The Risks of State Intervention in Preventing Prenatal Alcohol Abuse and the Viability of an Inclusive Approach: Arguments for Limiting Punitive and Coercive Prenatal Alcohol Abuse Legislation in Minnesota

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I. INTRODUCTION

Uniqueness and freedom have as their consequence that one can never regard other people merely as means, but must always treat them as ends in themselves. As beings they have the fundamental authority to define their existence and its meaning themselves, including their own values and their own morality. In this way it becomes not morality but ethics—understood as the meta-discussion of morals and how they function together in a common system, which is the universal basis for any discussion of values. We must therefore accept that we can find no universal morality. 

In 1997, Minnesota took up the far-reaching responsibility of studying the impact of Fetal Alcohol Syndrome (FAS) and Fetal Alcohol Effect (FAE) on the state. The first Governor’s Task Force on Fetal Alcohol Syndrome in 1997. See State of Minnesota, Suffer the Children: The Preventable Tragedy of Fetal Alcohol Syndrome (Feb. 1998) [hereinafter Suffer the Children]. First Lady Carlson is also a Referee in Minnesota District Court.

Fetal Alcohol Syndrome (FAS) and Fetal Alcohol Effect (FAE) are physical and mental birth defects that are the result of a woman’s ingestion of alcohol while pregnant. See The National Organization on Fetal Alcohol Syndrome [hereinafter NOFAS Fact Sheet], Fetal Alcohol Syndrome Fact Sheet [hereinafter NOFAS Fact Sheet] (visited Mar. 1, 1998) <http://www.nofas.org/stats.htm>. It is unknown how much alcohol consumption during pregnancy triggers the onset of FAS or FAE. Therefore, most studies and experts suggest that women should not drink at all while pregnant. See id. FAS is considered to be "the leading known cause of mental retardation." Id. FAS and FAE are not genetic; a pregnant woman must ingest alcohol, a teratogen, in order to expose a fetus to FAS and/or
Syndrome (FAS Task Force or Task Force) was an advisory group comprised of forty-six individuals representing all branches of state government, the legal, medical, educational and social service communities, as well as interested members of the general public. Among the diverse goals of the FAS Task Force were to hold open hearings across Minnesota and then to introduce new laws in the 1998 state legislative session to fund public awareness campaigns, increase community service programs, regulate maternal behavior, train health care professionals, educators, and social workers, and create more treatment opportunities for pregnant women and their FAS/FAE-affected children.

However, these laudable efforts are clouded by two actions—one successful, one failed for the meantime—which invite the ever-expanding national conflict between maternal and fetal rights deeper into Minnesota, and further encourage the emerging national policy endorsing punitive and coercive responses to maternal substance abuse. The successful action is a new law that provides legal immunity to health-care professionals who report pregnant women with drinking problems to the Maternal Child Substance Abuse Project or to a welfare agency. The law is similar to an

FAE. See Governor's Task Force Meeting on Fetal Alcohol Syndrome, Sept. 23, 1997 (minutes).

Symptoms associated with FAS include: “organ dysfunctions, growth deficiencies before and after birth, central nervous dysfunctions resulting in learning disabilities and lower IQ, and physical malformities in the face and cranial areas. In addition, children may experience behavioral and mental problems which progress into adulthood.” Id. FAE encompasses a similar set of symptoms as FAS but FAE-affected individuals do not exhibit the distinctive physical malformities associated with FAS. See id. See Section II for further details on FAS and FAE.

3. For a complete FAS Task Force member list see SUFFER THE CHILDREN, supra note 2, at 2.

4. See SUFFER THE CHILDREN, supra note 2. See also Susan Carlson, Carlson Administration Has Been Friend of Women's Health, STAR TRIB., Mar. 7, 1998, at 19A.

A centerpiece of our proposal is to provide services for chemically dependent pregnant women and women with children, services that are lacking in Greater Minnesota and in some parts of the metropolitan area... Programs like these will help women get prenatal care as well as services, such as child care, transportation, mental health, and whatever else they need to remain chemically free.

S.B. No. 3346 appropriated $5 million to FAS-related programs. S.F. No. 3346, 80th Leg., 3d Engrossment (Minn. 1998). For the text of the bill see infra note 74.

5. See H.F. No. 3645 subd. 4 (Minn. 1998).

Any person reporting in good faith and exercising due care shall have immunity from any liability, civil or criminal, that otherwise might result by reason of the person's actions pursuant to this section. No cause of action may be brought against any person for not making a report pursuant to this section.

Id.

"Pregnant women who abuse alcohol would be reported for chemical-use assessment or to a local welfare agency." Robert Whereatt, Fetal Alcohol Reporting Bill Goes to Governor, STAR TRIB., Apr. 1, 1998, at 3B. See also Conrad de Fiebre et al., Legislative Roundup: A Quick Guide to How Key Issues Were Resolved, STAR TRIB., Apr. 10, 1998, at
existing statute granting immunity to medical practitioners for reporting a
pregnant woman using controlled substances. According to its sponsors,
the purpose of the alcohol abuse bill is to prompt referrals for treatment and
education. However, the conceivable long-term result is that pregnant
women who drink will be deterred from seeking vital prenatal care and
personal treatment for fear of losing their parental rights (of the newborn or
of children they already have), losing temporary or permanent public
benefits and, as seen in some states, being subject to criminal prosecution.
Furthermore, the threat of liability-free reporting compromises the
confidential physician-patient relationship. The FAS Task Force has

18A. The Task Force report includes a proposal for mandatory reporting of alcohol use
during pregnancy that would give the woman an opportunity to voluntarily receive
treatment. See SUFFER THE CHILDREN, supra note 2, at 16. The report defines alcohol abuse
as meeting one of the following conditions:

[A woman]
1) requires detoxification during pregnancy
2) habitually consumes three or more drinks at one time since knowing of
pregnancy
3) refuses to stop excessive drinking during pregnancy
4) appears intoxicated based on two or more of the following indicators:
   odor of alcohol, slurred speech; disconjugate eyes (eyes do not track
together); impaired balance; difficulty remaining awake; consumption of
   alcohol; responding to sights or sounds that are not actually present; or
   extreme restlessness, fast speech or unusual belligerence.

Id.

6. MINN. STAT. § 626.5561 subd. 5(a) (1997). Unlike the alcohol reporting law, this
statute does not provide immunity to persons failing to make a report. Id. at subd. 5(b).

7. MINN. STAT. § 626.5561 subd. 5(b). The Bill's chief sponsor was Representative
Wes Skoglund, DFL-Minneapolis. See id. "If the woman doesn't comply with a plan drawn
up by the agency, the county can use civil commitment procedures to require treatment." de
Fiebre, supra note 5, at 18A.

8. See Interview with Deborah Thorp, M.D., Department Chair, Obstetrics and
Gynecology, Park-Nicollet Clinic/Health System Minneapolis, Minnesota, (Apr. 7, 1998)
(Notes on file with author). See also Patricia A. Sexton, Imposing Criminal Sanctions on
Pregnant Drug Users: Throwing the Baby Out With the Bath Water, 32 WASHBURN L.J.
410, 420-22 (1993); David F. Chavkin, For Their Own Good: Civil Commitment of Alcohol
and Drug-Dependent Pregnant Women, 37 S.D. L. REV. 224, 244 (1992). See generally
James M. Wilton, Compelled Hospitalization and Treatment During Pregnancy: Mental
Health Statutes as Models for Legislation to Protect Children from Prenatal Drug and

[P]rison is not the answer to the problems of high risk pregnant women,
including substance abusing or dependent women. Punitive strategies—
including incarceration, mandated treatment, or withdrawal of public service
benefits—which at times have been advocated to force high risk pregnant
women to modify their potentially risky health behaviors (such as substance
abuse) in order to improve the health of the fetus, may actually 'backfire' by
causing high risk women to avoid health and social services that could be
helpful to them.

Sandra L. Martin et. al., The Effect of Incarceration During Pregnancy on Birth Outcomes,

shall not, without the consent of the patient, be allowed to disclose any information or any
opinion based thereon which the professional acquired in attending the patient in a
acknowledged that “prenatal intervention should not be punitive,” yet laws expanding legal immunity send the opposite message, one that detracts conspicuously from an overall positive program of cooperative public measures.  

The FAS Task Force also sought to expand Minnesota’s Civil Commitment Act to include pregnant women who drink by modifying the definition of a “chemically dependent person.” Under the proposed civil commitment procedure, a woman who cannot or refuses to stop drinking would be referred for chemical screening and assessment, which could possibly lead to involuntary placement in a treatment program for the duration of her pregnancy. It is certainly true that pregnant women need access to alcohol and substance abuse treatment, especially women living in low-income communities. However, in the related contexts of civil professional capacity, and which was necessary to enable the professional to act in that capacity . . . .” Id. According to the Hippocratic Oath required of all physicians, confidentiality is a hallmark of the profession: “All that may come to my knowledge in the exercise of my profession or outside of my profession or in daily commerce with men, which ought not to be spread abroad I will keep secret and will never reveal.” STEDMAN’S MEDICAL DICTIONARY 799 (26th ed. 1995). See also Robert Whereatt & Gordon Slovut, Drastic Steps Aim to Fight Alcohol Use in Pregnancy, STAR TRIB., Feb. 6, 1998, at 1B.

10. SUFFER THE CHILDREN, supra note 2, at 23. “A judgmental attitude will sabotage prevention and treatment.” Id.

11. Id. at 15. The Task Force recommended the following:

Expand the Civil Commitment Act to allow for a pregnant woman unable to stop abusing alcohol to be placed in the least restrictive alternative necessary to receive appropriate treatment. Revise the definition of “chemically dependent person” to include a pregnant woman who has engaged in acts of alcohol abuse (as defined in the proposal for mandatory reporting). Include an evaluation component in any legislation implementing this expansion of the Civil Commitment Act.

Id. See also MINN. STAT. § 253B.02 (1995). If the court finds by clear and convincing evidence that the proposed patient is a mentally ill, mentally retarded, or chemically dependent person and, that after careful consideration of reasonable alternative dispositions, including but not limited to, dismissal of petition, voluntary outpatient care, informal admission to a treatment facility, appointment of a guardian or conservator, or release before commitment . . . it finds there is no suitable alternative to judicial commitment, the court shall commit the patient to the least restrictive treatment program which can meet the patient’s treatment needs .

Id. at subd. 1.

12. See Whereatt & Slovut, supra note 9, at 1B.

13. See Chavkin, supra note 8, at 240.

Treatment programs are not generally available to serve alcohol and drug-dependent women seeking treatment. Those programs that do exist all too frequently screen out pregnant women for admission. Public and third-party payment programs all too often do not cover or fail to fund the very services needed to treat dependence or addiction.

Id. “I’m worried that it’s not going to be women of privilege who get reported . . . .” Susan Wolf, Professor of Law and Medicine, University of Minnesota, quoted on Minnesota Public Radio, April 10, 1998. “Although white women abuse substances at higher rates, women of color are ten times more likely to be reported to law enforcement or child welfare
commitment and mandatory reporting, a treatment expansion proposal treads uncomfortably close to abridging a woman’s civil rights.\(^{14}\) Although the Minnesota legislature declined to enact a civil commitment measure during the 1998 session, it is by no means a non-issue. The mere suggestion of a punitive or coercive approach opens the door to more troublesome outcomes in the future, if only by virtue of the continual trend toward polarization of fetal and women’s rights in this country and the demonstrated tendency to discriminate on the basis of class and race in reporting and treatment contexts.\(^{15}\)

This paper explores the problems inherent in a state interventionist approach to prenatal alcohol use and abuse by women.\(^{16}\) In recent years, it has become evident that the public expects government and legal systems to enact and enforce tougher laws to curb women’s behavior during pregnancy.\(^{17}\) Punitive and coercive measures are increasingly

\begin{itemize}
    \item Lisa Janovy Keyes, Rethinking the Aim of the “War on Drugs”: States’ Roles in Preventing Substance Abuse by Pregnant Women, 1992 Wis. L. Rev. 197, 208 (1992).
    \item But what about a pregnant woman who is not an alcoholic yet refuses to stop drinking? Sen. Don Betzold, DFL-Fridley, an authority on civil commitment law, said courts generally have approved commitment laws that protect patients. But, he asked, at what stage of drinking would courts find commitment of a pregnant woman permissible?
    \item The focus of this paper will be on the use and abuse of alcohol during pregnancy. Many of the cited sources contemplate controlled substance use and abuse during pregnancy as well as related cases where state interests in fetal rights have come into conflict with a woman’s behavior. However, these sources advance theories and issues that are applicable to discussions concerning the subject of drinking during pregnancy.
    \item Priscilla Smith, a staff attorney with the Center for Reproductive Law and Policy in New York, says that prosecution of pregnant women for behavior that is harmful to their fetuses began during the mid-1980s. See Judy Peres, State Role Regulating Pregnancy Thwarted: Jehovah’s Witness Mom Wins Appeal, Chi. Trib., Mar. 29, 1998, at 1C. Most courts rejected these prosecutions by “ruling that a fetus is not a person under criminal statutes.” Id. However, recent decisions have marked a change in some courts’ approaches. See cases cited infra at note 18. See also Sharon Krum, Women: A Deadly Addiction, The Guardian (London), Aug. 7, 1997, at T4. “[T]he new zeal by American prosecutors to lash out at mothers who commit foetal [sic] abuse is rooted in anger rather than in compassion and common sense. ‘Clearly there is a sentiment that people are not taking responsibility for themselves or their babies….’” Id. (quoting Priscilla Smith, who heads the Center for Reproductive Law and Policy in New York City and represents Deborah
commonplace across the United States. Related cases have placed state interests in protecting the rights of a fetus in direct conflict with a woman’s rights of privacy and bodily integrity, further calling into question community and personal values surrounding the concept of maternal duty. In a society where one’s actions during pregnancy are scrutinized as a matter of public policy and obligation, it is no longer possible for the status of motherhood to belong to the individual woman. The fine line between morality and legality has disappeared, leaving a pregnant woman in a politically vulnerable position where her self-determination is negated by the ‘greater good’ of the law. Finally, in an environment where extreme criminal and civil ‘retaliatory’ actions become the norm, there can be no guarantee that the deterrent, utilitarian and rehabilitative goals of punishment will prevail. Future harms are only addressed in an overbroad manner that impossibly implicates individual liberty interests. In essence, only a societally-sanctioned revenge on the ‘bad mother’ is achieved through a punishment-oriented system. These negative circumstances serve no substantial state, fetal or maternal interests, and the


“Since 1985, at least 200 women in thirty states have been criminally prosecuted for the use of illicit drugs or alcohol during pregnancy through a variety of tactics.” Sarah Letitia Kowalski, Looking for a Solution: Determining Fetal Status for Prenatal Drug Abuse Prosecutions, 38 SANTA CLARA L. REV. 1255, 1255 (1998) (citing Philip H. Jos et. al., The Charleston Policy on Cocaine Use During Pregnancy: A Cautionary Tale, 23 J. L. MED. & ENCRS 120 (1995)).

18. See The CENTER FOR REPRODUCTIVE LAW AND POLICY, PUNISHING WOMEN FOR THEIR BEHAVIOR DURING PREGNANCY (Feb. 1996) [hereinafter PUNISHING WOMEN FOR THEIR BEHAVIOR DURING PREGNANCY]. Estimates indicate that at least 200 women in more than 39 states have been arrested and criminally charged for actions taken during their pregnancies. See LYNN M. PALTROW, CRIMINAL PROSECUTIONS AGAINST PREGNANT WOMEN: NATIONAL UPDATE AND OVERVIEW (1992). See also Whitner v. South Carolina, 492 S.E.2d 777 (1997); Zimmerman, 1996 WL 858598, at *1. In Grand Isle, Louisiana, police arrested Lori Ingram for negligent homicide after the medical examiner “concluded there was ‘strong likelihood’ that alcohol and drugs caused her baby to be stillborn.” Cocaine Law Targets Pregnant Black Women, OAKLAND POST, June 14, 1998, at 1. District Attorney Paul Connick Jr. is considering prosecuting Ingram for abusing alcohol while pregnant. Id.


20. See REGULATING WOMANHOOD 31 (Carol Smart ed., 1992). “The construction of women’s bodies as unruly and as a continual source of potential disruption to the social order has given rise to more and more sophisticated and flexible mechanisms for imposing restraint and achieving desired docility.” Id.


23. See DRESSLER, supra note 22, at 12.
problem continues.

After a brief overview of the current effects of FAS and FAE in Minnesota, and in the United States generally, and the FAS Task Force’s corresponding response, this paper will propose a value system for evaluating the problem of alcohol use and abuse during pregnancy. These values are collectively characterized as the Mutual Responsibility Approach (Mutual Responsibility Approach, Mutual Responsibility or approach). This system recognizes a unique symbiotic relationship between a pregnant woman and the state. In essence, if the state expects a woman to fulfill her maternal duty by not drinking or otherwise harming her fetus, then a woman may validly expect the state to help her achieve this goal through means that respect her individual civil rights, personal values and human dignity. Under the Mutual Responsibility Approach maternal duty is reaffirmed as a positive, individual experience that cannot be defined strictly by the state. Maternal duty can be recognized and encouraged legislatively under a system based on morality, but this morality cannot be monolithic in its definition. Pregnant women who drink have suspended their maternal duty but they are not without principles; these women still have the ability to meet their moral obligations but need assistance to do so. If the state does not respond to the needs of these women through education and treatment opportunities, the state itself is without morality.

The ideas encompassed by the Mutual Responsibility Approach favor inclusive problem-solving, which means a cooperative relationship between the pregnant woman and the state. Social responsibility is preferred over individual castigation. Primarily, the Mutual Responsibility Approach deconstructs the maternal-fetal conflict and reconfigures maternal duty as an individually-defined concept. This result recognizes that a woman has obligations to the health of her fetus, but these duties do not diminish her own identity or confer a greater societal duty. The Mutual Responsibility Approach recognizes that a woman’s environment—positive or negative— influences her relationship with the fetus. The Mutual Responsibility Approach also avoids blanket subjective assessments of maternal morality in the legal and social contexts. Universal morality systems are fundamentally unfair; communities of color, for example, are already harmed by a race-biased system of mandatory reporting,24 and therefore any value system must incorporate a philosophy that respects different solutions to the same problem. Mutual Responsibility also considers the constitutional clash between fetal and sex equality rights, and takes the position that FAS/FAE cannot be ‘ghettoized’ as a woman’s problem.

Finally, the Mutual Responsibility Approach will be contrasted with

24. See Keyes, supra note 13.
punitive and coercive tactics such as mandatory reporting, civil commitment and prosecution. The approach described herein rigorously advocates the characterization of alcoholism as a disease requiring treatment through increased rehabilitation opportunities—a stance taken by the FAS Task Force recommendations. In addition, the Mutual Responsibility Approach includes the added options of treatment on demand, community education, incentive programs and self-driven, nonjudgmental support opportunities that preserve a woman's individual rights while at the same time addressing a critical social problem. Overall, the values embodied by the Mutual Responsibility Approach emanate from the perspective that the state has an obligation to assist pregnant women in overcoming their use and abuse of alcohol.

II. FETAL ALCOHOL SYNDROME AND FETAL ALCOHOL EFFECT IN MINNESOTA AND THE UNITED STATES: THE FAS TASK FORCE RESPONSE

A) ORIGIN, EPIDEMIOLOGY AND SYMPTOMS

FAS was formally named in 1973, but the dangerous link between alcohol and pregnancy had been suspected for some time. Although a link between alcohol and pregnancy was suspected, FAS was rarely studied or taken seriously until recently. Many doctors during the 1950s and 1960s attributed possible alcohol-related disorders to poor home environment. Alcohol was often prescribed to pregnant patients as a means of relaxation. However, attitudes changed considerably by 1981 when the Surgeon General recommended that pregnant women and women considering pregnancy should avoid consumption of alcoholic beverages.

Despite warnings from medical experts, instances of FAS and FAE continue to occur. Recent studies indicate that 0.5 to 3 cases of FAS occur per 1,000 births, which translates into a range of 2,000 to 12,000 births in...
the United States each year.29 FAE may affect 36,000 newborns annually.30 In Minnesota, it is estimated that as many as 900 children are born with FAS or FAE per year.31 The state is currently home to some 16,000 FAS and FAE youth under the age of 21 who represent a cross-section of cultures, races and socio-economic groups.32 Further, some 27,000 babies born in Minnesota each year have had at least a small amount of prenatal alcohol exposure during their mother’s pregnancy.33

The effects of alcohol on a fetus are immediate and severe. Alcohol, a teratogen, affects the fetus within as little as fifteen minutes after the mother ingests a drink.34 The fetus will assume the same blood alcohol content as the mother but it will not metabolize and eliminate the alcohol as quickly.35 This combination of factors makes FAS and its related effects the leading cause of preventable mental retardation in both Minnesota and the United States,36 yet FAS remains among the most under-diagnosed of childhood disorders.37 There are no specific lab tests for determining the presence of FAS or FAE. Instead, diagnosis of these conditions depends entirely on clinical judgment and reliance on “minimal criteria” set by the Fetal Alcohol Study Group.38

FAS and FAE create permanent physical and mental conditions. These terms do not, as commonly misunderstood, simply describe a “drunk baby”

29. FAS, Executive Summary: Diagnosis, Epidemiology, Prevention and Treatment (Kathleen Stratton et al. eds., National Academy Press, Division of Biobehavioral Sciences and Mental Disorders) [hereinafter Executive Summary] (visited Mar. 1, 1998) <http://www.nap.edu/readingroom/books/fetal/index.html>.


31. See DOH/MOD Fact Sheet, supra note 25; FAS/FAE Task Force Public Hearing, Crookston, MN, Oct. 8, 1997 [hereinafter Crookston Task Force Hearing] (statement by Polk County attorney). See also SUFFER THE CHILDREN, supra note 2, at 10. “A previous report has put the number of Minnesota babies born with fetal alcohol syndrome and effects at 268 to 804 out of about 67,000 total in 1993 .... Various reports say fetal alcohol effects could be two to 10 times higher than fetal alcohol syndrome.”

32. See Memorandum to FAS Task Force from First Lady Susan Carlson (Aug. 21, 1997).

33. See SUFFER THE CHILDREN, supra note 2, at 10. One report estimates that 41 percent of women between the ages of 18 and 40 drank at least once while pregnant. Id.


35. See Dineen, supra note 25, at 18.

36. See id. at 3. See also The National Organization on Fetal Alcohol Syndrome (visited Mar. 1, 1998) <http://www.nofas.org/what.htm>. “In 1991, the Journal of the American Medical Association reported that FAS is the leading known cause of mental retardation.” Id. FAS surpasses both Spina Bifida and Down’s Syndrome in occurrence rates. Id.

37. See NOFAS Fact Sheet, supra note 2. “Some experts believe between one third and two-thirds of all children in special education have been affected by alcohol in some way.” Id. “A 100% misdiagnosis rate was reported in a Houston hospital study of 48 newborns known to have alcoholic mothers. By age one, six of the infants had significant signs of FAS but none had been diagnosed at birth.” Id.

38. SPARKS, supra note 25, at 79. See also Dineen, supra note 25, at 7.
or an infant born addicted to alcohol. Children exhibiting FAS have several prominent characteristics: abnormal facial features (small eyes, flat mid-face or thin upper lip), stunted or irregular physical growth, malformed internal organs and brain damage contributing to intellectual and emotional development delays. FAE children, on the other hand, share many of the same developmental symptoms as their FAS counterparts except for the telltale physical characteristics, making accurate diagnosis even more difficult for parents and medical or social professionals. FAS/FAE children (and affected adults) often have difficulty structuring time, are slow learners, suffer from poor memory, act on impulse, show inferior judgment, experience heightened sensory awareness, are fearless to the point of being dangerous to themselves and others, cannot handle money responsibly and verbalize better than they understand language. Thus, maternal alcohol consumption presents a host of dangers to a fetus that seem to surpass those presented by the use of other legal and illegal substances, including marijuana, cocaine, heroin and tobacco.

In addition, FAS and FAE problems tend to last into adulthood, while some cocaine and heroin related developmental damage tends to dissipate over

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39. See generally Executive Summary, supra note 29. See also SUFFER THE CHILDREN, supra note 2, at 8.
40. See SUFFER THE CHILDREN, supra note 2, at 8. See also Executive Summary, supra note 29.
41. See generally Dr. Lydia Caros, Medical Director, Indian Health Board of Minneapolis, Understanding Fetal Alcohol Syndrome—The Basics. See also SUFFER THE CHILDREN, supra note 2, at 8-9.
42. See Patricia Tanner-Halverson, Ph.D., Strategies for Parents and Caregivers of FAS and FAE Children [hereinafter Strategies] (visited Mar. 1, 1998), <http://www.nofas.org/strategy.htm>. A parent/foster parent stated that it is important to “[s]ee FAS/E children as lovable with unbearable problems. They do not have good reasoning skills, are quick to anger, and have low self-esteem, resulting in problems at school. The emotional drain on parents is overwhelming.” Crookston Task Force Hearing, supra note 31. A Supervisor at Family and Children’s Services stated,

I have a 27-year-old adopted daughter whose parents were both severe alcoholics. Last May she’d been drinking a lot, came to railroad tracks and didn’t want to wait for the train to pass, so she crawled under it, and lost both legs. This is one of the consequences of her poor decision-making ability. Now she’s adjusting to the loss but continues to make poor decisions.

43. See SUFFER THE CHILDREN, supra note 2, at 7. Alcohol consumption during pregnancy contributes to low birthweight, impaired growth, facial malformation, small head size, intellectual and developmental delays, hyperactivity/inattention, sleeping problems, poor feeding, excessive crying, organ damage, birth defects and respiratory problems. Marijuana use leads to intellectual and developmental delays, hyperactivity/inattention, sleeping problems and excessive crying. Cocaine use contributes to low birthweight, sleeping problems, poor feeding, and excessive crying. Heroin use engenders low birthweight, hyperactivity/inattention, sleeping problems, poor feeding, excessive crying, higher risk for Sudden Infant Death Syndrome (SIDS) and respiratory problems. Finally, tobacco use leads to low birthweight, hyperactivity/inattention, higher risk for SIDS and respiratory problems. See id.
To effectively respond to these problems, caregivers need to provide a predictable and positive yet disciplined environment for children with FAS/FAE. A lack of internal structure must be counterbalanced by a consistent (to the point of repetitive), stimulating (but only to a certain experiential point), and vigilant external structure. However, even with constant attention many FAS/FAE children encounter what are defined as "secondary disabilities," especially as they grow older. Secondary disabilities include attention deficit disorder, inappropriate sexual behavior, substance abuse, legal troubles, unemployment, and overall dependence on others in order to meet daily needs. Individuals with FAS/FAE are trusting, often to the point of naivete and therefore are extremely vulnerable to exploitation by others. Despite this extensive list of perceived and potential problems, many affected children are not always eligible for special education because they often score in the normal range on IQ tests. This is unfortunate because symptoms tend to grow worse without timely identification and professional assistance.

B) THE DEMOGRAPHY OF PREGNANT WOMEN AND ALCOHOL CONSUMPTION

Predicting the onset of FAS and FAE is impossible because little is known about the relationship of alcohol consumption and vulnerable phases of fetal development. In light of this uncertainty, the majority of medical experts operate under the assumption that any alcohol intake during pregnancy is categorically unsafe. Nonetheless, drinking during pregnancy appears to be on the rise in the United States after a brief decline during the mid-to-late 1980s. This increase is despite the fact that by
1990, a majority of women believed that ingesting excessive amounts of alcohol while pregnant was potentially harmful to the fetus.53 Between 1991 and 1995 more women than ever were drinking during pregnancy, and in greater amounts, even though many alcoholic beverage containers carried warning labels.54 Some researchers attribute this fact to recent reports about the health benefits of moderate drinking and a growing misperception that "binge drinking" is not a problem.55 Some studies estimate that three times as many women drink during pregnancy than use illegal drugs.56 Other studies have concluded that women are sixteen times more likely to use alcohol instead of cocaine during pregnancy.57

Knowledge about FAS/FAE varies regionally as well as across different age, racial, and income groups.58 Minnesota ranks as the fourth

percent of the pregnant women reported they had drunk an alcoholic beverage in the past month.

Id.

A recent study conducted by the Centers for Disease Control concluded that, [i]n 1995, four times as many pregnant women said they frequently consumed alcohol as in 1991. Frequent drinking is defined as having at least seven drinks in one week or at least five on one occasion. The number of pregnant women consuming any amount of alcohol rose, as well, increasing more than 60 percent between mid-1992 and 1995 . . . .

More Pregnant Women are Drinking, CDC Says; Switch in Trend Raises Concerns About an Increase in Fetal Alcohol Syndrome, STAR TRIB. (Minneapolis), Aug. 12, 1998, at 3E [hereinafter More Pregnant Women are Drinking].

53. See Mary C. Dufour et al., Knowledge of FAS and the Risks of Heavy Drinking During Pregnancy, 1985, 18 ALCOHOL HEALTH & RES. WORLD 86 (1994). The majority of women, which numbered from 89 to 92 percent, believed that "heavy drinking during pregnancy definitely or probably increases the chance of miscarriage, mental retardation, low birth weight, and birth defects." Id.

54. See More Pregnant Women are Drinking, supra note 51. See also Mother's Vices During Pregnancy; Drinking on Rise Despite Risks to Fetus, PLAIN DEALER (Cleveland), Feb. 16, 1998, at 1E. "A recent survey for the Centers for Disease Control and Prevention (CDC) in Atlanta reports that more pregnant women ages 18 to 44 drank alcohol in 1995 than 1991. And larger numbers of them consumed seven or more drinks per week." Id. In a telephone survey of 33,585 women, the CDC discovered that 3.5 percent of them drank frequently during pregnancy in 1995 as compared to .8 percent in 1991. This data indicates that at least 140,000 pregnant women are drinking at levels that pose a risk for FAS. See Field Voices Alarm Over Rise in Drinking During Pregnancy, 9 ALCOHOLISM & DRUG ABUSE WKLY. 3 (1997). Overall, the CDC has reported a "six-fold increase in the percentage of babies born with FAS over the past fifteen years. Since the Centers began tracking FAS, the rate has increased from one case per 10,000 live births in 1979 to 6.7 cases per 10,000 live births in 1993." NOFAS Fact Sheet, supra note 2. Research has shown that defects may result from ingestion of seven or less drinks per week. See Dineen, supra note 25, at 20 (citations omitted). Severe neurobehavioral problems result from consuming 14-28 drinks per week. Id.

55. See id.

56. See NOFAS Fact Sheet, supra note 2.

57. See, e.g., SPARKS, supra note 25, at 82 (citing NATIONAL INSTITUTE ON DRUG ABUSE, NATIONAL HOUSEHOLD SURVEY ON DRUG ABUSE: MAIN FINDING 1990, (1991)).

58. See Dufour et al., supra note 53, at 86. "Black women, Hispanic women and women with family incomes of less than $20,000 per year were less likely than all women combined to have heard of FAS. On the other hand, women ages 30 to 44 years, living in the
highest state in the nation for drinking by women of childbearing age. In Minnesota, women under the age of 35 are the most likely to report alcohol dependency problems. Recent statewide studies have found that excessive drinking can be traced to teenage girls as well. These trends indicate that information about prenatal alcohol use and its long-term effects is not reaching a significant portion of the population. On a national level, surveys show that many health care practitioners still do not discuss the subject of alcohol and drug use with their pregnant patients.

Statistics on alcohol use and abuse among pregnant women vary according to social classes and racial groups. Women in low-income communities tend to have their alcohol or drug use reported on a more frequent basis than women in middle- or upper-class communities because they must rely on public health care. Private physicians treating middle- and upper-class women are less likely to utilize testing or to question

Midwest, and with more than 12 years of education were more likely to have heard of FAS than were all women combined.”

59. *See Suffer the Children*, supra note 2, at 10. This statistic is based on the 1995 CDC survey which found that nearly 18 percent of Minnesota women age 18 to 44 said they “drank alcohol frequently” in the previous month, a rate the CDC defines as “more than 30 drinks in one month or five or more drinks at any one time.” *Id.* The national median is 11.5 percent. *See DoH/MOD* Fact Sheet, supra note 25.

60. *See Suffer the Children*, supra note 2, at 11. 85 percent of all pregnancies in Minnesota occur between the ages of 20 and 34. *Id.*

61. *See id.* According to a 1995 school survey, “in the month preceding 17 percent of the ninth-grade girls and 35 percent of the girls in 12th grade consumed four or more drinks at one time.” *Id.*

62. *See FAS/FAE* Task Force Public Hearing, Anoka, MN, Oct. 13, 1997. A women’s health instructor at North Hennepin Community College stated that “There is still a lot of misinformation about FAS, prenatal alcohol use, and alcoholism in general, particularly about the long-term effects.” *Id.* A county welfare worker noted that “[c]ulturally, we have an established norm that drinking and smoking are ways to have fun quick.” FAS/FAE Task Force Public Hearing, Duluth, MN, Oct. 23, 1997 [hereinafter Deluth Task Force Hearing].

63. *See NOFAS* Fact Sheet, supra note 2. A federally funded study in four U.S. Southern communities found that only 65 percent of women were asked by a physician or nurse about alcohol or drug use during their most recent pregnancy. Further, although most of the women who were asked acknowledged substance abuse, only three percent were referred to treatment. NOFAS Fact Sheet, supra note 2 (quoting Shelly Geshan, Southern Regional Project on Infant Mortality, 1993).

A national panel convened by the Josiah Macy Jr. Foundation found that most doctors do not even try to identify problems by asking patients questions about alcohol and drug habits, and do not know how to respond if they do find evidence of dependency. The panel called for an increase in mandatory training on substance abuse for medical residents as the first step toward improving treatment.

Susan Gilbert, *Doctors Found to Fail in Diagnosing Addictions*, N.Y. Times, Feb. 14, 1996, at C8, quoted in NOFAS Fact Sheet, supra note 2. “If the obstetricians are drinking, we’re a little bit hard-pressed to be telling our patients not to have any . . . there’s a credibility gap.” Interview with Deborah Thorp, M.D., supra note 8.

behavior based on the unfounded assumption that these women do not drink during pregnancy. A frequently quoted study undertaken during the late 1980's indicated that doctors reported African American women at a rate ten times that of Caucasian women, and poor women were more likely than others to be reported.

Native American communities show the highest FAS and FAE numbers in the country. The incidence rate overall is thirty-three times higher than among Caucasians. These numbers vary greatly from tribe to tribe and regionally, with the southwestern United States showing the greatest number of cases. In Minnesota, FAS and FAE has become so pervasive that one Upper Sioux community member recently stated that "some Indian parents thought their children had Indian features, but they were [actually] FAS features."

C) COSTS

Annual national estimates for treatment, special education, foster care, correctional and other administrative costs relating to FAS and FAE populations range from $75 million to $9.7 billion, depending on the recency and specificity of the particular study. In Minnesota, costs directly and indirectly related to the incidence of FAS and FAE continue to rise. The FAS Task Force acknowledges this fact as one of the motivating factors for implementing a comprehensive state-regulated legal, social and medical system to address the problem. During the 1995-96 school year alone the state spent nearly $700 million in special education services for 101,000 children; approximately $59 million is spent annually to incarcerate delinquent youth and $160,000 million goes toward incarcerating adults; $164 million per year is allocated to out-of-home placements for 17,500 children; chemical dependency treatment programs added up to $40 million in 1996; and the cost of services for people with mental retardation totaled $478 million in 1996. In an extreme case,

65. See id.
68. See Dineen, supra note 25, at 12-13.
70. See Fetal Alcohol Syndrome: Diagnosis, Epidemiology, Prevention and Treatment, Institute of Medicine (1996) quoted in NOFAS Fact Sheet, supra note 2. Under a conservative estimate of one FAS newborn per every 1,000 live births in 1980, "it cost approximately $14.8 million to treat them; $670 million to treat the 68,000 FAS children under 18; and $760 million to treat 160,000 FAS adults. Plus, indirect productivity losses were $510.5 million." SBADP Fact Sheet, supra note 29.
71. See Carlson, supra note 4, at 19A.
72. See SUFFER THE CHILDREN, supra note 2, at 11.
officials in one county estimate they will spend over $2 million dollars on
the needs of a single family.73

D) SELECTED FAS TASK FORCE RESPONSES

The FAS Task Force began its list of recommendations with the
premise that low public awareness is an impediment to prevention efforts.74
Statistics indicating rising incidences of drinking during pregnancy suggest
that minimal and arbitrary educational efforts have had little success in
changing habits within communities.75 Thus, any statewide campaign that
undertakes raising community consciousness of FAS and its related
disorders needs to be ongoing, positive, multi-cultural, age-differentiated
and highly visible.76 Additionally, toll-free help lines and other service-
oriented resources should be provided.77 Public awareness actions should
occur in connection with more visible warnings in alcohol advertising as
well as ordinances regulating placement of alcohol-related billboards in
certain communities.78 Aggressive social marketing requires solid data.
The Task Force recognized that studies and surveys have provided at best
an unfocused picture of FAS/FAE impact in the state.79

The Task Force found that more action needs to be taken to “identify,
warn and help women who are likely to drink during pregnancy.”80 It
recommended a program of systematically screening and identifying for

73. See id. at 3. “Six of twelve children in one family in our county were diagnosed with
fetal alcohol syndrome. All of the children, ranging in age from four to twenty-three, have
been placed in foster care for periods ranging up to a dozen years. None has graduated from
high school and three of the daughters have or are expecting children; one new baby is now
in foster care. Excluding medical care, the county has spent about $800,000 for foster care,
mental health and social services, day treatment, specialized care and more. Another $1.3
million will probably be needed to care for family members still under age 18.” Id. at 5.

74. See id. at 12. Note that much of this section concerns recommendations, not planned
actions as of yet. S.F. No. 3346, 80th Leg., 3d Engrossment (Minn. 1998). 3346 provides
certain fund appropriations for some of the programs and ideas discussed; other
recommendations may be undertaken at a later date with further appropriations. The $5
million appropriation will support the following:
(1) $850,000 to administer community grants for fetal alcohol syndrome
prevention and intervention as defined in Minnesota Statutes, section
145.9266, subdivision 4;
(2) $800,000 to expand maternal and child service programs under
Minnesota Statutes, section 254.17, subdivision 1;
(3) $850,000 to expand treatment services and halfway houses for pregnant
women and women with children; and
(4) $800,000 to develop and implement a public awareness campaign.
S.F. No. 3346, 80th Leg., 3d Engrossment (Minn. 1998).

75. See SUFFER THE CHILDREN, supra note 2, at 8-11.
76. See id. at 12.
77. See id. at 13.
78. See id.
79. Id.
80. Id. at 14.
treatment pregnant women who use or abuse alcohol. Screening will operate in conjunction with further training of health care professionals to counsel their patients about the dangers of using alcohol and drugs during pregnancy. The Task Force also addressed the problem of late or wrong diagnosis in relation to FAS and FAE by supporting the creation of a statewide diagnostic clinic network. Finally, the Task Force made several recommendations concerning the expansion of services to children affected by FAS and its related disorders. However, these childhood diagnosis and service subject areas are outside the scope of this paper.

III. CONSTRUCTING A MUTUAL RESPONSIBILITY APPROACH FOR DISCUSSING THE ISSUE OF ALCOHOL USE AND ABUSE DURING PREGNANCY


Traditionally, human society cannot tolerate a “bad mother.” From mythology and history to the headline news, mothers who harm their children, intentionally or not, are considered beyond redemption. It is often difficult to separate the women who act out of true cruelty or

81. Id. The controversial mandatory reporting immunity for medical professionals and Civil Commitment Act expansion is contained within this recommendation. See id. at 15. See also sources cited supra notes 5 and 11.
82. See SUFFER THE CHILDREN, supra note 2, at 15.
83. See id. at 17. Such a statewide diagnostic network would be run by the University of Minnesota, the Mayo Clinic and the Minnesota Children with Special Health Needs program at the Department of Health. See id.
84. See, e.g., EURIPIDES, MEDEA: MYTH AND DRAMATIC FORM (James L. Sanderson & Everett Zimmerman eds., 1st ed. 1967). Medea was a sorceress who was skilled in the use of drugs and poisons. She married Jason of the Argonauts and helped him procure the prized Golden Fleece. When Jason left Medea and their children (as many as seven, depending on the version of the story) to marry Glauce (or Creusa), Medea flew into a jealous rage. See id. at 3-7. In Euripides’ version of the myth, Medea kills their two children as revenge for Jason’s infidelity. See id. at 14. When Jason discovers Medea’s crime he says the following: “You abomination! Of all women most detested/By every god, by me, by the whole human race!/You could endure—a mother!—to lift sword against/Your own little ones...” Id. at 48 (lines 1201-1204).

Scottish-Irish and Japanese folk tales tell of women bringing their children “to the water’s edge for both protection and destruction,” imagery that summons the 1996 news story of Susan Smith who strapped her two young sons into the family car and then released the brakes, allowing the automobile to plunge into a lake, thereby drowning the helpless boys. Myra Yellin Outwater, Susan Smith Case Inspires Play on Dark Side of Motherhood, MORNING CALL, Jan. 30, 1998, at D12.

The wicked stepmother is a common theme in many folk and fairy tales. Bruno Bettelheim wrote in The Uses of Enchantment that “the idea of an angry, vengeful mother is so frightening to children that our fairy stories have bifurcated the maternal role. The cruel stepmother is a manifestation of her purely negative side, the fairy godmother her purely benevolent role.” Adrian Mourby, All About Evil: Why Can’t Society Accept That Women Can Be Bad Mothers?, THE GUARDIAN (LONDON), Feb. 13, 1997, at T4.
depravity from those who, tragically overwhelmed by internal or external
demands, cannot cope with their roles as protector and nurturer. Nonetheless, all are similarly ostracized by communities bent on revenge
for the loss of unqualifiedly innocent lives. Without a doubt the wrongs
that certain mothers have visited upon their children are abhorrent. But
when the intended or unintended target of a mother’s actions becomes the
fetus, the moral territory—the literal battleground of Roe v. Wade viability—becomes much more rugged and uncertain. It is against this
volatile backdrop that a discussion of values governing a mother’s role in
preventing FAS and its related disorders occurs.

1) Defining the.Undefinable: What is Personhood?

No discussion of fetal rights is apolitical because much of the
theoretical context is influenced by point-of-viability debates originating in
the abortion-rights controversy. The notion of viability was formalized
by Roe v. Wade, the landmark 1973 case describing the point of gestation at
which a state may legally proscribe a woman’s right to abortion. According to Roe, a woman may opt for abortion with the advice of her
physician during the first three months of pregnancy; the state regulates,
but cannot expressly limit, a woman’s right to choose an abortion during
the second three-month period. Abortions after the twenty-fourth week,
when the fetus is deemed capable of living outside the womb, are permitted
only as a means of preserving the life and health of the mother.

Most important to this discussion, the Supreme Court in Roe held that a
viable fetus is not a person, and thus cannot receive protection under the
Fourteenth Amendment. The Court also determined that the decision to

85. See sources cited supra note 84 and accompanying text.
86. 410 U.S. 113, 160 (1973). The Supreme Court held in Roe that the state may assert a
compelling interest over the health, safety and well-being of a fetus at the point of viability,
approximately 24 weeks into the pregnancy, when the fetus is capable of living outside of
the mother’s womb. See id. at 163. See also Page McGuire Linden, Drug Addiction During
Pregnancy: A Call for Increased Social Responsibility, 4 AM. U. J. GENDER & L. 105, 111-

87. See MacKinnon, supra note 21, at 1317.
88. 410 U.S. at 163-4.
89. Id. at 163.
90. See id. at 160.
91. Id. at 158.

No State shall make or enforce any law which shall abridge the privileges or
immunities of citizens of the United States; nor shall any State deprive any
person of life, liberty, or property, without due process of law; nor deny to
any person within its jurisdiction the equal protection of the laws.
U.S. CONST. amend. XIV, § 1.

Citing several references to the word “person” in the Constitution, the Court
concluded that “in nearly all these instances, the use of the word is such that it has
application only postnatally.” Roe, 410 U.S. at 157. “None indicates, with any assurance,
that it has any possible prenatal application.” Id. The Court also noted that during the
nineteenth century, abortion practices were “freer,” further evidence that the Fourteenth
terminate a pregnancy is included within the fundamental constitutional right of privacy.92 In Planned Parenthood v. Casey, the second important abortion decision, the Supreme Court reaffirmed the central holding of Roe, but rejected the trimester framework in favor of an undue burden analysis to determine the state’s interest in the potential for life.93 The focus on the point of viability, however, remained consistent with Roe.94

2) Personhood in Minnesota

A Minnesota statute defines viability as the ability “to live outside the womb even though artificial aid may be required.”95 The language at one time included the term “potentially viable” but this was declared “unreasonable and unconstitutional because it provided, at least in terms of abortion legislation, that the fetus could be considered potentially viable at the end of the twentieth week rather than the twenty-fourth week which contravened the holding in Roe.”96 Minnesota also follows the “born alive” rule, as exemplified by its vehicular homicide statutes, which holds that a state cannot prosecute a homicide unless a “person having an independent and separate existence from the mother” has been killed.97 In addition, the state maintains feticide laws that punish a third party for harming an embryo or nonviable fetus.98 An assailant who destroys an embryo or nonviable fetus interferes with a woman’s right to choose termination or birth under Roe and its progeny.99 Thus, the state’s interest in protecting

Amendment (adopted in 1868) did not contemplate the inclusion of the unborn in the term “person.” Id. at 158.

92. See id. at 153. The right to privacy is considered broad enough to encompass a woman’s decision to terminate her pregnancy but this right is not absolute. See id. at 154. For example, the state’s “important and legitimate interest in the health of the mother” occurs at the end of the first trimester, at which time the state may regulate the abortion procedure. Id. at 163. The Court disagreed that a fetus is a “person” for the purposes of due process analysis. Id. at 157.

93. Planned Parenthood of Southeastern Pennsylvania v. Casey, 505 U.S. 833, 878 (1992). A finding of an undue burden is a shorthand for the conclusion that a state regulation has the purpose or effect of placing a substantial obstacle in the path of a woman seeking an abortion of a nonviable fetus. A statute with this purpose is invalid because the means chosen by the State to further the interest in potential life must be calculated to inform the woman’s free choice, not hinder it. Id. at 877.

94. Id. at 860.


96. Id. (explaining Hodgson v. Lawson, 542 F.2d 1350 (8th Cir. 1976)).

97. State v. Soto, 378 N.W.2d 625, 630 (Minn. 1985). In Soto, the Minnesota Supreme Court held that the term “human being” as used in vehicular homicide statutes did not include a viable, eight-and-a-half-month old fetus capable of sustained life outside the mother. Id. To conclude otherwise, said the Court, would represent a substantial change in the criminal law that is within the sole province of the state legislature, not the judiciary. Id.

98. See State v. Merrill, 450 N.W.2d 318 (Minn. 1990).

99. See id. at 321-22. The state can therefore prosecute an assailant who causes the death
the potential for human life includes protection of the unborn through feticide laws. However, a simultaneous interest exists in a woman’s right to decide the fate of her embryo or fetus until the point of viability.\textsuperscript{100} Needless to say, Minnesota’s vehicular homicide and feticide decisions exemplify a poignant contradiction: personhood is defined as post-birth in some cases, but it is implied as pre-viability in others (meaning that a fetus is deemed “person” enough to be protected under criminal statutes).\textsuperscript{101} This is a clear example of careless lawmaking.\textsuperscript{102}

3) Personhood Under the Mutual Responsibility Approach

The Mutual Responsibility Approach advocates the use of the \textit{Roe} definition of personhood and the ‘born alive’ characterization.\textsuperscript{103} Further, the approach argues in favor of a uniform characterization of personhood in all areas of the law.\textsuperscript{104} Personhood is simply not the type of legal concept that can be adjusted depending on the unique circumstances of a case. When courts and state legislatures continually redefine the meaning of personhood, the general public becomes confused and begins to perceive of the law as an arbitrary concept that serves only those with interests more powerful than those of women who require treatment for substance abuse during pregnancy.

Although it is significant that feticide laws in Minnesota and other
states maintain the integrity of a woman’s right to choose, it is nonetheless troubling to see such a contradictory interpretation of ‘life’ present under the law. When definitions are too flexible, room remains for legal maneuvering that could lead to decisions adversely affecting a woman’s rights in relation to the fetus. This particular threat has not yet played out in Minnesota, but as indicated by other situations discussed throughout this paper, national trends suggest that every state should carefully weigh the consequences of any action involving maternal and fetal rights, lest the proper balance of interests be compromised.

The focus of the law during the pre-viability stage of fetal development needs to remain on the woman and her needs. The question is at what point, if ever, should a pregnant woman be penalized for her potentially harmful behavior? The Mutual Responsibility Approach asserts that automatic retribution is not productive in creating long-term individual or societal change. The law must take the position that, if a woman is incapable of meeting her maternal calling, then it is incumbent upon the state to recognize its own moral duty by providing accessible treatment and educational opportunities that do not focus on criminalizing behavior. If a pregnant woman does not respond to treatment or education, then the state may take further measures (i.e. civil commitment) to ensure both her own safety and that of the fetus. However, such extreme action should remain as a last resort option. The Mutual Responsibility approach seeks to resolve the maternal-fetal conflict by placing the interests of the pregnant woman first during the pre-viability stage, and then equalizing the fetal and individual interests post-viability.105

4) Resolving the Maternal-Fetal Conflict and Recontextualizing Maternal Duty

Poetically speaking, the source of a woman’s ‘power’ is her ability to create a new life. However, realistically, a woman’s reproductive capacity at this time of increasing maternal-fetal conflict seems to signal the end of her identity in the eyes of the state.106 The fetus and mother are not recognized as sharing interests—in fact, they assume adversarial roles. The fetus is to be protected from the mother, who becomes a depersonalized entity subordinated by her temporary status as a pregnant woman.107

105. See MacKinnon, supra note 21, at 1315.
106. See PATRICIA SPALLONE, BEYOND CONCEPTION: THE NEW POLITICS OF REPRODUCTION 18 (1989). Spallone’s book concerns the relationship of women to burgeoning in vitro fertilization medical technology, but many of her discussions regarding women’s modern reproductive identity apply to the discussion within this paper.
107. See MacKinnon, supra note 21, at 1315-16. “Women’s relation to the fetus is not that of a powerful, fully capacitated being in relation to a powerless, incapacitated, and incomplete one. Indeed, it shows how powerless women are that it takes a fetus to make a woman look powerful by comparison.” Id. at 1316-17. “The pregnant woman is more than a location for gestation. She is a woman, in the socially gendered and unequal sense of the word... the woman is not a mere vehicle for an event which happens to occur within her
Further, as the notion of fetal rights has expanded with legal decision-making and advances in medical technology, women are increasingly placed into an adversarial position with the developing fetus.\textsuperscript{108} Amidst this hostile context, the notion of maternal duty assumes a distinctly negative edge.

Maternal duty under the Mutual Responsibility Approach is defined as follows: to provide, to the best of a woman's individual ability, a healthy, stable environment for both the mother and her fetus, and later the mother and her child. Basic needs are met in this environment, and nurturing, loving relationships flourish. Individual liberties and personal beliefs are respected. Maternal duty is therefore an inherently private concept although presumably, the majority of women share its basic premise. The state has nothing to do with the meaning of maternal duty; instead this duty encompasses the 'intertwined interests' of the woman and fetus. How the woman chooses to accept her responsibility with regard to the fetus dictates how the state will respect her through the eyes of the law.\textsuperscript{109}

When, due to internal or external factors, a woman cannot meet her maternal duty, the state must provide her with the means by which she can resume her duty, because it is in society's best interest to perpetuate—but not dictate the parameters of—maternal duty. Maternal duty is not a universal concept; rather, it is defined by personal and cultural influences.


Technology, also largely controlled by men, has made it possible to view the fetus through ultrasound, fueling much of the present crisis in the legal status of the fetus by framing it as a free-floating independent entity rather than as connected with the pregnant woman. Much of the authority and persuasiveness of the ultrasound image derives from its presentation of the fetus from the standpoint of the outside observer, the so-called objective standpoint, so that it becomes socially experienced in these terms rather than in terms of its direct connection to the woman. Presenting the fetus from this point of view, rather than from that which is uniquely accessible to the pregnant woman, stigmatizes her unique viewpoint as subjective and internal. This has the epistemic effect of making the fetus more real than the woman, who becomes reduced to the "grainy blur" at the edge of the image. Id. at 1310-11.

\textsuperscript{109} See Kowalski, supra note 17, at 1262-63. Kowalski quotes Dawn Johnsen, who advocates a "facilitative model" for defining the fetus-mother relationship. Id. at 1263. This model "recognizes that women who bear children share the government's objective of promoting healthy births but that ... [w]omen inevitably must make numerous decisions that require them to balance varying and uncertain risks to fetal development against competing demands and interests in their lives." Id. at 1263 (citation omitted). Kowalski also explores two other models where the "mother and fetus possess conflicting rights" and where "the fetus has no rights until birth," id. at 1262, but settles on Johnsen's model as the most realistic solution. Id. at 1290.
If, and only if, a woman consistently cannot meet her maternal duty and proves too great a danger to her viable fetus or child, then the state may intervene with more extreme measures—but only after less restrictive alternatives to the problem have been explored. Arbitrarily applied punitive or coercive state strategies create a negative connotation for maternal duty. In a liability-oriented environment, women who abuse alcohol or other substances while pregnant are penalized without opportunity to shape their own personal relationships to maternal duty or to assume the course of treatment that will best facilitate a full and productive recovery process.

A pregnant woman has individual rights to privacy, bodily integrity and equal protection, but these rights conflict with impermeable negative definitions of maternal duty. This argument goes beyond individual accountability. A woman is responsible for her actions, but when her behavior arouses concern, the state has a moral duty to facilitate her rehabilitation by means of non-coercive cooperative policies that recognize the inherent struggles of pregnant women. There is no fundamental right to use alcohol or drugs during pregnancy; these actions endanger both the fetus and the mother and implicate the state’s interest in protecting both. However, it is not possible for the state’s “management” of a woman’s pregnancy” and her legitimate fundamental rights to constitutionally coexist. When a woman becomes pregnant, she does not suspend her rights for nine months so that the state may assert its interest over her fetus, and therefore over the woman herself. When a woman falters in fulfilling her maternal duty (or if she never actively seeks it, as in the case of impregnation by rape or a simple misuse of birth control), society needs to provide her with the means for finding solutions that do not penalize or coerce. A pregnant woman in need of help will not seek assistance when there are strings attached; as long as there are, the maternal-fetal conflict will persist, the state interest in healthy children and healthy mothers will go unmet, and the notion of maternal duty will remain negative.

110. See Linden, supra note 86, at 111.
A maternal duty renders a woman the guarantor of the mental and physical health of her fetus. Requiring a woman to conform to an objective standard limits her right to conduct her life and pregnancy as she sees fit. Also, imposing a duty may create an adversarial relationship between a woman and her fetus: a woman might view her fetus as a potential opponent rather than as a future child.
Lichtenberg, supra note 104, at 389.
111. See Linden, supra note 86, at 115.
112. Rachel H. Nicholson, No Pregnant Woman is an Island: The Case for a Carefully Delimited Use of Criminal Sanctions to Enforce Gestational Responsibility, 1 HEALTH MATRIX 101, 119 (1991), quoting John A. Robertson, who states “[f]ull freedom in procreation includes a woman’s freedom to make the myriad decisions she faces in gestating and giving birth to a child . . . . It is possible to distinguish ‘management’ of a woman’s pregnancy from the true right to freedom of procreation.” Id. at 120.
b) Reassessing Subjective and Objective Interpretations of Maternal Morality: Environmentally and Culturally Sensitive Responses

Maternal morality remains a one-dimensional false construct. A constant refrain in the movement toward laws penalizing pregnant women who drink is that “they don’t seem to care,” but this is simply not the case for the majority of pregnant women who drink.113 Proponents of alternatives to punitive and coercive measures recognize that most women who drink while pregnant (or conduct any other activity potentially harmful to the fetus) are not willfully harming the fetus; rather they have an addiction.114 Their actions are not dispositive indicators of poor parenting ability.115 Environmental factors such as racism, domestic violence, sexual abuse, unemployment, homelessness, poverty, discrimination based on sexual orientation, substandard living conditions, a bad childhood, lack of health insurance and the absence of geographically or culturally accessible treatment and counseling opportunities all contribute to a cycle of isolation for women of all classes and races.116 Residual effects of alcoholism include malnourishment, depression, poor self-image, self-destructive tendencies, fear of failure, lack of access to educational and medical resources, exposure to sexually transmitted diseases and chronic illness.117

113. Interview with Deborah Thorp, M.D., supra note 8. “They all care on some level, but it may be that the definition of how they care is not the same as how white middle-class America defines it. They all have a burden about what they’ve used.” Id.

The theory that pregnant women who abuse drugs [and alcohol] do not care about their children has no merit. Most pregnant addicts want to do what is best for their unborn child. However, pregnant addicts report that they feel so guilty about using drugs during their pregnancy that they consume more drugs in an attempt to alleviate self-loathing. Also, many pregnant addicts are victimized by influences they have no control over such as racial and economic discrimination. Sexton, supra note 8, at 430.

114. See PUNISHING WOMEN FOR THEIR BEHAVIOR DURING PREGNANCY, supra note 18.

115. See id.

116. See Punishing Women for Their Behavior During Pregnancy, supra note 18, at 9 (quoting Hortensia Amaro et al., Violence During Pregnancy and Substance Use, 80 AM. J. PUB. HEALTH 575, 578 (1990)). Substance abusers often battle the demons of their own violent childhoods or current domestic situations, and turn to alcohol and drugs to “self-medicate” and “alleviate the pain and anxiety of living under the constant threat of violence.” Id. Clinical studies have found that persons who abuse alcohol are more likely to report histories of physical and/or sexual abuse than persons in general populations . . . . Epidemiological surveys of adolescent populations also document strong association between an abuse history and alcohol or drug abuse, supporting speculation that traumatic early life events may increase vulnerability to alcohol and drug abuse.


117. For example, adverse pregnancy outcomes (miscarriages, low birthweight, and infant
These factors do not excuse irresponsible behavior, but an effective program of rehabilitation must consider a woman’s personal and cultural profile.

The problem of alcohol use and abuse during pregnancy crosses all class and cultural boundaries, making a uniform or unilateral response almost impossible to achieve.\(^\text{118}\) Government intrusion disproportionately affects women of color and women with little or no income.\(^\text{119}\) Poor women of color, in particular, have the least access to decent prenatal care, and yet mandatory reporting laws predominantly target these women.\(^\text{120}\) Because they often must rely on public clinics, and may lack access to the resources that will help them “conform to the white, middle-class standard of motherhood,”\(^\text{121}\) these women bear the brunt of enforcement efforts. In sum, they are subject to circumstances that raise several equal protection questions.

The Mutual Responsibility Approach for addressing FAS/FAE is built on a foundation of “cultural competency” and deconstruction of “social stigmatization.”\(^\text{122}\) Cultural competency in a social system requires all concerned to “draw on community-based values, traditions and customs, and to work with knowledgeable persons of and from the community to develop focused interventions and other supports.”\(^\text{123}\) A system of cultural competency, for example, treats women of color’s individual and cultural values with sensitivity. Such a system recognizes the existence of racism, but does not allow racism to be an excuse for harmful or destructive

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mortality) are more likely in homeless women with substance abuse because they are usually poorly nourished and have limited access to prenatal health care and substance abuse treatment services. In one comparative study of homeless women in New York City, 39 percent of pregnant homeless women were found to have received no prenatal care, compared to only 14 percent of low-income women living in public housing communities, and 9 percent of the general population.

U.S. DEP’T OF HEALTH & HUMAN SERVICES, PRACTICAL APPROACHES IN THE TREATMENT OF WOMEN WHO ABUSE ALCOHOL AND OTHER DRUGS 43-44 (1994) [hereinafter PRACTICAL APPROACHES]. FAS/FAE are symptoms of broader social concerns. One FAS Task Force member noted in the a community meeting that it’s hard for people to stay healthy when the resources aren’t there, and in the Phillips neighborhood [of Minneapolis] there is no grocery store with fresh produce or fresh juice. We need to make sure communities have good food and adequate housing available. One of the striking characteristics of prenatal alcohol exposure is poor nutrition, and we need to make sure that poor families have good nutrition.

FAS/FAE Task Force Public Hearing, Minneapolis, Minn. (Oct. 20, 1997) [hereinafter Minneapolis Task Force Hearing].

118. See Dufour et al., supra note 53.
120. See Schroedel & Peretz, supra note 15.
121. See Roberts, supra note 15, at 1422.
122. PRACTICAL APPROACHES, supra note 117, at 113, 124-25 (citations omitted).
123. Id. (citation omitted).
Cooperative relationships forged between non-coercive treatment networks and grassroots community and spiritual organizations catering to the distinct needs of different racial and income groups are necessary to fuel a value system analysis of FAS in Minnesota.

The social stigmatization suffered by pregnant substance-abusers often deters women from seeking help. As ‘bad mothers,’ they are haunted by negative reactions from all levels of the legal, social service and greater communities. The stigma of addiction combined with racial prejudice, poverty, domestic violence, unemployment and other emotional or physical stressors contribute to a woman’s feelings of isolation and disempowerment. The presence of these stresses, in turn, may make her less willing to take responsibility for her actions and to seek help. If the system is working against her through threats of punishment or restraint, she will be immobilized. The Mutual Responsibility Approach recognizes that this woman needs the most help of all.

c) Universal Prenatal Treatment and Education as Community Values

A fundamental disjuncture exists between coercive and proactive state measures. According to one commentator,

[w]hen the state intervenes to address substance abuse during pregnancy, the pregnant woman is forced to follow the dictates of the state. In contrast, when the state offers assistance to a pregnant woman, it is facilitating and expanding her choices so that, through her own free will, she may make decisions beneficial to both herself and her unborn child.

To adequately address the problem of FAS/FAE, the Mutual Responsibility Approach must be responsive to as many philosophies of treatment as possible, including treatment on demand, and must recognize that addiction is not a personal failing but rather a bona fide disease.

124. See id. at 114 (citations omitted).
125. See id. at 125.
126. Linden, supra note 86, at 135.

Cultural feminist theory, as applied to this problem, has two implications. First, cultural feminism stands for the proposition that society has an affirmative obligation to act in order to aid pregnant women addicted to controlled substances. Second, in fulfilling this obligation, society should act in a facilitative, rather than in an adversarial manner.

Id. at 114.
127. See Julia Elizabeth Jones, State Intervention in Pregnancy, 52 LA. L. REV. 1159, 1174 (1992). According to the American Medical Association, “it is clear that addiction is not simply the product of a failure of individual willpower.” Id. “Punishing a person for something that is beyond his or her control is not an effective deterrent to the punished behavior.” Id. See also Robinson v. California, 370 U.S. 660 (1962) (narcotic addiction not a punishable crime). Alcohol abuse is defined by diagnostic criteria developed by the American Psychiatric Association and published in the Diagnostic and Statistical Manual of
Treatment is generally defined to include detoxification, inpatient or outpatient care and counseling, maintenance, rehabilitation and, in some cases, long-term residence in a supervised environment. Treatment cannot be based on judgmental perspective. No good can come of a regimen that presumes pregnant substance abusers are operating solely from bad or selfish motives. In place of judgmental perspectives, a holistic approach that contemplates the many barriers that a woman must overcome to obtain treatment is a vital starting point for the healing process. Not all women will respond to this approach, but in truth, the small minority of hardcore users who will not respond to this approach are unlikely to utilize any support without state intervention. Treatment philosophies must address the needs of this minority, but an entire recovery network cannot be directed toward the worst abusers without treading on the protected arena of individual rights. This problem would be mitigated if the state made a commitment to offer prenatal alcohol treatment on demand without threat of potential penalties.

The failure of community education to curb the growing trend in drinking during pregnancy demonstrates that earlier intervention and more targeted efforts must be made. Social marketing has been extremely effective in informing the public about high blood pressure, cigarette smoking, safe sex, screening for breast or prostate cancer and other ‘need-to-know’ campaigns. The Mutual Responsibility Approach emphasizes education over punitive or coercive measures, but education cannot begin at age 21, the legal drinking age. The educational process must occur in middle and high schools as part of health and sexuality curricula, perhaps even during the later years of elementary education, when children are already receiving classroom exposure to anti-drug use messages. In addition, prevention campaigns must be conducted in all communities from rural to urban, and in all types of neighborhoods, wealthy and poor, so that the broadest audience can be reached.
d) Clash of Fetal and Sex Equality Rights: A Balancing of Interests

The Equal Protection Clause of the Fourteenth Amendment protects individuals from discrimination based on classification or identification with a certain disadvantaged group.\textsuperscript{133} The expansion of fetal rights poses a serious threat to a woman’s constitutionally-recognized liberty and privacy rights, extending the historic legacy of inferior treatment based solely upon a woman’s procreative ability.\textsuperscript{134} Specifically, if the fetus assumes the rights of a person under the law, then it may enjoy a superior position than a woman in the gender-constructed social hierarchy because fetal rights must necessarily compete against those of a pregnant woman — never a nonpregnant woman or a man.\textsuperscript{135} As legal theories of homicide and child neglect evolve to accommodate the burgeoning fetal rights movement, pregnant women will become increasingly vulnerable to an officially sanctioned system of unfair, coercive and punitive treatment. The Mutual Responsibility Approach recognizes that this trend cannot continue without significantly infringing on personal rights. The maternal-fetal conflict creates an untenable balance of power between a fetus and a pregnant woman and, by extension, the genders, because men can never experience this discrimination even though they access, utilize and ultimately benefit from the very same legal system.\textsuperscript{136}

Gender-based discrimination only receives intermediate (sometimes called "heightened") scrutiny in judicial analysis, meaning that a state action based on sex must “serve important governmental objectives and must be substantially related to the achievement of those objectives” in targeting alcohol billboard placement. See id. The media must be a partner to the state in public education efforts. See id.

\textsuperscript{133} U.S. CONST. amend. XIV, § 1. See supra note 91 and accompanying text.

\textsuperscript{134} See MacKinnon, supra note 21, at 1309.

Many of the social disadvantages to which women have been subjected have been predicated upon their capacity for and role in childbearing . . . . This point is not the biological one that only women experience pregnancy and childbirth in their bodies, but the social one: women, because of their sex, are subjected to social inequality at each step in the process of procreation. Encompassed are women’s experiences of “fertility and infertility, conception and contraception, pregnancy and the end of pregnancy, whether through miscarriage, abortion, or birth and child-rearing.”

Id. (quoting FACTUM OF THE INTERVENOR WOMEN’S LEGAL EDUCATION AND ACTION FUND, at 10; Sullivan and LeMay v. Regina, No. 21494 (Can. Sup. Ct. filed Feb. 22, 1989) (decision pending)).

\textsuperscript{135} See MacKinnon, supra note 21, at 1309-10.

\textsuperscript{136} Although the equal protection clause protects women from discrimination based on sex,

[\text{current doctrine, however, offers women no protection against discrimination that is based on real biological differences between women and men, and in fact denies that such discrimination is sex-based. Women are granted equal protection of the laws only to the extent that they are ‘similarly situated’ to men.}]

Johnsen, supra note 101, at 621.
order to be constitutional.\textsuperscript{137} The United States Supreme Court has chosen not to evaluate laws affecting pregnancy as to whether they discriminate against women, opting instead to decide whether the laws discriminate between pregnant and nonpregnant persons, and creating a subset of gender analysis that recognizes women and men can never be "similarly situated" in the area of fetal development.\textsuperscript{138} However, some federal laws have included pregnancy discrimination within sex discrimination regulations, especially in the area of employment protections.\textsuperscript{139}

The Mutual Responsibility Approach recognizes that the maternal-fetal conflict has its genesis in the continued disproportionate treatment of pregnant women under equal protection analysis. Pregnancy is an immutable characteristic, and therefore courts should apply strict scrutiny to any state action that qualifies a woman's right based on her pregnancy status.\textsuperscript{140} Further, the "similarly situated" threshold is a means of rationalizing different treatment between the sexes. Society places a low value on a pregnant woman's worth, especially when fetal rights are increasingly empowered, and the practice of rationalizing further distinctions only perpetuates long-standing polarities.\textsuperscript{141}

Fetal rights proponents argue that \textit{Roe} and its progeny conflict with the increasingly common prosecution of pregnant women who recklessly cause death or injury to their fetuses through the use of illegal drugs or through other forms of abuse and neglect.\textsuperscript{142} Although the majority of judicial and


\textsuperscript{140} See \textit{Johnsen}, supra note 101, at 622. "The ability to bear children is to sex discrimination what dark skin is to race discrimination. It is the immutable characteristic that distinguishes the disadvantaged from the advantaged and which historically has been used to justify the subordination of the disadvantaged." \textit{Id.}

\textsuperscript{141} See \textit{id.} at 624-25.

\textsuperscript{142} See \textit{Greenburg}, supra note 108, at 1. "Since at least the fourteenth century, the common law has been that the destruction of a fetus in utero is not homicide . . . . The rule has been accepted as the established common law in every American jurisdiction that has
statutory laws still rely on the "born alive" rule,143 some state legislatures and courts have explored the possibility of applying child abuse and neglect laws to the burgeoning rights of a fetus.144 These lawmaking attempts have sought to regulate an astounding breadth of maternal behavior that could negatively affect the fetus.145 Aside from the more obvious examples of substance abuse, proposals have defined negligent maternal behavior to include failure to follow doctor's orders, eating 'wrong' foods, and giving birth at home instead of the hospital.146 In Iowa, for example, the state assumed custody of a woman's baby, despite the fact that the child appeared healthy, because she allegedly failed to monitor the nutritional value of the foods she ate while pregnant.147 Connecticut considered a bill considered the question.” Commonwealth v. Cass, 467 N.E. 2d 1324, 1328 (Mass. 1984). “The live birth requirement was consistent with the concept that the fetus was an extension of the woman.” Sexton, supra note 8, at 414 n.35. It is important to note that Supreme Courts in Florida, Kentucky, Ohio, Nevada, and Wisconsin, and many lower courts, have often struck down drug delivery statutes because a fetus was not determined to be a person under the applicable criminal law. See Tamar Lewin, Abuse Laws Cover Fetus, a High Court Rules, N.Y. TIMES, Oct. 30, 1997, at A4. But see Whitner v. South Carolina, 492 S.E.2d 777 (1997). In Commonwealth v. Cass, for example, the Massachusetts Supreme Court held that a fetus was a person for the purposes of a vehicular homicide statute. 467 N.E.2d 1324, 1325 (Mass. 1984). A number of similar decisions have followed. See Sexton, supra note 8, at 415. Several states have adopted "feticide" legislation that punishes destruction of a fetus in the same manner as murder of a person. See id. at 415. These states include California, Illinois, Iowa, Mississippi, New Hampshire, Oklahoma, Utah, Washington and Wisconsin. See id. at 415 n.45.

143. See, e.g., State v. Soto, 378 N.W.2d 625, 630 (Minn. 1985).
144. See, e.g., Sexton, supra note 8 at 414-15. In the civil arena, a “majority of states now consider fetuses that have died in utero to be ‘persons’ under wrongful death statutes.” Johnsen, supra note 101, at 602. See also Daniel S. Meade, Wrongful Death and the Unborn Child: Should Viability Be a Prerequisite for a Cause of Action?, 14 J. CONTEMP. HEALTH L. & POL’Y 421 (1998).
145. See Sexton, supra note 8, at 415. In In re Fetus Brown, the Appellate Court of Illinois determined that it could not, however, prevent a pregnant woman from refusing medical treatment based on her religious beliefs that blood transfusions would harm her. 689 N.E.2d 397 (1997). Pamela Rae Stewart was charged with “failing to follow her doctor’s advice to stay off her feet, refrain from sexual intercourse, refrain from taking street drugs, and seek immediate medical attention if she experienced difficulties with the pregnancy.” Michelle Oberman, Sex, Drugs, Pregnancy, and the Law: Rethinking the Problems of Pregnant Women Who Use Drugs, 43 HASTINGS L.J. 505, 505-06 (1992) (quoting Mike Konon, Data Access to Fetus Case Put on Hold, SAN DIEGO UNION-TRIB., Oct. 24, 1986, at B1, B12).
147. See Sexton, supra note 8, at 416 n.49, quoting FALUDI, supra note 146, at 425.

In Michigan, a court held that a child could sue his mother for ingesting tetracycline while pregnant, "allegedly resulting in discoloration of the child’s teeth.” Johnsen, supra note 101, at 604, citing Grodin v. Grodin, 301 N.W.2d 869 (Mich. App. 1980). The court held that the standard of liability was that of a “reasonable pregnant woman.” Johnsen, supra note 101, at 604. In other cases courts have taken custody of fetuses to enjoin drug use and compelled women to have cesarean sections when they preferred vaginal delivery. See id. at 605 (citations omitted).

One commentator describes the criteria for a “reasonable pregnant woman” as
that would allow the state to revoke parental rights of pregnant women who abused illicit drugs (e.g., cocaine, marijuana, heroin) or alcohol.\textsuperscript{148} These laws are but a few examples of the inevitable slippery slope created by contradictory interpretations of personhood and legislative or judicial zeal for solutions that punish or coerce a woman during pregnancy without offering positive alternatives like treatment or education. These laws are cynical, short-term benefit attempts to appease public dismay with the growing problem of drinking during pregnancy. Such laws are grossly unfair because, under an Equal Protection analysis, they punish pregnant women disproportionately for behavior that is deemed legal for other members of society. In essence, such laws contemplate that a woman’s behavior during her pregnancy, legal or not, can be regulated without regard to existing governing doctrine stating that a fetus (even when viable) is not a person under the law. An inherent maternal-fetal conflict exists as a result of lawmaking that assumes a hierarchy of state and fetal interests over the interests of a woman. Because virtually every action a woman takes while pregnant has an impact on her fetus, the maternal-fetal conflict is debilitating to the point of incapacitation.\textsuperscript{149}

Minnesota has perpetuated the maternal-fetal conflict in the form of its mandatory reporting laws, now broadened by the recent FAS legislation.\textsuperscript{150} In 1989 and 1990, the state enacted legislation rejecting both the criminalization of prenatal substance abuse and the characterization of illicit drug use during pregnancy as child abuse in favor of creating a

\textsuperscript{148}See Bob Curley, \textit{Prenatal Drug Policies Need to Address Alcohol Too}, \textit{Alcoholism & Drug Abuse Wk.}, Apr. 1, 1996, at 3.

\textsuperscript{149}See Johnsen, \textit{supra} note 101, at 606-7. Drug and alcohol use, as well as smoking, have proven harmful to the fetus, but there are other possible hazards such as workplace risks, x-rays (inadequate shielding), certain prescription and over-the-counter medications (the acne medication Isotretinoin a.k.a. Accutane, androgen hormones, diethylstilbestrol or DES are all known teratogens; lithium, antibiotics like streptomycin and tetracycline, anticoagulants, thyroid drugs, and anticonvulsants are also potentially harmful), and even caffeine, though studies are inconclusive. \textit{See Vicki Seltzer, Be Careful What Substances Fetus is Exposed To}, \textit{Chl. Sun Times}, Dec. 24, 1997, at 44.

system of mandatory reporting.\textsuperscript{151} It is encouraging that Minnesota has consistently chosen to steer clear of criminalizing maternal behavior, but the mandatory reporting laws are by no means irreproachable. Civil commitment is sought only if a pregnant woman refuses recommended services or fails to succeed in treatment.\textsuperscript{152} The law purports to "reconceptualize . . . [the] mother and fetus as isolated adversaries."\textsuperscript{153} However, the law defines substance abuse during pregnancy as child neglect, skewing the balance toward the fetus as the intended beneficiary of the statutory benefit, rather than the mother.\textsuperscript{154} The use of child neglect laws emphasizes the rights of a fetus, a nonperson under the law, over a person in possession of civil rights who may act more responsively to treatment-directed personal responsibility programs if her interests are characterized as (at least) equal with those of her unborn child.\textsuperscript{155}

A social and legal system that questions a woman's actions during pregnancy without respecting her individual rights or offering the means to enact change serves as yet another example of institutional gender-based oppression. However, here the unfair treatment comes in the sympathetic guise of fetal rights. In other words, the continued trend towards punitive and coercive action in controlling behavior during pregnancy uses fetal rights as a tool for defining (and segregating) women in terms of their childbearing role, furthering their subordination in both the dominant legal and social hierarchies. Perhaps this turn of events is a not-so-subtle response from a patriarchal system threatened by the tremendous strides women have made in attaining influence within traditionally male power structures.\textsuperscript{156} Pregnancy has become the last frontier of gender regulation.

e) FAS is Not Just a Woman's Issue

Society has a tendency to characterize problems by the groups directly

\textsuperscript{151} See Lencewicz, supra note 150, at 621 (the Act mandates that reports of illicit drug use (and now alcohol use) should be forwarded to a social service agency).
\textsuperscript{152} See id.
\textsuperscript{153} Id. at 622.
\textsuperscript{154} See id.
\textsuperscript{155} See id.
\textsuperscript{156} See id. at 625.

The rationale behind using fetal rights laws to control the actions of women during pregnancy is strikingly similar to that used in the past to exclude women from the paid labor force and to confine them to the 'private' sphere. Fetal rights could be used to restrict pregnant women's autonomy in both their personal and professional lives, in decisions ranging from nutrition to employment, in ways far surpassing any regulation of competent adult men. The state would thus define women in terms of their childbearing capacity, valuing the reproductive difference between women and men in such a way as to render it impossible for women to participate as full members of society.

\textit{Id.} "Law from a male point of view combines coercion with authority, policing society where its edges are exposed: at points of social resistance, conflict and breakdown." \textsc{Catharine A. MacKinnon, Toward A Feminist Theory of State} 239 (1989).
affected. This limiting construct characterizes FAS and FAE as women’s issues. Under this narrow view it is only possible to prevent these disorders during pregnancy. The woman is the sole problem-solver. Compartmentalization makes it easier for social and legal systems to target women’s behaviors for control. The Mutual Responsibility Approach considers this point of view reductivist. The environment that engenders FAS and FAE is inhabited by men and women, adults and children alike. Essentially these problems affect everyone, however indirectly.

The saying, “it takes a village to raise a child,” may be overused at times in the political arena, but its intrinsic message is meaningful to the Mutual Responsibility Approach. A community’s interest in a child’s welfare needs to begin with the pregnant woman, the person who bears the responsibility—the maternal duty—to provide a safe, healthy environment for the development of her fetus. However, her duty does not exist in a vacuum. The FAS Task Force recognized as much by stating that “[p]revention efforts must not overlook males.” Men can be involved in parenting groups and other education efforts that increase their stake in the developing fetus and encourage them to support their pregnant partner in avoiding potentially harmful substances. If the father of the fetus (or relationship partner) is no longer in the pregnant woman’s life, she needs to rely on support systems from within her community—groups of other single pregnant women, for example, or counseling services that will teach her responsible behavior and provide resources that will help her avoid turning to alcohol for self-medication.

In sum, under the Mutual Responsibility Approach, the cycle of rights between the state and the pregnant woman begins and ends with maternal duty, but this duty cannot stand alone. Although women do not have enforceable rights to prenatal assistance that they can assert against the state, the state nonetheless has a level of moral commitment it should

157. An African proverb which has become widely used in child-development circles (and also the title of a 1995 book by Hillary Rodham Clinton). See Douglas J. Besharov, First Lady Knows Best, WASH. POST, Jan. 28, 1996, at Book World, at X1. According to Besharov, experts use the proverb “to mean that parents cannot do it all on their own, that they need support in raising children — and that children benefit from many non-parental influences, including the extended family, other adults, and various community institutions.” Id. at 23.

158. SUFFER THE CHILDREN, supra note 2, at 23.

159. See Duluth Task Force Hearing, supra note 62 (statement of Public Health Nurse). “A woman’s partner and her community are appropriate targets for preventive interventions and subjects for preventive intervention research.” See also Executive Summary, supra note 29.

160. This is in contrast to the right to due process in welfare cases, first announced in Goldberg v. Kelly, 397 U.S. 254 (1970), where the Supreme Court held that recipients of AFDC benefits had a right to a post-termination hearing because terminating benefits impacts important property interests. Without a hearing, recipients whose benefits were denied could possibly die because their benefits fulfilled a “brutal need”—the necessities of life. Id. at 261 (citing Kelly v. Wyman, 294 F.Supp. 893, 899, 900 (1968)).
meet in order to fully serve this segment of its constituency. In an environment where fetal rights are achieving greater recognition at the expense of women’s rights, it is imperative for the state to return its focus to the real problem at hand—a woman who drinks excessively while pregnant is a woman in crisis. She is not a criminal. She has not permanently failed to meet her maternal duty. The Mutual Responsibility Approach holds the state morally accountable in the same way that the state seeks to hold women morally accountable. In a democracy where checks and balances are the norm, this seems the only fair analysis.

IV. PUTTING THE MUTUAL RESPONSIBILITY APPROACH TO WORK: MANDATORY REPORTING, CIVIL COMMITMENT AND CRIMINAL PROSECUTION IN THE CONTEXT OF FAS PREVENTION

The reasons for using a value system to analyze legal responses to FAS/FAE are twofold. First, once one goes beyond the physiological aspects of the disorder, the issue of alcohol use during pregnancy emerges as complex and emotionally-charged. No single perspective could possibly encapsulate the multitude of external and internal forces affecting a woman’s use of alcohol during pregnancy. Therefore, a comprehensive system working toward the goal of reconciling the maternal-fetal conflict is required. Second, an inclusive approach asserted in combination with broad-based healing resources and community education will encourage women to seek support and participate in their own recoveries without fear of reprisal.

Proponents of coercive or punitive approaches to the problem of alcohol abuse during pregnancy assert that these methods will serve as a specific deterrent to the mother and as a general deterrent to other women who might act in the same manner. Under one tenet of utilitarianism, a law’s success in achieving deterrence is evaluated by weighing whether the infliction of punishment or penalties results in greater good to society than the harm necessarily suffered by the individual who is punished.

161. See Dressler, supra note 22, at 14. See also James Denison, The Efficacy and Constitutionality of Criminal Punishment for Maternal Substance Abuse, 64 S. CAL. L. REV. 1104, 1120 (1991). “Imprisonment might effect specific deterrence of fetal abuse by containing the individual convict’s destructive behavior toward her fetus and preventing further harm. Additionally, fetal abuse law might generally deter the maternal substance-abusing populace who feared the prospect of jail time and would opt to cure themselves of their addiction.” Id. at 1121.

162. See Denison, supra note 161, at 1120 (citations omitted).

Empirical evidence that these deterrent effects would occur would justify the law from a utilitarian perspective. However, if the harm the laws themselves inflicted were greater than the benefit of enforcing them, they would not be justified. If, for example, the discomfort of imprisonment and involuntary detoxification that convicted fetal abusers suffered were greater than the
FAS/FAE are serious problems facing this generation and forthcoming generations, but under a utilitarian approach the benefits of deterrence from punitive and coercive measures do not favor society to such an extent that individual rights of women can be compromised loosely. Punishment only addresses a portion of the problem. By temporarily detaining a woman for her actions, society addresses her needs at a discrete and finite level. The conditions under which she lives, both on a micro and macro level, are disregarded elements of the long-term resolution.

The trend towards punishment of expectant mothers portends a social benefit realized through unacceptably high costs. These costs are not only monetary—they encompass personal and community morale as well. An assaultive retributivist point of view is emerging in the United States toward women who abuse substances while pregnant. Retribution satisfies society's thirst for revenge against perceived 'bad mothers'; punishment demonstrates moral distaste for what is perceived as an immoral act.163 Protective retribution is also implied: "[p]unishment is not inflicted because society wants to hurt wrongdoers but because punishment is a means of securing moral balance in the society."164 Retributive approaches tend to suggest that society has constructed a universal line of morality over which an individual cannot cross without consequences. Such a line is necessary to a certain point, for without laws there would be anarchy. On the other hand, immutable lines do not address the reasons or motivations behind an individual's questionable behavior. In the realm of fetal rights, the line created by maternal duty tends to circumscribe a pregnant woman's private realm of morality. Under a retributive system, a pregnant woman's personal morality may conflict with society's universal morality, at times without her even knowing it, or without her control. Personal responsibility is important, but a retributive scheme does not allow a woman to recognize her role in assuming maternal duty. Swift punishment serves only harmful purposes when the target of retribution is a pregnant woman who drinks.

Under the Mutual Responsibility Approach advocated by this paper, a universal morality is not assumed and therefore neither assaultive nor protective retribution is broached as a meaningful way of addressing the problem of FAS/FAE. A rehabilitative approach contemplates the possibility of redemption.165 Certainly not everyone can be reformed. However, starting from a place of hope rather than one of condemnation is important for women who are clearly acting in an irresponsible manner, but

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extent to which enforcement would curb the fetal abuse problem, the laws would not be justified according to utilitarian theory.

Id. at 1121.

163. See DRESSLER, supra note 22, at 12.

164. Id.

165. See id. at 15.
do not have the personal or societal support systems in place to stop. It simply is not the case that pregnant women who drink deserve to be punished; they deserve help, when and where they need it, without imposition of a biased public morality. Fetal rights are never implicated by any of society's punitive or coercive approaches toward stopping pregnant women's behavior. Those rights are instead elevated above those of the woman, the person who is in the best (if temporarily disabled) position to make the right decisions for her fetus, and her future.

The uniform public morality suggested by the retributive model does not respect the individual pregnant woman's morality and therefore condemns without considering what the inevitable impact of punishment will be on society. For example, many commentators have suggested that a trend toward punitive and coercive measures will increase the incidence of abortion in this country. The state will be coercing women to seek abortions, based solely on the perception that they lack a choice between their personal freedom and the threat of arrest, incarceration or involuntary civil commitment. A woman is improperly deprived of her right of privacy guaranteed by the Roe protections when the state takes away her choices. Society does not benefit when abortions are performed under such coercive circumstances because the procedure is meant to be a private, voluntary choice asserted by a woman in consultation with her doctor. A myriad of rights are attacked in a punitive environment and nothing is gained because the long-term benefits of treatment and education are denied the priority they deserve.

A) MANDATORY REPORTING

Minnesota law requires that a physician who suspects alcohol or drug abuse order toxicology tests on pregnant women. The state legislature


168. MINN. STAT. § 626.5562 (1995). See also OFFICE OF THE INSPECTOR GENERAL, DEPARTMENT OF HEALTH AND HUMAN SERVICES, PRENATAL SUBSTANCE EXPOSURE: STATE CHILD WELFARE LAWS AND PROCEDURES, 7 (May 1992) [hereinafter PRENATAL SUBSTANCE EXPOSURE]. When a test is positive, a report is made to the appropriate child welfare agency but physicians also have discretion to report suspected use even if toxicology tests are negative. See MINN. STAT. § 626.5561 (1995). Not all cases are investigated by child welfare, but if an allegation is accepted and the fetus is considered to be at risk for abuse or
has now expanded the statutes to give legal immunity to health care providers who report women who drink.\textsuperscript{169} This law departs from the federal Child Abuse Prevention and Treatment Act, which also requires health care providers to report child abuse.\textsuperscript{170} However, the federal Act exempts the fetus, requiring a live birth before "asserting the force of law."\textsuperscript{171}

Mandatory reporting with or without legal immunity is problematic within the Mutual Responsibility Approach contemplated by this paper. It creates a maternal-fetal conflict, imposes limited concepts of personal maternal duty, discriminates against low-income women and communities of color, and promotes treatment in a solely coercive manner. Mandatory reporting is part of 'managing' a woman's pregnancy, representing a significant intrusion by the state and placing morality-based obligations to the fetus over a woman's rights to privacy and bodily integrity.\textsuperscript{172} It also places health care providers in a difficult ethical position: the doctor-patient relationship is confidential, with good reason.\textsuperscript{173} A patient who can speak freely with her doctor will likely receive the best care possible. However, now that Minnesota health care providers can report with immunity, women will be hesitant about openly discussing concerns regarding personal alcohol use during pregnancy.\textsuperscript{174}

Women who are drinking and women who are not drinking are both affected by mandatory reporting. In the wake of mandatory reporting, women who are drinking will be even less likely to seek the help they need, and even non-drinking women may refrain from asking questions for fear of a false report. The deterrent effect of this coercive measure actually backfires, creating an atmosphere of suspicion and deception, an unqualifiedly poor health care environment that disregards the paramount value of receiving vital prenatal care.\textsuperscript{175} This result may cause more women to totally avoid visiting health care providers, resulting in an

\begin{itemize}
\item \textsuperscript{169} See supra note 5.
\item \textsuperscript{170} 42 U.S.C. §§ 5101-5107 (1989) (quoted in Sexton, supra note 8, at 419).
\item \textsuperscript{171} Id.
\item \textsuperscript{172} For further discussion of the notion of mandatory reporting, see John A. Robertson, \textit{Procreative Liberty and the Control of Conception, Pregnancy, and Childbirth}, 69 Va. L. Rev. 405, 437 (1983).
\item \textsuperscript{173} See supra note 9.
\item \textsuperscript{174} See Sexton, supra note 8, at 420. Sexton states that "mandatory reporting requirements can deter pregnant mothers from seeking prenatal services and drug treatment programs." Id.
\item \textsuperscript{175} See id. "Doctors in Minnesota believe that the Reporting of Maltreatment of Minors Act is actually deterring pregnant drug users from treatment and causing them to withhold information from their doctors, despite the fact that the act imposes no criminal sanctions." Id.
\end{itemize}
increase in risky pregnancies and home births, which are not always the best or safest choice. In other cases, a woman may forgo care for the entire length of her pregnancy and then arrive at the hospital with absolutely no medical history that could assist the staff in her delivery. If an emergency should arise, dangerous and costly mistakes are more likely to occur.

Poverty and race have proven to be significant barriers to receiving adequate prenatal care. Mandatory reporting requirements, further liberated by legal immunity, will increase the unequal enforcement of reporting in low-income communities and disproportionate reporting of women of color who must rely on public clinics for prenatal care. Women receiving private health care are simply not reported as often as those receiving publicly-funded care, especially from diverse racial and ethnic communities. If women who have the means to afford private health care are not being reported on the same basis as women of color or low income women, equal protection concerns are raised on two levels: discriminatory state action based on income status and race.

Racial discrimination is analyzed under strict scrutiny, the most rigorous standard of judicial review, since race is considered a suspect class. To determine whether the mandatory reporting law with legal

176. See id.
177. See Chavkin, supra note 8, at 244.
178. See id.
179. See Sexton, supra note 8, at 422. See also Roberts, supra note 15.
180. See Schroedel & Peretz, supra note 15, at 341. Most studies are in relation to drug use, but a similar result may be inferred for alcohol use as well, since the circumstances for reporting are no different. "Even though pregnant white women were slightly more likely to test positive for drug use, African American women were ten times more likely to have those results reported to law enforcement officials." Id. (citations omitted).
181. U.S. CONST. amend. XIV. The Equal Protection clause of the Fourteenth Amendment "protects individuals from discrimination that is based on their membership in a disadvantaged group." Johnsen, supra note 101, at 620.
182. A statute will be upheld only if it is found to be necessary (not merely appropriate) to the attainment of some compelling (not merely desirable) governmental interest. Suspect classes include race, national origin and alienage. See Carolene Products, 304 U.S. 144, 153 n.4 (1938):

It is unnecessary to consider now whether legislation which restricts those political processes which can ordinarily be expected to bring about repeal of undesirable legislation, is to be subjected to more exacting judicial scrutiny under the general prohibitions of the Fourteenth Amendment than are most other types of legislation . . . [or] whether prejudice against discrete and insular minorities may be a special condition which tends seriously to curtail the operation of those political processes ordinarily to be relied upon to protect minorities, and which may call for a correspondingly more searching judicial inquiry.

immunity for health care professionals constitutes invidious racial discrimination, one must determine whether a compelling state interest exists.\textsuperscript{183} If a less discriminatory alternative is available it must be used in place of the more restrictive law.\textsuperscript{184}

Mandatory reporting with built-in legal immunity provides an example of 'purposeful' discrimination in the sense that it is a neutral law administered in an unequal manner.\textsuperscript{185} Some may argue that the disproportionate results of mandatory reporting are only a single factor for discerning intent and therefore strict scrutiny does not apply without further evidence of purposeful state action. However, there are many strong arguments to the contrary.\textsuperscript{186} The United States Supreme Court has recognized state-sanctioned selection processes that produce "unexplained racial disparities" as evidence of discriminatory purpose.\textsuperscript{187} In Pinellas County, Florida, for example, an African American woman arrested for exposing her newborn to cocaine made a prima facie case of unconstitutional racial discrimination based upon statistics on substance abuse reporting by race in the county.\textsuperscript{188} From a broader perspective,
analysis can also be made of the dominant "social patterns and institutions that perpetuate the inferior status" of women of color in mandatory reporting. An unintended "racial hierarchy" may be perpetuated by state action, leading to unequal treatment.

Establishing a prima facie case of discriminatory intent is more difficult for the class of low-income women. Strict scrutiny would not apply because poverty is not a suspect class, and therefore the government has less of a burden to meet in setting forth its interest in protecting the fetus from maternal substance abuse. The applicable standard would be either "intermediate scrutiny," meaning that a classification must be "substantially related to important governmental objectives" or even "rational basis," where the state has little burden to meet in enacting its laws equitably. Despite facing greater obstacles in obtaining a favorable standard of review, low-income women might successfully pose a due process challenge. For example, a lack of notice affects a protected liberty interest if public clinics fail to explain a pregnant woman's potential liability when she discusses her alcohol abuse during a doctor's visit.

Potential causes of action would rely on studies establishing disproportionate community impact to establish a case of arbitrary enforcement based on race or low-income status. Studies similar in theoretical approach to those undertaken by the Center for Race and Poverty, addressing disproportionate resource availability based on race

defendant could buttress her case with the study's finding that, despite similar rates of substance abuse, Black women were ten times more likely than white women to be reported to public health authorities for substance abuse during pregnancy.

Id. (citations omitted). See Chasnoff et al., supra note 66, at 1202.


190. Id.

191. This standard is commonly used in gender classification analysis. See, e.g., Craig v. Boren, 429 U.S. 190, 199-204 (1976) (applying intermediate scrutiny to Oklahoma statutes making gender-based differentials regarding the sale of nonintoxicating beer). The rational basis or mere rationality review is most often used in state economic/regulatory lawmaking.

192. See, e.g., Minnesota v. Clover Leaf Creamery Co., 449 U.S. 456 (1981) (applying rational basis to state statute banning the sale of milk in plastic non-returnable containers but allowing such sale in other types of non-returnable containers). If a statute completely lacks rationality it will be overturned under Equal Protection analysis. See, e.g., Logan v. Zimmerman Brush Co., 455 U.S. 442 (1982) (holding that Illinois fair employment practices act violated the Equal Protection clause because it established two classes of claimants—those whose claims were processed within the 120 day period and whose claims were given full consideration on the merits, and those whose claims were not processed within the 120 days and whose claims were accordingly terminated).

193. See Paul v. Davis, 424 U.S. 693, 701-10 (1976) (holding that reputation alone, apart from more tangible interests, was neither liberty nor property by itself sufficient to invoke the protections of the procedural due process clause, and thus could not support a § 1983 claim). Paul suggested that liberty interests include those guaranteed by specific provisions of the Constitution or Bill of Rights as well as those included under the penumbral rights of privacy and freedom from bodily restraint. Id. at 711-12. Further, a liberty interest includes not being subjected to state conduct that impinges upon a prior freedom. See id.
inherent within the Minneapolis public schools, could be successful in finding skewed mandatory reporting. Interested legal advocacy groups could pursue further action to address this issue.

Mandatory reporting places health care providers in a difficult position in relation to the state. Health care providers are bound to a duty of doctor-patient confidentiality, yet they must judge when and how to report their patients to legal and social authorities. Reporting can have a tremendous impact on a pregnant woman’s life aside from the potential loss of liberty. If she has children already, she may lose parental rights either temporarily or permanently. There are circumstances where a woman should receive help for the benefit of herself and her family. However, the state must decide which need is greater, the woman’s medical care during her pregnancy, or the ambiguous fetal interest. As the mandatory reporting law suggests, the woman is not the focus of the legislative agenda. The maternal-fetal conflict is exacerbated by such a situation.

With or without legal immunity, mandatory reporting violates many important privileges and rights and should therefore be removed from the list of health care provider duties in Minnesota. If treatment on demand is available, doctors will be able to make referrals when appropriate. Doctors will also have a much better chance to counsel those who need the most information about the risks they are taking by drinking while pregnant, because the deterrent effect created by the threat of punitive or coercive action will be removed.

B) CIVIL COMMITMENT

Involuntary civil commitment is a legal process “operating at the confluence of the public safety, justice and social service systems whereby an individual is found to pose harm to self or others.” Minnesota was the


195. Interview with Deborah Thorp, M.D., supra note 8. “The state ought to stay out of practicing medicine. If I don’t report I can get into a lot of trouble. It shouldn’t have to be my responsibility, I shouldn’t have to play detective. Personally I don’t think there should be any regulations.” Id. “Forcing the medical community to police the problem of drug abuse during pregnancy triggers ethical issues the medical community does not want to face.” Sexton, supra note 8, at 429. See also supra note 9.

196. See Lee, supra note 166, at 1219 n.198. “The fact that vertical transmission of AIDS is most common among drug-using women is an additional and particularly forceful reason to ensure that these women are not driven away from the health-care system.” Id. (citation omitted). Given that many women who abuse alcohol may not be using safer sex practices, this is yet another clear argument for keeping the channels of communication with health care open and nonpunitive.

197. PUNISHING WOMEN FOR THEIR BEHAVIOR DURING PREGNANCY, supra note 18, at 6, quoting Sandra Garcia, Ethical and Legal Issues Associated with Substance Abuse by Pregnant and Parenting Women, J. PSYCHOACTIVE DRUGS, 101, 105 (Jan.-Mar. 1997). Commitment statutes “limited to drug or alcohol addiction use such criteria as ‘addiction to
first state in the country to amend its civil commitment laws to include women who abuse drugs during pregnancy.\textsuperscript{198} The FAS Task Force tried unsuccessfully to influence legislation that would make alcohol use during pregnancy grounds for involuntary civil commitment.\textsuperscript{199}

Under the Mutual Responsibility Approach offered in this paper, involuntary civil commitment is not a desirable form of 'treatment' for pregnant women who drink because it is punitive by nature. The maternal-fetal conflict is once again heightened, maternal duty is negated entirely because the state assumes jurisdiction over a woman's autonomy, and a disproportionate impact on women of color and low-income women is possible. Further, in instances of budget and cost-cutting measures, the course of treatment becomes subordinate to incapacitation of the individual, rendering a civilly committed pregnant woman essentially a prisoner with no rehabilitative support.\textsuperscript{200}

Like mandatory reporting, civil commitment is not a 'self-implementing' procedure. Setting the process into motion requires an affirmative act in the form of a report to social or law enforcement authorities, followed by a court hearing.\textsuperscript{201} Such a process suggests that fundamental rights, including privacy, liberty and bodily integrity, in addition to equal protection concerns, will once again be called into question. Without treatment on demand, expanded treatment options or a more comprehensive universal prenatal care plan in place, it makes little sense (and it is constitutionally overbroad) to rely on involuntary civil commitment for all women who drink during pregnancy. Civil commitment should be a last resort for the individuals who simply cannot beat their addictions without a strong-arm approach.\textsuperscript{202} While the fact remains that some women are addicted beyond their own control, laws that punish without providing some measure of treatment and prenatal care first

drugs' or 'habitual drug use.' These criteria are generally used in conjunction with other criteria that focus on the impact of the drug or alcohol dependency on the individual." Chavkin, \textit{supra} note 8, at 267 (citations omitted). This observation assumes new significance when the fetus is involved, especially if the state is asserting a fetal right.\textsuperscript{198} See \textsc{Minn. Stat.} § 253B.02 (1995). \textit{See supra} note 11.

\textsuperscript{199} \textit{See supra} notes 11-14. The following states explicitly allow involuntary commitment of alcoholics under their general civil commitment statutes: Indiana, Oklahoma, Pennsylvania, Rhode Island, Tennessee, Virginia, West Virginia, Wisconsin. \textit{See Chavkin, supra} note 8, at 274 n.285 (citations omitted). South Dakota recently passed a law allowing judges to order pregnant women into treatment centers if a judge suspects they have been drinking too much. The amount of excessive alcohol intake will be left to the court's discretion. \textit{See James Langton, Mothers-to-be Who Drink Face Detention Under New Laws in Two American States, The Daily Telegraph} (London), May 31, 1998, at 37. The South Dakota law empowers friends or relatives of a pregnant woman caught drinking to commit her to an emergency detoxification clinic for a period of up to two days. \textit{See id.} Judges can order a pregnant woman confined for the full nine months of the pregnancy. \textit{See id.}

\textsuperscript{200} \textit{See Chavkin, supra} note 8, at 262.

\textsuperscript{201} \textit{See id.} at 243.

\textsuperscript{202} \textit{See id.} at 287.
only remove a woman’s right to make her own decisions, perpetuating personal and societal isolation that can only aggravate the problem.203

Civil commitment is a ‘paternalistic’ state tool that forces a pregnant woman into a short-term treatment situation that may or may not address her needs.204 A pregnant woman is placed in civil confinement because the state is interested in protecting her fetus; one could argue that the state is only secondarily concerned with helping the woman achieve sobriety.205

203. See Bob Herbert, Wisconsin Lawmaker’s Hidden Agenda, STAR TRIB., June 16, 1998, at 13A. In the article, Herbert quoted Lynn Paltrow, a New York lawyer, who stated that not only is the woman being punished, in the sense that her life now comes under state scrutiny from the moment of fertilization, but she is no longer allowed, like every other adult citizen, to make her own medical decisions about prenatal care, abortion or what kind of drug or alcohol treatment is best for her.

Id. According to Herbert, “Alcoholism and drug addiction are illnesses. But the fetal protection movement has not been accompanied by any serious effort to provide women with the alcohol and drug treatment that they need—or even, for that matter, adequate prenatal care. That is not part of the agenda.” Id. The agenda Herbert refers to is the erosion of a woman’s right to bodily integrity; in essence, passage of stiffer fetal homicide, civil commitment and other laws are a “back door” means of negating Roe. Id.


205. But see Chavkin, supra note 8, at 255. Although criminal prosecutions and child abuse and neglect proceedings tend to pit fetus against mother, the rhetoric of civil commitment systems is far more benign. These systems are described by their supporters as protecting the right of a child to a healthy start. However, these systems are also described as furthering the interests of the women involved by helping them get off alcohol or drugs.

Id.

In Wisconsin v. Kruzicki, a protective custody order was executed stating a young woman’s fetus should remain in a treatment center in the custody of the state. 541 N.W.2d 482, 485 (Wis. Ct. App. 1996). This clearly meant as long as the mother carried the fetus within her body she too would need to remain at the treatment center. See id. at 485. The woman had been using cocaine during her pregnancy and the court issued the order to protect the fetus. See id. at 485. The court used Wisconsin’s child protection (CHIPS) statute to allow a juvenile court to assert jurisdiction over the twenty-four-year-old woman and construe a fetus to fall under the definition of “child.” Id. The Wisconsin Court of Appeals denied the woman’s writ of habeas corpus for unlawful detainment and involuntary civil commitment. See id. at 498. However, the decision was later reversed by the Wisconsin Supreme Court, which found that the case was one of statutory construction. See Wisconsin v. Kruzicki, 561 N.W.2d 729 (1997). Applying principles of statutory construction, the court concluded that the Legislature did not intend to include a fetus within the Children’s Code definition of child. See id. at 731. The court also found that important social policy issues should be resolved by the Legislature, not the courts. See id. at 740. See also Carol Gosain, Protective Custody for Fetuses: A Solution to the Problem of Maternal Drug Use? Casenote on Wisconsin Ex. Rel Angela v. Kruzicki, 5 GEO. MASON L. REV. 799 (1997); Lee, supra note 166.
Civil commitment satisfies society’s retributive urge to hold the woman accountable for her behavior adverse to the developing fetus.\textsuperscript{206} Further, while some lower courts have considered less restrictive options, the United States Supreme Court has not ruled that states are required to utilize a less restrictive treatment approach than civil commitment as a constitutional requirement.\textsuperscript{207} All of these factors suggest that the state has little incentive to put funds toward voluntary treatment programs and universal prenatal care when involuntary civil commitment is not considered an overbroad solution to the problem of drinking during pregnancy.

Yet another disturbing issue is the type of setting in which a pregnant woman might be placed for the duration of her involuntary civil commitment. Options include correctional facilities, mental hospitals, residential treatment facilities or outpatient treatment settings.\textsuperscript{208} Of these choices, an outpatient setting would be optimal because a woman’s liberty interest would not be unduly compromised. Additionally, if she has other children, she will not be separated from them for too great a period of time. However, correctional institutions are often the first places women are sent if no other suitable facilities are available.\textsuperscript{209} Prisons are extremely inadequate environments for pregnant women.\textsuperscript{210} Few offer proper medical

\textsuperscript{206} See Morse, supra note 22, at 121.

Punitive purpose is a necessary condition of criminal confinement, whereas civil confinement does not aim to punish. Criminal confinement brands the detainee as blameworthy; civil confinement stigmatizes the detainee as nonresponsible. Civil commitment does not require the same procedural protections as criminal incarceration because the detention is not punishment and does not carry the same stigma.

\textit{Id.}

\textsuperscript{207} See Lake v. Cameron, 364 F.2d 657 (D.C. Cir. 1966). The Court of Appeals ordered the governmental agency wishing to commit a woman with Alzheimer’s disease to consider less restrictive options, but the court restricted its holding to the facts of the case, which presented “special features.” \textit{Id.} at 659, 662, \textit{quoted in} Chavkin, supra note 8, at 268.

\textsuperscript{208} See Chavkin, supra note 8, at 263.

\textsuperscript{209} \textit{See id.}

\textsuperscript{210} See \textit{id. See also} Linden, supra note 86, at 120; Schroedel & Peretz, supra note 15, at 350. \textit{But see} Martin, supra note 8, at 340:

The effects of incarceration on pregnancy are controversial. Some reports suggest that incarceration places pregnant women and their expected infants at increased health risk because of prison-induced stressors such as the women’s separation from family and friends and the women’s concerns regarding placement of the expected infant (infants are usually placed with a member of the mother’s family soon after birth.) However, other reports suggest that incarceration may promote the health of some pregnant women and may foster healthy pregnancy outcomes by supplying these often high risk women with shelter and regular meals, restricting their alcohol and illicit drug use, limiting demanding physical work, and providing appropriate prenatal health care services.

\textit{Id.} (citations omitted). However, two “exploratory, small-scale investigations on midwestern U.S. prisoners . . . found at least a quarter of the infants born to inmates had very poor birth outcomes—the infants required stays in neonatal units, died shortly after
care, the nutritional value of the prison diet is poor and overcrowded conditions are conducive to the spread of dangerous contagious diseases.211

The right to privacy and bodily integrity takes prominence in the Mutual Responsibility discussion of involuntary civil commitment. Intrusive treatment procedures have been held unconstitutional by recent judicial decisions because they interfered with the right to privacy and bodily integrity.212 The Supreme Court has also spoken on the issue of childbearing as a protected privacy right under the Constitution, affirming that an individual is entitled to “independence in making certain kinds of important decisions” which include childbearing.213 The state cannot interfere with this fundamental right.

Griswold v. Connecticut provides one of the strongest examples of the Court affirming personal autonomy in relation to the state.214 Connecticut had passed a statute making it a crime to “use[,] any drug, medicinal article, birth or both.” Id. (citations omitted)

211. See Chavkin, supra note 8, at 263.
Most prisons have inadequate protocols, staff or training to properly attend to the special needs of pregnant prisoners. The result has been widespread deficiencies in diet, nutrition, exercise, and seriously inadequate, if any, prenatal care. Pregnant women in jail are routinely subject to conditions which are hazardous to fetal health, such as gross overcrowding, twenty-four-hour lock up with no access to exercise or fresh air, exposure to tuberculosis, measles and hepatitis and a generally filthy and unsanitary environment.

Id.

Even though pregnant women need a diet high in proteins, vitamins, and nutrients, fourteen out of twenty-six prisons in one survey made no special provisions for providing pregnant [inmates] with special diets or supplementary vitamins. Only a few prisons have medical care available for female prisoners twenty-four hours a day and some do not even have contingency plans for medical needs during the night.

Schroedel & Peretz, supra note 15, at 350.
The miscarriage rate is also quite high in prison environments. See id.
212. See Johnsen, supra note 101, at 615-16.

Courts have held unconstitutional even isolated instances of the type of intrusions to which pregnant women could be continually subjected. For example, the Supreme Court has held that the state may not compel criminal suspects to undergo certain medical procedures, and a federal circuit court has recognized the right of even involuntarily committed mental patients to refuse medical treatment. The fact that these prohibited attempts at intrusions have involved those over whom the state traditionally exerts a great deal of authority—criminal defendants and mental patients—suggests the radical nature of the fetal rights trend and its incompatibility with our heritage of civil liberties. One judge, concurring in an order compelling a pregnant woman to submit to a cesarean section, acknowledged this anomaly: “The power of a court to order a competent adult to submit to surgery is exceedingly limited. Indeed until this unique case arose, I would have thought such power to be nonexistent.”

Id. (citations omitted).
The United States Supreme Court held that the law was an egregious encroachment on marital privacy. To enforce the law, the state would conceivably have to search marital bedrooms for signs of the use of contraceptives. In order to subject a pregnant woman to civil commitment, a similar type of monitoring would probably need to occur, especially if a woman is deterred from going to a medical clinic for fear of mandatory reporting. The only way the law could catch her in suspect behavior would be to constantly intrude upon her privacy.

Involuntary civil commitment introduces a particularly thorny problem into the privacy concerns of the value system analysis. When a state asserts a compelling or even substantial interest in securing fetal health through the incapacitation of the mother, there is no "bright line" that divides permissible and impermissible behaviors. Laws cannot help but be vague and overinclusive when their basis is the proverbial slippery slope of constitutional rights analysis. For example, smoking has proven harmful effects on a fetus. With the increased awareness piqued by the increased tobacco litigation, it follows that if a mother may be committed for drinking, a legal activity, she may also be committed for smoking, another legal activity. Similarly, if a woman engages in dangerous sports or other activities during pregnancy, could she be committed? An all fast-food diet is surely not good for a fetus. The list goes on into seemingly outrageous private territory.

Further, at what point may the state assert its interest in fetal rights in a civil commitment proceeding? Do the same viability criteria developed in

215. See id. at 480.
216. Id. at 485. The Supreme Court found that the case concerned a relationship lying within the zone of privacy created by several fundamental constitutional guarantees. See id. Further, the Court found that the statute, in forbidding the use of contraceptives, rather than the manufacture or sale, sought to achieve its goals through means that would have a maximum destructive impact upon the marital relationship. See id. The Court concluded that such a law could not stand in light of the principle that a "governmental purpose to control or prevent activities constitutionally subject to state regulation may not be achieved by means which sweep unnecessarily broadly and thereby invade the area of protected freedoms." Id. (quoting NAACP v. Alabama, 377 U.S. 288, 307 (1964)).
217. See id.
219. See id.
220. See Alcohol Syndrome: Offering Help for Pregnant Alcoholics, STAR. TRIB., Feb. 13, 1998, at 24A. See also Interview with Deborah Thorp, M.D., supra note 8: "I treated a woman who rode on a three-wheel [all-terrain vehicle] with no brakes and flipped it at 32 weeks [into her pregnancy]. That's at least as much of an egregious insult as someone who takes a few drinks." See also Lichtenberg, supra note 104, at 389 n.95: "[A] pregnant vegan vegetarian may choose not to eat any animal products. However, the state could conclude that a 'reasonable pregnant woman' would drink milk, thus requiring her to conform to this objective standard or risk liability." Id.
Roe and Casey apply, or may a state regulate a pregnant woman’s behavior while she is still entitled to abortion on demand?221 The state can assert an interest in fetal health throughout the gestational term. However, the problem remains that much of a woman’s actions have their greatest impact on the fetus during the first three months of pregnancy when often a woman does not even know of her pregnant status.222 It is unacceptable to punish a woman for an intentional act for which she had no notice. Such an attempt would severely infringe upon her civil liberties. Clearly, there are too many opportunities for the state’s interest in protecting fetal rights to encroach upon the fundamental rights of the mother; the conflict is too great. Involuntary civil commitment and other punitive measures should not survive in this very treacherous constitutional landscape.

C) CRIMINAL PROSECUTION

According to a 1988 Gallup poll, 48 percent of the respondents believed that women “should be held criminally accountable for any damage the infant suffers as a result of the mother’s behavior during pregnancy.”223 A decade later, this attitude persists, manifested in the fact that women are increasingly being prosecuted for their illegal and legal behavior during pregnancy. It is here that the maternal-fetal conflict is most volatile, where maternal duty must meet its highest standards, and where the potential for disproportionate impact on low-income women and women of color is glaring.

1) Zimmerman and the Born Alive Rule

The most notorious recent example of prosecuting a woman for her behavior during pregnancy is State v. Zimmerman, a Wisconsin case that may set the tone for future judicial and state action across the country.224 Deborah Zimmerman was in her ninth month of pregnancy and due to deliver in one week when she was brought to the hospital with a .30 percent blood alcohol level.225 The hospital elected to perform a cesarean section because the fetal heart rate was flat and an ultrasound revealed abnormal results.226 The defendant claimed she did not want the procedure and threatened to go home to “drink herself to death” because she did not want her unborn child.227 The cesarean was performed and a baby girl was delivered with a .199 percent blood alcohol level.228 The child was limp

221. See Greenburg, supra note 108, at 1. See generally Casey, 505 U.S. at 833; Roe, 410 U.S. at 113.
222. See Johnsen, supra note 101, at 620. See also Casey, 505 U.S. at 833.
223. Sexton, supra note 8, at 411 (citation omitted).
225. See id. at *1-2.
226. See id. at *1.
227. Id. at *2.
228. See id.
and unresponsive, and displayed the distinctive facial features associated with FAS. A preliminary hearing determined that there was probable cause to find that the defendant had attempted the first-degree intentional homicide of her full-term unborn child by knowingly consuming a "near-lethal" amount of alcohol. The hearing also determined that this was first degree reckless conduct. A motion to dismiss the case was denied.

The Circuit Court defined "human being" in the Wisconsin criminal statutes to mean "one who has been born alive." The defendant argued unsuccessfully that because she consumed the alcohol and made threats in the hours prior to the birth of her daughter, the conduct could not be construed as directed toward a person, and thus, she could not be guilty of attempted first degree intentional homicide. However, the court decided that because the child was born alive within hours of the defendant's conduct and that the "destructive effects of the defendant's massive consumption of alcohol were still ongoing" at the time of birth, she could be charged with the crime. The effect of this decision is similar to cases that punish women for the delivery of drugs in the brief moments between birth and cutting the umbilical cord. The court went on to hold that the "convergence in time of the instrumentality of murder (alcohol)" and when the fetus became a human being under the Wisconsin statute is sufficient to hold the defendant responsible for the harm she caused her child. The court concluded that Wisconsin law recognizes that a viable fetus has rights

229. See id.
230. Id. at *1.
231. See id. at *1.
232. See id. at *9.
233. Id. at *3; WIS. STAT. § 939.22(16) (1998).
235. Id.
236. See id.

A pregnant woman who consumes alcohol should know that it will enter her fetus. This also is common knowledge. In this case the defendant's pregnancy was virtually full term. The defendant knew or should have known that although her drinking might stop at some point, her pregnancy was at such a stage that the effects of her alcohol consumption would continue for hours and could reasonably extend into the time when she might give birth. The convergence in time of instrumentality of murder (alcohol) with the victim being born was not instantaneous such as when a bullet is fired from a gun toward a human target. Nevertheless, the convergence occurred and the elements of the crime have been established for probable cause purposes.

Id. But see Johnson v. State, 602 S.2d 1288, 1290 (Fla. 1992) (Florida Supreme Court held that the legislative history did not show a manifest intent to use the word delivery in the context of criminally prosecuting mothers for delivery of a controlled substance to a minor by way of the umbilical cord; and that the lack of legislative intent coupled with uncertainty that the term delivery applied to the facts of the case compelled construction of the statute in favor of Johnson).

This result opens the door for prosecution of conduct that occurs before the time of birth is imminent, although the court stopped short of making further pronouncements in deference to the legislature's power to clarify the extent to which a viable (or even nonviable) fetus can be protected. Nonetheless, it appears that the Zimmerman Court and prosecution team attempted to re-characterize Wisconsin's born alive rule to the farthest extent possible without encroaching upon legislative territory. Racine County District Attorney Joan Korb, who charged Zimmerman in the first place, was so angered by the case that she was fully prepared to use the court as a forum for influencing future legislature: "It's an obscenity that Deborah Zimmerman could attempt to drink her foetus [sic] to death without any consequences. It should be possible to punish a woman who threatens her foetus's [sic] life by getting drunk and using drugs." Judge Dennis Barry, who ordered Zimmerman to stand trial, has commented that there is no distinction between fetus and baby in the realm of abuse. The Wisconsin Supreme Court will decide this year whether prosecutors can charge Zimmerman with attempted first-degree intentional homicide and first-degree reckless injury. Meanwhile, Zimmerman has lost parental rights to her daughter.

Apparently the Wisconsin legislature listened when the court requested further guidance as to what extent a viable fetus may be protected under the law. The lawmakers created a bill that would permit the state to put
fetuses exposed to alcohol under the jurisdiction of juvenile courts. In June, Governor Tommy Thompson signed the bill into law that allows the state to take custody of pregnant women who exhibit a “serious and habitual ‘lack of self-control’ in the use of alcohol or drugs.” The law does not contain criminal sanctions, but does give the state authority to order a woman into “inpatient treatment.”

2) Stretching the Limits of Child Abuse and Neglect Statutes

South Carolina appears less willing than Wisconsin to await decisive legislative action on the point of viability. In *Whitner v. South Carolina*, the South Carolina high court determined that a viable fetus is a person under the state’s child abuse laws. Lawyers representing Cornelia Whitner, who pled guilty to child neglect after her baby was born with cocaine metabolites in its system in 1992, appealed the decision to the United States Supreme Court but certiorari was denied.

Under the South Carolina children’s code, a “child” means a “person under the age of 18,” the same as in Minnesota. However, the South Carolina Supreme Court interpreted the statute to mean that “a fetus having reached that period of prenatal maturity where it is capable of independent life apart from its mother is a person.” The court reasoned that because the state had upheld the viability of fetuses in wrongful death and civil liability cases, “it would be absurd to recognize the viable fetus as a person for purposes homicide laws and wrongful death statutes but not for purposes of statutes proscribing child abuse.” The Court also held that “the consequences of abuse or neglect which takes place after birth often pale in comparison to those resulting from abuse suffered by the viable fetus before birth. The policy of prevention [in the children’s code] supports a reading of the word ‘person’ to include viable fetuses.”

The *Whitner* dissent argued that the majority’s decision rendered the South Carolina child abuse laws vague, leaving pregnant women potentially liable for any conduct they engage in during pregnancy,

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Id. at 9.
246. See *States Look to Detention for Pregnant Drug Users*, STAR TRIB., May 2, 1998, at 15A.
247. Herbert, supra note 203, at 13A.
248. See id.
249. 492 S.E.2d 777 (1997).
252. See *State v. Soto*, 378 N.W.2d 625, 630 (Minn. 1985).
253. *Whitner*, 492 S.E.2d at 780 (citing Hall v. Murphy, 113 S.E.2d 790, 793 (1960)).
254. *Id.*
255. *Id.* at 780-81.
including smoking, drinking or failing to obtain prenatal care. The dissent pointed out that other hazards in the environment, such as toxins produced by paint or dry cleaners, can also adversely affect a fetus, as can contracting diseases like diabetes or cancer. The only law, concluded the dissent, that could possibly regulate the conduct of a mother toward her unborn child is an abortion statute under which a viable fetus is treated differently from a child in being.

South Carolina is not the only state to interpret its child abuse and neglect laws to include a fetus. Indiana, Nevada, Florida, and Oklahoma are among the increasing number of states to recognize this newfound status for a fetus under state statutes. Courts, as evidenced in Zimmerman, are following suit. However, child protection legislation and judicial action is a wholly inappropriate area in which to find jurisdiction over these cases. Child welfare laws are meant to balance the best interests of the child with family autonomy questions. Maternal health issues, on the other hand, rest entirely on a balancing test that compares “the state’s interest in protecting maternal and fetal health against a woman’s right to bodily integrity.” The wrong law under the wrong circumstances equals an impermissible state intrusion into women’s civil rights. This trend presents a fundamental conflict with Roe—the judicial system and state legislatures are acting in an ad hoc manner by reinterpretting a United States Supreme Court decision that has never been overruled. Essentially, the cart has been put before the horse: under child abuse or neglect laws, the state interest is in the health and well-being of a

256. Id. at 786-88. The majority insists that parents may already be held liable for drinking after a child is born. This is untrue, however, without some further act on the part of the parent. A parent who drinks and then hits her child or fails to come home may be guilty of criminal neglect. The mere fact of drinking, however, does not constitute neglect of a child in being. Id. at 788.

257. See PUNISHING WOMEN FOR THEIR BEHAVIOR DURING PREGNANCY, supra note 18, at 3.

258. See Whiter, 492 S.E.2d at 786.

259. See Sexton, supra note 8, at 415 n.48. Sexton also points out that Pete Wilson, during his term as United States Senator from California, campaigned for a Child Abuse During Pregnancy Prevention Act. See id. “Wilson stated to his fellow lawmakers that ‘the most sordid and terrifying story is that of exploding child abuse through the umbilical cord.’” Id. In a related action, “Illinois amended the definition of a neglected minor in the state’s Juvenile Court Act to include all children born with controlled substances in their bodies.” Id. (citing ILL. REV. STAT. ch. 37 § 2-3(1)(c) (1989))


261. See Wilton, supra note 8, at 167. “[C]hild protection law is inappropriate because it does not protect the pregnant woman’s constitutional right to bodily integrity.” Id.

262. See id.

263. Id.

264. See id. at 168.
child, not a fetus. Laws prosecuting pregnant women for child abuse or neglect are punitive measures for harming the potential of a child.265

3) Viability: Where to Draw the Line in the Criminal Arena?

In the minefield created by criminal prosecution of women who drink during pregnancy, no greater danger exists than the blurred viability lines. For many women, it may be at least one or two months before they realize that they are pregnant. By that time, they may have had a few social drinks, or even drank to excess on one or more occasions. It is during this time period that studies show the greatest possibility that fetal harm may occur.266 Therefore, a woman could be guilty of violating a law, and her only choice in avoiding the threat of prosecution would be to either avoid drinking altogether or take suitable contraceptive precautions (though even these offer no guarantee).267 There are many women who never planned their pregnancies. This due process quagmire would leave women in a constant state of alert, a categorically unfair abuse of the law. Courts would be faced with the unenviable choice of determining when the point of viability is met. Further, courts would have to decide when the woman knew she was at this point, a situation that would produce an evidentiary nightmare. To complicate matters, the state might have to prove that the woman did not intend to abort the fetus during the first two trimesters of her pregnancy.268 Statutes would therefore need to define when an offender must have actual knowledge of the pregnancy.269 Without this notice requirement, establishing proximate cause becomes an utterly subjective task: alcohol could be responsible for a birth defect, but so could a genetic anomaly, medical malpractice, exposure to any number of toxins, or a trauma (such as an automobile crash or an accidental fall) occurring during the term of pregnancy.270

Public understanding of fetal viability will become confused because the course of events described above sets up a vagueness problem which

265. See Oberman, supra note 145, at 528.
266. See Denison, supra note 161, at 1127 n.150.
267. See Susan R. Weinberg, A Maternal Duty to Protect Fetal Health?, 58 IND. L.J. 531, 540 (1983). Weinberg suggests that this result could be avoided by setting a reasonableness standard for liability. For a converse opinion consider John Robertson, who argues that the state interest in fetal life need not be grounded in Roe [viability], but may be seen as the logical extension of child abuse and neglect laws. Robertson theorizes that the child abuse laws are evidence of a mother’s ‘legal and moral duty to bring the child into the world as healthy as is reasonably possible.’

Oberman, supra note 145, at 530.
268. See Weinberg, supra note 267, at 539. “[A]lthough the state may in theory have the right to intervene in first-trimester pregnancies, it may not prosecute a woman for violating a maternal duty unless the state could prove that she did not intend to abort.” Lichtenberg, supra note 104, at 389.
269. See Denison, supra note 161, at 1125.
270. See id. at 1126-27.
could lead to a potentially irretrievable disruption of a woman’s privacy and bodily integrity rights under Roe. Laws punishing a woman for her actions during the first six months of pregnancy clash with the right to choose an abortion—a woman could be prosecuted for taking a drink, yet she is free to obtain an abortion, a procedure that destroys the fetus altogether.\textsuperscript{271} There is no logic to this scenario.\textsuperscript{272}

The viability dilemma also calls into question the subject of intent—the mens rea requirement of a crime.\textsuperscript{273} One commentator suggests that the intent element for a fetal abuse statute “might consist of knowing that or recklessly disregarding the likelihood that a child would be born defective due to the parents’ acts,”\textsuperscript{274} Again, if a woman does not know she is pregnant, any number of activities she undertakes, from smoking to going out dancing in a night club, would fit this category. Women who are geographically isolated and do not have ready access to educational material on the dangers of drinking during pregnancy would be held liable despite their inadequate notice. Any number of possible scenarios that comprise ‘normal, everyday life’ could come into conflict with such a standard of recklessness. A fetal abuse statute, therefore, would need to narrow the scope of intent and its timing while also recognizing a flexibility of circumstances. Otherwise, the law would be too vague and overbroad in its attempt to cover all of the conceivable bases. Even with this procedural safeguard, however, any punitive law would have to define maternal duty, and therefore would need to impose a uniform morality.\textsuperscript{275} Imposition of a uniform standard of liability would set a responsibility standard that interferes with existing protections afforded by a woman’s fundamental constitutional rights.\textsuperscript{276} As a result, the maternal-fetal conflict would be perpetuated.

V. TREATMENT AND PREVENTION OPTIONS AND INCENTIVES: DEVELOPING AN INCLUSIVE MODEL

Many studies have considered the effectiveness of treatment on alcohol abuse. However, the bottom line remains that “[t]reatment is better than no treatment, and the cost of treatment is generally recouped in savings in

\textsuperscript{271} See id. at 1126.

\textsuperscript{272} Yet some courts have held in the civil context that if the parents of a fetus know that proceeding with a pregnancy will result in harm to the fetus, and the child after the birth, there may be good cause to hold them liable for damages. See Curlender v. Bio-Science Laboratories, 106 Cal. App. 3d 811 (1980), cited in Denison, supra note 161, at 1126.

\textsuperscript{273} See DRESSLER, supra note 22, at 102. Mens rea “suggests a general notion of moral blameworthiness, i.e. that the defendant committed the actus reus of an offense with a moral blameworthy state of mind.” Id.

\textsuperscript{274} Denison, supra note 161, at 1128.

\textsuperscript{275} See Denison, supra note 161, at 1128.

\textsuperscript{276} See id.
other areas." Treatment not only addresses the core problem of alcohol dependency, but it also opens the doors to improvements in other aspects of an individual's life, including physical health, psychological well-being, employment opportunities and curbing of criminal tendencies. Therefore, treatment of alcohol abuse must be varied according to an individual's needs and should be accompanied by treatment of other life problems that are the result of excessive drinking.

The FAS Task Force has proposed many ideas for developing education, prevention and treatment options that will positively affect both pregnant women and society at large. However, several important treatment and education alternatives are missing most notably treatment on demand, intensive case management within such programs, and creative incentive programs. An inclusive approach is vital for responding to the FAS/FAE problem. In Maryland, for example, the state legislature provided over $1 million in start-up funds for The Center for Addiction and Pregnancy at Francis Scott Key Medical Center, one of the first programs in the country to employ an entirely voluntary, multidisciplinary approach

277. CHEMICAL DEPENDENCY TREATMENT PLAN, supra note 116, at 8.

The preponderance of evidence demonstrates significant reductions in health care costs following treatment. A review of cost-offset studies conducted by employee assistance programs, insurance companies and prepaid health plans reveals a remarkable consistency in the documented reduction in health care costs among insured groups. Medical care decreased following treatment for the treated individual as well as for family members. Savings over a two- or three-year period following treatment typically exceeded the costs of treatment.

Id. at 10 (citations omitted). "Study of chemical dependency treatment in Minnesota shows most costs are offset within one year by savings to the health care and criminal justice systems." MINN. DEP'T OF HUM. SERVICES CHEMICAL DEPENDENCY DIV., RESEARCH NEWS (July 1996). Annual cost offsets in Minnesota have been estimated as follows: $7.9 million in medical hospital costs, $10.8 million in psychological hospital costs, $3.3 million in Detox Admissions, $9.2 million in DWI arrests, and $8 million in other arrests. MINN. DEP'T OF HUM. SERVICES, CONSOLIDATED CHEMICAL DEPENDENCY TREATMENT FUND (1993).

278. See id. at 8-9.

Clients who have developed healthy personal relationships and demonstrated stable employment histories (even though disrupted by their alcohol and drug use) have a good prognosis for achieving abstinence from alcohol and drugs—and reestablishing their former stability. However, the prognosis is worse for those clients who bring to treatment fewer resources and social supports.

Id. at 12.

279. See id. at 9. "It is widely believed that 'matching' clients to programs of services that best meet their needs will improve treatment outcomes." Id. at 12 (citation omitted). "Chemical dependency treatment can and should be more flexible and client centered." MINN. DEP'T OF HUM. SERVICES CHEMICAL DEPENDENCY DIV., POL'Y NEWS, TREATMENT IN THE 21ST Century 1 (April 1997).

280. See Executive Summary, supra note 29. "Cultural, sociological, behavioral, public health, and medical disciplines are relevant to the prevention of FAS and related conditions." Id.
to treating pregnant women addicted to alcohol and drugs.\textsuperscript{281}

Minnesota is home to a variety of substance abuse treatment and counseling programs.\textsuperscript{282} An informal telephone survey revealed that many of these centers are open to pregnant substance abusers.\textsuperscript{283} The FAS Task Force would like to see more treatment opportunities made available.\textsuperscript{284} Under the Mutual Responsibility Approach, treatment should be modeled on the voluntary, multidisciplinary ideal. Treatment must be geographically and economically accessible to all women and must include provisions for women in need of childcare.\textsuperscript{285} Treatment must also be holistic in its approach, catering to a woman's immediate physical and spiritual needs.\textsuperscript{286} Spirituality is a particularly important aspect of the Mutual Responsibility Approach because it is the one aspect of an individual's personal morality that cannot be altered by coercive or punitive measures.\textsuperscript{287} However, spirituality cannot be a forced concept. Treatment should incorporate spiritual aspects only if the woman requests support in this area. Finally, treatment must be aimed toward achieving lasting results. A revolving door dependency on treatment benefits no

\textsuperscript{281} See Linden, \textit{supra} note 86, at 137.

\textsuperscript{282} A list obtained from the Minnesota Department of Human Services in March 1998 indicated well over 300 residential and outpatient treatment and counseling programs across the state, many of which purport to serve pregnant women. The types of resources available in Minnesota include primary inpatient (residential), primary outpatient, extended care, halfway houses, aftercare, board and lodging for indigent chronic alcoholics and peer support groups.

Still, resources for treatment remain low on a national basis:

[S]o long as the nation’s treatment slots are inadequate to meet the demand for voluntary treatment, the placement of a woman in treatment through mandatory measures means that a woman who would enter treatment voluntarily cannot be served. The system thereby perversely rewards those women who are unwilling to enter care voluntarily at the expense of those women who would voluntarily enter care.

Chavkin, \textit{supra} note 8, at 246.


\textsuperscript{283} Telephone survey conducted April 13-15, 1998.

\textsuperscript{284} \textit{See SUFFER THE CHILDREN, supra} note 2.

\textsuperscript{285} \textit{See Practical Approaches, supra} note 117, at 183.

\textsuperscript{286} \textit{See id.} at 190. “The concept of spirituality should not be confused with that of religion, which is the way we attempt to systemize belief in a higher power through specific definition and through rituals, rules of conduct and philosophical frameworks. In contrast, spirituality is not defined nor constrained by specific parameters.” \textit{Id.}

\textsuperscript{287} \textit{See id.} at 191. “Spirituality, because it has to do with what (whom) is important to us, is closely related to values, priorities, goals and preoccupations. It has to do with whatever is at the center of our life.” \textit{Id.} (citations omitted).
This goal can be met by involving the woman’s partner, family and friends in her recovery process, recognizing and respecting the realities of her living environment, no matter how bleak, and assisting the woman in finding ways to overcome the barriers of her addiction to find fulfillment in her life.

Treatment on demand is one solution gradually gaining acceptance in cities around the country. For example, in San Francisco, California, the city’s Board of Supervisors elected to implement a precedent-setting treatment on demand program for substance abusers living in poverty.

The city estimated its annual direct and indirect expenses in relation to “untreated substance abusers” totaled $1.7 billion annually; $47 million went toward substance abuse treatment but still 1,300 to 1,800 people were turned away from service centers on most days. The program provides treatment to abusers “within 48 hours” and focuses on perinatal services.

Such a concerted city-wide program allows officials to create a more systematic, inclusive treatment approach because communicative relationships are created between programs, city services and the clients themselves. However, the program has come under some criticism because of the city’s lack of beds and inadequate ongoing funding to assure treatment on demand is a continuing programmatic goal for the city.

In Baltimore, Maryland, a program similar in scope to San Francisco’s...
program treats addiction as a medical problem rather than a criminal problem.\textsuperscript{295} Funding is directed toward treatment and prevention efforts rather than enforcement and incarceration.\textsuperscript{296} Notably, the city's cause is being assisted by private philanthropist George Soros, who contributed $25 million to the effort.\textsuperscript{297} Increased spending by the city will open up 3,000 treatment slots, cutting waiting time from four months to only a few weeks.\textsuperscript{298}

San Francisco's and Baltimore's programs focus on drug users, but city officials recognize that alcohol use usually goes hand in hand with drug use. With an emphasis placed on pregnant abusers, it seems logical that a treatment on demand program would give priority to women who drink as well as those who use drugs. The goal remains the same: both San Francisco and Baltimore have created unique public and private cooperative programs that attack broad social problems with an eye toward long-term solutions to addiction and the side benefit of cutting costs. Both of these efforts are still in their beginning stages and it will be instructive to study their success rates over the coming years.

Incentive and support-based programs are another possible option for Minnesota. A recent study at Oregon State University found that "low-income pregnant women were far likelier to stop smoking if they were given vouchers worth $50 a month and had a partner's moral support than if they got only counseling and self-help literature."\textsuperscript{299} Although it is considered controversial to 'pay' people to stop their potentially harmful habits, such efforts often prove successful.\textsuperscript{300} Costs for such incentive programs are usually made up by potential savings in health care expenditures.\textsuperscript{301} Further, a positive, rather than a punitive or coercive approach, tends to achieve more immediate and lasting results. Such a program might be an interesting choice for state officials to consider. For example, pregnant women could receive vouchers that would apply towards groceries or baby supplies like formula and diapers in exchange for their pledge to stop drinking during pregnancy. Vocational rewards, such

\begin{itemize}
\item \textsuperscript{295} See Michael Grunwald, \textit{Mavericks in the War on Drugs; Baltimore Attempts to Treat Addiction as Illness, Not Crime}, BOSTON GLOBE, Nov. 12, 1997, at A1.
\item \textsuperscript{296} See id.
\item \textsuperscript{297} See id.
\item \textsuperscript{298} See id.
\item \textsuperscript{299} Patrick O'Neill, \textit{Study: Vouchers Persuade Pregnant Smokers to Quit}, STAR TRIB., Apr. 12, 1998, at E11.
\item After eight months of pregnancy, 34.6 percent of those who received vouchers were still smoke-free, compared with 9 percent of those who did not. Two months after they delivered their children, 24 percent of those who received vouchers were still smoke-free, compared with 5 percent of the others.
\item \textsuperscript{299} See id.
\item \textsuperscript{300} See id.
\item \textsuperscript{301} See id.
\end{itemize}
as access to job training programs or continuing education, would also be legitimate options.

Finally, education needs to be rigorous and should begin at an early age. The FAS Task Force acknowledged that the state must work in cooperation with the alcohol industry to coordinate advertising efforts.\textsuperscript{302} Statewide and local public awareness campaigns should be created that appeal to females and males, are culturally inclusive and target young people as well as adults.\textsuperscript{303} Prevention messages should also be part of school drug/alcohol education, sex education and parenting classes.\textsuperscript{304}

The Mutual Responsibility Approach insists that treatment and prevention efforts should be positive, nonjudgmental, culturally sensitive and accessible.\textsuperscript{305} Programs like treatment on demand and incentive opportunities can meet these criteria. While many of these efforts are premised on economic need, state authorities would be wise to explore how middle- and upper-class women are affected by prevention efforts as well.

\textbf{VI. CONCLUSION: RE-EVALUATING TRENDS IN LEGISLATIVE AND JUDICIAL ACTION UNDER THE MUTUAL RESPONSIBILITY APPROACH}

The Mutual Responsibility Approach offers an alternative means to punitive or coercive legislative and judicial action in response to the problem of women who drink during pregnancy. The approach starts with the state. Under the Mutual Responsibility Approach, the state must first consistently define \textit{Roe} viability under all criminal and civil laws.\textsuperscript{306} Viability is not a flexible notion; rather, it is a fixed point determined by the United States Supreme Court and supported by medical data.\textsuperscript{307} When a woman's individual rights are involved, there is no room for subjective lawmaking on the viability issue. If a woman and the state are to share in some reciprocal concept of moral and maternal duty, then viability must remain the constant that links these highly subjective duties.

When a state relies on a purely objective notion of maternal duty as a legal indicator for when to take action in cases of gestational abuse, it endangers a pregnant woman's right to privacy.\textsuperscript{308} Maternal duty is a

\begin{itemize}
\item \textsuperscript{302} See \textit{Suffer the Children}, supra note 2, at 4.
\item \textsuperscript{303} See id. at 12.
\item \textsuperscript{304} See id. at 13.
\item \textsuperscript{305} A recovering drug/alcohol addict stated that "[p]regnant women who are abusing drugs and alcohol need to know that someone cares, that they won't be judgmental. High risk women need to know that services are available, and that support is there for them." Minneapolis Task Force Hearing, supra note 117. The Mutual Responsibility Approach attempts to recognize these same needs.
\item \textsuperscript{306} See \textit{Lichtenberg}, supra note 104, at 377.
\item \textsuperscript{307} See \textit{Roe}, 410 U.S. at 113.
\item \textsuperscript{308} See \textit{Lichtenberg}, supra note 104, at 390. "The right of privacy articulated in \textit{Roe} should prohibit the state from intervening to prevent substance abuse in early pregnancy because the state's interest in protecting potential life is not compelling until viability." \textit{Id.}.
\end{itemize}
uniform concept only to the extent that a majority of societies recognize some form of this theoretical construct. However, beyond this, maternal duty should be defined in a unique manner by, and not for, each individual woman. If a state forces a woman to conform to a legislatively or judicially prescribed concept of maternal duty, it enacts an intolerant legal regime, one that fails to recognize personal, cultural and gender distinctions. By respecting a more fluid concept of morality in the realm of maternal duty, the state perpetuates a legal standard that actually embodies the very spirit of equal protection analysis. The right of privacy belongs to every individual despite their pregnant or nonpregnant status. How a pregnant woman chooses to conduct her life during pregnancy is a private matter to the extent that the state cannot intervene, at least in the first two trimesters, unless a complete breakdown of objective and subjective maternal duty occurs. Any other legislative liberty would elevate fetal rights above those of a woman, impermissibly conflicting with the Roe analysis and the Mutual Responsibility Approach posited in this paper.

In sum, legislative action should be directed away from punitive measures and toward increasing the variety of treatment opportunities available, including, most importantly, treatment on demand. In so doing, the legislature avoids laws like legal immunity for mandatory reporting, which conflict with critical physician-patient privileges and ultimately deter access to prenatal treatment for many women. The FAS Task Force provided the Minnesota legislature with important guidelines for fund allocation. As programs develop in the coming years, even greater attention needs to be paid to self-initiated treatment opportunities favoring a proactive healing approach that benefits the individual pregnant woman and by extension, her community.

In the judicial realm, courts need to avoid the 'creative’ use of laws that do not pertain to the fetus. Child neglect and abuse laws, for instance, were not meant to apply to the unborn. Courts that have chosen to make examples of women have exceeded the constitutional guarantees of privacy and strayed into judicial lawmaking in an attempt to satisfy a perceived public interest in retributive solutions. If this trend continues, the Roe precedent will become meaningless and we will be faced with the daunting problem of fifty states who perceive the concepts of viability and privacy in

309. Here legislative action must be particularly careful not to enact vague or overbroad laws. See Denison, supra note 161, at 1121-22.
310. See supra note 9.
311. See SUFFER THE CHILDREN, supra note 2.
312. See Lichtenberg, supra note 104, at 396. “Voluntary treatment programs avert the dilemma inherent in state intervention: although the United States Constitution probably does not prohibit early pregnancy intervention, policy and logic demand that the state not intervene before viability. Yet, tragically, most of the fetal damage occurs during early pregnancy.” Id.
313. See supra note 205.
different ways—a judicial anarchy that will hurt gender equality rights. A similar situation occurred before abortion became legalized. Disproportionate treatment amongst the states contributed to a dangerous environment where back-room abortions—accompanied by permanent injuries and sometimes death—were the norm.\footnote{See, e.g., Mark A. Graber, The Ghost of Abortion Past: Pre-Roe Abortion Law in Action, 1 VA. J. SOC. POL’Y & L. 309, 318-21 (1994).} Women should not have to retreat underground while they are pregnant in order to protect their privacy rights. It is much more reasonable for a state to enable women to achieve personal maternal duty through resources that support recovery. The courts need to cooperate with such a system.

The Mutual Responsibility Approach recognizes, overall, that education is the key to stopping the growth of FAS and FAE within the population. The FAS Task Force has made many important steps in targeting learning opportunities for individuals of all ages and both genders.\footnote{See SUFFER THE CHILDREN, supra note 2.} Education may not be the only solution for some women, but it is far preferable to criminalization or other restrictions of rights that serve only to frighten away those who need help the most.\footnote{See Denison, supra note 161, at 1140.} Under the Mutual Responsibility Approach, the only cycle perpetuated is one of societal evolution away from substance abuse during pregnancy. This can be achieved through accessible, voluntary treatment and education programs where individual dignity, not public shame, is the standard.

\footnote{315. See SUFFER THE CHILDREN, supra note 2.}
\footnote{316. See Denison, supra note 161, at 1140.}