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## CHAPTER THREE

### THE LEGAL INFRASTRUCTURE OF CHILDBIRTH

Law endorses the “right of every individual to the possession and control of his own person”<sup>1</sup> including a “liberty interest [under the Due Process Clause] in refusing unwanted medical treatment.”<sup>2</sup> However, in childbirth, the state controls the bodily choices of pregnant and birthing people through a patchwork of tort law standards and the regulation of healthcare providers, systematically enforcing compliance with particular, value-driven norms.<sup>3</sup> While courts have found abortion to be a fundamental right, they have declined to recognize a right to give birth free from government intrusion.<sup>4</sup> Regulation of abortion faces scrutiny under the “undue burden” standard,<sup>5</sup> but there is no legal limit on government intrusion on privacy through the regulation of childbirth.<sup>6</sup>

This Chapter examines the legal infrastructure around childbirth, honing in on the provision of healthcare as a mechanism for controlling reproduction.<sup>7</sup> Section A offers an introduction to the values and outcomes at stake in decisionmaking during birth. Section B discusses the role of law in childbirth in two areas: tort law and the regulation of midwives. Together, these legal structures result in limits on access to

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<sup>1</sup> Union Pac. Ry. Co. v. Botsford, 141 U.S. 250, 251 (1891); *see also* McFall v. Shimp, 10 Pa. D. & C.3d 90, 91 (C.P. Allegheny County 1978) (“For our law to *compel* [an individual] to submit to an intrusion of his body would change every concept and principle upon which our society is founded . . . and would impose a rule which would know no limits . . .”).

<sup>2</sup> Cruzan v. Dir., Mo. Dep’t of Health, 497 U.S. 261, 278 (1990).

<sup>3</sup> Criminal law is also central to state control of pregnant people — particularly of poor women and women of color — but is not the focus of this piece. For excellent coverage of this integral form of state control, *see generally* MICHELE GOODWIN, *POLICING THE WOMB* (2020); Cortney E. Lollar, *Criminalizing Pregnancy*, 92 IND. L.J. 947 (2017); and Lynn M. Paltrow & Jeanne Flavin, *Arrests of and Forced Interventions on Pregnant Women in the United States, 1973–2005: Implications for Women’s Legal Status and Public Health*, 38 J. HEALTH POL. POL’Y & L. 299 (2013).

<sup>4</sup> *See* Roe v. Wade, 410 U.S. 113, 154 (1973); *see also* Lange-Kessler v. Dep’t of Educ., 109 F.3d 137, 141–42 (2d Cir. 1997) (concluding that the “right to privacy does not encompass the right to choose a direct-entry midwife to assist with childbirth,” *id.* at 142); *People v. Rosburg*, 805 P.2d 432, 437 (Colo. 1991) (same); *Bowland v. Mun. Ct.*, 556 P.2d 1081, 1089 (Cal. 1976) (same).

<sup>5</sup> *See* Planned Parenthood of Se. Pa. v. Casey, 505 U.S. 833, 877 (1992) (plurality opinion) (holding that a statute that “has the purpose or effect of placing a substantial obstacle in the path of a woman seeking an abortion” places an “undue burden” on a fundamental right and is therefore invalid).

<sup>6</sup> In neither abortion nor childbirth does constitutional law recognize an affirmative right to care. *See* Harris v. McRae, 448 U.S. 297, 302, 317–18 (1980) (upholding the Hyde Amendment, which prohibits Medicaid funding of abortion except in cases of rape or incest or where the pregnant person’s life is in danger); cases cited *supra* note 4.

<sup>7</sup> Although 86% of women give birth by their mid-forties, *see* Gretchen Livingston, *They’re Waiting Longer, but U.S. Women Today More Likely to Have Children than a Decade Ago*, PEW RESEARCH CTR. (Jan. 18, 2018), <https://www.pewsocialtrends.org/2018/01/18/theyre-waiting-longer-but-u-s-women-today-more-likely-to-have-children-than-a-decade-ago/#fn-24248-1> [<https://perma.cc/89ER-PEZS>], the role of the law in childbirth has been underexamined.

care that deny pregnant persons the ability to make basic reproductive choices. Examination of the effects of tort doctrine alongside the regulation of midwives reveals the value-based posture of the law toward birth, discussed in section C. The two systems function quite differently: a runaway tort system encourages physicians to prioritize the fetus at all costs, giving them wide latitude to impose a distorted standard of care on pregnant people, while, in contrast, restrictive midwifery regulation denies various reproductive options to pregnant people — mimicking the hyper-regulatory oversight of abortion. In both arenas, the law departs from standard legal principles, displaying pregnancy exceptionalism. Both systems also exhibit fetal primacy, enforcing fetal interests over those of the pregnant person in material and symbolic ways.

*A. Birth Entails Values-Based Reproductive Decisionmaking*

Decisions about where, how, and with whom to give birth are meaningful reproductive health decisions. For many, they involve intimate considerations about the experience of bringing life into the world and meeting one's baby, connection with one's partner, self-empowerment, and connection with the divine.<sup>8</sup> Such choices implicate the kinds of deeply held values that constitutional law has protected in decisions about reproduction, procreation, and parenting.<sup>9</sup> Importantly, child-birth decisions often involve significant medical uncertainty: they cannot be easily resolved by reference to infant or maternal outcomes. Thus, when a pregnant person, a provider, or the state makes a decision about birth, they must fall back on their beliefs about the appropriate balance between competing values rather than scientific consensus.

For example, birthing people make choices between physician-attended hospital births and midwife-attended births, approaches which embody fundamentally different understandings of birth.<sup>10</sup> On the one hand, the medical model approaches birth as a pathological medical condition, requiring hospitalization and medical supervision, as well as frequent intervention.<sup>11</sup> Technology is dominant and perceived risk is

<sup>8</sup> Sylvia A. Law, *Childbirth: An Opportunity for Choice that Should Be Supported*, 32 N.Y.U. REV. L. & SOC. CHANGE 345, 352 (2008).

<sup>9</sup> Cf. *Casey*, 505 U.S. at 852 (discussing pregnancy as “unique to the human condition,” involving “sacrifices,” and entailing “spiritual imperatives”); see also *Lawrence v. Texas*, 539 U.S. 558, 567 (2003) (sex); *Roe*, 410 U.S. at 153 (abortion); *Griswold v. Connecticut*, 381 U.S. 479, 485–86 (1965) (contraception); *Meyer v. Nebraska*, 262 U.S. 390, 400 (1923) (parenting).

<sup>10</sup> See generally ROBBIE E. DAVIS-FLOYD, *BIRTH AS AN AMERICAN RITE OF PASSAGE* 51–59, 158–59 (1992) (describing and comparing the “technocratic” and “wholistic” models of birth).

<sup>11</sup> Celia Grigg et al., *An Exploration of Influences on Women's Birthplace Decision-Making in New Zealand: A Mixed Methods Prospective Cohort Within the Evaluating Maternity Units Study*, 14 BMC PREGNANCY & CHILDBIRTH 1, 3 tbl.1 (2014), <https://bmcpregnancychildbirth.biomedcentral.com/articles/10.1186/1471-2393-14-210> [https://perma.cc/L5CV-M8Y2].

central.<sup>12</sup> The process is doctor centered, with physicians directing the process and making the decisions.<sup>13</sup> Safety is narrowly defined around fetal wellbeing, which is prioritized over other core values.<sup>14</sup>

The midwifery model of care, on the other hand, understands birth to be a normal physiologic process.<sup>15</sup> Care supports “the physical, psychosocial and spiritual health, well-being and safety” of the birthing dyad.<sup>16</sup> The fetus and pregnant person are an “interdependent whole.”<sup>17</sup> Midwifery emphasizes individualized care, built on an “egalitarian relationship”<sup>18</sup> of “trust, honesty, and respect” between midwife and client.<sup>19</sup> The pregnant person is “autonomous and competent to make decisions regarding all aspects of her life.”<sup>20</sup> Finally, midwifery care seeks to “minimiz[e] technological interventions.”<sup>21</sup>

Aside from decisions about provider and place of birth, decisions about particular interventions — for example, whether to induce labor or use medication to speed it up, pain management options, and whether or not to have a cesarean — are rarely straightforward medical decisions.<sup>22</sup> All involve considerable scientific uncertainty and necessitate value-based tradeoffs.<sup>23</sup> In addition to competing risks, birthing people may weigh economic factors, obligations to other family, personal preferences, spiritual beliefs, mental health, long-term health consequences, and immediate postpartum implications in making these choices.<sup>24</sup>

While a highly medicalized approach to birth is dominant in the United States, its prevalence is not explained by superior outcomes.<sup>25</sup>

<sup>12</sup> *Id.*; see also JACQUELINE H. WOLF, CESAREAN SECTION: AN AMERICAN HISTORY OF RISK, TECHNOLOGY, AND CONSEQUENCE 5–7 (2018) (documenting how misperceptions of cesarean sections as less risky than vaginal birth have driven the rise in cesarean birth).

<sup>13</sup> Grigg et al., *supra* note 11, at 3 tbl.1.

<sup>14</sup> *Id.*

<sup>15</sup> MIDWIVES ALL. OF N. AM., STATEMENT OF VALUES AND ETHICS § III(B) (2010), <https://mana.org/sites/default/files/pdfs/MANASStatementValuesEthicsColor.pdf> [<https://perma.cc/YFE3-NVXR>] [hereinafter MANA, STATEMENT OF VALUES]; cf. *The Midwives Model of Care*, MIDWIVES ALL. OF N. AM., <https://mana.org/about-midwives/midwifery-model> [<https://perma.cc/7J3N-GVD8>].

<sup>16</sup> MANA, STATEMENT OF VALUES, *supra* note 15, § II(B).

<sup>17</sup> *Id.* § II(A).

<sup>18</sup> *Id.* § VI(A).

<sup>19</sup> *Id.* § VI(C).

<sup>20</sup> *Id.* § I(D).

<sup>21</sup> *The Midwives Model of Care*, *supra* note 15.

<sup>22</sup> See, e.g., Law, *supra* note 8, at 349–52 (outlining factors women weigh when choosing between cesarean and vaginal birth).

<sup>23</sup> See *id.*

<sup>24</sup> See *id.* at 351–52.

<sup>25</sup> Over 98% of births in the United States take place in hospitals. See Marian F. MacDorman & Eugene Declercq, *Trends and State Variations in Out-of-Hospital Births in the United States, 2004–2017*, 46 BIRTH 279, 280 (2019). Of hospital births, about 9% are attended by midwives. Amos Grünebaum et al., *US Midwife-Attended Hospital Births Are Increasing While Physician-*

In hospital births, between 27% and 41% of labors are induced, many without medical indication.<sup>26</sup> Another 40–50% involve the use of synthetic oxytocin, or Pitocin, to speed up the labor process.<sup>27</sup> About three quarters involve epidural pain medication, which numbs and immobilizes the birthing person from the waist down.<sup>28</sup> Since 1965, cesarean rates have climbed from 4.5% to 31.9%.<sup>29</sup> The rise in cesarean deliveries has not improved infant mortality,<sup>30</sup> which remains higher in the United States than in any other comparably wealthy nation.<sup>31</sup> Maternal mortality ranks fifty-fifth in the world, after Russia, and is climbing.<sup>32</sup> Infant and maternal death rates for Black and Indigenous people are two to five times those for white people.<sup>33</sup>

Midwifery care results in different outcomes than the medical model.<sup>34</sup> Home births and birth center births have cesarean rates of 5–6%.<sup>35</sup> The rates of postpartum hemorrhage or severe tearing are lower

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*Attended Hospital Births Are Decreasing: 2003–2018*, 223 AM. J. OBSTETRICS & GYNECOLOGY 460, 461 (2020).

<sup>26</sup> See Rebecca Dekker, *Evidence On: Inducing for Due Dates*, EVIDENCE BASED BIRTH (Feb. 24, 2020), <https://evidencebasedbirth.com/evidence-on-inducing-labor-for-going-past-your-due-date> [<https://perma.cc/8D2J-7LPC>]. Induction rates have almost tripled since 1990. William Grobman, *Induction of Labor with Oxytocin*, UPTODATE (Sept. 28, 2020), <https://www.uptodate.com/contents/induction-of-labor-with-oxytocin> [<https://perma.cc/6K43-9JSA>].

<sup>27</sup> See, e.g., CAROL SAKALA ET AL., NAT'L P'SHIP FOR WOMEN & FAMS., LISTENING TO MOTHERS IN CALIFORNIA: A POPULATION-BASED SURVEY OF WOMEN'S CHILDBEARING EXPERIENCES 40 fig.20 (2018), <https://www.chcf.org/wp-content/uploads/2018/09/ListeningMothersCAFfullSurveyReport2018.pdf> [<https://perma.cc/F565-QLJ5>].

<sup>28</sup> Alexander J. Butwick et al., *United States State-Level Variation in the Use of Neuraxial Analgesia During Labor for Pregnant Women*, 1 JAMA NETWORK OPEN 1, 6 (2018), <https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2719581> [<https://perma.cc/294X-W952>].

<sup>29</sup> WOLF, *supra* note 12, at 3–4.

<sup>30</sup> *Id.* at 3. Cesarean rates over 10% show no reduction in newborn or maternal mortality. WORLD HEALTH ORG. & HUM. REPROD. PROGRAMME, WHO STATEMENT ON CAESAREAN SECTION RATES 3 (2015), [https://www.who.int/reproductivehealth/publications/maternal\\_perinatal\\_health/cs-statement/en](https://www.who.int/reproductivehealth/publications/maternal_perinatal_health/cs-statement/en) [<https://perma.cc/ZA96-3PCD>].

<sup>31</sup> UNITED HEALTH FOUND., AMERICA'S HEALTH RANKINGS: ANNUAL REPORT 2018 54–55 & fig.62 (2018); Rabah Kamal et al., *What Do We Know About Infant Mortality in the U.S. and Comparable Countries?*, PETERSON-KFF HEALTH SYS. TRACKER (Oct. 18, 2019), <https://www.healthsystemtracker.org/chart-collection/infant-mortality-u-s-compare-countries> [<https://perma.cc/QLK6-5QFU>].

<sup>32</sup> See Julia Belluz, *We Finally Have a New US Maternal Mortality Estimate. It's Still Terrible.*, VOX (Jan. 30, 2020, 10:40 AM), <https://www.vox.com/2020/1/30/21113782/pregnancy-deaths-us-maternal-mortality-rate> [<https://perma.cc/8FST-XHJR>].

<sup>33</sup> See Emily E. Petersen et al., *Racial/Ethnic Disparities in Pregnancy-Related Deaths — United States, 2007–2016*, 68 MORBIDITY & MORTALITY WKLY. REP. 762, 763 (2019); Danielle M. Ely & Anne K. Driscoll, *Infant Mortality in the United States, 2018: Data from the Period Linked Birth/Infant Death File*, NAT'L VITAL STATS. REPS., July 16, 2020, at 1, 3.

<sup>34</sup> Importantly, midwives primarily care for low-risk people, so their outcomes are not directly comparable to those of hospitals writ large, whose caseloads include high-risk patients.

<sup>35</sup> Melissa Cheyney et al., *Outcomes of Care for 16,924 Planned Home Births in the United States: The Midwives Alliance of North America Statistics Project, 2004 to 2009*, 59 J. MIDWIFERY & WOMEN'S HEALTH 17, 20 (2014) (finding cesarean rate of 5.2%); Susan Rutledge Stapleton et

than in hospitals.<sup>36</sup> Neonatal intensive care unit admission is exceptionally low.<sup>37</sup> Less than 5% require oxytocin augmentation or epidural anesthesia.<sup>38</sup> Breastfeeding rates at six weeks are greater than 97%.<sup>39</sup> While studies are inconsistent, the best available data indicate that neonatal mortality at home or in a birth center is similar to that in hospitals.<sup>40</sup> Maternal mortality is roughly the same.<sup>41</sup> Midwife-led care in hospitals shows similarly strong outcomes.<sup>42</sup> Satisfaction with the birthing experience is higher under midwifery care,<sup>43</sup> which may improve

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al., *Outcomes of Care in Birth Centers: Demonstration of a Durable Model*, 58 J. MIDWIFERY & WOMEN'S HEALTH 3, 9 (2013) (finding cesarean rate of 6%).

<sup>36</sup> Andrea Nove et al., *Comparing the Odds of Postpartum Haemorrhage in Planned Home Birth Against Planned Hospital Birth: Results of an Observational Study of over 500,000 Maternities in the UK*, 12 BMC PREGNANCY & CHILDBIRTH 1, 4 (2012), <https://bmcpregnancychildbirth.biomedcentral.com/articles/10.1186/1471-2393-12-130> [<https://perma.cc/8PF7-AL8R>]; see also Cheyney et al., *supra* note 35, at 22.

<sup>37</sup> Cheyney et al., *supra* note 35, at 22.

<sup>38</sup> *Id.* at 23.

<sup>39</sup> *Id.*

<sup>40</sup> For U.S. data, see, for example, *id.* (finding intrapartum, early neonatal, and late neonatal mortality rates of 1.30, 0.41, and 0.35 per 1,000 respectively, excluding lethal anomalies); Rondi E. Anderson & Patricia Aikins Murphy, *Outcomes of 11,788 Planned Home Births Attended by Certified Nurse-Midwives*, 40 J. NURSE-MIDWIFERY 483, 490 (1995) (finding an intrapartum and neonatal mortality rate of 0.9 per 1,000 when congenital anomalies were excluded); Kim J. Cox et al., *Outcomes of Planned Home Births Attended by Certified Nurse-Midwives in Southeastern Pennsylvania, 1983–2008*, 58 J. MIDWIFERY & WOMEN'S HEALTH 145, 148 (2013) (finding no neonatal deaths when fatal anomalies were excluded). *But see, e.g.*, Amos Grünebaum et al., *Early and Total Neonatal Mortality in Relation to Birth Setting in the United States, 2006–2009*, 390 AM. J. OBSTETRICS & GYNECOLOGY 390.e1, 390.e3 tbl.2 (2014) (finding neonatal mortality rates of 1.26 per 1,000 at home and 0.55 per 1,000 with hospital physicians); Jonathan M. Snowden et al., *Planned Out-of-Hospital Birth and Birth Outcomes*, 373 NEW ENG. J. MED. 2642, 2645 (2015) (finding perinatal death rate of 3.9 per 1,000 planned at home versus 1.8 per 1,000 planned in hospital). There is much debate over the best methods for measuring home birth safety; for analysis of the quality of various studies, see generally Heather R. Elder et al., *Investigating the Debate of Home Birth Safety: A Critical Review of Cohort Studies Focusing on Selected Infant Outcomes*, 13 JAPAN J. NURSING SCI. 297 (2016); and S. VEDAM ET AL., HOME BIRTH: AN ANNOTATED GUIDE TO THE LITERATURE (2013), <https://www.midwife.org/acnm/files/ccLibraryFiles/Filename/00000003658/HomeBirthAnnotatedGuideToTheLiterature2013.pdf> [<https://perma.cc/W3A3-CFV3>].

<sup>41</sup> Because of the rarity of maternal death, it is difficult to gather sample sizes large enough to meaningfully compare it. Of the major studies on home birth and birth-center birth, only one recorded a maternal death. See Cheyney et al., *supra* note 35, at 23.

<sup>42</sup> Meg Johantgen et al., *Comparison of Labor and Delivery Care Provided by Certified Nurse-Midwives and Physicians: A Systematic Review, 1990 to 2008*, 22 WOMEN'S HEALTH ISSUES e73, e78 (2012) (finding that hospital midwives achieve similar or better outcomes than physicians and have lower rates of intervention).

<sup>43</sup> See, e.g., Charlotte Overgaard et al., *The Impact of Birthplace on Women's Birth Experiences and Perceptions of Care*, 74 SOC. SCI. & MED. 973, 978 (2012) (finding significantly higher satisfaction with birth experience and care in freestanding midwifery units than obstetric units in hospitals).

mental health outcomes.<sup>44</sup> In 2017, 62,228, or 1.61%, of births took place out-of-hospital, an 85% increase from 2004.<sup>45</sup>

Decisions in childbirth thus involve contestable choices about values made in the face of uncertainty. With this in mind, it becomes possible to see the restrictions on reproductive choice enforced by the legal infrastructure of childbirth not as a neutral codification of universal best practices but as a system based on a particular set of value judgments that cabins pregnant people's choices much more narrowly than medical evidence, standing alone, could support. Constitutional and common law commitments to bodily autonomy and personal choice in matters of health, reproduction, and parenting support control over such judgments by birthing people themselves.

*B. The Legal Infrastructure of Birth Restricts Access and Choice*

Health law shapes childbirth through tort law and provider licensure. Tort law crystallizes and enforces a narrow standard of care, limiting birth options providers will offer and incentivizing them to compel patient compliance for fear of liability. Meanwhile, restrictive midwifery regulation directly forecloses alternate care avenues, denying access to safe care and forcing people into unwanted procedures.

*i. Tort Law.* — Viewed as a whole, tort law functions to create a coercive birthing environment and to limit the range of birthing options available to birthing parents. It does so through two main moves: First, tort law offers huge damages awards for harm to the fetus during the birthing process, and little to no damages for harms to the pregnant person. The knowledge that fetal harm carries outsized liability “incentivizes doctors to distort fetal harms in ways that in turn distort the standard of care.”<sup>46</sup> Second, tort law fails to uphold informed consent, making it risky for providers to deviate from this distorted standard. Because of the legal incentives of tort law, providers work to persuade, manipulate, or coerce patients into conforming to the (distorted) standard of care. Taken together, tort law limits birthing people's ability to make healthcare choices in ways typical in other health fields.

*(a) Tort Law Distorts Standards of Care in Birth.* — In medical malpractice and negligence cases, departing from the “standard of care” constitutes a breach.<sup>47</sup> Ideally, the standard of care compels providers to adhere to evidence-based medicine. But the standard of care is not

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<sup>44</sup> See generally N. Shields et al., *Impact of Midwife-Managed Care in the Postnatal Period: An Exploration of Psychosocial Outcomes*, 15 J. REPROD. & INFANT PSYCH. 91 (1997) (finding that midwife-managed care may confer psychosocial benefits).

<sup>45</sup> MacDorman & Declercq, *supra* note 25, at 280.

<sup>46</sup> Jamie R. Abrams, *Distorted and Diminished Tort Claims for Women*, 34 CARDOZO L. REV. 1955, 1992 (2013) [hereinafter Abrams, *Distorted Tort Claims*].

<sup>47</sup> See *id.* at 1959–60.

explicitly tied to science; rather, it is determined according to “the customary practice” of providers.<sup>48</sup>

Professor Jamie Abrams has identified and chronicled the distortion of standards of care in childbirth.<sup>49</sup> With the advent of highly medicalized childbirth, “the fetus has become the dominant putative plaintiff” in modern tort law,<sup>50</sup> with eight-figure awards for fetal harm.<sup>51</sup> By contrast, tort claims based on harm to the birthing person are rare, and their “ultimate dollar value . . . is relatively small.”<sup>52</sup> Indeed, some courts seem to treat injuries to the pregnant person as “acceptable harms, regardless of the standard of care, [as long as] they result in healthy babies.”<sup>53</sup> Though tort law standards normally focus on minimizing *unreasonable* risk, the high cost of fetal harm promotes a fetal “primacy” that directs treatment toward eliminating *all* fetal risk.<sup>54</sup>

The court-enforced disparity between the value of maternal harm and fetal harm “invite[s] distortions in medical care and advice.”<sup>55</sup> Providers are incentivized to recommend care that minimizes fetal risk at all costs. The threat of liability for fetal harm may cause providers to exaggerate or misrepresent fetal risk levels to patients. Indeed, fear of litigation has been shown to be a leading factor in physicians’ decisions to perform cesarean sections.<sup>56</sup>

Critically, because the tort standard of care simply amalgamates common practice, the fetal primacy encouraged by tort law crystallizes into a legally enforceable standard of care. This standard of care, and the ensuing care options available to pregnant people, encompass a blend of the values of courts and the interests of medical providers.

(b) *Tort Law Fails to Require Informed Consent (or Any Consent at All) in Birth.* — Tort law regulation of medical care begins from two basic premises: First, a physician must obtain consent before subjecting a patient to a medical procedure.<sup>57</sup> Procedures cannot be forced, even

<sup>48</sup> PATRICIA M. DANZON, *MEDICAL MALPRACTICE: THEORY, EVIDENCE, AND PUBLIC POLICY* 139 (1985).

<sup>49</sup> See generally Abrams, *Distorted Tort Claims*, *supra* note 46.

<sup>50</sup> *Id.* at 1958 (emphasis omitted).

<sup>51</sup> *Id.* at 1976 (citing JOHN SEYMOUR, *CHILDBIRTH AND THE LAW* 348 n.39 (2000)).

<sup>52</sup> *Id.* at 1979.

<sup>53</sup> *Id.* at 1989; see also *id.* at 1980 (“In the few cases where birthing women have prevailed in maternal harms cases, it is generally through a fetal injury derivative claim . . .”).

<sup>54</sup> Cf. Jamie R. Abrams, *The Illusion of Autonomy in Women’s Medical Decision-Making*, 42 *FLA. ST. U. L. REV.* 17, 20 (2014) [hereinafter Abrams, *Illusion of Autonomy*].

<sup>55</sup> Abrams, *Distorted Tort Claims*, *supra* note 46, at 1992.

<sup>56</sup> Sunita Panda et al., *Clinicians’ Views of Factors Influencing Decision-Making for Cesarean Section: A Systematic Review and Metasynthesis of Qualitative, Quantitative and Mixed Methods Studies*, 13 *PLOS ONE* 1 (2018), <https://doi.org/10.1371/journal.pone.0200941> [<https://perma.cc/65TP-T4ZQ>] (finding that “[c]linicians’ fear of litigation was the most common factor influencing the decision to perform a [cesarean section] in 21 [of 34] studies” reviewed, *id.* at 17).

<sup>57</sup> See *Schloendorff v. Soc. of N.Y. Hosp.*, 105 N.E. 92, 93 (N.Y. 1914) (“[A] surgeon who performs an operation without his patient’s consent commits an assault . . .”).

to save the life of a third party.<sup>58</sup> Second, consent must be informed. The provider must explain the material risks and benefits of a treatment and its alternatives.<sup>59</sup> In childbirth, however, these principles are often warped or not applied at all. The existing legal posture makes it safer for physicians to act according to the standard of care — even against the consent of their patient — than to deviate from the standard of care to support the reproductive health choices of the pregnant person.

First, courts often uphold customary procedures when informed consent is not asked for or received.<sup>60</sup> Informed consent doctrine often determines breach based on whether a “reasonable patient” would have consented to a given treatment under the same circumstances if they had full information.<sup>61</sup> Under the “reasonable patient” standard, all birthing people are held to “determinations of reasonable behavior . . . entirely shaped by what ‘most women’ do.”<sup>62</sup> Because physician-driven decisionmaking goes “largely uncontested by the four million women who give birth in this manner each year,” it becomes presumptively unreasonable for any birthing person to deviate from “complete acceptance of medical guidance.”<sup>63</sup> The doctrine of informed consent in childbirth thus “perpetuates an illusion of autonomy that is problematic to the women who do not elect this framework.”<sup>64</sup>

Second, some courts avoid meaningfully applying the informed consent doctrine to childbirth at all by holding that specific procedures are covered by the pregnant person’s general consent to delivery care.<sup>65</sup> In one such case, *Sinclair v. Block*,<sup>66</sup> a court affirmed that the use of forceps in labor did not require “specific consent . . . because it would be covered by the patient’s general consent.”<sup>67</sup> The court went on to hold that “the informed consent doctrine does not apply to the natural delivery process” because the birthing person cannot “elect to remain in her present condition” so “there is no choice to make.”<sup>68</sup> Likewise, in *Hall*

<sup>58</sup> See *McFall v. Shimp*, 10 Pa. D. & C.3d 90, 90–92 (C.P. Allegheny County 1978).

<sup>59</sup> STEPHEN WEAR, *INFORMED CONSENT: PATIENT AUTONOMY AND CLINICIAN BENEFICENCE WITHIN HEALTH CARE* 10 (2d ed. 1998).

<sup>60</sup> See, e.g., *Charley v. Cameron*, 528 P.2d 1205, 1209–10 (Kan. 1974) (upholding use of forceps without disclosure of risks or obtaining consent because “[t]he use of forceps was a medical decision” indicated “whenever good medical judgment dictates [it]”).

<sup>61</sup> Heather Joy Baker, “*We Don’t Want to Scare the Ladies: An Investigation of Maternal Rights and Informed Consent Throughout the Birth Process*,” 31 *WOMEN’S RTS. L. REP.* 538, 545 (2010).

<sup>62</sup> Abrams, *Illusion of Autonomy*, *supra* note 54, at 41.

<sup>63</sup> *Id.* at 20.

<sup>64</sup> *Id.*

<sup>65</sup> See, e.g., *Charley*, 528 P.2d at 1209.

<sup>66</sup> 633 A.2d 1137 (Pa. 1993).

<sup>67</sup> *Id.* at 1139.

<sup>68</sup> *Id.* at 1140–41.

*v. United States*,<sup>69</sup> a court found that a patient who was given anesthesia without informed consent had “impliedly consented” to the use of spinal anesthetic because she “entered the hospital for the express purpose of being delivered of her child” and anesthetic during labor was “standard procedure.”<sup>70</sup> The implication of these cases is that once a laboring person agrees to be cared for by a certain provider they have no right to further information or control over the course of treatment.<sup>71</sup>

Third, some courts deviate even further from common law and constitutional principles, overriding patients’ explicit refusal and enforcing compliance with the standard of care via court orders.<sup>72</sup> For example, in *Pemberton v. Tallahassee Memorial Regional Medical Center, Inc.*,<sup>73</sup> a Florida woman decided to birth at home after physicians refused to respect her choice to have a vaginal birth.<sup>74</sup> During labor, the hospital obtained a court order, sent law enforcement to her house, and brought her forcibly to the hospital, where a cesarean was performed against her will.<sup>75</sup> The court found that “[w]hatever the scope of Ms. Pemberton’s personal constitutional rights . . . they clearly did not outweigh the interests of the State . . . in preserving the life of the unborn child.”<sup>76</sup> In another case of forced cesarean, the court similarly concluded that it was “appropriate to infringe upon the wishes of the mother to the extent it is necessary to give the child an opportunity to live.”<sup>77</sup> Other courts, however, have declined to order interventions in childbirth.<sup>78</sup>

<sup>69</sup> 136 F. Supp. 187 (W.D. La. 1955), *aff’d*, 234 F.2d 811 (5th Cir. 1956).

<sup>70</sup> *Id.* at 193.

<sup>71</sup> See Cristen Pascucci, *Being Admitted to the Hospital or Signing Consent Forms Is Not “Implied Consent,”* BIRTH MONOPOLY (Sept. 18, 2007), <https://birthmonopoly.com/implicit-consent> [<https://perma.cc/2X8H-UGLH>].

<sup>72</sup> See Elizabeth Kukura, *Birth Conflicts: Leveraging State Power to Coerce Health Care Decision-Making*, 47 U. BALT. L. REV. 247, 249–50 (2018) [hereinafter Kukura, *Birth Conflicts*]; see also Paltrow & Flavin, *supra* note 3, at 304–05, 310 tbl.1 (identifying thirty cases involving forced medical intervention, and noting that these totals represent a “substantial undercount” because many cases are “neither reported by the media nor brought to public attention,” *id.* at 304). One study found that courts almost always grant orders compelling intervention when requested, often within hours of the request being made. Veronika E.B. Kolder et al., Special Article, *Court-Ordered Obstetrical Interventions*, 316 NEW ENG. J. MED. 1192, 1193 (1987).

<sup>73</sup> 66 F. Supp. 2d 1247 (N.D. Fla. 1999).

<sup>74</sup> Pemberton had a vertical incision with her prior cesarean, rather than the more common horizontal incision. *Id.* at 1249. A prior vertical incision was thought to be associated with an increased risk of uterine rupture, but studies have since shown no increased risk. See Am. Coll. of Obstetricians & Gynecologists, *ACOG Practice Bulletin: Vaginal Birth After Cesarean Delivery*, 133 OBSTETRICS & GYNECOLOGY e110, e114 (2019) [hereinafter *ACOG Practice Bulletin*].

<sup>75</sup> *Pemberton*, 66 F. Supp. 2d at 1250.

<sup>76</sup> *Id.* at 1251 (citing *Roe v. Wade*, 410 U.S. 113 (1973)).

<sup>77</sup> *Jefferson v. Griffin Spalding City Hosp. Auth.*, 274 S.E.2d 457, 458 (Ga. 1981) (quoting the lower court’s order).

<sup>78</sup> See, e.g., *In re A.C.*, 573 A.2d 1235, 1237 (D.C. 1990) (en banc) (holding that “in virtually all cases the question of what is to be done is to be decided by the patient — the pregnant woman — on behalf of herself and the fetus”); *In re Baby Boy Doe*, 632 N.E.2d 326, 330 (Ill. App. Ct. 1994) (finding that “a

The message to providers in these cases is clear: physicians are the final decisionmakers, not the pregnant person, and no liability will attach so long as the provider follows the standard of care. By failing to uphold informed consent, the law incentivizes providers to induce patient compliance with a narrowly defined standard of care during childbirth, so as to avoid liability.

(c) *Doctrinal Implications: Limited and Coercive Care in Birth.* —

In the aggregate, tort law functions like a regulatory regime that limits the reproductive options available to birthing people to a narrow set of fetal-centric birthing practices. The threat of suit makes it risky for providers to deviate from these practices, even where deviations are supported by the science. Because of tort law, obstetric providers are unwilling to attend a wide variety of births, not because they encompass an objectively unreasonable level of risk, but because they are not typically done — and therefore liability will attach if something goes wrong.

In addition, tort law drives coercion in childbirth. It tasks providers with convincing patients to comply with the standard of care, even when doing so is against the pregnant person's best interest or express refusal. Indeed, manipulation and coercion of patient consent in childbirth, part of the wider phenomenon of "obstetric violence," are widely reported.<sup>79</sup> Roughly 28% of people birthing in the hospital experience mistreatment including violations of bodily autonomy; being shouted at, scolded, or threatened; and being ignored or refused requests for help.<sup>80</sup> There is currently little legal redress for such mistreatment.<sup>81</sup>

The few cases that bubble up into legal proceedings or the media provide a window into the escalating progression of abuse pregnant people who decline medical recommendations can face.<sup>82</sup> For example, in *Dray v. Staten Island University Hospital*,<sup>83</sup> a New York woman decided to try for a vaginal birth after two prior cesarean births.<sup>84</sup> Initially, her providers tried to manipulate her into compliance with dire warnings about the risks, despite the fact that she was a good candidate

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woman's competent choice in refusing medical treatment as invasive as a cesarean section during her pregnancy must be honored, even in circumstances where the choice may be harmful to her fetus").

<sup>79</sup> See Elizabeth Kukura, *Obstetric Violence*, 106 GEO. L.J. 721, 757–65 (2018) [hereinafter Kukura, *Obstetric Violence*]; Maria T. R. Borges, Note, *A Violent Birth: Reframing Coerced Procedures During Childbirth as Obstetric Violence*, 67 DUKE L.J. 827, 828 (2018).

<sup>80</sup> Saraswathi Vedam et al., *The Giving Voice to Mothers Study: Inequity and Mistreatment During Pregnancy and Childbirth in the United States*, 16 REPROD. HEALTH, June 11, 2019, at 1, 8, 11 tbl.6. Rates of mistreatment are higher for women of color. *Id.* at 8, 10 tbl.4. Mistreatment occurs in approximately 5% of births at home. *Id.* at 8, 11 tbl.6.

<sup>81</sup> Kukura, *Obstetric Violence*, *supra* note 79, at 780–81.

<sup>82</sup> See Paltrow & Flavin, *supra* note 3, at 305–09.

<sup>83</sup> 75 N.Y.S.3d 59 (App. Div. 2018).

<sup>84</sup> *Id.* at 62.

for vaginal birth after cesarean (VBAC).<sup>85</sup> During her six hours at the hospital before her doctor “decided to override her refusal” and perform a cesarean against her will,<sup>86</sup> the doctor became increasingly hostile. He threatened her with a court order and said “the state is going to take your baby away.”<sup>87</sup> He told Dray, “My license is more important than you.”<sup>88</sup> During the forced surgery, the doctor was “rough . . . almost as if to punish” Dray,<sup>89</sup> and lacerated her bladder in the process.<sup>90</sup>

Similarly, Michelle Mitchell, who declined a cesarean for a “large baby,” faced a series of threats and abuse before her forced surgery.<sup>91</sup> The doctor was belligerent, “shouting and swearing” at her, as well as threatening to have her baby removed and to obtain a court order.<sup>92</sup> Under threat of legal action, she submitted to forced surgery. Afterward, the doctor reported Mitchell to child protective services anyway.<sup>93</sup> As a result, the hospital would not release the baby to her, and she endured months of investigation before the complaint was dismissed.<sup>94</sup>

A key feature of provider coercion arises from the fact that, up to a point in pregnancy, providers can terminate care for patients that will not comply.<sup>95</sup> Critically, rather than recognizing vaginal birth as an inevitable physiological process that will unfold with or without action by the provider, and in which providers can intervene with medical procedures to assist the process, courts have embraced the medical construct of a vaginal birth as a “procedure” performed by a doctor. In response to pregnant people seeking to avoid forced intervention, courts have argued that a pregnant person has no “right to compel a physician or medical facility to perform a medical procedure in the manner she wishes

<sup>85</sup> See *id.*; *ACOG Practice Bulletin*, *supra* note 74, at e113 (“Given the overall data, it is reasonable to consider women with two previous . . . cesarean deliveries to be candidates for [attempting a VBAC].”).

<sup>86</sup> Page from SIUH Record, NYSCEF Doc. No. 15, *Dray v. Staten Island Univ. Hosp.*, No. 500510/2014 (N.Y. Sup. Ct. July 11, 2014).

<sup>87</sup> Appendix, Vol. I of II, at A-74, *Dray v. Staten Island Univ. Hosp.*, No. 2019-12617 (N.Y. App. Div. 2019).

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

<sup>89</sup> *Id.* at A-75.

<sup>90</sup> *Id.* The court has upheld the doctor’s actions, finding that the “interest in the well being of a viable fetus is sufficient to override a mother’s objection to medical treatment.” Order, NYSCEF Doc. No. 336, at 14, *Dray*, No. 500510/2014 (N.Y. Sup. Ct. Oct. 4, 2019). The court found that Dray’s claims for intentional torts like battery were time-barred, and that her claims for negligence and informed consent were grounded in “allegation[s] of intentional conduct rather than conduct that can be construed as a deviation from a reasonable standard of care.” *Dray*, 75 N.Y.S.3d at 63. The case is on appeal.

<sup>91</sup> Farah Diaz-Tello, *Invisible Wounds: Obstetric Violence in the United States*, 24 REPROD. HEALTH MATTERS 56, 58–59 (2016).

<sup>92</sup> *Id.* at 59.

<sup>93</sup> *Id.*

<sup>94</sup> *Id.* Mitchell sued for battery and lost. *Id.*

<sup>95</sup> Theresa Morris & Joan H. Robinson, *Forced and Coerced Cesarean Sections in the United States*, 16 CONTEXTS 24, 26 (2017).

against their best medical judgment.”<sup>96</sup> As a result, people seeking to choose a birthing method disfavored by the medico-legal system often struggle to find any provider to care for them.<sup>97</sup>

It is safe to assume that many pregnant people acquiesce in the face of manipulated risk presentations, the threat of termination of care,<sup>98</sup> or eventually under threat of child protective services or court orders. As providers offer an increasingly narrow set of birthing options, it becomes more difficult for birthing people to find the exceptional provider who is willing to attend a particular category of birth that is disfavored, like VBAC. By incentivizing medical professionals to ensure compliance with the fetal primacy model, the state is rarely required to do so itself. In this way medical providers serve as effective de facto law enforcement.

2. *Restricting Maternal Choice Through Midwifery Regulation.* —

The regulation of midwives stands in clear contrast to the legal infrastructure around physicians: Tort law grants the medical profession enormous leeway to set and maintain standards, and upholds the coercive power of physicians over patients, in a manner that indirectly limits options for care. Conversely, midwives are tightly regulated in ways that parallel abortion regulation and directly restrict the reproductive options available. Midwifery care offers the main alternative to the dominant medical model of childbirth; accordingly, restrictions on access to midwives are an effective means of curtailing reproductive choice.

States vary widely on which types of midwives they license, the scope of practice they allow those midwives, and access to birthing-center or home birth.<sup>99</sup> This section first discusses how restricting the practice of midwifery curtails reproductive decisionmaking. Second, it explores the

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<sup>96</sup> Press Release, Nat’l Advoc. for Pregnant Women, Florida Hospital Says It Will Force Pregnant Woman to Have Cesarean Surgery (July 25, 2014), <https://www.nationaladvocatesforpregnantwomen.org/press-release-florida-hospital-says-it-will-force-pregnant-woman-to-have-cesarean-surgery> [<https://perma.cc/WW5D-KWY6>] (quoting an order denying a pregnant woman a restraining order against a hospital that threatened to perform surgery on her “with or without [her] consent” and to have her child removed if she presented in labor).

<sup>97</sup> Both Dray and Mitchell had left practices earlier in pregnancy that were unwilling to respect their decisions. See Appendix, Vol. I of II, at A-29, *Dray v. Staten Island Univ. Hosp.*, No. 2019-12617 (N.Y. App. Div. 2019); Diaz-Tello, *supra* note 91, at 58-59.

<sup>98</sup> Obstetric care shortages are severe, making a threat to deny care dispositive for many. From 2004 to 2014, the percentage of rural counties that have no obstetric services increased from 46% to 55%. NAT’L ADVISORY COMM. ON RURAL HEALTH & HUM. SERVS., DEPT. OF HEALTH & HUM. SERVS., MATERNAL AND OBSTETRIC CARE CHALLENGES IN RURAL AMERICA 3 (2020). As of 2016, 70% of counties in the United States had no Certified Nurse Midwives. Brittany L. Ranchoff & Eugene R. Declercq, *The Scope of Midwifery Practice Regulations and the Availability of the Certified Nurse-Midwifery and Certified Midwifery Workforce, 2012-2016*, 65 J. MIDWIFERY & WOMEN’S HEALTH 119, 121 (2019).

<sup>99</sup> See Y. Tony Yang & Katy B. Kozhimannil, Commentary, *Making a Case to Reduce Legal Impediments to Midwifery Practice in the United States*, 25 WOMEN’S HEALTH ISSUES J. 314, 314 (2015).

use of targeted regulation of midwifery providers (TROMP laws) to further inhibit the practice of midwifery.

(a) *Restricted Midwifery Practice*. — When midwives are not permitted to practice, pregnant people lose access to a range of reproductive health options. Prohibiting midwives from attending various births effectively bans pregnant people from making those reproductive choices. In some cases such restrictions functionally mandate cesarean birth, denying certain people access to any care provider that would facilitate vaginal birth.<sup>100</sup>

The complexity and irregularity of midwifery regulation in the United States reflect the extensive efforts of medical associations to prohibit the practice of midwifery. Midwives attended the vast majority of births through the late nineteenth century, when a “physician-led campaign to prohibit midwives from practicing” began.<sup>101</sup> These efforts were successful: in the first half of the twentieth century, midwifery was almost eradicated, and most birth moved into the hospital.<sup>102</sup> Midwifery saw a resurgence in the seventies and has undergone waves of professionalization and fragmented state regulation since then.<sup>103</sup> However, physicians have continued concerted campaigns to restrict the practice of midwifery, hampering efforts to improve access.<sup>104</sup> The ongoing organized opposition by medical lobbying groups has fueled the uneven and restrictive regulatory framework present today.

Today, three types of credentialed midwives practice in the United States: Certified Professional Midwives (CPMs), Certified Midwives

<sup>100</sup> Insurance coverage continues to be a major barrier to access to out-of-hospital midwifery care, limiting the reproductive freedom of pregnant people based on income. See MacDorman & Declercq, *supra* note 25, at 285–86. Due to space constraints, this obstacle is not covered here in depth. Medicaid coverage of community birth and midwifery care varies by state, as does private insurance coverage. See *id.* Roughly two-thirds of planned home births are self-paid. *Id.* at 285.

<sup>101</sup> JUDITH PENCE ROOKS, *MIDWIFERY AND CHILDBIRTH IN AMERICA* 22 (1997); see *id.* at 17. Competition was a driving force for physicians, who saw birth as a route to high fees and new, long-term clients. See *id.* at 19. Physicians “publicly attacked” midwives as “poor, black, immigrants, dirty, illiterate, untrained, ignorant, immoral, drunken, . . . and . . . criminal abortionists.” *Id.* at 25.

<sup>102</sup> See *id.* at 31. Where midwifery declined, maternal and infant mortality rates climbed. *Id.* at 30. This was in spite of broader trends of gradually decreasing maternal and infant mortality. See *id.* at 31. Birth injuries from instrumental delivery by physicians and puerperal sepsis introduced in hospitals were likely driving factors. See *id.* at 25, 28–30.

<sup>103</sup> See *id.* at 60–64, 159–61, 225–28.

<sup>104</sup> In a 2007 report, the American College of Obstetricians and Gynecologists (ACOG) praised “deft political maneuvering and hardball tactics . . . by the State Medical Societ[ies]” to stop midwifery licensure. AM. COLL. OF OBSTETRICIANS & GYNECOLOGISTS, *ACOG STATE LEGISLATIVE UPDATE YEAR IN REVIEW* (2007), [http://collegeofmidwives.org/wordpress/wp-content/uploads/2011/09/e-7-ACOG\\_Insider\\_Midwifery-Review\\_2007.pdf](http://collegeofmidwives.org/wordpress/wp-content/uploads/2011/09/e-7-ACOG_Insider_Midwifery-Review_2007.pdf) [<https://perma.cc/YF5A-YAU6>]. In 2014, ACOG released a “State Legislative Toolkit” for state chapters to oppose expanded access to midwives. See AM. COLL. OF OBSTETRICIANS & GYNECOLOGISTS, *STATE LEGISLATIVE TOOLKIT: LICENSURE AND REGULATION OF CERTIFIED PROFESSIONAL MIDWIVES (CPMS)* (2014) (on file with the Harvard Law School Library).

(CMs), and Certified Nurse Midwives (CNMs).<sup>105</sup> All three train to serve as independent, primary care providers throughout the childbearing cycle, offering complete prenatal care, facilitating the birth, and giving care through the postpartum period.<sup>106</sup> All three also monitor for complications and transfer patients to physicians as needed for additional care.<sup>107</sup> Within this shared overall scope, their training and consequent scope of practice varies. The key relevant difference here is that CPMs train and practice almost exclusively at home or in birthing centers, while CNMs and CMs train and practice primarily in hospitals.<sup>108</sup>

(i) *Prohibiting Practice.* — Many states do not authorize legal practice by CPMs. CPMs can legally practice in thirty-four states and Washington, D.C.,<sup>109</sup> CNMs in all fifty states, and CMs in only a handful.<sup>110</sup> Because most CNMs and CMs practice in the hospital, birthing people in states that fail to license CPMs often have no legal care option to birth out of the hospital.<sup>111</sup> Many people in these states will choose “community birth”<sup>112</sup> regardless, creating strong demand for any underground midwife willing to serve them.<sup>113</sup> Midwives in these states risk

<sup>105</sup> CPMs are credentialed through the North American Registry of Midwives, while CNMs and CMs are credentialed through the American Midwifery Certification Board. See AM. COLL. OF NURSE-MIDWIVES, COMPARISON OF CERTIFIED NURSE-MIDWIVES, CERTIFIED MIDWIVES, CERTIFIED PROFESSIONAL MIDWIVES CLARIFYING THE DISTINCTIONS AMONG PROFESSIONAL MIDWIFERY CREDENTIALS IN THE U.S. (2017), <https://www.midwife.org/acnm/files/ccLibraryFiles/FILENAME/00000006807/FINAL-ComparisonChart-Oct2017.pdf> [<https://perma.cc/P48H-ZR5V>]. There are also noncredentialed midwives who range widely in their training and experience.

<sup>106</sup> See *id.*

<sup>107</sup> See *id.*

<sup>108</sup> *Id.* In broad strokes, other key differences are that CNMs train first as nurses and subsequently as midwives, while CMs and CPMs train directly as midwives. See *id.* CNMs and CMs train to provide primary gynecological care and in the use of a broad array of pharmacologic medications, while CPMs’ training in gynecologic care is typically more limited and they train primarily in the use of those medications used commonly in pregnancy, birth, and the postpartum period. See *id.* CNMs and CMs are required to have a graduate degree, while certification as a CPM requires either completion of a Midwifery Education Accreditation Council (MEAC) midwifery program or the North American Registry of Midwives (NARM) Portfolio Evaluation Process. *Id.*

<sup>109</sup> *CPMs Legal Status by State*, BIG PUSH FOR MIDWIVES, [https://www.pushformidwives.org/cpms\\_legal\\_status\\_by\\_state](https://www.pushformidwives.org/cpms_legal_status_by_state) [<https://perma.cc/4493-FU8Q>].

<sup>110</sup> *Legal Status of U.S. Midwives*, MIDWIVES ALL. OF N. AM., <https://mana.org/about-midwives/legal-status-of-us-midwives> [<https://perma.cc/9J7M-7SUV>].

<sup>111</sup> See AM. COLL. OF NURSE-MIDWIVES, FACT SHEET: CNM/CM-ATTENDED BIRTH STATISTICS IN THE UNITED STATES (2016), <http://www.midwife.org/acnm/files/ccLibraryFiles/Filename/00000005950/CNM-CM-AttendedBirths-2014-031416FINAL.pdf> [<https://perma.cc/4FFB-WLAH>] (finding 94.3% of births by CNMs/CMs occurred in hospital).

<sup>112</sup> There has been a recent turn away from the term “out-of-hospital” toward “community birth” because “out-of-hospital” “reifies hospital birth as normative and community birth as other.” Melissa Cheyney et al., Commentary, *Community Versus Out-of-Hospital Birth: What’s In a Name?* 64 J. MIDWIFERY & WOMEN’S HEALTH 9, 9 (2019). This Chapter uses both terms interchangeably.

<sup>113</sup> Some unlicensed states have fairly robust and open access to CPMs despite a lack of licensure, likely because state agencies have largely declined to prosecute them, while others have a hostile

being criminally charged for assisting people with their births.<sup>114</sup> Prosecution can arise seemingly out of the blue after many years without state enforcement, ensuring that midwives and the people they serve in unlicensed states live with the ongoing risk of prosecution and precipitous loss of access to care.<sup>115</sup>

The ongoing prosecution of Elizabeth Catlin, a New York CPM, is illustrative. New York allows for the licensure of CPMs, but the law has been implemented as to exclude them from licensure.<sup>116</sup> Catlin openly attended Mennonite women in rural New York for twenty-five years, and was the only midwife in the region.<sup>117</sup> In 2018, Catlin transferred a client into the hospital for additional care.<sup>118</sup> The baby was born at the hospital and later died.<sup>119</sup>

In December 2018, Catlin was arrested and charged with ninety-five felony counts, carrying a maximum prison sentence of 473 years.<sup>120</sup> At her hearing, Mennonite families, who describe Catlin's care as "like a mother,"<sup>121</sup> crowded the courthouse, singing "Amazing Grace."<sup>122</sup> With no midwives left, pregnant people in the community can either go to the hospital or birth at home alone, as several reportedly did after Catlin's arrest.<sup>123</sup>

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environment with limited access. *Compare Midwife Profiles*, MASS. MIDWIVES ALL., <http://mass-midwives.org/for-parents/members/#!directory> [<https://perma.cc/7ERA-5W6K>] (openly advertising names of CPMs despite lack of licensure), *with* ILL. COUNCIL OF CERTIFIED PRO. MIDWIVES, <http://illinoismidwives.org> [<https://perma.cc/MW8J-6DCQ>] (describing how CPMs "must practice underground" due to lack of licensure).

<sup>114</sup> See Indra Lusero, *Making the Midwife Impossible: How the Structure of Maternity Care Harms the Practice of Home Birth Midwifery*, 35 WOMEN'S RTS. L. REP. 406, 417 (2014).

<sup>115</sup> Cf. *id.* (describing the burdens of practicing or receiving care under threat of prosecution). Midwives in *licensed* states can also face substantial risks of prosecution for normal midwifery practice where they are overseen by hostile regulatory agencies, a fact that puts a chill on the ability of midwives to fully support birthing people's choices in those regions. See *id.* at 418–19.

<sup>116</sup> *Legal Status of U.S. Midwives*, *supra* note 110.

<sup>117</sup> See Tyler Pager, *She Helped Deliver Hundreds of Babies. Then She Was Arrested.*, N.Y. TIMES (Mar. 5, 2019), <https://www.nytimes.com/2019/03/05/nyregion/mennonite-midwife-arrest.html> [<https://perma.cc/SC64-Y8YY>].

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

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

<sup>120</sup> See Beth Greenfield, *Arrested Rural Midwife Heads to Trial on 95 Felony Counts: "I Don't Think Jack the Ripper Faced that Many Charges,"* YAHOO!LIFE (Jan. 29, 2020), <https://www.yahoo.com/lifestyle/arrested-rural-midwife-heads-to-trial-on-95-felony-counts-182148503.html> [<https://perma.cc/K5EC-Q6P8>]. The charges included criminally negligent homicide, identity theft, falsifying business records, and possession of a forged instrument. Gwen Chamberlain, *Dozens Pack Courtroom as Penn Van Midwife in High-Profile Case Says She's Innocent*, DEMOCRAT & CHRONICLE (Jan. 29, 2020, 2:46 PM), <https://www.democratandchronicle.com/story/news/politics/albany/2020/01/29/elizabeth-catlin-enters-not-guilty-plea-finger-lakes-midwife-case/4611106002> [<https://perma.cc/2QVG-WGPX>].

<sup>121</sup> Pager, *supra* note 117.

<sup>122</sup> Chamberlain, *supra* note 120.

<sup>123</sup> Pager, *supra* note 117.

New York's clampdown on midwives demonstrates the way in which prohibitions on midwifery care are analogous to bans on abortion. As with abortion care, lack of access to qualified midwives means that some pregnant people will birth without adequate care. Moreover, when hospital care is needed, unlicensed midwives may fear taking in a client due to the risk of prosecution. Prohibiting midwives from practicing thus simultaneously abridges the reproductive freedom for birthing people, while making the disfavored care option less safe for those who would choose it anyway.

(ii) *Limiting Scope of Practice.* — States also limit birthing people's reproductive freedom by prohibiting midwives from attending particular births. Such prohibitions are almost always in the name of safety, but the evidence of underlying risk varies greatly, or is often unknown.<sup>124</sup> Even where there is clear elevated risk, under normal circumstances, a care provider would discuss the risks and benefits of a given option, and the patient would decide how to proceed.<sup>125</sup> The regulation of particular, discrete health decisions in pregnancy thus departs from typical standards of healthcare law.

Scope of practice is most tightly regulated for community midwives, usually CPMs. These restrictions vary widely between states and creep into territory where people may reasonably disagree about the level of risk present, whether that risk is appropriate to assume, and whether the risk is increased by being in the home setting versus the hospital.<sup>126</sup> For example, despite a lack of evidence to support such measures, some states restrict access for people with a history of psychiatric ill-

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<sup>124</sup> Cf. Yang & Kozhimannil, *supra* note 99, at 314–15 (arguing that restrictions on midwifery have “historically been implemented and passed on the premise of supporting patient safety . . . , but an abundance of clinical evidence indicates that such restrictions may actually have an opposite effect, denying women access to potentially safe, high quality options for maternity care”).

<sup>125</sup> See WEAR, *supra* note 59, at 10.

<sup>126</sup> Cf. Kathi Valeii, *People Who Want Home Births Have to Jump Through All Kinds of Hoops*, VICE (Aug. 8, 2018, 6:40 PM), <https://www.vice.com/en/article/pawxyz/home-birth-midwife-restrictions> [<https://perma.cc/N22P-PFGK>] (noting that while some conditions excluded from community birth “seem[] like a legitimate obstacle to home birth,” others “seem laden with value judgments” (quoting civil rights attorney Jacqueline K. Hammack)); see also Am. Coll. of Nurse-Midwives, *Midwifery Provision of Home Birth Services*, 61 J. MIDWIFERY & WOMEN'S HEALTH 127, 129–30 (2015) (discussing conditions that may increase risk for homebirth).

ness,<sup>127</sup> or who are under or over a certain age<sup>128</sup> or body mass index.<sup>129</sup> Also prominent are restrictions on vaginal birth after cesarean births, though the balance of risks may weigh in favor of home VBAC for some.<sup>130</sup> While these conditions may lead birthing people to elect to plan a hospital birth or transfer to the hospital in some or even many cases, blanket restrictions that deny people the ability to weigh individual risks and make informed decisions apply a double standard to the birthing process that is rarely present in other healthcare settings.<sup>131</sup>

Moreover, when a person is denied midwifery care as an option, and the liability risk is too high for hospital providers to undertake a vaginal birth, the legal infrastructure effectively forces birth by cesarean. Pregnant people in these situations have been known to drive an hour or more to legal midwifery care or to hospitals that will respect their decisionmaking.<sup>132</sup> Some choose to birth alone at home.<sup>133</sup> But many, perhaps the vast majority, end up undergoing surgeries they were unable to refuse.

Prohibitions on community birth for pregnant people with a prior cesarean birth illustrate this phenomenon. Because roughly a third of births are by cesarean, these restrictions impact large numbers of people in subsequent pregnancies.<sup>134</sup> The evidence shows that attempting a VBAC is a safe option that should be offered to most people, even though it carries a 0.7% risk of uterine rupture.<sup>135</sup> People who achieve a vaginal birth experience significant health advantages over those who

<sup>127</sup> See, e.g., MONT. ADMIN. R. 24.111.610(1)(a)(viii) (2021) (prohibiting care where psychiatric illness required medication within six months prior to pregnancy); WYO. STAT. ANN. § 33-46-103(j)(i)(C)(XII) (2020) (requiring a midwife to recommend physician consultation for any history of psychiatric illness).

<sup>128</sup> See, e.g., ALASKA ADMIN. CODE tit. 12, § 14.150(b)(22) (2019) (requiring consultation with a physician, registered nurse, or CNM for people under fourteen); 7-13-1 ARK. CODE R. § 406.02(5) (LexisNexis 2020) (requiring physician approval for people over forty); ARIZ. ADMIN. CODE § R9-16-112(A)(4)-(5) (2020) (requiring consultation for people under sixteen and over forty).

<sup>129</sup> See, e.g., IDAHO CODE § 54-5505(1)(e)(i)(7) (2012) (prohibiting care for those with a “body mass index of forty (40.0) or higher”); MD. CODE REGS. 10.64.03(C)(33) (2015) (prohibiting care for those with “body mass index (BMI) of less than 18.5 or 35 or more”).

<sup>130</sup> For express prohibitions on VBAC, see, for example, Arkansas, 7-13-1 ARK. CODE R. § 406.01(22) (LexisNexis 2020), and Maryland, MD. CODE REGS. 10.64.03(11) (2015). For restrictions that effectively prohibit VBAC attendance, see Louisiana, LA. ADMIN. CODE tit. 46, § 5315(B)(1) (2019) (requiring physician collaboration that is unattainable), and New Jersey, N.J. ADMIN. CODE § 13:35-2A.9(b)(2)(v) (2020) (requiring VBAC occur with physician co-management). See also *infra* notes 134–144 and accompanying text.

<sup>131</sup> Cf. WEAR, *supra* note 59, at 10 (describing typical informed consent decisionmaking).

<sup>132</sup> See, e.g., Pager, *supra* note 117.

<sup>133</sup> Cf. Anita Evensen, *A Do-It-Yourself Approach to Pregnancy and Childbirth*, UNASSISTED BABY, <https://www.theunassistedbaby.com> [<https://perma.cc/ZRW8-B5ZZ>].

<sup>134</sup> In 2018, 15.66% of birthing people had a prior cesarean section. *Additional Data, MATERNAL CTRS. OF EXCELLENCE*, <https://www.maternalcoe.org/additionaldata> [<https://perma.cc/LUG4-EV4R>].

<sup>135</sup> *ACOG Practice Bulletin*, *supra* note 74, at e111.

have a repeat cesarean section, including avoiding major abdominal surgery, lower rates of serious complications and death, as well as lower risk of complications in future pregnancies.<sup>136</sup> When attempted after a cesarean, a vaginal birth is achieved 60–80% of the time.<sup>137</sup> However, because so few people are permitted to try, only 13.3% of people with a prior cesarean section had a vaginal birth in 2018.<sup>138</sup>

Due to the risk of liability,<sup>139</sup> people in large areas of the country cannot access a hospital that will permit them to attempt a VBAC.<sup>140</sup> They face a choice between a forced medical procedure and a community birth.<sup>141</sup> Outside the hospital, attempted VBAC results in a vaginal birth almost 90% of the time.<sup>142</sup> VBAC at home likely carries a higher risk of fetal death than VBAC in the hospital, but the absolute rate remains low.<sup>143</sup> For many people, the high chance of achieving the health benefits of a vaginal birth at home makes assuming some additional fetal risk acceptable, particularly when a previous hospital experience was negative.<sup>144</sup> Thus, when states ban access to midwifery care for people with a prior cesarean, they are consigning many to compelled cesarean birth.

(b) *Targeted Regulation of Midwifery Providers (TROMP Laws)*. — In addition to laws that restrict practice, a number of states single out midwives for regulations that appear to serve primarily to limit access to care.<sup>145</sup> In the abortion literature, similar regulations have been

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<sup>136</sup> *Id.* The benefits of avoiding multiple repeat cesarean deliveries makes access to VBAC an especially pressing issue for people who plan to have many babies, including those in religions that avoid birth control.

<sup>137</sup> *Id.* at e112.

<sup>138</sup> MICHELLE J.K. OSTERMAN, U.S. DEP'T OF HEALTH & HUM. SERVS., RECENT TRENDS IN VAGINAL BIRTH AFTER CESAREAN DELIVERY: UNITED STATES, 2016–2018, NCHS DATA BRIEF, NO. 359, at 1 (2020).

<sup>139</sup> ACOG *Practice Bulletin*, *supra* note 74, at e110.

<sup>140</sup> See Elizabeth Kukura, *Choice in Birth: Preserving Access to VBAC*, 114 PENN ST. L. REV. 955, 957 (2010) [hereinafter Kukura, *Choice in Birth*] (citing survey indicating that more than 800 hospitals had VBAC bans, while almost 400 others had de facto bans).

<sup>141</sup> *Id.* at 958.

<sup>142</sup> Cheyney et al., *supra* note 35, at 20–21.

<sup>143</sup> *Id.* at 23 (finding an intrapartum death rate of 2.85 out of 1,000 for attempted VBAC at home).

<sup>144</sup> Many people with prior cesarean sections may have experienced manipulation or coercion in a prior hospital birth that resulted in an unwanted or unnecessary cesarean, and seek to avoid a repeat of that experience. Cf. *Support*, INT'L CESAREAN AWARENESS NETWORK, <https://www.ican-online.org/support> [<https://perma.cc/666J-HPAZ>] (offering resources and support groups throughout the country for people to process their cesarean experiences and to discuss how to proceed with a subsequent birth).

<sup>145</sup> Valeii, *supra* note 126; see also Elizabeth Kukura, *Better Birth*, 93 TEMPLE L. REV. (forthcoming 2021) (manuscript at 65–69) (on file with the Harvard Law School Library) (documenting “Regulatory Hostility” toward midwives, including an array of barriers to practice).

deemed “targeted regulation of abortion providers,” or “TRAP laws.”<sup>146</sup> Such regulations include requirements that abortion clinics meet ambulatory care center standards despite a lack of medical necessity, that abortion providers have hospital admitting privileges though hospital transfers are exceedingly rare, or that abortion providers perform medically unnecessary ultrasounds on patients.<sup>147</sup> In practice, such laws make it challenging or impossible to offer abortion services, and they have been litigated under the “undue burden” standard as a result.<sup>148</sup>

Similarly, in childbirth, states have passed a number of superfluous regulations designed to inhibit midwifery practice, or TROMP laws (“targeted regulation of midwifery providers”).<sup>149</sup> For example, roughly half of states require CNMs, though trained as independent providers,<sup>150</sup> to enter into a written “collaborative” agreement with a physician in order to practice.<sup>151</sup> Such requirements “do not improve patient safety, [but] do negatively impact cost, access, and quality” of care.<sup>152</sup> Midwives struggle to find physicians willing to sign an agreement, and regularly pay thousands of dollars per year to maintain the agree-

<sup>146</sup> See, e.g., *Targeted Regulation of Abortion Providers (TRAP) Laws*, GUTTMACHER INST. (Jan. 22, 2020), <https://www.guttmacher.org/print/evidence-you-can-use/targeted-regulation-abortion-providers-trap-laws> [<https://perma.cc/JG5T-98FB>].

<sup>147</sup> See *id.*; Rachel Benson Gold & Elizabeth Nash, *TRAP Laws Gain Political Traction While Abortion Clinics — and the Women They Serve — Pay the Price*, 16 GUTTMACHER POL’Y REV., Spring 2013, at 7, 7.

<sup>148</sup> See Gold & Nash, *supra* note 147, at 10; see also *Whole Woman’s Health v. Hellerstedt*, 136 S. Ct. 2292, 2300 (2016) (striking down ambulatory care center and admitting privileges laws); *June Med. Servs. L.L.C. v. Russo*, 140 S. Ct. 2103, 2112–13 (2020) (plurality opinion) (striking down admitting privileges law).

<sup>149</sup> Though the term “TROMP law” used here is new, comparison of TRAP laws to midwifery regulation originated with practicing attorneys in the birth rights community. Susan M. Jenkins, longtime midwifery advocate and counsel to several major midwifery organizations, has called these laws “TRIP laws” (targeted regulation of intrapartum providers). Email from Susan Jenkins to author (June 28, 2016, 9:42 AM) (on file with the Harvard Law School Library). Other attorneys have challenged TROMP laws, including Indra Lusero in Colorado, Kesha Chiapinelli in Arkansas, Jacqueline Kaye Hammack in Mississippi, and Julie Gunnigle in Arizona. Email from Indra Lusero to author (Oct. 20, 2020, 5:30 AM) (on file with the Harvard Law School Library).

<sup>150</sup> CNMs routinely collaborate, consult, and refer in their capacity as independent providers. See, e.g., AM. COLL. OF NURSE-MIDWIVES, POSITION STATEMENT: COLLABORATIVE MANAGEMENT IN MIDWIFERY PRACTICE FOR MEDICAL, GYNECOLOGIC AND OBSTETRIC CONDITIONS (2014), <http://midwife.org/ACNM/files/ACNMLibraryData/UPLOADFILENAME/00000000058/Collaborative-Mgmt-in-Midwifery-Practice-Sept-2014.pdf> [<https://perma.cc/RZ5G-ARAF>].

<sup>151</sup> See *States that Allow CNMs to Practice and Prescribe Independently vs Those that Require a Collaborative Agreement*, MIDWIFESCHOOLING.COM, <https://www.midwifeschooling.com/independent-practice-and-collaborative-agreement-states> [<https://perma.cc/H4EA-XMUX>] (finding that nineteen states require written collaborative agreements, seven states require a collaborative agreement only for prescriptive authority, while twenty-four states and the District of Columbia support full autonomous practice); see also *Ranchoff & Declercq*, *supra* note 98, at 122 tbl.1 (presenting a taxonomy of state collaborative agreement and physician supervision regulations).

<sup>152</sup> Brendan Martin & Kyrani Reneau, *How Collaborative Practice Agreements Impede the Administration of Vital Women’s Health Services*, 65 J. MIDWIFERY & WOMEN’S HEALTH 487, 487 (2020).

ment.<sup>153</sup> In order to obtain an agreement, midwives may be forced to limit the care options they offer to those practices of which the physician approves, thereby denying people the much-needed access to alternative options. Collaborative agreements appear effective at stifling midwifery.<sup>154</sup> By targeting midwives with this arbitrary requirement, states thus significantly limit people's access to reproductive choice in birth.

Like abortion clinics, birth centers have been targeted with ambulatory care center laws and other restrictive facility requirements.<sup>155</sup> Such restrictions, designed with surgery in mind, are inapplicable in the birthing context.<sup>156</sup> Some states require hospital admitting privileges in order to operate a birth center.<sup>157</sup> Due to the many hurdles to achieving such privileges, these rules serve as a significant barrier to practice.<sup>158</sup>

In the case of CPMs, a number of arbitrary TROMP laws inhibit practice.<sup>159</sup> In Virginia, for example, CPMs are denied the ability to carry the lifesaving medications midwives use at births to stop hemorrhaging or provide supplemental oxygen, either in labor or to the newborn.<sup>160</sup> In Arkansas, birthing people cannot elect CPM care without submitting to a pelvic exam with a hospital provider.<sup>161</sup> In Arizona, regulations require midwives to perform repeated vaginal exams in labor — a rule that compromises both safety and autonomy.<sup>162</sup> These types of arbitrary TROMP laws reveal a value-laden attempt by the state to inhibit people's access and choice in birth to medicalized, fetal-centric practices, without a reasonable safety rationale.

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<sup>153</sup> *Id.* at 492, 494.

<sup>154</sup> See Y. Tony Yang et al., *State Scope of Practice Laws, Nurse-Midwifery Workforce, and Childbirth Procedures and Outcomes*, 26 *WOMEN'S HEALTH ISSUES* 262, 265 (2016) (finding that in states with autonomous midwifery practice, there were 4.85 CNMs per 1,000 births and 9.71% of births were attended by CNMs, while in those requiring collaborative practice there were 2.17 CNMs per 1,000 births and 7.01% of births were attended by CNMs); Ranchoff & Declercq, *supra* note 98, at 122 (finding "more than double the concentration of midwives in states with autonomous practices frameworks" than those requiring collaborative agreements or physician supervision).

<sup>155</sup> Letter from Lesley Rathbun, President, Am. Ass'n of Birth Ctrs., to Donald S. Clark, Sec'y, Fed. Trade Comm'n 8 (Apr. 30, 2014), [https://cdn.ymaws.com/www.birthcenters.org/resource/collection/DCBDA72A-41EA-4AFE-A8D1-1112542F4A0BC/FTC\\_Letter\\_-\\_4.30.14\\_with\\_appendices.pdf](https://cdn.ymaws.com/www.birthcenters.org/resource/collection/DCBDA72A-41EA-4AFE-A8D1-1112542F4A0BC/FTC_Letter_-_4.30.14_with_appendices.pdf) [<https://perma.cc/47AM-4JBA>].

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

<sup>157</sup> *Id.* at 11.

<sup>158</sup> *Id.* at 11–12.

<sup>159</sup> See Valeii, *supra* note 126.

<sup>160</sup> Michelle Andrews, *States Vary on What They Allow Midwives to Do*, NPR (Feb. 14, 2012, 10:37 AM), <https://www.npr.org/sections/health-shots/2012/02/14/146859861/states-vary-on-what-they-allow-midwives-to-do> [<https://perma.cc/M24Y-CMEJ>].

<sup>161</sup> See Valeii *supra* note 126.

<sup>162</sup> *Id.*; see also ARIZ. ADMIN. CODE § R9-16-108(J)(3)(c) (2020).

### C. Analysis

The law uses the provision of healthcare as a mechanism to constrain reproductive decisionmaking in childbirth. This section describes several key insights drawn from viewing the legal infrastructure of childbirth as a whole: pregnancy exceptionalism, the law's symbolic allegiance to fetal wellbeing over that of the pregnant person, and the role of medical providers as law enforcers.

*I. Pregnancy Exceptionalism.* — The law around childbirth breaks from standards and norms that control in healthcare regulation more broadly.<sup>163</sup> These departures help reveal the normative and ideological state of the law around childbirth. Bringing healthcare regulation of pregnancy in line with existing legal standards would, in itself, go a long way toward remedying the law in this area.

Pregnancy is an exception to the principle that the state should not mandate specific health practices, which are best decided between individuals and their providers.<sup>164</sup> Healthcare regulations typically defer heavily to health professions and patient choice to resolve tricky questions of medical uncertainty of risk.<sup>165</sup> In pregnancy, however, through granting outsized tort damages for fetal harm that distort the standard of care and failure to enforce informed consent — alongside intensive regulation of midwives — the law inserts itself into discrete health decisionmaking in a manner that departs from regulatory norms.

Pregnancy is also an exception from established principles of informed consent.<sup>166</sup> Normal principles of healthcare decisionmaking are cast aside, and the law permits a level of coercion by providers that would be unacceptable in any other healthcare setting.<sup>167</sup> Through the use of court orders, it also actively imposes coercion in ways that mark a clear break from its widely implemented standards for medical decisionmaking.<sup>168</sup>

<sup>163</sup> Professor Elizabeth Kukura has identified this pregnancy exceptionalism in multiple works. See, e.g., Kukura, *Birth Conflicts*, *supra* note 72, at 250 (discussing “the pregnancy exceptionalism that tolerates coercion in the provider-patient relationship”); Kukura, *Choice in Birth*, *supra* note 140, at 989–90 (arguing that birth, as “simply a common physiological process that may require medical care,” should be “governed by the same rules . . . as any other medical intervention”).

<sup>164</sup> See, e.g., *Health Professions Regulation in the U.S.*, HEALTH WORKFORCE TECH. ASSISTANCE CTR., <https://www.healthworkforceta.org/health-professions-regulation-in-the-us> [<https://perma.cc/QB4Q-ZAYB>] (collecting research and best practices, including that “legal scope of practice” should be “align[ed]” with “professional competence”).

<sup>165</sup> See Kukura, *Better Birth*, *supra* note 145 (manuscript at 68–69) (discussing the U.S. model of “self-regulated health care professions”).

<sup>166</sup> Cf. Julie D. Cantor, *Court-Ordered Care — A Complication of Pregnancy to Avoid*, 366 N. ENG. J. MED. 2237, 2240 (2012) (describing Laura Pemberton’s forced cesarean).

<sup>167</sup> Kukura, *Birth Conflicts*, *supra* note 72, at 250.

<sup>168</sup> See *supra* section B.1(c), pp. 2218–20.

Much of the exceptionalism around childbirth and law is unwritten. There is no formal legal exception for birth to the laws of informed consent,<sup>169</sup> nor does tort law doctrinally hold the fetal life to be more valuable than the pregnant person's.<sup>170</sup> The unwritten nature of these principles obscures the consistent policymaking at work in the law around childbirth. It may be that demanding a more formalistic approach by the law in this context could benefit birthing people.<sup>171</sup> This debate demands more attention, but regardless, commentators bringing the unwritten legal exceptionalism in childbirth to light enable such a conversation.

2. *Fetus over Pregnant Person.* — The law around childbirth inscribes a system of values that elevates the purported interests of the fetus over those of the pregnant person. Examination of the legal infrastructure reveals that the state has a preferred set of treatment options in childbirth: it approves of and seeks to enforce care that will minimize any perceived risk to the fetus, regardless of the costs to the pregnant person,<sup>172</sup> or to widely held values like autonomy, bodily integrity, parental rights, or religious liberty. Medical uncertainty regarding actual risk, which pervades the obstetric setting, allows for a persistent impression of potential fetal risk that must be avoided. The notion of “perceived risk” here is paramount: restrictions around reproductive choice in childbirth often rest on an impression of risk to the fetus rather than an actual, empirical risk to the fetus.<sup>173</sup> Put differently, the symbolic value of elevating the worth of the fetus over the pregnant person may be just as (or more) important to the state as physically protecting the health of the fetus over that of the pregnant person.

Tort law requires that pregnant people — and healthcare providers — display symbolic allegiance to a fetus-over-pregnant-person model, rather than conform to the best medical evidence. In some cases, it incentivizes care options that harm maternal outcomes and do not improve fetal outcomes, as in the case of continuous fetal monitoring.<sup>174</sup> Through the regulation of midwives, the law inhibits a range of birth

<sup>169</sup> Kukura, *Birth Conflicts*, *supra* note 72, at 281.

<sup>170</sup> Abrams, *Illusion of Autonomy*, *supra* note 54, at 30 (finding there is no “explicit tort standard or medical standard to address the anomalous nature of childbirth”).

<sup>171</sup> If policymakers and judges are required to confront pregnancy exceptionalism and make clear legal doctrine around when, for instance, a cesarean can be mandated against the will of a pregnant person, they may draw the lines more narrowly than they currently stand. Birthing people, aware of a formal exception, might be able to advocate around the issue more effectively.

<sup>172</sup> Abrams, *Illusion of Autonomy*, *supra* note 54, at 20 (observing that tort law “always prioritizes fetal risks over maternal risks regardless of likelihood or severity”).

<sup>173</sup> See WOLF, *supra* note 12, at 6 (noting “[p]erceived risk . . . is not risk” given clear evidence that, when not medically necessary, cesareans are riskier for the fetus and the mother than vaginal birth).

<sup>174</sup> See Margaret Lent, *The Medical and Legal Risks of the Electronic Fetal Monitor*, 51 STAN. L. REV. 807, 807–08 (1999); Thomas Sartwelle, *Electronic Fetal Monitoring: A Bridge Too Far*, 33 J. LEGAL MED. 313, 313–14 (2012).

options that show good outcomes for fetuses with far lower rates of complications for pregnant people, like community birth and even hospital midwifery care. Meanwhile, court orders routinely uphold fetal interests over maternal interests, illustrating that maternal sacrifice to the fetus will be enforced by the state if not given voluntarily.<sup>175</sup>

Notably, by enforcing standards distorted by a fetal-centric lens, and failing to capture the interdependent nature of risk to pregnant people and fetuses, the regulation of childbirth fails to produce strong outcomes for the fetuses it elevates.<sup>176</sup> This is because the fetal devotion present in law and medicine is more symbolic than empirical in nature. While the United States continues to restrict and limit pregnant people's ability to access midwives, countries throughout the industrialized world rely on midwives to attend roughly two-thirds of births and achieve lower rates of neonatal mortality.<sup>177</sup> Likewise, the distorted standards of care enforced through the United States' highly litigious tort law system limit access to safe care options for fetuses and may contribute to the rise in maternal mortality unique to the United States. By dropping the insistence on performative allegiance to fetal wellbeing over maternal, the law could approach childbirth with a clearer head and work to enable safer outcomes for birthing people and their babies.

3. *Medical Professionals as Law Enforcement.* — The legal infrastructure of childbirth tasks providers with enforcing a fetus-over-pregnant-person model on pregnant people. Through tort law, providers are incentivized to deny care to people who will not abide by these norms, or to manipulate and coerce pregnant people into compliance in order to protect themselves from potential liability. Where refusal is still present, medical providers police pregnant people by seeking formal legal help from courts, or child protective services, to bring people into compliance with the unwritten law.

Professor Michele Goodwin has identified the ways in which medical providers serve as law enforcement during pregnancy and birth, tasked

<sup>175</sup> Cf. Emily Jackson, *Afterword* to CHILDBIRTH, VULNERABILITY AND THE LAW: EXPLORING ISSUES OF VIOLENCE AND CONTROL 251, 251 (Camilla Pickles & Jonathan Herring eds., 2020) (discussing the presumption of maternal self-sacrifice in the law); Kukura, *Obstetric Violence*, *supra* note 79, at 776 (same).

<sup>176</sup> See Kukura, *Better Birth*, *supra* note 145 (manuscript at 11–12) (arguing that increased access to midwives is a solution to poor birthing outcomes in the United States).

<sup>177</sup> See Laura Attanasio & Katy B. Kozhimannil, *Relationship Between Hospital-Level Percentage of Midwife-Attended Births and Obstetric Procedure Utilization*, 63 J. MIDWIFERY & WOMEN'S HEALTH 14, 14 (2017); UNITED HEALTH FOUND., *supra* note 31, at 54–55 & fig.62. In 2014, after a rigorous review, the United Kingdom's National Health Service found that out-of-hospital birth with midwives is safer than hospital birth for most women, and now recommends it for most births. Sanjay Tanday, *Midwife-Led Units Safest for Straightforward Births*, NAT'L INST. FOR HEALTH & CARE EXCELLENCE (Dec. 3, 2014), <https://www.nice.org.uk/news/article/midwife-led-units-safest-for-straightforward-births> [<https://perma.cc/DX2Z-CCGD>].

with protecting fetuses from their pregnant parents.<sup>178</sup> She elucidates the way the dual roles required of medical professionals, that of a healthcare provider with a fiduciary duty to the patient and that of a state agent tasked with enforcing state interests, may conflict.<sup>179</sup> In wearing “two hats,” medical providers may subordinate patient health and privacy interests to state interests, particularly when they fear sanction via liability or other mechanisms for failing to do so.<sup>180</sup> In addition, medical providers’ professional and ethical duties may conflict with state interests.<sup>181</sup>

Professor Goodwin’s analysis emphasizes policing by medical professionals in relationship to court-ordered treatment, but the insight extends to tort law. By subjecting providers to liability when they stray from a commitment to enacting fetal primacy, and aligning provider interests with its own, the state enlists providers in the job of convincing patients to submit. Given the trust that patients invest in their healthcare providers, this mechanism works effectively to bring most birthing people along with a fetal primacy agenda. Medical providers have a slew of direct enforcement mechanisms available to them, from the ability to shape patient knowledge about risks and benefits, to the ability to perform procedures without patient consent with the backing of the law. Though different than reporting patients directly to state agencies or courts, the role of medical professionals as law enforcement driven by tort law is a key mechanism of legal control over pregnant people’s bodies and reproductive decisionmaking.

### *Conclusion*

The legal infrastructure of birth, through tort law incentives and regulation of midwives, drives lack of access and choice in birth. By shaping the provision of healthcare, law encodes particular values in the birthing process, promoting a fetal-centric and physician-controlled approach. In seeking solutions, advocates should focus on bringing the regulation of childbirth into alignment with healthcare and constitutional law more broadly, and on reforming areas of the law that can improve access to a broader spectrum of care.

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<sup>178</sup> Michele Goodwin, *Fetal Protection Laws: Moral Panic and the New Constitutional Battlefield*, 102 CALIF. L. REV. 781, 795–96 (2014).

<sup>179</sup> *Id.* at 797–98.

<sup>180</sup> *Id.*

<sup>181</sup> *Id.*