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REGULATING PREGNANCY BEHAVIORS: HOW THE CONSTITUTIONAL RIGHTS OF MINORITY WOMEN ARE DISPROPORTIONATELY COMPROMISED

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The regulation of a woman's behavior during pregnancy (pregnancy behavior) has become a prominent and controversial issue within the legal system.[1] Some women have been forced to engage in treatments favoring their unborn child at the expense of their own health or wishes,[2] or have been punished for their pregnancy behavior.[3] Specifically, legal actors have punished pregnant women for using illegal drugs while pregnant, forced pregnant women to undergo HIV testing, and coerced them into following doctors' orders (e.g., undergoing a Cesarean section).[4] These legal actions have created a special category of people within the legal system: pregnant women. Although the law does not generally force people to have medical treatments,[5] examples of the treatment pregnant

1. *See generally* LAURA E. GOMEZ, MISCONCEIVING MOTHERS: LEGISLATORS, PROSECUTORS, AND THE POLITICS OF PRENATAL DRUG EXPOSURE (1997) (describing how hospitals drug test pregnant women and then turn over the results to law enforcement for prosecution of maternal substance abuse); Leslie Ayers, *Is Mama a Criminal? An Analysis of Potential Criminal Liability of HIV-Infected Pregnant Women in the Context of Mandated Drug Therapy*, 50 DRAKE L. REV. 293, 314 (2002) (arguing that drug treatments should be mandatory for pregnant women with HIV to protect the health and welfare of the fetus); Brian Bornstein, *Pregnancy, Drug Testing, and the Fourth Amendment: Legal and Behavioral Implications*, 17 J. FAM. PSYCHOL. 220, 220, 227 (2003) (predicting the creation of policies that will effectively prosecute women for illegal drug use during pregnancy, while avoiding the constitutional pitfalls previously encountered); Jennifer Brown, *A Troublesome Maternal-Fetal Conflict: Legal, Ethical, and Social Issues Surrounding Mandatory AZT Treatment of HIV Positive Pregnant Women*, 18 BUFF. PUB. INT. L.J. 67, 68 (2000) (arguing that pregnant women should have the same opportunity to refuse medical treatment as other members of society).

2. *See In re* Jamaica Hosp., 491 N.Y.S.2d 898, 900 (App. Div. 1985) (holding that the state's interest as *parens patriae* in protecting the life of an unborn child—even before viability—negates a woman's right to refuse a blood transfusion on religious grounds); Crouse Irving Mem'l Hosp., Inc. v. Paddock, 485 N.Y.S.2d 443, 444-46 (App. Div. 1985) (holding that a pregnant woman may not refuse medical treatment despite her religious convictions when the treatment is necessary to preserve either the health and welfare of the unborn child or the life of the mother).

3. Carolyn Coffey, Note, Whitner v. State*: Aberrational Judicial Response or Wave of the Future for Maternal Substance Abuse Cases?*, 14 J. CONTEMP. HEALTH L. & POL'Y 211, 212 (1997) (finding that over the past twenty years, criminal charges for endangering fetuses during pregnancy through "drug use or other actions" have been leveled against more than two hundred women in thirty states).

4. *See Crouse Irving Mem'l Hosp., Inc.*, 485 N.Y.S.2d at 443 (requiring a woman in labor to allow the physician to stabilize her condition with a blood transfusion after she lost a significant amount of blood); *In re* Ruiz, 500 N.E.2d 935, 936-37 (Ohio Ct. Com. Pl. 1986) (holding that a viable fetus was a child under Ohio's existing child abuse statute, and thus convicting the mother of child abuse for her prenatal conduct—consuming cocaine and heroin); Brown, *supra* note 1, at 73-74 (stating that the 1996 amendments to the Comprehensive AIDS Resources Emergency Act and recent state legislation have created either mandatory HIV testing and counseling or a move towards such a mandate).

5. *See* Cruzan v. Dir., Mo. Dep't of Health, 497 U.S. 261, 278 (1990) (holding that a competent individual has a constitutional right to refuse unwanted medical care). *But see* Jacobson v. Massachusetts, 197 U.S. 11, 26-27 (1905) (upholding a mandatory vaccination law to halt the spread of smallpox because the liberty interest secured by

women receive demonstrate the legal system's willingness to force pregnant mothers to have medical procedures even though they may wish to avoid such treatment because of religious or other personal reasons.[6] This Article will argue that these legal actions may not only jeopardize the legal rights and health of women in general, but also unfairly target minority women.

The purpose of this Article is to provide an analysis based on psychological research and theory to determine whether regulating pregnancy behaviors has a discriminatory effect on minority women, and if so, discuss its implications on state and national policy. Part I reviews the various pregnancy behaviors that have been regulated and the controversy surrounding regulation. Part II presents evidence from psychological research and theory that suggests minority women could be disproportionately affected. Part III provides policy suggestions and recommendations for preventing or reducing the bias against minority women. Finally, Part IV concludes that broad changes need to be made at a societal level to eliminate the bias against minority women. This Article provides a unique analysis of this issue by applying psychological research and theory to examine a possible legal bias against minority women. Using the Health Belief Model (HBM), this Article explains why minority women make health decisions about their pregnancy that may put them at greater risk of being prosecuted.

I. REGULATION OF PREGNANCY BEHAVIORS AND VIOLATION OF RIGHTS

This Part outlines the legal system's attempt to make a woman legally responsible for the health and welfare of her fetus by regulating HIV testing and treatment, prenatal drug use, and adherence to doctors' orders. This Part also explores how these regulations infringe on various constitutional rights, including the right to religious freedom, the right to privacy, and the right to bodily autonomy.[7]

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the Constitution is not an absolute right and because "a community has the right to protect itself against an epidemic of disease which threatens the safety of its members"); Singleton v. Norris, 992 S.W.2d 768, 769-70 (Ark. 1999) (upholding the decision to force a death row inmate to take antipsychotic medication because "[t]he State has a due process obligation to provide appropriate medical care to persons in its custody" and because the medication was also necessary to protect the well-being of others, including inmates and guards). *See generally* Brown, *supra* note 1, at 82-83 (discussing whether the holding of *Cruzan* suggests that an HIV-positive pregnant woman could refuse Azidothymidine (AZT) treatments, especially if the state has a compelling interest in the health and welfare of the child).

6. *See generally* Ayers, *supra* note 1, at 299-301 (claiming that if the right to refuse medical care is not absolute, then the interests of preventing the spread of HIV might be compelling enough to sustain a state law requiring mandatory AZT treatment).

7. *See* U.S. CONST. amend. I (religious freedom); Lawrence v. Texas, 539 U.S. 558 (2003) (right to privacy); Planned Parenthood of Se. Pa. v. Casey, 505 U.S. 833

A. Regulation of Pregnancy Behaviors

1. HIV Testing and Treatment

There are two areas in which the legal system attempts to regulate HIV testing and treatment for pregnant women: mandatory HIV testing and forced Azidothymidine (AZT) treatment. Some state legislatures have considered legislation that would mandate HIV testing for all pregnant women.[8] In fact, Connecticut and New York allow hospitals to conduct HIV tests for pregnant women even when women do not specifically agree to the test. Although no state legislature currently has a mandatory HIV testing policy for pregnant women, most state policies either require hospitals to strongly lobby pregnant women to consent to prenatal HIV testing (opt-in approach) or notify pregnant women that an HIV test will be included in a standard set of prenatal tests and procedures if they do not refuse it (opt-out approach).[9]

Additionally, because medical research has determined that the drug AZT may help prevent the transmission of HIV to the fetus,[10] prosecutors

(1992) (upholding women's right to pre-viability abortion); Cruzan v. Dir., Mo. Dep't of Health, 497 U.S. 261, 278 (1990) (right to refuse medical treatment); *see also Casey*, 505 U.S. at 851 (O'Connor, J., plurality opinion) (finding that the Constitution protects personal decisions relating to marriage, procreation, contraception, family relationships, child rearing, and education because "[t]hese matters, involving the most intimate and personal choices a person may make in a lifetime, choices central to personal dignity and autonomy, are central to the liberty protected by the Fourteenth Amendment"); *In re* Brown, 689 N.E.2d 397 (Ill. App. Ct. 1997), *appeal denied*, 698 N.E.2d 543 (Ill. 1998) (right to refuse medical treatment on religious grounds). *See generally* Brown, *supra* note 1, at 80-87 (outlining the various constitutional issues presented by the regulation of pregnancy behaviors).

8. *See* Brown, *supra* note 1, at 74-75 (summarizing various federal and state mandatory testing initiatives); Jennifer Cooper, *The Politics of Pediatric AIDS*, 3 CARDOZO WOMEN'S L.J. 53, 59 (1996) (discussing New York Assembly Bill No. 6747-B, which, if passed, would have required confidential HIV-related information to be disclosed to the mother of a newborn if the child was tested for any purpose).

9. *See* Ctrs. for Disease Control & Prevention, *HIV Testing Among Pregnant Women–United States and Canada, 1998–2001*, 51 MORBIDITY & MORTALITY WKLY. REP. 1013, 1016 (2002), *available at* http://www.cdc.gov/mmwr/PDF/wk/mm5145.pdf (comparing the number of women who responded that they had, had not, or did not know if they had received an HIV test during pregnancy in opt-in and opt-out approaches); *see, e.g.*, DEL. CODE ANN. tit. 16, § 1204(a) (West 2008) (requiring an opt-in approach: "[a]s a routine component of prenatal care, every licensed health care provider who renders the primary prenatal care, regardless of the site of such practice, shall advise every pregnant woman who is his or her patient of the value of testing for Human Immunodeficiency Virus (HIV) infection and shall request of each such pregnant women informed consent to such testing."); CONN. GEN. STAT. ANN. § 19a-55 (West 2008) (requiring hospitals to test any newborn whose mother was not HIV tested during pregnancy and inform the mother of the results). *See generally* Bonita de Boer, *HIV Testing in Pregnancy*, http://www.avert.org/hiv-testing-pregnancy.htm (2008) (stating that mandatory HIV testing of newborns raises several ethical questions, such as possibly disclosing the mother's HIV status without her consent, thereby evading her right to privacy).

10. *See* Div. of AIDS, Nat'l Inst. of Allergy & Infectious Diseases et al.,

have brought criminal charges against pregnant women for refusing to undergo AZT treatment.[11] For example, Kathleen Tyson, an HIV-positive woman in Oregon, quit AZT treatments because of the side effects and her fear that the powerful drugs would harm her fetus.[12] After the child was born, she refused to allow the doctors to administer AZT drug treatments to her child and continued to breastfeed despite doctors' orders to stop. Although Tyson and her husband felt they were making a good choice for their child (i.e., believing that breast milk was better than formula), the hospital disagreed. Tyson was charged with "intent to harm" and the court issued an emergency order that reinforced the doctor's instructions.[13]

These actions demonstrate the willingness of legal actors to force mothers to engage in behavior that will protect the fetus, while compromising the mothers' health or personal autonomy. As discussed in the following section, the criminal prosecution of women who use drugs during pregnancy also relies heavily on this notion that the fetus's well-being, at least in some circumstances, should be placed above other considerations.

2. Illegal Drug Use

In addition to HIV testing and treatment, the legal system has also attempted to address maternal drug use during pregnancy, even where laws are not in place to address this issue specifically.[14] Antidrug distribution

Zidovudine for the Prevention of HIV Transmission from Mother to Child, 43 MORBIDITY & MORTALITY WKLY. REP. 285, 286 (1994), *available at* http://www.cdc.gov/mmwr/PDF/wk/mm4316.pdf (finding that the treatment of AZT, a.k.a. zidovudine, resulted in a 67.5% reduction in the risk of HIV transmission from mother to fetus in a study using 364 births); *id.* at 285 (noting that mother-to-infant transmission is the leading cause of HIV infections in children); Brown, *supra* note 1, at 70 (noting that AZT administered to a group of HIV-infected women during pregnancy and labor, and later to their newborns, reduced the risk of prenatal HIV transmission from 25% to 8%).

11. *E.g.*, George Kent, The Tysons' Missing Testimony 1 (Nov. 20, 1999) (unpublished paper, *available at* http://www2.hawaii.edu/~kent/tysons.pdf) (restating testimony used in the case of Kathleen Tyson, a mother who was criminally charged for refusing AZT treatments for her son); *see also* Brown, *supra* note 1, at 71 (noting that AZT can cause short-term effects ranging from simple headaches to bone marrow suppression and seizures, and that its long-term effects are unknown).

12. *See* Kathleen Tyson, *In the Eye of the Storm: A Mother's True Story of Confronting AIDS, Fate, and the State*, MOTHERING, Sept. 2001, *available at* http://www. mothering.com/articles/new_baby/breastfeeding/eye-of-storm.html (arguing that she did not want to expose her son to the serious side effects posed by AZT and that she chose breast milk because of its higher nutrition and immune system support than formula); Kent, *supra* note 11, at 1.

13. *See* Tyson, *supra* note 12; Kent, *supra* note 11, at 1.

14. *See In re* "Male" R., 422 N.Y.S.2d 819, 825 (Fam. Ct. 1979) (finding that a mother's prenatal abuse of barbiturates and alcohol may constitute neglect and an action by social services to terminate the mother's custody was not inappropriate); *see also* Coffey, *supra* note 3, at 216.

laws and "fetal abuse" statutes, where child abuse statutes are applied to include maternal prenatal conduct, have frequently been used to prosecute pregnant women for drug use.[15] Where the state successfully criminally prosecutes mothers under child abuse and neglect statutes, the state will assume temporary custody over the child or terminate a mother's parental rights.[16] During the past twenty years, at least two hundred women have been charged under these laws with "drug use or other actions"—such as drinking alcohol, smoking cigarettes, or consuming illegal narcotics—for putting a fetus in danger.[17] For example, in 2004, an Oklahoma woman was charged with first-degree murder when doctors said the woman's illegal drug use caused her baby to be stillborn.[18] The Oklahoma state law under which the woman was charged allows for murder charges to be filed if an individual's actions brought about the death of a viable fetus, which in the state of Oklahoma is legally defined as twenty-four weeks into a pregnancy.[19]

Additionally, states have also attempted to control substance abuse behavior during pregnancy through hospital drug testing and prosecution.[20] In 1999, at least thirteen states required public hospitals to test pregnant women who were suspected of drug abuse, and report results to social services or the police.[21] In 2001, the Supreme Court found a South Carolina hospital's policy unconstitutional.[22] The policy required hospital

15. *See* Coffey, *supra* note 3, at 224-32 (outlining and analyzing cases where state prosecutors used antidrug distribution laws and child endangerment and abuse statutes in attempts to convict pregnant women of prenatal substance abuse).

16. *See id.* at 216 (noting that terminating parental rights to gain permanent custody of a fetus is "based on the theory that the mother's prenatal conduct is probative of future mistreatment of the child"); *see also In re* Milland, 548 N.Y.S.2d 995, 999 (Fam. Ct. 1989) (holding that the child would be placed in danger if in the mother's custody because of her prenatal alcohol use and unwillingness to accept treatment for her alcohol dependency); *In re* Smith, 492 N.Y.S.2d 331 (Fam. Ct. 1985) (holding that a mother's unborn child could be considered a "person" in order to receive protection from the mother's misuse of alcohol under the Family Court Act); *In re* "Male" R., 422 N.Y.S.2d 819 (Fam. Ct. 1979) (holding that a child born suffering from mild drug withdrawal when his mother was an abuser of barbiturates was sufficient evidence to determine that the child was neglected); *In re* Ruiz, 500 N.E.2d 935, 939 (Ohio Ct. Com. Pl. 1986) (holding that a viable fetus is a "child" under a child abuse statute, and that the mother's use of heroin prior to the child's delivery was sufficient evidence that the child's addiction to heroin was a result of prenatal substance abuse).

17. Coffey, *supra* note 3, at 211.

18. Reuters, *Woman Charged Over Stillbirth*, Sept. 10, 2004, http://tvnz.co.nz/view/news_world_story_skin/446983%3Fformat=html.

19. *Id.* (noting that Oklahoma recognizes viability twenty-four weeks into a pregnancy).

20. *See* Enid Logan, *The Wrong Race, Committing Crime, Doing Drugs, and Maladjusted for Motherhood: The Nation's Fury over "Crack Babies,"* 26 SOC. JUST. 115, 118, 120 (1999).

21. *Id.* at 120.

22. Ferguson v. City of Charleston, 532 U.S. 67, 85-86 (2001) (determining that

staff to test pregnant women for cocaine and report positive results to law enforcement so that the mother could be prosecuted.[23] The Court made the following two rulings: (1) the urine tests were "searches" within the meaning of the Fourth Amendment, and (2) the tests, and subsequent reporting of positive results, were unreasonable searches absent patient consent.[24] While part of the Court's ruling protects the privacy rights of mothers, the Court noted that these searches are allowed if the state can show a "special need" outside of a general interest in crime control.[25]

Hospital drug testing programs and prenatal drug use prosecution are two ways in which the mother is held legally responsible for the health and welfare of her fetus.[26]

3. Doctors' Orders

Courts and prosecutors have also attempted to regulate pregnant women's adherence to doctors' orders.[27] The decisions by some doctors to seek court orders forcing women to have Cesarean sections (C-sections) have been particularly controversial.[28] While the majority of cases have ended with the mother successfully giving birth without intervention, there have been cases where courts have authorized the performance of C-sections over the objections of the pregnant women because doctors convinced the courts that such medical intervention was necessary to preserve the health or life of the fetus.[29] Women have also been prosecuted for refusing C-sections after their doctors determined that the procedure was needed to save the life of their fetuses. In 2004, for example, a prosecutor in Utah brought murder charges against Melissa Rowland after she delayed a C-section that doctors claimed would have saved the life of

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the threat of criminal sanctions to deter pregnant women from using cocaine cannot justify a departure from the general rule that an official nonconsensual search is unconstitutional if not authorized by a valid warrant).

23. *Id.* at 70, 72.

24. *Id.* at 76, 81-84.

25. *Id.* at 67.

26. *See Id.* at 70-72; Logan, *supra* note 20, at 118, 120.

27. *See* Michelle Oberman, *Mothers and Doctors' Orders: Unmasking the Doctor's Fiduciary Role in Maternal-Fetal Conflicts*, 94 NW. U. L. REV. 451, 452, 479-80 (2000); *see also* Nancy Rhoden, *The Judge in the Delivery Room: The Emergence of Court-Ordered Cesareans*, 74 CAL. L. REV. 1951, 1951 (1986).

28. *See* Rhoden, *supra* note 27, at 1953 (arguing that "abortion law, properly interpreted, precludes nonconsensual surgery").

29. *See In re* Madyun, 114 Daily Wash. L. Rptr. 2233, 2233, 2240 (D.C. Super. Ct. 1986) (upholding a court order forcing a woman to have a C-section against her will); David Weiss, *Court Delivers Controversy: Mom Rejects C-sections; Gives Birth on Own Terms*, TIMES LEADER (Wilkes-Barre, Pa.), Jan. 16, 2004, at 1A (describing a court order granting a hospital permission to perform a C-section against a patient's will); *see also* SHEENA MEREDITH, POLICING PREGNANCY: THE LAW AND ETHICS OF OBSTETRIC CONFLICT 64-65 (2005).

one of her unborn twins.[30] In another case in Illinois, the State sought a court order requiring Tabita Bricci, a pregnant woman, to submit to a C-section after she refused the procedure on religious grounds.[31]

In another instance, a doctor sought a court order against a woman to force her to receive a blood transfusion.[32] The doctor believed the transfusion was necessary to save the lives of both the mother and her fetus.[33] The mother refused the transfusion, however, maintaining that it was against her religion.[34] A hearing was held immediately in an Illinois circuit court during which the state asked that a temporary custodian be appointed for the fetus.[35] The custodian was given the right to consent to at least one blood transfusion, and more if the necessity arose.[36] Over the next two days, the mother received six units of blood and delivered a healthy baby.[37] This is one of many such cases.

These examples indicate that the constitutional rights of women are being violated because of their pregnancy status.

B. Violation of Rights

The controversies surrounding the decisions by courts and prosecutors noted above arose because attempts to regulate pregnancy behavior often infringe upon the constitutional rights of the mother. First, forcing a woman to undergo a medical procedure or regulating a woman's behavior while pregnant violates the right to bodily autonomy as protected by the Fourteenth Amendment.[38] The right of pregnant women to refuse

30. Alexandria Sage, *Utah C-Section Mom Gets Probation*, CBS NEWS, Apr. 29, 2004, http://www.cbsnews.com/stories/2004/03/12/national/main605537.shtml.

31. *In re* Baby Boy Doe, 632 N.E.2d 326, 327, 330 (Ill. App. Ct. 1994), *cert. denied*, Baby Boy Doe v. Mother Doe, 510 U.S. 1168 (1994); *see also* RACHEL ROTH, MAKING WOMEN PAY: THE HIDDEN COSTS OF FETAL RIGHTS 90 (2000) (stating that "pregnant women increasingly find themselves subject to a political mandate to conduct themselves in ways" that doctors, legislatures, and courts deem best); *id.* at 128 (stating that requests to review the appellate court's decision in the case of Tabita Bricci were denied and that Bricci gave birth naturally to a healthy baby).

32. *In re* Brown, 689 N.E.2d 397, 399 (Ill. App. Ct. 1997), *appeal denied*, 698 N.E.2d 543 (Ill. 1998).

33. In re *Brown*, 689 N.E.2d at 399.

34. *Id*.

35. *Id.*

36. *Id.* at 400, 406 (reversing the decision of the circuit court because "the circuit court erred in appointing a temporary custodian for Fetus Brown with the authority to consent to blood transfusions for Darlene Brown, and erred in appointing the public guardian *ad litem* for Fetus Brown").

37. *Id*. at 400.

38. *See* Cruzan v. Dir., Mo. Dep't of Health, 497 U.S. 261, 277 (1990) (finding bodily integrity as a liberty interest protected by the Fourteenth Amendment to the Constitution and stating that a competent person has a right to refuse unwanted medical treatment).

treatment that may benefit their fetuses has been upheld in several cases.[39] However, a woman's right to bodily autonomy has been undercut by the State's interest in protecting unborn human life. In *Roe v. Wade*, the Supreme Court found that the word "person" does not extend to the "unborn,"[40] but nonetheless found that the point at which the State's interest becomes "compelling" is at fetal viability.[41] In the years since *Roe*, the Supreme Court has modified and restricted a woman's right to bodily autonomy, while expanding the ability of the State to intervene for the benefit of the unborn. In *Planned Parenthood of Southeastern Pennsylvania v. Casey*, the Supreme Court rejected the trimester framework created in *Roe*, finding that this framework "undervalues the State's interest in potential life."[42] As a result, when a woman becomes pregnant, her medical decisions are potentially subject to governmental intervention. Whether a court forces a woman to engage in a particular medical procedure often depends upon which of two lines of reasoning a judge decides to follow.[43] A judge that draws upon cases emphasizing the right to be free from unwanted medical procedures will more likely defer to a woman's wishes, while a judge emphasizing the State's "compelling interest" in the potential life of the fetus will more likely approve a forced procedure.[44]

Regulation of women's behavior during pregnancy also violates the right to privacy, which the Supreme Court has found to be a fundamental liberty inherent in the First, Third, Fourth, Fifth, and Fourteenth Amendments.[45] In *Casey*, the Supreme Court affirmed an individual's right to personal autonomy.[46] As part of the constitutionally protected right to privacy, the

39. *See, e.g.*, *In re* Baby Boy Doe, 632 N.E.2d 326, 335 (Ill. App. Ct. 1994), *cert. denied*, Baby Boy Doe v. Mother Doe, 510 U.S. 1168 (1994); Mercy Hosp., Inc. v. Jackson, 510 A.2d 562, 565 (Md. 1986).

40. 410 U.S. 113, 158 (1973).

41. *Id*. at 163.

42. 505 U.S. 833, 873 (1992) (affirming *Roe*'s central holding that a woman has a right to terminate her pregnancy before viability, but rejecting the trimester framework as not part of the essential holding of *Roe*).

43. *See* Samantha Catherine Halem, Note, *At What Cost?: An Argument Against Mandatory AZT Treatment of HIV-Positive Pregnant Women*, 32 HARV. C.R.-C.L. L. REV. 491, 506-07 (1997) (comparing judges who rely on the right to refuse medical treatment with judges who consider the compelling state interest in protecting the unborn child).

44. *See id*.

45. Griswold v. Connecticut, 381 U.S. 479, 484 (1965); *see also* Olmstead v. United States, 277 U.S. 438, 478 (1928) (Brandeis, J., dissenting) (noting that the "the right to be left alone" is "the most comprehensive of rights and the right most valued by civilized men" and that "to protect that right, every unjustifiable intrusion by the Government upon the privacy of the individual, whatever the means employed, must be deemed a violation of the Fourth Amendment"), *overruled by* Katz v. United States, 389 U.S. 347 (1967), *and* Berger v. New York, 388 U.S. 41 (1967).

46. *Casey*, 505 U.S. at 851.

Court has confirmed the right of the individual to make certain kinds of choices freely, such as whether to terminate a pregnancy[47] or use contraception.[48] However, the Court circumscribed the right to privacy in order to protect a viable fetus. While the Court implied an unqualified right to privacy where reproductive rights were at issue in *Griswold v. Connecticut*,[49] the Court's later decision in *Roe* held that government intrusion of an individual's privacy is justified when the State can demonstrate a compelling or substantial government interest sufficient to outweigh the privacy interest.[50]

Finally, regulation of a pregnant woman's behavior violates the right to informed consent: if an individual does not consent, a doctor should not force a procedure on a patient, even when considered medically necessary.[51] The right to informed consent is particularly at issue when a patient refuses treatment for religious reasons.[52] However, courts have overridden this right when the State demonstrates a sufficiently compelling countervailing interest in protecting a viable fetus, and accordingly, these courts have forced medical procedures upon unwilling mothers.[53] In one example, although the presiding judge in In re *Jamaica Hospital* recognized that the pregnant patient had "an important and protected interest in the exercise of her religious beliefs,"[54] he nonetheless forced her to have a procedure because he felt compelled to "consider the life of the unborn fetus."[55]

Despite the Supreme Court's decisions in *Roe* and *Casey* clearly recognizing the competing state interest in the life of a viable fetus, many

47. *See* Roe v. Wade, 410 U.S. 113, 153 (1973) (concluding that the right of personal privacy includes a woman's decision whether to terminate her pregnancy).

48. *See Griswold*, 381 U.S. at 485.

49. *Id*.

50. *See id.*; *see also Roe*, 410 U.S. at 127-30 (holding that the fetus's development was a critical factor in both the woman's right to privacy and State's interest in potential life and that a woman's right to privacy gives way to the State's interest in potential life at the point where the fetus "has the capability of meaningful life outside the mother's womb").

51. *See* Whalen v. Roe, 429 U.S. 589, 593 (1977) (recognizing an "interest independence in making certain kinds of important decisions"); *see also* Schloendorff v. Soc'y of the N.Y. Hosp., 105 N.E. 92, 93 (N.Y. 1914) (Justice Cardozo noted that "[e]very human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient's consent commits an assault").

52. *See In re* Jamaica Hosp., 491 N.Y.S.2d 898, 899 (App. Div. 1985) (reasoning that while a patient has a constitutionally protected right to practice her religion, the life of the unborn fetus must also be weighed in medical choices).

53. *See id.*; *see also In re* Madyun, 114 Daily Wash. L. Rptr. 2233, 2240 (D.C. Super. Ct. 1986).

54. In re *Jamaica Hosp*., 491 N.Y.S.2d at 899-900.

55. *See id*.

researchers and legal scholars believe that a woman does not relinquish any rights when she becomes pregnant.[56] The Supreme Court, however, has yet to hear a case concerning the regulation of a pregnant woman's behavior and choices, other than on the issue of abortion. Thus the window remains open for the argument that women's right to be free from forced medical procedures trumps even the "compelling state interest" identified in *Roe* and *Casey.*

II. DISPROPORTIONATE HARM TO MINORITY WOMEN

Legal actions regulating pregnancy behavior demonstrate how women's rights have been marginalized through the legal system.[57] In addition, psychological research and theory suggests that the regulation of pregnancy behavior may disproportionately affect minority women.[58] Researchers developed a theoretical model demonstrating how individuals process health information and arrive at decisions, the Health Belief Model (HBM).[59] Characteristics prevalent among minority women in the U.S. may affect the information available to them and their subsequent decisions. Specifically, personal characteristics, such as education or income level, have a significant influence on the decisions minority women make about pregnancy behavior and could increase the probability that they will be affected by legal regulation of pregnancy.[60]

Studies have found that minority women have lower levels of trust in the medical system, higher arrest rates, and lower socioeconomic status than

56. *See, e.g.*, Halem, *supra* note 43 (arguing that mandatory AZT treatment for pregnant women violates constitutional rights). *See generally* Brown, *supra* note 1.

57. *See, e.g.*, Ferguson v. City of Charleston, 532 U.S. 67 (2001); *In re* Madyun, 114 Daily Wash. L. Rptr. 2233; State v. Luster, 419 S.E.2d 32 (Ga. Ct. App. 1992); *In re* Milland, 548 N.Y.S.2d 995 (Fam. Ct. 1989); *In re* Smith, 492 N.Y.S.2d 331 (Fam. Ct. 1985); *In re* "Male" R., 422 N.Y.S.2d 819 (Fam. Ct. 1979); *In re* Ruiz, 500 N.E.2d 935 (Ohio Ct. Com. Pl. 1986) (explaining that a state must have the ability to regulate pregnancy behavior to ensure that the state's interest has meaning).

58. *See* Dorothy E. Roberts, *Punishing Drug Addicts Who Have Babies: Women of Color, Equality, and the Right to Privacy*, 104 HARV. L. REV. 1419, 1419 (1991) (arguing that minority women are less able to comply with regulations and therefore the most affected by government regulation); *see also* Charles Abraham & Paschal Sheeran, *The Health Brief*, *in* PREDICTING HEALTH BEHAVIOR: RESEARCH AND PRACTICE WITH SOCIAL COGNITION MODELS 23, 23 (Mark Conner & Peter Norman eds., Open University Press 1st ed. 1996) (contending that researchers have found evidence that ethnicity plays a role in whether an individual will take preventative health steps).

59. *See* Abraham & Sheeran, *supra* note 58, at 23.

60. *See* Janice Blanchard & Nicole Lurie, *R-E-S-P-E-C-T: Patient Reports of Disrespect in the Health Care Setting and Its Impact on Care*, 53 J. FAM. PRAC. 721, 727 (2004) (reporting that minorities with lower incomes and lower education levels were more likely to feel discriminated against in healthcare situations and less likely to follow physician orders).

white women.[61] These characteristics translate into differences in the way minority women decide to engage in specific health behaviors, including pregnancy decisions, in comparison to white women. For example, a minority woman, who is likely to have a lower socioeconomic status than most white women, may not be able to afford to comply with some of her doctor's instructions.[62] As a result, pregnancy regulation has the potential to negatively impact health decisions made by minorities to a greater degree than decisions made by white women. Specifically, these characteristics either predispose women to be more likely to violate pregnancy regulations or dissuade women from seeking prenatal medical care.

The purpose of the following section is threefold. First, it will describe how people weigh different health options and arrive at decisions about their health behavior. Second, it will outline how three characteristics—socioeconomic status, doctor mistrust, and arrest rates—influence minority women's decisions about their health behavior. Finally, it will describe how minority women are more predisposed than white women to violating pregnancy-related legal regulations because of their health decisions.

A. Health Decision-Making

Extensive research has shown that the HBM accurately explains and predicts an individual's participation in a variety of health behaviors.[63] The HBM focuses on how an individual's attitudes and beliefs encourage or discourage particular health-related choices.[64] Specifically, the HBM is based on the following three questions that an individual must consider in relation to a particular health condition and health behavior: (1) can the negative health outcome be avoided; (2) does avoidance of the negative outcome require the performance of a particular health action; and, (3) can

61. *See generally* L. Ebony Boulware et al., *Race and Trust in the Health Care System*, 118 PUB. HEALTH REP. 358, 360-62 (2003) (describing differences in the level of trust a patient has in his or her doctor depending on the race of the patient); *see also* Patrick R. Clifford, *Drug Use, Drug Prohibition and Minority Communities*, 12 J. PRIMARY PREVENTION 303 (1992) (providing statistics on the rate of arrests of white people in comparison to minority arrests); Jeffrey G. Ghassemi, *Not Just Black and White: New Efforts Look More Deeply into Racial Comparisons of Health Care*, WASH. POST, July 25, 2006, at F01.

62. *See* Heather Antecol & Kelly Bedard, *The Racial Wage Gap: The Importance of Labor Force Attachment Differences Across Black, Mexican, and White Men*, 39 J. HUM. RESOURCES, 564, 566, 568 (2004).

63. *See generally* KAREN GLANZ & BARBARA K. RIMER, THEORY AT A GLANCE: A GUIDE FOR HEALTH PROMOTION PRACTICE 18-20 (2d ed. 2007) (outlining the Health Belief Model); Abraham & Sheeran, *supra* note 58 (detailing the Health Behavior Model); Ivan Rosenstock, *Historical Origins of the Health Belief Model*, 2 HEALTH EDUC. MONOGRAPHS 328 (1974) (describing the Health Belief Model).

64. *See* Abraham & Sheeran, *supra* note 58, at 25.

the particular health action be accomplished.[65] If an individual answers "yes" to all of these questions, then the individual may be capable of achieving positive health outcomes, or at least avoiding negative outcomes.[66] However, barriers often interfere with the confidence an individual has in answering "yes" to these questions.

Minority individuals, because of factors associated with minority status, sometimes do not believe they have the ability to perform behaviors necessary to avoid negative health conditions. Overall, minority women, when compared to white women, generally have a lower socioeconomic status,[67] have lower levels of trust in the medical system,[68] and are arrested at much higher rates than white women.[69] These factors limit the probability that pregnant minority women will be able to avoid certain negative health outcomes for their fetus. In terms of the HBM, these characteristics could prevent women from recognizing what behaviors are necessary to avoid such negative outcomes, or could cause women to believe that they are incapable of performing a necessary behavior. For example, a woman's low socioeconomic status may lead her to believe that she is incapable of participating in an expensive prenatal procedure a doctor recommends. Essentially, factors that characterize many minority women, such as low SES, low trust in the medical system, and high rates of legal problems and arrests, influence their decisions regarding health behavior.

B. Differences in the Level of Trust Women Have in the Medical System

Research has established that significant racial differences exist in how much individuals trust the medical community.[70] One study included a telephone survey that asked white, black, Latino, and Asian patients to

65. *See id.* at 36-43.

66. *See id.*

67. *See* Stephen Ohlemacher, *Race Still Divides U.S., Census Says: Disparities Widening in Incomes, Education*, CHI. TRIB., Nov. 14, 2006, at 3 [hereinafter Ohlemacher, *Race Still Divides*].

68. *See* Boulware, *supra* note 61, at 360-62 (contending that minorities are less likely to trust the medical system).

69. *See* ALLEN J. BECK & CHRISTOPHER J. MUMOLA, BUREAU OF JUSTICE STATISTICS BULLETIN: PRISONERS IN 1998 2, 8, 10 (1999), *available* at http://www.ojp.usdoj.gov/bjs/pub/pdf/p98.pdf (explaining that non-Hispanic black women are incarcerated at a rate of 200 per 100,000, compared to the rate of 25 per 100,000 for white non-hispanic women); Roberts, *supra* note 58, at 1419 (arguing that black women face a greater risk of being tested for drugs during pregnancy than white women); *see also* Antecol & Bedard, *supra* note 62, at 564; Boulware, *supra* note 61, at 360-62 (contending that minorities are less likely to trust the medical community); Ohlemacher, *Race Still Divides*, *supra* note 67.

70. *See* Boulware, *supra* note 61, at 360-62 (asserting that research shows racial differences in levels of trust toward the medical system).

assess their satisfaction in their physician on a variety of dimensions, including their level of trust in the relationship.[71] This study found that black respondents were less likely to trust their physicians than non-Hispanic white respondents, and were also more likely to be concerned about personal privacy and the potential for harmful experimentation in hospitals.[72] Additional studies have found that black, Asian, and Latino patients experience more disrespect from the medical community than white patients.[73] In addition, minorities are more likely to feel that they would have received better care if they were of a different race.[74]

Because minority women often mistrust their doctors, they are more likely than white women to have one of two thoughts when evaluating their health behavior according to the HBM: (1) they may not believe that certain decisions are necessary to avoid a negative health outcome, or (2) they may believe that they cannot perform the behavior necessary to avoid the negative health outcome. For example, a minority woman who has little trust in the medical system may not believe that AZT treatment will be effective in preventing HIV transmission to her fetus, or she may believe that there are too many negative side effects of the drug. Thus, the HBM would predict that in this instance, the woman does not believe that this particular health behavior is necessary to avoid a possible negative health outcome (i.e., transmitting HIV to her fetus). In essence, she weighs the costs, such as side effects, and the benefits, such as the possible prevention of HIV transmission, associated with the health behavior. Her conclusion, based on how she weighs the costs and benefits, affects her decision whether to engage in this health behavior.

If a woman fears that her doctor will make her do something against her will or report her to the police, her relationship with the doctor will be harmed. This is a significant problem where mandatory reporting policies are in place (e.g., a doctor is required to report a drug-user who is pregnant).[75] Due to beliefs commonly held by minority women, it is probable that they will not weigh and consider the information and recommendations given by their doctor in the same way as white women.[76]

71. *See id.*

72. *See id.*

73. *See generally* Blanchard & Lurie, *supra* note 60, at 725 (observing that 14% of Blacks, 19% of Asians, and 20% of Latinos surveyed reported disrespectful treatment from the medical system).

74. *See id.*

75. *See* Logan, *supra* note 20, at 133; *see also* Terry Adirim & Nandini San Gupta, *A National Survey of State and Maternal and Newborn Drug Testing and Reporting Policies*, 106 PUB. HEALTH REP. 292, 293 (1991) (stating that reporting policies might result in state custody of infants or abuse charges against mothers).

76. *See* Boulware, *supra* note 61, at 360-64 (observing that minorities are less likely to trust physicians and that a lack of trust affects perceptions of treatment and

Therefore, minority women are more likely to reject their doctor's advice and, as a result, face criminal prosecution.

C. Differences in Socioeconomic Status

In addition to differences in the levels of trust in doctors, minority and white women also differ overall in socioeconomic status. Race, ethnicity, and socioeconomic status are closely intertwined in the United States.[77] Minorities generally occupy a lower socioeconomic position within the United States than whites.[78] Minority and low socioeconomic status are associated with lower quality housing, nutrition, and education.[79] As a result, pregnant minority women are likely to weigh the consequences of their decisions differently than pregnant white women.

Lower socioeconomic status corresponds to low-paying job opportunities, which often do not provide benefits such as health insurance or paid vacation; instead, they merely offer hourly pay, often at the minimum wage. As a result, a pregnant woman must consider potential economic costs when deciding whether to engage in pregnancy behaviors (e.g., receiving a C-section) that will affect her employment. A woman in need of a C-section must consider the need to take unpaid time off from work to recover from surgery. Additionally, the expense of C-sections poses a significant burden on a woman without health insurance.[80] Women who undergo AZT treatment face similar problems; the side effects of AZT may cause women to miss work and could present an added medical expense.[81]

In addition, the majority of court-ordered C-sections, ordered without a written opinion from the court to create legal precedent, involved minority women.[82] Specifically, in 80% of these cases, the women affected were black, Latino, or Asian, and 27% of these women did not speak English as

possibly decision-making).

77. *See* Ghassemi, *supra* note 61, at F01.

78. *See* Ohlemacher, *Race Still Divides*, *supra* note 67.

79. *See generally* Ghassemi, *supra* note 61, at F01; Ohlemacher, *Race Still Divides*, *supra* note 67.

80. *See* Diane E. Judge, *C-Section on Demand: A Good Idea?*, 709 J. WATCH WOMEN'S HEALTH (2003) (stating that a C-section is "considerably more expensive than [a] vaginal delivery").

81. *See* Enid Vázquez, *Side Effect Chart: An Abbreviated At-a-Glance Guide to Potential HIV Drug Side Effects*, POSITIVELY AWARE, Jan.-Feb. 2007, 53, 53 (stating that possible side effects of AZT are "[h]eadaches, fever, chills, muscle soreness, fatigue, nausea, fingernail discoloration, anemia, and neutropenia").

82. *See* Veronika E.B. Kolder, Janet Gallagher & Michael T. Parsons, *Court-Ordered Obstetrical Interventions*, 316 NEW ENG. J. MED. 1192, 1192 (1987) (listing fifteen cases of court-ordered Caesarean operations).

their primary language.[83] All of the women in these cases were treated in a teaching hospital or received public assistance.[84] The HBM specifies that in order to avoid a negative health outcome, individuals must believe that they are capable of performing the necessary health behavior.[85] Due to their lower SES, it is likely that these women did not believe they were able to have a C-section.

Because of their lower economic status, minority women, more than their white counterparts, may conclude that the potential economic costs of the conduct suggested by their doctor are not worth the potential health benefits of the conduct. This suggests that because of their socioeconomic status, minority women may be at a higher risk of criminal prosecution for violating laws governing pregnancy-related behavior, and may also be forced to engage in more undesirable behavior than white women.

D. Differences in Rates of Arrest

Although drug use transcends all racial, socioeconomic, and geographic lines, minorities are disproportionately targeted for drug-related arrests, such that minority arrest rates for drug offenses are five times higher than for whites.[86] Black individuals constitute 37.3% of arrests for drug possession.[87] Additionally, while the rates of drug use among black and white pregnant women are similar, the majority of women reported to authorities for exposing their fetuses to illegal substances were black.[88] This means that a black woman is significantly more likely to be tested for drug use during pregnancy than a white woman. In addition, minority and low-income women are more likely than white women to be required to undergo drug testing during pregnancy.[89]

As a result, minority women may not go to doctors because they are afraid of being prosecuted, whereas white women, who are less likely to be

83. *See id*.

84. *See id*.

85. *See* Rosenstock, *supra* note 63, at 328.

86. *See generally* BECK & MUMOLA, *supra* note 69 (describing statistics establishing racial disparities in federal and state custody); Alfred Blumstein, *Racial Disproportionality of U.S. Prisons Populations Revisited*, 64 U. COLO. L. REV. 743, 751 (1993) (describing differences in arrest rates among minorities and whites and other factors associated with these arrest rates, such as location and policing trends).

87. *See* Fed. Bureau of Investigations, U.S. Dep't of Justice, *Crime in the United States, 1998: Uniform Crime Reports* 209, 209 (Washington, D.C.: USGPO, 1998).

88. *See* Roberts, *supra* note 58, at 1434 (explaining that despite little difference in substance abuse, black women are still ten times more likely than white women to be reported to health officials for drug abuse); Gina Kolota, *Racial Bias Seen on Pregnant Addicts*, N.Y. TIMES, July 20, 1990, at A13.

89. *See* Kolota, *supra* note 88 (suggesting that the disparity is partly because blacks go to public hospitals, which are more likely to drug test and report those results than private hospitals).

prosecuted, may not share this fear. According to the HBM, because a minority woman is more likely to fear prosecution, she is less likely to believe she is capable of performing the necessary health behavior—going to see a doctor. She may forego vital prenatal care in order to avoid the risk of criminal prosecution or drug testing, which may, in turn, significantly endanger her fetus.[90] The bias that exists in pregnancy regulation may, therefore, disproportionately harm the health of a minority woman, as well as the health of her fetus.

The evidence presented suggests that statutes and laws governing pregnancy behavior unfairly—even if unintentionally—negatively influence the pregnancy decisions and outcomes of minority women, which can lead to disproportionate harm in comparison to white women. Specifically, factors such as low socioeconomic status, lower trust in the medical community, and high arrest rates, may weigh upon the decisions minorities make about various health behaviors related to their pregnancy.[91] Due to these societal-level factors that characterize many minority women, their decisions regarding pregnancy behavior are not likely to align with the laws and policies that regulate pregnancy. As a result, the constitutional rights of minority women may be marginalized more often. Additionally, minority women may forego necessary treatment and care in order to avoid prosecution. Policy changes must be made to prevent the negative consequences that arise from pregnancy regulation.

III. POLICY IMPLICATIONS

The social issues discussed in this article—HIV transmission, drug use during pregnancy, and fetal harm—are serious problems. The existing punitive legal actions discussed, however, are not the best way to address these problems. Such legal action has the potential not only to violate women's constitutional rights, but to affect minority women disproportionately. The HBM predicts that the previously discussed factors, which characterize many minority women, may predispose them to making poor decisions regarding their pregnancy, affecting the way they make health decisions. As a result, minority women are more likely to be affected by statutes and regulations governing pregnancy behavior.[92] To

90. *See* Greg Alexander & Carol Korenbrot, *The Role of Prenatal Care in Preventing Low Birth Weight*, 5 FUTURE CHILD 103, 105 (1995) (discussing the link between low birth weight and prenatal care).

91. *See* Boulware, *supra* note 61, at 362; Clifford, *supra* note 61, at 312; Ghassemi, *supra* note 61, at F01 (establishing other factors pregnant minority women might consider, including increased likelihood of prison time if caught with drugs, their knowledge of historical race discrimination in the medical field, and their low socioeconomic status).

92. *See generally* Roberts, *supra* note 58, at 1434-52 (discussing the ways in which regulations make minority women turn away from optimal health choices: prosecutorial

reduce the disproportionate impact that pregnancy regulations and statutes have on the lives of minority women, the specific characteristics that contribute to the problem must be addressed. The following section will discuss ways in which low socioeconomic status, mistrust in the medical community, and high arrest rates, can be reduced.

A. The Role of Socioeconomic Status in Eliminating Bias in the Legal System

The first way to reduce the disproportionate harm that many minorities experience is to address the general socioeconomic gap between minorities and the white majority. Minorities have comparatively lower incomes than whites.[93] To improve socioeconomic status for minority groups, more money, at state and federal levels, needs to be funneled into improving the welfare system in low-income communities. Research has found that in the United States, welfare-to-work program recipients are more likely to work consistently and attain a higher paying job in comparison to welfare recipients not involved in a welfare-to-work program.[94] Welfare-to-work programs can increase the probability that minority women will be able to earn a livable salary, thereby reducing concerns over the financial costs that accompany pregnancy behavior decisions.

In addition, the federal government should provide money to improve the Medicaid system and encourage lower paying employers to provide health insurance.[95] This would increase the quality of medical care for all women of low socioeconomic status. By improving the Medicaid system, the financial burden associated with medical decisions would be significantly lessened.

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focus on crack cocaine isolates minorities; historical racial discrimination means blacks gravitate toward public hospitals that implement drug testing; the lack of formal screening processes at hospitals; and the racially discriminatory arrest statistics).

93. *See* Stephen Ohlemacher, *Whites' Income 2/3 Higher Than Blacks': Racial Gaps Continue—Some Increase*, CHI.-SUN TIMES, Nov. 14, 2006, at 22 (reporting that, according to the Census Bureau, white households had incomes that were two-thirds higher than blacks and 40% higher than Hispanics); *see also* Griff Witte & Nell Henderson, *Wealth Gap Widens for Blacks, Hispanics: Significant Ground Lost After Recession*, WASH. POST, Oct. 18, 2004, at A11 (noting that "[t]he widening wealth gap underscores the vast differences in the economic well-being of minority and white families").

94. *See* GAYLE HAMILTON ET AL., U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, EXECUTIVE SUMMARY: NATIONAL EVALUATION OF WELFARE-TO-WORK STRATEGIES (2001).

95. *But see* Lisa Dubay & Genevieve Kenney, *A National Study of the Impacts of Medicaid Expansions for Pregnant Women,* Urban Institute Working Paper 6217-11 (Washington: The Urban Institute, 1995) (suggesting research has established that despite expansions of the Medicaid program, these expansions made little impact on the health outcomes of pregnant women; specifically, the rates of adequate prenatal care and low birth-weight births were unaffected).

Improving minority women's socioeconomic status and satisfying their healthcare needs would allow them to worry less about the financial cost of medical care. It would also allow minority women to make medical decisions based on health concerns, instead of financial ones. Relieving these financial burdens will increase the probability that women will answer "yes" to the questions that comprise the HBM, reducing the chance that they will violate pregnancy regulations.

B. The Role of Increasing Trust in Eliminating Bias in the Legal System

Another way to reduce the bias against minority women is to reduce the mistrust between doctors and minority patients. Research shows that many minority patients mistrust their physicians.[96] One way that federal and state governments can reduce this mistrust is to create programs encouraging minorities to pursue careers in the medical field, particularly because minorities are significantly underrepresented in the medical profession.[97] Research has indicated that minority patients have a more positive experience in racially-concordant medical relationships.[98] Thus, increasing the number of minority doctors may result in more concordant pairings and encourage trust within doctor-minority patient relationships. This may further encourage minorities to follow their doctor's advice, thus reducing negative health outcomes.

Language barriers and cultural differences can also contribute to mistrust between doctors and minority patients.[99] In areas with large populations of non-English speaking patients, medical offices should employ interpreters. Additionally, research has determined that many doctors recognize the importance of cultural training.[100] Training could increase their ability to recognize characteristics associated with other cultures, thus fostering

96. *See* Boulware, *supra* note 61, at 362 (statistics show black respondents were less likely than their white counterparts to trust their physicians).

97. *See* Donald L. Libby, Zijun Zhou & David A. Kindig, *Will Minority Physician Supply Meet U.S. Needs: Projections for Reaching Racial Parity of Physicians to Population*, HEALTH AFF., July-Aug. at 205 (showing only 3.56% of physicians identified themselves as black).

98. *See* Lisa Cooper et al., *Patient-Centered Communication, Ratings of Care, and Concordance of Patient and Physician Race*, 139 ANNALS OF INTERNAL MED. 907, 910-11 (2003) (studies show race-concordant visits were longer, both parties spoke slower and patients were more likely to be satisfied with their visit and willing to recommend the physician to others).

99. *See, e.g.*, J. A. Chilton et al., *Cervical Cancer Among Vietnamese Women: Efforts to Define the Problem Among Houston's Population*, 99 GYNECOLOGIC ONCOLOGY S203, S205 (2005) (citing language barriers as a reason why Vietnamese women were not being properly screened for cervical cancer).

100. *See, e.g.*, Joel S. Weissman et al., *Resident Physicians' Preparedness to Provide Cross-Cultural Care*, 294 J. AM. MED. ASS'N 1058, 1063 (half of doctors reported they had little or no training in understanding how to address patients from different cultures).

better communication in the relationship.[101] Educational media designed to encourage minority women to trust their doctors may also be effective in enhancing trust. This may increase the probability that minority women will be able to answer "yes" to the questions that comprise the HBM, and thus make better health choices.

C. The Role of Lowering Arrest Rates in Eliminating Bias in the Legal System

Arrest rates also contribute to the disproportionate effects that pregnancy statutes and regulations have on minorities since minority women are arrested for drug-related offenses at substantially higher rates than white women.[102] This is closely related to the issue of trust; if women fear that doctors will report them to the authorities, they will be less likely to trust doctors. In addition to being arrested at higher rates, minority women are drug-tested more frequently in the peripartum setting, and positive drug tests may lead to prosecution.[103] To address this social issue, the federal and state governments need to work to eliminate the bias displayed by the medical community in testing minority women. Specifically, policy makers should fund training programs that emphasize racial sensitivity and focus on eliminating discrimination. These programs should be designed specifically for medical staff and should focus on how to avoid discriminatory behavior when performing the duties of their job.

IV. CONCLUSIONS

In the United States, legal regulation of pregnancy behaviors is controversial.[104] In addition to violating women's constitutional rights, the legal regulation of pregnancy behaviors involves unfair biases against minority women. Societal-level changes must be made to reduce racial bias successfully. The changes necessary to reduce racial bias require a massive shift in public values, as well as a reprioritization of issues by federal and state governments. Specifically, the policy recommendations discussed in this article will help women to base health decisions on medical advice from their doctor, and not on financial concerns, fear of

101. *See id.* at 1064.

102. *See* Roberts, *supra* note 58, at 1453 (arguing that the disparity between the number of blacks prosecuted and the percentage of pregnant substance abusers is racial discrimination).

103. *See* Hillary Veda Kunins et al., *The Effect of Race on Provider Decisions to Test for Illicit Drug Use in the Peripartum Setting*, 16 J. WOMEN'S HEALTH 245, 248 (2007) (study shows black women were 1.5 times more likely to be tested for illicit drugs than non-black women).

104. *See* GOMEZ, *supra* note 1; Ayers, *supra* note 1, at 301; Bornstein, *supra* note 1, at 227.

arrest, or mistrust. Although this goal seems lofty, the public must work toward eliminating the biases present in the legal system to avoid targeting certain groups for greater prosecution, and to provide a better quality of life for pregnant minority women. Although these changes are formidable, they are necessary to protect the constitutional rights of all pregnant women.