

# MIDWIVES AND PREGNANT WOMEN OF COLOR: WHY WE NEED TO UNDERSTAND INTERSECTIONAL CHANGES IN MIDWIFERY TO RECLAIM HOME BIRTH

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*The vast majority of births occur in hospitals attended by physicians. However, this has not always been the case. Prior to the turn of the twentieth century, home births held the majority and were primarily attended by midwives, the majority of whom were women of color and immigrant women. The move toward hospital birth is rarely discussed today and midwifery and home birth, though now both experiencing a small comeback, are often viewed with skepticism and fear. This Note discusses the raced and gendered history of this change in American birth norms and argues that the racist and sexist motivations and phenomena that prompted the move into hospitals and away from midwives is relevant to understanding current birth trends and statistics. The Note begins with an overview and discussion of the raced and gendered history of American midwifery. Next, the Note explains the history of the Medicalization of pregnancy and birth—here, exerting excessive medical rhetoric into and oversight over reproduction, and especially women of color’s reproduction, in order to control it. Finally the Note considers current home birth and midwifery trends and statistics and their connection to the race and gender discrimination of twentieth century birth and midwifery. The Note concludes that the racist and sexist underpinnings of the change from home to hospital birth still operate in our current birthing systems to keep women of color in hospitals and out of the midwifery profession.*

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## I. INTRODUCTION

On January 26, 2012, National Public Radio (NPR) published an article stating that, according to a new government study, home births have been rapidly increasing in popularity in the United States.<sup>1</sup> The article mentioned several doctors, midwifery advocates, and scientists who affirmed that midwife-assisted home birth is a safe alternative to hospital birth for low-risk pregnancies. It also discussed the personal story of a Washington D.C. based yoga instructor, Kate Miller, who had a perfectly safe and very positive home birth experience.<sup>2</sup> Overall, the article was supportive of the new trend. However, it omitted an explanation of one odd fact—the increase in home births is not occurring among all women. Instead, “the trend appears to be driven primarily by older White women...”<sup>3</sup> NPR could have included the fact that White women are actually four times more likely to have a midwife-assisted home birth than are women of color, and that less than five percent of midwives identify as Black or Hispanic.<sup>4</sup> Although this has not been the case historically, NPR did not question why the new trend is so racially stratified. This Note will focus on answering this question.

The United States has seen a dramatic shift in midwifery practice and prominence in the past century. Before the turn of the twentieth century, lay midwives<sup>5</sup>—most of whom were women of color and/or

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<sup>1</sup> Rob Stein, *Home Births Grow More Popular in U.S.*, NPR.ORG (Jan. 26, 2012),

<http://www.npr.org/blogs/health/2012/01/26/145880448/home-births-grow-more-popular-in-u-s>.

<sup>2</sup> *Id.*

<sup>3</sup> *Id.*

<sup>4</sup> JOYCE A. MARTIN ET AL., NAT'L VITAL STATISTICS REP., CTR. FOR DISEASE CONTROL AND PREVENTION, BIRTHS: FINAL DATA FOR 2010, 53 Table 20, (Aug. 28, 2012), *available at*

[http://www.cdc.gov/nchs/data/nvsr/nvsr61/nvsr61\\_01.pdf](http://www.cdc.gov/nchs/data/nvsr/nvsr61/nvsr61_01.pdf); Kerri Durnell Schuiling et al., *Findings from the American College of Nurse-Midwives' Membership Surveys: 2000-2003*, 50 J. MIDWIFERY AND WOMEN'S HEALTH 1, 8-15 (2005).

<sup>5</sup> An American lay midwife was historically and commonly considered one who had learned to practice midwifery through passed-down knowledge, and first-hand experience, and apprenticeship. GERTRUDE JACINTA FRASER, *AFRICAN AMERICAN MIDWIFERY IN THE SOUTH: DIALOGUES OF BIRTH, RACE AND MEMORY* 26 (1998). Today, lay midwives, often licensed as certified professional midwives (CPMs) or direct-entry midwives, are trained midwives without a nursing degree. A nurse-midwife is a certified nurse practitioner with supplementary training in midwifery.

immigrants—delivered the majority of babies in the country.<sup>6</sup> Shortly thereafter, a strong anti-midwifery campaign, coupled with racism, gained traction, quickly pushing midwives of color out of the profession and into virtual extinction.<sup>7</sup> The United States is now experiencing a renewed movement towards natural and non-hospital birth that has begun to bring the midwife out of the shadows of history.<sup>8</sup> Despite the resurgence, modern midwives are very rarely women of color, and they no longer predominantly serve women of color.<sup>9</sup> The profession has changed drastically, yet very few people seem to be asking why.

This Note argues that these demographic changes are not only symptoms of the White-centeredness of feminist and pregnancy discourse today, but also that this historical shift is intimately connected to the excessive regulation and medicalization of pregnant bodies of color that began alongside the anti-midwifery campaign. Both have led not only to the vastly disproportionate and discriminatory treatment of Black and Hispanic pregnant women and midwives, but also to the perceived disconnection of the predominantly White resurgence of midwife-assisted home birth to the oppressive structures which systematically pushed women and midwives of color into an overregulated birthing scheme.

In Part II, this Note will discuss the social and regulatory history of American midwives. In Part III, this Note will discuss the medicalization of pregnancy, labor, and delivery as women of color have experienced them. In Part IV, this Note will discuss the new trends toward home and non-hospital birth and the more current demographics of the midwifery profession. This Note will then conclude by arguing that women and midwives of color have been largely absent from the recent birthing trends because of a history of legal and social oppression and their disenfranchisement within the birthing system.

In short, midwifery regulation was—and is—part of a bigger endeavor to overregulate and medicalize women of color. This Note will ultimately advocate for greater inclusion of women and midwives of color in the home birth movement through an intersectional re-centering of the relevant discourses. But it will also argue that neither the medicalization of pregnant women of color, nor the regulation of midwives of color, can be fully understood unless understood together. Finally, the current home birthing trends cannot be fully understood or made more racially inclusive without first understanding why they are racially divided.

## II. HISTORY OF MIDWIFERY AND MIDWIFERY REGULATION

### A. Turn of the Century Midwives and Their Feminist Benefits

In colonial United States, midwives attended most births.<sup>10</sup> It was common for towns in the North and plantations in the South to have a town or resident midwife.<sup>11</sup> On Southern plantations, the midwife was often an enslaved woman.<sup>12</sup> Even as recent as 1900, midwives attended at least half of American births.<sup>13</sup> In Black and immigrant communities, these numbers were far greater: In 1918, for example, almost ninety percent of Southern Black women's births were attended by midwives, and in 1908, about ninety percent of laboring Italian-immigrant women in Chicago used midwives.<sup>14</sup> There were, of course, some White midwives

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*What is a Midwife?* MIDWIVES ALLIANCE NORTH AMERICA, <http://mana.org/about-midwives/what-is-a-midwife>. For the purposes of this paper, the term “midwife” will most often refer to lay midwives in section one unless otherwise specified.

<sup>6</sup> JUDY B. LITOFF, *AMERICAN MIDWIVES: 1860 TO THE PRESENT* 27 (1978).

<sup>7</sup> *See Id.* (arguing that the racism and sexism of the era fueled the anti-midwifery campaign).

<sup>8</sup> *See supra* note 1.

<sup>9</sup> Martin, *supra* note 4; Schuiling, *supra* note 4.

<sup>10</sup> *Supra* note 6 at 4.

<sup>11</sup> *Id.*

<sup>12</sup> *Id.*

<sup>13</sup> *Id.* at 27.

<sup>14</sup> *Id.*; *See also*, Sharon .A. Robinson, *A Historical Development of Midwifery in the Black Community: 1600-1940*, 29 J. NURSE-MIDWIFERY 247, 250 (1984) (affirming that midwives attended the vast majority of black women's births before and

at the turn of the 20th century; however, the majority of midwives in Northeastern states were immigrant women, and the majority in Southern states were older Black women, often called “granny” midwives.<sup>15</sup> Black midwives were typically trained through apprenticeships with older, more experienced female family members or peers.<sup>16</sup> At the turn of the century, the average cost of a midwife's services—including labor, delivery, post-natal care, housekeeping, and mother's help—was between two and ten dollars.<sup>17</sup> By comparison, the delivery services of a physician cost between ten and twenty five dollars, with extra costs for pre- and post-natal care.<sup>18</sup> Not only did low-income women of color prefer midwives for their lower cost, but also, as a 1924 survey out of Texas noted, women preferred to have the hired service of midwives because they were “really worth more” than physicians.<sup>19</sup>

American women thought the comfort of having another woman or group of women present during birth, as opposed to a male doctor, was as important a factor as cost. Judith Leavitt explains that women benefited from the psychological support and practical help from other women, friends, neighbors, and relatives until they began delivering their babies in hospitals.<sup>20</sup> Laboring women also received unique comfort from midwives and other female birth attendants, as “only a woman can know what a woman has suffered and is suffering.”<sup>21</sup> Pre-hospital birthing was thus something of a feminist endeavor in which women wanted and needed only each other, because they knew that their specific female experience made them more equipped than any male physician to aid a woman in a non-complicated labor and delivery.

## B. Turn of the Century Physicians and Anti-Midwife Sentiment

The once prominent and empowering feminist understanding of the birthing process changed after the turn of the twentieth century. As hospital births grew in prominence and male physicians began to attend more births, the “presence of this male authority figure changed the power structure in the [birthing] room.”<sup>22</sup> This anti-feminist power shift denied women—who were already seen as socially inferior and less capable than men—authority over their own bodies and births. For Black and immigrant women, who in the nineteenth and early twentieth century heavily relied on midwives, this anti-feminist power shift—which was specifically anti-black feminist, since almost all physicians at the time were White men—was more severely felt.

In the nineteenth and early twentieth centuries, physicians were rarely trained specifically in childbirth and had less experience in labor and delivery than midwives. Although physicians appeared in the birthing room as early as the mid-eighteenth century, the first record of any medical student viewing a live birth during training was not until 1850, about a century later.<sup>23</sup> Indeed, it was not until around 1820 that physicians were given substantive, formal medical training before practicing medicine or delivering babies.<sup>24</sup> Despite their lack of training or experience in obstetrics,<sup>25</sup> by the turn of the century, physicians attended almost fifty percent of American deliveries.<sup>26</sup> A 1910 study showed that the majority of schools offered such poor training to the

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directly after the turn of the twentieth century).

<sup>15</sup> *Id.* at 29, 31.

<sup>16</sup> FRASER, *supra* note 5, at 6

<sup>17</sup> LITOFF, *supra* note 6, at 28

<sup>18</sup> *Id.*

<sup>19</sup> *Id.* at 29; See also, Stacy A. Tovino, *American Midwifery Litigation and State Legislative Preferences for Physician-Controlled Childbirth*, 11 CARDOZO WOMEN'S L. J. 61, 74 (2004).

<sup>20</sup> JUDITH WALZER LEAVITT, *BROUGHT TO BED: CHILDBEARING IN AMERICA, 1750-1950* 87 (1986).

<sup>21</sup> *Id.* at 97, 99.

<sup>22</sup> *Id.* at 87, 107.

<sup>23</sup> LITOFF, *supra* note 6, at 20.

<sup>24</sup> Robinson, *supra* note 14.

<sup>25</sup> Obstetrics is a medical specialization in pregnancy and childbirth.

<sup>26</sup> LITOFF, *supra* note 6, at 27, 58.

students that physicians were just as responsible as midwives for the high U.S. Maternal Mortality Rates.<sup>27</sup> Tellingly, a 1911 survey noted "the majority of [medical schools] professors believed that they had never trained a person whom they felt was competent to become a professor of obstetrics."<sup>28</sup> Therefore, physicians and medical school professors themselves accepted that they had far less experience or expertise in childbirth than did midwives.

However, the lack of proper training and lack of statistics proving that physician births were safer did not stop doctors from opposing midwife-assisted birth. This opposition partially originated from the popular fear of overcrowding in the field of medicine and obstetrics specifically: Doctors viewed lay midwives as competitors and feared that they were diminishing their professional status and potential profits in the area of childbirth.<sup>29</sup> Perhaps because obstetrics had never been a common or popular medical field, precisely because the midwife effectively filled that social need, the worry was particularly high for obstetricians and professionals hoping to attract new doctors and medical students to that field. As Litoff puts it, "If obstetrics were to receive its due recognition, the midwife had to be eliminated."<sup>30</sup>

This fear coincided with the start of the Bureau of Census' annual collection and publication of death and birth statistics in 1900 and 1915 respectively and several advances in medical hygiene and infection prevention.<sup>31</sup> Previously, no one knew the raw percentages of infant and maternal births and deaths. Once the numbers were revealed to be quite high, anti-midwife physicians had the ammunition they needed to begin their midwifery elimination campaign. The perceived expertise that accompanied physicians, however, did little to decrease infant mortality.<sup>32</sup> When mortality rates decreased in the subsequent years, it was primarily due to simple yet new measures, like routine hand-washing and antiseptic and anti-bacterial regimens, which all could have easily been taught to midwives.<sup>33</sup>

The midwifery elimination campaign was not just a back-and-forth debate of death statistics, status, and medical hygiene; rather, it was a pointed, racial and gendered attack by White male professionals on the entire class of lay midwives of color. Evidence of this trend can be seen in an array of public and private documents dating back to the turn of the century. A 1906 New York midwife study by the Public Health Committee of the Association of Neighborhood Workers, for example, stated that the "the majority of [the] so-called midwives are foreigners of a low grade—ignorant, untrained women."<sup>34</sup> At a 1924 meeting of the Southern Medical Association, a physician stated that they must not attempt to make competent obstetricians out of the great army of ignorant women now practicing midwifery in this country.<sup>35</sup> A 1928 Virginia midwife study stated that doctors in the South did not want to "deal with the ignorant and superstitious negro [midwife]."<sup>36</sup> In the 1920s, the Director of the Mississippi Bureau of Child Hygiene, a White male, asked, "What could be a more pitiable picture than that of a prospective mother... and [midwife], filthy and ignorant, and not far removed from the jungles of Africa, laden with its atmosphere of weird superstition and voodooism?"<sup>37</sup>

These racist and xenophobic sentiments originally espoused by doctors and medical professionals soon gained traction with popular women's and housekeeping magazines that began publishing articles and

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<sup>27</sup> Robinson, *supra* note 14 at 249.

<sup>28</sup> LITOFF, *supra* note 6, at 65.

<sup>29</sup> *Id.* at 48; *See also*, FRASER, *supra* note 5, 59-60 (stating that, "for many physicians, therefore, the midwife problem would be solved only with the rapid abolition of these practitioners and the ascendancy of obstetrical science.").

<sup>30</sup> LITOFF, *supra* note 6, at 50.

<sup>31</sup> *Id.* at 50-51.

<sup>32</sup> Robinson, *supra* note 14 at 249.

<sup>33</sup> *Id.* at 19-20.

<sup>34</sup> *Id.* at 51.

<sup>35</sup> FRASER, *supra* note 5, at 59.

<sup>36</sup> LITOFF, *supra* note 6, at 75.

<sup>37</sup> *Id.* at 78.

propaganda warning expecting mothers of these "ignorant" and "dirty" midwives. The magazines also directly and indirectly supported physician-assisted birth by advocating for new methods of pain relief and for hospital hygiene. A *Harper's* article from 1930, for example, quoted midwives in colloquial Southern English, which made the midwives sound ignorant and thus unqualified when placed among the well-formed sentences of the author. A Black midwife quoted in the article, Aunt Elizabeth, said she could get "near about six dollars fo' ketchin' one bebbey," and the article's author quickly concludes, "The first step toward controlling the midwives, good, bad, and indifferent, is to round them all up in class and then briskly winnow them out," adding that the midwife has no place in twentieth century healthcare.<sup>38</sup> A *Good Housekeeping* article from 1914 indirectly opposed midwives by praising doctors' use of a new pain relief drug on laboring women. It advertised that "[the laboring woman] can be kept in a half-waking, half dreaming, but nearly painless state" and, in the case of cesarean section, "can be put to sleep entirely, and wake up to find it all over and see the light shining on her baby's face."<sup>39</sup> It noted that these methods, available only in hospitals and only when administered by doctors and nurses, make birth far safer than the natural (midwife) route.<sup>40</sup> And still others simply came out in support of highly regulating midwifery by pointing to physicians and hygiene professionals who praised new practices as means to saving lives.<sup>41</sup>

### C. Explicit Restrictions on Midwifery Practice

By 1930, lay midwife-attended births had dropped from fifty percent around the turn of the century to fifteen percent.<sup>42</sup> By 1950, eighty-eight percent of births occurred in the hospital, and by 1973, that number grew to over ninety-nine percent, where it has stayed until recent years.<sup>43</sup> The main culprit in the precipitous drop in lay midwifery was licensing laws and birthing regulations that quickly replaced the Black and immigrant midwives with White nurse-midwives and physicians.<sup>44</sup> By 1930, the same year that lay midwifery birth attendance dropped to fifteen percent, thirty-eight of the forty-eight states had registration or licensing laws regulating midwives; the federal government had passed maternity hygiene, birth reporting, and medical regulation laws restricting midwives as well as their patients; and, between 1908 and 1924, every state in the nation had created a bureau of child hygiene or an equivalent thereof.<sup>45</sup> Additionally, federal immigration restriction laws passed in the early 1920s effectively stopped the influx of immigrant midwives from outside of developed Western Europe, contributing to fewer immigrant women and, tangentially, fewer midwives.<sup>46</sup>

This Note will demonstrate the legal difficulties that midwives faced and how state and federal governments aided in their decreased numbers by focusing on three of those states, each with well-documented histories of midwifery regulation: Massachusetts, Alabama, and California.

#### 1. Massachusetts's Midwifery Ban

<sup>38</sup> Carolyn Conant Van Blarcom, *Rat Pie: Among the Black Midwives of the South*, HARPER'S MAGAZINE, Feb. 1930, at 325, 326, 332, available at <http://harpers.org/archive/1930/02/rat-pie/>.

<sup>39</sup> Wood Hutchinson, *When the Stork Arrives*, GOOD HOUSEKEEPING, July 1914, at 103; See LEAVITT, *supra* note 20, at 129 (noting that this once popular pain relief method was often called Twilight Sleep and did not actually relieve pain so much as it erased the memory of pain. In fact, the endeavor was quite painful. Women would often writhe on the bed in so much pain that they would be forcefully strapped down throughout their entire laboring and birthing process for "safety.")

<sup>40</sup> Hutchinson, *supra* note 39.

<sup>41</sup> Anna Steese Richardson, *Safeguarding American Mothers*, MCCLURE'S, July 1915, at 35, available at <http://babel.hathitrust.org/cgi/pt?id=coo.31924065818472;view=1up;seq=247> (stating that "strict supervision by the body issuing certificates allowing persons to practise medicine and midwifery is needed, in the endeavor to eliminate all persons who are incompetent . . .").

<sup>42</sup> LITOFF, *supra* note 6, at 114.

<sup>43</sup> *Id.*

<sup>44</sup> LITOFF, *supra* note 6, at 122-124.

<sup>45</sup> *Id.* at 51, 99.

<sup>46</sup> *Id.* at 113, 141.

Massachusetts was one of the earliest states to highly regulate midwives when it passed the Medical Practice Act in 1894 and a Birth Registration Act in 1897.<sup>47</sup> The Medical Practice Act noted that no person other than a licensed physician would be allowed to practice obstetrics anywhere in the state without facing criminal fines and/or imprisonment.<sup>48</sup> Though this statute did not explicitly outlaw midwifery, Massachusetts considered midwifery to be within the practice of obstetrics. As a result, any midwife who was not also a licensed physician (essentially all midwives at the time) would be committing a criminal offense if she continued practicing. The Birth Registration Act, on the other hand, noted specifically that "physicians *and midwives* shall on or before the fifth day of each month report to the clerk of each city or town a correct list of all children born therein during the month next preceding, at whose birth they were present," including the births of stillborn babies.<sup>49</sup> The penalty for not doing so was a fine between ten and fifty dollars, a significant amount at a time when midwives rarely charged over ten dollars for their services.<sup>50</sup> Together, these two statutes created a glaring paradox for midwives: A midwife who did not register the births she attended would be in violation of one statute, but if she registered those births willingly, she would be found in violation of the other and would be subject to criminal charges.

The most famous opposition to these statutes arose from the trials of a Finnish immigrant named Hanna Porn; within a four-year period, ten trials were held, and she lost all but one.<sup>51</sup> Ms. Porn received a lay midwifery license from the Chicago Midwife Institute, one of the few midwifery schools in the United States in 1896, and practiced as a lay midwife in Gardner, Massachusetts.<sup>52</sup> She served almost exclusively immigrant women in her surrounding communities, and achieved neonatal mortality rates that were less than half of those achieved by the average physician in her town.<sup>53</sup> Statistically, babies delivered by physicians in Gardner, Massachusetts, were more than twice as likely to die at or soon after birth than those babies Ms. Porn delivered. Perhaps due to her popularity and reliability, every case brought against her was brought not by aggrieved former clients, but by medical professionals claiming her illegal competition hurt business.<sup>54</sup>

It was through one of the cases against Ms. Porn that the court formally clarified the previously ambiguous bar against midwives present in the 1894 statutes. In the 1907 case, *Commonwealth v. Porn*, the court ruled that midwifery was a practice of obstetrics and was thus outlawed by the 1894 statute, making Ms. Porn guilty of practicing medicine without a proper license.<sup>55</sup> Although Ms. Porn argued that prohibition of midwives as a class was unconstitutional disparate treatment, the court chose not to rule on the federal constitutionality of the statute, and, to add insult to injury, fined Ms. Porn heavily for each case she lost.<sup>56</sup> Despite her trial losses, court orders prohibiting her from assisting deliveries, and several months served in prison in 1908, Ms. Porn continued her practice until her death in 1913.<sup>57</sup>

By 1913, forty percent of all births in Massachusetts were attended by midwives.<sup>58</sup> These numbers fell quite rapidly as authorities began arresting more practicing midwives as well as physicians who were

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<sup>47</sup> Tovino, *supra* note 19, at 82.

<sup>48</sup> Acts and Resolves Passed by the General Court of Massachusetts, ch. 458, 530-33 (1894), available at <https://archive.org/details/actsresolvespass1894mass>.

<sup>49</sup> Acts and Resolves Passed by the General Court of Massachusetts, ch. 444, 420-24 (1897), available at <https://archive.org/details/actsresolvespass1897mass> (emphasis added).

<sup>50</sup> *Id.*; LITOFF, *supra* note 6, at 28.

<sup>51</sup> Eugene R. Declercq, *The Trials of Hanna Porn: The Campaign to Abolish Midwifery in Massachusetts*, 84 AM. J. PUB. HEALTH 1022, 1022, 1027 (June 1994).

<sup>52</sup> *Id.* at 1022.

<sup>53</sup> *Id.* at 1023-24.

<sup>54</sup> *Id.*; Tovino, *supra* note 19, at 85.

<sup>55</sup> *Commonwealth v. Porn*, 82 N.E. 31, 31 (Mass. 1907).

<sup>56</sup> Tovino, *supra* note 19 at 84-85.

<sup>57</sup> *Id.* at 85.

<sup>58</sup> Declercq, *supra* note 51 at 1026.

found to have helped midwives or who falsely registered midwife births under their names.<sup>59</sup> It was not until 1975 with the passage of legislation permitting licensed *nurse*-midwives to practice *only* when under the supervision of a physician that any sort of midwife was again allowed to practice in the state of Massachusetts (though lay midwives are still prohibited there).<sup>60</sup>

## 2. Alabama Regulation

Beginning in 1918, Alabama required all midwives to pass an examination and to register for a license to practice.<sup>61</sup> By 1976, however, the state criminally outlawed new lay midwives while only temporarily exempting existing lay midwives and allowed nurse-midwives to practice only in hospitals or hospital-sponsored birth centers.<sup>62</sup> Additionally, the state (seemingly arbitrarily) began enforcing an old rule disallowing midwives over the age of sixty-five from practicing.<sup>63</sup> Consequentially, over 150 senior midwives in Alabama were told that they would have to immediately stop practicing despite the fact that younger lay midwives would remain legally allowed to practice under the law's temporary exemption until their current licenses expired or the county board revoked them.<sup>64</sup> All of these 150 senior midwives were Black women.<sup>65</sup>

In *State v. Kimpel*, the defendant, Toni Kimpel, a lay midwife charged with practicing nurse-midwifery without a license, argued that *Roe v. Wade* should be interpreted to include a woman's right to privacy in choosing how and by whom her baby is delivered, and, channeling Hanna Porn, that such a ban was a constitutional equal protection violation.<sup>66</sup> The court found both of these arguments without merit.<sup>67</sup> The court denied the possibility of race or gender or both being the basis for a suspect class by neglecting to discuss the racial or gender make-up of Alabama lay midwives. Following precedent in several other states, the court also ruled that the right to privacy did not cover choice in childbirth methods because a fetus is viable at the time of birth and, once a fetus is viable, "the mother's privacy rights are subjugated to the governmental interest in protecting both her and the child's safety."<sup>68</sup>

## 3. California Regulation

In 1976 and again in 1987, in *Bowland v. Municipal Court* and *Northup v. Superior Court* respectively, California courts stated that lay midwives were not legally allowed to practice medicine without licenses despite the fact that the California Medical Practice Act of 1976 did not expressly prohibit lay midwifery.<sup>69</sup> The restrictions in the state were later relaxed and made more explicit in the Licensed Midwifery Practice Act of 1993, after a Department of Consumer Affairs report confirmed that midwifery practice was much safer than previously thought.<sup>70</sup> This was essentially an affirmation that many of the highly unnecessary midwifery regulations of the twentieth century lacked merit. However, the new law had the adverse effect of vastly limiting midwifery by requiring midwives to work under the supervision of a licensed physician.<sup>71</sup> As a result,

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<sup>59</sup> *Id.*

<sup>60</sup> *Id.*

<sup>61</sup> Tovino, *supra* note 19, at 76.

<sup>62</sup> *Id.* at 76, 77.

<sup>63</sup> *Id.* at 77; *See also*, MARGARET CHARLES SMITH & LINDA JANET HOLMES, LISTEN TO ME GOOD: THE LIFE STORY OF AN ALABAMA MIDWIFE 143 (1996).

<sup>64</sup> Tovino, *supra* note 19, at 76, 77.

<sup>65</sup> *Id.*

<sup>66</sup> *State v. Kimpel*, 665 So.2d. 990, 994 (Ala. Crim. App. 1995).

<sup>67</sup> *Id.*

<sup>68</sup> *Id.*

<sup>69</sup> *Bowland v. Municipal Court*, 556 P.2d 1081, 1084 (Cal. 1976); *Northup v. Superior Court*, 237 Cal. Rptr. 255 (Cal. Dist. Ct. App. 1987) (the court specified that those, like defendants, claiming religious exemption, may be permitted to practice without licenses in certain circumstances); Cal. Bus. & Prof. Code § 2052, §2053 (West).

<sup>70</sup> Tovino, *supra* note 19, at 94.

<sup>71</sup> *Id.* at 95



insurance companies either refused to provide malpractice coverage or drastically increased doctors' insurance premiums when they supervised midwives.<sup>72</sup> Under economic and legal liability pressure, doctors began refusing supervisory requests and, by 2001, only one midwife in the entire state of California was able to obtain a physician supervisor.<sup>73</sup> This legislation, therefore, effectively eliminated legal midwifery practice in the state, despite being based on a study confirming the safety of midwife-assisted births.

After several court cases contested the law's detrimental effects, the California legislature amended it so that midwives would no longer have to disclose the name of their physician supervisors, making it more difficult for insurance companies to refuse to provide malpractice coverage. Although the amendment partially remedied the problem,<sup>74</sup> the fact remains that even in one of the most progressive states, midwifery is still seen, at least by insurance companies and courts, as something in need of strict regulation and direct medical oversight. This is unsurprising given the effectiveness of the original, racist anti-midwifery campaign of the early twentieth century.

## D. Midwifery Education and Its Exclusion of Women of Color

### 1. Federal Actions: The Sheppard–Towner Act

Explicit midwifery regulation over the past century has indeed been rampant, but it has not been the most destructive means of midwifery extinction. Though Massachusetts has historically been the strictest state in its midwifery regulation, other state regulations as well as federal statutes, though seemingly less restrictive, have done a great deal to aid in midwifery elimination. The Sheppard–Towner Act of 1921 was a federal statute created primarily to support and fund advances in maternal and infant health and mortality.<sup>75</sup> Specifically, it provided funding for registered nurses and physicians to travel to more rural areas—where midwives were still a practical necessity—and conduct educational sessions where they could educate midwives on new and life-saving hygiene regulations and methodologies.<sup>76</sup> Though this endeavor sounds supportive of midwifery in theory, in practice it became yet another vehicle for midwifery restriction.

The statute only provided funds to those states that agreed to certain regulatory schemes pertaining to midwifery practice. It established a hierarchical model in which public health nurses, overseen by higher-level health care professionals and Children's Bureau administrators, were given the power to choose which midwives they felt were trainable or competent enough to benefit from such classes and which should be restricted or eliminated from midwifery practice.<sup>77</sup> This was particularly problematic since the individuals making the decisions were White, and the midwives were predominantly Black.<sup>78</sup> This meant that, in one of the most racially charged eras in American history, the livelihoods of many women of color were placed directly in the hands of White actors already negatively disposed toward them for both social and competitive reasons. Furthermore, these classes and seminars sometimes lasted several days, if not longer, and although federally funded, were not free for midwives, as travel and lodging costs were not included.<sup>79</sup> The costs, therefore, acted as a barrier to poorer midwives of color who, without such training, would likely be eliminated from, or regulated out of, the profession. Some southern states, such as Georgia, Alabama, and Louisiana, did not take advantage of the federal funds at all, possibly out of a lack of interest in providing any kind of support to the Black midwives they wanted to eliminate.<sup>80</sup> In essence, the racially hierarchical

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<sup>72</sup> *Id.*

<sup>73</sup> *Id.*

<sup>74</sup> *Id.* at 98.

<sup>75</sup> Sheppard-Towner Maternity and Infancy Act, ch. 135, 42 Stat. 224 (1921) (repealed by Act of Jan. 22, 1927, ch. 53, §2, 4 Stat. 1024 (1927)).

<sup>76</sup> *Id.*

<sup>77</sup> FRASER, *supra* note 5, at 34.

<sup>78</sup> *Id.*

<sup>79</sup> *Id.* at 37.

<sup>80</sup> *Id.* at 31.

structure created by the Sheppard-Towner Act allowed for White professionals to directly and indirectly oversee, regulate, and control Black and immigrant midwives under the guise of educational and health advancement.

## 2. Other Subtle Yet Detrimental State Regulatory Endeavors

Many states that did not explicitly or heavily outlaw or restrict midwifery nonetheless adopted educational and training requirements that acted as bars to legally practicing midwifery. For example, South Carolina created a summer institute for midwifery using state and federal funds in the 1920s.<sup>81</sup> By the 1930s, the state had made yearly attendance at the institute a mandatory prerequisite for renewal of one's midwifery license or permit.<sup>82</sup> Since the permits themselves had also become mandatory and required a separate fee, many midwives of color, especially those who lacked the means to take time off or travel, simply could not by themselves afford to continue their work legally.<sup>83</sup> Similarly, Florida required that all midwives shadow fifteen physician-attended births to be eligible for a mandatory midwifery license and that each midwife have an active partnership with a physician in order to stay licensed.<sup>84</sup> This proved particularly difficult, as many of Florida's Black midwives lived in towns with few licensed physicians and did not have the means to routinely travel to those physicians. And, as noted above, many physicians did not support the continued practice of midwifery due to race- and gender-motivated fears of over-crowding, competition, and loss of status.<sup>85</sup>

## 3. Schools of Midwifery

The first schools and courses for midwifery cost over \$100, lasted anywhere from several months to over one year, and often required one to pass a literacy test.<sup>86</sup> These requirements posed difficulties for women of color, especially Black women who were generally still un- or under-educated post-abolition, and for many immigrants who did not speak English as a first language.<sup>87</sup> In the 1930s, when nurse-midwifery became a possible solution to the "midwife problem," only the literate, more affluent few—those capable of paying for and allotting sufficient time to graduating from a school for nurse-midwifery—could hope to legally and effectively join the profession.<sup>88</sup> Evidenced by the rapid decline in midwife-attended births in the same time period,<sup>89</sup> nurse-midwifery did not help save the midwife of color but instead worked as a racial and class barrier to the profession. In fact, as Litoff argues, it is partially because of the wildly successful smear campaigns against midwives of color that even White nurse-midwives, both then and now, are looked upon with skepticism and negativity.<sup>90</sup> However, the fact remains that nurse-midwives are today legally allowed to attend births and deliver babies in every state, but those midwives are not usually women of color, as they once predominantly were.

### III. THE MEDICALIZATION OF WOMEN OF COLOR'S REPRODUCTION

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<sup>81</sup> *Id.* at 36.

<sup>82</sup> *Id.*

<sup>83</sup> *Id.* at 37.

<sup>84</sup> DEBRA ANNE SUSIE, IN THE WAY OF OUR GRANDMOTHERS: A CULTURAL VIEW OF TWENTIETH CENTURY MIDWIFERY IN FLORIDA, 34 (2009).

<sup>85</sup> *Id.* at 50.

<sup>86</sup> LITOFF, *supra* note 6, at 35-37.

<sup>87</sup> *Id.*

<sup>88</sup> *Id.* at 126

<sup>89</sup> *Id.* at 114.

<sup>90</sup> *Id.* at 129.

It is true that the development and implementation of hygiene and educational regulations and requirements in the early decades of the twentieth century decreased infant and maternal mortality rates.<sup>91</sup> This Note also agrees that registering midwives and midwife births undoubtedly aided the data collection process for census statistics. This Note advocates both for natural, midwife-assisted birth, and for those births to be clean, sterile, and done by experienced midwives who take necessary precautions to ensure the safety of mother and baby. The problem with these requirements is not, therefore, the regulation of hygiene or requirements of having sufficient knowledge per se, but rather their socio-economically and racially disproportionate application and effect on Black and immigrant midwives and women. This racially disproportionate application connects midwifery regulation to another race-specific and even more pervasive regulatory scheme: medicalization.

Although the raced and gendered regulation and virtual elimination of lay midwives has been routinely happening since the turn of the twentieth century, it is not only the midwife of color who has felt the effects of regulation. Midwifery regulation is intimately connected to, and has important bearings on another regulatory phenomenon: the medicalization of pregnant women of color. This section will explain what medicalization is and why medicalization and midwifery regulation must be understood together in order to fully understand either and move forward.

Medicalization can be defined broadly as the identifying or viewing of a condition or behavior as being in need of medical intervention, treatment, or control.<sup>92</sup> In the context of a certain raced and gendered group's condition or behaviors—in this case the reproduction of women of color—medicalization takes on a deeper, more complex meaning. Here, medicalization is the direct or indirect systemic treatment and perception of women of color's reproduction as something degenerate, unruly, and in need of medical intervention and control.<sup>93</sup> This perception also bolsters the idea that pregnant or reproductive-age women of color need to be socially controlled through a medical framework.<sup>94</sup> At the turn of the twentieth century, and during the formative period of midwifery regulation, the medicalization of women of color's reproduction was much more directly and obviously racist and sexist.<sup>95</sup> As the Civil Rights Era moved the United States into a post-racial, neoliberal mindset, medicalization and midwifery regulation became much more indirect and systemic. The root problem, however, has persisted, and its historical and current stronghold on society will be discussed in the following sections.

### A. The Perceived Degeneracy of Women of Color

Negative notions associated with women of color's sexuality and reproduction have persisted throughout history: Enslaved women were the objects of White male sexual desire and abusive domination; for having to work while raising children, Black women post-slavery were perceived as lesser mothers and women; in the later twentieth century, we've seen stereotypes of the lazy "welfare queen" knowingly over-producing children at the expense of the lawful, White tax-payer, as well as the negligent drug-addicted mother who irresponsibly and cruelly reproduces "crack babies."<sup>96</sup> This sentiment is nothing new. What is relatively new is the scholarship and data that show us that these stereotypes have had startling, statistically significant, and systematic effects on pregnant women and mothers of color.

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<sup>91</sup> *Id.* at 54.

<sup>92</sup> Peter Conrad, *Medicalization and Social Control*, 18 ANN. REV. SOCIOLOGY 209, 210-11 (1992), available at <http://www.jstor.org/stable/pdf/2083452.pdf?acceptTC=true>.

<sup>93</sup> DOROTHY ROBERTS, *KILLING THE BLACK BODY: RACE, REPRODUCTION, AND THE MEANING OF LIBERTY*, 9 (1997).

<sup>94</sup> Conrad, *supra* note 92, at 215-16 (Arguing that childbirth is the primary example social control via medicalization as medical surveillance since it is seen as a deviant condition or behavior that can be checked by overbearing medical monitoring in all areas of obstetrics including pre and post natal care.).

<sup>95</sup> See Part I.

<sup>96</sup> ROBERTS, *supra* note 93 at 9, 18.

In her book, *Killing the Black Body: Race, Reproduction, and the Meaning of Liberty*, Dorothy Roberts notes that “white childbearing is generally thought to be a beneficial activity...Black reproduction, on the other hand is treated as a form of *degeneracy*.”<sup>97</sup> “The denial of Black reproductive autonomy,” she adds, “serves the interests of white supremacy.”<sup>98</sup> Khiara Bridges makes a similar argument noting that poor, pregnant women—who are disproportionately women of color—are perceived as “unruly bodies” and “the consequence [of that perception] is a medicalization of poverty, with the poor being treated as biological dangers within the body politic.”<sup>99</sup> Just like midwives of color, pregnant women of color were and are treated as degenerate, dangerous, and in need of control. Not only are pregnant women of color seen as things in need of regulation, but also they are seen that way because it subconsciously allows for the perpetuation of race, gender, and class hierarchies and structures.

As recent statistics show, this continues today. Women of color experience medicalized childbirth significantly differently than White women. In 2010, Amnesty International, an international human rights activism organization, published an extensive report detailing the particular disproportionalities and injustices women of color face in the American birthing system.<sup>100</sup> Titled *Deadly Delivery: The Maternal Health Care Crisis in America* (hereinafter referred to as the “AI Report”), its most shocking statistics include the following: women of color are at least twice as likely to be impoverished than White women;<sup>101</sup> Black women are four times more likely to die in childbirth than White women;<sup>102</sup> while forty-six percent of those deaths are preventable for Black women, only thirty-three percent are for White women<sup>103</sup>; and even though women of color represent thirty-two percent of women in America, they comprised fifty-one percent of all uninsured women in America as of 2010.<sup>104</sup> Despite these numbers, over ninety-five percent of women give birth in hospitals at a cost of between \$8,300 to \$18,900 depending on whether one has a vaginal or cesarean section birth and what procedures are performed.<sup>105</sup> Thus, a disproportionate number of women of color are both dying from childbirth and paying out of pocket for in-hospital birth. Statistics like these are but numerical indicators that the historical medicalization of women of color’s reproduction has not ended, but merely, changed forms. These changes, and their structural connections to midwifery regulation, are best understood through their common histories.

## 1. The History of Medicalization

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<sup>97</sup> *Id.* at 9.

<sup>98</sup> *Id.* at 5.

<sup>99</sup> KHIARA M. BRIDGES, *REPRODUCING RACE: AN ETHNOGRAPHY OF PREGNANCY AS A SITE OF RACIALIZATION*, 16 (2011).

<sup>100</sup> AMNESTY INTERNATIONAL, *DEADLY DELIVERY: THE MATERNAL HEALTH CARE CRISIS IN AMERICA* (2010), available at <http://www.amnestyusa.org/sites/default/files/pdfs/deadlydelivery.pdf>.

<sup>101</sup> *Id.* at 25

<sup>102</sup> *Id.* at 1.

<sup>103</sup> *Id.* at 20. Meaning that White women’s lives are saved in childbirth more often than are Black women’s.

<sup>104</sup> *Id.* at 4. Note that these numbers were calculated prior to the implementation of the Affordable Care Act. In 2010, roughly sixteen percent of U.S. adults were uninsured. This number has decreased to 11.4 percent as of mid-2015. OBAMACARE FACTS, <http://obamacarefacts.com/sign-ups/obamacare-enrollment-numbers/> (Last visited Mar. 14, 2016). Though the Affordable Care Act provides medical insurance, including maternity coverage, to a percentage of those previously uninsured, the Act is unclear as to whether and to what extent it requires coverage of midwifery care, free-standing birth centers, or home birth as it has not been in existence long enough for all requirements to be fully understood or implemented and because coverage still varies by state, by insurance provider. Nancy Metcalf, *Will Obamacare Cover Midwives and Birthing Centers*, CONSUMER REPORTS still varies (July 3, 2013, 10:08 AM), <http://www.consumerreports.org/cro/news/2013/07/will-obamacare-cover-midwives-and-birthing-centers/index.htm>

<sup>105</sup> *Id.* at 36.

The medicalization of pregnant women of color began in earnest during the first decades of the twentieth century—around the same time that the racist endeavor of midwifery regulation began. It began as a similarly racist endeavor—one into eugenics. Eugenics, the study and practice of population control through promoting the reproduction of “good stock” while discouraging or prohibiting the reproduction of “bad stock,” originated in England in the 1880s.<sup>106</sup> It was not until the turn of the century, however, that eugenics gained traction in the United States.<sup>107</sup> In 1911, Charles Davenport, a University of Chicago biologist, published the popular book *Heredity in Relation to Eugenics*, which reported pseudo-scientific research findings on the linkages between negative behavioral traits, disease, and race.<sup>108</sup> Davenport proposed to regulate “bad stock” through selective marriage, immigration, and sterilization policies.<sup>109</sup> American eugenicists and eugenisists<sup>110</sup> bolstered these arguments in favor of regulating Black and certain immigrant populations by claiming that their low IQ test scores were indicative of their inherent intellectual and mental inferiority to Whites.<sup>111</sup> This argument, however, ignored the possibility that, at the time, low IQ tests scores among Black Americans and certain immigrants instead resulted from their systematic denial of access to education.

The eugenics movement was so effective that, by 1913, twenty-four states and Washington D.C. had banned so-called “genetically defective” marriages;<sup>112</sup> by 1935, thirty-three states had laws allowing eugenics-based forced sterilizations;<sup>113</sup> and by 1940, thirty states had codified interracial marriage bans.<sup>114</sup> These anti-miscegenation laws worked hand in hand with the reporting laws, mentioned in Part I, which, by requiring birth attendants (midwives and physicians) to register all birth information, including the race of the child and parents, put midwives in a catch-22.<sup>115</sup> Furthermore, similar findings on the inferiority of Southern and Eastern European immigrants (groups to which the majority of immigrant midwives belonged) helped pass the National Origins Act of 1924 (also mentioned in Part I), legislation that heavily regulated immigration from these areas.<sup>116</sup>

Increased control of pregnant and reproductive-age women of color paralleled and directly intersected with midwifery regulation by using seemingly scientifically and socially necessary measures such as eugenics-based anti-miscegenation laws as well as birth reporting laws. The census and mortality statistics that proliferated of the anti-midwife campaign were also important to the eugenics movement. Gertrude Jacinta Fraser notes the Foucauldian idea that a great deal of the power of a bureaucratic state is contingent on its ability to “administer rather than take lives.”<sup>117</sup> In the context of a racially hierarchical society like our own, this means that the state can use population statistics on births, deaths, life expectancy, race, age, etc., to exert control and implement structurally racist and sexist agendas, such as eugenics, on its citizenry.

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<sup>106</sup> ROBERTS, *supra* note 93 at 59-60; *See also*, FRANCIS GALTON, INQUIRIES INTO HUMAN FACULTY AND ITS DEVELOPMENT, 24-25, 307 (MacMillan and Co., ed. 1883) (in which Galton, an English scientist, first used the term “eugenic”).

<sup>107</sup> ROBERTS, *supra* note 93 at 60

<sup>108</sup> *Id.* at 62.

<sup>109</sup> *Id.*; CHARLES DAVENPORT, HEREDITY IN RELATION TO EUGENICS, 219 (1911) (stating that “the population of the United States will, on account of the great influx of blood from South-eastern Europe, rapidly become darker in pigmentation, smaller in stature...more given to crimes of larceny, kidnapping, assault, murder, rape and sex-immorality...Since of the insane in hospitals there are relatively more foreign-born than native it seems probable that, under present conditions, the ratio of insanity in the population will rapidly increase.”).

<sup>110</sup> A eugenicist is an advocate of eugenics. A eugenisist is one who studies eugenics.

<sup>111</sup> ROBERTS, *supra* note 93 at 63.

<sup>112</sup> *Id.* at 65.

<sup>113</sup> NICOLE ROUSSEAU, BLACK WOMAN’S BURDEN: COMMODIFYING BLACK REPRODUCTION, 106 (2009).

<sup>114</sup> *Id.* at 71.

<sup>115</sup> FRASER, *supra* note 5 at 7.

<sup>116</sup> ROBERTS, *supra* note 93 at 65.

<sup>117</sup> FRASER, *supra* note 5, at 51.

In the context of midwifery regulation and medicalization, this was done primarily through the seemingly least invasive regulations: reporting birth statistics. Each state's anti-miscegenation laws were made more easily enforceable by the laws making it a crime for midwives and physicians to misrepresent or misreport information on birth certificates.<sup>118</sup> Thus, when midwives became required by law to submit birth certificates, which included a report of the baby's and parents' races, they were put in a terrible position. They could either incriminate their predominately Black and immigrant patients or incriminate themselves. If a patient birthed a mixed-race baby, her midwife could either report it truthfully, accusing her patient of criminal miscegenation or she could falsify her report, putting herself at risk of legal sanctions. The consequences were quite severe; in Virginia, for example, misrepresentation of race on such a document was a felony.<sup>119</sup>

This bureaucratic route to the implementation of eugenics laws is exemplified by a correspondence between the Virginia Registrar of Vital Statistics, Walter Plecker, and the eugenicist Harry Laughlin in the 1930s. In an attempt to bolster support for more thorough census data collection, Plecker assured Laughlin that such statistics would better allow authorities to monitor interracial procreation and ancestry. "I would feel somewhat easier," he said, "about the [effectiveness of anti-miscegenation laws] if I thought that these near-Whites would not produce children with negroid characteristics."<sup>120</sup> Whether we view it as a midwifery regulation used to promote a eugenics agenda or as a eugenics agenda that furthered the anti-midwifery campaign, the effects were the same: increased control of both midwives of color and of their patients of color. Therefore, a system of data collection that, on the one hand, was benefiting society by monitoring mortality and census data, was, on the other hand, also exerting a great deal of indirectly racist reproductive control over its Black and immigrant populations.

## 2. Sterilization, Birth Control, and the Denial of Autonomy

When the Great Depression hit, the fear that poor children and families of color would exhaust public funds sparked a severe and explicitly race-targeted attempt at reproductive control in the form of forced sterilization and disproportionate distribution of birth control to women of color.<sup>121</sup> Margaret Sanger's birth control crusade had begun to gain traction at just the time when racist Whites and eugenicists were advocating race-specific population control. In the late 1930s, Sanger and eugenicists began to work hand in hand on *the Negro Project*, a government funded endeavor to regulate Black reproduction.<sup>122</sup> The program, on its face, proposed to educate and provide communities of color with access to family planning information and health care options, but in practice, it allowed for the forced sterilization of tens of thousands of people of color.<sup>123</sup> Sanger, the women's reproductive rights pioneer, headed the *Negro Project* from 1939-1942 and sympathized with the eugenics agenda.<sup>124</sup> "Birth Control," she once said, "has been accepted by the most clear thinking and far seeing of the Eugenists themselves as the most constructive and necessary of the means to racial health."<sup>125</sup> At that time, many, like Sanger, perceived women of color's reproduction as reckless and detrimental to society at large, while, concurrently, state officials, eugenicists, and eugenicists were urging White women and families to have *more* children to offset the perceived overproduction of "bad stock."<sup>126</sup> It was not, therefore, that the population at large needed controlling during the troubled times following the Great Depression; It was that the White population needed to be preserved during those troubled times at the expense of the reproductive freedom of their Black neighbors. In the end, just like with midwifery regulation, the purportedly good intentions of this program resulted in the sinister control of women of color.

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<sup>118</sup> *Id.* at 74.

<sup>119</sup> *Id.*

<sup>120</sup> ROBERTS, *supra* note 93, at 72.

<sup>121</sup> ROUSSEAU, *supra* note 113 at 94, 97, 110.

<sup>122</sup> *Id.* at 110-11.

<sup>123</sup> *Id.*

<sup>124</sup> *Id.*

<sup>125</sup> ROBERTS, *supra* note 93 at 74-75.

<sup>126</sup> *Id.* at 73-74.

The program began with race-reporting regulations similar to those placed on midwives at the time. Sanger's birth control and family planning clinics, founded as the American Birth Control League in 1921—which later became the Planned Parenthood Foundation—began recording the races of their patients to compile statistics on the fertility rates of different races.<sup>127</sup> Presumably, this was in order to identify and more effectively control the biggest threats to the health of the White race; but in time, the program grew to be much more invasive. Between 1933 and the beginning of the 1960s, the Eugenics Commission of North Carolina sterilized 7,686 people, 5,000 of whom were Black.<sup>128</sup> In 1955, every single person sterilized in one South Carolina hospital was a Black woman.<sup>129</sup> In some cases of state-sponsored sterilization in North Carolina, since victims were considered mentally inferior or incapable, no consent was required before operating on them.<sup>130</sup> Between 1929 and 1941, over 2,000 eugenics sterilizations were performed per year; the U.S. government only stopped openly supporting eugenics once it became associated with its enemies, the Nazis, and their Holocaust.<sup>131</sup> By the time the forced sterilization laws were completely abolished in the 1970s, doctors had performed over 70,000 non-consensual sterilizations on the “unfit,” most of which were immigrants and people of color.<sup>132</sup>

Although the racist eugenics laws were repealed, disproportionately administered sterilizations on women of color have not stopped.<sup>133</sup> Just as midwifery regulation did not and has not stopped simply because the overtly racist anti-midwife propaganda of the early twentieth century ended, women of color were and are not free from this kind of reproductive control. Since the 1970s, sterilization has been offered and performed as a form of birth control disproportionately more often to women of color than to White women.<sup>134</sup> In the 1970s, several hospitals were exposed as having routinely performed sterilizations on Black women without proper consent. One such Boston hospital was routinely having medical students perform hysterectomies (a complete and irreversible removal of the ovaries and uterus) and tubal ligations (a possibly reversible severing of the fallopian tubes) on Black women for “training purposes.”<sup>135</sup> The same was reported in New York where the focus was on poor Black and Puerto Rican women.<sup>136</sup> Patients were being pressured or forced into signing their consent forms, and in most cases were not properly informed of the risks and alternatives; and the procedures, usually medically unnecessary, were often not being recorded.<sup>137</sup> In many cases across the country, the procedures were instead recorded as appendectomies (the removal of the appendix); in Southern states, for example, forced or coerced sterilizations were commonly referred to as “Mississippi appendectomies.”<sup>138</sup> In Puerto Rico in the 1960s, sterilization programs succeeded in sterilizing one third of its childbearing-age women, and similar endeavors on Native American reservations sterilized one quarter of Native American women in the 1970s.<sup>139</sup> A 1970 National Fertility Study reported that twenty percent of all married Black women, and almost twenty percent of married Hispanic women, had been sterilized; of those women sterilized through federally funded health programs, forty-three percent were Black.<sup>140</sup> Roberts notes

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<sup>127</sup> *Id.* at 75; ROUSSEAU, *supra* note 113, at 107.

<sup>128</sup> ROUSSEAU, *supra* note 113, at 110.

<sup>129</sup> ROBERTS, *supra* note 93, at 89-90.

<sup>130</sup> *Id.* at 90.

<sup>131</sup> *Id.* at 89; *See also*, PHILLIP REILLY, THE SURGICAL SOLUTION: A HISTORY OF INVOLUNTARY STERILIZATIONS IN THE UNITED STATES, 2, 101, 111-27 (1991) (discussing critiques of sterilization and eugenics during the first half of the twentieth century).

<sup>132</sup> ROUSSEAU, *supra* note 113, at 132.

<sup>133</sup> *Id.* at 132-33.

<sup>134</sup> *Id.* at 145-47

<sup>135</sup> ROBERTS, *supra* note 93, at 91.

<sup>136</sup> *Id.*

<sup>137</sup> *Id.* at 90-91.

<sup>138</sup> *Id.* at 90

<sup>139</sup> *Id.* at 94-95.

<sup>140</sup> ANGELA DAVIS, WOMEN, RACE, & CLASS, 219 (1981).

that publicly funded hospitals and doctors were in fact encouraged to irreversibly sterilize their patients.<sup>141</sup> In the 1970s, hysterectomies cost \$800 while tubal ligations cost only \$250. Since Medicaid reimbursed hospitals and doctors for these procedures, she explains, it was in their financial interest to perform the more dangerous and irreversible procedure on their patients, most of whom were poor women of color.<sup>142</sup>

### B. Medicalization Today

Just as feminist agency during childbirth was diminished when hospital and physician-assisted births replaced midwife-assisted and home births, so too has the agency and empowerment of pregnant women been undermined by medicalization and continued disproportionate sterilization. Sterilization is still more common among women of color than White women, and women of color still receive more sterilization counseling than White women.<sup>143</sup> As of 2002, over half of the women who are sterilized each year are poor Black women under twenty-four years old.<sup>144</sup> The AI Report notes that twenty-five percent of all women (of any race) who received cesarean sections felt pressured into the procedure while eleven percent felt pressured into taking contraction-inducing drugs such as Pitocin (which increase the likelihood of an eventual cesarean section).<sup>145</sup> Although some of the AI Report statistics are not broken-down by race, they state that White women were four times *more* likely than Black women to be given the choice to refuse a suggested episiotomy (cutting the vaginal opening in order to allow more room for baby's delivery).<sup>146</sup> This indicates that autonomy is denied to women unequally across races.

The AI Report statistics reinforce the arguments and theories espoused by the likes of Roberts and Bridges. For example, the AI Report found that, nationwide, bureaucratic procedures within the Medicaid system cause significant delays in care for pregnant women—a disproportionate number of whom are women of color.<sup>147</sup> This is similar to and reaffirms Bridges' finding that all pregnant women at her hospital of study (one primarily caring for the poor women of color in New York City), were required to see “abortion counselors, patient advocates, geneticists, HIV counselors, nurse/health educators, nutritionists, social workers, and financial officers” at the start of their admission for basic pre-natal care.<sup>148</sup> Not only are these sorts of bureaucratic policies riddled with negative assumptions about pregnant women of color without insurance or on Medicaid, they also force pregnant women of color to jump excessive hurdles before being provided with necessary care. By assuming women of color are more likely to have unwanted pregnancies, sexually transmitted infections, and little to no knowledge of sexual health or how to feed themselves and their families properly, it implies that such women are categorically unfit to be mothers.

Dorothy Roberts writes about the specific yet commonly unnoticed harm that positively perceived systems and institutions can do when they become punitive and primarily target marginalized groups. She notes that the American foster care system, one such positively perceived institution, in fact punishes low-income, Black mothers, especially those currently or previously incarcerated.<sup>149</sup> These women, being most likely to require welfare aid and more likely to struggle with domestic abuse and hunger, are also most likely to have their children taken away from them if they reach out for government help.<sup>150</sup> The system also makes it disproportionately difficult for those women to regain custody of their children.<sup>151</sup> “The analysis of the

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<sup>141</sup> ROBERTS, *supra* note 93, at 90.

<sup>142</sup> *Id.*

<sup>143</sup> ROUSSEAU, *supra* note 113 at 144-45.

<sup>144</sup> *Id.* at 145.

<sup>145</sup> AMNESTY INTERNATIONAL, *supra*, note 100, at 79.

<sup>146</sup> *Id.*

<sup>147</sup> *Id.* at 42.

<sup>148</sup> BRIDGES, *supra* note 99, at 41.

<sup>149</sup> Dorothy Roberts, *Prison, Foster Care, and the Systemic Punishment of Black Mothers*, 59 UCLA L. REV. 1474, 1484-86 (2012).

<sup>150</sup> *Id.*

<sup>151</sup> *Id.* at 1496-99.



roles Black mothers play in both the prison and foster care systems,” Roberts states, “reveals that these systems intersect with each other jointly to perpetuate unjust hierarchies of race, class, and gender...to discipline and control poor and low-income Black women by keeping them under intense state supervision . . .”<sup>152</sup> She also specifically states that pregnant women in prison—by a vast margin, women of color—are rarely given adequate prenatal care, and are often shackled to beds by their hands, feet, and stomachs during labor and delivery, only to have their children taken away from them immediately after birth.<sup>153</sup> These practices mirror the direct control of women of color's bodies through medicalization and indirect control of women of color's bodies through midwifery regulation. Both regulate women of color's reproduction through its primary actors—mothers, midwives, and babies—as well as through a regulatory system that is normalized by its appearance as a societal good.

All of these systems specifically control childbirth and motherhood because, as the eugenists argued, perpetuation of racial hierarchies is most effective and efficient when targeted at the reproduction of society. The gathering of birth and poverty statistics coupled with racial stereotypes, were not only effectively used to bolster support for the regulation of midwives, they were also used to sanction eugenics projects, forced sterilization of women of color, and over-medicalization of women of color. These attempts to control populations of color, Roberts argues, “serve primarily an ideological function . . . the chief danger of these policies is the legitimation of an oppressive social structure . . . by identifying procreation as the cause of Black people's condition, they divert attention from the political, social, and economic forces that maintain America's racial order.”<sup>154</sup> The issue here is not just that structural racism, patriarchy, and classism are apparent in midwifery regulation and medicalization; it is also that these structural inequalities are perpetuated under a guise of safety and progress. It is this guise that makes women and midwives of color specifically prone to state and social control. This point will perhaps become even more apparent in the next and final section.

#### IV. THE NEW HOME BIRTH MOVEMENT AND MIDWIVES TODAY

One might think, at this point, that the American birthing system as it was pre-regulation and hospital birth is unlikely to make a comeback, but this would be wrong. Home and midwife-assisted births, as previously stated, were steadily below one percent of American births since the 1970s and, in fact, between 1990 and 2004, home births had a small but steady decline from .67 percent to .56 percent of reported births.<sup>155</sup> However, since 2004, the United States has seen a rather dramatic incline in home births, increasing by twenty-nine percent between then and 2009.<sup>156</sup> Since midwives attend home births (both nurse and lay midwives), it seems midwives have not been lost to history after all. However, this is only part of the story. This newest iteration of the natural and non-hospital birth movement is also a story only fully understood through an intersectional lens.

##### A. White Home Birth Movement

As the NPR article in this Note's introduction stated—and no doubt this fact has been influenced in part by the popularity of television personality Ricki Lake's 2008 documentary, *The Business of Being Born*—it is White women who have been primarily responsible for the increased popularity of home and non-hospital births.<sup>157</sup> In 2010, the percentage of White women delivering outside of hospitals was 1.75 percent while

<sup>152</sup> *Id.* at 1491.

<sup>153</sup> *Id.* at 1494.

<sup>154</sup> ROBERTS, *supra* note 93 at 102.

<sup>155</sup> MARIAN F. MACDORMAN ET AL., NATIONAL CENTER FOR HEALTH STATISTICS, CENTER FOR DISEASE CONTROL AND PREVENTION, HOME BIRTHS IN THE UNITED STATES, 1990-2009, Figure 1 (Jan. 2012), *available at*, <http://www.cdc.gov/nchs/data/databriefs/db84.pdf>.

<sup>156</sup> *Id.*

<sup>157</sup> THE BUSINESS OF BEING BORN (directed by Abby Epstein, 2008). The film tells of the same startling cesarean and induction increases and midwife decreases as this paper though from a largely colorblind perspective, delving only

Black and Hispanic women were out of hospital at .48 and .41 percent respectively. This means that White women were about four times more likely to birth at home or in a freestanding birth center<sup>158</sup> unassisted by physicians.<sup>159</sup> The White female rate of non-hospital births increased from 1.09 percent to 1.75 percent just between 2009 and 2010; it's sobering to note that this difference, at .66 percentage points, is itself well over the entire percentage of Black or Hispanic women birthing at home in 2010.<sup>160</sup> Overall, although home-birth rates among women of color have actually decreased since the 1990s (though they are now on a small incline), the home birth rates of White women increased by thirty-six percent between 2004 and 2009 and by a staggering sixty-two percent just between 2009 and 2010.<sup>161</sup> Although these numbers among White women are small now, they show no signs of declining; in fact, they show every indication of continuing to rapidly increase. Thus, White women are and probably will continue to be the primary movers of birth from the hospital back into the home and back into the hands of midwives.

But it is not just the laboring women in this new natural birth movement who are White; midwives in the present movement are also White. In 2003, less than four percent of certified midwives (lay midwives with licenses) and nurse-midwives identified as Black or African American while less than two percent identified as Hispanic (not to mention that less than one percent were male).<sup>162</sup> In contrast, as of 2006, the percentage of women of color entering the general nursing field is higher, at over eleven percent for Black women and five percent for Hispanic women.<sup>163</sup> This leads to the assumption that though, to some degree (although still quite disproportionate to White women), women of color are able to cross the financial and licensing barriers into the nursing field, they are either choosing not to, or otherwise encountering further barriers to becoming midwives.

What other barriers exist today to prevent home births and the re-emergence of midwives of color? The AI Report notes that though states do not legally hinder nurse-midwives from attending births, twenty-four states and Washington, D.C. have legal barriers preventing certified lay midwives (CMs or CPMs) from doing so.<sup>164</sup> This is not surprising considering the White female beginnings of nurse-midwifery and the racist and sexist campaign against lay midwifery. Furthermore, twenty-seven states do not require private insurance companies to pay for nurse-midwife or midwife-assisted births and most other states only reimburse midwife-assisted births if they occur in hospitals.<sup>165</sup> A Wisconsin woman articulated this problem saying, "my daughter chose to have a midwife deliver her baby at home for a cost of under \$2,500. In the hospital system it would have cost us \$12,000, but because it was at home, insurance wouldn't pay for it."<sup>166</sup> Although the full pre- and post-natal services of a midwife cost thousands of dollars less than a hospital birth, laboring women on Medicaid or who are uninsured are still unlikely to be provided the option of a midwife or home birth as they will either be barred by insurance policies or by inability to pay out-of-pocket fees. Since private insurance policies are also not required to reimburse the costs of non-hospital births, the cost barriers to the

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minimally into the racial history of the anti-midwife campaign and not at all into the racial differences in access to midwives and in reproductive autonomy; MARTIN, *supra* note 4.

<sup>158</sup> Freestanding birth centers are midwife-staffed and home-like facilities unaffiliated with any hospital. They are quite rare in the United States. However, some hospitals have hospital-run birth centers which generally staff nurse-midwives and obstetricians but which still generally follow hospital procedures on labor and delivery. MORE BUSINESS OF BEING BORN: EXPLORE YOUR OPTIONS (directed by Abby Epstein, 2011). For the purposes of this Note, home birth will refer to births both at home and in freestanding birth centers.

<sup>159</sup> MARTIN, *supra* note 4.

<sup>160</sup> *Id.* at 2.

<sup>161</sup> MARTIN, *supra* note 4; MACDORMAN, *supra* note 155.

<sup>162</sup> Schuiling, *supra* note 4.

<sup>163</sup> Anita Ellery-Brown et al., *African American Nurse-Midwives: Continuing the Legacy*, MINORITYNURSE.COM, March 30, 2013, available at <http://minoritynurse.com/?s=african+american+nurse+midwives+continuing+legacy>.

<sup>164</sup> AMNESTY INTERNATIONAL, *supra* note 100 at 81.

<sup>165</sup> *Id.* State Medicaid Programs now have the option to cover births in freestanding birth centers if such coverage aligns with state law. Patient Protection and Affordable Care Act, 42 U.S.C. §18001, 124 Stat. 119, 292 (2010).

<sup>166</sup> *Id.* at 60.

otherwise least costly option might be more broadly prohibitive.<sup>167</sup> Therefore, if one chooses to have a home birth, she usually does so entirely at her own financial expense, regardless of whether or not she has insurance. This means that only affluent, and often White, women will have access to the non-hospital route.

It is no coincidence that midwifery and home birth were once so racially diverse but have reemerged racially stratified. The new home and natural birth movement is White-centered *because* we have forced out midwives of color and forced women of color in to a more highly regulated birthing system than White women. By doing so, we have curbed their reproductive autonomy more greatly than White women's. And by overregulating and stigmatizing lay midwifery in the past 100 years, we have incentivized the profession for the more affluent, often White, women who can afford to certify as nurse-midwives. The whiteness of these new trends is thus a symptom of the systematic race-based regulation of midwives and women of color. Midwives of color once tended to the natural, non-invasive births of women of all races and nationalities, providing women the support and care necessary to labor and deliver on their own terms. But now, the physician-assisted, hospital birth reigns supreme despite its current and historical over-regulation of bodies of color and revocation of agency along race and class lines.

If we ignore either race or class, but especially if we ignore both, and instead look at the story of the midwife and of medicalization through only the single-axis lens of gender (as did NPR and, to a large extent, *The Business of Being Born*), none of the patterns and structures that have so drastically altered American birthing since the turn of the twentieth century will be apparent, or even cognizable. Similarly, if we look color-blindly and only at the present make-up of hospital and home births without looking at the history, we do not easily see the racial connections and origins of the current disproportionalities, rather, we see the new surge in home birth as an abrupt and fleeting trend among the modern feminist middle and upper class. This is, primarily, a story of racism and classism against midwives and pregnant women of color. No other framework but an intersectional, black-feminist one will allow us to analyze the interconnectedness of these problems.

## V. CONCLUSION

When we fail to view the midwife and twentieth century birth and medical trends through an intersectional lens, we fail to see the marginalization, professional elimination, and disproportionality of the birthing statistics that negatively affect and oppress women of color. Therefore, what we need in order to confront this problem is to center low-income women of color's experiences and treatment (like the AI Report did) throughout the past 100 years in our discussions and analyses. While the White women's home and natural birth movement is marginally helpful in bringing back midwives and home births, its efforts clearly are not sufficiently advancing midwives of color and its efforts will certainly not help to stop the denials of liberty, agency, and respect to pregnant woman of color that are so deeply set into our current institutions. The racist regulatory schemes that eliminated the midwife are perpetuated by and connected to the regulatory schemes historically used and still being used to regulate pregnant women of color. Those structures and schemes still need to be tackled today. Insurance and hospital structures, structures that dictate licensing barriers and family planning distribution, and hygiene and safety discourses—all of which have and currently do perpetuate class, race, and gender biases against midwifery, home birth, and reproductive agency among low-income, pregnant women of color—are the structures in need of an intersectional, black feminist-centered shift in analysis.

The time has never been riper for an analytic change in these discourses. Feminism, though it should be a reality as opposed to a trend, has been gaining media coverage over the past several years with help from celebrity advocates such as Emma Watson and Beyoncé. The recent and ongoing incidents and discussions of police brutality have brought national and international attention to issues of racial injustice. And although they are centered around White women, projects like *The Business of Being Born*, and shows like BBC's *Call the*

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<sup>167</sup> *Id.* at 81.

*Midwife*—which is gaining an American viewership through its current availability on Netflix—are bringing midwifery back to our attention. All of this means that the American public, as well as American decision-making bodies, are perhaps more suited to tackle and discuss these issue than ever before, and we *must* take advantage of that.

It is a good first step simply to see the connections between the regulation of midwives, the oppression and control of pregnant women of color, and the lack of racial diversity in current home birth trends. But it is only the first step. We must also inform and help others understand that the more pregnant women of color were regulated, the more midwives were regulated and vice-versa. And when doctors and hospital birth replaced midwives, women of color, too, were moved into a highly regulated and bureaucratic hospital system that focused and still focuses much of its attention on limiting the autonomy of pregnant women of color. Therefore, we cannot fully understand the current disproportionalities in the natural birth movement and midwifery without first understanding their connection to the origins and history of medicalization and midwifery. We *must*, I believe, expose and stop these abuses and deconstruct the power structures that normalize and keep birth in the hands of hospitals and predominantly White, male physicians and bureaucrats. To do that, we will need to see this story as a women of color's story, one of oppression and suppression of the feminism and freedom that once ruled birth.