

# Michigan Law Review

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Volume 116 | Issue 7

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2018

## Informing Consent: Medical Malpractice and the Criminalization of Pregnancy

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### Recommended Citation

Laura B. Cohen, *Informing Consent: Medical Malpractice and the Criminalization of Pregnancy*, 116 MICH. L. REV. 1297 (2018).

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## NOTE

### INFORMING CONSENT: MEDICAL MALPRACTICE AND THE CRIMINALIZATION OF PREGNANCY

Laura Beth Cohen\*

*Since the early 1990s, jurisdictions around the country have been using civil child abuse laws to penalize women for using illicit drugs during their pregnancies. Using civil child abuse laws in this way infringes on pregnant women's civil rights and deters them from seeking prenatal care. Child Protective Services agencies are key players in this system. Women often become entangled with the Child Protective Services system through their health care providers. Providers will drug test pregnant women without first alerting them to the potential negative consequences stemming from a positive drug test. Doing so is a breach of these providers' duties to obtain informed consent from their patients before administering medical tests. Malpractice liability can deter providers from forcing women into the Child Protective Services system and forestall the use of civil child protective laws to criminalize pregnancy.*

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#### INTRODUCTION

In late July of 2014, Tammy Loertscher stopped using illicit drugs when she realized she was pregnant.<sup>1</sup> She had been self-medicating with methamphetamine and marijuana since she lost her job and thus her ability

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\* J.D., May 2018, University of Michigan Law School. I would like to thank all the *Michigan Law Review* editors who worked on this piece, particularly Mel Cassel, Sally Gu, Sam Jaffe, Paul Hoversten, and Charlie Stewart. I would also like to thank Lynn M. Paltrow, Nancy Rosenbloom, and everyone at National Advocates for Pregnant Women, both for the civil rights work they do on behalf of pregnant and parenting people and for their help on this Note. Lastly, I'd like to thank all of Volume 116, especially the Editorial Board, for giving me such an amazing year.

1. Amended Complaint at 4, *Loertscher v. Schimel*, No. 14-cv-870-jdp, 2015 WL 5749827 (W.D. Wis. Apr. 11, 2017), *appeal docketed*, No. 17-1936 (7th Cir. May 4, 2017).

to pay for her much-needed thyroid medication.<sup>2</sup> On August 1, she went to the Taylor County Department of Human Services (DHS) for help finding and paying for prenatal care and thyroid treatment.<sup>3</sup> DHS sent her to a nearby medical clinic.<sup>4</sup> She told the clinic staff that she had used drugs, had a thyroid condition, and suspected she might be pregnant.<sup>5</sup> The staff asked her for a urine sample, which she provided.<sup>6</sup> She tested positive for methamphetamine, amphetamine, and THC.<sup>7</sup> The clinic also determined that Ms. Loertscher had severe hypothyroidism, depression, and fatigue.<sup>8</sup> She agreed to enter the Behavioral Health Unit (BHU) for treatment.<sup>9</sup>

After she was admitted, clinic personnel shared Ms. Loertscher's medical records with DHS, a branch of the Wisconsin Department of Children and Families.<sup>10</sup> While Ms. Loertscher was in the BHU, her social workers repeatedly threatened her with civil confinement if she did not waive confidentiality regarding her medical records.<sup>11</sup> They also told her that failure to acquiesce to DHS's demands would result in her baby being taken away from her upon birth and put up for adoption.<sup>12</sup> In the meantime, Taylor County appointed an attorney to be the guardian ad litem for Ms. Loertscher's fetus.<sup>13</sup>

On August 4, Ms. Loertscher attempted to leave the BHU but was not permitted to do so because Taylor County had issued a custody order requiring her to stay.<sup>14</sup> At the time, Wisconsin had a law that allowed fetuses (and thus women) to be taken into custody by the state if there was evidence of prenatal drug use.<sup>15</sup> On August 5, Taylor County convened a phone hearing to determine whether it would detain Ms. Loertscher.<sup>16</sup> The hearing included counsel for Taylor County and the fetus's guardian ad litem, but it

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2. *Loertscher v. Anderson*, 259 F. Supp. 3d 902, 908 (2017).

3. *Id.* at 909.

4. *Id.* at 908–09.

5. Amended Complaint, *supra* note 1, at 4–5.

6. *Anderson*, 259 F. Supp. 3d at 909.

7. *Id.*

8. Amended Complaint, *supra* note 1, at 6.

9. *Anderson*, 259 F. Supp. 3d at 909.

10. *Id.*; Amended Complaint, *supra* note 1, at 6.

11. Amended Complaint, *supra* note 1, at 7.

12. *Id.*

13. *Id.* at 6–7.

14. *Anderson*, 259 F. Supp. 3d at 909–10; Amended Complaint, *supra* note 1, at 7.

15. *Anderson*, 259 F. Supp. 3d at 907. The statute stated that Wisconsin could take custody of an unborn child whose “mother habitually lacks self-control in the use of alcohol beverages, controlled substances or controlled substance analogs, exhibited to a severe degree, to the extent that there is a substantial risk that the physical health of the unborn child . . . will be seriously affected or endangered.” WIS. STAT. § 48.133 (1997). The Loertscher case is indicative of the fact that fetuses and women were taken into custody without any showing of severe substance abuse or risk to the health of the fetus.

16. *Anderson*, 259 F. Supp. 3d at 910.

did not include legal counsel of any kind for Ms. Loertscher.<sup>17</sup> During the call, Dr. Jennifer Bantz, an obstetrician who had briefly met Ms. Loertscher, provided Ms. Loertscher's confidential medical information to the judge.<sup>18</sup> At the end of the hearing, the county commissioner entered a custody order against Ms. Loertscher which required her to remain in a treatment facility for the duration of her pregnancy.<sup>19</sup> No evidence was presented regarding harm to the fetus.

Defying of the custody order, Ms. Loertscher checked herself out of the clinic on August 7.<sup>20</sup> Four days later, her fetus's guardian ad litem filed a motion for the Taylor County Court to hold Ms. Loertscher in civil contempt.<sup>21</sup> At the contempt hearing, Ms. Loertscher was again not provided with legal counsel, and the fetus's guardian ad litem "admit[ed] all of the allegations against Loertscher" on behalf of the fetus.<sup>22</sup> As a result, the court held Ms. Loertscher in contempt and ordered her to check into an inpatient treatment program or spend thirty days in jail.<sup>23</sup>

Ms. Loertscher ended up spending eighteen days in jail.<sup>24</sup> During the first few days of her incarceration she was denied her much-needed thyroid medication.<sup>25</sup> Then, when she experienced "cramping, pain, and vaginal discharge," her requests to see an obstetrician were denied.<sup>26</sup> The jail physician told Ms. Loertscher that there was "nothing" they could do about a miscarriage without first confirming the pregnancy, even though Ms. Loertscher's pregnancy was the reason she was in jail in the first place.<sup>27</sup> When Ms. Loertscher refused to take a pregnancy test, she was placed in solitary confinement.<sup>28</sup>

The solitary confinement cell was a room without windows containing only a toilet and a metal bed frame. The room was cold and filthy. The floor, walls, and toilet area had hair and feces on them, and there were fingernails visible beneath the mattress frame. There was no mattress on the bed. Ms. Loertscher was given only a roll of toilet paper. A guard provided a thin mattress and blanket in the evening and another guard took these away first thing in the morning. Ms. Loertscher remained in this cell for approximately 36 hours.<sup>29</sup>

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17. *Id.*

18. *Id.* at 911.

19. Amended Complaint, *supra* note 1, at 10.

20. *Anderson*, 259 F. Supp. 3d at 911.

21. *Id.*

22. *Id.*

23. *Id.*

24. *Id.* at 912.

25. Amended Complaint, *supra* note 1, at 15.

26. Amended Complaint, *supra* note 1, at 15; *accord Anderson*, 259 F. Supp. 3d at 912.

27. Amended Complaint, *supra* note 1, at 16.

28. *Id.*

29. *Id.*

Ms. Loertscher was denied prenatal care for the duration of her incarceration.<sup>30</sup> DHS determined that Ms. Loertscher had committed civil “child mistreatment” three months *before* she “delivered a healthy baby boy.”<sup>31</sup>

A Wisconsin district court recently held the law used to confine Ms. Loertscher unconstitutional,<sup>32</sup> but there are women all over the country with experiences like Ms. Loertscher’s. These women face grave consequences stemming from prenatal drug tests administered by their medical providers. Like Ms. Loertscher’s obstetrician, these doctors and nurses do not alert their patients to the adverse consequences that can stem from prenatal drug testing, including civil confinement and losing custody of their children.

Medical providers owe a duty to their patients. Before administering a test or performing a procedure, they must obtain their patients’ informed consent.<sup>33</sup> This means that providers must give enough information so that their patients can make informed decisions about whether or not to undergo a procedure.<sup>34</sup> If providers take action without first obtaining informed consent, they have committed malpractice and are consequently liable to their patients.<sup>35</sup> When providers perform prenatal drug tests without warning their patients of the potential adverse consequences, they have failed to obtain their patients’ informed consent to the tests and should be liable. Litigants can use malpractice liability to stop providers from drug testing pregnant women without their consent and thus forestall the use of child protective laws in criminalizing pregnancy.<sup>36</sup>

This Note examines how litigants can strategically utilize malpractice liability. Part I describes the political and legal circumstances surrounding drug use during pregnancy in the United States. Part II explains the doctrine of informed consent, including its normative underpinnings and jurisdictional differences. Part III suggests a way in which litigants can use medical malpractice litigation to stop medical professionals from drug testing pregnant women without their informed consent.

## I. EXAMINING THE LEGAL AND POLITICAL PROCESSES HOLDING WOMEN LIABLE FOR PRENATAL DRUG USE

In the 1980s and 90s, a massive media frenzy endorsed the view that crack use during pregnancy would create an inferior generation that would

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30. *Id.* at 17.

31. *Anderson*, 259 F. Supp. 3d at 913.

32. *Id.* at 915–22.

33. *See infra* notes 94–98 and accompanying text.

34. *Id.*

35. *See infra* note 99 and accompanying text.

36. “Criminalizing” here is used as an umbrella term to refer generally to laws that aim to police what women do during pregnancy using either civil or criminal sanctions. As will be described *infra*, the sanctions can look similar in both the civil and criminal contexts. *See also Criminalizing Pregnancy: Policing Pregnant Women Who Use Drugs in the USA*, AMNESTY INT’L (May 23, 2017), <https://www.amnestyusa.org/reports/criminalizing-pregnancy-policing-pregnant-women-use-drugs-usa/> [<https://perma.cc/Y65X-VWTZ>].

burden social services, especially the education system.<sup>37</sup> For example, in 1989, Charles Krauthammer wrote in the *Pittsburgh Post-Gazette* that “[t]he inner-city crack epidemic is now giving birth to the newest horror: a bio-underclass, a generation of physically damaged cocaine babies whose biological inferiority is stamped at birth.”<sup>38</sup>

Recently, however, the studies that caused the “crack baby” panic have been largely debunked; the effects they falsely attributed to cocaine are now understood to stem from poverty.<sup>39</sup> While alcohol and cigarettes have been shown to have long-term adverse effects if used during pregnancy,<sup>40</sup> the same has not been shown to be true of other recreational substances, including illicit drugs.<sup>41</sup> At this point, crack, meth, opiates, and other illicit or illicitly used drugs have not been shown to have significant, long-term adverse effects on users’ children.<sup>42</sup> Depending on the substance ingested, an infant may experience withdrawal symptoms upon birth.<sup>43</sup> For example, if baby was exposed to opiates in utero, he or she may experience Neonatal

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37. AM. CONG. OF OBSTETRICIANS & GYNECOLOGISTS, TOOLKIT ON STATE LEGISLATION: PREGNANT WOMEN & PRESCRIPTION DRUG ABUSE, DEPENDENCE AND ADDICTION 2 [hereinafter ACOG TOOLKIT], <https://www.acog.org/-/media/Departments/Government-Relations-and-Outreach/NASToolkit.pdf?la=EN> [<https://perma.cc/9KNH-E7FL>] (“Media reporting in the 1980s and early 1990s invented, promoted and perpetuated the [nonscientific] and highly stigmatizing term, ‘crack baby.’”); see, e.g., Charles Krauthammer, *Children of Cocaine*, *PITT. POST-GAZETTE*, Aug. 2, 1989, at 7, <https://news.google.com/newspapers?nid=1129&dat=19890802&id=zrFRAAAAIBA&sjid=W24DAAAIBA&pg=6587,202482&hl=en> (on file with the *Michigan Law Review*).

38. Krauthammer, *supra* note 37.

39. ACOG TOOLKIT, *supra* note 37, at 2 (“Today, overwhelming scientific consensus based on over 20 years of child development research has *not* identified a recognizable long-term condition, syndrome or disorder that should be termed ‘crack baby.’ It is now understood that poverty, poor nutrition and inadequate health care can account for many of the effects popularly, but falsely attributed to cocaine.”).

40. See generally Joseph F. Hagan, Jr., et al., *Neurobehavioral Disorder Associated with Prenatal Alcohol Exposure*, *PEDIATRICS*, Oct. 2016, at 1, <http://pediatrics.aappublications.org/content/early/2016/09/23/peds.2015-1553.full-text.pdf> [<https://perma.cc/VR37-LVWJ>]; *Tobacco Use and Pregnancy*, CENTERS FOR DISEASE CONTROL AND PREVENTION, <https://www.cdc.gov/reproductivehealth/maternalinfanthealth/tobaccousepregnancy/index.htm> [<https://perma.cc/7BKQ-NYMP>].

41. Libby Copeland, *Oxytots*, *SLATE* (Dec. 7, 2014, 7:52 PM), [http://www.slate.com/articledouble\\_x/doublex/2014/12/oxytots\\_and\\_meth\\_babies\\_are\\_the\\_new\\_crack\\_babies\\_bad\\_science\\_and\\_the\\_rush.html](http://www.slate.com/articledouble_x/doublex/2014/12/oxytots_and_meth_babies_are_the_new_crack_babies_bad_science_and_the_rush.html) [<https://perma.cc/S5HK-Z6BG>].

42. “There *are* drugs known to cause birth defects in developing babies, but they’re legal, not necessarily what you’d expect, and definitely not what women are arrested for using. The acne treatment Retin A, for instance, and antiepileptic drugs.” *Id.* (“Hendree Jones, a professor at the University of North Carolina School of Medicine and expert in [neonatal abstinence syndrome], says that from what she and other researchers have seen so far, once they’re treated, the so-called oxytots appear to be like other babies. She points to a recent meta-analysis showing that prenatal exposure to opioids ‘does not have deleterious effects on the children, at least up to age 5.’”). Many of the adverse effects found in previous studies can be explained by poverty. See ACOG TOOLKIT, *supra* note 37, at 2.

43. CHILDREN’S BUREAU, U.S. DEP’T OF HEALTH & HUMAN SERVS., PARENTAL DRUG USE AS CHILD ABUSE 2 (2015), <https://www.childwelfare.gov/pubPDFs/drugexposed.pdf> [<https://perma.cc/SR4M-G3HS>].

Abstinence Syndrome (NAS).<sup>44</sup> But, if treated properly, even NAS has not been shown to pose long-term health risks.<sup>45</sup> Scientists have reached similar conclusions regarding cocaine,<sup>46</sup> crack,<sup>47</sup> methamphetamine,<sup>48</sup> and marijuana.<sup>49</sup>

In the midst of this “crack baby” frenzy, a number of states looked for ways to penalize drug use during pregnancy.<sup>50</sup> Two routes presented themselves: the criminal justice system and the civil child protective system.<sup>51</sup> Prosecutors in a variety of jurisdictions have attempted to use existing criminal statutes to try to punish prenatal drug use.<sup>52</sup> These efforts have been generally unsuccessful,<sup>53</sup> but the South Carolina and Alabama supreme courts have nonetheless endorsed these tactics.<sup>54</sup> Additionally, some states have passed affirmative statutes that either add fetuses to the list of potential victims for existing crimes or explicitly criminalize drug use during pregnancy.<sup>55</sup>

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44. ACOG TOOLKIT, *supra* note 37, at 2–3.

45. *Id.* at 2 (“Unlike neonatal exposure to maternal alcohol and tobacco use, there have been no reported long term effects of maternal opioid use on the developing child. Longitudinal studies over 5 to 10 years have shown that children who experienced NAS as infants do not exhibit signs of physical or cognitive impairment as they mature.”).

46. Maia Szalavitz, *How Drug Laws Aimed at Pregnant Women Penalize Their Children*, VERGE (Mar. 25, 2016, 12:15 PM), <http://www.theverge.com/2016/3/25/11301898/prenatal-drug-testing-custody-laws-child-welfare> [<https://perma.cc/P899-3GJC>] (“Though using illicit drugs while pregnant is obviously potentially dangerous and best avoided, the most common recreational drugs that have been studied—like marijuana and cocaine—are not typically linked with irreparable damage.”).

47. *See supra* note 39.

48. Copeland, *supra* note 41.

49. *See Szalavitz, supra* note 46.

50. Erik Eckholm, *Case Explores Rights of Fetus Versus Mother*, N.Y. TIMES (Oct. 23, 2013), <http://www.nytimes.com/2013/10/24/us/case-explores-rights-of-fetus-versus-mother.html> (on file with the *Michigan Law Review*) (“Courts in more than 20 states have blocked the use of criminal child-abuse or related laws against pregnant women.”). It is important to note the misogynist underpinnings of such state actions. They have been said to be based on the idea that it is “morally egregious” for a woman to pursue any kind of pleasure at even a slight risk to her fetus. Copeland, *supra* note 41.

51. Kenneth A. DeVille & Loretta M. Kopelman, *Moral and Social Issues Regarding Pregnant Women Who Use and Abuse Drugs*, 25 OBSTETRICS & GYNECOLOGY CLINICS OF N. AM. 237, 239–41 (1998).

52. *See GUTTMACHER INST., Substance Use During Pregnancy*, <https://www.guttmacher.org/state-policy/explore/substance-abuse-during-pregnancy> [<https://perma.cc/RG89-WCTC>] [hereinafter GUTTMACHER STATE OVERVIEW].

53. *See generally* Krista Stone-Manista, *Protecting Pregnant Women: A Guide to Successfully Challenging Criminal Child Abuse Prosecutions of Pregnant Drug Addicts*, 99 J. CRIM. L. & CRIMINOLOGY 823 (2009); Cara Angelotta & Paul S. Appelbaum, *Criminal Charges for Child Harm from Substance Use in Pregnancy*, 45 J. AM. ACAD. PSYCHIATRY & L. ONLINE 193 (2017).

54. GUTTMACHER STATE OVERVIEW, *supra* note 52.

55. *See* Melissa Jeltsen, *Tennessee to Decide if It Will Keep Criminalizing Pregnant Women for Drug Use*, HUFFINGTON POST (Mar. 8, 2016, 12:39 PM), [https://www.huffingtonpost.com/entry/tennessee-criminalize-pregnant-women-drug-use\\_us\\_56dee8f9e4b0000de405c7f3](https://www.huffingtonpost.com/entry/tennessee-criminalize-pregnant-women-drug-use_us_56dee8f9e4b0000de405c7f3) [<https://perma.cc/8F9E-4B00>].

States also use their civil child protective services (CPS)<sup>56</sup> in a way that punishes women who use drugs during pregnancy.<sup>57</sup> CPS agencies vary state by state, but three features of the systems remain largely constant. First, they label women as child abusers, neglectors, or endangerers solely because of drug use during pregnancy, even without any finding of actual harm to any children or fetuses or any finding of intent.<sup>58</sup> Second, when a woman is labeled an abuser, she can lose custody of the children she already has or of the baby once it is born.<sup>59</sup> Finally, in order to regain custody, a woman must navigate a complex and costly civil court system, often without the benefit of legal counsel, unless she can pay for it herself.<sup>60</sup>

Despite ostensibly being intended to help children and families, these policies adversely affect both pregnant women and their children.<sup>61</sup> Women are, at times, forced to stop drug use and go through withdrawal without medical aid. This can be dangerous to both the mother and the fetus.<sup>62</sup> CPS agencies have been hostile to addiction treatment protocols, like the use of methadone or suboxone, despite the medical community's wide acceptance

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[//perma.cc/KC2Y-LLXZ](https://perma.cc/KC2Y-LLXZ); Leticia Miranda et al., *How States Handle Drug Use During Pregnancy*, PROPUBLICA (Sept. 30, 2015), <https://projects.propublica.org/graphics/maternity-drug-policies-by-state> [<https://perma.cc/P58R-ERR3>]; see also TENN. CODE ANN. §§ 39–13–101 to –102 (2016).

56. States vary in the nomenclature of their respective civil child protective agencies. For the purposes of clarity and succinctness, I use “CPS” as a catchall.

57. See GUTTMACHER STATE OVERVIEW, *supra* note 52.

58. *Id.*; Copeland, *supra* note 41 (describing an Ohio case where a woman was taken “to court [by CPS] for civil child abuse and neglect”). Even if a finding of harm were required, holding women liable (civilly or criminally) for their pregnancy outcomes is highly problematic. First, doing so would severely restrict pregnant women’s autonomy. Medical recommendations for what pregnant women should or should not do are often confusing or contradictory. If women can be held liable for harming their fetuses with illicit drugs, then why not hold them liable because they had a glass of wine or ate a piece of sushi or exercised too much or too little? See Emily Oster, *Take Back Your Pregnancy*, WALL ST. J.: SATURDAY ESSAY (Aug. 9, 2013, 6:31 PM) <https://www.wsj.com/articles/take-back-your-pregnancy-1376087501> (on file with the *Michigan Law Review*). Second, despite best efforts, things go wrong during pregnancy. Turning miscarriages into criminal investigations is cruel and can discourage women from seeking care during medical emergencies. See Lynn M. Paltrow & Jeanne Flavin, Opinion, *Pregnant, and No Civil Rights*, N.Y. TIMES (Nov. 7, 2014), <https://www.nytimes.com/2014/11/08/opinion/pregnant-and-no-civil-rights.html> (on file with the *Michigan Law Review*).

59. GUTTMACHER STATE OVERVIEW, *supra* note 52 (“[S]everal states have expanded their civil child-welfare requirements to include prenatal substance use, so that prenatal drug exposure can provide grounds for terminating parental rights because of child abuse or neglect.”).

60. *Id.* (stating that “some states, under the rubric of protecting the fetus, authorize civil commitment (such as forced admission to an inpatient treatment program) of pregnant women who use drugs”); Copeland, *supra* note 41 (describing the Alicia Beltran case in which Ms. Beltran was denied a lawyer despite the fact that her fetus was appointed a legal guardian). There has been a push to expand the right to counsel to civil cases, but it has not yet reached all states or all contexts. See NAT’L COALITION FOR CIV. RIGHT TO COUNS., <http://civilrighttocounsel.org/about> [<https://perma.cc/K9JA-MEBY>].

61. See Szalavitz, *supra* note 46.

62. *Id.*



of prenatal use of these medications.<sup>63</sup> Furthermore, involvement with CPS can create significant risks for children. Not only can they face separation from a birth parent, but children are also exposed to a heightened risk of abuse when they are placed in the foster system.<sup>64</sup>

These injustices are compounded by the fact that these women are not afforded the Fourth Amendment protections that the Constitution gives to criminal defendants. Women are subject to urine or blood tests which would be barred in a criminal context.<sup>65</sup> The United States Supreme Court held in *Ferguson v. City of Charleston* that it is unconstitutional for a hospital to collude with law enforcement in order to utilize positive prenatal drug test results to coerce women into treatment programs.<sup>66</sup> In that case, a public hospital in Charleston, South Carolina, conspired with law enforcement to arrest and prosecute women who were using cocaine during pregnancy.<sup>67</sup> The hospital staff tested patients for cocaine if the women met one of nine criteria established by the hospital.<sup>68</sup> If they tested positive, the hospital would relay the results to law enforcement.<sup>69</sup> The women could avoid arrest only through agreeing to drug treatment, regardless of whether they actually displayed an addiction problem or whether the fetus had been harmed.<sup>70</sup> The Court held that obtaining these test results in order to provide them to law enforcement without the informed consent of the mother violated the Fourth Amendment.<sup>71</sup> The Court noted that patients “undergoing diagnostic tests in a hospital [expect] that the results of those tests will not be shared with nonmedical personnel without [their] consent.”<sup>72</sup>

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63. *Id.* (“Many social workers see maintenance therapy as the equivalent of taking street drugs—despite the overwhelming medical consensus and the fact that once patients are stabilized, they are not emotionally or cognitively impaired and can successfully parent, drive, and even work high-level jobs. Worse, because family court judges are also often ill-informed about maintenance therapy, women are increasingly losing custody of their children for taking their medication exactly as prescribed.”).

64. *See id.*

65. AM. CONG. OF OBSTETRICIANS & GYNECOLOGISTS, COMM. ON HEALTH CARE FOR UNDERSERVED WOMEN, SUBSTANCE ABUSE REPORTING AND PREGNANCY: THE ROLE OF THE OBSTETRICIAN-GYNECOLOGIST (2011) [hereinafter ACOG COMMITTEE OPINION No. 473], [http://www.acog.org/Resources\\_And\\_Publications/Committee\\_Opinions/Committee\\_on\\_Health\\_Care\\_for\\_Underserved\\_Women/Substance\\_Abuse\\_Reporting\\_and\\_Pregnancy\\_The\\_Role\\_of\\_the\\_Obstetrician\\_Gynecologist](http://www.acog.org/Resources_And_Publications/Committee_Opinions/Committee_on_Health_Care_for_Underserved_Women/Substance_Abuse_Reporting_and_Pregnancy_The_Role_of_the_Obstetrician_Gynecologist) [<https://perma.cc/9YW5-G8KL>]; DAVID EVANS, DRUG TESTING LAW, TECHNOLOGY & PRACTICE § 2:11.

66. 532 U.S. 67, 70–72, 87 (2001).

67. *Id.* at 70–72.

68. The criteria were: lack of prenatal care; late prenatal care; incomplete prenatal care; abruptio placentae; intrauterine fetal death; preterm labor of no obvious cause; intrauterine growth retardation of no obvious cause; previously known drug or alcohol abuse; and unexplained congenital anomalies. *Id.* at 71 n.4.

69. *Id.* at 72.

70. *See id.* at 72–73.

71. *Id.* at 83–84.

72. *Id.* at 78.

CPS actions, however, are *civil*, not *criminal*, so the protections offered in *Ferguson* do not apply,<sup>73</sup> in spite of the fact that there are many practical similarities between women like Tammy Loertscher and the plaintiffs in *Ferguson*. They, similarly, were accused of using drugs while pregnant, and they also faced harsh consequences, including imprisonment. The difference was that Ms. Loertscher was not protected by the Fourth Amendment.

So protection for women like Ms. Loertscher must be found elsewhere because criminalizing pregnancy has perverse results.<sup>74</sup> First, it encourages women to terminate wanted pregnancies.<sup>75</sup> Since the “victim” of the drug use is the fetus, terminating the pregnancy moots the mother’s civil or criminal liability.<sup>76</sup> Even if a woman has a planned pregnancy, the expense and stigma of embroilment with CPS can make an abortion a potentially preferable option.<sup>77</sup> Second, criminalizing drug use during pregnancy can deter women from seeking prenatal care.<sup>78</sup> Women who use drugs during pregnancy, perhaps even more than those who do not, need prenatal care to ensure the well-being of both themselves and their fetuses.<sup>79</sup> These women may forego care, however, if they fear that they will be drug tested by their physicians and that the results will be given to CPS.<sup>80</sup> Third, punishing women fosters mistrust between pregnant women and their physicians.<sup>81</sup> The American College of Obstetricians and Gynecologists (ACOG) explains,

Legally mandated testing and reporting puts the therapeutic relationship between the obstetrician-gynecologist and the patient at risk, potentially placing the physician in an adversarial relationship with the patient. In one study, women who abused drugs did not trust health care providers to protect them from the social and legal consequences of identification and avoided or emotionally disengaged from prenatal care.<sup>82</sup>

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73. See *supra* notes 56–60 and accompanying text.

74. ACOG COMMITTEE OPINION No. 473, *supra* note 65 (“Substance abuse reporting during pregnancy may dissuade women from seeking prenatal care and may unjustly single out the most vulnerable, particularly women with low incomes and women of color.”).

75. ACOG TOOLKIT, *supra* note 37, at 4 (“Punitive laws may have the unintended effect of encouraging women to end wanted pregnancies. Women who do not think they can overcome a drug problem may seek to terminate a pregnancy to avoid arrest.”).

76. See Amended Complaint, *supra* note 1, at 15.

77. See *id.* at 20.

78. ACOG TOOLKIT, *supra* note 37, at 3 (“Criminal penalties are more likely to deter women from seeking beneficial health care than they are to protect children, reduce the use of harmful substances, or further the States’ policy of combating prescription drug abuse and diversion.”).

79. See ACOG COMMITTEE OPINION No. 473, *supra* note 65 (“Studies indicate that prenatal care greatly reduces the negative effects of substance abuse during pregnancy, including decreased risks of low birth weight and prematurity. Drug enforcement policies that deter women from seeking prenatal care are contrary to the welfare of the mother and fetus.”) (footnote omitted).

80. ACOG TOOLKIT, *supra* note 37, at 3.

81. ACOG COMMITTEE OPINION No. 473, *supra* note 65.

82. *Id.* (footnotes omitted).

Despite ACOG's stance, one way that women get swept into the CPS system is through their medical providers.<sup>83</sup> Individual practices and hospitals have a wide variety of prenatal drug-testing protocols.<sup>84</sup> Some have policies that look for certain risk factors and then only test women who fit these criteria.<sup>85</sup> Others leave testing completely to the discretion of individual providers.<sup>86</sup> Generally, low-income women and women of color are tested and subsequently penalized more often than white or wealthy women,<sup>87</sup> despite the fact that drug usage rates do not vary significantly along racial or socioeconomic lines.<sup>88</sup>

Before submitting to a drug test, pregnant women are not told that there can be serious consequences flowing from testing positive for certain drugs.<sup>89</sup> Administering medical procedures without first obtaining informed consent is medical malpractice.<sup>90</sup> Part II examines the doctrine of informed consent as part of medical malpractice.

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83. GUTTMACHER STATE OVERVIEW, *supra* note 52 (“A number of states require health care professionals to report or test for prenatal drug exposure, which can be used as evidence in child-welfare proceedings. And in order to receive federal child abuse prevention funds, states must require health care providers to notify child protective services when the provider cares for an infant affected by illegal substance use.”).

84. See, e.g., Amy Yurkanin, *Alabama Hospitals Have Less-than-Clear Intentions with Drug Tests Leading to Arrests of Pregnant Moms*, AL.COM (Sept. 30, 2015, 10:00 AM), [http://www.al.com/news/index.ssf/2015/09/covert\\_drug\\_tests\\_child\\_abuse.html](http://www.al.com/news/index.ssf/2015/09/covert_drug_tests_child_abuse.html) [https://perma.cc/UZL9-54EN]; CRICO, CLINICAL GUIDELINES FOR OBSTETRICAL SERVICES AT CRICO-INSURED INSTITUTIONS (2017 ed. 1988), <https://www.rm.harvard.edu/-/media/Files/-Global/KC/PDFs/Guidelines/crico-ob-guidelines-2017.pdf> [https://perma.cc/V272-TJF2]; *Consent for Maternity Services*, WOMEN'S HEALTH PARTNERS, LLC [http://myobgynoffice.com/your-visit/2015.04.22\\_WHP\\_Consent\\_for\\_Maternity\\_Services\\_Form\\_Security.pdf](http://myobgynoffice.com/your-visit/2015.04.22_WHP_Consent_for_Maternity_Services_Form_Security.pdf) [https://perma.cc/H2TR-STE9].

85. For example, in *Ferguson* the criteria included whether and how often the woman had received prenatal care, whether she had “abuse[d]” drugs or alcohol in the past, and whether there were unexplained adverse birth events. *Ferguson v. City of Charleston*, 532 U.S. 67, 71–72 (2001).

86. Private practices and birthing centers have discretion regarding who they test so long as they conform to federal law. See *infra* notes 143–144 and accompanying text.

87. See generally Lynn M. Paltrow & Jeanne Flavin, *Arrests of and Forced Interventions on Pregnant Women in the United States, 1973–2005: Implications for Women's Legal Status and Public Health*, 38 J. HEALTH POL., POL'Y & L. 299 (2013).

88. ACOG COMMITTEE OPINION No. 473, *supra* note 65.

89. See, e.g., *supra* note 84 and accompanying text; *Consent to Obstetrical Delivery*, VALLEY HOSP. (2006), <http://www.valleyhealth.com/pdf/Consent%20for%20OB%20Deliveries-Rev.%202-06.pdf> [https://perma.cc/BCV9-ZNLQ]; *Information About Maternidad La Luz*, MATERNIDAD LA LUZ, [http://www.maternidadlaluz.com/files/html/Informed\\_Consent\\_Eng.pdf](http://www.maternidadlaluz.com/files/html/Informed_Consent_Eng.pdf) [https://perma.cc/7RGC-9Q2S].

90. *Infra* Part II. There are narrow exceptions to this doctrine. See e.g., *infra* note 133 and accompanying text.

## II. THE DOCTRINE OF INFORMED CONSENT

Since the middle of the last century, the doctrine of informed consent has played a key role in the arena of medical malpractice liability.<sup>91</sup> Before the doctrine of informed consent, the medical profession operated under a paternalistic framework.<sup>92</sup> The prevailing assumption was that whichever course of treatment the doctor considered prudent would be the one that was undertaken, with little or no input from patients.<sup>93</sup> The doctrine of informed consent combats this and requires doctors to inform their patients so that those patients can make knowledgeable decisions regarding care.<sup>94</sup> This involves presenting patients with all of the different treatment options<sup>95</sup> (including refusal of care),<sup>96</sup> their risks,<sup>97</sup> and their benefits<sup>98</sup> Failing to obtain informed consent can subject physicians to liability for battery and/or for medical malpractice, depending on the jurisdiction.<sup>99</sup>

There are two different standards for evaluating whether doctors have sufficiently informed their patients: the *reasonable physician* or *community* standard and the *reasonable patient* or *materiality* standard.<sup>100</sup> American jurisdictions are approximately evenly split between these two standards.<sup>101</sup>

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91. Parris v. Limes, 277 P.3d 1259, 1263 (Okla. 2012) (“This requirement [that a physician obtain informed consent for medical treatment] is as essential as a physician’s care and skill in the performance of therapy.”); Arnold J. Rosoff, Book Review, 22 J. LEG. MED. 307 (2001) (reviewing FAY A. ROZOVSKY, CONSENT TO TREATMENT: A PRACTICAL GUIDE, THIRD EDITION (2000)).

92. Peter M. Murray, *The History of Informed Consent*, 10 IOWA ORTHOPAEDIC J. 104, 109 (1990), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2328798/pdf/iowaorthj00024-0107.pdf> [<https://perma.cc/3TCL-9YEN>].

93. Monya De, *Towards Defining Paternalism in Medicine*, AMA J. ETHICS, Feb. 2004, <http://journalofethics.ama-assn.org/2004/02/toc-0402.html> [<https://perma.cc/W3ZW-J33G>]. See also, Brian McKinstry, *Paternalism and the Doctor-Patient Relationship in General Practice*, 42 BRITISH J. GEN. PRAC. 340 (1992) (explaining the concept of paternalism as it occurs in general medical practice).

94. Rosoff, *supra* note 91, at 310 (“The physician’s task—or so the law conceived it—was to write upon a ‘blank slate’ and assure that the information the patient had was sufficient to support the patient’s decision on treatment.”).

95. See, e.g., N.Y. PUB. HEALTH LAW § 2805-d (1), (3) (McKinney 2017); Foote v. Rajadhyax, 702 N.Y.S.2d 153, 154 (N.Y. App. Div. 2000).

96. Rosoff, *supra* note 91, at 311 (describing the “right to refuse care” as the “‘flip-side’ of consent”).

97. Fournet v. Roule-Graham, 783 So. 2d 439, 444–45.

98. See Rosoff, *supra* note 91, at 308 n.3 (“To get an effective consent for treatment, the physician must disclose to the patient information about (1) the diagnosis, (2) the nature and purpose of the proposed treatment, (3) the risks and consequences of that treatment, (4) reasonably feasible alternatives to the proposed treatment, and (5) the prognosis, if the recommended treatment is not rendered.”).

99. See, e.g., Pizzalotto v. Wilson, 444 So. 2d 143 (La. Ct. App. 1983); McMichael v. Howell, 919 So. 2d 18 (Miss. 2005); Largey v. Rothman, 540 A.2d 504, 505 (N.J. 1988); Belcher v. Carter, 234 N.E.2d 311 (Ohio Ct. App. 1967); Tortorelli v. Mercy Health Ctr., Inc., 242 P.3d 549 (Okla. Civ. App. 2010)

100. Rosoff, *supra* note 91, at 308–09.

101. *Id.*

The reasonable physician standard hinges on medical customs and standard practices.<sup>102</sup> The reasonable patient standard hinges on what a *patient* would find to be material to the decision he or she must make.<sup>103</sup> The amount of information necessary to satisfy the doctrine under either standard fluctuates by jurisdiction, but it has generally been becoming more rigorous as medical technology becomes increasingly complex and patients become increasingly savvy.<sup>104</sup>

The strength of the reasonable patient standard varies by jurisdiction. Sometimes mere constructive knowledge that a patient “might have considered the information to be important” can create liability.<sup>105</sup> Other jurisdictions ask what information would be needed for a patient to make an intelligent decision.<sup>106</sup> And others ask that the patient be informed of “material” facts regarding the procedure.<sup>107</sup> Generally, the reasonable patient standard requires that patients have enough information to allow for “a meaningful exercise of the patient’s self-determinative right.”<sup>108</sup> Underlying this standard is the desire to allow patients “to determine [ ] the direction in which his [or her] interests seem to lie.”<sup>109</sup>

Likewise, the reasonable physician standard varies among jurisdictions. In some places, physicians are held to the standard of a “skilled practitioner of good standing.”<sup>110</sup> Alternatively, some merely require compliance with community or local standards.<sup>111</sup> Depending on the practices of the immediate community, a mere reference to the existence of risks, with no details about what they are in particularity, may be sufficient.<sup>112</sup> The remoteness of

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102. *Id.*; see, e.g., *Lockett v. Planned Parenthood of Ind., Inc.*, 42 N.E.3d 119, 129 n.11 (Ind. Ct. App. 2015).

103. Rosoff, *supra* note 91, at 309; e.g., *Duffy v. Flagg*, 905 A.2d 15, 20 (Conn. 2006).

104. Rosoff, *supra* note 91, at 309 (“Of course, under either standard, as medical progress increases the store of knowledge about treatment options, risks, and treatment alternatives, there will simply be more that patients want to know.”).

105. *Marsingill v. O’Malley*, 128 P.3d 151, 159 (Alaska 2006).

106. See, e.g., *Rojas v. Barker*, 195 P.3d 785, 788 (Kan. Ct. App. 2008); *Saks v. Ng*, 890 A.2d 983, 992 (N.J. Super. Ct. App. Div. 2006); *Flatt v. Katak*, 687 N.W.2d 208 (N.D. 2004).

107. See, e.g., *D.A.B. v. Brown*, 570 N.W.2d 168, 170 (Minn. Ct. App. 1997); *Barclay v. Campbell*, 704 S.W.2d 8, 9–10 (Tex. 1986).

108. See, e.g., *Geler v. Akawie*, 818 A.2d 402, 417 (N.J. Super. Ct. App. Div. 2003).

109. E.g., *Herrera v. Atl. City Surgical Grp.*, 649 A.2d 637, 640 (N.J. Super. Ct. Law Div. 1994).

110. E.g., *Jones v. United States*, 933 F. Supp. 894, 901–02 (N.D. Cal. 1996) (citing *Arato v. Aredon*, 858 P.2d 598, 605 (Cal. Ct. App. 1993) (en banc)) (applying California law).

111. See, e.g., NEB. REV. STAT. § 44-2816 (1976); *Gorab v. Zook*, 943 P.2d 423, 427–28 (Colo. 1997) (en banc); *Woolley v. Henderson*, 418 A.2d 1123, 1129–30 (Me. 1980); *Curran v. Buser*, 711 N.W.2d 562, 568 (Neb. 2006).

112. See, e.g., *Ditlow v. Kaplan*, 181 So. 2d 226, 228 (Fla. Dist. Ct. App. 1965).

the risk matters when evaluating whether the physician has behaved reasonably,<sup>113</sup> as does the magnitude of the potential harm.<sup>114</sup>

Despite these differences in the modes of evaluation, both standards are undergirded by the desire to ensure “respect for the dignity and autonomy of individuals in the health care context.”<sup>115</sup> The informed consent doctrine seeks to enforce the fiduciary nature of the doctor-patient relationship.<sup>116</sup> The purpose of the doctrine is to preserve bodily autonomy and self-determination for the patient.<sup>117</sup> These rights extend to “every human being of adult years and sound mind,” including pregnant women.<sup>118</sup> The ability of the patient to “exercise control over his or her body” is the very purpose of this body of law.<sup>119</sup> Whether or not liability attaches, patients have “the absolute right, for whatever reason, to prevent unauthorized intrusions and treatments.”<sup>120</sup>

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113. See, e.g., *Cowman v. Hornaday*, 329 N.W.2d 422, 427 (Iowa 1983); *Patten v. Gayle*, 69 So. 3d 1180, 1187 (La. Ct. App. 2011); *Leonhard v. New Orleans E. Orthopedic Clinic*, 485 So. 2d 1008, 1013 (La. Ct. App. 1986).

114. See, e.g., *Doerr v. Movius*, 463 P.2d 477, 479 (Mont. 1970).

115. Rosoff, *supra* note 91, at 312; e.g., *Roberts v. Connell*, 718 S.E.2d 862, 864 (Ga. Ct. App. 2011) (stating that informed consent “addresses the autonomy of a competent patient to determine what medical treatment he [or she] will allow or refuse”) (quoting *Pope v. Davis*, 582 S.E.2d 460, 461 (Ga. Ct. App. 2003)).

116. See, e.g., *Nixdorf v. Hicken*, 612 P.2d 348, 354 (Utah 1980) (“This duty to inform stems from the fiduciary nature of the relationship.”); *Stewart-Graves v. Vaughn*, 170 P.3d 1151, 1155 (Wash. 2007) (en banc) (“Under the doctrine of informed consent, a health care provider has a fiduciary duty to disclose relevant facts about the patient’s condition and the proposed course of treatment so that the patient may exercise the right to make an informed health care decision.”).

117. 79 A.L.R.2d 1028 § 1 (1961) (“Anglo-American law starts with the premise of thorough-going self-determination. It follows that each man [and woman] is considered to be master of his [or her] own body, and he [or she] may, if of sound mind, expressly prohibit the performance of life-saving surgery, or other medical treatment. A doctor might well believe that an operation or form of treatment is desirable or necessary, but the law does not permit him [or her] to substitute his [or her] own judgment for that of the patient by any form of artifice or deception.”).

118. E.g., *Rich v. Foye*, 976 A.2d 819, 831 (Conn. Super. Ct. 2007) (quoting *Duffy v. Flag*, 905 A.2d 15, 20 (Conn. 2006)); accord *In re A.C.*, 573 A.2d 1235 (D.C. 1990) (“It has been suggested that fetal cases are different because a woman who ‘has chosen to lend her body to bring [a] child into the world’ has an enhanced duty to assure the welfare of the fetus, sufficient even to require her to undergo caesarean surgery. Surely, however, a fetus cannot have rights in this respect superior to those of a person who has already been born.”) (internal citation omitted) (quoting John A. Roberts, *Procreative Liberty and the Control of Conception, Pregnancy, and Childbirth*, 69 VA. L. REV. 405, 456 (1983)); *Britt v. Taylor*, 852 So. 2d 1128, 1134 (La. Ct. App. 2003).

119. *Tinius v. Carroll Cty. Sheriff Dep’t*, 321 F. Supp. 2d 1064, 1086 (N.D. Iowa 2004) (applying Iowa law); accord *Dunn v. Yager* 58 So. 3d 1171, 1200 (Miss. 2011); *Acuna v. Turkish*, 930 A.2d 416, 424–25 (N.J. 2007).

120. *Rosales v. Loyola*, 973 So. 2d 858, 863 (La. Ct. App. 2007).

Such a sweeping doctrine collects even information that is collateral to a procedure, like information that is specific to the provider and their skills.<sup>121</sup> Informed consent also extends to merely diagnostic procedures,<sup>122</sup> like drug tests, even though they are minimally physically intrusive. So, information like the legal consequences experienced by Ms. Loertscher should be covered by the doctrine.<sup>123</sup> If the purpose of the doctrine of informed consent is to allow patients to have control over their futures, then it is intuitive that it would cover whether test results will be disclosed to a government agency.

### III. STRATEGIC APPLICATION OF MALPRACTICE LITIGATION TO DETER PROVIDERS FROM DRUG TESTING PREGNANT WOMEN WITHOUT INFORMED CONSENT

Under the reasonable patient standard, physicians can be held liable for failure to secure informed consent before drug testing a pregnant woman. Because Wisconsin uses the reasonable patient standard, the Tammy Loertscher case is illustrative. The clinic staff did not inform her that her private medical records would be shared with a third party.<sup>124</sup> They did not inform her that interacting with CPS agencies has been shown to be likely to have adverse consequences for both children and parents.<sup>125</sup> They did not inform Ms. Loertscher<sup>126</sup> that she could be taken into legal custody, denied medical care, prevented from taking her thyroid medication, and put at risk of losing custody of her fetus before they administered the drug test. Even if the clinic staff had no idea what the eventual consequences would be, they at least knew that CPS would intervene in her life—an intervention that the clinic staff gave Ms. Loertscher no opportunity to refuse. If they had told her any of these things, it is reasonable to think that she would have declined to submit to the test.

The Wisconsin Supreme Court has described its consent standard as emanating from “the personal liberties protected by the Fourteenth Amendment.”<sup>127</sup> Wisconsin courts ask, “given the circumstances of the case, what would a reasonable person in the patient’s position want to know in order to make an intelligent decision with respect to the choices of treatment or diagnosis?”<sup>128</sup> A reasonable person would likely want to know that the results of a diagnostic test may be shared with a third party. A reasonable pregnant

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121. *E.g.*, *Goodman v. United States*, 298 F.3d 1048, 1058 (9th Cir. 2002) (applying Maryland law); *DeGennaro v. Tandon*, 873 A.2d 191, 195 (Conn. App. Ct. 2005).

122. *See, e.g.*, *Garcia v. Robinson*, 349 P.3d 415, 419 (Haw. Ct. App. 2015).

123. *See* Rosoff, *supra* note 91, at 309.

124. Amended Complaint, *supra* note 1 at 6.

125. *See* Szalavitz, *supra* note 46 (describing studies indicating that “[b]etween a third and half of children who grow up in foster care report at least one experience of abuse or neglect” and that “foster homes increase a child’s risk of sexual abuse”).

126. *See* Amended Complaint, *supra* note 1 at 6.

127. *Outagamie Cty. v. Melanie L.*, 833 N.W.2d 607, 617 (citing *Lenz v. L.E. Phillips Career Dev. Ctr.*, 482 N.W.2d 60, 65 (Wis. 1992)).

128. *Martin v. Richards*, 531 N.W.2d 70, 79 (Wis. 1995).

woman would certainly want to know whether that third party had the legal power to terminate her parental rights or confine her against her will.

Like many jurisdictions, Wisconsin does not find the distinction between treatments and diagnostic procedures to be necessarily relevant in informed consent cases.<sup>129</sup> As such, it does not matter that a urine test is merely diagnostic—it still requires informed consent unless it falls within an exception. Wisconsin courts also do not “believe that a physician is necessarily absolved from providing pertinent medical information simply because the procedure he or she recommends is noninvasive.”<sup>130</sup> Furthermore, it stands to reason that because “[i]nformed consent is fundamentally about each person’s right to decide ‘what shall be done with his [or her] own body,’”<sup>131</sup> a drug test would fall within the doctrine in the prenatal context because the consequences of a positive prenatal drug test can include deprivations of physical liberty.<sup>132</sup>

Wisconsin statute section 448.30 codified Wisconsin’s informed consent standard and provided some exceptions to the standard:

- (1) Information beyond what a reasonably well-qualified physician in a similar medical classification would know.
- (2) Detailed technical information that in all probability a patient would not understand.
- (3) Risks apparent or known to the patient.
- (4) Extremely remote possibilities that might falsely or detrimentally alarm the patient.
- (5) Information in emergencies where failure to provide treatment would be more harmful to the patient than treatment.
- (6) Information in cases where the patient is incapable of consenting.<sup>133</sup>

The adverse effects of consenting to a drug test do not fall within any of these exceptions. First, while it could be true that physicians lack legal expertise and may not know the extent of possible adverse consequences, they certainly know whether the results will be given to a third party. And the very purpose of disclosing prenatal drug use to CPS is to ensure they will intervene in the life of the pregnant woman. So, while Dr. Bantz, for example, may not have known that Tammy Loertscher would end up in solitary confinement for thirty-six hours, she certainly knew that Ms. Loertscher was going to face some kind of legal intervention. Second, the risks are not apparent to the pregnant patient. If women knew, generally, that testing positive for drugs could result in a loss of liberty or of custody of their children,

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129. *Martin*, 531 N.W.2d at 78.

130. *Id.* at 79.

131. *Jandre v. Wis. Injured Patients & Families Compen. Fund*, 813 N.W.2d 627, 635 (Wis. 2012) (quoting *Martin*, 531 N.W.2d at 76) (second alteration in original).

132. See GUTTMACHER STATE OVERVIEW, *supra* note 52 (showing states in which substance use during pregnancy is considered child abuse or grounds for civil commitment).

133. WIS. STAT. § 448.30 (1981), *amended by* 2013 Wis. Act 111 (Dec. 13, 2013).



it is unlikely that any would acquiesce to the test.<sup>134</sup> Third, because it is providers themselves who decide whether or not to disclose any test results, they cannot claim either that the possibility of disclosure is extremely remote or beyond their knowledge. Lastly, pregnancy in and of itself does not render a woman incapable of consenting (or declining to consent) to a procedure.

Wisconsin sits at a key intersection. It uses the reasonable patient standard *and* it lacks any affirmative statutory requirement that medical professionals report prenatal drug use to a CPS agency. Fifteen other states also sit in this intersection:

Table 1 displays three categories of states for the purpose of the type of litigation proposed here. The fifteen Type 1 states are like Wisconsin—they are reasonable patient jurisdictions without statutory duties to report positive prenatal drug tests. The Type 2 states are the reasonable physician jurisdictions without statutory duties to report positive prenatal drug tests. The Type 3 states are the states that do have affirmative prenatal drug test reporting requirements. Liability will be easiest to impose in Type 1 states and most difficult to impose in the Type 3 states. The rest of this Part discusses each category in turn.

In strategically tackling this issue, it would be prudent to begin with the sixteen Type 1 states where liability is easiest to find.<sup>135</sup> Inflicting financial liability on doctors and hospitals is likely to change behavior. Furthermore, merely hearing that other physicians in your state have been held liable for the behaviors described above may induce providers to alter their policies in order to avoid costly litigation. Thus, lawsuits need not be filed against *every* doctor or hospital in each Type 1 state in order to change collective behavior.

There are nineteen states that use the reasonable physician standard and have no statutory prenatal drug use disclosure requirement.<sup>136</sup> Liability under the reasonable physician standard is more challenging to demonstrate than under the reasonable patient standard. Obstetricians, at times, practice medicine in an ethically complex situation where they feel they must serve both the interests of the pregnant woman and her fetus. They might sincerely feel that only an *unreasonable* pregnant woman would take into consideration personal adverse consequences when faced with an option to take a test that theoretically could improve the pregnancy outcome for the fetus.

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134. If women begin self-selecting out of prenatal drug testing because they know they will test positive, this could be a feature rather than a flaw in the strategy. But if states become concerned that no testing is happening, they may begin to mandate blanket testing. This would have perverse outcomes, as discussed elsewhere in this Note. *See supra* notes 75–82 and accompanying text. It would also allow for constitutional challenges, which current practices in the civil context have largely not.

135. *See supra* notes 125–134 and accompanying text.

136. These are the Type 2 states. *See supra* Table 1.

TABLE 1<sup>137</sup>

<b>Type 1 States</b>		
States using the reasonable patient standard that do not mandate reporting of prenatal drug use		
California	Ohio	Texas
Connecticut	Oregon	Vermont
Hawaii	Pennsylvania	Washington
Mississippi	South Dakota	West Virginia
New Jersey	Tennessee	Wisconsin
New Mexico		
<b>Type 2 States</b>		
States using the reasonable physician standard that do not mandate reporting of prenatal drug use		
Alabama	Indiana	Nevada
Arkansas	Kansas	New Hampshire
Colorado*	Kentucky**	New York
Delaware	Maine	North Carolina
Florida	Missouri	South Carolina
Georgia*	Nebraska	Wyoming
Idaho		
*Colorado and Georgia use a hybrid of reasonable physician and reasonable patient standards.		
**Kentucky mandates testing of prenatal drug use but does not mandate reporting.		
<b>Type 3 States</b>		
States mandating reporting of prenatal drug use		
Reasonable Patient Standard	Reasonable Physician Standard	
Alaska	Arizona	
Iowa*	Illinois	
Louisiana	Michigan	
Maryland	Virginia	
Massachusetts		
Minnesota		
Montana		
North Dakota		
Oklahoma		
Rhode Island		
Utah		
*Iowa mandates testing and reporting of prenatal drug use.		

137. Data about the informed consent standard comes from David M. Studdert et al., *Geographic Variation in Informed Consent Law: Two Standards for Disclosure of Treatment Risks*, 4 J. EMPIRICAL LEGAL STUD. 103, 106–09 (2007). Data about the legal duty to report prenatal

Such ideas are fueled by stereotypical conceptions of pregnant women as necessarily self-sacrificing.<sup>138</sup> A jury may be likely to find a physician free of liability for assuming that no woman would reasonably refuse a drug test while pregnant, or that any pregnant woman who uses drugs is not competent to make medical decisions. Expert testimony to the contrary would be key in these jurisdictions.

If the state uses the community standards approach, however, liability would be slightly easier to show than in the pure reasonable physician context. ACOG clearly states that physicians should obtain informed consent from pregnant women before performing drug tests.<sup>139</sup> ACOG's medical standards call for testing only in particular and rare cases, and still require informed consent.<sup>140</sup> They are vehemently opposed to providing CPS agencies with medical information regarding prenatal drug use absent a showing of actual abuse of living children or a specific statutory requirement.<sup>141</sup> They even encourage their providers to work to repeal legislation that requires reporting prenatal drug use to CPS agencies.<sup>142</sup> Because ACOG's recommendations aim to reflect best practices, their stance is convincing regarding the community standards for prenatal drug testing. Furthermore, as liability is imposed in the Type 1 states, it will only strengthen the argument that there is a community standard regarding obtaining informed consent before prenatal drug testing.

In the Type 3 states, physicians have an affirmative statutory duty to report prenatal drug use. The federal Child Abuse Prevention and Treatment Act requires reporting of infants who are born exhibiting signs of drug exposure.<sup>143</sup> But, these fifteen Type 3 states have gone beyond this to require

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drug use comes from *Miranda*, *supra* note 55. Additionally, in Kentucky and Iowa, providers have an affirmative statutory duty to test pregnant women if they suspect the woman is using drugs. *Id.* Minnesota and North Dakota have a similar requirement if there are suspected drug-related complications at birth. *Id.*

138. Copeland, *supra* note 41 (“The notion of a woman pursuing pleasure at the slightest risk to her fetus is seen as morally egregious—hence our culture’s ban on sushi for pregnant women, but not for the much more risky but workaday act of driving.”).

139. AM. CONG. OF OBSTETRICIANS & GYNECOLOGISTS, COMM. ON ETHICS, ALCOHOL ABUSE AND OTHER SUBSTANCE ABUSE DISORDERS: ETHICAL ISSUES IN OBSTETRIC AND GYNECOLOGICAL PRACTICE 2 (2015) [hereinafter ACOG COMMITTEE OPINION No. 633], <https://www.acog.org/-/media/Committee-Opinions/Committee-on-Ethics/co633.pdf?dmc=1> [<https://perma.cc/WG48-GCBC>].

140. ACOG TOOLKIT, *supra* note 37, at 4–5.

141. ACOG COMMITTEE OPINION No. 633, *supra* note 139, at 5 (“Obstetrician–gynecologists should function as patient advocates and oppose coercive screening, testing, and treatment interventions and prosecution of a particular population for substance use disorder. Obstetrician–gynecologists should protect patient autonomy, confidentiality, and the integrity of the patient–physician relationship to the extent allowable by laws regarding disclosure of substance use disorder.”).

142. *Id.* (“In states that mandate reporting, [policymakers], legislators, and physicians should work together to retract punitive legislation and identify and implement evidence-based strategies outside the legal system to address the needs of women with addictions.”).

143. CHILDREN’S BUREAU, *supra* note 43.

that tests showing prenatal drug use are reported to a CPS agency.<sup>144</sup> Whether or not this statutory requirement alleviates a physician of their ethical obligations to inform their patients before administering the test is uncertain. It is possible that the physician's duty to report does not override their duty to obtain informed consent. Whether or not the physician has to report the results of the test, the patient has a right to refuse the test in the first place.

Physicians, however, are typically free from malpractice liability when they adhere to mandatory reporting requirements.<sup>145</sup> In some states, mandatory reporting statutes even impose liability on physicians and other mandatory reporters who fail to make reports.<sup>146</sup> Given this carrot-and-stick approach to mandatory reporting, it is unlikely a court would impose financial liability where a physician conformed to a statutory obligation.<sup>147</sup> But if standard medical practices in the other thirty-five states fall into line with ACOG recommendations, then physicians and activists in the remaining fifteen states will have more ammo to use in convincing their state legislatures to change practices.

There are also non-litigation-based actions that can help to change medical practices in these Type 3 states. Alerting private practices and hospitals that they can avoid malpractice liability by simply informing their patients that test results could be shared with CPS agencies may change providers' behavior.<sup>148</sup> Arguments based on cost effectiveness are convincing. Informing patients costs almost nothing, while malpractice suits are expensive. Nonadversarial educational efforts aimed at changing attitudes toward prenatal drug use could also be effective. Hospitals and obstetricians want to maintain the trust of their patients and promote healthy birth outcomes, so presenting them with evidence-based approaches will change their behavior. Lastly, it is important to better educate providers about the legal repercussions of prenatal drug testing. Doctors and nurses are probably largely unaware of the magnitude of harm that can flow from a prenatal

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144. See note 137 and accompanying table.

145. E.g., MASS. GEN. LAWS ch. 119, § 51A(g) (2016) ("No mandated reporter shall be liable in any civil or criminal action for filing a report under this section or for contacting local law enforcement authorities or the child advocate, if the report or contact was made in good faith, was not frivolous, and the reporter did not cause the abuse or neglect."); TENN. CODE ANN. § 37-1-410(a)(1) (2014) ("The health care provider shall not be liable in any civil or criminal action that is based solely upon . . . [t]he health care provider's decision to report what the provider believed to be harm."); W. VA. CODE ANN. § 49-2-810 (LexisNexis 2015).

146. E.g., IOWA CODE § 232.75 (2015); MONT. CODE ANN. 41-3-207 (2015); N.Y. SOC. SERV. LAW § 420 (McKinney 2010); N.D. CENT. CODE § 50-25.1-13 (2007); OHIO REV. CODE ANN. § 2151.421 (LexisNexis 2017); 40 R.I. GEN. LAWS § 40-11-6.1 (2006 & Supp. 2016).

147. The ethical issues here are beyond the scope of this piece. Suffice it to say that whatever the statutory obligations of the medical professionals are, they ought not abrogate physicians obligations to inform their patients, because they do not change the bodily autonomy of the patient.

148. The efficacy of this strategy in jurisdictions with a duty to report positive prenatal drug tests will be lessened if that statutory duty abrogates or mitigates the patient's right to informed consent.

drug test, and educating them may make them think twice before administering the test at all.

#### CONCLUSION

Ms. Loertscher's story is an extreme example, but she is far from the only woman who has suffered shocking consequences after taking a prenatal drug test. In the United States, women have faced imprisonment, injury, and even death because their bodily autonomy was restricted during pregnancy.<sup>149</sup> It is not a coincidence that policies like the one that imprisoned Ms. Loertscher are favored by the forced-pregnancy<sup>150</sup> movement.<sup>151</sup> Like the other policies favored by this movement, they are intended to restrict women's ability to exercise control over their bodies, and they have a starkly disparate impact on poor women and women of color.<sup>152</sup> Medical providers, sadly, have become complicit. Pregnancy does not render a woman incapable of consenting to medical care or undeserving of bodily autonomy.<sup>153</sup> Denying pregnant women bodily autonomy is not merely misogyny—it is medical malpractice, and doctors should be held accountable.

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149. See *In re A.C. 573 A.2d 1235* (D.C. 1990) (describing how a woman and her baby were killed in the course of a forced caesarian section); Paltrow & Flavin, *supra* note 87; Ed Pilkington, *Indiana Prosecuting Chinese Woman for Suicide Attempt that Killed Her Foetus*, *GUARDIAN* (May 30, 2012, 1:36 PM), <https://www.theguardian.com/world/2012/may/30/indiana-prosecuting-chinese-woman-suicide-foetus> [<https://perma.cc/LMD7-6AN3>]; Julie Turkewitz & Jack Healy, *3 Are Dead in Colorado Springs Shootout at Planned Parenthood Center*, *N.Y. TIMES* (Nov. 27, 2015), <https://www.nytimes.com/2015/11/28/us/colorado-planned-parenthood-shooting.html> (on file with the *Michigan Law Review*). Their providers, especially abortion providers, similarly face violence. Alex Burness, *After 40 Years in Boulder, Abortion Doctor Warren Hern Is Still at War*, *DAILY CAMERA* (May 30, 10:00 AM, 2015), [http://www.dailycamera.com/news/boulder/ci\\_28215836/after-40-years-boulder-abortion-doctor-warren-hern](http://www.dailycamera.com/news/boulder/ci_28215836/after-40-years-boulder-abortion-doctor-warren-hern) [<https://perma.cc/PV5P-N4HH>] (describing Dr. Warren Hern as having stopped wearing a bulletproof vest after forced-pregnancy activists said that they were “gonna go for a head shot”); Joe Stumpe & Monica Davey, *Abortion Doctor Shot to Death in Kansas Church*, *N.Y. TIMES* (May 31, 2009), <http://www.nytimes.com/2009/06/01/us/01tiller.html?pagewanted=all> (on file with the *Michigan Law Review*).

150. Also known as the “pro-life” movement.

151. See Hunter Huxley, *Mother Imprisoned by Pro-Life Policies: Tamara Loertscher*, *DAILY KOS* (Apr. 5, 2016, 7:36 PM), <http://www.dailykos.com/story/2016/4/5/1511032/-Mother-Imprisoned-by-Pro-Life-Policies-Tamara-Loertscher> [<https://perma.cc/QWG6-ZJSX>]; *BIRTHRIGHT: A WAR STORY* (Abramorama 2017).

152. In the words of Richard Wexler, executive director of the National Coalition for Child Protection Reform, “[w]e don’t have a child welfare system, we have a parent punishment system.” Szalavitz, *supra* note 46. See generally Sarah A. Font et al., *Examining Racial Disproportionality in Child Protective Services Case Decisions*, 34 *CHILD. & YOUTH SERVICES REV.* 2188 (2012) (describing how child protective services investigations disproportionately affect poor families and black families).

153. See *In re A.C.*, 573 A.2d at 1247.