Right to Informed Consent, Right to a Doula: An Evidence-Based Solution to the Black Maternal Mortality Crisis in the United States

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RIGHT TO INFORMED CONSENT, RIGHT TO A DOULA: AN EVIDENCE-BASED SOLUTION TO THE BLACK MATERNAL MORTALITY CRISIS IN THE UNITED STATES

Cecilia Landor*

ABSTRACT

This Note seeks to build on existing research about how to improve childbirth in the United States for women, particularly for Black women, given the United States’ extremely high maternal mortality rate. Through examining the history and characteristics of American and Western childbirth, it seeks to explore how the current birth framework contributes to maternal mortality. To fight this ongoing harm, I suggest increasing access to doulas—nonmedical support workers who provide “continuous support” to the birthing person.1

Through this Note I seek to build on the research of others by identifying the ways medicalized birth practices fail women, particularly Black women, and possible solutions to this crisis. To that end, I examine the pathologization of childbirth, paternalism in medicine, and how the history of early gynecologists’ experimentation on enslaved Black women reverberates in the context of birth today, as both a cause of ongoing medical racism and paternalism, and as a symptom of misogyny, misogynoir, and racism.

Furthermore, this Note builds on existing work in this field by suggesting a solution that has become more popular in recent years: the use of doulas to improve labor and childbirth. I identify why doulas are such an excellent tool to combat the current issues that plague women’s pregnancy and births in this country, specifically against a backdrop of how medical paternalism, racism, and the law have hamstrung women’s ability to safely birth.

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1. I will alternate between using the terms “birthing person” and “woman” or “women” in this article.
Finally, I suggest a workable solution to increase the usage of doulas by women who most need support: adding doulas to the “maternity and newborn care” essential health benefit, one of ten essential health benefits private insurers are required to cover under the ACA.

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INTRODUCTION

The United States has an abysmal maternal mortality rate for such a highly developed nation. While maternal mortality globally is improving, the U.S. is actually going backwards—it is getting more dangerous to give birth in the United States, not less. Despite worsening maternal mortality, the United States spends more on hospital-based maternity care than any other developed country.2 This paradox begs the simple question: why? Maternal deaths during labor and childbirth are exceedingly preventable, making maternal mortality "an important indicator of the health of a nation."3 Data has been difficult to gather about maternal mortality; until 2003, it was not tracked consistently across states. Data-gathering has improved in recent years, but the maternal mortality rate has not. The CDC reports that about 700 women die yearly from complications related to pregnancy or childbirth,4 and the COVID-19 pandemic only exacerbated this—there was a 41% increase in maternal deaths in 2020.5

At the center of the maternal mortality crisis are women and birthing people of color. The increases in maternal deaths in the pandemic were most stark for Black and Hispanic women, reflecting an overall trend in maternal mortality in the United States.6 To that end, the dire state of maternal mortality in the United States can only be explained by considering the experiences of these populations. Examining the contours of issues unique to birthing people of color will give insight into how to build a system with foundations responsive to their needs.

Black women have the highest maternal mortality rates in the U.S. Staggering estimates showed that for every 100,000 live births in 2018, thirty-seven Black women—in comparison to fourteen white women—died of maternal causes.7 This is not a new phenomenon, but researchers still do not have a clear explanation for this disparity. They suspect that institutional racism is a factor, both inside the healthcare system

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2. Swapna Reddy, Nina Patel, Mary Saxon, Nina Amin, & Rizwana Biviji, Innovations in U.S. Health Care Delivery to Reduce Disparities in Maternal Mortality Among African American and American Indian/Alaskan Native Women, 8(2) J. PATIENT CENT. RES. REV. 140, 140 (2021). ("Despite spending more on health care than any other country, the United States has the worst maternal mortality rate among all developed nations.") [hereinafter Reddy et al.].
4. Elizabeth Chuck, 'No question' that U.S. maternal mortality rate will rise post-Roe, experts say, NBC News (June 30, 2022), [https://perma.cc/2963-W9R8].
5. Id.
6. Id.
7. Chuck, supra note 3.
and in society at large, as well as health conditions and resource issues that may be unique to Black women. And indeed, the data suggests this conclusion: women are dying during and after birth because they are Black. More specifically, Black women are dying from maternal causes because of the institutional and interpersonal racism they face in healthcare and society.

Without considering what brought the U.S. to the bottom of the list of countries in which women can safely birth, we will not be able to precisely identify the problematic foundations that need to be scrapped and rebuilt. Without acknowledging that the field of gynecology in the United States was built on the torture of nonconsenting enslaved women, we will not be able to separate the birth system of today from its roots. Ending the continued marginalization and dehumanization of Black women in the birth space requires disentangling historical threads in reproductive medicine to find which threads are based in evidence, and which are based in racism and misogyny.

While much has been written about the maternal mortality issues that women, particularly Black women, face in the United States, there is, unsurprisingly, no consensus on the best way to move forward. Tort recovery through the informed consent doctrine as it relates to labor and birth has been largely closed off to women for reasons that will be explored below. Outside of tort, law has had limited success as a tool to address the high maternal mortality rate.

This Note argues that doulas should be used to combat high maternal mortality rates in the U.S. While doulas are a small part of the current birth landscape, this Note argues that doulas are a key tool to improve birth. Part I of this Note describes the current landscape of birth and explores how the misogynistic marginalization of women-led birthing practices led to this state. Part II explains how the overmedicalization of modern birth is harmful and rooted in medical paternalism and racism. Finally, Part III suggests the use of doulas as a way to combat the obstetric violence women experience during labor and birth, and the high maternal mortality rates Black women and birthing people of color in this country face.

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I. THE EXISTING LANDSCAPE AND THE IMPLICATIONS OF NOT ACTING

A. The Current Landscape and Its Shortcomings

Ideally, no one should be dying from pregnancy-related causes, especially not in the United States. It seems impossible that the United States has the highest maternal mortality rate of a developed nation in the world. Maternal mortality rates decreased dramatically throughout the twentieth century, as public hygiene improved, antibiotics came into use, and surgery became safer.10 Since the late 1990s, however, and despite the improvement of maternity care, these rates have been increasing.11

But a closer look at the data shows that women are not dying equally across demographics. Black women are over three times more likely to die from maternal causes than white women.12 The impact of race in maternal and infant mortality is present across all facets of the data: for example, one study showed that Black children had higher birth and survival rates when Black doctors were attending.13 Another study showed that while causes of maternal death among white and Hispanic women were ranked similarly, for Black women preeclampsia/eclampsia (high blood pressure caused by pregnancy) was by far the leading cause of maternal death.14 No matter their socioeconomic status, Black women are specifically impacted by maternal mortality, dying from highly preventable causes at a rate three to four times higher than white women.15

Many of the conditions causing these maternal deaths are cardiovascular conditions.16 And—many of these deaths are highly preventa-

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11. Id.
13. Id.
16. POPULATION REFERENCE BUREAU, supra note 14.
ble when caught and treated early.\textsuperscript{17} The fact that Black women are being ignored by clinical providers suggests that ensuring that Black women are able to be \textit{heard} by their providers is of vital importance.\textsuperscript{18}

Roughly four million babies are born across the nation every year, making childbirth the leading reason for hospitalization in the United States.\textsuperscript{19} Hospitalized childbirth is an $111 billion industry;\textsuperscript{20} one might expect that U.S. birth outcomes are similarly gold-plated. To the contrary, the U.S. comes up \textit{last} when compared to nine other wealthy countries.\textsuperscript{21} In the U.S., cesarean section (C-section) deliveries cost 50% more nationally than vaginal births,\textsuperscript{22} and C-sections are the most common major surgery.\textsuperscript{23} Furthermore, the U.S. has a C-section rate of over 30%.\textsuperscript{24} This number is extraordinarily high considering the World Health Organization’s (WHO) position that a national rate of C-section higher than 10 to 15% does not correspond to a reduction in maternal and infant mortality.\textsuperscript{25} The WHO has also said, more forcefully, that there is “no justification for any region to have a [C-section] rate higher than 10-15%.”\textsuperscript{26}

So why does the U.S. differ so vastly from its peers globally, both in the high rate of cesarean deliveries and the high rate of maternal mortalities, \textit{despite} the fact that the U.S. spends more on healthcare per person than any of its peers?\textsuperscript{27} The United States’ position as an outlier can be explained if we ask one more question and look at who is experienc-

\begin{itemize}
\item[18.] Alexis Robles-Fradet & Mara Greenwald, \textit{Doulas Care Improves Health Outcomes, Reduces Racial Disparities and Cuts Costs}, NAT’L HEALTH L. PROGRAM (Aug. 8, 2022), [https://perma.cc/5XTC-C5XC].
\item[19.] Melia Thompson-Dudiak, \textit{The Black Maternal Health Crisis: How to Right a Harrowing History through Judicial and Legislative Reform}, 14 DEPAUL J. FOR SOC. JUST. 1, 10 (2021).
\item[20.] \textit{Id.} at 10.
\item[21.] Id. at 10-11.
\item[23.] Taylor et al., \textit{supra} note 15.
\item[25.] \textit{Id.}
\item[27.] Anna Bella Korbator, \textit{What Explains the United States’ Dismal Maternal Mortality Rates?}, WILSON CTR. (Nov. 19, 2015), [https://perma.cc/K5ZD-LMEL].
\end{itemize}
ing these unnecessary interventions and their attendant risks: Black women.

The maternal mortality of Black women specifically has risen in recent years—analyses in 2016 and 2017 found that the maternal mortality rate among Black women had increased from 2.5 times the rate of white women to 3.5 times the rate of white women. The primary causes of maternal death in Black women are postpartum cardiomyopathy, preeclampsia, and eclampsia. Black women are also twice as likely to die, before and after birth, of embolism or hemorrhage.

Some countries have begun to adopt the term “obstetric violence” to describe what happens to women in labor who receive procedures they have not consented to, placing medical malpractice in a gender-based violence framework. Gender-based violence against Black women, however, is not merely gender-based. It is also a form of racial subordination. Therefore, Black women’s high rates of C-sections are not just gendered violence but racial violence against Black women and Black people.

It is Black women’s maternal mortalities driving the U.S.’s high maternal mortality rate. In addressing the high maternal mortality rate, we need to address the specific issues facing Black women across the country—and the severity of needs increases relative to location. In Washington, D.C., the rate of maternal morbidity is nearly 42 maternal deaths for every 100,000 live births. In Chickasaw County, Mississippi, the rate is a sickening 595 maternal deaths per 100,000 live births.

While maternal mortality rates may vary geographically, they do not discriminate across socioeconomic background. This was apparent in Serena Williams’ struggles during her labor. The day after she gave birth, Serena Williams had trouble breathing and advocated for herself, letting her medical staff know about her history with embolisms. Williams asked for a CT scan and heparin, the treatment for a pulmonary embolism. Instead, the doctor gave her an ultrasound—which showed

29. Id.
30. Id.
32. Campbell, supra note 26, at 52.
33. Thompson-Dudiak, supra note 19, at 11.
34. Id.
35. Campbell, supra note 26, at 48.
36. Id.
nothing. She then was given a CT scan, which confirmed that she was having a pulmonary embolism. Serena Williams lived, but so many other women do not—like Shalon Irving, who also had a history of clotting and died three weeks after her baby was born. Shalon Irving was an epidemiologist at the CDC, and she was highly aware of the risks of her pregnancy as a Black woman. Serena Williams had presumably every possible resource at her disposal. Yet they both experienced the same issues that Black women all over the country face. These cases help illustrate that socioeconomic status and educational advancement do not protect Black women in the delivery room—college-educated Black women are more likely to experience severe complications in childbirth than white women without a high school diploma. The issue is not one of race, but racism.

1. Finding a Solution that Responds to Lived Experiences

Outside the delivery room, the U.S. first failed women in precluding national data collection about maternal mortality, which hindered the ability to fix the problem itself. On the standard U.S. death certificate, a checkbox for “pregnancy” was added for the first time in 2003. Prior to 2018, the U.S. had not published its maternal mortality rate since 2007 due to difficulty collecting consistent data across states. When the CDC did finally publish national data in 2018, it confirmed what researchers had already indicated: the United States’ maternal mortality rate was increasing, and Black women’s outcomes were particularly disparate.

37. Id.
38. Id.
39. Amy Roeder, America is Failing Its Black Mothers, HARV. PUB. HEALTH (Winter 2019), [https://perma.cc/5JY3-MUP6].
41. Id.
42. Id.
43. Korbatov, supra note 27.
45. See Working Together to Reduce Black Maternal Mortality, CTRS. FOR DISEASE CONTROL AND PREVENTION (Apr. 6, 2022), [https://perma.cc/AN2L-PCYZ]; See also Press Release, CTRS. FOR DISEASE CONTROL AND PREVENTION, First Data Released
The horrific history of sterilization against Indigenous and Black communities in the United States cannot be ignored in this exploration of how to improve birth outcomes for Black women. State control of Black women’s reproductive systems and reproductive health has a long and sinister history in this country—\(^{46}\) to create a respectful and culturally-competent framework for reproductive health, we need to examine that history in order to not repeat it.

Midwives have also been historically marginalized in the U.S., a fact that is tied to the history of racial subordination against Black people in this country. Before the end of slavery, “slave hospitals” were used for medical experimentation, due to the belief that Black bodies were impervious to pain.\(^{47}\) The history of gynecology is replete with horrors faced by enslaved women because of these mistaken beliefs that Black women “possessed ‘obstetrical hardiness,’ or a ‘primitive pelvis.’”\(^{48}\) Black women were nonconsenting subjects of the “bourgeoning American medical profession.”\(^{49}\) Along with the subjugation of Black bodies came the subjugation of the feminized practice of midwifery, which had been led by Indigenous healers and Black midwives.\(^{50}\)

The fact that the United States is at the forefront of science and medicine, but has not ensured a woman’s capacity to remain healthy through pregnancy and after, nor her ability to birth safely—what many call a crucial determinant of a nation’s health\(^{51}\)—should set off alarm bells. That this crisis is not being addressed, and that Black women are overwhelmingly the population suffering from this lack of action, coa...


47. Campbell, *supra* note 26, at 53.

48. *Id.*

49. *Id.* at 54.


lesce to convince us that racism is at the root of the maternal health crisis.

According to Nevillene White of New York State’s Department of Health, solving this crisis requires a multi-faceted solution. She says the problem of Black maternal mortality is not one that can be handled by a singular body—the state can’t unilaterally solve it, nor can community-based organizations, nor women themselves. White says that we need “to sit at the table together, with equal power together, and really address the issue.”

The New York State Department of Health brought together key stakeholders for listening sessions in communities that experienced disproportionately poor birth outcome rates, particularly Black women. Through these sessions, women explained the “significant barriers to optimal health” they were facing. These barriers included feeling their providers weren’t listening to them, and feeling that judgment, disrespect, bias, and racism affected the care they received. They had few social supports in their community, and received little information and education about pregnancy, birth, and postnatal care.

Through these listening sessions, the Department of Health created a comprehensive report to guide its efforts in eliminating maternal mortality disparities. To create a culturally competent solution, the Department of Health first had to listen to those who were experiencing the disparities. Understanding the actual barriers and the lived experiences of the Black women facing the disparities, as the Department of Health is doing, is a crucial first step.

Activists are using other channels to achieve change. Last year, Senator Cory Booker and Representatives Lauren Underwood and Alma Adams introduced the Black Maternal Health Momnibus Act, a comprehensive package of twelve bills that aim to address and make invest-

53. Id.
54. Id.
55. Id.
56. Id.
57. Id.
58. Id.
60. Nat’l Inst. for Child.’s Health Quality, supra note 52.
61. See id.
ments in the social determinants of maternal health. One bill focuses on increasing the perinatal healthcare workforce, another incentivizes continuity of care through one year postpartum, and a third invests in federal programs to address the increased threat to maternal health caused by COVID-19. This is the kind of legislation women need, instead of legislation that limits, controls, or reaches into the delivery room.

Standardizing medical protocols to deal with maternal health emergencies can also help. California was the first state to do this in 2008, and their maternal mortality rate is now considerably lower than the national rate. In 2006, California formed a maternal mortality review committee and began to research causes of maternal death in the previous five years. They found that for two birth complications in particular, hemorrhage and preeclampsia, women had the best chance of survival if treated properly. Targeting these two complications, California’s maternity care teams began to use a series of protocols which have since drastically reduced the state’s maternal mortality rate. The emphasis of these protocols is teamwork and communication. Through checklists, crash carts, drills, and teamwork, California hospitals reduced the maternal mortality rate by 55% by 2013.

Additionally, counterculture birth movements have increased in popularity in the past few decades as a reaction to the overmedicalization of birth. Interest in home birth has increased under COVID, with some women shying away from giving birth in a hospital. Integrating midwives into the current maternity care system would be beneficial for the system as a whole—easing the burden on obstetricians who may push women towards C-sections for fear of liability, and improving birth outcomes by having low-intervention births supervised by midwives.

63. Id.
64. Korbatov, supra note 26.
65. Renee Montagne, To Keep Women From Dying In Childbirth, Look To California, NPR (July 29, 2018), [https://perma.cc/H3KY-NPNM].
66. Id.
67. Id.
68. Id.
While headway is being made to address the problem of Black maternal mortality, more needs to be done. In determining the type of birth that all women in the United States should have, we need to explore the history of the type of birth that women are trying to escape.

II. HOW DID WE GET HERE?

A. Brief History of Childbirth

1. The Origins of Suppressing Women in Medicine:
The Witch Craze in the Early Modern Period

Before the creation of the male medical profession, the lay healers who served the peasant populations in Europe were women. The suppression of witches—the suppression of women as healers—is one of the first in a long history of struggles in male suppression of women in medicine. The witch hunting period lasted over 400 years; throughout this time the Church, with support from Europe’s monarchies, successfully branded peasant healer women as witches. This is an association that has continued to taint women healers such as the midwife.

The history and sociology of witch hunts is outside the scope of this note, but we must start here to track the trajectory of the deep-seated cultural suspicion of women healers. The most vicious witch hunts took place against the backdrop of the peasant revolts and social upheaval that cracked the foundations of feudalism. A woman healer was emblematic of an impermissible class transgression—to the upper classes, women healers and peasant uprisings were connected, and both were to be quashed.

According to the Church, the markers of a “witch” were displaying female sexuality, belonging to an organized group, and having “magical powers”—i.e., medical and obstetrical skills—that could heal or harm. By misfortune, such lay healers were at the center of the Catholic Church’s aggressive sweep against witchcraft. These peasant women

71. BARBARA EHRENREICH & DEIDRE ENGLISH, WITCHES, MIDWIVES, AND NURSES: A HISTORY OF WOMEN HEALERS 6 (2d ed. 1973) [hereinafter EHRENREICH ET AL.].
72. Id.
73. See id. at 6-7.
74. Id. at 6.
75. Id. at 8.
76. Id.
77. Id.
were often their communities’ only protection against the poverty and sickness they were stricken with, and yet the Catholic reverend-witch hunters assigned an indelible connection between the midwife and the witch.78 As they wrote, “no one does more harm to the Catholic Church than midwives.”79

These peasant healers found themselves caught in a class struggle—the greater the witch-healer’s power to help the peasantry, the less the peasantry needed God.80 Folk magic, even when successful at curing ailments, was something to be feared.81 This was despite the fact that the women who administered these magic charms and cures used herbal remedies that were based on evidence and shared knowledge.82 Many of these cures exist today in some form in modern pharmacology, such as painkillers, digestive aids, and anti-inflammatory treatments.83 Ergot, belladonna, and digitalis were all herbs commonly used by midwives to comfort women during labor, and are ingredients that still exist in medicine today.84

The Church, on the other hand, saw healing as the business of salvation, not of medicine; receiving remedies from a witch therefore posed a direct threat to salvation.85 While witch-healers were using ergot for labor pains, the Church’s position was that such pain was the Lord’s punishment for Eve’s original sin.86 The fact that the witch-healer’s methods worked was as much a problem for the Church as the very existence of witch-healers. The early witch-healer was an empiricist who tried things to see what happened; she didn’t just blindly believe.87 But the Church was not interested in empiricism; just the opposite—it sought to discredit the material world and foster distrust of the senses, a “devil’s playground” that sought to lure good men away from faith.

78. Id. at 13.
79. Id.
80. Id. at 14.
81. There is evidence that these “good Witches” were just as, if not more, of a threat. A leading English witch hunter cautioned people to remember that witches were “not only those which kill and torment, but all . . . commonly called wise men and wise women . . . which do no hurt but good, which do not spoil and destroy, but save and deliver . . . . It were a thousand times better for the land if all Witches, but especially the blessing Witch, might suffer death.” Id. at 12-13.
82. Id. at 14.
83. Id.
84. Ergot derivatives are used to hasten labor, belladonna is still used today as an anti-spasmodic, and digitalis treats heart conditions—a remedy that was discovered by an English witch. Id.
85. See id.
86. Id.
87. Id.
Empiricism is a call to the senses, which the Church saw as an invitation to betray faith.\(^{88}\)

Anti-empiricist and misogynistic, the Church sought to repress these women healers. The witch-hunting craze began in the 14th century.\(^{89}\) Not coincidentally, the century prior had seen the establishment of medicine as a secular science, and importantly, a profession—one that was closed to women.\(^{90}\)

2. The Rise of the Medical Profession and the Sidelining of Midwifery

The United States has one of the lowest percentages of women doctors in industrialized nations.\(^ {91}\) As of 2017, 58% of Finnish doctors were women; as were 48% of British doctors.\(^ {92}\) In the United States, on the other hand, women make up only 36% of doctors.\(^ {93}\) In the UK, Finland, and many other countries, midwifery is a mainstream occupation.\(^ {94}\) In the United States, the practice of midwifery is essentially outlawed.\(^ {95}\)

In the early 1800s, as male physicians in the United States grew in number, so too did their desire to distinguish themselves from lay healers.\(^ {96}\) Middle class men who served only those who could afford it, they called themselves “regulars” to differentiate themselves from the “irregular” practice of lay practitioners.\(^ {97}\) The “regulars” also offered gynecological care to wealthy women—a practice viewed with distaste and horror by the lower classes.\(^ {98}\)

In 1848, although they were by no means the only group serving the populace,\(^ {99}\) the “regulars” formed a national organization named the

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88 Id. at 14-15.
90 EHRENREICH ET AL., supra note 71, at 15.
92 Id.
93 Id.
94 EHRENREICH ET AL., supra note 71, at 21.
95 Id.
96 Id. at 23.
97 Id. at 23-24.
98 Id. at 23.
99 “At its height in the 1830s and 1840s, the Popular Health Movement had the “regular” doctors—the professional ancestors of today’s physicians—running scared.” When the movement devolved into unstable factions, ‘the ‘regulars’ went back on the offensive,” creating the AMA. Id. at 27-28.
American Medical Association (“AMA”). For the rest of the nineteenth century, the “regulars” were engaged in a sustained attack on lay women healers. In 1871, the doctor giving the presidential address to the AMA referred to the women who “seek to rival men” by practicing medicine in language that dripped with disdain, saying that they “command a sort of admiration such as all monstrous productions inspire, especially when they aim towards a higher type than their own.”

This vehement opposition to women in medicine was confined to the U.S.—European women faced no such virulence. For one thing, the medical profession in Europe was not as afraid of competition as in the U.S. Doctors in the U.S., on the other hand, conflated women in medicine with their distaste for strong feminist movements at the time. Male doctors in the United States correctly associated women in medicine with organized feminism—a movement which was repugnant to them and which they sought to stamp out.

In order to solidify a superior status, “regulars” needed recognition beyond their self-proclaimed expertise and technical knowledge, which they often actually lacked compared to lay healers. “Regular” doctors believed the way to legitimize and monopolize the nascent field of professional medicine was to secure the support of the upper classes. That required convincing the elite members of society of the need for their way of practicing medicine. For “regulars” to become the sole practitioners of medicine, at the exclusion of the lay healers, they needed ruling class patronage.

By chance, the “regulars” were in luck—two major societal developments coincided at the turn of the twentieth century and provided them a clear path to mainstream medical dominance. While American doctors were still prescribing mercury-containing minerals as medicine, European scientists had discovered germ theory, which engendered the first rational understanding of disease and disease prevention in his-

100. Id. at 28.
101. Id. at 27-28.
102. Id. at 28.
103. Id.
104. Id.
105. Id.
106. See id.
107. Id. at 30. See also id. at 23-24 (discussing the lack of medical knowledge of the “regulars” and their methods compared to the knowledge and methods of the lay healers).
108. Id. at 30.
109. Id.
110. Id.
A handful of Americans traveled to Germany to learn this science. When these newly-trained doctors returned, they created the first American medical school in the new German style: Johns Hopkins. Major innovations introduced by Johns Hopkins included the joining of “lab work in basic science with expanded clinical training” and reforming the requirements of a medical education, requiring four years of medical school after four years of college. Naturally, this created an instant barrier to the working class and working poor.

The other major development that allowed the “regulars” to claim superiority was the funding of Johns Hopkins by local philanthropists. By the late nineteenth century, exploitation of oil, coal, and labor had spawned massive fortunes for a select few. For the first time in the U.S., these huge concentrations of wealth from booming industries allowed for “organized philanthropy, i.e., organized ruling-class intervention in the social, cultural, and political life of the nation.” This turn towards organized philanthropy resulted in the emergence of foundations as influential financial institutions. When the Rockefeller and Carnegie foundations were created in the early twentieth century, they busied themselves with medical “reform” and “the creation of a respectable, scientific American medical profession.” Unsurprisingly, the group of doctors that these foundations decided to support and promote were the “regulars.”

In 1903, foundations began to give medical schools millions of dollars in donations with the implicit condition that the schools adhere to the Johns Hopkins model. To enforce conformity to the model, Carnegie sent a man named Abraham Flexner on a nationwide tour to every medical school in the country. Flexner decided which schools would receive a grant, and, as a result, which schools would survive. The schools that had money, like Harvard, had already begun to institute
“reforms” and were rewarded with more money by Flexner. Smaller schools with less money, usually sectarian schools that served Black people and women, faced a choice between disparagement in Flexner’s report or closure. When the Flexner Report was published in 1910, dozens of medical schools closed, including the “irregular” schools that served women and six of the eight medical schools that served Black people.

With this, medicine became a fully privileged institution, one accessible only through a long and costly education. But medicine was not just an occupation—it was a profession, an in-group of “regular” doctors excluding all other healers. The publication of the Flexner Report did not bestow any special knowledge or experience to “regular” doctors, but it lent them legitimacy and the “mystique of science.”

Because of the domestic domain in which birth was viewed, midwives were the last holdout. In 1910, the year of the Flexner Report’s publication, midwives attended roughly 50% of all births, primarily those of immigrants and Black people. Doctors detested this fact for multiple reasons. Midwives denied them “teaching material,” by practicing on poor women who could have benefitted medical research. Doctors also lamented the missed fees from these births, money they saw as belonging to “professionals.”

Obstetricians launched public attacks on midwives, labeling them as dirty and ignorant, and holding them responsible for the prevalence of preventable infections. In Europe, obstetricians shared their knowledge with midwives, benefitting both midwifery as an occupation and obstetric care in their countries. By contrast, American physicians had no such commitment to knowledge-sharing or improving obstetric care. Doctors were actually less competent than midwives in obstetrics at the time—they were equally responsible for infection and, with their eagerness to use unreliable surgical techniques, posed more of a threat to the mortality of the mother and fetus.

125 Id.
126 Id.
127 Id.
128 Id. at 33.
129 Id.
130 Id.
131 Id. at 34.
132 Id.
133 Id.
134 Id.
135 Id.
B. Slavery, Racism, and Medical Paternalism


For centuries, Black Americans have received second-class treatment in every facet of American society. For Black mothers, that treatment is worsening. Black women are 243% more likely to die from maternal causes than white women.136 Because American jurisprudence has not adequately committed to reckoning with racism’s current forms, there are significant barriers to using the law as a safeguard against discrimination and as a tool for redress.137 Both structural and individual racism contribute to the Black maternal health crisis.138 In other words, the two issues causing high rates of Black maternal mortality are ongoing systematic disparities and implicit bias.139

To understand the current stark disparities in maternal health, it is necessary to understand the role of Black women in the history of maternal health in America.140 Black women and their bodies played two crucial roles in the development of reproductive and maternal health in this country.141 First, they functioned as midwives for both Black and white mothers well into the twentieth century.142 So-called “granny midwives,” a by-product of the West African slave trade, used traditional African medicine that “espoused holistic, compassionate, and spiritual care for mothers.”143 While physicians would attend only the most complicated births, granny midwives attended the majority of births in the colonial era.144

Physicians and midwives at the time enjoyed a symbiotic and cooperative relationship, but this gave way in the early 1900s when physicians began a sustained campaign against midwives as a way to eliminate competition.145 Doctors used propaganda to portray midwives as “dirty, illiterate, ignorant, and irresponsible,” in comparison to their “clean” and “educated” hospital counterparts.146 They perpetuated racist myths
about Black midwives, aiming to convince women of the doctors’ racial superiority over the midwives, who were “a relic of barbarism.”

This racist propaganda could not have been further from the truth. Despite their general lack of formal training, midwives held themselves to cleanliness and sterility standards, and learned and shared skills through midwifery groups. The midwives’ roles went beyond assisting during labor—they supported women pre- and post-pregnancy, and sought to educate women about their health, filling the role of community health educator and social worker before those roles, as we know them today, existed.

In their effort to monopolize the field of medicine, physicians took advantage of discriminatory legal processes to systematically eliminate granny midwives from the field. Doctors on the state medical board frequently initiated criminal prosecutions against midwives, charging them with practicing unauthorized medicine. At this time, most new doctors had no clinical training in labor and birth because of modesty norms, which prevented physicians-in-training from attending labors. The granny midwives, on the other hand, had extensive experiential knowledge, and were in fact prevented from receiving a traditional education because of the myriad obstacles levied at Black people. Through manipulative tactics and misinformation campaigns, doctors were able to marginalize granny midwives. Once doctors had solidified their superiority in the landscape, it became easy for them to leverage the idea that childbirth was an “abnormal, pathogenic process, which required routine medical assistance to prevent disaster.” In other words, midwives’ skills were simply not up to scratch for the delicate task of delivering babies. This idea was reinforced by courts, discounting the practical abilities and positive outcomes of granny midwives while upholding physicians’ lesser skills in childbirth on the grounds of their professional and legal standing.

147. Id. at 7-8.
148. Id. at 8.
149. Id.
150. Id.
151. Id.
152. Id. at 9.
153. Id. at 8.
154. Id. at 9.
155. Id.
156. Id.
2. Rectifying the History of Experimentation in Modern Gynecology

The second major role that Black women played in the development of maternal health in the U.S. was the involuntary sacrifice of their bodies for the advancement of reproductive science.\textsuperscript{157} Black women’s bodies already brought wealth to white men through the exploitation of their reproductive capabilities in producing slaves and thus sustaining slavery.\textsuperscript{158} Rather than bestowing a special status on the mother for her reproductive value, the importance of the fetus over the mother was instead ingrained in gruesome ways. One common practice involved the digging of a hole that enslaved pregnant women would place their bellies in, so they could be lashed while protecting their fetuses.\textsuperscript{159}

The belief in the inferiority of Black women facilitated their severe dehumanization in the face of early medical experimentation.\textsuperscript{160} White doctors were fascinated by Black women’s bodies, believing they had “medical superbodies” and were incapable of feeling pain.\textsuperscript{161} When Congress abolished importing enslaved people, plantation owners turned to Black women to continue producing slaves for them.\textsuperscript{162} Forcing women to “breed” predisposed them to vesicovaginal fistula,\textsuperscript{163} a condition that resulted from the traumatic birthing experiences these women went through.\textsuperscript{164} In addition to this forced “breeding,” Black women experienced a second trauma from the unconsenting use of their bodies: early doctors took advantage of their traumatic births by attempting to repair the fistulae that had resulted.\textsuperscript{165}

Though lauded as an early “father of gynecology”—the so-called “Architect of the Vagina”—Dr. James Marion Sims was responsible for some of the most vicious and dehumanizing surgeries on enslaved wom-

\begin{itemize}
\item \textsuperscript{157} \textit{Id.} at 5.
\item \textsuperscript{158} \textit{See id.}
\item \textsuperscript{159} \textit{Id.} at 5-6.
\item \textsuperscript{160} \textit{See id.} at 5.
\item \textsuperscript{161} \textit{Id.} at 6.
\item \textsuperscript{162} Camille A. Nelson, \textit{American Husbandry: Legal Norms Impacting the Production of (Re)Productivity}, 19 YALE J. L. & FEMINISM 1, 7 (2007).
\item \textsuperscript{163} An abnormal opening between the bladder and vagina, causing incontinence and pain, vesicovaginal fistula is “among the most distressing complications of gynecologic and obstetric procedures.” Michael Stamatakos, Constantina Sargedi, Theodora Stasinou & Konstantinos Kontraoglou, \textit{Vesicovaginal Fistula: Diagnosis and Management}, 76(2) INDIAN J. SURG. 131, 131 (2014).
\item \textsuperscript{164} Campbell, \textit{supra} note 26 at 54-55.
\item \textsuperscript{165} \textit{Id.}
\item \textsuperscript{166} Nelson, \textit{supra} note 162 at 4.
\end{itemize}
Sims was by no means the first doctor to practice on enslaved women in the mid-nineteenth century, but he was by far the most famous at the time. The lack of adequate medical care meant that many women experienced debilitating pain and incontinence after childbirth. Additionally, in an effort to test his procedures before performing them on white women, Sims was sent enslaved Black women who had experienced birth complications to be his test subjects. In his search for a fistula cure, Sims experimented on three Black women for over four years—Anarcha, Betsy, and Lucy. In his “makeshift backyard hospital” Sims operated thirty times on Anarcha while she was on her hands and knees. Lucy, an eighteen-year-old, “endured an hour-long surgery, naked, screaming and crying out in pain, as nearly a dozen other doctors watched.” Sims cared horrifically little for the health of the women he experimented on—Sims noted that Lucy’s “agony was extreme,” and that she nearly died from methods he used, which were controversial even then.

Sims began to use the fistula procedure on white women only after he had “perfected” it through abusing enslaved women. Anesthesia was introduced in 1846, right in the middle of Sims’ macabre backyard operation spanning from 1844 to 1849, yet Sims never medicated the Black women he operated on. When he moved his practice to New York and began practicing on white women, he provided his white patients with anesthesia because, according to him, “they were unable to withstand the same operation without medication.”

The stereotypes Sims believed about Black women persist today. There is an “undercurrent of mistrust between Black women and their doctors,” and it cannot be uprooted without engaging with what Sims and his contemporaries wrought in the nascent fields of American medicine and gynecology. The stereotype of Black women’s inability to feel pain manifests today in myriad ways that continue to harm Black
mothers and their infants, from downplaying and ignoring Black women’s pain to “performing medically unnecessary cesarean sections.”

C. The Medicalization and Male Appropriation of Childbirth

Until the turn of the century, women typically gave birth in their homes with the assistance of a midwife and support from women relatives. As doctors sought ways to monopolize their profession, childbirth—until then a domestic domain—became the final frontier to conquer. Doctors extolled their superiority over midwives through their use of instruments, such as forceps and, coupled with the introduction of pain medication during labor, they began to market themselves as providers of a more modern, healthier, and more “scientific” childbirth. Their campaigns were successful—the number of physician-attended births began to rise, and by the early twentieth century, roughly half of all births were attended by physicians. For the first fifty years of the 1900s, the displacement of midwives at births had a stark racial divide. In 1935, 5% of white women employed the use of a midwife, compared to 54% of Black women. By the middle of the century, the use of midwives still reflected a racial divide, showing the preference of Black women in giving birth attended by midwives, away from the racism and discrimination they faced in hospitals. However, the physician-led campaign to marginalize midwives as the primary providers of support during childbirth continued in force—by the mid-1950s, only 3% of white women and 20% of Black women sought midwifery services.

Despite the vigor with which the physicians campaigned against midwife-attended births, there was no evidence that physician-attended births resulted in improved health outcomes. Both at a cultural level and in the medical field, the United States “embraced a medical model that conceptualizes birth as a condition to be managed or disease to be cured, rather than a normal physiological process.” The medical

176. Id.
177. Kukura, supra note 70, at 256.
178. Id.
179. Id. at 256-57.
180. Id. at 257.
181. Id.
182. EHRENREICH ET AL., supra note 71, at 33.
183. Kukura, supra note 70, at 257.
184. Id. at 256.
185. Id. at 259.
model of childbirth assumes that more intervention in the birth process is a good thing, because medical interventions increase safety without additional risks. But the question this raises is, risk to whom? The evidence is that common interventions in the U.S. have not made birth safer.

1. An Interventionist Approach: the Pathologization of Birth

In the United States, 98% of people give birth in a hospital, and nearly everyone who does so experiences some type of intervention. In this, the U.S. is not only an outlier, but an extreme one. Cesarean sections are the delivery method for approximately one-third of births in the U.S, far exceeding the World Health Organization’s recommendation that only 10-15% of births should be cesarean deliveries in industrial nations. Other common interventions during labor include epidurals, synthetic oxytocin (the breaking of the amniotic sac after labor has begun to speed up labor), use of IVs, and bladder catheters. Research shows that while the vast majority of American women experience low-risk pregnancies, interventions happen at high rates, and women are receiving interventions in situations where the best available knowledge does not indicate the necessity of intervention. Over 50% of women in labor received synthetic oxytocin to induce or speed up labor, and 36% had their membranes broken.

Yet intervention comes with risk. Certain interventions increase a person’s likelihood of needing subsequent interventions to manage complications or side effects from the first intervention. This is referred to as a “cascade of secondary interventions.” Other interventions continue to be widespread despite their lack of demonstrated benefit, such as continuous electronic fetal monitoring. Research shows that continuous monitoring has not improved outcomes, and that such monitoring often results in false positives that lead to unneces-

186. Id.
187. Id.
188. Id. at 256.
189. Id. at 259.
190. Id. at 260.
191. Id.
192. Id.
193. Id.
194. Id.
195. Id.
nary surgeries. Women are confined to their beds in order to enable this monitoring by nurses, even in the face of research showing that moving around and changing positions during labor hastens it and lessens its discomfort. Keeping women confined to beds serves two purposes: enabling remote monitoring by nurses and creating a record monitoring the fetus in the event of litigation. However, it also slows down birth by preventing gravity from assisting in the birth process. Slowed birth can contribute to the cascade of interventions.

Some interventions, such as the episiotomy, have successfully fallen out of favor after research reinforced what women had been reporting. An episiotomy involves a physician cutting a woman’s perineum, the muscle between her vagina and anus. During vaginal labor, the thin skin of the perineum stretches, and may tear. Until research established otherwise, doctors were “making space” by slicing through that thin skin and sewing it closed after, rather than waiting for the skin to tear on its own. In 2004, over 24% percent of births involved episiotomies—a considerable decrease from the United States’ episiotomy rate of 60.9% in 1979. Doctors believed that cleanly cutting the perineum would help with healing, highly flawed reasoning that modern science has since disproved. Unlike an episiotomy, which causes greater blood loss and more painful recoveries by disturbing muscle, nerves, and blood vessels, natural tearing occurs along natural tissue lines and borders.

While C-sections are the most common surgery in the United States, and the most common surgery among women of reproductive age, they have risks and “potential for great harm when overused.” Despite the frequency with which they occur, C-sections are major surgeries that have “significant downstream health consequences” and are

196. Id.
197. Id. at 260-61.
198. Id.
199. Id. at 261.
200. Id.
203. Id.
204. Id. at 184.
205. Id.
206. Id.
207. Id.
associated with an increase in maternal mortality. The US has an extremely high C-section rate, but C-sections are specifically used in greater numbers on low-income populations of color. The population with the lowest cesarean rate is women with “cumulative advantages”—i.e., white women who are college educated.

One of the causes for the high C-section rate is physician pressure to have the surgery. Extremely common in labor is encouragement or coercion into medical interventions on the part of the doctor. Even women who want to birth vaginally after having a C-section, which is often very safe, may be prevented from doing so because of hospital bans on “vaginal birth after C-section” (VBAC). Such unnecessary prevention leads to more overmedicalized births. Also concerning is the increase in primary cesareans in cases of “no indicated risk.” One study by leading childbirth researchers Dr. Marian MacDorman, Dr. Fay Mneacker, and Dr. Eugene DeClerq concluded this increase was rapid, and appeared to be the “result of changes in obstetric practice” rather than having to do with the medical profile of the woman or her request.

But the risks of an overmedicalized birth are not experienced by women equally. Even when accounting for comorbidities and socioeconomic status, Black women experience rates of C-section and its attendant risks at higher rates than white women across the board. Worryingly, this disparity exists even for those with the lowest-risk pregnancies (i.e., those without medical complications). Because of these disparities, healthy Black women with low-risk pregnancies are receiving unnecessary major surgeries and experiencing an increase in their risk of negative outcomes.

Maternity care in the U.S. follows the medical model, where pregnancy, labor, and birth are seen as inherently risky and in need of medical intervention—which, of course, can only be provided by the doc-

209. Spitzer, supra note 202, at 158.
210. Id. at 158-59.
211. Id. at 159.
212. Campbell, supra note 26, at 61.
213. Id. at 61-62.
214. Id.
215. Id. at 62.
216. Id.
217. Id.
218. Id. at 62-63.
Davis-Floyd calls this “technocratic birth,” a paradigm that gained foothold in the 1970s, while also beginning to increase risk of maternal morbidities. But the incentive for profit reared its ugly head, and interventions led to higher costs. While the “supervaluation” of technology may have been welcomed in many areas of medicine, it couldn’t add anything more to the natural process of birth once medicine and antibiotics had made it safe. Interventionist obstetrics, at a certain point, becomes harmful. In the global health field, researchers refer to this phenomenon by the acronym “TMTS,” meaning “too much too soon.” Conversely, “TLTL” refers to “too little too late.” Both of these types of care provision coexist in the U.S.

The concept of “TMTS” is connected to medical iatrogenesis, a term first defined in 1976 as injuries “done to patients by ineffective, unsafe, and erroneous treatment,” and then broadened in the 2000s to include the framework of “obstetric iatrogenesis.” Researchers view obstetric iatrogenesis as existing across a spectrum that ranges from “unintentional harm” to “overt disrespect, violence, and abuse” done to birthing women. Technocratic birth, the model of birth in the U.S., normalizes certain forms of mistreatment. But because of how modern maternity practices have developed (discussed in Part II), birthing women and providers don’t always recognize practices as abusive. Furthermore, the obstetric iatrogenesis that results from the technocratic birth model in this country disproportionately impacts Black and Indigenous populations.

As discussed earlier, there are serious racial disparities in maternal mortality between Black and white mothers in the U.S. Much is still unknown about why maternal mortality outcomes for Black and Indigenous mothers are so much higher than white mothers, but the data is

220. Id. at 189.
221. Id.
222. Id.
223. Id.
224. Id.
225. Id.
226. Id.
227. Id.
228. Id.
229. See supra Part I.
inescapably clear and provides many answers. First and foremost, racism—the stress and weathering caused by interpersonal and institutional racism, and particularly in the healthcare system—is perhaps the most significant factor. Connected to this are the lack of adequate resources—“maternity care deserts”—that Black women often live in, as well as higher rates of comorbid medical conditions. The life-course perspective—a multidisciplinary theory of understanding the mental, physical, and social health of individuals—suggests that socioeconomic and environmental stressors over time contribute to cumulative, transgenerational impacts on health of racial and ethnic minorities and those in lower socioeconomic status groups.

2. Male Appropriation and Professionalism in Medicine

“Professionalism in medicine is nothing more than the institutionalization of male upper-class monopoly. We must never confuse professionalism with expertise. Expertise is something to work for and to share; professionalism is—by definition—elitist and exclusive, sexist, racist, and classist.” —Barbara Ehrenreich

In the health system, women’s predominant role has been in nursing. This is not coincidental or accidental. It is the result of an eight-century-long campaign by the European and, later, the Anglo-American Christian male elite to sideline women in medicine. Nursing is a subservient role in a way that midwifery is not. It is a caretaking role, a “workplace extension of our roles as wife and mother.” It is not an accident that nursing and womanhood are tied together, no more than it is that nurses are socialized to believe that rebelling against the doctor is not “professional.” It’s not just her job at stake for a nurse who wants to

230 Julie Mottl-Santiago, Kirsten Herr, Dona Rodrigues, Catherine Walker & Emily Feinberg, The Birth Sisters Program: A Model of Hospital-Based Doula Support to Promote Equity, 31 J. HEALTH CARE FOR POOR & UNDERSERVED 43, 44 (2020) [hereinafter Mottl-Santiago et al.].
231 Id.; See generally Campbell, supra note 26.
233 Mottl-Santiago et al., supra note 230, at 43-44.
234 EHRENREICH ET AL., supra note 71, at 42.
235 Id. at 43.
236 Id.
237 Id.
question a doctor, but also her femininity. The male medical elite therefore have an interest in maintaining the sexism of society and the healthcare industry—doctors oversee a workforce primarily made up of women.

Even before the witch-hunting craze of the 14th century, women healers were already feeling the effects of the establishment of medicine as a secular science, thus, medicine as a profession. Traditionally, women healers served the peasant classes, but this new brand of medicine was not open to women. The encroachment had begun—long before they became branded as witches, the professionalization of medicine through university education meant that women were already being edged out of the practice of medicine.

Early medicine was completely divorced from science. From the fifth through thirteenth centuries, the Church’s de-emphasis on the physical and natural world prevented the development of medicine as a profession. The Europeans’ first contact with the Arabic world prompted a renewed interest in medicine, but because the Church controlled its development, it was more connected to religion than it was to anything based in science. The Church did not permit physicians to practice without the presence of a priest “to aid and advise them.” The line between priest and physician was fairly meaningless itself—physicians had to make sure their attention to the body “did not jeopardize the soul.” Their treatments were based largely on the writings of Galen, a Roman physician who had promoted the theory of “temperaments,” or humors. Especially noteworthy of medieval medicine was that experimentation did not exist—since the senses were to be distrusted, empiricism was out. Surgery was considered unrelated to medicine, viewed instead as degrading and menial work.

Left without the foundations of empiricism, university-trained physicians resorted to superstition when treating patients. Leeching was a common practice, as was eating foods that were believed to bring on

238. Id.
239. Id.
240. Id. at 15.
241. Id.
242. Id.
243. Id.
244. Id. at 15-16.
245. Id. at 16.
246. Id.
247. Id.
248. Id.
good humors. These trained physicians believed in the effectiveness of incantation and ritual. King Edward II of England’s physician treated toothache by touching a caterpillar to a needle and then touching the needle to the painful tooth. A common treatment for leprosy was to drink a broth made from the flesh of a black snake caught in a dry land among stones.

This was the state of the medical field when the Church began to target peasant witch-healers for practicing folk magic. In contrast to the Church’s physicians, witches were guided by empiricism and had an impressive understanding of the human body. Their knowledge had surpassed that of the university-trained physicians, who were preoccupied with things like astrology and alchemy (turning silver into gold). Despite evidence that witch-healers were knowledgeable and served as the peasantry’s only barrier against the sickness and death of the Middle Ages, witch-healers became the target of a campaign that continued for centuries with varying levels of force.

There was something heretical about women being smart enough to know medicine. The Malleus Maleficarum, the handbook that instructed how to determine if a woman was a witch through torture, proclaimed: “If a woman dare to cure without having studied she is a witch and must die.” A small few acknowledged the superiority of the witch-healers. Paracelsus, considered a pioneer in the medical revolution because of his emphasis on the importance of observation, burned all texts on pharmaceuticals that he owned, saying that he “had learned from the Sorceress all he knew.” But he was an outlier among the upper classes—male physicians in Europe were threatened by the abilities of these seemingly uneducated, illiterate women. The university-trained physicians sought to maintain their supremacy over these lay peasant healers, which they did by leveraging institutionalization against them. Male physicians charged women healers with illegally practicing medicine, arguing that the lay healers had usurped the profession, and re-

249. Id.
250. Id. at 17.
251. Id.
252. Id.
253. Id. at 16-17.
254. Id.
255. Id. at 17-19.
256. Id. at 19 (emphasis added).
257. Id. at 17.
questing criminal sanctions, including fines and imprisonment, against them.258

The nail in the proverbial coffin of the witch-healer’s skilled work were the witch hunts. Doctors served a role at witch trials—they provided “medical expertise” that served to both legitimize their profession while condemning the non-professional nature of the witch-healers.259 It was the doctor’s obedience to the Church and state over empirical methods (those used by the witch-healer) that gave him his higher status—he was aligned with God and law, morally and intellectually superior to the earthly baseness of the witch.260 Further, eliminating the witch-healer as a functional competitor to the doctor provided him another benefit: the witch-healer’s skills were often superior to medical doctors, but the cultural pervasiveness of the witch hunts meant that anything the doctor couldn’t explain away could be blamed on “witchcraft.”261

While the witch craze did not eliminate the lay woman healer, it left her with a mark of superstition so unshakeable that it became possible for male practitioners to enter the final domain of women healers—midwifery.262 So-called “barber-surgeons” in England began using forceps on women in labor, extolling this practice as technically superior.263 These men were nonprofessional practitioners, but forceps were a surgical instrument, and women were not allowed to engage in surgery.264 The communal service of midwifery was fertile ground for monetization, and on it the barber-surgeons created lucrative obstetrical practices.265 Trained physicians soon entered the field in the eighteenth century, and although female midwives in England protested vigorously against their dangerous use of forceps, it was to no avail.266 The damage had been done—the propaganda of the centuries-long witch craze had taken hold and it was easy to dismiss the midwives as ignorant and superstitious women.

Male appropriation of obstetrics fosters medical paternalism, which further divorces women from control over their own bodies. People, and particularly women, are socialized to place a certain blind trust in medi-

258. Id. at 19.
259. Id.
260. Id.
261. Id.
262. Id. at 19-20.
263. Id. at 20.
264. Id.
265. Id.
266. Id.
cal authority, and women are not immune to the forces of society that encourage deferential trust in doctors. Doctors are also not objective, despite their claim to be. These factors—the special trust we have in doctors, our perception of them as objective, and women’s willingness to give in to their advice—combine to lead to pervasive negative outcomes.

D. Childbirth and the Informed Consent Doctrine

The law recognizes that individuals have a right to self-determination and autonomy over their bodies, anchored specifically in the rights to refuse treatment, to privacy, and to the freedom of religion. The modern informed consent doctrine was first outlined in a case in 1957, but its roots can be traced back to the late 1800s. This right to autonomy over one’s person gives them the right to informed consent, a principle dictating that patients maintain control and “decision-making authority over their own care.” This creates an obligation for doctors “to make every effort to secure the consent of the patient to particular treatment.”

The doctrine originated in Justice Cardozo’s landmark opinion in *Schloendorff v. Society of New York Hospital*, where he recognized a fundamental principle of bodily autonomy: an individual has the right to control what is done to his body, regardless of whether it is harmful or beneficial. Therefore, absent patient consent, a physician’s medical intervention constitutes assault. In 1957, the *Salgo v. Leland Stanford Jr. University Board of Trustees* decision clarified the meaning of informed consent. It wasn’t simply agreement by the patient; it had to be appropriately informed consent. Prior to *Salgo*, malpractice litigation

268. Id.
272. Id. at 543.
273. Id. at 542-43.
275. Id. at 333.
276. Id. at 333-34.
focused solely on whether a patient had agreed to proceed with an intervention—if they had, the inquiry ended. The *Salgo* court broadened the inquiry, emphasizing the importance of educating the patient about the intervention so that they could make an informed decision about how to proceed.

However, the *Salgo* decision did not determine the scope of this adequate information. Initially, physicians’ disclosures were measured against customary disclosure standards in their respective communities. A physician was required only to disclose information in line with the type and scope customarily disclosed by the majority of physicians in the community in similar circumstances, even if that meant important information was not being shared with patients.

Courts later acknowledged the limitations of this community standard, concerned that it might incentivize physicians to adjust their customs downward and thus limit information typically given to patients. The D.C. Circuit’s decision in *Canterbury v. Spence* introduced a new disclosure standard, one that succeeded at addressing concerns raised by the gap in *Salgo*. This new standard took patients themselves into account. For consent to be considered adequately informed, the doctor was required to provide the patient with “information that a reasonable person in the patient’s position would consider important under the circumstances.” In other words, *Canterbury* required that patients have the right to be informed of their medical care in a way that made sense to them. Otherwise the informed part of informed consent would lose all its force.

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277. Lydia A. Bazzano, Jaquail Durant & Paula Rhode Brantley, *A Modern History of Informed Consent and the Role of Key Information*, 21 OCHSNER J. 81, 82 (2021) (“This legal ruling was the first to identify and focus attention on the need to provide the patient with any information about the potential benefits and the risks of any medical procedure.”).
278. Stohl, *supra* note 274, at 333-34.
279. *Id.* at 334.
280. *Id.*
281. *Id.*
282. *Id.*
283. *Id.*
284. *Id.* at 334-35.
285. *Id.*
286. *Id.* at 335.
1. The Informed Consent Doctrine’s Unique Application in Childbirth and its Subsequent Limits

The doctrine of informed consent has a unique application to childbirth. To her provider, a pregnant woman represents “two individual patients: the mother-patient and the fetus-patient,” to whom the obstetrician owes a duty of care throughout labor and delivery. The doctrine of informed consent dictates that both the mother and in utero fetus must consent to receiving medical care; the fetus does so through the mother, who provides third-party consent on its behalf.

What makes this doctrine unique in relation to childbirth is that the event of childbirth is “distinctly characterized in tort law by the literal emergence of a potential putative plaintiff.” Historically, a fetus was not considered distinct from its mother, with its own independent legal existence. But when medical developments allowed for doctors to capture the fetal heartbeat and prenatal imaging, the fetus by extension became personified. Bonbrest v. Kotz created the precedent that a fetus, subsequently born alive, was entitled to a legal claim independent of its mother. Various state courts have upheld similar causes of action for a fetus who experiences a breach of informed consent.

i. Fetal Dominance over Mothers

The fact that there is no physical way for the fetus to consent during its mother’s labor does not preclude the fetus’s right to informed consent in the eyes of the law, and thus its right to recover if it experiences in utero injury. Courts solve this problem by treating the fetus as incompetent—someone incapable of giving legal consent, but whose treatment is “authorized by a competent third party.” Just as a parent gives consent for a child’s medical services, in spite of the child being the patient, so too does the laboring mother give consent (or withdraws

287. Id. at 332.
288. Id. at 339.
289. Id.
292. Id. at 341.
293. Id.
294. Id. at 341-42.
295. Id. at 342.
296. Id.
consent) on the behalf of the fetus.297 In jurisdictions that treat the fetus as a legal entity with a separate right to recover, breaching the pregnant woman’s consent would thus expose her provider to two separate liabilities.298

While labor may involve medical emergencies, laboring women typically do not lose the ability during labor to give effective consent.299 Further, informed consent includes a woman’s right to withdraw previously provided consent.300 Courts have also upheld the effectiveness of consent given even when a laboring woman is highly medicated.301 The general pain and physical and emotional stress of labor are also not sufficient to remove the legal competency required for effective informed consent.302 Being in labor does not prevent a woman from being able to consent, just as being in labor “does not preclude a woman from withdrawing consent that was previously given.”303

While a pregnant woman and her fetus may each have an independent cause of action for a breach of informed consent, litigation today focuses almost wholly on the large verdicts begot by fetal harms. This focus sidelines maternal harms claims, claims which are rarely brought and receive nominal damages when they are.304 Prior to the twentieth century, birth was often focused on the mother and was a somber affair because of the risk of infant death. As birth became less risky, it became more celebratory and focused on the infant.305 With this increased focus eventually came the court-recognized duties owed to the fetus as well as the pregnant woman.306 Yet while birth injury lawsuits command massive verdicts, “birthing women rarely sue for maternal harms.”307 C-sections are major surgeries that can cause future problems, and vaginal births can also yield lasting harms, such as hysterectomies, strokes, chronic pelvic pain, tearing and resultant complica-

297. Id.
298. Id.
299. Id. at 345.
300. Id.
301. Id.
302. Id. (“Only when a woman loses her cognitive function—which, although rare, does occur in the context of childbirth—would she be deemed incompetent.”).
303. Id.
305. Id.
306. Id. at 1977.
307. Id. at 1979.
tions. Emotional symptoms such as trauma symptoms, depression, and posttraumatic stress disorder are also common.

The low dollar value of these claims and problematic maternal essentializing, whereby a healthy baby negates any maternal harm, mean that birth injury lawsuits are not often brought.

ii. The Disparate Impact Experienced by Black Women

The failure of informed consent as it relates to Black women means that because of providers’ inability to effectively communicate with their patients, Black women are not afforded adequately informed consent. *Canterbury v. Spence* promotes the reasonable patient standard, where the inquiry is focused on what information a reasonable patient would expect to be disclosed. However, the overmedicalization of Black women giving birth illustrates “a failure of informed consent to protect Black women from medical violence.” Black women are not being given the information that patient-centered care emphasizes, a phenomenon referred to as the “informed consent gap.”

Jennie Joseph, a British midwife who runs a birthing center in Florida named Commonsense Childbirth, believes the midwifery model mitigates the impact of systemic racial bias in the healthcare system. In Britain, most births are attended by midwives—midwives do not practice under obstetricians; rather, high-risk patients see both a midwife and an obstetrician. The midwifery model, in contrast to the medical model, emphasizes community-based care, both prenatal and postnatal; avoiding unnecessary interventions that can be harmful; and fostering close relationships between the provider and the patient.
Experts in maternal health who recommend lowering the U.S.’s astonishingly high C-section rate say that licensed midwives can be used to solve shortages in maternity care, especially for rural and low-income mothers.317

Racial disparities in C-section deliveries are prevalent in this country. The overmedicalization that Black women face at the hands of their providers cannot be divorced from the “long history of medical violence that impedes Black women’s reproductive autonomy.”318 Overmedicalization comes from implicit physician bias, as well as the racist presumption and myth that Black bodies are inherently different in some way.319 Biological differences in race are a racist myth, meaning Black women’s increased likelihood of having C-sections cannot be explained by pointing to “medical complications” that Black women are more likely to experience.320

This assumption, untenable in our modern world, is emblematic of medicine’s inability to confront racism itself as a risk factor for overmedicalization in birth.321 The stress and “weathering” Black women experience as a result of pervasive societal racism has increasingly become better documented. Medicine in the U.S. upholds structural racism and the individual racism and implicit bias of its providers, with the result that Black women are dying from childbirth in this country at a rate not seen before or elsewhere. A solution that addresses the maternal mortality crisis must address the medical racism that is a primary cause of the maternal mortality crisis.

2. Shortcomings of Tort: Informed Consent
Does Not Account for Obstetric Violence

Tort liability is the primary legal means available to a woman who seeks redress from her labor, but it is an inadequate tool for several reasons. In terms of promoting effective communication between a woman and her provider, tort—as a backward-looking tool—is limited. Tort is also unable to adequately address the intersecting forms of subordination that Black women experience from their providers in the course of receiving care.

317. Id.
318. Campbell, supra note 26, at 60.
319. Id. at 63.
320. Id. at 64.
321. Id. at 63-64.
Unfortunately, since mainstream healthcare often involves medically coercive tactics, they have become part of the lexicon in a way that harms women trying to recover. An appellate court in New York ruled that a woman “could not establish an independent physical injury based on a cesarean surgery after one twin was stillborn and the other died shortly after birth.” The court had heard testimony that cesareans are a potential outcome in any birth, and concluded that a C-section thus wasn’t a physical injury but a procedure that was acceptable as a method of delivery. The fact that C-sections are performed with such frequency belies their coercive use and precludes courts from finding C-section-related incidents to be injuries.

This view is a result of change in childbirth. When birth transitioned from home to hospital, part of the draw was “medicalization”—doctors had medicine that saved lives and helped pain. But the doctors were also all male, and had not seen or participated in labor and birth, and this resulted in the development of one-size-fits-all labor formulas that persist to this day. Many obstetricians have protocols about labor positions, preferring birthing persons to labor on their back for easy access for OB check-ins, rather than allowing free movement to stimulate labor and allow the mother comfort. Obstetricians also have protocols for continuous EFM, induction, and pushing, including telling women when they can or cannot push. If a birthing person suggests a different strategy, she may face threats, verbal abuse, and her provider may refuse to provide care unless she follows the institution’s policies.

The transition from home to hospital was also a transition from the birthing person being the chief decision-maker to the doctor being the one to lead the process, a primary cause of tension between birthing people and their providers during the process. In addition to women having to cede full agency in birth to their doctors, modern birth has forced women to fit into the “ideal” of a model hospital birth. This

323. Id.
324. Id. An appellate court in New York was similarly not willing to recognize an episiotomy so crude it had cut off part of the baby’s finger as an injury.
325. Id.
326. Best, supra note 202, at 177.
327. Id. at 178-79.
328. Id. at 179.
329. Id.
330. Id.
331. Id. at 179-80.
332. Id. at 180.
ideal laboring mother is a person who is in minimal to no pain, has a quick and uncomplicated labor, and accepts whatever the physician offers to her without question. This is in clear tension with how birth has existed for thousands of years, where birth was a communal, familial experience, guided by elder women who had experienced and attended births, and led by the birthing person herself.

The issue with tort as a remedy is that it does not address the specific misogyny and racism of obstetric violence, nor does it encompass an understanding of the pervasiveness of this issue. But it is not the individual nature of tort at issue in its effectiveness—a class action mechanism would be similarly useless because of the differences between each woman’s experience with her provider and birth. Much of the abuse women face at the hands of their providers, while egregious, would be deemed emotional abuse not constituting “violence,” and thus not likely to be compensable. This harm includes abusive language, humiliation, bullying, and rude, insulting, or unprofessional conduct—for example, one doctor “jeered” at a birthing patient in pain, saying she was being a baby crying for not getting her way; another told a patient that she would have to “earn her baby,” making her wait five hours until the anesthesia from the C-section wore off in order to hold her baby. The harm women suffer from emotional abuse would also likely not rise to the level of intentional infliction of emotional distress. Physical abuse at the hands of a provider, on the other hand, can include non-consensual surgeries, such as C-sections and episiotomies, non-consensual medical procedures, such as the use of epidurals and Pitocin, and physical restraint during labor. While physical abuse may seem more likely to be the basis of a successful lawsuit, that has not been the reality. Under a number of legal theories, many women have taken their providers to court after suffering physical abuse at their hands, but they have been largely unsuccessful due to differences in understanding of labor and delivery among women, their providers, and courts.

333. Id.
334. Id. at 189.
335. Id. at 188-89 (providing examples of the following: a doctor “jeered” at one woman, said she was just a baby crying for not getting her way; one woman was told she would have to “earn her baby” and wait five hours to hold her baby, until the anesthesia from the C-section wore off).
336. Id. at 189.
337. Id. at 190.
338. Id.
Women who have suffered harms during birth may bring battery claims and negligence tort claims against their providers. A battery consists of an unauthorized touch that is harmful or offensive, and a plaintiff in a medical battery case may recover by showing their lack of consent to the performed procedure. However, doctors can rebut the claim by showing that there was indeed consent. Consent in the medical sphere can be either express (verbal or written) or implied. Many touches may happen within the implied consent sphere during birth—a doctor is unlikely to repeatedly stop to ask for consent when touching, for example, because the patient has implicitly given their consent for certain touching by seeking and submitting to medical care. Courts have held that this type of care, including procedures such as vital sign checking and noninvasive tests, is care that mothers implicitly consent to upon entering a hospital.

Other procedures, however, are not implicitly consented to by availing oneself of medical care and thus require express consent. These include the most invasive types of “touching”—notably, episiotomies and cesareans. However, courts have not been willing to hold that express consent is required for surgery that results from childbirth because of the emergence of another patient (the child). This differentiates obstetrics from all other types of medicine, in which courts have always required informed consent prior to surgery. Both doctors and courts argue that once a pregnant woman avails herself of hospital care, she implicitly consents to “any and all procedures the physician deems necessary to deliver the child.” Naturally, there is a conflict of interest here—if a woman does not want a certain procedure, a doctor can argue that it would benefit the fetus. While this approach to informed consent directly contradicts how other areas of American law approach it, courts insist on viewing cases of obstetric violence differently, denying recovery to women and refusing to require physicians to obtain a birthing person’s express consent before performing surgery on them. Although obstetric violence cases meet the elements of a traditional battery claim,

339. Id. at 190, 195.
340. Id. at 190-91.
341. Id. at 191.
342. Id.
343. Id. at 192.
344. Id.
345. Id.
346. Id.
347. Id. at 192 n.157.
348. Id. at 192.
349. Id. at 193.
women are continuously prevented from recovering, on the basis of hav-
ing given “implied consent” simply by virtue of seeking treatment.350

There is an inability in the law to recognize obstetric violence and
harm that result from labor and delivery. The male professionalization
of medicine has appropriated childbirth, causing significant harm to
birthing people and women, particularly Black women. The law has re-
fused to allow redress for women who experience battery and negligence
at the hands of their providers, despite them clearly meeting the ele-
ments of their claims. This belies a clear misogyny in the law, and forces
us to look elsewhere for an answer to the maternal mortality and mor-
bidity crisis in this country. Part III explores a different answer to this
crisis: the use of doulas.

III. ENDING THE CRISIS

A. Doulas as a Solution to the Maternal Mortality Crisis

While there have been many different suggestions for how to solve
the maternal mortality crisis in the United States, one solution in par-
ticular stands at the forefront—doula care. Recent research has shown
that doula support is a life-saving intervention—a cost-effective way to
improve birth outcomes and prevent maternal deaths.351 As the mater-
nal mortality rate has continued to increase in the past thirty years, and
birthing people of color continue to face increasingly disproportionate
outcomes that show no signs of slowing down (COVID; the effects of
Dobbs), advocates and policymakers are turning to doulas’ promising re-

The role of a doula during labor and childbirth is a purely non-
medical one—doulas provide physical support, emotional support, and
informational support and advocacy.353 Culturally—and particularly in
the United States—we may think of modern hospital birth interven-
tions in the 21st century as so highly advanced as to be infallible. Yet
when it comes to birth, evidence shows that outside of clinical access it-
self, perhaps the most important factor contributing to a healthy labor

350. Id. at 194-95.
351. Why Are States Using Doulas to Improve Birth Outcomes and Maternal Health?, USA
FACTS (Jan. 11, 2023, 1:52 PM), [https://perma.cc/Z25A-5ELC] [hereinafter USA
FACTS].
352. Robles-Fradet & Greenwald, supra note 18.
353. USA FACTS, supra note 351.
and birth is something called “continuous support.” Modern hospital maternity practice has moved away from providing continuous support during labor—but a false cultural expectation persists that nurses will help birthing mothers through labor and delivery. Hospitals do not staff their maternity wards to allow for this kind of individualized support. One study found that new mothers expected their nurses to provide them one-on-one support for 53% of their labor; the actual time spent ranged between 6 and 10% of their total time laboring. In comparison, doulas spend considerably more time providing one-on-one support to a person in active labor. Research has shown that doulas spend six to eleven times more time with a patient than nurses and clinical providers do. Key to doulas’ work is the emphasis on their “constant presence” during labor. In 2017, a review of twenty-six studies, including over 15,000 people, on the use of continuous support for birthing women was published. The participants of the studies were randomized to receive either continuous support throughout labor, or “usual care.” Who provided the continuous support varied, including midwives and nurses employed by the hospital, as well as doulas, childbirth educators, retired nurses, or a person from the mother’s social circle such as a partner or female relative. Overall, those who received continuous support during labor were more likely to have vaginal births, and less likely to have pain medication, epidurals, C-sections, vacuum or forceps-assisted deliveries. Their labors were also shorter by about 40 minutes. Mothers who received continuous support were also less likely to have negative feelings about their labor and birth experience.

Doulas are advocates for birthing women, empowering women to communicate their needs and “actualize her dream of a healthy, positive birth experience.” While many partners or spouses are able and willing to provide emotional support to their birthing partner, they are un-
likely to have the knowledge to provide helpful physical support to counteract pain and help progress labor, nor the informational support to be able to provide the birthing person with information, advocacy, and reassurance. Doulas are trained in techniques and strategies to ease labor for the birthing woman, provide constant emotional support and encouragement, and act as advocates and intermediaries between women and medical providers. Myriad studies have shown that the continuous support doulas provide throughout childbirth reduces rates of cesarean sections and epidurals and increases rates of breastfeeding and maternal-infant bonding. The presence of doulas improves the overall labor and birth experience for birthing women, and there is evidence that they help reduce postpartum depression. Doula support has been found to have even greater positive outcomes for women who are marginalized, low-income, first-time mothers, mothers giving birth alone in a hospital, or mothers who have language or cultural barriers. As advocates, doulas amplify the mother’s voice if she is being dismissed or ignored, and help facilitate communication between the birthing person and provider, supporting the birthing person’s decisions and encouraging and empowering them to communicate and ask questions of their provider.

Studies on doula-assisted births show that doula care considerably improves health outcomes and leads to fewer interventions. The American College of Obstetricians and Gynecologists have said that the continuous support and presence of a doula during pregnancy is “one of the most effective tools to improve labor and delivery outcomes.” Interventions can lead to negative outcomes in birth when they are not needed, and research shows that such is frequently the case for Black women—doulas can help prevent this. Birthing people who are supported by doulas are less likely to have a C-section or other interventions.

Cesarean sections, preterm birth, and severe maternal morbidities and mortality are much more common among Black and Indigenous women than white women. Doula support improves birth outcomes, decreases cesarean deliveries, and makes childbirth a more positive expe-

365. Id. at 50.
366. Mottl-Santiago et al., supra note 230, at 44.
367. Id.
368. Gruber et al., supra note 355, at 49-50.
369. Dekker, supra note 358.
370. Robles-Fradet & Greenwald, supra note 18.
371. Id.
372. Hill et al., supra note 8.
rience for the birthing person. But because private insurance does not cover doulas, a coverage gap exists, and individuals who are low-income but not Medicaid-eligible—disproportionately women of color—have very limited access to doulas.

Another extremely significant benefit of increasing doula care to combat the maternal mortality crisis in this country (especially as directed specifically to combat the Black maternal crisis), is the work doulas do both pre- and post-birth to support their clients. Outcomes have been shown to improve even more when a doula provides prenatal care—research has shown that initiating doula care prior to birth has “documented health benefits”—working with a prenatal doula has proven to lessen the likelihood of preterm delivery or low birthweight. Having a doula prenatally helps a mother reduce her risk of experiencing postpartum depression, and being able to receive targeted and culturally-competent informational support throughout pregnancy helps birthing people develop healthy behaviors, communicate effectively with their providers about their birthing plans, and makes them more likely to “initiate and continue breastfeeding” for longer than they would otherwise have done.

B. Barriers to Care

While there may be other options for halting and reversing the maternal health crisis among women of color, none proves so immediately promising as doula support, which is already increasing in implementation and practice. Current efforts to provide doula access have focused primarily on increasing access to Medicaid recipients. But researchers have discovered that the pervasive racial disparities in maternal health outcomes are not tied to socioeconomic status or to educational attainment—racism in medicine is experienced “across income and education levels, indicating that racism in the health care setting is a driving force of disparities.” In other words, the race of the birthing person itself is the reason for poor outcomes. Therefore, a solution to respond to poor

373. Robles-Fradet & Greenwald, supra note 18.
375. Robles-Fradet & Greenwald, supra note 18.
376. Id.
377. Id.
378. Id.
health outcomes in Black and brown communities must take race into account when developing solutions to the maternal health crisis, because the crisis specifically affects women of color. A solution that focuses solely on Medicaid and socioeconomic indicators will not adequately address the issue.

Doulas are being increasingly integrated into state Medicaid programs, as states recognize their capacity to help or solve this crisis. Currently, there are two primary “types” of doulas in existence—private doulas and community-based doulas. To have a private doula attend your birth can cost up to $1,500—a price point that is simply not manageable for most people.379 However, while this sum may seem high, it pales in comparison to the costs that result from complications that arise in a hospital birth, which are both a) financial costs—all of the associated costs of maternity care and interventions such as C-sections—and b) physical and emotional costs for the birthing person, who may not have wanted or needed such extreme intervention.380

C. Translated into a Practical Solution

To try to find out more about the obstacles preventing more widespread use of doulas, I spoke to Anya Tanyavutti, then the Executive Director of Chicago Volunteer Doulas, an innovative nonprofit dedicated to providing low-income women and women of color in Chicago with free labor and postpartum support.

Ms. Tanyavutti said that states are indeed beginning to recognize that doulas are “a mitigation strategy to parent and infant death,” but that they don’t always want to pay for it. “It’s the intersection of racism and misogyny that leads to these state decisionmakers thinking that [doulas are] cheap,” she says. By devaluing the work doulas do, decisionmakers devalue the communities they are a part of and seek to help. Birth is long, typically at least several hours, and doula work is intense physical and emotional labor. While private clients may understand and be willing to pay a private doula’s rate, Ms. Tanyavutti says, states are simply not willing to reimburse at market rate, threatening doulas’ ability to make a living wage. “It feels like a lack of value and care for both Black birthworkers and the Black and Indigenous communities who are dying,” she said.

380. Id.
Ms. Tanyavutti is deeply frustrated by the state’s unwillingness to create infrastructure so that doulas can receive a living wage. “They cannot figure out how to stop killing us, but they want us cheap,” she said, referring to the state’s stinginess. “We know the state is wealthy and can pay us market-rate,” she said. Instead, “they want to nickel and dime us, when they literally are asking us to hold the line against the entire medical industrial complex.”

While states are beginning to utilize doulas to improve maternity care outcomes, limiting their usage to Medicaid recipients is a mistake, because of the fact that race plays a much larger role in birth outcomes than does socioeconomic status. Rather than focusing on Medicaid eligibility, doula care should be covered in the Affordable Care Act’s essential health benefits—specifically, maternity and newborn care. By amending the Affordable Care Act so that maternity and newborn care included doula support, private insurers operating in each state marketplace would be required to pay for doula services.

**CONCLUSION**

Childbirth moving from the home to the hospital was perhaps the “single most important transition in childbirth history.” The medicalization of birth and the male professionalization of medicine shifted the balance of power, pushing women out of their domestic support system and into the institutional setting of the hospital. Today, maternal mortality rates are increasing amongst Black, Hispanic, and Indigenous populations. The fundamental right to bodily autonomy in hospital maternity care is not being upheld, causing continuing harm to these communities.

To combat the maternal mortality crisis in this country, it is imperative that we commit to doula care as a frontline treatment for childbirth. Support for doulas is increasing across the country, but so far exists primarily for those who can pay for a private doula out-of-pocket, or for Medicaid recipients. This creates a vast coverage gap, and because

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381. See supra Part II.
382. For an overview of the ACA’s essential health benefits, see Information on Essential Health Benefits (EHB) Benchmark Plans, CTRS. FOR MEDICARE & MEDICAID SERVS. (last visited Mar. 19, 2023), [https://perma.cc/3AHG-8ZZX].
384. Nicholas Dumlao, US Maternal Mortality Increased 33% During Pandemic, Hitting Black and Hispanic Women Especially Hard, ABC NEWS (June 28, 2022, 11:30 AM), [https://perma.cc/P6GY-MMZ9].
385. Robles-Fradet & Greenwald, supra note 18.
maternal mortality does not discriminate by socioeconomic status, Medicaid reimbursement for doulas does not adequately address the maternal mortality crisis. To end the maternal mortality crisis in the United States, private insurers should be required to cover doulas under the “maternity and newborn care” essential health benefit, one of the ten essential health benefits all private insurers are required to cover under the Affordable Care Act.