**IN THE**

**COURT OF APPEALS OF INDIANA**

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**Cause No. 71A04-1504-CR-166**

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| PURVI PATEL, | ) | |
| | ) | Appeal from the St. Joseph County Court |
| *Appellant* | ) | |
| v. | ) | |
| | ) | Cause No.: 71D08-1307-FA-00017 |
| STATE OF INDIANA, | ) | |
| | ) | Hon. Elizabeth C. Hurley, Judge |
| *Appellee* | ) | |

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# BRIEF OF AMICUS CURIAE OF NATIONAL ADVOCATES FOR PREGNANT WOMEN AND EXPERTS IN PUBLIC HEALTH, HEALTH ADVOCACY, AND BIOETHICS

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## INTERESTS OF AMICI CURIAE

*Amici* are experts in public health, health advocacy, and bioethics.[1] *Amici* are concerned that the prosecution and conviction of Purvi Patel depart from the legal and social consensus in the U.S. that women should not be jailed for having abortions, for unattended births, or for how they respond to a pregnancy loss. The ramifications of punishing women for their pregnancy outcomes are profound. Allowing the judicial expansion of Indiana law to prosecute women in relation to their own pregnancies endangers public health and the civil rights of all people who are or may become pregnant.

## SUMMARY OF ARGUMENT

There is a strong consensus in the U.S. – including among those who oppose abortion[23] – that women should not face criminal punishment for having abortions. Likewise, every major medical and public health association in the U.S. agrees that women should not be prosecuted for their actions, inactions, or circumstances during pregnancy. The conviction of Ms. Patel defies that consensus. While the

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[1] A complete list of *amici* and statements of interest is attached as Appendix A.

[2] *See, e.g.,* Jessica Robinson, *Idaho Woman Arrested for Abortion is Uneasy Case for Both Sides*, NPR, April 9, 2012, http://www.npr.org/templates/story/story.php?storyId=150312812 (interviewing the president of the pro-life organization Susan B. Anthony List, who called Idaho's prosecution of a woman for terminating her own late second-trimester pregnancy "unacceptable:" "We do not think women should be criminalized. Criminal sanctions or any kind of sanctions are appropriate for abortionists, and not for women."). *See also* Andrea Rowan, *Prosecuting Women for Self-Inducing Abortion: Counterproductive and Lacking Compassion*, 18 Guttmacher Policy Review 70, 74 (2015) ("[A] host of other anti-abortion leaders" have claimed that protection, not punishment of women, is the aim of laws regulating abortion.").

Indiana General Assembly has unquestionably regulated abortion, and criminalized third parties who harm women's pregnancies, it has not enacted a modern law that makes it a crime for a woman to have an abortion or experience a pregnancy loss.

Yet the trial court permitted this misuse of Indiana's feticide law, the purpose of which is to protect pregnant women from violence, to punish Ms. Patel because she had or attempted to have an abortion. These actions are not criminal under Indiana's law that regulates abortion. In addition to its legally improper use of the feticide statute, the State charged Ms. Patel with neglect of a dependent, levied at her for what happened at birth and shortly thereafter. The jury convicted her of both crimes.

The consequences of improperly expanding Indiana law to encompass pregnancy and pregnancy outcomes are grave. Pregnant women in Indiana will face arrest, interrogation, and imprisonment based on anything they do that could be characterized as an attempt to terminate their own pregnancies. Gender-based stereotypes of how women are expected to behave during pregnancy, in the moments after delivery, and when seeking medical care, will inevitably affect these proceedings. As this brief explains, this is not speculation: courts around the country have rejected prosecutions of pregnant women for accusations ranging from self-injury to refusing cesarean surgery, and have cautioned that it is difficult, if not impossible, to prevent biased beliefs about gender and pregnancy from informing the outcome of such prosecutions.

Similarly, courts have warned against punishing women for poor pregnancy outcomes, including prosecuting women for what happens at an unattended birth and the minutes thereafter, because the inherent speculation in such prosecutions risks punishing someone innocent of any crime. But it is not only the potential criminal conviction of an innocent person that is at stake in cases like this one. Prosecuting women for their pregnancy outcomes also threatens public health, by deterring pregnant women from getting the health care they need. And by punishing pregnant women for their actions, inactions, decisions, or health status, the State violates their rights to due process, reproductive liberty, and equal protection of the law.

## ARGUMENT

Targeting pregnant women for criminal punishment in relation to their own pregnancies is a pernicious practice. Under such a regime, every person who may become pregnant is at risk of investigation, prosecution, and imprisonment. The General Assembly has not created nor endorsed such a regime. Affirming this misuse of Indiana law would endanger public health and violate civil rights.

### I. This prosecution defies legal norms in Indiana and throughout the U.S.

*Amici* urge this Court to reverse this wholly unauthorized use of Indiana law. It is the General Assembly that "has the authority to provide which acts shall be crimes in our society and to provide penalties therefor." *State v. Palmer*, 270 Ind. 493, 386 N.E.2d 946, 949 (Ind. 1979). The General Assembly has long rejected the notion that women should face criminal prosecution for having abortions.

### A. Indiana law does not permit jailing women for having abortions.

Women have used contraceptives and obtained abortions throughout history, regardless of legality. *Roe v. Wade*, 410 U.S. 113, 130-139 (1973).[4] When abortion was a crime in the U.S., women inevitably sought abortions underground, in what were often unsanitary conditions, or were forced to carry dangerous pregnancies to term. The resulting deaths and serious injuries to women were a public health crisis.[5] In general, states did not respond to this crisis by prosecuting the women who had abortions. *Id*. at 151. *See also McCormack v. Hiedeman,* 694 F.3d 1004, 1011 (9th Cir. 2012) (upholding a preliminary injunction against the prosecution of an Idaho woman who terminated her pregnancy using drugs she obtained online).

In keeping with the national consensus and long standing legal tradition, Indiana's abortion code does not permit criminal prosecution of the woman who has an abortion: it targets people who *provide* abortions. Indeed, the one exception proves the rule. In 1835, Indiana enacted its first statute directed at abortion, prohibiting "procurement of a miscarriage," which targeted exclusively third parties who caused a woman to miscarry. Ind. Rev. Stat. ch. XXVI, § 3, p. 224 (1838). Until 1881, it was not unlawful for a pregnant woman in Indiana to procure *her own* miscarriage. That year, the General Assembly enacted a statute that made it a

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[4] *See also* Amnesty International, *On the Brink of Death: Violence Against Women and the Abortion Ban in El Salvador* 10 (2014), *available at* http://www.amnesty.org/en/library/asset/AMR29/003/2014/en/b3f73e66-6732-4d4e-ad12-7b5dc04d23bc/amr290032014en.pdf (concluding that women will seek abortions regardless of illegality).

[5] Rosalind Pollack Petchesky, Abortion & Woman's Choice: The State, Sexuality, & Reproductive Freedom, 80 (1984).

misdemeanor for a pregnant woman to do so. Ind. Rev. Stat., Ch. 5, art. 2., §§ 1923, p. 358 (1881).

Significantly, there are no reported cases indicating that this statute was ever used against any woman for having an abortion. To the contrary, all reported Indiana abortion-related prosecutions were directed against third parties who performed or procured miscarriage. *Shuai v. State*, 966 N.E.2d 619, 635 (Ind. Ct. App. 2012), *trans. denied* 967 N.E.2d 1035 (Ind. 2012) (Riley, J., dissenting) (internal citations omitted). In 1977, the General Assembly repealed these criminal statutes. *See Clinic for Women v. Brizzi*, 837 N.E.2d 973, 989, n. 2 (Ind. 2005).[6]

This history shows that when the General Assembly intends to pass a law that punishes the women who have abortions, it does so explicitly. Further, the current abortion law's plain language demonstrates that it is directed at third parties – not at the people who have abortions. *See Basileh v. Alghusain,* 912 N.E.2d 814, 821 (Ind. 2009) (statutes that are "clear and unambiguous leave no room for judicial construction."). Ind. Code §16-34-2 regulates those who *provide* abortions, mandating, among other things, provider compliance with record-keeping, explicit information to be given to patients seeking abortions, and parental

[6] Like Indiana, the majority of states' criminal codes do not target women for having abortions. *McCormack*, 694 F.3d 1012-1013, n. 3 and n. 4. Those that do, do so explicitly. *See e.g.* New York Penal Law §§ 125.20, 125.55 ("self-abortion" is a misdemeanor), South Carolina Code Ann. § 44-41-10 (performing an abortion on oneself is a misdemeanor), Utah Code 76-5-201(4) (a woman may be guilty of criminal homicide "of her unborn child" if the death is caused by knowing or intentional acts; abortions performed by physicians are exempt), Idaho Code 18-606(2) (submitting to an abortion is a felony; held unconstitutional in *McCormack*, 694 F.3d at 1016). The constitutionality of these laws is doubtful after *McCormack*.

notice requirements. There is no provision that makes it a crime *for a woman to have an abortion* outside of a medical setting, or any provision that criminalizes *having* an abortion at a particular stage in pregnancy.

The State may not, by resort to the feticide law, circumvent the General Assembly's decision to regulate abortion providers, rather than women who have abortions. Indiana's feticide law is not an abortion law. *Baird v. State*, 604 N.E.2d 1170, 1189 (Ind. 1992), *cert. denied* 510 U.S. 893 (1993) ("A proper construction of the feticide statute . . . requires that it be viewed not as an illegal abortion statute, but as an extension of the laws of homicide to cover the situation in which the victim is not a "human being" . . . but a fetus."). Rather, it criminalizes third parties who harm women's pregnancies. *Kendrick v. State*, 947 N.E.2d 509, 514 n.7 (Ind. Ct. App. 2011), *trans. denied* 962 N.E.2d 649 (Ind. 2011), *cert. denied* 132 S.Ct. 1752 (2012) (reversing feticide conviction of a man who shot a pregnant bank teller in the stomach during a robbery, resulting in her serious injury and the stillbirth of her twins, noting that the State conceded that the crime of feticide is a crime against the pregnant woman); *see also Shuai*, 966 N.E.2d at 633 (Riley, J., dissenting).

Allowing Indiana's feticide law to apply to pregnant women in relation to their own pregnancies is an extraordinary departure from legislative intent, and would have absurd, unjust consequences. *See Mayes v. State*, 744 N.E.2d 390, 393 (Ind. 2001) ("The legislature is presumed to have intended the language used in the statute to be applied logically and not to bring about an unjust or absurd result.") (citation omitted). The Supreme Court of Florida recognized this

danger when it held that the state could not charge a pregnant teenager who shot herself with any crime in the "death of her born alive child resulting from self-inflicted injuries during the third trimester of pregnancy." *State v. Ashley,* 701 So.2d 338 (Fla. 1997). As that court explained, it could not "abrogate willy-nilly a centuries-old principle of the common law —which is grounded in the wisdom of experience and has been adopted by the General Assembly— and install in its place a contrary rule *bristling with red flags* and followed by no other court in the nation." *Id*. at 342-43 (emphasis added). *But see Shuai*, 966 N.E.2d at 630.[7]

The red flags raised by such prosecutions are not hypothetical. In Utah, a woman gave birth to twins. One was stillborn. Health care providers believed that the stillbirth was the result of the woman's decision to delay cesarean surgery, and she was arrested and charged with fetal homicide.[8] In Louisiana, a woman who went to the hospital for vaginal bleeding was incarcerated for over a year on charges of second-degree murder before medical records revealed she miscarried between 11

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[7] In 2012, a panel of this Court held that the state could proceed to trial against a pregnant woman who attempted suicide, and whose subsequently born child later died, for murder and attempted feticide. *Shuai*, 966 N.E.2d at 628. That decision marked the first time that an Indiana appellate court upheld the use of the criminal code to punish a woman in relation to her own pregnancy. *Id*. at 628; contrast *Herron v. State*, 729 N.E.2d 1008, 1011 (Ind. Ct. App. 2000). *Shuai* is not binding on this panel. *In re C.F.,* 911 N.E.2d 657, 658 (Ind. Ct. App. 2009) ("Indiana does not . . . recognize horizontal stare decisis."). Moreover, the *Shuai* Court misconstrued both common law and legislative intent, and did not consider either the serious consequences or the constitutional concerns implicated by judicial expansion of the feticide law.

[8] Howard Minkoff & Lynn Paltrow, *Melissa Rowland and the Rights of Pregnant Women*, 104 Ob. & Gyn. 6 1234 (Dec. 2004).

and 15 weeks of pregnancy.[9] In Pennsylvania, a woman spent a week in jail facing charges of "abusing a corpse" because she miscarried an approximately 19-week pregnancy at home and, unsure what to do, put the fetal remains in her freezer.[10] A couple in Los Angeles, following their doctor's advice to keep the remains from the woman's early miscarriage in their freezer while deciding whether to have tests or a cremation, had their home raided by the police and searched without a warrant because of what the police called "exigent circumstances" – the report (that had been made by the husband, at the direction of the funeral home), of a "fetus in a freezer."[11] In none of these cases were women ultimately convicted of any kind of crime. When the state polices pregnancy and its outcomes, these egregious cases are the inevitable result.

### B. Indiana law does not permit consideration of pre-birth circumstances in a neglect of a dependent charge.

This case is about more than punishment of a woman for attempting to terminate her own pregnancy. Ms. Patel was also convicted of neglect of a dependent, a crime that does not apply to conduct during pregnancy. *Herron*, 729 N.E.2d at 1011. Applying this charge to what happens at birth and immediately after requires great caution. As the Supreme Court of Wyoming recognized in 1954,

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[9] 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, 308 (2013).

[10] Gabrielle Banks, *Fetus Case Provides Rare Common Ground*, Pittsburgh Post-Gazette, May 24, 2007, http://www.post-gazette.com/news/health/2007/05/24/Fetus-case-provides-rare-common-ground/stories/200705240316.

[11] Steve Lopez, *Couple's Attempt to Do Right Thing Brings More Grief*, Los Angeles Times, March 11, 2009, http://articles.latimes.com/2009/mar/11/local/me-lopez11.

“[c]hildren are born of unattended mothers on trains, in taxis, and in other out of the way places, and we fear to open up a field for unjust prosecutions of actually innocent women.” *State v. Osmus,* 276 P.2d 469, 476 (Wyo. 1954) (reversing manslaughter conviction of woman who gave birth alone in her room, then put the deceased infant’s body under the bed for three days before leaving it along a highway, telling no one she had given birth); *see also Commonwealth v. Pugh*, 969 N.E.2d 672, 688 (Mass. 2012) (reversing a homicide conviction against a pregnant woman who delivered a breech-presentation fetus alone at home, explaining, “[s]peculation that the baby might have survived if the defendant had summoned medical help does not satisfy the Commonwealth's burden of proving causation beyond a reasonable doubt because that the baby “*might* have survived with proper care ... engender[s] considerable doubt as to what actually happened.”) (*citing Osmus,* 276 P.2d at 476). When childbirth is subject to criminal punishment, mere speculation about what might have happened is wholly insufficient to meet the State’s burden of proof. *Id.*

Moreover, the potential for unjust prosecution and conviction in cases like these is great. This is because it is often medically impossible to determine the cause of a particular birth outcome,[12] and because race and class prejudice influence

[12] *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”).

which women are targeted for investigation and arrest.[13] And biased beliefs about how pregnant women should behave make it difficult if not impossible to fairly subject pregnancy outcomes to judicial scrutiny. The Supreme Court of Illinois understood this, refusing to hold women civilly liable to their children for harms from an injury that occurred prenatally:

> If a legally cognizable duty on the part of mothers were recognized, then a judicially defined standard of conduct would have to be met. It must be asked, By what judicially defined standard would a mother have her every act or omission while pregnant subjected to State scrutiny? . . . In what way would prejudicial and stereotypical beliefs about the reproductive abilities of women be kept from interfering with a jury's determination of whether a particular woman was negligent at any point during her pregnancy?

*Stallman v. Youngquist*, 531 NE.2d 355, 360 (Ill. 1988).

Those biases – and abortion stigma[14] – raise concerns about whether the jury could treat the two counts brought against Ms. Patel as truly separate. Indeed, some of the testimony conflated the two counts. For example, Dr. Prahlow, the State's expert, testified that "extreme prematurity" could be one of the reasons that Ms. Patel's baby did not survive; he went on to attribute that "extreme prematurity" to an act of "homicidal violence," and directed the jury's attention to "what caused this baby to be born and it was the actions of another individual." Tr. p. 957-958. In

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[13] Paltrow & Flavin, *supra* note 9, at 311 (women targeted for criminal prosecution or forced intervention in relation to their pregnancies were disproportionately of color and almost universally poor).

[14] In recognition of this stigma, courts routinely permit plaintiffs challenging abortion restrictions to remain anonymous. *See, e.g., Davis v. Martinez,* 65 A.3d 810, 813 (Md. Ct. Spec. App. 2013) (citation omitted); *Roe v. Aware Woman Ctr. for Choice, Inc.,* 253 F.3d 678, 687 (11th Cir. 2001).

this manner, the jury heard that abortion is the same as homicidal violence, and was asked to consider pre-birth circumstances in a neglect of a dependent charge.

In addition, stereotypical beliefs about how pregnant women should behave were omnipresent in this trial. Prosecutors asked numerous witnesses to comment on Ms. Patel's demeanor and "flat affect" at the hospital, Tr. pp. 395, 430-431, 465-466, suggesting that there is one way women should act after an unattended birth, abortion, or pregnancy loss, and that the failure to meet that expectation indicates criminal culpability. This was also true of the prosecution's focus on what Ms. Patel had done with the body of what she believed – and Dr. Teas testified, Tr. p. d352 – was a nonviable fetus with no obvious signs of life. Tr. p. 362. As the California and Pennsylvania cases described above demonstrate, women who lose pregnancies outside a medical setting do not intuitively know what they are expected to do with miscarriage or stillbirth remains. The emphasis on this circumstance at trial is yet another aspect of how gender-based stereotypes inevitably infect these prosecutions.

## II. Punishing women for pregnancy outcomes, intentional or unintentional, endangers public health.

Responding to pregnancy outcomes through the criminal justice system is dangerous and counterproductive in every respect. It will not prevent poor pregnancy outcomes. In fact, it will increase the risks to maternal and fetal health among women who are trying to carry their pregnancies to term, especially those with stigmatized health problems like drug dependency. It will not prevent women from terminating their own pregnancies; instead, it will discourage them from seeking medical care if they have any complications.

### A. Criminalizing abortion has grave public health consequences.

The terrible result of the criminal approach to abortion is demonstrated in countries throughout the world where abortion is illegal. In El Salvador, where abortion is illegal under all circumstances, women are investigated and jailed for having abortions and miscarriages.[15] The extreme penalties for pregnancy complications – many unrelated to abortion – have led people, especially poor women, to avoid medical care.[16] Suicide is the third leading cause of maternal mortality in that country, and half of all teenage girls who committed suicide were pregnant when they took their own lives.[17]

The situation is similarly stark in Nicaragua, which enacted a criminal abortion ban in 2008 that "provides for lengthy sentences for women and girls" who have abortions, as well as their health care providers.[18] As of 2013, there were no reported arrests of either women or medical professionals pursuant to the abortion ban, but the law has nonetheless stopped women from seeking medical care for miscarriage and other pregnancy emergencies, undermining that country's efforts to reduce maternal mortality.[19] As the Nicaraguan experience demonstrates, even the *threat* of arrest and prosecution – in the absence of *actual* arrests and prosecutions – deters women from getting the health care they need.

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[15] *On the Brink of Death*, *supra* note 4, 34-35.
[16] *Id.*
[17] Nina Lakhani, *El Salvador: Where Women May Be Jailed for Miscarrying*, BBC News, Oct. 17, 2013, http://www.bbc.com/news/magazine-24532694.
[18] Amnesty International, *The Total Abortion Ban in Nicaragua: Women's Lives and Health Endangered, Medical Professionals Criminalized* 7 (2009), *available at* https://www.amnesty.org/en/documents/AMR43/001/2009/en/.
[19] *Id.* at 20-21.

Punishing and incarcerating women who have abortions has similarly deleterious affects around the world. In Rio de Janeiro, Brazil, where abortion is a crime except in cases of rape, fetal anencephaly, or where the pregnant woman's life is threatened, unsafe abortion is the third leading cause of maternal death.[20] Abortion bans also risk the lives of people who want to carry their pregnancies to term.[21] Women who are jailed for miscarriages and abortions throughout the world are often also mothers, whose children are left motherless and impoverished.[22]

Of course, none of these laws actually result in an end to abortion.[23] Thus, the trend worldwide is to move away from criminalizing abortion,[24] in recognition of the public health consequences that accompany such prohibitions.

### B. Prosecutions like this will not stop women from terminating their own pregnancies.

Upholding the conviction in this case will not ensure that women in Indiana obtain abortions only in (increasingly inaccessible[25]) medical settings. Abortions are

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[20] Ellen Mitchell et al., *Brazilian Adolescents' Knowledge and Beliefs about Abortion Methods: A School-Based Internet Inquiry*, 14 BMC Women's Health 1-2 (2014), *available at* http://www.biomedcentral.com/1472-6874/14/27.

[21] *See, e.g.,* Shawn Pogatchnik, *Ireland to Release Report on Savita Halappanavar, Woman Who Died After Denied Abortion,* Huffington Post, Aug. 13, 2013, http://www.huffingtonpost.com/2013/06/13/savita-halappanavar-report-ireland-abortion_n_3434769.html (describing the death of Savita Halappanavar, a miscarrying woman denied life-saving treatment because doctors detected a fetal heartbeat, explaining "some Irish doctors' wait-and-see approach, fearful of violating Ireland's constitutional ban on abortion, presented an unjustifiable courting of danger to the patient.").

[22] *See generally,* Lakhani, *supra* note 17.

[23] Rowan, *supra* note 2, at 70, 74 (explaining that rates of abortion in countries where abortion is illegal are as high or higher than in countries where abortion is accessible).

[24] *On the Brink of Death, supra* note 4, at 10.

sought outside medical settings for many reasons,[26] ranging from lack of access to clinical providers or health insurance,[27] to a desire for privacy,[28] to a fear of shame or stigma.[29] Punishment will not stop women from terminating their own pregnancies; it will result in women staying away from medical care if they have post-abortion complications to avoid punishment.[30] That is why public health organizations oppose criminalizing abortion,[31] just as those groups universally object to punitive responses to pregnancy outcomes.

### C. Every leading U.S. medical organization opposes punishing people for pregnancy outcomes.

All major U.S. public health and medical organizations have taken an unequivocal stance against criminal and other coercive responses to pregnancy and its outcomes. This is because threats of punishment deter people from seeking

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[25] Rowan, *supra* note 2, at 70 ("For women in large swaths of the U.S., access to abortion is more limited now than at any time since *Roe v. Wade."*).

[26] *See generally* Daniel Grossman et al., *Self-induction of Abortion Among Women in the United States*, 18 Reproductive Health Matters 136 (November 2010).

[27] *Id.* at 141; *see also*; *Harris v. McRae*, 448 U.S. 297, 338 (1980) (Marshall, J., dissenting) ("The Court's opinion studiously avoids recognizing the undeniable fact that, for women eligible for Medicaid -- poor women -- denial of a Medicaid-funded abortion is equivalent to denial of legal abortion altogether.").

[28] Jennifer Lee & Cara Buckley, *For Privacy's Sake, Taking Risks to End a Pregnancy*, NY Times, Jan. 4, 2009.

[29] *Id.* (interviewing a woman who used misoprostol to terminate her own pregnancy because she had no money to pay for a clinic abortion and no health insurance, and feared that her family might see her going into a clinic). *See also* Grossman et al., *supra* note 26 at 141.

[30] *See, e.g., On the Brink of Death*, *supra* note 4, 34-35.

[31] *See, e.g.,* American Public Health Association, *Policy Number 6803: Abortion* (Jan. 1, 1968); American College of Obstetricians & Gynecologists, Committee on Healthcare for Underserved Women, *Committee Op. No. 613: Increasing Access to Abortion* 1 (2014).

medical care and undermine the patient/provider relationship. *See, e.g., In re A.C.,* 573 A.2d 1235, 1248 (D.C. 1990) (reversing, as unconstitutional and dangerous to public health, court-ordered cesarean surgery that caused both the pregnant woman and her fetus to die). In the wake of cases like *A.C.*, and because of attempts to use criminal laws to punish pregnant women for using alcohol or other drugs, the American Medical Association (AMA) rejected any role for state coercion of pregnant women, including the use of criminal sanctions.[32]

The American College of Obstetricians and Gynecologists (ACOG) also opposes criminal prosecutions of pregnant women,[33] calling the use of legal sanctions to attempt to guarantee healthy birth outcomes "morally dubious."[34] The American Nurses Association, too, opposes punitive responses: "[t]he threat of criminal prosecution is counterproductive in that it prevents many women from seeking prenatal care and treatment."[35] These positions are informed by the understanding that the threat of arrest and imprisonment deters people from getting the health care they need. *See, e.g., Ferguson v. City of Charleston*, 532 U.S. 67, 78 n14 (2001) (citations omitted).

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[32] Report of AMA Board of Trustees, *Legal Interventions During Pregnancy*, 264 JAMA 2663, 2667 (1990).

[33] ACOG, Committee on Ethics, *Maternal Decision Making, Ethics, and the Law*, 106 Obstetrics & Gynecology 1127, 1135 (2005).

[34] *Id.*

[35] American Nurses Association, *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). *See also* National Perinatal Association, *Position Statement, Substance Abuse Among Pregnant Women* (Dec. 2013).

There is no real distinction between this prosecution and those universally opposed by leading medical groups. Whether the accusation is that a woman terminated her own pregnancy intentionally, or used criminalized drugs while pregnant, sanctions in each instance deter women from seeking needed medical care, and harm the relationship of trust between pregnant patients and their health care providers. *See, e.g., Jaffee v. Redmond*, 518 U.S. 1, 10 (1996) (upholding confidentiality of mental health records because "the mere possibility of disclosure may impede development of the confidential relationship necessary for successful treatment.").

When criminal laws are misused to punish pregnant women, a pregnant patient's every conversation with a health care provider becomes potential evidence in a criminal investigation. This is precisely what happened to a pregnant mother of two who fell down the stairs in Iowa; her statement to a nurse that she had considered an abortion was used against her in a police investigation.[36] As in many cases involving pregnancy, the provider in that case stepped outside the ethically appropriate role as "counselor and medical advisor,"[37] colluding with law enforcement to the detriment of both the individual patient, and public health.

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[36] Michelle Goodwin, *Fetal Protection Laws: Moral Panic and the New Constitutional Battlefront*, 102 Calif. L. Rev. 781, 806-808 (2014).

[37] *See, e.g.,* AMA*, supra* note 32, at 2666; *see also* Michelle Oberman, *Mothers and Doctor's Orders, Unmasking the Doctor's Fiduciary Role in Maternal-Fetal Conflicts*, 94 Nw. U. L. Rev. 451, 486-487 (2000) ("the doctor [who reports a patient to the authorities] has forsaken the trusted nature of the fiduciary relationship and has abandoned his obligations of loyalty to the patient who sought his care.").

In short, criminal punishment of pregnant women in relation to their pregnancies is deleterious to public health. Moreover, punitive responses to pregnancy outcomes have grave implications for civil rights.

## III. Prosecuting women for their pregnancy outcomes violates their constitutional rights.

Pregnant women's rights to due process and equal protection are violated when states single them out for prosecution. To ensure the constitutionality of Indiana's feticide law, it must be interpreted to prohibit the prosecution of women in relation to their own pregnancies. *See Morgan v. State*, 22 N.E.3d 570, 573-574 (Ind. 2014) (courts will "choose the interpretation [of the statute] that will uphold [its] constitutionality.") (*citing Sims v. U.S. Fidelity & Guar. Co.*, 782 N.E.2d 345, 349 (Ind. 2003)).

### A. Prosecuting women for pregnancy circumstances violates due process.

Upholding this conviction will allow the use of the feticide law to prosecute women based on a limitless number of undefined and unpredictable circumstances. Using the law in this manner would render the statute unconstitutionally vague.

A statute is void for vagueness if it "fail[s] to provide the kind of notice that will enable ordinary people to understand what conduct it prohibits" or it "authorize[s] and even encourage[s] arbitrary and discriminatory enforcement." *City of Chicago v. Morales*, 527 U.S. 41, 56 (1999). *See also Smith v. State*, 8 N.E.3d 668, 676 (Ind. 2014). I.C. § 35-42-1-6 states that a person commits the crime of feticide when he "knowingly or intentionally terminates a human pregnancy." As explained

earlier, this language has nothing to do with terminating *one's own* pregnancy, as evidenced by the fact that no woman in the history of Indiana – until now – was ever prosecuted for having an abortion. Moreover, interpreting this language to apply to pregnant women has the potential to reach virtually everything a woman does or does not do during pregnancy.

It is not possible to cabin prosecutions for pregnancy outcomes, because pregnancy is fraught with risks, many outside the pregnant woman's control. As the Kentucky Supreme Court has held, prosecuting women for pregnancy outcomes would create an infinite number of new crimes, calling this "a plainly unconstitutional result that would, among other things, render the statutes void for vagueness." *Cochran v. Commonwealth*, 315 S.W.3d 325, 328 (Ky. 2010). *See also State v. Wade*, 232 S.W.3d 663, 666 (Mo. 2007) ("[T]he logic of allowing such prosecutions would be extended to cases involving smoking, alcohol ingestion, the failure to wear seatbelts, and any other conduct that might cause harm to a mother's unborn child."); *Reinesto v. Super. Ct*, 894 P.2d 733, 736-37 (Ariz. Ct. App. 1995) (noting that poor nutrition, vitamin and iron deficiencies, poor prenatal care, insufficient or excessive weight gain, and ingesting caffeine may affect fetal health); *Kilmon v. State*, 905 A.2d 306, 311-12 (Md. 2006) (such prosecutions potentially penalize "engaging in virtually any injury-prone activity that, should an injury occur, might reasonably be expected to endanger the life or safety of the child.").

A focus on "intentional" conduct cannot cure this vagueness. This is because a vast array of actions that could affect a pregnancy outcome could be characterized

as intentional – including continuing to work while pregnant,[38] working long hours in an environment with exposure to chemicals,[39] lifting another child while pregnant,[40] or not wearing a seatbelt properly.[41] The only truly limiting principle would be to target those who intend not only the action, but also its outcome – the pregnancy termination. But if, in an attempt to defeat vagueness, the statute is expanded to apply to pregnant women who intend to have abortions, it will run afoul of the constitutional rights to reproductive liberty and equal protection.

### B. Punishing women for having or attempting to have an abortion is an unconstitutional burden on the abortion right.

In a case remarkably similar to this one, the Ninth Circuit Court of Appeals held that prosecuting a woman for terminating her own pregnancy is unconstitutional. *McCormack*, 694 F.3d at 1013. As the only federal appellate court to have addressed this question, the Ninth Circuit's holding provides powerful guidance that prosecuting women who terminate their pregnancies outside a medical setting violates the right to reproductive privacy. *See State v. Brown*, 840 N.E.2d 411, 417 (Ind. Ct. App. 2006) (citing *Michigan v. Long*, 463 U.S. 1032 (1983))

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[38] *See, e.g., Int'l Union, UAW v. Johnson Controls, Inc.*, 499 U.S. 187, 205 (1991) (rejecting workplace "fetal protection policies" and stating that "[e]mployment late in pregnancy often imposes risks on the unborn child") (citation omitted).

[39] *See generally* Reece Rushing, Center for Am. Progress, *Reproductive Roulette: Declining Reproductive Health, Dangerous Chemicals, and a New Way Forward* (2009), *available at* http://cdn.americanprogress.org/wp-content/uploads/issues/2009/07/pdf/reproductive_roulette.pdf.

[40] *See, e.g.,* American Pregnancy Association, *Lifting During Pregnancy*, http://americanpregnancy.org/is-it-safe/lifting-pregnancy/ (last visited Sep. 2, 2015).

[41] *See, e.g.,* Centers for Disease Control & Prevention, *Pregnancy Risk Assessment Monitoring System, Motor Vehicle Injuries*, http://www.cdc.gov/prams/pdf/snapshot-report/motorvehicleinjuries.pdf (last visited Sept. 16, 2015).

(state courts "may look to federal authority for guidance" in interpreting question of constitutional law).

Jennie McCormack terminated her late second-trimester pregnancy using medication she obtained online. *Id.* at 1008.[42] She was arrested and charged with violating Idaho's abortion law, which, unlike Indiana law, retained a pre-*Roe* provision criminalizing women for having abortions. *Id.* The Ninth Circuit affirmed a federal district court's injunction against the law. *Id.* at 1019. As the court explained, the Supreme Court "has not authorized the criminal prosecution of women seeking abortion care." *Id.* at 1018.

It did not escape the court's notice that women already face a host of barriers to obtaining an abortion. *Id.* at 1016-1018 (explaining that the law making it a crime to have an abortion "heaps yet another substantial obstacle in the already overburdened path that McCormack and pregnant women like her face when deciding whether to obtain an abortion."). Recognizing that reality, the Ninth Circuit held that prosecuting *women* for not complying with the "intricacies of state abortion statutes" that bind abortion *providers* is an unconstitutional burden on the abortion right. *Id*. at 1016.

Indiana abortion law, like Idaho's, includes numerous restrictions on abortion providers. I.C. § 16-34-1-1 *et. seq*. As long as Indiana abortion providers comply with these regulations, they cannot be charged with the crime of feticide. I.C. § 35-42-1-6. This makes sense, because, as explained above, the crime of feticide was intended to

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[42] *See also* Robinson, *supra* note 2 (providing details about Ms. McCormack's situation not recounted in the Ninth Circuit's opinion).

punish third parties who assault pregnant women, causing them to lose their pregnancies – not to regulate abortions. *Baird,* 604 N.E.2d at 1189. Allowing *women* to be charged with feticide if they have abortions outside the parameters of the complex and ever-increasing set of abortion regulations could not be what the General Assembly intended. Requiring women to be bound – on pain of criminal punishment – by regulations ranging from state-directed counseling to reporting requirements hardly comports with due process, let alone the abortion right. [43] And because such an interpretation of the law would uniquely burden women, it violates their constitutional right to equal protection.

### C. Punishing pregnancy outcomes, whether intentional termination or unintentional pregnancy loss, violates the Equal Protection Clause.

The Equal Protection Clause promises equality under the law. U.S. Const. amend. XIV, § 1. Unfortunately, the capacity for pregnancy has historically been used to undermine women's status as equal rights-holders, including justifying their exclusion from public life, *Hoyt v. Florida*, 368 U.S. 57 (1961) (upholding law limiting obligatory jury duty to men)), professions, *Bradwell v. State*, 83 U.S. 130

[43] While the Ninth Circuit focused on pre-viability abortions, its analysis holds regardless of the stage of a woman's pregnancy. Post-viability abortions will be necessary for some women's health; thus, the states may not unequivocally prohibit them. *Planned Parenthood v. Casey*, 505 U.S. 833, 879 (1992). Singling out some women who have later abortions for imprisonment will impose a substantial obstacle in the path of *all* women who seek abortions. Any woman, whether she seeks an early abortion or needs a late abortion for health reasons, would risk prosecution under the State's theory if she does not know and comply with the complex set of abortion regulations. Thus, prosecuting women like Ms. Patel, where viability is contested, just as thoroughly – and unconstitutionally – burdens reproductive privacy. *See McCormack*, 694 F.3d at 1018.

(1873) (upholding state's refusal to allow women a license to practice law)), and occupations, *Goesaert v. Cleary*, 335 U.S. 464 (1948) (permitting state to deny women bartending licenses unless a male relative owned the establishment in which they worked). The U.S. Supreme Court's reasoning in *Muller v. Oregon*, a case upholding a statute limiting women to ten hour work days, amply illustrates this discrimination: "[A]s healthy mothers are essential to vigorous offspring, the physical well-being of woman becomes an object of public interest and care in order to preserve the strength and vigor of the race." 208 U.S. 412, 421 (1908).

### 1. Singling out pregnant women for unique punishment is subject to heightened scrutiny under the Equal Protection Clause.

Today the Equal Protection Clause guarantees that treatment under the law may not be based on gender stereotypes, entrenched perceptions of proper gender roles, or generalizations regarding a person's abilities or characteristics based on gender. *See United States v. Virginia*, 518 U.S. 515 (1996) (invalidating maintenance of single-sex education program at Virginia Military Institute); *Johnson Controls,* 499 U.S. at 205 (holding that an employer may not exclude a fertile female employee from certain jobs because of its concern for the health of the fetus the woman might conceive); *Frontiero v. Richardson*, 411 U.S. 677 (1973) (holding that different qualification criteria for men and women military spousal dependency is unconstitutional and should be reviewed under heightened scrutiny); *Reed v. Reed*, 404 U.S. 71 (1971) (holding an Idaho statute preferring men as between persons equally qualified to administer estates unconstitutional); *Cmtys.*

*for Equity v. MI High School Athletic Ass'n*, 459 F.3d 676 (6th Cir. 2006) (finding a high school athletic association violated the constitution by scheduling girls' sports to play in disadvantageous, nontraditional seasons). The Clause prohibits predicating a person's legal status on "ideology about women's roles . . . when they are mothers or mothers-to-be." *Nevada Dep't of Human Res. v. Hibbs*, 538 U.S. 721, 736 (2003) (affirming Congress' Fourteenth Amendment power to enact the Family Medical Leave Act, citing Congressional testimony prior to its enactment).

Further, states may not single people out for gender-based differential treatment absent an "important governmental interest," and unless "the discriminatory means employed [are] substantially related to the achievement of those objectives." *Virginia*, 518 U.S. at 531 (citation omitted). The burden on substantive due process rights presented by this case also mandates a close look at the asserted interests and their impact on individual rights. *See, e.g., M.L.B. v S.L.J*, 519 U.S. 102, 120-121 (1996) (in the context of access to courts when family rights are at stake, holding that these cases raise intersecting equality and due process issues); *see also Obergefell v. Hodges*, 135 S. Ct. 2584, 2603 (2015) ("[T]he Due Process Clause and the Equal Protection Clause are connected in a profound way… this interrelation furthers our understanding of what freedom is and must become."); *Thornburgh v. Amer. Coll. of Obstetricians & Gynecologists*, 476 U.S. 747, 772 (1986) ("A woman's right [to end a pregnancy] freely is fundamental. Any other result . . . would protect inadequately a central part of the sphere of liberty that our law guarantees equally to all.").

### 2. Holding women criminally accountable for pregnancy outcomes is gender discrimination in service of no legitimate state interest.

Expanding Indiana's criminal code to punish pregnant women places burdens on women throughout their reproductive lives that those without the capacity for pregnancy will never face. Indeed, these burdens – because they entail the potential for criminal conviction, incarceration, and all the consequences that flow from being permanently branded a felon – are as or more destructive of gender equality as those burdens faced by women who sought admission to male-only schools, or freedom from gender-based workplace restrictions. They create a stamp of second-class status that undermines the right to participate in society as an equal.

Using Indiana's feticide law to encompass unintentional pregnancy loss or abortions – first in the case of Bei Bei Shuai, for attempting suicide, and now against Purvi Patel, for attempting or completing an abortion – puts pregnant women in Indiana in a class different from all others. Police may scrutinize their private medical records, and prosecutors and juries may second-guess their health care and reproductive decisions, depriving them as a class of their rights to bodily integrity and medical decision-making. *See e.g., In re A.C.*, 573 A.2d at 1248. They will be required to make sacrifices that no one else must, and that other courts have already rejected for pregnant women. *Id.*; *see also McFall v. Shimp*, 10 Pa.D. & C.3d 90 (Pa. 1978) (refusing to order a man to undergo a bone marrow transfusion for the benefit of a cousin who would otherwise die). Expecting such sacrifices from

pregnant women, under threat of criminal prosecution, creates a gender-based discrimination that cannot withstand constitutional scrutiny.

That is because this discrimination is not justified by a legitimate state interest. While Indiana has recognized a state interest in potential life, *see* I.C. § 16-34-1-1 (preferring childbirth over abortion), criminalizing abortion has never served that interest – it simply drives abortion underground, endangering public health.[44] Similarly, as explained above, punitive sanctions prevent pregnant women from seeking medical care, putting public health further at risk. Such outcomes are not substantially related to Indiana's interest in potential life. Indiana should not travel any longer down the path to being one of the few states that, despite all public health evidence against it, uses its criminal codes to police the health, actions, and circumstances of pregnancy.

## CONCLUSION

The Indiana General Assembly has not authorized the use of the criminal code to punish pregnant women for intentional and unintentional pregnancy outcomes. To do so would enshrine in law second-class status for pregnant women, subjecting virtually every aspect of their lives to state oversight and punishment. *Amici* urge this Court to reject this proposed expansion of Indiana law and reverse the conviction of Purvi Patel. Allowing this misuse of Indiana law would undermine public health and threaten the civil rights of all pregnant women in Indiana.

[44] *See, e.g.,* ACOG *Committee Op. No. 613, supra* note 31 at 2; *On the Brink of Death, supra* note 4.

Respectfully submitted this 2nd day of October, 2015.

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## CERTIFICATE OF WORD COUNT

Pursuant to Ind. Appellate Rule 44 F., I verify that this brief contains no more than 7,000 words, excluding the parts of the brief exempted pursuant to 44 C. I verify that this brief 6,977 contains words.

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## CERTIFICATE OF SERVICE

The undersigned hereby certifies that a copy of the foregoing has been served upon the following, by U.S. First Class Mail, postage prepaid, this ___ day of October, 2015:

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## APPENDIX: STATEMENTS OF INTEREST OF AMICI CURIAE

### Organizations

**National Advocates for Pregnant Women (NAPW)** is the only organization in the United States that works exclusively to defend the civil, constitutional, and human rights of pregnant women. A nonprofit public interest law organization, NAPW provides representation, consultation, and conducts research to identify cases where people have been targeted for prosecution, child welfare proceedings, and forced medical interventions because of their pregnancies. Founded in 2001, NAPW has been involved as *amicus* or counsel in cases throughout the country in which states have attempted to use the criminal law to punish pregnant women for the decisions they make, their health conditions, and their pregnancy outcomes.

**Indiana Chapter of National Organization for Women (Indiana NOW)** is a multi-issue, multi-strategy organization that takes a holistic approach to women's rights. NOW is a membership-based organization, with hundreds of thousands of contributing members and more than 500 local and campus affiliates in all 50 states and the District of Columbia. Our official priorities are winning economic equality and securing it with an amendment to the U.S. Constitution that will guarantee equal rights for women; championing abortion rights, reproductive freedom and other women's health issues; opposing racism and fighting bigotry against lesbians and gays; and ending violence against women. Since our national founding in 1966, NOW's goal has been "to take action" to bring about equality for all women. We are particularly concerned about this case because we are against criminalization of pregnancy, Indiana's feticide law was intended to apply to the knowing or intentional termination of another's pregnancy, and prosecuting women for their pregnancy outcomes will result in unintended consequences -- namely women will fear seeking help for emergencies relating to pregnancy, because of fear of prosecution. That can only result in worse pregnancy outcomes.

**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.

**National Perinatal Association (NPA)** promotes the health and wellbeing of mothers and infants, enriching families, communities and our world. NPA is a multi-disciplinary organization comprised of doctors, nurses, midwives, social workers, administrators, parents, and those interested in collaborating to improve perinatal health.

**Our Bodies Ourselves (OBOS)** provides clear, truthful information about health, sexuality and reproduction from a feminist and consumer perspective. OBOS vigorously advocates for women's health by challenging the institutions and systems that block women from full control over their bodies and devalue their lives. OBOS is noted for its long- standing commitment to serve only in the public interest and its bridge-building capacity. OBOS is dedicated to the autonomy and well being of all women.

**Physicians for Reproductive Health (PRH)** is a doctor-led national not-for-profit organization that relies upon evidence-based medicine to promote sound reproductive health care policies. Comprised of physicians, PRH brings medical expertise to discussions of public policy on issues affecting reproductive health care and advocates for the provision of comprehensive reproductive health services as part of mainstream medical care.

**Drug Policy Alliance (DPA)** is the nation's leading advocacy organization dedicated to broadening the public debate over drug use and regulation and to advancing pragmatic drug laws and policies, grounded in science, compassion, public health and respect for human rights. DPA is a non-profit, non-partisan organization with more than 25,000 members and active supporters nationwide. DPA has actively taken part in cases in state and federal courts across the country in an effort to bring current scientific and public health data to bear on drug-related issues, and to combat irrational fears, prejudices and misconceptions about various drug-related matters that have, with regrettable frequency, distorted sound public policies regarding drug users and their families.

## 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 advocated for better access to effective treatment instead of criminalization of the sick.

**Elizabeth M. Armstrong, PhD, MPA,*** holds a joint appointment in the Department of Sociology and the Woodrow Wilson School at Princeton University and is a faculty associate at both the Office of Population Research and the Center for Health and Wellbeing. She has published and authored articles in the scholarly literature on substance use during pregnancy, family planning, adolescent motherhood, and the sociology of pregnancy and birth, including the first book to challenge conventional wisdom about drinking during pregnancy: *Conceiving Risk, Bearing Responsibility: Fetal Alcohol Syndrome and the Diagnosis of Moral Disorder*. Her current research includes a longitudinal study of agenda setting around disease in the U.S. and a study of fetal personhood and obstetrical ethics.

**Sheila Blume, MD,*** is retired medical director of Addiction Services at South Oaks Hospital and Clinical Professor of Psychiatry at the State University of New York at Stony Brook. Dr. Blume is a Fellow and former President of the American Society of Addiction Medicine and a Distinguished Life Fellow of the American Psychiatric Association, where she chaired the Committee on Treatment Services for Addicted Patients for several years.

**Page Burkholder, MD** is a founding member of the Institute of Cognitive Therapy for Psychosis (ICTP) and is Board Certified in Psychiatry and Neurology with Additional Qualifications in Addiction Psychiatry. She is a graduate of the Public Psychiatry Fellowship at Columbia/Presbyterian, Assistant Clinical Professor of Psychiatry at SUNY Downstate/Brooklyn and a Fellow of the Academy of Cognitive Therapy. Currently the Director of Clinical Services at South Beach Psychiatric Center, NY, she is involved in the training and clinical implementation of Cognitive Therapy for Psychosis, combining her career-long dedication

to community psychiatry and the CBT for Psychosis collaborative approach to Recovery from Serious Mental Illness.

**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.

**R. Alta Charo, JD,*** is a professor of law and bioethics. An elected member of the National Academies' Institute of Medicine, and formerly a member of President Clinton's National Bioethics Advisory Commission, she has written over 100 articles and reports on ethics and policy relating to human reproduction, genetic health, and medical research.

**Julia Frank, MD*** focuses partly on perinatal psychiatric disorders and treatment, within the context of a more general psychiatric practice. Dr. Frank has also previously served as faculty advisor for a local chapter of Medical Students for Choice, and has developed curricula for medical students about the ethics, procedures and psychological outcomes of pregnancy or pregnancy termination.

**Wendy Chavkin, MD, MPH,*** is a Professor of Population and Family Health and Obstetrics-Gynecology at the Mailman School of Public Health and the College of Physicians and Surgeons at Columbia University. She has written extensively about women's reproductive health issues for over two decades and done extensive research related to pregnant women, punishment and barriers to care.

**Cherryl Friedman, MD,** is a retired Indiana psychiatrist, certified by the American Board of Psychiatry and Neurology. Dr. Friedman graduated from the Indiana University School of Medicine in 1976 and completed residency at the University's Department of Psychiatry. Dr. Friedman's entire psychiatric career was spent in private practice in Indiana, primarily maintaining a private practice in Noblesville. In addition, Dr. Friedman was one of the psychiatrists/owners of a multi-disciplinary mental health clinic, the Indiana Psychiatric Consortium, in Indianapolis. For about ten years Dr. Friedman was a Clinical Assistant Professor of Psychiatry in the Department of Psychiatry at the Indiana University Medical School. Dr. Friedman lectured to psychiatric residents in the area of Women's Issues and supervised some of the psychiatric resident physicians in psychotherapy. While treating a wide range of persons with psychiatric disorders, Dr. Friedman saw a good proportion of patients with Post-Traumatic Stress Disorder, Anxiety,

Depression and Dissociative Disorders, and later was trained and became certified in EMDR psychotherapy.

**Leslie Hartley Gise, MD,*** is Clinical Professor of Psychiatry at the John A. Burns School of Medicine, University of Hawaii. 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.

**Hilde Lindemann, PhD,*** is Professor of Philosophy and Associate in the Center for Ethics Humanities in the Life Sciences at Michigan State University. A Fellow of the Hastings Center and a past president of the American Society for Bioethics and Humanities, her ongoing research interests are in feminist bioethics, feminist ethics, the ethics of families, and the social construction of persons and their identities. She has published numerous books and articles, including *The Patient in the Family: An Ethics of Medicine and Families* with James Lindemann Nelson. She is the former editor of The Hastings Center Report and other journals, and co-editor of compilations.

**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, D.C., 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, 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 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.

**Terry McGovern, JD,*** is a Professor at Mailman School of Public Health at Columbia University. She directs the Gender, Rights and Health program and the human rights concentration. She is co-editor of Women and Girls Rising, progress and resistance around the world, a global anthology on women and girls rights as well as author of numerous articles including *No Risk, No Gain: Invest in Women and Girls by Funding Advocacy, Reproductive Health Matters*. She founded the HIV Law Project in 1989 and was lead counsel on successful litigation regarding gender discrimination against the FDA, HHS and numerous other policy entities. She was a senior Program Officer in the Gender, Rights and Equality Unit of the Ford Foundation from 2006-2012.

**Daniel R. Neuspiel, MD, MPH,*** is Director of Ambulatory Pediatrics at Levine Children's Hospital and Clinical Professor of Pediatrics at University of North Carolina School of Medicine in Charlotte, NC. As a pediatrician, he has cared for hundreds of drug-affected infants and children, has published research on the impact of maternal substance use and abuse on infants, and has lectured widely as an expert on this topic.

**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.

**Michael Perlin, JD,*** is the Director of the International Mental Disability Law Reform Project and the Online Mental Disability Law Program of the New York

Law School. He is an internationally-recognized expert on mental disability law, and has authored 23 books and nearly 300 scholarly articles on the subject. He has spoken and taught around the world on issues related to the human rights of people with mental disabilities. Under the aegis of Mental Disability Rights International (MDRI), a Washington, DC-based human rights advocacy NGO, Professor Perlin has done site visits and conducted mental disability law training workshops in Hungary, Estonia, Latvia, Uruguay, and Bulgaria. He has taught international human rights, criminal procedure and mental disability law in Finland, Israel, Taiwan, Nicaragua, Japan, and Indonesia.

**Dorothy E. Roberts, JD,*** is the fourteenth Penn Integrates Knowledge Professor, George A. Weiss University Professor, and the inaugural Raymond Pace and Sadie Tanner Mossell Alexander Professor of Civil Rights at University of Pennsylvania, where she holds appointments in the Law School and Departments of Africana Studies and Sociology. An internationally recognized scholar, public intellectual, and social justice advocate, she has written and lectured extensively on the interplay of gender, race, and class in legal issues and has been a leader in transforming public thinking and policy on reproductive health, child welfare, and bioethics. Professor Roberts is the author of the award-winning books *Killing the Black Body: Race, Reproduction, and the Meaning of Liberty* (Random House/Pantheon, 1997) and *Shattered Bonds: The Color of Child Welfare* (Basic Books/Civitas, 2002), as well as co-editor of six books on constitutional law and gender. She has also published more than eighty articles and essays in books and scholarly journals, including Harvard Law Review, Yale Law Journal, and Stanford Law Review. Her latest book, *Fatal Invention: How Science, Politics, and Big Business Re-create Race in the Twenty-First Century*, was published by the New Press in July 2011. Among her many public interest positions, Roberts is the chair of the Board of Directors of the Black Women's Health Imperative.

**Mishka Terplan, MD, MPH, FACOG,*** is Assistant Professor of Obstetrics, Gynecology & Reproductive Sciences and Epidemiology & Public Health at the University of Maryland School of Medicine and Staff Physician at Mercy Medical Center and Planned Parenthood. He is board certified in both OB/Gyn and Addiction Medicine and has done extensive research related to pregnant women with drug and alcohol problems.

**Bruce Trigg, MD,*** was, until 2011, the medical director of the Sexually Transmitted Disease program for Regions 1 and 3 of the New Mexico Department of Health. He also served as medical director of a public health program that offers

reproductive and infectious disease programs at the Bernalillo County Metropolitan Detention Center, in Albuquerque, NM. For 20 years Dr. Trigg provided clinical care to patients as part of the Milagro Program, for pregnant women who use drugs, at UNM Health Sciences Center. He is currently a Clinical Assistant Professor in the Department of Pediatrics at UNM and on the faculty of the Adolescent Reproductive and Sexual Health Education Project (ARSHEP) of Physicians for Reproductive Health. Since 2011, Dr. Trigg has been a clinician in Opioid Treatment Programs in Albuquerque and Santa Fe, NM where he treats patients with methadone and buprenorphine. Dr. Trigg attended the George Washington University School of Medicine in Washington, DC. He did his residency in pediatrics at the Albert Einstein College of Medicine in NYC and at the UNM School of Medicine. Dr. Trigg served three years with the US Public Health Service in the Indian Health Service in Native American communities in NM and AZ.

**Linda L.M. Worley, MD,*** former professor of Psychiatry with a secondary appointment in Obstetrics and Gynecology in the College of Medicine at the University of Arkansas for Medical Sciences (UAMS) is an Adjunct Professor of Medicine at the Vanderbilt School of Medicine. She is a board certified Psychiatrist with sub-specialization in Psychosomatic Medicine and is the Immediate Past President of the Academy of Psychosomatic Medicine. She received the American Psychiatric Association Gold Award for directing a model program for the nation for addiction treatment for women with their children.

**Tricia E. Wright, MD, MS, FACOG, Diplomate ABAM,*** is an assistant professor of Obstetrics, Gynecology at the University of Hawaii John A. Burns School of Medicine and the founder, former medical director, and now Women's Health Liaison of the PATH Clinic, an outreach clinic of Waikiki Health Center, which provides prenatal, postpartum and family planning to women with a history of substance use disorders. She is board certified in both OB/Gyn and Addiction Medicine and a Fellow of the American College of Obstetricians and Gynecologists. She specializes in taking care of pregnant women with substance use disorders and psychiatric illness. She won funding approval in 2006 from the Hawaii legislature to start the first perinatal clinic for women with substance use issues in the state. Her research interests include substance use disorders among pregnant women, including barriers to family planning, and best practices for treatment.

*****_Affiliation listed for identification purposes only_