



Report to the U.N. Special Rapporteur on Violence Against Women

Mistreatment and Violence Against Women During Reproductive Health Care
With a Focus on Childbirth in the United States of America

SUBMITTED BY

If/When/How: Lawyering for Reproductive Justice
Birth Rights Bar Association
National Advocates for Pregnant Women
Human Rights and Gender Justice Clinic, Main Street Legal Services at CUNY Law School

MAY 17, 2019

Introduction

Despite being a wealthy nation with advanced health technology, the United States suffers from stark disparities in access to care and outcomes of care. These inequalities, in addition to deeply entrenched racist and sexist attitudes, pave the way for mistreatment and disrespect in birth.

In 2014, the United Nations Committee on the Elimination of Racial Discrimination expressed concern with high maternal and infant mortality rates among African American communities.¹ The Committee recommended that the U.S. ensure effective access to affordable and adequate health-care services; eliminate racial disparities in the field of sexual and reproductive health; standardize data collection on maternal and infant deaths; and improve monitoring and accountability mechanisms for preventable maternal mortality, including at the state level.² Similarly, the UN Special Rapporteur on Extreme Poverty noted at the conclusion of a 2017 visit

¹ Committee on the Elimination of Racial Discrimination (CERD), *Concluding Observations—United States of America*, para. 15, UN Doc. CERD/C/USA/CO/7-9 (Sept. 25, 2014).

² *Id.*

that the U.S. features the highest maternal mortality rate among wealthy countries, and that Black women are three to four times more likely to die from childbirth.³

It is this context in which mistreatment and violence against women during pregnancy and birth occurs in the U.S. In addition to rising maternal mortality and racial disparities in health outcomes, the detention and criminalization of pregnant women is an increasing form of mistreatment and abuse during pregnancy and birth.

I. Lack of Research into Mistreatment and Violence in Obstetric Care in the U.S.

While research on mistreatment during childbirth is underdeveloped and data collection is woefully inadequate, it is clear that abuse, coercion, and disrespect in facility-based childbirth are significant problems in the United States, as confirmed by grassroots campaigns mounted by consumer advocacy groups soliciting women's stories, a series of recent legal cases, and reports of attorneys across the country who receive regular appeals from women seeking to prevent forced treatment, escape threatened legal action against them for declining treatment, or secure recourse for harm caused by mistreatment at the hands of their health care providers.

Mistreatment that women report experiencing during childbirth include (but are not limited to) the following types:

- Abuse in the form of forced and unconsented cesareans, episiotomies, cervical exams, and other labor and birth procedures, physical restraint, unconsented administration of medication;
- Coercion in the form of threats to secure a court order compelling treatment, threats to report a woman to the child welfare authorities as a child abuser for declining treatment, restrictions on access to vaginal birth after cesarean (effectively compelling women to undergo unnecessary surgery or forego care at that facility entirely), and the threatened withholding of pain medication in order to secure consent to treatment;
- Disrespect in the form of humiliating and degrading language, disclosure of private medical information, and judgmental attitudes about whether the patient would be a good parent or should be pregnant in the first place.

A. Women's Voices

³ Special Rapporteur on extreme poverty and human rights, *Report of the Mission to the United States of America*, para. 57, U.N. Doc. A/HRC/38/33/Add.1 (May, 4, 2018) (by Philip Alston).

Theresa Morris, Professor of Sociology at Texas A&M University, has interviewed over a hundred U.S. women on their encounters of forced, coerced, or pressured birth procedures. These women's stories indicated how some experience their labors and births as violent and traumatic. In addition, stories were collected for inclusion in a "Women's Voices" *amicus curiae* brief in support of Rinat Dray, who is currently suing her providers in civil court for forcing her to undergo cesarean surgery. Five of these stories, beginning with Dray's, are shared below.⁴

1. Rinat Dray

Rinat experienced difficult recoveries with her two previous cesarean births. She therefore sought out care that would best support her in achieving a vaginal birth with her third child. Despite her providers' previous encouragement, they not only withdrew support when Rinat went into labor, but also began to threaten her. Rinat describes the conditions placed on further care. "[The physician] said he would only do an exam if I agreed to a cesarean and signed a consent form. I said no, that I wanted more time. He said, 'I am not bargaining here.'" The physician went on to threaten her: "If you don't let me do a cesarean section, the state is going to take your baby away. You are acting like a person on drugs." Rinat emphasizes that she "was not on drugs or anything else that would alter my mental capacity throughout the entire process."

She asked to be transferred to a different hospital and was told, "No, we are going to go to court to force you to have a c-section." However, when she was pushed into the operating room against her consent at 2:30 pm, it was *without* a court order. She recalls the physician was "rough during the surgery, almost as if to punish me. He ended up severely injuring my bladder, cutting it from back to front. I was put under general anesthesia so a urologist could repair the injury. I did not emerge from sedation until around 8 pm that evening."⁵

While the physician's threats may seem unlikely and unconscionable, warnings of child protective services being called to remove children are not uncommon in cases of maternal disagreement with medical recommendations.⁶ This issue is further addressed in the submission to the Special Rapporteur from Movement for Family Power and other civil society organizations, submitted on May 17, 2019.

2. Kelly

⁴ Interviews on file with Theresa Morris, Professor of Sociology, Texas A&M University. See also Brief of Human Rights in Childbirth et al. as Amicus Curiae in Support of Plaintiff Rinat Dray, *Dray v. Staten Island Univ. Hosp.* No. 500510/14 (December 23, 2014).

⁵ Affidavit of Rinat Dray at 5, *Dray v. Staten Island Univ. Hosp.* No. 500510/14 (September 11, 2014).

⁶ Alexa Richardson, *The Use of Child Protective Services and Court Orders to Enforce Medical Compliance in the Labor and Delivery Room: How Threats of Legal Action Limit Reproductive Choice*, Harv. J.L. & Gender, online content (2018), <http://bit.ly/2Q9tk6l>.

Kelly was admitted to the hospital and given magnesium sulfate, a common treatment for women who have high blood pressure because of the risk of pre-eclampsia. Magnesium sulfate can make patients “woozy” so that they require supervision at minimum when standing, including walking to the restroom. The nurse assigned to Kelly insisted the Kelly be catheterized, something Kelly had refused. Kelly describes what happened next, “I specifically said that I did not want to be catheterized. And they forced me . . . The nurse had my husband lay over my body and hold me down and the whole time that they're doing this, I was like crying and cussing them out, like telling her, “fuck you, get the fuck off of me.” Like, screaming, “no, no.” It was literally like being raped. It was horrific.”⁷

3. Megan

Megan recounted forced and painful vaginal exams. She said, “The first one they did was so rough and so uncomfortable that I was literally crawling away from her on the bed and screaming out. Like tears were . . . streaming down my face. I was screaming, ‘Please stop! You have to stop! You have to stop!’ And she did not stop. She just kept pushing in harder. And I feel like--I've never been assaulted before—but . . . I mean, I remember her face. I remember seeing things in slow motion. I remember what it sounded like. I remember what it smelled like.”⁸

4. Rachel

Rachel gave birth vaginally. Following the birth, the doctor wanted to manually pull out Rachel’s placenta. Rachel describes, “After he was born, the doctor basically said, ‘OK. We're going to get the placenta out of you now.’ And I said, ‘You mean . . . you're going to pull it out?’ And he said, Yes.’ So, I said, ‘I'm not really comfortable with that. I don't want you to pull it out. I'll just deliver it on my own.’ And that really ticked him off . . . He stood up and turned around and said [that I] just delayed his OR by an hour and walked out of the room . . . He came back after that and said because we hadn't let him pull it out, he had to clear out the coagulants from my uterus. . . He ran his fingers up and down, and he actually put his finger in my anus . . . It was just humiliating in front of my husband and my friend was standing there. I had the roomful of nurses . . . I very much felt assaulted.”⁹

5. Patricia

A common theme of these stories is women experiencing their maternity care as traumatic and violating. Some women also perceive such assaults as punishment for planning a home birth that subsequently requires transfer to a hospital. Patricia was one such case, reporting that she

⁷ Interview on file with Theresa Morris, Professor of Sociology, Texas A&M University.

⁸ *Id.*

⁹ *Id.*

“was met with scorn and ridicule. I was subjected to repeated unconsented vaginal exams which were very painful. The OB threatened to leave me with 4th degree tears through my rectum if I did not consent to a c section, which I adamantly did not want.” She reflects that because she was a home birth transfer, she felt the doctors treated her as “some ignorant hippy” whose baby was “placed in grave danger by not coming straight to the hospital when I began labor.”¹⁰

Mistreatment and violence often arise from disagreement between the pregnant person and the care provider, whether the division is over course of treatment, location of birth, or other factors influenced by how the pregnant woman is perceived. The result can be attempts by the provider to substitute their own judgment for that of the pregnant person, or for the provider to invoke the power of the state to compel patient compliance. Unfortunately, factors within U.S. law both contribute to and fail to curb mistreatment and violence.

II. Factors in U.S. Law That Contribute to Experiences of Mistreatment and Violence

The protections of the U.S. Constitution promise equality on the basis of sex. Likewise, the statutory and common law protections that prohibit medical malpractice, neglect, and unconsented medical treatments apply to all people equally. Factors in U.S. law nevertheless enable mistreatment and violence towards pregnant individuals seeking reproductive health care for a range of health needs. These factors are rooted in paternalistic and racist notions of women’s ability to make healthcare decisions for themselves. The result is increasing use of the law’s power to restrict pregnant people’s agency and autonomy; these are the conditions that facilitate mistreatment and violence against women during reproductive health care.

A. Increasing Restrictions on Reproductive Health Care

In recent decades, both state and federal lawmaking bodies have enacted increasingly restrictive reproductive health policies. Many of these have imposed ever-stricter regulations on induced abortion that are not required by patient safety and impose burdensome costs and administrative requirements¹¹ They also include most recently attempts so extreme as to

¹⁰ Brief of Human Rights in Childbirth et al. as Amicus Curiae in Support of Plaintiff Rinat Dray at 14, *Dray v. Staten Island Univ. Hosp.* No. 500510/14 (December 23, 2014). Interview with Patricia on file with the Birth Rights Bar Association (September 4, 2014).

¹¹ Guttmacher Institute, *Targeted Regulation of Abortion Providers*, May 1, 2019, <http://bit.ly/2w300nL>; OBOS Abortion Contributors, *History of Abortion in the U.S.*, *Our Bodies Ourselves* (blog), May 18, 2016, <http://bit.ly/308AH2S>. See section titled “An ever-growing number of restrictions.”

prohibit abortion after six weeks or after fetal pole cardiac activity is perceptible.¹² A side-effect of treatment that singles out abortion providers for heightened regulation is the creation of artificial barriers among providers of reproductive health care to birthing people with diverse reproductive needs. The legal system essentially appoints physicians who do *not* provide abortion care to the top of the medico-legal hierarchy, with abortion providers relegated to a lower category. Such lack of integration extends even to *facility* legal status; for example, some states disincentivize the provision of abortion care in larger health care facilities by excluding abortion procedures from the tally required for Certificate of Need certification.¹³

Unfortunately, patients are not as easily separated into categories: the person who is carrying a pregnancy to term one year may be the same as one who is seeking an abortion the next year, or perhaps experiencing a spontaneous abortion (miscarriage). The hierarchy and derision visited upon people who terminate pregnancies inevitably spill over onto those who intend to give birth and parent a child - again, creating the conditions in which mistreatment and violence against women, as described above, take place.

B. Restrictive Midwifery Regulations

Restrictive midwifery regulations present a frequent barrier to community birth.¹⁴ Fifteen states do not legally recognize non-nurse midwives, thus limiting birth options available to women living in those jurisdictions. Even in states in which midwives are licensed, many are subjected to restrictive rules that prevent them from practicing to the full extent of their training; these restrictions include required collaborative agreements with supervising physicians, limitations on prescribing authority, and prohibitions on attending VBACs, twin deliveries, or breech births. Perhaps most notably, some states subject midwives to regulation and discipline by physicians, reflecting a direct conflict of interest. In Louisiana, for example, community midwives are regulated by the state board of medicine rather than by a body of their peers, situating physicians as gatekeepers to community birth.¹⁵ Such a regulatory framework violates the longstanding U.S. legal principle that licensed professions regulate

¹² Elizabeth Nash, Olivia Cappello, Sophia Naide, Lizamarie Mohammed, and Zohra Ansari-Thomas, *Radical Attempts to Ban Abortion Dominate State Policy Trends in the First Quarter of 2019*, Guttmacher Institute, Apr. 3, 2019, <http://bit.ly/2JpNecl>.

¹³ Certificate of Need is a regulation some states require before the acquisition of a health facility. By excluding abortion services from those counted in a CoN facilities will be disinclined to provide such services. See for example, Mich. Comp. Laws § 333.22224 (2013).

¹⁴ “Community birth” is variously known as “out-of-hospital birth” or “home and birth center birth.” The midwives who attend such births are known as “community midwives” for ease of referral to a group of midwives with diverse training methods and credentials.

¹⁵ The Midwife Practitioners Act, La. Rev. Stat. 37:3240, *et seq.*, gives the state board of medicine authority to regulate midwives in Louisiana, and the regulations the board has issued include a specific mandate that “[t]he licensed midwife practitioner shall provide care only to clients determined by physician evaluation and examination to be at low or normal risk of developing complications during pregnancy and childbirth.” La. Admin. Code Sec. 46:5315 A.

themselves.¹⁶ This common regulatory scheme is problematic also because it allows physicians, who have a financial interest in the provision of maternity care services, to wield regulatory authority over their competitors: midwives. Finally, physicians are simply ill-suited to the regulation of midwifery because it is a model of care outside physicians' area of expertise; physicians are trained in utilizing medications and surgery to treat complications of childbirth, whereas midwives are trained in protecting, supporting, and enhancing normal, low-risk childbirth.¹⁷

Community-based midwives are the demonstrated authority on low-risk birth. A state that conditions midwifery practice on the authorization of physicians creates a structural barrier to accessible community birth. Thus, by constraining the availability of relevant maternity care, the state perpetuates a formal, structural barrier to skilled attendance at delivery.

C. Attempts to Create Legal Recognition for Fetuses

An important driver in the mistreatment of pregnant patients has been an increased focus on the fetus as a separate juridical entity from the pregnant person. In *Roe v. Wade*, the U.S. Supreme Court case that articulates the constitutional underpinnings for the right to abortion, the Court noted that the Constitution's protections attach at birth.¹⁸ Abortion opponents seeking to re-criminalize abortion have attempted to create legal recognition for fetuses *in utero* by passing laws that impose penalties for harm to a fetus, beginning with criminal laws. The effect has been to render people giving birth susceptible to mistreatment by health care providers and other "caring professions" (such as social workers) as well as law enforcement officials and other agents of the state, whether through the use of threats (e.g., of calling the police) or through the direct action of police (as when shackling pregnant women who are incarcerated) who claim to be acting in the interest of the fetus.

1. Expansion of Criminalization of Harm to Fetuses

Throughout most of U.S. history, state penal codes adhered to the common law "born alive" rule, which limited criminal liability for harm to fetuses. A person could be charged with homicide for causing a woman to lose a pregnancy only if an infant was born and lived for some

¹⁶ Lawyers are governed by and held accountable to a disciplinary board of attorney peers. The same is true of health professions. See American Bar Association, Report of the Commission on Evaluation of Disciplinary Enforcement, *Lawyer Regulation for a New Century* (September 18, 2018) and George Annas, *The Rights of Patients*, American Civil Liberties Union, 7 (New York University Press 2004).

¹⁷ Judith Pence Rooks, *Midwifery & Childbirth in America* 126 (1997).

¹⁸ *Roe v. Wade*, 410 U.S. 113, 158 (1973) ("All this, together with our observation, *supra*, that, throughout the major portion of the 19th century, prevailing legal abortion practices were far freer than they are today, persuades us that the word "person," as used in the Fourteenth Amendment, does not include the unborn.").

amount of time before dying. If the fetus died *in utero*, the injury was a crime, but not homicide. In the late 1970s, lawmakers began to change criminal laws to increase punishment for harm to fetuses, either by creating new crimes with fetal victims (such as feticide or fetal assault),¹⁹ redefining “persons” or “victims” to include fetuses,²⁰ or both.²¹ Currently, at least 38 states and the federal criminal code feature laws that criminalize harm to fetuses.²² These laws have garnered widespread support because they are usually passed in the name of protecting pregnant women, often arising in the wake of high-profile acts of violence against pregnant women. In practice, however, these laws make women vulnerable to mistreatment and abuse during childbirth, and even subject to criminal prosecution.

Research indicates that in virtually every state in which the law punishes harm to fetuses, arguments that fetuses constitute an independent legal entity that permits the state to exert jurisdiction over them have been used to justify reporting pregnant people to law enforcement and subjecting them to criminal investigations, to the extent of imprisoning them on the basis of acts or omissions believed to have caused or even just *risked* harm to a fetus.²³ In fact,

¹⁹ *E.g.*, Mich. Comp. Laws §§ 750.322 (creating a crime for the “wilful killing of an unborn quick child by any injury to the mother of such child”) and (Mich. Comp. Laws §§ 750.323; creating a crime of manslaughter of a “quick child or mother from the use of medicine or instrument.”); R.I. Gen. Laws § 11-23-5 (criminalizing “willful killing of an unborn quick child by any injury to the mother of the child”); Wash. Rev. Code Ann. § 9A.32.060 (including “intentionally and unlawfully kill[ing] an unborn quick child by inflicting any injury upon the mother of such child” under the definition of manslaughter); Ind. Code § 35-42-1-6 (“A person who knowingly or intentionally terminates a human pregnancy with an intention other than to produce a live birth or remove a dead fetus commits feticide.”); 18 Pa. Cons. Stat. § 2603 (“An individual commits criminal homicide of an unborn child if the individual intentionally, knowingly, recklessly or negligently causes the death of an unborn child. . .”); Iowa Code § 707.7 (“Any person who intentionally terminates a human pregnancy, with the knowledge and voluntary consent of the pregnant person, after the end of the second trimester of the pregnancy where death of the fetus results commits feticide.”); Wis. Stat. Ann. § 940.01(1)(b)(“whoever causes the death of an unborn child with intent to kill that unborn child, kill the woman who is pregnant with that unborn child or kill another is guilty of a Class A felony”); Wash. Rev. Code Ann. § 9A.32.060 (1)(b)(“A person is guilty of manslaughter in the first degree when [...] He or she intentionally and unlawfully kills an unborn quick child by inflicting any injury upon the mother of such child.”)

²⁰ *E.g.* Tenn. Code Ann. § 39-13-214 (“[A]nother” and “another person” include a human embryo or fetus at any stage of gestation in utero, when any such term refers to the victim of any act made criminal by this part”). Other states have high court decisions expanding existing homicide laws to include fetuses, *e.g.*, *Commonwealth v. Lawrence*, 536 N.E.2d 571, 583 (Mass. 1989) (expanding definition of murder under the common law), *Commonwealth v. Cass*, 467 N.E.2d 1324, 1324 (Mass. 1984) (expanding definition of vehicular homicide at common law to include fetal victims).

²¹ *E.g.*, Miss. Code Ann. § 97-3-37 (“[T]he term “human being” includes an unborn child at every stage of gestation from conception until live birth and the term “unborn child” means a member of the species homo sapiens, at any stage of development, who is carried in the womb.) and Miss. Code Ann. § 97-3-19 (defining first-degree murder as [t]he killing of a human being without the authority of law by any means or in any manner [. . .] [w]hen done with deliberate design to effect the death of an unborn child”).

²² Nat’l Conference of State Legislatures, *Fetal Homicide State Laws*, May 1, 2018 <http://bit.ly/2qToXCL>.

²³ 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*, *Journal of Health Politics, Policy and Law*, Vol. 38, No. 2, (Apr. 2013), 326-327, <http://bit.ly/2q013FU>.

prosecutors seeking to radically expand criminal liability for women have permitted such arrests²⁴ even when the law explicitly prohibits charging women with a crime.²⁵

2. Criminalization of Pregnant People Who Use Drugs

People who use criminalized drugs are particularly vulnerable to mistreatment and abuse when giving birth. Pregnant people who self-disclose use of these drugs or test positive for them may be subjected to degrading or stigmatizing comments, find their pain disregarded or labeled as “drug-seeking behavior,” or have their confidentiality breached by misguided reporting to law enforcement. These repercussions occur despite the fact that individual ingestion of criminalized drugs is not defined as criminal behavior in most states, and despite constitutional jurisprudence that forbids penalizing people for suffering a substance use disorder.²⁶

Most U.S. courts faced with such prosecutions have agreed that absent explicit statutory authorization, laws protecting fetuses may not be used to punish the people who carry them.²⁷ However, these fundamental principles do not always succeed in preventing unlawful arrests and prosecutions, particularly given the general antipathy toward women perceived — often incorrectly — as having caused harm to a fetus.

For example, Melissa McCann Arms was reported to law enforcement by health care personnel who judged her to be acting “erratically” as she struggled to cope with her labor.²⁸ A nurse treating Ms. Arms called police and told them that she suspected her patient was under the influence of controlled substances, even though such reporting is not required by law and medical ethics forbid disclosing confidential patient information. While Ms. Arms was still in

²⁴ See Andrea Grimes, *Pregnant Texans are Being Charged with Crimes that Don't Exist*, Rewire, Oct. 16, 2014, <http://bit.ly/2px7wmX>.

²⁵ *E.g.*, Tenn. Code Ann. § 39-13-107(c) (“Nothing in subsection [. . .] shall apply to any act or omission by a pregnant woman with respect to an embryo or fetus with which she is pregnant, or to any lawful medical or surgical procedure to which a pregnant woman consents, performed by a healthcare professional who is licensed to perform such procedure.”).

²⁶ *Robinson v. California*, 370 U.S. 660 (1962).

²⁷ See, e.g. *Arms v. State*, 471 S.W.3d 637, 643 (Ark. 2015) (rejecting a prosecutorial attempt to reinterpret a statute prohibiting introducing a drug into the body of another person to apply to the relationship between the pregnant woman and a fetus); *State v. Louk*, 786 S.E.2d 219 (W. Va. 2016) (overturning a conviction for negligent homicide of a woman who experienced a drug overdose during pregnancy and gave birth to a child who died several days after birth); *People v. Jorgensen*, 41 N.E.3d 778 (N.Y. 2015) (overturning a manslaughter conviction of a woman involved in a car accident for giving birth to a baby who died shortly after emergency delivery); *State v. Stegall*, 828 N.W.2d 526, 528 (N.D. 2013) (holding child endangerment statute does not apply to acts committed on an unborn child, regardless of whether the child is subsequently born alive or dies in utero); *Cochran v. Commonwealth*, 315 SW3d 325, 328 (Ky. 2010) (recognizing that criminalizing harm to a fetus would yield a “plainly unconstitutional result”).

²⁸ *Arms*, 471 S.W.3d 637.

active labor, police officers presented her with a warrant for the collection of biological samples to test for criminalized drugs. She was questioned at her hospital bedside shortly after delivery and was accused by police of having harmed her baby when she admitted to having used a criminalized drug at an earlier point in her pregnancy.

Ms. Arms' ordeal continued far beyond her experience of disrespectful care at birth. Although she completed drug treatment and counseling and the state child welfare authority approved reunification with her child, she was charged with a poisoning crime (introducing a controlled substance into the body of another person).²⁹ She was sentenced by a jury to 20 years in prison, and had already served part of her sentence by the time the state high court overturned the conviction.

Ms. Arms was vindicated by the court, but she and her child suffered irreparable harm from the humiliation of a police investigation and her subsequent arrest. Unfortunately, they are not alone – hundreds of women have faced similar charges.³⁰ Medical and public health experts are unified in rejecting punitive responses to substance use during pregnancy, because such a response deters people from seeking prenatal care for fear of arrest or other punishment.³¹ Furthermore, despite the fact that drug use by Black and white women occurs at approximately the same rate in the U.S.,³² numerous studies and investigative news reports find that Black mothers and infants born to Black mothers are more likely than their white counterparts to have been screened or tested for criminalized drugs.³³

²⁹ Ark. Code Ann. § 5-13-210 was passed in response to concerns about people administering sedatives to unknowing victims in order to sexually assault them, or using addictive drugs as a means to control an exploited individual. The law does not mention pregnant women, fetuses, or transplacental transfer of substances.

³⁰ One study found 413 similar cases from 1973-2005, acknowledging that this is an undercount due to limitations on data collection posed by law enforcement practices. Paltrow and Flavin, *supra* note 23. More recent investigations have uncovered nearly 1000 arrests in Alabama from 2006-2016, and more than 100 arrests in Tennessee from 2014-2016.

³¹ American College of Obstetricians & Gynecologists, Committee on Health Care for Underserved Women, *Committee Opinion 473: Substance Abuse Reporting and Pregnancy: The Role of the Obstetrician-Gynecologist*, (Jan. 2011), <http://bit.ly/2JLJ4Mf>.

³² U.S. Dept. of Health & Human Services, *Results from the 2013 National Survey on Drug Use and Health Summary of National Findings* (2014), <http://bit.ly/2HzMMGd>.

³³ Ira J. Chasnoff, Harvey J. Landress & Mark E. Barrett, *The Prevalence of Illicit-Drug Or Alcohol use during Pregnancy and Discrepancies in Mandatory Reporting in Pinellas County, Florida.* "New England Journal of Medicine 322 (17): 1202-1206 (1990); Marc A. Ellsworth, Timothy P. Stevens & Carl T. D'Angio. *Infant Race Affects Application of Clinical Guidelines when Screening for Drugs of Abuse in Newborns*, *Pediatrics* 125 (6): e1379-85 (2010); Troy Anderson, *Race Tilt in Foster Care Hit; Hospital Staff More Likely to Screen Minority Mothers*, *Daily News of Los Angeles*, June 29, 2008, available at <http://bit.ly/2LROec8>; Sarah C. Roberts & Amani Nurujeter, *Women's Perspectives on Screening for Alcohol and Drug use in Prenatal Care*, *Women's Health Issues* 20 (3): 193-200 (2010); Brenda W. Rotzoll, *Black Newborns Likelier to be Drug Tested: Study*, *Chicago Sun-Times*, Mar. 16, 2001.

3. Criminalization of Abortion and Pregnancy Loss

Pregnant people who give birth are not alone in being subjected to disrespect and abuse when seeking reproductive health care, due to laws and legal arguments that seek to cast fetuses as victims. Women who end their own pregnancies using abortion pills or other means, or who have stillbirths or miscarriages that they cannot explain to the satisfaction of medical personnel, are treated with suspicion and even reported to law enforcement.

Indiana resident Purvi Patel was charged with feticide for allegedly having taken pills she obtained through the internet to end her pregnancy.³⁴ Ms. Patel came to the attention of law enforcement when she sought emergency help for a severe hemorrhage at a Catholic hospital. The obstetrician treating her, a member of an anti-abortion professional society, summoned police to her hospital room; Ms. Patel endured a 3 a.m. bedside interrogation with no attorney present as she recovered from surgery to remove a retained placenta. After a spectacle of a trial in which she was cast as cold, calculating, and selfish by prosecutors, she was convicted and sentenced to 20 years in prison. Fortunately, the Court of Appeals of Indiana ruled that neither Indiana's feticide law nor its criminal abortion laws were intended to punish women for self-inducing abortions. In 2018 the law was amended to prevent similar prosecutions from recurring. Nevertheless, with a felony conviction on her record³⁵ and her name notorious in local and national media, it is unlikely Ms. Patel will ever be truly free of the stigma related to her unlawful incarceration.

Ms. Patel's is just one of the many arrests for abortion or suspected abortion: even though abortion is legal in the U.S. and the vast majority of states do not authorize criminal punishment for self-managed abortion, at least 21 people have been criminally prosecuted since the year 2000 for ending a pregnancy or helping someone else do so.³⁶ The continued criminalization of people who have abortions and pregnancy losses creates an atmosphere of fear and mistrust when people seek health care, deterring them from seeking help when they most need it.

³⁴ See Emily Bazelon, *Purvi Patel Could Be Just the Beginning*, N.Y. Times, Apr. 1, 2015, <http://nyti.ms/2pifkxs>; and *Purvi Patel is Released After Feticide Conviction Overturned*, Indianapolis Star, Sept. 1, 2016, <http://indy.st/2qQ1O4f>.

³⁵ Ms. Patel was also charged with child neglect leading to death based on a theory that she had delivered a live infant. Even though the evidence presented at trial included a long-discredited "fetal lung float test," a jury found that Ms. Patel delivered a live but fatally premature infant. The appellate court, forced to give deference to this finding, nevertheless ruled that the state had failed to prove that Ms. Patel did anything after the birth that contributed to the death of the infant, meaning that the most she could have been convicted for was child neglect without the penalty enhancement for a resulting death. Her sentence was reduced accordingly.

³⁶ See SIA Legal Team, *Roe's Unfinished Promise: Decriminalizing Abortion Once and For All* (2017) <http://bit.ly/2Vjp62g>.

C. Lack of Appropriate Legal Framework Through Which to Address Rights Violations in Reproductive Health Care

The United States' domestic human rights jurisprudence is generally constrained by interpretations of the U.S. Constitution and features specific limitations that prevent access to justice for people who have experienced harm in reproductive health care, including a lack of an explicit regard for economic, social, and cultural rights; a narrow view of state responsibility for the acts of non-state actors; and limited accountability for gender-based violence. Those seeking redress for experiences of obstetric violence are therefore forced to rely on a hodgepodge of legal theories: civil suits for medical malpractice or civil battery; constitutional rights cases that require a government actor and the presence of a "suspect class" defined in prior jurisprudence,³⁷ and any other legal theories a plaintiff can scrape together. *This theme is also discussed below in the section on accountability mechanisms.*

At the same time, concepts applied in abortion case law, most particularly the right to privacy,³⁸ are inverted and then incorrectly applied to cases of rights in pregnancy and childbirth. Courts like the one in *Pemberton v. Tallahassee* have held that because *Roe* allows the state an interest in the matter of abortion after the point of fetal viability, the state holds the same power over the decisions of a birthing person who intends to carry a baby to term.³⁹ In the case of *Pemberton*, the result was court-ordered cesarean surgery.

In addition, the privacy framework inherently fails to provide an affirmative right for people who wish to terminate their pregnancies (as states may adopt policies designed to dissuade women from terminating pregnancies and there is no government obligation to fund abortion care even if the state funds all other medical care) *and* for those who wish to carry to term. The

³⁷ The U.S. Constitutional Equal Protection doctrine requires that courts examine the intended purpose of classifications made by the law for the purposes of discrimination. Some classifications are considered "suspect" because of histories of systematic oppression through legal discrimination, and courts are therefore required to question those classifications (referred to in jurisprudence as "scrutiny"). The level of scrutiny assigned correlates to past injustices (e.g., discrimination on the basis of race receives "strict scrutiny") and the higher the requisite scrutiny, the greater the burden on the defending state to show that the law in question served a government need and that the discriminatory means are sufficiently related to the need. Under this framework, discrimination on the basis of gender does not receive strict scrutiny, but is acknowledged to be a "quasi-suspect" classification and receives 'intermediate scrutiny' and requires that the state offer an "exceedingly persuasive justification" for such discrimination. *See, e.g., United States v. Virginia*, 518 U.S. 515 (1996).

³⁸ The privacy framework was established in *Griswold v. Connecticut*, 381 U.S. 479 (1965) and later used as the basis of the decision in *Roe v. Wade*, 410 U.S. 113 (1973).

³⁹ Elizabeth Kukura, *Revisiting Roe to Advance Reproductive Justice for Childbearing Women*, 94 *Notre Dame Law Review Online* 20 (2018), citing *Pemberton v. Tallahassee Mem'l Reg'l Med. Ctr.*, 66 F. Supp. 2d 1247 (N.D. Fla. 1999).

health care a pregnant person receives before fetal viability is protected from government intrusion – and arguably from affirmative assistance as well. Although Medicaid offers pregnant people heightened eligibility for health care, the type and quality of care available is often stratified by race and class, leaving these birthing people with fewer choices of provider and model of care, and with the greater racial disparity in birth outcomes that is a prominent marker of U.S. maternal and infant health.⁴⁰

V. Factors in the U.S. Health Care System that Contribute to Experiences of Mistreatment and Disrespect

Four structural and intermediary factors connect with the broader context in which mistreatment and violence occur during childbirth. These factors perpetuate maternal health inequities within a continuum of sexual and reproductive rights violations and thus indirectly constrain the maternity care options of U.S. birthing people.

A. Fragmentation of the Health Care System and Insurance Coverage

The complex interplay of public and private health insurance availability and coverage erects significant bureaucratic barriers to maternity care access.⁴¹ Insurance coverage indelibly influences U.S. maternity care access in yet another example of the health finance infrastructure role in raising maternal health inequity. The reality is that birthing at home or in a birth center is not financially feasible for low-income individuals when these services are not covered by their insurance plan.⁴²

The positive contributions of the 2010 Affordable Care Act⁴³ to improving maternal health are under continual political threat, causing confusion among health care consumers, especially less sophisticated ones who may be most at risk for poor outcomes in the wake of minimal or no prenatal care, no access to midwives, and coverage that terminates 60 days postpartum. Furthermore, fragmentation enables different compensation for vaginal birth versus cesarean birth; in addition, different rates are paid by public and private insurance. This dynamic creates

⁴⁰ Rachel Jones, *Why Giving Birth in the U.S. Is Surprisingly Deadly*, National Geographic, Dec. 13, 2018, <https://on.natgeo.com/2VYVnvn>. See also Roni Caryn Rabin, *Huge Racial Disparities Found in Deaths Linked to Pregnancy*, N.Y. Times, May 8, 2019, <https://nyti.ms/2Jruuu3>; Khiara Bridges, *Reproducing Race: An Ethnography of Pregnancy as a Site of Racialization* (University of California Press, 2011).

⁴¹ Indra Lusero, *Making the Midwife Impossible: How the Structure of Maternity Care Harms the Practice of Home Birth Midwifery*, 35 Women's Rights Law Reporter 431-434 (2014).

⁴² See India Amos, *Home Birth: Out of Reach for Appalachians*, Rewire.News (2018), <http://bit.ly/2EffVpb>. See also Michelle Andrews, *Health Law Provides No Guarantees Of Access To Midwives, Birthing Centers*, Kaiser Health News (2014), available at <http://bit.ly/2Hvhkst>.

⁴³ Patient Protection and Affordable Care Act, 42 U.S.C. § 18001 (2010).

perverse incentives for providers to "manage" childbirth in such a way as to maximize reimbursement but not maximize quality or effectiveness.⁴⁴

B. Maternity Care Deserts

Rural America in particular is plagued by large geographic regions in which neither obstetric nor midwifery services are accessible to pregnant and birthing individuals: more than 1,200 of the 3,136 U.S. counties have neither an obstetrician nor a midwife.⁴⁵ A simple solution exists: state authorization of midwives to provide independent midwifery care within their scope of practice, including the operation and provision of care at freestanding birth centers. Yet even in a climate of scarce maternity care resources, an institutional bias in favor of physicians restricts access to midwifery care with a concomitant adverse effect on maternal health outcomes in rural areas.

C. Institutional VBAC Policy

Through institutional policy, hospitals routinely prohibit health care providers from attending vaginal deliveries where the birthing person has had prior cesarean surgery (known as "vaginal birth after cesarean" or "VBAC").⁴⁶ By doing so, these facilities essentially - and sometimes expressly - prohibit pregnant people from giving birth without agreeing in advance to a cesarean section. Current evidence demonstrates that a vaginal delivery following cesarean surgery is usually safe, and that repeat cesarean surgery carries substantial risk.⁴⁷ Furthermore, when hospitals take VBAC off the table, they appropriate birthing people's power to make decisions based on weighing risks and benefits and combining those factors with personal values and circumstances; by doing so, they violate birthing people's autonomy and informed consent.

D. Defensive Medicine Undermines Informed Consent

⁴⁴ Carol Sakala & Maureen P. Corry, *Evidence-Based Maternity Care: What It Is and What It Can Achieve*, Co-published by Childbirth Connection, the Reforming States Group, and the Milbank Memorial Fund (2008). Available at: <http://bit.ly/2VlYsVL>.

⁴⁵ March of Dimes, *Nowhere To Go: Maternity Care Deserts Across the U.S.* (2018), <http://bit.ly/2JHUWip>. See also American College of Obstetricians & Gynecologists, Committee on Health Care for Underserved Women, *Committee Opinion No. 586: Health Disparities in Rural Women* (Feb. 2014) (recognizing significant health disparities between rural and urban populations), available at <http://bit.ly/2VuP7a2>

⁴⁶ Data collected by the International Cesarean Awareness Network's "VBAC Ban Call Project." Mapping of U.S. VBAC Ban Hospitals & Stories, at Birth Monopoly, available at <https://birthmonopoly.com/vbac-bans/>

⁴⁷ American College of Obstetricians & Gynecologists, *Clinical Management Guidelines for Obstetrician-Gynecologists*, Number 184, November 2017: Vaginal Birth After Cesarean Delivery." *Obstetrics & Gynecology* 130, no. 5 (November 2017): 1168–69. See also Jen Kamel, *Eleven Things to Love about ACOG's 2017 VBAC Guidelines*, VBAC Facts, Oct. 25, 2017. <http://bit.ly/2WPTHlh>; Jen Kamel, *The Three Biggest Concerns with ACOG's VBAC Guidelines*, VBAC Facts, Oct. 31, 2017, <http://bit.ly/2VJAwG>.

The failure of hospitals to offer VBAC is a logical consequence of the medicalization of childbirth and the role of defensive medicine in the United States. Because of the minimal social safety net to care for maternal and infant injuries sustained in childbirth and because the majority of American births occur in hospitals, hospital-based maternity care providers are frequently the target of litigation initiated by families who experience adverse birth outcomes. In a cultural climate where medical interventions in childbirth are the norm, and hospital-based providers are incentivized to avoid legal liability, the right to informed consent has been corrupted.⁴⁸ Instead of an ongoing process centered on individual counseling about risks, benefits, and alternatives, informed consent in hospitals typically consists of the birthing person being asked to sign blanket consent forms upon admission to the hospital. Frequently this "consent" is sought during labor when the birthing person does not have an opportunity to fully review or comprehend what they are being asked to sign; rarely is there any opportunity to ask questions or hold a meaningful discussion with a physician about risks, benefits, and alternatives.

III. The Failure of Accountability Mechanisms in the United States

Health facilities and individual providers are not properly held accountable for substandard care. As a result, accountability mechanisms fail to ensure redress for victims of mistreatment and violence.

To understand the structural context surrounding these mechanisms, a basic understanding of the U.S. organization of health care is key: there is no uniform health system, no national health service, no single-payer system, and no universal health care coverage. The United States does not recognize or enact the right to health or health care.⁴⁹ Instead, a hybrid system includes public and private payors as well as public and private facilities, and most but not all individuals access either or both. The majority of hospitals are non-governmental organizations, while a handful are publicly owned and operated. Of the public hospitals, most are operated by state and local governments rather than the federal government.⁵⁰

In keeping with the federal/state divide, accountability mechanisms are hybrid creations in other respects. Facilities and providers are generally regulated separately. No single mechanism exists for holding facilities or providers accountable, much less facilities and providers together. Accountability may come about in these systems through disconnected mechanisms like licensing, credentialing/accreditation, meeting payor requirements, data reporting, or via

⁴⁸ See Elizabeth Kukura, *Obstetric Violence*, 106 *Geo. L.J.* 721 (2018).

⁴⁹ Annas, *supra* note 16.

⁵⁰ American Hospital Association, *Fast Facts on U.S. Hospitals, 2019* (January 2019), available at <http://bit.ly/2Q9czZD> (finding of the 6210 total hospitals in the U.S. 972 are run by state and local governments, 208 by the federal government. The federal facilities are mostly for special populations, not the general public. The majority of U.S. facilities are run by private for-profit or non-governmental organizations.)

specific statutes or regulations.⁵¹ *Appendix A features a table with examples relevant to childbirth in each of these categories.*

No unifying law coordinates accountability; no single law requires payors to include particular providers in their plans. Mechanisms to address mistreatment and violence during birth fail at least in part because these accountability mechanisms are disconnected (there is no overarching authority), complex (they require use of experts), and lack direct feedback loops (complaints rarely reach someone with authority to make redress or change policy).

Failure to meet accreditation standards⁵² might affect a facility's ability to receive payment from a third-party payor, but the facility might nevertheless remain licensed by a state. Failure to meet a specific law might mean a fine or disciplinary action is imposed by the state licensing agency, but those penalties offer no redress for a person who was harmed by the failure.

One of the most egregious forms of mistreatment during childbirth is the forcible imposition of an episiotomy or cesarean surgery. The ongoing case of Rinat Dray in New York provides an all-too-vivid example. Even though the N.Y. Patient Bill of Rights explicitly furnishes patients with a right to refuse - a right supported by the U.S. Constitution and so interpreted by the Supreme Court⁵³ - and even though Ms. Dray explicitly refused surgery and that refusal was noted in her chart, not only was she subjected to a forced surgery in 2011, but she is still fighting this violation in state court today.⁵⁴ The court dismissed Ms. Dray's claims of violation of the Patient Bill of Rights because that law does not include a private right of action; it also dismissed a negligence claim for lack of informed consent. The State Department of Health, responsible for oversight of facility adherence to the Patient Bill of Rights, first investigated Ms. Dray's allegations in 2018, seven years after the event, and only then after media attention and public pressure spurred a state legislator to ask the Department for an investigation.

Ms. Dray's case demonstrates how this hybrid system of accountability leaves gaps that fail to ensure redress for victims of mistreatment and violence. Unlike Ms. Dray, most people are not

⁵¹ See generally, Annas *supra* note 16.

⁵² Policies that guide health responses to violence against women do exist and even align with WHO guidelines and standards on this issue; however, they are standards for accreditation by the Joint Commission, a private organization that accredits hospitals and other health care organizations. A payor - for example, a government program like Medicaid - may require an institution to meet Joint Commission standards, but an individual woman who has experienced harm cannot use the Joint Commission Standards to get redress from a facility for a lack of care.

⁵³ *Cruzan v. Director, Missouri Department of Health*, 497 U.S. 261 (1990).

⁵⁴ *Dray v. Staten Island Univ. Hosp.* No. 500510/14 (December 23, 2014).

able to file a lawsuit or even retain an attorney, which explains the rarity of such cases.⁵⁵ Individual litigation of malpractice claims is generally low (approximately 2% of injured people litigate) and the rate of such litigation for mistreatment or disrespect during birth is probably even lower, although the precise rate is not known.⁵⁶ The rate by which individuals contact other entities to seek accountability for harms, such as licensing, credentialing/accreditation, payor, or data reporting entities is also not known, but several advocacy organizations provide materials and advice to assist pregnant and postpartum people in filing complaints.⁵⁷

Injured patients experience even greater difficulty in achieving redress through international human rights law, even when these laws have been adopted into professional standards. For example, the World Health Organization recommendations regarding violence against women have been incorporated into Joint Commission standards,⁵⁸ but no mechanism exists by which individuals can require facilities to meet those standards or challenge facilities for not meeting the standards. Indeed, the Joint Commission has been characterized as “collegial rather than regulatory.”⁵⁹ To the extent that such standards exist with regard to violence against women, a long road lies ahead before mistreatment during pregnancy and birth is understood as violence against women, much less before those standards are used or effectively leveraged by individuals who have been harmed.

In addition to the lack of accountability mechanisms, societal factors prevent accountability of facilities for mistreatment and disrespect of patients during pregnancy and birth. First is paternalism of medicine, that persists despite having been named and addressed now for decades.⁶⁰ Pregnancy and birth add a heightened dose of gender-based paternalism that further affects care and the lack of accountability of facilities for mistreatment.⁶¹

In addition, patients experience an entirely new set of challenges when they set out to find advocacy or other help to redress the mistreatment or disrespect they experienced. For these

⁵⁵ They do nonetheless happen. See, e.g., Rebecca Grant, *Ethics of the delivery room: Who's in control when you're giving birth?* Independent (Dec. 18, 2017); <https://ind.pn/2w9H9c9>; Beth Greenfield, *Woman Sues Hospital Over Traumatic Birth That 'Turned Our Family Life Upside Down'*, Yahoo News (Nov. 19, 2015), <https://yhoo.it/2Yw2ed3>.

⁵⁶ Kenneth C. Chessick & Matthew D. Robinson, *Medical Negligence Litigation is Not the Problem*, 26 N. Ill. U. L. Rev. 563, 566 (2006) (discussing research that concluded fewer than 2% of those injured by medical negligence sued) (footnotes omitted); David Pratt, *Health Care Reform: Will it Succeed?*, 21 Alb. L.J. Sci. & Tech. 493, 570 (“Only about 2% of malpractice incidents result in a lawsuit: physicians think the rate is 30% to 60%.”).

⁵⁷ See, e.g., toolkits from consumer advocacy groups Improving Birth, <http://bit.ly/2Jqp1U7>, the International Cesarean Awareness Network, <http://bit.ly/2W8iseS> and Citizens for Midwifery, <http://bit.ly/2YE0UVP>

⁵⁸ See, e.g., Joint Commission Standards PC.01.02.09, RI.01.06.03, HR.01.05.03. Available at: <http://bit.ly/2Hz1AEG>. The Joint Commission accredits and certifies health care organizations and programs in the United States.

⁵⁹ Annas, *supra* note 16.

⁶⁰ See generally Jay Katz, *The Silent World of Doctor and Patient*, (Johns Hopkins University Press 2002) (first published in 1984).

⁶¹ See generally Nancy Ehrenreich, *The Reproductive Rights Reader: Law Medicine and the Construction of Motherhood* (New York University Press 2008).

violations, U.S. law does not ensure the right to an attorney or any assistance with attorney fees. In the absence of a government-sponsored attorney, individuals must be able to pay independently for legal services, or must find an attorney who will base payment on a portion of the eventual settlement (which then requires those attorneys to accept only cases that promise high economic settlements and a good chance of obtaining them). Otherwise, patients are left interacting with a hybrid system of government-sponsored and civil society organizations that provide only some degree of advocacy and self-help.⁶²

IV. Conclusion

Initial data collection and research establishes that abuse, coercion, violence and disrespect in facility-based childbirth are significant problems in the United States, and that the existing legal system not only fails to address this problem, but reinforces it. Full informed consent is required by law, but undermined on the ground by policy and practice. Policymakers have long acknowledged the serious problem of violence against women and have instituted appropriate protections and remedies, but these fail to address mistreatment and violence perpetrated during reproductive health care or childbirth.

This document has shown the many forms of abuse, coercion, disrespect, and violence suffered by U.S. patients receiving facility-based maternity care, beginning with lack of informed consent and ending with racially disparate infant and maternal mortality. The existing accountability infrastructure in the U.S. is inadequate to provide redress for victims of mistreatment and violence, acknowledgement of wrongdoing, guarantees of non-repetition, or protection of human rights.

This state of events, the creation of an irregular and fragmented health care system and a similarly unequal and often unresponsive legal system, must be specifically addressed as gender violence and a violation of birthing people's human rights. The establishment of norms to counter these problems, as delivered by the international human rights community, would provide a welcome standard for the U.S. to follow.

⁶² See generally, American Bar Association, *The Justice Gap: Measuring the Unmet Civil Legal Needs of Low-income Americans* (2017). Available at: <http://bit.ly/2WP87BA>.

ANNEX 1: Examples of Disparate Accountability Mechanisms Relevant to Childbirth

Licensing	Credentialing/ Accrediting	Payor requirements	Data reporting	Specific laws
Each state licenses providers (states vary; some states do not license all midwives)	NGOs establish standards for provider credentials (MDs of varying specialties, and 3 different midwifery credentials)	Third-party payors require certain standards be met before facilities can be reimbursed	A federal agency provides funds to state health departments who collect certain pregnancy related data (not all states participate)	State Patient Bill of Rights (not all states have one; most do not include a private right of action)
States license hospitals	NGOs establish standards for facility accreditation (The Joint Commission for hospitals and the Commission for the Accreditation of Birth Centers)	Third-party payors require certain standards be met before providers be reimbursed	Some states require birth-related reporting, like New York, that requires hospitals make their cesarean surgery rates public (but this varies widely)	The Emergency Medical Treatment and Labor Act prohibits hospitals from failing to provide care to stabilize people in emergencies and labor.
Some states license birth centers (some do not)		Sometimes these standards are related to credentials or accreditation (sometimes not)	Some states have review committees for maternal mortality where all deaths are reported and reviewed (not all do)	The Affordable Care Act includes a provision that requires Medicaid reimbursement for birth center facility services.
Some licenses refer to credentials/ accreditation (some do not)		Some laws, mostly at the state level, regulate how insurance companies deal with facilities and providers		Every state has a common law right to informed consent supported by a constitutional right (as defined in US Supreme Court law).