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REVISITING *ROE* TO ADVANCE REPRODUCTIVE JUSTICE FOR CHILDBEARING WOMEN

*Elizabeth Kukura**

The rewritten opinions that comprise *Feminist Judgments*¹ together provide a powerful critique of judicial decisionmaking that renders certain women's experiences invisible. By reimagining key Supreme Court decisions, the opinion writers unmask various ways that gendered conceptions of social roles are deeply entrenched in the rulings and reasoning of the highest court of the United States. The authors also show, through their alternative texts, that opinions which are celebrated as women's rights victories can nevertheless impede progress toward equality and liberty.

Kimberly Mutcherson's rewritten concurrence in *Roe v. Wade*² illustrates the missed opportunities and unintended consequences that have made the landmark 1973 opinion a mixed bag for childbearing women.³ In the opinion, "Justice" Mutcherson grounds the abortion right in both the due process and equal protection guarantees of the Fourteenth Amendment, articulating a powerful equality argument for legal abortion. In doing so, she rejects the trimester framework laid out in Justice Blackmun's opinion,⁴ recognizing that by associating state regulation of abortion in the interest of protecting potential human life with a fixed point in time, Blackmun failed to anticipate how the use of a viability standard could be used to whittle away women's reproductive autonomy in the name of fetal protection.⁵

Despite its well-known reputation as the case that legalized abortion rights, *Roe* has legal implications for women who choose not to terminate their pregnancies, as well as for pregnant women who never contemplate abortion. Laura Pemberton had probably never thought much about the *Roe* decision or considered it relevant

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1 FEMINIST JUDGMENTS: REWRITTEN OPINIONS OF THE UNITED STATES SUPREME COURT (Kathryn M. Stanchi, Linda L. Berger & Bridget J. Crawford eds., 2016) [hereinafter FEMINIST JUDGMENTS].

2 410 U.S. 113 (1973).

3 Kimberly M. Mutcherson, *Rewritten Opinion in Roe v. Wade*, in FEMINIST JUDGMENTS, *supra* note 1, at 151, 151–67.

4 *See* 410 U.S. at 163.

5 Mutcherson, *supra* note 3, at 151–52.

to her personal life when she became pregnant with her second child in 1995.⁶ A medical condition called placenta previa had required that she deliver her first baby by cesarean, but as a supporter of natural childbirth and wanting a large family, she decided to pursue a vaginal birth after cesarean, commonly referred to as VBAC.⁷ Although she had weighed the risks and benefits of VBAC with those of an elective repeat cesarean and had reached an informed decision to attempt a VBAC, she was unable to find a doctor willing to support her and ultimately decided to give birth at home.⁸

When Pemberton went into labor, she began contracting as expected and labored for about a day without sign of complication before becoming concerned about dehydration.⁹ She decided to visit the hospital for IV fluids before returning home to deliver the baby.¹⁰ However, the medical staff at the hospital refused to provide fluids unless she consented to a cesarean and, in fact, decided to seek a court order compelling her to deliver by cesarean.¹¹ When Pemberton learned from a sympathetic nurse about the hospital's plans, she snuck down the back stairs of the hospital in her bare feet and went home to continue laboring.¹² Shortly thereafter, the sheriff and state's attorney removed her from her home—strapping her legs together on a stretcher—and took her back to the hospital for a hearing, in which the judge ordered her to submit to a cesarean, even though she could feel the fetus progressing into her birth canal without complication.¹³

When she later sued, the federal district court rejected Pemberton's claims that her constitutional rights had been violated.¹⁴ Generally, when confronted with a conflict over forced medical treatment during pregnancy, courts turn to the abortion rights doctrine for guidance. In cases where a woman withholds consent to cesarean surgery, courts have interpreted *Roe*'s recognition of a state interest in the fetus to justify overriding a cesarean refusal—reasoning that after viability, the state's interest in protecting fetal life trumps a woman's constitutional rights. The court that considered Pemberton's treatment refusal concluded that the “balance tips far more strongly in favor of the state” and its interests in protecting fetal life because the woman sought “only to avoid a particular procedure for giving birth, not to avoid

6 Laura Pemberton, Speech at the 2007 National Summit to Ensure the Health and Humanity of Pregnant and Birthing Women (Jan. 20, 2007), <https://vimeo.com/4895023> [hereinafter Pemberton Speech].

7 *Id.*

8 *Id.* Women across the United States have reported difficulty finding a physician or hospital that supports VBAC, despite research supporting its safety and concerns about the number of medically unnecessary cesareans performed each year. See Elizabeth Kukura, *Choice in Birth: Preserving Access to VBAC*, 114 PENN ST. L. REV. 955, 959–77 (2010) (describing the controversy around VBAC); Elizabeth Kukura, *Obstetric Violence*, 106 GEO. L.J. 721, 743–47 (2018) (discussing VBAC restrictions as a form of coercion in maternity care) [hereinafter *Obstetric Violence*].

9 Pemberton Speech, *supra* note 6.

10 *Id.*

11 *Id.*

12 *Id.*

13 *Id.*

14 Pemberton v. Tallahassee Mem'l Reg'l Med. Ctr., Inc., 66 F. Supp. 2d 1247, 1249 (N.D. Fla. 1999).

giving birth altogether.”¹⁵ It also reasoned that bearing an unwanted child is a greater intrusion on a woman’s liberty interest than having a cesarean to deliver a wanted child, so the state’s interest was even stronger relative to the woman’s interest than it had been in *Roe*.¹⁶

As various commentators have observed, the comparison between compelled treatment in pregnancy and abortion rights is a flawed one.¹⁷ Unlike in the abortion context, where a woman seeks to terminate an unwanted pregnancy, a woman who has decided to carry a pregnancy to term is presumably making decisions with her baby in mind—and arguably is the party most motivated to make the best possible decisions to protect fetal health and well-being. But since the onset of technology that has enabled visualization and treatment of fetuses in utero, the field of obstetrics has wrestled with and ultimately accepted the idea of a two-patient model—where doctors understand themselves to be treating two separate patients. The misreading of *Roe* in *Pemberton* and elsewhere both draws on and helps to perpetuate the concept of maternal-fetal conflict. This idea frames disagreement over treatment as conflict between the woman and the fetus she is carrying, rather than as conflict between a patient and provider about medical treatment during pregnancy, thus enabling the doctor to assert his or her own values in the name of protecting the fetus.¹⁸

Research and advocacy in recent years suggest that patient mistreatment is an underrecognized problem within maternity care. Advocates use the term “obstetric violence” to identify a variety of different types of conduct that occurs on a continuum from abuse to coercion to disrespect.¹⁹ Obstetric violence may include forced cesareans or episiotomies, the physical restraint of a laboring woman, unconsented medical procedures, or verbal abuse.²⁰ It may also take the form of coercion to secure a woman’s consent to labor induction, cesarean, or another form of medical intervention; healthcare providers sometimes threaten to seek a court order or make a child welfare report if a woman declines the intervention; or a woman who has previously delivered by cesarean may be coerced into an unwanted and medically unnecessary repeat cesarean due to hospital-wide restrictions on

¹⁵ *Id.* at 1251.

¹⁶ *Id.* at 1251–52.

¹⁷ See, e.g., Nancy K. Rhoden, *The Judge in the Delivery Room: The Emergence of Court-Ordered Cesareans*, 74 CALIF. L. REV. 1951, 1953 (1986).

¹⁸ See Michelle Oberman, *Mothers and Doctors’ Orders: Unmasking the Doctor’s Fiduciary Role in Maternal-Fetal Conflicts*, 94 NW. U. L. REV. 451, 452 (2000).

¹⁹ See *Obstetric Violence*, *supra* note 8, at 763–64 (discussing the emergence of obstetric violence as a legal concept in Latin America and its adoption by advocates concerned with the mistreatment of childbearing women in the United States).

²⁰ *Id.* at 734–38. Many instances of obstetric violence involve a disagreement between a patient and her healthcare provider about the appropriate amount of medical intervention, often reflecting a patient’s desire to forego or delay medical intervention and a provider’s desire to pursue a more interventionist approach to managing labor or delivering the baby. *Id.* at 765–78 (discussing factors that contribute to or tolerate the mistreatment of women during childbirth, including economic and legal pressures, as well as powerful social norms about self-sacrificing mothers and the superiority of medical experts).

VBAC.²¹ Still other women endure insults, withheld treatment, or emotional pressure during labor and delivery.²²

Laura Pemberton experienced coercion, threats, and ultimately a court-ordered cesarean. Her case is an example of how *Roe* has been imported into the childbirth context and misapplied to subordinate women's interests to perceived fetal interests. By rejecting the trimester framework as flawed and unworkable, Mutcherson's reimagined opinion in *Roe* rejects the articulation of the state's interest in the potentiality of human life that has subsequently migrated to the childbirth context and restricted women's decisionmaking during labor and delivery. In doing so, it precludes the kind of reasoning that supports medical and legal judgments about the fetus as a separate entity that needs protection from the pregnant woman. And indeed, it explicitly anticipates and rejects the idea that the state can make demands on a pregnant woman in order to benefit the fetus.

Reimagining the role of the fetus in abortion jurisprudence tackles an important way that the law has fallen short of protecting and vindicating women who are mistreated during childbirth, but this reframing does not reach all the ways that mistreatment occurs in maternity care. Here, Mutcherson's equal protection analysis is instructive. She explains that abortion restrictions rely on gendered stereotypes about women, particularly that women have a duty to become mothers and should be prepared to sacrifice other aspects of their lives, such as education or career, in order to fulfill that duty. Accordingly, she concludes that "to demand that [a woman] use her body to pursue the plans of another, whether a fetus, the state, a husband, a boyfriend, or a physician, is to treat her as unequal to other competent adult decision makers."²³

The opinion's equal protection analysis urges readers to consider how a sex equality approach to abortion legalization might possibly have helped alter such social norms, including those norms relating to gender and maternity that play a role in enabling and tolerating obstetric violence. For example, society's widespread expectation of maternal self-sacrifice makes it difficult for courts to recognize injuries associated with forcing medical treatment on an unwilling woman in labor. Women who are mistreated by their healthcare providers during childbirth face an uphill battle against societally entrenched maternal values, which suggest that good mothers are those who subordinate their own needs—and bodies—in service of their children and families.

The powerful idea of the self-sacrificing mother is particularly relevant in the context of so-called maternal-fetal conflict. When courts apply abortion doctrine to grant court orders compelling cesareans, courts send a message to doctors that paternalism toward childbearing women is not only acceptable, but necessary. Women with healthy babies who bring suit over their own injuries are perceived to be acting selfishly, and women themselves may internalize these social expectations, downplaying the extent of their physical and emotional injuries. Judges and juries see a healthy baby and do not recognize separate harms to the woman as such, often telling women to be grateful and stop complaining. By identifying and unmasking

21 *Id.* at 738–50.

22 *Id.* at 750–54.

23 Mutcherson, *supra* note 3, at 163.

the “romantic view of pregnancy and motherhood,” Mutcherson’s opinion acknowledges the burdens of pregnancy and motherhood, which opens up the possibility of recognizing the physical and emotional harms women suffer due to mistreatment during childbirth as true harms.²⁴

The rewritten *Roe* adds important layers to the constitutional analysis, explicitly identifying what women lose when abortion is banned and discussing the disproportionate harm abortion restrictive laws cause women of color, poor women, and other women who are marginalized. This important context reflects judicial decisionmaking that acknowledges the actual lived experiences of the people whose lives are shaped by constitutional rulings. As Rachel Rebouché notes in her commentary on the rewritten opinion, Mutcherson’s concurrence “might have provided future courts stronger language for grounding abortion protections in the rights of women.”²⁵ By rejecting the trimester framework’s focus on the fetus and articulating a powerful sex equality basis for abortion legalization, this opinion would likely have foreclosed reliance on *Roe* to justify the kind of pregnancy exceptionalism that permits healthcare providers to force unwanted medical treatment on women just because they are pregnant. Not only does the rewritten *Roe* help us imagine the world that might have been, but it also reminds us that when jurists fail to consider the realities of women’s lives, we risk settling for an impoverished conception of reproductive autonomy.

24 *Id.* at 164.

25 Rachel Rebouché, *Commentary on Roe v. Wade*, in *FEMINIST JUDGMENTS*, *supra* note 1, at 146, 150.