Stopping Criminalization at the Bedside

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Abstract: Low-income women and, disproportionately low-income women of color seeking reproductive and pregnancy care are increasingly subject to what this article terms carceral care – care compromised by its' proximity to punishment systems. This article identifies the legal and health care practice mechanisms leading to carceral care and proposes solutions designed to stop criminalization at the bedside.

Between 2014 and 2016, Tennessee prosecuted over 120 women for fetal assault, a crime defined as the in-utero transmission of narcotics.[1] Over 90% of the Tennessee criminal court charging documents included information obtained in the health care setting.[2] The negative effects of these disclosures on patient trust and patient care are clear. As one effected woman reported, "when I was pregnant, I was scared to death to have that open relationship with my doctor because the laws in effect prevented ... it from being a care issue. It became a law, a liability issue. I was freaking terrified."[3] The very real possibility of prosecution forced her to engage in what Fong has called "selective visibility,"[4] weighing the legal risk of disclosing potentially medically relevant information against any possible risk to their health of non-disclosure.

This is not new. Subordinated communities have long experienced the effects of racialized and gendered drug and reproductive health policies and reproductive control. Neoliberal policies have further weakened the social contract, weaponized access to remaining public services, and contributed to hyperregulation[5] and criminalization. Agencies that purport to support (as well as those that police and prosecute) have both long surveilled and intervened in poor families.[6] Health professionals, reflecting their normative and privileged social status, have historically over-reported patients in their care to surveillance and policing agencies. This information sharing is complex and often far exceeds what is required by law. And community members have responded tactically, seeking both to benefit from the help that agencies

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offer while strategically minimizing the real harms of engagement.[7]

Post-*Dobbs*, selective and strategic engagement by those subject to criminalization has become significantly more visible. While the criminalization of pregnancy complications has a long history, the fall of *Roe* and the rise of abortion bans have raised the specter of a growth in these prosecutions. Seeking to capitalize on the increased attention, post-*Dobbs*, to the criminalization of pregnancy and the reliance, in these prosecutions, on presumptively confidential healthcare information, this essay lays out the substance of this problem and calls for solutions at the bedside that protect healthcare privacy.

We begin with one assumption and two key terms. First, we assume that selective visibility and strategic engagement by pregnant and parenting people is an entirely logical and predictable response to the criminalization of reproductive conduct. Second, our analysis is grounded in two key terms: *criminalization* and *carceral care.* Criminalization "occurs when seeking assistance in a social welfare program puts stigmatized members of society at risk for punishment in the criminal and [family regulation] system."[8] Criminalization also refers broadly not only to the formal criminal legal system, but to other punitive systems, in particular the family regulation (or child welfare) system. One effect of broad criminalization is what we here term *carceral care* — a form of care compromised by its proximity to and relationship with carceral systems.

The Road to Carceral Care

To put it somewhat too reductively, there are two paths into carceral care. First, a request or need for healthcare or social support leads to carceral exposure. This is the road to care experienced by the patient quoted above. She needed reproductive healthcare but was aware that seeking care could lead to criminal charges. The second path is different and far more difficult to address. Through this path, individuals first find themselves in carceral systems because of alleged neglect, abuse, or criminal acts. They then enter a set of systems that have become the default location for care. This reality is perhaps most deeply explored in the book *Jailcare,* where Sufrin describes the ways in which, for a particular deeply marginalized group of women in San Francisco, the local jail was the sole site for accessing healthcare.[9] On this path too, care is deeply corrupted by its location inside carceral settings. This essay, however, focuses exclusively on the first path — the legal, structural, and practice mechanisms that facilitate the travel of healthcare information from clinical to carceral systems — and the consequences to quality of care inherent in that path.

A variety of legal and structural mechanisms lay down pathways by which information obtained in a medical setting can be pulled into carceral settings. While the Health Insurance Portability and Accountability Act (HIPAA) protects information disclosed to or obtained by healthcare providers in a medical setting, when carceral actors seek medical information, HIPAA is more like a leaky faucet than a secure barrier.

Leaky Faucets and Legal Magnets

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HIPAA contains significant exceptions to patient consent for medical information disclosure that facilitate criminalization of medical care. First, HIPAA allows disclosure "as required by law."[11] Given the increase in state laws criminalizing pregnancy, absent additional state protections, this exception opens the door to any state law requiring the reporting of individually identifiable medical information. HIPAA also contains exceptions allowing for disclosure for "law enforcement purposes,"[12] for "judicial and administrative proceedings,"[13] "to a public health or other appropriate government authority authorized by law to receive reports of child abuse or neglect,"[14] and, in certain circumstances, to report information concerning "crime victims."[15] In short, when it comes to crimi-

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nalization, HIPAA does very little to protect disclosure of information obtained healthcare settings.

HIPAA's leaky faucet is compounded by a variety state and federal laws that function like magnets, pulling healthcare related information out of medical and into carceral systems. Central among those are state mandatory report laws, which require healthcare providers to report suspected cases of child abuse or neglect. In the specific context of reproductive healthcare, substance use, and family regulation, the federal Child Abuse Prevention and Treatment Act (CAPTA) requires every state to have in place "policies and procedures ... to address the needs of infants born with and identified as being affected by substance abuse [sic] ... including a requirement that health care providers involved in the delivery or care of such infants notify the child protective services system of the occurrence of such condition in infants."[16] In addition, twenty-six states require healthcare providers to report when they treat infants who show evidence at birth of having been exposed to drugs, alcohol, or other controlled substances; twenty-three states include "prenatal exposure to controlled substances" in their legal definition of abuse or neglect,[17] and three states authorize civil commitment of pregnant people to protect the fetus they are carrying.[18] Adding all this to the post-*Dobbs,* anticipated increase in prosecution for pregnancy-related conduct that will rely upon information disclosed in a healthcare setting, the problem is enormous.

"Mandatory Reporting" and (other) Health Professional Misinformation

State agency response to suspected child abuse is, understandably, organized as urgent — with "emergency petition" hearings for temporary custody occurring within days of an initial report.[19] But this regime of urgency, when applied to substance exposure in pregnancy and combined with leaky faucets, legal magnets, and the widespread and inappropriate use of urine drug tests, has imported wholesale the mechanisms of family regulation into the birthing and newborn setting.

Rates of separation vary but there are states where over 4% of infants are discharged into the custody of someone other than the birth parent.[20] Health professionals are the largest source of reports to family surveillance agencies, increasing 400% over the past decade.[21] There are marked racial inequities in drug testing, child welfare reports, and consequence. Rates of drug use do not differ by race; however, Black pregnant people are almost twice as likely to be drug tested[22] and between 4 to 10 times more likely to be reported to child welfare than White pregnant people.[23] Black and American Indian children are overrepresented in foster care at 2 to 11 times the rate of White children in the setting of parental substance use.[24]

The health professional practice of drug testing, with reflexive reporting to family surveillance, so called "test and report," rests upon misinformation and an overstatement of "risk" related to in-utero substance exposure. The primary source of information that initiates a report is a positive drug test, even though CAPTA does not require drug testing and does require a demonstrable health impact beyond drug exposure.[25] Professional society recommendations are clear: a drug test is neither an appropriate assessment of addiction nor a means of assessing child safety.[26] Pregnant people who use drugs are not more likely to abuse or neglect their children,[27] and children are more likely to experience abuse or neglect in foster care than in the general population.[28]

Harms of Carceral Care

Carceral care is unsafe for patients and their families. Legitimate fear of being reported leads pregnant people who use drugs to avoid medical care and deploy strategic engagement when they must. Carceral care can lead patients to make choices based not on the standard of care but instead on the carceral consequences of the decision. For example, women likely choose to detox during pregnancy rather than follow the follow the standard of care and take maintenance medications because detoxification will avoid positive toxicology report that could lead to a report to family regulation authorities.[29]

Carceral care also harms health professionals. Work environments that are misaligned with one's values cause moral injury and contribute directly to the demise of empathy, provider burnout, staff attrition, and further discriminatory care.[30] Carceral care is not only unsafe for patients, but it represents a perversion of all four pillars of medical ethics.

From Mandatory Report to Mandatory Support

To address the harms of carceral care, we must decriminalize healthcare by constructing legal and practice barriers between care provision and punishment. As those directly affected have framed it, we must replace mandatory report with mandatory support.[31]

As to legal solutions, both leaky faucets and legal magnets need to be addressed. HIPAA and other federal and state health privacy laws must be strengthened to limit state agency and law enforcement authority to obtain and use health care information

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against patients. As one of us suggested in a recent paper, Congress should reform HIPAA by importing and enacting provisions from The Confidentiality of Alcohol and Drug Abuse Patient records rule use of reproductive medical data in civil and criminal proceedings. Those regulations specify that designated records "may not be disclosed or used in any civil, criminal, administrative, or legislative proceedings conducted by any Federal, State, or local authority, against a patient," absent a court hearing weighing "the public interest and the need for disclosure against the injury to the patient, to the physician-patient relationship, and to the treatment services" and a clear finding authorizing disclosure.[32] Similar protections for reproductive medical data would go a long way to addressing the leaky faucets we have described. As to the magnets, we join those most directly impacted by the family regulation system and call for the repeal of CAPTA and mandatory report.[33] These legal reforms would place primary responsibility for care where it belongs — in healthcare and community settings.

But legal reform is only the beginning. One reason health and other professionals report to family surveillance is because they wish to connect a particular family to social services,[34] even though healthcare institutions are among the most resourced in a community, and child welfare agencies primarily provide surveillance and not direct services. Reliance on reporting and outsourcing care is unique to hospital-based birth, as hospitals do provide comprehensive social services for patients and their children in the context, for example, of cancer care.[35] Health systems can keep care in house for pregnant and parenting people who use drugs. The involvement of family policing in medical care reflects the extension of carcerality into health which reifies discrimination and compounds judgement that pregnant people who use drugs deserve only punishment.

In addition, social service agencies outside carceral systems can provide needed and non-carceral support. Early Head Start provides comprehensive child development and family support services to low-income pregnant people, infants, toddlers, and their families. Maternal, Infant, and Early Childhood Home Visiting programs support pregnant and parenting people, are HRSA funded, and are available in almost every jurisdiction in the US.[36] There are limited institutional connections between the birthing hospital and these programs and many providers are unaware of them. Consequentially, utilization is low, especially for people who use drugs.[37]

Pregnant and parenting people who use drugs are caught at the intersection of racialized drug policies and gendered (and increasingly punitive) reproductive health policy. Health professional complicity with carceral care is increasing and unexamined. To make birth safe, we must realign medical practice with professional ethics, decriminalize healthcare, and undo a legalized system that punishes rather than protects pregnant people, their children, and their communities.

Note

The authors have no conflicts of interest to disclose.

References

1. W.A. Bach, *Prosecuting Poverty, Criminalizing Care* (New York: Cambridge University Press, 2022): at 85.
2. *Id.*, at 130.
3. O.A. Bowers et al., *Tennessee's Fetal Assault Law: Understanding Its Impact on Marginalized Women*, December 14, 2020, *available at* <https://www.sisterreach-tn.org/uploads/1/3/3/2/133261658/abbreviated_fetal_assault_rpt.pdf> (last visited August 16, 2023).
4. K. Fong, "Concealment and Constraint: Child Protective Services Fears and Poor Mothers' Institutional Engagement," *Social Forces* 97, no. 4 (2019): 1785-1810, at 1789.
5. W.A. Bach, "The Hyperregulatory State: Women, Race, Poverty and Support," *Yale Journal of Law and Feminism* 25, no. 2 (2014): 317-379.
6. American Civil Liberties Union, *If I Wasn't Poor I Wouldn't Be Unfit: The Family Separation Crisis in the U.S. Child Welfare System*, November 17, 2022, *available at* <https://www.hrw.org/report/2022/11/17/if-i-wasnt-poor-i-wouldnt-be-unfit/family-separation-crisis-us-child-welfare#1644> (last visited August 16, 2023).
7. *See e.g.*, M. Bell, "Situational Trust: How Disadvantaged Mothers Reconceive Legal Cynicism," *Law and Society Review* 50, no. 2 (2016): 314-347, at 325-26.
8. See Bach, *supra* note 1 at 7.
9. C. Sufrin, *Jailcare: Find the Safety Net for Women Behind Bars* (Berkeley: University of California Press, 2017).
10. For a more detailed discussion of HIPAA and its exceptions in the context of reproductive criminalization, *See* W.A. Bach and N. Terry, "HIPAA v. Dobbs," forthcoming *Berkeley Technology Law Journal*, *available at* <https://papers.ssrn.com/sol3/papers.cfm?abstract_id=4219854> (last visited August 16, 2023).
11. 45 C.F.R. 164.512(a) (2016).
12. 45 C.F.R. 164.512(f) (2016).
13. 45 C.F.R. 164.512(e) (2016).
14. 45 C.F.R. 164.512(b)(1)(i).
15. 45 C.F.R. 164.512(f)(3).
16. 42 U.S.C.A. 5106a(b)(2)(B)(ii) (2019).
17. Child Welfare Information Gateway, *Parental Substance Abuse and Child Abuse*, July 2019, *available at* <https://www.childwelfare.gov/topics/systemwide/laws-policies/statutes/parentalsubstanceuse/> (last visited August 16, 2023).
18. Wis. Stat. Ann. § 48.193 (2022); S.D. Codified Laws § 34-20A-63 (2023); Minn. Stat. Ann. § 253B.02 (2023). *See also* Okla. Stat. Ann. tit. 63, § 1-546.5 (2023) (authorizing the district attorney to convene multidisciplinary team to consider filing a petition for involuntary commitment); La. Stat. Ann. § 40:1121.24 (2023) (same).
19. *See e.g.* Mass. Gen. Laws Ann. ch. 119, § 24 (2022) (requiring a hearing within 72 hours of removal).
20. S. W. Patrick, et al., "Improving the Child Welfare System to Respond to the Needs of Substance-exposed Infants," *Hospital Pediatrics* 9, no. 8 (2019): 651-654, at 653.
21. Administration for Children & Families, U.S. Department of Health & Human Services, *NCANDS*, July 1, 2021, *available*

The Journal of Law, Medicine & Ethics, 51 (2023): 533-537. © 2023 The Author(s)

at <https://www.acf.hhs.gov/cb/research-data-technology/reporting-systems/ncands> (last visited August 16, 2023).
22. H.V. Kunins et al., "The Effect of Race on Provider Decisions to Test for Illicit Drug Use in the Peripartum Setting," *Journal of Women's Health* 16, no. 2 (2007): 245-255, at 245.
23. I.J. Chasnoff et al., "The Prevalence of Illicit-Drug or Alcohol Use during Pregnancy and Discrepancies in Mandatory Reporting in Pinellas County, Florida," *The New England Journal of Medicine* 322 (1990): 1202-1206, at 1202; S.C. Roberts and A. Nuru-Jeter, "Universal Screening for Alcohol and Drug Use and Racial Disparities in Child Protective Services Reporting," *The Journal of Behavioral Health Services & Research* 39, no. 1 (2012): 3-16, at 12.
24. E.D. Kokaliari et al., "African American Perspectives on Racial Disparities in Child Removals," *Child Abuse & Neglect* 90 (2019): 139-148, at 139; E.S. Ketteringham et al., "Healthy Mothers, Healthy Babies: A Reproductive Justice Response to the 'Womb-to-Foster-Care Pipeline,'" *The City University of New York Law Review* 20, no. 1 (2016): 77-125, at 89; L. Sangoi, "Whatever They Do, I'm her Comfort, I'm her Protector: A Report on the Child Welfare and Foster System by Movement for Family Power," June, 23, 2020, *available at* <https://drugpolicy.org/resource/MFPreport> (last visited August 16, 2023); M.C. Smid and M. Terplan, "What Obstetrician–Gynecologists Should Know About Substance Use Disorders in the Perinatal Period," *Obstetrics and Gynecology* 139, no. 2 (2022): 317-337, at 318; Children's Bureau (Administration on Children, Youth and Families, Administration for Children and Families), United States Department of Health and Human Services, *Child Maltreatment 2020*, January 19, 2022, *available at* <https://www.acf.hhs.gov/cb/data-research/child-maltreatment> (last visited on August 16, 2023).
25. National Advocates for Pregnant Women, *Understanding CAPTA and State Obligations*, October 2020, *available at* <https://www.pregnancyjusticeus.org/wp-content/uploads/2020/11/2020-revision-CAPTA-requirements-for-states-10-29-20-1-1.pdf> (last visited August 16, 2023).
26. American Society of Addiction Medicine, *Public Policy Statement on Substance Use and Substance Use Disorder Among Pregnant and Postpartum People,* October 22, 2022, *available at* <https://sitefinitystorage.blob.core.windows.net/sitefinity-production-blobs/docs/default-source/advocacy/2022-sud-pregnant-postpartum.pdf?sfvrsn=61e2c93a_7/%20 2022-SUD-Pregnant-Postpartum%20.pdf%22%20\t> (last visited August 16, 2023); American Society of Addiction Medicine, *Public Policy Statement on Substance Use, Misuse, and Use Disorders During and Following Pregnancy, with an Emphasis on Opioids,* January, 18, 2017, *available at* <https://www.ncdhhs.gov/media/1802/open> (last visited August 16, 2023); American Society of Addiction Medicine, *Advancing Racial Justice in Addiction Medicine,* February 25, 2021, *available at* <https://www.asam.org/advocacy/national-advocacy/justice> (last visited August 16, 2023).
27. E. Austin et al., "Prenatal Substance Exposure and Child Maltreatment: A Systematic Review," *Child Maltreatment* 27, no. 2 (2022): 290–315, at 291-308.
28. M.I. Benedict et. al., "Types and Frequency of Child Maltreatment by Family Foster-care Providers in an Urban Population," *Child Abuse & Neglect* 18, no. 7 (1994): 577-585, at 577; M.I. Benedict et al., "The Reported Health and Functioning of Children Maltreated While in Family Foster Care," *Child Abuse and Neglect* 20, no. 7 (1996): 561-571, at 561. P.T. Billings, et al., *Outcomes Research Report #8, Child Maltreatment in Foster Care*, April 8, 2004, *available at* <https://digitalprairie.ok.gov/digital/collection/stgovpub/id/14502/> (last visited August 16, 2023); F.G. Bolton, et al., "For Better or Worse? Foster Parents and Foster Children in an Officially Reported Child Maltreatment Population," *Children and Youth Services Review* 3, no. 1-2 (1981): 37-53, at 37; M. Cavara and C. Ogren, "Protocol to Investigate Child Abuse in Foster Care," *Child Abuse & Neglect* 7, no. 3 (1983): 287-295, at 287; G. Tittle, et al., "Child Maltreatment in Out of Home Care: What Do We Know Now?" 2001, *available at* <https://cfrc.illinois.edu/pubs/rp_20011001_ChildMaltreatmentInOutOfHomeCareWhatDoWeKnowNow.pdf> (last visited August 16, 2023).
29. See Bach, *supra* note 1, at 176-186.
30. M. Terplan, "Test or Talk: Empiric Bias and Epistemic Injustice," *Obstetrics and Gynecology* 140, no. 2 (2022): 150-152, at 1.
31. Social Workers Against Mandates, *Mandated Supporting*, Social Workers Against Mandates, 2021, *available at* <https://static1.squarespace.com/static/5c8ad6374d546e4cda43d02e/t/61bba98df456a46da4ca4035/1639688591387/Mandated+Supporting+Module+2021.pdf> (last visited August 16, 2023).
32. 42 CFR Part 2, promulgated pursuant to 42 U.S.C.A. § 290dd-2(b)(2)(c) (2020).
33. *See e.g.,* A. Albert et al., "Ending the Family Death Penalty and Building a World We Deserve," *Columbia Journal of Race and the Law* 11, no. 3 (2021): 860-894, at 1.
34. K. Fong, "Getting Eyes in the Home: Child Protective Services Investigations and State Surveillance of Family Life," *American Sociological Review* 85, no. 4 (2020): 610-638, at 620.
35. *See e.g.,* M. Mutebi et al., "Breast Cancer Treatment: A Phased Approach to Implementation," *Cancer* 126, no. Suppl 10 (2020): 2365-2378, at 1.
36. Maternal and Child Health, Health Resources & Service Administration, "Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program, December 2022, *available at* <https://mchb.hrsa.gov/programs-impact/programs/home-visiting/maternal-infant-early-childhood-home-visiting-miechv-program> (last visited August 16, 2023).
37. Children's Defense Fund, *The State of America's Children 2020*, May 3, 2021, *available at* <https://www.childrensdefense.org/wp-content/uploads/2020/02/The-State-Of-Americas-Children-2020.pdf> (last visited August 16, 2023).

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