

**Report to the U.N. Special Rapporteur on the Right to Health**

**Dr. Tlaleng Mofokeng**

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**Violence and Its Impact on the Right to Health**

Submitted by: If/When/How: Lawyering for Reproductive Justice[[1]](#footnote-1)

Type of Stakeholder: Civil Society Organization

Name of State: United States of America

Dear Dr. Mofokeng:

We are grateful for the opportunity to respond to your request for input on violence and its impact on the right to health. We write to highlight violations of the right to health experienced by people during the perinatal period caused by state and institutional violence, including harmful obstetric practices, criminalization of pregnancy and pregnancy outcomes, and punishment through civil family regulation. This violence leads to adverse health outcomes disproportionately affecting people marginalized on the basis of race, poverty, immigration status, and LGBTI identity.

**I. Information on gender and race-based violence, its effect on the right to health, and the impact of COVID.**

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 stem from deeply entrenched racist and sexist attitudes, which also give rise to mistreatment and disrespect in birth. The result is a devastating cycle of harm in which Black, Indigenous, and other people of color – who most need high-quality, patient-centered healthcare – instead receive negligent, abusive, and even violent treatment, and are punished by the state for the adverse outcomes that inevitably ensue.

The racial disparities in outcomes for Black and other birthing people of color have long been raised as areas of concern by U.S. civil society. In 2014, the United Nations Committee on the Elimination of Racial Discrimination expressed concern with high maternal and infant mortality rates among Black communities.[[2]](#endnote-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.[[3]](#endnote-2) Similarly, the UN Special Rapporteur on Extreme Poverty noted at the conclusion of a 2017 visit that the U.S. has the highest maternal mortality rate among wealthy countries, and that Black women are three to four times more likely to die from childbirth.[[4]](#endnote-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 women on the basis of their pregnancy or pregnancy outcomes is an increasing form of mistreatment and abuse during the perinatal period. Within the past two decades, more than 1200 women have been arrested or otherwise deprived of their liberty based on the outcome of their pregnancy.[[5]](#endnote-4) With the U.S. Supreme Court poised to overturn *Roe v. Wade,* a key precedent articulating the constitutional underpinnings for the right to abortion, the threat that women and other birthing people will face violence at the hands of the state – whether indirectly through denial of abortion care or directly through arrest and incarceration – is more urgent than ever. The right to health in the context of reproduction must include the right to make decisions about pregnancy, abortion, and birthing free from punishment by the state or private actors.

These problems have only been exacerbated by the COVID-19 pandemic. In addition to making it more difficult to access care because of personnel and equipment shortages in hospitals, many birthing people faced restrictions on their ability to bring a companion to support them in labor.[[6]](#endnote-5) Many times, this meant having to choose between their partner and a doula.[[7]](#endnote-6) Without the support of a doula or loved one, birthing people have reported experiencing more bias and racism within the health care system.[[8]](#endnote-7) As a result, the longstanding crisis of racialized harm experienced by people seeking maternity care is magnified by the acute crisis of the COVID-19 pandemic.

**II. Legal frameworks addressing these forms of violence, redress options, and impunity.**

The mistreatment, abuse, and violence that birthing people in the United States experience are prohibited by law; however, it persists largely without legal redress, and in many instances occurs under color of law. Pregnant people, and especially pregnant people of color, report that health care providers employ a variety of threats, such as court orders for unwanted procedures and reports to child welfare authorities, to induce compliance with medical advice.[[9]](#endnote-8) This is a perversion of the core legal principle that people have sovereignty over their own bodies.

More than a century of legal precedent dictates that every adult of sound mind has the right to be free from unwanted touching – even if for the purposes of medical treatment.[[10]](#endnote-9) Freedom to make decisions about one’s own body is encompassed by U.S. Constitution’s protections as well.[[11]](#endnote-10) Likewise, the state may not transgress this right except under limited circumstances upon showing of a compelling state interest that is actually advanced by the incursion into bodily autonomy, and that the incursion is no greater than necessary to effectuate that interest.[[12]](#endnote-11) As the U.S. Supreme Court has observed, “[n]o right is held more sacred, or is more carefully guarded by the common law, than the right of every individual to the possession and control of his own person, free from all restraint or interference of others, unless by clear and unquestionable authority of law.”[[13]](#endnote-12) While the law generally serves to protect, rather than limit, this fundamental right to mastery over one’s body.

Unfortunately, current law fails to adequately remedy these violations. 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. Recognition of a fundamental right to reproductive freedom has eroded slowly over the course of the past 50 years, and rapidly over the past 2 years. Those seeking redress for experiences of obstetric violence are therefore forced to rely on a patchwork of partially-relevant legal theories: civil suits in tort that may be cost prohibitive, civil rights claims that are tightly circumscribed by legal precedent, and any other legal theories a plaintiff can scrape together.

At the same time, concepts applied in abortion case law, most particularly the right to privacy,[[14]](#endnote-13) 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.[[15]](#endnote-14) In the case of *Pemberton*, the result was court-ordered cesarean surgery.

**III. Examples of the types of state and non-state structural and institutional violence, and who is affected.**

While much obstetric violence in the United States occurs cloaked in state power, it is no less violent than the “obstetric slaps”[[16]](#endnote-15) and symphysiotomies[[17]](#endnote-16) endured by birthing people in other countries. It may involve unwanted intrusions like vaginal examinations, episiotomy (cutting the perineum), or even cesarean surgery. It may involve forcibly subduing a pregnant person in service of a medical intervention, such as in the case of a Nigerian woman in Illinois who was so distressed after being told she would be forced to have a court-ordered cesarean section that she physically resisted, only to be placed in leather restraints and bite through her intravenous line.[[18]](#endnote-17) It may be unnecessary, as was the case with a Black mother in Georgia who was given a dire prognosis of near-certain death to her fetus and ordered to submit to surgery, only to have the condition resolve and deliver a healthy baby.[[19]](#endnote-18) Or it may ultimately futile, as was the case with the court-ordered bed rest and cesarean section forced upon a Florida woman that failed to prevent her pregnancy loss.[[20]](#endnote-19)

As with most forms of invidious discrimination prohibited by law, the underlying racial bias is generally not documented by the perpetrator. Nevertheless, people of color report significantly more disrespect and mistreatment during their birth experiences.[[21]](#endnote-20) One study of court-ordered cesareans published in the *New England Journal of Medicine* found that people of color and immigrants were more likely to be subjected to court-ordered cesareans – 81% of the cases involved women identified as Black, Asian, or Hispanic; 24% did not speak English as a primary language.[[22]](#endnote-21)

The factors that precipitate the conflict leading to threats may themselves be racialized. Frequently, the source of divergence between the individual’s decisions about medical treatments and the physician’s recommendations is the patient’s religious or cultural beliefs. For instance, members of the Jehovah’s Witnesses, a majority non-white religion[[23]](#endnote-22) that rejects the use of blood transfusions, have been subjected to proceedings to legally compel transfusions believed to be of benefit to the fetus.[[24]](#endnote-23) In one case, a Black Jehovah’s Witness was “yelled at and forcibly restrained, overpowered, and sedated” in order to be administered a blood transfusion doctors believed would help her fetus.[[25]](#endnote-24) A Black Muslim woman, declining cesarean surgery on the basis that “a Muslim woman has the right to decide whether or not to risk her own health to eliminate a possible risk to the life of her undelivered fetus,” was forced to undergo surgery, with the court opining that “[a]ll that stood between the […] fetus and its independent existence, separate from its mother, was, put simply, a doctor's scalpel.”[[26]](#endnote-25) Muslims in the United States, like Jehovah’s Witnesses, are majority non-white.[[27]](#endnote-26)

The obstetric violence emerging from pregnant patient’s refusals based in their faith can also affect white women who are members of religious minorities. An Orthodox Jewish Israeli woman in New York, who wished to avoid a third cesarean section because of her desire to preserve her ability have more children according to her faith’s dictates, was forced to undergo cesarean surgery *without a legal process* when a hospital enforced its undisclosed policy of overriding the decisions of pregnant patients with viable fetuses.[[28]](#endnote-27) Conversely, a Romanian woman narrowly avoided a court-ordered cesarean section in Illinois after having declined surgery on the basis of her religious belief in faith healing.[[29]](#endnote-28) Her case was unusual in that she had the opportunity for development of the record, appellate review, and participation of civil rights advocates including the American Civil Liberties Union.[[30]](#endnote-29) According to one survey, 88% of court orders for surgery were granted within six hours; 19% were granted within an hour, usually by telephone.[[31]](#endnote-30)

Some of these hostile interactions between health care provider and patient are captured in reported case law; a much greater number of interactions never become reported case law simply because the threat is effective in coercing compliance.[[32]](#endnote-31) This is especially so when the threat involved, as discussed below, is removal of the child the birthing person is bringing into the world.

**IV. Information on the impact of criminalization of abortion and drug abuse, and harmful practices in obstetric care.**

***State and institutional violence through use of the criminal legal system.*** Medical and public health experts are unified in rejecting punitive responses to the outcomes or circumstances of pregnancy, because such a response deters people from seeking prenatal care for fear of arrest or other punishment.[[33]](#endnote-32) In spite of this recognition, people who self-manage their abortions and those who use criminalized drugs are particularly vulnerable to mistreatment and abuse when they seek health care, resulting in denial of the highest attainable standard of health.

Pregnant people who self-disclose use of these drugs or test positive for them (often without having been provided informed consent for the test) 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.[[34]](#endnote-33) Furthermore, despite the fact that drug use by Black and white women occurs at approximately the same rate in the U.S.,[[35]](#endnote-34) 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.[[36]](#endnote-35)

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. Even though abortion remains legal in the U.S. and the vast majority of states do not authorize criminal punishment for self-managed abortion, dozens of people have been criminally prosecuted since the year 2000 for ending a pregnancy or helping someone else do so.[[37]](#endnote-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.

***State and institutional violence through the use of the civil child welfare system.*** Among the coercive tactics used to induce compliance with medical advice is threatening to involve child welfare authorities.[[38]](#endnote-37) Legal precedent acknowledges that parents’ right to make medical decisions on behalf of their children can be constrained when it threatens the child’s health.[[39]](#endnote-38) But a fetus is not a child, nor are a person’s decisions about something as intimate as how to give birth and which potentially life-altering medical interventions they should undertake indicative of their ability to properly care for a child once born.

By invoking the threat of child welfare intervention, health care providers suggest that fetuses are children to which the state can stand as ultimate parent (*parens patriae*), irrespective of the fundamental right to bodily self-determination of the pregnant parent, and the harm they face in unwanted medical intrusions. This threat is particularly toxic when applied to communities like Black and Indigenous people, who are already over-surveilled and over-represented within the child welfare system.[[40]](#endnote-39) And the “mutual deference” afforded between child welfare authorities and health care providers frequently means that the fundamental rights at issue are given short shrift.[[41]](#endnote-40)

The involvement of child welfare authorities in birthing may mean that a person’s right to parent is dictated by how they cope with their labor and their willingness to accept the resulting state interference with their parenting. One New Jersey woman, whose parental rights were ultimately terminated, was described by medical records as “erratic,” “irrational,” and “uncooperative” in the midst of active labor when she declined to pre-authorize cesarean delivery.[[42]](#endnote-41) These notations seemingly failed to take into account that she was subjected to threats and psychiatric examinations because of her decisions while in labor. Although the surgery was never needed and the baby was delivered healthy, the mother’s unwillingness to fully submit to the numerous interventions demanded by the child welfare authorities became its own basis to deny her right to parent her own child. It is therefore unsurprising that some birthing parents simply give in. As one mother explained, “I didn’t fight because I knew that [child welfare authorities] would be an issue . . . I already had that fear put into me.”[[43]](#endnote-42) Even investigations that do not lead to removal of the child from the family can deprive the infant-parent dyad of critical bonding time, the ability to establish breastfeeding,[[44]](#endnote-43) and the dignity of the irreplaceable first moments of life.

**V.** **Responses provided by the State and/or other to survivors of violence.**

Recognition of the harm experienced by people who suffer mistreatment, abuse, and obstetric violence is virtually nonexistent. The United States does not recognize or enact the right to health or health care.[[45]](#endnote-44) 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.[[46]](#endnote-45)

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 specific statutes or regulations.[[47]](#endnote-46)

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 standards[[48]](#endnote-47) might affect a facility’s ability to receive payment from a third-party payor, but the facility might nevertheless remained 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.

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.[[49]](#endnote-48) 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.[[50]](#endnote-49)

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,[[51]](#endnote-50) 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.”[[52]](#endnote-51) 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 being named and addressed now for decades.[[53]](#endnote-52) Pregnancy and birth add a heightened dose of gender-based paternalism that further affects care and the lack of accountability of facilities for mistreatment.[[54]](#endnote-53)

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 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.[[55]](#endnote-54)

**IV.** **The needs of survivors of the abovementioned forms of violence, and examples of progress.**

The experiences of mistreatment and violence faced by birthing people in the United States, both prior to and during the COVID pandemic, point to a need for key improvements in the health care and legal systems.

**Increase options for culturally concordant, person-centered midwifery care.** One important way to meet the shortfall in pregnancy-related care is to shore up the workforce of midwives, who have specialized expertise in normal pregnancy and physiologic care. As the COVID-19 pandemic continues, the importance of being able to provide community-based care outside of hospital settings (which may be overwhelmed by COVID patients or unsafe for medically-vulnerable pregnant people), has become clear. Certified Professional Midwives (CPMs) are the only midwives who specialize in community-based care in homes and freestanding birthing centers, and can safely provide care to people with low-risk pregnancies. CPMs have particularly been shown to drastically reduce adverse outcomes such as preterm birth and low birth weight among Black and Indigenous women. Illinois recently became the 36th state to pass a law authorizing CPM practice. Other states should follow suit, and ensure that health insurers – including publicly-funded insurance – cover services from CPMs in all practice settings. States should also ensure that the requirements for licensure do not act as barriers to the profession for people from communities most affected by adverse birth outcomes.[[56]](#endnote-55)

**Ensure access to continuous labor support.** A key intervention in ensuring that everyone can fully enjoy the right to health and experience respectful care at birth is ensuring that everyone has access to continuous labor support. This could be from a *doula* (labor support professional who specializes in the non-medical aspects of childbirth), or from a family member or other trusted individual who is provided training in how to provide support. For people who are most likely to experience adverse pregnancy outcomes because of marginalization due to race and poverty, this intervention can be life-saving. In some U.S. jurisdictions, including Florida, Minnesota, New Jersey, and Oregon, there has been progress in passing legislation requiring state based Medicaid programs to cover doula services.[[57]](#endnote-56) It is critically important that doulas and other community stakeholders — particularly Black, Indigenous, and other people of color, whose outcomes are most in need of intervention — be a part of the design of any such program from its inception. Inclusive processes can help ensure equity among the birth workforce by setting rates and methods of reimbursement allow doulas to earn a fair wage for their labor, creating paths to certification that eliminate unnecessary barriers, and allowing doulas to maintain autonomy in their practice so that they can best serve birthing people free from constraints imposed by the health care systems that have failed them.

**End the criminalization of abortion, miscarriages, and other pregnancy outcomes.** In January of 2021, in response to public outcry about the criminal prosecution of two women who were arrested after seeking medical care for stillbirths, California Attorney General Rob Bonta issued a Legal Alert clarifying that California law does not permit criminal punishment of people’s reproductive outcomes.[[58]](#endnote-57) This is in line with the vast majority of U.S. jurisdictions. Law enforcement leaders should take similar steps to ensure that the criminal legal system is not a site of violence for people seeking medical assistance if they end or lose a pregnancy.

**Develop state and civil society partnerships to advance reproductive justice for birthing people.**  In 2015, the New York City Department of Health and Mental Hygiene undertook a multi-year campaign to advance reproductive justice. As a part of this process, the Health Department held community listening sessions in neighborhoods across New York City to hear people’s sexual and reproductive health concerns. A concern that was raised again and again was reports of coercion and threats by health care providers trying to force pregnant people to acquiesce to medical advice, including threats to use court orders or reports to child welfare authorities. Birth Justice activist called on the Health Department to create and disseminate a resource that would raise consciousness among patients and educate providers about human rights of birthing people. These concerns led to the development of the New York City Standards for Respectful Care at Birth, a document co-created by the Heal Department and members of the Sexual and Reproductive Justice Community Engagement Group. This document lays out the fundamental rights of all birthing people, including the right to receive information about all proposed treatments, to consider alternatives, and to decline medical recommendations.

**Ensure accountability for discriminatory harm against birthing people.** In 2021, the New York City Commission on Human Rights Commission adopted new rules to clarify the scope of protections from discrimination on the basis of pregnancy under New York City’s Human Rights Law. This body of law provides an avenue for redress for people who experience discrimination in public accommodations. As a result of cooperation between civil society and advocates within the state system, the rules were included to specify that policies that deny people their right to informed consent and refusal of unwanted medical treatment on the basis that they are pregnant is a form of actionable discrimination.

1. For more information, please contact Farah Diaz-Tello, Senior Counsel and Legal Director, at farah@ifwhenhow.org. This questionnaire response may be published on the Special Rapporteur’s page on the OHCHR website. If/When/How gratefully acknowledges the valued partnership of other civil society organizations that have co-authored and co-developed other documents from which the responses to this questionnaire emerge, with whom we stand in solidarity. They include the Birth Rights Bar Association, Elephant Circle, the Human Rights and Gender Justice Clinic at the City University of New York School of Law, National Advocates for Pregnant Women, and Movement for Family Power. [↑](#footnote-ref-1)
2. 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). [↑](#endnote-ref-1)
3. *Id*. [↑](#endnote-ref-2)
4. 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). [↑](#endnote-ref-3)
5. *See,* National Advocates for Pregnant Women, *Arrests and Other Deprivations of Liberty of Pregnant Women, 1973-2020* (Sept 2021), <https://bit.ly/3tES9gI>; Farah Diaz-Tello, If/When/How: Lawyering for Reproductive Justice, *Roe’s Unfinished Promise: Decriminalizing Abortion Once and For All* (2017), <http://bit.ly/2WvuEm2>. [↑](#endnote-ref-4)
6. See generally, Christina Capatides et al., *Pregnant Women Are Being Forced to Give Birth Alone as Hospital Restrict Visitors During Coronavirus*, CBS News, (March 26, 2020), <https://cbsn.ws/33Q62xC>. [↑](#endnote-ref-5)
7. Collier Meyerson, *Doulas Are Going Virtual*, Intelligencer, New York Magazine (April 12, 2020), <https://nym.ag/3nCuHgp>. [↑](#endnote-ref-6)
8. *See generally,* Anna North, *America is failing Black moms during the pandemic* (Aug. 10, 2020), <https://bit.ly/3qFYJSs>. [↑](#endnote-ref-7)
9. *See, e.g.,* Farah Diaz-Tello, *Invisible Wounds: Obstetric Violence in the United States*, 24 Reprod. Health Matters, 56 (2016); Elizabeth Kukura, *Birth Conflicts: Leveraging State Power to Coerce Health Care Decision Making*, 47 U. Balt. Law Rev. 247 (2018); Nancy K. Rhoden, *The Judge in the Delivery Room*, 74 Cal. L. Rev. 1951 (1986). [↑](#endnote-ref-8)
10. *Schloendorff v Socy. of New York Hosp.*, 211 N.Y. 125, 129 (1914). [↑](#endnote-ref-9)
11. *See, e.g., Cruzan v. Dir., Mo. Dep't of Health*, 497 U.S. 261, 289 (1990)(O’Connor, J., concurring)(“[T]he liberty guaranteed by the Due Process Clause must protect, if it protects anything, an individual's deeply personal decision to reject medical treatment. . . .”). [↑](#endnote-ref-10)
12. *See Washington v. Glucksberg*, 521 U.S. 702, 721 (1997). [↑](#endnote-ref-11)
13. *Union Pac. Ry. Co. v. Botsford*, 141 U.S. 250, 251 (1891). [↑](#endnote-ref-12)
14. 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). [↑](#endnote-ref-13)
15. 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). [↑](#endnote-ref-14)
16. *See, e.g.,* Meghan A. Bohren et al., *“By Slapping their Laps, the Patient will Know That You Truly Care for Her”: A Qualitative Study on Social Norms and Acceptability of the Mistreatment of Women During Childbirth in Abuja, Nigeria*, SSM – Population Health, Dec. 2016, 640. [↑](#endnote-ref-15)
17. *See* Survivors of Symphysiotomy, *Report Submission to the United Nations Special Rapporteur on Violence Against Women*, May 2019, <https://bit.ly/3GGhsm9>. [↑](#endnote-ref-16)
18. *See* Janet Gallagher, *Prenatal Invasions & Interventions: What’s Wrong With Fetal Rights*, 10 Harv. Women’s L.J. 9, 9-10 (1987). [↑](#endnote-ref-17)
19. *See Jefferson v. Griffin Spalding County Hospital Authority*, 274 S.E.2d 457 (Ga. 1981). [↑](#endnote-ref-18)
20. *See Burton v. State*, 49 So. 3d 263 (Fla. Dist. Ct. App. 2010). *See also*, *In re A.C.*, 573 A.2d 1235, 1240-41 (1990) (Infant delivered via court-ordered cesarean died shortly after birth, and surgery contributed to the death of the mother.). [↑](#endnote-ref-19)
21. Vedam et al, *The Giving Voice to Mothers Study: Inequity and Mistreatment During Pregnancy and Childbirth in The United States*, 16(1) Reprod. Health 77, (June 11, 2019). [↑](#endnote-ref-20)
22. Veronika Kolder, Janet Gallagher, & Michael T. Parsons, *Court-Ordered Obstetrical Interventions*, 316 New Eng. J. Med. 1192 (1987) [↑](#endnote-ref-21)
23. Michael Lipka, Pew Research Ctr., *The Most and Least Racially Diverse U.S. Religious Groups,* (July 27, 2015),<https://pewrsr.ch/3rynT4s>. [↑](#endnote-ref-22)
24. *In re Jamaica Hospital*, 128 Misc. 2d 1006 (N.Y. Sup. Ct. Queens County, Apr. 22, 1985) (authorizing a blood transfusion over the religious objection of an 18-weeks pregnant Latina Jehovah’s Witness). *But cf.,* *In re Fetus Brown*, 689 N.E.2d 397 (Ill. App. 1997)(reversing appointment of guardian ad litem with authority to approve unconsented transfusion for the benefit of the fetus); *Mercy Hosp. v. Jackson*, 489 A.2d 1130 (1985) (affirming trial court denial of hospital’s petition for a guardian to consent to unwanted blood transfusion of a Jehovah’s Witness for the benefit of her fetus), vacated as moot by *Mercy Hosp., Inc. v. Jackson*, 510 A.2d 562 (1986) [↑](#endnote-ref-23)
25. *In re Fetus Brown*, 689 N.E.2d 397, 404 (Ill. App. 1997). [↑](#endnote-ref-24)
26. *In re* Madyun Fetus, 114 Daily Wash. L. Rptr. 2233 (D.C. Super. Ct. Oct. 29, 1986), *reported at* 573 A.2d 1259, 1262 (D.C. Sup. Ct. 1986). [↑](#endnote-ref-25)
27. Lipka, *supra* note 22. [↑](#endnote-ref-26)
28. *Diaz-Tello*, supra note 8 at 57. *See Dray v. Staten Island Univ. Hosp.*, No. 500510/14 (N.Y. Sup. Ct. Dec. 15, 2015) [↑](#endnote-ref-27)
29. *In re Baby Boy Doe*, 632 N.E.2d 326 (Ill. App. Ct. 1994). [↑](#endnote-ref-28)
30. I*d.* [↑](#endnote-ref-29)
31. Kolder et al, *supra* note 21, at 1195. [↑](#endnote-ref-30)
32. Nancy K. Rhoden, *Cesareans and Samaritans,* 15 J. L. Med. & Health Care 118, 118 (1987); Theresa Morris & Joan H. Robinson, *Forced and Coerced Cesarean Sections in the United States*, 16 Contexts 24, 25-26 (2017) (noting that approximately one-third of the cases of forced or coerced cesarean examined in the study involved a birthing parent appealing a loss of parental rights). [↑](#endnote-ref-31)
33. E.g., Am. Coll. Obstetricians & Gynecologists*, Statement of Policy: Opposition to the Criminalization of Individuals During Pregnancy and the Postpartum Period* (2020), <https://bit.ly/3KoIpNB>; Am. Coll. 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>. [↑](#endnote-ref-32)
34. Robinson v. California, 370 U.S. 660 (1962). [↑](#endnote-ref-33)
35. 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>. [↑](#endnote-ref-34)
36. 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. [↑](#endnote-ref-35)
37. *See* Farah Diaz-Tello, If/When/How: Lawyering for Reproductive Justice, *Roe’s Unfinished Promise: Decriminalizing Abortion Once and For All* (2017) <http://bit.ly/2Vjp62g>. [↑](#endnote-ref-36)
38. Kukura, *Birth Conflicts*, *supra* note 8, at 254-264. [↑](#endnote-ref-37)
39. *Prince v. Massachusetts*, 32 U.S. 158, 166-67 (1944). [↑](#endnote-ref-38)
40. Children’s Bureau, Dep’t of Health and Human Servs., *Child Welfare Practice to Address Racial Disproportionality and Disparity*, at 2-3 (Apr. 2021), <https://bit.ly/3FIbiRc>. [↑](#endnote-ref-39)
41. *Cf.* Clara Presler, *Mutual Deference Between Hospitals and Courts: How Mandated Reporting from Medical Providers Harms Families*, 11 Colum. J. Race & L. 733, 741 (2021) (Noting that, in child welfare cases related to living children, “when the issue is or appears to be medical, the court system does not function as the objective check the system envisioned it to be. Instead, he courts defer to the report absent a countering medical opinion [ . . .] Deference [. . . renders] the legal system both impotent and complicit in the resulting harm.”) [↑](#endnote-ref-40)
42. *N.J. Div. of Youth & Family Servs. v. V.M.*, 974 A.2d 448, 449 (N.J. Super. Ct. App. Div. 2009) (per curiam). [↑](#endnote-ref-41)
43. Morris, *supra* note 31, at 26. [↑](#endnote-ref-42)
44. Kukura, *Birth Conflicts*, *supra* note 8, at 264. [↑](#endnote-ref-43)
45. George Annas, *The Rights of Patients*, American Civil Liberties Union, 7 (New York University Press 2004). [↑](#endnote-ref-44)
46. 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.) [↑](#endnote-ref-45)
47. *See* *generally*, Annas *supra* note 44. [↑](#endnote-ref-46)
48. 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. [↑](#endnote-ref-47)
49. 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%.”). [↑](#endnote-ref-48)
50. *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>. [↑](#endnote-ref-49)
51. *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. [↑](#endnote-ref-50)
52. Annas, supra note 44. [↑](#endnote-ref-51)
53. *See generally* Jay Katz, *The Silent World of Doctor and Patient*, (Johns Hopkins University Press 2002) (first published in 1984). [↑](#endnote-ref-52)
54. *See generally* Nancy Ehrenreich, *The Reproductive Rights Reader: Law Medicine and the Construction of Motherhood* (New York University Press 2008). [↑](#endnote-ref-53)
55. *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>. [↑](#endnote-ref-54)
56. Beth Hundsdorfer, *New Law Provides for Licensure Path of Certified Professional Midwives in Illinois*, Capital News Illinois, Dec. 14, 2021, <https://bit.ly/33NnLpu>. [↑](#endnote-ref-55)
57. Alexis Robles-Fradet, National Health Law Program, *Medicaid Coverage for Doula Care: State Implementation Efforts*, Dec. 18, 2021, <https://bit.ly/3Kq6TGc>. [↑](#endnote-ref-56)
58. California Department of Justice, Press Release, *Attorney General Bonta: California Law Does Not Criminalize Pregnancy Loss,* Jan. 6, 2022, <https://bit.ly/33Mz7KG>. [↑](#endnote-ref-57)