

ABANDONING WOMEN TO THEIR RIGHTS: WHAT HAPPENS WHEN FEMINIST JURISPRUDENCE IGNORES BIRTHING RIGHTS

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“An important task of feminist ethics is to . . . offer alternative models for medical relationships that neither replace patient authority with technical expertise nor abandon patients to their ‘rights,’ where that amounts to granting them the opportunity to assert their independent authority in a hostile, frightening environment.”¹

INTRODUCTION

Women’s legal rights during childbirth must be addressed as an essential part of the range of social justice concerns relevant to women’s lives. Realizing birthing rights requires protecting individual women’s abilities to make healthcare decisions free from coercion and discrimination, without abandoning women to their rights.² Beyond individual autonomy in decisionmaking, the spectrum of birthing rights includes guaranteeing access to culturally appropriate and supportive maternity care, such as independent midwifery, and securing a woman’s freedom to give birth safely and with dignity in the location of her choice. Scholars and students³ in the fields of law,⁴ bioethics,⁵ anthropology,⁶ and sociology⁷ have

* J.D., 2010, University of Maryland School of Law, M.P.H. 2007, University of Virginia. This paper was selected as the first place winner of the 2011 National Advocates for Pregnant Women’s law student writing contest. I wish to thank the staff of NAPW for the inspiration to write this piece and for their tireless devotion to protecting the human rights of birthing women. My very special thanks go to Farah Diaz-Tello and Jill Arnold for their encouragement and friendship, and to Katie Prown, Renee Cramer, and Anne Blackfield for their comments and suggestions. This article is dedicated to the memory of my mother, Maureen Sundman Angevine.

¹ SUSAN SHERWIN, NO LONGER PATIENT: FEMINIST ETHICS AND HEALTH CARE 137 (1992), quoted in Karen H. Rothenberg, *New Perspectives for Teaching and Scholarship: The Role of Gender in Law and Health Care*, 54 MD. L. REV. 473, 475 (1995).

² Some commentators have addressed birthing rights issues from the point of view of women’s request for intervention in the absence of medical indication. See Sylvia A. Law, *Childbirth: An Opportunity for Choice that Should Be Supported*, 32 N.Y.U. REV. L. & SOC. CHANGE 345 (2008) (arguing that cesarean delivery on maternal request should be supported as much as vaginal delivery). I acknowledge the many ways in which women’s lives and health are compromised without access to appropriate medical care. Without discounting the importance of this issue or placing normative value on fewer medical interventions in childbirth, this paper analyzes the threats posed to birthing rights when women seek to give birth without medical intervention or when they refuse medically recommended interventions.

³ Several student-written pieces have appeared recently focusing on birthing rights. See, e.g.,

reviewed these issues, yet these studies remain curiously absent from gender discrimination and feminist jurisprudence texts commonly used in American law schools.⁸ Childbirth and midwifery are also absent as a distinct subject in the Model Curriculum on Reproductive Rights, Law and Justice developed by Law Students for Reproductive Justice, a national network that “educates, organizes, and supports law students to ensure that a new generation of advocates will be prepared to protect and expand reproductive rights as basic civil and human rights.”⁹ Meanwhile, women’s rights have been subtly and less-subtly violated by state actors—from legislatures and administrative agencies that restrict access to care providers, to courts and child welfare authorities that punish women for their birthing choices. As a result, the potential for feminist legal analysis of women’s rights in childbirth has not been fulfilled.

The goals of this Article are twofold. First, this Article will demonstrate that while birthing rights issues have been familiar areas of concern for feminist scholarship on women’s rights to privacy and equality, neglecting to integrate this work into the law school classroom fails to promote effective legal advocacy for pregnant women. The violation of women’s rights during childbirth is a more common problem than reported legal opinions indicate,¹⁰ and few lawyers are prepared to protect clients prospectively or to vindicate women’s rights post-childbirth.

Sarah D. Murphy, *Labor Pains in Feminist Jurisprudence: An Examination of Birthing Rights*, 8 AVE MARIA L. REV. 443, 443-71 (2010) (arguing the absence of birthing rights from feminist jurisprudence demonstrates a lack of concern in feminism for women’s lived experiences of motherhood, and contending this absence is due to the prominence of “radical feminism [a theory] . . . espoused by Catherine McKinnon”). The author believes “to emphasize birthing rights would be to legitimize motherhood,” and therefore, birthing rights fail to fit into a perceived feminist agenda. *Id.* at 470-71; see also Krista Stone-Manista, *In the Manner Prescribed by the State: Potential Challenges to State Enforced Hospital Limitations on Childbirth Options*, 16 CARDOZO J.L. & GENDER 496 (2010); Benjamin Grant Chojnacki, *Pushing Back: Protecting Maternal Autonomy from the Living Room to the Delivery Room*, 23 J.L. & HEALTH 45 (2010).

⁴ See, e.g., Nora Christine Sandstad, *Pregnant Women and the Fourteenth Amendment: A Feminist Examination of the Trend to Eliminate Women’s Rights During Pregnancy*, 26 LAW & INEQ. 171 (2008).

⁵ See Rebecca Kukla et al., *Finding Autonomy in Birth*, 23 BIOETHICS 1 (2009).

⁶ See CHRISTA CRAVEN, PUSHING FOR MIDWIVES: HOMEBIRTH MOTHERS AND THE REPRODUCTIVE RIGHTS MOVEMENT (2010).

⁷ See RAYMOND DEVRIES, MAKING MIDWIVES LEGAL: CHILDBIRTH, MEDICINE AND THE LAW (2d ed. 1996).

⁸ See KATHERINE T. BARTLETT & DEBORAH L. RHODE, GENDER AND LAW: THEORY DOCTRINE, COMMENTARY (4th ed. 2006); HERMA H. KAY & MARTHA S. WEST, CASES AND MATERIALS ON SEX-BASED DISCRIMINATION (6th ed. 2005); D. KELLY WEISBERG, FEMINIST LEGAL THEORY (1996).

⁹ *Motivation*, LAW STUDENTS FOR REPRODUCTIVE JUSTICE, http://lsrj.org/history_and_accomplishments/ (last visited Sept. 24, 2012). The model curriculum can be found at http://lsrj.org/documents/resources/LSRJ_Model_Curriculum_2d_ed.pdf. The curriculum includes a section entitled “General Pregnancy Rights” and “Forced Cesarean Sections,” but does not address the issue of women’s rights in childbirth specifically nor does it include any reference to midwives. *Model Curriculum for courses in Reproductive Rights Law & Justice*, LAW STUDENTS FOR REPRODUCTIVE JUSTICE 38-40 (2008), http://lsrj.org/documents/resources/LSRJ_Model_Curriculum_2d_ed.pdf.

¹⁰ See JENNIFER BLOCK, PUSHED: THE PAINFUL TRUTH ABOUT CHILDBIRTH AND MODERN MATERNITY CARE (2007).

This Article begins with a description of the doctrinal categories of law that individual birthing rights implicate, and illustrates, through a discussion of coerced and court-ordered cesarean sections, how feminist scholarship has called into question whether those protections are equally afforded to pregnant women. Detailed analysis will show how various courts have applied or misapplied precedent and relied on medical authority to the detriment of a woman's constitutional right to bodily integrity. The cases discussed below illustrate the ways in which violations of women's birthing rights become evident and demonstrate a profound disrespect for women as individuals with equal civil and human rights. These cases also reveal troubling racial and ethnic disparities, as the case law has unequally been targeted towards minority women.¹¹

Second, this Article connects violations of women's rights in childbirth with women's unequal ability to access maternity care outside of the hospital. Focusing on legislative efforts to increase access to midwives, this Article suggests that the interplay between individual affronts to women's rights and state prohibition of midwifery can be a convergence point for future feminist legal scholarship from an intersectional perspective. The Article then analyzes the effect of limiting maternity care options for women by discussing the legal status of direct-entry midwives and the impact of the legal status of midwives on the women they serve. Prohibitions against midwifery are a significant threat to women's birthing rights because they make access to care more difficult and because legal restrictions against midwifery are emblematic of violations of birthing rights in general. Failure to address these interconnected and interdependent issues in the classroom represents a tremendous missed opportunity, at the very least because approximately eighty-five percent of women will carry a pregnancy to term and give birth at some point during their reproductive lives.¹²

PUTTING RIGHTS IN CONTEXT: MATERNITY CARE IN THE UNITED STATES

The United States is one of the highest spenders of all industrialized countries on healthcare. In 2008, healthcare costs amounted to about 16.2% of the nation's gross domestic product.¹³ Most births in the United States occur in hospitals.

¹¹ See Veronica E.B. Kolder et al., *Court-Ordered Obstetrical Interventions*, 316 NEW ENG. J. MED. 1192, 1193 (1987) (reporting the results of a national survey on court-ordered interventions, in which 81% of respondents were non-white women and 24% of respondents were women for whom English was not their primary language); see also Nancy Ehrenreich, *The Colonization of the Womb*, 43 DUKE L.J. 492 (1993) (analyzing the fact that courts have been willing to coercively intervene in certain women's reproductive lives as a power struggle over the control of reproduction and the meaning of motherhood).

¹² CTR. FOR DISEASE CONTROL AND PREVENTION, RECOMMENDATIONS TO IMPROVE PRECONCEPTION HEALTH AND HEALTH CARE — UNITED STATES: A REPORT OF THE CDC/ATSDR PRECONCEPTION CARE WORK GROUP AND THE SELECT PANEL ON PRECONCEPTION CARE (2006), available at <http://www.cdc.gov/mmwr/PDF/rr/rr5506.pdf>.

¹³ *Background Brief: U.S. Healthcare Costs*, KAISER FAMILY FOUNDATION, <http://www.kaiseredu.org/Issue-Modules/US-Health-Care-Costs/Background-Brief.aspx> (last visited Sept. 24, 2012).

However, in 2006, there were 38,568 out-of-hospital births in the United States, including 24,970 home births, and 10,781 births occurring in freestanding birthing centers.¹⁴ With over 4.2 million births in 2008, pregnancy and delivery is the most common reason for hospitalization, and about thirty percent (1.4 million) of births occur by cesarean section.¹⁵ Maternity care is a major cost to both private and public health care payers, including twenty-six percent of costs to Medicaid and thirty-five percent of charges billed to private insurance companies.¹⁶ For many women, the experience of pregnancy and childbirth is their first experience as a patient within the health care system. For the high cost of modern maternity care in the United States, the outcomes for women and babies are comparatively poor,¹⁷ disproportionately so for women and children of color.¹⁸

Law has the power to preserve the status quo, and it also has the ability to play a part in improving the maternity care that women receive and healthcare outcomes. A question for feminist legal scholars and feminists working in women's health, therefore, is how law can work towards achieving justice for birthing women.¹⁹

I. RIGHTS AND CHILDBIRTH

The right to bodily integrity is protected as a fundamental right under the penumbra of rights protected by the Fourteenth Amendment.²⁰ The law has extended this right to healthcare situations through the doctrine of informed consent and its corollary, informed refusal.²¹ Professor B. Jessie Hill observes that there are two distinct lines of constitutional doctrine related to the right to make health care decisions,²² which serve as a framework to connect the discussion of individual women's decisions about healthcare during pregnancy with the

¹⁴ Marian F. MacDorman, et al., *Trends and Characteristics of Home and Other Out-of-Hospital Births in the United States, 1990–2006*, NATIONAL VITAL STATISTICS REPORTS (2010), http://www.cdc.gov/nchs/data/nvsr/nvsr58/nvsr58_11.PDF.

¹⁵ *U.S. Maternity Care Facts and Figures*, CHILDBIRTH CONNECTION, <http://www.childbirthconnection.org/article.asp?ck=10621>.

¹⁶ *Id.* The data reports that the average payment for vaginal childbirth in the United States exceeds \$8,000, for cesarean birth, the payment exceeds \$13,000. *Id.*

¹⁷ According to Amnesty International, a woman in the United States has a greater lifetime risk of dying during pregnancy or birth than women in 40 other countries. Amnesty International, *Deadly Delivery: The Maternal Healthcare Crisis in the USA 1* (2010), available at <http://www.amnestyusa.org/dignity/pdf/DeadlyDelivery.pdf>.

¹⁸ *Id.* (documenting poor outcomes and barriers to care for minority women, undocumented immigrant women, and women who rely on Medicaid for health care coverage).

¹⁹ See Dawn Johnsen, *Shared Interests: Promoting Healthy Births Without Sacrificing Women's Liberty*, 43 HASTINGS L.J. 569 (1992).

²⁰ See *Rochin v. California*, 342 U.S. 165 (1952) (finding that the state cannot force a suspect in a criminal case to have his stomach pumped), cited in *Washington v. Glucksberg*, 521 U.S. 702, 720 (1997).

²¹ Nan Hunter, *Rights Talk and Patient Subjectivity: The Role of Autonomy, Equality, and Participation Norms*, 45 WAKE FOREST L. REV. 1525, 1528 (2010) [hereinafter, Hunter, *Rights Talk*].

²² B. Jessie Hill, *The Constitutional Right to Make Medical Treatment Decisions: A Tale of Two Doctrines*, 86 TEX. L. REV. 277, 277-78 (2007).

discussion of state regulation of midwifery. Hill's thesis deals with patients' rights to affirmatively choose treatments from effective—but not legally recognized—options. She describes two lines of cases in constitutional law: the public-health line, which emphasizes “the police power of the state over individual rights,” and the autonomy line, which emphasizes “individual bodily integrity and dignity interests.”²³ She notes that while the cases have developed in parallel, “appearing to represent airtight doctrinal categories,” they actually interpret the same fundamental question of “whether an individual has a constitutional right to protect her health by making autonomous decisions about medical treatment.”²⁴ Birthing rights have never reached the Supreme Court, but state courts have likewise dealt with the individual rights and public health aspects of birth in these categories. Hill concludes, as this Article similarly finds, that the “constitutional right to protect one's health should be consistently recognized; that the recognition of this right should not be artificially limited by excessive deference to . . . findings of medical fact; and that this right will have to be carefully balanced against the state's real and legitimate interest” in regulating public health.²⁵ In considering the ways in which reproductive justice strives to protect individual *and* collective women's rights in childbirth, Hill's insight highlights the false separation between public health and autonomy.²⁶

A. Informed consent and informed refusal of medical treatment

The origin of informed consent and informed refusal in American common law finds its home in the nineteenth and early-twentieth century tort law of battery. The tort of battery consists of intentionally causing harmful or offensive contact with the person of another, regardless of whether harm is ultimately caused.²⁷ The

²³ *Id.* at 278.

²⁴ *Id.*

²⁵ *Id.* at 282. Hill's paper compares the Supreme Court's and federal courts' decisions related to medical marijuana and “partial-birth” abortions. Hill's framework explicitly assumes that a “doctor and patient have agreed on a particular course of treatment that . . . is prohibited by law.” *Id.* at 345 n.16.

²⁶ According to Hill's framework, *Jacobson v. Mass.* represented the first of the “public health” line of cases emphasizing police power over individual rights. Hill, *supra* note 22, at 297-98 (“[T]he liberty secured by the Constitution of the United States to every person within its jurisdiction does not import and absolute right in each person to be, at all times and in all circumstances, wholly freed from restraint.” (quoting *Jacobson v. Mass.*, 197 U.S. 11, 26-27 (1905))). Hill discusses the Court's decision to exclude the plaintiff's evidence of the potential harm of vaccinations which closely parallels some courts' decisions to disregard or downplay evidence women present in defense of their birthing choices or supporters of midwifery present in defense of midwives and/or access to midwifery practice. The reasoning in *Jacobson* has been specifically used to restrict reproductive liberties in *Buck v. Bell*, where the court stated that “[t]he principle that sustains compulsory vaccination is broad enough to cover cutting the Fallopian tubes[.]” *Id.* at 300 (quoting *Buck v. Bell*, 274 U.S. 200, 207 (1927)). The autonomy line of cases begins with *Griswold v. Connecticut* and the right to protect one's own health by making autonomous medical treatment decisions by recognizing individual dignity interests. *Id.* at 312.

²⁷ RESTATEMENT (SECOND) OF TORTS § 18 cmt. c (2006) (“[T]he plaintiff's grievance consists in the offense to the dignity involved in the unpermitted and intentional invasion of the inviolability of his person and not in any physical harm done to his body . . . [and] it is not necessary that the plaintiff's actual body be disturbed.”).

United States Supreme Court began to articulate this protection for the first time in *Union Pacific Railway Co. v. Botsford*, in 1891, where the Court found that:

No right is held more sacred, or is more carefully guarded by the common law, than the right of every individual to the possession and control of his own person, free from all restraint or interference of others, unless by clear and unquestionable authority of law . . . To compel any one, and especially a woman, to lay bare the body, or to submit it to the touch of a stranger, without lawful authority, is an indignity, an assault, and a trespass.²⁸

As the doctrine expanded to the context of the physician-patient relationship, Justice Cardozo, then serving on the New York Court of Appeals, found that “[e]very human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient’s consent commits an assault, for which he is liable in damages.”²⁹ Scholars have cited this case as “early evidence for the women’s health movement,” and a “protofeminist departure point for resistance of women patients to a broad range of misogynist practices in later decades[,]” in part because the case involved a woman who underwent a hysterectomy without her consent.³⁰

The informed consent doctrine reflects the dominant value placed on bodily autonomy, and it introduced the idea of the patient as a rights-bearing subject in American jurisprudence.³¹ The concept of informed consent has evolved to include a positive physician-centered duty sounding in negligence, rather than battery, requiring doctors to provide patients with information critical to decision making.³² Courts have determined that a physician must give the patient the information necessary to understand the consequences of a medical decision, the risks and benefits of the proposed treatment, and the alternatives, including the alternative of doing nothing.³³ Depending on the jurisdiction, some courts adopt a physician-centered standard, which is based on what information a reasonable physician would provide, while others take a patient-centered approach, requiring

²⁸ *Union Pacific Ry. Co. v. Botsford*, 141 U.S. 250, 251-52 (1891) (holding that the circuit court has no power to compel a woman who is the plaintiff in a personal injury action to submit to a surgical examination as to the extent of her injury sued for without her consent). The language in this statement suggests that there is a unique level of gender-specific indignity experienced by a woman forced to receive treatment.

²⁹ *Schloendorff v. Soc’y of N.Y. Hosp.*, 105 N.E. 92, 93 (1914) (finding that a physician could be liable for operating on a patient who had consented only to examination).

³⁰ Hunter, *Rights Talk*, *supra* note 21, at 1531.

³¹ *Id.* at 1529. For a discussion about the development of informed consent in law and ethics, see RUTH R. FADEN & TOM L. BEAUCHAMP, *A HISTORY AND THEORY OF INFORMED CONSENT* (1986). According to Hunter, extensive historical analysis of this subject remains to be done, and would include the influence of movements such as the right-to-die campaigns, the disability rights movement, and others. Hunter, *Rights Talk*, *supra* note 21, at 1549 n.13.

³² Jamie Staples King & Benjamin Moulton, *Rethinking Informed Consent: The Case for Shared Medical Decision Making*, 32 AM. J.L. & MED. 429, 437 (2006).

³³ *See, e.g., Canterbury v. Spence*, 464 F.2d 772 (D.C. Cir. 1972).

doctors to provide information that a reasonable patient would deem necessary.³⁴ The emphasis on a patient's understanding and appreciation of the options underscores the belief that the patient—rather than the doctor—is in the best position to determine which risks she will accept,³⁵ and represents an important integration of the concept of autonomy in the common law of informed consent.³⁶

Courts have upheld a patient's right to refuse medical treatment, even when the refusal will lead to the death of another person.³⁷ In an oft-quoted articulation, a Pennsylvania court refused to compel a man to submit to a bone marrow transplant in order to save the life of his cousin, who was dying of leukemia.³⁸ Such an order would “change every concept and principle upon which our society is founded. To do so would defeat the sanctity of the individual, and would impose a rule which would know no limits[.]”³⁹ The court noted that the man's refusal was morally indefensible, but legally could not be overridden because he was under no legal duty to rescue another person.⁴⁰

The Constitution likewise protects informed refusal of unwanted medical procedures. The Supreme Court held that an individual maintains a constitutionally protected liberty interest in refusing treatment, even when her life is at risk.⁴¹ As with many other constitutional protections, however, the right to refuse medical treatment is not absolute, as it can be weighed against state interests.⁴² The state may weigh the individual's liberty interest against its own interests in preventing homicide and suicide, protecting innocent third parties, maintaining the ethical integrity of the medical profession, and preserving human life.⁴³ In the context of an individual's right to consent to medical treatment, and surgery in particular, the Supreme Court has emphasized that risk to the patient weighs heavily against the interest of the state, as does the extent of the intrusion and the reason the state seeks to intrude.⁴⁴ In cases where an individual's decision to accept or to refuse treatment impacts only the individual person, courts have taken an extremely

³⁴ King & Moulton, *supra* note 33, at 438. For a discussion of the foundational cases under each standard, see *id.* at 439-47.

³⁵ See Nancy K. Rhoden, *The Judge in the Delivery Room: The Emergence of Court-Ordered Cesareans*, 74 CAL. L. REV. 1951, 1969 (1986).

³⁶ FADEN & BEAUCHAMP, *supra* note 31, at 43.

³⁷ McFall v. Shimp, 10 Pa. D. & C.3d 90 (Pa. Com. Pl. 1978).

³⁸ *Id.* at 91.

³⁹ *Id.*

⁴⁰ *Id.*

⁴¹ Cruzan v. Dir., Mo. Dept. of Health, 497 U.S. 261 (1990); *but see* Sell v. United States, 539 U.S. 166 (2003) (holding that the state may force defendants awaiting trial to receive antipsychotic drugs if the treatment is medically appropriate and the defendant is dangerous).

⁴² See, e.g., Winston v. Lee, 470 U.S. 753, 760 (1985) (weighing the individual's interest in privacy and bodily integrity against society's interest in conducting the procedure, and holding the Fourth Amendment protected the robbery suspect from being forced to undergo surgery to remove a bullet that could be used as evidence against him).

⁴³ See *Cruzan*, 497 U.S. at 282.

⁴⁴ *Winston*, 470 U.S. at 761 (holding the surgery and its attendant risks were overly intrusive and therefore, those risks outweighed the state's interest in obtaining evidence of a crime).

cautious approach to permitting forced medical treatment. However, as will be shown below, pregnancy sometimes invokes a separate set of rules.

B. Birthing Rights Violations: Illustrative Cases

Feminist scholars have argued that depriving women of their rights during pregnancy deprives women of legal personhood,⁴⁵ diminishes women's autonomy, and derogates women's claim to full citizenship.⁴⁶ Nevertheless, many courts have deprived women choosing between different modes of delivery of their rights to informed consent and refusal by over-relying on evidence from medical providers, and by misapplying abortion law to women not seeking abortions. This Section deals with several instances of court-ordered intervention during childbirth that have appeared in reported cases in the United States since the early 1980s.

Courts have generally taken one of two approaches in resolving the matters. One approach involves an explicit balancing of a woman's rights against an asserted state interest in the fetus.⁴⁷ Under the second approach, courts analyze whether or not pregnancy diminishes a competent adult's right to refuse medical treatment even in life-threatening emergencies.⁴⁸ Using the first approach, courts rely upon a state interest in fetal life based on the holding of *Roe v. Wade*,⁴⁹ despite the fact that *Roe* declined to acknowledge a state interest in fetal life except insofar as to permit states to regulate abortion.⁵⁰ In nearly all cases where a balancing test is applied, the state's interest in the fetus is found to trump the woman's liberty- or privacy-based right to refuse the recommended medical care. Women prevail only when courts find that a pregnant woman, like any other adult, is protected in her right to determine the medical care she wishes to receive.

The first example of the balancing strategy can be seen in the case of Jessie Mae Jefferson, who was court-ordered to submit to a cesarean section after she refused on religious grounds.⁵¹ Two concurring opinions demonstrate the judicial approach to the decision as a balancing between the woman's right to refuse surgery for herself, and the state's interest in protecting fetal life: one judge affirmed that "the power of a court to order a competent adult to submit to surgery is exceedingly limited. Indeed, until this unique case arose, I would have thought

⁴⁵ Dawn Johnsen, *The Creation of Fetal Rights: Conflicts with Women's Constitutional Rights to Liberty, Privacy, and Equal Protection*, 95 YALE L.J. 599, 620 (1986).

⁴⁶ April Cherry, *Roe's Legacy: The Nonconsensual Medical Treatment of Pregnant Women and Implications for Female Citizenship*, 6 U. PA. J. CONST. L. 723, 725 (2006).

⁴⁷ See, e.g., *Jefferson v. Griffin Spalding Cnty. Hosp. Auth.*, 274 S.E.2d 457, 457 (Ga. 1981); *In re A.C.*, 573 A.2d 1235, 1249, 1254, 1259 (D.C. 1990).

⁴⁸ See, e.g., *In re A.C.*, 573 A.2d. 1235, 1245-46 (D.C. 1990); *In re Baby Boy Doe*, 632 N.E.2d 326, 401 (Ill. App. 1994).

⁴⁹ *Roe v. Wade*, 410 U.S. 113, 163-65 (1973) (demonstrating that personhood status for the fetus is not necessary to erode women's rights in childbirth).

⁵⁰ *Id.*; Cherry, *supra* note 46.

⁵¹ *Jefferson*, 274 S.E.2d at 457.

such power to be nonexistent.”⁵² However, the court concluded that the right to refuse treatment is not enjoyed by an “expectant mother in the last weeks of pregnancy.”⁵³

In the *Jefferson* case, Georgia’s child protective service agency petitioned for temporary custody of the fetus as “a deprived child without proper parental care.”⁵⁴ Relying on *Roe v. Wade*, the court reasoned that since it would be a crime to abort the fetus in Georgia, it was “appropriate to infringe upon the wishes of the mother to the extent . . . necessary to give the child an opportunity to live.”⁵⁵ The court granted the order to carry out the surgery, concluding that a viable human being—i.e., the fetus—was entitled to state protection.⁵⁶

Following this approach, a court ordered cesarean surgery in a 1986 case of a nineteen-year-old first time mother in Washington, D.C.⁵⁷ The woman, Ms. Madyun, and her husband arrived at D.C. General Hospital, where a physician recommended an immediate cesarean, citing an increased risk of infection with each hour after the water breaks.⁵⁸ The woman’s water had been broken for seventy hours. Madyun understood the increased risk of infection, but refused the surgery because there were no objective indications that she or her fetus was in distress.⁵⁹ When the hospital petitioned the court to order the surgery, Madyun and her husband were represented by counsel and the fetus was appointed a guardian ad litem in an emergency hearing.⁶⁰ The couple cited their religious belief that, in the Muslim faith, women decide what risks are appropriate to take for themselves and their babies in childbirth.⁶¹ The physician requesting the order testified that there was a 50-75% risk of sepsis if the fetus was not delivered immediately; in contrast,

⁵² *Id.* at 460.

⁵³ *Id.* (citing *Raleigh Fitkin-Paul Morgan Memorial Hosp. v. Anderson*, 201 A.2d 537 (N.J.), *cert. denied*, 377 U.S. 985 (1964)) (holding that a woman pregnant with a viable fetus had no right to refuse a life-saving blood transfusion). The court in *Anderson* found that “because the welfare of the child and mother are so intertwined and inseparable [it] would be impracticable to attempt to distinguish between them.” *Anderson*, 201 A.2d at 538.

⁵⁴ *Jefferson*, 274 S.E.2d at 460.

⁵⁵ *Id.* at 458.

⁵⁶ *Id.* at 459.

⁵⁷ Cynthia Gorney, *Whose Body is it, Anyway? The Legal Maelstrom That Rages When The Rights of Mother and Fetus Collide*, WASH. POST (Dec. 13, 1988), available at <http://www.highbeam.com/doc/1P2-1295209.html>.

⁵⁸ *Id.* Madyun and her husband first attended Greater Southeast Community Hospital and were turned away for lack of insurance. This case occurred the year that the Emergency Medical Treatment and Active Labor Act, a federal law prohibiting hospitals from turning away women in active labor, was enacted in 1986. *Id.*

⁵⁹ *Id.*

⁶⁰ *In re Madyun*, 114 Daily Wash.L.Rptr. 2233 (D.C. Super. Ct. 1986). Ayesha Madyun was not represented as herself, but as one of the parents of Fetus Madyun. The opinion notes that Mr. Madyun was given the opportunity to consent to the surgery, and also refused. *Id.* The opinion of Superior Court Judge Richard A. Levie in *In re Madyun* also appears as an Appendix to *In re A.C.*, 573 A.2d 1235 app. (D.C. 1990).

⁶¹ *Id.*

if the fetus was delivered immediately, the risk to the woman was only 0.25%.⁶²

Citing *Roe v. Wade* and *Jefferson v. Griffin Spalding*, the *Madyun* court asserted that the state's "important and legitimate" interest in the potentiality of human life becomes compelling at the time of viability.⁶³ Further, the court found that the law affecting the state's power to protect a child *already born* applied to these facts because the pregnant woman was at term and ready to deliver.⁶⁴ The court noted:

All that stood between the Madyun fetus and its independent existence, separate from its mother, was, put simply, a doctor's scalpel. . . . It is one thing for an adult to gamble with nature regarding his or her own life; it is quite another when the gamble involves the life or death of an unborn infant.⁶⁵

The judge took notice of the apparent "sincer[ity]" of the Madyuns' religious beliefs, but asserted that their "stronger [reason]" for refusing the surgery was their opinion that other measures could be taken to encourage spontaneous delivery.⁶⁶ The court refused to "ignore the undisputed opinion of a skilled and trained physician to indulge the desires of the parents."⁶⁷ Given the "significant" risk to the fetus and the "minimal" risks to Madyun, the cesarean was ordered.⁶⁸ The deference to one physician's opinion to the exclusion of the pregnant woman's expressed needs and beliefs demonstrates the court's unabashed preference for medical knowledge.

Soon after, courts began to adopt the second approach for resolving hospital requests to compel women to undergo cesarean surgery. In an en banc decision, vacating a lower court order, the D.C. Court of Appeals held that the medical decisions of a pregnant woman could not be overridden, even if a viable fetus would be harmed by the choice.⁶⁹ In that case, a woman was twenty-six weeks pregnant when her doctors discovered terminal cancer, and she was expected to live only a few days. The hospital sought the court's counsel to determine what should be done, fearing litigation if no effort was made to preserve the life of the fetus.⁷⁰

⁶² Although the physician testified that an immediate cesarean posed a 0.25% risk to the woman, the opinion does not indicate the nature of the potential harm to the woman. *Id.*

⁶³ *In re A.C.*, 573 A.2d app. at 1262

⁶⁴ *Id.*

⁶⁵ *Id.* at 1262-63.

⁶⁶ *Id.* at 1263.

⁶⁷ *Id.* (citing *Prince v. Mass.*, 321 U.S. 158, 170 (1944) ("Parents may be free to become martyrs themselves. But it does not follow they are free, in identical circumstances, to make martyrs of their children[.]"). The record also indicates that the physician was a resident; there is no evidence of a second opinion from an experienced supervisor. *Id.* at 1261.

⁶⁸ *Id.* at 1264.

⁶⁹ *In re A.C.*, 573 A.2d 1235 (D.C. 1990).

⁷⁰ See Margaret Diamond, *Echoes From Darkness: The Case of Angela C.*, 51 U. PITT. L. REV. 1061 (1990) for a detailed factual account of the case of *In re A.C.* The fact that the hospital, rather than the treating physicians, initiated the court order, shows that the patient-physician relationship in modern medicine must be understood as part of an institutional health care system.

At a hearing that occurred in the hospital the next morning, Carder and her fetus were represented separately.⁷¹ Physicians testified that the woman would not survive surgery and the fetus was given a fifty-to-sixty percent chance of survival.⁷² The woman and her family opposed surgery given these odds; nevertheless the order was granted.⁷³ In an emergency appellate panel held over the telephone, the attorney for the hospital argued that “unintended consequences on the mother” are “insignificant in respect to the mother’s very short life expectancy.”⁷⁴ Surgery was performed and the baby survived for two hours. Carder survived the surgery and regained consciousness long enough to learn of the court order and the death of her child, and then she died a few days later.⁷⁵

The court found that the right to forgo medical treatment is of constitutional magnitude, and involves a right to bodily integrity that is “not extinguished simply because someone is ill, or even at death’s door[,]”⁷⁶ or, importantly, even when that person is pregnant. The en banc decision rejected the lower court’s finding that the fetus was an innocent third party entitled to the state’s protection.⁷⁷ Instead, the court cited *McFall v. Shimp* to support the notion that there is no general legal duty to rescue, and, furthermore, that “a fetus cannot have rights . . . superior to those of a person who has already been born.”⁷⁸ In addition to the critical recognition of the strength of a woman’s liberty interest during pregnancy, two policy reasons supported the decision: first, the American Public Health Association’s argument that coerced treatment would erode the trust between women and doctors and drive high-risk women out of the health care system; and second, the procedural shortcomings in such time sensitive circumstances do not allow adequate ability for the woman to organize a defense.⁷⁹

Four years later, an Illinois appellate court’s decision indicated that perhaps the *In re A.C.* decision would signal the end of courts’ implementation of balancing tests used to determine whether a court can override a competent woman’s refusal of cesarean surgery. In *In re Baby Boy Doe*, the court held that a woman’s decision not to undergo a cesarean section must be honored, despite potential harm to a viable fetus.⁸⁰ Tabita Bricci, a 22-year-old immigrant from Romania,⁸¹ was 35 weeks pregnant when her physician recommended immediate delivery via cesarean

⁷¹ *In re A.C.*, 573 A.2d 1235, 1239 (D.C. 1990).

⁷² *Id.* Carder’s physician also testified that she had approximately twenty-four hours to live, no matter what else was done. *Id.*

⁷³ *Id.*

⁷⁴ Diamond, *supra* note 70, at 1065.

⁷⁵ *Id.* at 1062, 1066.

⁷⁶ *In re A.C.*, 573 A.2d 1235, 1247 (D.C. 1990).

⁷⁷ Diamond, *supra* note 70, at 1066-67.

⁷⁸ *In re A.C.*, 573 A.2d at 1244.

⁷⁹ *Id.* at 1248. Over thirty amicus briefs were filed with the court. *See* Diamond, *supra* note 70, 1095 n.5.

⁸⁰ *In re Baby Boy Doe*, 632 N.E.2d 326, 401 (Ill. App. 1994).

⁸¹ Tracy Shryer, *Woman at Center of Dispute Gives Birth*, L.A. TIMES, Dec. 31, 1993.

section or induction of labor.⁸² She refused on religious grounds, stating that her Pentecostal Christian faith instructed her to deliver vaginally.⁸³ The hospital and the doctor sought a court order to compel immediate surgical delivery, first by seeking wardship of the fetus, and then by seeking to appoint a guardian to Bricci.⁸⁴ The U.S. Supreme Court denied certiorari several months later.⁸⁵

In *Baby Boy Doe*, the Illinois appellate court considered the various legal frameworks under which forced treatment decisions could be made. First, the court cited an absolute right to refuse medical treatment under Illinois common law.⁸⁶ Turning to the question of duty, the court noted that “[a] woman is under no duty to guarantee the mental and physical health of her child at birth, and thus cannot be compelled to do or not do anything merely for the benefit of her unborn child.”⁸⁷ The court used the rationale that “a woman’s right to refuse invasive medical treatment, derived from her rights to privacy, bodily integrity, and religious liberty, is not diminished [by] pregnancy,” and “the woman retains the same right to refuse invasive treatment, even of lifesaving or other beneficial nature, that she can exercise when she is not pregnant[.]” because “[t]he potential impact upon the fetus is not legally relevant.”⁸⁸

While it explicitly reinforced the right of a pregnant woman to refuse treatment even when it would save the life of her fetus, the *Baby Boy Doe* court engaged in an analysis of the level of risk that was acceptable to compel treatment.⁸⁹ The court firmly decided that Illinois courts must not engage in a balancing of interests of the type seen in *Jefferson v. Griffin Spalding*. The court cited *Cruzan* to uphold Bricci’s due process right under the Fourteenth Amendment to refuse unwanted medical treatment, stating that the *Jefferson* court had either failed to recognize or failed to appreciate the magnitude of the constitutional

⁸² *In re Baby Boy Doe*, 632 N.E.2d at 327.

⁸³ *Id.*

⁸⁴ *Id.* The State later withdrew its petition for wardship. *Id.* at 330.

⁸⁵ *Id.* (cert. denied 510 U.S. 1168 (1994)).

⁸⁶ *In re Baby Boy Doe*, 632 N.E.2d at 330.

⁸⁷ *Id.* at 332.

⁸⁸ *Id.* at 401 (citing *Stallman v. Youngquist*, 531 N.E.2d 355, 360 (Ill. App. Ct. 1988) (holding that a fetus had no cause of action against its mother for prenatal injuries, and that only a legislature could make such a profound change to the law)). For a detailed analysis of this case and a comparative discussion of court-ordered cesareans in the United Kingdom, see SHEENA MEREDITH, *POLICING PREGNANCY: THE LAW AND ETHICS OF OBSTETRIC CONFLICT* (2005). When faced with similar cases, British courts have ruled that all competent individuals, regardless of pregnancy status, have an absolute right to refuse surgery for any reason *or for no reason at all*. This is the analysis that gender justice requires if women are to be free and equally autonomous decision makers over their own bodies, lives, and health; however, it is rare for American courts not to demand women’s reasons for their reproductive decisions. *Id.* See also Beth A. Burkstrand-Reid, *The Invisible Woman: Availability and Culpability in Reproductive Health Jurisprudence*, 81 U. COLO. L. REV. 97, 144 (2010) (discussing cases in which the judges appear to blame women for the lack of available reproductive health services or procedures, including physicians who would attend them in the birth they desire).

⁸⁹ *In re Baby Boy Doe*, 632 N.E.2d 326.

questions at hand.⁹⁰ However, the *Baby Boy Doe* court left open the possibility that “relatively non-invasive and risk-free procedure[s],” such as blood transfusions, might be compelled consistently with its holding.⁹¹ It seemed from this court’s opinion that the magnitude of the constitutional interest may be related to the magnitude of the intervention and the risk to the woman as opposed to the fetus.

As we have seen, courts need no help deferring to the analysis and distribution of risk presented by a physician or hospital. One reason may be that the hearings are conducted with inadequate procedural due process: over the telephone, at the bedside of laboring woman, often without representation, and with the woman unable to retain counsel or mount a thorough defense of her legal rights.⁹² However, if courts fail to recognize the constitutional magnitude of a woman’s rights, they maintain this deference to physician opinion, even when the woman appears with her own experts.

For example, in 1996, a civil rights lawsuit ensued after a sheriff was dispatched to drag the laboring Laura Pemberton from her home to undergo a court-ordered cesarean.⁹³ Pemberton filed an action against state for violations of her constitutional rights, for false imprisonment, and for medical malpractice, but the court found no constitutional violations.⁹⁴ Using *Roe v. Wade* as its authority, the court rejected the claimed violations of substantive and procedural rights under the First, Fourth, Eighth and Fourteenth Amendments.⁹⁵

The court noted that Ms. Pemberton’s desire only to avoid a “certain procedure” for giving birth, rather than complete avoidance of childbirth altogether, justified the invasion of her bodily integrity.⁹⁶ Furthermore, the court did not ascertain the legal relevance of which party should be responsible for evaluating

⁹⁰ *Id.* at 331.

⁹¹ *Id.* at 333. The court answered this question in the negative several years later. *In re Fetus Brown*, 689 N.E.2d. 397 (Ill. App. Ct. 1997) (holding that compelling a blood transfusion was inconsistent with a pregnant woman’s liberty interests).

⁹² In *Burton v. Florida*, a judge wrote in his concurring opinion, “the proceeding below violated Samantha Burton’s constitutional right to appointed counsel in this case. Accordingly, I would reverse on these constitutional grounds as well.” 49 So.3d 263, 266 (Fla. 1st Dist. Ct. App. 2010) (Van Nortwick, J., concurring).

⁹³ See BLOCK, *supra* note 10, at 249. The court notes that she and her husband left the hospital “surreptitiously” against medical advice. *Id.*

⁹⁴ *Pemberton v. Tallahassee Mem’l Reg’l Med. Ctr. Inc.*, 66 F.Supp.2d. 1247, 1250 (N.D. Fla. 1999). At the initial hearing where a state court judge authorized the procedure, Pemberton did not have a lawyer present, demonstrating the problems with ensuring due process protections for bedside court orders of cesarean surgery. *Id.*

⁹⁵ *Id.* at 1251. According to the court, the state’s compelling interest in the life of the fetus under *Roe* permits a state to force woman in the third trimester of pregnancy “to bear a child she does not want[.]” *Id.* at 1252 n.9. Therefore, “whatever the scope of Ms. Pemberton’s personal constitutional rights in this situation, they clearly did not outweigh the interests of the State of Florida in preserving the life of the unborn child.” *Id.*

⁹⁶ *Id.* at 1253. The court characterized Pemberton’s case as “extraordinary and overwhelming[.]” *Id.* at 1254. It was the sort of case to which the *In re A.C.* court had left the door open for possible coercive action. *Id.* at 1257 n.18.

and deciding between risks of surgery and risks of a poor outcome if surgery were avoided.⁹⁷ Pemberton presented her own account of the risk of foregoing the recommended cesarean, which the court decried as “bravado” in presenting evidence contrary to the hospital physicians.⁹⁸ Although plaintiff’s evidence was given by Dr. Marsden Wagner, an international expert on childbirth and a former director of maternal-child health at the World Health Organization, the court characterized this as the “rhetoric” of an “advocate.”⁹⁹

Misuse of abortion-related precedent and extreme deference to physician opinion continues to put birthing women’s rights in peril. In 2009, a Florida court forced a Samantha Burton to comply with medical orders for bed rest and to eventually undergo a cesarean.¹⁰⁰ Burton was in her twenty-fifth week of pregnancy and wanted to leave the hospital in order to seek a second opinion after a doctor had ordered bed rest for the remaining fifteen weeks of gestation. When she appealed the decision, an appellate court held that the appropriate test to overcome a woman’s right to refuse medical intervention during pregnancy is whether the state’s interest is sufficient to override her constitutional right to the control of her person.¹⁰¹

The appellate court decided that the state had not met the necessary threshold showing of a state interest sufficient to trigger the balancing test;¹⁰² that is, the state did not show that the fetus was viable.¹⁰³ As the state had made no such showing, balancing was not employed and Burton prevailed. The court also concluded that the state would have to show that the proposed method for pursuing the compelling state interest is “narrowly tailored in the least intrusive manner possible to safeguard the rights of the individual.”¹⁰⁴ If, as in many cases of compelled treatment for childbirth, the pregnant woman has little or no due process and no legal representation, once the balancing stage is reached, the definition of “narrowly tailored” and “least intrusive manner” could be entirely left to whatever the physician or hospital presents to the court.

While the *Burton* court ultimately ruled in favor of the pregnant woman, the case was not a victory for birthing rights. In fact, the decision left several questions unanswered, perhaps even putting women’s rights in more serious peril by returning to the flawed reliance on *Roe v. Wade* to define the state interest, just as the courts did in *Jefferson* and *Pemberton*. The *amicus* brief filed by the American

⁹⁷ See generally *id.*

⁹⁸ *Id.* at 1252.

⁹⁹ *Id.* at 1257 n.15.

¹⁰⁰ *Burton v. Florida*, 49 So.3d 263, 266 (Fla. 1st Dist. Ct. App. 2010). The compelled cesarean nevertheless resulted in a stillbirth—demonstrating that despite deference to medical opinion, the desired outcomes are not always achieved.

¹⁰¹ *Id.* (rejecting the best interest of the child standard).

¹⁰² *Id.* at 264.

¹⁰³ *Id.* at 265-66.

¹⁰⁴ *Id.* at 266 (citing *In re Guardianship of Browning*, 568 So. 2d 4, 14 (Fla. 1990)).

Civil Liberties Union and the American Medical Women's Association did not distinguish the holdings of *Roe* and its successors, none of which establish a state interest in a fetus outside of the context of prohibiting abortion.¹⁰⁵ The brief cited the *Roe* line of cases for the proposition that the Supreme Court "has repeatedly protected a woman's constitutional right to make independent medical decisions related to her pregnancy, including, ultimately, the choice whether to continue a pregnancy."¹⁰⁶ The *amici* also urged the court to distinguish *Burton* from *Pemberton* based on their facts, rather than offering a correct characterization to clarify what a state interest in fetal life properly consists of, and why that interest is inadequate to override the woman's right to bodily integrity through informed refusal.¹⁰⁷ If birthing women are to prevail against courts seeking to substitute their judgment for women's constitutional rights, feminist jurisprudence must build to teach students a nuanced analysis of how birthing rights can be distinguished from abortion. Without serious attention to this question in feminist jurisprudence courses, casebooks, and elsewhere, women will continue to be abandoned to exercise their rights in extremely hostile environments.¹⁰⁸

To feminists already concerned with birthing rights, these observations are not new. Scholars have been writing and thinking for decades about how women's relationship to the state is altered by pregnancy and childbirth, especially when the state forces women to accept treatment they do not want or fails to make available the means by which women can make decisions about their reproductive lives.¹⁰⁹ Nevertheless, courts have not caught up, and meanwhile, ever more hostile legislation that may have the effect of controlling the bodies and lives of pregnant women, such as fetal personhood laws, has been introduced.¹¹⁰ Violations of the

¹⁰⁵ *Burton v. Florida*, AMERICAN CIVIL LIBERTIES UNION (Aug. 13, 2010), available at <http://www.aclu.org/reproductive-freedom/burton-v-florida>. For a discussion on courts' error in applying *Roe* to override women's medical decisions not related to abortion, see Cherry, *supra* note 46, at 728 ("The expansion of the state's interest outside of the abortion context miscomprehends and diminishes the interest of the woman in her fetus and in her own health.").

¹⁰⁶ *Burton*, *supra* note 105. The *Roe* analogy is inadequate considering that the woman in *Burton* wanted to make a medical decision that was against her physician's advice. *Roe* undeniably frames the right to abortion for women whose doctors agree with that medical treatment decision. The court in *Roe* said, "the abortion decision and its effectuation must be left to the medical judgment of the pregnant woman's attending physician[.]" *Roe v. Wade*, 410 U.S. 113, 153 (1973).

¹⁰⁷ *Id.* at 178 n.7.

¹⁰⁸ In addition to the tool of court-ordered cesarean surgery, states have violated women's legal rights in childbirth by imposing child protective interventions on women who make their own decisions during childbirth. In New Jersey, a woman eventually lost custody of her child after her refusal to pre-authorize cesarean surgery—which was ultimately not needed—sparked concern about her mental well-being and prompted hospital authorities to contact child welfare. See N.J. Div. of Youth and Family Serv. v. V.M., 974 A.2d 448 (N.J. Sup. Ct. App. Div. 2009). See also, Jessica Waters, *In Whose Best Interest?* New Jersey Division of Youth and Family Services v. V.M. and B.G. and *the Next Wave of Court-Controlled Pregnancies*, 34 HARV. J. L. & GENDER 81 (2011).

¹⁰⁹ Harvard Law Review, *Rethinking Motherhood: Feminist Theory and State Regulation of Pregnancy*, 103 HARV. L. REV. 1325, 1326 (1990) ("As . . . fetal endangerment and the urgency of state regulation increase, the legal analysis must shift from an assumption of conflict to an acknowledgment of the interdependence of the maternal-fetal relationship.").

¹¹⁰ For example, Amendment 62 on the Colorado ballot in 2010 would have defined the term

constitutional rights of fully competent persons to make healthcare decisions related to childbirth serves to illustrate the unfinished work of securing women's dignity and equality under the law.

II. CHILDBIRTH OUTSIDE OF THE HOSPITAL: ACCESS TO MIDWIFERY CARE

A. Introduction

This Article argues that rather than remaining a glaring lacuna in feminist legal thought about reproductive rights and gender equality, birthing rights can be a point of convergence and growth for feminist legal scholars. Section I of this essay reviewed the ways in which “clinical medicine is a venue rife with power relations”¹¹¹ for birthing women; among those the relationship between the woman, her care provider and institution, and the state. This Section expands the analysis to include the relevant power relations at play when women seek maternity care outside of the biomedical model,¹¹² including midwifery. It does not retell the history of midwifery or its regulation, but rather, sets guideposts to several points of analysis that could be a fruitful area of exploration for feminist legal scholars, in particular, efforts to expand access to Certified Professional Midwives (“CPMs”), who serve women outside of the hospital.¹¹³

Support for midwives has been an area of focus for some feminist women's health advocates¹¹⁴ and mainstream feminist organizations,¹¹⁵ and is understood as

“person” in the Colorado Constitution “to include any human being from the beginning of the biological development of that human being.” *Colorado Fetal Personhood*, Amendment 62, Colo. Const. art. II, available at [http://www.leg.state.co.us/LCS/Initiative%20Referendum/0910InitRefr.nsf/0/ed0d797d3ffe6fb0872576f5005c1efd/\\$FILE/Amendment%2062.pdf](http://www.leg.state.co.us/LCS/Initiative%20Referendum/0910InitRefr.nsf/0/ed0d797d3ffe6fb0872576f5005c1efd/$FILE/Amendment%2062.pdf) (the measure was broadly defeated).

¹¹¹ Hunter, *Rights Talk*, *supra* note 21, at 1535.

¹¹² Throughout, I will use the term “biomedical” model to describe physician-led or hospital based maternity care for childbirth. For a detailed description of the difference between practice models and underlying philosophies between biomedicine and midwifery, see Suzanne Hope Suarez, *Midwifery is Not the Practice of Medicine*, 5 *YALE J.L. & FEMINISM* 315 (1993).

¹¹³ According to the National Association of Certified Professional Midwives (“NACPM”), the professional organization of CPMs, these midwives “practice as autonomous health professionals working within a network of relationships with other maternity care professionals,” and follow The Midwives Model of Care, which is based on the fact that pregnancy and birth are normal life events. The Model of Care includes: “monitoring the physical, psychological and social well-being of the mother throughout the childbearing cycle; providing the mother with individualized education, counseling and prenatal care, continuous hands-on assistance during labor and delivery and postpartum support; minimizing technological interventions; and identifying and referring women who require obstetrical attention.” NACPM, *What is a Certified Professional Midwife?*, <http://www.nacpm.org/what-is-cpm.html> (last visited Sept. 19, 2012).

¹¹⁴ See, e.g., *Letters Respond to Lancet Home Birth Editorial With Feminist Perspective*, OUR BODIES OURSELVES (Oct. 19, 2010), <http://www.ourbodiesourblog.org/blog/2010/10/letters-respond-to-lancet-home-birth-editorial-with-feminist-perspective> (responding to an editorial in British medical journal *The Lancet*, stating that “[w]omen have the right to choose how and where to give birth, but they do not have the right to put their baby at risk”).

¹¹⁵ 1999 National Organization for Women Conference Resolution, cited in CRAVEN, *supra* note 6, at 28.

a critical part of the reproductive justice framework.¹¹⁶ Like some feminist scholarship, “reproductive justice draws attention to cultural and socio-economic inequalities because everyone does not have equal opportunity to participate in society’s cultural discourses.”¹¹⁷ In discourses about pregnancy, this includes “public policy decisions based on cultural and economic values, such as abortion, midwifery and mothering.”¹¹⁸ Women seek alternatives to physician-directed maternity care for a variety of reasons ranging from personal safety and financial considerations to religious, cultural, and political beliefs.¹¹⁹ This is especially true for people who believe that the manner in which they give birth imparts deep meaning to their understanding of the world and their place within it. Many women across the United States who wish to give birth outside of a hospital or utilize midwifery-led care find their options restricted, and as reproductive justice advocate Loretta Ross notes, not everyone has the opportunity to make these choices equally.¹²⁰

A recent *Time* magazine article about women who give birth at home draws a connection between the illegal status of midwives and restrictions on abortion, a parallel that seems obvious to some,¹²¹ but which has not made its way to the feminist legal academy. The journalist begins with a common story occurring for women across the United States:

When Hillary McLaughlin found out she was pregnant, she was unable to legally obtain the service she needed. So she looked for an underground contact. She got a woman’s name—just a first name—and a phone number from a friend who advised her to destroy the evidence as soon as she made the call. When McLaughlin reached the woman, however, the woman told her she no longer “did that” and that she wasn’t willing to risk going to jail for it anymore. Turned off by all the “whisper, whisper, cloak-and-dagger stuff,” McLaughlin decided to “jump state lines” from Illinois to Missouri

¹¹⁶ See, e.g., Luz Reproductive Justice Think Tank Manifesta (last visited Sept. 19, 2012), <http://www.luzthinktank.org/luzmanifesto> (“We defend access to family planning, comprehensive sex education, and the right to determine the course of pregnancy and method of childbirth should be available for all people at all stages of life.”); see also, Farah Diaz-Tello & Lynn Paltrow, *NAPW Working Paper: Birth Justice as Reproductive Justice January 2010 Draft*, available at www.advocatesforpregnantwomen.org/BirthJusticeasReproRights.pdf.

¹¹⁷ Loretta J. Ross, *Understanding Reproductive Justice: Transforming the Pro-Choice Movement*, at 10 (2006), available at http://www.sistersong.net/reproductive_justice.html.

¹¹⁸ *Id.*

¹¹⁹ See Debora Boucher et al., *Staying Home to Give Birth: Why Women in the United States Choose Home Birth*, 54 J. MIDWIFERY & WOMEN’S HEALTH 119 (2009); Melissa J. Cheyney, *Homebirth as Systems-Challenging Praxis: Knowledge, Power, and Intimacy in the Birthplace*, 18 QUAL. HEALTH RES. 254 (2008).

¹²⁰ Ross, *supra* note 117.

¹²¹ Anne Bartow, *Midwives and Home Births*, FEMINIST L. PROFESSORS BLOG (Apr. 3, 2006), www.feministlawprofessors.com/2006/04/midwives-and-home-births (“It is fairly simple to make connections between the regulation of midwifery and home birthing with other reproductive freedom issues like abortion[.]”). The post from which this quote was taken links to a 2006 *New York Times* article about midwifery. The post is one of only three posts relating to midwives or midwifery on the blog, none of which were academic articles on the subject.

to find a legal provider.¹²²

The subject of the story was seeking not an abortion, but a midwife to attend the home delivery of her baby in Illinois, a state where the practice of midwifery without a nursing license is illegal. In states where midwives *are* legally authorized to practice, they do not provide home birth services, and in states where the demand outstrips their capacity to provide services, women like Hillary McLaughlin have few options. Before *Roe*, feminists observed that illegal abortion in the United States posed threats to individual liberties as well as the public's health, and the same is true for midwifery.¹²³ Restricting women's ability to hire a midwife to attend out-of-hospital childbirth requires women to resort to underground maternity care for which there is no quality control mechanism, other than the criminal justice system, and for which women have faced reprisal from the state.¹²⁴ Hillary's ability to seek out and find an underground contact speaks to her social and informational privilege; her ability to go to another state gives some indication of access to economic resources.

Barriers to care include legal restrictions on the practice of midwifery and insurance restrictions on reimbursement for midwifery services.¹²⁵ Currently, thirty-three states require private insurance reimbursement for midwives, but often only for nurse-midwives practicing in the hospital setting.¹²⁶ Where midwives practice illegally, most women are required to pay for their services out-of-pocket, typically between \$2,000 and \$5,000. Some private insurance will reimburse for the care provided by an unlicensed midwife, but Medicaid will not. Therefore, women who are unable to pay for care out of pocket do not have the option of receiving care from a midwife.

B. Politics, Patients, and Legal Access to Midwives

Reproductive justice demands that all pregnant people have an equal opportunity to make and exercise decisions about their care, including out-of-hospital birth. While no state regulates the location where a woman must give birth, all states have the power to license and regulate health professionals who attend birth as a component of state police power.¹²⁷ Historically and currently, states have exercised regulatory power over midwives in a variety of ways, thereby

¹²² Catharine Elton, *American Women: Birthing Babies at Home*, TIME (Sept. 4, 2010), available at www.time.com/time/magazine/article/0,9171,2011940,00.html.

¹²³ This analogy does not intend to diminish the essay's earlier argument about the misapplication of the state interest in fetal life stated by abortion law to birthing rights, but rather to draw a parallel to the public health implications of prohibitions against abortion and midwifery.

¹²⁴ See discussion, *infra* Part II.B.

¹²⁵ *Deadly Delivery*, *supra* note 17, at 81.

¹²⁶ *Id.*

¹²⁷ LAWRENCE O. GOSTIN, PUBLIC HEALTH LAW: POWER, DUTY, RESTRAINT 254 (2000) ("In addition to licensing and regulating health care professionals such as physicians, nurses, dentists, and pharmacists, states license professionals such as barbers, electricians, morticians and plumbers who engage in trades that affect public health and safety.").

controlling the conditions under which some women experience childbirth.¹²⁸ Currently, Certified Professional Midwives legally authorized to practice in twenty-seven states,¹²⁹ and there are campaigns underway in other states to increase that number. For example, The Big Push for Midwives Campaign was launched in 2007 with the mission “to educate state and national policymakers about the reduced costs and improved outcomes associated with out-of-hospital maternity care and to advocate for expanding access to the services of Certified Professional Midwives, who are specially trained to provide it.”¹³⁰ Many of these advocates have taken a legislative route to expand access to midwifery care, arguing that “unless proponents can convince skeptical courts that midwifery is a fundamental constitutional right, prompting strict scrutiny of state regulations restricting its availability, activists should focus on convincing legislatures that independent licensing of midwifery is in the best interests of the state.”¹³¹ These legislative efforts are a pitched battle between midwifery supporters and foes.

Numerous courts have been asked and have declined to protect a woman’s right to midwife-attended birth as a fundamental constitutional right. In *Bowland v. Municipal Court*, a midwife was prosecuted for violating a California law forbidding unlicensed individuals from attending women in childbirth.¹³² The midwife asserted that her client’s privacy right “encompasses the liberty to choose whomever she wants to assist in the delivery of her child.”¹³³ The Supreme Court of California found that while the right to privacy protects “certain personal choices related to childrearing, marriage, procreation and abortion,” *Roe v. Wade* specifically excludes the woman’s right to decide the manner and circumstances under which her child is born.¹³⁴ Unlike the courts in the compelled cesarean cases discussed earlier, the *Bowland* court correctly characterized the holding of *Roe v. Wade*, noting that the state’s interest in viable fetal life gives the state the power to

¹²⁸ Several types of midwives currently practice in the United States. Certified Nurse-Midwives are licensed to practice in every state, although with varying degrees of professional autonomy and physician supervision. Nurse-midwives become certified by first completing nursing credentials, followed by graduate level training in midwifery. AMERICAN COLLEGE OF NURSE-MIDWIVES, www.midwife.org/program_types (last visited Sept. 4, 2012). Many nurse-midwives practice in hospital settings, others in freestanding birth centers, and others in women’s homes, or a combination of locations. This article focuses on Certified Professional Midwives, who enter the profession of midwifery directly and not through nursing. *Id.*

¹²⁹ THE BIG PUSH FOR MIDWIVES, <http://www.pushformidwives.org> (last visited Sept. 4, 2012).

¹³⁰ *Id.* The Big Push for Midwives is comprised of state-level organizations such as the North Carolina Friends of Midwives, <http://ncfom.org/>; Friends of Michigan Midwives, www.friendsofmichiganmidwives.org; Ohio Families for Safe Birth, <http://safebirthohio.org>; Alabama Birth Coalition, www.alabamabirthcoalition.org; Indiana Midwifery Task Force, www.indianamidwiferytaskforce.org; South Dakota Safe Childbirth Options, www.sdsafebirth.org; and Illinois Coalition for Midwifery, www.illinoismidwifery.org.

¹³¹ Suarez, *supra* note 112, at 358-59.

¹³² *Bowland v. Mun. Ct.*, 18 Cal.3d 479 (Cal. 1976).

¹³³ *Id.* at 494.

¹³⁴ *Id.* at 495.

proscribe the performance of abortions.¹³⁵ Nevertheless, the court misapplied the result, finding that *Roe* recognized a state interest in the “life and well being of an unborn child” that permitted a legislative policy decision to require that childbirth attendants hold valid licenses.¹³⁶ Courts in Maryland,¹³⁷ Massachusetts,¹³⁸ and Colorado¹³⁹ have also considered and rejected the argument that the right to privacy extends to a woman’s right to choose whomever she wishes to attend her in childbirth, such as an unlicensed midwife.

State regulatory power over midwives can promote reproductive justice or it can introduce barriers to access. Over-regulation of midwives demonstrates one way in which regulation can create problems related to social and economic justice because licensure “parcels out authority based upon the discretion of officials” who may exercise this discretion in a discriminatory fashion.¹⁴⁰ In the early 1900s, registration and licensure of midwives has been documented as a part of efforts to eliminate midwifery,¹⁴¹ many of the efforts were fueled and reinforced by race- and class-based prejudices against women of color and immigrant midwives.¹⁴² In her exploration of midwifery regulation, Professor Stacey Tovino highlights decisions across several states in which courts deferred to legislative findings—motivated by physicians attempting to eliminate midwifery—to justify stringent regulation of midwives and to uphold physician supervision of midwifery practice.¹⁴³ Noting these concerns, some scholars have suggested that state regulation of midwives “formalizes the dominance of physicians over them” to the detriment of the profession and the women it serves.¹⁴⁴ Beyond explicitly outlawing midwifery practice, administrative agencies and legislatures have shown preference for the biomedical model, showing the way in which “birth and approaches to birth, both conventional—i.e., hospital—and alternative—i.e., home birth and midwifery—are now interpreted within the framework of what obstetricians consider ‘safe’ for the fetus, for the parturient woman, and in a liability sense, for themselves.”¹⁴⁵ Privileging of the biomedical model as the best protector of public health is not exclusive to midwifery, but rather is a part of “a long, checkered history of both public-mindedness and protectionism” of physician

¹³⁵ *Id.*

¹³⁶ *Id.*

¹³⁷ *Hunter v. Maryland*, 676 A.2d 968 (Md. Ct. Spec. App. 1996) (finding that reference to privacy interests articulated in *Griswold v. Connecticut* did not apply to the right to choose a midwife).

¹³⁸ *Leigh v. Bd. of Registration in Nursing*, 506 N.E.2d 91 (Mass. 1987).

¹³⁹ *Colorado v. Rosburg*, 805 P.2d 432, 437 (Colo. 1991).

¹⁴⁰ GOSTIN, *supra* note 127, at 255.

¹⁴¹ See DEVRIES, *supra* note 7.

¹⁴² CRAVEN, *supra* note 6, at 61.

¹⁴³ Stacey A. Tovino, *American Midwifery Litigation and State Legislative Preference for Physician-Controlled Childbirth*, 11 CARDOZO WOMEN’S L.J. 61 (2004).

¹⁴⁴ DEVRIES, *supra* note 7, at 140.

¹⁴⁵ Chris Hafner-Eaton & Laurie K. Pearce, *Birth Choices, the Law, and Medicine: Balancing Individual Freedoms and Protection of the Public’s Health*, 19 J. HEALTH POL. POL’Y & L. 813, 816 (1994).

control over health policy.¹⁴⁶

Physician control of health policymaking is beginning to change in the United States, and experts predict that patient participation will only continue to amplify this trend.¹⁴⁷ Midwifery clients, who see themselves as co-creators of their care, have taken on a political identity in pursuit of better maternity care.¹⁴⁸ In *Pushing for Midwives: Homebirth Mothers and the Reproductive Rights Movement*, anthropologist Christa Craven describes how movements to secure access to midwives in recent years have both paralleled and been at odds with the broader reproductive rights movement.¹⁴⁹ According to her analysis, the history of struggles to gain access to safe, dignified care during childbirth reveals much disparity in the ways that women from different race, class, religious and socioeconomic groups experienced and continue to experience maternity care in the United States.¹⁵⁰

Professor Craven's book recounts recent efforts to license and regulate CPMs in Virginia, showing how organizers were successful in legislative campaigns by casting access to midwifery as a "consumer rights" issue. Consumerism, though, "both fails to capture what is unique about the experience of health care and also implicitly cabins individual agency and responsibility to market-related interactions."¹⁵¹ Those who can participate in the market can participate in the choice of a midwife. Craven posits that feminist scholars have an important role to play in evaluating this strategy as it pertains to reproductive justice by exploring its potential negative consequences "for the very women it seeks to liberate."¹⁵² Feminist legal scholars also bear this responsibility because law plays a central role in health policy.

Because privileging of the biomedical model reinforces physician control in healthcare policymaking,¹⁵³ it is not surprising that medical authorities have mounted a strong opposition to midwifery consumer efforts. In 2008, the American Medical Association issued a statement calling for model legislation "in

¹⁴⁶ William M. Sage, *Relational Duties, Regulatory Duties, and the Widening Gap Between Individual Health Law and Collective Health Policy*, 96 GEO. L.J. 497, 498-99 (2008) (discussing physician response to the "partial birth" abortion ban, and mandatory insurance coverage for post-childbirth hospitalization—i.e., "drive-through delivery" laws—as well as routine coverage for mammography for women in their forties).

¹⁴⁷ See Hunter, *Rights Talk*, *supra* note 21.

¹⁴⁸ It is neither possible nor correct, however, to characterize their movement as universally feminist. Midwifery supporters claim a diversity of political and religious beliefs. Some have strong anti-abortion sentiment based in Christian ideals; others identify as liberal feminists committed to women's choice and control over reproduction. Craven writes: "Delayed concern over women's rights during childbirth is in part why many homebirth [mothers] distanced themselves from the feminist movement for reproductive rights." CRAVEN, *supra* note 6, at 48.

¹⁴⁹ *Id.* at 2.

¹⁵⁰ *Id.* at 25.

¹⁵¹ Hunter, *Rights Talk*, *supra* note 21, at 1525.

¹⁵² CRAVEN, *supra* note 6, at 3.

¹⁵³ Sage, *supra* note 146, at 2.

support of the concept that the safest setting for labor, delivery, and the immediate post-partum period is in the hospital, or a birthing center within a hospital complex . . . or in a freestanding birthing center,” without any evidence to back up the claim.¹⁵⁴ The American College of Obstetricians and Gynecologists’ (ACOG) statement on home births declares that “[u]nless a woman is in a hospital, an accredited freestanding birthing center, or a birthing center within a hospital complex, with physicians ready to intervene quickly if necessary, she puts herself and her baby’s health and life at unnecessary risk,” and that choosing to give birth at home “is to place the process of giving birth over the goal of having a healthy baby.”¹⁵⁵ The statement further asserts that ACOG does not support the provision of maternity care by certain midwife providers.¹⁵⁶ Taken together, these statements and policies could be used to curtail a woman’s right to choose the location and provider for childbirth.¹⁵⁷

Professor Tovino’s research about the treatment of midwives in court opinions identifies the potential race, class and gender-based motivations of legislative and judicial deference to physician controlled childbirth, particularly various courts’ disdain for the positive health outcomes that midwives can achieve for women and babies in their care.¹⁵⁸ She concludes that such deference “suggests that the women midwives’ experiential knowledge was both subordinate to the male physician’s . . . scientific knowledge and rejected as a means of

¹⁵⁴ Clarence S. Avery, Jr., MD, *Memorial Resolutions: Section 205 House Deliveries (2008)*, AMA HOUSE OF DELEGATES, available at <http://www.ama-assn.org/resources/doc/hod/a08resolutions.pdf>.

¹⁵⁵ *ACOG Statement on Home Births*, ACOG OFFICE OF COMMUNICATIONS (Feb. 2008), www.acog.org/from_home/publications/press_releases/nr02-06-08-2.cfm.

¹⁵⁶ *Id.*

¹⁵⁷ This prediction is more than alarmist conjecture: Laura Pemberton planned a homebirth with a midwife and was physically abducted from her home and returned to the hospital for a cesarean. See *supra* Section I. For an interesting analysis of Pemberton, see Beth A. Burkstrand-Reid, *The Invisible Woman: Availability and Culpability in Reproductive Health Jurisprudence*, 81 U. COLO. L. REV. 97, 144 (2010). The author argues that the court found Pemberton culpable for the lack of VBAC services she desired, allowing the court to truncate her health interest. Pemberton, however, was not seeking VBAC services at the hospital. She desired a home birth with a midwife.

Some states have enforced their views of appropriate decision-making in childbirth with regard to the choice of a maternity care provider through the intervention of child protective services. Authorities in Illinois recently removed a baby from the custody of a mother after she gave birth at home with the assistance of a midwife, citing medical neglect, because a physician had previously recommended cesarean section. See Jennifer Lance, *CPS Removes Illinois Baby Because of Home Birth “Medical Neglect”* (Sept. 15, 2010), <http://ecochildsplay.com/2010/09/15/cps-removes-illinois-baby-because-of-home-birth-medical-neglect>. In that case, both mother and child were healthy but the family decided to seek medical assistance to check up on the child after birth. *Id.* Other states have criminally charged women who deliver babies outside of the hospital with child endangerment. In Ohio, the mother and father of the Levier family were charged with neglect after the mother gave birth at home, albeit to a healthy baby. See Kathy Jacobson, *Ohio Family Facing Prosecution for Home Birth; Healthy Baby, Healthy Mom*, TRANSITION IN ACTION SOCIAL NETWORK BLOG (Sept. 29, 2009, 5:15 PM), http://transitioninaction.com/profiles/blog/show?id=2320371%3ABlogPost%3A30889&commentId=2320371%3AComment%3A31765&xg_source=activity. The parents posted an online plea for help and support, stating, “It’s time for us to stand up for our rights as women, parents and law abiding citizens who don’t want the government trampling on our rights to live and raise our families as we choose!” *Id.*

¹⁵⁸ Tovino, *supra* note 143, at 106.

establishing professional and legal standing.”¹⁵⁹ This observation parallels the way that courts treat individual women’s choices in childbirth in cases like Pemberton, discussed in Part I.¹⁶⁰ The structural framework Professor Hill proposes applies well to the birthing rights issues discussed herein:¹⁶¹ women’s rights to make medical decisions regarding childbirth, and the state’s role in protecting public health by making safe birthing choices available, are both fundamentally questions of whether and how the law protects the right to make autonomous treatment decisions. In evaluating midwifery laws, those factors have included race, class, and gender classifications.¹⁶² Explicit or implicit use of gender and race stereotypes by the courts and legislatures should spark feminist interest and examination, and could fit squarely into casebooks on the topic.

CONCLUSION

This Article proposes that feminist lawyers can and must play a part in developing a robust conception of reproductive justice that includes birthing women, centering and prioritizing the needs of those with the least access to reproductive freedom. Over-reliance on medical authority both by the courts and by state legislatures, and the misapplication of abortion precedent seem to be the two fundamental obstacles towards women enjoying meaningful birthing rights. One of the ways feminist jurisprudence can play its part is by asking its students critical questions about these issues, and teaching them to make connections between policy, advocacy, strategy and scholarship. For these reasons, birthing rights should be included in academic discussions about gender equality and reproductive rights law.

¹⁵⁹ *Id.*

¹⁶⁰ *Supra* Part I.B. Specifically, see the court’s dismissal of Laura Pemberton’s presentation of alternative medical evidence regarding the risks and benefits of cesarean section. *Id.*

¹⁶¹ Hill, *supra* note 22, at 277.

¹⁶² Tovino, *supra* note 143, at 105 (suggesting that if attorneys arguing against a law that effectively outlawed midwifery practice in Alabama had highlighted the disparate impact that the law had on black midwives, the outcome of the case may have preserved midwifery practice).