Breastfeeding Controversies: The Debate Continues
Legal Considerations/Controversies
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Setting the Legal Stage

Breastfeeding is optimal for infant nourishment

1. Health Canada, the American Academy of Pediatrics, the World Health Organization (WHO), the Academy of Breastfeeding Medicine, the United Nations Children's Fund (UNICEF) and other reputable health authorities agree that breast milk is optimal nutrition for infants and provides unparalleled benefits for health, growth, immunity and development. Emotional (psychosocial), environmental and economic benefits of breastfeeding also are well-documented. In 2003, the WHO went so far as to recommend "enacting **imaginative legislation** protecting the breastfeeding rights of working women and establishing means for its enforcement." [emphasis added]
2. As part of an effort to promote and facilitate breastfeeding in the United States, President Obama signed the Patient Protection and Affordable Care Act into law in March 2010. Section 4207 of this Act provides nonexempt breastfeeding employees with "reasonable break time" and a private place, other than a bathroom, to express breast milk during the workday up until a child's first birthday. Employers with fewer than fifty (50) employees able to demonstrate hardship in complying with this law may be exempted. The law does not preempt state laws that provide greater protections to employees. Today, most states have breastfeeding laws that allow women to breastfeed in any public place and in some cases states have laws that excuse breastfeeding mothers from jury duty.

The right to breastfeed is protected by law.

3. In *Dike v. Orange County*, the United States Court of Appeals for the Fifth Circuit held that breast feeding is a constitutional right protected under the Ninth and Fourteenth Amendments to the United States Constitution. (Dike v. Orange County Sch. Bd., 650 F. 2d 783 (5th Cir 1981)). The Court noted, "Breastfeeding is the most elemental form of parental care. It is a communion between mother and child that, like marriage is intimate to the degree of being sacred." The Court further likened a decision to breastfeed to protected liberties found in procreation, contraception, abortion and family relationships, and observed, "[i] n light of the spectrum of interests that the Supreme Court has held specially protected we conclude that the Constitution protects from excessive state interference a woman's decision regarding breastfeeding her child." The Court held that a public employer's interference with a woman's decision to breastfeed must "further sufficiently important state interests, and be closely tailored to effectuate only those interests."

4. A woman's **Right to Bodily Autonomy** is protected under the Fourteenth Amendment to the United States Constitution. For example, the United States Supreme Court has ruled that a woman has a right to decide to have an abortion (Roe v. Wade, 410 U.S. 113). However the State/Government also has rights, and once the fetus becomes viable and the State has a compelling interest [in the viable fetus] the state can intervene on behalf of the fetus. This analysis is easily translated to breastfeeding. While states have enacted laws protecting a woman's right to breastfeed at work and in public, the State may decide that when a woman is breastfeeding and ingesting/ injecting/smoking a substance that is perceived to put the infant at risk, there is a compelling state interest to intervene on behalf of the newborn. Using this analysis, even if the breastfeeding mother is using legal drugs, such as ETOH, the state could argue that in certain circumstances the child is at risk for abuse /neglect.
5. A woman's **Right to Privacy** is protected by the First, Third, Fourth, Fifth and Fourteenth amendments and includes, for example, the right to use contraception or decide to terminate a pregnancy. However, as in the *right to autonomy*, the Supreme Court has circumscribed the right to privacy to protect a viable fetus. In other words, government intrusion into a woman's privacy is justified when the State can prove a compelling or substantial government interest that outweighs the privacy interest. Again, it is not difficult to see how a state could translate this to prove that a woman's right to breastfeed is trumped by the state's compelling interest to protect the infant.
6. A woman has a **Right to Procedural Due Process** under the Due Process Clause of the Constitution which states that" [n]o State shall…deprive any person of life, liberty, or property, without due process of law." This means, in part, that courts must interpret and apply existing laws as intended by the legislature – which is why it is important to understand what the legislature intended.
7. Example of State Law: New York State has been extremely proactive in support of breastfeeding and amended its Civil Rights Act in 1994 to include the right to breastfeed. The New York legislature noted that breastfeeding is "the most basic act of nurture between mother and baby."
    a. § 79-e. Right to breast feed. "Notwithstanding any other provision of law, a mother may breast feed her baby in any location, public or private, where the mother is otherwise authorized to be, irrespective of whether or not the nipple of the mother's breast is covered during or incidental to the breast feeding."
    b. § 2505-a. Rights of breastfeeding mothers. **Breastfeeding Mothers' Bill of Rights**: "Choosing the way you will feed your new baby is one of the important decisions you will make in preparing for your infant's arrival. Doctors agree that for most women breastfeeding is the safest and most healthy choice. It is your right to be informed about the benefits of breastfeeding and have your health care provider and maternal healthcare facility encourage and support breastfeeding …"

[Editor's Note: I encourage you to take a peek at this exhaustive Bill of Rights in detail – see http://www.health.ny.gov/publications/2028.pdf]

Constitutional rights are not absolute.

8. The right to breastfeed, however, is not absolute and must be balanced against countervailing interests. In other words, while there is a strong presumption that a breastfeeding mother has a right to make decisions for her child, including the decision to breastfeed, this presumption is trumped if it is determined that the mother is not acting in the best interest of the child.

Parental rights also are protected by the Constitution but they too are not absolute

9. Parental rights are afforded constitutional protection and parents are given enormous deference by the courts.
10. This means that as a general rule parents have a right to raise their children however they see fit.
    a. In 1923, the United States Supreme Court determined that the Due Process Clause of the Fourteenth Amendment gives parents a substantive **fundamental** right to make decisions for their children. See *Meyer v. Nebraska*, 262 U.S. 390 (1923) [emphasis added].
    b. The Court repeatedly has noted that parental rights warrant deference and should be protected absent a powerful countervailing interest.
11. By classifying parental rights as *fundamental*, state action to terminate these rights is subject to a *strict scrutiny* analysis and requires clear and convincing evidence that termination is warranted.
    a. Fundamental Rights are a well-defined group of rights identified by the United States Supreme Court that require a high degree of protection from government intrusion. Laws limiting these rights must pass strict scrutiny to be upheld. Examples include:
        a. See Bill of Rights
            1. Freedom of Speech
            2. Freedom of Religion
        b. Right to Self-Determination
        c. Right to Privacy
        d. Right to Marry
        e. Right to Use Contraception
    b. Strict Scrutiny is the most stringent standard of judicial review in the United States.
12. Take Away: Parental rights are highly protected but are not absolute.

13. In evaluating whether parental rights should be terminated (to any degree), courts unanimously seek the best interests of the child. If a court decides that a parent's conduct is not in the child's best interest, then the parent's decision-making powers may be overridden.
14. The state's interest in the child is known as *parens patriae*, which translates to "parent of the country." This is a common law doctrine originating in England that permitted the king to assume a general guardian role over his subjects.

NAS is on the Rise Setting in Motion Tensions Between Rights of Parents and the State

15. See timely article in **The Boston Globe**, front page on March 30, 2014: *Cases of Newborns with Addictions Soaring*, by Jenifer McKim and Michael Bottar (but note sensationalist language in article).
    a. On 3-27-14, Governor Deval Patrick declared a public health emergency to combat the increasing abuse of opiates, and ordered that police, firefighters, and other emergency personnel be equipped with Narcan.

Child Abuse and Neglect Laws (See *80 Points of Light* for more detailed review)

16. Typically, in child abuse and neglect cases, there are competing rights of the parents (as noted under Parental Rights) and the State. The law's basic premise is that it is the child's best interests, which are paramount. Allegations of abuse and neglect, especially when illegal drugs are involved, may lead to early intervention by child welfare authorities to protect a child at risk. As we discussed during our last session, in practice some courts have ruled that children born with positive toxicology screens for illegal drugs and/or other evidence of prenatal drug exposure may be removed, at least temporarily, from their parents' custody.
17. Most states, like **New Hampshire** and **Vermont** have statutes mandating that health care providers (and a laundry list of other mandatory reporters), *shall report* reasonable suspicions of child abuse or neglect to child protective services.
    a. For example, in Vermont, a mandatory reporter "who has reasonable cause to believe that any child has been abused or neglected shall report or cause a report to be made in accordance with the provisions of section 4914 of this title within 24 hours." The Vermont definition of an abused child is as follows: **"An "abused or neglected child" means [in pertinent part] a child whose physical health, psychological growth and development or welfare is harmed or is at substantial risk of harm by the acts or omissions of his or her parent or other person responsible for the child's welfare."** [emphasis added]
    b. Keep in mind that under the federal law CAPTA healthcare providers must have policies and procedures in place to notify Child Protective Services of *all* infants born and identified as affected by illegal substance abuse, withdrawal symptoms resulting from prenatal drug exposure, or a Fetal Alcohol Spectrum Disorder and to establish a plan of safe care for these newborns. The CAPTA report is separate

and distinct from a duty to report abuse and neglect under the state child abuse/neglect law(s). Reporting under CAPTA shall not be construed to be child abuse or neglect and is intended to "identify infants at risk of child abuse and neglect so appropriate services can be delivered to the infant and mother to provide for the safety of the child."

General Problems Faced by Providers

18. Many drug treatment programs are not well-suited to mothers, who need child care and a treatment philosophy different from the "confrontational" style typical of some programs.
19. Mothers who are fearful of the "system" and punitive action will be deterred from breastfeeding or will lie about their drug history.
20. The information providers gather about a mother's abuse history often is flawed. If a mother admits she is using a certain drug, providers often are willing to believe her. But if she denies it (or is not asked about it) providers may miss identifying maternal substance abuse.
21. It is hard to quantify the exact risk to the baby if a substance abusing mom breastfeeds. The risk to the baby depends on the type of drug she uses, the amount she takes, and how often she takes it. It also depends, in part, upon an accurate history.
22. Providers try to allow breast feeding if the substance-abusing mother satisfies certain criteria (e.g. enrolling in a program, being clean for a certain number of weeks etc.), but some providers believe these are made-up criteria and not based on good research. A mother who has been in a program for just two weeks might quit substance abuse successfully and never relapse, whereas a mother who has been clean for eight weeks might fall off the wagon.
23. It is hard to control what parents do at home. They may breastfeed the baby against provider recommendations.
24. Health professionals often exhibit bias against the substance abusing mother and sometimes recommend against breast feeding for flimsy or unsubstantiated reasons.
25. Lack of evidence-based guidelines
26. Sometimes scientific evidence is inconclusive or contradictory causing confusion for the provider. This makes it difficult to know what is optimal or even safe for mother and child.
    a. See Maine Supreme Court case *In re Nikolas E.*, (1998)
        i. Maine Supreme Court affirmed that an HIV positive mother had the right to refuse to treat her HIV positive son with AZT because the mother's decision was "rational and reasoned"' given that the "likely effects of the treatments on the child" were unknown.
        ii. When the defendant mother decided to postpones AZT treatments, her physician reported her to the state child protective services and recommended that her parental rights be removed.
        iii. The State of Maine responded by arranging a meeting between the defendant mother and a group of pediatric AIDS specialists but mom was undeterred.

iv. The State then filed a petition for a child protection order.
v. The District Court denied the order and the Maine Supreme Court heard the case on appeal.
vi. The Maine Supreme Court reviewed the opinions of the pediatric AIDS specialists who were consulted on the case and concluded, "*The Department has proven that according to the current conventional medical wisdom in the relatively new and rapidly evolving art of treating children with certain elevated levels of HIV in the blood, that Nikolas would benefit from such treatment. However, it has not sufficiently proven what that benefit will likely be and that no significant injury or harm may ultimately befall the child if that therapy is commenced* ***.... With the relative uncertainty of efficacy of the proposed treatment, it can only reasonably be left up to the parent to make an informed choice in this regard****."[emphasis added]*

b. Even [scientific] studies involving the benefits of breast milk over formula may differ as noted in a recent article in **The New York Times***: Is Breast-Feeding Really Better?* by Nicholas Bakalar, **The New York Times**, March 4, 2014.
c. Scientific opinions change, which may lead to provider lack of confidence in the scientific "*opinion du jour*." For example, between 1983 and 2001, The Academy of Pediatrics (AAP) had a long-standing recommendation against breastfeeding if the maternal methadone dose was above 20 mg/day. However, in 2001, the AAP lifted the dose restriction of maternal methadone allowing methadone-maintained mothers to breastfeed. [Note however despite the fact that this ban has been lifted, by the AAP, methadone-maintained mothers continue to face barriers to breast feeding. See article by Tara Hilton referenced below].
d. Difficulty separating out effects of intrauterine exposure from postnatal exposure via breastfeeding.
e. Sparse pharmacokinetic data

27. Providers are aware of other behaviors and exposures that may pose risks to a newborn, including but not limited to nicotine use, alcohol consumption, poor nutrition, domestic violence, homelessness and the use of legal substances - which may present a higher risk than some of the illegal substances.
28. Child Protective Services in most states are understaffed and overextended.

Best Practices

29. Adhere to certain ethical principles of respect and beneficence
    a. Respect
        i. Respect the breastfeeding woman as an autonomous decision maker

b. Beneficence
    i. Maximize good consequences for mother and child
    ii. First Do No Harm
    iii. Do everything possible to preserve and maintain relationship between mother and child
    iv. Utilize intervention strategies that benefit mother and child and strengthen and maintain family unit

30. Know your state laws about confidentiality: Federal regulations concerning the confidentiality of alcohol and drug abuse patient information (42 CFR Part 2) takes precedence over State laws, *except in cases where child abuse is concerned*. Therefore it is critical that you know your state child abuse laws so that you don't promise confidentiality if you cannot deliver on that promise.
31. Adhere to federal and state laws and be aware of state advisories and recommendations.
    a. Keep up-to-date about changing state and federal laws.
    b. Report to child protective services as the law dictates
    c. *Location Location Location*: State laws determine the fate of substance-abusing lactating women. Pay attention to your state laws but understand that sometimes the state may have a reasonable approach but a local county prosecutor will take an extreme punitive stand. You need to know the local position.
32. Most states have an Office of Substance Abuse and Mental Health Services, or its equivalent, which provide information about substance use and breastfeeding. For example, the State of Maine's website warns, "Maternal substance abuse is not a categorical contraindication to breastfeeding. Adequately nourished narcotic-dependent mothers can be encouraged to breastfeed if they are enrolled in a supervised methadone maintenance program and have a negative screening for HIV and illicit drugs…" The site identifies and comments on the following substances: Alcohol, Buprenorphine, Cocaine, Marijuana, Methadone, Methamphetamine, and Tobacco. As you develop your own hospital policies and procedures, you should cross reference your state advisories.
33. Be familiar with current CDC Guidelines
    a. The CDC believes there are rare cases when human milk is not recommended and has stated, "Under certain circumstances, a physician will need to make a case-by-case assessment to determine whether a woman's environmental exposure or her own medical condition warrants her to interrupt or stop breastfeeding."
34. Be familiar with current American Academy of Pediatrics Guidelines.
    a. The American Academy of Pediatrics maintains an extensive list of prescription and non-prescription drugs, indicating their compatibility with breastfeeding
    b. "Maternal substance abuse is not a categorical contraindication to breastfeeding. Adequately nourished narcotic-dependent mothers can be encouraged to breastfeed if they are enrolled in a supervised methadone

maintenance program and have negative screening for HIV and illicit drugs."

c. "Street drugs such as PCP … cocaine, and cannabis can be detected in human milk, and their use by breastfeeding mothers is of concern, particularly with regard to the infant's long-term neurobehavioral development and thus are contraindicated."

35. Develop a patient and family centered interdisciplinary *plan of care* policy for babies born to women with suspected or documented illegal substance abuse. Collaborate with local/regional Child Protective Services. Policy should include guidelines for identifying women and newborns at risk for withdrawal from substance use/abuse.
36. Provide adequate INFORMED CONSENT addressing both risks and benefits of a decision to breastfeed depending upon the facts and circumstances in a given case. DOCUMENT this discussion in the medical record.
37. Develop hospital guidelines and stick to them. Be consistent.
    a. Develop specific clinical guidelines that maintain continuity of care among healthcare providers.
        a. Make sure guidelines are compliant with State law
        b. Editor's Pick: Utilize excellent resource from *ABM Guidelines for Breastfeeding and the Drug-Dependent Woman* by Lauren Jansson. *See Bibliography.*
    b. Care and recommendations should not vary depending upon which provider is on duty.
    c. Standardize! Standardize! Standardize!

<u>Examples of Different Punitive Legal Approaches</u>

38. We noted during my session last fall that circumstances exist in which pregnant women have been deprived of their liberty and subject to arrests, detentions and forced interventions absent any due process rights (including but not limited to the right to effective counsel) and despite a panoply of appellate court decisions dismissing or reversing these actions. *Pregnant* woman using illegal drugs have been prosecuted under existing criminal laws or by expanding the civil definition of child abuse or neglect to include prenatal substance abuse. Other types of charges that have been filed against pregnant women who use illegal drugs include but are not limited to: Felony Child Abuse/Neglect; Corruption of a minor ; Chemical Endangerment; Assault with a deadly weapon; Reckless injury; Delivering drugs to a minor [through umbilical cord]. In many of these cases, the prosecutors failed because the courts refused to find that a fetus is a person. [Editor's Note: Although cases involving pregnant women and fetuses often result in courts refusing to identify a fetus as a person, cases involving lactation and newborns would not need to cross that hurdle and therefore theoretically would be easier to prosecute.]

39. Every state has its own child abuse and endangerment laws that may include manufacturing controlled substance in the presence of a child, to giving drugs to a child, or using a controlled substance that impairs a care givers ability to adequately care for a child. I encourage anyone interested in reading a great summary to check out the **Quinnipiac Law Review** article listed in the Bibliography. As noted in this article, at the same time methamphetamine use began to skyrocket in the late 1990's many states began passing state statutes that protected children from endangerment by exposure to controlled and chemical substances. Colorado's child endangerment statute states, "Methamphetamine use and manufacturing place countless Colorado children at risk of methamphetamine ingestion and exposure to toxic chemicals, weapons, pornography, predators, and impaired and neglectful caretakers. These children are at increased risk of neglect as well as physical and sexual abuse." Other state statutes are less specific and simply protect children from exposure to "any controlled substance" or to "drug distribution activities." Examples of these latter statutes include Maine and New Jersey.
40. The Utah drug endangerment statute is particularly interesting in light of the *Utah v. Draper* case discussed below.
    a. When the statute first was passed in 2000 it stated, "Any person who knowingly or intentionally causes or permits a child or elder adult to be at risk of suffering bodily injury from exposure to, ingestion of, inhalation of, or contact with a controlled substance, chemical substance, or drug paraphernalia … is guilty of a felony of the third degree."
    b. All of the above becomes a first degree felony if the child or elder adult actually dies as a result of the said exposures.
    c. Although the Utah code defines "chemical substance", "child," "controlled substance," and "drug paraphernalia," it does not define "exposure to", ingestion of" "inhalation of" and "contact with."
    d. In 2002, Utah amended this statute and took out the "risk" part so that under the new law, prosecutors only have to prove that the defendant "knowingly or intentionally caused or permitted a child or elder to be exposed to, to ingest or inhale, or to have contact with a controlled substance, etc."
    e. In addition, the legislature added an affirmative defense regarding prescription drugs and stated that the defendant could claim that "the controlled substance was provided by lawful prescription for the child or elder adult, and that it was administered to the child or elder adult in accordance with the prescription instructions provided with the controlled substance."
    f. In 2011, the statute again was amended so that the definition of "chemical substance" was expanded to include: (A) a substance intended to be used as a precursor in the manufacture of a controlled substance; (B) a substance intended to be used in the manufacture of a controlled substance; or (C) any fumes or by-product resulting from the manufacture of a controlled substance.

g. The 2011 legislature also included a definition for the term "exposed to" which includes (1) As used in this section: "Exposed to" means that the child or vulnerable adult: (i) is able to access or view an unlawfully possessed:(A) controlled substance; or (B) chemical substance (ii) has the reasonable capacity to access drug paraphernalia; or (iii) is able to smell an odor produced during, or as a result of, the manufacture or production of a controlled substance. (See *Utah v. Draper* below)

41. **Utah v. Draper** (Utah Court of Appeals, Case No. 20040879-CA Filed January 12, 2006): Summary of Facts:
    a. In 2004, a police officer executed a search warrant of Becky Draper's residence. Draper was on the scene and spoke with the police officer. She told the police that her husband had been selling marijuana for 18 months but she did not admit to any drug use herself.
    b. The police search revealed marijuana and drug paraphernalia in a basement room. There was also some cash in the Draper's bedroom as well as a small amount of marijuana.
    c. A few weeks later, an investigator with the Division of Child and Family Services (DCFS) made an unannounced visit to the Draper's home regarding potential child endangerment of TD, a six-month old child. During this conversation, Becky Draper admitted to using marijuana twice since TD was born.
    d. During this same conversation Draper began to breastfeed TD while the investigator told her about "the dangers of using marijuana and nursing" The investigator did not request a drug test of Becky Draper or TD.
    e. Becky Draper was later charged with one count of endangerment of a child, which is a third degree felony in Utah (Utah Code Ann. Section 76-5-112.5 (2003), after she allegedly exposed her child to marijuana, a controlled substance by breast-feeding.
    f. The only evidence presented was the testimony of the DCFS investigator.
    g. The trial court found that it had enough evidence (presumably the testimony of the investigator) to conclude that "breast-feeding will transmit the marijuana … through breast milk to the child if it is smoked."
    h. The Appeals Court overturned the trial court's decision and determined that there was no admissible evidence in support of this finding because the investigator lacked the scientific expertise to reach this conclusion. The Court noted, …"even if we were to infer that Draper nursed mere hours after consuming marijuana, the nature and duration of any resulting contamination would remain issues requiring expert testimony or other scientific evidence to establish, the details of which would not be subject to judicial notice…. The presence of marijuana in Draper's breast milk at the time she nursed TD is the heart of the State's case against Draper. Without some expert testimony suggesting that Draper's breast milk was

likely to have contained a controlled substance at any particular time, there is no probable cause to believe that she violated section 76-5-112.5 on the theory charged by the State…."

i. The Court concluded that the prosecution could have proceeded on a theory of exposure to a controlled substance through contaminated breast milk if the State had presented sufficient expert testimony to establish the existence, nature, and duration of the contamination. However, since the State failed to do so, the Court found in favor of the breastfeeding mother.

42. Nicole Cummings from NY faced criminal charges for breast feeding her 14-month-old infant while using cocaine. In this case traces of cocaine were found in the infant's blood.
43. Kathleen Tyson of Eugene, Oregon was HIV positive. When her son was born in December 1998 and testing HIV negative, the pediatrician advised that the child be given AZT and not breastfed. (AZT was the first drug approved for the treatment of HIV and it belongs to a class of drugs called nucleoside analogs. Short term side effects include nausea, bone marrow suppression, and periodic seizures to name a few. Long term side effects include cancer and significant damage to the reproductive system. Long term effects on infants is less clear) Ms. Tyson refused to agree with this plan and shortly thereafter she and her husband were charged with intent to harm. The Court ordered the Tysons to begin administering AZT for six weeks and to stop breastfeeding. The Court took legal custody but allowed the Tysons to retain physical custody. Note: The CDC policy continues to be that HIV-infected women in the United States should not breastfeed their infants.
44. Tabitha Walrond, a poor 19-year-old mother was charged with manslaughter and was convicted of criminally negligent homicide after her child died of malnutrition. Wolrond breastfed her child.

a. *Mother Convicted in Infant's Starvation Death Gets 5 Years' Probation* (**The New York Times,** 9-9-1999)

"A Bronx woman who was convicted of criminally negligent homicide in the starvation death of her infant son was sentenced yesterday to five years' probation by a judge who said that a jail term would "not serve the public interest or rehabilitate the defendant." The woman, Tabitha Walrond, 21, shed tears of relief as she was sentenced in State Supreme Court in the Bronx by Judge Robert H. Straus, who rejected the prosecution's request for a jail term of six months.

But Judge Straus admonished Ms. Walrond to accept responsibility for the death of her 2-month-old son, Tyler, and to "reject the theories of victimization" advanced by people who have protested her conviction. He also ordered her to undergo psychological counseling.

Ms. Walrond, who was 19 when Tyler died in August 1997, had been breast-feeding the boy, but her lawyers argued during the three-week trial that she was unaware that her surgically reduced breasts were producing insufficient milk. They also argued that she was misguided by her own mother and that when she sought help for her son she was rebuffed by the health care system because he had no Medicaid card.

Judge Straus said yesterday that despite the mitigating circumstances in the case, "The mother is the bottom line." "The buck stops here," he said. Addressing Ms. Walrond, he added, "The only victim in this case is Tyler Walrond, though in many ways you are a victim of yourself."

The judge said he had received about 900 letters from around the world, all supporting Ms. Walrond and asking for leniency, but he added, "These cases are not decided by plebiscite." He called the jury's verdict "correct"; it acquitted Ms.Walrond of second-degree manslaughter but convicted her of the lesser charge of negligent homicide.

The Bronx District Attorney, Robert R. Johnson, said that although the judge had rejected his request for a six-month prison term for Ms. Walrond, he was pleased that her sentence would include counseling. "I felt that treatment was the paramount concern," he said. "I think justice has been done." Quoting from a psychiatric evaluation of Ms. Walrond, which the prosecution had requested, the judge said Ms. Walrond lacked insight into the emotional problems that may have contributed to her failure to perceive that her son was in dire need of medical attention.

Dr. Robert H. Berger, the psychiatrist who conducted the evaluation, said Ms. Walrond showed signs of "narcissistic personality disorder" that may have caused her to react defiantly when her self-esteem was in jeopardy -- as when her ex-boyfriend and his mother told her the baby was too thin and, days before Tyler's death, urged her to feed him formula in addition to breast milk. When, in addition to lacking child-care skills, she found herself incapable of negotiating the obstacles of the health care system and unable to cope with "continued feelings of rejection and loss associated with her breakup," Dr. Berger wrote in his assessment for the prosecution, "Ms. Walrond reacted with extreme passive-aggressiveness." Unconsciously, he said, her "feelings that others were withholding from her the attention and assistance she was owed led her in turn to withhold from her son." But he added, "I believe that Ms. Walrond feels genuine remorse, a profound sense of loss, and she accepts some, although perhaps insufficient, responsibility."

Marcia Purrell, the baby's paternal grandmother, read a long statement to the court before Ms. Walrond was sentenced and held up photos of the baby as a healthy eight-pound newborn and as a corpse. "Tabitha, how could my beautiful grandson change from this to that?" she asked. "How could your mother -- especially your mother and her family -- allow this to happen?" She asked that Ms. Walrond be sentenced to jail, "or an institutional setting so you will get the help that you need."

What happened in the last six weeks of Tyler's life may remain psychologically unclear, the judge said. "In this case there is no classic physical abuse of the child or intent to harm a child, I'm certain of that." Among the hundreds of letters, postcards and E-mail messages the judge and prosecutors in the case received, some from as far away as Japan, were many from mothers who said that they, too, had almost let a child starve to death while breast-feeding with the best of intentions. Lactation experts testified at the trial that nursing mothers who see a baby every day may misperceive even extreme weight loss, until a pediatrician weighs the baby.

But misperception "is not an absolute defense to criminally negligent homicide," Judge Straus said. He added, "If something like this were to occur again, there might well be another prosecution."

In June, two weeks after her conviction in Tyler's death, Ms. Walrond was arrested in a Bronx park by police officers responding to a complaint that people were smoking marijuana there. She was charged with possession of three bags of the drug. Judge Straus called the marijuana charge, on which Ms. Walrond is still awaiting sentencing, "relatively benign," but warned her that another arrest could lead to the revocation of her probation and imposition of a prison term in the negligent homicide.

Among the conditions of Ms. Walrond's probation are that she hold a job or be enrolled in school, and that if she has a child during the period of probation, that she take parenting classes. She has recently been accepted by a four-year-college, her lawyer told the court, and is already receiving services from a mentoring program recommended by the judge. "You've suffered the loss of your child," the judge told her. "I don't think anything can be worse."

Downside and Potential Consequences of Punitive Approach

45. Responding to issues of drug use through punitive measures will likely yield worse outcomes for infants and children and are counterproductive.
46. On the flip side, programs that support and nurture women lead to improved outcomes in their infants. Nurture the mother … nurture the child.
47. Existing punitive legal actions against pregnant or lactating women have the added burden of affecting minority women disproportionately.
48. The American Medical Association, the American Academy of Pediatrics, the American Nurses Association, as well as many other public health organizations, medical groups and other experts oppose legislation that criminalizes maternal drug addiction.
49. Studies have shown that a woman's effort to change addictive behavior may be frustrated by child welfare interventions because the interventions typically are adversarial in nature and mandate unrealistic timetables.
50. The punitive approach incorrectly treats addiction as a moral failing. Instead, addiction, according to ACOG is a "chronic, relapsing, biological and behavioral disorder with genetic components … subject to medical and behavioral management in the same fashion as hypertension and diabetes." This definition is of critical importance because it means our mandate is to treat the drug-addicted mother- just as we would treat a mother with diabetes.
51. The 2012 Florida Legislature adopted legislation creating a Statewide Task Force on Prescription Drug Abuse and Newborns, chaired by Attorney General Pam Bondi, to examine the extent of prescription drug abuse among expectant mothers, including costs of caring for babies with neonatal abstinence syndrome, long-term effects of the syndrome, and prevention strategies. I urge you to take a look at the February 2013 Final Report.

Women Involved in Substance Abuse Treatment Programs -Buprenorphine or Methadone

52. Most medical authorities agree that while breastfeeding may be a difficult choice for the opioid-drug-dependent woman, drug-exposed infants and their mothers stand to benefit significantly from breastfeeding.
53. In an ideal world drug-dependent women who are pregnant and wish to breastfeed should take part in comprehensive substance abuse treatment long before labor and delivery.
54. Women who abuse drugs during pregnancy are not one-size-fits-all and therefore specific prenatal treatment plans need to be developed to meet the needs of each individual woman while preparing her for parenting, breastfeeding, and post-partum substance abuse treatment. Treatment plans may need to include transportation to and from a treatment facility.
55. Remember that women should be given consistent, evidence-based information about the risks and benefits of breastfeeding in each specific case. This is, in fact, an **informed consent** discussion.
56. Methadone, buprenorphine and naltrexone are agents approved by the FDA for use in the Rx of opioid dependence.

a. According to product labeling, potential effects on breastfeeding infants from methadone and buprenorphine include lethargy, respiratory difficulty and poor weight gain.
b. Most research supports the conclusion (see Glatsetin) that exposure of infants to methadone through their mother's breast milk is minimal and women using methadone for treatment of opioid dependence should not be discouraged from breast feeding.
c. Long-term effects of **methadone** are not known. However, it has been reported by the American Academy of Pediatrics that methadone levels in human breast milk are low- with calculated infant exposures less than 3% of the maternal weight-adjusted dose.
d. The Academy of Breastfeeding Medicine suggests that concentrations of **methadone** in human milk are indeed low and "therefore women stable on methadone maintenance should be permitted to breastfeed if desired." The Academy recognizes that infants with significant NAS symptoms may have trouble with breastfeeding mechanics but despite this, breastfeeding should be encouraged because infants who are successfully breastfed are less likely to have severe NAS.
e. Although the manufacturer of **buprenorphine** recommends against breastfeeding while taking this medication, many case studies indicate that the amount of buprenorphine in human milk is small and unlikely to have negative effects on the developing infant. According to the American Academy of Pediatrics infant exposure appears to be approximately 2.4% of the maternal weight-adjusted dose. There is some indication- from animal studies- which may or may not correlate with humans- that the drug decreases milk production and viability of offspring.
    a. If buprenorphine is used during breastfeeding, the fact that the drug-manufacturer recommends against it must be discussed with the patient as part of the informed consent process. DOCUMENT! DOCUMENT! DOCUMENT!
f. As far as **naltrexone**, FDA labeling advises caution when using this drug in nursing infants of opioid-dependent women. It appears that published information about this drug comes from one (1) case report that estimates infant exposure at only 0.86% of the maternal weight-adjusted dose.
g. Although some studies as reported by the American Academy of Pediatrics conclude that transferred amounts of methadone or buprenorphine to the breast fed infant are not sufficient to prevent symptoms of NAS, there is evidence that the breast milk may play a role in decreasing NAS symptoms and shortening the length of their hospital stay. According to one study (2012) by Pritham, Paul, and Hayes, neonates who were breastfed were less likely to require treatment for

NAS and had shorter hospital stays leading some to conclude that breastfeeding may actually protect neonates withdrawing from opiates. (See Bibliography)

57. Pregnant women who take methadone or buprenorphine during pregnancy typically get increasing doses in the third trimester and after birth those doses are tapered.
58. Neonates experience abrupt withdrawal at birth and typically are treated with oral morphine, tincture of opium, methadone or buprenorphine. Other combinations of drugs such as opiates plus phenobarbital have been effective as well.
59. AGOG (2012) supports breastfeeding in opioid-dependent women who are involved in substance abuse treatment so long as they 1) screen negative for HIV; abstain from using ETOH, illicit drugs and amphetamines; and have no other contraindications for breastfeeding. Their statement is in part: "Women should be counseled that minimal levels of methadone and buprenorphine are found in breast milk regardless of the maternal dose. Although the current buprenorphine package advises against breastfeeding, a consensus panel reported that the effects on breastfed infants are minimal and, therefore, not a contraindication. Breastfeeding should be encouraged in women without HIV who are not using additional drugs and have no other contraindications."
60. The American Academy of Pediatrics (2012) also supports breastfeeding among opioid – dependent women in substance abuse treatment. Their policy states, "Adequately nourished narcotic dependent women can be encouraged to breastfeed if they are enrolled in a supervised methadone maintenance program and have negative screening for HIV and illicit drugs."
61. Centre for Substance Abuse Treatment in Canada states, "Although the packaging on buprenorphine formulas Subutex and Suboxone advise mothers treated with these medications not to breastfeed, CSAT states that any effects of these medications on the breastfed infant would be minimal and that breastfeeding is therefore not contraindicated. However, given the limited literature in this area, physicians are advised to use their professional judgment in their recommendations."
62. Most maternal/newborn units encourage breastfeeding if the maternal urine drug screen is negative for illicit substances. At Dartmouth-Hitchcock Medical Center the policy for women with a history of substance abuse is as follows:

For mothers who wish to breastfeed, the following criteria must be met:

1. Mother has been compliant with standard of care prenatal visits for at least the third trimester of pregnancy (10 weeks prior to birth) *AND*
2. Mother has had negative drug of abuse screening for at least the third trimester of pregnancy (including upon admission to the BP for mothers with substance use during known pregnancy) *AND*
3. Mother has been compliant in a drug addiction treatment program for at least the third trimester of pregnancy (10 weeks prior to birth).

• If a drug addiction treatment program is not available, mother must meet strict criteria above.

• A drug addiction treatment program is not mandatory if the mother is in an established recovery period and there are no concerns for substance use during pregnancy (compliant with standard prenatal visits, negative drug of abuse screening per screening guidelines).

63. Given this type of hospital policy, it is important that opioid-dependent women understand the benefits of breastfeeding for infant and maternal health early on- even at the first prenatal visit- with reinforcement at subsequent visits. They also must understand the hospital's policy for breast feeding. Last minute surprises are bad.
64. During prenatal visits healthcare providers must evaluate the mother-infant dyad when considering breastfeeding. Some factors to consider:
    a. Whether or not woman has received consistent prenatal care
    b. Maternal desire to breastfeed
    c. Maternal drug use and substance abuse treatment histories
    d. Medical and psychiatric status and medication needs
    e. Infant health status
    f. Status of family/community support systems as well as lactation support
    g. Willingness of mother to engage in substance abuse treatment and consent to having substance abuse treatment counselor share PHI with other providers as needed

<u>Cannabis *aka* Marijuana</u>

65. Cannabis (marijuana) is a **Schedule I drug of the Controlled Substances Act**. Schedule I drugs, substances, or chemicals are defined as drugs with no currently accepted medical use and a high potential for abuse. Schedule I drugs are defined as the most dangerous drugs of all the drug schedules with potentially severe psychological or physical dependence. Some examples of Schedule I drugs are: heroin, lysergic acid diethylamide (LSD), marijuana (cannabis), 3,4-methylenedioxymethamphetamine (ecstasy), methaqualone, and peyote.
66. Legal Landscape of Marijuana in the United States:
    a. The States:
        a. Colorado and Washington have legalized recreational marijuana sales.
            1. Gov. John W. Hickenlooper of Colorado estimated that taxes from legal marijuana sales would be $134 million in the coming fiscal year.
        b. Bills or initiatives to legalize non-medical marijuana for adult use- taking the same or similar approaches as Washington State and Colorado- have been introduced in at least 17 states. Most of those efforts are considered unlikely to succeed this year.
        c. According to a 2-26-14 article in *The New York Times*, Oregon and Alaska will likely be next to outright legalize marijuana. In Alaska, sufficient

signatures have been collected to get the legalization initiative on the ballot. Under Alaska state law the vote will occur during the Aug. 19 primary, not in the general election.

d. Decriminalization means that marijuana remains illegal, but the penalties are softened or reduced to fines. District of Columbia lawmakers voted in March 2014 to decriminalize the possession of small amounts of marijuana. The measure would make possessing up to an ounce of marijuana a civil infraction punishable with a fine as low as $25 and seizure of the drug. Medical marijuana is legal in DC but the penalty for possession of recreational marijuana is up to six months in jail and up to a $1,000 fine.

e. Medical marijuana use already is legal in 20 states and the District of Columbia.

b. Feds

a. Marijuana is illegal under federal law but the Obama administration has promised not to interfere with the rollout of legal marijuana in states so long as states are successful in keeping it out of the hands of minors and other safety measures are met.

b. The Treasury Department just issued guidelines intended to make it easier for banks to do business with legal marijuana businesses.

67. Need for more robust scientific evidence:

a. Tetrahydrocannabinol (THC) is present in human milk, and metabolites not found in human milk are found in infant feces and urine which indicates that THC is absorbed and metabolized by the infant but it is not clear whether or not there are long-term effects on infant development from perinatal THC exposure.

b. 'To the Editor" *The New York Times* 2-19-2014: Orrin Devinsky and Daniel Friedman's Op-Ed essay, "We need Proof on Marijuana" (Feb 13), highlights a significant problem with current drug policy. While there is no shortage of anecdotal evidence about the medical benefits of marijuana, federal barriers prevent doctors from scientifically studying marijuana. The fact that the Controlled Substances Act lists it as a Schedule 1 substance- like heroin or LSD- is part of the problem. Researchers seeking access to it must jump through complicated bureaucratic hoops. In fact, a federal administrative law judge ruled in 2007 that researchers had been denied adequate access to marijuana. That is part of the reason that I, joined by 17 of my House colleagues, have formally requested that President Obama reschedule marijuana from Schedule 1 to a less restrictive classification. More than one million people legally use medical marijuana in 20 states and the District of Columbia. It's time the federal government caught up with the rest of America. Earl Blumenauer (2-14-14, Democrat representing the Third District of Oregon)

68. Pregnant women have been prosecuted for using marijuana while pregnant and it seems to me that it is not a large leap for these same prosecutors to go after women who are using marijuana while breast feeding. Breastfeeding is an easier case for these prosecutors to make because they will not have to cross the hurdle of whether a fetus is a person under a given

state law and because they can charge women under existing criminal or civil child abuse/neglect statutes.

a. In the case of Alma Baker, the state of Texas had passed a law in 2003, known as the Prenatal Protection Act (SB 319), which stated that for the purposes of murder and aggravated assault, a fetus was "an unborn child at every stage of gestation from conception to birth." (*see also* Laci Peterson law). The purpose of this kind of law, as noted during my last session, is to charge a perpetrator with two crimes if he/she kills a pregnant woman. The District Attorney in Potter County, Texas, Rebecca King, began charging pregnant women themselves with Delivery of a Controlled Substance to a Minor. Under this law, King charged Alma Baker because Baker, who delivered twins in 2003, tested positive for marijuana. Baker pled guilty to the charge in exchange for five-years' probation, a fine of $1,000.00, compulsory parenting classes and 250 hours of community service.
b. Lynn Paltrow 's response: " There is no question that every leading medical group opposes what DA King is doing as dangerous to fetal health. What people have found is that laws like these frighten women away from getting the care they could get if it were appropriate and available." Others saw King as making an end run around *Roe v. Wade*.

69. Most clinicians recommend that lactating women refrain from using marijuana. Many states have similar guidelines. Maine, for example, states the following about marijuana on its Office of Substance Abuse and Mental Health Services website: "Marijuana should not be used by nursing mothers because it may impair their judgment and child care abilities. Marijuana should not be smoked by anyone in the vicinity of infants because the infants may be exposed by inhaling the smoke. Some evidence indicates that paternal marijuana use increases the risk of sudden infant death syndrome in breastfed infants."
70. What about lactating women in Washington State and Colorado where marijuana is now legal, or women consuming medical marijuana in states where it is legal?
    a. In one article (Murfin, Cheryl, *The Great Ganja Debate*, **Seattle Child Newsletter**, www.seattlechild.com/article/great-ganja-debate) the author writes, "Now that marijuana use is legal in Washington, some moms and childbirth professionals are hoping there can be an open discussion about its use to treat common pregnancy issues including chronic vomiting, sleeplessness, anxiety, labor pain and postpartum stress. Currently most health care providers recommend that pregnant and nursing women abstain from marijuana use. However, scientific research on the drug's long term effects on children is incomplete and sometimes wrong."
    b. A professor of Pediatrics at the University of Washington, Leslie Walker, noted, "The fact that marijuana is legal does not change its addictive properties nor change the dangers to the unborn child."

c. The Washington Department of Health has commented, "We have done no independent research on this issue, and have no real expertise regarding marijuana and its health impacts."

71. There are plenty of unknowns about marijuana including but not limited to:
    a. Long-term effects of marijuana on a breastfeeding child.
    b. How marijuana impacts a mother's ability to care for her child.
    c. Interaction with other medications.
    d. Legal liability implications for lactation consultant or nurse.
72. Pumping and dumping is not an option with marijuana because marijuana can linger in the body for weeks.
73. ACOG recommends that women should <u>not</u> be tested for marijuana without their consent.
74. Marijuana does cross the placenta resulting in detectable cord blood levels. Marijuana can also be found in breast milk in what most believe to be very low levels. One study indicated that exposure to the neonate was 0.8% that of the mother. (Djulus J, Moretti M, Koren G. Marijuana use and breastfeeding. Can Fam. Phys. 2005; 51:349-350).
75. Major issues with marijuana involve [anecdotal] threats to health and safety via increased sedation of the breast-fed child or maternal impairment while mom is using marijuana.
76. While other substances found in breast milk such as caffeine and alcohols are not contraindicated for breast feeding, marijuana is more controversial because it is illegal in most states.

<u>Drug testing</u>

77. If you are considering drug testing, mothers should be informed about this prospectively (*not post hoc*) and the rationale for testing should be documented in the medical record.
    a. This should be an on-going discussion that begins prenatally and continues after birth and during lactation.
        a. According to ACOG Committee Opinion Number 524, May 2012, "Screening for substance abuse is part of complete obstetric care and should be done in partnership with the pregnant woman. Both before pregnancy and in early pregnancy, all women should be routinely asked about their use of alcohol and drugs, including prescription opioids and other medications used for nonmedical reasons."
    b. Some states/hospitals suggest that a woman's general consent to treatment upon admission covers drug testing in the perinatal period. While you need to consult with your own legal counsel about this, in my opinion it is a dangerous precedent to rely on a general consent to drug test mom.
    c. If a woman refuses testing, document the refusal and do not test over her objection.
        a. **Fourth Amendment**: The Fourth Amendment of the United States Constitution governs all searches and seizures conducted by government

agents: "The right of the people to be secure in their persons, houses, papers, and effects, against unreasonable searches and seizures, shall not be violated, and no warrants shall issue, but upon probable cause, supported by oath or affirmation, and particularly describing the place to be searched, and the persons or things to be seized." (refer to *80 Points of Light*)

d. Testing of the newborn, however, remains an option.

Interesting Issues Involving Breasts and the Law Unrelated to NAS

78. It has been reported that the United Arab Emirates is requiring women to breastfeed until their babies reach the age of two (2). If a mother fails to meet the requirement, her husband can sue her. The law was introduced as part of a revised Child Rights Law. According to one article in the *Washington Times*, lawmakers argued that breast milk is the healthiest option for a baby and that it is a mother's "duty" to breastfeed.

79. *Breast-Feeding Services Lag Behind the Law* ,Catherine Saintlou, **The New York Times**, September 30, 2013 : "First efforts at breast-feeding are not as intuitive as it seems," said Dr. Linda Rosenstock, chairwoman of the Institute of Medicine's committee on preventive services for women, adding**,** "Some women need additional professional support so they do it well and continue to do it." Despite the law, many new mothers have found it nearly impossible to get timely help for breast-feeding problems since Jan. 1, when health insurers began updating their coverage. While a 2011 Surgeon General's report hailed lactation consultants as important specialists, few insurers have added them to their networks. Some insurers simply point women to pediatricians not necessarily trained in lactation. Even then, women often must locate help on their own, leading to delays that jeopardize a mother's milk supply. Breast-feeding advocates fear this mandate is falling victim to bureaucratic foot-dragging, cost-saving and ambivalence. "It's abysmal, the state of lactation services being provided by insurance companies currently," said Susanne Madden, a founder of the National Breastfeeding Center, which last month published an unsettling assessment of the breast-feeding policies of insurers nationwide. Twenty-eight out of 79 received D's or F's. New mothers face a number of obstacles in breast-feeding, including insufficient milk or a painful infection. Problems must be resolved quickly: when a baby is hungry, there is little time to wrangle with an insurer over payment for a breast pump or a lactation consultant. A delay can mean that mothers turn to formula, don't establish an adequate supply, or quit. In August, when her son had trouble latching, Maryanne Conte, 40, called her insurer, Blue Cross Blue Shield Illinois. Time was of the essence, as her doctor said the baby was failing to thrive. A customer representative confirmed that lactation consultations were covered, Ms. Conte said, but could not name anyone in-network nearby or confirm coverage for the consultant her pediatrician had recommended. She paid $240 out of pocket for a house call from that consultant, and with some assistance, her son opened his jaw wider to feed more effectively and her milk production increased. Two months postpartum, she is exclusively breast-feeding. But Blue Cross Blue Shield Illinois would not reimburse the fee. "I don't understand how an insurer can get away with denying lactation consultations that they are required to provide," said Jonathan Conte, 31, her husband. Mary Ann Schultz, a spokeswoman for the insurer, said Ms. Conte's specialist did not have "state-recognized certification," and so would not be covered. She said Ms. Conte had been told as much. After reviewing the call notes, Ms. Schultz also said Ms. Conte never asked for providers in Brooklyn, where she lives. The Health and Human Services Department says insurers cannot deny lactation services simply because they lack trained providers in-network; they are obligated to cover one out of network. An unreasonable delay is also not acceptable. "We are committed to working with insurers and consumers to ensure that women receive the benefits they are entitled to under the law," said Joanne Peters, a spokeswoman for the department. Jessica Lang Kosa, a lactation consultant in Newton, Mass., says some mothers are sent on wild goose chases. Their insurers tell them to find a consultant certified by the International Board of Lactation Consultant Examiners, then to call back to check if that person's services are covered. But it's "an exercise in futility," Ms. Kosa said, because the insurer often has no such lactation consultants as providers. Aetna is a notable exception. The insurer has lactation consultants in-network, and it covers out-of-network consultants. But other insurers advise women to

get help from an in-network ob-gyn or a pediatrician. “It’s the lactation visits that many insurers are not covering, the face-to-face clinical evaluation by somebody who can provide a higher level of care,” said Marsha Walker, of the U.S. Lactation Consultant Association. “A physician doesn’t have the time and, a lot of times, does not have the training to do this.” Just as the health care act doesn’t specify what kind of breast pump insurers have to furnish, it doesn’t say who qualifies as a “trained provider” of lactation counseling. Tamara Hawkins, a nurse practitioner and lactation consultant in Manhattan, said, “I don’t think they will be able to justify they are giving women the help they need without bringing on specialized lactation consultants.” The law does permit insurers to require that providers be state-licensed in order to be included in an insurer’s network. Lactation consultants are not currently licensed by states, but now some are pushing for it**.”**

80. Jacob Gershman, **The Wall Street Journal Law Blog**, 3-17-14: “An opinion handed down by the Eight U.S. Circuit Court of Appeals last week described a difficult situation for one mother just back on the job from maternity leave. As recounted in the ruling, Angela Ames was feeling overwhelmed with work on her first day back as a loss-mitigation specialist at Nationwide Mutual Insurance Co. in Iowa. Her two-month-old baby needed to be nursed, according to the ruling, but she couldn’t use the company’s lactation room because she hadn’t completed the paperwork that mothers are required to fill out for access. After waiting for a “wellness” room to open up, her boss warned her that she had two weeks to get done all the work that had piled up during her absence. As she became visibly upset, her boss told her: “You know, I think it’s best that you go home to be with your babies.” He then handed her a pen and a piece of paper and dictated her resignation letter, according to the ruling. For Ms. Ames, it was a rough morning, one that when combined with other alleged actions on the part of the company constituted discrimination. The Eighth Circuit, however, disagreed. MS. Ames sued Nationwide in 2012, alleging sex and pregnancy discrimination. She claimed the lack of an available lactation room, “her urgent need to express milk,” and Nationwide’s “unrealistic and unreasonable expectations about her work production” left her no choice but to resign, according to the court records. Her claim was supported by the U.S. Equal Employment Opportunity Commission, which filed a friend-of-the-court brief arguing that she had been a victim of discrimination. In an unanimous decision that upheld a lower-court ruling, the Eighth Circuit concluded that Nationwide didn’t force her to resign but instead “sought to accommodate [her] needs. “Although Nationwide incorrectly calculated Ames’s [Family & Medical Leave Act] leave, it made efforts to ameliorate the impact of its mistake. . . . Furthermore, even though [Nationwide department head Karla] Neel discouraged Ames from taking unpaid leave up to August, Neel gave Ames an extra week of maternity leave, which gave Ames more than thirty days to prepare for her return to work. Rather than intentionally rendering Ames’s work conditions intolerable, the record shows that Nationwide sought to accommodate Ames’s needs. “Moreover,” continued the panel, “Ames was denied immediate access to a lactation room only because she had not completed the paperwork to gain badge access. Every nursing mother was required to complete the same paperwork and was subjected to the same three-day waiting period.” The Eighth Circuit also noted that by not going back to the wellness room to see if it were open or alerting human resources about her predicament, Ms. Ames “failed to avail herself of the channels of communication provided by Nationwide to deal with her problem. “ “Nationwide is fully committed to supporting the health and wellness needs of all of our associates, including providing lactation space when needed,” a Nationwide spokeswoman said in a statement. “We agree with the court’s decision.” Paige Fiedler, an attorney representing Ms. Ames, said the court”failed to recognize that the company had a duty to provide her with a private sanitary room to express milk.”Frustrated, some mothers have also complained to their state insurance commissioners, according to the National Association of Insurance Commissioners, or turned to advocacy groups. “It’s not surprising insurance companies are saying no,” said Judy Waxman, of the National Women’s Law Center. “We have to keep pushing them and educating them and telling them what the law really says.”

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