescue. . . . For our law to *compel* defendant to submit to an intrusion of his body would change every concept and principle upon which our society is founded. To do so would defeat the sanctity of the individual, and would impose a rule which would know no limits, and one could not imagine where the line would be drawn.²⁸

In re A.C. denies that a fetus may have special claims on the pregnant woman: “a fetus cannot have rights in this respect superior to those of a person who has already been born.”²⁹

The appellate court’s decision also acknowledges the pregnant woman’s due process rights, expressing concern that any case considering an emergency order to mandate intervention for fetal protection will involve such intense time pressures that the woman will simply be unable to “prepare meaningfully for

22. *In re A.C.*, 573 A.2d at 1237; see Pope, *supra* note 8, at 165; see also *Coercive and Punitive Governmental Responses*, *supra* note 18.

23. *Id.* at 1238-48; see Pope, *supra* note 8, at 165; see also *Coercive and Punitive Governmental Responses*, *supra* note 18.

24. Debra A. DeBruin & Mary Faith Marshall, *Policing Women to Protect Fetuses: Coercive Interventions During Pregnancy*, 12 ANALYZING VIOLENCE AGAINST WOMEN 95-111 (2019).

25. *In re A.C.*, 573 A.2d at 1247.

26. See *id.* at 1244.

27. *McFall v Shimp*, 10 Pa.D. & C.3d 90, 91 (Allegheny County Ct. 1978).

28. *Id.*

29. *In re A.C.*, 573 A.2d at 1244.

trial.”³⁰ The court further stated “[t]he procedural shortcomings rampant in these cases are not mere technical deficiencies. They undermine the authority of the decisions themselves...”³¹ In cases where clinicians impose coercive interventions without a court order,³² there is not even any pretense of due process.

Finally, the appellate court’s decision reflects a concern with the consequences of coerced intervention:

Rather than protecting the health of women and children, court-ordered caesareans erode the element of trust that permits a pregnant woman to communicate to her physician without fear of reprisal all information relevant to her proper diagnosis and treatment. An even more serious consequence of court-ordered intervention is that it drives women at high risk of complications during pregnancy and childbirth out of the healthcare system to avoid coerced treatment.³³

The legal reasoning set forth in *In re A.C.* mirrors the commitment in bioethics to the principles of respect for persons and beneficence, as well as the fiduciary nature of the clinician-patient relationship. Indeed, Allen noted that “[t]he decision in *In Re A.C.* reaches virtually the identical conclusion [as the American College of Obstetricians and Gynecologists (hereinafter “ACOG”) Ethics Committee’s 1987 Opinion on Maternal-Fetal Conflict] but does so through primarily legal analysis as opposed to the medical-ethical reasoning used in the Committee Opinion.”³⁴ In addition, Pope notes that the position taken by appellate courts in cases involving coercive cesarean sections is supported by “leading relevant medical societies and human rights organizations.”³⁵ He concludes: “[a] woman’s right to refuse a cesarean is clearly established in both appellate court opinions and codes of medical ethics.”³⁶

While *In re A.C.* focuses on coercive cesarean sections, the bioethical considerations grounding ethics guidance on coercive cesareans applies to other unwanted medical interventions as well. Concerns about self-determination and bodily integrity, the well-being of women and their babies, and the moral importance of the fiduciary nature of the clinician-patient relationship are

30. *Id.* at 1248.

31. *Id.* (quoting Janet Gallagher *Prenatal Invasions & Interventions: What’s Wrong With Fetal Rights*, 10 HARV. WOMEN L.J. 9, 49 (1989)).

32. Pope, *supra* note 8, at 166; Elizabeth Kukura, *Obstetric Violence*, 106 Geo L.J. 721,731 (2018).

33. *In re A.C.*, 573 A.2d at 1248 (internal citation omitted).

34. *Id.* at 38.

35. Pope, *supra* note 8, at 164; cf Norman C. Frost et al., *Fetal Therapy: Ethical Considerations*, 81 AM. ACAD. OF PEDIATRICS: COMM. OF BIOETHICS 898, 899 (1988); *Refusal of Medically Recommended Treatment During Pregnancy*, AM. C. OBSTETRICIANS AND GYNECOLOGISTS 1, 1 (2016); Helene Cole, *Legal Interventions During Pregnancy: Court-Ordered Medical Treatments and Legal Penalties for Potentially Harmful Behavior by Pregnant Women*, 264 J. AM. MED. ASS’N 2663, 2664 (1990).

36. Pope, *supra* note 8, at 170.

foundational in bioethics, not limited to the context of cesarean sections. The principle of respect for persons grounds fundamental concern for rights of self-determination and bodily integrity – moral and legal rights that women do not lose due to pregnancy. The violation of trust inherent in the imposition of coercive interventions undermines the clinician-patient relationship – a problem in itself given that it “transforms the woman’s physician into her adversary, disrupting the treatment relationship,”³⁷ and for its potential to drive women away from needed care during pregnancy. The principle of beneficence requires a concern with the well-being of pregnant women and the babies they will birth, and so provides ethical foundation for the concern about influences that might undermine access to supportive care. Thus, the ethical and legal consensus prohibiting coercion should be understood to apply generally to any unwanted medical interventions in pregnancy.

Nevertheless, coercive medical interventions continue to be imposed upon pregnant women.³⁸ If trial courts are continuing to provide emergency orders to permit coercion, then they ignore or flout established precedent in doing so. Sometimes, clinicians forgo court orders and simply coerce women to sign “consent” forms for the procedures in question, for example, by threatening them with removal of child custody or abandonment by the clinician if she refuses.³⁹ Additionally, sometimes clinicians override the woman’s refusal of consent and impose the intervention on their own or with the support of institutional policy, though without a court order.⁴⁰ In such cases, women have had mixed results in securing legal redress. For instance, it may be difficult to prove that the woman was coerced into “consenting” if there is a signature on a consent form, and likewise, juries may be unlikely to award damages for dignitary harms in the absence of severe physical harm.⁴¹ The overwhelming cultural view concerning birth – one that affects the judgment of judges and juries alike – places “the existence of a healthy baby” as a higher priority than the rights and welfare of the mother.⁴²

Kolder *et al.*’s survey of fellowship directors in maternal-fetal medicine found that 46% believed that pregnant women who refused medical recommendations should be detained to ensure compliance, and 47% endorsed the use of court-ordered medical interventions.⁴³ This study preceded the establishment of legal precedent discussed above.⁴⁴ Nevertheless, these attitudes

37. Kukura, *supra* note 32, at 743.

38. Paltrow & Flavin, *supra* note 4, at 306-08; Pope, *supra* note 8, at 164-66.

39. Pope, *supra* note 8, at 167; Kukura, *supra* note 32, at 747-48.

40. Pope, *supra* note 8, at 167; Kukura, *supra* note 32, at 751.

41. Pope, *supra* note 8, at 166-68; *Cf.* Kukura, *supra* note 32, at 780-81.

42. Kukura, *supra* note 32, at 788.

43. Kolder *et al.*, *supra* note 15, at 1193.

44. *In re A.C.*, 573 A.2d 1235 (D.C. 1990).

persist. More recently, Samuels *et al.* surveyed obstetricians and health lawyers and found that 51% of respondents would be highly likely to use a court order if both the woman and the fetus were healthy.⁴⁵ Members of the two professions did not differ significantly in their responses.⁴⁶ These studies do not address the willingness of health professionals to impose coercive interventions without a court order, but they do establish willingness over time to override women's autonomy and bodily integrity in pursuit of fetal benefit.

Samuels *et al.* thus recommend that women "should seek out providers who share their philosophy regarding the rights of pregnant women."⁴⁷ However, this is an unrealistic solution for many women due to geographic and insurance/cost barriers to accessing maternity care.⁴⁸ They also rightly recommend that: (1) providers never go to court before calling an ethics consult, (2) ACOG and obstetric training programs develop educational modules about coercion, and (3) there be a "national dialogue about the role of court orders so that women can be assured that the care they receive will be equitable and predictable."⁴⁹ These recommendations highlight an important role for bioethics in countering use of coercion. Perhaps even more can be done. For example, some have suggested conceiving of birth plans as advance directives to promote pregnant women's autonomy.⁵⁰ However valuable written preferences may be to communication, the barrier to promoting women's autonomy during pregnancy is not typically a lack of communication but rather the willingness of health providers and legal professionals to override women's autonomous decisions. Thus, while we endorse the value of birth plans, we fear that they are unlikely to prompt change concerning coercive interventions in the current cultural climate. Another, perhaps more powerful option, is this: ACOG's Code of Professional Ethics warns that "noncompliance with the Code ... may affect an individual's initial or continuing Fellowship in the American College of Obstetricians and Gynecologists."⁵¹ To date, ACOG has refrained from withholding or removing

45. Terri-Ann Samuels et al., *Obstetricians, Health Attorneys, and Court-Ordered Cesarean Sections*, 17 *WOMEN'S HEALTH ISSUES* 107, 108 (2007).

46. *Id.*

47. *Id.* at 112.

48. *Nowhere to Go: Maternity Care Deserts Across the U.S.*, MARCH OF DIMES, https://www.marchofdimes.org/materials/Nowhere_to_Go_Final.pdf (last visited Sept. 9, 2019).

49. Samuels et al., *supra* note 45, at 113. While Samuels *et al.*, do not note this, the use of ethics consultation to resolve cases of conflict over treatment refusals is specifically advocated by the American College of Obstetrician and Gynecologists. *Refusal of Medically Recommended Treatment During Pregnancy*, AM. C. OBSTETRICIANS AND GYNECOLOGISTS 1, 5 (2016).

50. See Nayna C. Philipsen and Dorothy R. Haynes, *The Similarities Between Birth Plans and Living Wills*, 14 *J. PERINATAL EDUC.* 46, 47-48 (2005); see also Nadia N. Sawicki, *Birth Plans as Advance Directives*, BILL HEALTH BLOG (May 1, 2017), <https://blog.petrieflom.law.harvard.edu/2017/05/01/birth-plans-as-advance-directives/>.

51. *Code of Professional Ethics*, AM. C. OF OBSTETRICIANS & GYNECOLOGISTS (ACOG) (Dec. 2018), <https://www.acog.org/About-ACOG/ACOG-Departments/Committees-and-Councils/Volunteer->

Fellowship from those who have imposed coercive interventions on their patients, thus violating the Code of Ethics. Were ACOG to begin using this authority, it might powerfully counteract provider willingness to override women's autonomy.

At a more systemic level, beyond the attitudes and actions of individual providers, Kukura argues that economic incentives built into our health care system reward intervention, promoting conflicts of interest and pressure to perform lucrative procedures.⁵² While abundant reason exists to question the current economic incentives in clinical care, these same incentives operate in clinical contexts other than obstetric care without the same embrace of coercive intervention. Oppressive norms regarding gender primarily ground coercive practices: women's rights and interests are subordinated to those of fetuses, and women are denied the moral or epistemic authority to determine what is best for themselves and their fetuses. Kukura acknowledges that these norms influence legal practices around coercion when she states, "[s]ociety's widespread expectation of maternal self-sacrifice makes it difficult for courts to recognize the injury associated with forcing medical treatment on an unwilling woman in labor."⁵³

II. OTHER FORMS OF COERCION

Pregnant women are subjected to a wide array of coercive interventions beyond forced medical interventions. For example, they have been arrested and detained not only for fetal harms related to illegal substance use, but also for doctor prescribed methadone therapy, falling down the stairs, attempting suicide, failing to wear a seatbelt, and other behaviors that would not have resulted in arrest or detention had the women not been pregnant.⁵⁴ Consider the following cases. For example, Casey Shehi took half a Valium two times late in her pregnancy to manage extreme distress, believing that doing so would not harm her fetus, because her doctor had prescribed painkillers during her pregnancy.⁵⁵ Given a routine drug screen during labor, she tested positive for benzodiazepines.

Agreement/Code-of-Professional-Ethics-of-the-American-College-of-Obstetricians-and-Gynecologists?IsMobileSet=false.

52. Kukura, *supra* note 32, at 766-769.

53. Kukura, *supra* note 32, at 776.

54. Paltrow & Flavin, *supra* note 4, at 300, 332; *Criminalizing Pregnancy: Policing Pregnant Women Who Use Drugs in the USA*, AMNESTY INTERNATIONAL 7, 61 (2017), <https://www.amnesty.org/download/Documents/AMR5162032017ENGLISH.pdf>; Nina Martin, *Take a Valium, Lose Your Kid, Go to Jail*, PROPUBLICA (Sept. 23, 2015), <https://www.propublica.org/article/when-the-womb-is-a-crime-scene>; Lynn M. Paltrow & Lisa K. Sangoi, *The Dangerous State Laws that are Punishing Pregnant People*, THINKPROGRESS (Sept. 28, 2016, 5:36 PM), <https://thinkprogress.org/criminalization-pregnancy-us-43e4741bb514/>.

55. Nina Martin, *Take a Valium, Lose Your Kid, Go to Jail*, PROPUBLICA (Sept. 23, 2015), <https://www.propublica.org/article/when-the-womb-is-a-crime-scene>.

However, her baby was healthy, and his drug test came back negative.⁵⁶ Nevertheless, she was arrested and “charged with ‘knowingly, recklessly, or intentionally’ causing her baby to be exposed to controlled substances in the womb — a felony punishable in her case by up to 10 years in prison.”⁵⁷ Additionally, Bei Bei Shuai attempted suicide while pregnant.⁵⁸ She survived, but her baby — who was delivered by cesarean section when she was taken to the hospital — did not.⁵⁹ Prosecutors charged her with feticide and murder.⁶⁰ Shuai spent over a year in jail,⁶¹ then was released on bail and subjected to electronic monitoring for more than a year. In the face of strong public outcry against her prosecution, she was offered a plea deal which she accepted very shortly before her trial was to begin. The result was that she pled guilty to “criminal recklessness,” which is a misdemeanor.⁶² It is important to keep in mind that attempted suicide is not a crime.

While *In re A.C.*'s legal precedent may not extend to these types of cases, the ethical arguments do apply here. Consider Nelson *et al.*'s commentary on self-determination in this context:

The prospect of courts literally managing the lives of pregnant women and extensively intruding into their daily activities is frightening and antithetical to the fundamental role that freedom of action plays in our society. ... It is far better simply to avoid compelling pregnant women to live as seems good to a particular physician, judge, or even to the rest of us than to force them to sacrifice their wills and their bodies on the altar of someone else's notion of the good.⁶³

Liberty and self-determination are fundamental values in our culture and not remotely limited to the context of medical intervention.⁶⁴ In the broader context, limits on freedom are often justified if one's exercise of liberty harms others. Because coercion in pregnancy is rationalized by avoidance of fetal risk — or punishment for actions that allegedly cause fetal risk — we shall consider the application of the harm principle in the section on fetal personhood below.

56. *Id.*

57. *Id.*

58. *Shuai v. State*, 966 N.E.2d 619, 622-23 (Ind. App. Ct. 2012).

59. *Id.*

60. *Id.*

61. Ed Pilkington, *Indiana Prosecuting Chinese Woman for Suicide Attempt that Killed her Foetus*, THE GUARDIAN (May 30, 2012 1:36 PM) <https://www.theguardian.com/world/2012/may/30/indiana-prosecuting-chinese-woman-suicide-foetus>.

62. *Shuai*, 966 N.E.2d at 622-23; see also NAT'L ADVOCES. FOR PREGNANT WOMEN, *Thank You! Bei Bei Shuai is Free and More!*, (Aug. 6, 2013)

<https://www.nationaladvocatesforpregnantwomen.org/thank-you-bei-bei-shuai-is-free-and-more/>.

63. Lawrence J. Nelson et al., *Forced Medical Treatment of Pregnant Women: Compelling Each to Live as Seems Good to the Rest*, 37 HASTINGS L.J. 703, 756-57, 763 (1986).

64. *Id.* at 714, 755.

Due process rights are an additional concern in this broader context. Paltrow and Flavin's review demonstrates that, in a majority of cases, coercion is imposed without prospective evidence of harm to the fetus or baby, or of a causal link between the actions of the woman and adverse outcomes, such as stillbirth.⁶⁵ In these broader cases of coercion, compromises of due process are not as inherent as they are in the emergent context of coercive medical interventions. However, these flagrant violations of due process rights are even more morally problematic because they are more readily avoidable.

Finally, concerns about the negative consequences of coercion extend to this broader context as well. *In re A.C.* decried the corrosive effect of coercive medical interventions on trust in the clinician-patient relationship and the resulting tendency of patients to avoid seeking care.⁶⁶ While the imposition of coercion outside of the health care context may not involve the violation of fiduciary duties, evidence suggests that fears of prosecution, or removal of child custody (not only of the newborn, but of the woman's other children as well) for drug or alcohol use drive pregnant women to avoid prenatal care or hospital delivery.⁶⁷ According to Paltrow and Flavin:

Our findings challenge the notion that arrests and detentions promote maternal, fetal, and child health or provide a path to appropriate treatment. Significantly, detention in health and correctional facilities has not meant that the pregnant women (and their fetuses) received prompt or appropriate prenatal care. Our research into cases claiming that arrests and detentions would ensure that pregnant women were provided with appropriate drug treatment or that only women who had refused treatment would be arrested or prosecuted overwhelmingly found that such claims were untrue. In some cases, women were arrested despite the fact that they were voluntarily participating in drug treatment. Our findings also lend support to the medical and public health consensus that punitive approaches undermine maternal, fetal, and child health by deterring women from care and from communicating openly with people who might be able to help them.⁶⁸

Therefore, coercive interventions are antithetical to duties of beneficence.

65. Paltrow & Flavin, *supra* note 4, at 317-18.

66. See generally *In re A.C.*, 573 A.2d 1235 (D.C. 1990).

67. See Rebecca Stone, *Pregnant Women and Substance Use: Fear, Stigma, and Barriers to Care*, 3 HEALTH & JUST. 1, 3 (2015); *Coercive and Punitive Governmental Responses to Women's Conduct During Pregnancy*, AMERICAN CIVIL LIBERTIES UNION (ACLU), <https://www.aclu.org/other/coercive-and-punitive-governmental-responses-womens-conduct-during-pregnancy> (last visited, Feb. 3, 2020); Phillip H. Jos, Mary Faith Marshall and Martin Perlmutter, *The Charleston Policy on Cocaine Use During Pregnancy: A Cautionary Tale*, 23 J.L. MED. & ETHICS 120, 125 (1995).

68. Paltrow & Flavin, *supra* note 4, at 332.

III. FETAL PERSONHOOD

Some types of laws—including fetal homicide laws, laws regarding chemical endangerment of the fetus, and recent state abortion bans—have been interpreted as recognizing the legal personhood of the fetus, and hence have been (or, if they withstand legal challenge, will be) used to rationalize coercion in pregnancy.⁶⁹ How would legal recognition of fetal personhood affect the legal and moral analyses outlined above regarding coercive interventions in pregnancy?

None of the overlapping legal and ethical arguments against coercive medical interventions would be undermined by a legal recognition of fetal personhood. The arguments concerning the woman's self-determination and bodily integrity rely centrally on the rejection, as expressed in *McFall v. Shimp*, of the permissibility of forcing one person to submit to unwanted procedures for the benefit of another.⁷⁰ Since both *McFall* and *Shimp* were adults, neither party's personhood was open to question in that case. Extending personhood to the fetus does nothing to affect the applicability of this reasoning to pregnancy. Similarly, women's due process rights must be respected regardless of the moral status of the fetus. The argument regarding the consequences of imposing coercive medical interventions becomes even *more* pressing if the fetus is recognized as a person because persons have stronger moral claims on others than nonpersons do. Concerns that the prospect of being subjected to coercive interventions may undermine obstetric care indicate that the best way to safeguard fetuses is to forgo the use of coercion. Moreover, the use of coercion is premised on the misguided (and unethical) assumption of a maternal-fetal conflict. As Oberman notes, "these are not maternal-fetal conflicts at all, but rather maternal-doctor conflicts."⁷¹ In reality, fetal well-being is almost always consonant with the interests of the pregnant woman.⁷² ACOG addresses disagreements between the pregnant patient and her clinician:

However, a pregnant woman and her obstetrician–gynecologist may disagree about which clinical decisions and treatments are in her best interest and that of her fetus. As with a nonpregnant patient, a pregnant woman may evaluate the risks and benefits of recommended medical

69. See Paltrow & Flavin, *supra* note 4, at 335-36; see also Lynn M. Paltrow and Lisa K. Sangoi, *The Dangerous State Laws That Are Punishing Pregnant People*, THINKPROGRESS (September 28, 2016) (last visited September 16, 2019) <https://thinkprogress.org/criminalization-pregnancy-us-43e4741bb514/>; see generally Glen A. Halva-Neubauer and Sara L. Zeigler, *Promoting Fetal Personhood: The Rhetorical and Legislative Strategies of the Pro-Life Movement after Planned Parenthood v. Casey*, 22 FEMINIST FORMATIONS 101 (2010).

70. See *McFall v. Shimp*, 10 Pa. D & C.3d 90, 91 (Allegheny County Ct. 1978).

71. Michelle Oberman, *Mothers and Doctors' Orders: Unmasking the Doctor's Fiduciary Role in Maternal-Fetal Conflicts*, 94 NW. U. L. REV. 451, 454 (2000).

72. AM. COLL. OF OBSTETRICIANS AND GYNECOLOGISTS (ACOG), COMM. OP. NO. 664, REFUSAL OF RECOMMENDED TREATMENT DURING PREGNANCY, 1, 1, 3 (2016).

treatment differently than her obstetrician–gynecologist and, therefore, may refuse recommended therapies or treatments. Such refusals are based not only on clinical considerations but also on the patient’s roles and relationships; they reflect her assessment of multiple converging interests: her own, those of her developing fetus, and those of her family or community.⁷³

The notion that clinicians or judges are better positioned to make such assessments is shamefully arrogant. Yet, in our culture, women’s interests are subordinated to concerns about fetal well-being and women’s judgments about fetal well-being are subordinated to those of clinicians, judges, and legislators.

What about other forms of coercion? Consider, for example arrests and detentions of women who use illicit drugs during pregnancy. How would women’s rights to self-determination balance against fetuses’ purported personhood rights in such cases? Arrests and detentions involve dramatic limitations of a person’s rights and liberties. The harm principle dictates that limitations on liberty may be justifiable if the exercise of liberty causes harm to others. So, there may be a place for balancing rights and interests if we were to recognize fetal personhood. However, Paltrow and Flavin found, in many cases, allegations against women lacked evidence of risk of harm, or evidence of causal connection between the woman’s actions and risk of fetal harm.⁷⁴ The harm principle simply does not justify coercive intervention in such cases. Moreover, the reliability and validity of the evidence base regarding perinatal exposure to drugs is evolving, arguably hampered in the past at least in part by the exclusion of pregnant women from federally funded human subjects research. The overriding problem - which speaks directly to the hypocrisy of punitive and coercive interventions based largely on clinical and judicial assumptions - is clearly acknowledged in the recent National Institutes of Health multi-institute funded Healthy Brain and Child Development Study, which acknowledges that “[t]he effects of early exposure to opioids on infant and child development are unknown.”⁷⁵ The study cohort includes pregnant women, and over a ten year period will gather “data on pregnancy and fetal development; infant and early childhood structural and functional brain imaging; anthropometrics; medical history; family history; biospecimens; and social, emotional and cognitive development.”⁷⁶

Moreover, incursions against women’s due process rights, such as warrantless drug testing of pregnant women⁷⁷ and prosecuting them without

73. *Id.*

74. Paltrow & Flavin, *supra* note 4, at 318.

75. *HEALTHY Brain and Child Development Study*, NAT’L INST. OF HEALTH, <https://heal.nih.gov/research/infants-and-children/healthy-brain> (last updated Nov. 26, 2019).

76. *Id.*

77. *Ferguson v. City of Charleston*, 532 U.S. 67, 69-70 (2001).

appropriate proof of harm resulting from their actions,⁷⁸ cannot be tolerated. Considerations of the fetus' moral status do nothing to undermine the woman's due process rights. And given the evidence that such arrests and detentions deter women from seeking prenatal care and treatment for substance use disorder, it should again be recognized that zealous pursuit of punishment of women may be counterproductive in terms of fetal protection.

Rather than punishment per se, authorities sometimes impose forced treatment for substance use disorder.⁷⁹ However, there is research that challenges the justification of such forced treatment:

Experts have noted that little evidence exists to support compulsory treatment modalities, and that the onus is therefore on advocates of such approaches to provide scientific evidence that compulsory treatment is effective, safe, and ethical. The results of the present systematic review, which fails to find sufficient evidence that compulsory drug treatment approaches are effective, appears to further confirm these statements ... Governments should therefore seek alternative, evidence-based policies to address drug dependence.⁸⁰

In addition to concerns about effectiveness, the case of Alicia Beltran illustrates the harms that can accompany forced treatment for pregnant women.⁸¹ Ms. Beltran volunteered information about her past struggle with addiction to Percocet during her first prenatal visit and told her clinician that she had already stopped using the drug.⁸² When she was advised to take Suboxone to treat her addiction, she declined. She was arrested and taken to a hospital for a clinical exam, which showed her fetus to be healthy and her pregnancy progressing normally. Despite that determination, she was then led in shackles to a hearing in family court. Her fetus had legal representation at the hearing, but Ms. Beltran did not, despite her request for an attorney.⁸³ She was sent to mandated treatment,

78. Paltrow & Flavin, *supra* note 4, at 218.

79. *Substance Use During Pregnancy*, GUTTMACHER INST. (Sept. 1, 2019), <https://www.guttmacher.org/state-policy/explore/substance-use-during-pregnancy>.

80. Dan Werb et al., *The Effectiveness of Compulsory Drug Treatment: A Systematic Review*, 28 INT'L J. DRUG POL'Y 1, 1 (2016).

81. See Daniella Silva, *Shackled and Pregnant: Wis. Case Challenges 'Fetal Protection' Law*, NBC NEWS (Oct. 24, 2013, 12:32 PM), <https://www.nbcnews.com/news/us-news/shackled-pregnant-wis-case-challenges-fetal-protection-law-flna8C11457748>; see also Erik Eckholm, *Case Explores Rights of Fetus Verses Mother*, THE NEW YORK TIMES (Oct. 23, 2020) <https://www.nytimes.com/2013/10/24/us/case-explores-rights-of-fetus-versus-mother.html>; NAT'L ADVOCS. FOR PREGNANT WOMEN, *The Case of Alicia Beltran*, (Oct. 4, 2019) <https://www.nationaladvocatesforpregnantwomen.org/napw-the-case-of-alicia-beltran/>.

82. Silva, *supra* note 81; Eckholm, *supra* note 81; NAT'L ADVOCS. FOR PREGNANT WOMEN, *supra* note 81.

83. Silva, *supra* note 81; Eckholm, *supra* note 81; NAT'L ADVOCS. FOR PREGNANT WOMEN, *supra* note 81.

where she was detained for more than 70 days before finally being released.⁸⁴ She lost her job as a result of her long absence from it.⁸⁵ The case provides a clear example of violation of due process rights. In addition, Ms. Beltran was deprived of her liberty without clear and compelling justification of harm to her fetus, or benefit to her fetus from the forced treatment. On the contrary, Ms. Beltran's resulting unemployment created greater vulnerability for herself and her fetus.

Referrals to voluntary treatment are more appropriate. However, here unjust patterns of racial disparities pervade practice. Even in programs of universal drug screening in pregnancy, white women are more likely to receive referral to treatment, while black women are more likely to be reported to Child Protective Services.⁸⁶

Of course, these ethical considerations against the use of coercive interventions do not necessarily prevent such interventions, as data show that providers and legal authorities are willing to pursue them even when legal precedent, a paucity of evidence, and ethical guidance makes it clear they should not. Fetal personhood laws could further embolden providers to take matters into their own hands. But the legal status of the fetus would not undermine the moral and legal status of the woman: she maintains her personhood even when pregnant. Moreover, coercion tends to be counterproductive with respect to fetal outcomes. Thus, the widespread assumption that legal designation of the fetus as a person would justify broad imposition of coercive interventions against pregnant women is simply unfounded.

IV. BRINGING JUSTICE TO BEAR

While it is rarely noted in legal and ethical analyses of coercion in pregnancy, we must also consider concerns of social justice.⁸⁷ Substantial socioeconomic and racial disparities exist in pregnancy outcomes even after controlling for variables such as access to prenatal care and other health behaviors. Research indicates that these disparities are linked to social

84. See Eckholm, *supra* note 81; see also NAT'L ADVOCES. FOR PREGNANT WOMEN, *The Case of Alicia Beltran* (Oct. 4, 2019), <https://www.nationaladvocatesforpregnantwomen.org/napw-the-case-of-alicia-beltran/>.

85. Silva, *supra* note 81; Eckholm, *supra* note 81; NAT'L ADVOCES. FOR PREGNANT WOMEN, *supra* note 81.

86. Darla Bishop et al., *Pregnant Women and Substance Use: Overview of Research & Policy in the United States*, JACOBS INST. WOMEN'S HEALTH 8, 54 (Feb. 2017), https://publichealth.gwu.edu/sites/default/files/downloads/JIWH/Pregnant_Women_and_Substance_Use_updated.pdf.

87. Debra A. DeBruin & Mary Faith Marshall, *Policing Women to Protect Fetuses: Coercive Interventions During Pregnancy*, ANALYZING VIOLENCE AGAINST WOMEN 95, 102 (Wanda Teays, ed., Springer 2019).

determinants of health.⁸⁸ In addition to the social injustice inherent in such health disparities, they pose two additional justice concerns in the context of coercive interventions, which are disproportionately imposed against poor women and women of color.⁸⁹ First, as noted above, women are often held accountable for poor pregnancy outcomes even when no evidence ties those outcomes to abusive or neglectful behavior on the part of the woman.⁹⁰ Thus, disparities in pregnancy outcomes pose a double whammy for disadvantaged women. Not only are outcomes likely to be poorer for these women than for more privileged women, but those outcomes may expose the women to coercive interventions. Second, there is a hypocrisy inherent in using coercion to enforce norms regarding individual behaviors while turning a blind eye to the social determinants of health. Our society does little to address health concerns such as environmental exposures, but we prosecute women for substance use⁹¹ and suicide attempts⁹² during pregnancy while failing to address systemic barriers to access for mental health and substance use disorder treatment.⁹³ It is troubling that social action to protect fetuses has not “had much ‘application outside of the context where

88. Phillip Blumeshine et. al., *Socioeconomic Disparities in Adverse Birth Outcomes: A Systematic Review*, 39 AM. J. PREVENTATIVE MED. 263, 270 (2010); Paula Braveman, *What is Health Equity: And How Does a Life-Course Approach Take Us Further Toward It?*, 18 MATERNAL & CHILD HEALTH J. 366, 367 (2014); Paula A. Braveman, et al., *The Role of Socioeconomic Factors in Black-White Disparities in Preterm Birth*, 105 AM. J. PUB. HEALTH 694, 694 (2015); Paula Braveman et al., *Worry About Racial Discrimination: A Missing Piece of the Puzzle of Black-White Disparities in Preterm Birth?*, 12 PLOS ONE 1, 2 (2017); Simone C. Gray et al., *Assessing the Impact of Race, Social Factors and Air Pollution on Birth Outcomes: A Population-Based Study*, 13 ENVT'L HEALTH 1, 1, 2, 7 (2014).

89. See Kolder et al., *supra* note 15, at 1197; see also Paltrow & Flavin, *supra* note 4, at 300-01, 311-12.

90. Paltrow & Flavin, *supra* note 4, at 317-18.

91. See generally Paltrow & Flavin, *supra*, note 4; see also *Substance Abuse During Pregnancy*, GUTTMACHER INST. (Sept. 1, 2019), <https://www.guttmacher.org/print/state-policy/explore/substance-use-during-pregnancy>; Phillip H. Jos, Mary Faith Marshall and Martin Perlmutter, *The Charleston Policy on Cocaine Use During Pregnancy: A Cautionary Tale*, 23 J.L. MED. & ETHICS 120, 122, 127 (1995).

92. *Shuai v. State*, 966 N.E.2d 619, 622-23 (Ind. App. Ct. 2012); Paltrow & Flavin, *supra* note 4, at 314; Jason Foster, *Woman Faces Charge of Killing Unborn Child After Suicide Attempt*, THE HERALD (Feb. 21, 2009 12:54 AM), <https://www.heraldonline.com/news/local/article12250463.html>.

93. See e.g. *2017 State of Mental Health in America – Access to Care Data*, MENTAL HEALTH AMERICA (2020), <https://www.mhanational.org/issues/2017-state-mental-health-america-access-care-data>; see generally Samuel R. Bondurant, Jason M. Lindo & Isaac D. Swensen, *Access to Substance Abuse Treatment, Drug Overdose Deaths, and Crime*, ECONOFACT (Mar. 16, 2018), <https://econofact.org/access-to-substance-abuse-treatment-drug-overdose-deaths-and-crime>; Darla Bishop et al., *Pregnant Women and Substance Use: Overview of Research & Policy in the United States*, JACOBS INST. WOMEN'S HEALTH 8, 28 (Feb. 2017), https://publichealth.gwu.edu/sites/default/files/downloads/JIWH/Pregnant_Women_and_Substance_Use_updated.pdf; Anna Gorman, *Barriers Remain Despite Health Law's Push to Expand Access to Substance Abuse Treatment*, KAISER HEALTH NEWS (Apr. 10, 2014), <https://khn.org/news/substance-abuse-treatment-access-health-law/>.

women are punished.’ ... ‘We don’t see any mass class action coming out of Flint.’”⁹⁴

V. CONCLUSION

We have shown that ethical considerations mirror - indeed inform - legal analyses of coercive interventions, and that these ethical considerations offer clarity in the absence of legal precedent with other uses of coercion in pregnancy. We have explored the potential legal and ethical significance of fetal personhood laws in this context and argued that ethical considerations of social justice must supplement legal and ethical approaches to coercion during pregnancy that focus on individual rights and duties of beneficence. We believe that bioethics has a fundamental and ongoing role to play at the bedside, within professional associations, in the education of clinicians and jurists, in joining and authoring amicus briefs in legal cases, and in fostering a national conversation about the harms to women, to their children, to public health, and to the integrity of professional obstetricians and jurists imposed by coercive interventions in pregnancy.

94. Jacob Rosenberg, *The Marsha Jones Case is Just the Latest Battle Over Fetal Personhood*, MOTHER JONES (July 3, 2019) (quoting Michelle Goodwin, law professor at the University of California Irvine), <https://www.motherjones.com/politics/2019/07/the-marshae-jones-case-is-just-the-latest-battle-over-fetal-personhood/>.