

Poor Women and the Protective State

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This Article puts poor, pregnant women's current experience with the state into conversation with the science of prenatal and early childhood brain development and looks at the effect on women's autonomy of government regulation of individual behaviors that may harm fetal brain development. Drawing upon ethnographic fieldwork with poor, pregnant women that reveals that indigent women's current experience with the regulatory state is one in which their autonomy is already grossly compromised, this Article argues that the infringement on vulnerable populations' privacy rights is guaranteed should the government attempt to manage or reduce assaults on prenatal brain development through the regulation of individual behaviors. Regulations that focus on individuals should be drafted with a focus on social justice in order to protect the autonomy of poor women affected by these laws. This Article suggests, however, that a better approach is regulation on the macro-level—through legislation that requires product testing and prevents manufacturers from introducing certain chemicals into the marketplace or environment.

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Research in the neurosciences has demonstrated that there are many categories of chemicals that may adversely affect the developing brain. The sheer ubiquity of these chemicals is staggering, and our exposure to them seems unavoidable; indeed, they are present in everything from the food supply to flame retardants, pesticides, jewelry upholstered furniture, and domestic animals.¹

The goal of this Article is to put poor, pregnant women's current experience with the state into conversation with the science of prenatal and early childhood brain development. Specifically, this Article asks how the autonomy of poor, pregnant women and mothers may be impacted by government regulation of individual behaviors that may harm fetal brain development. Based on indigent women's current experience with the regulatory state, the infringement on vulnerable populations' privacy rights is guaranteed should the government attempt to manage or reduce assaults on prenatal brain development through the regulation of individual behaviors. This Article suggests that the preferable route of regulation is on the macro level—through legislation that requires manufacturers to test their products for the neurodevelopmental hazards they pose or else prohibits or limits the introduction of harmful chemicals into the marketplace and the environment. If the regulatory focus is on the individual, however, the question of social justice should be at the forefront of drafters' minds in order to reduce the inevitable autonomy-reducing effects that it will have on poor women.

Beginning in the spring of 2005, I conducted anthropological fieldwork for eighteen months in the obstetrics clinic of a public hospital in Manhattan.² Most of the women receiving prenatal care in the clinic during that time relied upon Medicaid, specifically the New York State Prenatal Care Assistance Program ("PCAP"), to cover the costs of their healthcare.³ My research revealed that poor women's current experience with the regulatory state, as dramatized by their experience navigating the requirements of PCAP, is one in which their autonomy is denied and their privacy rights and expectations are presumed to be nonexistent or negligible. There are many PCAP requirements that allow the government access to certain intimate provinces of poor women's lives. However, the two requirements most relevant to the potential regulation of assaults on

1. See generally TRACEY WOODRUFF ET AL., U.S. ENVTL. PROT. AGENCY, EPA 240-R-03-001, AMERICA'S CHILDREN AND THE ENVIRONMENT: MEASURES OF CONTAMINANTS, BODY BURDENS, AND ILLNESSES (2003).

2. For an extensive analysis of my research in the Alpha obstetrics clinic, see KHIARA M. BRIDGES, REPRODUCING RACE: AN ETHNOGRAPHY OF PREGNANCY AS A SITE OF RACIALIZATION (2011).

3. PCAP is a smaller program within the larger New York State Medicaid program that provides comprehensive prenatal care services to women who would otherwise be uninsured or underinsured. See N.Y. ST. DEP'T OF HEALTH OFF. OF MEDICAID MGMT., PRENATAL CARE ASSISTANCE PROGRAM (PCAP): MEDICAID POLICY GUIDELINES MANUAL (2007).

prenatal brain development are the psychosocial assessment⁴ and the nutritional assessment.⁵

During the psychosocial assessment, a social worker screens the patient for several “risk factors,” including: (1) The unplanned-ness and/or unwanted-ness of the current pregnancy, (2) the woman’s intention to give the infant up for adoption or to surrender the infant to foster care, (3) HIV-positive status, (4) a history of substance abuse, (5) a lack of familial or environmental support, (6) marital or family problems, (7) a history of domestic violence, sexual abuse, or depression, (8) mental disability, (9) a lack of social welfare benefits, (10) a history of contact with child protective services, (11) a history of psychiatric treatment or emotional disturbance, and (12) a history of homelessness.⁶ If a woman has a risk factor, the social worker asks more searching questions about it because the social worker has the responsibility of connecting the woman with other professionals or specialists who may be able to help her.⁷

It is an understatement to describe the psychosocial assessment as intrusive. Even without a “risk factor,” the woman must submit to a series of intimate questions designed to discover relevant information; with a “risk factor,” the series of questions grows longer and more intimate. It deserves underscoring that women in New York are led into these conversations only when they are poor, pregnant, and seeking state-assisted prenatal care.⁸ Wealthier women with private insurance can avoid enduring such conversations.

During the nutritional assessment, the patient meets with a nutritionist who records any known food or non-food allergies, documents whether the patient has had trouble eating due to nausea or vomiting, and provides standard information to the patient about the nutritional

4. See N.Y. COMP. CODES R. & REGS. tit. 10, § 85.44(d)(6) (2012) (“Providers shall conduct a psychosocial assessment of each patient, to identify social, economic, psychological and emotional problems which present obstacles to health and treatment. When problems are identified the [preferred primary care provider] shall make referral, as appropriate to the patient needs, to the local Department of Social Services, community mental health resources, alcohol and substance abuse providers and support groups or social/psychological specialists.”).

5. *Id.* § 85.44(d)(7) (“The provider shall establish and implement . . . a program of nutrition screening and counseling which includes: (i) individual nutrition risk assessment, including screening for specific nutritional risk conditions at the initial visit and continuing reassessment as needed; [and] (ii) professional nutrition counseling, monitoring and follow-up of all patients at nutritional risk.”).

6. Alpha Hospital Psychosocial Screening Form (on file with Author).

7. See BRIDGES, *supra* note 2, at 57.

8. See *id.* at 89–90 (observing that only the most savvy women can avoid the intrusiveness of the PCAP informational canvassing, which can be done by receiving care from a healthcare provider who accepts PCAP/Medicaid but who is not affiliated with a hospital and therefore has the discretion (produced by the lack of institutional oversight) to ignore his legal obligation to conduct an informational canvassing).

requirements of pregnant women.⁹ Afterwards, the patient is asked to recount what she ate for breakfast, lunch, and dinner the previous day.¹⁰ She is then given an itemized food chart—for example, milk, cheese, eggs, fruit, vegetables, chocolate, and candy.¹¹ She is asked to circle how many times per day or per week she consumes the foods. In the event that the nutritionist deems the patient's diet unsatisfactory (which appeared to be a standard practice during my time in the clinic), she checks a box labeled "inadequate/unusual dietary habits."¹² The patient is then asked to make a verbal commitment to meet the nutritional needs of herself and her fetus.¹³

In many cases, the nutritional assessment is not a patient's only encounter with a nutritionist. If at any point during a woman's pregnancy, her provider feels that she has gained too much or not enough weight, she must participate in additional consultations with the nutritionist.¹⁴ It deserves underscoring that women in New York are only led into these relationships of dietary surveillance when they are poor, pregnant, and seeking state-assisted prenatal care. Wealthier women with private insurance can avoid enduring such surveillance.

The effect of the consultations with the nutritionist and social worker, as well as the other professionals with which pregnant women must consult,¹⁵ is that poor women's private lives are made available for state surveillance and problematization. Pursuant to the PCAP mandate, private information about women's health¹⁶ and economic statuses¹⁷ is

9. *Id.* at 54.

10. *Id.*

11. *Id.*

12. *Id.*

13. *Id.*

14. *Id.* at 56–57.

15. These include a Medicaid financial officer and a nurse or health educator. See N.Y. COMP. CODES R. & REGS. tit. 10, § 85.44(c)(1)(ii) (2012) ("Facility staff shall assist the patient with arrangements or make arrangements for the patient for off-site services, facilitate receipt of those services, monitor reports of results of off-site services, and integrate results into patient records."); *id.* § 85.44(d) ("The facility shall provide, directly or by contract, . . . services . . . [including] family planning . . . and prenatal care and services.").

16. Information about women's health status is obtained by a registered nurse, who takes the woman's medical history with guidance provided by a standardized form produced by the American College of Obstetricians and Gynecologists ("ACOG"); the ACOG Antepartum Record. See ACOG Antepartum Record, Form A, available at http://forms.twobgyn.com/Forms/ACOG_Forms.pdf. ACOG is a nonprofit organization comprised of physicians that sets standards of healthcare in the OB/GYN specialty. See Carolyn Jacobs Chachkin, *What Potent Blood: Non-Invasive Prenatal Genetic Diagnosis and the Transformation of Modern Prenatal Care*, 33 AM. J.L. & MED. 9, 33–35 (2007) (noting that the guidelines that ACOG articulates for the practices of obstetrics and gynecology frequently become the standards of care). The ACOG Antepartum Record solicits sociological data such as birth date, age, marital status and, interestingly, race. See ACOG Antepartum Record, *supra*. Moreover, it solicits information about the woman's history with a number of medical problems that may complicate pregnancy and childbirth, including diabetes, hypertension, heart disease, gynecologic surgery,

gathered and recorded. Their diets are quantified and censured.¹⁸ Their histories with substance abuse, sexual abuse, public assistance, and any form of contact with the state are considered significant and relevant.¹⁹ In essence, a poor, pregnant woman's privacy interest—that is, her interest in preventing the government from intruding into her personal, intimate affairs—has been violated.

Moreover, this invasion of poor, pregnant women's privacy facilitates the enduring surveillance and regulation, and potential punishment, of poor families by the state. Subsequent to enrolling in PCAP, the state has all the information necessary to sweep poor families within the ambit of child protective services, the foster care system, Immigration and Customs Enforcement, and, if deemed necessary, the criminal justice system.

PCAP is not unique to New York State; several other states' Medicaid-funded prenatal care programs are similar insofar as they require pregnant women to submit to nonmedical assessments. For example, "nutrition services,"²⁰ "health education services,"²¹ and "psychosocial services"²² are offered to poor, pregnant women as part of California's Comprehensive Perinatal Services Program. This statute makes clear what should be covered as part of health education services:

[C]urrent health practices; past experience with health care delivery systems; prior experience with and knowledge about pregnancy, prenatal care, delivery, postpartum self-care, infant care, and safety; client's expressed learning needs; formal education and reading level; learning methods most effective for the client; educational needs related to diagnostic impressions, problems, and/or risk factors identified by staff; languages spoken and written; mental, emotional, or physical disabilities that affect learning; mobility/residency; religious/cultural influences that impact upon perinatal health; and client and family or support person's motivation to participate in the educational plan.²³

The statute is equally clear about psychosocial service coverage:

[C]urrent status including social support system; personal adjustment to pregnancy; history of previous pregnancies; patient's goals for herself in this pregnancy; general emotional status and history; wanted or unwanted pregnancy, acceptance of the pregnancy; substance use

anesthetic complications, and uterine anomalies. *Id.*

17. *See supra* notes 6–7 and accompanying text.

18. *See supra* notes 9–13 and accompanying text.

19. *See supra* notes 6–7 and accompanying text.

20. CAL. CODE REGS. tit. 22, § 51348(c) (2012) ("A complete initial nutrition assessment shall be performed at the initial [prenatal care] visit . . . [and] at least once every trimester . . . that addresses [t]he prevention and/or resolution of nutrition problems. . . . [with the goal of] helping the patient understand the importance of . . . maintain[ing] good nutrition during pregnancy and lactation.").

21. *Id.* § 51348(d).

22. *Id.* § 51348(e).

23. *Id.* § 51348(d)(2)(A).

and abuse; housing/household; education/employment; and financial/material resources.²⁴

Moreover, pregnant women must be reassessed every trimester during their pregnancy and once again postpartum.²⁵

In Massachusetts, the Medicaid prenatal care program requires that providers give health-care counseling, which includes instruction on “hygiene and nutrition during pregnancy” as well as “family planning.”²⁶ Moreover, the provider is required to refer the patient to a social worker, “as needed.”²⁷ In Illinois, the Medicaid statute has spelled out in exacting detail an exhaustive itemization of services that providers must give to poor, pregnant women seeking prenatal care.²⁸ As part of the standard medical history that a healthcare provider asks of a patient, he must gather information about her “social and occupational . . . background, health habits, [and] previous pregnancies.”²⁹ The patient must also have counseling with respect to a wide range of issues, including physical activity and exercise, child care arrangements, and parenting skills, including:

meeting the physical, emotional and intellectual needs of the infant, with specific appraisal to detect parents at risk of child abuse or neglect[;] . . . [e]motional and social changes occasioned by the birth of a child, including changes in marital and family relationships, the special needs of the mother in the postpartum period, and preparing the home for the arrival of the newborn[;] . . . postpartum family planning options[; and] [o]ther relevant topics in response to patient concern.³⁰

What motivates the state’s inquiry of pregnant women? Ostensibly, the government’s interest is in protecting the fetus and the child, once she is born, from abuse or neglect.³¹ The state’s inquest and its ability to intrude in provinces that most would describe as “private,” are based on its *parens patriae* power, by which the state has authority to limit individual and parental rights in order to protect children.³² This conflict between the individual’s interest in protecting herself from state intervention in personal and familial matters and the state’s interest in protecting the

24. *Id.* § 51348(e)(1)(A).

25. *Id.* § 51348(d)(2)(B), (d)(4).

26. 130 MASS. CODE REGS. § 433.421(B)(5) (2012).

27. *Id.* § 433.421(B)(4)(c).

28. See ILL. ADMIN. CODE tit. 77, § 630.30(b) (2011).

29. *Id.* § 630.30(b)(3)(A).

30. *Id.* § 630.30(b)(3)(L).

31. See Laura A. Rosenbury, *Between Home and School*, 155 U. PA. L. REV. 833, 846 (2007) (observing that the state may intervene in the parent-child relationship in order to protect the child’s welfare).

32. See Vivian Hamilton, *Principles of U.S. Family Law*, 75 FORDHAM L. REV. 31, 42–43 (2006) (describing the concept of *parens patriae* as existing in tension with parental authority and noting that the state exercises its power of *parens patriae* in order to “protect families’ more vulnerable members”).

child from the parent who raises her is an enduring, recurrent one.³³ While many scholars have criticized the discriminatory enforcement of child protection laws, insofar as poor, racially-marginalized families are disproportionately swept within the state's "protective" ambit,³⁴ most scholars do not question that it is legitimate for the state to limit individual and parental rights when the circumstances demand it.³⁵

With respect to pregnant women seeking state-assisted prenatal healthcare, if the state's inquisitive net yields information suggesting that a woman is likely to put her fetus or child in danger, then it is more likely that the state will keep the woman within its regulatory apparatus in order to protect this child once it is born. The exhaustiveness of inquiries that intrude upon spaces that most consider private might be thought necessary because the end goal is the protection of the child. The means to that end—the violation of poor women's rights to privacy—is thought to be an unfortunate, yet essential, fact.

This is the experience of poor, pregnant women with the state; their privacy and autonomy is far more limited than the privacy of wealthier women who do not have to rely upon the state for assistance. This leads to

33. This conflict has been explored extensively in the literature analyzing the child protective system. See, e.g., Susan Vivian Mangold, *Transgressing the Border Between Protection and Empowerment for Domestic Violence Victims and Older Children: Empowerment as Protection in the Foster Care System*, 36 NEW ENG. L. REV. 69, 74 (2001) ("While parents have a right to raise their children free from state intervention, children have a countervailing right to protection from abuse and neglect. This tension between parental rights and child protection is the key conflict in the child protection system . . ."). Dorothy Roberts has explored this conflict in her analysis of the prosecutions of pregnant drug addicts. See Dorothy E. Roberts, *Punishing Drug Addicts Who Have Babies: Women of Color, Equality, and the Right of Privacy*, 104 HARV. L. REV. 1419, 1422 (1991) ("[P]unishing a woman for using drugs during pregnancy pits the state's interest in protecting the future health of a child against the mother's interest in autonomy over her reproductive life—interests that until recently had not been thought to be in conflict.").

34. See, e.g., Annette R. Appell, *Protecting Children or Punishing Mothers: Gender, Race, and Class in the Child Protection System*, 48 S.C. L. REV. 577, 580 (1997) [hereinafter Appell, *Protecting Children*] ("This essay addresses the policies, practices, and perspectives that help to fuel the growing industry that has arisen from the state's 'protective' involvement with poor families and families of color and the state's punitive treatment of the mothers of these families."); Annette R. Appell, *Virtual Mothers and the Meaning of Parenthood*, 34 U. MICH. J.L. REFORM 683, 770–79 (2001) [hereinafter Appell, *Virtual Mothers*] (describing the predominance of poor families of color within the child protection system); Naomi R. Cahn, *Models of Family Privacy*, 67 GEO. WASH. L. REV. 1225, 1244 (1999) (noting that poor women are more likely to be swept up within the ambit of child protection systems and agencies); Sally K. Christie, *Foster Care Reform in New York City: Justice for All*, 36 COLUM. J.L. & SOC. PROBS. 1, 12–15 (2003) (investigating the causes of the overrepresentation of poor and African American children in foster care).

35. See Appell, *Virtual Mothers*, *supra* note 34, at 703 (observing that parents have the right to raise their children without state interference unless there is proof that they are abusing or neglecting their children); see also Martha Albertson Fineman, *What Place for Family Privacy?*, 67 GEO. WASH. L. REV. 1207, 1215 (1999) (noting that parental conduct is deferred to unless it is abusive or neglectful).

the question: What can we expect from laws that are motivated by developments in neuroscience that demonstrate the potentially hazardous effects of some behaviors on fetal brain development and that are designed to regulate those behaviors? We can expect the state to cast an *even more exhaustive* inquisitory net. We can expect the state to ask questions about the frequency with which a woman comes into contact with flame retardants, pesticides, certain types of jewelry, upholstered furniture, domestic animals, and certain foods in the food supply—in addition to the questions that the state already asks. Moreover, we can expect that the state will maintain a supervisory, regulatory, and occasionally punitive presence in *even more* poor women's lives than at present.

I should underscore again that while wealthier women and poor women may engage in the same potentially harmful behaviors, the likelihood that poor women will be “caught” doing them is greater. As law professor Annette Appell wrote:

Poor families are more susceptible to state intervention because they lack power and resources and because they are more directly involved with governmental agencies. . . . [P]oor families lead more public lives than their middle-class counterparts: rather than visiting private doctors, poor families are likely to attend public clinics and emergency rooms for routine medical care; rather than hiring contractors to fix their homes, poor families encounter public building inspectors; rather than using their cars to run errands, poor mothers use public transportation.³⁶

In conclusion, we must be attuned to social justice issues should we attempt to address the potentially hazardous effects of individual behaviors on fetal brain development through law and legal regulation. The better approach is a macro-level intervention: Instead of regulating the amount of mercury-laden fish a pregnant woman eats, we ought to regulate industries so that there is no mercury in the fish. If regulation is at the individual level, however, there is a certain inevitability to the disparate impact that such regulations will have on poor women. But if this impact is on the forefront of the minds of the regulations' drafters then we may be able to avoid the potential damaging effects of the laws. That may be the best that we can hope for.

36. Appell, *Protecting Children*, *supra* note 34, at 584 (footnotes omitted).