ACOG
The American College of Obstetricians and Gynecologists

Opposition to Criminalization of Individuals During Pregnancy and the Postpartum Period

Statement of Policy

Confidentiality and trust are at the core of the patient–practitioner relationship. Policies and practices that criminalize individuals during pregnancy and the postpartum period create fear of punishment that compromises this relationship and prevents many pregnant people from seeking vital health services. Criminalization of pregnant people violates the pillars of medical ethics including patient autonomy (bodily autonomy despite the potential life within the pregnant person, the right to refuse care), justice (gendered discrimination), beneficence, and non-maleficence [(1)]. The American College of Obstetricians and Gynecologists (ACOG) opposes any policies or practices that seek to criminalize individuals for conduct alleged to be harmful to their pregnancy.

Background

Criminalization of pregnancy is the punishing or penalizing of individuals for actions that are interpreted as harmful to their own pregnancies, including enforcement of laws that punish actions during pregnancy that would not otherwise be criminal or punishable [(2)]. Criminalization also occurs when laws not specific to pregnancy are either applied in a discriminatory way against pregnant people or have a disproportionate effect on pregnant people. Criminalization has taken many forms including, but not limited to, the passage of fetal assault laws, policies that punish or penalize pregnant people for substance use during pregnancy, and the practice of judicial intervention or legal attempts at coercion for refusal of care during pregnancy.

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Fetal Assault Laws

As of 2018, 38 states had laws in which the "victim" of a crime can include a fetus, generally called "fetal assault," "fetal homicide," or "fetal protection" laws [3]. Twenty-nine states apply these laws at any stage of gestation during pregnancy. Although the majority of these states prohibit charging pregnant people with crimes for the outcomes of their own pregnancies, fetal assault laws and similar statutes have been adopted across the United States as a way to limit behaviors during pregnancy that legislators deem harmful to the fetus. Often these laws are passed under the guise of protecting pregnant people, but instead they are being used to punish individuals for a wide range of actions. For example, pregnant people have been charged with committing crimes for attempting suicide, substance use disorder, and suspicion of self-managed abortion [4]. These laws increase the risk of prosecution, especially for those from marginalized communities, establishing a form of criminal liability that applies only to pregnant people [5]. For example, most of the people arrested for self-managed abortion came to the attention of law enforcement when they sought emergency medical care [6]. The fear of interrogation, arrest, and prosecution while seeking health care services and medical treatment creates a barrier to accessing care [4]. Any statute or legal measure that utilizes the criminal legal system as a way to control or manage behaviors during pregnancy is counterproductive to the overarching goal of improving maternal and neonatal outcomes [7]. The American College of Obstetricians and Gynecologists opposes the prosecution of a pregnant person for conduct alleged to have harmed their fetus, including the criminalization of self-managed abortion [4, 8, 9].

Substance Use Disorder in Pregnancy

Clear evidence exists that criminalization and incarceration for substance use disorder during pregnancy are ineffective as behavioral deterrents and harmful to the health of the pregnant person and their infant [7, 9]. Despite the fact that leading medical organizations agree that a positive drug test should not be construed as child abuse or neglect, biologic testing of pregnant people and newborns for the presence of licit and illicit substances is often an institutional policy put in place with the intention of promoting public health [1, 10]. These policies instead use screening tests as an indicator of child abuse, which results in reporting or referrals to Child Protective Services [1,9]. This routine practice, sometimes termed "test and report," disrupts bodily autonomy of the pregnant person and their newborn and is inconsistent with treating substance use disorder as a health condition with social and behavioral dimensions (See "Test and Report: Bad for Children and Families" at https://www.huffpost.com/entry/test-and-report-bad-for-children-and-families_b_5175106; See "Written Testimony to the Committee on General Welfare: Impact of Marijuana Policies on Child Welfare" at https://www.bronxdefenders.org/written-testimony-to-the-committee-on-general-welfare-impact-of-marijuana-policies-on-child-welfare/). Before performing any test on the pregnant individual or neonate, including screening for the presence of illicit substances, informed consent should be obtained from the pregnant person or parent. This consent should include the medical indication for the test, information regarding the right to refusal and the possibility of associated consequences for refusal, and discussion of the possible outcome of positive test results [11]. In addition, obstetrician–gynecologists or other obstetric care practitioners should consider patient self-reporting as an alternative, which has been demonstrated repeatedly to be reliable in conditions where there is no motivation to lie, and in clinical settings where there are no negative consequences attached to truthful reporting [1, 12].

Despite institutional and health care practitioner level policies that support the practice of universal "test and report," evidence shows that substance use testing and subsequent referrals are not universal or uniform [13]. Bias and racism play a role in discriminatory behavior when determining who and when to test or report. Despite similar rates of drug use between people of different races and income levels, medical professionals and the foster system overwhelmingly target people who are poor and people of color for pre- and post-natal drug testing and reporting to child protective services (See "Violence Against Women in the Medical Setting: An Examination of The U.S. Foster System" at https://ccrjustice.org/sites/default/files/attach/2019/06/MFP_NAPW_UN_VAW_Submission-

20190531-Final.pdf). Moreover, evidence does not support universal screening as leading to treatment nor does it support that the treatment provided as a result of identification during the course of prenatal care is effective [14].

The social stigma and threat of criminal prosecution prevent many pregnant people from seeking prenatal care and treatment for their substance use disorder [9, 15]. Those who access care fear that requirements for physicians, social workers, and other health care practitioners to act as both health service practitioners and mandated reporters will result in arrest and prosecution. The laws, regulations, and policies that require health care practitioners and human service workers to respond to substance use and substance use disorder in a primarily punitive way, require health care providers to function as agents of law enforcement.

Refusal of Care/Treatment

ACOG policy states that pregnancy is not an exception to the principle that a decisionally capable person has the right to refuse treatment, even treatment needed to maintain their own life [11]. Therefore, the decision to refuse recommended medical or surgical intervention, such as a pregnant person refusing treatment for themselves or their fetus in utero or for refusal to undergo a recommended cesarean delivery, should be respected. Lack of respect for this right of refusal undermines individual agency and autonomy (see "The Use of Child Protective Services and Court Orders to Enforce Medical Compliance in the Labor and Delivery Room: How Threats of Legal Action Limit Reproductive Choice" at https://harvardjlg.com/2018/11/the-use-of-child-protective-services-and-court-orders-to-enforce-medical-compliance-in-the-labor-and-delivery-room-how-threats-of-legal-action-limit-reproductive-choice/). The College opposes the use of coerced medical or surgical interventions for pregnant people, including the use of the courts to mandate medical intervention for unwilling patients [11]. The American Medical Association also supports this premise in its statement regarding legal interventions during pregnancy. This AMA statement says that judicial intervention is inappropriate when a person has made an informed refusal of a medical treatment designed to benefit their fetus [16]. Of note, coercive tactics often lead individuals to acquiesce without a court order. The physician's duty is to provide appropriate information so that the pregnant person may make an informed and thoughtful decision, not to dictate what that decision should be [16]. ACOG believes that it is unethical for medical practitioners to use manipulation, coercion, or threats of criminalization to compel patients toward a particular medical decision or treatment, including during pregnancy and the postpartum period [11].

Implicit bias regarding race and class often influence the decision to utilize coercive tactics or judicial intervention. Coercive tactics including court orders are more commonly applied to individuals with low incomes, young people, people of color, and people who are immigrants [17, 18].

Conclusion

Criminalization of pregnant people for actions allegedly aimed at harming their fetus poses serious threats to people's health and the health system itself. Threatening patients with criminal punishment erodes trust in the medical system, making people less likely to seek help when they need it. Criminalization makes people less safe and harms the confidential patient–practitioner relationship by creating uncertainty as to whether law enforcement will become involved. In the worst circumstances, this leads people to be treated as suspects instead of patients, subject to bedside interrogations and legal scrutiny [6, 9]. Harm reduction strategies should be implemented in order to reduce negative consequences and support agency and autonomy in the decision making of pregnant and parenting people.

ACOG is committed to the elimination of policies or practices that criminalize people during pregnancy and the postpartum period for conduct alleged to be harmful to a pregnancy through the following actions:

- Advocating for an approach that centers on primary prevention of substance use disorder, improving access to treatment, and promoting the patient-practitioner relationship rather than punitive measures through the criminal legal system (1 – ACOG CO 633, 2015; 8 - ACOG CO 711, 2017; 19 – Patrick and Schiff, 2017);
- Opposing mandated or required drug testing, especially covert drug testing, for the purpose of detecting substance use. Instead of biologic testing, obstetrician/gynecologists and other health care practitioners should consider relying on self-reporting through routine screening for substance use disorder and conversations with patients. Routine laboratory testing of biologic samples is not required (1 – ACOG CO 633, 2015);
- Opposing the lack of uniform policy in screening, testing, and reporting for substance use that allows for biases and racism and relies solely on physicians' suspicion to determine practice;
- Advocating against laws, practice, and policy that allow for testing of individuals or newborns for illicit substances without consent (1 – ACOG CO 633, 2015; 8 - ACOG CO 711, 2017; 11 – ACOG CO 664, 2016);
- Educating health care practitioners against reporting patients to law enforcement or subjecting

patients to interrogation for suspicion of self-managed abortion (4 – ACOG, 2017); and

- Supporting the education of physicians, hospital administrators, attorneys, judges, and individuals about the unconstitutionality of unconsented and refused surgery (11 – ACOG CO 664, 2016).

References

1. Alcohol abuse and other substance use disorders: ethical issues in obstetric and gynecologic practice. Committee Opinion No. 633. Obstet Gynecol 2015;125:1529-37.
2. Amnesty International. Criminalizing pregnancy. Policing pregnant women who use drugs in the USA. London: Amnesty International; 2017. Available at: https://www.amnesty.org/download/Documents/AMR5162032017ENGLISH.pdf. Retrieved January 13, 2021.
3. National Conference of State Legislatures. State laws on fetal homicide and penalty enhancement for crimes against pregnant women. Washington, DC: NCSL; 2018. Available at: https://www.ncsl.org/research/health/fetal-homicide-state-laws.aspx. Retrieved January 13, 2021.
4. American College of Obstetricians and Gynecologists. Decriminalization of self-induced abortion. Position Statement. Washington, DC: American College of Obstetricians and Gynecologists; 2017. Available at: https://www.acog.org/clinical-information/policy-and-position-statements/position-statements/2017/decriminalization-of-self-induced-abortion. Retrieved January 13, 2021.
5. Diaz-Tello F, Mikesell M, Adams JE. Roe's unfinished promise: decriminalizing abortion once and for all. Oakland, CA: If/When/How; 2018. Available at: https://www.ifwhenhow.org/resources/roes-unfinished-promise/. Retrieved January 13, 2021.
6. If/When/How. Making abortion a crime (again): how extreme prosecutors attempt to punish people for abortions in the U.S. Oakland, CA: If/When/How; 2019. Available at: https://www.ifwhenhow.org/resources/making-abortion-a-crime-again/. Retrieved January 13, 2021.
7. National Perinatal Association. NPA Position Statement 2017. Perinatal substance use. Lonedell, MO: NPA; 2017. Available at: http://www.nationalperinatal.org/resources/Documents/Position%20Papers/2017_Perinatal%20Substance%20Use_NPA%20Position%20Statement.pdf. Retrieved January 13, 2021.
8. Opioid use and opioid use disorder in pregnancy. Committee Opinion No. 711. American

8. Opioid use and opioid use disorder in pregnancy. Committee Opinion No. 711. American College of Obstetricians and Gynecologists. Obstet Gynecol 2017;130:e81-94.

9. Substance abuse reporting and pregnancy: the role of the obstetrician–gynecologist. Committee Opinion No. 473. American College of Obstetricians and Gynecologists. Obstet Gynecol 2011;117:200-1.

10. Center for Substance Abuse Treatment. Drug testing in child welfare: practice and policy considerations. Rockville, MD: Substance Abuse and Mental Health Services Administration; 2010. Available at: https://ncsacw.samhsa.gov/files/DrugTestinginChildWelfare.pdf. Retrieved January 13, 2021.

11. Refusal of medically recommended treatment during pregnancy. Committee Opinion No. 664. American College of Obstetricians and Gynecologists. Obstet Gynecol 2016;127:175.

12. Darke S, Burns L. Commentary on Friguls et al. (2012): illicit drugs and pregnancy--testing is not a substitute for good clinical rapport. Addiction 2012;107:1480-1.

13. Dailard C, Nash E. State responses to substance abuse among pregnant women. Guttmacher Policy Rev 2000;3(6):3-6. Available at: https://www.guttmacher.org/gpr/2000/12/state-responses-substance-abuse-among-pregnant-women. Retrieved January 13, 2021.

14. Roberts SC, Nuru-Jeter A. Universal alcohol/drug screening in prenatal care: a strategy for reducing racial disparities? Questioning the assumptions. Matern Child Health J 2011;15:1127-34.

15. Schempf AH, Strobino DM. Drug use and limited prenatal care: an examination of responsible barriers. Am J Obstet Gynecol 2009;200:412.e1-10.

16. American Medical Association. Legal interventions during pregnancy H-420.969. Chicago, IL: AMA; 2018. Available at: https://policysearch.ama-assn.org/policyfinder/detail/women?uri=%2FAMADoc%2FHOD.xml-0-3712.xml. Retrieved January 13, 2021.

17. Morris T, Robinson JH. Forced and coerced cesarean sections in the United States. Contexts 2017;16:24-9.

18. Vedam S, Stoll K, Taiwo TK, Rubashkin N, Cheyney M, Strauss N, et al. The Giving Voice to Mothers study: inequity and mistreatment during pregnancy and childbirth in the United States. GVtM-US Steering Council. Reprod Health 2019;16:77-2.

19. Patrick SW, Schiff DM. A public health response to opioid use in pregnancy. Committee on Substance Use and Prevention. Pediatrics 2017;139:e20164070.

Approved by the Board of Directors: December 2020

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