

12-18-2013

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Recommended Citation

Brown, Lisa. "When a Woman's Choice is Not a Choice." Health Law & Policy Brief 3, no. 2 (2009): 25-31.

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WHEN A WOMAN'S CHOICE IS NOT A CHOICE

Lisa Brown*:

My name is Lisa Brown and I am the general counsel for the National Abortion Federation (NAF). NAF is the professional association of abortion providers in the United States and Canada. Our members include clinics, doctor's offices, and hospitals who together care for more than half of the women who chose to have an abortion each year. The mission of NAF is to ensure safe, legal, and accessible abortion care to promote health and justice for women.

I am here today to talk about Medicaid and abortion care. I am going to begin my presentation with an overview of some statistics about the women who choose abortion in the United States and then talk a bit about the Medicaid system itself. I will conclude with an analysis of how the treatment of abortion care by Medicaid disproportionately impacts low income women and creates disparities in the ability of these women to exercise their choice of abortion when faced with an unintended pregnancy.

Despite the fact that abortion is a controversial political topic, it is also one of the safest and most common medical procedures provided in the United States. Nearly half of all pregnancies in the U.S. are unintended and four in ten of those pregnancies will end in abortion. This means that by age forty-five, almost one-third of American women will have had an abortion. In terms of numbers per year, in 2005 there were 1.21 million abortions provided in the United States. This is a common procedure that many American women will experience in their lives.

When in their pregnancies do women have abortions? Almost ninety percent of abortions are performed in the first trimester of pregnancy, which is the first twelve weeks after the first day of the last menstrual period. What are some of the general characteristics

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of women having abortions? The majority of women having abortions are in their twenties. Most abortions are obtained by those who have never married. Married women account for a lower proportion of abortions in part because they have low rates of unintended pregnancy. Those who do experience an unintended pregnancy are more likely than unmarried women to continue that pregnancy.

The largest racial ethnic identification of women having abortions is non-Hispanic white. However black and Hispanic women together make up more than half of women having abortions. This proportion is greater than their proportion in the population partly because they have a higher rate of unintended pregnancy.

Forty-three percent of women identify themselves as Protestant. The proportion of abortion patients who are Catholic is slightly lower than the Catholic proportion of the entire population. Thirteen percent of abortion patients say they are Born Again or Evangelical Christians. Twenty-two percent of abortion patients claim no religious identification. That is compared with only about sixteen percent of the general population that claims no religious identification.

The need for abortion spans the economic spectrum. However, low income women are over-represented among abortion patients. Some fifty-seven percent of women having abortions in 2000 were poor or low income, which means they were living at less than twice the poverty level. To put this into context, twenty-seven percent of women were living below 100 percent of the Federal Poverty Level, which means

they earned approximately \$900 a month to support an individual or \$1,500 a month for a family of three. Only twenty-five percent of women reported living more than 300 percent above the Federal Poverty Level, which is still not a lot of income. A family of three would be earning approximately \$4,500 per month.



In addition to being disproportionately low income, many women face significant barriers to obtaining abortion care. Eighty-seven percent of U.S. counties had no abortion provider in 2005, a number that has increased steadily since the 1970s. In non-metropolitan areas, ninety-seven percent of counties had no provider. As a result, many women must travel substantial distances to access this service. The Guttmacher Institute has found that about one in four women who have an abortion travel fifty miles or more for the procedure, a significant distance and a documented barrier to timely care.

Over the past several years, the abortion rate in the United States has declined. The rate of unintended pregnancy has remained generally the same across the whole population. Notably, however, the rate of unintended pregnancy has increased by twenty-nine percent among women living below the poverty level and sixteen percent of women who are poor account for thirty percent of unintended pregnancies.

Because a disproportionate number of low income women will experience an unintended pregnancy, they are also a population that is greatly affected by access to abortion services. Funding from state and federal Medicaid programs influence what choices are available for low income women seeking abortion care. Low income women disproportionately rely on the Medicaid system. Medicaid is the nation's state/federal health coverage program for the poor. It provides over twenty million low income women with basic health and long term care coverage. Eligibility for Medicaid is based on meeting federal income and categorical requirements. Under Medicaid, states receive federal matching funds to provide healthcare for low income individuals. In order to receive these funds, states must provide a certain core set of services to specific groups and individuals.

Over two-thirds of adults on Medicaid are women. Women are more likely to have lower incomes and to meet the eligibility criteria for Medicaid. Women are also more likely than the general population to be of reproductive age, poor, minorities, less educated, and parents. Nearly two-thirds of adult women on Medicaid are in their reproductive years and rely on Medicaid coverage for family planning and pregnancy related care.

State Medicaid programs must cover pregnant women with incomes up to 133% of the Federal Poverty Level - this is approximately \$1,200 a month for one person - during pregnancy and up to sixty days postpartum. States may elect to cover women with incomes that are higher than those in the guidelines, and can receive federal matching funds for coverage of pregnant women with incomes up to 185% of the Federal Poverty Level. States have a wide variety of coverage limits from 133% of the Federal Poverty Level in some states to 275% in Minnesota. To put this in context, that is not a lot of money. For a family of three under the 2009 Federal Poverty Guidelines, 133% is \$2,029 per month or a total income of \$24,350 per year for the entire family.

Unless medically necessary services are specifically excluded or deemed optional by the Federal Government, states participating in the Medicaid program are mandated to reimburse Medicaid enrolled health care professionals for providing those services. Unfortunately, abortion has become one of the most ostracized medical procedures in the Medicaid system. Between the *Roe v. Wade* decision in 1973 and 1976, Medicaid paid for abortions without any express restrictions. In 1976, Representative

Henry Hyde introduced an amendment to limit federal funding of abortion services. The Hyde Amendment, which is reapproved by Congress each year, allows federal funding for abortions only in cases of rape, incest, or life endangerment. This restriction was challenged in court and in 1980 the U.S. Supreme Court ruled in *Harris v. McRae* that the Hyde Amendment's prohibitions on abortion, including those on medically necessary abortion care, were constitutional.

The Court also upheld the right of a state participating in the Medicaid program to fund only those abortions for which it received federal funding rather than all medically necessary abortions. Justice Marshall strongly dissented on the basis that denying medically necessary care to poor women is equivalent to denying them access to legal abortion altogether. However, several state challenges have proven successful. Although there are still restrictions, several state constitutions provide greater protection than the federal constitution does. Lawsuits requiring Medicaid coverage using state funds for abortions in all or most medically necessary circumstances have been successful in thirteen states. Despite these lawsuits, the effect of the Hyde Amendment on low income women has been drastic. In thirty-three states and the District of Columbia, Medicaid only provides funding for abortions in cases of rape, incest, or life endangerment.

A low income woman seeking an abortion for other reasons, even those related to her health, is left with few options. Often women are forced to sell their possessions or use money set aside for rent or groceries to pay for an abortion. Six in ten low income women report wanting to have their abortion earlier. Without public funding, abortion is essentially not an option for many women. Studies have shown that eighteen to thirty-five percent of women who would have had an abortion carried their pregnancy to term in absence of funding. Across the country, private funders assist thousands of Medicaid enrolled or Medicaid eligible women with raising the money for abortion care each year.

The Hyde Amendment and restrictions on Medicaid funding also have a broad impact on abortion providers who find it difficult to find the funds to provide care for low income women and often charge on a sliding scale for those who should be covered by Medicaid. In states where Medicaid does cover all or most medically necessary abortions using state Medicaid dollars providers report a series of administrative barriers to receiving reimbursements, even for filing reimbursements with the Medicaid program. Providers report they often have to jump through many hoops and fill out extra paperwork for abortion procedures or face having their reimbursements routinely denied or held for up to a year when they legally should be covered. Women report being told by their Medicaid office that Medicaid would never cover abortion even in states where Medicaid is required to fund it in all or most health circumstances. This campaign of administrative barriers and disinformation adds to the confusion that the Medicaid system causes and the burden that these restrictions place on low income women.

In closing, Justice Brennan stated in his dissenting opinion in *Harris v. McRae* that the Hyde Amendment is an attempt to "impose the political majority's judgment" on a woman making a reproductive choice that the government disfavors. The Hyde Amendment "imposes that viewpoint only upon that segment of our society which, because of its position of political powerlessness, is least able to defend its privacy rights." *Harris v.*

McRae, 448 U.S. 297 (1980). NAF remains committed to ensuring that low income women have equal access to abortion services, regardless of their ability to pay or the Medicaid system in their state. Activists are working together across the country to raise awareness of the Hyde Amendment and its effect on low income women and NAF is a member of a broad campaign to educate members of Congress and the Administration about the harmful effects of the Hyde Amendment. To achieve reproductive equality for all women and ensure that each woman has the ability to make the choice that is right for her, restrictive barriers such as the Hyde Amendment must be abolished.

Dr. William Parker*:

I am going to continue with the theme of discussing the notion of choice, which for me is kind of a bad word. I think it is a notion that is antiquated when you look at the context in which most women make the decision of whether to continue their pregnancy.

I have laced the words together a little bit differently: abortion care, Medicaid, and disparity. Lisa laid out the fact that Medicaid is the system of social insurance for most people who meet the means test of being in poverty. It certainly describes poor women and women of color, but the two are not always the same. What I would like to do is try to connect some of the dots for you and review a few of the things she said, and maybe create a different context around them, particularly as they pertain to race and ethnicity. I will then talk specifically about how my practice as an abortion care provider has been impacted by the reality of Medicaid and the Hyde Amendment.

To very briefly summarize what Lisa said, about six million pregnancies happen annually, and about half of those are unintended. However, unintended does not necessarily mean unwanted. When we look at those unintended pregnancies, the majority of women who become pregnant, albeit unintended, will continue their pregnancies. Forty-eight percent of those unintended pregnancies will end in abortion. When we convert that to a rate, over time you can see that there has been a constant fall in the number of abortions. Everybody wants to take credit for that, from people who talk about abstinence-only education to people who create more effective means of contraception. Whatever the reason the rate is falling, we will take it.

Data examined in the aggregate does not always tell the whole story. You can look at unintended pregnancy as a proxy for the likelihood of a woman to continue to consider discontinuing her pregnancy. While unintended pregnancy rates have either stagnated or fallen when the data is disaggregated and unintended pregnancy rates are explored by various perimeters, one finds that in some sectors of the population unintended pregnancy has increased. This is evident particularly amongst poor women, while it has decreased amongst women with a higher income. While there has been a small decrease for women of means there has been larger increase for women with limited resources. It has shifted the dilemma of pregnancy decision-making to women who are more likely to have

adverse circumstances affecting their reasoning. Women who experience unintended pregnancy are disproportionately poor. While sixteen percent of women are poor, they account for thirty percent of unplanned pregnancies, a disproportionate share.

Now to introduce a different frame, that is that being in poverty and being a person of color is oftentimes synonymous, it is not always the same. When considering women of African-American descent, they account for twenty-six percent of the unintended pregnancies, while they make up fourteen percent of the population. A similar trend is true for Hispanic women. Again, Hispanic women represent a disproportionate share of unintended pregnancies compared to their portion of the population.

Unintended pregnancy is a proxy for the likelihood of a woman choosing to discontinue her pregnancy, but that does not necessarily mean an abortion, as we saw that in the majority of unintended pregnancies women continue their pregnancy. If we were to convert that disproportionate representation in poverty to a rate, it makes sense that when you look at women below the level of poverty, they have the highest rate of abortion. Because they have the highest rate of unintended pregnancy, they are more likely to be in a circumstance that will prompt them to consider abortion.

African-American women have the highest rate of abortion, followed by Latino women. Women of color represent the highest rate of abortion, which is counterintuitive when often times in the media the feminist movement has been perceived to be largely for white women. In reality, the notion that feminism empowers white women to have abortions would fly in the face of their numbers. It is amazing how forces that are against a woman's right to choose will spin this to say now we are talking about eugenic and genocidal notions in terms of who has abortions.

What prompts the rates that I have shown you? There has been some survey research of women who recently had abortions. When asked about the reasons why they chose to discontinue their pregnancies, most women gave multiple reasons. The average woman would give about five reasons why she chose to terminate her pregnancy. The majority of those reasons are related to the responsibilities that many women face by continuing a pregnancy that they materially, socially, and otherwise cannot afford. Most women have reasons that are related to their social economic status, trending towards the conclusion that women who rely on public assistance are affected in an adverse way by the Medicaid policies that restrict their access.

If you look at the reasons why a woman would delay having an abortion to a later gestational age in pregnancy, aside from not realizing that she is pregnant, the major reason is the difficulty arranging logistics, which is often a financial burden. You can now understand why women relying on public assistance who cannot access funding for abortion services delay the procedure. The relative safety of abortion is linked to the procedure occurring in the safest timeframe where there are least likely to be complications. If you look over time, even a week's increase in the gestational age makes a big difference in the risk for mortality and morbidity.

If you look at the number of deaths per 100,000 live births, death in the context of pregnancy, whether you're talking about abortion or childbirth, is a very rare thing. When it does occur, if you look at women who continue their pregnancy to term, their risk for death is roughly ten times more if you

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continue your pregnancy to term rather than if you have an abortion at any point. I am not advocating for a woman to discontinue a pregnancy, but it is to say that when women are forced to delay their decision-making for whatever reason, they exponentially or at least significantly increase their risk for morbidity and mortality, as demonstrated in published research by my friend at CDC, Dr. Linda Bartlett. She showed that when you delay the decision to have an abortion by even a week, you significantly increase a woman's risk. Hence, policies that selectively disadvantage some women over others devalue the lives of women who rely on public assistance, thereby by forcing them to take unnecessary risks when seeking abortions.

I have been able to see the implications of such policies first-hand over the last few years as an abortion provider. I want to present three cases that I have managed in the last year and give you the fact patterns. They are all three women of different backgrounds with different medical problems, but what they have in common is that they all rely on Medicaid funding for their health care. I will talk about these facts to give some texture to the complexity of abortion decision making and explain why we sought to have these women covered by Medicaid to have their procedure. I will also tell you the outcome of the coverage determination.

The first case was a twenty-five year old African American woman who had AIDS. She was in renal failure and on dialysis three times a week. She found that she was twelve weeks pregnant. The common medical wisdom is that she probably would not survive a pregnancy if she chose to continue. Initially, she made the decision to discontinue the pregnancy. Then she became conflicted and decided not to discontinue – but then ultimately decided that she wanted to be around for as long as she could to raise the two children that she already had. We approached Medicaid for permission to provide the services. Under the Hyde Amendment, as Lisa shared with you, there are three circumstances under which women can access Medicaid coverage for abortion services. The the people evaluating the case decided that the condition was life threatening to the mother and as a result, they authorized coverage for the procedure.

The next case was a thirty year old Hispanic woman who had one child and was nine weeks pregnant because her birth control method failed. Having an underlying condition that increased her risk for blood clots, she could not take birth control pills. She had not yet heard about the IUD, although she had by the time she met me. She also had a seizure disorder. In the management of her blood clotting condition and her seizure disorder, she was also on two medicines that were known to be teratogenic or had a high likelihood of causing birth defects. Now, the pregnancy would also increase her risk for having another blood clot that could go to her lungs and kill her. When we presented this case to Medicaid and they determined that although her story was very compelling there was no immediate, absolute threat to the life of the mother. There was no documented abnormality of the pregnancy even though she was on two medications that had a very high likelihood of causing birth defects. In that case, the procedure was not authorized and Medicaid refused to pay for her care.

The third case was a twenty-seven year old young Caucasian woman who had two kids, was 13 weeks pregnant, and was hospitalized because the heart valve that she had replaced began to leak, causing chest pain. She thought that she might be pregnant and was also on the blood thinner that was a known teratogen. She also had cocaine and alcohol binges, creating multiple teratogenic exposures. She also had a heart condition that would probably worsen with the progress of her pregnancy. We painted this medical picture for Medicaid and again the determination was that there was no immediate, absolute threat to the life of the mother or the fetus and the procedure was not authorized.

Now when I say that the procedure was not authorized, it does not mean that the care was not provided. It just means that we could not get the preauthorization to pay for the care that the woman needed. As a provider, when I have a woman who has need, my medical reasoning and decision-making should not be effected by the woman's ability to pay. On a daily basis, I try to make sure that it is not.

When a patient is faced with the dilemma of whether to sign a promissory note that might be demanded of her by an institution saying if we let you have this care, you have to agree that you are going to pay this money, for some it becomes cheaper to continue the pregnancy than to figure out where they are going to get the resources. It becomes quite clear how Medicaid policy with regard to the Hyde Amendment effects and compromises the care and well-being of women and my ability to provide the best care that I can as a provider.

It does so in a couple of ways. It imposes a financial barrier to health care that women would otherwise be entitled to as a part of their medical coverage, creating hardship. It also creates health disparities by imposing financial barriers that lead to differences in morbidity and mortality risks between groups on the basis of race and socioeconomic status. In other words, poor women have limited access to services. As I said earlier, poverty, race, and ethnicity are not always synonymous. Anything that delays the decision-making process results in women having to take increased and absolute risks with their lives.

Female Participant:

How long does it take to get a preauthorization?

Dr. William Parker:

Actually they try to do so in an expeditious manner. Usually because the answer is no, it does not take long, sometimes forty-eight hours. Most of the time, once you get someone to take the information, they will pledge a decision in twenty-four to forty-eight hours. We usually try to help navigate the maze for them. Most people do not know where to go or who to call. They do not usually have the numbers or the kind of diagnostic codes and all the other things that are required. There seems to be an air of whimsicality in the decision making. That is my assessment. They find ways to deny the most compelling cases and then cover things I would not expect.

Jill Morrison*:

Thank you for having me here. My purpose is to put to rest any doubts that the public scrutiny, the debate, the controversy, and the state intervention in pregnant women's lives is over once she decides whether to have a baby.

There have been numerous efforts to intervene in the lives of pregnant women. The most obvious example is efforts to prosecute pregnant women based solely on their drug use during pregnancy. At the National Women's Law Center (NWLC), where I work, we oppose such prosecutions. They are bad public health policy because they discourage pregnant women from seeking prenatal care and they violate the Constitution on several grounds. Our work on that issue relates closely to what I will discuss today, the prosecution of women for their birthing decisions and other actions during pregnancy. I decided not to focus on addiction because addiction is not a choice. It did not fit within the title "*When a Woman's Choice is Not a Choice*," but as you can see, the issues are similar.

Because drug users are so stigmatized, it is sometimes difficult to have empathy for them as women who are equally deserving of reproductive justice. The cases I am going to discuss are far more empathetic. At the same time they expose and support the exact same misconceptions and arguments that we use to oppose punitive measures against pregnant addicts. We cite these same cases when we submit amicus briefs to courts explaining why prosecuting pregnant women for child abuse, child neglect, or homicide is rooted in sex discrimination. I am happy to report that every court to consider the issue has agreed that criminal laws were not intended to be used in this manner.

The question at issue is the same for cases involving both drug use and medical decision-making during pregnancy. Once pregnant, what is a woman's duty to ensure the best possible health outcome for her unborn child? What actions can be taken against her by a third party who believes that she is not acting in the best interest of her fetus? What are your rights when it comes to making medical decisions for yourself presuming that you are not pregnant? Well here are the principles that apply, presuming you are in support of Constitutional rights.

First I will talk about your rights regarding the acceptance and refusal of medical care. In *McFall v. Shimp*, a man refused to donate blood marrow to his cousin. He happened to be the only match for that cousin. So what was the outcome? The court decided he did not have to donate. Why? He has a right to bodily integrity. There is no right to receive a donation of bodily fluids, organs, or anything else from another person. *Cruzan* held that competent adults have a right to refuse medical care even if it results in their own death. These are core principles protecting bodily integrity and autonomy. Yet we have many examples of attempts to violate these principles where pregnant women are concerned.

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To begin, there are cases involving women's refusals to submit to Caesarian sections. In the leading case, *In Re A.C.*, Angela Carder struggled with cancer since the age of thirteen, but decided to get married and have a baby after going into remission. The cancer returned in the twenty-fifth week of her pregnancy and she lapsed into a coma. The hospital, George Washington University Hospital in Washington, D.C. was especially concerned about her declining condition given the fact that the fetus was viable. The hospital petitioned the court for an order to force Ms. Carter to have a Caesarian section despite the opposition of her husband and family. The court ordered the surgery. Ms. Carter's treating doctors refused to perform the surgery because they were aware of her wishes. A staff obstetrician grudgingly agreed to perform the surgery. In the meantime, Ms. Carter came out of the coma and was told about the planned surgery. When told she might die as a result, she said over and over again that she did not want it done. Despite this, a panel of the appeals court met and quickly upheld the lower court's decision. They performed a cesarean operation on her that she expressly did not want. The baby died within two hours of delivery. Angela Carter lasted another two days. There is no doubt whatsoever that the surgery hastened her death.

Her family requested a hearing from the court of appeals trying to make sure that no woman ever again was subjected to such treatment. The full D.C. Court of Appeals reversed the panel's decision. The court reviewed the other decisions that had refused to require organ donations between relatives and concluded a fetus cannot have rights in this respect superior to those of a person who has already been born.

Since that case, virtually every court has supported a pregnant woman's right to make medical decisions that may endanger the fetus or a pregnant woman's right to refuse treatment for the fetus' benefit. The case *In Re Baby Boy Doe* was technically rendered moot before the court could hear it because the mother had a vaginal birth, but the court heard the case anyway because it was apparent that this situation could arise again. In that case, the state claimed that the lower court was correct in ordering a woman to have a Caesarian section after balancing the state's interest in fetal life against the right of a pregnant woman to choose her own medical care. The appeals court rejected this argument finding that a woman's competent choice to refuse medical treatment as invasive as a Caesarian section must be honored even in circumstances where the choice may be harmful to her fetus.

One reported case to the contrary graphically illustrates the incredible violation of liberty and autonomy that occurs when the government oversteps its bounds. Laura Pemberton had previously had a Caesarian section, but wanted to give birth vaginally during her next pregnancy. This situation is called a VBAC, and many hospitals and doctors refuse to do them, claiming that they put women at risk of uterine rupture. Pemberton's doctor refused to attempt such a delivery and Pemberton decided to give birth at home. During her home birth, she became dehydrated and decided to go to the hospital for IV fluids. The attending physician at the hospital refused to give her IV fluids and instead called the hospital administration. The administration then called its lawyer, who then called the state's attorney. In the meantime, Laura Pemberton, who was full term and in labor, 'slipped' out of the hospital. What followed was an almost unbelievable

scene. A woman in labor is taken from her home to the hospital by law enforcement to submit to a court-ordered Caesarian section.

Ms. Pemberton sued, alleging a violation of her rights to bodily integrity and to refuse medical treatment. She lost, ironically enough, based on the court's application of *Roe v. Wade*. The court focused solely on the part of *Roe v. Wade* that says that the state has an interest in a viable fetus. The court concluded that because the state has an interest in a viable fetus, it could properly express that interest by ordering the Caesarian section to save the fetus's life. Of course, it is impossible to know whether Ms. Pemberton could have had a healthy delivery without the Caesarian section, but the evidence is certainly in her favor. Ms. Pemberton went on to deliver four children vaginally including a set of twins. So doctors don't always know best.

The case of Melissa Ann Rowland shows that the state is willing to go beyond mere aggressive intervention to criminal prosecution. Ms. Rowland was threatened with a homicide charge for not having a Caesarian section. Eventually the prosecutor dropped the charges, claiming that he did so only because Rowland was mentally ill.

Currently, a New Jersey Appeals Court is considering whether the state can base a child neglect proceeding solely on a pregnant woman's refusal to give advanced consent to a Caesarian section just in case any problems arose during delivery. Keep in mind that there was no indication that the woman would actually need a Caesarian section. As she went into labor, the hospital handed her a bunch of papers and she chose not to sign the one that says I will have a Caesarian section if it is needed. The state moved to terminate her parental rights alleging neglect. The state also moved against her husband because he agreed with her decision to withhold consent.

It is not just refusals to have Caesarian sections that evoke state intervention and criminal charges against pregnant women. Here are a few other cases that involve a pregnant woman's right to refuse medical care. In *In Re C.M.*, the New Jersey Division of Youth and Family Services filed a negligence complaint against an HIV positive woman because she refused to take medication during her pregnancy that would reduce the risk of her fetus being born with HIV. The court rejected the allegation of negligence stating that a pregnant woman's decision to refuse medical treatment that would benefit her fetus is a part of her constitutionally protected right to privacy. In *Taft v. Taft*, the Massachusetts Supreme Court vacated a lower court decision ordering Mrs. Taft to have her cervix sewn to prevent a possible miscarriage. She had a weak cervix and there is a surgery that can be done called a 'purse string' surgery. She did not want to have it, but Mr. Taft asked for a court order. The court refused to order the surgery.

Unfortunately, as you can see from these cases, often women are forced to vindicate their rights only after their rights have been violated. So they are doing so on behalf of others who may be in similar circumstances in the future. This raises the question of how many other women are subjected to such treatment and simply do not have the resources, the energy, the wherewithal, or the motivation to find an attorney and try to remedy the rights of others, especially considering that these women have a newborn baby at home. For every one of these cases that occurs that actually comes to court, just think of how many others are out there.

Why does this keep happening? These principles about bodily integrity and autonomy are deeply engrained in our constitutional jurisprudence. So why are states, prosecutors, and hospital administrators not getting the message? The United States Supreme Court once upheld a statute limiting women, but not men, to ten hour work days. According to the Court, the state presented adequate justification for the infringement on women's liberty because "healthy mothers are essential to vigorous offspring, the physical well being of women becomes an object of public interest and care in order to preserve the strength and vigor of the race."

If you have ever been visibly pregnant at any point in your life you are acutely aware of the public interest in pregnant women. When you are visibly pregnant, some people seem to think that you are public property. People believe they can touch you, they can give you advice, and tell you what to do and more importantly, what not to do. This is the interest that these state actions are actually reflecting. This is why those who are expected to uphold the law, prosecutors and other state officials, initiate prosecutions that they know are unconstitutional. This is why those who are best versed on principles of informed consent, doctors and hospital administrators, enthusiastically violate these principles when it comes to pregnant women.

Underlying these infringements on pregnant women's liberty is the discriminatory notion that women's best and perhaps only contribution to society is her fulfillment of her reproductive role. Women are expected to be self-sacrificing and altruistic; to submit their very lives for the sake of their children. A 'real' mother would not even want to assert the same liberty and autonomy rights as other individuals. Again, if this is something that you think is untrue or an overstatement, I would have to ask why we keep seeing these cases over and over again.

Regarding the Hyde Amendment, I was very interested Doctor in what you were saying about how arbitrarily these decisions are made. I was wondering if politically it would be more palatable to revise the regulations to broaden the medical bases for which what you call life endangerment as opposed to overturning the Hyde Amendment. And to Lisa, whether or not that would be possible. Although the movement has talked about overturning Hyde, I am so not optimistic about that. I know regulations are a lot easier to change than laws.

Dr. William Parker:

I think from a medical standpoint, the notion of what is considered an absolute versus a relative indication is important. It is almost like with medical expertise, you know the plan is fine. I think the Hyde Amendment has its greatest impact in terms of the way it introduces administrative delay. If you create a process that is even more nuanced, it still does not get around the notion that people bring the values to the decision making process that they bring. If I thought that refining the process would make a difference, I would be an advocate for that. At the end of the day what I find is that it will never trump the moral context in which many people process abortion care.

Lisa Brown:

I definitely agree with that in terms of the states that require Medicaid to fund all or most medically necessary abortions. They have found other

ways to make it difficult. Although it is not as difficult and you have more likelihood of having your abortion funded in one of those states than in a Hyde only state, we have providers in one state who all work together and all have found that they have completely different experiences with the Medicaid office depending on who they talk to, how big their clinic is, and how they interact with the Medicaid office on family planning and other issues besides just abortion.

If they already have a relationship with the Medicaid office, and the Medicaid office funds other procedures for them, then they are more likely to get their abortion procedures funded. Even then, the Medicaid office routinely loses their paperwork. There is a clinic in another state that actually physically goes to the Medicaid office and hands in their paperwork because it has gotten lost so much of the time.

Female Participant:

I have a question for Miss Morrison. Have you seen cases of women wanting to do home birth as opposed to delivering in the hospital? Have you ever seen litigation forcing a woman to go to a hospital on the day of delivery?

Jill Morrison:

I have not seen it litigated yet, but given the clash between some medical authorities and midwives in some states, I really do think it is just a matter of time. We are going to get to the point where doing anything against

your doctor's advice can be a cause to bring child neglect or criminal proceedings against you.

Dr. William Parker:

One of the things that I have seen is the introduction of the notion of vicarious liability breeding contempt between midwives and obstetricians such that there are barriers to women if they make the decision for a home birth or if they make a decision to have their care with a midwife that decision becomes binding and absolute. It puts them on a path where, in some ways, they have restricted access to the interventional care that they can obtain with an obstetrician.

We had a forum in California where we sought to explore to what degree the statutory and regulatory mechanism of the state could intercede between insurance companies breeding these contemptuous relationships that ultimately penalize women. Basically what you are saying is if you want to have a certain type of birth experience and you make that decision, you are locked out of the health care system where we could optimize your outcome by creating this defensive posture for obstetricians. If I am having a conversation with Miss Morrison and she is a midwife and she says I have this patient who has a high blood pressure, what do you think I ought to do? If she mentions that we had a conversation, the concept of vicarious liability says that I am liable even though I've never met this patient. As a person who's practicing defensively, I say oops, I cannot talk to you. At the end of the day it is the woman who is in her care that pays.