UNITED STATES DISTRICT COURT
DISTRICT OF MAINE

UNITED STATES OF AMERICA,	)	
	)	
	)	CRIMINAL ACTION
vs.	)	
	)	Docket No. 09-19-B-W
	)	
"Ms. T",	)	
	)	
Defendant.	)	

AMICUS CURIAE BRIEF OF MEDICAL, PUBLIC HEALTH, AND HIV EXPERTS AND ADVOCATES IN SUPPORT OF BAIL PENDING APPEAL OR, IN THE ALTERNATIVE, RE-SENTENCING

SUBMITTED BY:

National Women's Health Network, National Association of People with AIDS, Frannie Peabody Center, Mardge H. Cohen, M.D., Howard Minkoff, M.D., ACT UP Philadelphia, African Services Committee, AIDS Foundation of Chicago, Alliance of AIDS Services – Carolina, American Medical Students Association, Black Women's Health Imperative, Chicago Women's AIDS Project, Circle of Care, Community HIV/AIDS Mobilization Project, HIV Law Project, Immigrant Legal Advocacy Project, Liberty Research Group, National AIDS Fund, National Latina Institute for Reproductive Health, Rebecca Project for Human Rights, Twin States Network, Women Organized to Respond to Life-threatening Disease (WORLD),Women Rising Project, Women Together for Change Project, Jeff Berry, Wendy Chavkin, M.D., MPH, Leslie Gise, M.D., & Sean Strub.

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INTERESTS OF AMICI

As fully described in the Appendix A, *amici* are individuals and organizations who have recognized expertise and longstanding concern in the areas of maternal, fetal and neonatal health and in the treatment of HIV, particularly in the treatment of pregnant women living with HIV. *Amici* share this Court's desire to ensure that Ms. T receives the most appropriate and effective medical care. *Amici*'s public health and ethical mandates, however, require them to bring to this Court's attention the fact that Ms. T's sentence cannot be reconciled with evidence-based medical practices for pregnant women living with HIV, the Federal Sentencing Guidelines or legal principles concerning the constitutional rights of pregnant women and persons living with HIV.

STATEMENT OF FACTS

On May 14, 2009, Ms. T was sentenced to a term of 238 days in prison, a period of 7.9 months for the crime of possession and use of false immigration documents. S. Tr. at 22.[1] The recommended sentence in the Federal Sentencing Guidelines is zero to six months. *Id*. at 18. After having served 114 days, both Ms. T's counsel and the United States Attorney agreed that the appropriate sentence would be "time served." *Id*. at 3, 11, 12. This Court also acknowledged that "[o]rdinarily, I would give you what is called a time-served sentence." *Id*. at 19.

When this Court, however, learned that Ms. T was pregnant and HIV positive, it decided otherwise. PSH Tr. at 2. Although defense counsel explained that arrangements had been made for medical treatment outside of jail, *id.* at 4, S. Tr. at 2-3, 7, 25, the Court was "concerned … that if I release you today, that you may not be getting the medicine

[1] Hereinafter the transcript from the sentencing hearing on May 14, 2009 is referred to as "S. Tr." The transcript of the pre-sentencing hearing on May 8, 2009 is referred to as "PSH Tr."

you need for your child, and I'm inclined to keep you in jail … to prevent your child from being born HIV positive." S. Tr. at 20.

Based upon available information, and without benefit of briefing, expert testimony, or the participation of *amici* to address either the specific legal or medical issues, this Court extended Ms. T's sentence to ensure that she would remain in jail past her due date "to make sure that she, in all likelihood, had delivered and had a healthy baby." PSH Tr. at 6. Ms. T is currently incarcerated at Cumberland County Jail.

SUMMARY OF ARGUMENT

It is clear that the primary reason that Ms. T's sentence was extended, was to protect an "innocent person," Ms. T's "unborn child." PSH Tr. at 6; S. Tr. at 5, 8, 13. This Court acknowledged its concern: "that if she is released early, she will end up transmitting HIV to a wholly innocent person … I think I would bear that responsibility, and I don't intend to do it." *Id.* at 13. This Court explained: "I am not doing this to punish you. I'm doing it because under the law I have to take into consideration your medical condition, and the law allows me to do that, and I think it's only fair to your child to make sure that your child, to the extent possible, … is not born HIV positive." *Id.* at 20.

As *amici* clarify below, legal principles as well as public health principles concerning maternal and fetal health support this Court's initial instinct to release Ms. T for time served and to now release the Defendant on bail pending appeal.

ARGUMENT

I. Enhancing a Pregnant Woman's Sentence to Advance Fetal Health Is Not Supported By the Plain Language or Legislative Intent of the Federal Sentencing Guidelines.

Although, as this Court pointed out, the need for medical care may, on rare

occasions, be considered when determining a sentence, S. Tr. at 20, neither the plain language of the sentencing guidelines nor their legislative intent support upward or downward departures based on pregnancy, HIV status or the protection of the "unborn." When a federal statute or guideline is intended to reach or address pregnancy or "the unborn" it says so specifically. *See, e.g.*, *Burns v. Alcala*, 420 U.S. 575, 586 (1975) (refusing to interpret "dependent child in the federal AFDC program to include "unborn children."); 42 U.S.C. § 1395w-22(d)(3)(B)(i) (2009) (Medicare statute defining an "emergency medical condition" as a condition which would "plac[e] the health of the individual (or, with respect to a *pregnant* woman, the health of the woman *or her unborn child*) in serious jeopardy") (emphasis added).

The Federal Sentencing Guidelines, however, do not mention pregnancy, HIV or the unborn, nor do they authorize longer sentences to address these or any other condition that may be dangerous to future children. This is so despite the fact that neither pregnancy, HIV nor other medical conditions are unusual among federal inmates. *See United States v. Pozzy*, 902 F.2d 133, 138-39 (1st Cir. 1990) ("The pregnancy of convicted female felons is neither atypical nor unusual.").

Moreover, the First Circuit has specifically ruled that pregnancy is "not legally justified as a basis for a departure" explaining that "If [the Sentencing Commission] had thought pregnancy was a sentencing factor to be considered, the Commission would have said so." *Pozzy* at 139. The court found that the downward departure "was unreasonable as a matter of law" citing "§ 5H1.10 of the Guidelines that "states that sex is 'not relevant in the determination of a sentence.'" *Id.* at 138.

In *United States v. Booker*, 543 U.S. 220 (2005), the United States Supreme Court

held that the sentencing ranges established by Federal Sentencing Guidelines are advisory rather than mandatory. *Booker,* however, did not make the entire Sentencing Act advisory, only the sentencing ranges. *Booker* at 259 ("the remainder of the Act satisfies the Court's constitutional requirements"). Thus the prohibition on sex as a relevant consideration, which the *Pozzy* court recognized as including pregnancy, remains.

Moreover, to the extent the guidelines indicate that a medical condition and the need for medical care may be considered, it is clear that it is for the purpose of downward departures from the guidelines ranges, and not upward departures for the purpose of providing medical care in the federal prison system. *See, e.g.,* § 5H1.4 of 2008 Federal Sentencing Guidelines Manual ("an extraordinary physical impairment may be a reason to depart downward; *e.g.*, in the case of seriously infirm defendant, home detention may be as efficient as, and less costly than, imprisonment"). *Amici* are unable to identify any cases where a health condition or medical care justified an upward departure from the sentencing guidelines. Finally, "Congress's basic goal in passing the Sentencing Act was to move the sentencing system in the direction of increased uniformity." *Booker* at 253; 18 U.S.C. § 3553(6). Enhancing Ms. T's sentence not only has no support in the plain language of the Guidelines, it also violates Congress and the Commission's intent to ensure uniformity.

II. Courts have overwhelmingly refused to interpret existing laws to permit incarceration or punishment of pregnant women to advance fetal health interests.

The Oklahoma and Wisconsin Supreme Courts have considered whether existing law could be interpreted to permit the incarceration of a pregnant woman for the explicit purpose of promoting fetal health. Both held that the law did not permit detention for this

purpose. *See, In re Unborn Child of Starks*, 18 P.3d 342, 334 (Okla. 2001) (calling the drastic increase of bail to prevent a pregnant woman from exposing her fetus to methamphetamine, "inefficacious and un[en]forceable as an unauthorized application of judicial force"); *State ex. rel. Angela M.W. v. Kruzicki*, 561 N.W.2d 729 (Wis. 1997) (holding that the state's juvenile code did not permit the incarceration of a pregnant woman to prevent her from using cocaine in an effort to protect her fetus). *See also People ex. rel. H.*, 74 P.3d 494 (Colo. App. 2003), (dependency and neglect statute does not authorize incarceration of pregnant woman to advance health interests of the fetus). *Cf. Ferguson v. City of Charleston*, 532 U.S. 67 (2001) (special need to advance fetal health does not provide an exception to the 4th Amendment's prohibition on unwarranted searches and seizures). *See also In re A.C.*, 573 A.2d 1235, 1244 (D.C. 1990) (*en banc*); (concluding that asserted state interests in promoting health of viable fetuses do not permit detention and forced medical interventions on pregnant women).

This Court also expressed concern that it might have an obligation to protect Ms. T's future child from crimes, analogizing the transfer of HIV to an "unborn child" to "an ongoing assault." S. Tr. at 31-34. Courts, however, have overwhelmingly refused to interpret existing criminal laws to permit prosecution of pregnant women for allegedly endangering the health of the fetuses they carry. *See e.g. United States v. Foreman*, No. A.M.C. 028008, 1990 WL 79309 (A.F.C.M.R. May 25, 1990) ("we can find no legal basis, absent specific statutory authorization, to suggest that an unborn fetus was intended as a potential victim of criminal neglect" under the Uniform Code of Military Justice); *State v. Geiser*, 763 N.W.2d 469 (N.D. 2009); *Kilmon v. State*, 905 A.2d 306 (Md. 2006); *State v. Aiwohi*, 123 P.2d 1210, 1214 (Haw. 2005) (reversing manslaughter conviction

based on allegation that drug use during pregnancy caused infant death observing that "[a]n overwhelming majority of the jurisdictions confronted with the prosecution of a mother for her own prenatal conduct, causing harm to a subsequently born child, refuse to permit such prosecutions").[2]

While focusing on the fact that existing legislation does not authorize prosecution based on an alleged potential harm to the future child created during pregnancy, many courts recognize the significant due process implications of adopting such a judicial interpretation and the extent to which such an interpretation contradicts public health interests in advancing both maternal and fetal health. *See, e.g.*, *Johnson v. State*, 602 So. 2d 1288, 1297 (Fla. 1992) (reversing convictions for "delivering drugs to a minor" via the umbilical cord because "[t]he Court declines the State's invitation to walk down a path that the law, public policy, reason and common sense forbid it to tread").

III. Medical and Public Health Groups Unanimously Condemn Attempts to Protect Fetuses by Incarcerating Pregnant Women.

Numerous public health groups have recommendations regarding the treatment of HIV positive pregnant women. None of them suggest that incarceration is ever an appropriate response.[3] Moreover, the U.S. Public Health Service Task Force Perinatal

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[2] South Carolina is the only state that, as a result of judicial interpretation, has held that creating risk of harm to a viable fetus may be treated as child abuse. *Whitner v. South Carolina,* 492 S.E.2d 777 (S.C. 1997). In this closely divided opinion, the Court itself described as "radically different" from that of its sister states. Id at 782-83. South Carolina, however, recently acknowledged that due process requires sound scientific evidence in order to prove an allegation that something a pregnant woman did caused harm to a viable fetus. *McKnight v. State*, 661 S.E.2d 354 (S.C. 2008) (vacating conviction because defense counsel failed to challenge "*apparently outdated scientific studies* propounded by the State's witnesses" and failed to present expert testimony about "recent studies showing that cocaine is no more harmful to a fetus than nicotine use, poor nutrition, lack of prenatal care, or other conditions commonly associated with the urban poor.").

[3] See e.g. U.S. Preventive Services Task Force, *Recommendation Statement Screening for HIV*, Apr. 2007, http://www.ahrq.gov/clinic/uspstf05/hiv/hivrs.htm; Am. Acad. Pediatrics & Am. Coll. Obstetricians & Gynecologists, *Joint Statement on Human Immunodeficiency Virus Screening*, July 2006, http://www.acog.org/departments/perinatalHIV/sop9905.cfm; Am. Pub. Health Ass'n, *Women, Family Planning, and HIV Disease*, Jan. 1990,

Guidelines explicitly states: "Coercive and punitive policies are essentially counterproductive in that they may undermine provider-patient trust and could discourage women from seeking prenatal care and adopting health behaviors that optimize fetal and neonatal well-being."[4]

The American Medical Association,[5] the American College of Obstetricians and Gynecologists,[6] the American Academy of Pediatrics,[7] the March of Dimes,[8] the National Association of Public Child Welfare Administrators,[9] the American Nurses Association[10] and the Center for the Future of Children,[11] the National Perinatal Association[12] and the American Psychiatric Association[13] all oppose attempts to protect or improve fetal health by incarcerating pregnant women. The medical and public health consensus is that such approaches "ultimately undermine the health of pregnant women and their fetuses."[14] Exposure to infectious disease,[15] poor sanitary conditions, poor nutrition,[16] sexual

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http://www.apha.org/advocacy/policy/policysearch/default.htm?id=1223.

[4] U.S. Public Health Service Task Force, Perinatal HIV Guidelines Working Group, *Recommendations for Use of Antiretroviral Drugs in Pregnant HIV-Infected Women for Maternal Health and Interventions to Reduce Perinatal HIV Transmission in the United States*, Apr. 29, 2009, at 1 [Hereinafter "USPHSTF"].

[5] Am. Med. Ass'n Bd. of Trustees, *Legal Interventions During Pregnancy*, 264 JAMA 2663, 267 (1990).

6 Am. Coll. Obstetricians & Gynecologists, Committee Opinion 321 (Nov. 2005) ("Pregnant women should not be punished for adverse perinatal outcomes. The relationship between maternal behavior and perinatal outcome is not fully understood, and punitive approaches threaten to dissuade pregnant women from seeking health care and ultimately undermine the health of pregnant women and their fetuses.") Add the recent MFM guidelines cite from the 2000's

7 Am. Acad. Pediatrics, Comm. on Substance Abuse, *Drug-Exposed Infants*, 86 Pediatrics 639, 642 (1990).

8 March of Dimes, *Statement on Maternal Substance Abuse* 1 (Dec. 1990).

9 Nat'l Ass'n Pub. Child Welfare Admin., *Guiding Principles for Working with Substance-Abusing Families and Drug-Exposed Children: The Child Welfare Response* (Jan. 1991).

10 Am. Nurses Ass'n, *Position Statement* (Apr. 5, 1992).

11 Ctr. for the Future of Children, *Recommendations, 1 The Future of Children 8* (1991).

12 Nat'l Perinatal Ass'n, *Position Statement, Substance Use Among Women* (no date).

13 Am. Psychiatric Ass'n, *Care of Pregnant and Newly Delivered Women Addicts, Position Statement*, APA Document Reference No. 200101 (March 2001).

[14] Am. Coll. Obstetricians & Gynecologists, *Committee Opinion 321*, 106 Obstetrics & Gynecology 1127 (2005).

[15] Am. Med. Ass'n Bd. of Trustees, *Legal Interventions During Pregnancy*, 264 JAMA 2663, 267 (1990).

[16] Nat'l Council on Crimes and Delinquency, The Spiral Risk: Health Care Provision To Incarcerated Women 16 (2006), *available at* http://www.nccd-crc.org/nccd/pubs/2006_spiral_of_risk.pdf.

abuse,[17] high stress levels[18] and poor mental health care,[19] are also risks pregnant women face during incarceration.

As the United States Attorney in this case conceded at the sentencing hearing "[t]he Bureau of Prisons is not well designed to accomplish necessarily the end of providing medical care to a defendant and her unborn child." S. Tr. at 24. *See also* Appendix B. Thus, this Court's assumptions about the value of incarceration are not supported by medical and public health groups concerned with maternal and fetal health.

IV. Current Treatment Regimens for HIV Do Not Support the Assumption that Maternal and Fetal Health Will Be Advanced by Incarceration.

At the sentencing hearing, this Court stated "This is a situation where if she doesn't get the treatment that is critical, someone is going to be born with a terrible disease and will have to suffer for their life[.]" S. Tr. at 6. Fortunately, being HIV positive is no longer a death sentence. Moreover, even without any medical intervention, approximately 75% of children exposed to HIV in utero and during childbirth will not develop HIV. While it is true that with proper medical support transmission rates can be reduced to 2%, as the discussion below demonstrates, this can be accomplished most effectively through access to specialized and flexible care that is best provided outside of the jail and prison setting.

A. Appropriate Health Interventions for Pregnant HIV-Infected Women

While all babies born to mothers living with HIV test positive for HIV antibodies,

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[17] Office of the Inspector General, U.S. Dept. of Justice, Deterring Staff Sexual Abuse of Federal Inmates, Apr. 2005, http://www.usdog.gov/oig/special/0504/final.pdf (Kathleen Sawyer, a former Bureau of Prisons Director, stated that inmate sexual abuse was the "biggest problem" she faced as Director.)

[18] Megan Bastick & Laurel Townhead, Women in Prison: A Commentary on the UN Standard Minimum Rules for the Treatment of Prisoners at 42 (June 2008) ("The high level of stress that accompanies incarceration itself has the potential to adversely affect pregnancy.").

[19] *See, e.g.,* Dawn Gagnon & Bill Trotter, *Officials Working to Prevent Suicides in Maine Jails*, BANGOR DAILY NEWS, Sept. 13, 2007, at A4 (discussing responses to 44th suicide attempt in Maine jails from 2002 to 2007).

this does not necessarily mean these babies will develop HIV. Without any medical intervention, approximately 75% of these children will not develop HIV.[20] Prophylactic measures such as antiretroviral therapy ("ARV therapy") in combination with the use of elective cesarean section delivery when appropriate reduce the perinatal transmission rate still further, to less than 2%.[21]

In order to ensure the health of a pregnant woman living with HIV and provide the best chance of preventing perinatal transmission, it is vital that pregnant HIV positive women have access to medical staff trained to tailor her drug therapy to her specific medical needs and adjust it according to her response and side-effects. In this case, the Court focused on the presumed availability of AZT to Ms. T if she were to remain in federal custody, *see* S. Tr. at 29, based on the understanding that AZT treatment is "therapy that is vital for the infant." S. Tr. at 2-5. [22] Although AZT monotherapy has proven effective, current guidelines indicate that a three-drug combination regimen is preferred for treatment of the woman's own infection as well as prevention of transmission to her fetus. USPHSTF at 5. Moreover, the timing of the pharmacologic intervention will depend on whether the mother needs ARV therapy for her own health, or whether the purpose of the ARV therapy is to lower the risk of transmission to her fetus. *Id.* at 19-20. It is essential for physicians to understand these nuances and to be able to prescribe and alter treatments to respond to the changing needs of a pregnant woman living with HIV.

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[20] Joseph P. McGowan & Sanjiv S. Shah, *Prevention of Perinatal HIV Transmission During Pregnancy*, 46 J. Antimicrobial Chemotherapy, 657-668 (2000).
[21] *See Achievements in Public Health: Reduction in Perinatal Transmission of HIV Infection—United States, 1985–2005*, 55 MMWR 592 (2006).
[22] The Court believed that Ms. T would be unlikely to receive AZT if she were released from prison. *See* S. Tr. 29.

It is also vital for a pregnant woman living with HIV to be treated by a physician with the experience to understand and respond to the unpleasant and debilitating side effects of ARV treatment that may compel some patients to stop taking them or miss doses. Missing doses may lead to drug resistance, which results in a decrease in treatment options. This particular problem can be complicated by drug regimens that require people to take multiple pills several times a day. Thus, medication adherence counseling and side effect management are essential components to proper care.

These complex sets of factors require care by physicians with experience in HIV and those with obstetric expertise, as well as coordination of care between these specialists, and the ability to tailor treatment to the particular needs of the woman. The USPHSTF states "Medical care of the HIV-infected pregnant women requires coordination and communication between HIV specialists and obstetrical providers." *Id*. at 16. In addition, USPHSTF guidelines require the provision of support services, mental health services, and drug abuse treatment, depending on the individual circumstances of the woman.[23] Moreover, specialists should develop long term plans with the pregnant woman for continuity of medical care.

B. Appropriate HIV Care Is Not Consistently Available in Correctional Facilities.

Adequate HIV treatment regimentation is variable across the country, but "lack of experienced HIV clinicians, lack of concern over inmate confidentiality, and medical segregation have resulted in dismal outcomes."[24] *See also* Declaration of Dr. Robert

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[23] *Id.* ("Coordination of services among prenatal care providers, primary care and HIV specialty care providers, mental health and drug abuse treatment services, and public assistance programs is essential to ensure adherence of the infected woman to antiretroviral treatment regimens.").

[24] Sandra A. Springer & Frederick L. Altice, *Managing HIV/AIDS in Correctional Settings*, 2 CURRENT HIV/AIDS REPORTS 165 (2005). *See also* Press Release, American Civil Liberties Union, Lives of HIV Positive Prisoners in Mississippi Saved by Lawsuit, Says the ACLU (April 1, 2005), http://www.aclu.org/prison/medical/14739prs20050401.html (quoting U.S. Magistrate Judge Jerry Davis as

Cohen, Appendix B (describing the variability in HIV care in US jails and prisons, often leading to poor outcomes).

The National Commission on Correctional Health Care ("NCCHC") Standards for Health Services creates best practices for the provision of health services in correctional settings and to govern its accreditation program for prisons and jails. But even accredited correctional medical units face significant challenges in their efforts to ensure quality medical care in the midst of numerous, and often competing, priorities around security and safety. HIV care and women's health care, including in pregnancy, are both specifically identified in NCCHC 'Position Statements,' which are released when "issues arise or medical/technical advances are made that the standards do not address."[25]

The NCCHC's position statement on Women's Health Care in Correctional Settings speaks to the unique and persistent challenges in addressing the often complicated and high-risk pregnancies of incarcerated women: "Pregnant inmates have high levels of psychological distress, yet often do not receive counseling and support services. Likewise, screenings for postpartum physical and psychiatric complications often are not performed."[26] Similarly, the NCCHC's statement on the Administrative Management of HIV in Correctional Institutions recognizes "The correctional administrator's role in assuring continuity of care, one of the most challenging factors to

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stating "Great strides were made in the treatment of HIV-positive inmates[.]"); Paul von Zielbauer, *As Health Care in Jails Goes Private, 10 Days Can Be a Death Sentence*, N.Y. TIMES, Feb. 27, 2005, at M-1, available at http://www.nytimes.com/2005/02/27/nyregion/27jail.html?pagewanted=1&_r=3 (describing a woman in Albany County Jail who went into labor in the facility's maternity unit and the death of her infant three days later. An investigation revealed that prison health nurses failed to properly care for the mother and her baby. "The medical staff made an appointment with an obstetrician it paid to visit every two weeks, but Ms. Venny never saw him, state investigators said; nurses ordered her files from a Bronx women's clinic, but never received them.").

[25] Nat'l Comm. on Corr. Health Care, *Position Statements*, Oct. 9, 2005, http://www.ncchc.org/resources/statements/intro.html.

[26] Nat'l Comm. on Corr. Health Care, *Position Statements: Women's Health Care in Correctional Settings*, Oct. 9, 2005, http://www.ncchc.org/resources/statements/womenshealth2005.html.

HIV care in jails and prisons, cannot be overstated. Improved patient outcomes are directly related to the administration's ability to monitor and enhance the management of its HIV program."[27]

Prison medical conditions need not reach the level of gross medical neglect, the constitutional minimum,[28] to be life threatening to pregnant HIV-infected women. Because of issues like cumbersome intake procedures and unpredictable lockdowns for security concerns, lapses in ARV schedules are common occurrences in correctional settings nationwide and in Maine. For example, in response to a 2008 lawsuit alleging an inmate was deprived of his HIV medications in the Cumberland County Jail, Sheriff Mark Dion acknowledged that "there was a lag time in assessing his particular need[,]" a delay may have allowed his HIV to become drug-resistant.[29] *See also* Appendix B, Declaration of Robert L. Cohen, M.D. ("It is very common for prisoners to have frequent and prolonged interruptions of their anti-retroviral medications."). Further barriers to standard of care treatment for pregnant HIV-infected women arise in small or remote correctional settings, where specialty care is handled predominantly through outside referrals, not medical staff on-site.[30] Finally, the lack of prison nursery programs raises significant concerns for the continued health and well-being of babies after delivery due to separation from their mothers immediately after birth.[31]

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[27] Nat'l Comm. on Corr. Health Care, *Position Statements: Administrative Management of HIV in Correctional Institutions*, Oct. 9, 2005, http://www.ncchc.org/resources/statements/admin_hiv2005.html.
[28] *See Estelle v. Gamble*, 429 U.S. 97 (1976).
[29] Trevor Maxwll, *Man's Lawsuit Says Jail Withheld Medical Care*, PORTLAND PRESS HERALD, Feb. 26, 2008, *available at* http://pressherald.mainetoday.com/story.php?id=172048&ac=PHnws.
[30] See e.g. Cumberland County Sheriff's Office, 2007 Annual Report. http://www.cumberlandso.org/Sheriff/PDF%27s/Annual%20Report%202007/2007%20CCSO%20Annual%20Report%20final%20(16%20pgs).pdf.
[31] *See* Women's Prison Ass'n, Mothers, Infants and Imprisonment: A National Look at Prison Nureries and Community-Based Alternatives, May 2009, http://www.wpaonline.org/pdf/Mothers%20Infants%20and%20Imprisonment%202009.pdf (noting that

V. Continued incarceration of Ms. T violates numerous constitutional rights.

While this Court need not reach constitutional issues, *amici* note that interpreting the Guidelines to permit incarceration of pregnant women to "make sure" that they have "delivered … a healthy baby," S. Tr. at 2, or to prevent "grievous injury to a wholly innocent person" S. Tr. at 31, would render this application of Guidelines unconstitutional. Because every circumstance, condition, experience, action or inaction of a pregnant woman can influence fetal health and could become a basis for incarceration or upward sentencing, deprivations of liberty based on alleged risks to fetal health violate Constitutional guarantees of liberty, privacy, equality, due process and freedom from cruel and unusual punishment. U.S. CONST. amend. IV, V, VI, VIII, XIV.

As the Maryland Court of Appeals recently noted in refusing to interpret Maryland's criminal child endangerment statute to apply to the context of pregnancy, pregnant women could otherwise be subjected to liability for "engaging in virtually any injury-prone activity" such as:

> [C]ontinued use of legal drugs that are contraindicated during pregnancy, to consuming alcoholic beverages to excess, to smoking, to not maintaining a proper and sufficient diet, to avoiding proper and available prenatal medical care, to failing to wear a seat belt while driving, to violating other traffic laws in ways that create a substantial risk of producing or exacerbating personal injury to her child, to exercising too much or too little[.]

Kilmon, *supra* at 311-12. *See also Stallman v. Youngquist*, 531 N.E.2d 355, 361 (Ill. 1988) (refusing to recognize the tort of maternal prenatal negligence, noting that holding her liable for this would "infringe[] on her right to privacy and bodily autonomy.").

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nursery programs and community-based residential parenting programs are only available a limited number of correctional facilities nationwide.).

A woman who cannot overcome a health problem in the short term of a pregnancy faces a stark choice – become subject to incarceration for the alleged benefit of the fetus, or obtain an abortion and avoid imprisonment altogether or, as in this case, for an extended length of time.[32] Incarcerating a woman because she continues a pregnancy to term in spite of a health problem violates the right to procreate. *See, e.g.*, *Planned Parenthood v. Casey*, 505 U.S. 833, 859 (1992) (noting that *Roe v. Wade*, 410 U.S. 113 (1973) "had been sensibly relied upon to counter" attempts to interfere with a woman's decision to become pregnant or to carry to term).

Extending incarceration based on claims of fetal protection also singles out women for enhanced penalties and thus violates constitutional prohibitions on gender discrimination. *See Lovill v. State,* No. 13-07-00529-CR, 2008 WL 5275531 (Tex. App. Dec. 22, 2008), *discretionary rev. granted*, PD-09-0401 (Tex. Ct. Crim. App. May 6, 2009) (finding selective prosecution including revocation of probation because of pregnancy implicates the Equal Protection Clause). Incarceration for the status of HIV and pregnancy also implicates the 8th Amendment's prohibition on cruel and unusual punishment. *See Robinson v. California*, 370 U.S. 660 (1962). Further, incarceration with the goal of providing medical care implicates the right to parent and the right to refuse medical treatment. In deciding that an HIV positive pregnant woman's choice to

[32] Courts dismissing prosecutions against women for allegedly endangering fetal health have recognized the possibility of coerced abortions. *See e.g.*, *Johnson v. State*, 602 So. 2d 1288, 1296 (Fla. 1992) ("Prosecution of pregnant women for engaging in activities harmful to their fetuses or newborns may also unwittingly increase the incidence of abortion."). In *State v. Greywind*, Martina Greywind was charged with reckless endangerment based on the claim that by inhaling the vapors of paint fumes, she was creating a substantial risk of serious bodily injury or death to her fetus. After she obtained an abortion, the prosecutor dropped the case, stating "[d]efendant has made it known to the State that she has terminated her pregnancy. Consequently, the controversial legal issues presented are no longer ripe for litigation." Motion to Dismiss With Prejudice, *State v. Greywind*, No. CR-92-447 (N.D. Cass County Ct. Apr. 10, 1992). See *also* Gail Stewart Hand, *Women or Children First?*, GRAND FORKS HERALD, July 12, 1992, at 1.

not take retroviral medication did not constitute civil child abuse or neglect, the New Jersey Supreme Court held:

> The decisions she makes as to what medications she will take during her pregnancy … are left solely to her discretion after consultation with her treating physician. The right to make the decision is part of her constitutional right to privacy, which includes her right to control her own body and destiny. Those rights include the ability to refuse medical treatment, even at the risk of her death or the termination of her pregnancy.

New Jersey Division of Youth and Family Services v. L.V., 899 A.2d 1153, 1158 (N.J. 2005). Because it is clear that the Guidelines were written to avoid these kinds of Constitutional issues, this Court should grant bail pending appeal or re-sentence Defendant to time served.

CONCLUSION

For the foregoing reasons, *amici* respectfully request this Court to release Defendant on bail pending appeal, in the alternative, re-sentence Defendant to time served.

Respectfully Submitted,

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