VIRGINIA: IN THE CIRCUIT COURT FOR THE COUNTY OF TAZEWELL

COMMONWEALTH OF VIRGINIA,

Plaintiff,

v. CASE NO. CR12-1503-00; 1503-01; 1504-00

KAREN ANN ELDER,

Defendant.

AMICUS CURIAE BRIEF OF MEDICAL, PUBLIC HEALTH, ADDICTION TREATMENT, AND BIOETHICS EXPERTS AND ORGANIZATIONS IN SUPPORT OF KAREN ELDER'S MOTION TO DISMISS

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INTEREST OF *AMICI CURIAE*

Amici include experts in maternal, fetal, and child health, addiction treatment, bioethics, and public health, and are committed to improving the health of pregnant and parenting women and their children. *Amici* seek to bring to this Court's attention the ways in which arresting, prosecuting, and incarcerating women for suffering perinatal loss will undermine public health, lead to absurd results not intended by the Commonwealth, and violate numerous fundamental constitutional rights in the service of no compelling, important, or even rational purpose.

This case involves the claim that Ms. Elder experienced a pregnancy loss because of the combined toxic effects of certain medications. At the outset, *amici* do not assert that there are no health risks associated with drugs taken by pregnant women, whether or not they are prescribed, unprescribed, or over-the-counter. Nor do *amici* endorse the non-medicinal use of drugs during pregnancy, including alcohol or tobacco. Nevertheless, there is a clear consensus among medical and public health professionals that punishing women for the circumstances or outcomes of their pregnancies undermines maternal, fetal, and child health, and would generate negative health consequences for women and children in the Commonwealth. Statements of interest of *amici* are set out in Appendix A.

STATEMENT OF THE CASE

Karen Elder is a 48 year-old woman who was taking prescribed, unprescribed, and over-the-counter medication throughout the course of her pregnancy to manage chronic pain, anxiety, depression, and discomfort caused by ovarian cysts.[1] On September 6, 2011, at 37 weeks

[1] Clinch Valley Medical Center, Neonatal Delivery Record - 9-6-2011; CVMC, Stat Broadcast Report, Urine toxicology - 9-6-2011; CVMC, Home Medication Discharge Orders - 9-7-2011; Bluefield Women's Center, P.C., Karen Elder, Chart #12825 - 7-13-2011; Family Healthcare, Shelley R. Miller, FNP, Progress Notes - 12-27-2010, 1-21-2011, 2-18-2011, 3-18-2011, 4-15-

pregnant, she went to the Emergency Room at Clinch Valley Medical Center after going into labor.[2] According to the medical examiner's report of investigation, the child, Kenna Adkins, was stillborn, but had been resuscitated with a very faint pulse and no discernable blood pressure until hospital staff pronounced the time of death 30 minutes later.[3] The same report cites the cause of death as a "germinal matrix hemorrhage of the brain and combined toxic effects of phentermine, acetaminophen, diphenhydramine, tramadol, and hydrocodone," nearly all of which were either prescribed to Ms. Elder or over-the-counter.[4] While it is unclear from the available records whether Ms. Elder was actively struggling with addiction or had resorted to self-help to manage her physical pain, depression, and anxiety, it is clear that she was coping with several serious health issues, and was also a victim of intimate partner violence.[5]

After suffering the trauma of a perinatal loss, Ms. Elder was investigated by the Richlands Police Department.[6] On September 11, 2012, a Grand Jury indicted Ms. Elder for involuntary manslaughter and child endangerment.[7] Ms. Elder was incarcerated for approximately seven months following the indictment and, although released briefly on conditions of pre-trial services, she remains incarcerated.

2011, 5-12-2011, 6-9-2011, 7-8-2011, 8-5-2011, 9-2-2011; CVMC, Karen Ann Elder Consultation - 9-7-2011.

[2] CVMC, Emergency Room; Southwest Virginia Network PCI, Patient Notes, Karen Elder - 9-6-2011; CVMC, Consultation, Karen Elder - 9-7-2011.

[3] Department of Health, Office of the Chief Medical Examiner, Western District, Report of Investigation, p. 2.

[4] *Id.* at p. 2. Acetaminophen and diphenhydramine are both commonly used over-the-counter medications. Ms. Elder's medical records also confirm that she was taking lawfully prescribed lorcet, klonopin, neurontin, and ultram (tramadol) throughout her pregnancy.

[5] CVMC, Karen Elder, Patient Notes 9-6-2011, p. 2; CVMC, Karen Elder, Consultation - 9-7-2011, p. 1 of 4; Family Healthcare, Shelley R. Miller, FNP, Progress Notes - 12-27-2010, 1-21-2011, 2-18-2011, 3-18-2011, 4-15-2011, 5-12-2011, 6-9-2011, 7-8-2011, 8-5-2011, 9-2-2011; Bluefield Women's Center, P.C., Karen Elder - 4-7-2011, 7-13-2011.

[6] CVMC, Karen Elder - 9-7-2011; time 0030, Patient Notes, p. 3.

[7] Grand Jury Indictment, In the Circuit Court of Tazewell County, Virginia, Karen Ann Elder, Grand Jury Date - 9-11-2012.

SUMMARY OF ARGUMENT

In this case, the prosecution seeks to contort Commonwealth law to permit the criminal punishment of a woman who became pregnant, carried that pregnancy to term, but was unable to ensure a healthy birth outcome.[8] Even under the best circumstances—when a woman becomes pregnant, has access to, and can afford the highest quality medical care, lives in a safe and healthy environment, and has no underlying health problems, no history of trauma, and no other significant life stresses—there still is no guarantee that her pregnancy will continue to term or result in the birth of a healthy baby. This is not the fault of individual women. This is the nature of pregnancy. Nevertheless, the Commonwealth seeks to radically transform the legal and medical understanding of pregnancy by making birth outcomes and perinatal loss the subject of the Commonwealth's criminal laws.

The Commonwealth asks this Court to expand the scope of two such laws. The prosecution alleges that Ms. Elder gave birth to a child whom she unintentionally killed "as the proximate result of negligence so gross, wanton, and culpable as to show a reckless disregard for human life." Indictment, Count I; *see also* Va. Code § 18.2-36. It also alleges that Ms. Elder, by willful act or omission, "cause[d] or permit[ted] serious injury to the life" of her child. Indictment, Count II; *see also* Va. Code § 18.2-371.1(A). The judicial expansion of these laws, however, has significant and dangerous consequences for public health, including deterring pregnant women from getting the health care they need, and discouraging those who do seek care from speaking honestly about drug use with their health care providers. Moreover, the penalties

[8] This is not the first time a Commonwealth prosecutor has attempted to expand the Commonwealth's laws to apply to pregnancies and pregnancy outcomes. In *Commonwealth v. Smith*, No. CR91-05-4381 (Franklin Cty. Cir. Ct. September 23, 1991), the Franklin County Circuit Court dismissed with prejudice the indictment for felony child neglect. The Order of Dismissal states that the statute "was not intended by the Virginia General Assembly to extend to fetuses or apply to prenatal conduct by a pregnant woman." *See* Appendix B.

imposed—arrest, imprisonment, and family separation—undermine the health and wellbeing of pregnant women, mothers, and their families.

In recognition of these consequences, every major public health and professional medical organization in the United States opposes the criminal prosecutions of women who become pregnant and whose actions or inactions are believed to have harmed or risked harm to the fertilized eggs, embryos, or fetuses they carry. *Amici* address these consequences in detail below, and emphasize that the health issues addressed in this brief are not mere policy arguments or matters properly left to the legislature. When the Commonwealth seeks to establish a new, unprecedented, and legislatively unintended interpretation of a criminal law that will lead to absurd and dangerous consequences—as it will here—it is the independent duty of the courts to consider those consequences. If the legislature actually intended its involuntary manslaughter and child endangerment laws to permit prosecutions of women who suffer pregnancy losses, then this Court must consider whether the law is constitutional. In cases where state actions impinge on fundamental rights—as this prosecution does—courts must determine whether and what recognized state interests justify that infringement. And, if the rights at stake are fundamental, the courts must determine whether the means chosen to advance those interests—in this case, criminal investigation, arrest, prosecution, and incarceration—actually do so.

Because the laws as expanded by the Commonwealth would lead to dangerous results, and because the state action in this case does not meet even minimal standards of rationality, *amici* urge this Court to dismiss the involuntary manslaughter and child endangerment charges against Ms. Elder.

ARGUMENT

As Ms. Elder's Motion to Dismiss explains, the involuntary manslaughter and child endangerment laws, on their face, do not apply.[9] *See Hubbard v. Henrico Ltd. Partnership*, 497 S.E.2d 335, 339 (Va. 1998) (explaining that when a statute is "clear and unambiguous . . . a court may look only to the words of the statute to determine its meaning."). Even if ambiguous, however, courts must conclude that the legislature did not intend and would not want an interpretation of the law that leads to absurd results. *See, e.g., Virginia Elec. & Power Co. v. Citizens for Safe Power*, 284 S.E.2d 613, 615 (Va. 1981) (courts "presume that the General Assembly does not intend the application of a statute to lead to irrational consequences"); *Paugh v. Henrico Area Mental Health & Developmental Services*, 743 S.E.2d 277, 283 (Va. 2013) ("[A] statute should, if possible, be given a reasonable construction which will effect rather than defeat a legislative purpose.") (quoting *Ambrogi v. Koontz,* 297 S.E.2d 660, 664 (Va. 1982)).

Although this Court need not reach constitutional issues at all in order to dismiss this prosecution, the Commonwealth may not abridge fundamental constitutional rights without compelling justification, narrowly tailored to advance the asserted interests. Prosecuting women for involuntary manslaughter and criminal child abuse for experiencing perinatal loss violates women's constitutional rights to procedural due process and procreative privacy.[10] When the application of a law threatens constitutional rights, courts are called upon to evaluate the state interests involved. *See, e.g., Youngberg v. Romeo*, 457 U.S. 307, 320–21 (1982), *citing Poe v. Ullman*, 367 U.S. 497, 542 (1961) (Harlan, J., dissenting) ("In determining whether a substantive right protected by the Due Process Clause has been violated, it is necessary to balance "the

[9] These arguments are explained in detail in Ms. Elder's Motion to Dismiss. *Amici* support these arguments and do not repeat them here.

[10] These arguments are also raised in Ms. Elder's Motion to Dismiss. *Amici* support these arguments and do not repeat them here.

liberty of the individual" and "the demands of an organized society"); *Delaware v. Prouse*, 440 U.S. 648, 654 (1979) ("T]he permissibility of a particular law enforcement practice is judged by balancing its intrusion on the individual's Fourth Amendment interests against its promotion of legitimate governmental interests"); *Connick v. Myers*, 461 U.S. 138, 142 (1983) (Our task . . . is to seek "a balance between the interests of the [employee], as a citizen, in commenting upon matters of public concern and the interest of the State, as an employer, in promoting the efficiency of the public services it performs through its employees.") (internal citation omitted). Depending on what right is at stake and the level of scrutiny accorded its imposition, courts must also consider whether and how the law's application serves that interest. *See, e.g., McCabe v. Commonwealth*, 650 S.E.2d 508, 510–11 (Va. 2007) (government interference with a "fundamental right or liberty interest survives constitutional scrutiny only if it is narrowly tailored to serve a compelling state interest.") (citing *Washington v. Glucksberg*, 521 U.S. 702 (1997)).

Permitting prosecutions of women for the circumstances or outcomes of their pregnancies would lead to absurd and dangerous results, and would violate fundamental constitutional rights in service of no state interest. Public health is undermined; maternal, fetal, and child health is threatened; and the consequences to individual women and their families have far-reaching effects that ultimately harm the health and welfare of their communities.

I. Major Medical and Public Health Associations in the United States Oppose Prosecuting Pregnant Women for the Circumstances or Outcomes of Their Pregnancies.

For more than two decades, every major U.S. public health and medical organization to address this issue has taken an unequivocal stance against criminal responses to a woman's pregnancy and the actions, inactions, or circumstances that may (or may not) affect her

pregnancy outcome. These organizations developed specific responses in the wake of proposed punitive state actions to address a perceived problem of drug use during pregnancy, and in light of cases where pregnant women were ordered to undergo unconsented medical interventions—including a high profile case in which neither the mother nor the newborn survived the forced cesarian surgery.[11] In June 1990, the American Medical Association ("AMA") issued a report, "Legal Interventions During Pregnancy,"[12] in which it assessed the considerations involved in state action against pregnant women. For a number of reasons, the AMA rejected any role for criminal sanctions or civil liability.[13] Similarly, in a series of statements, the American College of Obstetricians and Gynecologists ("ACOG") rejected criminal prosecutions of pregnant women. In its analysis, "Maternal Decision Making, Ethics, and the Law," the ACOG Committee on Ethics concluded, "pregnant women should not be punished for adverse perinatal outcomes."[14]

Other health care associations share these concerns. The American Academy of Pediatrics warns that "punitive measures taken toward pregnant women, such as criminal prosecution and incarceration, have no proven benefits for infant health."[15] Likewise, the American Public Health Association stresses that drug use during pregnancy is a public health concern, and recommends that "no punitive measures should be taken against pregnant women"

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[11] Helen Cole, for the American Medical Association Board of Trustees, *Legal Interventions During Pregnancy*, 264 JAMA 2663, 2664 (1990) (hereinafter "AMA").
[12] *Id.*
[13] *Id*. at 2670.
[14] American College of Obstetricians and Gynecologists, Committee on Ethics, *Maternal Decision Making, Ethics, and the Law*, 106 OBSTETRICS & GYNECOLOGY 1127, 1135 (2005) (hereinafter "ACOG").
[15] American Academy of Pediatrics, Committee on Substance Abuse, *Drug Exposed Infants*, 86 PEDIATRICS 639, 641 (1990).

for illicit drug use.[16] The American Nurses Association notes that "[t]he threat of criminal prosecution is counterproductive in that it prevents many women from seeking prenatal care and treatment."[17] And according to the American Psychological Association, "no punitive action should be taken against women on the basis of behaviors that may harm a developing fetus."[18]

The Commonwealth, consistent with national and international bodies, recognizes that maternal, fetal, and child health are significant public health concerns. On the world stage, the United Nations member states adopted maternal and child health as Millennium Development Goals.[19] At the national level, the federal Office of Disease Prevention and Health Promotion of the Department of Health and Human Services notes that "[i]mproving the well-being of mothers, infants, and children is an important public health goal for the United States."[20] Heeding this call, the Virginia State Department of Health has created an office dedicated to improving the health of women, infants, children, and families.[21] As a 2011 Needs Assessment of the Commonwealth's Office of Family Health Services illustrates, the array of recommended

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[16] American Public Health Ass'n, *Illicit Drug Use by Pregnant Women*, Pol'y No. 9020 (1990).
[17] American Nurses Ass'n, *Position Statement on Opposition to Criminal A Prosecution of Women for Use of Drugs While Pregnant and Support for Treatment Services for Alcohol and Drug Dependent Women of Childbearing Age* (Apr. 5, 1991).
[18] American Psychological Ass'n, *Resolution on Substance Abuse by Pregnant Women* (Aug. 1991). *See also* American Psychiatric Ass'n, Position Statement, *Care of Pregnant and Newly Delivered Women Addicts*, APA Document Reference No. 200101 (Mar. 2001) (also opposing criminal prosecution of pregnant women for the use of substances that risk harm to fetuses, urging treatment as the appropriate response).
[19] United Nations, *We Can End Poverty: Millenium Development Goals and Beyond 2015*, Goal 4: Reduce Child Mortality, http://www.un.org/millenniumgoals/childhealth.shtml, Goal 5: Improve Maternal Health, http://www.un.org/millenniumgoals/maternal.shtml (last visited January 22, 2015).
[20] Office of Disease Prevention and Health Promotion, *Maternal, Infant, and Child Health*, HealthyPeople.gov, http://www.healthypeople.gov/2020/topics-objectives/topic/maternal-infant-and-child-health (last visited January 22, 2015).
[21] Virginia State Department of Health, Office of Family Health Services, Maternal and Child Health Division, http://www.vdh.state.va.us/ofhs/childandfamily/ (last visited Jan. 14, 2015).

public health responses to ensure maternal, fetal, and child health does not include arresting, prosecuting, and incarcerating pregnant women and mothers.[22]

Positions opposing prosecution are informed by the understanding that punishment of women in relationship to their own pregnancies does not further public health. Specifically, criminal investigation, arrest, prosecution, and imprisonment deters pregnant women from getting the health care they need, and is too often selectively applied to those who are already disproportionately targeted by the criminal justice system: poor women and women of color.[23]

II. Punishing Women for Their Pregnancy Outcomes Undermines Public Health.

Responding to a woman who suffered a perinatal loss by arresting and prosecuting her undermines public health, implicates the constitutional rights to privacy and bodily integrity, and is in service of no rationale, let alone an important or compelling one. Rather, subjecting women to investigation, arrest, and potentially years in prison based on their actions or inactions during pregnancy or the actual outcome of those pregnancies undermines numerous state interests, including important state interests in maternal, fetal, and child health, and the wellbeing of communities.

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[22] *See* Virginia Department of Health, Office of Family Health Services, *Virginia Title V 2011 Needs Assessment*, 167–169 (July 15, 2010) (stating that Virginia's priorities include: alleviating families' multiple life stressors and their serious physical and mental health consequences; using a socio-ecological approach to health that addresses social and environmental determinants of health; improving pre- and inter-conception health, including family planning; addressing mental health and social-emotional needs, including substance abuse, addiction, and violence; and more. In this lengthy document, not one stakeholder and not one recommendation indicate that punitive measures against pregnant women should be implemented to protect maternal and fetal health).

[23] AMA*, supra* note 5, at 2668; ACOG, *supra* note 8, at 1134-1135; 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*, 38 J. HEALTH POL., POL'Y & L. 299, 300–01 (2013) (documenting hundreds of arrests, prosecutions, forced cesarean sections, and other forced medical interventions directed at pregnant women during the period studied, and finding that "low-income women and women of color, especially African American women, are overrepresented among those who have been arrested or subjected to equivalent deprivations of liberty").

A. Pregnancy is a health condition with many potential outcomes and health consequences, few of which are entirely under the control of the pregnant woman.

Pregnancy is an extremely common experience for women. By age 44, approximately 85% of women in the U.S. will have been pregnant and had at least one birth.[24] Because of cultural expectations about wanted pregnancies and happy outcomes, it is not always acknowledged that pregnancy is a health condition, which brings with it many symptoms, some life altering. The risks pregnancy poses to a woman's health can be profound. A significant number of women who become pregnant experience depression;[25] others will experience gestational diabetes that, while treatable, carries risks to the fetus and the pregnant woman;[26] others may suffer from hypertension, which, if not treated early, can develop into preeclampsia, a condition dangerous to both pregnant women and fetal health.[27] In sum, pregnancy-related health conditions range from mild discomfort to life-threatening illnesses to maternal death.[28]

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[24] Centers for Disease Control & Prevention, 55 (No. RR-6) Morbidity and Mortality Weekly Report 2, *Recommendations to Improve Preconception Health and Health Care –United States: A Report of the CDCIATSDR Preconception Care Work Group and the Select Panel on Preconception Care* (Apr. 21, 2006), *available at* http://www.cdc.gov/mmwr/PDF/rr/rr5506.pdf.

[25] *See, e.g.,* David Bornstein, *Treating Depression Before It Becomes Postpartum*, NY Times (Oct. 16, 2014), http://opinionator.blogs.nytimes.com/2014/10/16/treating-depression-before-it-becomes-postpartum/?_php=true&_type=blogs&_r=0 (describing increasing attention to treating depression before and during pregnancy, and some successful programs that have reduced depression for pregnant women).

[26] *See* Eunice Kenney Shriver Nat'l Institute of Child Health and Development, *Will Gestational Diabetes Hurt My Baby?,* NIH.gov (updated Sept. 11, 2006) (explaining some of the risks of gestational diabetes to the fetus and to the short and longterm health of the pregnant woman).

[27] American Pregnancy Ass'n, *Gestational Hypertension: Pregnancy-Induced Hypertension* (last updated Jan. 2014), http://americanpregnancy.org/pregnancy-complications/pregnancy-induced-hypertension/.

[28] Amnesty International, *Deadly Delivery: The Maternal Health Crisis in the USA, One-Year Update* 3, 5-7 (2011) (women in the U.S. face a higher risk of dying in childbirth than women in 49 other countries, including all European countries).

At this moment in history, medical science cannot always determine the cause of maternal or fetal health complications during pregnancy.[29] But many life and health conditions over which women may or may not have some degree of control may impact the health of pregnant women and their pregnancy outcomes. These include poverty, lack of access to prenatal care, stress, pre-existing health conditions like diabetes or obesity, intimate partner violence, birth spacing, and more.[30] [31] As both qualitative and quantitative data from the Commonwealth's Office of Family Services confirms, especially for women in the southwestern region of the state where Ms. Elder lives, there is an "unmet need to improve preconception health for pregnant women and women of childbearing age."[32] Rather than following the Commonwealth's recommendations for meeting those needs, however, the prosecution asks this Court to address maternal health conditions with handcuffs, not medical care. Indeed, this prosecution presents the radical idea that there is a role for criminal justice authorities in evaluating the cause and consequences of anything deemed "harmful" to a pregnancy, all from the moment a pregnancy begins.

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[29] *See, e.g.,* Donald J. Dudley et al., *A New System for Determining the Causes of Stillbirth*, 116 OBSTETRICS & GYNECOLOGY 254, 258 (August 2010) (a significant proportion of stillbirths, for example, continue to evade scientific understanding of the cause or contributing factors).

[30] *See* N. Tanya Naggahawatte & Robert Goldenberg, *Poverty, Maternal Health, and Adverse Pregnancy Outcomes*, 1136 N.Y. ACAD. SCI. 80, 80-85 (2008).

[31] *Amici* note that several of the aforementioned health conditions are indeed applicable to Ms. Elder, including lacking access to prenatal care and being a victim of intimate partner violence. *See* P.A. Janssen et al., *Intimate partner violence and adverse pregnancy outcomes: a population-based study,* 188 AM. J. OF OBSTETRICS & GYNECOLOGY 1341 (May 2003) (reporting an association of intimate partner violence and perinatal death).

[32] *See* Virginia Department of Health, Office of Family Health Services, *Virginia Title V 2011 Needs Assessment*, 61 (July 15, 2010), *available at* http://www.vdh.virginia.gov/OFHS/documents/2012/policyandassesment/pdf/2011%20Virginia%20MCH%20Needs%20Assessment.pdf.

B. Perinatal loss is a common pregnancy outcome, yet its causes are not well understood.

Perinatal loss[33] is an unexpected and often shocking, yet all too common pregnancy outcome. According to the Center for Disease Control and Prevention's most recent yearly statistics on fetal and perinatal mortality in the United States, 26,972 pregnancies ended in stillbirth and 27,850 ended in early neonatal death.[34] 1,358 of those perinatal losses occurred in the Commonwealth.[35] Despite its relative frequency, perinatal loss frequently goes explained,[36] but has many common causes, including conditions that develop during pregnancy.[37] Viewed separately from stillbirth, early neonatal death in the United States is most commonly caused by preterm birth and low birth weight.[38] But even when a precipitating factor like premature birth is identified, the root causes of that condition are often not well understood.[39] Further, identifying a single cause of perinatal loss is extremely difficult, as fetal demise can be very complex, and

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[33] While there is no universally accepted definition of perinatal loss, it most commonly refers to the loss of a pregnancy through stillbirth or early neonatal death. World Health Organization, Maternal, newborn, child and adolescent health, *Maternal and perinatal health*, http://www.who.int/maternal_child_adolescent/topics/maternal/maternal_perinatal/en/ (last visited January 15, 2015). A stillbirth is the death of a fetus anytime after the 22nd week of gestation and prior to delivery. *Id.* An early neonatal death occurs within the first 7 days of life. *Id.* While it is unclear whether Ms. Elder suffered a stillbirth or early neonatal death, *amici's* analysis of the public health implications remain the same.

[34] Marian F. MacDorman et al., Centers for Disease Control and Prevention, National Vital Statistics Report, Vol. 60, No. 8, *Fetal and Perinatal Mortality, United States, 2006* (August 28, 2012), *available at* http://www.cdc.gov/nchs/data/nvsr/nvsr60/nvsr60_08.pdf.

[35] *Id.* at 16.

[36] Ruth C. Fretts, *Etiology and Prevention of Stillbirth*, 193 AM. J. OF OBSTETRICS & GYNECOLOGY 1923, 1925 (March 2005) (the majority of late stillbirths are unexplained); *see also* Melissa A. Sims & Kim A. Collins, *Fetal Death: A 10-Year Retrospective Study*, 22 AMERICAN JOURNAL OF FORENSIC MEDICINE & PATHOLOGY 261 (2005).

[37] World Health Organization, *Neonatal and Perinatal Mortality: Country, Regional & Global Estimates*, 4 (2006), *available at* http://whqlibdoc.who.int/publications/2006/9241563206_eng.pdf.

[38] *See supra* note 28.

[39] *See, e.g.,* PRETERM BIRTH: CAUSES, CONSEQUENCES, AND PREVENTION, p. 2 (Richard E. Behrman & Adrienne Stith Butler, eds., 2007) ("Preterm birth is a complex cluster of problems with a set of overlapping factors of influence.")

may result from the cumulative effect of several risk factors, none of which may be obvious.[40] Here, the bare assertion that the "combined toxic effects" of medications present in the newborn's system were the proximate cause of this tragic loss fails to account for the other conditions that could have contributed to or even caused the newborn's death.

Prosecuting pregnant women for perinatal loss—whether a stillbirth or an early neonatal death—wrongly lays at their feet the blame for this sad outcome. In fact, there are some maternal factors—particularly cigarette smoking—that are associated with stillbirth.[41] But association is not the same as causation, and a statistically notable increase in general risk tells nothing about whether, in a particular case, that risk factor actually caused, or even contributed to, perinatal mortality. Numerous other factors may increase a woman's likelihood of suffering a perinatal loss. These include genetic predisposition, environmental hazards, intimate partner violence, paternal factors, lack of access to health care, stress, and the fact that many health care providers have not adopted simple monitoring methods shown to help reduce the incidence of stillbirth.[42]

Threatening arrest, investigation, and punishment of women because of a pregnancy outcome will not reduce neonatal death or perinatal mortality; but those punitive sanctions do deter women from getting prenatal care (as noted above, a risk factor for stillbirth) and increase stress and fear (also a risk factor for negative pregnancy outcomes). While none of these responses actually improve maternal, fetal, and child health, they do ruin the lives of women and their families and undermine public health in the Commonwealth.

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[40] *See, e.g.,* Donald J. Dudley et al., *A New System for Determining the Causes of Stillbirth*, 116 OBSTETRICS & GYNECOLOGY 254, 258 (August 2010) (a significant proportion of stillbirths, for example, continue to evade scientific understanding of the cause or contributing factors).
[41] R.L. Goldenberg et al., *Stillbirth: A Review*, 16 J. OF MATERNAL-FETAL & NEONATAL MEDICINE 79, 82 (2004).
[42] *Id*. at 80-88.

III. Punitive Responses to Drug Use During Pregnancy Are Counterproductive to the Important Goal of Improving Maternal, Fetal, and Child Health.

As the position statements from public health and medical organizations in Section I of this brief make clear, punitive responses to drug use during pregnancy deters women from seeking care and speaking openly with their health providers if they do.[43] These responses also create an incentive for women to terminate wanted pregnancies rather than face arrest and prosecution upon giving birth.[44] None of these outcomes advance state interests in maternal, fetal, and child health.

In this case, the nature of Ms. Elder's drug use is unclear from the indictment and the available medical records. While it is apparent that Ms. Elder was coping with several conditions for which she was lawfully prescribed a majority of these medications, it is difficult to determine whether Ms. Elder was struggling with addiction or if the she was using certain drugs as a self-help measure to manage her pain, depression, and anxiety. Because this case raises the issue of drug use during pregnancy—an issue that has been the subject of significant alarm, misinformation, and prejudice—*amici* address some of these common myths and misunderstandings to make clear that none provide a justification for the prosecution in this case.

A. Drug use during pregnancy—whether or not the pregnant woman has a diagnosed substance use disorder—is a health issue, not a matter for criminal intervention.

Addiction, as recognized by medical and public health organizations and government agencies, is not a failure of will, but rather, has complex environmental and hereditary

[43] *See supra* notes 5–12 and accompanying text.
[44] M.L. Poland et al., *Punishing pregnant drug users: Enhancing the flight from care*, 31 DRUG ALCOHOL DEPEND 199 (1993).

dimensions.[45] As a result, it is now widely accepted that "addiction is subject to medical and behavioral management in the same fashion as hypertension and diabetes."[46]

As a matter of both law and science, addiction is characterized by compulsion and inability to abstain.[47] Therefore, refraining from drug use is not simply matter of choice, as achieving long-term abstinence can be extraordinarily difficult and often requires appropriate treatment and support.[48] It is particularly unrealistic for the Commonwealth to expect, much less require on pain of extensive imprisonment, that a pregnant woman struggling with chronic health issues, without proper treatment, should have simply stopped using drugs during her pregnancy.

However, even if Ms. Elder's drug use was not the result of drug dependence or addiction, responding to her pregnancy and use of medications by expanding the scope of the Commonwealth's criminal laws is counterproductive. People in the U.S. increasingly resort to self-help for medical information and treatment,[49] and commonly obtain drugs through sources

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[45] American College of Obstetricians & Gynecologists, Committee on Health Care for Underserved Women, *Substance Abuse Reporting and Pregnancy: The Role of the Obstetrician-Gynecologist*, Committee Opinion No. 473 (Jan. 2011) ("Addiction is a chronic, relapsing biological and behavioral disorder with genetic components."); Office of Nat'l Drug Control Policy, *2013 National Drug Control Strategy,* http://www.whitehouse.gov/ondcp/national-drug-control-strategy ("addiction is not a moral failing but rather a disease of the brain that can be prevented and treated").

[46] American College of Obstetricians & Gynecologists, Commmittee on Health Care for Underserved Women, *Substance Abuse Reporting and Pregnancy: The Role of the Obstetrician-Gynecologist*, Committee Opinion No. 473 (Jan. 2011).

[47] American Soc'y of Addiction Medicine, Definition of Addiction (Apr. 19, 2011), http://www.asam.org/for-the-public/definition-of-addiction (addiction is characterized by "inability to consistently abstain, impairment in behavioral control, craving, and diminished recognition of significant problems with one's behaviors. . . . Without treatment or engagement in recovery activities, addiction is progressive and can result in disability or premature death."); 42 U.S.C. § 201(q) (a drug-dependent person is someone who is using a controlled substance "and who is in a state of psychic or physical dependence, or both").

[48] American Soc'y of Addiction Medicine, *supra* note 41.

[49] June Forkner-Dunn, *Internet-based Patient Self-care: The Next Generation of Health Care Delivery*, 5 J. MED. INTERNET RES. e8, Intro. (2003).

other than physical pharmacies (such as through the mail and online).[50] Although much of this takes place outside the regulatory scheme governing the medical professions and pharmaceuticals,[51] the typical response to this phenomenon is not to criminalize people for their attempts to treat their own health conditions.[52] That is because regulation of the medical profession and drugs is done to protect individuals and the public from harm to their health[53]—not to punish people for seeking to address the health problems they face.

Regardless of whether Ms. Elder engaged in self-help to manage her health conditions or was struggling with a diagnosable substance use disorder, responding by prosecuting her under a proposed judicial expansion of criminal law is a dangerous and counterproductive response. Prosecution will not address the medical conditions at the heart of drug use. Nor will it promote or guarantee healthy birth outcomes and, by discouraging prenatal care, may increase the likelihood of such outcomes. Indeed, the "relationship between maternal behavior and perinatal

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[50] *See, e.g.,* Grazia Orizio et al., *Quality of Online Pharmacies and Websites Selling Prescription Drugs: A Systematic Review*, 13 J. MED. INTERNET RES. (2011) (as of 2011, exact numbers of online pharmacies and people purchasing prescription drugs online were difficult to obtain, but one survey estimated that at least 4% of Americans had made such purchases, there were between approximately 3,500 and 5,000 such pharmacy sites, and "prescription or over-the-counter drugs" was the fifth most common internet search in the U.S.).

[51] *See, e.g..,* Anupam B. Jena et al., *Prescription Medication Abuse and Illegitimate Internet-Based Pharmacies*, 155 ANNALS OF INTERNAL MEDICINE 848, 849-850 (2011).

[52] *Id*. (recommending improved federal and state regulation and oversight of financial institutions, internet pharmacy sites, and prescribers, as well as physician education, noting that "every patient is susceptible" to obtaining controlled substances through unregulated, possibly illegal online pharmacies. Notably, there is no recommendation that patients, including those who may be abusing controlled substances, be prosecuted).

[53] *See Ritholtz v. Commonwealth*, 35 S.E.2d 210, 211 (Va. 1945) (upholding regulations on optometry against a constitutional challenge, and referencing the state interests in public health as the basis for regulating the practice of medicine: "Restrictions and regulations of the sale of eyeglasses are measures directed to the prevention of harm to the public health and are within the exercise of the police power of the state, and it could not be said that restricting the advertisement of prices and the sale of spectacles and eyeglasses as merchandise was so arbitrary or unreasonable as to contravene the proper exercise of the police power of the Commonwealth.").

outcome is not fully understood, and punitive approaches threaten to dissuade pregnant women from seeking health care and ultimately undermine the health of pregnant women and their fetuses."[54]

B. Punishing pregnant women deters them from seeking health care they need.

If this prosecution is allowed to proceed, it will set a precedent that allows the Commonwealth to investigate, arrest, and prosecute all pregnant women whose actions (or inactions) are alleged to have threatened fetal health. This would not be limited to drug use, but would grant prosecutors virtually limitless power to second-guess any decision made by a pregnant woman—ranging from taking recommended, prescribed medications[55] to changing cat litter.[56] As policy statements and studies indicate, this kind of prosecution will discourage pregnant women who need health care from seeking it.[57] Instead of getting care for alcoholism,

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[54] ACOG at 1135.

[55] The majority of pregnant women experience health conditions that require medication. *See, e.g.,* Maria A. Morgan et al., *Management of Prescription and Nonprescription Drug Use During Pregnancy,* 23 J. MATERNAL-FETAL & NEONATAL MED. 813, 815–17 (2010) (finding that among surveyed obstetricians and gynecologists, "approximately a third of their pregnant patients took at least one prescription medication other than prenatal vitamins during pregnancy prior to labor"). Many of those medications present side effects in the newborn. *See, e.g.,* THE MERCK MANUAL OF DIAGNOSIS AND THERAPY*,* 1859, 1861 (R. Berkow ed., 16th ed. 1992) (detailing danger of aspirin, thyroid medication, and antihypertensive drugs).

[56] Anne Drapkin Lyerly et al., *Risk and the Pregnant Body*, 39 HASTINGS CENTER REPORT 34, 38 (Nov. 2009) (the restrictions cited in the article range from admonishing pregnant women for changing cat litter and sitting in the bathtub for more than 10 minutes, to instructing them to avoid eating an array of foods and listening to loud music, to encouraging sleeping in a specific position every night). *See also,* Arlene Eisenberg et al., WHAT TO EXPECT WHEN YOU'RE EXPECTING, 54–57 (2nd ed. 1996).

[57] American Academy of Pediatrics, *supra* note 9, at 641; ACOG, *supra* note 8, at 1134; American Psychological Association, *supra* note 12. *See also* American College of Obstetricians and Gynecologists, Committee on Health Care for Underserved Women, *Substance Abuse Reporting and Pregnancy: The Role of the Obstetrician-Gynecologist*, 117 OBSTETRICS & GYNECOLOGY 200 (2011) ("Seeking obstetric–gynecologic care should not expose a woman to criminal or civil penalties."); M.L. Poland et al., *Punishing pregnant drug users: Enhancing the flight from care*, 31 DRUG ALCOHOL DEPEND 199 (1993); Sarah C.M. Roberts & Cheri Pies, Complex Calculations: How Drug Use During Pregnancy Becomes a Barrier to Prenatal Care, 15

drug addiction, depression, or other important health needs, pregnant women may try to avoid detection by physicians or other health care providers. *See, e.g., Ferguson v. City of Charleston*, 532 U.S. 67, n14 (2001), *citing Whalen v. Roe*, 429 U.S. 589, 599-600 (1977) (recognizing that being reported to the police in the context of prenatal care "may have adverse consequences because it may deter patients from receiving needed medical care"). As a result, physicians, nurses, psychologists and others are less able to provide the kinds of treatment that could address the woman's medical condition and help avert fetal harm.

If this prosecution proceeds, the Commonwealth will, counter to its own goals, have increased the likelihood that pregnant women who are struggling with mental health problems, drug addiction, or any number of other health conditions, will be reluctant to go to a hospital, clinic, or physician's office for fear that they will be reported to law enforcement officials.[58] As a result, measures that could protect their health and their pregnancies will not be implemented, and the opportunity to prevent harm will be lost.

C. Punishing women in relation to their own health conditions during pregnancy separates families and harms children.

Judicially expanding the Commonwealth's criminal laws to permit prosecutions of women for the outcomes of their pregnancies not only increases the risk that women will avoid

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J. MATERNAL & CHILD HEALTH 333 (2010); Sarah C.M. Roberts & Amani Nuru-Jeter, Women's Perspectives on Screening For Alcohol and Drug Use in Prenatal Care, 20 WOMEN'S HEALTH ISSUES 193 (2010).

[58] *See, e.g.,* Martha A. Jessup, *Extrinsic Barriers to Substance Abuse Treatment Among Pregnant Drug Dependent Women*, 33 J. DRUG ISSUES 285 (2003) (finding that women identified fear of punitive actions from helping institutions and individuals as a major barrier to prenatal care); Sarah Roberts, "*You Have to Stop Using Before You Go to the Doctor": Barriers to Prenatal Care for Women Who Use Drugs During Pregnancy*, Presentation at Am. Public Health Ass'n Annual Meeting (Nov. 6, 2007), *available at* http://apha.confex.com/apha/135am/techprogram/paper_149351.htm ("For women who want a healthy baby and want to reduce or stop their drug use, fear of being reported to CPS is an additional barrier to care."); *see also* S. J. Ondersma et al., *Prenatal Drug Exposure and Social Policy: The Search for an Appropriate Response*, 5 CHILD MALTREATMENT 93 (2000).

prenatal care, but also increases the risk to their health and their children's wellbeing when punitive sanctions are employed. Punishing women for adverse pregnancy outcomes means that mothers end up in jail. For incarcerated people throughout the United States, jail and prison often means that the jailed person will lose, or never receive, necessary health care, putting their health and their lives at risk.[59]

And the negative consequences to children of having an incarcerated parent are increasingly understood. Those consequences include the struggles with education, housing, and basic needs that flow from family disruption,[60] as well as the increased likelihood of foster care and long-term state involvement.[61] But these children are also at risk of harm to their health, including mental health, from both the separation from their parent and the stigma that attaches to the children themselves from having a parent in jail.[62] Even after incarceration, the stigma of conviction lingers in a host of legal and social consequences to the person who has been convicted, making it difficult to get public benefits such as housing and food stamps, to find employment, to pay off court-imposed fines and other sanctions, and to participate in full

[59] *See, e.g., Estelle v. Gamble*, 429 U.S. 97 (1976) (establishing that prisons have an Eighth Amendment obligation to meet incarcerated people's serious medical needs); *see generally* Margo Schlanger, *Inmate Litigation*, 116 HARV. L. REV. 1555 (2003).
[60] *See* Nancy G. Levigne et al., *Broken Bonds: Understanding and Addressing the Needs of Children of Incarcerated Parents*, Urban Institute (2008) (hereinafter "*Broken Bonds"*); Erik Eckholm, *In Prisoners' Wake, A Tide of Troubled Kids*, NY Times (2009).
[61] *Broken Bonds, supra* note 54, at 4–5.
[62] *Id.* at 7–9; *see also* Kristin Turney, *Stress Proliferation across Generations? Examining the Relationship between Parental Incarceration and Childhood Health*, 55 J. HEALTH & SOCIAL BEHAVIOR 302 (2014) (concluding that children's health disadvantages are an overlooked and unintended consequence of mass incarceration with serious implications for population-level racial, ethnic, and social class inequalities in children's health).

citizenship.[63] Not just the formerly imprisoned person, but also their children feel the economic and social impact of this ongoing stigma.

In short, a criminal justice response does nothing to improve birth outcomes, and in fact worsens public health and family and child wellbeing. Moreover, punishing women in relation to their own health conditions during pregnancy violates women's constitutional rights to procedural due process and procreative privacy. In no case—and certainly not in Ms. Elder's case—does arresting, prosecuting, and incarcerating a woman for suffering a perinatal loss further any state interest.

CONCLUSION

Neither Commonwealth law nor the Constitution authorizes this prosecution, and allowing it to proceed will not serve any state interest. Prosecuting women for perinatal loss not only diverts resources from identifying and attacking the true causes of stillbirth and early newborn deaths, but also undermines important public health interests in maternal, fetal, and child health. Moreover, arresting, jailing, and pursuing criminal charges against women who have already experienced profound trauma and grief is cruel and inhumane. It sends a public message that woman are to blame for perinatal loss, when in fact its causes are often unknown and are difficult to link with maternal or paternal actions, inactions, or circumstances that may (or may not) affect pregnancy outcomes. Charging Ms. Elder with involuntary manslaughter and child endangerment for suffering a perinatal loss is wholly unsupportable as a matter of constitutional law, because it does not serve—and in fact runs counter to—any state interest.

[63] *See, e.g.,* MARC MAUER & MEDA CHESNEY-LIND, EDS., INVISIBLE PUNISHMENT: THE COLLATERAL CONSEQUENCES OF MASS IMPRISONMENT (2002).

Accordingly, *amici* respectfully request that this court dismiss the involuntary manslaughter and child endangerment charges against Ms. Elder.

Date: January 29, 2015

Respectfully submitted,

\s\
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CERTIFICATE

In accordance with Rule 5a:19(f) of the Rules of the Supreme Court of Virginia, the undersigned hereby certify that on January 29th, 2015, seven copies of the *Amicus Curiae* Brief in Support of Defendant Karen Ann Elder have been filed with the Clerk of the Circuit Court of Tazewell County. One copy of the *Amicus Curiae* Brief has been mailed to counsel for Defendant, Penny E. Nimmo, Esquire (VSB# 37634), Broadwell, Gillespie & Nimmo, P.C., PO Box 784, Cedar Bluff, VA 24609, and to counsel for the Tazewell County Commonwealth, Dennis H. Lee, Esquire, Tazewell County Commonwealth Attorney's Office, PO Box 946, Tazewell, VA 24651.

In accordance with Rule 5A:4(d), I further certify that the amicus curiae brief in support of defendant Karen Ann Elder complies with the word count requirement of Rule 5A:19(a). Excluding those parts specifically exempted from that rule, this amicus brief contains 6,860 words.

\s\
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APPENDIX A

Organizations

National Advocates for Pregnant Women ("NAPW") is a non-profit reproductive justice organization that advocates for the human and civil rights, health, and welfare of all women, focusing particularly on pregnant and parenting women, and those who are most vulnerable to state control and punishment. Through litigation, representation of leading medical and public health organizations and experts as amicus, and through organizing and public education, NAPW works to ensure that women do not lose their constitutional, civil, and human rights as a result of pregnancy. The organization also conducts research, and has published a peer-reviewed study on prosecutions of and forced medical interventions on pregnant women. NAPW believes that health and welfare problems experienced by women during pregnancy should be addressed as health issues, not as crime, and promotes policies that actually protect maternal, fetal, and child health.

Abortion Care Network ("ACN") is the leading national organization working to de-stigmatize and normalize the experiences of women who undergo an abortion. ACN offers support and training to the abortion care community, especially to counselors, advocates, clinic administrators and medical support staff, who care directly for women and their families. Founded in 2008 as a successor to the National Coalition of Abortion Providers, ACN has created a network of independent abortion providers, supportive allied organizations, and socially conscious individuals who are deeply invested in creating an environment where women who choose to have an abortion, and those that provide care, are no longer shamed for their choices. ACN reaches millions of women across the country through our members and through on-line venues, and seeks to help its patient-members fulfill all of their reproductive and parenting needs.

American Academy of Addiction Psychiatry ("AAAP") is an international professional membership organization founded in 1985 with approximately 1,500 members. Membership consists of psychiatrists who work with addiction in their practices, faculty at various academic institutions, primary care health professionals, residents and medical students who are making a contribution to the field of Addiction Psychiatry. AAAP is the leading professional membership organization for learning and sharing about the art and science of Addiction Psychiatry research and clinical treatment; transforming lives through a commitment to using evidenced based research to continually improve clinical approaches and outcomes of their patients; a caring and engaging group of like-minded professionals who excel at translating work from the laboratory to solutions required in the real world; a collegial environment where health professionals have the opportunity to meet new colleagues, learn up close from thought leaders and contribute their own knowledge to an ever-expanding dialogue; commits to building collaborative efforts that provide an ideal forum for health professionals. AAAP opposes the prosecution of pregnant women based on the belief that the disclosure of personal drug use to law enforcement for use in criminal prosecutions will undermine prenatal care, discourage many women from seeking substance abuse treatment, and damage the medical provider-patient relationship that is founded on principles of confidentiality.

National Council on Alcoholism and Drug Dependence, Inc. ("NCADD"), and its Network of Affiliates, provides prevention, education, information, referral, advocacy, and hope in the fight against the chronic diseases of alcoholism and other drug addictions. Founded in 1944 and based in New York, NCADD Affiliates historically have provided confidential assessment and referral services for persons addicted to alcohol and other drugs and their families. In 1990, the NCADD Board of Directors adopted a policy statement on "Women, Alcohol, Other Drugs, and Pregnancy" recommending that "[s]tates should avoid measures which would define alcohol and other drug use during pregnancy as prenatal child abuse and should avoid prosecutions, jailing, or other punitive measures which would serve to discourage women from seeking health care services."

National Women's Health Network ("NWHN") improves the health of women by influencing public policy and providing health information to support decision-making by individual consumers. Founded in 1975 to give women a greater voice within the health care system, NWHN aspires to a health care system that is guided by social justice and reflects the needs of diverse women. NWHN is committed to advancing women's health by ensuring that women have self-determination in all aspects of their reproductive and sexual health; challenging the inappropriate medicalization of women's lives; and establishing universal access to healthcare that meets the needs of diverse women. The core values that guide NWHN's work include its belief that the government has an obligation to safeguard the health of all people; that it values women's descriptions of their own experiences and believes health policy should reflect the diversity of those experiences; and that it believes evidence rather than profit should determine what services and information are available to inform women's health decision-making and practices. NWHN is a membership-based organization supported by 8,000 individuals and organizations nationwide.

Physicians for Reproductive Health ("PRH") is a doctor-led national organization that uses evidence-based medicine to promote sound reproductive health care policies. Physicians for Reproductive Health unites the medical community and concerned supporters to improve access to comprehensive reproductive health care, including contraception and abortion, especially to meet the health care needs of economically disadvantaged patients.

Individuals

Pippa Abston, MD, PhD, FAAP, is a pediatrician and Assistant Professor of Pediatrics practicing in Alabama. She is on the board of Physicians for a National Health Program and is Physician Coordinator for North Alabama Healthcare for All. In her book, *Who is My Neighbor: A Christian Response to Healthcare Reform*, she explains why providing good healthcare to everyone in our country would improve not only the quality of our medical system but our economic health. She is also on the board of NAMI Alabama, a chapter of The National Alliance on Mental Illness, as advocacy chair. In her family, practice, and community work, she has witnessed first-hand the effects of addiction as a medical illness and has advocated for better access to effective treatment instead of criminalization of the sick.

Annette Ruth Appell, JD,* is Professor of Law at Washington University Law School and, by courtesy, at the Brown School of Social Work at Washington University. She teaches Children and the Law and directs the Children & Family Advocacy Clinic, which provides legal representation, including guardian ad litem representation, to children and families in child abuse and neglect, domestic violence, custody, adoption, and guardianship matters. She has published numerous articles and book chapters in the areas of children's' rights, children's legal representation, child welfare, motherhood, family law, and adoption.

John Arras, PhD,* is Porterfield professor of biomedical ethics, professor of philosophy, and professor of public health sciences at the University of Virginia. His research falls into two broad categories: (1) reflections on method in practical ethics, including varieties of 'principlism,' moral theory, case-based reasoning, narrative, pragmatism, human rights, etc.; and (2) more occasional topics of current ethical controversy, such as physician-assisted suicide, research ethics, public health, and reproductive ethics. He served for five years as a founding member of the ethics committee at the Centers for Disease Control and Prevention, and also served as a member of the ethics committee of the March of Dimes. He is currently a member of President Obama's Commission for the Study of Bioethical Issues (www.bioethics.gov), and is a longtime fellow at the Hastings Center. The views he expresses here are his own, not those of any of the above institutions.

Lama Bazzi, MD,* is a Clinical Assistant Professor of Psychiatry at SUNY Stony Brook Medical Center. She is active in the American Psychiatric Association (APA), and sat on the Council on Psychiatry and the Law and the Committee on Judicial Action. Dr. Bazzi actively participated in the writing of Amici Briefs to the Supreme Court on behalf of the APA. Currently, she is the Medical Director of the Assisted Outpatient Treatment Program in Suffolk County. As both a community psychiatrist and a forensic psychiatrist, Dr. Bazzi has evaluated and treated a large number of women, many of whom suffer from substance use disorders. Much of Dr. Bazzi's clinical work in the public sector focuses on reducing stigma surrounding mental illness in women and harm reduction in patients with substance use disorders. In her forensic practice, she strives to educate of the courts and judges on how psychiatric issues influence criminal and civil legal matters.

Daniel Becker, MD* is a professor of internal medicine at the University of Virginia School of Medicine where he also directs the Center for Biomedical Ethics and Humanities.

Susan C. Boyd, PhD,* is a Professor in the Faculty of Human and Social Development, University of Victoria, BC, Canada. She is a drug policy researcher and author of numerous journal articles and books, including: *Hooked: Drug War Films from Britain, Canada, and the U.S.*; *From Witches to Crack Moms: Women, Drug Law, and Policy*; *Mothers and Illicit drugs*; and co-editor of *With Child: Substance Use During Pregnancy: A Woman-Centered Approach*.

Nancy D. Campbell, PhD,* is the author of Using Women: Gender, Drug Policy, and Social Justice (Routledge 2000), a history of how pregnant women are used to call for drug policies that are unjustifiably harsh and ill considered in terms of their social consequences.

Beth Epstein, PhD, RN,* is an Associate Professor of Nursing at the University of Virginia. She serves on the Ethics Committee and Ethics Consult Service, and Directs the Moral Distress Consult Service for the University of Virginia Health System. She conducts research in the ethical aspects of family-centered care in critical care settings and teaches ethics in the School of Nursing.

Fonda Davis Eyler, PhD,* is a Professor Emeritus in the Department of Pediatrics of the University of Florida College of Medicine and is also a licensed Developmental Psychologist. From 1988 to 2011, Dr. Eyler was Developmental Director of Early Steps, an early intervention program for children from birth to three years of age, who lived in the surrounding sixteen counties and had developmental delays and disabilities. She was a Principle Investigator on a prospective, longitudinal research study that has been following a cohort of the children born to women who used cocaine during their pregnancy and a matched comparison group of pregnant women who were not addicted to cocaine and their children. Dr. Eyler brings a wealth of knowledge concerning the impact on children of drug abuse during pregnancy.

Ruth R. Faden, PhD, MPH, is the Andreas C. Dracopoulos Director of the Johns Hopkins Berman Institute of Bioethics and the Philip Franklin Wagley Professor of Biomedical Ethics. Dr. Faden is a member of the Institute of Medicine and a Fellow of the Hastings Center and the American Psychological Association. She has served on numerous national advisory committees and commissions, including President Clinton's Advisory Committee on Human Radiation Experiments, which she chaired. Dr. Faden is a co-founder of the Hinxton Group, a global community committed to advancing ethical and policy challenges in stem cell science, and the Second Wave project, an effort to ensure that the health interests of pregnant women are fairly represented in biomedical research and drug and device policies. In 2011, Dr. Faden was the recipient of Lifetime Achievement Awards from the American Society for Bioethics and Humanities (ASBH) and Public Responsibility in Medicine and Research (PRIMR).

Leslie Hartley Gise, MD,* is Clinical Professor of Psychiatry at the John A. Burns School of Medicine, University of Hawai`i. She has extensive experience teaching at the professional level regarding substance use disorders in women, and she worked at a facility treating drug and alcohol addicted pregnant and parenting women for eight years. She is past President of the North American Society for Psychosocial Obstetrics and Gynecology under ACOG.

Charles A. Hite, MA, CIP,* is Director of Biomedical and Research Ethics at Carilion Clinic in Roanoke, Virginia. Mr. Hite's work is focused on education, policy and clinical consultation services. He supports the ethics training program for residents and other health care professionals at the clinic's medical center. He also directs the clinic's program to protect human research subjects and serves on two research ethics review committees. He is co-editor of "Introduction to Clinical Ethics," a textbook on medical ethics used a medical schools and health care institutions across the country.

Stephen R. Kandall, MD, FAAP, served as Chief of Neonatology at Beth Israel Medical Center from 1976 to 1998 and retired in 1998 as Professor of Pediatrics at the Albert Einstein College of Medicine. Most of Dr. Kandall's 90 contributions to the medical literature deal with perinatal drug use, and he has contributed chapters to many standard textbooks, including *Substance*

Abuse: A Comprehensive Textbook and Principles of Addiction Medicine, as well as his own definitive book on the history of women and addiction in the United States, *Substance and Shadow*. Dr. Kandall has lectured throughout the United States, as well as Belgium, Italy, Austria and Australia. He has served as president of his local medical societies, as an advisor to many commissions and panels on drug abuse (including the March of Dimes, Narcotic and Drug Research, Inc., and the Scott Newman Foundation in Los Angeles), and currently advises legislative subcommittees on perinatal health in North Carolina.

Mary Faith Marshall, PhD, FCCM, is the Emily Davie and Joseph S. Kornfeld Professor and Director of the Program in Biomedical Ethics, and Professor of Public Health Sciences at the University of Virginia School of Medicine. Dr. Marshall is an elected fellow in the American College of Critical Care Medicine and is a former Fellow of the Kennedy Institute of Ethics at Georgetown University. She is past-president of the American Association of Bioethics and Humanities and past-president of the American Association for Bioethics. Dr. Marshall was the chairperson of the National Human Research Protections Advisory Committee, DHHS, has been an on-site reviewer for the Office for Human Research Protections, and has served on several special emphasis panels regarding clinical trials and research ethics at the National Institutes of Health. She has testified before Congress on the subject of perinatal substance abuse. She sits on the Ethics Committees of the American College of Obstetricians and Gynecologists and the American College of Critical Care Medicine.

Anna Mastroianni, JD, MPH,* Professor of Law has substantial work experience and has produced many influential publications in health law and bioethics, with specific expertise in issues affecting women, reproduction and families. Formerly a practicing attorney in Washington, DC, she is a tenured faculty member of the University of Washington School of Law and has graduate faculty appointments in the School of Public Health and School of Medicine. She is also Affiliate Faculty at the Treuman Katz Center for Pediatric Bioethics at Seattle Children's Hospital. Her work with the Institute of Medicine is considered a seminal analysis of the medical, legal and ethical challenges surrounding the inclusion of women (particularly pregnant women and women of childbearing potential) in research. She is currently co-investigator on an NIH-funded research project evaluating the legal and ethical issues of including pregnant women in HIV research. In her capacity as Trustee of the Population Council, an international research and services organization based in New York, she oversees domestic and international activities involving health, reproduction and pregnancy. Professor Mastroianni teaches graduate courses in the Schools of Law, Medicine and Public Health in family law and health law and publishes and lectures internationally.

John J. McCarthy, MD, APBN, ABAM,* is the Medical Director of the BAART/Bi-Valley Medical Clinic, an outpatient addiction treatment program that specializes in the medical treatment of addiction to opiates, based in Carmichael, California. Dr. McCarthy also serves as an Assistant Professor of Psychiatry at the University of California, Davis. He has been published numerous times on the issues of opiate use impacts on maternal and perinatal health and appropriate treatment. He is Board certified in Psychiatry and Addiction Medicine.

Robert Newman, MD, MPH,* was until January 2001, President and CEO of Continuum Health Partners, Inc., a $2.2 billion hospital network in New York City. Prior to the creation of

Continuum in 1997 he was CEO of the Beth Israel Health Care System for 20 years. He is now President Emeritus of Continuum. For over 40 years Dr. Newman has played a major role in planning and directing some of the largest addiction treatment programs in the world - including the New York City Methadone Maintenance and Ambulatory Detoxification Programs, which in the mid-1970s served some 33,000 patients annually. He has also been a strong addiction treatment advocate in Europe, Australia and Asia. Throughout his career he has championed the right of drug-dependent persons to treatment access and choice of provider, and the right to be cared for under the same conditions as apply to the management of all other chronic medical conditions.

Lois Shepherd, JD,* is the Peter A. Wallenborn, Jr. and Dolly F. Wallenborn Professor of Biomedical Ethics at the University of Virginia, where she directs the programs in law and medicine at the Center for Biomedical Ethics and Humanities. She is also a Professor of Public Health Sciences and Professor of Law at the University of Virginia. She is the co-author of a leading casebook, Bioethics and the Law (3rd ed. Wolters Kluwer), as well as the author of If That Ever Happens to Me: Making Life and Death Decisions After Terri Schiavo (2009) and numerous law review and medical journal articles on law and medicine, including reproductive medicine.

* Institutional affiliation is for identification purposes only.

APPENDIX B

V I R G I N I A :

IN THE CIRCUIT COURT FOR THE COUNTY OF FRANKLIN

COMMONWEALTH OF VIRGINIA,

Plaintiff,

v. No. CR-91-05-4381

BRITTA C. SMITH,

Defendant.

ORDER OF DISMISSAL

On June 3, 1991, the defendant in this case, Britta C. Smith, was indicted by a grand jury of this County on a single count of felony child neglect under Va. Code Ann. § 18.2-371.1, after having given birth on February 20, 1991, to a child who tested positive for benzoylecgonine, a metabolite of cocaine. On September 6, 1991, the defendant moved to dismiss the indictment.

Having had the benefit of extensive briefing and oral argument on the defendant's motion, this Court concludes that § 18.2-371.1, including the amendments thereto enacted in 1990, was not intended by the Virginia General Assembly to extend to fetuses, or to apply to prenatal conduct by a pregnant woman. Therefore, the facts of this case do not present a violation of the statute.

Accordingly, the indictment is hereby dismissed with prejudice, and the instant case stricken from the docket of this Court.

The clerk is directed to send a copy of this order to all counsel of record.

IT IS SO ORDERED.

B.A. Davis III

B.A. DAVIS, III
Circuit Judge

Dated: 9.23.91

A Copy Teste:
Wm. J. Walker, Jr., Clerk
Deputy Clerk