IN THE SUPREME COURT OF THE STATE OF NEW MEXICO

STATE OF NEW MEXICO, Plaintiff-Appellant, v. **ALEXEE J. TREVIZO**, Defendant-Appellee.	**No. S-1-SC-40478**

AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS' MEMORANDUM BRIEF AS AMICUS CURIAE

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TABLE OF CONTENTS

Page

TABLE OF AUTHORITIES

Page(s)

Cases

New Mexico Constitutional Provisions and Rules

Other Authorities

IDENTITY AND INTEREST OF AMICI CURIAE[1]

The American College of Obstetricians and Gynecologists (ACOG) is the nation's leading group of physicians providing evidence-based obstetric and gynecologic care. As a private, voluntary nonprofit membership organization of more than 60,000 members, ACOG strongly advocates for equitable, exceptional, and respectful care for all people in need of obstetric and gynecologic care; maintains the highest standards of clinical practice and continuing education of its members; promotes patient education; and increases awareness among its members and the public of the changing issues facing patients and their families and communities. ACOG opposes medically unnecessary laws or restrictions that serve to delay or prevent care. ACOG has previously appeared as amicus curiae in jurisdictions throughout the country, and its briefs and guidelines have been cited by numerous courts as providing authoritative medical data regarding childbirth and abortion.[2]

INTRODUCTION AND SUMMARY OF THE ARGUMENT

On May 18, 2023, Alexee Trevizo was charged with one count of first-degree murder, or in the alternative, child abuse resulting in death and one count of

[1] No counsel of a party authored this brief in whole or part, and no person other than amici or their counsel made any monetary contribution intended to fund the preparation or submission of this brief.

[2] See, e.g., June Med. Servs. LLC v. Russo, 140 S. Ct. 2103, 2131 (2020); Whole Woman's Health v. Hellerstedt, 579 U.S. 582, 612–13 (2016); Stenberg v. Carhart, 530 U.S. 914, 928 (2000); Whole Woman's Health v. Paxton, 978 F.3d 896, 910 (5th Cir. 2000); Planned Parenthood S. Atl. v. State, 882 S.E.2d 770, 787–88 (S.C. 2023).

tampering with evidence based on the outcome of her pregnancy. [**RP 1].** In her answer-brief, Ms. Trevizo asks the court to reject the state's violation of her constitutional right against self-incrimination and the protections guaranteed to her by the physician-patient privilege under Rule 11-504 NMRA. Understanding how these violations intersect with harm to the health care system and the clinician-patient relationship is critical to the Court's adjudication of the issues under consideration.

On January 27, 2023, Ms. Trevizo, unaware of her pregnancy, presented at Artesia General Hospital with her mother, experiencing acute lower back pain and bleeding. **[RP 154-155 ¶¶ 1-5].** While at the hospital, Ms. Trevizo asked to go to the bathroom. **[RP 156 ¶¶ 5(l-m)].** Although hospital personnel were aware that Ms. Trevizo was pregnant, she was not informed of the positive pregnancy test. Instead, she was disconnected from intravenous medications, including morphine, and allowed to escort herself, unattended, down a hall to a public restroom. **[RP 156 ¶¶ 5(k-m)].** She spent eighteen minutes alone in the bathroom undergoing what clinical signs in the factual record indicate was likely precipitous labor, delivering a neonate with no apparent signs of life.[3] [**RP at 156 ¶¶ 5(m-q), 158 ¶ 11**].

[3] Precipitous labor is extremely rapid labor defined as expulsion of the fetus within less than 3 hours of commencement of regular contractions. Shunji Suzuki, *Clinical Significance of Precipitous Labor*, 7:3 J. Clin. Med. Res. 150–153 (2015), http://doi.org/10.14740/jocmr2058w.

Upon discovery of the neonate in the bathroom, hospital staff began treating Ms. Trevizo as a criminal defendant, rather than a patient in crisis. Despite Ms. Trevizo's acute postpartum needs, she was detained by law enforcement officers, who remained in the room while she underwent a vaginal examination and was interrogated by the attending physician. **[RP 158 ¶ 13; Def. Ex. H, Body Cam. at 9:43-13:30].**

Guiding codes of medical ethics unequivocally place the patient first and center in the care relationship.[4] Beneficence, the obligation to promote the well-being of others, and non-maleficence, the obligation to do no harm and cause no injury, have been the cornerstones of the medical profession since the Hippocratic traditions nearly 2,500 years ago.[5] Similarly, patient autonomy, another foundational principle of patient care, places patient wellbeing at the forefront of the medical setting, holding that patients should be made aware of their condition and given all information necessary to make important medical decisions and give fully informed

[4] ACOG, *Code of Professional Ethics, Ethical Foundations* § I (2018), ("welfare of the patient (beneficence) is central to all considerations in the patient-physician relationship") code-of-professional-ethics-of-the-american-college-of-obstetricians-and-gynecologists.pdf; American Medical Association, *Code of Medical Ethics,* [hereinafter *AMA Code*], *Principles of Medical Ethics* § VIII (2001) (describing a physician's "responsibility to the patient as paramount."), https://code-medical-ethics.ama-assn.org/principles; *AMA Code, Opinion 1.1.1 Patient-Physician Relationships*, (enshrining the "physicians' ethical responsibility to place patients' welfare above the physician's own self-interest or obligations to others, to use sound medical judgment on patients' behalf, and to advocate for their patients' welfare") https://code-medical-ethics.ama-assn.org/sites/amacoedb/files/2022-08/1.1.1.pdf.

[5] ACOG, Committee Opinion No. 390, *Ethical Decision Making in Obstetrics and Gynecology* 1 (2007, reaffirmed 2019).

consent.[6] Informed consent before treatment has been required in American medical practice since before the nation's founding.[7] That principle was affirmed by the United States Supreme Court in *Schloendorff v. Society of New York Hospital*, where Justice Cardozo wrote "[e]very human being of adult years and sound mind has a right to determine what shall be done with his body."[8]

Confidentiality, trust, and honesty are at the core of the relationship between a patient and their health care clinician. Because protecting and preserving that relationship is essential to an effective health care system, the duties to center the interests of the patient and safeguard confidential communications are fundamental ethical obligations of all health care professionals.[9] The criminalization of pregnancy outcomes threatens that confidentiality and trust, endangering the wellbeing of individual patients and the stability of the health care system as a whole. It also has

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[6] ACOG, Committee Opinion No. 819, *Informed Consent and Shared Decision Making in Obstetrics and Gynecology* (Feb. 2021); ACOG, Committee Opinion No. 385, *The Limits Of Conscientious Refusal In Reproductive Medicine* 1–3 (2007, reaffirmed 2019); American College of Emergency Physicians (ACEP), *Code of Ethics for Emergency Physicians*, § II.B.3 (2023) ("physicians must inform the patient with decision-making capacity about the nature of his or her medical condition, treatment alternatives, and their expected consequences").

[7] *Slater v. Baker & Stapleton* (C.B. 1767).

[8] *Schloendorff v. Soc'y of New York Hosp.*, 211 N.Y. 125, 129, 105 N.E. 92, 93 (1914).

[9] *AMA Code, Principles of Medical Ethics* § VIII ("[a] physician shall, while caring for a patient, regard responsibility to the patient as paramount"); § IV ("[a] physician shall respect the rights of patients … and shall safeguard patient confidences and privacy"); ACOG, *Code of Professional Ethics, Code of Conduct* § I.1 ("The clinician-patient relationship is the central focus of all ethical concerns, and the welfare of the patient must form the basis of all medical judgments"); § I.2 (a medical professional should serve as the "patient's advocate" and "exercise all reasonable means to ensure the most appropriate care is provided to the patient."); § I.3 ("The patient–physician relationship has an ethical basis and is built on confidentiality, trust, and honesty.").

a demonstrably disproportionate impact on pregnant people of color and those with fewer resources, contributing to the disparities in maternal and fetal mortality and morbidity experienced by marginalized populations. In this case, Ms. Trevizo's need for clear information and honest, timely and compassionate health care was supplanted by the interests of law enforcement, with harmful consequences.

When the state enforces laws and policies that criminalize people for the circumstances or outcomes of their pregnancies and deputizes medical professionals in pursuit of that goal, it intrudes upon the sanctity of the clinician-patient relationship. Whether the charge is for self-managing an abortion outside of the formal medical system, for an act or omission believed to have increased risk to a fetus, or for negative pregnancy outcomes, including stillbirth or neonatal demise, prosecuting people for the outcomes of their pregnancies is bad public policy that runs contrary to tenets of sound medical practice and ethics and diminishes the quality of care that patients receive.

ARGUMENT

I. The Confidentiality of the Clinician-Patient Relationship is Fundamental to the Health and Welfare of Patients.

In medicine, the patient is paramount and medical ethics require that clinicians center their needs.[10] "The relationship between a patient and a physician is based on

[10] ACOG, *Code of Professional Ethics, Code of Conduct* § I.1, The welfare of the patient must form the basis of all medical judgments.

trust, which gives rise to physicians' ethical responsibility to place patients' welfare above the physician's own self-interest or obligations to others, to use sound medical judgment on patients' behalf, and to advocate for their patients' welfare."[11] A trusting and open dialogue between patient and clinician is essential to achieving the best health care outcomes. Thus, a core principle of medical ethics is the protection of patient confidentiality, allowing clinicians the ability to counsel patients honestly and without judgment, based on patients' best interests and the best available scientific evidence.[12] Likewise, patients must be able to trust and meaningfully engage with their entire medical team. [13]

Rules protecting confidential patient communications are among the most ancient and enduring components of medical ethics codes.[14] These rules are based on the

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[11] *AMA Code*, *Opinion 1.1.1 Patient-Physician Relationships*.

[12] *AMA Code*, *Principles of Medical Ethics* § IV ("A physician shall respect the rights of patients, colleagues, and other health professionals, and shall safeguard patient confidences and privacy within the constraints of the law."); ACOG, *Code of Professional Ethics, Code of Conduct* § I.3 ("The patient–physician relationship has an ethical basis and is built on confidentiality, trust, and honesty").

[13] *See* ACOG, *Legislative Interference with Patient Care, Medical Decisions, and the Patient-Physician Relationship, Statement of Policy* (2013, reaffirmed & amended 2021) (calling laws that "require physicians to give, or withhold, specific information when counseling patients, or that mandate" which procedures physicians can perform "ill-advised.") https://www.acog.org/clinical-information/policy-and-position-statements/statements-of-policy/2019/legislative-interference-with-patient-care-medical-decisions-and-the-patient-physician-relationship; American Nurses Association (ANA), *Position Statement: Privacy and Confidentiality* (1974-2015, reaffirmed & amended 2024) (directing nurses to "advocate for policies that ensure individuals' right to privacy and protect against unwanted, unnecessary, or unwarranted intrusion into a person's life.") https://www.nursingworld.org/globalassets/docs/ana/practice/official-position-statements/privacy-and-confidentiality-position-statement_revised_bod-approved_final.pdf

[14] ACOG, Committee Opinion No. 390; ACOG, *Code of Professional Ethics, Code of Conduct* § I.7.

principle of respect for patient autonomy, which includes a patient's right to privacy, and on the physician's responsibility to act as an advocate for their patient and safeguard patient information.[15] Rules of confidentiality are also justified by their impact: the assurance of privacy in communications encourages patients to disclose information that may be essential in making an accurate diagnosis and planning appropriate treatment.[16] Amicus strongly opposes the interpretation of policies or laws in ways that interfere with a clinician's ethical requirement to protect private medical information. This position has never been more important than it is today, when evidence-based medicine is under assault and health care professionals and patients face the very real prospect that their work and care will be targeted for investigation.[17]

II. Criminalizing Pregnancy Outcomes is Inconsistent with Expert Consensus, Harms the Clinician-Patient Relationship, and Worsens Maternal Health Outcomes.

The criminalization of pregnancy outcomes is hazardous to maternal and infant health and has devastating consequences for patients and the health care system. It prevents people from seeking medical care when they need it, subjects

[15] ACOG, Committee Opinion No. 390.
[16] *Id.*
[17] Medical technology is expanding exponentially, and health care professionals are already facing complex ethical questions relating to the confidentiality of patient information and the use of emerging technologies. Rapid advances in artificial intelligence ("AI") are impacting patient care, and the plethora of emerging AI tools that record and transcribe detailed information relating to patient examinations and disclosures only heightens the importance of addressing confidentiality effectively and consistently with a clinician's ethical obligations.

them to law enforcement investigations in the midst of medical emergencies, and consigns them to stigma and condemnation in their communities. The harms of criminalization are disproportionately borne by patients who already face challenges accessing quality health care, compounding disparate health outcomes and contributing to maternal and infant mortality and morbidity.

A. Expert Consensus Supports Non-Punitive Responses to Pregnancy Outcomes.

Major medical and public health organizations recognize that punishing pregnant people for conduct during pregnancy or adverse pregnancy outcomes (i.e., miscarriage, stillbirth, or neonatal loss) is counterproductive to public and individual health.[18] The threat of punitive consequences erodes trust in the clinician-patient relationship and the medical system, driving pregnant people away from seeking prenatal and other medical care, thus risking the health of the pregnant patient and the fetus.[19] Criminalization also harms patient safety by creating uncertainty as to whether law enforcement will become involved in medical crises. In the worst circumstances, such as those faced by Ms. Trevizo, this can diminish patient care

[18] ACOG, *Opposition to Criminalization of Individuals During Pregnancy and the Postpartum Period* (Dec. 2020), https://www.acog.org/clinical-information/policy-and-position-statements/statements-of-policy/2020/opposition-criminalization-of-individuals-pregnancy-and-postpartum-period.

[19] *See, e.g.*, *Medical and Public Health Group Statements Addressing Prosecution and Punishment of Pregnant Women*, PREGNANCY JUSTICE (revised June 2023) (listing fifteen national public health and medical associations that have issued policy statements in opposition to criminalizing prenatal conduct), https://www.pregnancyjusticeus.org/wp-content/uploads/2023/09/Medical-Public-Health-Statements-2023.pdf.

and lead people to be treated as suspects instead of patients, subject to bedside interrogations and legal scrutiny.[20] While law enforcement involvement in certain cases is appropriate, it should never interfere with or take priority over a clinician's primary duty to care for the patient's wellbeing.[21] "Medical providers' ethical duties are to the patients—not to law enforcement."[22]

Major medical and public health associations are in broad consensus that the threat of punitive sanctions places pregnant people in an untenable situation, forcing them to choose between risking punishment for seeking care or risking their health and the health of their pregnancy by foregoing care. The American Academy of Pediatrics (AAP), one of the nation's leading medical groups committed to the health and well-being of children, has "reaffirm[ed] its position that punitive measures taken toward pregnant women are not in the best interest of the health of the mother-infant dyad."[23] The AAP opposes punitive responses because they "are ineffective and may have detrimental effects on both maternal and child health."[24] Similarly,

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[20] *See* ACOG, *Opposition to Criminalization of Individuals During Pregnancy and the Postpartum Period*.
[21] *See* ACEP, *Law Enforcement Information Gathering In The Emergency Department* (2003, amended 2010, 2017, 2023), (explaining that "[l]aw enforcement information gathering activities in the [Emergency Department] should not interfere with essential patient care"), https://www.acep.org/siteassets/new-pdfs/policy-statements/law-enforcement-information-gathering-in-the-emergency-department.pdf.
[22] Michele Goodwin, *Policing the Womb, Invisible Women and the Criminalization of Motherhood* 104 (Cambridge Univ. Press 2020).
[23] AAP, *A Public Health Response to Opioid Use in Pregnancy* 139 PEDIATRICS 3, 4 (2017), http://pediatrics.aappublications.org/content/pediatrics/early/2017/02/16/peds.2016-4070.full.pdf
[24] *Id.* at 3.

the National Perinatal Association, the leading voice of professionals who care for newborns immediately after birth, has cautioned against a punitive approach through either the criminal or child welfare system because of its adverse effect on maternal and infant health, explaining that "[t]he threats of discrimination, incarceration, loss of parental rights, and loss of personal autonomy are powerful deterrents to seeking appropriate prenatal care."[25] Indeed, there is wide agreement among national public health authorities that the prosecution of pregnant people based on the outcome of their pregnancy is counterproductive. Among these organizations are the American Academy of Family Physicians,[26] the American Medical Association,[27] the American Nurses Association,[28] the American Psychiatric Association,[29] the

[25] National Perinatal Association, *Position Statement 2017: Perinatal Substance Use* 2, http://www.nationalperinatal.org/resources/Documents/Position%20Papers/2017_Perinatal%20Substance%20Use_NPA%20Position%20Statement.pdf.

[26] AAP, *A Public Health Response to Opioid Use in Pregnancy*, 139 PEDIATRICS 3, 4 (2017).

[27] AMA Policy Statement H-420.962, *Pregnancy and Childbirth, Perinatal Addiction—Issues in Care and Prevention* (last modified 2019), https://policysearch.ama-assn.org/policyfinder/detail/prenatal?uri=%2FAMADoc%2FHOD.xml-0-3705.xml.

[28] ANA, *Non-punitive Treatment for Pregnant and Breastfeeding Women with Substance Use Disorder* (2017), ("Contrary to claims that prosecution and incarceration will deter pregnant women from substance use, the greater result is that fear of detection and punishment poses a significant barrier to treatment."), https://www.nursingworld.org/globalassets/docs/ana/ethics/nonpunitivetreatment-pregnantbreastfeedingwomen-sud.pdf.

[29] American Psychiatric Association (APA), *Assuring the Appropriate Care of Pregnant and Newly-Delivered Women with Substance Use Disorders* (2019), https://www.psychiatry.org/getattachment/d0fe00fd-8b78-47e2-9098-63dc6917e1d4/Position-Assuring-Appropriate-Care-of-Pregnant-and-Newly-Delivered-Women-with-SUDs.pdf.

American Psychological Association,[30] and the American College of Emergency Physicians.[31] [32]

B. Prioritizing an Immediate Punitive Response Over the Clinician-Patient Relationship and the Provision of Medical Care Inappropriately Converts the Clinician into an Arm of Law Enforcement and the Emergency Room into an Interrogation Room.

The need to protect patient confidentiality and center the interests of the patient is not theoretical. Studies consistently show that "fear of being reported to the police or child welfare authorities [is] related strongly to a lack of prenatal care."[33] In this case, the prioritization of the punitive response over Ms. Trevizo's care and the state's attempt to use statements made to her healthcare team in the

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[30] APA, *Pregnant and Postpartum Adolescent Girls and Women with Substance-Related Disorders* (updated 2020), ("Punitive approaches result in women being significantly less likely to seek substance use treatment and prenatal care due to fear of prosecution and fear of removal of children from their custody. This places both the mother and her children at greater risk of harm.") (internal citations omitted), https://www.apa.org/pi/women/resources/pregnancy-substance-disorders.pdf.

[31] *See* ACEP, *Law Enforcement Information Gathering in The Emergency Department* (explaining that "[l]aw enforcement information gathering activities in the [Emergency Department] should not interfere with essential patient care."

[32] While this deterrent effect is frequently observed in cases involving substance use disorder in pregnant people, it is not cabined to that context. Indeed, the U.S. Supreme Court has recognized the gravity of preserving trust between clinician and patient, writing in the context of the relationship between a therapist and their patient that "the mere possibility of [a therapist's] disclosure may impede development of the confidential relationship necessary for successful treatment." *Jaffee v. Redmond,* 518 U.S. 1, 10 (1996).

[33] Ashley H. Schempf & Donna M. Strobino, *Drug Use and Limited Prenatal Care: An Examination of Responsible Barriers*, 200 Am. J. Obstet. Gynecol. 412.e1 (2009); Laura J. Faherty et al., *Association of Punitive and Reporting State Polices Related to Substance Use in Pregnancy with Rates of Neonatal Abstinence Syndrome*, 2 JAMA Network Open, e1914078 (2019); Daisy Goodman & Bonny Whalen, *It's Time to Support, Rather than Punish, Pregnant Women with Substance Use Disorder*, 2 JAMA Network Open e1914135 (2019).

midst of medical needs, run contrary to decades of established medical guidance. If the court allows the state's violations of Ms. Trevizo's constitutional right against self-incrimination and the protections guaranteed to her by the physician-patient privilege under Rule 11-504 NMRA, it will have a negative impact on the already dire state of maternal and fetal health by sending a message that drives more pregnant and postpartum people away from health care at a time when maternal and infant mortality and morbidity are on the rise.[34]

Pregnancy and childbirth create inherent dangers and medical concerns. Unfortunately, pregnant people in the United States are less likely to survive pregnancy than those in other high-income countries.[35] And, while maternal mortality rates are decreasing in other nations, the number of people dying due to complications from pregnancy and childbirth continues to rise in the United States.[36] In the U.S., maternal mortality more than doubled between 2000 and 2020,

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[34] Daniel Grossman, et al., *Care Post-Roe: Documenting cases of poor-quality care since the Dobbs decision* (May, 2023), https://search.issuelab.org/resources/42929/42929.pdf; Kim Bellware & Emily Guskin, *Effects of Dobbs on maternal health care overwhelmingly negative, survey shows* (June 21, 2023), https://go.gale.com/ps/i.do?id=GALE%7CA753884754&sid=googleScholar&v=2.1&it=r&linkaccess=abs&issn=01908286&p=AONE&sw=w&userGroupName=anon%7E6a35aa95&aty=open-web-entry.

[35] *See* Laura G. Fleszar et al., *Trends in State-Level Maternal Mortality by Racial and Ethnic Group in the United States*, 330 JAMA 53 (July 3, 2023) ("Over the past 2 decades, maternal mortality in other high-income countries has decreased while in the US it has increased."), https://jamanetwork.com/journals/jama/article-abstract/2806661.

[36] *See* Munira Z. Gunja et al., *The U.S. Maternal Mortality Crisis Continues to Worsen: An International Comparison,* COMMONWEALTH FUND (Dec. 1, 2022) (reporting that the U.S maternal mortality rate is triple the rate in most other high-income countries), https://www.commonwealthfund.org/blog/2022/us-maternal-mortality-crisis-continues-worsen-international-comparison.

increasing from 9.8 maternal deaths per 100,000 live births to nearly 24 maternal deaths.[37] By 2021, this rate has risen to 32.9 maternal deaths.[38] The Centers for Disease Control and Prevention reports that 1,205 women died of pregnancy complications in 2021 alone, compared to 861 maternal deaths in 2020.[39] Driving pregnant and parenting people away from prenatal and obstetric care will worsen this public health crisis.

Despite the rise in maternal mortality and morbidity in the United States, recent research demonstrates that pregnancy criminalization has increased significantly since the Supreme Court's decision in *Dobbs v. Jackson Women's Health Organization*, 597 U.S. 215 (2022).[40] The inevitable consequence of this rise in criminalization is a decline in patient willingness to seek care and communicate

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[37] *See* Lucy Tu, *Why Maternal Mortality Rates are Getting Worse Across the U.S.*, SCI. AM. (July 25, 2023), https://www.scientificamerican.com/article/why-maternal-mortality-rates-are-getting-worse-across-the-u-s/.

[38] *See* Donna L. Hoyert, *Maternal Mortality Rates in the United States, 2021* (Table) (last reviewed Mar. 2023), https://www.cdc.gov/nchs/data/hestat/maternal-mortality/2021/maternal-mortality-rates-2021.htm#:~:text=The%20maternal%20mortality%20rate%20for,20.1%20in%202019%20.

[39] *Id.*, tbl.1. The risk of dying from pregnancy or childbirth does not fall equally on all women. Alarmingly, Black women are significantly more likely to die from pregnancy-related causes than their white and Hispanic counterparts. *Id*. at fig.1.

[40] *See* Wendy A. Bach & Madalyn K. Wasilczuk, *Pregnancy as a Crime* (2024). *See also* Michele Goodwin, Policing the Womb: Invisible Women and the Criminalization of Motherhood (2020) (explaining the variety of ways legislators interpret the law to criminalize pregnancy as follows: ("(1) old laws are applied and interpreted in new ways; (2) old laws are slightly amended to expand existing prescriptions and sanctions; (3) new laws are applied in unintended ways against pregnant women; and (4) new laws are introduced that expressly create new prescriptions and sanctions").

openly with their provider during the pre and postpartum periods.[41] Tragically, this has already happened in states that have expanded existing criminal laws to arrest and prosecute women for adverse pregnancy outcomes.[42] A research study analyzing the consequences of Tennessee's fetal endangerment law—enacted into law under the erroneous supposition that the criminalization of risky behavior ultimately benefits fetal and infant health—found that during the implementation of the law, Tennessee saw an increase in fetal and infant deaths.[43] Further, Tennessee experienced a decrease in prenatal care, gestation lengths and Apgar scores.[44] The law inadvertently encouraged pregnant people to forgo prenatal care out of fear of prosecution, resulting in worse health outcomes for infants and fetuses, the population the legislation purported to protect.[45] Tennessee ultimately let the law sunset because of its disastrous impact on maternal and infant health.[46]

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[41] *See* Am. Coll. of Obstetricians and Gynecologists, Statement of Policy, *Opposition to Criminalization of Individuals During Pregnancy and the Postpartum Period* (2020), https://www.acog.org/clinical-information/policy-and-position-statements/statements-of-policy/2020/opposition-criminalization-of-individuals-pregnancy-and-postpartum-period.

[42] Meghan Boone & Benjamin J. Michael, *State Created Fetal Harm*, 109 Geo. L. J. 475, 504 (2021) (finding that Tennessee's fetal endangerment law meaningfully worsened fetal, infant, and maternal health outcomes through the inadvertent effect of encouraging pregnant people to forgo prenatal care due to fear of prosecution).

[43] *Id.* at 506–07.

[44] *Id.*

[45] *Id.*

[46] Orisha A. Bowers et al., *Tennessee's Fetal Assault Law: Understanding its Impact on Marginalized Communities* PREGNANCY JUSTICE (2020) 7, 11, https://www.pregnancyjusticeus.org/wp-content/uploads/2020/12/SisterReachFinalFetalAssaultReport_SR-FINAL-1-1.pdf.

In Ms. Trevizo's case, actions taken by law enforcement and her care team placed criminalization over care. Ms. Trevizo was not informed of her positive pregnancy test. **[RP 156 ¶ 5(l)]**. The clinician then waited to speak to Ms. Trevizo until police arrived, only telling her about the discovery of the deceased fetus or neonate once in the presence of law enforcement. **[RP 157 ¶¶ 6–7]**. Her doctor then examined and questioned Ms. Trevizo in front of law enforcement while Ms. Trevizo was being detained in the immediate postpartum period. **[RP 157 ¶¶ 8-9].** It is clear from law enforcement and hospital staff's interactions with Ms. Trevizo that she was not handled as a patient in need of treatment but as a suspect of wrongdoing. It is reasonable to presume that law enforcement's response served to deter and diminish Ms. Trevizo's ability to communicate openly with her provider in the traumatic and vulnerable moments after having given birth unexpectedly. Indeed, as a result of the intrusion of law enforcement into her hospital room, bodycam footage of these interactions is now readily available to the public through the internet and social media, with countless content creators and consumers picking apart and scrutinizing Ms. Trevizo's words, actions and reactions in the most ruthless of terms. The deterring effect that this kind of response can and does have on pregnant patients is detrimental to care and abrogates the protections created by clinician-patient confidentiality. Even in cases where it is appropriate to involve law enforcement,

clinicians must always act in ways that prioritize their patients and refrain from making decisions that harm their patient's immediate care.[47]

The effort to use Ms. Trevizo's statements made in the midst of a medical event to health care professionals responsible for her care against her in court is misguided and counterproductive at best. It will send a message to pregnant people in New Mexico that they could be charged with murder if they do not have a healthy pregnancy and birth. And, it criminalizes stillbirth, a prevalent pregnancy outcome.[48] Seeking obstetric–gynecologic care should not expose a patient to criminal or civil penalties based on statements made while attempting to access that care.

C. Criminalizing Pregnancy Outcomes and Turning Providers into Interrogators Destroys the Clinician-Patient Relationship, Leading to Mistrust in Providers and the Health Care System

Patient safety and well-being are of paramount importance and must remain central to the practice of health care, even in the face of adverse pregnancy outcomes. Criminalizing people for reproductive outcomes violates their state and federal constitutional rights by inserting punitive state proceedings into some of the most

[47] *See* ACOG, Committee Opinion No. 390 3–4.

[48] Stillbirth unfortunately occurs in approximately one in every 160 pregnancies each year, and they are unique in their inexplicability, with the most frequently cited cause being listed as "unspecified." *See* Stillbirth Collaborative Research Network Writing Group, *Cause of Death Among Stillbirths*, 306:22 JAMA 2459 (2011) https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4562291/; *see also* Donna L. Hoyert & Elizabeth W. Gregory, *Cause of Fetal Death: Data from the Fetal Death Report*, *2014*, 65 Nat'l Vital Stats. Rep. 4 (2016) (rates of reported stillbirth with an unspecified cause of death "ranged from 18.3% to 75.4%").

intimate aspects of their lives and creating inherently discriminatory legal standards that punish people based on their pregnancy status.[49] Penalizing people who experience pregnancy losses thwarts rather than advances maternal or infant health and hinders the fair administration of law.

Law enforcement intrusion into the clinician-patient relationship during adverse pregnancy outcomes worsens maternal and neonatal health care, violates long-established and widely accepted principles of medical ethics, and irreparably harms the trust inherent to the therapeutic relationship between patient and provider.[50] When that trust is eroded by threats of criminalization, patients' ability to communicate openly and honestly in a clinical setting erodes along with it.[51] When police are present in a patient room during what should be a confidential discussion around the patient's care, it instead coopts the role of medical professionals away from scientific, ethical, and clinical standards of care, changing their role from that of physician to that of law enforcement agent.[52]

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[49] *See* NM Const., art. II, § 18 ("No person shall be deprived of life, liberty or property without due process of law; nor shall any person be denied equal protection of the laws. Equality of rights under law shall not be denied on account of the sex of any person.").

[50] Such interference violates the principles of beneficence, non-maleficence, justice, and autonomy. *See* ACOG, *Legislative Interference with Patient Care, Medical Decisions, and the Patient-Physician Relationship* (2013, reaffirmed & amended 2021). *See also AMA Code, Opinion 1.1.1 Patient-Physician Relationships* (explaining that providers have the "ethical responsibility to place patients' welfare above the physician's own self-interest or obligations to others").

[51] *See* Megan Y. Harada et al., *Policed Patients: How the Presence of Law Enforcement in the Emergency Department Impacts Medical Care*, 78:6 ANNALS OF EMERGENCY MEDICINE 738–748 (2021), https://www.annemergmed.com/article/S0196-0644(21)00380-2/fulltext.

[52] *See* Ji Seon Song, *Policing the Emergency Room*, 134 Harv. L. Rev. 2646 (2021). *See also* Priscilla A. Ocen, *Birthing Injustice: Pregnancy as a Status Offense*, 85 Geo. Wash. L. Rev. 1163,

The best practice guidelines established by The American College of Emergency Physicians (ACEP) prohibits sharing the details of medical decision-making with law enforcement and reminds providers that they may "conscientiously object" to complying with legal orders that violate the rights or jeopardize the welfare of their patients.[53] This guidance is necessary because when law enforcement is brought into the clinical setting during a critical moment of patient examination and treatment, the physician's considerations are necessarily divided between care for the patient and managing the expectations, inquiries and interests of the state actor.[54] Similarly, the American Medical Association (AMA) Code of Ethics tells us that physicians must neither conduct nor directly participate in an interrogation, because serving as physician-interrogator "undermines the physician's role as healer," eroding trust in both the individual physician and in the medical profession as a whole.[55] The AMA goes on to prohibit providers from monitoring interrogations with the intention of intervening in the process, explaining

1195–96 (2017); Dorothy E. Roberts, *Prison, Foster Care, and the Systemic Punishment of Black Mothers*, 59 UCLA L. Rev. 1474, 1476 (2012); Dorothy E. Roberts, *Punishing Drug Addicts Who Have Babies: Women of Color, Equality, and the Right of Privacy*, 104 Harv. L. Rev. 1419, 1420–21 (1991).

[53] Samantha Chao et al., *Best Practice Guidelines for Evaluating Patients in Custody in the Emergency Department*, JACEP Open 2024, 5:2 e13143, doi: 10.1002/emp2.13143, https://pmc.ncbi.nlm.nih.gov/articles/PMC10960077/.

[54] *See* Ji Seon Song, *Cops in Scrubs*, 48 Fla. St. L. Rev. 861 (2021).

[55] *See AMA Code, Opinion 9.7.4 Physician Participation in Interrogation* (2015, reaffirmed 2022) (defining "detainee" as "a criminal suspect, prisoner of war, *or any other individual who is being held involuntarily*"). https://code-medical-ethics.ama-assn.org/ethics-opinions/physician-participation-interrogation.

that such conduct constitutes direct participation in interrogation. Similarly, ACOG opposes all laws and practices that interfere with the sanctity of the clinician-patient relationship and detract from the quality of care patients receive.

In this case, police were present in Ms. Trevizo's room, detaining her by their own admission, in the midst of acute postpartum care, hearing every word delivered by her provider, who waited to speak with Ms. Trevizo until they were present. Until detectives arrived, all of the officers on-scene were male, and they separated Ms. Trevizo from her mother while she was bleeding, despite the provider's admission that Ms. Trevizo was still in the midst of a medical crisis. **[See Axon Body Cam. X6031529F at 1:53:40; Axon Body Cam. X6031747N at 7:10].** It is beyond question that this series of events interfered with the trust and confidentiality fundamental to the clinician-patient relationship, let alone Ms. Trevizo's necessary medical care.

Care for the patient and the protection of patient privacy must always take priority, particularly while care is actively underway. Interference that disrupts this balance of interests harms patient care and undermines trust in medical institutions and personnel.

III. Criminalizing Pregnancy Outcomes Disproportionately Harms Vulnerable Populations and Exacerbates Existing Health Disparities.

As explained above, confidentiality and trust are at the core of the clinician-patient relationship. Policies and practices that criminalize individuals during

pregnancy and the postpartum period compromise this relationship and create a fear of punishment that deters pregnant people from seeking vital health services. These policies and practices have a long history of inequitable application to historically-marginalized populations, especially people of color, people with fewer financial resources and people who are geographically located in rural areas – the very same populations that are "more likely to face barriers in accessing routine health care services," including prenatal care.[56]

The intersections of gender, race, poverty and bias create conditions that exacerbate risk factors for pregnant people.[57] As a result of these compounding, intersectional inequities, Black patients are more likely to face "higher rates of many preventable diseases and chronic health conditions including higher rates of diabetes, hypertension, and cardiovascular disease," all of which can contribute to complications during pregnancy.[58] Black pregnant people are three times as likely as White pregnant people to die during pregnancy.[59] They are twice as likely to

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[56] Lyndsey S. Benson et al., *Early Pregnancy Loss in the Emergency Department*, *2006–2016*, JACEP Open 2021 2:6 e12549 ("EPL-related care accounts for over 900,000 ED visits in the United States each year."), https://pmc.ncbi.nlm.nih.gov/articles/PMC8571073/.

[57] *See generally* Abdulrahman M. El-Sayed et al., *Social Environments, Genetics, and Black–White Disparities in Infant Mortality*, 19 Pediatric & Perinatal Epidemiology 546 (2015), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4676266/. *See also* William J. Hall et al., *Implicit Racial/Ethnic Bias Among Health Care Professionals and Its Influence on Health Care Outcomes: A Systematic Review*, 105 Am. J. Pub. Health 79, 120 (2015).

[58] National Partnership for Women & Families, *Black Women's Maternal Health: A Multifaceted Approach to Addressing Persistent and Dire Health Disparities* 1 (2018), https://nationalpartnership.org/wp-content/uploads/black-womens-maternal-health-2018.pdf.

[59] *Id.*; Hoyert, *supra* note 39 (reporting the Black maternal mortality rate at 69.9 deaths per 100,000 live births, compared to 26.6 for white women).

experience stillbirth, nearly twice as likely to deliver preterm (i.e., before 37 weeks), and three to four times as likely to experience a very early preterm birth.[60]

Infant mortality in the United States for Black infants is now more than double that of White infants.[61] In New Mexico, the infant mortality rate among babies born to Black birthing people is over three times the state rate.[62] These findings hold across socioeconomic strata, even comparing births among low-income White parents without a high school education to births among educated middle-class Black parents.[63]

The same populations that suffer the greatest risk of maternal and infant mortality also experience the worst barriers to prenatal care. Persons in poverty and persons of color are more likely to encounter multiple obstacles to prenatal care, including lack of insurance or transportation, depression, fear of reprisal, social

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[60] *See* CDC, *Data and Statistics on Stillbirth* (updated May 15, 2024), https://www.cdc.gov/stillbirth/data-research/?CDC_AAref_Val=https://www.cdc.gov/ncbddd/stillbirth/data.html; CDC, *Preterm Birth* (updated May 15, 2024) (showing that, in 2022, the rate of preterm birth among Black women (14.6%) was approximately 50 percent higher than the rate of preterm birth among white women (9.4%)), https://www.cdc.gov/maternal-infant-health/preterm-birth/index.html; March of Dimes, *Very preterm by race: United States, 2020-2022 Average* (updated Jan. 2022), https://www.marchofdimes.org/peristats/data?top=3&lev=1&stop=64&ftop=66&reg=99&obj=1&slev=1.

[61] CDC, *Infant Mortality* (updated Sept. 2024) (reporting the Black infant mortality rate at 10.9% per 1,000 live births compared to 4.5% among white infants), https://www.cdc.gov/reproductivehealth/maternalinfanthealth/infantmortality.htm.

[62] March of Dimes, *2023 March of Dimes Report Card for New Mexico* (2023), https://www.marchofdimes.org/peristats/reports/new-mexico/report-card.

[63] Richard V. Reeves et al., *6 Charts Showing Race Gaps Within the American Middle Class,* BROOKINGS INST. (Oct. 21, 2016), https://www.brookings.edu/blog/social-mobility-memos/2016/10/21/6-charts-showing-race-gaps- within-the-american-middle-class.

stigma, and other poverty-related barriers.[64] These same challenges exist for Black patients when accessing quality contraceptive care and counseling, as compared to White patients.[65] Age is also a risk-factor for pregnancy, as young maternal age is also associated with increased risk of serious pregnancy-related complications like preeclampsia, preterm birth, severe neonatal conditions, and infant death.[66] While marginalized groups are forced to navigate the highest barriers to care and the worst maternal health care outcomes, they are also the historical focus of criminal prosecutions and investigations for alleged crimes such as fetal abuse.[67]

A recent report of these cases, analyzing 1,396 criminal arrests over 16.5 years found that 85% of cases were brought against low-income pregnant people who

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[64] *See* N. Tanya Nagahawatte & Robert L. Goldenberg, *Poverty, Maternal Health, and Adverse Pregnancy Outcomes*, 1136 Annals N.Y. Acad. Sci. 80 (2008), https://pubmed.ncbi.nlm.nih.gov/17954684/.

[65] *Black Women's Maternal Health*, *supra* note 60.

[66] World Health Organization, *Adolescent Pregnancy* (Apr. 10, 2024), https://www.who.int/news-room/fact-sheets/detail/adolescent-pregnancy; D. Jeha et al., *A Review of the Risks and Consequences of Adolescent Pregnancy*, 8 J. Neonatal Perinatal Med. 1 (2015); *see also* T. Ganchimeg et al., *Pregnancy and Childbirth Outcomes Among Adolescent Mothers: A World Health Organization Multicountry Study*, 121 BJOG. 40, 45 (2014) (increased risk of pregnancy-related complications remains when controlling for county, marital status, educational attainment, and parity), https://pubmed.ncbi.nlm.nih.gov/24641534/.

[67] For example, a 2013 systematic study of pregnancy criminalization cases, analyzing 413 arrests and forced interventions over a 30-year period, found that 71% of cases were brought against low-income women who qualified for indigent defense. Of the 368 cases where information on race was available, 59% involved women of color, most of whom were Black women (52% of 368 cases). *See* Lynn M. Paltrow & Jeanne Flavin, *Arrests of and Forced Interventions on Pregnant Women in the United States, 1973–2005: Implications for Women's Legal Status and Public Health*, 38 J. Health Politics, Policy & L. 299, 310 tbl.1, 311 (2013), https://read.dukeupress.edu/jhppl/article- pdf/38/2/299/360112/JHPPL382_09Paltrow_Fpp.pdf.

qualified for indigent defense.[68] The same report noted that medical professionals or hospital-based social workers were the most common sources of information leading to arrests related to pregnancy, with one in three cases instigated by a medical professional.[69]

Should the Court reverse the trial court's order to suppress and vacate, the Court will de facto deputize clinicians as law enforcement agents, discouraging people of color and those with fewer resources or in rural communities—the very people who already are most at risk for catastrophic pregnancy outcomes—from seeking life and health-saving medical care and ultimately increase maternal and fetal mortality and morbidity.

CONCLUSION

For the reasons set forth herein, Amicus respectfully urges this Court to affirm the district court's order, protecting Ms. Trevizo's constitutional right against self-incrimination and preserving the physician-patient privilege.

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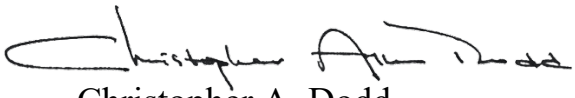
[68] Purvaja S. Kavattur et al., *The Rise of Pregnancy Criminalization: A Pregnancy Justice Report,* PREGNANCY JUSTICE (Sept. 2023) 4, 14, https://www.pregnancyjusticeus.org/wp-content/uploads/2023/09/9-2023-Criminalization-report.pdf.
[69] *Id.* at 4.

Respectfully submitted,



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CERTIFICATE OF COMPLIANCE

Undersigned counsel certifies this brief was prepared in 14-point Times New Roman typeface using Microsoft Word, and the body of the brief contains 3679 words, and thus complies with Rules 12-318(F) and 12-305 NMRA.

/s/ Christopher A. Dodd
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CERTIFICATE OF SERVICE

The undersigned certifies that a true and correct copy of the foregoing document was filed and served on all counsel of record on November 6, 2024, through the Odyssey E-File & Serve System.

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