6

Revisiting the Fiduciary Relationship

Is it ethical when doctors breach their pregnant patients' confidentiality? Is it legal? What about HIPAA (properly known as the Health Insurance Portability and Accountability Act of 1996)?[1] Are there different rules for pregnant women than for men? These are some of the questions women ask me after I give a talk. I understand this bewilderment and, for many, fear. At the heart of their questions resides this chilling thought: Could this happen to me or my daughter? Depending on where they live, the answer may be yes. And, increasingly, wealth will not save them. This Chapter focuses on the physician-patient relationship, although I am mindful that nurses wield enormous power and can also be complicit in undermining pregnant women's privacy and breaching confidentiality.

In 2015, I received an invitation to give a talk to a conservative women's group in Laguna Niguel, a suburban community in Orange County, California. I agreed and the date was set months off. Orange County, often described as a Republican stronghold dating back to Presidents Richard Nixon and Ronald Reagan, was reliably "red." Former congressman Dana Tyrone Rohbacher, considered one of the most conservative members of Congress, represented the district for thirty years. And, within Orange County, Laguna Niguel was regarded as one of the more conservative communities.

The organizers scheduled the talk at a beautiful local country club. Despite the enduring drought, the gardens and golf course were lush. In Orange County, where an annual income of $84,000 per year now qualifies as low-income,[2] the grounds of the country club gave no hint of the grave need for water in the state. The community was gated, which is not unusual in Southern California, where many people live in such communities. This tends to signify that something inside the gates is worthy of protection from outsiders. The audience largely reflected the town's demographics – 80 percent white, with a clustering of women of Persian and Asian descent. The women gathered for the talk in a beautifully appointed room. They were smart, elegant, and wealthy. I was the academic who had recently relocated to Southern California from the Midwest.

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I came with a story to tell. It was a time in our nation's political history when the fight to upend women's reproductive healthcare and rights had been led by Republicans at the state and federal levels. In the few years leading up to the talk, more antiabortion and anticontraceptive legislation had been proposed and enacted than in the three prior decades combined. Just the year before, the United States Supreme Court's conservative majority ruled in *Burwell v. Hobby Lobby* that corporations with religious objections could circumvent federal law requiring that contraceptives be covered in insurance plans.

I pondered, How would my audience receive the talk I planned to give? Would this turn into what pundits on the Left and Right were calling "gotcha" moments, designed not to illicit information and nuanced debate but political or ideological attack? Admittedly, I was concerned. After fumbling and failing with technology and the projector refusing to project, I settled into a conversation about women's reproductive health, rights, and the myriad injustices cropping up around the country. The crux of the talk was that pregnancies were being policed in clandestine and nefarious ways and often at the center of poor decision-making were medical professionals.

This was not a new set of issues or talk for me; I had shared aspects of my research at law schools, universities, and in other settings. More often than not, those audiences would likely self-identify as liberal, feminist, or progressive. Yet, even in those settings, I encountered doubters or those who, deep down, believed that women arrested and convicted for "endangering" their fetuses somehow deserved the criminal punishment they received. In fact, at one elite law school the reception to this work was so jarring that probably they and I could not wait for it to be over.

In that case, a member of the faculty whose wife had recently given birth seemed very offended by the subject of my work – or maybe the work itself. He took umbrage at the notion that doctors could be irresponsible in prescribing opioids for their patients, particularly pregnant women. He scoffed at this and behaved as if the notion was absurd. He challenged my comparison of poor pregnant women to wealthier women (as I suggested pregnancy could be challenging, no matter the socioeconomic distinctions).

Perhaps he was thinking that his wife and her pregnancy were very different from those of the women I wrote about. After all, he taught at a top law school, with an elite academic background. And possibly his wife was of a similar background. My point was that the same traumas and ailments that would lead privileged white women to seek medical relief such as prescription medications from their doctors was really not that much different than poor women also seeking help. Albeit, for pregnant women, their drugs were not negotiated in clinics and hospitals. The professor claimed one real difference was that "prescription medications do not harm patients." His colleagues nodded. I was baffled. I had an endowed chair in health law, he did not.

During the question and answer period, the professor announced to me and his colleagues that "doctors would never prescribe anything that would harm patients." Again, his colleagues nodded. He chuckled at the notion that white women could become addicted to prescription medications like OxyContin. That was in 2012. As I finish this book, the *New York Times*, *Wall Street Journal*, *Washington Post*, and virtually every other major and local news media in the United States have announced that Purdue Pharma and the Sackler family have reached a multibillion-dollar settlement to dismiss lawsuits related to the thousands of deaths and overdoses related to OxyContin.

However, my talk in Laguna Niguel was different, particularly for me. By the end of the talk, several women raised their hands almost as in a confessional. They understood the challenges of pregnancy and that doctors were offering cocktails of potent drugs to wealthy pregnant women. The news media in 2015 was just beginning to scratch the surface of the opioid crisis. Yet there were other issues they wished to raise with regard to the physician-patient relationships and the problems related to the authority physicians wield over their female patients.

They began telling their stories. One began crying, recalling how her doctor refused to provide medical care, even though she was miscarrying, because it would mean terminating the pregnancy. She recounted how she almost died. Another woman told the story of her doctor threatening to call the police if she refused to be compliant with his recommendations for the pregnancy. Another woman recounted switching doctors, because she felt uncomfortable by her medical provider's demands that she schedule and undergo a cesarean delivery rather than vaginal delivery. Despite their affluence, wealth did not spare the women. They recalled various indignities and threats, religious objections and interventions, and other harms carried out by their medical providers. Only one woman stated that she decided to fight back and threatened to sue her doctor – while she was pregnant.

As hands were raised and stories told, it became clear to each of us that any woman could potentially be vulnerable to surveillance, policing, and criminalization during pregnancy, even in California, a state that embedded a woman's right to reproductive privacy in its constitution. One woman asked, "Where can women turn to?" Another woman, looking at the audience and directing her question at them as much as at me, asked, "Are women wrong to trust their doctors? And if women can't trust their doctors during pregnancy, what are they to do?" Some of the women expressed feeling vulnerable rather than confident with their doctors. For years, I warned that poor women, particularly those who are Black, were simply the canaries in the coalmines and that a medical and political culture that devalues women's reproductive autonomy, privacy, and basic dignity could potentially respond unjustly to all women regardless of race and class. That message resonated with the women gathered at my talk. I stayed an extra two hours before saying goodbye.

6.1 THE FIDUCIARY RELATIONSHIP

As this Chapter explains, physicians owe their patients care, confidentiality, loyalty, and trust, and the principle that undergirds all of this – the fiduciary relationship – is not contingent on the sex of the patient. However, with increased pressure from state legislatures and prosecutors, some doctors and nurses have abrogated their responsibilities to their patients. Among them, some are genuinely fearful that unless they adhere to whatever law enforcement demands of them, they may lose their licenses to practice medicine. Some of these doctors are genuinely ambivalent about their duties. In child abuse cases, they are mandatory reporters, meaning they must inform state authorities of suspected abuse. Does the same hold true with a pregnancy, where there is a fetus, but not a living child? Some prosecutors make such claims, stating there is no difference between a five-year-old child and a five-week-old fetus. In light of such rhetoric, these doctors tell me they feel powerless. Others claim that their religious values inform and direct their decision-making regarding pregnant patients' reproductive health. Among these doctors and nurses are some who also refuse to provide emergency contraceptives, such as Plan B, to patients even after rape, which would protect the woman from becoming pregnant. To them, the life worth defending and healing is that of the "unborn."

Others, however, may be confused about their ethical and legal duties, even though medical organizations have articulated clear opposition to doctors serving as deputized law enforcement, snitching on their pregnant patients, and releasing confidential medical information to police and prosecutors. The reasons for this opposition are not new but long-standing in law and medical ethics, because physicians (like lawyers) have a fiduciary relationship with the individuals whom they serve. The textbook definition of a fiduciary is one who owes a legal obligation to another. However, this is no ordinary duty, but rather, in the words of Professor Kenneth Rosen, one of "extreme fidelity."[3]

The late, defining voice on fiduciary law, Professor Austin Scott, wrote, "A fiduciary is a person who undertakes to act in the interest of another person. It is immaterial whether the undertaking is in the form of a contract. It is immaterial that the undertaking is gratuitous."[4] Indeed, perhaps the worst breaches of all are when a fiduciary commits acts without the consent of the principle (beneficiary), engages in conduct intended to undermine the beneficiary, or when the fiduciary self-deals – meaning commits acts that benefit himself.

Fiduciaries are explicitly obligated to act in their client's best interests and to subordinate their personal and professional interests to the benefit of the client. In law, we refer to this as the "fiduciary obligation" or "fiduciary duty," and it applies to doctors and nurses (as well as lawyers and others who by their position owe a very special duty to others). Simply put, fiduciaries must be undivided in their loyalty to their beneficiaries. Legal philosophers and courts describe the fiduciary's duty of loyalty as being rooted in moral law.[5]

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Justice Benjamin Cardozo – one of the most revered legal jurists of the twentieth century – described the fiduciary duty as "the duty of the finest loyalty."[6] In a landmark decision, *Meinhard v. Salmon*, which dealt with fiduciary duties among business partners, the famous judge emphasized that fiduciaries are "held to something stricter than the morals of the market place."[7] In fact, not their honesty, but rather "the punctilio of an honor the most sensitive, is ... the standard of behavior." This, he said is "unbending and inveterate."[8] Plainly stated, the fiduciary duty requires, "uncompromising rigidity."[9] Make no mistake, the benefits of the fiduciary relationship are to inure to the patient or client – and solely him or her – and not the fiduciary. Nor is the fiduciary relationship contingent on special considerations of others.

An elementary exercise for law students on this point goes something like this: Brad, a college freshman, is arrested in state X for driving under the influence. His frantic parents consult, hire, and pay for a lawyer to represent him. Who is the client – Brad or the parents? Even though it might appear that the parents are the client, because they found the lawyer and pay to retain her, the answer is that the son, Brad, is the client and, as such, the lawyer owes her loyalty to Brad, despite his parents paying the legal fees.

Years ago when teaching legal ethics, I would add additional facts – imagine Brad informs the lawyer that while driving under the influence he injured a pedestrian on the night of his arrest and, since that time, has learned that the person died. Can the lawyer disclose this to law enforcement? What if the lawyer learns that another person, Kelly, was arrested for killing the pedestrian struck by Brad? May the lawyer disclose this information to law enforcement and prosecutors? The answers to the above questions are all no. The lawyer is obligated to keep Brad's confidence to herself, even if he is not paying her legal fees. The duties of loyalty, care, and confidentiality prohibit the lawyer from disclosing Brad's secrets. The lawyer is even obligated to make efforts so that the "inadvertent or unauthorized disclosure of, or unauthorized access to" this information does not occur.[10] Importantly, these types of hypotheticals derive from actual legal cases – and not simply the lofty musings of a law professor.[11]

Briefly, consider the case of Robert Garrow and his attorneys Frank Armani and Francis Belge. The lawyers were appointed to represent Garrow in the brutal murder case of Phillip Domblewski, an eighteen-year-old college freshman. Domblewski was camping with three friends when Garrow attacked and tied them to trees. Domblewski's friends were able to escape, but sadly he was not. Garrow disclosed this and more to the attorneys. He told them about other murders, abductions, and rapes that he had committed, including where he had disposed of the bodies. He relayed in gruesome detail the defilement of two female victims. The lawyers confirmed this information – one took photos of the disclosed remains. However, the lawyers did not reveal what they knew. Eventually, Garrow confessed (while on direct examination by Belge at trial). He was sentenced to life in prison. Of Garrow,

one newspaper wrote that he was "a malignant cancer on the society that fostered him." The paper said he was "less than useless to the human race."

However, it was only after Garrow confessed at trial that the lawyers acknowledged what they knew. Lawyers commended Armani and Belge for maintaining client confidentiality – even under such aggravating and vexing circumstances. After all, Armani's daughter was the classmate of one of the victims. Nonetheless, the lawyers were ridiculed in the local paper and among lay people in their town. They lost business and one of them stopped practicing law. They were the subjects of a grand jury investigation where Belge was convicted. In dismissing those charges, a judge lauded Belge for zealously protecting his client's rights. When parents of one victim filed an ethics complaint against the lawyers, that too was dismissed. Citing ethical cannons and codes, the Committee on Professional Ethics of the New York State Bar Association stated:

> Both the fiduciary relationship existing between lawyer and client and the proper functioning of the legal system require the preservation by the lawyer of confidences and secrets of one who has employed or sought to employ him. A client must feel free to discuss whatever he wishes with his lawyer and a lawyer must be equally free to obtain information beyond that volunteered by his client. A lawyer should be fully informed of all the facts of the matter he is handling in order for his client to obtain the full advantage of our legal system. It is for the lawyer in the exercise of his independent professional judgment to separate the relevant and important from the irrelevant and unimportant. The observance of the ethical obligation of a lawyer to hold inviolate the confidences and secrets of his client not only facilitates the full development of facts essential to proper representation of the client but also encourages laymen to seek early legal assistance.[12]

This duty of confidentiality is no more nor less stringent in relation to other fiduciary matters: trusts and estates, financial dealings, or medicine.

So, if the patient is the sole beneficiary of the medical relationship – not relatives or police officers, prosecutors, judges, or legislators – why is it that in states like Alabama doctors are reporting poor pregnant women to law enforcement? Confidentiality and loyalty are not new concepts in medicine. Most patients intuitively know and understand this – even if they cannot explain how they know or became aware that their physicians owe them undivided loyalty, confidentiality, and a commitment to "do no harm or injustice to them."

Some patients might point to the Hippocratic Oath, which dates back to 460–370 BC, as their source of knowledge about what their medical personnel owe them, including privacy. This makes sense – after all, the oldest surviving fragments of the Hippocratic Oath date back to AD 275. For millennia, patients have understood their physicians' duties of confidentiality and loyalty to be inviolable and sacrosanct. They believe this important bond of confidentiality to be unbreakable under nearly all circumstances – much like a lawyer's obligation to a client.

As the next section illustrates, contemporary fetal protection cases illustrate how doctors who snitch on their patients or who threaten them with arrest because they refuse cesarean sections, or who prioritize serving prosecutors over their pregnant patients, ignore fiduciary standards embedded not only in ethics but also in law. The institutional shifts that embed doctors as criminal law gatekeepers have led to the abdication of their legal fiduciary duties to their pregnant patients, perhaps to protect their medical licenses, despite the fact that trust and loyalty remain vital to the physician-patient relationship.

6.2 ETHICS AND MEDICINE

The principles that undergird the fiduciary relationship between lawyer and client are no less important and venerated in the medical context. Nonetheless, when law enforcement tracks and arrests a pregnant woman, usually this is the result of a medical provider surreptitiously disclosing private, confidential medical statements and records of their female patients – without informed consent. The cruelty of this clandestine behavior must be understood in the contexts of medical providers' obligations to the women they surrender to the police. Medical providers' ethical duties are to the patients – not to law enforcement. These obligations to the patients are not contingent on whether the pregnant patients have medical insurance or can pay for the care provided, or on whether the doctors believe the pregnant women who seek their care will be lousy mothers.

The fiduciary obligation of doctors is rooted not only in law but also in an internationally recognized code of ethics imposed on doctors, derived from the trials at Nuremberg.[13] As medical providers cast a punitive gaze on pregnant women, often overlooked or simply ignored are these foundational, internationally agreed upon bioethics principles: informed consent, autonomy, social justice, and voluntary participation. The earliest collective iteration of these principles dates from the adjudicative process in the criminal trials of Nazi doctors at Nuremberg, whose deliberate disregard for the health and safety of nonconsenting human subjects in their research studies on sterilization, serology, and human survival under distressing conditions resulted in deaths and severe disabilities among survivors.[14] Nazi doctors disregarded the humanity of the children, women, and men they subjected to this horrific research and their aggressive eugenics practices.

American and international medical ethics are rooted in the collapse of Nazi Germany and the subsequent trials at Nuremberg, where Third Reich physicians and researchers revealed the mass horrors of their human experimentation and broader brutality in the quest for scientific knowledge. The Nuremberg Doctors' Trial (one of thirteen criminal trials at Nuremberg) was conducted by the International Military Tribunal at Nuremberg and presided over by an international panel of judges. It began in 1946 and concluded in 1947.

The Nuremberg Doctors' Trials contributed to the articulation and establishment of universally recognized human rights principles in law and medicine that specify doctors' fiduciary duties and form the ethical framework for the physician-patient relationship. Originally, these principles defined the general standard in medical experimentation on human subjects. However, as described in this Chapter, they now cohere to form the basis for physician fiduciary obligations to patients – namely, that voluntary consent is an essential component of any medical treatment; that confidentiality is essential to the physician-patient relationship and medical providers should not violate this principle; that medical providers should avoid subjecting patients to unnecessary suffering, including, but not limited to, unnecessary reproductive surgeries; and that patients must be at liberty to withdraw from medical treatment, even if rejecting medical assistances might result in their deaths.

The principle of preserving patient confidence is enshrined in law and ethics. The American Medical Association offers this clear statement on the issue: "The physician should not reveal confidential information without the express consent of the patient," and in limited cases where an exception is enforced by law or court order, the Association cautions that the physician should notify her patient and only "disclose the minimal information required by law, advocate for the protection of confidential information."[15] Equally, the Privacy Rule established by HIPAA protects against medical providers' disclosure of individuals' health information.[16]

In fact, the bases for some of these principles predate Nuremberg. Some of the principles were already rooted in law. For example, informed consent for medical treatment, particularly surgery, was already founded in American law and affirmed by courts. Dating back more than a century, U.S. courts established that express or implied consent must be granted by patients prior to surgery. Justice Cardozo's famous dictum – "Every human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient's consent commits an assault for which he is liable in damages" – highlights the standard for informed consent in a case where a female patient claimed that doctors removed a tumor from her uterus against her will and without regard to her specific instructions prohibiting them from doing so.[17]

Decades later, courts throughout the United States would repeatedly chastise doctors for causing women's suffering by removing their uteruses without their consent. This strange and horrific pillaging of women's most intimate organs resulted in rulings like *Hundley v. St. Francis Hospital*, where a court held that a "jury could find that it is not accepted surgical practice to remove [the uterus] when there are no pathological abnormalities."[18] Similarly, in *Steele v. St. Paul Fire & Marine Ins. Co.*, a Louisiana court held that a woman unnecessarily suffered the "removal of a healthy organ of her body, i.e., her uterus and the unnecessary loss of her childbearing potential."[19] In Maryland, a court affirmed a jury award of $1,200,000 in a case involving a nonconsensual hysterectomy.[20] More recently, courts have awarded significant settlements in cases where plaintiffs successfully alleged unnecessary hysterectomies.[21]

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Courts have also recognized the right to confidentiality as distinct from, but complimentary to, the privacy right to control one's information. In reproductive rights cases, the U.S. Supreme Court has explained that privacy rights encompass two distinct spheres: an individual's interest in independent decision-making and in avoiding or refusing disclosure of intimate information, including medical records.[22] In *Eisenstadt v. Baird*, which addressed single women's access to contraception, the Court ruled that "if the right of privacy means anything, it is the right of the individual ... to be free from unwanted governmental intrusions into matters so fundamentally affecting a person as the decision whether to bear or beget a child."[23]

Not only does a woman possess a right to control her reproductive healthcare, and a right to the privacy associated with it, she also possesses the right to refuse a doctor's care. In *Norma Wons v. Public Health Trust of Dade County*, the Florida Court of Appeals held that a competent adult woman possesses the lawful right to refuse blood transfusions even when she might die and leave behind minor children. In that case, the court ruled that "the state has no compelling interest under the circumstances of this case sufficient to override the patient's constitutional right (a) to practice her religion according to her conscience, and (b) to lead her private life free from unreasonable government interference."[24]

6.3 LAW AND MEDICINE

The modern fiduciary relationship between healthcare providers and their patients represents a complex set of physician obligations that flow to their patients as a bundle of rights. Courts explain that the fiduciary relationship demands an important level of care, confidence, and loyalty across a broad sphere of physician-patient interactions.[25] For example, the Kansas Supreme Court stated decades ago that "[t]he courts frequently state that the relationship between the physician and his patient is a fiduciary one," placing upon the physician "an obligation to make a full and frank disclosure to the patient of all pertinent facts related to his illness."[26] The court stated that "each man is considered to be master of his own body" even if he expressly rejects "the performance of life-saving surgery, or other medical treatment."[27]

This was not an unusual or rare position for the court to take. Rather, it was consistent. For example, the California Court of Appeals, likely the first court to adopt the legal criterion of "informed consent" (replacing a general consent standard), clarified that "[a] physician violates his duty to his patient and subjects himself to liability if he withholds any facts which are necessary to form the basis of an intelligent consent by the patient to the proposed treatment."[28] The Minnesota Supreme Court issued a similar rule in 1958. That court explained that while it did not wish to burden the medical profession and its progress, physicians were nevertheless obligated to inform patients about their medical treatment, including less invasive surgical alternatives, in order to allow the patient to decide whether to

live with the "serious consequences" of refusing medical care.[29] In other words, a doctor's fiduciary obligations to her patients is expansive; it includes confidentiality, providing clear information, obtaining informed consent before proceeding with medical interventions, maintaining trust, and more. The legal obligations of physicians in relation to their patients impose duties on the provider and give legal rights to the patient. These legal rights provide a sanctuary for patients.

My point here is that the legal rights owed to a patient and the obligations of a physician or any other medical provider, including nurses, are no less salient when the patient is pregnant. American law begins with the premise of self-determination and that each patient is the master of her own body, vested with the authority to grant a physician the license to treat a condition or to expressly refuse medical interventions and therapies.[30] From this muscular legal principle spring forth other patient rights as well as constraints on healthcare providers. Notably, a physician's multiple duties to inform pregnant patients about the risks and benefits of a given medical treatment, recognize potential physicians' conflicts of interests, safeguard confidence, and perform medical duties with competence and care give rise to enforceable legal obligations vital to the interests of her patients. Among this bundle of rights is the basic "natural right" to be left alone.

The Supreme Court underscored the magnitude of the physician-patient relationship and the significance of loyalty, trust, and confidence in *Jaffee v. Redmond*, explaining that "the mere possibility of a therapist's disclosure may impede development of the confidential relationship necessary for successful treatment."[31] The Court also recognized that the privilege should extend to social workers. Justice Stevens, writing for the majority, stated that "protecting confidential communications between a psychotherapist and her patient" sufficiently promoted important interests.[32] Justice Stevens compared the patient's private communications with her therapist to the protected speech between spouses and between attorneys and their clients, ruling that the conversations and notes exchanged between a police officer who shot and killed a man during the course of responding to a "fight in progress" and her therapist were protected from compelled disclosure.

It is not only courts that have reinforced the importance of medical professionals maintaining confidentiality, so too have federal and state laws. Federal law further clarifies and codifies confidentiality requirements among some medical professionals, including those working on federally funded drug treatment programs, prohibiting the organizations involved from divulging patient records. For example, federal law prohibits the disclosure of:

> Records of the identity, diagnosis, prognosis, or treatment of any patient which are maintained in connection with the performance of any program or activity relating to substance abuse education, prevention, training, treatment, rehabilitation, or research, which is conducted, regulated, or directly or indirectly assisted by any department or agency of the United States.[33]

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In a special section on criminal proceedings, the federal law further emphasizes that "no record . . . may be used to initiate or substantiate any criminal charges against a patient or to conduct any investigation of a patient."[34] Courts and Congress are not alone in having issued clear pronouncements about the legally enforceable fiduciary duties placed on doctors, so too have all fifty state legislatures and the District of Columbia, medical boards, and professional organizations. For example, in 2013 the North Dakota State Board of Medical Examiners issued a stinging censure against a doctor for breaching patient confidence to an insurer, referring to the physician's actions as "engaging in conduct that is dishonorable, unethical . . . and that is likely to deceive, defraud, or harm the public," and noting that "breaching the confidentiality between physician and patient is proscribed" by North Dakota statutes.[35] In another 2013 case (decided on the very same day), that Board of Medical Examiners suspended the license of a physician who accessed the medical records of an individual who was not her patient, which it found to have violated that individual's physician-patient confidentiality.[36]

In addition to state oversight boards disciplining, suspending, and terminating the licenses of doctors who have trampled their patients' privacy, national medical organizations have warned their membership against abusing their patients' trust. The American Medical Association (AMA) and the American Public Health Association (APHA) offer unequivocal statements that the role of doctors and nurses must be first and primarily to serve patients' needs and not law enforcement goals. These medical organizations justifiably caution against states' efforts to conscript physicians and nurses into serving as informants, because it confuses the role of health care providers, misleads patients without providing any notice, and potentially chills the physician-patient relationship.

Taking fiduciary duties seriously, what then explains, let alone justifies, the dilution, if not abandonment, of legal and ethical obligations by doctors in cases involving pregnant patients – to the point that doctors threaten their pregnant patients with arrests for refusing cesarean sections, alert law enforcement when their pregnant patients confide about drug use or addiction, or seek to civilly confine their patients either by imposing bed rest or for the purported benefit of the fetus? Why have long-standing principles of the medical fiduciary relationship been abrogated in cases of pregnancy?

Professor Michelle Oberman explains that a double standard has emerged in the context of pregnancy, whereby doctors see not one but "two lives involved."[37] She wisely warns that doctors who embrace this view in the name of pregnancy ultimately advance the view that "women should have fewer rights than do their male counterparts," which Oberman argues is a "legally and ethically obsolete premise."[38] I agree. However, the fetal protection cases described in this book, many of which were not envisaged even fifteen years ago, now challenge whether these assumptions are obsolete. They are outmoded for sure, but sadly present.

6.4 THE CORRUPT PHYSICIAN-PATIENT RELATIONSHIP

Ferguson v. City of Charleston[39] represents such a shift in the role of medical staff from serving the needs of patients to gathering medical evidence for the state to use against them. In that case, ten women initiated section 1983 litigation[40] against the Medical University of South Carolina (MUSC) and local government officials, claiming that they were the victims of warrantless and nonconsensual searches initiated and performed by medical staff. Medical officials at MUSC had volunteered to serve as informants against their patients, initiating contact with a local prosecutor, Charles Condon, upon learning that he campaigned to extend child abuse laws to the use of drugs by pregnant women. Condon then established an interagency task force, which included police, the local prosecutor's office, and hospital staff. Together, they created what plaintiffs called the "Search Policy."

In a series of memoranda and meetings, Condon and his team informed medical personnel how to collect urine samples for use in criminal investigations and protect the samples' chain of custody, and also devised the method by which MUSC staff would report to police. Law enforcement staff trained the doctors and nurses, and Condon provided written guidance "listing criminal charges that could apply to women coming under the Search Policy."

According to court records, medical staff at MUSC, along with police and prosecutors, "disproportionately targeted indigent, African-American women for search and arrest."[41] In their search program, of the thirty women arrested twenty-nine were African American. Special dispensation was sought for at least one white woman who, although not arrested, otherwise met the criteria for arrest. In that instance, "Nurse Brown admitted that she called the Solicitor's office and requested another 'chance' on behalf of a white patient who should have been arrested under the Policy's terms."[42]

For the one other white woman ensnared by the Search Policy, racial profiling may have contributed to her arrest as well, because a nurse and member of the interagency task force made a point of notating the patient's chart with the following information: "patient live[s] with her boyfriend who is a Negro."[43] While this notation did not serve a medically relevant purpose, it revealed that an illicit extralegal consideration – race – was involved in the implementation and enforcement of South Carolina's fetal protection law.[44]

In fact, this particular nurse admitted at trial that she believed interracial relationships violated "God's way"[45] and "raised the option of sterilization for black women testing positive for cocaine, but not for white women."[46] This search process introduced a level of unusual cruelty into the delivery of medicine, altering a common understanding about hospitals providing safety, comfort, and respite to those seeking medical help. As transcripts in the case reveal, some women subject to arrest were "denied the opportunity to change out of their hospital gowns or to make a phone call to family members to make arrangements for the care of their

children."[47] In other instances, police apprehended the new mothers "while still bleeding, weak and in pain from having just given birth."[48] Some were handcuffed and shackled, with chains circling their abdomens. Leg irons were used in some cases. For any woman who could not walk, "a blanket or sheet would be placed over the woman, and she would be wheeled out of the hospital to a waiting police car and transported to jail."[49]

The collaboration between MUSC medical staff and law enforcement to obtain incriminating evidence against pregnant women seeking prenatal care exposes a provocative and dangerous example of physicians wielding significant discretion in the furtherance of a criminal law purpose rather than serving patients' medical interests. In fact, the medical director of the Neonatal Intensive Care Unit testified that the drug screens and medical tests conducted on the poor, Black pregnant women were solely for law enforcement purposes and not for medical reasons.[50]

The discretionary power described above, much like that prosecutors or police officers are afforded, can be corruptible and vulnerable to selective, but largely unchecked, enforcement, social bias, political ideology, and prejudice. This is particularly worrisome in physician-patient contexts because doctors and nurses enjoy unique and limitless access to patients' medical, social, and personal histories. Yet, unlike police and prosecutors, doctors do not receive legal training to understand patients' constitutional rights. There is no detached scrutiny by a neutral authority or judge to assess the permissibility of doctors gaining access to patient information for law enforcement purposes. No legal authority supervises the subjective dealings of doctors who may use the veil of medicine to obtain information for nonmedical purposes. By contrast, police cannot sign their own search warrants, and for good reason. Justice Brandeis explained that the "greatest dangers to liberty lurk in the insidious encroachment by men of zeal, well-meaning, but without understanding."[51]

Entangling doctors into quasi agent roles circumvents legal process and deceives patients, because pregnant women lack notice and warning that, while in the physical care of their physicians, a prenatal visit may also serve as a potential criminal investigation. Famously, in *Miranda v. Arizona* the Supreme Court ruled that in criminal investigations suspects in police custody must be warned of their right not to self-incriminate lest their constitutional rights be violated.[52] From this, "Miranda rights" emerged, resulting in the following warning becoming ubiquitous with law enforcement: "You have the right to remain silent. Anything you say can and will be used against you in a court of law. You have the right to an attorney. If you cannot afford an attorney, one will be provided for you. Do you understand the rights I have just read to you? With these rights in mind, do you wish to speak to me?" A corollary principle does not exist in medicine; there is no medical Miranda warning, although there should be, especially to avoid law enforcement circumventing legal process by using medical providers as proxies.

The *Ferguson* case is also about deception. Alarmingly, in *Ferguson* medical staff lured women into a legal trap under the pretense of providing medical services. For example, the lead nurse searched Darlene Nicholson's urine under the guise of medical treatment for hydration and threatened arrest after a positive urinalysis. Ms. Nicholson testified:

> They said I was dehydrated and I needed to be hooked up to glucose. . . . They told me to drink lots of water. . . . I asked them if I was to be hooked up to the glucose machine. . . . They just told me to keep drinking water . . . and told me to use the bathroom in a cup. . . . And I asked what for and they said to see if I had enough fluid in my system so they could send me home.[53]

Court documents further expose the extent of the hospital's deception, threats, and entrapment. Sandra Powell arrived at MUSC in labor. There, she was informed that because of a positive urine toxicology screen for cocaine, she would be arrested immediately. When Ms. Powell begged for medical help – "Please, what could I do to stop this or could you help me?" – the nurse "responded simply that she would 'be locked up.'"[54] Ms. Powell was arrested, "still in pain and bleeding from childbirth." To cover her body, she was given only a thin hospital gown on her transport to jail.[55] The nature of the arrests belies claims that the program had a medical emphasis.[56] In fact, patients arrested during the Search Policy's early months did not receive any drug treatment referral and "no opportunity to obtain treatment as an 'alternative' to arrest." Instead, "each aspect of the Search Policy was designed to assist law enforcement personnel in performing their duties."[57]

From the very start of MUSC's campaign to lure drug-dependent women to the hospital, the hospital staff's efforts took on a criminal focus. Mr. Good, MUSC's general counsel, even penned a letter to the local prosecutor indicating this. He wrote, "I read with great interest in Saturday's newspaper accounts of our good friend, the Solicitor for the Thirteenth Judicial Circuit, prosecuting mothers who gave birth to children who tested positive for drugs." On behalf of the hospital, Mr. Good asked that the prosecutor inform him "if your office is anticipating future criminal action" and inquired as to "what if anything our Medical Center needs to do to assist you in this matter."[58] *Ferguson* court documents, including memoranda, briefs, court transcripts, plaintiff exhibits, joint exhibits, and the briefs' appendices illuminate that the program's primary goal was to facilitate the arrests and criminal prosecutions of patients who used crack cocaine during their pregnancies by selectively targeting them for drug screenings rather than women who used other illicit substances generally.

For example, an MUSC physician testified that "although ingestion of heroin or alcohol poses serious risks of fetal harm, the nine criteria established by the taskforce members for searching pregnant women were drafted specifically to uncover cocaine use."[59] The Supreme Court's ruling that the MUSC program

violated the *Ferguson* plaintiffs' Fourth Amendment rights, because the program authorized nonconsensual searches and seizures without a valid warrant, holds promise for future pregnant women who are tracked and arrested under similar circumstances. However, as a practical matter, such legal victories may obscure the immediate costs associated with this type of racial profiling and arrests. Nor did the plaintiffs' victory in *Ferguson* signify an end to the very conduct at issue in that case. It should have done so, but it did not. More typical of the current efforts to upend reproductive rights is the tendency for legislators and prosecutors to seek to relitigate their losses.

Moreover, the problems extend beyond the physician's office, clinic, and hospital. Consider the following. Pregnant patients may not know that they risk the termination of parental rights after two years of incarceration. This matters, because legal appeals may take years after conviction. Even waiting for trial can take years. Pregnant women caught in the criminal justice system often experience pressure to accept corrosive plea deals – sometimes under threat of life sentences. Sadly, in today's political climate a poor pregnant woman takes these risks – when she simply wants prenatal care.

In assessing fetal protectionism, medical personnel may – and frequently do – make wrong calls. To comply with state statutes that encroach on and burden pregnant women's constitutional rights, doctors increasingly subordinate ethical obligations to their pregnant patients, while prioritizing punitive legal redress over medical treatment. It is not surprising that medical personnel are poor interpreters of state law. They are neither elected nor appointed. They are not trained or studied in the law or legislative processes. Worst of all, fetal protection laws' coercive effects and absurd outcomes harm not only pregnant women and their children but also the medical profession.

6.5 CONCLUSION

Most doctors seek to provide the best care possible for their pregnant patients and to keep them healthy and safe. However, the increased politicization of pregnancy and reproductive health catch doctors in ideological crosshairs, shifting reproductive health to a deeply political space that has very little to do with the provisions of healthcare. Instead, the politicization of reproductive healthcare generally, and pregnancy specifically now implicate criminal and civil law with significant consequences for women caught within that web.

For pregnant women, regardless of income, detecting and defending against the pitfalls of reproductive healthcare in the United States is a serious matter. Spotting when and whether medical providers might engage in conflicting behaviors, conflating their roles as medical providers with that of criminal informants can be virtually impossible. Lab coats and stethoscopes do not give this away. Nor is it likely that a doctor will reveal his or her conflicted interests to

patients before taking on the role of their medical provider. Patients assume that voluntary interactions with physicians pave the path toward promoting their health and that confidentially sharing their social and medical histories serve to achieve that goal.[60] Unfortunately, a culture where doctors breach confidentiality and share private patient information caution against that presumption, which is not good for society.

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