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Pregnancy and State Power

Prosecuting Fetal Endangerment

For all the important and even urgent attention to reproductive rights, focused on preserving abortion access in an era of political and judicial backlash, far less advocacy is devoted to protecting the liberty and dignity interests of women who wish to remain pregnant. That is, abortion rights are the primary focus of reproductive privacy advocacy movements in the United States and have been for some time.[1] Arguably, abortion has become so fundamentally intertwined linguistically and conceptually with the terminology of "reproductive privacy" and "reproductive rights" that little else fits within the taxonomy. This is a mistake.

One might even argue that the right to be free from government intervention in pregnancy has been excised from the framework of reproductive rights altogether, as some feminist scholars now refer to pregnancy preference as "birth activism" rather than as a part of the bundle of rights framed within reproductive privacy.[2] Pro-choice, or even to exercise choice, within this narrow conception of reproductive rights serves only to affirm an abortion right.[3] The reductive meaning of having choice is the ability to exercise agency over pregnancy termination. Unfortunately, this approach to reproductive rights suffers significant blind spots because it ignores the spectrum of reproductive health decisions a woman is called to make and in which women can be subjected to state power.

A reproductive rights framework that anticipates pregnancy termination as the primary or exclusive legal or social obstacle a woman may encounter fundamentally misreads reproductive health and the social contexts in which women live their lives. From a legal perspective, a conspicuously narrow reading of reproductive rights limits rather than expands rights for women, because it ignores the importance of choosing when and under what circumstances to give birth, terminate a pregnancy, parent or not to parent.

The case of *Captain Susan Struck v. Secretary of Defense*[4] advances my argument. Captain Struck became pregnant during air force service in 1970, while stationed in Vietnam. The U.S. Air Force's regulation 36-12 prohibited pregnant women as well as mothers from serving in its military division at that time.[5] The

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Air Force presented Captain Struck with an ultimatum: terminate the pregnancy or leave the military base within forty-eight hours.[6] In the years before *Roe v. Wade*, military bases were among the few places where a woman could legally obtain an abortion.

However, Captain Struck did not want an abortion, which the military demanded she have. Instead, her choice was to continue the pregnancy and not suffer the stigmatizing repercussions of both losing her job and livelihood for making that decision. Seeking compromise and under immense pressure, Captain Struck offered to surrender the child for adoption after its birth. The Air Force rejected this option and discharged Captain Struck.[7] She appealed the discharge seven times, including to the Secretary of the Air Force; in each instance, she lost.

Eventually, Captain Struck appealed her case to the District Court for the Western District of Washington, claiming that the Air Force regulations violated equal protection of the law. She argued that the regulation constituted an unconstitutional sex-based classification and, as applied, infringed upon her right to privacy. According to Captain Struck, this infringement interfered with the ability to conduct her personal life. Struck also argued that the regulations infringed on her right to free exercise of her religion, because she was Catholic.

The district court held that the Air Force regulation concerning pregnant officers was reasonable and constitutional.[8] The court dismissed her motion. Captain Struck's application for a stay pending appeal failed too. A team of four lawyers from the American Civil Liberties Union (ACLU), including Ruth Bader Ginsburg, appealed Struck's case to the Ninth Circuit Court of Appeals.

The Ninth Circuit Court of Appeals dismissed her claim, noting that, had there been "an attack by the enemy" at the hospital in which she served, "a not improbable consequence might have been" that Captain Struck would have become "a patient instead of a nurse."[9] According to the Ninth Circuit, "as such, instead of being a useful soldier, she would have been a liability and a burden to the Air Force."[10] The court found it "irrelevant" that "other personnel, males and non-pregnant females, might have been disabled and made useless" in the hypothetical "attack."[11] In 1972, a year before the Supreme Court decided *Roe v. Wade*, it granted *certiorari* in Captain Struck's case.[12] In response, the military waived the application of its regulation on pregnancy and rescinded Struck's discharge.[13] By that time, Captain Struck had placed her baby for adoption.[14] She never had another child.

Captain Struck's experience serves as an important reminder that any reproductive rights framework that defines or equates abortion as its chief agenda problematically excludes or ignores a broader bundle of choices and rights essential to women's health, autonomy, privacy, and equality. They include contraception, testing and treatment for sexually transmitted infections (STIs), pregnancy screenings, pre- and postnatal care, and, of course, the equally important right to maintain or terminate a pregnancy.

Contemporary fetal protectionism now includes sanctioning women for refusing cesarean surgeries.[15] It also includes forcibly confining them to administer bed rest[16] and instigating arrests and prosecutions for otherwise legal conduct.[17] Frequently, class matters as much as race, meaning that Black and Latina women no longer serve as the default targets of fetal protection prosecutions and laws.[18]

For example, in 2015, journalist Nina Martin reported that in Alabama alone, nearly 500 "new and expecting mothers" had been prosecuted in recent years for violating the state's chemical endangerment statute.[19] Most of these pregnant women were white and overwhelmingly poor.[20] A decade ago, my research began articulating these concerns, including a prediction that fetal protection prosecutions could jump the so-called color line.[21] That is, Black women were simply the euphemistic canaries in the coal mine.

One could argue that robust legislative and prosecutorial action in reproductive health might nonetheless exist even if feminists shifted the reproductive rights framework to make it more inclusive. Yet, that argument would miss an important point. Imagine if civil rights leaders, advocates, and pundits during the racially oppressive Jim Crow era had narrowed their vision of civil rights to school integration. Rather than viewing *Brown v. Board of Education*[22] as the last train stop on a path to freedom, equality, and citizenship, it was only the beginning of securing a broader bundle of rights.

The traditional reproductive rights framework operates much to the detriment of a broader set of conditions fundamental to a meaningful privacy right. It ignores or pays inadequate attention to a host of legal concerns affecting pregnancy and liberty, including pregnancy discrimination,[23] forced and coerced sterilization,[24] and the rise in threats of criminal prosecutions and sanctions against poor pregnant women.[25] Most obviously, a failure to integrate a broader perspective and framework into the reproductive rights discourse harms poor women, and among them women of color in particular.

This Chapter introduces a problem concerning overlooked victims who may be perceived as having far less noble lives compared to a military officer. It turns to the difficult cases of women who are otherwise perceived as "bad mothers" for the choices they make, including to be pregnant at all or to birth in a particular manner.

The Chapter has three goals. First, it traces a story of legal innovation – how old law has been used in new ways to punish pregnant women and how new laws emerge to do the same. From the perspective of legislators and prosecutors who seek to cabin or limit reproductive rights, they are the innovators, experimenting with new types of legislation, pushing the envelope, increasing prosecutions, expanding the type of conduct punishable under their laws, and spreading their messaging to other states. Second, it helps us see the women affected by criminal policing of pregnancy in ways that quantitative data alone cannot do. In this way, we better understand what is at stake so as to inspire action. Third, I argue that how a movement

conceptualizes an issue frames what it sees. Because mainstream reproductive rights advocacy groups framed reproductive rights and choice in a narrow way regarding abortion, they failed to see what was happening in other areas of women's reproductive health.

2.1 SETTING THE STAGE: ETHNOGRAPHY AND THE LEGACY OF THE PAST

In 2012, the British publication *The Guardian* reported that there is a "creeping criminalisation of pregnancy across America."[26] Shocking yet nonetheless true, to be pregnant and poor in the United States is to play a game of roulette with one's privacy, presumed confidential relationship with medical providers, and basic constitutional and medical rights. Christine Taylor discovered this after falling down steps in her Iowa home. A trip and fall resulted in her arrest while returning home from the hospital. Taylor was jailed for attempted feticide.[27] Why? She was pregnant when the stumble occurred.

On the one hand, Taylor's arrest was alarming – a potent reminder about the recasting of laws intended to protect women from domestic violence, adapted and transformed to use in their surveillance and punishment. Ironically, some feminist organizations supported the enactment of feticide laws by state legislatures as a means of addressing the increased incidences of domestic violence during a woman's pregnancy.[28] Most did not foresee the potential reconditioning of such legal tools in the service of criminalizing pregnant women's behavior.

Currently, thirty-eight states have implemented feticide statutes – a particularly worrying species of fetal protection laws – up from zero in 1986.[29] Nearly thirty states have enacted "fetal homicide laws that apply to the earliest stages of pregnancy ('any state of gestation/development,' 'conception,' 'fertilization,' or 'post-fertilization')."[30] In 2004, President George Bush signed into law the Unborn Victims of Violence Act,[31] which recognizes an embryo or fetus in utero as a legal victim if killed or harmed during the commission of any one of over sixty federal crimes.

On the other hand, criminal prosecutions of pregnant women dated back to the late 1980s, invigorated by the nation's war on drugs. Prosecutors' creative application of child abuse statutes, anticorruption laws, and drug conveyance legislation, among others, provided a foundation for arrests and prosecutions of poor Black pregnant women.[32] These vulnerable women embodied the cautionary metaphor of the miner's canary. They served as an advanced warning for detecting dangers ahead when their physicians were complicit in their arrests, police searched their medical records, and then prosecutors mounted criminal charges against them.

This Chapter takes up the challenge presented by Professor Victoria Nourse when she argued that "we must take the ethnographer's view of experience about our most basic cultural and social concepts, whether they find their way into law cases or newspapers, diaries or Supreme Court opinions."[33] By doing so, this Chapter contributes to scholarship seeking to "dislodge even the firmest of our contemporary

concepts,"[34] which includes the concept of reproductive rights and notions related to poor pregnant women's dignity and social value. Otherwise, we fail to take them into account in our framing of legal issues, including women's constitutional reproductive rights, and thus our responsiveness to their plights.

2.1.1 *Canaries in the Coal Mines*

In 1999, Regina McKnight, a poor Black farmworker, became the first woman to be prosecuted and convicted in the United States for a stillbirth.[35] A South Carolina court sentenced her to twenty years in prison, suspended to twelve years. McKnight suffered a cascade of harms and subsequent punishment by the state. She was a twenty-one-year-old rape survivor. The year before she gave birth, she suffered the loss of her mother, killed by a hit-and-run driver.[36] She was no hardened criminal; she had no prior convictions.[37] She suffered from depression and anxiety, which led to self-medication – illicit drugs purchased off the streets of South Carolina. Without her knowledge or consent, McKnight's doctors turned her medical records and tests over to the police, who, without scientific support, claimed that the stillbirth she endured must have resulted from the illicit substance.[38]

In Regina McKnight's case, the state built and rested its prosecution on the fact that she birthed a dead baby.[39] Indeed, the prosecutor claimed that he did not care whether the drugs she ingested were illegal or not: "if we determine you are medically responsible for a child's demise, we will file [homicide] charges."[40] The dogged nature of his prosecutions trickled down to the hospital level as prosecutors collaborated with nurses and doctors to catch poor pregnant women as they came for prenatal care. In 2008, the South Carolina Supreme Court unanimously overturned the conviction based on, among other things, a finding that prosecutors put forth faulty scientific evidence at trial.[41] But by that time Regina had served nearly a decade in prison.

Regina's case is illustrative of a broader pattern in South Carolina, where dozens of poor pregnant women suffered similar fates. Paula Hale, also a rape victim from South Carolina, likely did not expect that, by carrying her pregnancy to term rather than aborting, she would be "dragged out of the hospital in chains and shackles."[42] Lynn Paltrow, Executive Director of National Advocates for Pregnant Women (NAPW), compared the disturbing images of law enforcement entering hospitals, separating newborn Black babies from their mothers, and carting the women off in shackles and chains, to the cruelty embedded in antebellum slavery.[43]

In Hale's case, medical staff at the Medical University of South Carolina (MUSC) voluntarily submitted her prenatal screenings, which showed evidence of drug use, to police and prosecutors.[44] Charles Condon, the former state prosecutor in South Carolina responsible for the shackling and arrests of many poor rural women, passionately extolled in an essay that he needed more than carrots to encourage pregnant women to avoid unhealthy habits; he needed "a real and very strong

stick."[45] Arrests and criminal prosecutions serve as this "strong stick" in South Carolina and elsewhere in the United States.

Many of the women prosecuted by Condon sought prenatal care at state-subsidized medical facilities. They wanted to maintain their pregnancies and give birth. Seeking prenatal care was a sign that, despite their drug dependency, they wanted help. Some had responded to public service announcements and billboards cheerfully advertising that help was available even for women with drug addictions: the only thing the women needed to do was to show up. Prior to their treatment at MUSC, little did these women know that Condon actively collaborated with administrators and medical providers at the hospital, receiving the patients' medical records, toxicology screenings, and the health records of their newborns without patient consent.[46] Nor were these women aware that race would play a central role in their care and the state's surveillance.

According to court documents from a class action lawsuit filed by some of the women,[47] during Condon's era of policing pregnancy in the 1990s most of the women to whom he applied his stick at MUSC were Black, even though the rates of illicit drug use are similar among Black and white women.[48] Of the dozens of women arrested at that facility for exposing their fetuses to illicit drugs, all were Black with one exception. Special dispensation was sought for at least one white woman who, although not arrested, otherwise met the criteria for arrest.[49] In that instance, a lead collaborator "admitted that she called the [prosecutor's] office and requested another "chance" on behalf of a white patient who should have been arrested under the Policy's terms."[50] For the only other white woman identified or targeted by MUSC medical staff, racial profiling may have contributed to her arrest, because a nurse and member of Condon's interagency task force made a point of notating the patient's chart with the following information: "patient live[s] with her boyfriend who is a Negro."[51]

While this notation did not serve a medically relevant purpose, it does reveal that an illicit extralegal consideration – race – was involved in the implementation and enforcement of Condon's interagency policing of pregnant women.[52] This particular nurse admitted at trial that she believed interracial relationships violated "God's way,"[53] and "raised the option of sterilization for Black women testing positive for cocaine, but not for White women."[54] An MUSC physician testified that, "although ingestion of heroin or alcohol poses serious risks of fetal harm, the nine criteria established by the taskforce members for searching pregnant women were drafted specifically to uncover cocaine use."[55]

Condon's search process introduced an unusual level of cruelty into the delivery of medicine, altering a common understanding about hospitals providing safety, comfort, and respite to those seeking medical help. As transcripts in the case reveal, some women subjected to arrest were "denied the opportunity to change out of their hospital gowns or to make a phone call to family members to make arrangements for the care of their children."[56] In other instances, police apprehended the new

mothers "while still bleeding, weak and in pain from having just given birth."[57] Some were handcuffed and shackled, with chains circling their abdomens. Leg irons were used in some cases. For any woman who could not walk, "a blanket or sheet would be placed over the woman, and she would be wheeled out of the hospital to a waiting police car and transported to jail."[58]

Across the nation in the late 1980s, throughout the 1990s, and into the new millennium, cases like those at MUSC could be and were easily misread as poor Black women lacking concern, care, and discipline for their pregnancies – based on their arrests, prosecutions, and plea deals. Journalists could point to the records of arrests and plea deals and draw the conclusion that "a bio-underclass, a generation of physically damaged cocaine babies whose biological inferiority is stamped at birth," lurked among Americans in poor neighborhoods, born to Black mothers.[59]

The award-winning journalist Charles Krauthammer warned that this was "worse than 'brave new world.'"[60] He interviewed Douglas Besharov, the former director of the National Center on Child Abuse, who originally coined the term "bio-underclass." Besharov predicted that up to 15 percent of African American children have "permanent brain damage" due to fetal crack exposure, but this was based on no scientific or other empirical data. According to Besharov, "[t]he inner-city crack epidemic is now giving birth to the newest horror: a bio-underclass."[61] Besharov told Krauthammer that this was a particularly acute problem in the Black community. However, Professor Carl Hart, a behavioral neuroscientist at Columbia University, who investigates neuropharmacological effects of psychoactive drugs, reminds us that "the majority of crack users were white."[62]

Krauthammer's reporting fitted the widely accepted and adopted view: a consensus of narratives among journalists published in the *New York Times*, *Washington Post*, and *Rolling Stone* magazine, among others, prophesied that "crack babies" would grow up to be "joyless," their futures would be "bleak," and schools were destined to be overwhelmed by their presence in the classroom.[63] Some journalists described these babies as having smaller brains, physical abnormalities, and various physical disabilities.[64] Krauthammer wrote that infants born to mothers who used crack risked having "abnormal genitals and intestinal organs."[65] He urged that these offspring would suffer "permanent brain damage." The future he forecasted included "probable deviance … [and] permanent inferiority."[66] At best, he predicted, their lives would be "menial." This, he claimed, was "biologically determined from birth."[67]

Similarly, journalist Ellen Hopkins wrote in the *Rolling Stone* magazine that babies born to "crack-addicted mothers are like no others." She claimed these offspring were "brain damaged in ways yet unknown, they're oblivious to any affection." She asked, "how do you care for a baby who hates to be held?" The only problem with this reporting is that it was inaccurate.

Today, Hopkins' claim that babies born to crack-addicted mothers do not want to be looked at, regarded with affection, or held would be met with serious skepticism.

This would certainly not be said of white babies born to opioid-addicted white mothers. But such reporting was largely unchallenged at the time. The strange conclusion from all of this was that these babies lacked the capacities to appreciate affection or even a parent's warm gaze and that they were biologically and mentally inferior. In this vein, Hopkins wrote that "[a]ctually any human contact can overwhelm a crack baby."[68]

By notable contrast, journalists rarely referenced two prominent researchers conducting the most empirically relevant and rigorous studies on fetal impacts from cocaine and other drug exposures – Dr. Claire Coles and Dr. Hallam Hurt. I interviewed both for this book.[69] Drs. Coles and Hurt challenged the prevailing anecdotal evidence that linked crack to genetic malformations and chronic syndromes in babies and children. Dr. Claire Coles, a professor of psychiatry and behavioral sciences, who also directs the Maternal Substance Abuse and Child Development (MSACD) program at Emory University in Atlanta, Georgia, studies the effects of teratogens on behavior and development in babies through adolescence. Specifically, her research examines social, biological, and neurological development in children prenatally exposed to cocaine, alcohol, and tobacco.

Dr. Coles recalled that when she refused to concur with the anecdotal news accounts about babies prenatally exposed to crack, journalists rebuffed her data, dropping her as a medical source or expert.[70] According to her, she was "blacklisted." There was a notable difference in the way the media portrayed Blacks and their use of cocaine compared to whites. Dr. Coles told me, "It was a complicated issue. We were studying alcohol and pregnancy. In the eighties there was the upswing in cocaine use; it was upscale [and] it was fashionable to talk about it. You could go to a party and people were talking about cocaine. People would wear silver spoons around their necks. It was fashionable [for white people]."

In fact, when she first started studying cocaine, "[w]e noticed in the eighties women beginning to use cocaine in pregnancy; it was wealthier white women." However, the media began selling a story that was race-related, which, according to Dr. Coles, "tapp[ed] into a deep fear that people have about the other. In the cocaine era, [the other] were the poor Black people. Even now there is a huge fear about more Black people." She explained that we injure those whom we fear and "then we have to find a justification for that fear." Today, she notes, "the whole thing is about reproduction now and there seems to be a terrible fear." Dr. Coles described this "fear" as an "irrational kind of thing going on . . . from some deep sociological fear."

The media refused to engage with the basic science. Across several interviews and meetings with Dr. Coles, she explained that the rhetoric around babies born addicted to crack and going through withdrawal were not accurate. She explained that "withdrawal is a particular condition related to developing a resistance to drugs like Valium, alcohol, heroine, depressants . . . it changes the membranes and the body builds up resistance to the drug." The result is that "you have to take more; when you take away the drug, the body pushes back and reacts to the absence of the substance it is used to." However, "gradually over time, the body adjusts to it." But

what about cocaine, I wanted to know. She explained that this "does not occur with cocaine" because, as she pointed out, "cocaine is a stimulant and not a depressant." Dr. Coles told me, "This is drugs 101 and no one should be getting confused about this who knows anything about medicine."

The consequences of the fearmongering were real. Dr. Coles felt an urgency to relate what she knew, which was based on scientific evidence derived from her studies. She was concerned that "because of the way this was portrayed, children were being put in foster care, women put in jail," much of it on the basis of inaccurate information associated with crack. At one point, she told me that "legislators called the university so that I would be fired." Fortunately for her and Emory University, the chair of her department at the time – someone whom she described as "old-fashioned" – cared about scientific integrity and believed that "there is a tradition in the academic world that you don't attack people for their scientific research." However, newspapers were not "happy" with her research findings because "it was not a good story."

Equally, Dr. Hurt's groundbreaking longitudinal research on gestational drug exposure, underserved youth, and high-risk infants provided pertinent, empirically grounded counternarratives to the crack baby myth that had surfaced in the 1980s.[71] Former Chair of the Division of Neonatology at the Albert Einstein Medical Center in Philadelphia, Dr. Hurt cautioned, for example, that poverty had as significant (if not greater) an impact on a child's brain than gestational exposure to crack.[72] So why was crack so deeply racialized? Dr. Hurt believed that "it was just easier to go after the bad ones," and the "bad ones" or "bad mothers" were Black. She told me that she thinks this is still the case.

When I interviewed her on an early morning in the thick of summer in 2013, she explained, "First I need to tell you what we did. We excluded [pregnant women] pre–thirty-four weeks." This meant that she enrolled subjects who were farther along in their pregnancies to test the effects of crack use during pregnancy. By enrolling women at an advanced gestational period in their pregnancies, the women were likely to have been using crack cocaine for a longer period of time. She cautioned, "I should also tell you that I don't think cocaine is a good thing to do during pregnancy. It is deleterious in pregnancy."

That said, the women they enrolled "were heavy users." They used "up to ninety-nine days." She did not want women who "snorted one line . . . we didn't do that." Instead, she said, "we only enrolled those who used in two trimesters. That sets the scene for the relatively well child born at term or near term." For years, Dr. Hurt followed the offspring of women in her study who were heavy crack users. At the time of our interview, there were still 110 in the study (down from the 224 when enrolment was at its peak). The oldest children at the time of her study's conclusion were in their early twenties. It was planned to be a two-year study and she never planned that it would extend as long as it did. And so she followed the kids through elementary school, middle school, high school, and – for those who did attend – college. She

explained that "for years we were trying to unravel the difference from the two groups, looking at play activities, responses to stress, and cognitive abilities" – that is, comparing the kids exposed to crack in utero with the average kids who grew up alongside them in poverty. Although "every now and then a blip [would appear] where there was a difference," in terms of "positive urine screens, teen parents, adjudication, and school failure [or success] there was no difference."

However, these were not the accounts that journalists and their editors published. Rather, reporters and editors invested in the crack baby myth to such a degree that reporting on the subject lacked the rigor commonly associated with their flagship news organizations.[73] Typical of this type of journalism were reporters filming babies afflicted by heroin exposure or prematurity and attributing the effects to crack.[74]

By the early 2000s, the racial stereotypes and conflations associated with so called crack babies began to give way, following publications in scientific journals. Scientific evidence mounted by the doctors Hurt, Coles, Deborah A. Frank, and others exposed the gaps and unfounded, unconfirmed claims in prior research.[75] The leading American medical journals, the *New England Journal of Medicine* and the *Journal of the American Medical Association*, announced their rejection of the term "crack baby" in future publications.[76] In 2013, the *New York Times* issued a video retraction of its reporting on this subject.[77] The newspaper acknowledged that it "ran articles and columns that went beyond the research."[78]

Yet, because of the absence of surveillance and arrests of white women for illicit drug use, illegal use of prescription medications, or abuse of prescription medications during pregnancy or otherwise, a false narrative emerged. To policymakers, pundits, and perhaps even to women's rights organizations, it appeared that drug addiction during pregnancy existed primarily, if not exclusively, among Black women. In significant part, this was due to who was targeted by medical providers and law enforcement for surveillance and arrest, rather than who illicit drug users happened to be. A study conducted by the National Center for Perinatal Addiction Research and Education found that about 15 percent of white and Black women use illicit drugs during pregnancy.[79] However, "Black women were 10 times as likely as whites to be reported to the authorities, and poor women were more likely to be reported than middle-class women."[80]

This data comports with an ACLU study in the 1990s, which found that 80 percent of the women targeted for criminal intervention for drug use during pregnancy were Black, Latina, and "members of other minorities."[81] Importantly, prosecutors and news organizations aided in this. Prosecutors claimed that the Black women whom they prosecuted manifested an extreme indifference to human life. News organizations supplied slanted accounts about drug abuse in the United States.

Prosecutors and legislators lacked interest in a more nuanced account of drug use during pregnancy. Lawmakers and prosecutors invested attention and resources in connecting illicit drugs to pregnancy, and therefore fetal harms, ignoring what would blossom and devolve into the opioid crisis. At meetings with legislators and

lectures in the early 2000s, I began calling attention to these matters, but my efforts had limited effect and met with unease on both sides. In some instances, my foreshadowing of what lay ahead with opioid addiction among white women including during their pregnancies encountered strong resistance and utter disbelief. In fact, from time to time, predominantly white academic audiences seemed outraged and hostile by what I reported. Perhaps they were dumbfounded; I was presenting data on opioid addiction not yet in the public sphere and it challenged these audiences on many levels. At the root of the resistance might have been naiveté, implicit racial bias, or both.

Frequently, I was told that doctors would never prescribe anything that was not "good" or "healthy" for their (white) pregnant patients. And perhaps even more telling, scholars, prosecutors, legislators, and others seemed skeptical about comparing the pregnancies of women who were prescribed medications by doctors with the pregnancies of women who acquired their drugs "on the streets." They were different. Perhaps so, but the drugs were not as dissimilar as they wanted to believe. Today, the "National Prescription Opiate Litigation," consolidated cases in federal court, is seeking almost $50 billion to settle lawsuits related to opioid addiction.

In 2011, a groundbreaking study conducted by Dr. Allen A. Mitchell, Director of the Slone Epidemiology Center, debunked presumptions and racial stereotypes about drug use during pregnancy. The study, *Medication Use During Pregnancy, with Particular Focus on Prescription Drugs: 1976–2008*, published in the peer-reviewed *American Journal of Obstetrics and Gynecology*,[82] found that educated white women were more likely to rely on prescription medications like Xanax, Demerol, Valium, Tylenol with codeine, Oxycontin, and Ritalin during pregnancy and their use of these drugs increased with age.[83]

Moreover, more than 70 percent of women reported taking at least one medication that was not a vitamin or mineral during the first trimester of pregnancy, and that drug use increased with age and by race. The study's conclusion: white women were more likely to ingest prescription medications during pregnancy generally, and they relied on more prescription medications during pregnancy as they aged. Importantly, the cocktail of prescription drugs used more often by white women during pregnancy "affect[s] the function of the placenta ... which can affect the blood supply to the baby or cause preterm labor and birth."[84]

The seductive appeal of racialized accounts of drug addiction and pregnancy played to common, and even dangerous, stereotypes affecting not only the women involved but also their offspring, as well as women who would become its future targets. Race obscured recognition of underlying reproductive privacy discrimination against women more generally. Mainstream women's rights organizations, including those that focus on reproductive rights, such as Planned Parenthood, ignored the civil liberties concerns undergirding the pregnancy-based prosecutions poor Black women encountered during the 1990s and early 2000s.

Reproductive rights advocacy organizations paid little attention to the underlying justifications put forth by law enforcement to justify pregnancy-based surveillance

and arrests, including fetal personhood. As a result, reproductive rights organizations seemed to ignore the precedents accumulating in states' courts, the evolving prosecutorial and legislative strategies to justify intervention in women's pregnancies, and the possibility that one day fetal health concerns articulated by states could implicate abortion rights. Tellingly absent from the amicus briefs filed in the landmark prosecution of Regina McKnight were any from women's reproductive rights advocacy organizations. The narrow framing of reproductive rights in terms of abortion rights would come back to haunt as new laws and jurisprudence propagated.

2.1.2 *The Past's Legacy: Preservation Through Transformation*

Like eugenics decades before, the crack baby myth conflated random health conditions with heredity and genetics. Once more, similar solutions were proposed: sterilize them.[85] The vilified, poor, addicted Black mother of the 1990s occupied a point on a longer timeline, dating back at least decades, if not centuries. What many journalists covering the crisis of addiction failed to account for was the longer arc of female marginalization and subjugation associated with pregnancy, particularly the enactment of eugenics laws in the early twentieth century. Proposals to sterilize Black women in the 1990s fitted the dynamic described by Reva Siegel as "preservation-through-transformation."[86] That is, "efforts to dismantle an entrenched system of status regulation can produce changes in its constitutive rules and rhetoric, transforming the status regime without abolishing it."[87]

The history of eugenics and its influence on the regulation of reproduction in the United States (even now) remains instructive for myriad reasons, including for developing strategies to address the current opioid crisis and for avoiding prior pitfalls. Reflecting on the similarities that link the political strategies and social sentiments of the eugenics period and the era of intensified crack addiction is valuable for women's movements – namely, an inward-facing reflection would illume not only the historical failure to include marginalized women in the enterprise of "women's rights," but more importantly, their purposeful exclusion.

In other words, the women's movements of the early twentieth century perpetuated the very stereotypes that harmed the broader reproductive rights enterprise for all women. A lengthy accounting of that history is not the work of this Chapter. However, it is worth briefly examining here that highly regarded feminists supported eugenics platforms, which, in Justice Oliver Wendell Holmes's words, explicitly sought to "cut [] the Fallopian tubes" of "unfit women."

Famously, Margaret Sanger, the founder of what is today Planned Parenthood, lectured on the importance of "reducing 'the rapid multiplication of the unfit and undesirable.'"[88] As Adam Cohen wrote, "[m]any influential feminists supported the cause" and were "particularly influential at the grassroots level."[89] Indeed, "women were among the most active lobbyists for eugenics laws of all kinds" and "legislators . . . considered eugenics, with its focus on reproductive issues, a proper

realm for female guidance."[90] Their efforts bore fruit. Interestingly, the enterprise of choice, which Sanger promoted in relation to family planning (i.e., contraception access), was not intended for the women thought unworthy of childbearing, because, for those women, sterilization was perceived as the only option as it would eliminate their future choices.

In 1927, more than twenty years after the first eugenics law was enacted in Indiana, the U.S. Supreme Court issued the landmark decision of *Buck v. Bell*, upholding the constitutionality of Virginia's Eugenical Sterilization Act.[91] In an 8–1 decision, the Court ruled that the power that gives states the authority to vaccinate is broad enough to compel the forced sterilization of women and men deemed socially unfit.[92] Writing for the majority, Justice Holmes issued a haunting condemnation of vulnerable women, declaring that "three generations of imbeciles are enough."[93]

The case centered on Carrie Buck, whom Holmes described as "a feeble minded white woman."[94] He claimed that she was the "daughter of a feeble minded mother"[95] and "the mother of an illegitimate feeble minded child."[96] These statements were inaccurate. However, the state presented evidence that the Court found persuasive. One evaluation of Carrie's "fitness" came from Harry H. Laughlin, who, although not a physician (and though he never examined her), was a distinguished leader in the eugenics movement, serving as the superintendent of the Eugenics Record Office in the Department of Genetics at the Carnegie Institute and the "eugenics expert" to various congressional committees, including the Committee on Immigration and Naturalization.[97]

In Carrie Buck's case, her poverty, perceived intellectual shortcomings, teenage pregnancy (the result of a rape), and family history of alcoholism were invoked to justify the state's reprisal and her sterilization.[98] The Court found:

> It would be strange if it could not call upon those who already sap the strength of the State for these lesser sacrifices, often not felt to be such by those concerned, in order to prevent our being swamped with incompetence. It is better for all the world, if instead of waiting to execute degenerate offspring for crime, or to let them starve for their imbecility, society can prevent those who are manifestly unfit from continuing their kind.[99]

In the wake of the Supreme Court declaring the Virginia eugenics law constitutional, more than 60,000 Americans were convicted of social unfitness and surrendered to public health officials for compulsory sterilizations.[100] Aided by the enactment of eugenics legislation, the "stick" approach to poor, vulnerable women's reproductive health was operationalized. At its core, it featured surveillance, government intrusion, reprisal, and retribution to discourage not only vice but also sex, single parenting, and reproduction among the socially undesirable. At their core, these policies were rooted in social judgments about the poor. These were not platforms imposed on feminist elites.

In the United States, eugenics was practiced and perfected on the bodies of children – young girls under the age of eighteen. In North Carolina, nearly 30 percent of forced sterilizations were inflicted on children "under age 18" and Black

people comprised 60 percent of all sterilization victims.[101] Two examples among the many thousands deserve mention. Elaine Riddick, raped as a little girl, did not know until many years later that the state of North Carolina sterilized her at the age of fourteen.[102] Even in the 1970s, states continued to carry out these practices. In 1974, Alabama sterilized sisters Mary Alice and Minnie Relf when aged fourteen and twelve respectively. Years later, a lawsuit filed by the Southern Poverty Law Center on behalf of the Relf sisters revealed that federally funded programs sterilized 100,000 to 150,000 people each year.[103] Clearly, some of those sterilizations may have been voluntary, but the majority were likely facilitated through coercive means.

Sixty years after *Buck v. Bell*, legislators proposed similar laws in response to crack addiction. Among the chief lobbying organizations targeting Black women was Children Requiring a Caring Kommunity (CRACK), which proposed legislation and offered payments to women who agreed to sterilization.[104] Barbara Harris, the founder of CRACK, defended its mission to a reporter in the following terms: "How many victims does this person need to have before she doesn't have the right to have children?"[105]

Harris's style of frank talk and activism impressed lawmakers and resonated with many who were deeply concerned about the health of babies born to addicted women.[106] According to her, "if they are drug addicts, they are drug addicts by choice. . . . People say it is a disease, fine. But it is a disease of choice – however they go there and whatever their background and however screwed up their life is. The babies don't have a choice." The bottom line, she said, is that "these women are literally having litters of children . . . not acting any more responsible than a dog in heat."[107] As alarming as her messaging might be viewed today, for a period of time the organization successfully cultivated its appeal among donors and legislators, with offices throughout the United States, including in Detroit, Houston, Nashville, New Orleans, Pittsburgh, San Francisco, Seattle, and Washington, D.C. The rebranded organization, now Project Prevention, based outside Charlotte, North Carolina, has shifted its mission to offering cash incentives to women and men who agree to use "long term or permanent birth control."[108] It no longer focuses solely on women using crack. Yet this type of messaging continues to resonate. Unwanted, coercive, and even illegal sterilization practices continue.

More recently, in 2009, a twenty-one-year-old mother of three agreed to a tubal ligation as a condition for probation after she pleaded guilty to possession with intent to distribute marijuana. Reports about that case emphasize that the West Virginia mother was unmarried.[109] One could argue that this type of sterilization was less coercive than the compulsory sterilizations of the early twentieth century, because women like Carrie Buck had no choice, unlike in this case. However, such arguments are inherently problematic, if not altogether flawed, particularly when anyone, let alone a mother of three, weighs incarceration against returning to her children.

In Tennessee, prosecutors now negotiate plea deals based on women agreeing to sterilization.[110] It is difficult to determine the frequency of such negotiations,

particularly in instances where the woman (or man) refuses. Nevertheless, the handful of cases since 2010 in Nashville alone where women have agreed to sterilization as part of their plea deals (and an early release or probation) indicate that such negotiations are occurring.[111]

Nor are these concerns geographically dependent or limited to the south. A 2013 legislative report conducted by California's state auditor Elaine Howe found "numerous illegal surgeries and violations of the state's informed-consent law."[112] The investigator reported that nearly 150 women were sterilized while incarcerated in California prisons during the period 2006–2010.[113] In a letter to former Governor Jerry Brown, Ms. Howe wrote that in some instances women were sterilized without physicians signing the forms or certifying the competency of the women or that they understood the lasting effects of the procedure.[114] In other instances, the state's Correction Office ignored the state's waiting period before the sterilizations could take place.

At least 25 percent of the sterilizations occurred without any lawful consent and the "'true number' of illegal procedures might be higher," according to the audit, because "records were lost in a routine purging."[115] The state claimed the sterilizations occurred without its approval because in 2006 the federal receiver's office assumed jurisdiction over medical care in the state's prisons. Yet this provided little solace to incarcerated women whose illegal or coercively facilitated sterilizations were enabled by agents and employees of the state, as well as those with whom the state contracted. Coercive sterilizations epitomize the preservation of status-based interventions in women's reproductive health, even though laws and formal policies may have changed.

2.2 CONCLUSION

Poverty, addiction, homelessness, and promiscuousness chiefly represented categories of "impurity" and "unfitness." Placement into one of these categories could, and too frequently did, result in criminal incarceration or psychiatric institutionalization in state-run asylums. Carrie Buck, the unsuccessful petitioner in *Buck v. Bell*, lived in such an institution. States justified incarcerations and the forced sterilizations practiced on unfit boys, girls, and women as a means of protecting the welfare of its citizens from the so-called degeneracy rampant among the lower classes.

The vestiges of that legacy survive, or at least the moral intuitions and foundations remain. For example, *Buck v. Bell* has never been overturned. It continues to serve as a chilling example of how the pregnancy penalty endures. The case exemplifies the failure of the law and the Supreme Court to intervene on behalf of vulnerable citizens against abuses of state power.

Yet, it is not enough to make the case that women's reproduction at times has been subject to the property interest of others, including the state. For example,

that alone does not satisfy my inquiry here, nor explain why contemporary wars are waged about women and their prenatal conduct. What story can be told to explain why doctors, judges, legislators, and prosecutors police women's reproduction?

Another way to view the trend toward criminal punishment of pregnant women is that it serves to punish vice and status.[116] James Fitzjames Stephen argues that society must feed its desire to scapegoat others and to generate resentment or even hatred for those who breach moral codes in society. He suggests that there is a fundamental human desire for revenge, even if one is not harmed by the act one seeks to avenge– it is enough that the act was immoral and threatens harm to the moral fabric and values of a society. This view of crime and punishment is informative in relation to the punishment of pregnant women in the United States. Stephen wrote that criminal punishment can be rationalized because "the feeling of hatred and the desire of vengeance are important elements in human nature which ought in such cases to be satisfied in a regular public and legal manner."[117]

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