NO. 2010-M-819-SCT

IN THE SUPREME COURT OF THE STATE OF MISSISSIPPI

RENNIE T. GIBBS

Appellant,

vs.

STATE OF MISSISSIPPI

Appellee.

On Grant of Interlocutory Appeal from the Circuit Court of Lowndes County

REPLY BRIEF OF THE APPELLANT

Oral Argument Requested

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INTRODUCTION

To his credit, the Attorney General does not attempt to defend the depraved heart murder indictment or argue that the depraved heart murder statute allows prosecution for the death of an unborn child. This is wise given that the depraved heart homicide statute, Miss. Code Ann. § 97-3-19(1)(B), does not encompass "unborn child[ren]" and the "unborn child" offenses statute, Miss Code Ann. § 97-3-37, does not include depraved heart murder as an offense for which an "unborn child" can be a victim. Indeed, it would be inconsistent to defend the prosecution's depraved heart indictment in light of the Attorney General's opinion letter a few years ago (discussed at pp. 8-9 of our opening brief) clarifying that the crime of child endangerment may not be used to address the issue of pregnancy and drug use. Op. Atty. Gen. No. 2007-00182, Brewer, April 16, 2007, 2007 WL 1725165 (Miss. A.G.).

The Attorney General's primary argument is that this Court should never have granted the petition for interlocutory appeal *even though the State did not oppose it at the time.* The Circuit Judge recommended that interlocutory appeal be granted on what he called this "case of first impression." Record Excerpts Tab 2. ("R.E. 2"). The petition was filed, an amicus brief on behalf of leading health organizations was filed in support of the petition, the State did not exercise its right under Miss. R. App. Proc. 5(a) to oppose the petition, and this Court properly granted it.

Now, however, long after the opportunity to oppose this appeal has passed, and after this Court has accepted the case, the Attorney General contends this Court should turn back the clock and revisit a decision it made many months ago. In so doing, the Attorney General argues for the first time: 1) that the Circuit Court must first conduct a trial to establish facts before the

legal issue presented by this appeal can be resolved and 2) that even if this Court holds that the depraved heart murder provision does not apply to a pregnant teenager who experiences a stillbirth, Ms. Gibbs still could be prosecuted for manslaughter and therefore the interlocutory appeal is not appropriate.

As explained in the first section of this reply brief, and as the Circuit Judge recognized when he recommended an interlocutory appeal, the issue here is a legal issue --- whether a crime even exists under the relevant statutes for someone who, to quote the indictment, allegedly "kill[ed] her unborn child . . . by using cocaine while pregnant" (R.E. 3) --- and it is unnecessary for this Court to go back and once again address whether an interlocutory appeal should have been granted in the first place. As explained in the second section of this reply brief, this appeal is based in part on arguments that would preclude not only a depraved heart murder prosecution, but also a manslaughter prosecution. This is for the reasons set forth in Sections I(C) through I(F), for many of the reasons listed in Section II of our opening brief, and for the reasons discussed in the amicus briefs. Given that the Attorney General has indicated that Ms. Gibbs likely will be prosecuted for manslaughter even if this Court agrees that the indictment does not charge an offense under the depraved heart murder statute, this Court should also address whether a crime exists under the manslaughter statutes for the actions described in the indictment. For the reasons explained in our opening brief, and in Section II of this reply brief, the manslaughter statutes were not intended to be used as mechanisms for punishing pregnant women who experience pregnancy losses and would be unconstitutional if they did. Therefore, any manslaughter prosecution should not be permitted to go forward. The third section of this reply brief addresses the Attorney General's arguments regarding the submission of amicus briefs on behalf of numerous leading medical, public health, and health advocacy organizations.

ARGUMENT

I. A Trial Is Not Necessary Before Resolving Whether the Homicide Statute Authorizes Prosecution and Punishment Of Women Who Experience Miscarriages or Stillbirths.

The question to be resolved here is akin to the question reviewed on an interlocutory basis in Laurel Yamaha, Inc. v. Freeman, 956 So.2d 897 (Miss. 2007), a case cited in our petition for interlocutory appeal and ignored by the Attorney General in his brief. In that case, this Court reviewed whether the law authorized a wrongful death action against a motorcycle dealer by the parents of a motorcyclist killed in an accident. Like the defendants in Laurel Yamaha, Ms. Gibbs is threatened with trial on a theory of liability never before recognized under Mississippi law, one with broad practical implications. Resolving whether such a crime was enacted and intended by the state Legislature and, if it was, whether it is constitutional, will materially advance the litigation, save the state from a costly and timely murder trial, save Ms. Gibbs from irreparable and substantial injury from being subjected to a murder trial and possible murder conviction, prevent unnecessary future arrests and prosecutions, and advance state interests in maternal, fetal and child health by refusing to rewrite state law in a manner that, as overwhelmingly recognized by leading health organizations, is likely to undermine these state interests.

This is not an appeal that will require the court to weigh the state's evidence, determine facts at issue or consider whether the prosecution has proven each element of the charge. The indictment charging Ms. Gibbs alleges, in relevant part, "Rennie Gibbs did ... kill her unborn child, a human being, ... by using cocaine while pregnant with her unborn child ... in violation of MCA § 97-3-19." (R.E. 3). It is unnecessary to go beyond these allegations in the indictment to determine whether the provisions of Mississippi's homicide law apply to pregnant women

who experience miscarriages and stillbirths. This appeal asks this Court to determine whether such crimes exist in the first instance, not whether the state can prove that it happened.

As set forth in Ms. Gibbs's *Petition for Permission to File Interlocutory Appeal* at 3-5, trial in this case will be long and costly. The prosecution will be required to use scientific experts to prove causation, and the defendant, who is indigent, will have to have the opportunity to challenge the prosecution's evidence with her own state-funded experts. Expert evidence and testimony is so critical that the South Carolina Supreme Court unanimously overturned a conviction in a similar case, holding that trial counsel was ineffective because she failed to call experts to testify on "recent studies showing cocaine is no more harmful to a fetus than nicotine use, poor nutrition, lack of prenatal care, or other conditions commonly associated with the urban poor." McKnight v. State, 661 S.E.2d 354, 358 n.2 (S.C. 2008). Before embarking on an extended and costly trial, the Circuit Judge wisely concluded that a higher court should first determine whether the legislature even intended for a woman to be charged with murder because she experienced a pregnancy loss.

As explained in Section II of this reply brief, the Attorney General is incorrect when he suggests that a prosecution of Ms. Gibbs could properly be brought under the manslaughter statutes. But even if she could be prosecuted for manslaughter, that is not a reason to revisit the grant of interlocutory review in this case. Instead, this Court should definitively determine that the depraved heart statute cannot be used in this instance. A trial for a non-existent crime is wasteful under a number of scenarios. For example, if the jury convicted the defendant for murder, this Court would have to reverse that conviction and then remand for a second trial for manslaughter only (assuming the manslaughter statutes apply). If the depraved heart charge went forward and a lesser-included manslaughter charge were given, the jury might convict Ms.

Gibbs of manslaughter as a compromise verdict in a situation where it might acquit her if manslaughter were the only charge (assuming it applies). Given that the Attorney General has not defended the depraved heart charge in his brief to this Court, and given that this Court has already granted interlocutory review, the Court should definitively resolve the depraved-heart issue and hold that the depraved-heart statute cannot be used in this instance.

For these reasons, and for all of the reasons set forth in the *Petition for Permission to File Interlocutory Appeal*, this Court should reject the Attorney General's belated argument that the Court should never have granted interlocutory review in the first place.

II. Even For Offenses Such As Manslaughter That Specifically Apply To An "Unborn Child," the Legislature Has Only Authorized the Prosecution and Punishment Of Third Parties Who Harm the Unborn Child and Not Pregnant Women Who Experience Miscarriages Or Stillbirths.

Given that the Attorney General has raised the specter of prosecuting Ms. Gibbs for manslaughter, this Court should resolve whether the prosecution can proceed under the manslaughter statutes in this case. As explained in Sections I(C) through I(F) of our principal brief, the legislative history in Mississippi, the principle that ambiguity must be resolved in favor of the defendant, the absurd and harmful results of prosecuting women for their pregnancy outcomes (even in cases involving alleged drug use), and the decisions by other state courts, all point to the conclusion that even for those offenses that specifically apply to an "unborn child," the Legislature has authorized only the prosecution of third parties who harm the unborn child and not the pregnant woman herself. The Attorney General does not respond in substance to any of these contentions and utterly fails to demonstrate that the Legislature intended any of its homicide laws, including those for manslaughter, to authorize the prosecution or punishment of pregnant women who experience miscarriages or stillbirths.

We are aware of no Mississippi case interpreting the manslaughter or murder laws to apply to pregnant women who experience stillbirths. The fact that a statute includes the word "unborn" does not also mean it includes "pregnant women" in relationship to their own health and pregnancy outcomes. This is clearly demonstrated by the fact that the Mississippi legislature on multiple occasions separately considered and repeatedly rejected numerous attempts to extend the law, including the manslaughter statutes, to authorize prosecution of women and mothers who have drug problems or have experienced adverse pregnancy outcomes. (App. Br. at 9-12).

The prosecution seeks to mischaracterize this case as one about whether a pregnant woman has the "right" to use cocaine. But that is not the issue. This is not a prosecution for violation of Mississippi's drug laws. The principal question is whether the legislature intended generally worded traditional criminal provisions such as the homicide laws, including manslaughter statutes which encompass harm to an "unborn child," to go beyond the prosecution of third parties and also authorize the prosecution of a pregnant woman who suffers a miscarriage or stillbirth.

As explained in Sections I(E) and II(B) of our principal brief, a broad range of actions, inactions, and conditions may contribute to pregnancy outcome. (App. Br. at 13-19, 27-33.) It would be unprecedented for a legislature to authorize a prosecution for manslaughter, or any other homicide, against women who experience miscarriages and stillbirths. Absent a statute that clearly does so, this Court should not allow the prosecution to go forward with any homicide prosecution, including one under the manslaughter statutes.

Applying a homicide statute to the woman who carried and bore the risk of the pregnancy herself is radically different than applying it to third-party wrongdoers who hurt pregnant women and harm the unborn child. In Stallman v. Youngquist, 521 N.E.2d 355, 359 (Ill. 1988), a case

that only sought to impose civil liability, the Supreme Court of Illinois recognized that imposing legal liability on pregnant women is very different from imposing it on third-parties because of the "serious ramifications for all women and their families, and for the way society views women and women's reproductive abilities." Id. at 357. As the court explained:

> The relationship between a pregnant woman and her fetus is unlike the relationship between any other plaintiff and defendant. No other plaintiff depends exclusively on any other defendant for everything necessary for life itself. No other defendant must go through biological changes of the most profound type possible at the risk of her own life, in order to bring forth an adversary into the world. It is after all, the whole life of the pregnant woman which impacts on the development of the fetus. As opposed to the third-party defendant, it is the mother's every waking and sleeping moment which for better or worse shapes the prenatal environment which forms the world for the developing fetus. That this is so is not a pregnant wóman's fault: it is a fact of life.

Id. Thus the court concluded that,

> Holding a third person liable for prenatal injuries furthers the interests of both the mother and subsequently born child and does not interfere with the defendant's right to control his or her own life. Holding a mother liable for unintentionally infliction of prenatal injuries subjects to State scrutiny all the decisions a woman must make in attempting to carry a pregnancy to term and infringes on her right to privacy and bodily autonomy.

Id. at 360. As a result, the court held that there is no cause of action rendering a woman liable to her fetus for unintentional prenatal injuries and refused to create a legal duty on the part of the woman to guarantee a healthy prenatal environment when she herself has no guarantee of such an environment.[1] That court refused to make mother and child "legal adversaries from the moment of conception until birth," for "[a]ny action which negatively impacted on fetal development would be a breach of the pregnant woman's duty to her developing fetus." Id. at

[1] Brief for American College Of Obstetricians and Gynecologists et al. as Amici Curiae Supporting Defendant, Rennie Gibbs, (Case No. 2010-M-819-SCT), at 14 (discussing unavailability of substance abuse treatment services for pregnant teenage girls) (citations omitted).

359-60.

As explained in Section I(C) of our principal brief, the Legislature has considered and rejected no less than four attempts to subject women who experience a miscarriage or stillbirth allegedly because of their drug use during pregnancy to manslaughter charges. See S.B. 2602, 1998 Leg., Reg. Sess. (Miss. 1998) (App. A-3); S.B. 2221, 1999 Leg., Reg. Sess. (Miss. 1999) (App. A-4); S.B. 2314, 2000 Leg., Reg. Sess. (Miss. 2000) (App. A-5); S.B. 2123, 2002 Leg., Reg. Sess. (Miss. 2002) (App. A-7). It also rejected an attempt to apply the penal code to make drug use during pregnancy a crime under the state's felonious child abuse statute. H.B. 1393, 2002 Leg., Reg. Sess. (Miss. 2002) (App. A-13). In addition, the legislature has made clear that where the law does address the outcome of pregnancy, it does not seek to hold pregnant women responsible. For example, women upon whom an illegal partial-birth abortion is performed may not be prosecuted for conspiracy. Miss Code Ann. 41-41-73(1) (emphasis added) (App. A-8). Also, under the prospective abortion prohibition statute, any person, *except the pregnant woman*, may be prosecuted for performing or inducing an abortion. Miss. Code Ann. § 41-41-45(4) (2009) (App. A-9).

As set forth in our principal brief, Section 97-3-19(1) is *unambiguous* in that the depraved heart homicide provision does not apply to harm to unborn children, even as to third parties. (App. Br. 6-7.) If, however, there is any perceived ambiguity, it must be resolved in favor of Ms. Gibbs. McKlemurry v. State, 417 So.2d 554 (Miss. 1982); Tipton v. State, 41 So. 3d 679, 682 (Miss. 2010). This is true not only for a depraved heart murder prosecution, but of the manslaughter prosecution suggested by the Attorney General's brief. The language of the relevant statutes does not specifically authorize the prosecution for manslaughter of pregnant women who engage in allegedly harmful activity and suffer a miscarriage or stillbirth. Any

such prosecution requires a clear legislative directive and any ambiguity must be resolved in favor of Ms. Gibbs.

Section I(E) of our principal brief argued that rewriting broadly-worded criminal homicide statutes to permit prosecution of women who have experienced an adverse pregnancy outcome would undermine maternal, fetal and child health, open the door an unlimitable range of circumstances in which pregnant women and new mothers could be prosecuted and generally would lead to absurd results that were clearly not intended by the legislature. (See App. Br. at 13-19). The Attorney General's only response to these arguments, is that they "ignore[] another option that that the mother could choose: she could choose not to [use cocaine] while pregnant." (State Br. at 10). Of course, the question of choice, when someone is suffering a drug addiction, is a complicated one. As Appellant's main brief, several amicus and both legal and medical authority confirm, drug use is such a complex issue precisely because it is incredibly difficult for people, no matter how highly motivated, to overcome a drug addiction problem. See Linder v. United States, 268 U.S. 5, 18 (1925); Robinson v. California, 370 U.S. 660, 667 n. 8 (1962).[2] At any rate, the issue is not about choosing or not choosing to use drugs. The issue is whether this Court should authorize homicide prosecutions of pregnant women absent clear direction from the legislature, particularly given the broad range of actions, inactions and conditions that may increase the risk of miscarriages and stillbirths and that could lead to the prosecution of women who suffer them, and given the adverse public health consequences outlined in our brief and the amicus briefs. The Attorney General has not demonstrated that the Court should embark on that path.

[2] Brief for American College Of Obstetricians and Gynecologists et al. as Amici Curiae Supporting Defendant, Rennie Gibbs, (Case No. 2010-M-819-SCT), at 13.

In a single paragraph, (State Br. at 10-11), the prosecution dismisses the overwhelming jurisprudence from other jurisdictions where appellate courts have refused to rewrite state criminal laws to permit the prosecution of women who become pregnant and attempt to continue those pregnancies to term despite having used an illegal drug. The prosecution does not dispute that this Court has looked to the decisions of other state courts as persuasive authority, particularly when there is no Mississippi case directly on point, Paz v. Brush Engineered Materials, Inc., 949 So.2d 1 (Miss. 2007), but urges this Court to ignore those decisions in this instance without explaining why.

Even states that have laws treating embryos and fetuses as human beings, legally separate from the pregnant woman, have refused to interpret general criminal statutes as permitting prosecution of the pregnant woman herself. For example, Missouri has a broad statute, § 1.205, declaring the governmental intent to protect the life of the "unborn." Nevertheless, courts in Missouri refused to reinterpret state child abuse law to permit prosecution of drug using pregnant women. State v. Wade, 232 S.W.3d 663 (Mo. Ct. App. 2007) (affirming the dismissal of child endangerment charge based on allegation that child tested positive for methamphetamine and marijuana at birth). The Commonwealth of Kentucky has legislatively adopted an expansive definition of "human being" as "any member of the species homo sapiens from fertilization until death." Ky. Rev. Stat. Ann. § 311.720 (5) (Banks-Baldwin 2002). This definition applies not only to Kentucky's abortion statutes but to other "laws of the Commonwealth unless the context otherwise requires." Ky. Rev. Stat. Ann. § 311.720 (Banks-Baldwin 2002). Yet, the Kentucky Supreme Court has twice rejected attempts by prosecutors to use these provisions to transform its wanton endangerment statute into a mechanism for punishing pregnant women who allegedly risk harm to an unborn child. Cochran, 315 S.W.3d at

325.

In essence, the prosecution is seeking to persuade this Court to depart from the overwhelming jurisprudence in this nation and to authorize homicide prosecutions of pregnant women who experience miscarriages and stillbirths despite the absence of a clear legislative directive. However, the Attorney General has not provided any reasoned argument that would support such a departure.

Our principal brief set forth why an application of Mississippi's depraved heart murder law to a woman who experienced a miscarriage or stillbirth would violate her rights to due process, to privacy, to be free from cruel and unusual punishment and to equal protection guaranteed by the Mississippi and United States Constitutions. (See App. Br. at 25-36.) This analysis applies equally to the lesser-included manslaughter provisions under the law. In single paragraphs, the prosecution addresses each of these points without seriously disputing them and attempts to avoid the discussion altogether.

With respect to the due process right to notice, the Attorney General argues that this Court cannot determine now whether the state's extension of the homicide law to pregnant women should be given only prospective application and must wait until the completion of a costly and lengthy trial. (State Br. at 11-12). A trial, however, is completely unnecessary to resolve the question as to whether a person of reasonable intelligence would be on notice that a court would suddenly reinterpret its homicide laws and begin applying them to pregnant women who experience miscarriages and stillbirths.

Regarding the vagueness argument, the Attorney General claims that "[a] person of ordinary intelligence knows that [using cocaine] by itself subjects pregnant women to prosecution for possession of cocaine. A person of ordinary intelligence knows that [using

cocaine] could be an act imminently dangerous to human life and is prohibited by law." But that does not put a woman on notice that she could be prosecuted for homicide if she continued her pregnancy after having used cocaine. The manslaughter statutes, which specifically reference the "unborn child," but not a pregnant woman, would become unconstitutionally vague if they were judicially rewritten to apply to pregnant women who seek to carry to term. As indicated in appellant's principal brief, numerous types of actions and inactions, conditions, circumstances and situations during pregnancy could be characterized as harmful to the unborn child. (App. Br. at 28).

With respect to the constitutional right to procreative privacy, the Attorney General claims, in effect, that pregnancy had nothing to do with the charge (see State Br at 12). As the indictment makes clear, pregnancy and pregnancy outcomes are essential elements of the alleged crime. A regime that threatens prosecution and punishment for murder in the event of an adverse pregnancy outcome represents a grave affront to the liberty to which women are entitled because it places an extraordinary burden on women who carry their pregnancies to term.

With respect to the equal protection issue, the prosecution seeks to rely on Michael M. v. Superior Court of Sonoma County, 450 U.S. 464, 469 (1981), (State Br. at 16), which is not relevant. Unlike Michael M., this case involves a situation where a woman allegedly used an illegal drug, and but for her pregnancy, she would not be subject to prosecution for any crime greater than what any other person could be prosecuted for.

In responding to the issue of cruel and unusual punishment, the Attorney General does not address the Supreme Court's decision in Robinson v. California, 370 U.S. 660, 667 (1962), but instead argues that because appellant has not yet been found guilty or punished for any crime, the claim cannot be evaluated. The question is not whether a particular sentence is cruel

and unusual, but whether it is constitutional to punish a woman because of her status as a pregnant person and an addict. The Attorney General does not respond to that argument.

III. The Court Can and Should Consider the Medical, Scientific and Public Health Expertise and Authorities Provided By the 70 Organizations And Individuals Who Have Appeared As Amici

The Attorney General dismisses the expertise and authority of 70 organizations and individuals as various "policy arguments" not applicable at this point in the proceedings. The amicus briefs, however, bring highly relevant medical, scientific and public health information to this Court's attention. They help inform the analysis of this case and shed light on legislative intent. As the amicus briefs make clear, no state interest is served by prosecuting women for murder or manslaughter because they suffer miscarriages or stillbirths.. That being the case, it is unlikely the legislature intended the homicide laws to encompass such prosecutions. As far as we are aware, this is the first time a prosecutor in the state of Mississippi has applied the state's homicide laws to a woman who experienced a stillbirth. That is why it is appropriate for this Court to consider the views of the amici in analyzing the prosecutor's radical departure in this case.

The prosecution fails to address the adverse impact on maternal, fetal and children's health that prosecuting women for pregnancy outcomes will cause. Appellant notes that since the filing of its initial memorandum, the American College of Obstetricians and Gynecologists ("ACOG") issued a Committee Opinion opposing the use of incarceration and the threat of incarceration to address the issue of substance abuse during pregnancy. ACOG urges physicians to ask for the retraction of state legislation that punishes – or even threatens to punish – women who experience substance abuse problems during pregnancy. ACOG states "[s]tudies indicate that prenatal care greatly reduces the negative effects of substance abuse during

pregnancy, including decreased risks of low birth weight and prematurity. Drug enforcement policies that deter women from seeking prenatal care are contrary to the welfare of the mother and fetus."[3]

In addressing the points made by amici, the prosecution asserts that allowing this prosecution to go forward under broadly worded homicide provisions will not set a precedent for the prosecution of women for miscarriages or stillbirths unrelated to illegal drug use. Not only have numerous sister state courts recognized this possibility (App. Br. at 32) (citing Cochran v. Commonweatlh, 315 S.W.3d 325, 328 (Ky. 2010); Kilmon v. State, 905 A.2d 306, 311-12 (Md. 2006); Reinesto v. Superior Court, 894 P.2d 733, 736-37 (Ariz. App. 1995)), the experience in South Carolina and cases from other states demonstrate this to be true. In less than a year of the decision in Whitner v. State, 492 S.E.2d 777 (S.C. 1997), the precedent was used to arrest a pregnant woman accused of drinking alcohol while pregnant.[4] In 2008, it was used to charge Jessica Clyburn, an 18 year old, eight months pregnant woman, with no drug problems but with a history of depression, when she lost her pregnancy after attempting to kill herself by jumping out a window [5] Charged with homicide by child abuse based on the Whitner and McKnight precedent (involving allegations of illicit drug use), she pled guilty to avoid the possibility of spending years in jail while the charges were challenged. In Utah, a similar theory to the one

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[3] Am. Coll. Obstetricians & Gynecologists, Substance Abuse Reporting and Pregnancy: The Role of the Obstetrician-Gynecologist, ACOG Committee Opinion, NO. 473 (2011) (Supplemental Appendix, Tab #1).

[4] Melissa Manware, *Infant Born Drunk*, THE STATE (Columbia), Sept. 24, 1998 (Supplemental Appendix, Tab #2).

[5] Jason Foster, Woman faces charge of killing unborn child during August suicide attempt, Herald (Feb. 21, 2009)available at http://pqasb.pqarchiver.com/heraldonline/access/1649810951.html?FMT=ABS&FMTS=ABS:FT&type=current&date=Feb+21%2C+2009&author=Jason+Foster+%2F+jfoster%40heraldonline.com&pub=Herald&edition=&startpage=A.1&desc=Woman+faces+charge+of+killing+unborn+child; last accessed February 7, 2011; (Supplemental Appendix, Tab #3).

urged by prosecution here was used to arrest for murder a pregnant woman who suffered a stillbirth, allegedly as a result of refusing cesarean surgery earlier in her pregnancy.[6] These cases demonstrate that as a matter of legal analysis, a statute so broadly worded cannot be limited to pregnant women who use illegal drugs.

Finally, the prosecution contends that if the Court accepts the arguments made by amici, the Court will be creating a special defense for addicts. (State Br. at 17, 18.) But we are not arguing that a murder can be excused by an addiction. Rather, we argue that the homicide statutes do not apply to a woman who suffers a miscarriage or stillbirth after engaging in allegedly harmful activity.

CONCLUSION

For the foregoing reasons, and on the basis of the authorities cited, the judgment of the Circuit Court of Lowndes County should be reversed and the indictment dismissed.

Respectfully submitted,

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[6] Richard L. Berkowitz, M.D., *Should Refusal to Undergo A Cesarean Section Be A Criminal Offense?* 140 AM. J. OBSTET. & GYNECOL. 1220 (2004) (Supplemental Appendix, Tab #4).

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SUPPLEMENTAL APPENDIX

The American College of Obstetricians and Gynecologists
Women's Health Care Physicians

COMMITTEE OPINION

Number 473 • January 2011

Committee on Health Care for Underserved Women

This information should not be construed as dictating an exclusive course of treatment or procedure to be followed.

Substance Abuse Reporting and Pregnancy: The Role of the Obstetrician–Gynecologist

Abstract: Drug enforcement policies that deter women from seeking prenatal care are contrary to the welfare of the mother and fetus. Incarceration and the threat of incarceration have proved to be ineffective in reducing the incidence of alcohol or drug abuse. Obstetrician–gynecologists should be aware of the reporting requirements related to alcohol and drug abuse within their states. They are encouraged to work with state legislators to retract legislation that punishes women for substance abuse during pregnancy.

A disturbing trend in legal actions and policies is the criminalization of substance abuse during pregnancy when it is believed to be associated with fetal harm or adverse perinatal outcomes. Although no state specifically criminalizes drug abuse during pregnancy, prosecutors have relied on a host of established criminal laws to punish a woman for prenatal substance abuse (1). As of September 1, 2010, fifteen states consider substance abuse during pregnancy to be child abuse under civil child-welfare statutes, and three consider it grounds for involuntary commitment to a mental health or substance abuse treatment facility (1). States vary in their requirements for the evidence of drug exposure to the fetus or newborn in order to report a case to the child welfare system. Examples of the differences include the following: South Carolina relies on a single positive drug test result, Florida mandates reporting newborns that are "demonstrably adversely affected" by prenatal drug exposure, and in Texas, an infant must be "addicted" to an illegal substance at birth. Most states focus only on the abuse of some illegal drugs as cause for legal action. For instance, in Maryland, the use of drugs such as methamphetamines or marijuana may not be cause for reporting the pregnant woman to authorities (2). Some states also include evidence of alcohol use by a pregnant woman in their definitions of child neglect.

Although legal action against women who abuse drugs prenatally is taken with the intent to produce healthy birth outcomes, negative results are frequently cited. Incarceration and the threat of incarceration have proved to be ineffective in reducing the incidence of alcohol or drug abuse (3–5). Legally mandated testing and reporting puts the therapeutic relationship between the obstetrician–gynecologist and the patient at risk, potentially placing the physician in an adversarial relationship with the patient (6, 7). In one study, women who abused drugs did not trust health care providers to protect them from the social and legal consequences of identification and avoided or emotionally disengaged from prenatal care (8). Studies indicate that prenatal care greatly reduces the negative effects of substance abuse during pregnancy, including decreased risks of low birth weight and prematurity (9). Drug enforcement policies that deter women from seeking prenatal care are contrary to the welfare of the mother and fetus.

Seeking obstetric–gynecologic care should not expose a woman to criminal or civil penalties, such as incarceration, involuntary commitment, loss of custody of her children, or loss of housing (6). These approaches treat addiction as a moral failing. Addiction is a chronic, relapsing biological and behavioral disorder with genetic components. The disease of substance addiction is subject to medical and behavioral management in the same fashion as hypertension and diabetes. Substance abuse reporting during pregnancy may dissuade women from seeking prenatal care and may unjustly single out the most vulnerable, particularly women with low incomes and women of color (10). Although the type of drug may differ, individuals from all races and socioeconomic strata have similar rates of substance abuse and addiction (11).

Pregnant women who do not receive treatment for drug dependence cannot be assumed to have rejected treatment (12). The few drug treatment facilities in the United States accepting pregnant women often do not provide child care, account for the woman's family responsibilities, or provide treatment that is affordable. As of 2010, only 19 states have drug treatment programs for pregnant women, and only nine give priority access to pregnant women (1).

Obstetrician–gynecologists have important opportunities for substance abuse intervention. Three of the key areas in which they can have an effect are 1) adhering to safe prescribing practices, 2) encouraging healthy behaviors by providing appropriate information and education, and 3) identifying and referring patients already abusing drugs to addiction treatment professionals (13). Substance abuse treatment programs integrated with prenatal care have proved to be effective in reducing maternal and fetal pregnancy complications and costs (14).

The use of the legal system to address perinatal alcohol and substance abuse is inappropriate. Obstetrician–gynecologists should be aware of the reporting requirements related to alcohol and drug abuse within their states. In states that mandate reporting, policy makers, legislators, and physicians should work together to retract punitive legislation and identify and implement evidence-based strategies outside the legal system to address the needs of women with addictions. These approaches should include the development of safe, affordable, available, efficacious, and comprehensive alcohol and drug treatment services for all women, especially pregnant women, and their families.

Resource

Guttmacher Institute. Substance abuse during pregnancy. State Policies in Brief. New York (NY): GI; 2010. Available at: http://www.guttmacher.org/statecenter/spibs/spib_SADP.pdf. Retrieved September 10, 2010.

This report lists policies regarding prosecution for substance abuse during pregnancy and drug abuse treatment options for pregnant women for each state. It is updated monthly.

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The State Columbia, SC
Sept 24, 1998

Infant born drunk

Intoxicated mom is facing charges

By MELISSA MANWARE
Knight Ridder Newspapers

LANCASTER — A Lancaster woman has been charged with unlawful conduct toward a child after she went into labor drunk and gave birth to an intoxicated baby boy, police said Wednesday.

Lisa Reid, 31, of 105 N. Market St., was arrested Wednesday by Lancaster police after she was released from Springs Memorial Hospital.


Reid

Reid had a 0.14 percent blood-alcohol level when she gave birth early Tuesday morning, Lt. Susan Hunter said. A jury may infer that someone is legally drunk if his or her blood-alcohol level is 0.10 percent or more. The newborn had a 0.107 percent blood-alcohol level.

He was still in the hospital Wednesday, but seemed to be doing fine, said Jerry Adams, a spokesman for the state Department of Social Services.

Reid's alcohol-related arrest may be one of the first in the area since the U.S. Supreme Court confirmed a state Supreme Court ruling that a *viable fetus — one that can live* outside the womb — is entitled to same protection as a child.

Police across the state have been arresting pregnant drug addicts since the ruling, mostly under the charge of child neglect. Some prosecutors have said they will use the ruling to pursue charges against mothers of babies born with fetal alcohol syndrome.

Adams said Reid's newborn experienced symptoms of withdrawal, but it is too early to tell if he suffers from the syndrome or any other long-term effects.

Lancaster Associate Judge Darlene Whitley advised the Lancaster Police Department on the charge. She said unlawful conduct toward a child carries a maximum jail sentence of 10 years.

Pediatricians familiar with

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INFANT
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the effects of alcohol on the unborn said two of every 1,000 babies born in America are diagnosed with fetal alcohol syndrome. Another three to five per 1,000 newborns show less-severe symptoms and are diagnosed with *Fetal* Alcohol Effects.

Dr. Chuck Engstrom, who works at Carolinas Medical Center in Charlotte and was not involved in Reid's case, said babies of women who drink alcohol during their pregnancy are often underweight and have heart and kidney problems. They grow more slowly than other children, and can have problems with their extremities, he said.

"In a baby exposed to alcohol, you can have developmental delays. It can be very severe or it can be mild," he said. "It could lead to hyperactivity, intellectual impairment, kidney abnormalities. You just don't know the effects when the baby is in the nursery."

Reid's baby was still in the Springs Memorial nursery.

Adams said the child's mother has custody, but the hospital won't let the baby go without DSS approval. Reid has been released from jail on a $10,000 bond, Hunter said. She and her other children are living with her mother, Adams said.

Social Services is investigating the household.

"This is an unusual case by its very nature," he said. "We are doing an investigation of the family and home to assess any possibility of threat or neglect to the children. We will take whatever steps are necessary to make sure there is no threat of harm."

Jason Foster, jfoster@heraldonline.com">

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Woman faces charge of killing unborn child during August suicide attempt

By Jason Foster - jfoster@heraldonline.com

A Rock Hill woman has been charged with homicide by child abuse after police say her unborn baby died when the mother tried to commit suicide by jumping out a window.

Jessica Marie Clyburn, 22, was booked on the charge Thursday evening, though her baby died after the suicide attempt last August, according to an arrest warrant.

Police say Clyburn was eight months' pregnant when she jumped from a fifth-floor window Aug. 17 at the Cobb House apartments on East Main Street and landed on a canopy four stories below. She was taken to Carolinas Medical Center in Charlotte for treatment, and it was discovered that her baby had died from the fall, the arrest warrant notes.

Clyburn told police she jumped because she was afraid her unborn child's father, whom she lived with, was going to leave her, according to the original police report from August. The report states Clyburn's mother told police her daughter suffers from bipolar disorder and epilepsy.

It took six months to charge Clyburn because police were waiting on forensics evidence to come back from the North Carolina medical examiner, Rock Hill police Lt. Brad Redfearn said.

After police got the forensics report, which confirmed that Clyburn's baby died in the fall at the apartment complex, the charge was made, Redfearn said.

"Anything you do to a child that causes them harm and causes them to die is homicide by child neglect," Redfearn said. "She's ultimately responsible for that child. She is responsible for that child's safety."

A charge of homicide by child abuse is often controversial when it involves an unborn baby. The S.C. Supreme Court ruled in 1997 that a fetus able to survive outside the womb is considered a person under child-abuse and neglect laws. That threshold is generally around 25 weeks.

Some feel charge is absurd

Much of the debate over the charge centers around women who are prosecuted after their babies die because of the mother's drug use during pregnancy.

Opponents say the charge is absurd in those cases because it fails to address the true problem drug addiction -- and get the mothers the help they need.

Lynn Paltrow, executive director of the New York-based nonprofit National Advocates for Women, said charging Clyburn is equally "sadistic."

"You clearly have a person who obviously has psychiatric problems. To respond by prosecuting her for murder is so irrational and cruel, I don't even know where to begin," she said. "I think this is a good example of how South Carolina is leading the nation in just counterproductive punishment."

wasn't available Friday. Most people prosecuted on the charge end up pleading to a lesser offense and get probation or have pre-trial intervention, said Rauch Wise, a Greenwood attorney who has represented four women who faced the charge.

Compounding a tragedy?

Of the women Wise has represented, two cases were dismissed before trial, one was dismissed on appeal, and another was reversed on post conviction relief.

"What the state is doing is taking one tragedy and compounding it," Wise said of Clyburn's case.

"I don't want to make light of this person's tragic situation," he said, "but I truly wonder if the state would take the same position ... if she had elected to claim the viable fetus on her income tax return for the previous year."

Clyburn was being held Friday without bond at Moss Justice Center in York.

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Should Refusal to Undergo a Cesarean Delivery Be a Criminal Offense?

Richard L. Berkowitz, MD

Those providing medical care for pregnant women certainly know that they are responsible for both the woman herself and the 1 or more fetuses she is carrying. Regardless of when one believes that life begins, we all understand that concerns about the well-being of a "viable" human fetus are as relevant as those relating to the mother who is carrying it. Book titles, conferences, and untold numbers of peer-reviewed articles refer to the "Fetus as a Patient," and those of us who focus our attention on the provision of antenatal medical and/or surgical therapy are constantly aware of the fact the recipient of our care is a resident in the pregnant woman's uterus. Physicians naturally strive to maximize beneficial outcomes for their patients, and often serve as advocates on their behalf—but are there limits to that advocacy?

Caring for more than 1 patient in a pregnancy can be very complicated because sometimes the best interests of the separate parties are in conflict. Ongoing compromise of 1 twin in utero at 27 weeks might dictate that rapid delivery would be life-saving, but that delivery could seriously jeopardize the other twin from the sequelae of severe prematurity. The appropriate therapy of worsening hemolysis, elevated liver enzymes, low platelets syndrome at 26 weeks is delivery for maternal indications, but that could seriously endanger a baby born at such an early gestational age. The first case is extremely difficult and involves a kind of "Sophie's choice," but this type of decision is most frequently made by informed parents after evaluating the degree of compromise being suffered by the affected twin and the track record of the neonatal intensive care unit into which the delivered babies will be going. The second case is usually unambiguously decided in favor of the mother, regardless of the gestational age, because of the well-established principal in our society that concerns about the medical well-being of a mother outweigh those relating to her fetus. In the case of *Senberg v Carhart* (530 US 914 [2000]), the Supreme Court has specifically ruled that a late-term abortion cannot be prohibited when a mother's health is at stake.

More than a quarter of American deliveries are currently performed by cesarean, for a variety of reasons. Women undergoing those procedures voluntarily agree to undergo major abdominal surgery to maximize the potential for a healthy outcome for their babies, even though in most cases there is no direct health benefit for the mother. Many other examples exist of things done by and to pregnant women for the express purpose of benefiting their fetuses. These range from reduction in daily alcohol consumption, and acceptance of bed rest for preterm contractions to major dietary alterations, multiple finger sticks, and frequent injections for the management of insulin-dependent diabetes, the performance of transabdominial intravascular transfusions for the treatment of severe fetal anemia in utero, and even submission to open surgical repair of neural tube defects. All of these things are done selflessly but voluntarily. What, however, should be done if a woman doesn't choose to act in what her caregivers think is in the best interests of her fetus? Is she obligated to do so? Prosecutors in Utah undoubtedly feel that she is.

Melissa Rowland was charged with the murder of her stillborn twin because she failed to accede to the advice of her obstetrician to undergo a cesarean delivery.

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These charges were subsequently dropped when she accepted a plea of child endangerment for using drugs during pregnancy. The facts of the case are tragic. Ms. Rowland is a woman with a long history of mental illness and substance abuse. According to press reports,[1–4] her first set of twins was born when she was 14 years old, 2 of her 6 children were given up for adoption, 1 was taken away by child protective services, and she had been convicted of child endangerment of 1 of the others. She had undergone 2 prior cesarean deliveries and claimed that she was terrified to have another because the doctors wanted to cut her open from "breast bone to pubic bone." She was advised to have a cesarean delivery on January 2, 2004 because of decreased amniotic fluid volume and poor fetal growth. She initially refused but finally agreed to undergo an abdominal delivery 11 days later. One twin was born alive and survived but tested positive for cocaine and alcohol. The other was judged to have died in utero approximately 2 days earlier. The Salt Lake County District Attorney's Office filed murder charges under a state statute that defines a fetus as a person for the purposes of criminal prosecution.

In this issue of *Obstetrics & Gynecology*, Minkoff and Paltrow[5] discuss the justification for, and implications of, this judicial action and find them to be extremely concerning. They present several legal and ethical arguments against forcing a woman to undergo a cesarean delivery, but the one I find most compelling is that relating to the case of *McFall v Shimp* (10 Pa DC3d 90 [1978]) adjudicated by the Allegheny County Court in 1978. In that case the first cousin of a man with life-threatening aplastic anemia was found to be the only compatible donor for a marrow transplant. He refused his cousin's request to undergo a marrow aspiration and was subsequently brought to court to seek an injunction compelling him to submit to the procedure. While finding the potential donor's refusal to help his cousin reprehensible, the court denied the plaintiff's appeal. In addition to the statement quoted in the article by Minkoff and Paltrow, the opinion from that case states, "Our society, contrary to many others, has as its first principle the respect for the individual, and that society and government exist to protect the individual from being invaded and hurt by another," (*McFall v Shrimp*) and "For a society which respects the rights of one individual, to sink its teeth into the jugular vein or neck of one of its members and suck from it sustenance for another member, is revolting to our hard-wrought concepts of jurisprudence. Forcible extraction of living body tissue causes revulsion to the judicial mind. Such would raise the specter of the swastika and the Inquisition, reminiscent of the horrors this portends" (*McFall v Shrimp*).

If a 3-month-old neonate requires a renal transplant, its mother cannot be forced to provide a kidney even if she has the only compatible one to be found. Therefore, assuming that she is competent to make rational decisions, forcing a woman to undergo a major operative procedure when she is pregnant denies her the rights she will have after she has delivered. This is clearly discriminatory. If the undelivered mother is found to be incapable of making a rational decision, other mechanisms should be brought into play to decide on an appropriate course of action; Ms. Rowland's competence was not raised as an issue in her case.

Minkoff and Paltrow[5] eloquently point to the problems that can follow from the notion that pregnant women can be found criminally negligent for behavior that endangers their fetuses. Will we be jailing women for refusing to reduce their cigarette consumption during pregnancy or being unwilling to undergo a multifetal pregnancy reduction in a high-order multiple pregnancy that results in the birth of very premature infants? There is no end to the variations on that theme. Given the propensity in this country to assign blame for virtually any bad outcome, think of the multiple possible recriminations that can be assigned whenever a baby is born that is less than perfectly healthy.

Despite my strong advocacy for the fetus, I agree with the conclusions reached by Minkoff and Paltrow.[5] Informed consent means that individuals being offered a medical option have the right to refuse it. We obtain informed consent before performing cesarean deliveries for precisely that reason. There is no question that pregnancy is a unique state and that obstetric patients have an ethical responsibility to optimize the outcome for their fetuses, but that does not mean that they should surrender their legal rights to have control over what is done to their bodies.

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I certify that a copy of the foregoing has been delivered by mail to the following:

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This 7th day of February, 2011.

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