In the

SUPREME COURT OF THE STATE OF SOUTH CAROLINA

STATE OF SOUTH CAROLINA,
Respondent,

v.

BRENDA KAY PEPPERS,
Appellant.

Case No. 98-GS-30-0809

Appeal from Laurens County

Court of General Sessions

Larry R. Patterson, Circuit Court Judge

BRIEF AS AMICI CURIAE IN SUPPORT OF APPELLANT, BRENDA PEPPERS
SUBMITTED BY

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INTRODUCTION

This brief Amici Curiae is filed by medical and public health professionals in support of Brenda Kay Peppers' appeal of her conviction for unlawful conduct towards a child; a charge levied against Ms. Peppers for being pregnant and using cocaine. It is Amici's firm belief that the legal basis for Ms. Peppers' prosecution and conviction, namely, this Court's decision in South Carolina v. Whitner, 492 S.E.2d 777 (S.C. 1997), cert. denied, 118 S.Ct. 1857 (1998), lacks scientific validity, is undercut by the United States Supreme Court's recent opinion in Ferguson v. City of Charleston, South Carolina, 121 S.Ct. 1281 (2001), and is causing substantial harm to the very health interests the panel majority professes to protect. For these reasons, explained more fully below, Amici respectfully request that this Court overturn the Whitner decision and direct the trial court to grant Ms. Peppers' motion to quash her indictment.

INTEREST OF AMICI CURIAE

The legal issues presented by Ms. Peppers' conviction cannot properly be decided in isolation from the scientific, medical, and public health contexts in which her prosecution is rooted. The just resolution of these issues depends on an understanding of these contexts and an appreciation of

adverse consequences this Court's decision in this case can have on the health of South Carolinians, particularly pregnant and parenting women.

Amici are state and national professional associations of physicians, nurses, public health officers, substance abuse treatment professionals, and medical researchers that have a keen understanding of issues of substance abuse, pregnancy, neonatal health, and medical ethics.[1] Amicus Curiae Ira Chasnoff, M.D., a leading physician, researcher and author in the field of prenatal drug exposure, appears in his individual capacity to inveigh against the erroneous reliance by the Whitner Court on his research, and that of his peers, in ostensible support of its flawed and dangerous opinion. 492 S.E.2d at 782.

While there is great variety among Amici as to experience, expertise, and perspective on medical, scientific, and public health issues, Amici are united in their condemnation of South Carolina's prosecution of pregnant drug users and the Whitner decision. Amici join together in this brief to explain why the prosecution under S.C. Code § 20-7-50 of women who ingest drugs, particularly cocaine, while pregnant, flies in the face of good medicine. Amici additionally join in informing this Court of the significant damage that the application of the Whitner decision has already wrought,

[1] Descriptions of the Amici are set forth as Appendix A to this brief.

and the considerable danger it portends for treatment professionals and their patients.

STATEMENT OF THE CASE

On September 30, 1996 Brenda Kay Peppers suffered a stillbirth. At the time, Ms. Peppers had been diagnosed with the HELLP Syndrome, Rec. on App. at 13, ll 9-10, a pregnancy-related, life-threatening condition for both mother and fetus characterized by hemolysis ("H") (the breaking down of red blood cells), elevated liver enzymes ("EL"), and low platelet count ("LP").

In July 1998, the Attorney General of South Carolina indicted Ms. Peppers on a charge of Unlawful Conduct Towards a Child in violation of S. C. Code § 20-7-50. The charge was based upon the fact that the stillborn fetus was found to have traces of cocaine in its system. According to the State, the alleged offense occurred between June 30, 1996 and September 30, 1996. On June 10, 1999, Ms. Peppers moved to quash the indictment on the ground that it failed to allege a cognizable crime, in violation of the state and federal constitutions. The trial court denied her motion.

Ms. Peppers then entered a plea of guilty and was given a two years suspended sentence and two years probation. At the time of her plea, the

State acknowledged that it had no proof that cocaine adversely affected the health of Ms. Peppers' fetus or precipitated the stillbirth, of its own accord or in conjunction with the HELLP Syndrome. Rec. on App. at 13, ll 7-25.

On June 18, 1999, Ms. Peppers filed her Notice of Intent to Appeal. In November 2000 Ms. Peppers' appeal was certified to the South Carolina Supreme Court, upon its own motion and pursuant to the provisions of Rule 204(b) of the South Carolina Appellate Court Rules. On April 23, 2001, this Court granted the motion of Amici Curiae for leave to file this brief.

SUMMARY OF ARGUMENT

Amici are firmly convinced, based on years of clinical experience and rigorous scientific study, that prosecutions such as the one at issue here are medically unsound and yield adverse health consequences, particularly for the women and children whose interests they purportedly protect.

South Carolina's Supreme Court stands alone among the fifty states in permitting the prosecution, conviction, and punishment for child endangerment of pregnant drug users for ingesting substances on which they are dependent. The highest courts of every other state to have addressed this issue have repudiated the approach taken in Whitner. Moreover, this term the United States Supreme Court called into question the fundamental

underpinning of South Carolina's prosecutions of women for drug use during pregnancy. See Ferguson v. City Of Charleston, 121 S.Ct. 1281 (2001). In so doing, the Court observed that the leading medical and public health organizations had all rejected South Carolina's policy as deeply flawed and counterproductive to the health and well-being of women, fetuses, and children. See e.g., Ferguson infra at 1292, n 23. See also Amicus Brief of the American Medical Association to the South Carolina Supreme Court, South Carolina v. Whitner, No. 24468 (filed September 28, 1994).

In the case at bar, this Court has the opportunity to re-visit the Whitner decision, jettison the position adopted by the narrow majority in that case, and join the medical and public health community and other state courts in a reasonable and well-founded approach to dealing with drug use during pregnancy.

The assumption that animates the prosecution of Brenda Kay Peppers – that the dangers of maternal cocaine use are fundamentally different from or more serious than other behaviors that may pose risk of fetal harm – has been shown to lack scientific basis. While not denying the obvious advisability of protecting fetuses from exposure to potential teratogens, Amici bring to this Court's attention the fact that the so-called "crack baby"

crisis that prompted both these prosecutions and the policy struck down as unconstitutional by the Supreme Court in Ferguson, was myth and misnomer. The most thorough and comprehensive scientific survey assessing the impact of maternal cocaine use on pregnancy outcomes and child development fails to link in utero cocaine exposure with chronic, adverse consequences. See generally Wendy Chavkin, Cocaine and Pregnancy – Time to Look at the Evidence 285 JAMA 1626 (2001). Put simply, the prosecution of pregnant cocaine users for Unlawful Conduct Towards a Child in violation of S.C. Code § 20-7-50 lacks adequate grounding in science and medicine.

In addition, the Whitner decision fails to take account of the special medico-ethical relationship between a patient and her health care provider. While the ethical duties of honesty and confidentiality ultimately rest on principles of morality, their practical importance to the daily delivery of health care is considerable. Competent health care cannot be rendered unless a patient trusts her caregiver sufficiently to share medically relevant, but potentially embarrassing (or incriminating) information; or, for that matter, unless she is willing to see a treatment provider in the first place. Patient trust does not automatically attach: it must be earned and sustained by treatment professionals. The challenges of establishing this relationship

are particularly formidable where a patient is poor, drug-dependent, or pregnant; or (as in this case) all three. Research and clinical experience teach that when (as here) the personal risks of seeking medical care are raised to intolerably high levels, it is more likely that prenatal care and patient candor – and not drug use – will be what is deterred, often with tragic health consequences. This dangerous dynamic is precisely what has ensued in South Carolina since the Whitner decision.

Finally, it will be shown that the Whitner decision fails provide a clear analytical system for resolving the question of what type of conduct taken during pregnancy will subject women to criminal liability or obligate health care professionals to report pregnant women to state law enforcement officials for investigation and possible arrest and charging. The recent and conflicting experience of state law enforcement and public health agencies demonstrates the "irretrievably confused" messages sent by the decision and the need for a "fresh start." Holtzscheiter v. Thomson Newspapers, 506 S.E. 2d 497, 513 (Toal, J., concurring).

Because the Whitner decision cannot be justified by scientific research, because its impact on maternal and fetal health is directly contrary to the stated goals of both this Court and the State, and because as case law it lacks predictability and has confounded state actors and the general public,

Amici urge the Court to replace the Whitner decision with legal precedent that is consonant with good science and sound medicine, and that protects -- not corrodes -- core tenets of clinical practice.

ARGUMENT

I. The South Carolina Supreme Court Stands Alone in Using Child Neglect Statutes to Punish Women for Conduct During Pregnancy.

A. Other State Appellate Courts Have Repudiated the Whitner Reasoning and Policy.

As the dissenting justices of this Court and the rulings of every state appellate court to have addressed this issue have observed, the extension of child abuse statutes to include maternal conduct that may endanger a fetus leads to absurd, unintended, and dangerous results. Health and social services professionals, among others, must guess whether, for example, a pregnant woman's failure to obtain prenatal care, to quit smoking or drinking, to stop taking over-the-counter medicine, or to refrain from playing rigorous sports constitutes unlawful behavior. See Whitner, 492 S.E.2d 777, at 787, 788 (Moore, J., dissenting) (Noting that the majority of this Court "embark[ed] on a course of judicial activism rejected by every other court to address the issue," and by doing so rendered the statute

unconstitutionally vague because "a pregnant woman potentially [will now be] criminally liable for myriad acts which the legislature has not seen fit to criminalize."); Nevada v. Encoe, 885 P.2d 596, 598 (Nev. 1994) (per curiam); Commonwealth v. Welch, 864 S.W.2d 280, 283 (Ky. 1993); Reinesto v. Arizona, 894 P.2d 733, 736-37 (Ariz. Ct. App. 1995).

The high courts of Kentucky, Nevada, and Ohio have declined to extend the use of child neglect statutes to punish women for their conduct during pregnancy, recognizing that the due process guarantee of notice and its prohibition against vague criminal statutes precludes such prosecution. See Sheriff v. Encoe, 110 Nev. 1317, 1319, 885 P.2d 596, 598 (1994); Commonwealth v. Welch, 864 S.W.2d 280, 283 (Ky. 1993); State v. Gray, 62 Ohio St.3d 514, 584 N.E.2d 710 (Ohio 1992). From 1977 to the present[2], prosecutors in more than thirty states have attempted to use existing criminal laws to punish women for pregnancy-related behavior that posed potential harm to fetuses.[3] With the sole exception of the South Carolina Supreme Court, every state court of last resort, as well as all intermediate appellate

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[2] See Reyes v. Superior Court of San Bernadino Cty, 75 Cal. App.3d 214 (4th Dist. 1977).

[3] While many of those charged under such laws were addicted to illegal substances during pregnancy, others were charged for engaging in other conduct, such as drinking alcohol. See, e.g., State v. Zimmerman, No. 96-CF-525, slip op. (Cir. Ct. Racine Cty, Wis. Sept. 18, 1996), appeal filed, No. 96-2797-C.R. (Wis. Ct. App. Dist. II).

courts[4] and numerous trial courts that have addressed this issue, have rejected the use of child endangerment and similar criminal statutes to punish women for their conduct during pregnancy.

As the Kentucky Supreme Court in Welch explained when reviewing such a prosecution:

> The mother was a drug addict. But, for that matter, she could have been a pregnant alcoholic, causing fetal alcohol syndrome; or she could have been addicted to self abuse by smoking, or by abusing prescription painkillers, or over-the-counter medicine; or for that matter she could have been addicted to downhill skiing or some other sport creating serious risk of prenatal injury, risk which the mother wantonly disregarded as a matter of self-indulgence. What if a pregnant woman drives over the speed limit, or as a matter of vanity doesn't wear the prescription lenses she knows she needs to see the danger of the road? The defense asks where do we draw the line on self-abuse by a pregnant woman that wantonly exposes to risk her unborn baby? The Commonwealth replies that the General Assembly probably intended to draw the line at conduct that qualifies as criminal, and then leave it to the prosecutor to decide when such conduct should be prosecuted as child abuse in addition to the crime actually committed.

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[4] See, e.g., Reinesto v. Superior Court, 182 Ariz. 190, 894 P.2d 733 (Ct. App. 1995) (in dismissing child abuse charges filed against a woman for heroin use during pregnancy, court held that the ordinary meaning of "child" excludes fetuses, and to conclude otherwise, would offend due process notions of fairness and render statute impermissibly vague); Collins v. State, 890 S.W.2d 893 (Tex. App. El Paso 1994) (charges brought for substance abuse during pregnancy dismissed because application of the statute to prenatal conduct violates federal due process guarantees); State v. Dunn, 82 Wash. App. 122, 916 P.2d 952 (1996) (holding that the legislature did not intend to include fetuses within the scope of the term "child" which was defined "as a person under eighteen years of age"), review denied, 130 Wash. 2d 1018, 928 P.2d 413 (1996); State v. Gethers, 585 So. 2d 1140 (Fla. App. 1991) (dismissing child abuse charges brought for prenatal drug use on ground that such application misconstrues the purpose of the law).

> However, it is inflicting intentional or wanton injury upon the child that makes the conduct criminal under the child abuse statutes, not the criminality of the conduct per se. The Commonwealth's approach would exclude alcohol abuse, however devastating to the baby in the womb, unless the Commonwealth could prove an act of drunk driving; but it is the mother's alcoholism, not the act of driving that causes the fetal alcohol syndrome. The "case-by-case" approach suggested by the Commonwealth is so arbitrary that, if the criminal child abuse statutes are construed to support it, the statutes transgress reasonably identifiable limits; they lack fair notice and violate constitutional due process limits against statutory vagueness.

864 S.W.2d at 283 (emphasis added).

Similarly, in Encoe, the Nevada supreme court held that its child neglect statute, NRS § 200.508, did not apply to a mother's prenatal substance dependency. The Encoe court "recognized that due process prohibits courts from interpreting existing laws in an unforeseeable or unintended manner," and stated that such an interpretation would render the statute unconstitutionally vague. 885 P.2d at 598. “To hold otherwise,” reasoned the court, “would ... open the floodgates to prosecution of pregnant women who ingest such things as alcohol, nicotine, and a range of miscellaneous, otherwise legal, toxins.” Id. at 598.

As the next section makes clear, the United States Supreme Court further called into question the wisdom of the prosecutorial policies sanctioned by Whitner and signaled the important role that the medical

community can and should play in informing the legal community about the appropriate scope and application of certain criminal laws.

B. The United States Supreme Court Recently Questioned the Medical Evidence Justifying the Whitner Decision.

On March 21 of this year, the United States Supreme Court ruled that South Carolina's interest in conducting nonconsensual, suspicionless drug testing of pregnant women to gather evidence for possible criminal charges as part of a government effort to deter pregnant women from ingesting cocaine and other drugs cannot justify circumventing the warrant requirement of the Fourth Amendment. Ferguson, 121 S.Ct. at 1293. While the Ferguson Court did not directly address the lawfulness of prosecuting pregnant drug users for child endangerment, the Court's analysis does cast serious doubt on the proposition, endorsed by the Whitner majority, that the prosecution of pregnant drug users is a valid way to protect fetuses. As the Court observed,

> It is especially difficult to argue that the program here was designed simply to save lives. Amici claim a near consensus in the medical community that programs of the sort at issue, by discouraging women who use drugs from seeking prenatal care, harm, rather than advance, the cause of prenatal health.

Ferguson, 121 S.Ct. at 1292, n 23. See also, Brief for American Medical Association as Amicus Curiae at 6–22, Ferguson, 121 S.Ct.; Brief for American Public Health Association, et al., as Amici Curiae, Ferguson, 121 S.Ct.). Indeed, more than one hundred leading physicians and researchers from around the country specializing in prenatal care and child development encouraged the Surgeon General of the United States to intervene to protect the rights and health of the pregnant patients affected by the testing policy at issue in Ferguson. As these experts stated:

> Threat-based approaches have been shown to deter pregnant and parenting women not from using drugs, but from seeking health care. In short, the Charleston policy undermines rather than advances the interest in maternal, fetal, and child health.

Susan L. Adams, et al., An Open Letter to the United States Surgeon General David Satcher, M.D., The Hill, Oct. 4, 2000, at 7. See Appendix B. What is more, in the Supreme Court, "[w]hile dozens of medical, public health and civil rights groups filed or joined briefs in support of the women's appeal, not one friend-of the court- brief was filed on the city's side." Linda Greenhouse, Justices Consider Limits of the Legal Response to Risky Behavior by Pregnant Women, New York Times, Oct. 5, 2000 (emphasis added).

Just as the U.S. Supreme Court gave legal expression to its concern that the city policy at issue in Ferguson dramatically departed from the

accepted teachings and practices of the medical profession, so to should this Court correct the dangerous imbalance created by Whitner between the criminal law and the public health.

C. Public Health and Medical Organizations Uniformly Condemn South Carolina's Prosecution of Pregnant Drug Users.

Every major medical and public health organization to examine the issue has repudiated the prosecution of pregnant drug users, like that permitted by Whitner, as counterproductive to the health and well-being of both mother and fetus.

In 1994, the American Medical Association ("AMA") filed an amicus brief with this Court in the Whitner case urging this Court to strike down prosecution of a pregnant drug-dependent woman for child abuse based on the woman's ingestion of cocaine while pregnant. A copy of the AMA brief is attached as Appendix C. In so arguing, the AMA was acting upon an earlier resolution of its Board of Trustees that observed that if the criminal justice system is used to deal with drug-abusing mothers, "[p]regnant women will be likely to avoid seeking prenatal or other medical care for fear that their physicians' knowledge of substance abuse or other potentially

harmful behavior could result in a jail sentence rather than proper medical treatment."[5]

The Southern Regional Project on Infant Mortality ("The Project") echoes this warning. The Project, an initiative of the Southern Governors' Association and the Southern Legislative Conference, undertook a comprehensive three-year study of perinatal substance abuse in southern states, including South Carolina. Leading the list of the study's conclusions and recommendations, the Conference urges: "Emphasize prevention and treatment rather than punitive measures." Specifically, the Conference found:

> It is clear from these findings that fear of losing children is a major reason women delay or avoid seeking treatment. If pregnant women . . . feel that they will be "turned in" by health care providers or substance abuse treatment centers, they will avoid getting care. If women are able to discuss their addiction with providers without fear of retribution . . . they are more likely to enter treatment. Attempts to impose criminal penalties for alcohol or drug use during pregnancy exacerbate women's fears and make it less likely they will seek or receive the care they need for either their pregnancies or their addiction.[6]

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[5] American Medical Ass'n, Legal Intervention During Pregnancy: Court-Ordered Medical Treatment and Legal Penalties for Potentially Harmful Behavior by Pregnant Women, 264 JAMA 2663, 2669 (1990). The AMA accordingly resolved that "[c]riminal sanctions or civil liability for harmful behavior by the pregnant woman toward her fetus are inappropriate." Id. at 2670.

[6] Southern Regional Project on Infant Mortality, A Step Toward Recovery: Improving Access to Substance Abuse Treatment for Pregnant and Parenting Women 21 (1993); accord Southern Legis. Summit on Healthy Infants and Families, High Risk Pregnancies/Substance Abuse (Oct. 4-7, 1990) ("[S]tates should adopt, as preferred

The American Society of Addiction Medicine concurs. This organization comprised of the leading specialists in the field of substance abuse treatment and prevention, states that:

> [t]he imposition of criminal penalties solely because a person suffers from an illness is inappropriate and counterproductive. Criminal prosecution of chemically dependent women will have the overall result of deterring such women from seeking both prenatal care and chemical dependency treatment, thereby increasing, rather than preventing, harm to children and to society as a whole.[7]

The National Association for Perinatal Addiction Research and Education further warns that:

> The prospect of criminal prosecutions . . . places health care practitioners in a conflict position, forcing them to choose between maintaining their patient's [sic] confidentiality or reporting them, ultimately to the police, a position many doctors and nurses find intolerable.
>
> . . .
>
> The key to intervention will be access to health care for high risk women, not the threat of criminal prosecution.[8]

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methods, prevention, intervention, and treatment alternatives rather than punitive actions to ameliorate the problems related to perinatal exposure to drugs and alcohol.").

[7] American Soc'y of Addiction Med., Bd. of Directors, Public Policy Statement on Chemically Dependent Women and Pregnancy (Sept. 25, 1989).

[8] National Ass'n for Perinatal Addiction Research and Educ., Policy Statement No. 1, Criminalization of Prenatal Drug Use: Punitive Measures Will Be Counter-Productive (1990).

Even the United States General Accounting Office concludes that "the threat of prosecution poses . . . [a] barrier to treatment for pregnant women . . . . These women are reluctant to seek treatment if there is a possibility of punishment . . . . [W]omen in need of treatment are well aware of the threat [of child abuse prosecutions]."[9]

In short, it is not mere speculation that the threat of criminal prosecution deters pregnant drug users from seeking both drug treatment and prenatal care: multiple studies and a wealth of clinical experience have shown this to be the case. It is therefore understandable that every leading public health and medical organization to have considered the subject has opposed prosecuting pregnant women for using drugs.[10]

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[9] US General Accounting Office, ADMS Block Grant: Women's Set Aside Does Not Assure Drug Treatment for Pregnant Women 5, 20 (1991). See also Stephen Kandall, Substance and Shadow: Women and Addiction in the United States 278-79 (1996).

[10] See, e.g., National Council on Alcoholism and Drug Dependence, Women, Alcohol, Other Drugs and Pregnancy (1990) (A "punitive approach is fundamentally unfair to women suffering from addictive diseases and serves to drive them away from seeking both prenatal care and treatment for their alcoholism and other drug addictions. It thus works against the best interests of infants and children . . . ."); American College of Obstetricians and Gynecologists ("ACOG") Committee Opinion 55 (Oct. 1987) (resort to the courts "is almost never justified" in treating pregnant women); ACOG Technical Bulletin 195, Substance Abuse in Pregnancy 1 (1994) ("In some states, the legal requirements regarding reporting substance abuse threaten to interfere with patient confidentiality and the entire physician-patient relationship."); American Academy of Pediatrics, Comm. on Substance Abuse, Drug- Exposed Infants, 86 Pediatrics 639, 642 (1990) ("The public must be assured of nonpunitive access to comprehensive care which will meet the needs of the substance-abusing pregnant woman and her infant."); American Nurses Ass'n, Position Statement (Apr. 5, 1992) ("ANA . . . opposes any legislation that focuses on the criminal punishment of the mothers of drug-exposed infants . . . . The threat of criminal prosecution is counterproductive in that it prevents

D. The South Carolina Legislature Has Consistently Refused to Pass Laws Criminalizing Addiction During Pregnancy.

On eleven separate occasions the South Carolina Legislature has refused to enact laws criminalizing pregnant women for using drugs. In so doing, the state's legislators, like the Ferguson Court, have heeded the warnings of health professionals discussed above. Although the Whitner majority did not follow the Legislature's lead, this case affords the Court the opportunity to harmonize its jurisprudence with the judgment of the state Legislature. What is more, newly published medical data, discussed in the next section, firmly support the Legislature's stance, and provide this Court a compelling reason to re-visit the flawed assumptions on which the Whitner decision is premised.

II. Science Has Failed to Substantiate the Alleged Harms that Prompted the Prosecution of Ms. Peppers and Other Women.

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many women from seeking prenatal care and treatment for their alcohol and other drug problems."); California Medical Ass'n, Policy Position ("[T]o bring criminal charges against a pregnant woman for activities which may be harmful to her fetus is inappropriate. Such prosecution is counterproductive to the public interest as it may discourage a woman from seeking prenatal care or dissuade her from providing accurate information to health care providers out of fear of self-incrimination.") quoted in American Medical Ass'n, Legal Intervention During Pregnancy: Court-Ordered Medical Treatment and Legal Penalties for Potentially Harmful Behavior by Pregnant Women, 264 JAMA 2663, 2669 (1990). See also, State v. Luster, 419 S.E.2d 32, 35 n.2 (Ga. 1992) (listing medical and public health organizations opposing the prosecution of women for cocaine use during pregnancy); Marilyn L. Poland et al., Punishing Pregnant Drug Users: Enhancing the Flight From Care, 31 Drug and Alcohol Dependence 199 (1993).

Underlying the majority opinion in Whitner and the prosecution of Ms. Peppers is an assumption that cocaine ingested during pregnancy poses a unique danger to the developing fetus. Although this belief is consistent with the sensationalistic media accounts of the 1980s, it is without scientific and clinical support.[11] In so noting, Amici do not condone the use of illegal drugs. Furthermore, Amici in no way wish to downplay the harm that ingesting any substance could potentially cause to a fetus or child. Indeed, Amici share a professional dedication to avoiding and reducing any such

[11] See generally Deborah Frank et al., Growth, Development, and Behavior in Early Childhood Following Prenatal Cocaine Exposure: A Systematic Review, 285 JAMA 1613 (2001). See also Albert J. Tuboku-Metzger et al., Cardiovascular Effects of Cocaine in Neonates Exposed Prenatally, 13 American J. of Perinatology 1 (1996) (study of chronic cocaine use among pregnant subjects finding no direct effects on the health or development of newborns); Bertis B. Little et al., Is There a Cocaine Syndrome? Dysmorphic and Anthropometric Assessment of Infants Exposed to Cocaine, 54 Teratology 145 (1996) (finding no recognizable constellation of dysmorphic features to distinguish between cocaine-exposed and non-exposed infants); Nancy Stewart Woods et al., Cocaine Use During Pregnancy: Maternal Depressive Symptoms and Infant Neurobehavior over the First Month, 16 Infant Behavior and Dev. 83, 92 (1993) (finding no differences in neurobehavioral performance of cocaine-exposed infants when compared to non-exposed infants); Claire D. Coles et al., Effects of Cocaine and Alcohol Use in Pregnancy on Neonatal Growth and Neurobehavioral Status, 14 Neurotoxicology and Teratology 23, 31-32 (1992) (finding prenatal cocaine exposure effects fetal growth but that cocaine-exposed infants do not appear otherwise impaired physically or behaviorally in the neonatal period); Barry M. Lester et al., Data Base of Studies of Prenatal Cocaine Exposure and Child Outcome, 27 J. of Drug Issues 487 (1997) (concluding that knowledge about the existence or extent of effects of prenatal cocaine exposure on child outcome is limited, scattered, and compromised by methodological shortcomings); Ellen Hutchins, Drug Use During Pregnancy, 27 J. of Drug Issues 463, 466 (1997). See also Laura E. Gomez, Misconceiving Mothers: Legislators, Prosecutors, and the Politics of Prenatal Drug Exposure 23-25 (1997) (discussing the failure of longitudinal studies to find statistically significant differences between cocaine-exposed children and non-exposed children).

dangers. Nonetheless, Amici are duty bound to inform this Court of the overwhelming scientific and medical evidence that contradicts the underlying premises of its Whitner decision.

The majority opinion in Whitner is predicated on the assumption that prenatal exposure to cocaine causes long-term, deleterious effects on fetal and child development different in scope, degree and kind from risks posed by maternal behavior or exposure to other substances, licit or illicit. For years scientific studies by and large failed to validate this assumption. But whatever lingering doubt may have been justified by the former state of the research, the latest and best entry in this field offers compelling evidence that it is wrong to single out maternal cocaine use for special opprobrium.

The Journal of the American Medical Association ("JAMA"), one of the most distinguished peer-reviewed medical journals in the United States, recently published a comprehensive, systematic, and authoritative analysis of all medical research assessing the relationship between maternal cocaine use during pregnancy and adverse developmental consequences for the fetus and child. See Deborah Frank et al., Growth, Development, and Behavior in Early Childhood Following Prenatal Cocaine Exposure: A Systematic Review, 285 JAMA 1613 (2001) [hereafter "A Systematic Review"]. The full text of the article is attached as Appendix D. This landmark report not

only exposes as erroneous and unfounded the assumptions that underlie a series of prosecutions of pregnant cocaine-dependent women in South Carolina, but also eviscerates the express rationale for the majority opinion in Whitner.

Using carefully developed selection criteria, the JAMA researchers identify all seventy-five English-language studies of the effects of in utero cocaine exposure. See A Systematic Review at 1614. They then undertake a detailed review of all the studies that complied with accepted scientific practices.[12] The researchers conclude that:

> [T]here is no convincing evidence that prenatal cocaine exposure is associated with any developmental toxicity difference in severity, scope, or kind from the sequelae of many other risk factors. Many findings once thought to be specific findings of in utero cocaine exposure can be explained in whole or in part by other factors, including prenatal exposure to tobacco, marijuana, or alcohol and the quality of the child's environment. [13]

Specifically, the JAMA researchers found that when studies were controlled for prenatal exposure to tobacco and alcohol, prenatal cocaine

[12] "Detailed review was … restricted to studies that … met 3 criteria: (1) samples were prospectively recruited; (2) examiners of the children were masked to their cocaine exposure status; and (3) the cocaine-exposed cohort did not include a substantial proportion of children also exposed in utero to opiates, amphetamines, or phecyclidine, or whose mothers were known to be infected with the human immuniodeficiency virus (HIV)." Id. at 1613, 1614.

[13] Id. at 1621, 1624.

exposure is not associated with physical growth retardation, id. at 1613; there is little or no impact of prenatal cocaine exposure on children's scores on assessments of cognitive development, id.[14]; "[p]roblem-solving abilities [do] not differ between cocaine-exposed and unexposed preschoolers," id. at 1617; nor does cocaine exposure impact standardized language measures, id. at 1620. In fact, the oldest group of children studied to date registered no effect from in utero cocaine exposure on any IQ scales or academic achievement, id. at 1616 (citing Gale Richardson et al., Prenatal cocaine cocaine exposure: effect on the development of school age children 18 Neurotoxicol Teratol 627 (1996))[15]

Upon an exhaustive review of the medical research, the only effect of prenatal cocaine exposure that the JAMA researchers uncovered is the potential for decreased emotional expressiveness. A Systematic Review at 1620. And even this finding is tempered by the observation that "[f]ull-term

[14] Amicus Curiae Ira Chasnoff, a physician on whose research this Court relied in reaching its decision in Whitner, authored a study finding "no incremental impact of cocaine use" on assessment tests of 6-month-old infants. See id. at 1615.

[15] See also Gail A. Wasserman et al., Prenatal Cocaine Exposure and School Age Intelligence, 50 Drug & Alcohol Dependence 203, 209 (1998) ("prenatal cocaine exposure does not seem to confer an additional risk for adverse developmental outcome"); Hallam Hurt et al., Children with In Utero Cocaine Exposure Do Not Differ from Control Subjects On Intelligence Testing, 151 Arch. Ped. Adolesc. Med. 1237 (1997).

cocaine-exposed infants show[] better arousal modulation than their unexposed counterparts." Id. at 1617.

In light of these findings, the JAMA researchers condemn as "irrational[]" policies that selectively "demonize" in utero cocaine exposure and that target pregnant cocaine users for special criminal sanction. Id. at 1621.

The Whitner majority's misplaced belief in the so-called "crack baby" phenomenon is particularly troubling given the greater magnitude of risk to fetal and child development posed by many licit substances and everyday circumstances. For example, as the JAMA researchers point out, prenatal exposure to tobacco is "the major predicator" of abnormalities in infant muscle tone at 6 weeks. Id. at 1616 (citing, Delia Dempsey et al., Tonal abnormalities are associated with maternal cigarette smoking during pregnancy in utero cocaine exposed infants 106 Pediatrics 79 (2000)). In fact, medical research connects tobacco use with a host of adverse outcomes for pregnancy.[16] The same can be said for alcohol[17], not to mention a wide

[16] Low birth weight, Sudden Infant Death Syndrome, spontaneous abortion, premature rupture of the membranes, and abnormal placentation are associated with maternal tobacco use. See, e.g., Lony C. Castro et al., Maternal Tobacco Use and Substance Abuse: Reported Prevalence Rates and Associations with the Delivery of Small for Gestational Age Neonates, 81 Obstetrics and Gynecology 396 (1993); Office on Smoking and Health, The Health Consequences of Smoking: Nicotine Addiction 602 (1988). The teratogenic effects of tobacco and alcohol are particularly relevant because women who ingest cocaine during pregnancy are more likely to use tobacco and alcohol than are non

range of commonly prescribed medications, including psychiatric medications, such as anticonvulsants,[18] lithium and other mood-stabilizers,[19] antipsychotics, and benzodiazepines (the class of medications which includes Valium, Librium and Xanax),[20] some antibacterials (especially

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cocaine-users. Margaret Bendersky et al., Characteristics of Pregnant Substance Abusers in Two Cities in the Northeast, 22 Am. J. Drug & Alcohol Abuse 349, 353 (1996).

[17] Fetal Alcohol Syndrome is the leading cause of mental retardation in the United States. Loretta P. Finnegan & Stephen R. Kandall, Maternal and Neonatal Effects of Alcohol and Drugs in Substance Abuse, A Comprehensive Textbook 513, 529 (J.H. Lowinson et al. eds., 1997) [hereafter "Comprehensive Textbook"].

[18] A leading scientific text notes that the teratogenic affects of anticonvulsants were identified in the 1960's, especially those caused by the drug Dilantin, commonly prescribed for epileptics and that "[n]o dose response curve has been demonstrated, nor has a "safe" dose been found below which there is no increased teratogenic risk." Kenneth L. Jones, Smith's Recognizable Patterns of Human Malformation 495 (5th ed. 1997) [hereafter "Smith's Recognizable Patterns of Human Malformation."]. Other anticonvulsants associated with facial malformations, mental deficiencies, speech disorders, and cardiovascular defects include trimethadione, paramethadione, valproic acid, and warfarin. Id. at 495-505. With respect to trimethadione in particular, it warns that "the frequency and severity of defects associated with maternal use of these drugs during pregnancy are high enough to warrant consideration of early elective termination of pregnancy." Id. at 500 (citing G.L. Feldman et al., The Fetal Trimethadione Syndrome, 131 Am. J. Dis. Child 1389 (1977)). Another standard medical text notes: "An association of fetal abnormalities with anticonvulsants is strengthened by increasing reports of cleft palate, cardiac abnormalities, craniofacial anomolies, nail and digit hypoplasia, visceral defects, and mental subnormality in children of epileptic mothers taking anticonvulsant drugs." The Merck Manual of Diagnosis and Therapy 1859 (R. Berkow ed., 16th ed. 1992) [hereafter "Merck Manual."].

[19] "Among psychotropic drugs, lithium has been more strongly associated with congenital anomolies than have other agents . . . . [N]umerous publications indicate an increased incidence of cardiovascular abnormalities, particularly an increase in Ebstein's anomoly in infants born of lithium-treated mothers." Jerrold G. Bernstein, Handbook of Drug Therapy in Psychiatry 415 (2d ed. 1988) (citing Gail E. Robinson et al., The Rational Use of Psychotropic Drugs in Pregnancy and Postpartum 31 Can J. Psychiatry 183 (1986)).

[20] Bernstein, infra, at 407 ("Lithium presents a significant risk to fetal development if taken during the first trimester . . . . Benzodiazepines and meprobomate have a significant risk of teratogenic effects. . . ."). The specific birth defects (or "anomalies")

Tetracyclines),[21] anticoagulants,[22] thyroid medications,[23] and antihypertensive drugs.[24] Even "[l]arge doses of aspirin may result in delayed onset of labor, premature closure of the fetal ductus arteriosus . . . or neonatal bleeding"[25] (emphasis added). Furthermore, there is long-standing scientific consensus that prenatal exposure to adverse environmental factors such as poor nutrition, substandard housing and a lack of social supports and services (all of which are associated with poverty) can also profoundly affect

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associated with these and other psychiatric medications taken during pregnancy include: growth retardation and oral clefts (barbiturates); cleft palates, neurologic depression and low Apgar scores (benzodiazepines); "severe anomalies in 12% of newborns" (meprobomate); respiratory distress (antidepressants); chromosomal gaps and breaks, congenital heart anomalies; reduced thyroid function; and external ear malformations (lithium carbonate and the other mood-stabilizing drugs). Id. at 407-421 (citing W.S. Barry and S.M. St. Clair, Exposure to Benzodiazepines in Utero 1 Lancet 1436 (1987)); M.J. Whittle and K.P. Hanretty, Prescribing in Pregnancy: Identifying Abnormalities, 293 Br. Med. J. 1485 (1986).

[21] Tetracycline has been associated with permanent discoloration of the teeth, enamel hypoplasia, and a lowered resistance to caries, as well as retarded bone growth, especially when taken during the latter part of the pregnancy. Merck Manual at 41.

[22] Certain anticoagulants can cause nasal abnormalities, bone stipling, bilateral optic atrophy, varying degrees of mental retardation, microcephaly, and occasionally fetal and maternal hemorrhage. Smith's Recognizable Patterns of Human Malformation at 504.

[23] Some thyroid medications taken during pregnancy can cause severe hypothyroidism, fetal goiter, or scalp defects. Merck Manual at 1859.

[24] Antihypertensive drugs may cause fetal respiratory depression, hypotension, paralytic ileus, bradycardia, hypoglycemia, and varying degrees of intrauterine growth retardation. Id. at 1861.

[25] Id. at 1859; see also Linda J. Van Marter et al., Persistent Pulmonary Hypertension of the Newborn and Smoking and Aspirin and Nonsteroidal Antiinflammatory Drug Consumption During Pregnancy 97 Pediatrics 658 (1996) (maternal consumption of aspirin during pregnancy found to be consistently associated with pulmonary hypertension of the newborn, an important cause of respiratory failure in neonates).

infant health,[26] as can a childhood spent in the care of adults who suffer from depression or other serious mental illness.[27]

In bringing these examples to the Court's attention, Amici Curiae do not mean to suggest that prosecutors or courts should extend South Carolina's criminal code to reach women who use tobacco, alcohol, or prescription medications while pregnant, or who carry children to term while living in poverty or suffering from major mood disorders. As Amici endeavor to show throughout this brief, such a move would hurt, not help, the health of women and fetuses. Rather, Amici wish to underscore that the Whitner decision invites excess and incoherence in its application by prosecutors and courts. The next section illustrates why this is so.

III. The Whitner Decision is Inherently Unclear and will Continue to Cause Widespread Confusion.

As noted above, the leading medical and health associations and various state courts have warned about the sweeping, arbitrary and deleterious consequences that can result when child endangerment laws are

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[26] Nora S. Gustavsson & Ann E. MacEachron, Criminalizing Women's Behavior, 27 J. of Drug Issues 673, 675-76 (1997).

[27] See, e.g., Jeir A. Doane, Family Interaction and Communication Deviance in Disturbed and Normal Families: A Review of Research, in Advances in Family Psychiatry - Vol. II 113 (J.G. Howells ed., 1980).

applied to maternal conduct during pregnancy. The fears of these commentators are confirmed by the South Carolina experience in the wake of the Whitner decision. As illustrated below, the result has been that Whitner provides "no clear analytical system for resolving" the question of what type of conduct undertaken during pregnancy will subject women to criminal liability or obligate health care professionals to report pregnant women to state law enforcement officials for investigation and possible arrest and charging. Holtzscheiter v. Thomson Newspapers, 506 S.E. 2d 497, 505 (1998) (Toal, J., concurring). Consequently, the law in this area "lacks consistency and predictability, and confounds the . . . bar [and] members of the general public." Id.

For example, in May 2000 the South Carolina State Department of Alcohol and Other Drug Abuse Services ("DAODAS") – a state agency whose primary function is to safeguard the health of state residents – designed, paid for and published 50,000 brochures for the general public warning that "[n]ot only is it dangerous for pregnant women to smoke, drink, use other drugs or engage in other activities that risk harming their babies, but [in light of the Whitner decision] it's also a crime in South Carolina." South Carolina Department of Alcohol and Drug Abuse

Services, Important Facts to Remember: A Special Delivery Should be Handled With Care, (May 2000).

The Department's straightforward reading of the scope of Whitner illuminates that decision's breath-taking expansion of the criminal code into the private lives of unsuspecting South Carolinians: smoking while pregnant may suddenly be a criminal act. Whereas prior to Whitner a pregnant woman suffering from a nicotine or other drug or alcohol addiction had a medical condition that could be treated by a health professional devoted to her well-being, after Whitner this woman is transformed into a would-be criminal, and her physician into a quasi-agent of law enforcement, required to report the pregnant patient's conduct to state authorities.

As it so happens, the chilling scenarios foreseen by appellate jurists and South Carolina health officials already have begun to play themselves out: at least one South Carolinian has been prosecuted under S.C. Code § 20-7-510 for consuming alcohol while pregnant. See Melissa Manware, Infant Born Drunk: Intoxicated Mom Is Facing Charges, The State (Columbia, S.C.), Sept. 24, 1998, at A1 (reporting the charging of a woman with unlawful conduct toward a child after delivering an "intoxicated" baby).

To be sure, the confusion resulting from the Whitner decision is underscored and even exacerbated by the various positions publicly taken by

the state's chief law enforcement official, Attorney General Charles M. Condon. For example, Mr. Condon has stated that he will not prosecute women for smoking tobacco while pregnant, while acknowledging that the Whitner decision might authorize such prosecutions. (In this vein, he ordered a recall of the DAODAS brochures). Nevertheless, as the case of the "infant born drunk" makes clear, the consumption of other licit substances, such as alcohol, can expose pregnant women to criminal charges.

A 1997 Attorney General Opinion only muddies the waters. The Opinion responds to a request by the Department of Social Services to clarify the scope and application of the Whitner decision. Specifically, the Department asked: "What level of restriction on the privacy rights of the mother would be justified when the activities affecting the fetus or potentially affecting the fetus are legal activities?" 1997 S.C. AG LEXIS 175 at 12. In response, General Condon notes that the Whitner decision "does not clearly draw a line on the basis of legal versus illegal conduct," Id. at 13, and that it is "capable of being read both broadly as well as narrowly." Id. at 21 (emphases added). The State's chief law enforcement officer refuses to provide an authoritative legal interpretation, and even appears willing to delegate the task of interpretation to the Department of Social

Services or the Legislature. See id. at 22 ("While the court in Whitner arguably has given DSS the go-ahead to apply the Children's Code to cases involving viable fetuses where the conduct itself is not illegal, we would advise the agency to tread lightly in this area"); id. (calling for further elucidation by the General Assembly).

The vagueness and inconsistency of these positions not only exacerbate the confusion wrought by the Whitner decision, but, more importantly, underscore the fact that, in the final analysis, the Whitner decision is unworkable. It is unworkable regardless of whether (to adopt General Condon's terminology) one chooses to read Whitner "broadly" or to read it "narrowly." Under a "broad" interpretation virtually any conduct or omission during a pregnancy could be deemed a risk to the fetus and therefore be the basis for criminal prosecution of a pregnant woman. Law enforcement are thus given free reign to intrude on every aspect of a pregnant women's life. Moreover, a wide variety of state officials and medical, public health and social services professionals would have imposed on them the sweeping and heretofore unimagined duty of reporting for investigation and possible prosecution all instances of potentially harmful conduct that come to their attention.

Under a "narrow" interpretation of Whitner, only conduct that is already illegal and that poses a danger to fetuses would be actionable under the state's child endangerment laws. While this narrow interpretation might clarify somewhat law enforcement's duties, the chief drawback to this interpretation is that it is intellectually, medically, and ethically unsound. If the goal is to protect fetal well-being, the distinction between legal and illegal conduct, or licit and illicit substances, is meaningless – or worse, absurd. The conduct that the law declares to be lawful or unlawful, or the drugs that the law deems to be licit or illicit, are not based on – and do not even loosely track – notions of fetal endangerment, as discussed above. The research contrasting the in utero effects of cocaine with the in utero effects of tobacco, malnutrition, and certain chemotherapies suggest as much. Furthermore, as discussed below, this narrow interpretation is deterring pregnant women who abuse illicit drugs from seeking or continuing prenatal care and/or substance abuse treatment for fear of being reported, arrested, prosecuted, convicted and imprisoned for their conduct. The adverse health consequences for women, fetuses and children of this deterrent effect are potentially devastating.

The incoherency of these "broad" and "narrow" interpretations helps explain the confusion wrought by the Whitner decision. It also serves to

make plain that, in the final analysis, the Whitner decision defies a principled or sensible application, not least because it eschews the essential teachings of medicine and public health. The final section of this brief elaborates on the harms caused by the Whitner decision to both treatment providers and their patients.

IV. The Whitner Decision Endangers Patient Health by Jeopardizing the Therapeutic Relationship Between Patients and their Treatment Providers.

In declaring a viable fetus to be a "child" within the meaning of the State Children's Code, this Court's decision in Whitner imposes upon physicians, substance abuse treatment providers, and social service professionals a heretofore unimaginable duty: to divulge to state authorities, for possible prosecution, the identities and medical information of pregnant women who engage in conduct or activities that may "adversely affect[]" the health or welfare of the fetus. S.C. Code § 20-7-510. Professionals who fail to disclose such information now themselves face criminal fines and imprisonment under state law. See S.C. Code § 20-7-560. Yet, as the preceding section illustrates, the potential scope of the Whitner ruling is immense. And as the brochure published by the Department of Alcohol and Other Drugs indicates, unless Whitner is overturned, health care and social

services providers will be saddled with duties of unknowable dimensions and sweeping breadth as they attempt to divine what actions or omissions by pregnant women might trigger their statutory reporting requirement.

A. The Whitner Decision Erodes Confidentiality Between Patients and their Health Care Providers.

A fundamental shortcoming of Whitner is its disregard for importance of the therapeutic relationship between patients and their treatment providers. The obligations of loyalty, confidentiality, and candor that characterize this relationship are ethical and fiduciary imperatives for treatment professionals. The American Medical Association's Code of Medical Ethics requires physicians to act in the best interest of individual patients, to "deal honestly with patients", and to "safeguard patient confidences". American Medical Ass'n, Current Opinions of the Council on Ethical and Judicial Affairs, E - Principles of Medical Ethics (Preamble). See also, id. at §10.01; 23 S.C. Code Ann. Regs. 81-60 (1976). Physicians are also duty-bound to protect and foster patients' free, uncoerced choices in pursuing treatment, to treat patients equally, and to advocate on the patient's behalf. Id.

Whitner eviscerates these ethical obligations. Instead, the decision encourages care providers to be dishonest in their dealings with patients and

to use promises (or assumptions) of non-disclosure as well as the trust inherent in their professional relationships to extract private and potentially inculpatory information. It short-circuits health providers' obligations to obtain suitable, individualized treatment for the patients who entrust their care to them. In fact, medical personnel have even been compelled to turn patients over to police after they had given birth with no apparent regard for the health consequences of jailing the mother of a newborn. Finally, with respect to the duty to treat patients equitably, the prosecutions brought pursuant to Whitner have largely targeted poor patients seeking care at public hospitals who have few, if any, other health care providers to turn to. In short, Whitner instructs South Carolina treatment professionals to ally themselves with the interests of law enforcement rather than with the interests of their patients and these patients' medical interests.[28]

The ethical obligations contravened by Whitner serve a critical, practical purpose in the effective delivery of health care. As the United States Supreme Court recognized in Jaffe v. Redmond, 518 U.S. 1 (1997), confidentiality and trust are not solely matters of principle: "the mere possibility of disclosure [of patients' confidences] may impede development

[28] Notably, some variation of each of these ethical breaches took place at the Medical University of South Carolina in Charleston at the urging of then Solicitor Condon. See Ferguson, 121 U.S. at 1285.

of the . . . relationship necessary for successful treatment." Id. at 10. The effective practice of medicine is impossible without these safeguards.

> To make diagnoses and treat patients effectively, the physician must obtain sensitive information about a patient. A patient must be willing to tell a physician, who is often a total stranger, about such matters as drug usage . . . and to allow the physician to examine intimate parts of his or her anatomy. The promise of confidentiality encourages patients to disclose sensitive subjects to a physician without fear that an embarrassing condition will be revealed to unauthorized people . . .

Robert Arnold et al., Medical Ethics and Doctor/Patient Communication, in The Medical Interview: Clinical Care, Education and Research 345, 365 (Mack Lipkin, Jr. et al., eds., 1995).

Patients' assumptions that their relationship with their health care providers is one of trust are fragile and cannot long survive breaches of confidentiality of the sort compelled by Whitner. Even the possibility that treatment professionals will share personal medical records and test results with police – let alone that they might perform such tests with the purpose of obtaining incriminating evidence – does lasting harm to the relationships necessary for medical care and is injurious to the broader public health. The United States Supreme Court recently discussed this danger in the Ferguson case, recognizing that an intrusion into the privacy between health care provider and patient "may deter patients from receiving needed medical

care." Ferguson, 121 S.Ct. at 1289, n 14. See also Whalen v. Roe, 429 U. S. 589, 599–600 (1977).

B. The Erosion of Patient Confidentiality Has Heightened Consequences for Pregnant Substance Abusers.

The prospect that confidentiality might be breached affects patient care in another important way. Not only are persons needing treatment deterred from seeking medical care, but those who do see physicians and nurses are less likely to provide the sort of candid disclosure that is often vital for effective medical treatment, particularly when doing so can result in filing of criminal charges.

Unsurprisingly, what is true about patients generally, applies with particular force to patients with substance abuse problems:

> It is quite clear that part of treating [a chemically dependent person] as a patient includes embracing all of the appropriate ethical constraints of health care delivery . . . . Possibly at the top of the list of ethical issues that are of very special and fundamental importance to this group of patients is the appropriate maintenance of confidentiality.

Mary Jeanne Kreek & Marc Reisinger, The Addict as a Patient, in Comprehensive Textbook at 826-27. Cf. 42 U.S.C. § 290dd-2 (prohibiting federally assisted drug-abuse treatment programs from divulging patient

identities and records); id. at § 9501(1)(H) (codifying patients' "right to confidentiality" of mental health records).

This is even more urgently the case when drug-dependent patients are pregnant. For nearly three decades researchers have tracked the special treatment needs of pregnant, drug-dependent women. Pregnant drug-dependent women suffer from depression at high rates and from low self-esteem, and many experience intense guilt and sadness about the fetal health consequences of their substance abuse. In all cases, their decision to seek prenatal care is itself a highly positive step. And because such patients are often dealing with a history of abuse, untreated post traumatic stress disorders, as well as barriers to care – including lack of child care, transportation, and safe housing – it is particularly critical that they form a strong "therapeutic alliance" with those helping them. See e.g., National Institute on Drug Abuse Capsules, Women and Drug Abuse (June 1994) (Among drug using women, 70% report having been abused sexually before the age of 16 and more than 80% had at least one parent addicted to alcohol or one or more illicit drugs); Marsha Rosenbaum, Women: Research and Policy, in Comprehensive Textbook 654, 654-665 (1997) ("Researchers have consistently found high levels of past and present abuse in the lives of

women drug users. Many have suggested that there is a relationship, if not absolutely causal, between violence experienced by women and drug use.").

Pregnant drug users, however, are particularly reticent to see physicians, and are especially reluctant to give accurate information concerning the nature and extent of their drug use. See Southern Regional Project on Infant Mortality, A Step Toward Recovery: Improving Access to Substance Abuse Treatment for Pregnant and Parenting Women 21 (1993). See also United States General Accounting Office, Report to the Chairman, Senate Comm. On Finance, HRD-90-138, at 9-10 (1990) ([S]ome drug-using women are now delivering their infants at home in order to prevent being reported to . . . authorities"); L.G. Tribble et al., Analysis of a Hospital Maternal Cocaine Testing Policy: In Association with Prenatal Care Utilization Patterns (Nat'l Perinatal Ass'n 1993) (finding that pregnant women were deterred from accessing prenatal care and obstetrical services at the Medical University of South Carolina because the hospital disclosed patients' confidential medical information to law enforcement officials).

Indeed, South Carolina's Department of Alcohol and Other Drug Abuse Services acknowledges on its state government website that "[u]nfortunately . . . there are women who do not seek treatment, primarily out of fear; fear of what others might say; fear of prosecution; fear of losing

their children; fear of losing their jobs; and fear of losing the support of their families." SC Department of Alcohol and Other Drug Abuse Services Website, http://www.daodas.state.sc.us/web/treatment.html#womenchildren at 5-6 (visited May 7, 2001).

The reluctance of pregnant substance abusers to seek medical treatment or confide fully in those providing treatment has serious adverse health consequences for the women and their fetuses – the very health interests the State wants to protect. Open communication with treatment providers regarding drug use is necessary to ensure optimum safety before, during and after deliveries. When substance abusing pregnant women feel secure in confiding in health professionals, the treatment providers can offer a number of proven interventions that substantially increase the health outcomes for children after delivery. One of the most effective weapons against infant mortality is early, high-quality, comprehensive prenatal care. See, e.g., Southern Regional Project, supra at 6. Indeed, prenatal care has been shown to markedly improve pregnancy outcomes among women with addictions: pregnant women who use cocaine, among other substances, but who have at least four prenatal care visits have been found to significantly reduce their chances of delivering low birth weight babies. Andrew Racine et al., The Association Between Prenatal Care and Birth Weight Among

Women Exposed to Cocaine in New York City, 270 JAMA 1581, 1585-86 (1993).

Even if the pregnant patient does not reduce or discontinue drug use, health risks associated with prenatal drug exposure can be mitigated substantially through prenatal care and counseling if the patient embraces the therapeutic relationship. Racine, supra, at 1585-86. Adequate parenting skills and a supportive environment also appear to help lessen the risk of serious harm. See, e.g., Loretta P. Finnegan & Stephen R. Kandall, Maternal and Neonatal Effects of Alcohol and Drugs in Comprehensive Textbook at 529. In sum, a climate of confidentiality is essential for the effective provision of treatment to substance abusing pregnant women. The Whitner decision, however, thwarts this goal.

C. Whitner Has Deterred Pregnant Women From Seeking Health Care in South Carolina.

The Whitner decision has produced real and devastating consequences for pregnant women in South Carolina, many of whom are now avoiding prenatal care and drug and alcohol treatment for fear that confiding their health problems to their physicians or counselors could lead to their arrest and imprisonment and the removal of their children from their care. After

the highly publicized prosecution of Cornelia Whitner and this Court's decision upholding her conviction and sentence on July 15, 1996, at least two substance abuse treatment programs in Columbia, South Carolina that give priority to pregnant women reported precipitous drops in admissions for pregnant women. The records of the Women's Community Residence, a halfway house for women substance abusers, show that admissions of pregnant women fell 80% (from 10% to 2% of the total number of women treated at the facility) between July 1, 1996 and June 30, 1997. See Statement of Interest of South Carolina Association of Alcoholism and Drug Abuse Counselors, Appendix to Brief as Amici Curiae in Support of Petition for Certiorari to the US Supreme Court, Whitner v. South Carolina, No. 97-1562 (filed April 8 1998) at i See Appendix F. At the Women's Intensive Outpatient program, an intensive day program which provides child care, admissions of pregnant women declined 54% (from 13% to 6% of the total number of women treated at the facility) during roughly the same period. Id.

Yet more troubling, for the first time in a decade, the state recorded a significant increase in infant mortality. This increase coincided with the Whitner decision and the publicity surrounding it. Infant Mortality on Rise in '97, Post & Courier (Charleston, S.C.), Feb. 19, 1999, at B1. During

roughly the similar period of time, the number of abandoned babies in South Carolina increased twenty percent. Associated Press, Discarded Children Increasing, The Post & Courier (Charleston, S.C.), Apr. 19, 1999.

Meanwhile, South Carolina ranks last among the states in spending on programs that address the effects of alcohol and drug abuse. See Kim Baca, South Carolina spends the least on substance abuse prevention, Associated Press State and Local Wire, Jan 29, 2001 (noting that in 2000, the state was only "able to treat about 52,000 of 310,000 South Carolinians identified as having substance abuse problems."); Associated Press State and Local Wire (Jan 29, 2001) (citing National Center on Addiction and Substance Abuse, Shoveling Up: The Impact of Substance Abuse on State Budgets). Even the Attorney General admits that "a wide array of treatment services are desperately needed in every community in the state." Charles Condon, Attorney General, Whitner Implementation Plan, reprinted as Appendix A in, Lawrence J. Nelson & Mary Faith Marshall, Ethical and Legal Analysis of Three Coercive Policies Aimed at Substance Abuse by Pregnant Women, 185a, 9 (1998).

The state's "women, and pregnant women in particular, remain underserved . . . ." Drug Strategies, South Carolina Profile (1998) at 12. For many women, successful treatment requires comprehensive residential

programs that do not force mothers to be separated from their children. See e.g., Embry M. Howell et al., A Review of Recent Findings on Substance Abuse Treatment for Pregnant Women, 16 J. Subst. Abuse Treat. 195 (1999). Studies have found that "women who have their children with them during residential treatment are less likely to drop out and are more successful after treatment than women whose children are not with them during treatment." See e.g., Drug Strategies, Keeping Score: Women and Drugs: Looking at the Federal Drug Control Budget 17 (1998). According to DAODAS, South Carolina now has six women's long-term residential treatment programs. South Carolina DAODAS Website, http://www.daodas.state.sc.us/web/treatment.html#womenchildren at 6 (visited May 7, 2001). Each of these programs, however, sharply limit the number of children the mother may keep with her to one or two, and all impose strict age limits for those children, one program capping the child's age at one year, and two other programs at five years. Id. Thus, for many if not most women, these programs will require the women to be separated from some or all of their children as a condition of receiving treatment. In addition, each program has a limited number of total beds, for women and children, ranging from 10 beds to 24. Id. Even assuming that no women brought their children to treatment (thereby preserving all beds for women),

these long-term residential treatment programs can accommodate only about 100 women. See id.[29] Yet it is estimated that as many as 49,735 women of child-bearing age may need drug or alcohol treatment each year in South Carolina. Email from Ned Self, Research Analyst, DAODAS, to Wyndi Anderson of 4/24/01. See Appendix E.

While some of these statistics can perhaps be attributed to the fear and confusion generated by the Whitner decision, others of these numbers are clearly independent of it. But all of these facts help paint an important picture of the social context into which the Whitner decision was delivered and in which it continues to operate. If allowed to remain on the books, the Whitner decision will likely erect further obstacles to the access and adequate provision of prenatal care and drug treatment for a population that already faces myriad and significant barriers to health care in South Carolina.

[29] One of the six residential women's programs may be forced to close its doors. See Ben Brazil, Rehab group on Navy base faces eviction, The Post and Courier, Jan 20, 2001 at B1 (describing how a "highly-successful, live-in drug treatment center" might be evicted from location next to environmental cleanup site on a former Navy base.); Ben Brazil, Step Ahead may have new home on old base, The Post and Courier, Feb. 19, 2001 at B1 (describing environmental ruling that the program must vacate current building, reporting that they may have new space but lack funding to make the site habitable, and how it will have to shut down if the funds are not obtained.); Ben Brazil, Gift proposal could save rehab home, The Post and Courier, March 31, 2001 at B1 (describing offer of matching grant by local philanthropist, the possibility that the City will not match the

CONCLUSION

Although substance abuse treatment may not be a field characterized by lockstep uniformity of professional judgment, medical and substance treatment professionals join together in proclaiming that the prosecution of women for exposing their fetuses in utero to cocaine or other drugs departs drastically from a basic, widely shared understanding of what is considered medically appropriate. Three decades of research confirm that punitive approaches to the problem of drug use during pregnancy are counterproductive to the health interests of women and their children. The recent publication of a meta-study in one of the leading medical journals calls into serious question the very premise of harm upon which the prosecution of Ms. Peppers -- and the decision of South Carolina v. Whitner -- are predicated.

Because the Whitner decision lacks grounding in the teachings of the medical and social sciences, the precedent it establishes, as evidenced by the inconsistent interpretations of two state agencies, is "hopelessly and irretrievably confused"; indeed, "nothing short of a fresh start can bring any sanity, and predictability, to this very important area of the law." Holtzscheiter 506 S.E. at 513 (Toal, J., concurring).

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grant, and how one of the program's relocation options conflicted with the city's long-

For the reasons state above, both the Whitner decision and Ms. Peppers' conviction should be overturned in the interests of justice, medicine and public health.

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May 8, 2001

term redevelopment plan for the area).

A. APPENDIX A

Amicus Curiae American Public Health Association ("APHA") is a national organization devoted to the promotion and protection of personal and environmental health. Founded in 1872, APHA is the largest public health organization in the world, representing over 50,000 public health professionals. It represents all disciplines and specialties in public health, including maternal and child health and substance abuse. APHA strives to improve public health for everyone by proposing solutions based on research, helping to set public health practice standards, and working closely with national and international health agencies.

Amicus Curiae South Carolina Medical Association ("SCMA") is the primary professional association for individuals licensed to practice medicine in South Carolina. SCMA has over 5,500 members representing all medical specialties that provide medical services to the citizens of the state. SCMA's primary mission is to foster high ethical and clinical standards for the practice of medicine in South Carolina. To this end, SCMA opposes policies and practices that undermine patient confidentiality and weaken the trust between health care providers and patients that promotes positive treatment outcomes.

Amicus Curiae American Nurses Association ("ANA") is a professional organization representing this nation's over 2.2 million registered nurses. ANA is committed to ensuring the availability and accessibility of health care services. It believes that access to maternal-child health services is particularly critical to efforts to prevent disease and to provide early intervention for health care problems. Thus, it opposes all barriers to prenatal care. ANA is concerned that when health care providers divulge patient information to law enforcement officials, women in need of prenatal care and/or substance abuse treatment are deterred from seeking these essential services.

Amicus Curiae South Carolina Nurses Association ("SCNA") is a professional organization representing registered nurses in South Carolina. SCNA strongly supports health care for a number of vulnerable populations, and believes patients must be secure in the knowledge that their treatment providers are wholly devoted to treatment and are not doubling as the agents of law enforcement. In 1991, SCNA issued a position statement opposing the criminal prosecution of women for drug use while pregnant. SCNA

continues to believe that the breaching of patient confidentiality and the threat of criminal prosecution deters pregnant women who suffer from chemical dependence from seeking and obtaining prenatal care.

Amicus Curiae American Academy on Physician and Patient ("AAPP") is devoted to improving public health through research and education about the doctor-patient relationship, which lies at the core of effective health care. Since its founding in 1979, AAPP has developed, evaluated, and promulgated the leading model of medical education regarding the physician-patient relationship, and has trained over 3,000 physicians. The AAPP has shown that the therapeutic relationship between physician and patient depends on the assurance of confidentiality and physicians' unfettered ability to counsel and care for their patients. The AAPP, with a membership of more than 550 physicians from 10 countries, is devoted to strengthening the physician-patient relationship, and hence the quality of patient care, by promoting collaborative relationships between doctors and patients. The strength of the therapeutic relationship, in turn, affects the patient's willingness and ability to follow through with the treatment and the patient's response to the treatment. To compromise the doctor-patient relationship is to compromise care, and thereby to damage health, increase suffering, escalate medical costs, and decrease life expectancy. The AAPP believes that the decision of South Carolina v. Whitner, by re-writing South Carolina's reporting law to include fetal abuse, strikes at the core of the physician-patient bond, undermining the trust and confidence essential to the critical relationship between health care professionals and their pregnant patients.

Amicus Curiae American Academy of Addiction Psychiatry ("AAAP") is an international professional membership organization founded in 1985 with approximately 1,000 members in the United States and around the world. The membership consists of psychiatrists who work with addiction in their practices, faculty at various academic institutions, non-psychiatrist professionals who are making a contribution to the field of addiction psychiatry, residents and medical students.

Amicus Curiae Association of Maternal and Child Health Programs ("AMCHP") is a nonprofit organization that actively promotes and advances national and state programs and policies on behalf of maternal and child health needs and programs. AMCHP provides expert technical assistance on reproductive health, adolescent and school health, teen pregnancy

prevention, HIV, tobacco control and smoking cessation, immunization, children with special health care needs, perinatal and women's health, data and assessment, and service delivery and other health related issue. AMCHP represents state public health leaders and others working to improve the health of women of reproductive age, children and youth, including those with special health care needs, and their families.

Amicus Curiae Institute for Health and Recovery ("IHR") is a non-profit organization dedicated to developing a comprehensive continuum of care for families affected by substance abuse, especially women and their children. IHR focuses on the development of prevention, intervention, treatment services and the integration of gender-specific services within substance abuse prevention and treatment. IHR serves individual women and men, and families, with a continuing emphasis on pregnant and parenting women and their children. IHR members know firsthand the fears pregnant substances abusing women have regarding prosecution, causing them to be reluctant to seek prenatal care and substance abuse treatment. With over 10 years of experience in working with pregnant women who use drugs, IHR rejects policies such as those under which Brenda Peppers was prosecuted.

Amicus Curiae Ira J. Chasnoff, M.D., is President of the Children's Research Triangle and a Professor of Clinical Pediatrics at the University of Illinois College of Medicine in Chicago. The author of four books and numerous articles, as well as the principal investigator on more than two dozen federal grants to research the effects of drug use on pregnancy, Dr. Chasnoff is one of the leading researchers in the field. His research projects include multiple studies of the long-term cognitive, developmental, behavioral and educational effects of prenatal exposure to alcohol, cocaine, and other drugs; the effects on birth outcome of prenatal treatment and counseling for pregnant drug abusers; and the effectiveness of both outpatient and residential treatment programs for pregnant drug abusers. Dr. Chasnoff is a Fellow of the American Academy of Pediatrics and the recipient of many awards. As a researcher whose work was relied upon by the South Carolina Supreme Court in its decision in South Carolina v. Whitner, Dr. Chasnoff joins as an Amicus Curiae in this case based on his conviction that the research in the field does not justify policies that seek to punish women for drug use during pregnancy.