

**IN WHOSE BEST INTEREST? NEW JERSEY DIVISION
OF YOUTH AND FAMILY SERVICES V.
V.M. AND B.G. AND THE NEXT WAVE OF
COURT-CONTROLLED PREGNANCIES**

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INTRODUCTION

On April 16, 2006, V.M., a forty-two-year-old married woman in her thirty-fifth week of pregnancy, voluntarily checked into St. Barnabas Hospital in Livingston, New Jersey.¹ During active labor, V.M. “consented to the administration of intravenous fluids, antibiotics, oxygen, fetal heart rate monitoring, an episiotomy and an epidural anesthetic,” but refused to sign a form consenting to a cesarean section (“c-section”).² V.M. ultimately did

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¹ N.J. Div. of Youth & Family Servs. v. V.M. (*In re J.M.G.*), 974 A.2d 448, 450 (N.J. Super. Ct. App. Div. 2009) (per curiam) (Carchman, J., concurring).

² *Id.* A cesarean section, commonly known as a “c-section,” “is defined as the birth of a fetus through incisions in the abdominal wall (laparotomy) and the uterine wall (hysterotomy).” F. GARY CUNNINGHAM ET AL., WILLIAMS OBSTETRICS 544 (23d ed. 2010).

not have a c-section, and V.M.'s child, J.M.G., was safely born in "good medical condition" through a vaginal birth.³ However, during a subsequent child welfare determination, V.M.'s "failure to cooperate with medical personnel" during labor and delivery, and specifically "V.M.'s refusal to consent to a c-section factored heavily into [the trial judge's] decision" that J.M.G. was "an abused and neglected child."⁴ As a result of this finding, the state removed J.M.G. from her parents' custody and placed her in the custody of the New Jersey Division of Youth and Family Services ("DYFS").⁵ After an appellate court upheld the trial court's abuse and neglect finding, but did not explicitly address the lower court's reliance on the refusal to consent to a c-section,⁶ the New Jersey Supreme Court and the United States Supreme Court respectively denied certification and certiorari.⁷ Accordingly, the New Jersey trial court's explicit reliance on a woman's refusal to consent to a c-section as a basis for a child neglect finding was never directly addressed by a higher court, leaving other trial courts in a position to make the same finding in the future.

This Article will examine *New Jersey Division of Youth and Family Services v. V.M. and B.G.* ("*New Jersey v. V.M.*") to explore the continued regulation and control of women's reproductive decisions and the startling new reality that women's practice of protected legal activities during pregnancy may play a role in the loss of child custody. Part I of this Article will detail *New Jersey v. V.M.*'s factual and procedural history, focusing in particular on the legal ramifications of V.M.'s refusal to consent to a c-section. Part II will briefly summarize the recent history of state regulation of fertility, pregnancy, and childbirth. The section will explore the progression from eugenics-based court-ordered sterilizations in the early part of the twentieth century to the more recent criminal and civil sanctioning of pregnant women for their actions (or failures to act) while pregnant. Finally, Part III will place *New Jersey v. V.M.* in the context of this history of reproductive regulation and argue that a pregnant woman's refusal to consent to a c-section should not be a consideration in subsequent child welfare cases. Permitting such a consideration will have wide-ranging consequences for multiple areas of reproductive rights. First, allowing a c-section refusal to factor into child welfare proceedings opens the door to extensive regulation of women's legal

³ *V.M.*, 974 A.2d at 452 (Carchman, J., concurring).

⁴ *Id.* at 450. Although Judge Carchman's concurrence states that the c-section refusal "factored heavily" into the abuse and neglect finding, the majority, while acknowledging that the trial judge "in fact, did rely, in part on such [c-section] refusal in his findings of abuse and neglect," took the "view that there was substantial additional evidence of abuse and neglect that supported the ultimate findings." *Id.* at 449 (majority opinion). Judge Carchman likewise stated that V.M.'s "combative" behavior during labor, her psychiatric history, and the opinion of the hospital's psychiatrist supported the abuse and neglect finding. *Id.* at 464-65 (Carchman, J., concurring).

⁵ *Id.* at 449 (majority opinion).

⁶ *Id.* (stating that the court did not consider the issue of V.M.'s c-section refusal).

⁷ *V.M.*, 974 A.2d 448, cert. denied, 983 A.2d 1110, 1113 (N.J. 2009), cert. denied, 130 S. Ct. 3502 (2010).

actions while pregnant. Second, the specter of child welfare proceedings looming over the delivery room may have incredibly coercive effects on women making labor and birth decisions, and it increases the already significant power that medical professionals have over women's medical decision-making. This potential regulation and the coercion that may result raise significant concerns about a woman's protected right, which is grounded in privacy and liberty interests, to make medical decisions during pregnancy and childbirth. Finally, I will argue that *New Jersey v. V.M.* extended the protections of the abuse and neglect statute to prenatal conduct without a statutory basis to do so, and, through this creation of fetal personhood, set a dangerous precedent for women's reproductive autonomy.

I. *New Jersey Division of Youth and Family Services v. V.M. and B.G.*

As explained more fully below, the question of J.M.G.'s custody was, and remains, the subject of multiple, ongoing proceedings in the New Jersey courts. There were two separate tracks for these proceedings: the abuse and neglect proceedings and the termination of parental rights proceedings.⁸ DYFS conducted the initial proceeding pursuant to New Jersey's Abandonment, Abuse, Cruelty and Neglect Act.⁹ It was during this hearing that the trial judge "heavily" weighed V.M.'s refusal to consent to a c-section in coming to his ultimate finding that J.M.G. was an abused and neglected child.¹⁰ Separate parental rights termination proceedings followed this abuse and neglect determination, and on December 19, 2008, V.M. and B.G.'s parental rights were terminated.¹¹

I note at the outset that my intent is *not* to question the New Jersey courts' decisions regarding termination of parental rights, as those proceedings largely focused on evaluations of V.M. and B.G.'s fitness as parents based on their actions *after* the birth of J.M.G. rather than on V.M.'s actions during childbirth, which were at issue in the abuse and neglect proceedings.¹² Indeed, in an August 6, 2010 decision reversing and remanding the

⁸ *V.M.*, 974 A.2d at 456 (Carchman, J., concurring) (noting separate abuse and neglect litigation and termination of parental rights litigation).

⁹ *Id.* at 450. See N.J. STAT. ANN. §§ 9:6-8.21-8.106 (West 2002 & Supp. 2006). The statute cited is the version in effect at the time of trial. Since then the statute has been amended slightly. See N.J. STAT. ANN. §§ 9:6-8.21-8.106 (West 2002 & Supp. 2009).

¹⁰ *V.M.*, 974 A.2d at 450 (Carchman, J., concurring).

¹¹ *Id.* at 450 n.2. The termination of parental rights proceedings were pursuant to N.J. STAT. ANN. § 30:4C-15.1 (West 2008). This decision has since been remanded for further proceedings. N.J. Div. of Youth & Family Servs. v. V.M. (*In re* Guardianship of J.M.G.), Nos. A-2649-08T4, A-3024-08T4, A-3336-08T4, A-3342-08T4, 2010 WL 3075628, at *33-34 (N.J. Super. Ct. App. Div. Aug. 6, 2010) (per curiam) (reversing and remanding on the grounds that the state did not meet its burden of proving each prong of New Jersey's four-pronged parental rights termination statute).

¹² For a summary of the parental rights termination proceedings and the evidence presented therein, see generally *V.M.*, 2010 WL 3075628, at *5-22 (summarizing evidence presented during parental rights termination proceedings).

parental rights termination decision, the appellate court noted this distinction, stating:

In contrast to the Title 9 [abuse and neglect] trial, V.M.'s failure to consent to a c-section did not form a major portion of the evidence presented in the guardianship trial, nor was it a 'major consideration' in the court's decision [T]o the extent the judge considered the issue, it has no place in this termination proceeding.¹³

Accordingly, I focus on the abuse and neglect proceedings and the narrow legal question of whether a woman's refusal to consent to a c-section should, as a matter of law, be considered *at all* when a subsequent child welfare decision is made. The factual and procedural recitation below is thus largely limited to those facts that pertain to the question of whether a refusal to consent to a c-section, particularly when the child is born healthy, should factor into child welfare decisions.

A. *V.M.'s Labor and Delivery*

On April 16, 2006, V.M., a forty-two-year-old college-educated woman, checked into St. Barnabas Hospital in Livingston, New Jersey.¹⁴ She was accompanied by her husband of eleven years, B.G.¹⁵ V.M. was thirty-five weeks pregnant with her first child and in labor.¹⁶

V.M. signed a consent form for multiple medical interventions during labor and delivery, including the use of "intravenous fluids, antibiotics, oxygen, fetal heart rate monitoring, an episiotomy and an epidural anesthetic."¹⁷ However, V.M. chose not to sign the advance consent to a c-section.¹⁸ The attending obstetrician, Dr. Shetal Mansuria, informed V.M. of the risks of refusing a c-section if the fetus were to go into distress and told V.M. that there was a "nonreassuring fetal status."¹⁹ V.M. again refused to consent to a c-section.²⁰ V.M. also refused to wear an oxygen mask and "refused to remain still in order to allow for fetal heart monitoring."²¹ She "thrashed about to the extent that it was unsafe for the anesthesiologist to administer an epidural,"²² but an epidural was ultimately achieved.²³ Throughout V.M.'s

¹³ *Id.* at *26 (internal citation omitted).

¹⁴ *V.M.*, 974 A.2d at 450 (Carchman, J., concurring).

¹⁵ *Id.*

¹⁶ *Id.*

¹⁷ *Id.*

¹⁸ *Id.*; Brief of Experts in Maternal and Neonatal Health, Birth, and Child Welfare as Amici Curiae Supporting Appellants at 4–5, *V.M.*, 974 A.2d 448 (No. A-4627-06T4), available at http://advocatesforpregnantwomen.org/VMAmicus_redacted_withcover.pdf.

¹⁹ *V.M.*, 974 A.2d at 451 (Carchman, J., concurring). B.G. told "a nurse that he was also aware of the risks, but deferred to V.M.'s decision." Brief of Experts in Maternal and Neonatal Health, *supra* note 18, at 4.

²⁰ *V.M.*, 974 A.2d at 451 (Carchman, J., concurring).

²¹ *Id.*

²² *Id.*

active labor, the hospital records describe V.M. as “‘very boisterous and yelling and screaming at the top of her lungs,’”²⁴ “erratic,” and “non-compliant.”²⁵ Court records also indicate that “V.M. . . . call[ed] the Livingston Police to report that she was being abused and denied treatment.”²⁶

Because of hospital personnel’s perception of V.M.’s “extreme behavior and signs of developing fetal distress, hospital staff requested an emergency psychiatric evaluation to determine V.M.’s competency.”²⁷ Dr. Devendra Kurani performed the psychiatric consultation.²⁸ During the examination, V.M. disclosed that she had a “psychiatric history and had been on medication prior to getting pregnant.”²⁹ After the one-hour consultation, Dr. Kurani ultimately determined that V.M. was competent to make medical decisions, and he specifically concluded that V.M. “display[ed] capacity for informed consent for c-section[,] . . . manifest[ed] no evidence of psychosis[,] . . . [and was] fully alert and oriented and aware of the circumstances.”³⁰

Despite the fact that V.M. was “no longer agitated” after meeting with Dr. Kurani and receiving an epidural, hospital personnel ordered a second psychiatric consult from Dr. Jacob Jacoby.³¹ However, prior to the completion of the second psychiatric evaluation, V.M. gave birth vaginally “without incident” to a healthy baby girl, J.M.G.³² J.M.G. was born in “good medical condition” and showed no evidence of exposure to drugs or alcohol.³³ After delivery, V.M. apologized to the hospital staff for her “inappropriate behavior” during labor.³⁴ V.M. and B.G. also “added their daughter to their health care policy and purchased a crib.”³⁵ In his subsequent report, Dr. Jacoby raised concerns about V.M. and B.G.’s ability to parent J.M.G. Dr. Jacoby also recommended that the issue “‘be more fully evaluated by state social services.’”³⁶

²³ *Id.* at 450.

²⁴ *Id.* at 451.

²⁵ *Id.* at 450.

²⁶ *Id.* at 451.

²⁷ *Id.*

²⁸ *Id.*

²⁹ *Id.*

³⁰ Brief of Petitioner for Writ of Certiorari at 3–4, *V.M.*, 974 A.2d 448 (No. A-2649-08T4) (on file with author); *see also V.M.*, 974 A.2d at 451 (Carchman, J., concurring) (noting Dr. Kurani’s conclusion that V.M. “had the capacity for informed consent with regard to the c-section”).

³¹ Brief of Petitioner, *supra* note 30, at 4.

³² *V.M.*, 974 A.2d at 451 (Carchman, J., concurring).

³³ *Id.* at 452.

³⁴ Brief of Petitioner, *supra* note 30, at 4; *see also* N.J. Div. of Youth & Family Servs. v. *V.M.* (*In re* Guardianship of J.M.G.), Nos. A-2649-08T4, A-3024-08T4, A-3336-08T4, A-3342-08T4, 2010 WL 3075628, at *15 (N.J. Super. Ct. App. Div. Aug. 6, 2010) (per curiam) (noting that V.M. calmed down and apologized after delivery).

³⁵ Brief of Experts in Maternal and Neonatal Health, *supra* note 18, at 6.

³⁶ *V.M.*, 974 A.2d at 452 (Carchman, J., concurring).

B. DYFS and Family Court Proceedings

Following this healthy delivery, on April 18, 2006, a social worker at St. Barnabas Hospital contacted the DYFS to “report concerns over releasing J.M.G. to her parents’ care.”³⁷ A DYFS caseworker interviewed hospital staff as well as V.M. and B.G.³⁸ and ultimately informed V.M. that she would not be able to take J.M.G. home when the infant was discharged.³⁹ On April 20, 2006, DYFS filed a complaint under New Jersey’s child abuse and neglect statute,⁴⁰ requesting custody, care, and supervision of J.M.G. on the basis that J.M.G. “was ‘in imminent danger of becoming impaired as a result of the failure of the parent . . . [to] exercis[e] a minimum degree of care in supplying the child with . . . surgical care [the c-section].’”⁴¹ A court hearing regarding J.M.G.’s custody was scheduled for the same day, but neither V.M. nor B.G. attended the hearing.⁴² The Superior Court of New Jersey, Chancery Division, Family Part granted the state custody of J.M.G.⁴³ V.M., who had already been released from the hospital, visited J.M.G. in the hospital every day until J.M.G. was discharged and placed in foster care on April 24, 2006.⁴⁴

During the subsequent abuse and neglect fact-finding hearings on May 9 and May 24, 2006,⁴⁵ the state Deputy Attorney General maintained that DYFS was proceeding under the theory that V.M. had abused and neglected her child by failing to consent to the c-section, stating: “[g]iven her . . . psychiatric condition [V.M.] refused treatment at the hospital in terms of allowing the [c]-section to be done . . . [V.M.] took it upon herself to have

³⁷ *Id.* Dr. Jacoby’s report of his uncompleted evaluation of V.M. concluded that she was “cognitively intact,” but indicated concerns, likely based in part on conversations with V.M.’s prior treating psychiatrist about V.M.’s ability to parent. *Id.* V.M.’s prior psychiatrist, Dr. Seltzer, told Dr. Jacoby that V.M. “suffered from either a schizoaffective disorder or a bipolar disorder” and indicated that she was “concerned about V.M.’s ‘ability to care for her child in a responsible manner.’” *Id.* at 451.

³⁸ *Id.* at 452. During these interviews, V.M. and B.G. denied that V.M. had refused to consent to the c-section and denied her history of psychiatric illness. *Id.*

³⁹ *Id.*; see also Brief of Experts in Maternal and Neonatal Health, *supra* note 18, at 6 (noting that V.M. “became very upset” after being informed that J.M.G. “would not be coming home with [V.M. and B.G.]” from the hospital).

⁴⁰ Abandonment, Abuse, Cruelty and Neglect Act, N.J. STAT. ANN. §§ 9:6-8.21–8.106 (West 2002 & Supp. 2006).

⁴¹ Brief of Petitioner, *supra* note 30, at 9.

⁴² *V.M.*, 974 A.2d at 452 (Carchman, J., concurring). DYFS claimed that it made multiple attempts to notify V.M. and B.G. of the hearing; V.M. claimed that she did not have notice of the hearing. *Id.* at 452–53.

⁴³ Brief of Petitioner, *supra* note 30, at 6.

⁴⁴ N.J. Div. of Youth & Family Servs. v. V.M. (*In re* Guardianship of J.M.G.), Nos. A-2649-08T4, A-3024-08T4, A-3336-08T4, A-3342-08T4, 2010 WL 3075628, at *4 (N.J. Super. Ct. App. Div. Aug. 6, 2010) (*per curiam*).

⁴⁵ V.M.’s testimony at these hearings differed sharply from the hospital’s accounts of the birth; V.M. claimed that she had consented to the c-section and had been subjected to poor treatment by hospital staff. *V.M.*, 974 A.2d at 453 (Carchman, J., concurring).

her needs addressed first before having the needs of the child addressed.”⁴⁶ The trial judge “identified the issue before him as whether J.M.G. was in imminent danger between April 16 and April 18;”⁴⁷ that is, whether J.M.G. was in danger during labor and delivery and the two days following her birth. The judge considered medical records indicating that V.M. had been under a psychiatrist’s care for eleven years and that she had been diagnosed with post-traumatic stress disorder, panic disorder, and major depression and had shown signs of paranoia and psychotic ideations.⁴⁸ In addition, however, the judge heard testimony from V.M. that hospital staff had treated her poorly during labor and delivery, that she had been in extreme pain, and that she had consented to the c-section when initially admitted to the hospital.⁴⁹ While emphasizing that his decision was not solely based on V.M.’s refusal to consent to a c-section, and intimating that V.M.’s medical decisions and behavior were related to her mental illness,⁵⁰ the judge found:

[W]ith the mother’s life and baby’s life in balance, I think it was negligent . . . not to accede to what the doctors requested. Possibly this was caused by her not taking the medication which [V.M.’s prior psychiatrist] had prescribed for her. And if so, that’s the type of thing that may be curable. Nevertheless, it is my decision by a preponderance of the evidence that she refused to cooperate with the medical professional at St. Barnabas Hospital during child-birth. I’m not finding that by clear and convincing evidence because I think the case was not that strong and there were mitigating factors.⁵¹

The trial judge then found that under the New Jersey abuse and neglect statute V.M. was “negligent,” and that J.M.G. was an abused or neglected child.⁵² The judge also “rejected B.G. as a custodial parent.”⁵³

A September 15, 2006 compliance review followed. At this hearing, the judge ordered that a psychiatric evaluation of V.M. be performed.⁵⁴ During a March 19, 2007 permanency hearing, the trial judge found that it

⁴⁶ Brief of Petitioner, *supra* note 30, at 7–8. The state relied on New Jersey annotated statute § 9:6-8.21(c)(4)(a) (West 2002 & Supp. 2006), which defines an abused or neglected child as one “whose physical, mental, or emotional condition has been impaired or is in imminent danger of becoming impaired as the result of the failure of his parent or guardian, as herein defined, to exercise a minimum degree of care (a) in supplying the child with adequate food, clothing, shelter, education, medical or surgical care.”

⁴⁷ *V.M.*, 974 A.2d at 453 (Carchman, J., concurring).

⁴⁸ *Id.* at 452–53. V.M. discontinued her treatment in early 2006 despite her psychiatrist’s documented recommendation that she continue. *Id.* at 453.

⁴⁹ *Id.* at 453.

⁵⁰ *Id.* at 464; Brief of Petitioner, *supra* note 30, at 10.

⁵¹ Brief of Petitioner, *supra* note 30, at 10 (quoting the judge at the fact-finding hearing).

⁵² *V.M.*, 974 A.2d at 453 (Carchman, J., concurring).

⁵³ *Id.*

⁵⁴ *Id.* at 454.

would “not be safe to return [J.M.G.] home in the foreseeable future because [of V.M.’s] . . . psychiatric condition” and ordered that J.M.G. remain in foster care and that DYFS find a pre-adoptive home.⁵⁵ DYFS filed a complaint for termination of parental rights on April 26, 2007,⁵⁶ and on December 19, 2008, V.M.’s and B.G.’s parental rights were terminated.⁵⁷

C. Superior Court Appellate Proceedings

V.M. and B.G. appealed both the initial finding of abuse and neglect and, in a separate action, the termination of parental rights.⁵⁸ Regarding the finding of abuse and neglect, the Appellate Division of the New Jersey Superior Court, in a per curiam decision, affirmed the finding as to V.M.⁵⁹ Noting that the trial judge had partly relied on V.M.’s refusal to consent to a c-section, the court held that the issue of whether her decision could, “as a matter of law, be considered an element of abuse and neglect” did not need to be decided, given that in the appellate court’s view, “independent evidence” supported the abuse and neglect finding.⁶⁰

In a concurring opinion, however, Judge Carchman argued that the refusal to consent to a c-section could not, as a matter of law, be a factor in an abuse and neglect determination.⁶¹ Judge Carchman found sufficient support for the contention that the fetus “is not a ‘child’ as contemplated by [the New Jersey abuse and neglect statute]” and thus that “any decisions that [V.M.] made with regard to prenatal treatment and surgery cannot form the

⁵⁵ *Id.* at 455. Although these facts are outside the scope of this article, these later proceedings revealed conflicting evidence about whether V.M. may have been suffering from psychosis. During the March 19, 2007 permanency hearing, the psychiatrist who performed evaluations of both B.G. and V.M. for DYFS concluded that V.M. suffered from chronic paranoid schizophrenia and that B.G. was suffering from “*folie à deux*,” a condition where one person (B.G.) adopts the psychoses of another (V.M.). *Id.* at 454. The psychiatrist concluded that neither V.M. nor B.G. was a fit parent, and that returning J.M.G. to her parents would place J.M.G. in danger. *Id.* V.M.’s and B.G.’s psychiatric expert proffered a different conclusion, finding that both V.M. and B.G. were fit parents. *Id.* at 454–55.

⁵⁶ *Id.* at 455.

⁵⁷ *Id.* at 450 n.2.

⁵⁸ *Id.* at 450 n.2, 455. On August 6, 2010, the New Jersey Superior Court Appellate Division reversed the termination of parental rights and remanded for further proceedings. The court found that the state had not met its burden of proving that each of the four prongs of the New Jersey termination statute, § 30:4C-15.1(a), was satisfied. N.J. Div. of Youth & Family Servs. v. V.M. (*In re* Guardianship of J.M.G.), Nos. A-2649-08T4, A-3024-08T4, A-3336-08T4, A-3342-08T4, 2010 WL 3075628, at *33–34 (N.J. Super. Ct. App. Div. Aug. 6, 2010) (per curiam). This decision does not disturb the initial abuse and neglect finding regarding V.M.

⁵⁹ *V.M.*, 974 A.2d at 449. The Appellate Division reversed the finding of abuse and neglect as to B.G., noting that “B.G. could not have forced his wife to cooperate with hospital staff” and that a finding of abuse as to B.G. “was clearly not supported by the record.” *Id.* at 465 (Carchman, J., concurring).

⁶⁰ *Id.* at 449 (majority opinion) (noting that there was “substantial additional evidence” to support the finding).

⁶¹ *Id.* at 464 (Carchman, J., concurring).

basis of a finding of abuse and neglect.”⁶² Nevertheless, Judge Carchman considered V.M.’s other behavior during labor and delivery—including her refusal to remain still for epidural administration and fetal monitoring, her “combative” and “erratic” conduct, and her call to the police to report that she was being abused by hospital staff—and found that this constituted sufficient evidence to support the trial judge’s ultimate finding of abuse and neglect.⁶³

V.M. appealed the Superior Court Appellate Division’s affirmance of the abuse and neglect finding. The New Jersey Supreme Court denied certification in February 2010, and the U.S. Supreme Court denied certiorari in June 2010.⁶⁴ Accordingly, the lower court’s decision remains as an example for future trial courts to follow, including its reliance on V.M.’s refusal to consent to a c-section as a basis for a neglect finding.

II. A BRIEF HISTORY OF THE REGULATION OF FERTILITY, PREGNANCY, AND CHILDBIRTH

State regulation of women’s fertility and pregnancies is not a new phenomenon. Understanding the history of state regulation of women’s reproductive choices and health is critical to understanding the intense coercion inherent in permitting a woman’s labor and birth decisions to factor into subsequent child welfare determinations.⁶⁵ This section briefly summarizes the recent history of state-compelled permanent and temporary sterilization, state regulation of pregnancy, and state regulation of labor and delivery.

A. *Controlling Fertility*

The eugenics movement of the early twentieth century, which sought “to give to the more suitable races or strains of blood a better chance of prevailing speedily over the less suitable,”⁶⁶ was the impetus for many com-

⁶² *Id.*

⁶³ *Id.*

⁶⁴ N.J. Div. of Youth & Family Servs. v. V.M. (*In re J.M.G.*), 974 A.2d 448 (N.J. Super. Ct. App. Div. 2009), *cert. denied*, 983 A.2d 1110, 1113 (N.J. 2009), *cert. denied*, 130 S. Ct. 3502 (2010).

⁶⁵ While “coercion” is a common term, Sarah Gill’s excellent article regarding legislative efforts to “coerce” women to have Norplant (a hormonal contraceptive) implanted shaped my thinking throughout this article. I thus credit her for my use of the term in this context. See Sarah Gill, *Discrimination, Historical Abuse, and the New Norplant Problem*, 16 WOMEN’S RTS. L. REP. 43, 48 (1994) (discussing the “economic coercion” inherent in linking, for example, welfare benefits to Norplant use) (citing Julie Mertus & Simon Heller, *Norplant Meets the New Eugenicians: The Impermissibility of Coerced Contraception*, 11 ST. LOUIS U. PUB. L. REV. 359, 382 (1992)).

⁶⁶ PAUL A. LOMBARDO, THREE GENERATIONS, NO IMBECILES: EUGENICS, THE SUPREME COURT, AND *Buck v. Bell* 7 (2008) (quoting FRANCIS GALTON, INQUIRIES INTO HUMAN FACULTY AND ITS DEVELOPMENT 24 n.11 (1883)). Galton is credited with coining the term “eugenics.” *Id.*

pulsory sterilization laws.⁶⁷ Eugenics advocates believed that “forced sterilization of the ‘undesirable’ and ‘feebleminded’ could cure America’s social ills.”⁶⁸ In 1907, Indiana was the first state to enact a compulsory sterilization statute.⁶⁹ Twenty-three states enacted similar laws over the next twenty years.⁷⁰

In the 1927 case of *Buck v. Bell*, the U.S. Supreme Court considered the constitutionality of one of these laws: a Virginia statute permitting compelled sterilization of institutionalized mental health patients “afflicted with hereditary forms of insanity [or] imbecility” if it was “for the best interest of the patients and of society that an inmate . . . should be sexually sterilized.”⁷¹ The Court deferred to the Virginia legislature in upholding the statute, thus permitting the sterilization of the then-twenty-one-year-old Carrie Buck, whom the state had deemed “feeble-minded.”⁷² In its decision, the Court relied on eugenics-based arguments, stating:

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

⁶⁷ Vanessa Volz, *A Matter of Choice: Women with Disabilities, Sterilization, and Reproductive Autonomy in the Twenty-First Century*, 27 *WOMEN’S RTS. L. REP.* 203, 205 (2006).

⁶⁸ Michael G. Silver, *Eugenics and Compulsory Sterilization Law: Providing Redress for the Victims of a Shameful Era in United States History*, 72 *GEO. WASH. L. REV.* 862, 864 (2004).

⁶⁹ *Id.* at 866.

⁷⁰ *Id.*

⁷¹ *Buck v. Bell*, 274 U.S. 200, 206 (1927).

⁷² *Id.* at 205, 207. Carrie Buck was admitted to the Virginia Colony for Epileptics and Feeble-minded when she was seventeen years old. See LOMBARDO, *supra* note 66, at 103, 105. Her mother, Emma Buck, had previously been independently committed to the same institution. *Id.* at 105. Both “had been declared ‘feebleminded.’” *Id.* at 104. Vivian, Carrie’s illegitimate daughter, was also considered feeble-minded, having been declared of “below average” intelligence when she was eight months old. *Id.* at 108, 130. In upholding the sterilization statute, the Supreme Court crudely stated that “[t]hree generations of imbeciles are enough.” *Buck*, 274 U.S. at 207.

After her sterilization and release from the institution, Carrie Buck married and remained so until her husband’s death twenty-five years later. LOMBARDO, *supra* note 66, at 189–90. Because she had been sterilized, Carrie was not able to have any more children. Her only daughter, Vivian—who had been raised by foster parents—died at the age of eight of a secondary infection after contracting measles. *Id.* at 190. Subsequent research has revealed that the state’s determination that Carrie and Vivian were feeble-minded was flawed, at best. For example, Vivian had completed the second grade by the time of her death at age eight. Although she was an “average student,” she made her school’s Honor Roll at one point, and she was posthumously characterized as “very bright.” *Id.* at 190, 192. Additionally, Carrie’s lawyer proved less than competent. As Lombardo found, her lawyer

offered no rebuttal to the state’s arguments for surgery; he called no witnesses to counter the experts who had condemned the Buck family; he never explained that Carrie had not become a mother by choice, but that she had been raped[,] . . . [and he was] a major supporter of the sterilization campaign.

Id. at xi.

continuing their kind. The principle that sustains compulsory vaccination is broad enough to cover cutting the Fallopian tubes.⁷³

The Court's blessing of Virginia's statute opened the door for other states to enact their own compulsory sterilization statutes. In the ten years following the *Buck v. Bell* decision, twenty states enacted laws authorizing compelled sterilization.⁷⁴ It has been estimated that over 60,000 people were sterilized pursuant to these laws.⁷⁵

While *Buck v. Bell* is now considered a stain on the nation's jurisprudence,⁷⁶ and the Supreme Court has since recognized a fundamental right to procreate,⁷⁷ *Buck v. Bell's* echoes continue to reverberate in current legislative policy and jurisprudence. Some of these echoes are explicit: several states still have involuntary sterilization statutes on the books,⁷⁸ and most states permit judicially authorized compelled sterilizations in the civil context for persons declared legally incompetent.⁷⁹ Often, those subject to compelled sterilizations are women with mental disabilities,⁸⁰

⁷³ *Buck*, 274 U.S. at 207.

⁷⁴ Silver, *supra* note 68, at 867 (citing Paul A. Lombardo, *Three Generations, No Imbeciles: New Light on Buck v. Bell*, 60 N.Y.U. L. REV. 30, 31 n.5 (1985)).

⁷⁵ *Id.* at 863 (citing PHILLIP R. REILLY, *THE SURGICAL SOLUTION: A HISTORY OF INVOLUNTARY STERILIZATION IN THE UNITED STATES* 2 (1991)).

⁷⁶ Michelle Oberman, *Thirteen Ways of Looking at Buck v. Bell: Thoughts Occasioned by Paul Lombardo's Three Generations, No Imbeciles*, 59 J. LEGAL EDUC. 357, 361 n.21 (2010) (collecting criticism).

⁷⁷ Fifteen years after the *Buck v. Bell* decision, in *Skinner v. Oklahoma ex rel. Williamson*, 316 U.S. 535 (1942), the Supreme Court considered an Oklahoma criminal sterilization statute that permitted the state to sterilize a person with two or more convictions for crimes "amounting to felonies involving moral turpitude." *Id.* at 536. Striking down the Oklahoma statute, the Court declared for the first time that the right to procreate is a fundamental right and that any attempts to limit that right are subject to the strictest scrutiny. *Id.* at 541. The Court took note of the history behind compulsory sterilization laws, stating that "[t]he power to sterilize . . . [i]n evil or reckless hands . . . can cause races or types which are inimical to the dominant group to wither and disappear." *Id.* The *Skinner* decision, however, was limited to the issue of the constitutionality of punitive criminal sterilizations and thus did not overrule *Buck* nor end the practice of sterilizing people committed to the state's custody. LOMBARDO, *supra* note 66, at 232–33. Additionally, the Court's decision ultimately rested on fairly narrow equal protection grounds: that it was unconstitutional for the sterilization law to apply unequally to two people who had committed essentially the same nature of crime depending on whether the crime was classified as one involving "moral turpitude." See *Skinner*, 316 U.S. at 538–43.

⁷⁸ Volz, *supra* note 67, at 207 (citing, as of 2006, Arkansas, Delaware, Georgia, Idaho, Mississippi, North Carolina, Vermont, and Virginia).

⁷⁹ *Id.* at 208.

⁸⁰ See *id.* at 207–09 (summarizing application of involuntary sterilization laws to women with mental disabilities); see also, e.g., *N.C. Ass'n for Retarded Children v. North Carolina*, 420 F. Supp. 451, 455 (M.D.N.C. 1976) (upholding North Carolina's sterilization statute as applied to mentally retarded persons); *Cook v. State*, 495 P.2d 768, 770, 771–72 (Or. Ct. App. 1972) (upholding forced sterilization of seventeen-year-old girl with "severe emotional disturbance" and brain damage on the grounds that she would "be unable to provide a proper environment for a child because of [her] own mental illness or mental retardation").

who may well have been called “feeble-minded” in the *Buck v. Bell* era.⁸¹

Other echoes of *Buck v. Bell* are quieter and involve “coerced,” rather than compelled, sterilization. For example, in the 1990s, state legislatures nationwide introduced dozens of bills relating to Norplant, a hormonal contraceptive implant that can only be inserted or removed by a medical professional.⁸² Some of these bills provided financial incentives to women on public assistance for having Norplant inserted, and others conditioned receipt of public assistance on the insertion of Norplant.⁸³ Given that roughly fifty percent of Medicaid recipients in the United States are black or Hispanic,⁸⁴ these efforts, much like eugenics-based efforts a century earlier, uniquely targeted women of color.⁸⁵ The “economic coercion” inherent in the Norplant legislative efforts sharply limited women’s ability to make unfettered reproductive choices.⁸⁶ As Gill notes, “While these circumstances might not be as deliberate as the forced sterilization of the eugenics movement, the players and outcome are similar: the government is targeting women of low income and women of color with policies that limit reproductive choice and encourage sterilization, be it temporary or permanent.”⁸⁷

More recently, judges have begun coercing both permanent and temporary sterilizations in the criminal context. As Professor Jeanne Flavin chronicles, courts now use “no-procreation orders” as bargaining chips during the criminal plea bargaining and sentencing processes.⁸⁸ These orders, often conditions of probation, order women not to get pregnant and men not to impregnate a woman for a set time period.⁸⁹ The coercive nature of such

⁸¹ See LOMBARDO, *supra* note 66, at 104 (explaining that Carrie Buck, who was ultimately sterilized after the Supreme Court’s decision in *Buck v. Bell*, was declared “‘feebleminded’”).

⁸² Gill, *supra* note 65, at 45 (noting that over twenty-five such bills had been proposed in state legislatures by the end of 1994).

⁸³ *Id.*

⁸⁴ Kaiser Family Found., *Distribution of the Nonelderly with Medicaid by Race/Ethnicity*, STATEHEALTHFACTS.ORG, <http://www.statehealthfacts.org/comparebar.jsp?ind=158&cat=3> (showing that approximately forty-nine percent of Medicaid recipients in the United States are black or Hispanic).

⁸⁵ Gill, *supra* note 65, at 46–47.

⁸⁶ *Id.* at 48 (quoting Mertus & Heller, *supra* note 65, at 382).

⁸⁷ *Id.* at 47.

⁸⁸ JEANNE FLAVIN, *OUR BODIES, OUR CRIMES: THE POLICING OF WOMEN’S REPRODUCTION IN AMERICA* 37–38 (2009). Some of these orders have involved permanent sterilization. For example, Professor Flavin recounts that in a 2005 Georgia case, a judge ordered Carisa Ashe, a thirty-four-year-old woman arrested for the death of her infant daughter, to undergo a tubal ligation as a condition of her voluntary manslaughter plea agreement. Facing life in prison if convicted of murder, Ms. Ashe accepted the plea deal and agreed to be permanently sterilized. In exchange, she received a sentence of five years’ probation. *Id.* at 37.

⁸⁹ See *Pregnancy and Reproductive Rights Related Sentencing and Probation Conditions*, NAT’L ADVOC. FOR PREGNANT WOMEN (Mar. 8, 2004), http://advocatesforpregnantwomen.org/issues/procreation_penalties/pregnancy_and_reproductive_rights_related.php (collecting cases, and noting that while many of the orders were invalidated by higher courts on appeal many other orders “go unappealed”).

“deals” is hard to ignore: failure to accept such a condition of probation could mean that the defendant will instead serve jail time.⁹⁰ Relatedly, oversight of such orders is limited, as criminal defendants are unlikely to appeal a condition of probation given that the alternative to probation is often incarceration.⁹¹ While it is thus difficult to quantify how many such orders have been issued or implemented—as the probationary orders are often not codified in reported decisions and appellate review is limited—reproductive rights scholar Rachel Roth reports instances of “no-procreation” orders in more than 20 states.⁹²

The scope of such orders can be very specific in mandating how conception should be prevented. For example, some judges have gone so far as to mandate that female defendants agree to have contraceptive devices, such as Norplant, implanted as part of the “no-procreation” order.⁹³ Further, some of these procreation bars are quite lengthy. For example, in 2008, a Texas judge sentenced a twenty-year-old woman to ten years of probation after she admitted to failing to “provide protection and medical care” to her nineteen-month-old daughter.⁹⁴ The baby’s father had beaten the baby to the point that her bones were broken.⁹⁵ A condition of the mother’s ten-year probationary period was that she not become pregnant during that time.⁹⁶ Justifying his order, Judge Charlie Baird stated,

Under Texas law, judges can impose any condition on probation so long as it’s reasonable [She] has a fundamental right to reproduce, so I couldn’t order her to be sterilized. But she can be forced to forfeit certain fundamental rights I’m not even preventing her from having intimate sexual relations. I’m only preventing her from becoming pregnant.⁹⁷

⁹⁰ Rachel Roth, “No New Babies?” *Gender Inequality and Reproductive Control in the Criminal Justice and Prison Systems*, 12 AM. U. J. GENDER SOC. POL’Y & L. 391, 408 (2005) (“[There is a] fine line between coercion and ‘choice’ when someone confronts the power of the state. With their freedom on the line, defendants in criminal cases are extremely vulnerable to ‘suggestions’ that they sacrifice their sexuality, bodily integrity, and reproductive intentions for the future, allowing judges to structure defendants’ lives under the guise of ‘voluntary’ decisions.”).

⁹¹ *Id.* at 405–06; see also KATHARINE T. BARTLETT, ANGELA P. HARRIS & DEBORAH L. RHODE, *GENDER AND LAW: THEORY, DOCTRINE, COMMENTARY* 1154–55 (3d ed. 2002) (noting that defendants may accept probationary conditions, and decline to appeal such an order, due to their fear of jail time).

⁹² Roth, *supra* note 90, at 406.

⁹³ See, e.g., Gill, *supra* note 65, at 46 n.22 (collecting six cases where women convicted of child abuse or child abandonment were ordered to use Norplant as a condition of probation).

⁹⁴ Dan Slater, *The Judge Says: Don’t Get Pregnant; A Lapsed Law Now Sees New Life*, WALL ST. J., Sept. 25, 2008, at A18.

⁹⁵ *Id.*

⁹⁶ *Id.*

⁹⁷ *Id.*

Although Judge Baird seemed to think that this order was the touchstone of reasonability, a ten-year ban on procreation during a woman's prime reproductive years is, as Laurence Tribe has stated, "tantamount to sterilization."⁹⁸

B. Controlling Pregnancy

In addition to using tools such as no-procreation orders to control the future reproductive decisions of women, in the 1980s states began to regulate women's behavior *while* pregnant. In particular, many states began criminally prosecuting women who used illegal drugs while pregnant.⁹⁹ By 1992, at least twenty-four states had criminally prosecuted over 160 women for substance abuse while pregnant.¹⁰⁰ Approximately seventy-five percent of these prosecutions were against women of color.¹⁰¹ From 1990 to 2006, women were arrested for using drugs while pregnant in at least forty states, with a dozen such arrests occurring in 2006 and 2007 alone.¹⁰² These prosecutions proceeded under a myriad of theories, including that drug use while pregnant constituted criminal delivery of a controlled substance to a minor and that drug use constituted criminal child abuse or endangerment.¹⁰³ At least one court has upheld the criminal child abuse theory: in 1997, the Supreme Court of South Carolina held that a viable fetus was a "child" under the state's child endangerment statute, and therefore it was permissible to charge a pregnant woman with criminal child neglect for her use of crack cocaine during the third trimester of her pregnancy.¹⁰⁴ While most other appellate courts have invalidated such prosecution theories by holding that the fetus is not a child under the child endangerment statutes,¹⁰⁵ it is critical

⁹⁸ *Id.*

⁹⁹ Dorothy E. Roberts, *Unshackling Black Motherhood*, 95 MICH. L. REV. 938, 941–44 (1997) (detailing such efforts in South Carolina, and noting that prosecution overwhelming targeted black women). See generally BARTLETT, HARRIS & RHODE, *supra* note 91, at 1150–58 (summarizing criminal prosecutions and civil commitments of pregnant women).

¹⁰⁰ Roberts, *supra* note 99, at 938 (citing Lynn M. Paltrow, *Winning Strategies: Defending the Rights of Pregnant Addicts*, CHAMPION, Aug. 1993, at 18, 19).

¹⁰¹ *Id.*

¹⁰² FLAVIN, *supra* note 88, at 108.

¹⁰³ See BARTLETT, HARRIS & RHODE, *supra* note 91, at 1151 (collecting cases); see also James G. Hodge, Annotation, *Prosecution of Mother for Prenatal Substance Abuse Based on Endangerment of or Delivery of Controlled Substance to Child*, 70 A.L.R. 5TH 461 (2008) (collecting cases in which women's substance abuse while pregnant led to charges of child abuse or endangerment, possession of controlled substances, or delivery of controlled substances to a child, but noting that most courts have rejected these theories of prosecution).

¹⁰⁴ *Whitner v. State*, 492 S.E.2d 777 (S.C. 1997). The baby was born with cocaine metabolites in its system. *Id.* at 778.

¹⁰⁵ See BARTLETT, HARRIS & RHODE, *supra* note 91, at 1151 (collecting cases); see also FLAVIN, *supra* note 88, at 108–09 (noting that every state except South Carolina "has dismissed prosecutions or overturned convictions," often because the courts found that state legislation was not designed to apply to conduct during pregnancy).

to remember that many women may plead guilty to such crimes in order to avoid jail time. Accordingly, these women do not challenge their prosecutions or convictions and thus do not have the benefit of appellate review.¹⁰⁶ Indeed, prosecutions in South Carolina under theories of “unlawful child neglect” continue to this day.¹⁰⁷

Currently, drug use during pregnancy is not an independently codified crime in any state. However, states continue to use creative, non-criminal methods to target pregnant women’s substance abuse, such as allowing prenatal substance abuse to provide grounds for termination of parental rights under child abuse and neglect statutes, permitting civil commitment of pregnant women during their pregnancies, or mandating that health care workers test for or report evidence of prenatal drug exposure.¹⁰⁸

More recent efforts have attempted to extend the state’s oversight of women’s conduct while pregnant to actions unrelated to drug use. For example, in 2010, Utah State Representative Carl D. Wimmer introduced a bill in the Utah state legislature that would have criminalized any “reckless act” by a pregnant woman that led to the death of the fetus she was carrying.¹⁰⁹ Critics of the bill cautioned that the law “would cast suspicion, potentially, on every single miscarriage.”¹¹⁰

C. Controlling Labor and Birth

Multiple actors have increasing control over women’s choices during labor and delivery. Hospitals, medical professionals, and even insurers are able to limit women’s birth choices by, for example, “pushing” c-sections, limiting vaginal births after c-sections (commonly known as “VBACs”), and limiting the circumstances under which women can elect alternative birth

¹⁰⁶ See Roberts, *supra* note 99, at 939 (“Most women charged with prenatal crimes are pressured into accepting plea bargains to avoid jail time.”).

¹⁰⁷ *South Carolina: Leading The Nation in the Prosecution and Punishment of Pregnant Women*, NAT’L ADVOC. FOR PREGNANT WOMEN (July 17, 2006), http://advocatesforpregnantwomen.org/issues/punishment_of_pregnant_women/south_carolina_leading_the_nation_in_the_prosecution_punishment.php (collecting cases, and noting that there have been 80 prosecutions of pregnant women in South Carolina since 1989).

¹⁰⁸ *State Policies in Brief: Substance Abuse During Pregnancy*, GUTTMACHER INST. (May 1, 2010), http://www.guttmacher.org/statecenter/spibs/spib_SADP.pdf (reporting that as of May 2010, “[fifteen] states consider substance abuse during pregnancy to be child abuse under civil child-welfare statutes, and [three] consider it grounds for civil commitment,” and that “[fourteen] states require health care professionals to report suspected prenatal drug abuse, and [four] states require them to test for prenatal drug exposure if they suspect abuse”); see also April L. Cherry, *The Detention, Confinement, and Incarceration of Pregnant Women for the Benefit of Fetal Health*, 16 COLUM. J. GENDER & L. 147, 164–72 (2007) (documenting attempts to civilly commit pregnant women in Wisconsin, South Dakota, and Minnesota).

¹⁰⁹ Kirk Johnson, *Utah Bill Would Criminalize Illegal Abortions*, N.Y. TIMES., Feb. 28, 2010, at A16. The bill was ultimately withdrawn.

¹¹⁰ *Id.* (quoting Nancy Northup, president of the Center for Reproductive Rights).

options such as home births.¹¹¹ Of particular note is the state's power to use its interest in "protecting" an "unborn child" to compel a pregnant woman to undergo medical treatment, such as a compelled c-section, against her will.¹¹²

While some courts have held that women cannot be forced to undergo c-sections,¹¹³ other courts have ordered that a c-section be performed without the woman's consent and against her express medical decisions to the contrary. For example, in the 2004 case of *Pemberton v. Tallahassee Memorial Regional Medical Center, Inc.*,¹¹⁴ a federal district court in Florida reviewed a lower court order that had authorized a compelled c-section on a woman, Laura Pemberton, who expressly refused to consent to the procedure. The hospital asserted that the c-section was medically necessary in part because the nature of a previous c-section put Ms. Pemberton at greater risk of uterine rupture during a subsequent vaginal birth.¹¹⁵ After the c-section was performed against her will, Ms. Pemberton sued the hospital in federal district court. The federal court held that the state's interest "in preserving the life of the unborn child" justified the lower court's order compelling the c-section because the "full-term baby's birth was imminent, and . . . the mother sought only to avoid a particular procedure for giving birth."¹¹⁶ This state interest in the "life of the unborn child," the court held, outweighed the woman's multiple constitutional interests in refusing to consent to a c-section.¹¹⁷ The premise that the c-section was "necessary" may have been

¹¹¹ See generally Benjamin Grant Chojnacki, *Pushing Back: Protecting Maternal Autonomy from the Living Room to the Delivery Room*, 23 J.L. & HEALTH 45, 55–75 (2010) (noting the increasing role these actors play in limiting women's birth choices).

¹¹² See Cherry, *supra* note 108, at 160–62 (collecting cases of court ordered medical treatment).

¹¹³ See, e.g., *In re A.C.*, 573 A.2d 1235, 1252 (D.C. 1990). The District of Columbia Court of Appeals vacated a lower court order compelling a c-section on the grounds that a pregnant woman has the right to refuse medical treatment, and stated that "the [pregnant woman's] wishes, once they are ascertained, must be followed in virtually all cases, unless there are truly extraordinary or compelling reasons to override them [S]ome may doubt that there could ever be a situation extraordinary or compelling enough to justify a massive intrusion into a person's body, such as a caesarean section, against that person's will." *Id.* (internal citation and quotation omitted). The c-section, however, had already been performed. *Id.* at 1238.

¹¹⁴ 66 F. Supp. 2d 1247 (N.D. Fla. 1999).

¹¹⁵ *Id.* at 1249.

¹¹⁶ *Id.* at 1251. Ms. Pemberton had originally labored at home, but went to the hospital to get fluids after becoming dehydrated. Upon arrival, she was told by the doctor that she could not have an IV unless she consented to a c-section, prompting her to leave the hospital. The state then obtained a court order, sent law enforcement to her home, and took Ms. Pemberton to the hospital in an ambulance against her will. She was then forced to have a c-section. FLAVIN, *supra* note 88, at 115–16.

¹¹⁷ *Pemberton*, 66 F. Supp. 2d at 1251–54. The constitutional interests at issue spanned the First, Fourth, and Fourteenth Amendments and included "a right to bodily integrity, a right to refuse unwanted medical treatment, and a right to make important personal and family decisions." *Id.* at 1251.

flawed, as Ms. Pemberton has had four successful vaginal births since her forced c-section.¹¹⁸

Pemberton is not an isolated case. One report found that as of 2005, court orders compelling consent to a c-section—many focusing on the state's interest in protecting the fetus—have been issued in at least a dozen states.¹¹⁹ Nor is there any indication that court-ordered c-sections are subsiding, as there have been several such orders in the past few years. Amber Marlowe is such an example. In January 2004, Ms. Marlowe went into labor with her seventh child; all six previous children had been born vaginally.¹²⁰ After she refused to consent to a c-section, the Pennsylvania hospital obtained a court order appointing the hospital as the legal guardian of the unborn child, temporarily restraining the Marlowes from refusing to consent to the c-section, and permitting hospital staff to perform the c-section “if the professional medical judgment of [the hospital] and the treating obstetrician is that such a procedure is necessary.”¹²¹ In the meantime, Ms. Marlowe and her husband fled the hospital to a second hospital, where Ms. Marlowe gave birth vaginally, without incident, to a healthy, eleven-pound baby.¹²²

One of the most recent instances of a court-ordered c-section involved a mother of two who was pregnant with her third child. In 2009, Samantha Burton, in her twenty-fifth week of pregnancy, voluntarily entered a Tallahassee, Florida hospital because she was experiencing some pregnancy complications.¹²³ While admitted, Ms. Burton refused to comply with the treatment recommended by her attending physician, and the State of Florida successfully obtained a court order requiring that Ms. Burton be confined to the hospital, denying her request to change hospitals, and authorizing the

¹¹⁸ FLAVIN, *supra* note 88, at 116.

¹¹⁹ Lisa Collier Cool, *Could You Be Forced to Have a C-Section?*, BABY TALK, May 2005, available at http://www.advocatesforpregnantwomen.org/main/publications/articles_and_reports/could_you_be_forced_to_have_a_csection_1.php; see also *In re Madyun*, Misc. No. 189-86 (D.C. Super. Ct. July 26, 1986), reprinted in *In re A.C.*, 573 A.2d 1235 app. at 1264 (D.C. 1990) (ordering c-section “given the significant risks to the fetus versus the minimal risks to the mother” and the compelling interest in saving life of fetus); *Jefferson v. Griffin Spalding Cnty. Hosp. Auth.*, 274 S.E.2d 457, 459 (Ga. 1981) (denying stay of c-section order where there was ninety-nine percent chance that the baby would not survive a vaginal delivery).

¹²⁰ Collier Cool, *supra* note 119. A routine ultrasound showed that the baby was very large, perhaps approaching thirteen pounds. Although fetal monitoring showed no signs of fetal distress, the hospital recommended that Ms. Marlowe have a c-section. After she repeatedly refused, the hospital went to court to attempt to obtain permission to perform the c-section against Ms. Marlowe's will. *Id.*

¹²¹ Special Injunction Order and Appointment of Guardian at para. 2, *WVHCS-Hosp., Inc. v. Doe*, No. 3-E 2004 (Pa. Ct. Com. Pl. Jan. 14, 2004), available at <http://advocatesforpregnantwomen.org/WVHCSBabyDoevJaneandJohnDoe.pdf>.

¹²² Collier Cool, *supra* note 119; see also John & Amber Marlowe, *Why We Marched*, NAT'L ADVOC. FOR PREGNANT WOMEN (Apr. 26, 2004), <http://advocatesforpregnantwomen.org/Marlowe.pdf>.

¹²³ Brief of Amici Curiae American Civil Liberties Union et al. in Support of Appellant at 2, *Burton v. Florida*, No. 1D09-1958, 2010 WL 3168124, at *1 (Fla. Dist. Ct. App. Aug. 12, 2010).

hospital to provide any treatment—including a compelled c-section—necessary to “preserve the life and the health of Samantha Burton’s unborn child.”¹²⁴ After three days of court-ordered confinement in the hospital, Ms. Burton was subjected to a surgical c-section, during which it was discovered that the fetus had already died.¹²⁵ After Ms. Burton was released from the hospital, she sued the State of Florida for deprivation of liberty and medical decision-making authority.¹²⁶ While on appeal, the Florida appellate court reversed the order, although as noted, Ms. Burton had already been subjected to the forced c-section.¹²⁷

New Jersey v. V.M. continues and extends this trend of state regulation of women’s fertility and pregnancies. Part III argues that permitting a woman’s legal medical decisions during pregnancy, labor, and delivery to factor into subsequent child welfare decisions—as was the case with V.M.’s refusal to consent to a c-section—sharply extends these previous regulation efforts. This extension both runs afoul of women’s protected privacy interests in making medical decisions free from undue coercion and expands fetal personhood without a statutory basis to do so.

III. ANALYSIS

As noted above, litigation regarding the custody of J.M.G. proceeded on two related tracks: (1) the initial abuse and neglect hearings and (2) the subsequent parental rights termination proceedings. It is clear that the New Jersey courts charged with rendering custody decisions during the latter parental rights termination proceedings did not rest their decisions solely on the c-section refusal; rather, they also considered several other complex factors, including V.M.’s psychiatric history and both parents’ actions subsequent to J.M.G.’s birth.¹²⁸ I draw no conclusion about V.M.’s or B.G.’s ultimate fitness as parents, nor do I dispute that factors other than V.M.’s c-section refusal were potentially significant and properly considered during the parental rights termination proceedings.¹²⁹

That said, it was the initial finding of abuse and neglect, based largely on V.M.’s c-section refusal, which spawned the subsequent parental termination proceedings. Without the initiation of those abuse and neglect proceedings, and the subsequent finding of abuse and neglect, the parental rights

¹²⁴ Order Authorizing Medical Treatment at 2–3, *Burton*, 2010 WL 3168124, at *1 (No. 1D09-1958).

¹²⁵ Brief of Amici Curiae American Civil Liberties Union, *supra* note 123, at 3.

¹²⁶ *Id.* at 2.

¹²⁷ *Burton*, 2010 WL 3168124, at *1–3.

¹²⁸ See N.J. Div. of Youth & Family Servs. v. V.M. (*In re* Guardianship of J.M.G.), Nos. A-2649-08T4, A-3024-08T4, A-3336-08T4, A-3342-08T4, 2010 WL 3075628 (N.J. Super. Ct. App. Div. Aug. 6, 2010) (per curiam) (summarizing parental rights termination proceedings and reversing termination for further proceedings).

¹²⁹ I note, however, that the parental rights termination was reversed and remanded. *Id.* at *34.

termination proceedings may never have commenced. Accordingly, I focus on the question that compelled Judge Carchman's concurrence: should a pregnant woman's refusal to consent to medical care, and particularly a c-section refusal, be considered during a child welfare determination? I argue that it should not. As is discussed below, allowing a woman's childbirth decisions to factor into such a determination may have wide-ranging negative implications both for women's privacy interests and their concomitant ability to make the medical decisions that are in their best medical and legal interests.

A. *Using Women's Lawful Decisions and Actions During Child Welfare Proceedings*

As explored in Part II, the current legal landscape is that the state can, in some circumstances, exercise control over whether and when women may get pregnant (e.g., no-procreation orders), over pregnant women's conduct (e.g., prosecutions of women for potential harm to fetus from actions while pregnant), and over how women ultimately deliver their babies (e.g., court-ordered c-sections). Each of these efforts at controlling fertility, pregnancy, or childbirth pits the reproductive and medical autonomy of women against the authority of the state to "protect" a fetus. Scholars have repeatedly examined such "maternal-fetal conflicts," which Michelle Oberman describes as centering on "when and whether it is appropriate for the law to dictate a pregnant woman's behavior in an effort to benefit her unborn fetus."¹³⁰ This conflict between a woman's right to bodily autonomy and fetal rights underlies much of the regulation of women's reproductive decisions described in Part II, and it is squarely present in *New Jersey v. V.M.* In explaining the initiation of abuse and neglect proceedings against V.M., the State's argument centered on V.M.'s psychiatric history and her vehement attempts to make independent medical decisions, using those as a rationale to challenge both V.M.'s competency to make the c-section decision and, ultimately, her competency as a mother. As the Deputy Attorney General explained, the abuse and neglect proceedings were grounded in the fact that "[g]iven [V.M.'s] . . . psychiatric condition, [V.M.] refused treatment at the hospital in terms of allowing the c-section to be done [V.M.] took it upon herself to have her needs addressed first before having the needs of the child addressed."¹³¹ The fact that V.M. was right—that is, that she did not need a c-section to have a safe, healthy birth—was seemingly of no consequence.

At first glance, it appears that V.M.'s case falls squarely within the parameters of this ongoing maternal-fetal conflict debate. It is important to

¹³⁰ Michelle Oberman, *Mothers and Doctors' Orders: Unmasking the Doctor's Fiduciary Role in Maternal-Fetal Conflicts*, 94 *Nw. U. L. Rev.* 451, 452 (2000); see also *id.* at 451–53 nn.4–10 (discussing maternal-fetal conflict literature).

¹³¹ Brief of Petitioner, *supra* note 30, at 7–8.

note, however, that the V.M. case goes beyond the question of *whether* the law can interfere with a pregnant woman's medical decision-making to the question of whether the existence of the conflict itself can result in a woman losing custody of her child. If the answer is yes, as intimated by *New Jersey v. V.M.*, this permits the maternal-fetal conflict to manifest into an overarching threat that non-compliance with medical recommendations will result in the loss of one's child—even if no harm to the child results.

The rationale adopted by the trial court in *New Jersey v. V.M.* (and allowed to stand by the appellate court) could open the door to wide-reaching regulation of pregnant women's legally protected activities and decisions. Such attempts, including oversight of pregnant women's medical intervention refusals, go far beyond previous efforts to regulate the *illegal* activity of pregnant women. When pregnant women are prosecuted for drug use, their underlying activity of purchasing or possessing drugs contravenes criminal drug laws. Even in cases of maternal criminal drug activity, however, critics have argued and courts have recognized that it is questionable whether punishing drug-addicted women for the additional "crime" of potential harm to the fetus is legally justified.¹³²

The justification for "punishing"¹³³ women like V.M. for their *lawful* medical decisions rests on even shakier legal ground, as the underlying criminal violations are not present. More importantly, V.M.'s decision to refuse medical intervention is a constitutionally protected one. The Supreme Court has squarely recognized that "a competent person," as V.M. was found to be,¹³⁴ "has a generally protected liberty interest in refusing medical treatment."¹³⁵ While this interest must be balanced against the "relevant state interests"¹³⁶—which in V.M.'s case was arguably the state's interest in protecting the fetus—multiple courts faced with balancing a woman's liberty interest with the state's interest in protecting fetal life have found that the fundamental right to make medical decisions includes decisions made during pregnancy.¹³⁷ Indeed, in 2005, a New Jersey court found that the very New Jersey abuse and neglect statute later at issue in *New Jersey v. V.M.*

¹³² See FLAVIN *supra* note 88, at 108–09 (noting that the charges and prosecutions of pregnant women who use drugs are almost always found to be legally unfounded or unconstitutional); Cherry, *supra* note 108 (arguing that criminal punishment of pregnant women for potential harm to a fetus violates both the right to be free from unwarranted detention and the right to privacy); Roberts, *supra* note 99, at 940 (noting that almost every appellate court to consider criminal convictions of women for drug use while pregnant has overturned the convictions).

¹³³ Brief of Experts in Maternal and Neonatal Health, *supra* note 18, at 42 (noting that removal of a child is, indeed, a "punish[ment]").

¹³⁴ N.J. Div. of Youth & Family Servs. v. V.M. (*In re J.M.G.*), 974 A.2d 448, 451 (N.J. Super. Ct. App. Div. 2009) (per curiam) (Carchman, J., concurring) (noting Dr. Kurani's conclusion that V.M. "had the capacity for informed consent").

¹³⁵ *Cruzan v. Dir., Mo. Dep't of Health*, 497 U.S. 261, 278 (1990).

¹³⁶ *Id.* at 279 (quoting *Youngberg v. Romeo*, 457 U.S. 307, 321 (1982)).

¹³⁷ *In re A.C.*, 573 A.2d 1235, 1252 (D.C. 1990) (vacating a lower court order compelling a c-section on the grounds that a pregnant woman has the right to refuse medical treatment, as "the [pregnant woman's] wishes, once they are ascertained, must be fol-

does not and cannot be construed to permit government interference with a woman's protected right to control her body and her future during her pregnancy The right to make [a medical] decision is part of her constitutional right to privacy, which includes her right to control her own body and destiny. Those rights include the ability to refuse medical treatment, even at the risk of her death or the termination of her pregnancy.¹³⁸

April Cherry has further argued that the privacy rationale articulated in *Griswold v. Connecticut*¹³⁹ and *Eisenstadt v. Baird*¹⁴⁰ could also provide constitutional protection for women's actions during pregnancy:

Griswold and *Eisenstadt* articulate a constitutional right to engage in reproductive decision making [Criminal punishment of pregnant women] for the benefit of the fetus may discourage women from procreating or encourage some women to abort their fetuses to avoid incarceration [T]hese state actions violate pregnant women's right to privacy under the rubric articulated in *Griswold* and *Eisenstadt* and are therefore unconstitutional.¹⁴¹

Although Cherry is referring to the criminal prosecution of pregnant women, the underlying principle stands: the privacy right encompasses a woman's right to make medical decisions regarding her pregnancy and to be free from independent punishment for harm to the fetus from actions while pregnant.

The *New Jersey v. V.M.* court's decision that V.M.'s c-section refusal was actionable under the abuse and neglect statute flies in the face of New Jersey precedent holding that the statute cannot reach prenatal conduct and contravenes the well-settled principle that competent people, pregnant or not, have a constitutionally protected liberty/privacy right to refuse medical treatment. If extended to future cases, the *New Jersey v. V.M.* rationale could open the door to significant infringements on women's liberty and privacy interests.

Most immediately, it could provide a theory under which to scrutinize a wide range of women's birth decisions. Medical intervention refusals or at-

lowed in virtually all cases") (internal citation omitted); *V.M.*, 974 A.2d at 464 (Carchman, J., concurring) ("The decision to undergo an invasive procedure such as a c-section belongs uniquely to the prospective mother"); N.J. Div. of Youth & Family Servs. v. L.V. (*In re C.M.*), 889 A.2d 1153, 1158 (N.J. Super. Ct. Ch. Div. 2005) (woman had protected right to make medical decisions during pregnancy). Likewise, as Oberman notes, many scholars have analyzed the maternal-fetal conflict (and indeed, analyzed the conflict in the context of c-section refusals), with the vast majority concluding that it is legally "impermissible to infringe upon the pregnant woman's autonomy rights." Oberman, *supra* note 130, at 453.

¹³⁸ *L.V.*, 889 A.2d at 1158.

¹³⁹ 381 U.S. 479 (1965) (fundamental privacy right embodied in First, Third, Fourth, Fifth, and Ninth Amendments includes right of married couples to obtain birth control).

¹⁴⁰ 405 U.S. 438 (1972) (extending privacy right to obtain contraceptives to non-married people).

¹⁴¹ Cherry, *supra* note 108, at 183.

tempts to make alternative birth decisions—such as giving birth at home, at a birthing center, or under the supervision of a midwife or doula—may now all provide grounds for child welfare agencies and courts to question whether the woman acted “in the best interests” of the fetus during pregnancy. As was illustrated in *New Jersey v. V.M.*, it would not matter whether such deliveries resulted in births of healthy babies; the simple refusal to accede to medical advice could be deemed “negligent” and thus grounds for interruption or termination of parental rights.¹⁴²

Likewise, both the majority and concurring opinions provide a basis for scrutinizing whether women are acting “appropriately” during labor and delivery. The time period at issue in V.M.’s case was April 16, 2006 (when V.M. entered the hospital) through April 20, 2006 (when the initial hearing was held). J.M.G. was not in her mother’s custody between April 17th and 20th.¹⁴³ Thus, the only day at issue during the abuse and neglect hearing was April 16—that is, the day V.M. was in labor and delivering J.M.G. Although stating in his concurrence that “any decisions that she made with regard to prenatal treatment and surgery cannot form the basis of a finding of abuse and neglect,” Judge Carchman squarely (and inconsistently) relied on V.M.’s other prenatal conduct during labor and delivery and stated that V.M.’s “‘combative,’ ‘uncooperative’ . . . and ‘inappropriate’” behavior during labor supported the finding that V.M. placed J.M.G. in imminent danger.¹⁴⁴ Notably, this behavior occurred before V.M. was given an epidural, when it is probable that she was in considerable pain. Indeed, her “combative” behavior stopped after she received pain relief.¹⁴⁵ Thus, under both the majority’s and Judge Carchman’s rationales, a woman’s “combative” behavior during active labor and delivery—even before she receives pain medication—is fair game for scrutiny during a subsequent child welfare determination.

Further, in addition to allowing scrutiny of women’s behavior during labor, it is but a small step for such oversight to be applied to *legal but potentially inadvisable* actions throughout the entirety of pregnancy.¹⁴⁶ For

¹⁴² See Brief of Experts in Maternal and Neonatal Health, *supra* note 18, at 7; *V.M.*, 974 A.2d at 453 (Carchman, J., concurring).

¹⁴³ Brief of Petitioner, *supra* note 30, at 16 (noting that “V.M. never had control of her daughter after delivery”).

¹⁴⁴ *V.M.*, 974 A.2d at 464 (Carchman, J., concurring).

¹⁴⁵ Brief of Petitioner, *supra* note 30, at 3–4 (noting that Dr. Kurani’s report stated that “[a]fter the epidural she had calmed down considerably and she was no longer agitated”).

¹⁴⁶ See BARTLETT, HARRIS & RHODE, *supra* note 91, at 1150–52 (collecting literature and discussing whether prosecution of women for drug use while pregnant could extend to a pregnant woman’s other activities, such as smoking, drinking, or failing to follow her doctor’s medical advice). Although somewhat beyond the scope of this article, it is worth noting that, in addition to penalties in the civil system, the potential for *criminal* punishment for legal actions while pregnant, including medical decision-making, is all too real. For example, the legislation proposed in Utah that would have criminalized “reckless acts” by a pregnant woman could most certainly have allowed prosecution for birth decisions deemed “reckless.” See *supra* notes 109–110 and accompanying text. Indeed,

example, what of the pregnant woman who (legally) drinks alcohol or smokes while pregnant?¹⁴⁷ With recent research indicating that such activities potentially pose similar or even greater risks to a fetus than does, for example, cocaine use,¹⁴⁸ it is not difficult to imagine a court concluding that a woman who smokes or drinks during pregnancy neglected or abused her unborn child. Similarly, what of activities on which the research is divided or unclear and obstetricians' opinions are likely to vary, such as whether drinking coffee or eating fish is advisable during pregnancy?¹⁴⁹ Could a woman engaging in these activities, even if following her own doctor's advice, find herself embroiled in subsequent child welfare hearings, defending her decisions while pregnant in order to keep custody of her child—whether or not there was ultimate harm to the child? More closely tied to *New Jersey v. V.M.*, what of the woman with a history of psychiatric illness who elects to discontinue psychiatric medication during pregnancy? V.M., for example, “stopped taking the psychotropic medication prescribed by Seltzer for fear of adverse effects on her unborn child.”¹⁵⁰ The fact that she was not taking the medication was explicitly noted in the trial court's abuse and neglect finding, with the judge stating, “with the mother's life and baby's life in balance, I think it was negligent . . . not to accede to what the doctors requested. Possibly this was caused by her not taking the medication which Dr. Seltzer had prescribed for her”¹⁵¹ But, had V.M. continued the medication, resulting in harm to her child in utero, could she have, in a

Samantha Burton's initial refusal to consent to certain medical care could well have been deemed criminally “reckless” given that her baby did not survive. See *supra* notes 127–131 and accompanying text (discussing *Burton* case).

¹⁴⁷ See BARTLETT, HARRIS & RHODE, *supra* note 91, at 1152 (suggesting that criminal prosecution of pregnant women for drug use could extend to alcohol or tobacco use).

¹⁴⁸ See, e.g., Susan Okie, *The Epidemic That Wasn't*, N.Y. TIMES, Jan. 27, 2009, at D1 (reporting that long-term effects on children exposed to cocaine before birth are “relatively small” and less severe than effects of prenatal exposure to alcohol and “comparable” to tobacco exposure); Maia Szalavitz, *The Demon Seed That Wasn't: Debunking the “Crack Baby” Myth*, CITY LIMITS MONTHLY, Mar. 1, 2004, available at http://advocatesforpregnantwomen.org/issues/pregnancy_and_drug_use_the_facts/the_demon_seed_that_wasn't_debunking_the_crack_baby_myth.php (quoting testimony from Dr. Deborah Frank, Associate Professor of Pediatrics at Boston University School of Medicine, that “there are small but identifiable effects of prenatal cocaine-crack exposure on certain newborn outcomes, very similar to those associated with prenatal tobacco exposure”).

¹⁴⁹ See, e.g., Roger Harms, *Pregnancy and fish: What's too little—or too much?*, MAYOCLINIC.COM (Mar. 20, 2009) <http://www.mayoclinic.com/health/pregnancy-and-fish/pr00158> (noting division of authority over whether pregnant women should limit consumption of fish due to concerns over mercury levels); Steve Mitchell, *2-cup coffee habit may double miscarriage risk: Doctors divided on hazards of moderate caffeine consumption in pregnancy*, MSNBC.COM (Jan. 21, 2008), <http://www.msnbc.msn.com/id/22718279> (summarizing new study finding that caffeine intake increases miscarriage rate, but noting division of medical opinion).

¹⁵⁰ N.J. Div. of Youth & Family Servs. v. V.M. (*In re* Guardianship of J.M.G.), Nos. A-2649-08T4, A-3024-08T4, A-3336-08T4, A-3342-08T4, 2010 WL 3075628, at *2 (N.J. Super. Ct. App. Div. Aug. 6, 2010) (per curiam).

¹⁵¹ N.J. Div. of Youth & Family Servs. v. V.M. (*In re* J.M.G.), 974 A.2d 448, 464 (N.J. Super. Ct. App. Div. 2009) (per curiam) (Carchman, J., concurring).

classic catch-22, faced a neglect proceeding or charges of transmission of a controlled substance to a minor?

With *New Jersey v. V.M.* as precedent, each of these scenarios could prompt medical personnel or state officials to investigate whether the woman was being “neglectful” even when engaging in lawful activities—thus providing a basis for further infringement of women’s protected privacy and liberty rights. Even if such investigations do not lead to legal proceedings, simply the possibility that the state could commence an investigation will introduce a powerful coercive element into the labor and delivery ward.

B. Coercing Birth Decisions

As discussed in Part II, the state has the power to coerce women’s reproductive decisions. For example, women have been coerced into accepting no-procreation orders as a condition of probation in exchange for avoiding jail time.¹⁵² This same coercive element may be present in the delivery room if courts permit women’s birth decisions to factor into subsequent child welfare decisions.

It is important to note that even absent the specter of a potential child welfare proceeding, women already face considerable pressure to consent to medical interventions during birth. It is well-documented that the c-section rate has risen dramatically over the past several decades. Nearly one-third of U.S. women now give birth via c-section, and from 1996 to 2007, the national c-section rate rose by fifty-three percent.¹⁵³ Some commentators attribute this rise to doctors’ desires to reduce potential liability for medical malpractice, to reduce birth times, or even to “solidify their importance within a medical community that is beginning to recognize the utility of delivering with a midwife.”¹⁵⁴ Others cite increasing maternal age and doctors’ increasing reluctance to allow vaginal births after previous c-sections (“VBACs”) or vaginal births of babies in the breech position.¹⁵⁵

Accompanying this trend is the ever-present characterization of pregnant women’s refusals to consent to medical care as “mere choices.” A case in point: in ordering a c-section, the *Pemberton* court dismissively characterized Ms. Pemberton’s interest as “[seeking] only to avoid a particular procedure for giving birth,” and, not surprisingly, found that the state’s interest in protecting the fetus trumped Ms. Pemberton’s interest.¹⁵⁶ The court’s discus-

¹⁵² See *supra* notes 88–98 and accompanying text.

¹⁵³ Jenifer Goodwin, HealthDay, *Cesarean Rates Reach Record High*, MEDICINET.COM (Mar. 23, 2010), <http://www.medicinenet.com/script/main/art.asp?articlekey=114662>.

¹⁵⁴ Chojnacki, *supra* note 111, at 68–69 (citing MARSDEN WAGNER, BORN IN THE U.S.A: HOW A BROKEN MATERNITY SYSTEM MUST BE FIXED TO PUT WOMEN AND CHILDREN FIRST 39 (2006)).

¹⁵⁵ Goodwin, *supra* note 153.

¹⁵⁶ *Pemberton v. Tallahassee Mem’l Reg’l Med. Ctr., Inc.*, 66 F. Supp. 2d 1247, 1251 (N.D. Fla. 1999).

sion of the potential risks to Ms. Pemberton from a forced c-section was relegated to a footnote, and the risks dismissed as “far less” than the risks associated with a vaginal birth.¹⁵⁷

Disturbingly, this dismissal of women’s reproductive health decisions as “mere choices” has found recent support from the Supreme Court. In the 2007 case of *Gonzales v. Carhart*,¹⁵⁸ the Court upheld a federal law known as the Partial Birth Abortion Ban Act of 2003. The Act made it a federal crime to perform a second trimester abortion procedure known as an intact dilation and extraction.¹⁵⁹ While the Act contained an exception for instances when a woman’s *life* was in danger, it did not contain an exception for instances when a pregnant woman’s *health* was in danger.¹⁶⁰ The Court’s blessing of the Act marked the first time since *Roe* that an abortion restriction that did not contain a health exception was deemed to pass constitutional muster.¹⁶¹ In justifying the lack of a health exception, the Court noted that other abortion procedures were still available to women, even though the Respondents presented medical evidence at multiple trials showing that the now-banned procedure may be safer than other second trimester procedures for women seeking abortions.¹⁶² The Court, in contrast to the decisions of the three federal district courts that found the lack of a health exception to be fatal,¹⁶³ dismissed this evidence, reasoning that “[w]hen standard medical options are available, mere convenience does not suffice to displace them; and if some procedures have different risks than others, it does not follow that the State is altogether barred from imposing reasonable regulations.”¹⁶⁴

The Court concluded that the ban of a procedure that may be the safer option for some women was justified, as doctors who perform abortions do not have “unfettered choice in the course of their medical practice.”¹⁶⁵ Following the Court’s decision, the American College of Obstetricians and Gy-

¹⁵⁷ *Id.* at 1254 n.18 (stating that Ms. Pemberton’s expert witness “confirm[ed] that there are risks from caesareans . . . [but] fail[ed] to quantify the risk of serious harm to either the mother or the baby”); see also Beth A. Burkstrand-Reid, *The Invisible Woman: Availability and Culpability in Reproductive Health Jurisprudence*, 81 U. COLO. L. REV. 97, 144 (2010) (noting that the *Pemberton* court’s focus on the health of the fetus allowed it to “truncate” the consideration of the risks posed to Pemberton’s health).

¹⁵⁸ 550 U.S. 124 (2007).

¹⁵⁹ *Id.* at 124.

¹⁶⁰ *Id.* at 124, 161 (“[The Act] does not allow use of the barred procedure where necessary, in appropriate medical judgment, for [the] preservation of the . . . health of the mother.” (internal quotation marks omitted)).

¹⁶¹ *Id.* at 171 (Ginsberg, J., dissenting).

¹⁶² *Id.* at 161–62 (majority opinion).

¹⁶³ *Id.* at 178–79 (Ginsberg, J., dissenting) (“Based on thoroughgoing review of the trial evidence and the congressional record, each of the District Courts to consider the issue rejected Congress’ findings as unreasonable and not supported by the evidence. The trial courts concluded, in contrast to Congress’ findings, that ‘significant medical authority supports the proposition that in some circumstances, [intact D & E] is the safest procedure.’” (internal citations omitted)).

¹⁶⁴ *Id.* at 166 (majority opinion).

¹⁶⁵ *Id.* at 163.

necologists (“ACOG”), a leading professional medical association, lambasted the decision as “discount[ing] and disregard[ing] the medical consensus that intact [dilation and extraction] is safest and offers significant benefits for women suffering from certain conditions that make the potential complications of [other abortion procedures] especially dangerous.”¹⁶⁶

The increased prevalence of c-sections as go-to procedures for doctors and the dismissal of women’s reproductive health decisions as “mere choices” puts increased pressure on women to consent to c-sections and other medical interventions.¹⁶⁷ This pressure will only multiply if women know that any birth decision (and particularly decisions that contravene medical advice) could be scrutinized by hospital psychiatrists, lawyers, and ultimately judges who determine whether a parent is fit. Indeed, V.M.’s medical decisions were continually second-guessed by hospital staff (prompting two psychiatric evaluations *while in labor*), and ultimately scrutinized by a judge who determined that her c-section refusal—which caused no harm to V.M. or her baby—was neglectful.¹⁶⁸ Notably, the c-section rate in New Jersey, where V.M. gave birth, is currently the highest in the nation at 38%.¹⁶⁹ And, incredibly, the c-section rate at St. Barnabas Medical Center, the hospital where V.M. gave birth, is even higher: in 2008, a reported 49.3% of births at the hospital were via c-sections,¹⁷⁰ which was 17.5% above the national average of 31.8%.¹⁷¹ This pressure toward c-section births ignores the reality that c-sections carry unique health risks for a woman. The maternal mortality rate associated with c-sections ranges from three to nine times that associated with vaginal birth.¹⁷² C-section deliveries are also associated with increased risk of severe maternal health risks: “the maternal morbidity rate is increased twofold with cesarean delivery com-

¹⁶⁶ ACOG Statement on the U.S. Supreme Court Decision Upholding the Partial-Birth Abortion Ban Act of 2003, AM. CONG. OF OBSTETRICIANS & GYNECOLOGISTS (Apr. 18, 2007), http://www.acog.org/from_home/publications/press_releases/nr04-18-07.cfm.

¹⁶⁷ See Brief of Experts in Maternal and Neonatal Health, *supra* note 18, at 41 (describing a study that shows that significant portions of women who had c-sections felt pressure to do so).

¹⁶⁸ See *supra* notes 27–35, 50–52 and accompanying text.

¹⁶⁹ Goodwin, *supra* note 153.

¹⁷⁰ Brief of Experts in Maternal and Neonatal Health, Birth, and Child Welfare, Amici Curiae, in Support of Reversal of the Judgment of the Trial Court at 50–51, N.J. Div. of Youth & Family Servs. v. V.M. (*In re* Guardianship of J.M.G.), Nos. A-2649-08T4, A-3024-08T4, A-3336-08T4, A-3342-08T4, 2010 WL 3075628 (N.J. Super. Ct. App. Div. Aug. 6, 2010) (per curiam), available at http://advocatesforpregnantwomen.org/FGamicusBrief_filed.pdf; Brief of Experts in Maternal and Neonatal Health, *supra* note 18, at 50–51; CUNNINGHAM, *supra* note 2, at 544.

¹⁷¹ CUNNINGHAM, *supra* note 2, at 544 (“From 1970 to 2007, the cesarean delivery rate in the United States rose from 4.5 percent of all deliveries to 31.8 percent.” (citations omitted)).

¹⁷² *Id.* at 547 (“[The study] showed that whereas emergency cesarean delivery was associated with an almost ninefold risk of maternal death compared with that of vaginal delivery, even elective cesarean delivery was associated with an almost threefold risk.”).

pared with vaginal delivery.”¹⁷³ A 2007 study found that even planned, low-risk c-sections (as opposed to emergency c-sections) posed greater risks to women than vaginal births, including “increased postpartum risks of cardiac arrest . . . wound hematoma . . . hysterectomy . . . major puerperal infection . . . venous thromboembolism . . . and hemorrhage requiring hysterectomy.”¹⁷⁴

As with other efforts to regulate women’s fertility or pregnancies, there is also a real danger that doctors’ and courts’ scrutiny will be focused on—and thus coercive efforts targeted at—the most vulnerable groups of pregnant women.¹⁷⁵ For example, will women with past histories of substance abuse or psychiatric treatment (the “feeble-minded”) face even harsher scrutiny during the birth process? Will “boisterous,” “erratic,” or “noncompliant”¹⁷⁶ behavior during active labor serve as a red flag, triggering calls to Social Services, even if the behavior was unrelated to mental illness? Indeed, the conflation of vehement non-consent with mental illness may have occurred in V.M.’s case, as the court stated that V.M.’s refusal to follow the hospital staff’s advice may have been “caused by her not taking [her] medication.”¹⁷⁷ Likewise, what about the woman whose labor and delivery *is* affected by her mental state? An expert psychologist testifying on behalf of B.G. and V.M. during the parental termination proceedings noted that V.M. was “stressed given this was her first pregnancy, she had a fever, the baby was premature, and her obstetrician was not available, so she was being treated by an unfamiliar physician.”¹⁷⁸ This stress, coupled with V.M.’s history of PTSD, made it

not surprising that she panicked at the time of delivery. Her agitation and exaggerated response to being approached about the possibility of a Cesarean section are consistent with the emotional vulnerability present in a PTSD sufferer. Additionally, [V.M.]

¹⁷³ *Id.*; see also Linda C. Fentiman, *The New “Fetal Protection”: The Wrong Answer to the Crisis of Inadequate Health Care for Women and Children*, 84 DENV. U. L. REV. 537, 569–70 (2006) (noting that the American Medical Association and the American College of Obstetrics and Gynecology each have adopted strong positions against compelled medical treatment).

¹⁷⁴ SHILIANG LIU ET AL., MATERNAL HEALTH STUDY GROUP OF THE CANADIAN PERINATAL SURVEILLANCE SYSTEM, *Maternal mortality and severe morbidity associated with low-risk planned cesarean delivery versus planned vaginal delivery at term*, 176 CANADIAN MED. ASS’N J. 455, 455 (2007).

¹⁷⁵ Brief of Experts in Maternal and Neonatal Health, *supra* note 18, at 43–44 (arguing that the regulation of pregnant women’s medical decisions “is most likely to be applied against vulnerable women”).

¹⁷⁶ N.J. Div. of Youth & Family Servs. v. V.M. (*In re J.M.G.*), 974 A.2d 448, 450–51 (N.J. Super. Ct. App. Div. 2009) (per curiam) (Carchman, J., concurring).

¹⁷⁷ *Id.* at 464; see also Brief of Experts in Maternal and Neonatal Health, *supra* note 18, at 40–43 (arguing that trial court erred in suggesting that c-section refusal was caused by mental illness).

¹⁷⁸ N.J. Div. of Youth & Family Servs. v. V.M. (*In re Guardianship of J.M.G.*), Nos. A-2649-08T4, A-3024-08T4, A-3336-08T4, A-3342-08T4, 2010 WL 3075628, at *15 (N.J. Super. Ct. App. Div. Aug. 6, 2010) (per curiam).

had stopped all of her medication because of her pregnancy. Therefore, she did not have the buffer to her anxiety that would have been provided by her medication.¹⁷⁹

After the *New Jersey v. V.M.* decision, women with histories of psychiatric illness or treatment may face increased pressure to consent to medical interventions in order to avoid later judicial scrutiny of their mental health histories and behavior during childbirth.¹⁸⁰

Women in labor already face intense pressure to be “compliant” patients throughout the birth process, and, increasingly, compliance seems to mean agreeing to medical interventions. One way to guarantee such compliance is to allow the specter of child welfare proceedings to enter the delivery room. A woman who knows that her refusal to consent to medical interventions during labor and delivery—or her decision to give birth at home or in a birthing center—could result in an abuse or neglect investigation or a finding of neglect, is surely not acting without coercion.¹⁸¹ It is, as V.M. argued when seeking a writ of certiorari, “to hang a sword of Damocles above every parent’s head, particularly those in the vulnerable state of giving birth.”¹⁸² And with such a threat looming, women are more likely to cede their protected liberty and privacy interests in making their own medical decisions.

C. Codification of Fetal Personhood

In order to find liability for neglect under the New Jersey abuse and neglect statute, the trial court needed to find that J.M.G.’s

physical, mental, or emotional condition has been impaired or is in imminent danger of becoming impaired as the result of the failure of [her] parent or guardian, as herein defined, to exercise a minimum degree of care (a) in supplying the child with . . . medical or surgical care.¹⁸³

The judge presiding over the abuse and neglect fact-finding hearing explicitly relied on the c-section refusal as a basis for his neglect determination.¹⁸⁴

¹⁷⁹ *Id.*

¹⁸⁰ See Brief of Petitioner, *supra* note 30, at 23 (arguing that the decision may “encourage hospital staff or government agencies to venture on fishing expeditions into the mental health histories of patients who decline medical treatment”).

¹⁸¹ See Chojnacki, *supra* note 111, at 66 n.76 (noting that the *V.M.* decision could have a “chilling” effect on women’s labor and birth choices).

¹⁸² Brief of Petitioner, *supra* note 30, at 22.

¹⁸³ N.J. STAT. ANN. § 9:6-8.21(c)(4) (West 2002 & Supp. 2006).

¹⁸⁴ N.J. Div. of Youth & Family Servs. v. V.M. (*In re J.M.G.*), 974 A.2d 448, 453 (N.J. Super. Ct. App. Div. 2009) (per curiam) (Carchman, J., concurring).

Applying a plain reading of this statute to V.M.'s case, however, it is clear that V.M.'s c-section refusal could not reasonably create liability thereunder. First, the trial judge made no factual findings that J.M.G. was ever harmed—either in utero or after birth—by V.M.'s c-section refusal.¹⁸⁵ Second, any argument that J.M.G. was “in imminent danger of becoming impaired” is belied by the record. J.M.G. was born “in good medical condition” through a vaginal delivery and was not in V.M.'s control after delivery.¹⁸⁶ Third, and most critically, prior to delivery J.M.G. was not a “child” falling under New Jersey's abuse and neglect statute, and thus V.M.'s action during labor could not amount to statutory abuse or neglect.

The statutory language—or more precisely, its silence—is clear: nowhere does the New Jersey statute expressly include a fetus in the definition of “child,” yet the court explicitly treated V.M.'s fetus as a child in finding that V.M.'s actions while pregnant amounted to neglect.¹⁸⁷ This judicial expansion of the child endangerment statute contradicts the basic principle of statutory interpretation that the plain language of a statute should dictate its interpretation: “The preeminent canon of statutory interpretation requires us to presume that [the] legislature says in a statute what it means and means in a statute what it says there. Thus, [the] inquiry begins with the statutory text, and ends there as well if the text is unambiguous.”¹⁸⁸ Furthermore, “nothing in the [New Jersey child endangerment statute] suggests that the Legislature intended the term ‘child’ to encompass a fetus.”¹⁸⁹ Moreover, New Jersey case law makes clear that the fetus “is not a ‘child’ as contemplated by [the abuse and neglect statute].”¹⁹⁰

¹⁸⁵ *Id.* at 459.

¹⁸⁶ *Id.* at 452; Brief of Petitioner, *supra* note 30, at 16 (noting that “V.M. never had control of her daughter after delivery”).

¹⁸⁷ See *V.M.*, 974 A.2d at 459 (Carchman, J., concurring) (statute defines “child” as “any child alleged to have been abused or neglected” and does not mention a fetus); see also Brief of Experts in Maternal and Neonatal Health, *supra* note 18, at 11–16 (arguing that under the plain meaning of the statute “fetus” is not included in the definition of “child”).

¹⁸⁸ *BedRoc Ltd. v. United States*, 541 U.S. 176, 183 (2004) (internal citation omitted); see also Brief of Experts in Maternal and Neonatal Health, *supra* note 18, at 11 (“It is axiomatic that interpreting the scope of a statute begins with its text.” (citing *State v. Bunch*, 180 N.J. 534, 543 (2004))).

¹⁸⁹ *V.M.*, 974 A.2d at 464 (Carchman, J., concurring); see also Brief of Experts in Maternal and Neonatal Health, *supra* note 18, at 11–16 (arguing that including a fetus under the definition of child in the child endangerment statute would be contrary to legislative intent).

¹⁹⁰ *V.M.*, 974 A.2d at 464 (Carchman, J., concurring); see also *id.* at 460–61 (collecting cases in New Jersey and other jurisdictions where courts have held that criminal liability under child abuse or endangerment statutes cannot rest solely on a pregnant woman's drug use); *N.J. Div. of Youth & Family Servs. v. L.V. (In re C.M.)*, 889 A. 2d 1153, 1158 (N.J. Super. Ct. Ch. Div. 2005) (“This proscription against finding that a mother committed an act of abuse or neglect against her child by her actions before the child's birth, without attendant suffering or injury after birth, recognizes that the protections afforded by the Act are limited to the child's situation after his or her birth and not while a fetus. Also, since the Act clearly does not expressly include a fetus in its definition of a child, its protection does not extend to the child before birth.”).

The New Jersey trial court's use of the abuse and neglect statute to punish V.M.'s c-section refusal marks a baseless extension of the statute to protect the fetus, and thus creates an implicit fetal personhood. To be sure, fetal personhood in the child welfare context has already been recognized by some states. As discussed above, a minority of states statutorily considers drug abuse while pregnant to constitute child abuse under child welfare laws.¹⁹¹ Here, however, the New Jersey legislature had *not* included a "fetus" in the definition of "child" under its abuse and neglect law. Thus, to properly make a finding of child neglect, the trial court needed to rely on harm or potential harm to J.M.G. *after* her birth. Given that V.M. never had control of her child after birth, V.M. could never have caused such harm.

This extension of the abuse and neglect statute is alarming on several levels. First, the application of the abuse and neglect statute to the prenatal context opens the door for the application of other New Jersey child welfare laws to the prenatal context, even in the absence of an express or even legislatively-implied indication that the law should so apply.

Second, this extension was used to target the actions of V.M., a pregnant woman. This not only intensifies the "maternal-fetal" conflict discussed above,¹⁹² but raises the specter of other laws of general application outside of the child welfare context—civil or criminal—being used to target pregnant women's actions. Both the federal government and the states have explicitly codified fetal personhood in the context of punishing third parties for harm to a pregnant woman and/or fetus, but importantly, these efforts have largely explicitly excluded the pregnant woman from prosecution.¹⁹³ Here, a law *without* an explicit codification of fetal personhood was used to punish a pregnant woman by taking away her child based at least in part on her actions before the child was born.

Finally, the further codification of fetal personhood represents yet another step toward dismantling the reproductive rights of women, particularly the right to choose to end a pregnancy through abortion. In finding that a woman's privacy right encompasses the right to choose abortion, *Roe v. Wade* explicitly relied on the recognition that a fetus is not a "person" warranting protection under the Fourteenth Amendment.¹⁹⁴ Were it otherwise,

¹⁹¹ GUTTMACHER INST., *supra* note 108 (reporting that as of October 2010, "15 states consider substance abuse during pregnancy to be child abuse under civil child-welfare statutes").

¹⁹² See *supra* notes 130 & 137 and accompanying text (discussing maternal-fetal conflict).

¹⁹³ See, e.g., the Unborn Victims of Violence Act of 2004, 18 U.S.C.A. § 1841 (2006). This law criminally punishes anyone, *other than the pregnant woman herself*, who harms or causes the death of a child in utero. *Id.* § 1841(c)(3). This crime is treated as a separate offense from any harm to the pregnant woman, and thus recognizes the fetus as an independent victim. *Id.* § 1841(a)(1). As defined by the law, an unborn child is "a member of the species homo sapiens, at any stage of development, who is carried in the womb." *Id.* § 1841(d).

¹⁹⁴ *Roe v. Wade*, 410 U.S. 113, 158 (1973) ("[T]he word 'person,' as used in the Fourteenth Amendment, does not include the unborn."); see also Planned Parenthood of

abortion of a fetus would be the killing of a person and thus the legal equivalent of homicide. Recognition of this fact has prompted a deliberate campaign to establish fetal personhood among those opposed to abortion. Indeed, pro-life, anti-abortion groups such as Concerned Women for America, the National Right to Life Committee, and Americans United for Life explicitly support efforts to “establish legal status for the unborn as being human and having life.”¹⁹⁵ While I do not suggest that the New Jersey courts were part of this campaign, it is clear that those committed to overturning *Roe* can and will seize on any codification of fetal personhood to use as a step toward the criminalization of abortion.

CONCLUSION

In *New Jersey v. V.M.*, the trial court explicitly relied on a pregnant woman’s refusal to consent to a c-section to support a finding of child abuse and neglect, despite the fact that the child was born healthy through a vaginal delivery. In doing so, the court extended the child welfare statute to cover a woman’s actions prior to giving birth and essentially deemed a fetus to be a “child” under the law. This extension of the state’s abuse and neglect statute contradicted the plain statutory text and infringed on V.M.’s constitutionally protected right to make medical decisions while pregnant by “punishing” her for those decisions through the child welfare process. The New Jersey courts’ willingness to use labor and birth decisions in subsequent child welfare determinations could signal a new era in the regulation of women’s activities throughout the entirety of pregnancy and childbirth. It potentially opens the door for unprecedented coercion in the delivery room as the threat of subsequent child welfare proceedings hangs over the head of laboring women. As demonstrated by the history of state regulation of fertility, pregnancy, and childbirth, the most vulnerable women—particularly women with a history of mental health treatment whose stress during labor could be conflated with a lack of competency—could be targeted by and be susceptible to these coercive efforts. Indeed, “[b]ased on the [appellate court’s] decision . . . one is forced to conclude that under New Jersey law, a woman with a history of mental health treatment can abuse and neglect her child solely by giving birth to her.”¹⁹⁶

Se. Pa. v. Casey, 505 U.S. 833, 846 (1992) (affirming the “essential holding” of *Roe v. Wade*).

¹⁹⁵ Elizabeth Hurley, *More States Are Passing Fetal Homicide Laws*, LAC NEWS (Apr. 27, 2005), http://www.cwalac.org/printer_202.shtml.

¹⁹⁶ Brief of Petitioner, *supra* note 30, at 15.

