UNIVERSITY OF CALIFORNIA,
IRVINE

Delivering Bad News: The Processes and Consequences of Criminalizing Pregnancy

DISSERTATION

submitted in partial satisfaction of the requirements
for the degree of

DOCTOR OF PHILOSOPHY

in Criminology, Law and Society

by

Laura Ann BrennanKane

Dissertation Committee:
Professor Elliott P. Currie, Chair
Professor Emeritus C. Ronald Huff
Professor John Dombrink

2016

DEDICATION

To the women in my study and others like them whose stories should be told:

Hope Ankrom, Alicia Beltran, Nina Buckhalter, Samantha Burton, Angela Carder, Lisa Epsteen, Jamie Lynn Fisher Russell, Rennie Gibbs, Jennifer Goodall, Martina Greywind, Melanie Green, Michelle Greenup, Darlene Johnson, Jennifer Johnson, Amanda Kimbrough, Rachel Lowe, Regina McKnight, Pamela Rae Stewart Monson, Kari Parsons, Purvi Patel, Laura Pemberton, Diane Pfannenstiel, Melissa Rowland, Bei Bei Shuai, Julie Starks, and Christine Taylor.

To Jessica Grebenkemper, who enriched my life and will not be forgotten. May I continue to be inspired by you to do the work that is needed to change the lives of both men and women.

For justice, equality, and peace.

TABLE OF CONTENTS

ACKNOWLEDGEMENTS

First, to Dr. Elliott Currie, my dissertation chair, who gave willingly of his time and never turned me away. I will never forget your kindness as I navigated a difficult time in my life. Thank you for your unwavering support.

To Dr. Ron Huff, thank you for your friendship and your guidance. I hope to make you proud as I continue to learn how to be a leader.

To Dr. John Dombrink, thank you for always keeping your door open to me. Please know how important you have been to students and their successes.

To Drs. Donna Schuele, Sora Han, and JoAnn Prause: thank you for your willingness to serve on my proposal committee and offer insight and help to make the dissertation move out of its infancy.

It is with gratitude that I acknowledge the support of my department and the School of Social Ecology. I received funding in 2015 in the form of the Social Ecology Dean's Dissertation Writing Fellowship.

To the Bryn Mawr women who continue to lift me up in times of gladness and sorrow: Dr. Laura Sockol, Dr. Christin Mulligan, Dr. Katie Eichhorn, Laura Kramer, Sruti Bhaumik, Malorie Garrett, Katherine Chinn, Marcelina Chavira, Jen Dodwell Fung, Heidi Winkel Tierney, Erin Schifeling, and many others. Thank you for hosting me, helping me edit, listening to me kvetch, and making me feel like I belong. Anassa Kata! Done is good.

To my friends at UCI: Especially my 2008 cohort including: Dr. Crystal Null, Dr. Sonya Goshe, Dr. David Fontenot, Bryan Burton, and Jessica Grebenkemper. I really don't think I would have made it without all of you. You have touched my life and I value each of you for your talents and friendship. To Dr. Preston Reed, Amy Reed, and Dr. Joe Tatar: I was never a PSB student, but I never felt like an outsider. Thanks for all of the happy birddays.

To Adam Gibson, Missy Coleman, Pat Donnelly, Brian Blalock, Llanerch Presbyterian Church members, Chaz Meyers, Nancy and Roy, and Andrew Brice: thanks for always being there when I needed it.

To my immediate family: Mom, Dad, and Carolyn. I love you.

To Charlie, my feathered child, who melts my heart and drives me crazy at the same time. Thanks for making me get out of this chair and play with you.

Last, but not least, to Joel, who has seen all of my sides and chosen to love me despite and because of them. Thank you for seeing me through this and believing in me at all times. Thanks especially for that walk that ended up being 21 pages.

CURRICULUM VITAE

LAURA BRENNANKANE

EDUCATION

PhD	Criminology, Law and Society University of California, Irvine Dissertation: *Delivering Bad News: The Processes and Consequences of Criminalizing Pregnancy*	2016
AM	Criminology University of Pennsylvania Thesis: *A Systematic Review of Mandatory Prosecution of Domestic Violence*	2008
AB	Mathematics and French Studies Bryn Mawr College *Cum laude*	2007

TEACHING EXPERIENCE at Capital University

Juvenile Delinquency	Spring 2016
Principles of Sociology	Spring 2016
Principles of Sociology Recitation	Spring 2016
Principles of Criminology	Spring 2016
Principles of Sociology	Fall 2015
Principles of Sociology Recitation	Fall 2015
Principles of Criminology	Fall 2015
Social Deviance and Social Control	Fall 2015

TEACHING EXPERIENCE at University of California, Irvine

Crime Measurement,	Summer 2014
Family Law	Spring 2014
Introduction to Criminology, Law and Society	Summer 2013

TEACHING ASSISTANT EXPERIENCE at University of California, Irvine

Naturalistic Field Research for Ken Chew	Spring 2015
Power, Constructions of Deviance, and Social Control for Bryan Sykes	Fall 2014
Naturalistic Field Research for Mona Lynch	Winter 2014
Miscarriages of Justice for Ron Huff	Fall 2013
Criminological Theory for Paul Jesilow	Spring 2013

Classics in Crime Cinema for James Diego Vigil	Spring 2012
White Collar Crime for Paul Jesilow	Winter 2012
Crime Measurement for Richard McCleary	Fall 2011
Field Study for John Dombrink	Summer 2011
Community Context of Crime for Elliott Currie	Spring 2011
Crime Hotspots for Richard McCleary	Winter 2011
Naturalistic Field Research for Joanne Frattaroli Zinger	Fall 2010
Forensic Psychology for Michael Flesock	Summer 2010
Drug Abuse and Prevention for Zuzana Bic	Spring 2010
US Law and Native Americans for Justin Richland	Winter 2010
Naturalistic Field Research for Joanne Frattaroli Zinger	Fall 2009
Juvenile Delinquency for Cheryl Maxson	Spring 2009
Miscarriages of Justice for Simon Cole	Winter 2009
Research Design for JoAnn Prause	Fall 2008

TEACHING ASSISTANT EXPERIENCE at Upper Darby School District

English Language Learners program (elementary school)	Summer 2005
English Language Learners program (elementary school)	Summer 2004
Transitional Education Program (elementary and high schools)	Summer 2002

GRADER EXPERIENCE at University of California, Irvine

Sociology of Law for Carroll Seron	Winter 2013
American Legal Thought for Donna Schuele	Fall 2012
Crime and Public Policy for Elliott Currie	Fall 2012

TUTOR EXPERIENCE

- Tutored one graduate student in the Masters of Advanced Study in Criminology, Law and Society program in Applied Statistics in Spring 2014 at University of California, Irvine.
- Tutored one undergraduate in Statistical Analysis in Social Ecology in Spring 2014 at University of California, Irvine.
- Tutored two graduate students in the Masters of Advanced Study in Criminology, Law and Society program in Applied Statistics in Spring 2013 at University of California, Irvine.
- America Counts Tutor: Tutored math to elementary school children from 2004-2007 at Bryn Mawr College.

GUEST LECTURER at the University of California, Irvine

Brennankane L. (November 2013). *Life After Wrongful Conviction.* Miscarriages of Justice.

PRESENTATIONS

Mong, S., Kardaras, B., BrennanKane, L. (March 2016). *Capital University Sociology and Criminology Department service learning and high impact engagement projects academic year 2015-2016.* Capital University Showcase of Student Learning in Columbus, OH.

BrennanKane, L. (November 2015). *Using just in time teaching in criminology courses.* The Annual Meeting of the American Society of Criminology in Washington, D.C.

BrennanKane, L. (November 2014). *Bumps in the road: Taking stock of defining pregnant women's behaviors as criminal.* The Annual Meeting of the American Society of Criminology in San Francisco, CA.

BrennanKane, L. (August 2014). *Bumps in the road: Understanding the paths taken to arrest pregnant women.* The Annual Meeting of the Society for the Study of Social Problems in San Francisco, CA.

BrennanKane, L. (April 2014). *Criminalizing pregnancy: Exposing the practices of regulating pregnant women.* The Inaugural Associated Graduate Students Symposium at the University of California, Irvine in Irvine, CA.

BrennanKane, L. (November 2013). *Criminalization of pregnancy: Ending reliance on the criminal justice system.* The Annual Meeting of the American Society of Criminology in Atlanta, GA.

McCleary, R., & BrennanKane, L. (2012). *Exploring the logic of Criminological theories and their relationship to tautologies*. Working group in Criminology, Law and Society

Kane, L., Hughes, R., and Cheng, L. (August 2007). *Using Wavelets to Explore Heatlets.* Bryn Mawr College Undergraduate Summer Research Poster Session in Bryn Mawr, PA.

SERVICE to the university

Summer Orientation Academic Advisor	Summer 2016
Preregistration Volunteer	May 2016
Moderator, Capital University Undergraduate Research Symposium	April 2016
Service Learning Work Group, Capital University	2016-present
Sustainability Committee, Capital University	2016-present
Collegiate Fellowship Interviewer, Capital University	2016-present
Social Sciences Working Group, Capital University	2015-present
GOLD Representative for Orange County, CA, Bryn Mawr College	2014-2015
Alumnae Interviewer for Orange County, CA, Bryn Mawr College	2010-2015

SERVICE to the department

Sociology and Criminology Major/Minor Advisor, Capital University	2015-present
Speaker Series: "Careers from the Inside," Capital University	2016
Pedagogy Committee Co-Chair, University of California, Irvine	2014-2015
Graduate Student Representative, University of California, Irvine	2012-2013
Comps Committee, University of California, Irvine	2011-2012

WIG Committee, University of California, Irvine 2010-2012
Senior Mathematics Student Representative, Bryn Mawr College 2006-2007

FELLOWSHIPS AND AWARDS

Social Ecology Dean's Dissertation Writing Fellowship ($6180 plus tuition) 2015
Graduate Student Summer Research Support ($1300) 2014
MAS Professional Development Fellowship ($5700 plus tuition) 2013
Graduate Student Summer Research Support ($2500) 2012
Graduate Student Summer Research Support ($1000) 2011
Graduate Student Summer Research Support ($1500) 2010
Graduate Student Summer Research Support ($2000) 2009
Summer Math Research ($3500) 2007
Thomas Raeburn White Scholarship ($7500) 2006
Summer language study abroad (at Institut d'Avignon)
La Bourse Marandon ($2500) 2006
Summer language study abroad (at Institut d'Avignon)

TRAININGS

Interpreting IDEA Evaluations 2016
High Impact Educational Practices 2015
Promotion and Tenure Process 2015
iClickers for the Instructor - How to Make It a Success 2014
8 Tech Tools to Enhance Your Teaching 2014
Respect the Copyright of Others 2014
Prezi: A Presentation Tool Beyond PowerPoint 2014
How to Create a Memorable Academic Presentation by Barbara S. Giordano 2014
iClickers for the TA - How to Make It a Success 2014
Dynamic Assessments (and Instruction) with EEE Quiz 2014
Flipping the Classroom Proseminar 2014
Engage and Educate Your Audience with PowerPoint 2014
Teaching Assistance Professional Development Program 2008

PROFESSIONAL ASSOCIATIONS

American Sociological Association
American Society of Criminology
Society for the Study of Social Problems

LEADERSHIP

America Reads/America Counts Tutor Coordinator 2005-2007

ABSTRACT OF THE DISSERTATION

Delivering Bad News: The Processes and Consequences of Criminalizing Pregnancy

By

Laura Ann BrennanKane

Doctor of Philosophy in Criminology, Law and Society

University of California, Irvine, 2016

Professor Elliott Currie, Chair

Legal, medical, and social regulation of pregnant women has been an understudied topic in sociology and criminology. While difficult to say how pervasive this phenomenon is, Paltrow and Flavin (2013) have the most comprehensive research on its magnitude. They documented 413 women who were civilly or criminally confined because of their pregnancies. My research sought to extend this work by understanding the processes, legal hurdles, and specific details of each woman's story as she came under scrutiny during her pregnancy. What was it about pregnancy that invoked the use of legal force to control a woman's body? How did doctors, nurses, and other medical professionals respond to women who had problematic pregnancies? Using 26 case studies of women who were criminalized based on their pregnant status, I

examined the processes by which these women were regulated and why the regulation occurred. Although each case is unique, when taken as a whole, I found that the women were not trusted to make good decisions on behalf of their fetuses and that doctors, nurses, police, social workers, and judges intervened to take away their agency. Criminal and civil laws were mobilized against women to force them to conform to the wishes of these social control actors. I give several policy suggestions in order to effect change and argue that creating a culture of prevention would lead to better success at fostering good pregnancy behaviors and would ensure the goal of healthy children more than the current reliance on criminalization practices. I suggest that prevention, not regulation would be a better process for both the mother and the baby because it reduces actual harm, but also because it has practical economic implications and gives doctors the ability to do what they do best: practice medicine, not law.

INTRODUCTION: The Problem

I live in a world where each day I see progress toward equality for different groups of people; however, even with these steps forward, women still continue to face domination, hatred, and blame for processes and natural functions that are out of their control. Women are subjected to multiple messages about their bodies throughout their lifetimes: the disgust of menstruation, the denial of access to birth control based on age or geographic location, differently enforced school dress codes, the necessity of shaving, and so on. Even as legal rights have been extended to women, economically, politically, and socially, women are not equal to men in America. The wage gap, the lack of a female President of the United States, and the "second shift" where women come home from work and take care of the household and children (Hochschild & Machung, 1989; Pew Research Center, 2015) are all telling of inequality that still exists between men and women.

As I was studying in graduate school, I became concerned about all of the news stories I saw where mothers were arrested, jailed, and scrutinized for the actions they had taken with regard to their children. Sometimes these practices were the *best* the mother could do due to her constrained set of choices, yet she was still penalized to the fullest extent of the law. With a lack of compassion, authorities responded that their hands were tied and that they had little power to do anything but arrest them, prosecute them, and/or remove their children from the home. From my view, the system felt broken that women were trying the best that they could and those choices resulted in very real consequences for them and/or their children. Because a dissertation must be feasible in addition to significant (and interesting), I narrowed my project in scope from the larger topic of motherhood regulation to a realistic project on the criminalization of pregnant women. Criminalization of pregnancy is brought about by many different agents of social

control, including doctors, hospitals, courts, police, and politicians. The process by which a normal life event becomes framed as a problem leads me to unpack how pregnancy is scrutinized, legislated, and criminalized. Located on the University of California Irvine's School of Social Ecology's website, I strive to keep with the spirit of their mission: to do socially relevant research that exposes problems using multi-disciplinary and holistic lenses and offers real-world solutions.

This work focuses on 26 pregnant women and their encounters with law enforcement, judges, and medical personnel. I tell their stories: the details of their legal battles, their pleas for help and agency, and the processes through which social control mechanisms, those that are legal and medical, regulated and criminalized these women. This monograph features women like Amanda Kimbrough who lost her son and sits in prison as she serves a sentence for violating the chemical endangerment law in Alabama, Christine Taylor who was arrested because hospital staff questioned her intentions when she fell down stairs at home in Iowa, Jennifer Johnson whose case had to go to the United States Supreme Court (SCOTUS) in order to vacate a conviction that she had delivered drugs to her newborn children from the time she had given birth to the time the umbilical cord was clamped, and Lisa Epsteen who felt bullied by and fearful of her medical team when she was threatened with law enforcement intervention if she did not have a cesarean-section (c-section) surgery.

The similarity of the cases of each of these four women seems apparent at first blush. Obviously each of these women was expecting to be a mother at the time that her conduct caused others to take notice of her. It should be noted that in all four cases the conduct of the women was scrutinized because of their common status: pregnant. These four examples also show that at some point their conduct was considered and subsequently regulated at the federal or state

levels. Moreover, to be clear, Kimbrough's charge was because of her drug use, but she was not arrested for selling or possessing drugs. Instead, she was charged under Alabama's Code, §26-15-3.2 (3): Alabama's Chemical Endangerment Law, where the language for her offense reads, "Violates subdivision (1) and the exposure, ingestion, inhalation, or contact results in the death of the child. A violation under this subdivision is a Class A felony." Kimbrough would not have been charged with violating this law if she had not been pregnant. In fact, all four examples share what Paltrow and Flavin (2013) call the "'but for' factor" (p. 301). There likely would not have been action taken against the women (drug testing of the newborn, questions about the woman's accidental fall, speculation at what point drugs might have been delivered to the infant, threats because of a patient's decision to avoid major surgery) "but for" the status of the women as pregnant. McGinnis (1990) similarly argues that when drug use or alcohol use is not a crime in and of itself, for a crime to occur, the substance use must be accompanied with another harm, one that is regulated by law. Thus, if a pregnant woman uses drugs or alcohol, which are often not crimes themselves, and these women are arrested for drug or alcohol use without violating another law, then the pregnant drug use constitutes a "new status-based criminal offense" (McGinnis, 1990, p. 520). Moreover, since *Robinson v. California* (1962), SCOTUS held that simply being a drug addict is not a criminalizable offense. Consequently, McGinnis argues that the criminalization of pregnant drug addicts is doubly worrisome for it criminalizes two statuses that cannot be criminalized according to the Constitution: drug addict and pregnant. "The result of criminalizing the coexistence of two unpunishable statuses- drug addiction and pregnancy- is the creation of a new status crime" (McGinnis, 1990, p. 520). This use of status as a justification to regulate and/or criminalize the conduct of a woman calls into question whether women are then treated fairly (with regard to their constitutional protections like due process), without

prejudice because of their status, and are actually given resources to remedy any problems that caused them to come under scrutiny in the first place. In many cases, the answers are no, no, and no.

Why is this a concern?

We regulate some women by status: the status of "pregnant." The process by which we regulate and criminalize these women is not transparent nor does it necessarily apply to all pregnant women equally. The first major problem of regulating pregnancy is that we deem certain actions illegal for pregnant women but legal for others who are not pregnant. Thus, it can be said that we are not actually regulating conduct, but status. For example, Michelle Oberman (1992) claims that the only reason the women she reviews in her article were criminalized was not actually due to their actions, but rather that they were pregnant at the time they took those actions. Society places special expectations on women who become pregnant because we value the children that these women bear. In fact, Hulsey (2005) argues that "[s]ingling out pregnant women implies that they have a higher moral obligation to their children than do fathers or non-pregnant mothers" (p. 94). We obviously want pregnant mothers to take the best care of themselves and their future children in order to have the best society and future that we can. We want to produce healthy, intelligent, capable minds, workers, and citizens, but should we regulate by status to accomplish this goal? If society accepts that the goal is valid, does that in turn give us permission to regulate by status? Is it always wrong to regulate by status? For example, we do it for juveniles out of concern for their protection (i.e., *parens patriae*), but should we in all cases for pregnancy? Where do the boundaries exist for this kind of paternalistic care? The present chapter illustrates that criminalizing the status of pregnancy is problematic because it a) is discriminatory, b) pits mother against fetus, c) ignores greater social issues by framing the

problems as individual ones, d) ignores the context of women's lives, e) possibly violates due process rights of the pregnant woman f) wrongly asks the criminal justice system to act as social service provider, and g) defaults to reactive practices, ignoring prevention.

Criminalization of pregnancy not only targets women of a certain status, but also opens up these women to discriminatory practices— especially for those who possess multiple statuses, particularly those who are poor or who are minorities. Intersectionality, the concept developed by Kimberlé Crenshaw (1998), is particularly salient to this work. First, intersectionality necessitates that we consider how multiple statuses interact with one another, such that the effects are not simply additive or completely predictable. Crenshaw (1998) argues that single attributes— like gender, race, age, and class— intersect to form complex statuses. For example, in her work, she shows that even when one characteristic is shared by two groups (such as race), once a second characteristic is introduced (such as sex), the resulting treatment may not be equal for both groups. Through analysis of court cases, Crenshaw shows that black women are not only treated differently from white women, but also from black men. Women may face discrimination because of their sex, but black women face that discrimination in both similar and different ways from white women (and even black men). Instead, black women face challenges and receive benefits that are not predicated on black men's or white women's experiences. Instead, they have their own unique experiences because of the pairing of both race and sex- two statuses that *cannot* be decoupled. Generally, research on sex discrimination focuses on the experiences of white women rather than a more holistic treatment of all groups of women. This point is salient for this work, as many of the women who experience criminalization have not just one status, but often, two or three (or more) and their types of statuses are ones that put women at risk of regulation and control. While these ideas are crucial to thinking about which

groups are hit hardest by regulation, Crenshaw does not create a schema to help courts, police, or prosecutors to develop a policy that would recognize these compound statuses. This work will attempt to help fill that gap. As discussed above, in this piece I treat pregnancy as a status. Consequently, considering intersectionality, what are the implications for a pregnant woman of color, low income, and young age, if she comes under the surveillance of the criminal justice system? Will her statuses dictate more lenient or harsher punishment compared to her non-pregnant peers, pregnant women of means, or white women? Will she be more likely or less likely than her peers to receive treatment and resources? Second, women who are marginalized in multiple ways face barriers to resources that women who have fewer vulnerable statuses do not face. Third, compared to women with access to resources, choices about behavior and conduct are more constrained for women who do not have resources (Maher, 1990).

There has been some empirical research done on the intersectionality of pregnant women. Using interviews with pregnant women, Whiteford and Vitucci (1997) examined a Florida law that allowed public hospitals to drug test infants without parental consent. Whiteford and Vitucci point out that many poor women and women of color are arrested for drug use (and thus endangerment to the child). This is not necessarily because they use more drugs than other women, but because poor and minority women are subjected to drug tests more often than other women. Therefore, it appears that more poor and women of color use drugs, when in reality, testing is not consistent between groups, leading to a selection bias. In addition, at this time, doctors routinely tested for the presence of crack cocaine, a drug that has been linked to the African American population whereas alcohol, the choice of many European-American women, was excluded. Noble (1997) also argues that medical practitioners in California are more likely

to report child abuse and the suspicion of drug use in women of color, women with lower socioeconomic statuses, and women on government insurance (e.g., Medicaid).

Medically, pregnant women are treated as having different rights from other patients (Meredith, 2005; Johnsen 1987). For example, a pregnant woman could be forced against her will to undergo a cesarean section surgery. However, there is no statute that compels a mother to save the life of her dying, postnatal child through a medical procedure that she does not wish to have. This raises questions of equity in that pregnant patients are different from other kinds of patients, but also shifts all of the bodily duties of care to one expecting parent, the pregnant woman. There remains a question as to whether it is a concern, and if so, the extent of that concern, that doctors can mandate certain treatments, procedures, or surgeries for pregnant women that would not be mandated for non-pregnant patients. It is further problematic that there is a lack of voice and agency ascribed to an entire class of people if pregnant women are not fully able to determine what happens to their bodies.

Legally, for most of the country's history, the pregnant woman and her fetus were considered one entity. A trend that has been on the rise is the treatment of mother and fetus as separate legal entities while they share one body. One obvious problem is the situation when the mother's needs conflict with the needs of the fetus. For example, if it is revealed that an early term pregnant woman has cancer and must undergo chemotherapy to survive, the prognosis for the fetus is poor. If the mother decides to forego chemotherapy until after the birth, she may produce a healthy baby but die of cancer after the baby is born. This scenario presents an actual medical dilemma that must be solved by the law since there is little that medicine can do to benefit both parties—a choice must be made where one life is prioritized.

The reconciliation of the needs of the mother and the needs of the fetus can also be recast as *the rights of the mother versus the rights of the fetus*. Katherine Beckett (1995) argues that "[t]he apparent independence of the fetus has given rise to a definition of pregnancy as a conflict of rights between a woman and her fetus" (p. 593). As court cases reverse the earlier tendency to consider mother and fetus as one entity, this notion of independence opens the door to allow parents, especially mothers, to be liable for their conduct when pregnant. Beckett notes that if a mother can be held liable for harm done to a fetus in the womb when she takes prescription drugs (p. 594), the *slippery slope* of liability is opened to allow other forms of conduct to be criminalized. Can women who eat poorly or even engage in activities like strenuous exercise be held responsible for any harm that results from their conduct? Moreover, would our society benefit from children being able to critique their mothers' prenatal conduct, especially in a formal setting such as a court?

The next area of concern revolves around the treatment of women's pregnancies as matters of civil and criminal law that involve a dispute between two parties, the mother and the fetus who is represented by the state. By allowing these matters to be addressed by courts, harms are framed as individual (and possibly rare) issues. If problematic pregnancies are so harmful that we need to create criminal sanctions, we miss the bigger picture of an ill society when we only see *individuals* go to court. Women who are labeled as bad pregnant mothers (especially those who take drugs or fail to seek medical care) are often viewed as *individuals* with problems, rather than framed as part of a larger, more systemic problem where many women are products of economic deprivation and lack of social supports. Individual problems lead to responses that are individualistic as well. Taking the example of the pregnant woman who avoids appointments, the response is often that there is right of protection and care due to the fetus that

was not adequately supplied by the mother. As society sees the fetus as a being that cannot care for itself, its rights trump the mother's rights to make personal, health care decisions for herself. Thus, the response is to reprimand the mother, an individual, and move on, rather than consider that there may be many more just like her, who lack economic resources or face barriers to adequate care. The example of the pregnant drug user also elicits a response that is individualistic; one in which the user is treated as a deviant rather than sick or addicted. Here a "social problem is recast as a crime problem" (Maher, 1990 p. 118; Stephenson & Wagner, 1993).

While framing the problem of criminalization of pregnancy as a societal one is important, we should not focus so much on that general issue as to lose the context of each woman's life. Dawn Johnsen (1987) argues that it may be proper for society to consider that a mother does have a reasonable responsibility to care for a fetus while it is in the womb, but that it is inappropriate to judge that mother's conduct *post hoc*, especially where hindsight is, as they say, 20-20. Johnsen argues that at any point, any small decision could impact the life or health of the fetus. Often her choices about the care for herself and her future child rest on her income, environment, and personal health. There cannot be a "one size fits all" model of pregnancy because it ignores women's real life situations.

In addition, and of crucial importance, when a fetus and its mother are treated as separate entities, it opens the door for the fetus to go to court against the woman, but also for the state to prosecute the woman on behalf of a vulnerable victim. First, it is confusing to scholars, policy makers, and the general public that the state can represent a being inside another being, thus giving both legal standing even though they share a body. Second, most pregnant women do not go into pregnancy thinking that they will have to face legal challenges stemming from their

pregnancies. By framing criminal conduct based on the status of pregnant, we ignore the cultural definition that many women assign to the time: a natural evolution of the growth of her family in which she must make choices on the behalf of her fetus, but also herself. Thus, when such an occasion arises that she is charged by the state, for a woman to know that her actions are criminal, she must have "notice and fair warning" (McGinnis, 1990). Without such warning, her due process rights may be violated. McGinnis argues that prosecutions of pregnant drug users violate the due process rights of pregnant women in two ways: 1) women are not provided "notice and fair warning" and 2) legislatures, not judges, should define criminal conduct. First, McGinnis claims that women must be provided some kind of notice that their conduct is criminal. The legal justification for notice is derived from the ex post facto clause[1] of Article 1, Section 9 of the Constitution. Thus, if a judge were to "enlarge" a law to include conduct that previously had been ignored or was unpredictable in its inclusion, this might be considered a violation of a woman's due process rights. Second, McGinnis claims that courts should determine legislative intent when applying statutes so that courts are not the ones making law, but rather interpreting it. This situation of the "enlargement" of laws is particularly salient for the criminalization of pregnancy because pregnant women are charged with child abuse, child endangerment, feticide, manslaughter, and other crimes that they do not expect. Many of them might expect that they are violating drug possession laws, but some do not realize that they have committed a crime at all. Certainly it would be a surprise to many women that a home birth would result in a child neglect charge. Violation of due process is certainly one of the most

[1] The ex post facto clause of the Constitution means that a new law cannot penalize those who violated the law before it was in effect. Thus, for example, if walking barefoot outside becomes against the law tomorrow, I cannot be prosecuted tomorrow for having done it today (while it was still legal).

worrisome issues that can be extracted from the criminalization of a status since we consider due process rights to be fundamental rights of all citizens.

Sociologist Kathryn Ann Farr (1995) argues that it has been the practice since the 1940s to allow parents to sue third parties for harm to the woman/fetus because they were considered one entity. Third parties generally include the doctor and other medical staff who may have harmed the infant prenatally. This definition did not include the conduct of the mother. It was not until the 1970s with the decision of *Roe v. Wade* (1973) that fetal protection supporters felt threatened and subsequently mobilized. The term "fetal abuse," she argues, refers "almost exclusively to the behavior of the pregnant woman, behavior that is perceived to be in direct conflict with the interests and ultimately the rights of the fetus" (Farr, 1995, p. 236). Importantly, this change in definition of fetal abuse has opened the door for the prosecution of drug-addicted women and even those who do not seek adequate medical care during pregnancy. The boundaries of the abusive behavior are not defined and due to precedent, any action a pregnant woman takes that is not in full benefit of the fetus, may result in a fetal abuse charge.

Suppose for a moment that the conduct of a pregnant woman truly violates the law and she therefore deserves punishment and/or help from the criminal justice system. Questions will always exist about what punishment and/or rehabilitation is appropriate for her situation, but what is often ignored is how the sanction also hurts her family, especially her fetus or newborn. For example, after a woman gives birth in custody, her baby is taken from her. There is a potential for the child to suffer ill health effects from this separation (Hulsey, 2005). The removal of the child prevents the formation of a mother-child bond and the benefits of breast milk. A study of multiple facets of reproductive care in New York state prisons revealed that mothers who gave birth while serving their sentences were deprived of their state rights to have

their infants in their rooms with them because the infants were housed in the nursery and the mothers in a secure ward. The ward and the nursery were far from each other and the ability to visit with, bond with, and breastfeed the child was out of the mother's control and managed by the correctional officer and/or the nurses—often to the frustration of the mother. The report recommends:

> Allowing mothers who want to breastfeed to do so is vital not only because all mothers deserve to have such choices respected but also because breastfeeding provides significant benefits. Nursing strengthens babies' immune system, brain development and vision, and helps mothers physically recover from childbirth while lowering their risk of cancer, heart disease, hypertension, diabetes and high cholesterol. It also helps mothers and babies form critical early bonds. Establishing breastfeeding as soon as possible is important because it lays a foundation for successful breastfeeding and because mothers only produce colostrum – the first stage of breast milk that contains essential nutrients and antibodies – for a few days after delivery. (Kraft-Stoler, 2015, pp. 118-119)

Additionally, for the woman, the criminal justice system is not an ideal place to seek treatment. This system has "historically poor systems in place to assist [pregnant drug users]" (Hulsey, 2005, p. 95). By asking the criminal justice system to handle/manage even one type of problematic pregnancy (i.e., drug users), let alone others, we must consider the healthcare of the woman (pre- and postnatal). Moreover, if we do ask the criminal justice system to handle all of these women, very specific resources must be in place, including "appropriate treatment services for substance abuse as well as prenatal care…for pregnant incarcerated women" (p. 95). This problem has multiple facets that must be considered when placing the burden on a system that was not designed to provide social support.

One way to reduce reliance on the criminal justice system as an agent of change is to let nature take its course without intervention. Empirical research undertaken by Kreager, Matsueda, and Erosheva (2010) found that women in disadvantaged communities who transition to motherhood reduce their delinquency, smoking of marijuana, and drinking of alcohol. The authors found that the transition to motherhood actually has a bigger impact than the transition to marriage on curbing delinquent behavior. As this research supports, leaving pregnant women alone may do more good than harm. Without any external intervention, those who are involved in delinquent activities actually start to refrain once they are pregnant, thus giving less credibility to the concept of criminalizing all potentially problematic pregnancies. It is clear that some women make good choices without being told to do so by formal social control entities.

Finally, criminalization is a reactive practice that does not get to the root cause of behavior that society condemns. It is often the recommendation of researchers to treat pregnant women with drug problems like other drug users: consider them to be ill (rather than deviant or harmful to society) and give them treatment (Farr, 1995; Hulsey 2005; Johnstone & Miller, 2008; Mariner, Glantz, & Annas, 1990; McGinnis, 1990; Nolan 1990; Paltrow, 1990). For example, Logli[2] (1990) says "society, including the medical and social welfare establishment, must be more responsive in providing readily accessible prenatal care and treatment alternatives for pregnant addicts" (p. 28). Women who are not drug users, but rather encounter concern from doctors because of medical issues, may end up avoiding medical care or even becoming adversaries with their current doctors. Stephenson and Wagner (1993) recommend that the best policies do not involve "coercive measures" but rather offer women access to medical services that they describe as "high quality and affordable" (p. 181).

[2] Interesting because Logli actually served as the prosecutor trying to secure charges against Melanie Green when her baby died (which did not happen, the jury failed to indict).

Scope of the Problem

Women's reproduction has been the subject of numerous pieces of empirical research in numerous fields including medicine, public health, sociology, law, anthropology, political science, and many others. Prominent scholars on reproduction and race, such as Dorothy Roberts, and reproduction and drugs, like Susan Boyd, address the real world and legal issues that women face as the legal and medical spheres overlap, but their work does not investigate the number of prosecutions or arrests of pregnant women. In fact, much of what we know about the magnitude of this problem comes from news articles, famous court cases, and law review articles. For example, Professor of Law at Cleveland State University, April Cherry's 2007 article on the confinement of pregnant women for the protection of the fetus is mostly (and importantly) a legal analysis and not an assessment or census of the number of women who are subjected to such provisions. Cherry's analysis depends on court cases and case studies from newspapers to show exactly how certain women's battles have gone in court when those women were faced with preventative incarceration. The thorough analysis done by Cherry is important work in understanding how the law is constructed, framed, and used against these women but it does not give us greater insight into how many women are affected or the demographics of those women. The numbers of women who are on preventative detention are hard to ascertain because of the lack of a paper trail. Some women come to detention through doctors (and therefore the legal counsel of the hospital or through social services) and others through "deals" made off of the record with judges because these women are criminal defendants and can serve less jail time (or none) in the long run if they conform to standards to keep themselves healthy and crime-free throughout the pregnancy.

The most recent and comprehensive look into this problem comes from the research of Paltrow and Flavin in April 2013. Legal expert and activist Lynn Paltrow is the executive director and founder of the National Advocates for Pregnant Women. In America, from 1973 to 2005, Paltrow and Flavin documented 413 women whose pregnancies were "a necessary factor leading to the attempted and actual deprivations of her liberty in its most concrete sense: physical liberty" (p. 301). The period of 1973 to 2005 was chosen to exclude illegal abortions that occurred before the landmark court case, *Roe v. Wade* (1973) and up to 2005 to ensure that court cases had a conclusion (i.e., no pending appeals). Paltrow and Flavin used numerous sources to obtain the cases that went into their dataset, including published works and searches of legal, medical, and news databases. Finally, they used police and court records as primary documents to corroborate facts and personal interviews with participants when other documents were missing. Paltrow and Flavin's triangulation of the facts of the cases was strong, although it is clear that cases that were not part of the published literature (published articles, and/or any of the databases) would not have made the sample. Therefore, the estimate that Paltrow and Flavin have provided is an underestimate of the number of women who have been affected by this phenomenon. Moreover, women who were confined in hospitals or charged in tribal legal courts were less likely to be part of the sample and therefore the true number is underestimated because the records of these women do not exist or are less likely to be published than women who are a part of the U.S. legal criminal system (p. 304). Paltrow and Flavin argue that while their study "undercounts" the actual number of women, this is the most inclusive study of the demographics and case histories of pregnant women who actually are criminalized (p. 305).

Of these 413 cases, 56% were from southern states, 22% from the midwest, 15% from the west and Pacific, and 7% from the northeast. One percent of the cases were considered under

federal jurisdiction. Race of the woman was identified for almost 90% of the cases (n=368). Black women, 52% of the cases, were overly represented in the sample. White women made up 41% of the sample. Women who were identified as American Indian made up 3% of the sample, as did women who were identified as Hispanic/Latina. Women labeled as Asian/Pacific Islander comprised 1% of the sample. As expected, the ages of the pregnant women fell into a well-defined range, from 12 to 43. In 60% of the cases, women were ages 21 to 30. Notably, 71% of the sample was defined as "economically disadvantaged" by the fact that they qualified for a public defender. Paltrow and Flavin found that the women in the sample did not receive automatic care for themselves, nor their fetus/child when in the custody of law enforcement. In fact, the impetus to arrest these women to get them treatment rarely resulted in said treatment. Moreover, while women all over the country have experienced these interventions, women of color who live in the southern United States are disproportionately targeted. Women who are intersectional and who already face disadvantages in general, are especially at risk of discrimination and criminalization when coupled with the status of pregnant.

Study Design

This dissertation seeks to add to the knowledge base of what is known about how and why pregnancy is criminalized in America today. This dissertation is a piece of a larger body of work that examines the structural systems of control imposed on women's bodies. By narrowing to the time of pregnancy instead of all periods during which women's bodies are scrutinized, I was able to look at how law, courts, police, hospitals, and doctors all play roles to regulate women's conduct and their bodies (which are sometimes coupled and sometimes distinct elements). To date, empirical studies on this topic as a holistic phenomenon are sparse. Studies that do try to understand the relationship between pregnancy and crime often focus on drug use,

drug testing of pregnant women, or women who are in custody and pregnant (see Levi and Waldman, 2011) but little treatment is given to the process by which this relationship is formed and almost no work has been done to think holistically about multiple kinds of problematic pregnancies. This dissertation has many goals. One is to fill in the gaps of what we know about pregnancy and its criminalization through a thorough qualitative analysis—something only partially attempted by Paltrow and Flavin (2013).

Using 26 case studies of women who encountered various forms of social control during their pregnancies, my goals were to take stock of this phenomenon, examine how it happens, and underscore the congruities through which these different methods manifest themselves. My research is largely process-oriented and qualitative. I used unobtrusive methods to gather data and open and focused coding procedures to analyze the data. Second, the dissertation pulls from many different sources of information on pregnancy, women, crime, law, and medicine. One of my intentions with the project was to seek out different angles through which pregnancy can be examined and get those literatures to speak to each other. Finally, my last purpose was to not only report the process of criminalization and explain this phenomenon, but also to use those cases to develop a framework that actually attempts to remedy the problem. In the penultimate chapter I outline ways to reconsider this problem such that fewer women will be impacted during this time in their lives through preventative, rather than criminalizing processes.

Chapter Descriptions

The dissertation is broken up into a beginning where I frame my study and explain my methods, followed by the actual data in narrative form, the analysis and finally policy recommendations and a conclusion. Taking these chapters as a whole, I argue that the regulation of bodies of pregnant women comes in many forms that stem from multiple kinds of control

agents, including medical systems and law enforcement, and that this regulation is counterproductive and could be done in a better way. Specifically, I set up the theoretical perspectives that are relevant to this project in Chapter 1. I found it useful to consider literatures on law and crime: how law both limits and creates opportunities for crime, and why those mechanisms would be relevant for the policing of women's bodies. I also consider sociological scholarly works that explore the nature of a "good" versus "bad" mother and how those expectations might spill over to pregnant women and their behaviors. In Chapter 2 I discuss the methodology, fleshing out my processes of gathering and analyzing data. Chapter 3 is the data chapter where the women's stories are presented in narrative form. I give the reader the opportunity to really see how each woman's story is unique, yet that there are patterns that undergird them even when the stories come from women who lead very different lives. Chapter 4 offers an analysis of the findings. Here I lay out how the criminalization process happens, why it happens, and what it means. First, it happens through creative use of current laws to pursue pregnant women when they otherwise might "get away" with their behaviors. Most of the women also followed the predictable pattern of being informally controlled at a hospital that led to some kind of police or judicial involvement. Generally, these processes show that women are not trusted to make good decisions, that structural problems are reduced to individual issues, and clarifying law means disruption in the lives of real women. Finally, I examine the role of the criminal justice system specifically in these cases and how it is neither effective at controlling the behaviors of the women nor helping their babies. Chapter 5 offers alternatives and policy recommendations. The major thrust of that chapter is an argument that criminalization must end now and that a preventative alternative would be more effective, but also a necessary step to uphold social justice and human rights. Chapter 6 wraps up the piece and offers suggestions for

future research. This work is largely descriptive and analytical, seeking to account for the ways that pregnancy is framed as a status to be regulated, how it turns criminal, and the forces through which it does so.

CHAPTER 1: Theoretical Framework

Chapter Overview

In this chapter I outline the theoretical perspectives that contribute to the framing of the criminalization of pregnancies. Several theoretical viewpoints guide this project. The debate on the purpose of law, the concepts of overreach of law and overcriminalization, rights discourse and the construction of problems, theories of punishment, feminist criminology, constructing bad mothers, and social control play the most prominent roles in framing the problem. These particular lenses help to define the project as a whole, bounding it in scope, while illuminating debates and conversations that are relevant to the phenomenon of criminalization of pregnancy as a matter of law, but also of practical significance for social policy.

Philosophers, sociologists, political scientists, and criminologists continue to debate which laws are necessary to regulate society and how to determine what those laws are. Many criminologists argue in favor of keeping laws that prohibit conduct that harms others; however, they would decriminalize and/or continue to keep licit those behaviors that do not harm others, even if they cause self-harm. The discussion of decriminalization of these victimless crimes (also known as vice crimes), including drug use/possession, is particularly important for this work because it includes many women who use drugs while pregnant. Some background on the necessary bounds of law is needed to thoroughly consider drug use during pregnancy.

Coupled with the appropriate scope of law must be a conversation surrounding "too much law" and what that means, especially when laws are created based on morality. Morality, an ever-evolving set of ideas about what is right and just, probably does not make for a good basis for law because it 1) excludes (and possibly oppresses) the minority, but 2) also shifts over time as society changes and deviant behavior becomes normal.

Embedded within the term criminalization is an inherent allusion to the criminal justice system. Thus, related to the scope of law, this work must be address questions of what is meant by punishment and how that punishment is meted out, but moreover, questions of suitability arise when one considers how pregnancies are actually handled in the criminal justice system's physical locations (i.e., jails, prisons, court rooms, etc.) and who is actually affected by the punishment.

Often in a discussion about pregnancy, politicians frame the issue in terms of rights. This dissertation acknowledges that that framework exists, but chooses to couch the topic in terms of a social problem that is constructed. Accepting that pregnancy regulation is a social process, it allows for understanding the impact of that regulation on pregnant women, their unborn children, other family members, and agents of social control without creating a hierarchy of deservedness.

Feminist criminology has long chastised criminologists for ignoring women and their role in crime. While both the Uniform Crime Reports (UCR) and the National Crime Victimization Survey (NCVS) reveal that women do not commit crime at the same rates that men do, excluding women from the equation completely is shortsighted and problematic. In this dissertation, at least some women are accused of committing crimes, so acknowledging the work that has been done to explore why and how women are framed as criminals is essential.

While women is the sample are not technically mothers until they give birth, some are already mothers of additional children and even for those who are going to be first time mothers, society views them as soon-to-be-mothers; therefore mother is not an unreasonable title for an expectant mother. Not all women in society are considered to be acceptable mothers, especially due to secondary characteristics like sexuality, sexual identity, socioeconomic status, and racial background. This literature acknowledges that good/bad mothers are socially constructed by

society, something that has been extended to the time of pregnancy, leading to a framing of good/bad pregnancy behavior.

Finally, social control is important for this piece as several agents of social control are called upon to regulate the acceptable behaviors of pregnant women. Also, it is important not only what happens but how the process happens. If the public only sees the results of criminalization, the end may appear natural and inherent rather than a socially constructed process and a morally divisive issue.

The Purpose of Law

Debates about which behaviors should be regulated and criminalized are commonplace in the fields of sociology, criminology, and philosophy. In the nineteenth century, one of the most influential philosophers was John Stuart Mill whose essay "On Liberty" spoke directly to the idea of limited formal social control over individuals in a free society (as cited in Meier & Geis, 2006). Mill argued that preventing harm to others must be the only reason that the state can wield power such that it curbs the free will of the public. In fact, Mill argued that neither harm to self, nor conduct that was merely seen as immoral (or offensive) to others, were good enough reasons to criminalize behavior. Prevention of harm to others would be the only good reason to criminalize behavior. Mill's work, while influential, did not lay out a specific way to determine how much harm to others would necessitate the criminalization of an activity. It is easily understood that all activities carry some risk, but it is not clear that all harms must be prevented. Salient to this work is the question of those boundaries— should we regulate harm done to others, and if so, how much harm has to be done for us to criminalize it?

Like Mill, Oberman (1992) also argues that we are using the criminal justice system to punish morality. She cites examples of women whom she argues were brought to court to

regulate their sexuality, addiction, or even their ability to become pregnant. The specific women she cites are not only pregnant women, but also women of color, young women, and impoverished women. Like Crenshaw, Oberman recognizes that pregnancy is a status that is criminalized, but also the intersections of race, age, and class complicate it, such that new, compound statuses emerge that need to be considered. This intersectionality is of crucial value when we ask if the punishments that are being doled out are fair, in that they are consistent among all types of women. In addition to punishment, we must also ask if resources and services are equally distributed among all pregnant women. Importantly for this work, it is not enough to just ask why certain women are targeted for punishment, but rather to understand whether those same women are given a chance to prevent a problematic pregnancy in the first place.

Herbert Packer (1968) frames his search for the limits of law through a discussion of morality. He agrees with Mill that harm to others is a good criterion for categorizing offenses as criminal. Packer rejects immorality as a reason to criminalize because it is not clear whose morality should dictate what is criminalized. In fact, a "harm to others" type test prevents the use of morality as the basis of criminalizing behavior. Harm to others also invites a discussion of costs and benefits, such that context and other considerations must be weighed before a final judgment of behavior as criminal can be established. Again, like Mill, Packer does not answer the question of how harmful the conduct must be to others, but he does present a very important point about the need to balance harm and freedom of conduct without making decisions about the legality of behavior based on intuition or personal feelings.

Stewart (2010), who takes a different view from Packer, argues that the harm principle, the prevention of harm through the regulation of conduct through law, should be considered

neither necessary nor sufficient as a standard for criminalization. Although there are multiple definitions, the harm principle, as applied by Stewart, cannot allow the prevention of harm to be the only motivation to make some act criminal. For example, cooking on a stove could lead to a fire, a gas leak, or burns to the chef. Heated food is not essential to human survival and stoves could cause harm, but we do not ban them nor the practice of cooking. Problematically, some crimes do not cause direct harms, yet they are crimes, like gambling, prostitution, and drug possession. What do we do with those cases? According to Stewart, the harm principle generally leaves open two ways to justify the criminalization of a behavior without direct harms: 1) find an indirect harm and 2) not criminalize the conduct at all. Stewart claims that neither of these options is all that desirable- the first takes harmless behavior and criminalizes it, but the second leaves criminal conduct legal. Stewart favors the second option because the first expands the number of behaviors that we can criminalize, does exactly what the harm principle says it will not do- makes illegal behaviors that do not cause direct harm, and finally, criminalizes "harmless conduct on the ground that it causes fear, worry, and distress in others" (p. 34). For this project, the problem with considering indirect harms is that those harms can be so broad that criminalization is no longer narrowly defined. Consider a pregnant woman who smokes cigarettes. She may be directly harming herself (and her fetus), but she is also indirectly polluting the air and possibly exposing others to second hand smoke. Where does her liability for harm to others end if we criminalize cigarette smoking? Instead of using the harm principle to decide what conduct should be considered illegal, Stewart offers the idea that all people have certain inalienable rights and that those rights should be considered before (and independently of) the rights that people have to activities that may cause harm. If people have rights to do something because of their natural rights as citizens, it does not matter if their conduct causes

harm or not, they have the right to it and the conduct cannot be rendered illegal. Also, by natural extension, if conduct infringes on another's rights, even if no harm occurs, that conduct is sufficient, although not necessary, to justify criminalization. Thus, coupling the harm principle with rights gives a foundation for criminalizing behaviors and narrows the number of behaviors that can be criminalized. For this project, reframing the discussion to include the inalienable rights of pregnant women while considering the harm done to others is particularly compelling especially as questions abound about the harms done to the fetus and the state's interest in propagation.

Overreach of Law and Overcriminalization

The debates about the proper reach of law, especially when it comes to morality, are also relevant for this project. In an early discussion, Morris and Hawkins (1972) argue that many crimes including drug use, abortion, gambling, and vagrancy are actually regulations of morality and therefore the use of the law (and eventually law enforcement) to regulate these behaviors is inappropriate. Morris and Hawkins argue that law's primary purpose should be to "protect our persons and our property" (p. 2) in contrast to others, such as Lord Patrick Devlin, who argues that law is a codification of our moral beliefs (Meier & Geis, 2006). Therefore, if law is only supposed to keep us from hurting others, it is overreaching into the private spheres when it seeks to regulate morality through control of behavior. In fact, this overreach creates more crime by 1) classifying more behaviors as criminal that would not be if they were absent from the code, but 2) producing logistic problems that help foster more crime. Examples of these logistic problems may be corruption infiltrating legitimate businesses, drug users forming subcultures, or the diversion of police to do social work activities such that they do not protect society from serious crime. Morris and Hawkins focus on crimes that are considered "victimless" such as gambling,

prostitution, drug use, drunkenness, and so forth. This point is salient for this work, as the topic of criminalization of pregnancy may reflect this same kind of overreach of law. In some cases, regulation of pregnancy is an example of the regulation of morality and determining the law's proper reach when it comes to pregnancy is something that has not been adequately explored. This work seeks to address this deficiency. Moreover, like the increase in the prisoner population and a disparate impact on men of color from our nation's "War on Drugs," criminalizing pregnancy through the use of social control agents may also have unanticipated consequences.

Sanford Kadish (1967), similarly, notes that the criminal justice system is overly used to control behaviors that are antithetical to our morality. At the time of his writing, many behaviors were illegal (e.g., homosexuality, abortion, etc.) that are now legal, but Kadish's message is still relevant: all costs and benefits should be considered before we criminalize any behavior that we wish to regulate. Without doing so, we may end up with laws that are on the books but are not prosecuted (what he calls "dead letter laws"). While this seems trivial at first glance, it could be harmful. First, laws that the legislature enacts but law enforcement does not enforce give the message to society that really the behavior is tolerable. Second, although law enforcement may not act in most cases, leaving laws on the books means they could be used in a discriminatory fashion against certain groups. Third, as the legislature adds more codes to the books, the police are left to figure out which laws are important to enforce and which are not. Kadish, like Morris and Hawkins (1972), argues that leaving it up to the police to decide what is actually harmful could leave the door open for "genuinely threatening conduct" to go unenforced or at least under-enforced (p. 157). Finally, as police are asked to wear multiple hats (e.g., law enforcer and social worker), Kadish argues that police are diverted away from protecting citizens from

crime due to the enormous amount of resources that are spent on providing social services. If Kadish is right and laws and their application are confusing to police and citizens, how can we ensure they are used in a non-discriminatory manner? For this project there is a growing concern that with so many laws on the books, it is easy to find or adapt regulations that fit our current worries about conduct during pregnancy (particularly pregnant drug use). The use of law in this way does not address root causes of the actual problem. Moreover, pregnancy requires services, at the very least basic health care and nutrition. If we use the criminal justice system to handle problematic pregnancies, we are asking an already strained system to devote more of its resources to a few women and give less resources to deal with more pressing and larger scale issues (e.g., gun crime and white collar crime). Economically we should ask if the criminal justice system is the best place to serve these women. Morally we should ask the same thing.

Finally, the present study engages with the concept that redundancies in the criminal code should be eliminated (Husak, 2008). An example of this is driving while talking on a cell phone. It is already illegal to drive recklessly. Thus, to Husak, this seems redundant; there is already a law and to add a subset to the law does not change the original law. Therefore a driver talking on a cell phone could be charged with reckless driving without the need to add a cell phone clause (because we suppose that a driver using a cell phone who is not driving recklessly is not an actual problem). He would argue that this additional law only serves to complicate the law and is actually superfluous. This work will piece together the intent of the legislature to see if it is necessary to have specific language to warn pregnant women that their conduct is illegal or whether general laws will be sufficient. For example, pregnant women who use drugs may know that they are violating drug laws, but may be surprised to find that they could also be prosecuted under child abuse statutes.

Theories of punishment

Like the overcriminalization literature, punishment literature offers an important lens with which to view the criminalization of the behavior of pregnant women. This literature suggests that defaulting to the criminal justice system creates a variety of potential unintended consequences. For example, not only are those who are legally guilty punished, but the families of those in the criminal justice system also face difficulties. Comfort (2007) describes the range of disadvantages that stem from incarceration including familial the economic pressures, the mental health of children whose parents are in custody, and the difficulties of finding of a job once back in society. Those who have been through the criminal justice system retain vestiges of that period in the form of their criminal record. This record can hurt one's chances of getting a job, which affects one's ability to provide for oneself and a family. Pager (2003) shows that generally, men are less likely to get a follow-up interview when they have a record, but that black men are at a severe disadvantage compared to whites. Similarly, Western (2006) found that once there is a record, wage levels are limited, types of jobs are limited, and wages over a lifetime have slow growth. While not directly addressed in these studies, it is important to explore how pregnant women/recent mothers who have multiple statuses, especially poor, minority, and/or single parent, would be especially adversely affected by these impacts of criminal justice processing.

One reason that is given for arresting pregnant drug users is that their arrests will lead to treatment; however, as noted above in the problem section, the criminal justice system does a particularly poor job of actually treating women once they are in the system. Similarly, von Hirsch and Maher (1992) point out that it is problematic to shift to a criminal justice system modeled on treatment alone. They raise questions of fairness and proportionality of punishment

to sentence. If the criminal justice system is a system that punishes and "condemns," (p. 27) how does one decide a sentence if treatment is the model? The sentence length rests on the ability to rehabilitate. Since one would not be rehabilitated in the same amount of time as those who commit like offenses, this leaves room for inequitable sentences. Thus, von Hirsch and Maher note that a system designed to blame/condemn is using "social and personal characteristics" (p. 28) to determine sentence length, which ultimately does not indicate to society exactly how bad we consider the behavior (assuming sentence length and harm done correlate). Thus, if we move to a model of treatment only, 1) Can we expect that pregnant women will actually get the treatment they need in a prison? 2) How do we ensure that there is no discrimination against them because they are pregnant? It would be easy to mandate jail time (with treatment) until a pregnant woman gives birth while giving a non-pregnant woman a shorter sentence. 3) Is the criminal justice system even the appropriate place for treatment to occur? Prisons inherently condemn (von Hirsch & Maher) and it is unknown how likely it would be for them to shed their natural proclivity to sanction, and transition to a treatment-only system.

Rights Discourse vs. Constructionist Perspective

Rights discourse also provides an important perspective by raising questions of how we should consider the relationship between a woman and her fetus. For some scholars, this framework of rights is useful and productive. For this paper, I avoid using rights as the sole vehicle to frame my discussion of pregnant women's needs and agency. For example, do both mother and fetus enjoy separate rights and if so, whose rights are preferred when those rights are in conflict with each other? Using the rhetoric of rights only creates a balancing test; a clear-cut decision is impossible. Using this framing, women should have the right to reproductive freedom (Smith, 2005). If women have the right to reproductive freedom, this inherently allows

for a challenge from others to their rights as well. It opens the door for the father to claim his *right* to have a child or from the fetus to assert its *right* to be born. While this particular example focuses on abortion, the rights of the fetus and the rights of the woman as a separate entity are certainly unclear and cast questions such as: who has greater need, the woman or the fetus? This potential antagonistic relationship between fetus and mother (Handwerker, 1994; Maher, 1990) creates what Johnsen (1987) calls a "new threat to pregnant women's autonomy" (p. 33). By placing the rights of the fetus in contention with the rights of the woman, Johnsen notes that there are constitutional issues present, but also that the connection of the fetus as part of the mother is denied. The two are now seen as separate entities.

Maher (1990) argues that couching women's needs as rights- rights to bodily integrity, healthcare, abortion, and so forth— we lose out on attacking the social dimensions of the problem and the best we can get is a solution based in law where there are limits to those rights. Laws can easily give women the right to things (e.g., healthcare) but they do not provide for help with logistics, transportation, knowledge, and so on. Moreover, a woman's right to something is often limited in law to whatever the government has judged is adequate for the average citizen. This may not be adequate for all women, leaving some with no help because neither law nor social institution is there to support them. Instead Lisa Maher (1990), Laura Gomez (1997), Susan Boyd (2004), and others frame their analyses in terms of how social problems are constructed. Pertinent to this work, Maher notes that a rights based analysis sees criminalization as something that stems from moral conflicts or legal entitlements and that it fails to see that criminalization is actually a response to a social problem. Since a rights based viewpoint does not consider the process through which some behaviors become criminal, it cannot ask questions

about the appropriateness of the problem being defined as criminal nor what we gain and lose from such a classification (Cohen, 1988 as cited in Maher, 1990, p. 125).

Feminist Criminology

Broadly, feminist theory identifies a gap in criminology— the lack of exploration of gender and sex roles in the crime and the criminal justice system. While there are factions within feminist criminology, and there is no specific point of view that all feminists take, the following literature is useful for considering how the criminalization of pregnancy may be conceptualized.

Law and its enforcement are considered by radical feminists to be part of a patriarchal system that is designed to keep men in power and control women and girls. Often, the system is focused on controlling feminine sexuality (Chesney-Lind, 2006). Moreover, the criminal justice system's interests coincide with those of the patriarchy. The criminal justice system reinforces class and racial privilege, which in turn maintains the patriarchy. Feminist scholars argue that research and theory should "focus" on the effects of this reinforcement by looking at intersectionality (Chesney-Lind, 2006, p. 9).

Carol Smart (1989) interprets the concept of power as being "refracted" rather than an absolute (p.97). As medical technology has developed and we know more about the way women's bodies work (and especially with regard to reproduction), we see that law's evolution is not linear, but rather that it puts forth multiple definitions (refractions), ones that control women's bodies (limits on abortion) but also allow freedoms (such as legal, early abortions). In general, law appears generous and liberal, but under its veil is an intrusion into the most private spheres of life, including regulation of the physical body.

If we consider the law to be gendered, Snider (1998) argues that laws can hurt women because the interpretation of those laws is left to those who have power and women are unable to

reframe those interpretations. She claims that "[l]aws, however complex and ambiguous, do not generally wreak havoc upon dominant groups. They are practically never interpreted in ways which threaten the rights of males or upper class people, because both dominant ideology and social practice direct judges away from this reconstruction of reality…." (p. 254). Thus, we should be concerned that for pregnant women, who are neither male, nor a dominant class, that the interpretation of broad laws may in fact hurt them. Because "[h]istory illustrates that law has generally acted to reinforce dominant gender, race, and class patterns" (Snider, 1998, pg. 246) not only does the criminal justice system continue to bolster these patterns, but also the system is designed to transform criminals into outcasts or rebels, whereby they lose their voices and legitimacy. In fact, she argues that such a system is a mechanism for social control, which changes the dynamic between those who are labeled criminals and those who are not. Snider goes further to say that we can hardly attempt to change such an inherently rigid system. Thus, the idea of transforming the criminal justice system into a system of resources or a mode of feminist empowerment is at the very least, difficult, if not impossible. This again begs the question, if the criminal justice system cannot be molded into a system of treatment or resources, should the first step of addressing problematic behaviors be arrest for pregnant women?

Most directly related to this work, Maher (1990) argues that it is both "discriminatory and unjust" to criminalize a woman's conduct during pregnancy because many poor and minority women are left without access to resources (p. 119). Maher examines the plight of women who do not have access to health care, education, or support networks. Without those resources, their choices about their behavior are limited. Maher does not include younger women (teenagers) as a category, but it is clear that these women often lack resources, especially knowledge of their own bodies, to make appropriate decisions about a pregnancy.

Not only does criminalization seem to target certain kinds of people, but also it is possible that this process intends to send a message to the broad communities of the ones who are prosecuted. For example, as certain kinds of women disproportionally come under scrutiny, Maher (1990) suggests that from a social constructionist perspective, the agenda to criminalize pregnant drug use simultaneously corresponds to society's need to "express animus, resentment, and disapprobation at women in general and, in particular… minorities, druggies, and women who fail to conform to engendered cultural expectations" (pgs. 123-124). Thus, she argues that criminalization of pregnancy fits squarely within a process to redefine "cultural and moral boundaries" (p. 123) and is a tool of oppression that makes middle class and white America feel less threatened by a class of people who continually try to exercise their right to power (p. 124).

Finally, as we consider that some pregnant women commit very serious crimes, Daly (1998) challenges feminist criminologists' thinking to not only describe women as victims of circumstance, but rather give some agency to their actions, even if it means we label them as criminal.

> Not surprisingly, initial feminist efforts to describe women lawbreakers discussed these women's acts in the context of their economic survival and their history of physical or sexual victimization. But where does victimization end and responsibility for acts that harm others begin? (Daly, 1998, p. 149)

Important for this work going forward, not all of the women in the sample are model mothers. In fact, at least one was charged with abusing her children by hitting them with a belt. Daly questions, "how should feminist scholars represent women who abuse, harm, or hurt others?" (p. 149). This works takes into consideration that real women have real problems that might engender violence. Expanding on Daly's question of harm, I ask whether there should be a

bright line drawn between women who actually harm versus women who are perceived as harmful and whether that distinction is actually practiced by those who uphold the law. Are all pregnant women painted with the same brush?

Bad Mothers

Society often assumes that women have a natural ability to nurture, so much so that it is common parlance to speak of "maternal instinct." Dorothy Roberts (1993) argues that women who are not the stereotypical mother- women who are lesbians, single, poor, or of minority status, are treated differently by the law from other mothers because the law is created and framed around the mores and norms of middle-class, white men. That difference comes from the belief that women who are not ideal mothers are not able to be rehabilitated, unlike other mothers who have been wayward and can be returned to their status as a fit mother. Moreover, Roberts explains that black mothers and white mothers are not only treated differently by authorities, but the concept of black motherhood is regarded differently from white motherhood. Roberts argues that the law couches bad mothering in neutral terms where no specific type of woman is singled out, yet certain types of women are more likely to be regulated and controlled by the criminal justice system; thus discrimination takes place not at the level of the law on the books, but when law is actually utilized against women. Likewise, Regina Austin (1989) has argued that women who commit atypical female crimes, crimes other than shoplifting or prostitution, are more likely to be seen as unfit mothers especially if those crimes run directly counter to the supposition that women are nurturers and protectors. Violence is one category of crime that is particularly "unfeminine" where women may receive harsh penalties for violating the law and violating gender norms (Richer, 2000). Additionally, the scrutiny of a woman's conduct as "ideally feminine" begins well before the woman gives birth.

Crucial to this piece, motherhood, like pregnancy, is not a static concept with an objective definition. Instead, a single mother might view her own relationship with her child as empowering, whereas society might see that relationship as lacking in advantages for the child or as proscribed for children born out of wedlock (Austin, 1989). It is possible that women who are poor, women who are unmarried, women of color, women who consider abortion, and women who are substance abusers may value their pregnancies and see them differently from others in the community and society at large who might be more apt to view these pregnant women as deviant or unworthy.

Control

David Garland (2001) argues that we adapt our social controls to fit the ever-changing nature of society, especially as economic conditions and social patterns that undergird society expand and contract. From the late twentieth century until present day, with a retrenchment to politically conservative ideology coupled with more expanded standards of personal freedoms, we have seen an accelerated use of crime control policies to enhance governmental control. This has led to harsh penalties and mass incarceration. Currently, because we have become used to the controls around us, we may cease to question the motivations and the necessity of responses of control. For criminalizing pregnancy, this is a useful framework to uncover the methods through which doctors, hospitals, police, and judges try to control undesirable situations and the pregnant women who cause them, especially when these controls are often seen as individual responses to individuals behaving badly, rather than systematic forms of punishment.

Also salient to this work, Jonathan Simon (2007) argues that since the 1960s, politicians have moved to establish the average citizen as a potential crime victim. Fear of crime rhetoric has allowed for a shift that expands social regulation from the government into other more local

bodies such as schools, families, communities, and businesses. Importantly for this work, hospitals, which are generally considered to be healthcare facilities, not social control agencies, may be filling a need extended to them through this period of "governing through crime." For example, Simon says "we can expect people to deploy the category of crime to legitimate interventions that have other motivations" (p. 4), meaning that pregnancy is recast as a crime problem, especially with regard to women who harm a fetus through drug use, when in reality the underlying motivation to regulate pregnancy may have more to do with abortion politics than the health of children. Simon argues that by framing the problem as an issue of crime, rather than a polarizing issue like abortion, there is support for legislation and acceptance of control of a social phenomenon.

Relevance

This chapter has laid out several ways in which scholars have considered, interpreted, and studied law, medicine, sociology, philosophy, and criminology that are informative to this project. Because scholars have recognized that both micro processes of how meaning is made and more macro debates concerning the proper limits of criminal law are important objectives to understanding a social phenomenon, I have purposefully kept this dissertation open to multiple lenses and fields of study. The dissertation is still bounded in scope and chooses to be informed more by some lenses than others (e.g., problem construction over rights rhetoric; limited exploration of abortion and politically charged literature). I felt that to keep this expansive view, a qualitative case study approach was best. In the next chapter I lay out my methodology: how I constructed the study, how I carried it out, and why I chose certain elements and processes.

CHAPTER 2: Methodology

Chapter Overview

In this chapter I give details about the study design, implementation, and analysis of the data. First, I outline the purpose of the project. Next, I discuss the pros and cons of qualitative research generally. Finally, I give the research questions, describe the data collection, and identify the type of data analysis. Not included in this section, but rather addressed in the final chapter is an in-depth treatment of the strengths and limitations of this particular study, including threats to internal and external validity.

Purpose

The purpose of the project is to show that the criminalization of pregnancy should be examined in a holistic context, of which only small pieces have already been done. Like a jigsaw puzzle in a box, each piece is important. Each piece contains an image, but that image is only a small part of the whole. The whole picture cannot be seen until the entire puzzle has been put together. Criminalization of pregnancy is like the jigsaw puzzle: pieces have been carved out in the medical, feminist, law, and drug policy arenas, but these works do not all speak to each other such that they form a larger picture of the problem. I seek to put together all of these snippets of the problem in a comprehensive way that explores its complexities.

Research Questions

My research sought to understand the processes, legal hurdles, and specific details of each woman's story as she came under scrutiny during her pregnancy. What was it about pregnancy that invoked the use of legal force to control a woman's body? How did doctors, nurses, and other medical professionals respond to women who had problematic pregnancies? Was it only drug use or were there other reasons that women were arrested, detained, confined,

or threatened with legal action? Mainly, I sought to uncover the ways that women came to the attention of the criminal justice system and other informal mechanisms of control. In the same vein, once I documented the processes and outcomes, I asked if there could be a better way of handling these types of cases- a way in which long term success for all people, the mother, the baby, and the public alike, could be implemented. I purposefully examined women who had dissimilar outcomes, looked at the multiple mechanisms by which they were controlled, and kept my search open to women from all different parts of the country- meaning they were subject to different laws under their particular jurisdictions, making comparison difficult. I wanted to see the underlying threads to see how all of these women's experiences were connected, but also what could be done differently to prevent and provide for better outcomes for women and children.

Case Studies

My research data consist of case studies of women who were subjected to regulation because they were pregnant. According to Thomas (2011):

> Case studies are analyses of persons, events, decisions, periods, projects, policies, institutions, or other systems that are studied holistically by one or more methods. The case that is the subject of the inquiry will be an instance of a class of phenomena that provides an analytical frame—an object—within which the study is conducted and which the case illuminates and explicates. (p. 513)

My subject is pregnancy, through which I analyze regulation of bodies by mechanisms of social control. My outcome variable was regulation, allowing for multiple definitions of that phenomenon, including arrest, confinement, judicial intervention, surgery, and legal punishment.

Researchers using case studies may feel that worried about the methodological rigor of

using a small sample size to expound upon a phenomenon. This is common and usual:

> As the design of the case study is presented often as open-ended and untethered—and methodological eclecticism is emphasized in commentary on design—researchers may feel unguided about structure: Open-endedness is extended to an unwarranted expectation of structural looseness, and, in the absence of a structure that maps out potential routes to follow, important pointers may be missed. (Thomas, 2011, p. 519)

However, because case studies do allow for an in-depth tracing of events, looking at both "within" a case (how did events play out within just one person's story and their logical consistency) as well as "across cases" where processes and outcomes can be compared among cases, the small sample size is necessary to achieve feasibility. Especially as the concept of regulating pregnancy is somewhat hard to operationalize, case studies allow for the broadening of the dependent variable, which may be hard to do with quantitative data. As well, because of the nature of case studies, their structure allows for an in-depth understanding of the paths taken to achieve a certain outcome, even allowing for different paths to lead to the same outcome. This "equifinality," allows for a researcher to better understand how a process unfolds and a better parsing out of which variables are important when noting a case's trajectory (George & Bennett, 2005). For this work, some women had very similar pregnancies and behaviors, but their regulation was very different; others had very different stories but similar outcomes.

George and Bennett (2005) explain that a case study researcher must identify the research objective with regard to theory building. I identify this study as a "Building Block" study where: "'Building Block' studies of particular types or subtypes of a phenomenon identify common patterns or serve a particular kind of heuristic purpose" (p. 76). This means that my purpose is not to test theory or only provide description of a phenomenon. Instead, I allow for

common patterns across cases that may seem dissimilar when taken separately, but speak to a larger process when grouped together. Moreover:

> Each block- a study of each subtype- fills a "space" in the overall theory or in a typological theory. In addition, the component provided by each building block is itself a contribution to theory; though its scope is limited, it addresses the important problem or puzzle associated with the type of intervention that led to the selection and formulation of the research objective. Its generalizations are more narrow and contingent than those of the general "covering laws" variety that some hold up as the ideal, but they are also more precise and may involve relations with higher probabilities. In other words, the building block developed for a subtype is self-sufficient; its validity and usefulness do not depend upon the existence of other studies of different subclasses of that general phenomenon. (George & Bennett, 2005, p. 78)

Thus, my study is not dependent on previous studies to be useful nor does it require that all cases be similar. Each subtype of outcome (e.g., criminal arrest vs. civil confinement) may not produce generalizable knowledge, but it helps to understand the phenomenon of pregnancy regulation more holistically.

Christine Williams (1991) endorses the case study method for studying women, but makes it clear that one cannot have "unbounded" case studies. One must select one's subjects carefully based on *a priori* criteria. To be included as a case study, women had to be pregnant when something happened to them because of their pregnancy or they were pregnant at the time of a crime.

Data Collection

My dissertation data have mainly come from three sources: a) published research b)

published law review articles and c) internet news sources. Using a modified snowball sampling technique, I built up the 26 case studies. Newspaper articles often mentioned one or two cases. As I researched those in depth, more cases came to light. This was also true of books and published journal articles. One famous case would be discussed in detail and that would prompt me to search for more information on that woman. As I followed up, those sources sometimes added detail to the known case, but many also pointed to a new case. I stopped adding cases when I felt that I started to see repeating patterns that were generalizable even though each woman's story was different. It is possible that there are more cases that exist that would bolster or even refute my claims. Part of the issue with this subject is that it is not exactly clear how many women are affected by these regulatory processes. After reading the stories, I imagine that many are forced into surgery, arrested, drug tested, or confined but they never go to court, hire a lawyer, contact a civil liberties group, or contact the press. These processes may go unnoticed by many as not problematic, or are regarded as things that one has no power to control. Lastly, dissertations must be completed in a reasonable number of years, and sifting through many more than a score of cases would add richness, but complicate one's ability to be finished.

I do not claim that these 26 cases are necessarily generalizable to the broader pregnant American population. I cannot even assert that these 26 cases are even representative of the 413 cases that Paltrow and Flavin (2013) found. Even though that may be true, the lives of these 26 women were impacted by their status as pregnant and rich data can be extracted from even a few cases lending support for key patterns, processes, and outcomes for those who have been criminalized during their pregnancies. I have not engaged in cherry picking (where the data I have selected specifically supports the argument I am trying to make) nor have I suppressed any details of any of the women's stories in order to make the stories fit nicely together. Any case

where a pregnant woman was confined, arrested, jailed, or legally threatened was a viable data point for this study and was included if there was enough information about her case. One case, that of Monica Morillo Gonzalez, was rejected because of a dearth of information.

Data Analysis

I used content analysis to extract meaning from my data. First I read as many accounts as I could about each woman. I then put each case into my own words, using words of the woman and those in her life (the doctor, a spouse, a child, an advocate etc.) as much as possible. After each case was written, I read and reread my data. I used each woman's story as a "recording unit, the smallest body of content (or text) in which a reference appears and is noted" (Frankfort-Nachmias & Nachmias, 2008, p. 298). Next I asked the same set of questions to each recording unit. I asked: 1) Who is the woman? (subject) 2) What is the conflict? (conflict) 3) How does the conflict unfold (process) 4) Where did the conflict take place? (location) 5) What was the resolution of the conflict? (ending) 6) What were the feelings, words, motivations, and interests of the actors in the story? (values) and 7) What goals were achieved/were attempted? (goals). Frankfort-Nachmias and Nachmias call this "'What It Said' Categories" (p. 299). Finally, I grouped the data thematically based on the answers to the above questions, specifically looking for underlying threads through multiple stories.

Being the only researcher in a qualitative study is both a benefit and a drawback for coding reliability. It is beneficial to only have one coder because all codes are consistent and there are no discrepancies (where there might be if there were two or more coders and inter-rater reliability would suffer); however, this is also where the difficulty lies. Having more than one coder or allowing a comparison between the researcher's code and that of the research subjects'

would increase the likelihood that the researcher is accurately interpreting the data and not analyzing based on her own biases and/or point of view.

Ethical Considerations

Although my data were publically available and thus the consent of my subjects was not an issue, it is still important for subjects to have privacy. Photographs of the women were not included in this project nor are addresses beyond city and state. Moreover, I was careful to note the tone and bias of each source of data so that I could assess the agenda and bias of the information.

Biases and Personal Biography

Throughout this project I had to remain aware of and check my biases and my own statuses. I am a white, liberal, heterosexual, middle class, well-educated woman who has never been pregnant. I do not face institutional racism, issues of poverty, or drug addiction. I self-identify as a critical criminologist and have a stake in seeing the criminal justice system loosen its grip on people I believe could be better served through services than punishment. By maintaining strict adherence to data inclusion criteria and coding schemata, I attempted to keep my own personal views from influencing the data and my analysis.

Strengths of Archival Research

Archival research has many benefits. First, archival data is a type of unobtrusive measure. Data are not manipulated by the researcher- the data existed in their current state before the research study began and remain after the research study has concluded. Second, research subjects cannot be influenced by researcher bias as they might be in interviews. Third, my data are publically available, which means that one can corroborate and replicate my findings with ease.

Limitations of Archival Research

Archival research suffers from multiple forms of censorship. Because I used newspaper accounts, court cases, and published works, there were limits on the amount of space that was used to examine and explain each of the women's stories. Second, while quotes from the women did accompany many of the newspaper stories, official court case records and previously published works often summarized details, editing the history and not allowing the woman to make meaning of it herself.

The Case for Qualitative Research on Women

Daly and Chesney-Lind (1988) suggest that because of the focus on men in past research on crime, we must start over to understand how women fit into the equation of crime. Moreover, it is not sufficient to just add in women to what we already know. The feminist analysis specifically revolves around the claim that gender is a social and complex phenomenon that is rooted in biological sex and reproductive ability, although not defined by it, such that just adding in women would not fully capture the process or the intricacy that women and their place in the social structure add (Daly & Chesney-Lind, 1988). Thus, they suggest that until the 1980s there was restraint on delving in depth into the lives of women and girls. It is clear that feminist theory and criminology have both come far since the 1980s, but the topic of regulating women by the status of pregnant is current and needs to be fleshed out. For example, Purvi Patel was sentenced to 20 years in prison when she did not properly seek medical care to either end her pregnancy or save her baby when she did give birth. Patel's case made national news as women began to worry about how they themselves might be regulated just like Patel. First, these cases are actually important to the everyday woman and scholars who study women's issues should be leading the charge to find out why this regulation is happening and what can be done to fix it.

Moreover, these cases are not isolated events. If the media is the only entity that takes up the mantle to report these plights, when the next big news story hits, the problem will fade from the country's consciousness and the opportunity to see significant patterns will be lost. It is therefore the job of scholars to find and understand big social problems, including how women's bodies are regulated in multiple ways.

CHAPTER 3: The Women's Stories

Chapter Overview

My task for this chapter is to give details of the lives of some of the women affected by regulations, policies, and laws when these women were pregnant. Many women came under scrutiny for using drugs and others for merely seeking care while pregnant. My first goal of this chapter is to acquaint the reader with the stories of the pregnant women. I provide "facts"[3] rather than commentary in this chapter in order to paint a picture of these women's paths to regulation.

I present 26 stories in this chapter. To make them manageable and organized, I have grouped them by several analytic themes. Each theme speaks to the conflict that brought about the regulation of the pregnant woman by an authority. All of the conflicts ended with some kind of initial regulation, but the actual process for each woman was different. The conflicts are broken down into the driving force of the case- why the woman was regulated. For example, some cases are primarily about cesarean sections, while others are about the death of a fetus or infant. The timing of regulation also differed for each type of case. Some women were regulated well after the conflict took place, others immediately after the conflict was identified. Below, I give a brief introduction to each theme, but largely allow the reader freedom to read each story without much commentary. Many of the women's stories could fit in one or more of the themes that I have developed below. I have purposefully chosen what I consider to be the most important point of that story and placed it with stories that have the same message, but in the chapter that follows I will preserve the fluidity of each story, allowing them to overlap and

[3] Facts are often subjective and vary according to the person or document telling the story. I have tried to triangulate data to provide the most accurate description of events.

speak to one another. In the analysis chapter I report trends, processes, outcomes, legal issues, and medical ramifications at work in the lives of pregnant women.

Death of the fetus

This first theme encompasses the women whose babies were stillborn. Each woman was blamed for the death of her fetus and charged with a type of murder or feticide (the willful killing of a fetus). These women were accused of committing the most heinous crimes of the sample: culpable homicide, homicide by child abuse, depraved-heart murder, and feticide.

Nina Buckhalter (2009)

At 31 weeks pregnant, Nina Buckhalter gave birth to a daughter, but she was stillborn. She was indicted by a grand jury for "culpable-negligence manslaughter" where Buckhalter was charged that she:

> did willfully, unlawfully, feloniously, kill Hayley Jade Buckhalter, a human being, by culpable negligence, contrary to and in violation of Section 97-3-47, of the Mississippi Code of 1972, as amended; against the peace and dignity of the State of Mississippi. (*State v. Buckhalter*, 2013).

The indictment did not specify that she had taken drugs or how Buckhalter had killed her daughter.

The Supreme Court of Mississippi found two things: 1) This was an inappropriate charge because Buckhalter should have been charged under another specific criminal statute about pregnant women who take drugs. She could only be charged on the manslaughter charge if she could not face another charge and the Supreme Court of Mississippi concluded that she should have been charged under two other sections of 97. Specifically, 1) Section 97-3-3: "Any person wilfully [*sic*] and knowingly causing, by means of any instrument, medicine, drug or other

means whatsoever, any woman pregnant with child to abort or miscarry . . . shall be guilty of a felony unless the same were done by a duly licensed, practicing physician" or 2) Section 97-3-19 (1): "The killing of a human being without the authority of law by any means or in any manner shall be murder . . . (d) when done with deliberate design to effect the death of an unborn child." The state court did not address whether Buckhalter could be the killer of her own fetus in the manner described by the manslaughter statute. The statute states that manslaughter occurs through the actions of "another." This issue remains in Mississippi: Can a pregnant woman be considered the "another" who kills her own fetus?

This case ended by affirming the lower court's ruling, the indictment against Buckhalter was dismissed even though the issues brought forth by both the state and the appellee were not addressed. Buckhalter could still be indicted again with different charges from before, especially ones that were specifically spelled out by the state court as acceptable.

Rennie Gibbs (2006-2014)

In 2006, Rennie Gibbs, a 16-year-old, gave birth to a stillborn child. The child was born with her umbilical cord wrapped around her neck. The post-mortem showed that the child had traces of byproducts of cocaine in her system, although cocaine itself was not present. Gibbs was charged with "depraved-heart murder." Mississippi Code § 97-3-19-1 (b) states:

> 1) The killing of a human being without the authority of law by any means or in any manner shall be murder in the following cases: (b) When done in the commission of an act eminently dangerous to others and evincing a depraved heart, regardless of human life, although without any premeditated design to effect the death of any particular individual.

This is a second-degree murder charge and can carry a penalty of up to life in prison.

I could not find out what happened between 2006 and 2014, (it is possible that she was imprisoned) but she went in front of a judge on April 3, 2014 and her case was dismissed. Citing precedent established in *State v. Buckhalter (2013)*, the case was thrown out, but Gibbs could be retried if indicted on separate charges (not unlike Buckhalter, herself).

Regina McKnight (1999-2008)

Regina McKnight, 22, homeless and with an IQ of 72, gave birth to a stillborn baby girl on May 15, 1999. She weighed 5 pounds and was between 34 and 37 weeks old. The baby had benzoylecgonine in her system. The pathologist who testified in the case stated that the only way for that substance to be in her system was through cocaine use. McKnight was charged with homicide by child abuse. According to the court case, Dr. Proctor, a criminal pathologist, examined the baby. By South Carolina law, a viable fetus is considered a person, therefore the charge of homicide was applied instead of the charge of feticide, for which McKnight may or may not have been eligible depending on the prosecutor's interpretation of her drug use. At her first trial the jury could not decide in one day and was sent home. Some members of the jury researched medical conditions at home and a mistrial was declared. There was a second trial. She was found guilty in a half an hour by the jury and sentenced to 20 years in prison, eight of which were suspended. McKnight had no criminal record prior to this conviction. Upon appeal, the court decided that the PCR (post-conviction relief) court had erred such that the new court granted relief to McKnight based on her ineffective assistance of counsel where her counsel could have argued that other factors had caused the stillbirth. Convicted in 2001, McKnight's relief came in 2008, seven years into her 12-year sentence.

Purvi Patel (2013)

Purvi Patel, 33, of Indiana went to the hospital with heavy bleeding. After questions from the hospital staff, Patel admitted to giving birth to a baby and discarding it in a dumpster. After a search for the body of the dead fetus, police interrogated her in her hospital room after surgery was performed to remove the placenta. Patel claimed that the baby was born dead (i.e., a stillborn). There was controversy at the trial about the state of the baby at birth (i.e., alive or dead). One expert testified that the fetus was only 24 weeks at the time of birth and therefore not viable. Another expert claimed the baby was born alive and took at least one breath. It is clear from medical science that there is great dispute among pathologists about how to tell if a baby were alive at birth via the lungs. One test used at the trial was the "floating lung test" which has not been clearly established by medical science as a valid test (and may be subject to an appeal via *Daubert v. Merrell Dow Pharmaceuticals* (1993) or incompetence of counsel claim for not adequately challenging the test). The prosecution argued that had the baby been born alive, Patel did not do enough to save it.

Second, Patel lived in a household where she hid her pregnancy from her parents and her father even testified at the trial that he taught her not to have sexual intercourse until marriage. Patel testified that she panicked when the baby was born dead. Not knowing what else to do she wrapped the body and threw it in a dumpster behind a local store.

Finally, Patel ordered abortifacients from Hong Kong according to text messages that she exchanged with a friend. At the trial one medical professional testified that had Patel taken the drugs, but there was no evidence in her toxicology screen. Another medical expert testified that the drugs she did order would only be effective in aborting a pregnancy if Patel were nine or fewer weeks pregnant. Clearly, if she had tried to abort the baby herself, she was unsuccessful. She was still found guilty of feticide. Feticide in Indiana is:

> A person who knowingly or intentionally terminates a human pregnancy with an intention other than to produce a live birth or to remove a dead fetus commits feticide, a Level 3 felony. This section does not apply to an abortion performed in compliance with…. (Indiana Code §35-42-1-6)

The prosecutor claimed that she was guilty if she had tried to "terminate" the pregnancy, regardless of her success. This does not comport with the actual legal language.

Patel, who was sentenced to 20 years in prison on both the neglect and feticide charges, is currently in prison waiting to appeal. She was sentenced to 30 years for felony neglect, but 10 of those years were suspended. She is also serving a concurrent sentence of six years for feticide. Her appeal will be handled by those who work on cases of wrongful convictions (Chowdhury, 2015).

Drug deliverers

Two of the four women in this section could have easily fit into the category above—they had babies who died; however, all of the women in this section had babies who were born alive, making them distinct from the stillborn cases above. All four women faced sanctions, but less severe charges than the ones above. The cases below turn not on the outcome of the baby (dead or alive) but rather on the conduct of the mother, specifically, her drug use. Each case is framed based on drug use as means to deliver drugs to the fetus/child.

Melanie Green (1989)

In February 1989, 24-year-old Melanie Green of Illinois and her newborn girl tested positive for cocaine. According to the pathologists at the hospital, the placenta had ruptured due to cocaine use and the fetus was deprived of oxygen before and during the birth. The lack of oxygen caused the brain to swell and the baby died after two days of life (Logli, 1990). On May

9, 1989, Green was charged with involuntary manslaughter and delivery of a controlled substance. The Grand Jury declined to indict. Reasons for a failure to indict are secret (as well as Grand Jury deliberations), thus, we do not know why Green was not indicted.

Amanda Kimbrough (2008)

Amanda Kimbrough had her third child at age 28. Her son, Timmy Jr. was born on April 29, 2008, prematurely. At 25 weeks and 5 days of gestation, Timmy Jr. weighed only 2.1 pounds and lived for only 19 minutes. The court documents detail the day that Kimbrough went into labor. She experienced labor pains and went to the hospital even though she was preterm. Her doctor diagnosed her with said preterm labor and "occult cord prolapse." This means that the umbilical cord enters the birth canal ahead of the fetus thereby cutting off the blood flow. The doctor also ordered a urine test to screen for drugs. Her test came back positive for methamphetamine. The doctor and her husband both questioned her about drug use during pregnancy but she denied it to both men.

After undergoing a c-section, Timmy was born but complications were present. Timmy was not breathing and his heart rate was low for a newborn. Hospital staff performed CPR to the point where he was stable enough to be intubated. After intubation, Timmy's condition deteriorated and he died. The pediatric doctor thought that Timmy died of "respiratory arrest secondary to prematurity" (court document, p. 8) (which makes sense that his lungs were not developed enough to sustain his life) but the medical examiner determined that Timmy died of "acute methamphetamine intoxication" (court document, p. 8) when she performed the autopsy. Methamphetamine was present in Timmy's blood and liver at the autopsy.

Kimbrough's two children were immediately removed from the home and placed with the children's maternal grandmother when Kimbrough tested positive at the hospital. No date was

given in the court report. Allegedly, Kimbrough admitted to the social worker that she had smoked meth with a friend three days before she had the labor pains. In July 2008 the children were returned to their home and to Kimbrough's custody when the Department of Human Resources (i.e., child protective services) determined that the kids would be safe in her charge. The New York Times article says that Kimbrough was only allowed supervised visits of her children while they were with their grandmother and that Kimbrough was required to attend parenting classes and drug treatment. These statements do not appear in the court report.

In September 2008, after the birth and death of her son, Kimbrough was charged with violating Code, §26-15-3.2 (3): Alabama's Chemical Endangerment Law, where the language for her offense reads, "Violates subdivision (1) and the exposure, ingestion, inhalation, or contact results in the death of the child. A violation under this subdivision is a Class A felony." Kimbrough would not have been charged with violating this law if she had not been pregnant. Facing a penalty of 10 years to life, Kimbrough pleaded guilty at the behest of her lawyer and received the minimum sentence of 10 years.

Particularly important to the case, Kimbrough argued multiple times that the definition of the word "child" in the law should not have included her fetus. Kimbrough claimed that she was not given notice that the law was employing an expansive definition to include born and unborn offspring, thus violating her due process rights. Ultimately the Supreme Court of Alabama did not agree that the word child was vague.

Two poignant pieces of information from the New York Times article are: 1) "There have been approximately 60 chemical-endangerment prosecutions of new mothers in Alabama since 2006, the year the statute was enacted. Originally created to protect children from potentially explosive meth labs, Alabama's chemical-endangerment law prohibits a 'responsible person'

from ‘exposing a child to an environment in which he or she . . . knowingly, recklessly or intentionally causes or permits a child to be exposed to, to ingest or inhale, or to have contact with a controlled substance, chemical substance or drug paraphernalia’” (Calhoun, 2012) and 2) “Criminal convictions of women for their newborns’ positive drug tests are rare in other states, lawyers familiar with these cases say. In most places, maternal drug use is considered a matter for child protective services, not for law enforcement” (Calhoun, 2012).

Hope Ankrom (2009)

On January 31, 2009, Hope Ankrom, 26, gave birth to a son. She tested positive for cocaine before the birth and her son tested positive for cocaine after he was born. Records from the doctor and self-report to the Department of Human Resources caseworker established that Hope had used marijuana. The doctor’s records showed cocaine use through the pregnancy, but Hope denied cocaine use to the caseworker. She was arrested on February 18, 2009 and on August 25, 2009 a grand jury indicted her for violating the Alabama’s chemical endangerment law. She was denied her motion to dismiss the case (by the trial court on October 15, 2009) and pled guilty to the charge on April 1, 2010. She was sentenced to three years in prison but ended up with a suspended sentence and one year’s probation.

Importantly, it was in the motion to dismiss that Ankrom argued that the term “fetus” never was intended to mean “child” in the chemical endangerment law and that it shouldn’t apply to her because her fetus was not a child, it is against public policy, she was not accorded fair notice that her conduct was illegal because the statute did not specify a fetus, and that the state could have, but refused to, include language in the statute that specifically addressed the harm of a fetus as part of the chemical endangerment law. The court reasoned that none of the above mattered, rather that because her child was born and tested positive after being born, this

counts as delivering drugs to a child. Note that her conduct before she gave birth resulted in her delivering drugs to child through her umbilical cord. Had the baby been born dead, it is not clear that she could have been charged. This seems to present an equal protection violation, because women who engage in the same conduct while pregnant, namely taking drugs, would have charges brought only if the baby died. This is not consistent with other types of laws regarding harm to individuals. Neither the defense nor the court addressed the issue of harm. It is not clear that the conduct (taking drugs) produced harm to the fetus/baby.

Jennifer Clarice Johnson (1989)

Florida resident Jennifer Johnson, 26 at the time her conviction was vacated, a black woman, was charged with delivering drugs to minor children (Boyd, 2004). The delivery allegedly happened between the time that she gave birth and before the umbilical cord was cut. The "delivery" occurred through the umbilical cord. Johnson was charged for using cocaine and subsequently delivering that cocaine through her blood into both her son (born in 1987) and daughter (born in 1989) through the umbilical cord. Both children tested positive for cocaine and Johnson admitted to using before the births (Lewin, 1992). Testimony indicated that there was about 60-90 seconds between the birth and the severing of the cord in the case of both babies. It is clear that Johnson had a drug addiction. It is also clear that she was forthcoming about her drug use and sought help for her fetus on at least one occasion after she became worried about her drug use during her pregnancy. It is possible that Johnson did pass the drugs onto both babies, but the manner in which the drugs passed was likely during gestation, not actually from the time of birth to the cutting of the cord. Johnson was found guilty of two counts of drug delivery and sentenced to 15 years of probation in July of 1989 (Lewin, 1992). The Fifth District Court of Appeals affirmed the decision in April 1991 (Lewin, 1992). In July 1992, the

Supreme Court of Florida concluded that a) the legislature had never intended for delivery of drugs to a minor to occur in this manner, and there is no precedent for blood flow that one cannot control (i.e., intent to deliver) and b) laws that are unclear must be interpreted loosely in favor of the accused, rather than strictly where the favor is for the state, and c) that it is unfair to treat drug use during the birthing process as criminal when drug use during a pregnancy (i.e., in utero) is not a criminal behavior. Moreover, the court suggested that should it be of interest to the state to include pregnancy in the definition of the illegality of delivering drugs to a minor, the law needs to be amended to clarify their stance on pregnancy transmission.

Repeat offenders: Unresolved underlying issues

The two women in this section have slightly different stories from the rest of the women. Both women had past encounters with the criminal justice system and their pregnancies, while relevant, were more at the periphery of their stories than the other women in the sample. Johnson went to court and had her fertility regulated seemingly because she was pregnant and had a past with child abuse. Greywind, a repeat offender, was charged with reckless endangerment for sniffing paint, lost custody of the rest of her children, was a repeat drug offender, and was homeless. These women are not *ideal* mothers and are likely the some of the least sympathetic of sample. The regulation that occurred did not get at the root of many of the issues that each woman had, especially violent tendencies, drug addiction, and lack of shelter.

Darlene Johnson (1990-1991)

I was unable to secure the case (*People v. Johnson* (1991)); however, I was able to glean several facts from published sources. Johnson, 27, was pregnant when charged with child abuse from beating two of her four children with a belt. She was sentenced to use a hormonal birth control implant rod, Norplant, that is injected into the arm of a woman. At the time of Johnson's

hearing, the drug had been recently approved by the FDA. The condition to use the birth control as part of her probation came as a surprise to both Johnson and her lawyer as it was not part of the plea bargain to which she had agreed (1 year of jail and 3 years of probation). Johnson's lawyer was not present for her sentencing because he felt that the terms were clearly specified and allowed a colleague to take his place. Johnson agreed to the jail, probation, and implant sentences at the sentencing, but her lawyer returned and tried to vacate her acceptance based on the fact that she probably did not fully understand about the drug and that she was diabetic and therefore not necessarily a good candidate for this drug. Her retraction was denied by the sentencing judge. She appealed the denial and was waiting for the appellate hearing when she was caught[4] using cocaine. She was sentenced to prison for five years and her probation was revoked. The Court of Appeals (California) was never able to review this issue or deliver an opinion.

Martina Greywind (1992)

Martina Greywind, 28, a homeless American Indian woman, was arrested on February 7, 1992 in Fargo, ND. She was charged with reckless endangerment for sniffing paint. She was approximately 12 weeks pregnant. Importantly, Greywind had several children who were previously taken from her by the state. On February 10, 1992 she pled guilty without a lawyer. She was sentenced to 9 months on a state prison farm in order to participate in a chemical dependency program (*State v. Greywind*, 1992). Greywind became embroiled in a battle for her fetus. There were multiple parties who were interested in whether she kept or aborted her fetus.

[4] I use the term "caught" here, but I am not sure if she came forward about her drug use or if she was suspected of it by her probation officer and somehow it was shown that she had used cocaine (i.e., actual drugs found, toxicology screen, lie detector test, suspicious behavior, alert by another ("snitch"), or other means. The point is that the reader should pay less attention to the word used to express her capture and more to the fact that she went to prison for her drug use.

Members of the religious group Lambs of God were in jail with Greywind and found out about her pregnancy. The group then a) offered her money to bail her out if she kept the baby and b) filed a petition to have her brother declared her legal guardian. The result of the petition was decided by a judge but the parties were told not to disclose the result. Part of the affidavit that the brother provided included facts that Greywind had been abusing drugs since the age of 10 and she had been arrested a dozen times in the past year.

Kolata (1992) reports that she faced 1 year in prison and a $1000 fine. On February 12, 1992 she withdrew her plea because her lawyer claimed that she did not understand the charge. She pled not guilty. A judge allowed her to leave the jail to go to a medical appointment (or appointments) to have an abortion. On March 30, 1992 she filed to drop the charges. The assistant prosecutor did dismiss the charges with prejudice (meaning that she cannot be retried for this offense), stating:

> On February 10, 1992 [Martina Greywind] was charged with the offense of Reckless Endangerment, a class A misdemeanor. The defendant has recently undergone treatment at the North Dakota State Hospital and is presently in custody at the Cass County Jail on a subsequent and pending charge of Inhalation of Volatile Chemicals in violation of N.D.C.C. Section 12.1-31-06. Defendant has made it known to the State that she has terminated her pregnancy. Consequently, the controversial legal issues presented are no longer ripe for litigation. Further, the likelihood of this extreme factual situation recurring is limited. In the interest of preserving limited prosecutorial and judicial resources, Plaintiff hereby moves to dismiss the Complaint in this action with prejudice. (*State v. Greywind*, 1992)

Confined against their will

The women in this section faced confinement in hospitals, treatment programs, and jails. In this section, it is clear that the purpose of confinement was for the protection or best outcome for the fetus, even if against the woman's wishes. Moreover, at least one woman was confined even though no actual problem had been corrected; her regulation was based on rules rather than context.

Kari Parsons (2005)

In 2005 in Maryland, Kari Parsons, a convicted shoplifter, was sentenced to probation that included mandatory drug screens. Once she tested positive, the seven-month pregnant woman went in front of a judge who placed her in jail for the protection of her fetus. Three weeks later Parsons gave birth to her son alone in a jail cell. Parsons knew that she was in labor and the other women helped time her contractions. After she repeatedly asked for transportation to a hospital, the guards placed Parsons alone in a cell. The cell contained little more than a toilet and bed without sheets. She gave birth alone. She and the baby were healthy, but her son developed an infection because of the dirty conditions of the cell. Obviously, the judge's concern for her fetus was ignored in practice.

Julie Starks (1999)

"Julie Starks, a twenty-five-year-old white pregnant woman in Oklahoma, was arrested in a trailer that was allegedly being used, or that had once been used, to manufacture methamphetamine" (Paltrow & Flavin, 2013, p. 318). As per the Supreme Court of Oklahoma facts, Starks was arrested for production and possession of methamphetamine. She and the father of her unborn child were both arrested. His bail was set at $25,000 and hers at $25,000 and raised to $200,000. After the raise in bail, an emergency hearing was held where Starks was without counsel. The trial court initiated the hearing and it was used to determine the custody of

Starks' fetus. Because the fetus was viable, and the state has an interest in the survival of a viable fetus, the state (the trial court) took temporary, emergency custody of her fetus. After some more hearings (attempts to vacate the judgment and bail decrease) it was confirmed that not only was the fetus in the custody of the Department of Human Services, but that should Starks post bail, she might be placed in a foster home and/or in a secure birthing facility for the actual birth. Additionally the state filed a petition to name the fetus as "deprived" (i.e., abused, neglected, or abandoned) under Oklahoma Children's Code.

"While incarcerated in the county jail, Starks experienced dehydration and premature labor, developed urinary tract infections and sinus problems, and lost twelve pounds" (Paltrow & Flavin, 2013, p. 319). She spent more than a month in jail before the bail was lowered (Paltrow & Flavin, 2013).

The Supreme Court of Oklahoma reduced her bail to the original amount (equal to that of her male companion) and found that the order that she give birth in a secure facility to be "an unauthorized application of judicial force" (court opinion, paragraph 6). The trial court then held another hearing where it imposed other restrictions on Starks should she post bail (urine drug tests at random times, disclosure of current residence, drug and alcohol "assessment," and at least one pre-natal visit per week). They also continued to maintain that DHS had custody of her fetus.

Starks' baby was born on November 2, 1999. On November 3, the trial court placed the baby in DHS custody. On November 12, the DA changed the petition to say that the infant (rather than the fetus) was a "deprived child" based on the Oklahoma Children's Code and it was all based on Starks' conduct on August 23, 1999, the date of her arrest. A jury found her guilty of depriving her child, even though no evidence of deprivation since the birth was presented.

The court found that the Oklahoma Children's Code cannot apply to a fetus- regardless of whether it is viable or not. They based their decision on the interpretation of legislative intent and the definition of child as it had been applied to laws and court cases before (*stare decisis*).

Rachael Lowe (2005)

Rachael Lowe, 20, went voluntarily to get treatment for her Oxycontin addiction at Waukesha Memorial Hospital in Wisconsin. She was reported by medical personnel at the hospital under the "cocaine mom law" where:

> An order of the judge if made upon a showing satisfactory to the judge that due to the adult expectant mother's habitual lack of self-control in the use of alcohol beverages, controlled substances or controlled substance analogs, exhibited to a severe degree, there is a substantial risk that the physical health of the unborn child, and of the child when born, will be seriously affected or endangered unless the adult expectant mother is taken into custody and that the adult expectant mother is refusing or has refused to accept any alcohol or other drug abuse services offered to her or is not making or has not made a good faith effort to participate in any alcohol or other drug abuse services offered to her. The order shall specify that the adult expectant mother be held in custody under s. 48.207 (1m).

From there, she was taken to St. Luke's Hospital (an hour from her residence) and detained in the psychiatric ward against her will. She remained there for 12 days before a hearing was convened. She was prescribed drugs in the ward and not given an appointment to see an obstetrician. She was apparently being treated for her substance abuse although prescribed more drugs (anti-anxiety, sleeping pills, and nasal congestion relief). She was eventually released and required to "provide urine samples and to cooperate with law enforcement and health

professionals" (Paltrow and Flavin, 2013, p. 307-308). Also Paltrow and Flavin indicate that the husband had to take time off to deal with this situation and she actually lost her job.

Alicia Beltran (2013)

On July 18, 2013 Alicia Beltran from Wisconsin was arrested when she was 14 weeks pregnant. Taken from her home to a holding cell and later in shackles to family court, Beltran was told that her doctor and a social worker had spoken and were worried about Beltran's former Percocet addiction. She was given a prescription for Suboxone, a treatment for opiate addiction. Beltran said that she could not afford the prescription and instead got some from a friend. By taking the prescribed drug and stepping down her dosage, she weaned herself off of medication altogether. At that appointment Beltran tested positive for some of the Suboxone, but no other drugs. Later, her urine tested negative for all drugs. After her appointment, the social worker came to her house and told her to restart the anti-addiction treatment (Suboxone). Beltran claimed that she was free of the addiction and did not want to recommence treatment. Two days after the visit, she was taken into custody. She was charged with endangering her fetus by not going on an anti-addiction drug. At the hearing, an obstetrician made a statement that Beltran "exhibits lack of self-control and refuses the treatment we have offered her." This doctor did not meet Beltran prior to issuing that statement in court. Further, the doctor said, "The child's life depends on action in this case."

Beltran, 28, was confined for 78 days in a drug-treatment center. At the court, she asked for a lawyer, but was not given one. Her fetus was appointed a guardian ad litem. She was confined under Wisconsin's "cocaine mom" law (see above in the Lowe case) where any pregnant woman who does not conform to alcohol or drug standards (meaning she takes drugs or

alcohol “to a severe degree” or does not attend treatment) can be legally confined against her will.

Beltran lost her job and was scared: “this is supposed to be the happiest part of my pregnancy, and I’m just terrified” (Eckholm, 2013).

Samantha Burton (2009)

At age 26, Samantha Burton was on her third pregnancy. Burton, not exactly a model pregnant woman, had a hard time giving up smoking during her pregnancy. At 25 weeks she experienced pre-labor pains and was sent to a hospital to be examined. Once the pregnancy was stabilized (such that she did not give birth early) Burton was ordered to remain on bed rest at that hospital for the remainder of her pregnancy. Burton neither liked her physician at the hospital nor did she consider this advice practical given her status as mother and employee (Fish, 2010). The hospital stepped in to make sure that she did not leave and a lawyer on behalf of the hospital contacted a judge to get a court order that she remain. The court agreed that Burton should stay at the hospital, submit to treatments and procedures, and not be allowed to change hospitals or seek a second medical opinion. After three days of confinement, Burton miscarried and she was released.

Burton appealed the decision of the emergency trial court even though her claim about confinement was now moot. In a 2-1 decision, the District Court of Appeal of Florida, First District found that the State of Florida had indeed not proven its claim of compelling interest such that it violated Burton’s rights and reversed the trial court’s decision.

Florida precedent, *In re Dubreuil* (1994) suggests that women may not be compelled to submit to medical procedures to save their own lives. The Dubreuil decision hinges on multiple factors not present in this case (such as the life of the pregnant women was in jeopardy, the child

was already born when the medical action was taken against Dubreuil to save her life, and the argument was whether she should live or not to take care of her children) nevertheless, this precedent is key. Dubreuil coupled with Burton's constitutional right to refuse medical attention, made it clear that the trial court erred. First, for a state to have a compelling interest in the life of an unborn child such that it overrides the pregnant women's constitutional rights to bodily integrity and decision-making, the fetus must be viable. The state made no such claim of viability at the trial. Even if they had, they would still have to pursue action that would affect the pregnant woman's rights as little as possible. With no comment, the court found that the state had not correctly balanced the interests of the state against the rights of Burton and reversed.

Treatment by their own rules

All of the women in this section fit into at least one other section, especially Laura Pemberton who fits into the category of compelled surgeries (see below). This category specifically speaks to how pregnant women might delay medical treatment or choose alternative birth scenarios that go against customary medical advice. Here, I have highlighted the women's unwillingness to follow directives that led to their regulation.

Pamela Rae Stewart Monson (1987)

A white woman from San Diego, Pamela Stewart Monson, age 27 in 1987, was charged with "failing to summon medical" attention promptly when she went into labor (Chambers). Ignoring the advice of her doctor, Stewart Monson used amphetamines, had sexual intercourse with her husband, and delayed getting medical attention when she started bleeding. She waited about 6 hours to go to the hospital. Stewart Monson's son was born with brain damage and did not live for more than two months. Stewart Monson was charged under California Penal Code Section 270, which reads:

If a parent of a minor child willfully omits, without lawful excuse, to furnish necessary clothing, food, shelter or medical attendance, or other remedial care for his or her child, he or she is guilty of a misdemeanor punishable by a fine not exceeding two thousand dollars ($2,000), or by imprisonment in the county jail not exceeding one year, or by both such fine and imprisonment. If a court of competent jurisdiction has made a final adjudication in either a civil or a criminal action that a person is the parent of a minor child and the person has notice of such adjudication and he or she then willfully omits, without lawful excuse, to furnish necessary clothing, food, shelter, medical attendance or other remedial care for his or her child, this conduct is punishable by imprisonment in the county jail not exceeding one year or in a state prison for a determinate term of one year and one day, or by a fine not exceeding two thousand dollars ($2,000), or by both such fine and imprisonment. This statute shall not be construed so as to relieve such parent from the criminal liability defined herein for such omission merely because the other parent of such child is legally entitled to the custody of such child nor because the other parent of such child or any other person or organization voluntarily or involuntarily furnishes such necessary food, clothing, shelter or medical attendance or other remedial care for such child or undertakes to do so.

Further:

Proof of abandonment or desertion of a child by such parent, or the omission by such parent to furnish necessary food, clothing, shelter or medical attendance or other remedial care for his or her child is prima facie evidence that such abandonment or desertion or omission to furnish necessary food, clothing, shelter or medical attendance or other remedial care is willful and without lawful excuse.

The Municipal Court Judge dismissed the charges determining that the law (above) under which she was charged, was improperly applied— it was meant for collecting support from absent spouses, not to be used against the pregnant woman herself. The spirit of the law was largely about money, not medical attention.

Melissa Ann Rowland (2004)

In 2004, Melissa Rowland, 28, was charged with first-degree murder for delaying a c-section that might have saved the life of one of her twin children. Rowland did seek care and obtained medical advice about how to proceed with giving birth. She refused that advice that she sought. The doctor recommended an emergency c-section because of low amniotic fluid and poor fetal vital signs. For about two weeks Rowland continued the pregnancy without surgery. On January 13, 2004 she consented to the surgery where the female twin was born alive and the male twin was a stillborn. The daughter tested positive for cocaine and alcohol. Rowland willingly gave up the daughter for adoption; one report even indicates that that is the reason she went to Utah—their lenient adoption statutes (Pollitt, 2004).

Medical examiners testified that had the surgery been scheduled for earlier in January, both twins would have survived. Rowland was charged with murder of the stillborn male due to her apparent indifference for his wellbeing (instead of being charged with manslaughter). This was not Rowland's first time in court. She had been adjudicated for larceny and child endangerment in her past. Despite her record, because of her mental illness (Rowland had been diagnosed with oppositional defiant disorder) and her suicide attempts in jail, the prosecution dropped the charge in exchange for a plea bargain. By pleading to a lesser charge of two counts of child endangerment, Rowland was able to leave jail and serve out a term of 18 months of probation. Rowland was also compelled to go to drug treatment.

Laura Pemberton (1996)

Laura Pemberton, a white resident of Florida, had a c-section with her first child and the complication of the c-section incision (vertical and quite deep compared to the more standard horizontal one) made it so that no doctor would agree to allow Pemberton to try a vaginal birth after cesarean (VBAC) with her second child. After attempting a home delivery with a midwife, she became dehydrated. She tried to get fluids at the local hospital but the doctor she saw refused to help her. "Dr. Thompson declined to assist in that plan by ordering only an IV and instead notified hospital officials of the situation. Hospital officials set about securing additional opinions from board certified obstetricians Dr. A.J. Brickler and Dr. David R. O'Bryan, the chairman of the hospital's obstetrics staff. Dr. Brickler and Dr. O'Bryan each separately concurred in the determination that a caesarean was medically necessary" (*Pemberton v. Tallahassee Memorial Regional Medical).* Both doctors asserted that a vaginal birth would be significantly risky, possibly causing uterine rupture and the death of the baby.

The Pembertons returned home without care. In Florida, a procedure cannot occur without a patient's consent unless a court orders it (due process is a requirement) so the hospital called a judge to come and rule. A hearing began without the patient present and the judge ordered that she return. Pemberton was escorted by a police officer and a person working with the hospital against her will (in an ambulance). The hearing then resumed at the hospital. She was given a chance to speak to the judge, but no lawyer was provided. She was compelled to have the c-section. Paltrow and Flavin (2013) note that she gave birth to three more children after this event via VBAC. They note the grossly exaggerated danger she faced— she and her children survived the subsequent vaginal births.

Three years after the surgery, Pemberton sued the hospital seeking damages from the hospital in federal court. The hospital moved for summary judgment and the District Judge granted summary judgment in favor of the hospital.

Seeking help

This section encompasses the women who needed assistance but were criminalized instead. Their stories include regulation after a home accident, domestic violence, a miscarriage, an ectopic pregnancy, and suicide. All spent time in jail. One woman even died because she did not get adequate care. The following stories emphasize suspicion and/or concern for rules over compassion for the women and their circumstances.

Diane Pfannenstiel (1990)

Pfannenstiel, 29, was charged with drinking while pregnant and prosecuted for felony child abuse in 1990 in Wyoming. Pfannelstiel, who was 4 months pregnant at the time, returned home from an alcohol rehabilitation program and her husband assaulted her (Goodman, 1990). She left home and contacted a local group that helps domestic violence victims. The group brought her to the hospital because they felt that it was important that her injuries be examined. Due to her intoxication, she was arrested and jailed. Later she was charged with felony child abuse for drinking alcohol. At trial the judge did dismiss the charges (Roth, 2000) but she did serve at least a day in jail during the arrest and her husband served no time for beating her. The judge dismissed the charges because the prosecution could not show that harm had come to the fetus (Lewin, 1990). At the time (and as far as I know now), drinking while pregnant was not a crime in Wyoming and Pfannenstiel was old enough to legally drink alcohol.

Michelle Marie Greenup (2004)

Michelle Marie Greenup, a 26 year old black woman from Louisiana, was charged with second degree murder and jailed after going to a hospital where she complained of pain and bleeding. After questioning her, doctors suspected that the baby had been born alive. She was then questioned by police and finally told them the baby had indeed been born alive. In reality, she had miscarried and her fetus was only 11-15 weeks old. That fact was only established after her counsel obtained her medical records while she was in jail. It could be that her birth control shot ("Depo-Provera") caused the miscarriage- as it can after being given to someone who is pregnant. Greenup pled guilty to violating the public health law about disposing of human remains. This is a misdemeanor. Paltrow and Flavin (2013) make it clear that this public health law was not designed to be used against pregnant women after a miscarriage.

Bei Bei Shuai (2010)

Bei Bei Shuai, a resident of Indiana, was pregnant and recently upset by the breakup with her boyfriend, the father of the unborn child. On December 31, 2010, after her boyfriend left to return to his wife, Shuai attempted suicide by ingesting rat poison (Pollitt, 2012). Her friends rescued her before she died and she was hospitalized. Shaui was 33 weeks pregnant. The baby was delivered by c-section, but died a few days later.

Shuai continued treatment in the hospital for depression/mental health issues after the baby died (Rovner, 2012). Once Shuai was released she returned to her life and work. In March 2011 she was arrested for attempted feticide and murder. On Friday, August 2, 2013 a plea deal was reached such that Shuai pled guilty to criminal recklessness (Turner, 2013). Her sentence carried a 178 day jail term, but since Shuai got credit for the 435 days that she served, she was released from jail (Turner, 2013). The original charges of murder and attempted feticide would have carried a penalty of up to 65 years in prison (Turner, 2013).

Christine Taylor (2010)

In 2010, at age 22, Taylor fell down the stairs of her home in Iowa. She called paramedics. She was checked out by the medical professionals and cleared but she chose to go to the hospital to make sure that she and the baby were both okay. While in the hospital she allegedly admitted to the nurse (or doctor) that she was estranged from her husband and that she had considered aborting the fetus or giving up the baby for adoption. She felt that a third child might be too much to take care of as a single mother. She claimed that she changed her mind and wanted to keep it. Police were called and interrogated her. She was charged under Iowa's feticide law for "attempted feticide." She spent two days in jail. Taylor was in her second trimester, not her third so the law was not applicable and charges were dropped. Three weeks after the arrest, the prosecutor claimed that it was the hospital doctors who erred in determining how far along she was.

Jamie Lynn Fisher Russell (2013)

In Pauls Valley, Oklahoma, Jamie Lynn Russell (also known as Jamie Lynn Fisher (her maiden name); Russell will be used in this document) went to the emergency room complaining of pain. A report states that she was in so much pain that she could not lie down and asked for pain medication. News articles report that she was considered combative by the staff. As such, the hospital labeled her uncooperative and a nurse asked a police officer to help. The hospital asked her to leave and the officer helped her to pack her belongings and found pill bottles containing controlled substances (Oxycodone (opioid, a pain medication), Alprazolam (generic of Xanax, an anti-anxiety medication) that were not prescribed to her. A family member did say that the pills were the medications of a different family member and the officer noted it, but arrested Russell anyway claiming that he did not have time to investigate the matter. Russell

was arrested for possession of a controlled, dangerous substance. According to the law firm hired by Russell's family to investigate this matter, Russell was drug tested upon admission to the hospital and the tests came back negative. The hospital did release her (considering the whole reason the officer was there was to help her leave anyway), stating that she was "fit for incarceration" (Kemp, 2013). Russell was placed in a holding cell in the jail and found unresponsive two hours after she was booked. She was taken back to the hospital that had released her where she died the next day. The medical examiner ruled that the cause of her death was an ectopic pregnancy. Russell was 33 and the mother of a 10-year-old son. After the Oklahoma State Bureau conducted an investigation, no criminal charges have been filed nor are charges expected to be filed in the future.

Unwanted surgeries

In this final section, each woman was compelled to undergo surgery. Two of the three cases involve a cesarean surgery where the woman and the baby lived. One case involves cesarean surgery where neither the mother nor the child survived.

Angela Carder (1987)

Angela Carder had cancer when she was a teenager. In remission, at age 27, Carder married and became pregnant. At 25 weeks of pregnancy, doctors found an inoperable tumor in Carder's lung that would kill her. Carder agreed to have life promoting treatments done to extend her life so that her fetus would have a chance at being viable (being able to live outside of the womb). Her condition deteriorated more rapidly than the doctors expected and in her 26th week a c-section was needed to deliver the baby. The hospital asked for a court decision about whether to perform the c-section because Carder could no longer make her wishes known. A doctor testified that the fetus had a 50-60% chance of survival if the c-section were performed.

The court granted the c-section on the grounds that without knowing what Carder wanted, and the baby being viable, it was enough that the District of Columbia (Washington D.C.) had a compelling interest in saving the life of the unborn child. Angela Carder's baby died two hours after the surgery and Carder herself died two days later.

Evidence from the facts presented at the trial show conflicts between how much Carder wanted treatment for herself and for her child. Since her tumor was inoperable, she was able to have chemotherapy and other treatments that would harm her fetus. The trial revealed that she wanted medications to keep her comfortable even though they may have harmed the fetus. Also, Carder first accepted the court order for the c-section but then suddenly changed her mind and mouthed that she did not want to undergo the procedure. It is possible that the c-section hastened her death. Eventually, the District of Columbia Court of Appeals heard the appeal and found that if a patient cannot make a decision about her own medical treatment (in this case Carder was too sedated to do so), a process called substituted judgment may be used ("substitute itself as nearly as may be for the incompetent, and ... act upon the same motives and considerations as would have moved her" (*in Re AC* (1990)). Basically, someone must act as a proxy for the person who cannot chose for herself. The court acknowledged that this is often used in cases where the patient would prefer to die (known as "right to die"). The court vacated the ruling and remanded the case back down to be tried again.

Jennifer Goodall (2014)

Goodall, a 29-year-old Florida mother, had three previous cesarean section surgeries (c-sections). The trouble started when Goodall entered into her fourth pregnancy and wanted to try to have a VBAC instead of defaulting to a c-section. Women who have had c-sections in the past are often counseled to have them again (for both medical reasons and convenience),

although a trial of labor after cesarean (TOLAC) is recommended by the America College of Obstetricians and Gynecologists for women with low risk factors and at medical facilities that can provide emergency surgery should it become necessary. Goodall was allegedly counseled at her medical appointments to schedule a c-section even though she wanted to do a trial of labor (the process of trying a vaginal birth, that if successful leads to a vaginally born baby (vbac)). To be clear, Goodall was not a patient who thwarted her doctors at every turn or made rash decisions. Instead, she rationally considered the available research and her options. She released a statement saying, "My decision to allow labor to proceed before consenting to a surgical intervention is based on years of research, careful consideration of the risks to me and my baby, and my family's needs. All I want is to be able to go to the hospital when I'm in labor and have my medical decisions respected -- and my decision is to proceed with a trial of labor and not have cesarean surgery unless some medical complication arises that makes cesarean surgery necessary for my or my baby's health" (Mosbergen, 2014).

On July 10, 2014 Goodall received a letter written by the CFO of her hospital that sums up conversations that she had had with her doctors about intentions she had for her delivery and her refusal to schedule a c-section. The letter also contained three paths of action that the hospital intended to follow after her case was reviewed by the hospital's Ethics Committee. One, the hospital was going to contact the Department of Children and Family Services about her refusal to undergo the c-section. Two, the hospital was going to ask a judge to intervene to decide about her treatment and care. Three, should she go to that hospital while in labor, a c-section would be performed with or without her consent. Goodall changed hospitals and was able to try a trial of labor that she did eventually abandon for a c-section because the labor was not progressing.

On Saturday, July 26, 2014 Goodall posted to her Facebook the following message: "This was all I wanted to begin with. I am grateful to the medical staff at another hospital who assisted us in a safe and healthy delivery. Now, my family's focus is on welcoming our newborn into our family with love, and on my physical and emotional recovery from the intensity of the last few days." (Gluck, 2014; Mosbergen, 2014).

Lisa Epsteen (2013)

Lisa Epsteen, 35, was pregnant with her fifth child in 2013 in Florida. Tuesday, March 5, 2013, Epsteen was past due and went in for a checkup. Her exam showed that the fetus was in distress and that both the mother's condition (gestational diabetes) and the fetus' position made her a good candidate for cesarean surgery. As well, Epsteen's previous births were by c-section and although Epsteen had wanted to do a VBAC (vaginal birth after cesarean) she agreed to go in on Friday, March 8 for a planned c-section. Her concerns about doing it on Tuesday were twofold: 1) she was driving the only family car and was not sure how her husband would get to the hospital and 2) her child would have no child care if she had to give birth right then. The language of the article does not make it clear whether the child was with her and she would not be able to get him/her to a stable location or if the child was already being cared for by someone else in another location and it would have been a problem for the caregiver to retain temporary physical custody of that child. Either way, her concerns, while ordinary, were important as Epsteen made her decision.

Wednesday she had an email from her doctor, which provided both a level of concern about her fetus and a threat with action by law enforcement. The email read: "'I am deeply concerned that you are contributing to a very high probability that your fetus will die or your child will incur brain damage if born alive. At this time, you must come in for delivery. I would

hate to move to the most extreme option, which is having law enforcement pick you up at your home and bring you in, but you are leaving the providers of USF/TGH no choice'" (Stein, 2013). Epsteen's response was to get the National Advocates for Pregnant Women (NAPW) involved. The NAPW had a lawyer return an email to the doctor that told him to cease his threats against Epsteen.

"'Honestly, I feel abandoned. There has to be a level of trust between provider and patient, and that has been betrayed,' said Epsteen, who said she now fears returning to USF and Tampa General for her planned delivery. 'It's circumstances like this that make women feel like they have no options but to birth their babies on their own — and put themselves in more dangerous circumstances — because they feel bullied'" (Stein, 2013). Epsteen in her own words felt 1) abandoned, 2) betrayed, and 3) bullied by a doctor which seems to go against their medical ethics of not doing harm. The case ended with her having the c-section surgery on Friday as planned where she gave birth to a healthy 11-pound boy.

CHAPTER 4: Analysis of the Regulatory Process

Chapter Overview

This chapter takes stock of the cases and the patterns that undergird them. As I described in Chapter 3, the women's stories are all different, but several themes and patterns flow through them. These underlying themes appear again and again throughout the cases, manifested in different scenarios, such that we should be concerned about how pregnant women are treated in American society.

In this chapter I lay out the processes by which several different kinds of pregnant women have been regulated. At first blush, some of their stories seem too disparate to have anything in common other than that they involve pregnant women, but that is actually only one very basic pattern that applies to them. In this chapter I first explain how this regulation manifests itself in most cases showing how both status and the medical system are key players in how a woman begins the process of regulation. Next I move into questions of why this regulation happens, noting several consistencies among their stories, and finally I move into questions of what this actually means and why we should care.

How? Pregnant Status Offenses

As I have noted above, obviously, the data all contain women who were pregnant. More important than just this fact, that status has an active part in how the women were actually regulated. This is not necessarily worrisome on its face: society may wish for pregnant women to be treated differently from the rest of the population. Women who are pregnant may need specific services, help, treatment, and so forth such that differential treatment may not a bad thing. What is worrisome is the sort of treatment that actually results when pregnant women are targeted. The main way I see this regulation by status as problematic is what I call "creative

criminal justice." Using coercive powers that are delegated to them, such as arrest, charging, bail, and sentencing discretion, criminal justice entities were able to selectively target pregnant women for excessive or distinct punishment based on status.

Creative criminal justice. First, Julie Starks was not arrested for her status of pregnant; she was arrested just like her male companion for drug possession and drug production. This seems fair and unbiased at first glance, but her status mattered greatly in the way she was treated once she was in the criminal justice system: her bail was raised to an amount eight times that of her non-pregnant companion even though they were arrested at the same time in the same location. Immediately after her bail was raised, a hearing was held for the custody of her fetus. It is very clear that the state took an interest in regulating Stark due to her pregnancy and not because of her specific crime or past offenses.

Alicia Beltran, who did not break the law, was arrested for failing to take an anti-addiction drug after she had *already* beaten her drug addiction. Even though Wisconsin has the "Cocaine Mom" law that allows for the legal confinement of a pregnant person if there is severe drug or alcohol use, Beltran did not qualify to be arrested under this law because she had stopped taking drugs. Creatively, she was charged with endangering her fetus by not taking the prescription drugs and a doctor whom Beltran had never seen testified against her at her hearing giving references to her character that could not be substantiated. As a society we should worry that a person can be arrested for failing to take prescription drugs, even if those drugs are for the benefit of the woman and her fetus. In general, people do not always make the healthiest choices for themselves when it comes to exercise, healthful foods, and nutrition, but American culture allows for us (and often encourages us) to decide what we do with our bodies. Even the right amount of exercise or which foods are healthful are debated by experts and often requirements

vary from person to person. There is no one size fits all model of health. Taking this a step further, we know that prescription medications may cause harmful side effects and that only after weighing those effects with the purpose and need of the medication, should a doctor and patient make an informed choice about usage. Moreover, it is not clear that in this case that those drugs would have benefitted Beltran or her fetus and it is contrary to the medical ethos of "do no harm" to require that a person take legal drugs that are not helpful to a person's wellbeing. Here, Beltran was regulated by the medical system because she was pregnant, but the reason that she ended up in a drug treatment center was not due to her need for treatment, but because her doctor and a social worker mobilized the formal use of the criminal justice system- an arrest coupled with expert testimony that she could not contradict. It is very likely that had Beltran not been pregnant, medication and confinement would not have been forced on her. Finally, there is an argument to be made that Beltran's status of pregnant determined her legal intervention forcing her to take prescription medication. The Cocaine Mom law cannot be used against non-pregnant people, but moreover, there are only limited populations who are forced to take medication- children, those in psychiatric care, those in prison, and those in the hospital, but Beltran was arrested and forced to take prescription medication when she was not a criminal, sound of mind, and rid of her addiction. There are many reasons that we do not want precedent that forces people to take medication through court order. First, even after extensive testing, not all prescription medications are safe, not all people will remember to take their medications, some will take them improperly, not all people can afford prescription medications (including Beltran herself), and ultimately, it is an overreach of government power to tell people which substances to ingest for their health. Law is largely proscriptive, thus the government telling people *what not to do* is normal, but mandating that someone ingest prescription medication is an overreach

of the law that should only be reserved for the most serious of cases where a severe mental illness has been diagnosed or criminal guilt has been proven.

In Laura Pemberton's case, the hospital used the criminal justice system to make sure that a police officer took her into custody so that she would have to attend a hearing (as mandated by the state for any procedure that is not agreed to by the patient) so that Pemberton would be forced to deliver her child by c-section. While not the most egregious use of the criminal justice system, it is problematic that a hospital would send police to a patient's home in order to make sure that the hospital was conforming to the guidelines of the law. Of course hospitals and doctors need to protect themselves from lawsuits, but here we have a case where the letter of the law is upheld, but not the spirit of it. This use of law enforcement to make sure that Pemberton had her "fair" hearing should be concerning to us because the hearing itself could never be fair. First, Pemberton did not have access to legal counsel, but more importantly she could never be in a position to adequately speak on her own behalf. She was under duress (i.e., labor and forced relocation to the hospital). It is clear that once she was forcibly removed from her home and taken to the hospital, a chain of events began that proposed little chance for Pemberton being able to choose the manner in which she gave birth. Do we want to live in a world where hospitals and police decide our medical care for us?

Jennifer Clarice Johnson was charged with delivering drugs to her newborn children via the umbilical cord moments between birth and the severing of the umbilical cord. This is the most creative charge of the sample because Johnson could not be a drug deliverer to minors while she was still pregnant and once the cord was clamped, she would no longer be responsible for any drug transmission that was done through bodily exchange, thus the only choice the prosecution had was to charge her with drug delivery during the 60 to 90 seconds that the

children were alive but not yet separated from her. This case is worrisome because the charge is so specific in nature (i.e., after birth, before clamping) but there is little evidence that can be used to verify this process and it used a perverted definition of drug deliverer, inconsistent with the intent of the legislature. This case is problematic because it looks like the justice system went out of its way to try to pin something on Johnson when no other criminal offenses seemed to fit. This case reads almost as a vendetta that her drug use during pregnancy could not go unpunished. First, Johnson sought help during her pregnancies for her drug use- clearly she was not negligent. Second, Johnson's status as a drug user neither prompted help nor action against her while she was not pregnant. Once she was pregnant and continuing to use drugs, still nothing was done. When she was ready to give birth there was a distinct shift in the attention she received. On both occasions, the doctors quickly acted to test the infants for drugs. Thus it was the presence of a potential life that prompted action, not a concern for a current life: a person who needed (and asked for) help. The lesson that the public takes away from this case is that babies' lives matter more than other bodies' lives do. If one is a drug user and not pregnant, nothing is done. Once a fetus or an infant is involved, formal mechanisms of social control grind into gear in ways that penalize the pregnant body. The pregnant person suffers a formal punishment that the non-pregnant body does not. We should be wary of a criminal justice system that seeks to scrutinize our every behavior in order to accuse us of breaking the law, especially if a reading of that law is twisted to create a transgression. Ideally, Americans are entitled to the predictability of law. Pregnant women should not be an exception to this principle. Even more noteworthy, related to status, pregnant bodies should not be more monitored than other bodies for the same behaviors and issues (e.g., drug addiction) for the purposes of punishment or to shore up the collective conscience. Pregnant women do face

increased surveillance because of very public, physical changes, but also because many seek medical care as they navigate nine months of these changes. These codified penalties and punishments attached to behaviors during pregnancy and the additional chance of detection creates a situation where a pregnant person can be at the mercy of the doctor or law enforcement when she does something that is judged to be not in the best interest of the fetus.

Finally, the most telling example of this regulation by status theme is the creative use of sentencing by the judge in Darlene Johnson's case. Johnson's case is not about her pregnancy per se, but rather the active sentencing condition that she not become pregnant again. Beyond the personal medical implications for Johnson, it is inappropriate for a judge to regulate the fertility of an offender even when she is clearly not a good parent. First, judges are not equipped to prescribe a medical device or medication; this is out of the purview of their duty and expertise. Second, it is unclear if the judge would have sentenced her to birth control had she not been pregnant at her sentencing hearing, but even if her status of pregnant did not dictate this creative addition to her sentence, her status as a potential pregnant woman certainly did. Arguably, this control of fertility also applies to Purvi Patel who was sentenced to 20 years in prison. Should she serve the full sentence, Patel will be 53 when she returns to the civilian life. One consequence of such a lengthy sentence is that it is likely that she will not be able to conceive another child at that age. The prison sentence effectively curtails her ability to ever become a biological mother. Both of these cases call attention to the fact that the criminal justice system, whether purposefully or by collateral consequence, is actually determining that there are some women who are so unfit to be mothers that if we sentence them to a long enough term or demand that they use birth control as part of their probation, we will not have to worry about them fulfilling that undesirable role of bad mother. Both cases present dangerous precedents for

problematic women who come after them. These future pregnant women may actually turn out to be decent mothers but need a second chance and/or help, but may not get what they need to be successful. Giving the criminal justice system the power to regulate fertility through punishment is a very scary prospect indeed. Should Americans see this power as legitimate without considering the sexist and racist implications of these punishments, it becomes the latest manifestation of patriarchal control of women's bodies and certainly has ties to the vestiges of slavery where regulation of the fertility of bodies of color was common (Roberts, 1997).

Clearly, regulation by status is present in all of the cases. Thus, regulation by status is a clear and obvious theme that brings all of these cases together, but more important questions about why this happens and what it means remain to be answered. Regulation by status is only the *beginning* of the story. I suggest that while I explore several different questions related to the process of regulation in this section, this regulation by status is a very important variable and for those scholars interested in women's treatment by social institutions, this is a tactic that is used to promote conformity to rules and laws.

How? Hospital-to-Prison Pipeline

The second obvious pattern in the data was that virtually all of the cases in my study included a visit to a hospital or doctor that prompted law enforcement action. Only four women, Greywind (directly arrested on the street for sniffing paint), Darlene Johnson (arrested for child abuse), Starks (directly arrested for manufacturing/possessing methamphetamines), and Parsons (failed a drug test while on probation) came to law enforcement attention without going to a hospital or doctor first. While these women are not a part of the hospital-to-prison pipeline, it should be noted that if one were to view this as a broader category of tracking the behavior of women by social control agents, Parsons would qualify because her behavior was monitored as

part of her probation. Therefore, since the justice system is so intrinsically linked to the medical realm in most cases, it is problematic to separate these two spheres of influence.

A critique that is often levied on the school-to-prison pipeline is that police and school resource officers are used to respond to disciplinary issues that have traditionally been handled by teachers and administrators (Simon, 2007; ACLU, 2016). The same kind of critique can be applied to what I call the hospital-to-prison pipeline. First, doctors and hospitals are quick to mobilize law enforcement agents, particularly police and judges without thinking about the ramifications of that referral. This played out in especially harsh ways for Jamie Fisher Russell and Diane Pfannenstiel. Second, it is clear that this quick use of law is inappropriate and shortsighted. Hospitals and their staff should not practice law, take law into their own hands, or do anything beyond their medical competency especially when they are ignorant of the letter of the law.

Arguably, Russell is probably the most gripping story of how not to treat an ill person. Russell was seeking treatment for pain and could not relax enough to get a proper diagnosis. There are many things that the hospital staff could have done to help her be less combative other than involve security which would not have resulted in them turning her away from receiving a diagnosis and/or treatment. Mechanisms like pain management, help from family to calm her, anti-anxiety drugs, a friendly staff person who could comfort her, and other measures could have been utilized before police were asked to escort her out. If her behavior had continued to escalate and police were absolutely necessary, once controlled substances were found in her possessions she was not in a position to defend the pill bottles due to her pain. At that point, a reasonable guardian should have been appointed so that she could receive medical care and the issue of arrest could be handled at a later date. The hospital could have retained custody of

Russell while the police officer spent time investigating the pill possession. It is possible that Russell was the legal or de facto guardian of a family member for whom the medications were prescribed. It is not unreasonable to expect competent adults to handle medications of those who cannot: such as children, the mentally disabled, and the elderly. A family member did say that the pills were those of another family member. Had there been an investigation, a reasonable answer to her possession could have been substantiated. Russell paid for the hospital's quick dismissal of her symptoms with her life.

Pfannenstiel, who lived through her experience, had similarly horrifying treatment. I do not know the exact nature of how the hospital staff treated her (it is possible that they were pleasant and respectful to Pfannenstiel) but they took a woman who had been injured by her spouse and contacted police because she was pregnant and drunk. The hospital staff had a duty to examine and treat Pfannenstiel's injuries inflicted by her husband, her intoxication notwithstanding. It is inappropriate to refer drunk or high patients to law enforcement unless those patients are a danger to themselves or others and even then a hospital can serve as a secure facility to correctly decide how to handle the person. Even if the hospital personnel felt that Pfannenstiel had harmed her fetus by drinking, they would have been the ones who could intervene with medical techniques to try to mitigate the damage. Jail cells cannot and will not help fetuses.

It should strike reasonable citizens as a miscarriage of justice that an abused person spent a night in jail awaiting adjudication after seeking medical treatment for injuries. Medical doctors are not legal experts who know when their states require them to drug test or report when they suspect their patients of drug use. The 2016 Guttmacher Institute report details how pregnant drug use is codified (criminal, child abuse, or legal grounds for civil confinement), what must be

done when the drug use is suspected (report and/or test), and available treatment for pregnant drug users (targeted treatment programs, priority admission into established general drug treatment programs, pregnant women considered a protected class who are not allowed to be discriminated against in admission to drug programs funded by public monies). Only 15 states require reporting when drug use is suspected. Of those states, only three require drug testing. One state, Kentucky, requires testing but not reporting. All told, 16 states require testing, reporting, or both. It is clear based on this small sample of women that doctors do not know the law and routinely and inappropriately default to using law enforcement help for women with addictions to both legal drugs (i.e., prescription pills, alcohol, and cigarettes) and illicit drugs.

This automatic application of an unnecessary system does have practical and legal implications for women. Consider Christine Taylor who confided in the nurses and doctors at the hospital that she had considered options other than keeping the baby because of the economic and practical concerns of being a single mother of three. After her arrest Taylor was detained for two days and eventually the charges were dropped. She will always have the arrest on her record unless she files paperwork and pays money to have it expunged. This small mistake by hospital staff may cost Taylor economic troubles such as the loss of her job or government assistance and could make her more estranged from her community, neighbors, family, and friends.

Why? Women are not Trusted to Make Good Decisions

In the last chapter I established that the regulation of pregnant women occurs under a variety of circumstances such as during the actual birthing process, through routine medical examinations, during scheduled surgeries, and through various interactions with doctors, social workers, nurses, and other care givers; interactions that often lead to criminal justice involvement in some form. This section begins the exploration of the question of what the data

reveal about why this regulatory process is happening. Again, because each case has different circumstances, is located within different jurisdictions from the others, and involves women who come from a variety of socioeconomic and racial statuses, these underlying threads are not due to one causal variable or isolated to one kind of woman. Rather, this theme that women cannot be trusted underpins several of the stories and speaks to why this type of regulation is so compelling to many agents of social control.

Miscarriages. First, it is very concerning that there is not a clear message throughout the country as to what women should expect when a miscarriage occurs. Miscarriages are not uncommon. The rate is approximately 15-20% in women who know they are pregnant (U.S. National Library of Medicine, 2016). This is likely a conservative estimate, because miscarriages probably do occur to women who do not know that they are pregnant. Therefore the rate of miscarriages among all pregnant women is likely higher. Miscarriages are defined as the loss of a pregnancy before 20 weeks of gestation, but most miscarriages occur before week 13. This is why there is a culture of silence surrounding pregnancy announcements. Women are cautioned to keep news of a pregnancy within a small circle of family members until the beginning of the second trimester when the danger of miscarriage has passed. Stillbirths are rare, but not unheard of. According to the World Health Organization, the recommended definition of a stillborn is a baby born without life signs or a baby born after 28 weeks of gestation without life signs. Approximately 1% of pregnancies in America end in a stillbirth, averaging about 24,000 babies per year (MacDorman & Gregory, 2015). In total, "there are more than 1 million lost pregnancies each year in the United States" (MacDorman & Gregory, 2015, p. 1). From 1995 to 2013, the stillborn rate for non-Hispanic, Black women was approximately twice (or more) than that of non-Hispanic White women (MacDorman & Gregory, 2015) Thus, there is

evidence that miscarriages and stillbirths do affect a significant percentage of pregnant women; therefore, it should not be shocking to doctors to have patients who experience a pregnancy loss. Moreover, even though the rate of stillbirths is low, the fact that a Black woman is at least two times as likely to have a stillbirth than a White woman suggests that a doctor should not be suspicious about having more Black patients who suffer miscarriages than White patients.

Several of the women in the study miscarried or had stillborn babies. Many women make good decisions when it comes to getting help for a spontaneous abortion- they seek medical attention when they notice symptoms of a miscarriage, like bleeding or pain; however, not all women may handle stress and scary medical situations in a calm manner. Medical research is still unable to predict which women will have stillbirths, although we now know some factors that are associated with them.

> The NIH network researchers also found that most stillbirths could not be accounted for by pregnancy history and other maternal characteristics at the time the women in the study learned they were pregnant. However, the researchers found that some characteristics were associated with an increase in risk for stillbirth. These include a previous stillbirth, being a first-time mother, a history of miscarriage in earlier pregnancies, gestational diabetes, AB blood type, drug addiction, smoking three months before getting pregnant and maternal overweight and obesity. The researchers could identify a probable cause of death in 61 percent of cases and a probable or possible cause of death in 76 percent of cases. (NIH, 2011)

Thus, it is not a rare occurrence, but it is also hard for doctors and women to know whether they will experience a miscarriage or a stillbirth. Because women do not expect this outcome, some women panic or handle the situation in a way that seems cruel, such as Purvi Patel's discarding

of the body of the stillborn baby in a dumpster. We can condemn Patel and claim that at 33 years old she should have known to call 911 and seek medical help. It is reasonable that Patel's age makes us less sympathetic to her reaction, but her familial situation was extreme. She was employed by and living with her family, yet acting contrary to their expectations and wishes. It is possible that when the baby was born dead that she hoped to preserve the fiction that she was following the rules outlined by her family of not having sex before marriage; after all there was nothing that could be done for the baby and it is not clear that Patel would have any means of financial support or housing if her family disowned her. Patel's story expresses a need for both more cultural understanding of pregnancy as an unhappy event for some such that abortion and adoption are necessary services, but also for good doctors who can not only identify physical needs for the pregnant woman and her fetus, but also things that they may need to have a healthy baby that are beyond medical care including a supportive environment and shelter.

Even women who do the right thing and go to professionals for help may be criminalized. Michelle Marie Greenup sought medical attention when she experienced pain and bleeding. Greenup was pressured by police to admit that she had given birth to a live baby even though in reality she had had a miscarriage. Even after being arrested, jailed, and having the charges dropped, she still had to plead guilty to violating a human remains disposal law. This raises several concerns. First, this law was not meant to be used against pregnant women (Paltrow & Flavin, 2013) but second, how do women know what to do if they do have a miscarriage at home? Is it the responsibility of a pregnant woman to anticipate that she might lose her baby and have a plan if that reality unfolds? It seems likely that should society deem miscarriage and stillbirth education to be so important, the burden actually falls on the medical system to tell patients what to do and whom to contact. We do not criminalize people when they have

emergency medical events like strokes and heart attacks, why should miscarriages be viewed differently?

Legislators certainly are interested in codifying miscarriages. Representative Bobby Franklin of Georgia presented a bill (HB1) in 2010-2011 to curtail abortions by focusing on what he called "prenatal murder."

> "Prenatal murder" means the intentional removal of a fetus from a woman with an intention other than to produce a live birth or to remove a dead fetus; provided, however, that if a physician makes a medically justified effort to save the lives of both the mother and the fetus and the fetus does not survive, such action shall not be prenatal murder. Such term does not include a naturally occurring expulsion of a fetus known medically as a "spontaneous abortion" and popularly as a "miscarriage" so long as there is no human involvement whatsoever in the causation of such event.

It is clear from Franklin's wording that natural miscarriages would not be criminal, but how would one establish that a miscarriage had no human involvement? Would all miscarriages be investigated? This bill did not pass. Before Franklin's bill, Senator Mark Obenshain of Virginia introduced SB 962 in 2009, a bill that actually spelled out what must happen in the event of each miscarriage. The bill would require that any miscarriage be reported to the police. A summary of the bill reads:

> Requires that when a fetal death occurs without medical attendance upon the mother at or after the delivery or abortion, the mother or someone acting on her behalf, within 24 hours, report the fetal death, location of the remains, and identity of the mother to the local or state police or sheriff's department of the city or county where the fetal death occurred. The bill also specifies that no one shall remove, destroy, or otherwise dispose

of any remains without the express authorization of law-enforcement officials or the medical examiner, and that a violation of this section is a Class 1 misdemeanor.

Like Franklin's bill, this bill also did not pass, but the fact that two state legislators in two states have recently tried to tie miscarriages to abortions shows legislators are interested in investigating miscarriages to make sure that they are not abortions.

It is a slippery slope to investigate and criminalize all miscarriages. First, because it is a common event, investigations will tie up resources. Second, medical professionals and researchers are not really sure why women have miscarriages, investigating all of them may not provide answers and might cause more suspicion on the woman and her actions during the pregnancy. Third, it may be emotionally traumatic for a woman to relive the miscarriage if it was a wanted pregnancy. Finally, it calls into question what might be gained by the knowledge of the cause of expiration- do we arrest the woman, make her go on mandatory birth control, monitor her every behavior while pregnant in the future? It is unclear what the purpose and consequences would be if investigations became mandatory, possibly with detrimental and deterrent effects to women.

C-sections. Not all of the women in the data set committed a crime or were investigated for a crime. Some women were just trying to have their babies and were subjected to regulation by doctors. This section unpacks how women's bodies were regulated through coercion and threats.

First, women in the sample were not always given a choice about how to proceed with their birth, even after reasonable attempts at open and honest communication by the patient to uncover her options. Jennifer Goodall was a model patient. She carefully weighed her options, was open with her doctors about wanting to try a trial of labor after cesarean (TOLAC), she

realized that she might have to have surgery if the TOLAC was unsuccessful, and she was concerned about her own wellbeing and the welfare of her fetus. Even after having a rational and informed discussion, the hospital still threatened her with referrals to child and family services, judicial intervention to force her to have surgery, and surgery against her will should she arrive at the hospital while in labor. This is a prime example of how the best of pregnant patients, even when informed, compromising, and rational are not trusted to make good decisions about their own healthcare.

Consequently, it is not surprising that if we cannot trust rational, well-informed women to make decisions on their own behalf, there is little hope for those who are *not* model patients. Samantha Burton and Melissa Rowland provide excellent examples of women who refused to be model patients, even at the expense of the health of their fetuses. It seems at first that I am actually arguing that these women did deserve to be regulated because they made choices antithetical to their potential offspring, but in fact it is precisely these women who need more help and to be treated on case-by-case basis by those who are in a position to provide services.

Burton was a mother, had a job, and refused to quit smoking during her third pregnancy. Ordered to stay in her current hospital and submit to all procedures (including surgery should the doctors so choose) by court order, she felt that confinement in a hospital for the duration of her pregnancy was not an option. On top of that, she did not even like her doctor. Here, regardless of how obstinate, difficult, or combative a patient, a woman must be given freedom and flexibility to see a doctor of her choice. Even women at low-income clinics are still able to choose their doctors and switch if they are displeased, even if the choices are more constrained than those with private insurance. Smoking does have adverse effects on the growth and development of a fetus (CDC, 2016), but that does not mean that a woman should not have

access to a second opinion from another doctor before civil confinement is imposed. The appeals court did find that the trial court had violated Burton's rights, but not before Burton endured three days of confinement and the loss of her fetus. I do not suggest here that the miscarriage could have been prevented at that stage, but potentially Burton would have benefitted from a program that allowed her to try to quit while she continued to work and mother her children at the start of her pregnancy such that drastic measures, ones that were against her rights, but also against her practical needs, could have been avoided completely. Working with pregnant women in the beginning of their pregnancies (or before them!) allows women to make better decisions for themselves and their fetuses.

Melissa Rowland is arguably one of the most egregious cases of worrisome women in this data set: a woman many would be quick to judge deserving of punishment for her failure to act, causing one of her twins to be born stillborn. She has a criminal history and a mental illness diagnosis of oppositional defiant disorder. Disregarding these two very serious issues, Rowland did two things right: she sought medical advice and she moved to a state where she would be able to put up her future children for adoption, knowing that she would not be able to care for them. What she could have done better was to actually follow the advice that she had sought. Knowing that she had a mental disorder that caused her to be resistant to advice that she did seek, a treatment team or others whom Rowland trusted could have helped her to make a better decision for her twins. Moreover, it is imperative that we ask if Rowland's failure to act on behalf of the fetus such that the best course of action would entail major surgery for Rowland is really a crime that the justice system wants to a) prosecute and b) punish. Does a pregnant woman have the duty to care for her child even before she has given birth? Arguably she does. At the current stage of medical science, however, this is never a burden that a man has to carry,

nor is it one for which he can be subjected to penalties. This is true even if he is the father and will have that duty of care once the child is born; his duty of care begins at birth, not a moment before. Bearing the species puts an enormous burden on women that it does not put on men and if prosecution and punishment are added to that burden, services to help women through difficult times, including managing mental illness while pregnant, must be paramount, otherwise it is difficult to imagine how prosecuting a woman for not having surgery is just. Rowland may not be a sympathetic woman and her inaction may make many question her fitness to be able to birth children at all, but those attitudes miss the point. Questioning a woman's ability to be a good parent as a prerequisite to be allowed to procreate harkens back to American eugenics where forced sterilization was a practice that was both legal and deemed good public policy to thwart the expected problem of "degenerates" who might rely on government assistance (*Buck v. Bell,* 1927; Ko, 2016). Instead I suggest that Rowland and the problematic women like her will continue to exist because humans are not perfect. They mess up. We would do better and be less likely to have events where we consider these women to be monsters if we gave them support along the way, recognizing their shortcomings and needs.

Law in hospital rooms. We trust women so little that we decide their fate at the worst time for them: while they are vulnerable. In this section I note several women whose medical or legal status was decided when they most needed the protections of the Fifth Amendment and the legal right to counsel. The language of the Fifth Amendment makes it so that this protection is clearly applied against self-incrimination in criminal cases, but *Kastigar v. United States* (1972) allows for it to be used in any type of proceeding, including civil and investigatory ones such that:

> There are a number of exemptions from the testimonial duty, the most important of which is the Fifth Amendment privilege against compulsory self-incrimination. The privilege reflects a complex of our fundamental values and aspirations, and marks an important advance in the development of our liberty. It can be asserted in any proceeding, civil or criminal, administrative or judicial, investigatory or adjudicatory; and it protects against any disclosures that the witness reasonably believes could be used in a criminal prosecution or could lead to other evidence that might be so used. This Court has been zealous to safeguard the values that underlie the privilege.

It is unclear that most of the women thought to use this privilege when speaking to their doctors or that it would even be useful or necessary for them to employ it. Additionally, the right to counsel only exists when one is under criminal arrest, a condition that was not clearly satisfied for any of the women in the sample. Angela Carder, Laura Pemberton, and Purvi Patel all had people in their hospital rooms who decided matters for them. For Carder it was a c-section surgery, for Pemberton, civil confinement, and for Patel it was doctors and police who questioned her about the circumstances under which she gave birth.

Laura Pemberton's hearing to determine how she would give birth started before she arrived at the hospital, after she had started the labor process, and after being forcibly escorted from her home to the hospital. Pemberton was not given a lawyer, but allowed to speak on her own behalf to the judge. Clearly after being in labor for hours where she was dehydrated, Pemberton was not in the best place to be her own advocate for birth. Pemberton was compelled to have the surgery. Like Pemberton, Angela Carder was compelled to have surgery, one that it is not clear that she wanted and one that possibly hastened her terminal condition. Pemberton and the hospital should have worked out her birthing procedure well before the date of delivery

since typically one has months to do this. A common consensus could have been reached had the two parties trusted each other enough to reason out a procedure that made sense to both parties. The Carder case is less problematic and more instructive- not all women are healthy enough to make decisions for themselves at the time of birth. Doctors and patients need to have candid conversations about who will make decisions on behalf of the patient should she become incapacitated and unable to decide for herself in the moment. This conversation must happen well before the actual birth takes place.

Another concerning case is that of Julie Starks who was under arrest for production and possession of drugs. Once under arrest, a court hearing was held to determine the custody of her fetus. Custody hearings are not criminal cases and therefore Starks had no right to counsel of her own and because she was under arrest already, it is likely that she did not have many resources to mobilize in order to hire counsel to attend the court hearing with her. It is clear here that even though the state had legal custody over Starks and physical custody over her body (she was in jail) the state made sure that it retained control of her body even outside of the jail through the use of the fetus' custody hearing. In this way, the government found a loophole to continue to regulate Starks' behavior under the guise of only regulating the fetus (which is regulating her by default since they are physically inseparable beings until birth).

Purvi Patel is clearly an example of what we do not want for women who are in a vulnerable position. A woman's flight risk before and after labor is questionable (Levi & Waldman, 2011). Just having left surgery and having experienced a stillbirth, Patel was not going anywhere; questioning her could have waited until she was formerly under arrest and moved to the jail. Not only does questioning someone in their hospital room create an atmosphere where the patient feels inferior (e.g., lack of proper clothes, literal subordinate

position on a bed, limited ability to control one's environment) in Patel's case, it was not clear that she was ever under arrest, that she could have requested counsel, or that she could have invoked her Fifth Amendment rights. She could have requested counsel or stayed silent regardless of her arrest status, but she may not have known that nor taken questioning by the police as a serious event until she realized that she was under arrest. In general, people should know if they are under arrest before they are questioned by the police. Police and hospital collusion has not always been supported by the courts. The US Supreme Court did find that state hospitals and police working together, even when the aim is drug treatment and/or crime control, may not develop policies that have the primary purpose of collecting evidence to aid law enforcement. In *Ferguson v. The City of Charleston, South Carolina* (2001) SCOTUS found that using diagnostic tests (like drug tests) as evidence for law enforcement when the tests are not voluntary or performed without patient consent is in violation of the Fourth Amendment where the search is considered unreasonable. This case may be useful for Patel's case and cases like it, in that there may be more room for courts to look at police intervention in a vulnerable place like a hospital room since they were unwilling to let police and hospitals work together solely for crime control, even crime that is legitimately important to the state to control.

Legal Medications. None of the women in my sample were incarcerated solely because of their illegal[5] drug possession. Above I discussed the creative charging of women who were using illegal drugs and how simple drug possession was not a charge that was employed even when applicable and that other laws were mobilized against women who used drugs who could be charged with neither distribution nor possession. Here I discuss legal drugs and medications

[5] Jamie Fisher Russell was not arrested for the possession of an illegal drug, but rather the possession of a controlled substance (prescription medication) that was not hers, and Julie Starks was arrested for both possession and production of methamphetamine.

that women used during their pregnancies and how even though they were trying their best through difficult circumstances such that in every case someone intervened, not to help, but to make decisions on behalf of the woman.

Legally, those addicted to drugs may not be arrested or charged on those grounds alone as established in *Robinson v. California* (1962): the criminalization of a status, drug addict, is contrary to the Eighth Amendment. Boiled down, this means that Americans are legally allowed to be drug addicts and should not fear criminal prosecution. Restricted by this precedent, Wisconsin has found a loophole. Those addicts who are not arrested for production, possession, or sale can still be controlled and *civilly* confined via Wisconsin's Cocaine Mom law under the guise of *treatment*. Alicia Beltran and Rachel Lowe were both legally allowed to be drug addicts but their pregnancies set them apart from others of the same status. What is particularly striking about both cases is that Beltran did not need help and Lowe sought help, yet both had to go to court and were legally compelled to get treatment (needed or not). Lowe, who asked for help, was prescribed medications beyond those to treat an opioid addiction, was expected to cooperate with law enforcement (even though she had not been arrested), and she lost her job. Beltran's case is worse in that she was compelled to fight an addiction that she had already overcome and she also lost her job. The application of a law that specifically was meant for women who had refused drug treatment or who had been lax about participating in services is problematic when used in a punitive way. It is clear that both Beltran and Lowe were trying to do the best that they could for their fetuses such that wielding law as a weapon to make sure that they submitted to the will of the state is an obvious display of lack of trust on behalf of these women to do the right thing.

Voluntariness. Each woman sought medical attention of her own volition. Without coercion, these women were trying to seek routine or emergency care. Yes, some of the women can be criticized for seeking attention too late or making poor decisions out of panic or pain, but holistically these women did the best they could based on their own set of circumstances. Problematically, at least Lisa Epsteen felt bullied and was not sure about her future care. She felt that she might consider home birth instead of facing continued coercion. If women are not trusted to make good decisions and should medical care be forced upon women, they may choose never to return.

Why? Institutional Problems are Cast as Individual Troubles

C. Wright Mills, creator of the concept of the sociological imagination, believed that personal troubles and larger societal issues are actually linked, such that something with which an individual struggles is often rooted in larger, public structures and policies (Mills, 1959). From this perspective, we note that an individual's drug use is certainly a personal trouble, but cultural and recreational drug use, drug laws, drug availability, the profitability of drugs, and so forth are actually rooted in macrosocial processes and institutions, not individuals. Thus this section fleshes out the consequences of treating these women as if they are individuals with troubles while the larger systemic issues are ignored.

Rennie Gibbs was 16 years old when she gave birth, Regina McKnight had an IQ of 72, Purvi Patel lived with a family where sex was prohibited until marriage, Martina Greywind was homeless, Darlene Johnson beat her children, Kari Parsons was a shoplifter, Samantha Burton was a smoker, Melissa Rowland was mentally ill, Diane Pfannenstiel was abused by her spouse, Bei Bei Shuai was suicidal, Angela Carder was dying, Christine Taylor was overwhelmed about a third child, and several other women were drug addicts or had had previous c-sections. These

women could easily be defined by their own problems (she is a drug addict or she is a shoplifter) and we could consider them in isolation, but especially drug use or things done in desperation (e.g., suicide attempts, wrapping a fetus in plastic and putting it in a dumpster, confessing feeling overwhelmed by a third child and an estranger husband) it is clear that these women did not all start using drugs just because they thought they might like to try them or become desperate suddenly. Drug use, mental illness, low IQ, teen pregnancy, domestic violence, and so forth are systemic and societal concerns, not just the mere problems that affect these particular women.

Consider Bei Bei Shuai and Christine Taylor as examples of when only personal troubles are taken into account and the roots of issues are not contemplated. Both Shuai and Taylor were harmed by an incident at home, Shuai's purposeful ingestion of rat poison in a suicide attempt and Taylor's accidental fall down the stairs. Shuai survived but her baby did not. Even though Shuai was so upset by her circumstances that she tried to kill herself (not the fetus, although the fetus would have expired with her by extension), the fact that her life was turned upside down by the want of her romantic partner and that she was likely clinically depressed were not considered. The root of her fetus' demise was not Shuai's maltreatment of the fetus, but rather that she did not want to continue living. It is unreasonable to assume that women with mental health issues will not get pregnant. In a similar vein, Taylor was estranged from her husband, raising two children as a single mother, and considered (but did not act on) abortion and adoption as avenues for her third pregnancy. It is also unreasonable to expect that women who are single, in poverty, young, drug addicted, and so forth will wait until their circumstances change to have a child at the perfect time for them. For many women, there is no such thing as the perfect time to have a child. Moreover, some women will never leave poverty or get married. Should we penalize them or overly scrutinize women because they do not fit our idea of motherhood?

What does this mean? Women Become Legal System Experiments

Given that children are a vulnerable population who are unable to care for themselves outright, parents have a duty to them to see that they are given the essentials to thrive. The charges against Buckhalter (culpable negligent manslaughter), Gibbs (depraved-heart murder), McKnight (homicide by child abuse), and Patel (feticide and neglect) should be taken very seriously as they represent some of the most heinous crimes in our criminal code and they involve a population that is vulnerable. Because of the gravity of the charges (and their penalties), society's desire for children to be nurtured, and the desire to be clear on the conduct that the state will and will not tolerate, all of these court cases should have been handled with the utmost scrutiny and attention to detail to make sure that the precedent that was created was accurate. Three of four of the cases were overturned in some way. Buckhalter's and Gibbs' indictments were dismissed, McKnight's conviction was vacated, and Patel's convictions are currently being appealed. Due to the adversarial nature of the court system, the prosecution and defense weave stories that implicate or render innocent a defendant that may confuse juries, but it is incumbent upon the judge of the court, a trained and credentialed professional, to correctly allow evidence and experts to become part of the proceedings. Without this honing of relevant material, appeals are brought forth and indictments are thrown out. These trials are actually quite serious because they disrupt the lives of women waiting to be tried and women waiting for their appeals. A second issue is that it sends the wrong message to the public when there is no consistent message about lawful behavior. The maximum amount of care should be taken to make sure that the defendant is appropriately charged, the evidence in the court is accurately presented, and that the defendant is not subjected to extra-legal punishment by awaiting her trial.

It might be reasonable to investigate women whose fetuses expire or whose babies die, but many of the women in the data set who were arrested, prosecuted, and/or went to court were brought into the criminal justice system because of harm done to the fetus/baby. Moreover, these women like Melanie Green, who was not indicted, Jennifer Johnson, whose conviction was vacated, Martina Greywind who was arrested but charges were dropped, Julie Starks whose child deprivation adjudication was overturned, Samantha Burton whose civil confinement violated her rights, Pamela Stewart Monson whose charges were dismissed, Dianne Pfannenstiel whose charges were dismissed, and Christine Taylor whose charges were dropped, all had to wait for the justice system to catch up with them. Many of the women tried for murder, manslaughter, drug charges, and other offenses were imprisoned and then let out later. Because the law does not account for every contingency or circumstance, these women had to go through the courts where eventually it was decided that they did not violate the law or that their rights had actually been violated. This is not necessarily a negative result, but rather the way that law is made and refined, but it still calls into question the upheaval that some must face in order to figure out the application of law. In some cases, like Stewart Monson's case, the law was clear, but when the law was written, the intended offender was a deadbeat dad, not the pregnant woman. As we make legislation, we should consider the impact that it does have on those who are innocent, especially those who lose their jobs, friends, money, and other sources of support while awaiting "justice."

What does this mean? Women are Left Without Resources

Powerlessness. Medical professionals worked with courts and/or law enforcement to get what they wanted in each case. When women became uncooperative, they were threatened with police or court action as well as actually arrested. From the ER doctor who reported Taylor, the

ER that labeled Russell, the doctor who threatened Epsteen, the hospital that got a court order to confine Burton, to the hospital that threatened multiple sanctions against Goodall, all of these medical professionals went outside of their authority and jurisdiction in order to be buttressed by another institution of social control. These women were always in the subordinate position such that none had a lawyer at the time of the conduct nor connections to change the situation for themselves, nor did they have any institutional back up like the doctors did.

Sans Dignity. A theme that is coupled with powerlessness is the absence of dignity. This is an overall theme among the women: dignity is missing. Some of these women, like Lisa Epsteen , Laura Pemberton, and Jennifer Goodall, just wanted compassion for their attempt at a non-surgical birth. Others like Rachel Lowe and Jennifer Johnson were upfront about their addictions and wanted help to stop using drugs. Doctors, law enforcement, judges, social workers, prosecutors and others seemed to have little compassion for these women and their problems as these agents tried to uphold the law, and did not consider the wishes, feelings, and limitations of the women. Women, once regulated to a status of powerless, have little ability to communicate their wishes for a vaginal birth if the doctor sees them as uninformed or difficult patients. It is even harder for a powerless women to tell a judge that she refuses to have a hearing in her hospital room while she is wearing a hospital gown and chained to myriad instruments. The ultimate loss of power and dignity belongs to the women who were imprisoned (both in hospitals and carceral settings) where they had no control over their medications, clothing, movement, diet, or medical appointments.

Without dignity in the process of childbirth, when we strip away the sense that these women are human and are worthy of compassionate care, what hope can society possibly have for them to raise children who will feel included by a society that has rejected their mothers? At

a time when women feel uncomfortable from all of the physical changes and the new routines that pregnancy brings, preserving their dignity in everyday encounters is a small price to pay.

What does this mean? Children are not served

Some who read these cases may still argue that even though women were treated poorly that the end results justifies the means. Moreover, helping a vulnerable population may just be worth it, even if it means that women are targeted to receive treatment and/or punishment. The problem is that these data reveal that children did not necessarily have good outcomes because more social control was applied. While this study is not comparative in that it does not include women who were not regulated, thus making a discussion of relative outcomes impossible, it is not without merit to discuss the circumstances of the fetuses, children, and women even without the comparison group.

Rachel Lowe was not allowed to see an obstetrician while she was confined under a law that specifically was designed to prevent harm to a fetus. Not being able to see a doctor who is specialized in the care of the fetus certainly does not help the fetus. Julie Starks was held in a cell where she did not have sanitary conditions nor did she receive adequate health care (she lost 12 pounds). The fetuses of many of the women expired because law enforcement and/or doctors acted in a reactive capacity where women were investigated after drug use was suspected or when a cause of death was sought. Moreover, Rachel Lowe and Alicia Beltran lost their jobs, leaving less money to take care of their babies once they were born. Certainly having precarious financial stability does not help future children.

Criminal Justice Issues

Currently the trend in criminal justice is to use risk analysis software (e.g., realignment in California and Ohio's use of ORAS) to let out prisoners who pose little threat of harm to the

community (Walker, 2013). In April 2014 the United States Sentencing Commission changed the federal guidelines for drug trafficking offenses, lowering the levels, which effectively makes sentences shorter. In July 2014 the US Sentencing Commission voted to approve an amendment that allows low-level drug offenders to also be retroactively eligible for early release. The coupling of these measures, risk analysis and changes in guidelines, means that we should expect fewer people sentenced to long terms in prison for drugs. What it does not mean is that drug offenders will automatically get more services, such as treatment or diversion out of jail and prisons to treatment facilities. In fact, "from 1986 to 1996, despite the fact that the rate at which women used drugs actually declined substantially, the number of women incarcerated in state facilities for drug offenses increased by 888%, compared to a rise of 129% for non-drug offenses" (The Sentencing Project, 2007).

An important finding in this dissertation is that women who used drugs while pregnant and were criminally charged were not charged with simple possession, but rather much worse crimes like manslaughter, murder, child abuse, child endangerment, and so forth. Even in the wake of ratcheting down sentences for drug addicts, some of these women who are also addicts will not benefit from the use of new guidelines because of the severity of their crimes. Their punishment may be longer than their non-pregnant counterparts for the same drug problem. Moreover, because their crimes are against family members, they are at risk of losing custody of their current and/or future children, a sanction that is not usually imposed on others who are similarly situated. The loss of custody may be permanent, leaving pregnant women without the option of making better choices. We must ask ourselves if we really want a justice system that does not make room for people to have second chances.

It is not clear how any of these women benefitted by the treatment that they received. Jail time did not change the fact that Taylor fell down the stairs. Russell's two hours in the jail cell might actually have killed her. Epsteen had to hire a lawyer to tell the doctor to cease his threats, but she still underwent the same procedure like she had planned. Burton was compelled to do as the doctors required, but this treatment did not save her fetus.

An overarching theme of this dissertation has been to highlight the ways in which a pregnant woman's status affects the ways in which she is treated: specifically, with regard to the threat of sanction and the actual sanctions she receives. Thus, if pregnant women and non-pregnant people commit the same crime under the same circumstances that result in different charges, one likely possibility is it is the status of pregnant that determines the charge and the sanction. It is clear then, that by continuing to regulate pregnant women differently from non-pregnant women and men, especially in a climate where drug use is being less scrutinized than previously, drug use surveillance during pregnancy is not just about saving a vulnerable fetus since little is done to actually ensure healthy deliveries. Instead it must be construed as an attack on the way that women make choices about their own reproduction and their behavior during that reproductive stage. Here we see that this attack fits nicely within the bad mothering framework that others (e.g., Roberts (1993), Schiff (1997), and Austin (1989)) have described. In fact, the results of this dissertation extend those ideas. It is not just that women are taking power from the patriarchy, or that they commit crimes that are not appropriate to the female gender, or even that they face a double standard such that fathers can commit crimes without worry that they have violated gender norms. Instead, it is all of these things and two more. First, these women not only violate female norms, but the supposed innate trait that all women have: maternal instinct. To some, this in and of itself is a violation deserving of punishment (Stone-

Manista, 2009), but second, these women have committed crimes against their own children at a time when no one can remove them to another environment. Other than outright murdering one's child, harm in the womb is possibly one of the most offensive crimes women can commit against their own children— and therefore an expression of the most heinous violations of female norms and expectations. These women are solely responsible for continuing to gestate the fetus until it is viable outside of the womb, therefore giving pregnant women power. Thus, even though there is mass critique of the overreach of the criminal justice system and there are attempts to cut back on the number of citizens who are behind bars, we see a continuation of prosecutions, arrests, civil confinements, and legal actions against pregnant women because the state has recognized that in order to maintain its dominance, pregnant women's power must be surveilled, regulated, and curtailed.

Even more than a sanction for bad behavior, some of these sentences leave women unable to procreate after prison, another enhanced punishment for straying outside of the norms of motherhood. American legal precedent has upheld the right of women to use multiple forms of medications, prophylactics (i.e., condoms), devices, and surgeries to control their fertility through landmark court cases such as *Griswold v. Connecticut* (1965), *Eisenstadt v. Baird* (1972), and *Roe v. Wade* (1973). As noted above, it is possible that one reason extensive penalties are applied to women who lose their babies is that the state purposefully makes it so that they will not be able to be mothers to children who have been removed from their care and they will be too old to procreate when they are released from prison. This effectively means that they can never be mothers. Without grave harm, women should not be behind bars so long as to have their fertility expire. It is not the duty of the court to decide what kind of future mother a woman might be, only what punishment she must serve for her current crime. To do otherwise

would be an overreach of the law that extends beyond its right to punish harms that have been done; the court is actually doing violence to women when they are not able to choose for themselves. In fact, this overreach suggests a particularly slippery slope where entire groups of undesirable women can be rendered sterile by exploiting the passage of time. Moreover, these long sentences do not allow for women to have second chances at being good mothers. For some, they will never be able to bear a child again. For others, it may be a struggle to regain custody of a child. Still, for others, custody may no longer be an option as a woman may be away too long for her child to be reunited with her in a legal parent-child relationship. As such, this piece highlights the need for women to be allowed to make their own fertility choices, which means giving reasonable sentences based on the harm done. The next chapter explores ways to prevent the need for the criminal justice system to be involved in healthcare decisions, but also tackles the issues of what it should do if it must become involved.

CHAPTER 5: Policy Implications

Chapter Overview

In this chapter I suggest multiple policies that are informed by evidence-based research, practices recommended by professional medical bodies, and hallmarks of successful programs that promote healthy mothers and babies. I start with the argument that our first step is to stop the criminalization and regulation of the practices, statuses, and misfortunes of pregnant women by the legal and medical systems. Based on previous chapters, force and penalties do not seem to be good motivators for change, they are not cost effective, and they do not produce results that maximize benefits for healthy women and children. Second, while simultaneously changing the legal and medical responses, I suggest that prevention of harm be a primary mission for health officials. I offer several aspects of care on which we should focus and include replicable model programs. Finally, intervention, when necessary, should be planned and coordinated based on real obstacles that women face.

Having analyzed several different cases where a woman's status of pregnant or conduct while pregnant has led to regulation, two things are quite clear. First, criminalization of pregnancy does *not* prevent the morbidity or mortality of babies, thus not advancing the goals of society to have safe, healthy children. Therefore, the first step to remedying this problem is to stop criminalizing these women. Second, since this approach does not work, there needs to be an alternative that actually works to accomplish justice and prevent harm— both for women and their children. Below I give several suggestions about how to proceed by addressing an

inherently healthcare-related problem with healthcare-related solutions. In this chapter my goal is to give the reader a guide for better outcomes for these women and women like them.

Stop Criminalization

The first step in helping pregnant women and their future children is to stop using the criminal justice system (and all of its components including police, jails, judges, prisons, and lawyers) as the default mechanism by which to regulate status and behavior. This step needs to occur immediately and apply to all women regardless of jurisdiction. Below I give five reasons for this argument including a) it is discriminatory, b) it furthers problems already encountered by the justice system, c) it is against human rights and social justice, d) it creates a fetal and maternal rights conflict, and e) it does not work.

Discrimination. The criminalization of pregnancy is discriminatory in three ways. First, the methods of discovery of drug use vary between pregnant women. Second, the types of drugs that women use are differentially targeted. Third, the charges that are brought against pregnant women are different from non-pregnant people, even for the same behavior.

Many scholars (Beckett, 1995; Boyd, 2004; Roberts, 1997) have found evidence that pregnant women who are poor and women of color are more likely to be drug tested. As well, women are tested for certain drugs over others, regardless of the amount of harm done by a drug. For example, according to the facts of the case in *Ferguson v. Charleston*, in Charleston, South Carolina the Medical University of South Carolina (MUSC) created a protocol to screen the urine of women who fit one or more of the following nine criteria:

1. No prenatal care
2. Late prenatal care after 24 weeks gestation
3. Incomplete prenatal care

4. Abruptio placentae [separation of the placenta from the uterus before birth]

5. Intrauterine fetal death

6. Preterm labor "of no obvious cause"

7. IUGR [intrauterine growth retardation] "of no obvious cause"

8. Previously known drug or alcohol abuse

9. Unexplained congenital anomalies

The women who fit these criteria were screened only for evidence of cocaine use and it is has been argued that the policy itself was racist. First, the women's positive results were turned over to law enforcement, although later they were given a choice of being arrested or agreeing to start drug treatment. Second, 29 of 30 women who were arrested were black. In a final review of the policy, SCOTUS found in favor of the drug-tested women because the policy violated the women's Fourth Amendment rights, namely the right of protection from unreasonable searches by the government. The hospital was the only public hospital that served poor women in the area (Roth, 2002) and its public nature makes it bound by constitutional protections. The women were not told that they were being tested, they were not asked for consent, and the nature of the policy was such that the Court found the objective to be a law enforcement goal rather than a health-oriented one. This case alone gives evidence that pregnant women are screened when non-pregnant people are not (and if they are screened, not turned over to law enforcement) and pregnant women who use public hospitals are more likely to be women of color and little means, thus setting up those populations to be scrutinized more than their pregnant peers.

Second, Kadish (1967) was also concerned about who applies the laws and to whom they are applied. This manifests itself in the criminalization of pregnancy in two ways: 1) police and doctors effectively make law instead of legislatures (which judges then have to spend time

overturning) and as I have argued above, 2) pregnant women are treated differently from their non-pregnant counterparts both in surveillance by doctors and through the criminal charging process. From a democratic perspective, citizens should be concerned about nonelected authorities making and enforcing rules that are not sanctioned by elected officials. Moreover, as the courts have determined, at least in part, when legislatures do their jobs and enact law, it is expected that those laws will be enforced by their spirit under which they were created. Instead this dissertation has highlighted the creative use to "seize" people who otherwise could not be charged, could be charged under a more narrow crime, or should not be included, but through reinterpretation of the letter of the law includes pregnant women when they were never intended as a target of the law.

Pregnant women suffer two biases: they are treated differently from non-pregnant people but they are also treated differently from each other. By using discretion we risk discriminately finding fault with a few kinds of women (e.g., poor, homeless, women of color, drug addicts, single mothers, the mentally ill, those in pain, etc.). If we do regulate some kinds of women for their conduct and/or status and depend on the criminal justice system to handle that regulation, we will continue to unfairly apply the law.

Contributes to a Broken System. Many criminologists have critiqued the current penology, namely, the crisis of mass incarceration and its collateral and lasting effects that extend into civilian life (for example see: Clear, 2008; Pager, 2003; Pettit & Western, 2004). Legal scholars such as Michelle Alexander have offered a critique that the criminal justice system is now just the newest iteration of codes that keep certain people's (in particular Black men's) rights in check— Alexander (2010) finds that on its surface the criminal justice system acts as colorblind and race-neutral, but its underlying logic and devastating effects are actually a

function of systematic racial control. To many it is clear that the shift from a more rehabilitative ideology to mass incarceration as the dominant paradigm has not been successful in that we incarcerate far too many people now. For example, California was recently found to be in violation of the Eighth Amendment due to overcrowded prisons and was forced to remedy it with haste (*Brown v. Plata*, 2011). Criminalizing pregnancy adds to the problems of overcrowding if women are sentenced to jails and prisons.

Even though there is change, it is not clear how fast or what its magnitude will be, especially for women. Even though legal changes are reducing the number of prisoners, most prisoners are men. Based on the Bureau of Justice Statistics report by Glaze and Kaeble (2014), at the end of 2013 women accounted for approximately 18% of the correctional population, including jail, prison, parole, and probation. From 2000 to 2010 correctional populations of both men and women grew although women's annual growth rate was approximately twice as fast as men's. In 2000 there were approximately 5 times as many men as women in the correctional system (5,389,600 men and 1,078,400 women). By 2013 that ratio had dropped to approximately 4.5 times (5,642,700 men and 1,256,300 women). A report on the state and federal policies and conditions for incarcerated pregnant women argues that not only have we seen an increase in the number of female prisoners, but that women have "borne a disproportionate burden of the war on drugs, resulting in a monumental increase of women who are facing incarceration for the first time, overwhelmingly for non-violent offenses" (Saada Saar & Morrison, 2010, p. 5). Criminalization of pregnancies contributes to the growing problem of mass incarceration.

Another cost of criminalizing pregnancy is the conditions we have chosen to regulate, like stillbirths, drug use, and non-compliant patients, once regulated, leave little room for

discussions about the actual harm done, the frequency of the behavior, and the likelihood a woman will do it again. Once these behaviors are criminalized, there is no consideration of mitigating factors like how the behavior may be a one time event or that the drug used may not actually cause harm. Legislation, once passed, is hard to repeal even when research reveals competing findings. The war on drugs is a good example of how penalties became severe without much empirical backing and law has been slow to change to undo its mistakes.

Moreover, pregnancies are now scrutinized such that for nine months a woman has to be on her best behavior and a model patient or risk being questioned about every choice she makes. This type of surveillance upon private life is worrisome from the government, but also from hospitals where power is unchecked. While the Constitution provides some protections here from illegal search and seizure and from unlawful detention, by reframing behaviors as criminal instead of health-related, those protections offer very little real help. If a woman's behavior is grave enough that there is probable cause to arrest her, she may legally be searched (e.g., drug tested) and lose her liberty.

Many women in the current study had health issues, drug addictions, and mental illnesses. These conditions are not dissimilar from health problems that plague women in prisons where more than one half of women in both state and federal prison report having one or more illnesses (Maruschak, 2008). Using law to control, although not to solve, health issues is an overreach of criminal law into extra-legal affairs. Even more problematically, the law is sometimes used to force women into treatment, into having surgery, or into confinement. Here law is active; a force wielded against pregnant women. This coercive use of law is certainly an overreach of law if law is meant to be a harm reduction mechanism, a set of codified norms, or rules by which we live.

Against Human Rights. The tacit acceptance of prioritizing the health of the fetus by regulating women's bodies is contrary to principles of human rights. First, as a fundamental right as a human, women must be able to choose whether or not to procreate, with whom, and how. To violate any of those principles leads to slavery of a pregnant body where a woman becomes a mere vessel for genesis. This dissertation has revealed that those basic rights have been narrowed in scope as fetal personhood becomes more legally entrenched— not just in terms of abortion; women who fully intend to carry a fetus to term are also regulated. Second, there are more humane ways of treating women who need help than putting them in prisons or jails or confining them in hospitals, especially because they do not get adequate and context-specific care in these settings. Shackling of pregnant prisoners, lack of obstetric care, mandatory prescription pills, and lack of drug treatment are all practices that diminish dignity.

Dorothy Roberts (1997) argues that reproductive limitations, because they are so tied with race, are violations of liberty and equality. As the basis for one of her arguments, she situates reproductive oppression within the Thirteenth Amendment, claiming that not allowing black women complete control over their reproduction it is just another "badge of slavery" (p. 304). Similarly, I believe that this can be argued for all women- it should be a fundamental human right to choose to procreate and the manner in which it is done. Equally important, by criminalizing pregnancy we do not fulfill a social justice goal of ensuring that all women have equal access to healthcare. As revealed above, the access to healthcare that these women receive in jails and prisons is minimal at best and sometimes nonexistent at worst. This criminalization also does nothing to alleviate structural issues like poverty and access to good healthcare, or individual problems like drug addiction or depression.

Against Social Justice. Third, criminalizing pregnancy does the opposite of what social justice principles advocate. Social justice for pregnant women demands at least two things: 1) a more equitable access to resources for *all* women and 2) comprehensive and quality healthcare. The criminal justice system does not provide education for pregnant women and limits their access to food stamps and other government assistance upon reentry. It simply tells women not to do that behavior, but does not offer an alternative. For women who enter the justice system during pregnancy, their care is not necessarily better than on the outside, but for women who are arrested post-partum, they did not necessarily receive good healthcare during their pregnancies. In order to utilize the criminal justice system as a help mechanism, it is necessary for women to commit a crime to benefit from help. First, it is not clear how helpful this system really is, but second, that premise means that it would only be designed to help some women and possibly punish them at the same time. The criminal justice system, as social justice demands, cannot actively help *all* pregnant women get better medical treatment. Finally, as Beckett and Herbert (2009) have argued:

> One of our core arguments is that it is a flawed endeavor to use the criminal justice system to address the manifestations of social disadvantage. This is especially obvious when one considers behaviors such as injection drug use or chronic alcoholism. As much as we might hope that the threat of punishment would hasten the cessation of these behaviors, this is wishful thinking in a vast number of cases. (pgs. 153-154)

Women who have problematic pregnancies often face some kind of disadvantage, if not multiple kinds. These women may try to fix their behaviors, but without a supportive system that tries to manage the multiple dimensions of their problems, it is unclear how the criminal justice system can hope to fix a person when several issues may prevent that change. Threatening punishment

to deter behaviors like substance use or questioning a doctor's recommendation does not necessarily lead to a cessation of the behaviors, and in some cases, like Goodall's, it can enhance those behaviors. Finally, Richer (2000) argues that the criminal justice system "must be weary [*sic*] of criminalizing actions based on traditional gender stereotypes, especially when society has also failed to help those women in compromising circumstances through other means" (p. 1142). Richer's point is well taken: the first thing society could do is help, rather than condemn, but policies and laws should not be based on myths that are perpetuated about the female sex and the ideal mother or pregnancy.

Fetal vs. maternal rights. Legal and medical criminalization hinges on the proposition that the fetus is a person with rights and therefore can be harmed and should be protected because of its vulnerable status. Having healthy babies is a noble and worthy goal of social policy. The problem occurs when this protection pits two entities who share the same body against each other. In these situations, at worst, in order to reach an outcome, there is no compromise; only one party is satisfied. This of course is not necessary, there are ways in which both entities may be mutually satisfied and actions benefit both. Regulating and criminalizing women prevents this second scenario where compromises are possible, aiding both woman and fetus. Moreover, using this framework of rights, we sometimes come to an impasse where no matter what one entity will be harmed. Ignoring context and situation-dependent variables does not allow for the possibility that sometimes we must choose to save only one life. What is best for the fetus may not be possible for the pregnant woman and vice versa. Alternatives that precede criminalization may preempt the need to choose if conflicts are averted.

Does not work. Finally, if the above reasons were not enough to stop this practice of criminalizing pregnancy, the bottom line is that it does not work. First, using legal sanctions as a

method of deterring people from committing crime has not been borne out empirically as an effective approach to crime reduction. Of the three principles of the theory, certainty of getting caught has been the strongest motivator for people not to commit crime (compared to quickly being caught or the severity of the punishment) although that certainty is often misperceived (Akers & Sellers, 2009). In fact, more empirical support has been offered for informal social controls that govern us (Zimring & Hawkins, 1973). For example, the wish to please our parents, feeling the embarrassment of being arrested if it were to become known to our friends and neighbors, rules ingrained by religion, and keeping our jobs are informal reasons for us not to break the law. For this project, not only is it clear that women were surprised about medical, judicial, and police regulation of their pregnancies, but for some extra-legal factors played more of a role in shaping their conduct than formal laws did. Thus, it is clear that a reason to stop criminalizing is that the deterrence of behaviors that concern us are not well regulated by law and could be more accurately regulated by informal social controls. Thus, a clear reason to stop using criminal law as a mechanism to stop behaviors that concern us is that we have a better and more effective alternative. This reduction of problem behaviors is more likely to be accomplished by informal social controls.

A second and even more critical issue is that prisons and jails are not good places for women to be pregnant. Like the case of Kari Parsons, who was imprisoned for the benefit of her fetus and then gave birth alone in her cell, most woman do not get the healthcare that they need in a carceral setting. Some might argue that Parsons was just one woman and we should not draw conclusions based on one person's experience, but the phenomenon is larger than just her case. In fact,

> Forty-three states [86%] do not require medical examinations as a component of prenatal care [in carceral settings]. Forty-one states [82%] do not require prenatal nutrition counseling or the provision of appropriate nutrition to incarcerated pregnant women. Thirty-four states [68%] do not require screening and treatment for women with high-risk pregnancies. (Saada Saar & Morrison, 2010, p. 6)

It is clear that if 86% of states do not even have policies that require medical exams as part of the care that women should receive while they are incarcerated, this is not the system in which to place pregnant women in order to get them care, much less quality healthcare. Other aspects of pregnancy services are also limited in prisons and jails. In New York, pregnant women are deprived of good nutrition, adequate amounts of food, seasonally appropriate clothing, and subjected to uncomfortable pat downs and strip searches (Kraft-Stolar, 2015). On the whole, because carceral healthcare facilities are modeled on sex-neutral policies (Hotelling, 2008), they are not equipped to give pregnant women good healthcare and should not be a reason that a judge sends a woman to jail or prison.

Moreover, if protection of the fetus is the reason to send women to jail and it clearly does not result in adequate care for the pregnant woman, what of the child after it is born? In many settings, if the mother is not released with the child at birth, the infant must be picked up by a relative or the infant is moved into the foster care system (Hotelling, 2008). For this particular project, it is not clear that any of the sampled women would have been released on the birth of their babies and of course some women were arrested after the birth of their children. If separation of mother and child occurs, scholars are concerned with at least two aspects of child and maternal development. First, the mother-child bond that many women and their babies share at birth may be disrupted, which may lead to attachment problems with the child. Second,

mothers must learn some skills to be good mothers (e.g., how to correctly hold a baby, how to get a baby to latch correctly for feeding, how and when to burp a baby, what different cries might signify, when to let a baby explore and when to intervene, etc.). Cassidy et al. (2010) found that women who participated in a diversion program had outcomes that were similar to low-risk mothers on both attachment and skills (what they call maternal sensitivity). Moreover, children who breastfeed receive protection from certain illnesses, diseases, and ailments (Ip et al., 2007). Mothers may benefit from breastfeeding by possible weight loss and possible reduced chance of breast and ovarian cancer. Ip et al. (2007) did find an increased risk of postpartum depression with short-term breastfeeding or not breastfeeding at all. More must go into understanding this process and its association, but until that relationship is better understood, it is better for criminal justice agencies to be aware of the potential risks of separating mother and child. To date, the literature suggests that it is better for mothers and their newborns to be together.

Finally, this dissertation has addressed the intended function of criminalizing pregnancy and how it plays out in practice. If the purpose is to ensure healthy pregnancies with optimal outcome for the babies, by criminalizing women we are not addressing the root of the problem that actually leads to problematic pregnancies. In actuality it is a myriad of factors, none of which are addressed by regulation. As well, turning to the criminal justice system and hospital directives to solve problematic pregnancies comes at a point where there is already a problem to be fixed. It is too late to establish mutually beneficent behaviors, solutions, and agreements between the pregnant woman and the system when regulation is imposed. Instead of a source of help, regulation functions as a punishment mechanism, often unfairly to women who had few choices or too little information to make better, more reasoned decisions. It is better to intercede well before problems develop, not after they are firmly entrenched. Regulation and

criminalization are not capable of meeting this obligation as they currently operate and a better alternative must be developed.

How do we fix this?

Unlike Martinson (1974), whose skepticism about rehabilitation in the penal system led to the "nothing works" rhetoric and an unanticipated death of the treatment ideal in incarceration, this dissertation attempts to offer certain solutions to the problem at hand, mainly social and structural issues that prevent pregnant women from maximizing their agency and obtaining quality healthcare. I refuse to declare that "nothing works" or that this problem is hopeless. As I argued above, criminalizing pregnancy is not helping, but this does not mean that there is nothing we can do. In this section I argue that the main ways to address the problem are to change our views on healthcare, give women information to make good choices, spend money on prevention, and have a safety net in place to catch women via intervention. The last section gives key aspects of programs that we should consider as we work to help pregnant women as well as model programs that have been assessed.

Change our views on healthcare

By rejecting women's abilities to make decisions about their own bodies without risk or fear of punishment, we return to a model of medical care that is outdated. The doctor-patient relationship is an important one. Women who are pregnant need to receive standard, regular care. There are multiple models that give patients agency over their care as opposed to the paternalistic model, where the doctor only provides medical information such that the patient has little to no choice in her decision, which leaves women without agency. This model is deemed inappropriate for any reasonable woman and only recommended in emergency situations where the patient is not able to weight the risks and benefits of treatment and no proxy is available to do

so for her. Technically, this model, while not recommended for most women, would actually be acceptable as long as a woman is given the option to choose this model over others. Should a woman do whatever her doctor suggests and she is fine with that situation, she should be allowed to have that relationship with her doctor. Other models that the American Congress of Obstetricians and Gynecologists (ACOG) recommends include an informative model (the doctor provides information only and does not offer a recommendation, although this is probably not ideal in establishing a true partnership), the interpretive model (this lets the doctor present multiple options and allows the patient to suss out the right option for her based on the information provided and how it accords with her values and background), and the deliberative model (whereby the doctor provides information about care as well as his/her own values and uses morality to help guide the discussion) (ACOG, 2008). It is clear that one of the most important things to emerge from the themes in the previous chapter is that patients and doctors should have better communication and choices about care should be carefully and openly considered by both parties.

A finding from this dissertation is that there is a power imbalance that exists in the doctor-patient relationship. First, doctors are professionals who have expertise in medical matters through education and experience. This status of expert can contrast vastly with the backgrounds and experiences of some women such that doctors must consider their words and actions carefully. Second, the responses of the doctors in these situations were disproportionate to the problems that existed. Epsteen was so affected by the threat against her that she had to change hospitals. This is not a reasonable expectation for all pregnant women. Logistic, economic, distance, trust, and insurance concerns all play a part in where a woman decides to receive her care. Some women may literally not have a choice about where they receive care

(e.g., women on public assistance, women in rural areas, etc.). Finally, it is clear that doctors are experts at medicine and should function only as medical providers. Police serve and protect their citizens and courts dispense justice and resolve disputes. Should a dispute arise between an individual and an entire medical team or hospital, the individual is at a disadvantage because she is as Galanter (1974) says, "a one-shotter" (p. 97). As hospitals (or health systems that own hospitals) have legal departments, those legal teams are experts at law and have connections in the legal realm. Especially if the medical team can show that the woman is agitated or makes decisions that seem counter to the expert authority (although perfectly within her right to make), the framing of the woman as disobedient or unreasonable quickly allows the court to side with the reasonable and expert medical professionals.

Instead of promoting relationships where doctors and patients oppose each other, doctors can do more to work with these women so that they feel empowered and safe by the choices that they make. The women in these examples were reasonable, with the exception of Russell. Even Russell may have been reasonable once she was treated. It is obvious that she was not faking her pain and the duty to care for people does not only extend to those who are nice or pleasant. Russell's condition was life threatening and because of her behavior, she was denied care. When women are not able to make decisions on their own, it is perfectly reasonable for doctors to work with family members or others who can step in to be a guardian *ad litem*. Clearly, in these cases threats did not change the minds of the women and only served to exacerbate the situation.

Finally, I suggest that medical professionals and police may need to work together sometimes (to report child abuse, rape, domestic violence, gunshot wounds, etc.) but in cases where doctors have any doubts, the doctrine of doctor-patient confidentiality should be upheld as the primary duty. Doctors are not experts in the stigma that the criminal justice system

engenders nor do they understand the process by which people get trapped in such a system. Allowing their duty to law enforcement to supersede their duty to their patients can have disastrous effects for some.

Promote Continuity of Healthcare. Today's American system emphasizes that doctors specialize in types of medicine (e.g., surgeons, pediatricians, oncologists, etc.) such that general practice and family medicine practitioners are not as common as they once were. It has been suggested in this present study and elsewhere (e.g., Husak, 2002) that women who are substance users are less likely to seek treatment for their drug use if their fear punishment or penalties. Lester, Andreozzi, and Appiah (2004) suggest that there are three ways to detect drug use during pregnancy: 1) by selective or targeted screening, 2) by universal screening, and 3) by self-report. Selectively screening patients can lead to legal troubles because hospitals and doctors are not allowed to screen pregnant women for the sole purpose of reporting to law enforcement even if the ultimate intent is to get women into court mandated treatment programs (*Ferguson v. City of Charleston* (2001)). Selective screening may be biased and target women of certain types (race, ethnicity, class, etc.) or may be left to each doctor individually, not catching some women who need care. Alternatively, universal screening eradicates bias but may be resource intensive and/or mandate that doctors report based on their state's statutes. A third option is asking the women about their drug use (including licit and illicit, prescribed and non-prescription drugs). The issue of bias is eliminated if all women are asked, but there is the chance that women will not report some or all of the drug use. Nondisclosure is a serious and worthy issue, but one that could be lessened in the right circumstances. I argue that ongoing care with the same doctor, one a woman trusts, will raise the probability that a woman would truthfully report her drug use.

This is subject to memory recall issues, but initially knowing if a woman uses any drugs is the first step in identifying someone who needs help.

A second step can then be taken to have the woman document the frequency and quantity of her drug use. Current health care practices should emphasize consistent doctor-patient relationships where women and their doctors get to know each other and bonds are formed. Doctors should carefully consider the order in which they broach topics with their patients. It may not be appropriate to ask about drug use at the first appointment, but instead only offer information to the patient. I do not suggest a delay to provide care on the part of physicians, but rather, that they use their best judgment about when a patient might be the most likely to speak candidly about substance use. Literature has shown that continuity of care does increase maternal satisfaction (as described above) but there is a question as to whether seeing the same doctor would produce more accurate self-reported drug use than women who see many doctors during their care. Research that focuses on self-reported smoking behavior of women (often a dichotomous variable showing smoker versus non-smoker) does not adequately account for the kind of care women received during their pregnancies. Therefore it is unknown if self-report could be used in place of drug screening for women who have established, continuous care with a sole doctor. Acknowledging that there is currently a lack of evidence of the efficacy of such an approach, it does seem worthwhile to at least see if less invasive practices give way to better doctor-patient relationships as measured by trust and healthy outcomes.

Promote Successful Birth Outcomes. A major push in the social sciences and policy arenas has been to gather data to analyze the effectiveness of programs to ensure that money is well spent on improvement and that politics and rhetoric do not overshadow actual results. So-called evidence-based programs and policies use multiple techniques to gauge effectiveness. For

example, meta-analyses are used so that the results of many studies are considered and the bias or methodological limitations of any particular study are minimized. One such study shows that based on the "results of 22 trials involving 15,288 women, conducted in 16 countries under a wide variety of circumstances" (Hodnett, Gates, Hofmeyr, & Sakala, 2012, p. 15) women who had some sort of continuous support person (nurse or midwife; doula; partner, family member, or friend) were more likely to have a vaginal birth, give birth without an epidural, and less likely to be dissatisfied with their experiences compared to women who did not have continuous support. Women with support were also more likely to have a shorter labor and less likely to need an intervention to help with the birth, such as use of forceps or a cesarean section delivery. The authors explain that overall, across the studies, consistent support was found for having a support person and no harmful effects were noted. They recommend that this be a routine practice for hospitals and not the exception.

Use midwives. Cartwright and Thomas (2001) examine the transformation that childbirth has taken from being dangerous to being risky. First, childbirth has always been dangerous for women. Minor and serious complications for both the mother and the infant are present including mortality for one or both. Cartwright and Thomas argue that danger was a "fatalistic outlook on birth" and that by constructing danger as risk, we instead allow for "an activist stance" where challenges can be met with science and medical technology (p. 218). Through a process of multiple steps, Cartwright and Thomas show that danger can become risk and can be controlled with medical technologies. The first step is to select which dangers out of all of the dangers will become risks. The next step is to make those dangers quantifiable, measureable, and visible. Finally, once we have the ability to measure those dangers, we must select thresholds for which those dangers are normal or abnormal and be able to track the progress from

one state to the other. The danger is now a risk: one we can measure, observe, track, and treat. Most importantly, the use of risk instead of danger implies that we have the possibility to control it. In fact, as obstetricians gain greater control over problems during pregnancy and childbirth, the failure to deliver perfect results can lead to lawsuits. Ironically, once technologies have been developed to predict and treat problems and those technologies become mainstream, the rates of lawsuits increase because now the doctors were supposed to find (and if possible cure) the problem. Moreover, it is not always clear that medical interventions are useful for the average pregnancy. The fetuses of women who have low risk pregnancies do not benefit from electronic fetal monitoring and even the use of "safe" and standard technologies still present risks, such as epidurals, which can cause sudden drops in blood pressure, ringing in the ears, and difficulty pushing (American Pregnancy Association, 2016).

Since 1969, 99% of American babies have been born in hospitals (Boucher, Bennett, McFarlin, & Freeze, 2009). In 2014 the Centers for Disease Control and Prevention (CDC) reported that 1.36% of all births occurred outside of a hospital (MacDorman, Mathews, & Declercq, 2014). Before 1940, most American babies were born at home with the assistance of midwives (Boucher, Bennett, McFarlin, & Freeze, 2009). Currently, midwives are legally permitted to practice in 28 states (MANA, 2015). Each state has its own legal requirements, ranging from licensure for anyone who wants to be a midwife, to the need for a midwife to have nursing degree, to statutes permitting midwives, but red tape effectively not allowing for actual practice.

In 2005, Beckett and Hoffman studied the social movement of birth activists and its relationship to the licensure of midwives in order to determine the influence of midwives to effect change, but also the ability for this social movement to resist the cultural hegemony of

modern medicinal childbirth. Data from various documents, audio recorded legislative debates, observations, and interviews were collected and analyzed. Directly important for the current study is the finding that midwifery, which was normal in the early 1900s (and before), became a subject of great debate which led to a determined effort to regulate and license midwives. As norms changed and the default became to go to the hospital, birth activists pushed back to allow women to be able to choose to give birth at home. As midwives were forbidden from practicing, women were forced to go to the hospital in order to be in the care of a medical/birth expert. While Beckett and Hoffman focus on the social movement to reinstate midwives, they do not discuss the point that women were no longer able to make a choice about how they gave birth. This disempowerment of women to choose what to do with their bodies reinforces patriarchal and hegemonic practices of law and lawmakers to restrict what women can do with their bodies. It is therefore not surprising that regulating pregnancy is just a continuation of regulating women's bodies.

Hatem, Sandall, Devane, Soltani, and Gates (2009) performed a meta-analysis that reviewed studies based on midwife-led care compared to medical-led care and combined care and found many of the same effects as Hodnett et al. (2012). Distinctly important for midwife-led care, patients experienced less medically intensive care than other women, but also were more likely to share their birthing experience with a midwife they get to know during pregnancy, and the women felt in control of the delivery process. Thus, midwifery, currently a form of resistance against the hegemonic practices of the medical community, should be reframed as part of the usual and normal experience for women who are not at risk for major medical complications. Hatem et al. as well as Hodnett et al. do caution that women with risky pregnancies or medical histories, which might indicate complications, should still be supervised

by medical professionals in a medical setting, but this opens the door for the majority of women to use midwives to their benefit.

Bringing back the practice of using midwives in most birth scenarios offers several benefits. First, it may lead to fewer birth interventions, second it gives power to women to make active decisions about their care— important for women who were forced into c-sections, and third, and most central to this argument, it provides a person whom the patient can trust. A midwife can offer care throughout and after the pregnancy. Imagine if midwives acted as liaisons between pregnant women and medical staff in the event of an emergency. Midwives would be able to keep the pregnant woman calm and be effective and knowledgeable communicators with medical practitioners. It is also possible that women with addiction, financial, abuse, and other types of issues would be able to get referrals for help from someone they actually trust to help them.

Communicate Ahead of Medical Procedures. Patients and doctors need to maintain an open dialogue to discuss the birthing plan before the birth and the progression of the birth during the event. Cesarean sections, epidurals, episiotomies, and other procedures should remain options for the patient and doctor to choose, especially in emergency situations, but original plans should remain in effect until an emergency or impasse arises. Pregnancy should be viewed as any other medical condition—one where the patient has the right of refusal or acceptance of treatment as well as informed consent.

Power to Make Informed Decisions. All women deserve the ability to make informed choices about their healthcare and wellbeing. From a medical standpoint, birth control methods need to be tested and safe for all citizens of childbearing ages. The choice of method should remain with a woman, counseled by her doctor who can recommend the best method(s) based on

a checklist of factors including medical history, risks, costs, failure rate, and routine. When one method is no longer suitable, others should be discussed as desired. In general, birth control and pregnancy should be seen as routine, normal parts of the lives of women. All women deserve information given to them by a qualified physician about reproduction and their bodies at all stages of life, including pre-menstrual, childbearing, and menopausal. Knowledge of available options empowers women to make choices about their reproduction that best suits them.

For a woman who wants to conceive and bear a child, information is crucial before, during, and after pregnancy. While many consider information to literally be at our fingertips because phones and computers can easily access search engines, not all women are as lucky. Ownership and access to computers, phones, and the internet may not be free. More importantly, the knowledge that can be gleaned on the internet is not always accurate. It can be very difficult to parse out fact from fiction and vetted knowledge from suspected knowledge. Moreover, knowledge does change as medical science advances and what is known about pregnancy may be hard to interpret by lay readers. Doctors need to provide knowledge to patients. Information *before* and *during* is crucial to help women achieve the best outcomes possible for themselves and their future children. To name a few items, before pregnancy, information on smoking cessation, prenatal vitamins, sexually transmitted infections, diet, all legal and illicit drugs, exercise, on-going health issues, and stages of pregnancy should be discussed. During pregnancy a conversation about vaccines, a birthing plan, hormone fluctuations, readying the home, possible side effects, genetic testing, and other pertinent advice should be given. Women should be given space to learn information, ask questions, seek more advice, and then have time to process and follow up. Logistic, financial, emotional, and practical assistance may be required to get a potential mother care- not just the best that she can afford, but the care that all women

deserve. Doctors may want to couple their services with those who are able to provide legal and financial counsel and aid.

An example of a successful, evidence-based program is the Nurse-Family Partnership. This program is specifically designed to help vulnerable, low-income women. The program has several important measurable impacts including fiscal benefits and a number of reductions in crime, but it also provides less calculable impacts like care and guidance to first-time mothers. Some of the measurable benefits include reductions in child abuse, reductions in juvenile arrests, fewer trips to the emergency room for accidents, and less dependence on social safety nets like foods stamps and Medicaid (Nurse Family Partnership, 2014). Some of the benefits that are less measurable include the fact that the nurses are well educated (a BSN or higher is required) and the services that they provide to the mother start early in the pregnancy and continue until the child turns two. This means that nurses are there to help pregnant women combat issues like substance abuse, find appropriate prenatal care, formulate appropriate healthful eating and exercise habits, help set up the home in advance of the baby's arrival, and so forth. Once the baby is born, the nurse can help with breastfeeding, changing, illness, and other routine activities. The nurse can also look for signs of postpartum depression and other early signs of problems. As the baby grows, the nurse continues to visit and can help with discipline, milestones, diet, and even family planning. The nurse may serve not only as a trustworthy guide, but she may also function as the mother's cheerleader: encouraging good habits and other pro-social behaviors like continuing education and networking with peers. Overall, this program does not seek to replace the mother with a nurse, but rather empowers a new mother by providing her with a source of support and guidance that she can lean on when she has questions or feels frustrated.

Alcohol and Drug Use. Currently there is no test for chronic or periodic alcohol use during pregnancy even though Fetal Alcohol Syndrome (the worst of a spectrum of disorders) is well documented and caused by drinking alcohol during pregnancy. Although science is still debating the like between damage and alcohol consumption, when the alcohol is consumed during the pregnancy timeline, whether there is a link to race or medical history of the mother, and other issues, doctors generally advise complete abstinence during pregnancy. Blood alcohol concentration, alcohol metabolites in urine, and breathalyzer tests are useful to see if a woman has recently had a drink, but less helpful to understand chronic use. Questionnaires that ask about alcohol use may be helpful, but depend on honesty and self-report (which may not be accurate even when the woman is being truthful).

Prescription, over-the-counter, cigarette, and illicit drug use and abuse are also important considerations for doctors and their pregnant patients. In 1999, 3.4% of pregnant women self-identified as using illicit drugs (Lester, Andreozzi, & Appiah, 2004). This usage is considerably lower than the child-bearing population, but should be considered a conservative estimate based on the nature of self-report. While Lester, Andreozzi and Appiah (2004) recommend using meconium testing (first stool sample of an infant) coupled with maternal self-report to understand a woman's drug use during pregnancy (based on accuracy and confirmation of results), this should be continued for research but not as a basis upon which to understand maternal drug use during pregnancy. This kind of confirmation might help researchers and doctors to understand the prevalence, frequency, and drugs used during pregnancy, but testing one mother to confirm or deny her use after she has given birth presents a "gotcha moment." More importantly, testing after birth does nothing to curb an addiction during pregnancy. Using the continuity of care model, a woman who trusts her doctor and does not fear consequences of

reporting, may disclose issues surrounding all kinds of substance use. Moreover, little is known about polydrug effects on the mother and fetus even though it is more common that single drug use (Lester, Andreozzi, & Appiah, 2004). Finally, illicit drugs are often stigmatized, but abuse of prescription pills and over-the-counter drugs can be just as harmful as "street drugs." In fact, pharmacologically there may not be a large difference between the illicit drug and the prescription drug (e.g., marijuana and HTC). Demonizing one class of drug and categorizing women as bad mothers based on an addiction does not get at the root of the problem. Tools, education, and chances to quit or step down use must be prioritized.

Finally, using the continuity of care model, patients may be able to make more informed decisions about waiting to conceive a child until drug/alcohol use (of any kind) has been reduced or stopped compared to patients who do not have trusting or ongoing relationships with their medical providers. This approach focuses on prevention of harm before pregnancy even begins in order to give the woman and the fetus the best chance at a healthy pregnancy.

Intervention

The sections above focused on reframing how we think about healthcare and prevention efforts. Unfortunately no system, even if ingrained, will be perfect. Not all women will be caught by the "prevention safety net." Intervention efforts must be developed in addition to preventative schemas.

Currently when we consider helping pregnant women who have substance abuse issues, the options for drug treatment in the legal arena are through constitutionally mandated health care in criminal justice facilities (judicially interpreted in notable court cases such as *Newman v. Alabama* (1972) and *Estelle v. Gamble* (1976)), drug/family dependency courts, and residential and/or community treatment services that are compulsory as part of probation or parole. The

other common way to get help is through the medical arena, through hospitals, doctors, and residential and outpatient treatment centers. As I have argued above, if our country implements a systematic and purposeful preventative approach in the medical community then intervention becomes a secondary means of help where only women who have fallen through the cracks need assistance.

Assuming prevention is the first priority but that intervention strategies need to be fleshed out as well, in this section I will argue that 1) prevention will reduce current costs associated with pregnant women and their treatment if only because fewer women will need to be treated and more importantly, 2) the medical system is superior to the criminal justice system in its ability to offer services that are less coercive and better suited to women's needs, but steps need to be taken to make sure that medicine, not law, is being practiced by the medical community. Specifically I show that replicating the ideals of drug courts in the medical setting removes the punitive and coercive factors that judges rely on as motivators for the successful completion of a program, but moreover that this location is better suited to give pregnant women, as a special population, services and help that they need to have healthy babies.

If women are prevented from becoming substance abusers, prevention efforts, including education and resources should cost less in the long run than treating women once they have a substance abuse problem. Even for the women who fall through the cracks and for whom intervention becomes necessary, there will literally be fewer of them than currently, reducing the fiscal impact of treatment. Additionally, if the continuity of care model does work generally and some women do need special attention (for myriad reasons including health problems, substance abuse issues, lack of transportation, mental health issues, etc.) there are fewer women to accommodate and better care can be devoted to those who are at higher risk of pregnancy

complications. Currently, the best places for women to get enhanced healthcare, including, but not limited to drug addiction support, is in medical settings. That being said, this dissertation has highlighted some instances where the medical and legal systems collude to harm, rather than help, women. Medical care should be the solitary mission of healthcare institutions. Using several actors to give "wrap-around" services to women, promotes not only trust and helpfulness, but leaves a woman's dignity intact. A "one-stop-shop" may be useful for women to get coordinated benefits, reduce travel to multiple specialists, combat comorbidity, and reduce the likelihood of "falling through the cracks" if multiple points of contact exist.

Currently, drug courts offer an interesting model for treatment. Those who have been arrested, but face minimal penalties due to the nature of the offense, may be eligible for services rather than legal punishment; however, drug courts do rely on punishment as a fallback position should a person fail to get through the program. Even small punishments may be indicated during the course of treatment if some standards are not met.

Using the threat of punishment to underpin treatment, especially in relation to medical issues or social myths about gender roles during pregnancy, should not be the goal. In fact, punishment should be abolished as a mechanism to produce compliance. Consider Tennessee. Tennessee's narcotic problem became a matter of great importance such that the government felt it was time to intervene. From 2001 to 2011 the rate of drug dependent babies delivered in Tennessee grew by 10 fold. In 2012, Alabama and Tennessee tied for the highest rate of painkiller prescriptions in the United States. Per 100 people, 143 painkiller prescriptions were written (CDC, 2014). That's more than one prescription per person. Armed with data like these, in 2014 Tennessee passed its Fetal Assault law (Tenn. Code Ann. § 39-13-107). The law reads:

(a) For the purposes of this part, "another," "individuals," and "another person" include a human embryo or fetus at any stage of gestation in utero, when any such term refers to the victim of any act made criminal by this part.

(b) Nothing in this section shall be construed to amend the provisions of § 39-15-201, or §§ 39-15-203 -- 39-15-205 and 39-15-207.

(c) (1) Nothing in subsection (a) shall apply to any lawful act or lawful omission by a pregnant woman with respect to an embryo or fetus with which she is pregnant, or to any lawful medical or surgical procedure to which a pregnant woman consents, performed by a health care professional who is licensed to perform such procedure.

(2) Notwithstanding subdivision (c)(1), nothing in this section shall preclude prosecution of a woman for assault under § 39-13-101 for the illegal use of a narcotic drug, as defined in § 39-17-402, while pregnant, if her child is born addicted to or harmed by the narcotic drug and the addiction or harm is a result of her illegal use of a narcotic drug taken while pregnant.

(3) It is an affirmative defense to a prosecution permitted by subdivision (c)(2) that the woman actively enrolled in an addiction recovery program before the child is born, remained in the program after delivery, and successfully completed the program, regardless of whether the child was born addicted to or harmed by the narcotic drug.

Thus, a pregnant woman may be charged with assault if she gives birth to a narcotic addicted or narcotic harmed baby. She may not be charged with assault if she undergoes a legal surgical procedure (code for abortion). An example of an affirmative defense is if you were charged with murder, but the killing happened because you were defending yourself. Self-defense is an affirmative defense to what would otherwise be a crime. Tennessee has provided pregnant

women with a way out of being prosecuted for their drug use: treatment. The problem is that treatment as defined in the statute, active enrollment before the birth, remaining enrolled after the delivery, and successful completion of the program are vague requirements. How much time before birth and after birth does a woman need to be enrolled? What is the definition of success? Does it depend on the individual program's definition of success or does it only mean drug-free? Is it something else? The language of the law itself is vague, presenting problems, but it pales in comparison to the logistical problems of actually getting treatment in Tennessee. According to Nina Liss-Schultz (2016) only 11 of 39 residential treatment centers even accept pregnant women. This means that there are only about 130 spots open to pregnant women statewide. In 2005 TennCare (Tennessee's Medicaid) discontinued methadone clinic services for adults (TennCare, 2016). This means that impoverished women have few opportunities to actually get treatment. Women began to be arrested under the law when their newborns tested positive for drugs after delivery. Several women have already been arrested and charged under this law. Liss-Schultz's news article chronicles the story of Brittany Hudson, who at 24 years old knew about the law and actively avoided getting prenatal care because she knew she could get in trouble. She gave birth in the back of a friend's car. Eventually she was arrested and charged under the Fetal Assault law. Hudson's story has a happy ending- she has joint custody over her child and she is no longer addicted to prescription drugs, but not all women are as lucky. Hudson now works with pregnant drug addicts at a treatment center and says that she encounters many women who avoid getting any kind of prenatal care for two-thirds of their pregnancies. Tennessee has seen how problematic this law has been such that women actively *avoid* healthcare, the exact opposite of its intention. On Tuesday, March 22, 2016 the legislature voted and the law will not be renewed. Tennessee's Fetal Abuse law will expire on July 1, 2016.

Why did Tennessee's punitive law fail? First, criminalizing help does not work, but second it certainly does not work if adequate resources are not in place. The women in Tennessee were afraid of getting in trouble and avoided medical care, but even those who became desperate and tried to find help were turned away. Instead, Tennessee should have promoted and enhanced their own legislation that gave pregnant drug addicts priority in drug treatment centers and helped to keep mother and baby together after birth (known at the Safe Harbor Act of 2013, Tennesee Code Annotated § 33-10-104(f)). Creating laws to help women is not enough; resources must be allocated and developed for women who *will* fall through the cracks.

CHAPTER 6: Conclusion

Chapter Overview

In the previous chapter I explored the policy implications of problematic pregnancies and some solutions. I suggested that prevention, not regulation would be a better process for both the mother and the baby because it reduces actual harm, but also because it has practical economic implications and gives doctors the ability to do what they do best: practice medicine, not law. In this chapter I will relate my project to previous literature, explore the strengths and limitations of the project comment, suggest directions for future studies, and conclude.

This dissertation has addressed the ongoing issue of the formal and informal regulation of women's reproduction in America. From what is controversial: abortion, contraception coverage, and women's chastity, to what is exciting: pregnancy announcements, gender reveals, and baby showers, pregnancy-related issues are constantly discussed in America. This project has highlighted one specific area of pregnancy that is not only uncomfortable to address, but also one that may seem to many as completely justifiable considering that we are regulating on behalf of an entity unable to protect itself. The project has shown, though, that despite good intentions, this promise falls short and neither babies nor women benefit. Moreover, even if babies did benefit, I argue that the ends do not justify the means. Women must be given a certain amount

of power to ensure their own bodily integrity, freedom from balancing tests that pit their rights against their own flesh and blood, and resources that promote successful birth outcomes. The criminalization of women's status as pregnant is a real issue that many women face and much of the added regulation comes from an anxiety that women will make poor choices. This anxiety is rooted in real fears, but ignores actual outcomes for children and does not consider structural inequalities; some women are doing the best they can and society judges that effort to be inadequate. A fundamental shift of how we pursue problematic pregnancies is needed. This reframing must involve at least two levels of transition, one that does not depend on punitive measures to control birth outcomes and another that rethinks how society treats women such that all are entitled to consistent healthcare, quality service, and information to make good choice.

Previous literature

Previous literature (Boyd, 2004) has suggested that social justice may be achieved through the decriminalization of drugs so that resources are not diverted toward the War on Drugs and rather toward social services. This dissertation suggests that even women who are engaged in legal behaviors such as smoking or drinking alcohol may be subject to law enforcement penalties such that legalizing drugs is not enough to stop pregnant women from being targeted with legal regulations. In fact, it is not clear that adding or deleting laws will enhance the quality of women's lives when they are pregnant. Roberts (1997) argues that if the state were truly interested in protecting a child from harm, especially from women who do drugs during pregnancy, they would enact laws that help women to break their addictions while pregnant, not after birth, when the damage has been done (assuming there is some type of long or short term damage associated with the drug use). My work supports Roberts' claim more than it does Boyd's.

Dorothy Roberts (1997) asserts that "reproductive liberty" is one avenue that can contribute to the fight against "racial injustice" (p. 309). By exchanging the "negative right" to liberty for a definition that favors a "positive right," Roberts believes that we should no longer just be protected from governmental intrusion, where the government is doing its job as long as it does not act. Rather we should insist on a government that is proactive and productive in securing resources and structural changes that actually enhance women's lives. Roberts envisions an "affirmative duty of government to protect the individual's personhood from degradation and to facilitate the processes of choice and self-determination" (p. 309). Further, Roberts claims that this extension of services and reframing of the government's affirmative duty must acknowledge race as a critical part of reproductive justice and freedom. By changing the structure so that Black motherhood is no longer criminalized, we acknowledge how intertwined the fights for reproductive justice and racial equality actually are. Roberts most firm claim is that Black women must be allowed to make the decision to have (or not have) children. While these policies that regulate what pregnant women cannot do with their bodies seem individualized or scattershot, the history of regulating Black women's bodies is so entrenched in American history that it is necessary to recognize that it is an entire racial group that is harmed, not just a few selected members of society.

Roberts (1997) also argues that "It is *the choice of carrying a pregnancy to term* that is being penalized" (p. 181, original emphasis) but I think that this has changed. With my data, it is not only women who are penalized for doing drugs and having the baby- and although I agree that is part of it, it is more. Women whose babies died after birth were subjected to the worst penalties, save Purvi Patel, whose dual convictions of feticide and neglect of a dependent made it so that she was penalized both for conduct during the pregnancy and at the birth. While there is

an appeal forthcoming, Patel's conviction shows that she was neither allowed to have a baby nor allowed to *not* to have a baby. In both cases she was doomed. My data show that many kinds of pregnant women suffer consequences: noncompliant patients, women who do drugs, women who contemplate abortions, women who try to commit suicide, and even women who just want to be in control of their own reproduction (literally have a say in how they give birth). Roberts' research indicates that women who smoke crack are targeted. Again, she is right; it is easy to see how society frames Black women as unfit to procreate with all of the political rhetoric constantly referring to them as welfare queens, bad mothers (e.g., see Patricia Hill Collins' concept of the "mammy" who is a good surrogate mother to white children but neglects her own), and the mothers of crack babies. In my work, women who are poor, of any color, but especially women of color and women who are immigrants or children of immigrants, are prosecuted.

Strengths and Limitations

This study, like all research, has strengths as well as shortcomings. First, the data in this study were gathered from published pieces of scholarly works, journalism, and court cases. Published news sources are fact-checked and reviewed by editors, scholarly pieces are peer-reviewed and/or critiqued before publication, and official court documents contain background information of the case that has been established under the threat of perjury. These sources have been vetted but may lack voice or original quotes from the women themselves. To complement this shortcoming, I also used blogs and other online content. These sources suffer from the lack of confirmation of facts, but offer the rich, context-based perspectives of the women and/or their friends. For all cases I attempted triangulation where once I knew a woman's name, I endeavored to find many sources that told her story. In many cases I was successful and was

able to compile a narrative based on two or more published pieces (with the addition of online content in some cases).

Second, bias may have been present at the collection, data analysis, and interpretation stages. To avoid issues at the collection stage, I used the process of triangulation to verify my facts from multiple sources. At the data analysis and interpretation stages I was careful to ask consistent questions of the data. Because the data were collected via secondary sources, I did not suffer from biasing my research subjects nor did I lead them in any way. Further, because of the multiple pathways into regulation, I have avoided using causal language to show that one action caused another. Another tactic I used to shore up internal validity was to check for outliers (or the negative case). It is important that one makes sure that the full story is told and to not just use data that fit a predetermined message. Moreover, looking for cases that do not fit the general pattern helps to refine one's analysis such that all cases are better captured by a more complex and refined explanation. Overall, I let the data guide my work.

While rigorous in the attempt to accurately report the facts of each woman's story, I am limited in external validity, or generalizability. Due to the limited number of cases and the inability to control the selection of cases, 1) how pervasive coercion is in the population of pregnant women is unknown and 2) it is not known how representative these case studies are of women who have experienced regulated pregnancies. Even if these women are not representative, this study does show that women face a spectrum of penalties for their actions and statuses. As George and Bennett (2005) explain, "in view of these trade-offs case study researchers generally sacrifice the parsimony and broad applicability of their theories to develop cumulatively contingent generalizations that apply to well-defined types or subtypes of cases with a high degree of explanatory richness" (p. 31). While these 26 women may face unusual

circumstances and penalties, their stories are not simply anecdotal. Instead, through systematic analysis of these cases, I unearthed underlying threads of coercive treatment and problems that plague the criminal justice system. Indeed, this work confirms some of the findings and histories documented by Paltrow and Flavin (2013), but also adds to them.

This study was also limited by time and feasibility. To add further richness to this study, my future plans include interviewing women in this study to give more insight to how they viewed their experiences and the meaning they ascribe to the events surrounding their pregnancies. In addition, changing the unit of analysis from individuals (i.e., pregnant women) to systems (i.e., medical offices, hospitals, courts, and police) would allow for a more thorough investigation, and offer a broader perspective of the problems with implementation of treatment and birthing plans, successful deliveries of healthy babies, and daily obstacles faced by medical and legal actors. I have argued in this piece that the context of pregnant women's lives must be contemplated when considering their conduct, but I have not investigated the quotidian routine of a maternity ward to suitably understand the balance between a pregnant woman's wishes and needs and the hospital's demands and necessary practices.

Finally, the current study benefits from a holistic point of view that allows for the integration of several different literatures on the subject of pregnancy; however, this work could not address all situations of pregnancy and family life that have been explored in the work done by other legal scholars, sociologists, and criminologists. Pregnancy and its characterization as a disability within the legal framework, paid family leave, women's continued role as the primary caregiver for children, domestic violence against a pregnant woman, and the treatment of women in jail/prison are all subjects that are worthy of deeper treatment than could be provided in this

manuscript. Certainly each of these topics is relevant to issues of law and could be expounded on by future works.

Future Studies

This study has attempted to shed light on the multiple ways in which pregnant women are regulated and criminalized by social control actors in the medical and legal spheres using qualitative analysis of the case studies of the pregnant women. Future studies should embrace alternative ways to continue the work that has begun here. I was unable to assess the magnitude to which pregnant women are coerced into having medical procedures that they are unwilling or inadequately prepared to have. Future studies could be designed to understand this trend in a given area, and thus an in-depth qualitative study, or throughout the United States as a whole using quantitative measures.

Second, although there are studies that have documented the medical treatment that women receive in jail and prison, including shackling during the birthing process, further work could ascertain the overall extent to which jail and prison are beneficial and harmful to the pregnant woman and her fetus. All medications cleared by the Food and Drug Administration (FDA) must indicate what they know about the effects of a medication on the fetus and a conclusion about whether that drug is safe during pregnancy. Like this labeling policy by the FDA, future research can classify imprisonment policies and procedures, including birthing procedures, as appropriate, risky, or not recommended for pregnant inmates. A classification system may help jails and prisons meet the needs of pregnant inmates without compromising the goals of maintaining order and safety for all inmates.

Finally, while my task has been to bring together multiple lenses of scholarship, consider different types of cases, and add policy relevant information, I have done very little by way of

theory testing using case studies. A future study may consider why it is that we regulate pregnant women and subject those theories to testing through case studies. Where the theories do not fit the actual events, theory refinement must occur to account for the discrepancies between the prediction and the real world events. Moreover, George and Bennett (2005) indicate that theory testing using case studies gives rise to understanding the "scope conditions of theories" (p. 75), that is, when theories are more and less likely to apply to real cases.

REFERENCES

American Congress of Obstetricians and Gynecologists (ACOG). Retrieved from: www.acog.org

American Pregnancy Association. (2016, February 28). Epidural anesthesia. Retrieved from: http://americanpregnancy.org/labor-and-birth/epidural/

Akers, R. L., & Sellers, C. S. (2009). *Criminological theories: Introduction, evaluation, and application* (5th ed.). New York, New York: Oxford University Press.

Alexander, M. (2010). *The new Jim Crow: Mass incarceration in the age of colorblindness.* New York, New York: The New Press.

American Civil Liberties Union (ACLU). (2016, May 6). What is the school-to-prison pipeline? Retrieved from: https://www.aclu.org/fact-sheet/what-school-prison-pipeline

American College of Obstetricians and Gynecologists. (2008). Surgery and Patient Choice. *Obstetrics and Gynecology, 111,* 243-247.

American Pregnancy Association (http://americanpregnancy.org/labor-and-birth/epidural/).

Austin, R. (1989). "The black community," its lawbreakers, and a politics of Identification. *Southern California Law Review, 65,* 1769-1817.

Beckett, K. (1995). Fetal right and "crack moms": Pregnant women in the war on drugs. Contemporary *Drug Problems, 22,* 587-612.

Beckett, K. (2005). Choosing cesarean: Feminism and the politics of childbirth in the United States. *Feminist Theory, 6,* 251-275. doi: 10.1177/1464700105057363

Beckett, K., & Herbert, S. (2009). Banished: The new social control in urban America. New York, New York: Oxford University Press.

Beckett, K., & Hoffman, B. (2005). Challenging medicine: Law, resistance, and the cultural politics of childbirth. *Law & Society Review, 39,* 125-170. doi: 10.1111/j.0023-9216.2005.00079.x

Boyd, S. C. (2004) From witches to crack moms: Women, drug law, and policy. Durham, North Carolina: Carolina Academic Press.

Boucher, D., Bennett, C., McFarlin, B., & Freeze, R. (2009). Staying home to give birth: Why women in the United States choose home birth. *Journal of Midwifery and Women's Health, 54,* 120-126.

Cartwright, E., & Thomas J. (2001). Constructing risk: Maternity care, law, and malpractice. In R. DeVries, C. Benoit, E. van Teijlingen, & S. Wrede (Eds.), *Birth by design: Pregnancy, maternity care, and midwifery in North America and Europe* (pp. 218-28). New York, New York: Routledge.

Cassidy J., Ziv, Y., Stupica, B., Sherman, L J., Butler , H., Karfgin, A., Cooper, G., Hoffman, K. T., & Powell, B. (2010). Enhancing attachment security in the infants of women in a jail-diversion program. *Attachment & Human Development,12,* 333-353, doi: 10.1080/14616730903416955

Centers for Disease Control and Prevention (CDC). (2014, July 1). Opioid painkiller prescribing infographic. Retrieved from: http://www.cdc.gov/vitalsigns/opioid-prescribing/infographic.html#infographic1

Centers for Disease Control and Prevention (CDC). (2016, May 1). Smoking during pregnancy. Retrieved from: http://www.cdc.gov/tobacco/basic_information/health_effects/pregnancy/

Cherry, A. L. (2007). The detention, confinement, and incarceration of pregnant women for the benefit of fetal health. *Columbia Journal of Gender and Law, 16,* 147-197.

Chesney-Lind, M. (2006). Patriarchy, crime, and justice: Feminist criminology in an era of backlash. *Feminist Criminology, 1,* 6-26. doi: 10.1177/1557085105282893

Clear, T. R. (2008). The effects of high imprisonment rates on communities. *Crime and Justice, 37,* 97-132. doi: 0192-3234/2008/0037-0004$10.00

Comfort, M. (2007). Punishment beyond the legal offender. *Annual Review of Law and Social Science, 3,* 271-296. doi: 10.1146/annurev.lawsocsci.3.081806.112829

Crenshaw, K. (1998). A Black Feminist Critique of Antidiscrimination Law and Politics. In The politics of law: A progressive critique 3rd edition David Kairys (Ed.).

Daly, K. (1998). "Women's Pathways to Felony Court: Feminist Theories of Lawbreaking and Problems of Representation" Chapter 8 in *Criminology at the Crossroads: Feminist Readings in Crime and Justice.* Kathleen Daly and Lisa Maher (Eds). New York, New York: Oxford University Press.

Daly, K., & Chesney-Lind, M. (1988). Feminism and criminology. *Justice Quarterly, 5,* 497-538. doi: 10.1080/07418828800089871

Farr, K. A. (1995). Fetal abuse and the criminalization of behavior during pregnancy. *Crime and Delinquency, 41,* 235-245. doi: 10.1177/0011128795041002005

Frankfort-Nachmias, C., & Nachmias, D. (2008). Research methods in the social sciences. New York, New York: Worth Publishers.

Galanter, M. (1974). Why the "haves" come out ahead: Speculations on the limits of legal change. *Law and Society Review, 9,* 95-160. doi: 10.2307/3053023

Garland, D. (2001). The culture of control: Crime and social order in cotemporary society. Chicago, Illinois: The University of Chicago Press.

George, A. L. & Bennett, A. (2005). Case studies and theory development in the social sciences. Cambridge, Massachusetts: MIT Press.

Glaze L. E., & Kaeble, D. (2014, December). Correctional populations in the United States, 2013. (NCJ 248479). *Bureau of Justice Statistics.*

Gomez, L. E. (1997). *Misconceiving mothers: Legislators, prosecutors, and the politics of prenatal drug exposure.* Philadelphia: Temple University Press

Goodwin, M. (2014, April). *Pregnant Women and the Medical-Legal Divide.* Lecture conducted at The Howard A. Schneiderman Memorial Bioethics Lecture Series, Irvine, CA.

Guttmacher Institute. (2016, March 1). Substance abuse during pregnancy. Retrieved from: https://www.guttmacher.org/sites/default/files/pdfs/spibs/spib_SADP.pdf

Hackshaw, A., Rodeck, C., & Boniface S. (2011). Maternal smoking in pregnancy and birth defects: A systematic review based on 173678 malformed cases and 11.7 million controls. *Human Reproduction Update, 17,* 589-604. doi:10.1093/humupd/dmr022

Handwerker, L. (1994). Medical risk: Implicating poor pregnant women. *Social Science and Medicine, 38,* 665-675. doi: 10.1016/0277-9536(94)90457-X

Hatem M., Sandall J., Devane D., Soltani H., & Gates S. (2008). Midwife-led versus other models of care for childbearing women (review). *The Cochrane Library, 4,* 1-105.

Hochschild, A. R., & Machung, A. (1989). *The second shift: Working parents and the revolution at home*. New York, New York: Viking Penguin.

Hodnett, E. D., Gates, S., Hofmeyr, G. J., & Sakala, C. (2012). Continuous support for women during childbirth (review). *The Cochrane Library, 10,* 1-113.

Hotelling, B. A. (2008). Perinatal needs of pregnant, incarcerated women. *Journal of Perinatal Education,17*, 37–44, doi: 10.1624/105812408X298372

Hulsey, T. (2005). Prenatal drug use: The ethics of testing and incarcerating pregnant women. *Newborn and Infant Nursing Reviews, 5,* 93-96. doi: 10.1053/j.nainr.2005.03.004

Husak, D. (2008). *Overcriminalization: The limits of the criminal law*. New York, NY: Oxford University Press Incorporated.

Ip, S., Chung, M., Raman, G., Chew, P., Magula, N., DeVine, D., Trikalinos, T., Lau, J. (2007). Breastfeeding and maternal and infant health outcomes in developed countries (Number 153) Boston, Massachusetts: Tufts-New England Medical Center Evidence-Based Practice Center.

Johnsen, D. (1987). A new threat to pregnant women's autonomy. Hastings Center Report, 17, 33-40. doi: 10.2307/3563181

Johnstone, T., & Miller, M. K. (2008). The court's role in promoting comprehensive justice for pregnant drug and alcohol users. *Juvenile and Family Court Journal, 59,* 39-54. doi: 10.1111/j.1755-6988.2008.00014.x

Kadish, S. H. (1967). The crisis of overcriminalization. *The Annals of the American Academy of Political and Social Science, 374,* 157-170. doi: 10.1177/000271626737400115

Ko, L. (2016, January 26). Unwanted sterilization and eugenics programs in the United States. Retrieved from: http://www.pbs.org/independentlens/blog/unwanted-sterilization-and-eugenics-programs-in-the-united-states/).

Kraft-Stoler, T. (2015). *Reproductive injustice: The state of reproductive health care for women in New York state prisons.* New York: Correctional Association of New York.

Kreager, D. A., Matsueda, R. L., & Erosheva, E. A. (2010). Motherhood and criminal desistance in disadvantaged neighborhoods. *Criminology, 48,* 221-257. doi: 10.1111/j.1745-9125.2010.00184.x

Lester, B., Andreozzi, L., & Appiah, L. (2004). Substance use during pregnancy: Time for policy to catch up with research. *Harm Reduction Journal, 1,* 1-44. doi:10.1186/1477-7517-1-5

Levi, R., & Waldman, A. (Eds.). (2011). Inside this place, not of it: Narratives from women's prisons. San Francisco, California: McSweeny's Books.

Liss-Schultz, N. (2016, March 14). Tennessee's war on women is sending new mothers to jail. *Mother Jones.* Retrieved from: www.motherjones.com

Logli, P. A. (1990). Drugs in the womb: The newest battlefield in the war on drugs. *Criminal Justice Ethics, 9,* 23-29. doi: 10.1080/0731129X.1990.9991869

MacDorman M. F., & Gregory E. C. (2015). Fetal and perinatal mortality: United States, 2013. *National Vital Statistics Report, 64,* 1-24.

MacDorman, M. F., Mathews, T. J., Declercq, E. (2014). Trends in out-of-hospital births in the United States, 1990–2012. (NCHS Data Brief 144). Retrieved from: http://www.cdc.gov/nchs/products/databriefs/db144.htm

Maher, L. (1990). Criminalizing pregnancy – The downside of a kinder gentler nation? *Social Justice, 17,* 111-135. Retrieved from: http://www.jstor.org/stable/29766562

Mariner, W. K., Glantz, L. H., & Annas, G. J. (1990). Pregnancy, drugs, and the perils of prosecution. *Criminal Justice Ethics, 9,* 30-41. doi: 10.1080/0731129X.1990.9991870

Martinson, R. (1974). What works? Questions and answers about prison reform. *The Public Interest, 35,* 22–54.

Maruschak, L. M. (2008, April 1). Medical problems of prisoners. (NCJ 221740). Retrieved from: http://www.bjs.gov/content/pub/pdf/mpp.pdf.

McGinnis, D. M. (1990). Prosecution of mothers of drug-exposed babies: Constitutional and criminal theory. *University of Pennsylvania Law Review, 139,* 505-539. doi: 10.2307/3312287

Meier, R. F., & Geis, G. (2006*). Criminal justice and moral issues.* Los Angeles, California: Roxbury Publishing Company

Meredith, S. (2005). *Policing pregnancy: The law and ethics of obstetric conflict.* Aldershot, England: Ashgate Publishing Company.

Midwives Alliance North America (MANA). (2015, July 16). State by state. Retrieved from: http://mana.org/about-midwives/state-by-state#DC,%20http://narm.org/pdffiles/Statechart.pdf

Mills, C. W. (1959). The sociological imagination. Oxford, England: Oxford University Press.

Morris, N. & Hawkins G. (1972) *The Honest Politician's Guide to Crime Control.* Chicago, Illinois: The University of Chicago Press.

National Institutes of Health (NIH). (2011, December 13). Placental, pregnancy conditions account for most stillbirths. Retrieved from: http://www.nih.gov/news/health/dec2011/nichd-13.htm

Noble, A. (1997). Is prenatal drug use child abuse?: Reporting practices and coerced treatment in California. In P. G. Erickson, D. M. Riley, Y. W. Cheung, & P. A. O'Hare (Eds.), *Harm reduction: A new direction for drug policies and programs* (pp. 174-191). Toronto, Canada: University of Toronto Press Incorporated.

Nolan, K. (1990). Protecting fetuses from prenatal hazards: Whose crimes? What punishment? *Criminal Justice Ethics, 9,* 13-23. doi: 10.1080/0731129X.1990.9991868

Nurse Family Partnership. (2014, September). Benefits and costs. Retrieved from: http://www.nursefamilypartnership.org/assets/PDF/Fact-sheets/NFP_Benefit_Cost.aspx

Oberman, M. (1992). The control of pregnancy and the criminalization of femaleness. *Berkeley Women's Law Journal, 7,* 1-12.

Packer, H. L. (1968). *The limits of the criminal sanction*. Stanford, California: Stanford University Press.

Pager. D. (2003). The mark of a criminal record. *American Journal of Sociology, 108,* 937-975. doi: 0002-9602/2003/10805-0001$10.00

Paltrow, L. M. (1990). When becoming pregnant is a crime. *Criminal Justice Ethics, 9,* 41-47. doi: 10.1080/0731129X.1990.9991871

Paltrow, L. M., & Flavin, J. (2013). Arrests of and forced interventions on pregnant women in the United States, 1973-2005: Implications for women's legal status and public health. *Journal of Health Politics, Policy, and Law, 38,* 299-343. Advance online publication. doi: 10.1215/03616878-1966324

Pettit, B., & Western, B. (2004). Mass imprisonment and the life course: Race and class inequality in U.S. incarceration. *American Sociological Review, 69,* 151–169.

Pew Research Center http://www.pewsocialtrends.org/2015/11/04/raising-kids-and-running-a-household-how-working-parents-share-the-load/

Richer, C. J. (2000). Fetal abuse law: Punitive approach and the honorable status of motherhood. *Syracuse Law Review, 50,* 1127-1150.

Roberts, D. E. (1993). Motherhood and crime. *Iowa Law Review, 79,* 95-141.

Roberts, D. E. (1997). *Killing the black body: Race, reproduction, and the meaning of liberty.* New York, New York: Random House, Inc.

Roth, R. (2002). The perils of pregnancy: Ferguson v. City of Charleston. *Feminist Legal Studies, 10,* 149–158.

Saada Saar M., & Morrison, J. C. (2010, October). *Mothers behind bars: A state-by-state report card and analysis of federal policies on conditions of confinement for pregnant and parenting women and the effect on their children.* Washington, D. C.: The Rebecca Project for Human Rights and the National Women's Law Center.

Schiff, C. (1997). Child Custody and the Ideal of Motherhood in Late Nineteenth-Century New York. *Georgetown Journal on Fighting Poverty, 4,* 403-420.

Schur, E. M. (1984). *Labeling women deviant: Gender, stigma, and social control.* New York, New York: Random House, Inc.

Simon, J. (2007). Governing through crime: How the war on crime transformed American democracy and created a culture of fear. Oxford, England: Oxford University Press.

Smart, C. (1989). *Feminism and the power of law.* London, England and New York, New York: Routledge.

Smith, A. (2005). Beyond pro-choice: Women of color and reproductive justice. *NWSA Journal, 17,* 119-140. doi: 10.1353/nwsa.2005.0019

Snider, L. (1998). "Feminism, Punishment, and the Potential of Empowerment" Chapter 14 In Kathleen Daly, K., & Lisa Maher, L. (Eds.) Criminology at the Crossroads: Feminist Readings in Crime and Justice. New York, New York: Oxford University Press.

School of Social Ecology. (2015, May 1). History and mission. Retrieved from: https://socialecology.uci.edu/pages/history-and-mission

Stephenson, P. A., & Wagner, M. G. (1993). Reproductive rights and the medical care system: A plea for rational health policy. *Journal of Public Health Policy, 14,* 174-182. doi: 10.2307/3342963

Stewart, H. (2010). The limits of the harm principle. *Criminal Law and Philosophy, 4,* 17-35. doi: 10.1007/s11572-009-9082-9

Stone-Manista, K. (2009). Protecting pregnant women: A guide to successfully challenging criminal child abuse prosecutions of pregnant drug addicts. *Journal of Criminal Law and Criminology, 99,* 823-856. doi: 0091-4169/09/9903-0823

TennCare (2016, May 12). TennCare Timeline. Retrieved from: https://www.tn.gov/tenncare/article/tenncare-timeline

The Sentencing Project. (2007, May). Women in the criminal justice system. Retrieved from: http://www.sentencingproject.org/doc/publications/womenincj_total.pdf

Thomas, G. (2011). A typology for the case study in social science following a review of definition, discourse, and structure. *Qualitative Inquiry, 17,* 511-521 doi: 10.1177/1077800411409884

U. S. National Library of Medicine (2016, February 12). Miscarriage. Retrieved from: https://www.nlm.nih.gov/medlineplus/ency/article/001488.htm

Von Hirsh, A., & Maher, L. (1992). Should penal rehabilitation be revised? *Criminal Justice Ethics, 11,* 25-30.

Walker, J. (2013, October 11). State parole boards use software to decide which inmates to release: Programs look at prisoners' biographies for patterns that predict future crime. *Wall Street Journal.* Retrieved from: http://www.wsj.com/articles/SB10001424052702304626104579121251595240852

Wang, W. (2014). *On weekends, dads find more time for leisure than moms.* Retrieved from the Pew Research Center website: http://www.pewresearch.org/fact-tank/2014/04/18/on-weekends-dads-find-more-time-for-leisure-than-moms/

Western, B. (2006). Punishment and inequality in America. New York, New York: Russell Sage Foundation.

Whiteford, L. M., & Vitucci, J. (1997). Pregnancy and addiction: Translating research into practice. *Social Science and Medicine, 44,* 1371-1380. doi: 10.1016/S0277-9536(96)00323-1

Williams, C. L. (1991). Case studies and sociology of gender in J. R. Feagin, A. M. Orum, G. Sjoberg (Eds.), *A case for the case study* (pp. 224-243). Chapel Hill, North Carolina: The University of North Carolina Press.

World Health Organization (WHO). (2016, January 15). Stillbirths. Retrieved from: http://www.who.int/maternal_child_adolescent/epidemiology/stillbirth/en/

Zimring, F., & Hawkins, G. (1973). *Deterrence.* Chicago, Illinois: University of Chicago Press.

Court Cases:

Brown v. Plata, 563 U.S. 493 (2011).

Buck v. Bell, 274 U.S. 200 (1927).

Daubert v. Merrell Dow Pharmaceuticals, 509 U.S. 579 (1993).

Eisenstadt v. Baird, 405 U.S. 438 (1972).

Estelle v. Gamble, 429 U.S. 97 (1976).

Ferguson v. The City of Charleston, South Carolina, 532 U.S. 67 (2001).

Griswold v. Connecticut, 381 U.S. 479 (1965).

Kastigar v. United States, 406 U.S. 441 (1972).

Newman v. Alabama, 349 F. Supp. 278 (1972).

Robinson v. California, 370 U.S. 660 (1962).

Roe v. Wade, 410 U.S. 113 (1973).

Hope Ankrom Sources:

Calhoun, A. (2012, April 25). The criminalization of bad mothers. *The New York Times Magazine.* Retrieved from: www.nytimes.com

Ex parte Amanda Helaine Borden Kimbrough v. State of Alabama. 1110176 and 1110219. (2013).

Alicia Beltran Sources:

Eckholm, E. (2013, October 23). Case explores rights of fetus versus mother. *The New York Times.* www.nytimes.com

Marcotte, A. (2013, October 25). Pregnant woman forced into drug-treatment program despite being drug-free. Only her fetus got a lawyer. *Slate*. www.slate.com

Silva, D. (2013, October 24). Shackled and pregnant: Wisconsin case challenges 'fetal protection' law. *NBC News.* www.nbcnews.com

Nina Buckhalter sources:

Bassett, L. 2013, May 23). Mississippi case could lead to prosecution of women who have miscarriages. *The Huffington Post.* www.huffingtonpost.com

Le Coz, E. (2013, May 29). Mississippi stillborn manslaughter charge raising fears. *USA Today.* www.usatoday.com

Sheppard, K. (2013, May 23). Mississippi could soon jail women for stillbirths, miscarriages. *Mother Jones.* www.motherjones.com

State v. Buckhalter 119 So. 3d 1015 Mississippi Supreme Court (2013).

Samantha Burton sources:

Belkin, L. (2010, January 12). Is refusing bed rest a crime? *NYTimes.com*. Retrieved from: http://parenting.blogs.nytimes.com/2010/01/12/is-refusing-bed-rest-a-crime/

Burton v. State of Florida, 49 So. 3d 263 (2010).

Burton v. State of Florida (2010*).* Amicus Brief. ACLU. (2009). ID09-1958.

Fish, Jonathan. (2010). Fetal advocacy and the wisdom of judicial intervention. *Health Law Perspectives.* Retrieved from: www.law.uh.edu/Healthlaw/persepectives/2010/(JF)%20Florida.pdf.

James, S. D. (2014, January 14). Pregnant woman fights court-ordered bed rest. *ABC News*. Retrieved from: http://abcnews.go.com/Health/florida-court-orders-pregnant-woman-bed-rest-medical/story?id=9561460

In re Dubreuil, 629 So. 2d 819 (Fla.1994).

Angela Carder Sources:

Crawford, J., & Griffin, J. L. (1993, December 19). Caesarean case poses a dilemma for hospitals. The Chicago Tribune. www.articles.chicagotribune.com

Ehrlich, J. B. (2008). Breaking the law by giving birth: The war on drugs, the war on reproductive rights, and the war on women. *N.Y.U. Review Of Law & Social Change, 32*, 381-421.

Hacker, K. (1988, February 7). Life-and-death decree against the wishes of a family, a court orders a caesarean on a dying mother and opens up a raft of complicated and controversial questions. *The Philadelphia Inquirer.* www.articles.philly.com

In Re AC, 573 A .2d 1235 (1990 D.C. App.).

Lisa Epsteen sources:

Doctor tells pregnant woman he will get cops to bring her to hospital after she refuses C-section - and warns her baby could die if she refuses procedure (2013, March 7). *DailyMail.co.uk.* Retrieved from: http://www.dailymail.co.uk/news/article-2289646/Doctor-sends-pregnant-woman-email-saying-hell-tell-police-bring-hospital-refuses-C-section-week-date.html

Doctor threatens to call cops on pregnant woman if she doesn't have emergency c-section. (2013, March 7). *CBS News*. Retrieved from: http://tampa.cbslocal.com/2013/03/07/doctor-threatens-to-call-cops-on-pregnant-woman-if-she-doesnt-have-emergency-c-section/

Livingston, B. (2013, March 8). Physician Sought To Use Police to Force Woman Into Hospital For Birth. *Political-Conservatives.blogspot.com.* Retrieved from: http://political-conservatives.blogspot.com/2013/03/where-has-personal-freedom-gone.html

Stein, L. (2013, March 6). USF obstetrician threatens to call police if patient doesn't report for c-section. *TampaBay.com.* Retrieved from: http://www.tampabay.com/news/health/usf-obstetrician-threatens-to-call-police-if-patient-doesnt-report-for/2107387

Stein, L. (2013, March 8). Woman angry over approach to pregnancy. *HeraldTirbune.com* Retrieved from: http://www.heraldtribune.com/article/20130308/ARCHIVES/303081052

Jamie Lynn Fisher Russell sources:

Kemp, A. (2013, February 4). Family of Pauls Valley woman who died in police custody seeks answers. *NewsOK.com.* Retrieved from: http://newsok.com/family-of-pauls-valley-woman-wh
o-died-in-police-custody-seeks-answers/article/3751456

OKLawBlogger. (2013, February 12). Family suspects malpractice after ectopic pregnancy death. *Oklahoma-Criminal-Defence.com*. Retrieved from: http://oklahoma-criminal-defense.com/blog/2013/02/family-suspects-malpractice-after-ectopic-pregnancy-death/

Portfield, B. (2013, March 28). No charges in jail death case. *PaulsValleyDailyDemocrat.com.* Retrieved from: http://www.paulsvalleydailydemocrat.com/x765749306/No-charges-in-jail-death-case

Wells, J. (2013, January 7). Pregnant Pauls Valley mother dies in jail. *KFOR.com*. Retrieved from: http://kfor.com/2013/01/07/pregnant-pauls-valley-mother-dies-in-jail/

Rennie Gibbs Sources:

Balko, R. (2014, March 19). Another Mississippi outrage: Young mother faces life in prison for stillborn child. *The Washington Post.* www.washingtonpost.com

McDonough, K. (2014, April 3). Murder charges dismissed against Mississippi woman on trial for giving birth to a stillborn. *Salon.* www.salon.com

Pilkington, E. (2011, June 24). Outcry in America as pregnant women who lose babies face murder charges. *The Guardian.* www.theguardian.com

Jennifer Goodall sources:

Gluck, F. (2014, July 29). Woman in legal fight over c-section delivers baby. *USA Today*. Retrieved from: http://www.usatoday.com/story/news/nation/2014/07/29/fla-baby-c-section/13318391/

Mosbergen, D. (2014, July 28). Pregnant mom says hospital threatened to call child services unless she has c-section. *The Huffington Post.* Retrieved from: http://www.huffingtonpost.com/2014/07/28/forced-c-section-jennifer-goodall_n_5627933.html

Martina Greywind Sources:

Kolata, G. (1992, February 26). Woman in abortion dispute ends her pregnancy. *The New York Times.* www.nytimes.com

State v. Greywind, No. CR-92-447 (N.D. Cass County Ct. Apr. 10, 1992).

Melanie Green Sources:

Logli, P. A. (1990). Drugs in the womb: The newest battlefield in the war on drugs. *Criminal Justice Ethics, 9,* 23-29. doi: 10.1080/0731129X.1990.9991869

Reardon, P. (1989, May 11). 'I loved her,' mother says 'shocked' over arrest in baby`s drug death The Chicago Tribune. www.articles.chicagotribune.com

Michelle Marie Greenup Sources:

Paltrow, L. M., & Flavin, J. (2013). Arrests of and forced interventions on pregnant women in the United States, 1973-2005: Implications for women's legal status and public health. *Journal of Health Politics, Policy, and Law, 38,* 299-343. Advance online publication. doi: 10.1215/03616878-1966324

Darlene Johnson Sources:

People v. Darlene Johnson, No. 29390 (January 2, 1991)

Roberts, D. E. (1997). *Killing the black body: Race, reproduction, and the meaning of liberty.* New York, New York: Random House, Inc.

Jennifer Clarice Johnson Sources:

Boyd, S. C. (2004) From witches to crack moms: Women, drug law, and policy. Durham, North Carolina: Carolina Academic Press.

Jennifer Clarice Johnson v. State of Florida, 602 So. 2d 1288 (1992)

Lewin, T. (1992, July 24). Mother cleared of passing drug to babies. *The New York Times.* www.nytimes.com

Amanda Kimbrough sources:

Calhoun, A. (2012, April 25). The criminalization of bad mothers. *The New York Times Magazine.* Retrieved from: www.nytimes.com

Ex parte Amanda Helaine Borden Kimbrough v. State of Alabama. 1110176 and 1110219. (2013).

Rachael Lowe Sources:

Calhoun, A. (2015, October 12). Jailed for using drugs while pregnant. *The Atlantic.* www.theatlantic.com

Paltrow, L. M., & Flavin, J. (2013). Arrests of and forced interventions on pregnant women in the United States, 1973-2005: Implications for women's legal status and public health. *Journal of Health Politics, Policy, and Law, 38,* 299-343. Advance online publication. doi: 10.1215/03616878-1966324

Regina McKnight Sources:

Herbert, B. (2001, May 24). In America; stillborn justice. *The New York Times.* www.nytimes.com

Bhargava, S. (2004). Challenging punishment and privatization: A response to the conviction of Regina McKnight. *Harvard Civil Rights-Civil Liberties Law Review, 39,* 513-542.

Kari Parsons Sources:

Ehrlich, J. B., & Paltrow, L. (2006, September 20). Jailing pregnant women raises health risks. *Women's eNews.* http://womensenews.org

Grigsby,S. (2015, January 25). When the state claims custody of a fetus, it requires an incubator. *Daily Kos.* www.dailykos.com

Purvi Patel Sources:

Bazelon, E. (2015, April 1). Purvi Patel could be just the beginning. *New York Magazine.* www.nytimes.com

Carmon, I. (2015, April 2). How Indiana's pregnancy law targets women. MSNBC. www.msnbc.com

Chowdhury,J. (2015, March 31). Indiana sentences Purvi Patel to 20 years for feticide. *NBC News.* Retrieved from: www.nbcnews.com

Laura Pemberton Sources:

Paltrow, L. M., & Flavin, J. (2013). Arrests of and forced interventions on pregnant women in the United States, 1973-2005: Implications for women's legal status and public health. *Journal of Health Politics, Policy, and Law, 38,* 299-343. Advance online publication. doi: 10.1215/03616878-1966324

Pemberton v. Tallahassee Memorial Regional Medical, 66 F. Supp. 2d 1247 (1999).

Diane Pfannenstiel Sources:

Beck, J. (1990, February 8). Womb not a haven for the babies of women who drink. *The Chicago Tribune.* www.articles.chicagotribune.com

Goodman, E. (1990, February 11). Being pregnant, addicted: It`s a crime. *The Chicago Tribune.* www.articles.chicagotribune.com

Lewin, T. (1990, February 5). Drug use in pregnancy: New issue for the courts. *The New York Times.* Retrieved from: www.nytimes.com

Roth, R. (2000). *Making women pay: The hidden costs of fetal rights.* Ithaca, New York: Cornell University Press.

Melissa Ann Rowland Sources:

Grace, F. (2004, March 12). Utah C-Section Mom Gets Probation *CBS News.* www.cbsnews.com

Mother charged in caesarean row. (2004, March 12). *BBC News.* news.bbc.co.uk

Pollitt, K. (2004, April 8). Pregnant and dangerous. *The Nation.* www.thenation.com

Turley, J. (2004, March 21). When choice becomes tyranny. *Los Angeles Times.* www.latimes.com

Bei Bei Shuai Sources:

Pilkington, E. (2012, May 30). Indiana prosecuting Chinese woman for suicide attempt that killed her foetus. *The Guardian.* www.theguardian.com

Pollitt, K. (2012, March 7). Protect pregnant women: Free Bei Bei Shuai. *The Nation.* www.thenation.com

Rovner, (2012, May 18). Woman who tried to commit suicide while pregnant gets bail. *NPR.* www.npr.com

Turner, N. (2013, August 7). Newsflast: Plea deal confirmed for Bei Bei Shuai. *Ms. Blog.* www.msmagazine.com

Julie Starks Sources:

In The Matter of J.B.C., Julie Starks, Appellant, v. State of Oklahoma, Appellee, 18 P.3d 342 (2001).

Paltrow, L. M., & Flavin, J. (2013). Arrests of and forced interventions on pregnant women in the United States, 1973-2005: Implications for women's legal status and public health. *Journal of Health Politics, Policy, and Law, 38,* 299-343. Advance online publication. doi: 10.1215/03616878-1966324

Pamela Rae Stewart Monson Sources:

Chambers, M. (1986, October 9). Dead baby's mother faces criminal charge on acts in pregnancy. *The New York Times.* Retrieved from: www.nytimes.com

Chambers, M. (1987, February 27). Charges against mother in death of baby are thrown out. *The New York Times.* Retrieved from: www.nytimes.com

Warren, J. (1987, February 27). Infant death case: Mother innocent of prenatal crime. *Los Angeles Times.* www.latimes.com

Christine Taylor sources:

Hayes, K. (2010, March 2). Did Christine Taylor take abortion into her own hands? *CBS News*. Retrieved from: http://www.cbsnews.com/news/did-christine-taylor-take-abortion-into-her-own-hands/

Newman, A. (2010, April 18). Iowa "feticide" law could be used to target mothers. *Huffington Post.* Retrieved from: http://www.huffingtonpost.com/amie-newman/iowa-feticide-law-could-b_b_463153.html

Profile: Christine Taylor. (2010). *HistoryCommons.org*. Retrieved from: http://www.historycommons.org/entity.jsp?entity=christine_taylor_1