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Lawyering for Reproductive Justice

Birthing Rights

IF/WHEN/HOW ISSUE BRIEF

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INTRODUCTION

If/When/How recognizes that most law school courses are not applying an intersectional, reproductive justice lens to complex issues. To address this gap, our issue briefs and primers are designed to illustrate how law and policies disparately impact individuals and communities. If/When/How is committed to transforming legal education by providing students, instructors, and practitioners with the tools and support they need to utilize an intersectional approach.

If/When/How, formerly Law Students for Reproductive Justice, trains, networks, and mobilizes law students and legal professionals to work within and beyond the legal system to champion reproductive justice. We work in partnership with local organizations and national movements to ensure all people have the ability to decide if, when, and how to create and sustain a family.

INFORMED CONSENT AND COERCIVE MEDICAL TREATMENT DURING PREGNANCY

Legal and ethical principles regarding a person's ability to make decisions regarding healthcare, bodily autonomy, and the right to informed consent are often set aside when that person is pregnant. Recent policies and laws enacted with the intention to protect the fetus as a separate entity from the pregnant woman have challenged the rights of people to make decisions regarding their healthcare.

- In order to realize reproductive justice and self-determination in healthcare, people need access to informed consent, patient autonomy, and access to reliable information and options at all stages of pregnancy. Informed consent requires that patients have access to information about the risks and benefits of various treatment options, including inaction, and the ability to choose between these options.[1] Only when all these elements are satisfied can a person make a voluntary, appropriate, and deliberate decision regarding their treatment.[2]
- The World Health Organization indicates that Caesarean section ("C-section") rates of greater than than 10% do not reduce maternal and infant mortality.[3] Between 1996 and 2009, the C-Section rate in the U.S. increased. Currently, the U.S. stands at 32%,[4] a very high rate compared to other countries worldwide.[5] However, the rate of C-sections in the U.S. is in decline and is currently at its lowest since 2007.[6] The rate of C-section among black women is among the highest (35.5%) and has largely remained unchanged,[7] while C-section rates among white and Hispanic women continue to decline.[8]
- Financial incentives and time constraints likely contribute to the U.S.'s high C-sections. Doctors and hospitals often make more money for C-sections instead of vaginal deliveries.[9] In addition, the American College of Obstetricians and Gynecologists ("ACOG") and the Society for Maternal-Fetal Medicine note that a normal delivery actually takes longer than a C-section, and doctors are likely to rush time with one patient to attend to the next.[10] The assertion that the rate of C-sections is influenced by time and money is bolstered by the fact that almost half of the C-sections performed in the U.S. are done in cases where babies could be safely delivered vaginally.[11]
- During the 1980's and early 1990's, the U.S. saw a trend in court decisions and government action attempting to "protect" women by regulating their conduct while pregnant.[12] While litigation has reduced the number of these cases in successive years, the occurrence of court-ordered treatment for pregnant people has not ended.[13] Some data indicates that the majority of people forced to undergo court-ordered C-sections are low-income women of color.[14]
    - For example, in 2009 in Tallahassee, Florida, Samantha Burton was 25 weeks pregnant when her membranes burst, a sign of premature labor.[15] Even though she was found to not be in labor, her doctor ordered her to remain on bed rest.[16] When she decided to leave the hospital against the doctor's orders to care for her two children at home, the obstetrician obtained a court order requiring Burton to undergo any medical treatment the doctor deemed necessary to save the fetus.[17] Burton testified to the court by phone from the hospital and without counsel.[18] After three days of forced hospitalization and a compelled C-section, Burton suffered a stillbirth and was released.[19] Burton later appealed the court order, and the Florida District Court of Appeal ruled in her favor, holding that the state did not have a compelling interest great enough to override Burton's right "to be let alone and free from government intrusion into [her] life,"[20] including her fundamental constitutional right to refuse medical intervention.

Additionally, a 2015 New York state trial court ruled that a state's interest in a fetus may allow providers to override the medical decisions of a pregnant person.[21]

- While the incidence of court-ordered treatment of pregnant people is relatively rare, many people face a variety of obstacles in exercising informed consent and/or refusing certain medical inventions during childbirth:
  - Most people do not plan to deliver by C-section.[22] Yet, about one third of all births in the U.S. are via C-section,[23] including 16% of births to first-time mothers.[24] One in three mothers delivers their babies via C-section under the assumption of decreased risk to the fetus.[25]
  - The opportunity to give vaginal birth after Cesarean ("VBAC") is an important option for pregnant people. According to the Mayo Clinic, research on women who attempted a trial of labor after C-section shows that 60-80% have had successful vaginal delivery.[26] However, many pregnant people are not able to access VBAC at countless hospitals in the U.S. due to formal and de facto bans.[27] As a result, a growing number of pregnant people must either consent to a subsequent C-section against their wishes, or decide to deliver vaginally outside a hospital setting.[28]

MIDWIVES AND DOULAS

- Midwives are healthcare professions who offer care to women during pregnancy, childbirth, and postpartum.[29] Midwives also provide preventative care and can help detect complications in the mother and child.[30] Generally, midwives do not intervene in labor and delivery until necessary and use physiological management during labor.[31]
  - The Midwives Model of Care strives to offer women individualized counseling and care that extends beyond labor and delivery and into postpartum.[32] People turn to midwifery care in search of a model that normalizes pregnancy and birth and focuses on the physical, social, and psychological needs of the mother.
  - Midwives pursue various routes to training and education in the U.S., and are subject to a complex set of state regulations depending upon their certification and license.[33]
  - Certified Nurse-Midwives ("CNM") practice legally in every state and territory, though with varying levels of autonomy and physician oversight.[34]
    - When serving senior women receiving Medicare, CNMs were previously, reimbursed at the rate of 65% of the physician rate.[35] As of January 1, 2011, the CNM reimbursement rate increased to 100% of the Medicare Part B fee schedule, as a part of The Patient Protection and Affordable Care Act ("ACA;" see more on the ACA below).[36]
    - Medicaid pays for approximately half of U.S. births.[37] As of 2013, Medicaid reimbursements for CNMs were 100% relative to physician reimbursement rates in 24 states.[38] Only four states offer less than 79% Medicaid reimbursement rates relative to physician reimbursement rates for CNMs.[39]
  - Another category of midwives is known as Certified Professional Midwives ("CPM"), who train directly in the Midwifery Model (without becoming nurses), to provide care to pregnant people and newborns.[40] A CPM is nationally certified through the North American Registry of Midwives, and if a license is available, it is issued by the state within which the midwife practices.[41] Currently, CPMs can legally practice in 30 states, and eleven states have pending CPM legislation.[42] There are fifty distinct jurisdictions, licensing laws, professional licensing boards, and sets of regulations in the U.S. regarding CPM licensing.[43]
- In contrast to midwives, doulas are nonmedical persons who assist before, during and after labor, and provide physical assistance, information, and support to the pregnant person, family, and partner.[44] In the largest study regarding doulas, research showed that doula-supported pregnant people were 28% less likely to have a C-section and 31% less likely to use synthetic oxytocin to speed up labor.[45] Further, doula-supported pregnant people were 34% less likely to rate their childbirth experience negatively.[46] Doulas provide continuous support to the pregnant person before, during, and immediately after delivery.[47] Whereas midwives provide clinical services, doulas provide nonclinical emotional support and comfort measures.[48] Some doulas also provide support and care for people receiving medication or surgical abortion, as well as for people who have experienced a miscarriage or other pregnancy loss.[49]
- Increasing access to midwives, doulas, and options for VBAC and homebirth is integral to achieving reproductive justice. Such access not only allows people to make decisions about whether and when to have children, but also how they are treated during pregnancy, labor, and childbirth.[50]

OUT-OF-HOSPITAL "HOME" BIRTHS

The frequency of planned out-of-hospital births in the U.S. has recently increased,[51] yet the practice continues to be controversial: ACOG warns that while planned homebirths result in less maternal intervention, "they are associated with a twofold increase in perinatal death" when compared to planned hospital births.[52] A 2015 study by the New England Journal of Medicine examined almost 80,000 pregnancies in Oregon, finding that the babies of people who planned out-of-hospital deliveries died during the birth process or within the first month after birth at a rate 2.4 times higher than women who planned hospital deliveries.[53] Out-of-hospital births additionally carried greater risk of neonatal seizures, the newborn requiring ventilators, or the mother needing blood transfusions.[54]
There are many reasons why people choose out-of-hospital births. One reason may be that out-of-hospital births are much less likely to result in C-sections—5.3% of out-of-hospital births required C-sections compared to 24.7% of hospital births.[55] Out-of-hospital births also involved fewer interventions to augment labor, and mothers had fewer lacerations.[56] Though perinatal mortality was higher in planned out-of-hospital births than planned in-hospital births, the absolute risk of death was found to be low in both settings.[57] ACOG also recently released an opinion stating that risk can be reduced through appropriate planning, and that a pregnant person's medically informed decision should be respected, regardless of risk profile.[58]

PREGNANCY & PARENTING SUPPORT FROM THE AFFORDABLE CARE ACT

The Patient Protection Affordable Care Act ("ACA") passed in 2010, which increases access and affordability of healthcare insurance and coverage for pregnant people.[59] The Act appropriates $25 million annually from 2010 to 2019 for state grants to assist pregnant and parenting teens and women.[60] The ACA includes protection for childbearing women and newborns through the inclusion of maternal and newborn care in a defined package of "essential health benefits."[61] Beginning in 2014, essential services must be covered in policies available through state insurance exchanges.[62] The ACA also created two new programs for families, the Maternal, Infant and Early Childhood Home Visiting Program and the Pregnancy Assistance Fund.[63]

- **The Maternal, Infant and Early Childhood Home Visiting Program** awards grants for services in at-risk communities, with a focus on strengthening families and community resources and improving maternal and newborn health, child health, and school readiness.[64]
- **The Pregnancy Assistance Fund** provides grants to states and Native American tribes to help support pregnant and parenting teens and women who are enrolled in higher education programs with child care, housing, baby supplies and food, and other support and protective services.[65] The Fund also provides grants to organizations to provide personal responsibility education to young people to reduce pregnancy and sexually transmitted infection rates by teaching them to delay sexual activity and increase contraceptive use when sexually active.[66]

SOCIAL SAFETY NET POLICIES

- In 1996, Congress enacted the Personal Responsibility and Work Opportunity Reconciliation Act ("PRWORA"),[67] which eliminated the federal guarantee of Aid to Families with Dependent Children and created Temporary Assistance for Needy Families ("TANF"). This legislation is often referred to as the "Welfare Reform," which took place under the Bill Clinton administration.
- One of PRWORA's major goals is to reduce the number of children born "out-of-wedlock."[68] The "Bonus to Reward Decrease in Illegitimacy," a PRWORA provision, gave a special cash reward to the five states that demonstrated the highest net decrease in out-of-wedlock births while keeping the ratio of abortions to live births below the 1995 level.[69]
- Following welfare reform, welfare-eligible women had an increased likelihood of being uninsured pre-pregnancy and a higher probability of delaying enrollment into Medicaid until the prenatal period.[70]
- Under TANF, states have discretion to implement "child exclusion" or "family cap" policies, which deny additional benefits to a child born into a family already receiving TANF benefits.[71] Such policies effectively punish the children and families on welfare by denying them needed aid.

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- Currently, fifteen states still have family caps, which vary from state to state, some being quite complex in nature:[72]
  - As of July 2016, Arizona families on welfare can no longer stay on welfare for longer than twelve months—thus imposing the most restrictive welfare rules in the country.[73] A family of three in Arizona with no income would receive no more than $278 per month.[74]
  - Idaho has no family size statute, but the state caps welfare benefits at $309 per month, regardless of the size of the family, creating a family cap by default.[75]
- Since 2004, Maryland, Minnesota, Illinois, Wyoming, Nebraska, and Oklahoma have repealed their caps, and other states have modified or revised their programs.[76] As of June 2016, California became the seventh state to repeal its welfare family cap, known as the Maximum Family Grant.[77]
- New Jersey was the first state to create a family cap in 1992.[78] In June 2016, New Jersey lawmakers voted to repeal the state's maximum family grant rule, but Gov. Chris Christie (R) vetoed the repeal, stating that the caps "provide for equal treatment of welfare recipients and other residents, who do not automatically receive higher incomes follow the birth of a child."[79]
- Many state legislatures intended for family caps to dissuade low-income families from increasing their family size; however, reports show that people who are enrolled in welfare have the same size families as those who do not receive welfare; in fact, there is strong evidence to show that family caps actually increase poverty.[80]

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