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Medical Violence, Obstetric Racism, and the Limits of Informed Consent for Black Women

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Medical Violence, Obstetric Racism, and the Limits of Informed Consent for Black Women

Colleen Campbell

The United States' alarmingly high C-section rate and its equally alarming maternal mortality rate make it clear that reproductive healthcare is failing women. But it is especially failing Black women, who are today disproportionately exposed to these and other reproductive health risks just as they have been throughout history. The Michigan Journal of Gender & Law selected this Essay because it traces a direct line from early gynecology's reliance on the bodies of unconsenting Black women to how medicine and the law's failure to reckon with this history continues to harm Black women now. While these institutions now purport to embrace ethical principles like bodily autonomy and individual agency, this Essay critically examines why Black women must still navigate reproductive healthcare against a backdrop of both racist medical violence that puts their health at risk and a legal doctrine of informed consent that cannot realistically protect them.



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MEDICAL VIOLENCE, OBSTETRIC RACISM, AND THE LIMITS OF INFORMED CONSENT FOR BLACK WOMEN

Colleen Campbell*

This Essay critically examines how medicine actively engages in the reproductive subordination of Black women. In obstetrics, particularly, Black women must contend with both gender and race subordination. Early American gynecology treated Black women as expendable clinical material for its institutional needs. This medical violence was animated by biological racism and the legal and economic exigencies of the antebellum era. Medical racism continues to animate Black women's navigation of and their dehumanization within obstetrics. Today, the racial disparities in cesarean sections illustrate that Black women are simultaneously overmedicalized and medically neglected—an extension of historical medical practices rooted in the logic of biological race. Though the principle of informed consent traditionally protects the rights of autonomy, bodily integrity, and well-being, medicine nevertheless routinely subjects Black women to medically unnecessary procedures. This Essay adopts the framework of obstetric racism to analyze Black women's overmedicalization as a site of reproductive subordination. It thus offers a critical interdisciplinary and intersectional lens to broader conversations on race in reproduction and maternal health.

* Acting Assistant Professor of Lawyering, N.Y.U. School of Law. This paper is in honor of Lucy, Betsey, Anarcha, and the Black American women whose bodies were sacrificed on the altar of medical progress. I would like to thank Elizabeth Armstrong, Khiara Bridges, Tod Hamilton, and Melissa Murray for your insights contributing to the development of this paper. Your incisive reflections pushed me conceptually and analytically at various stages to work through my ideas. In addition, this paper benefited profoundly from the critical and expert support of the editors of the *Michigan Journal of Gender & Law*, including Rachel Czwartacky and Megan Kelly. I am most grateful for your feedback. Additionally, I extend my deepest gratitude to the following students for their research assistance: Bianca Morris and Hannah Grace. Lastly, to Ruha Benjamin, Khiara Bridges, Patricia Hill Collins, Kimberlé Crenshaw, Dána-Ain Davis, Dorothy Roberts, and the other Black women and critical scholars whose research permits me to do this work: Thank you most profoundly. Any mistakes are mine alone.

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INTRODUCTION

The issue of maternal health disparities has received increased public attention since Serena Williams shared her nearly fatal birth story.¹ A day after giving birth to her daughter via C-section, Williams had trouble breathing.² With her history of embolisms, Williams lives in fear of blood clots, and assumed she was having another pulmonary embolism.³ When she alerted a nurse and asked for a CT scan and a blood thinner, the nurse assumed she was confused because of her pain medicine.⁴

Instead, the doctor performed an ultrasound—also known as a Doppler—of her legs.⁵ “I was like, a Doppler? I told you, I need a CT scan and a heparin drip.”⁶ Williams again insisted she was having an embolism.⁷ When the ultrasound revealed nothing, she eventually underwent a CT scan, which showed several small blood clots in her lungs.⁸

1. Rob Haskell, *Serena Williams on Motherhood, Marriage, and Making Her Comeback*, VOGUE (Jan. 10, 2018), <https://www.vogue.com/article/serena-williams-vogue-cover-interview-february-2018> [<https://perma.cc/LS3J-6598>].

2. *Id.*

3. *Id.*; see also Jennifer Drysdale, *Serena Williams Cries over Near-Death Experience After Giving Birth in ‘Being Serena,’* ENT. TONIGHT (May 9, 2018), <https://www.etonline.com/serena-williams-cries-over-near-death-experience-after-giving-birth-in-being-serena-101980> [<https://perma.cc/N88N-XZV6>].

4. Haskell, *supra* note 1.

5. *Id.*

6. *Id.*

7. Drysdale, *supra* note 3.

8. Haskell, *supra* note 1.

She was immediately put on the heparin drip, which saved her life.⁹ “I was like, listen to Dr. Williams!”¹⁰

Though Williams lived to tell her story, her experience sheds light on why Black women navigate pregnancy as potentially deadly terrain—because of medical racism and obstetric violence. For instance, in obstetrics, the vast power differentiation between providers and patients often renders informed consent a legal fiction. Informed consent presumes not only the ability to grant consent, but the ability to engage in informed refusal.¹¹ Otherwise put, it contemplates the ability to freely express a different opinion than the provider. This is crucial because women know their bodies most intimately.¹² Nevertheless, women often encounter authoritarian physicians unwilling to consider their expertise on their own bodies, which inhibits them from challenging providers.¹³ Moreover, those who do challenge medical authority are often silenced, dismissed, or ignored.¹⁴ For example, although Williams engaged in informed refusal by asserting her own bodily expertise, she still found herself dismissed.

Not only does challenging medical authority require considerable personal capacity to be an agent of one’s own medical treatment, the medical system also places an unreasonable burden on women to be both advocates and patients when they are most vulnerable: in childbirth. For Black women, the consequences of this expectation can be deadly. In addition to the *gendered* violence in obstetrics, medical *racism* subjects Black women to medical exploitation and dehumanization. Theories of biological race, in particular, continue to shape physician treatment recommendations and increase Black women’s overexposure to unnecessary and invasive surgical procedures.¹⁵

9. *Id.*

10. *Id.*

11. See Lane v. Candura, 376 N.E.2d 1232, 1236 (Mass. App. Ct. 1978) (“The law protects [a patient’s] right to make her own decision to accept or reject treatment, whether that decision is wise or unwise.”). For a social justice critique of informed consent and liberal autonomy bioethics, see Ruha Benjamin, *Informed Refusal: Toward a Justice-Based Bioethics*, 41 SCI. TECH. & HUM. VALUES 967 (2016).

12. Nancy Ehrenreich, *The Colonization of the Womb*, 43 DUKE L.J. 492, 568 (1993) (noting judicial acceptance of medical staff data as legitimate, but that the “more ‘contextualized’ knowledge conveyed by laboring women, such as conclusions based on accounts of their previous labors, was ‘easily dismissed as personal, subjective, idiosyncratic . . . in a word, unscientific’”).

13. Dominick L. Frosch, Suepatra G. May, Katharine A.S. Rendle, Caroline Tietbohl & Glyn Elwyn, *Authoritarian Physicians and Patients’ Fear of Being Labeled “Difficult” Among Key Obstacles to Shared Decision Making*, 31 HEALTH AFFS. 1030, 1033 (2012).

14. See Ehrenreich, *supra* note 12, at 551–52 (describing the treatment of women of color, including dismissal and disparagement, as a “violent effort at subjugation” because of their race and gender).

15. See *infra* Part II.

This Essay thus adopts a critical race analysis of medicine. It illustrates how medical racism and institutional practices expose Black women to unnecessary and riskier surgical interventions. In obstetrics particularly, Black women are simultaneously overmedicalized *and* medically neglected, a paradigm that is an extension of historical medical practices and rooted in the logic of biological race.¹⁶ This Essay argues that medicine, through overmedicalization, undermines Black women's reproductive agency. Moreover, despite the protections guaranteed by law, the doctrine of informed consent cannot protect Black women from routinized medical exploitation. In making this argument, this Essay also counters the hegemonic biological construction of Black women's bodies as a site of pathology, and instead centers the pathologies of racism and medical violence in the discourse on reproductive health.

The research literature amply documents the history of Black women's medical exploitation. As property, enslaved women could not legally consent to or refuse the violence of white male physicians. Thus, early gynecology particularly thrived on the exploitation of Black women. Part I explores this long history of medical violence, which continued into the twentieth century in the form of sterilization abuse and coercive experimental birth control therapies.

Physicians today still construe Black bodies through the prism of biological race and, as a result, as perpetually high-risk bodies. Biological race thus operates as both a cause of and a perverse justification for Black women's overmedicalization and increased exposure to invasive risk management techniques. Part II examines the racial disparities in C-section rates to demonstrate that Black women's disparate exposure to the surgical scalpel is partly driven by non-medical risk factors and a host of other institutional forces.¹⁷

A key critique of the doctrine of informed consent is that it emphasizes individual agency and decision-making. This formal liberal conception of autonomy invariably obscures medical violence against vulnerable communities.¹⁸ Furthermore, it presumes that medical decision-making occurs within a vacuum, unencumbered by systems of power and inequality.¹⁹ Part III interrogates the doctrine's failure to militate against rac-

16. See generally HARRIET A. WASHINGTON, *MEDICAL APARTHEID: THE DARK HISTORY OF MEDICAL EXPERIMENTATION ON BLACK AMERICANS FROM COLONIAL TIMES TO THE PRESENT* (2006) (examining the long history of medical experimentation on African Americans).

17. Marian F. MacDorman, Fay Menacker & Eugene Declercq, *Cesarean Birth in the United States: Epidemiology, Trends, and Outcomes*, 35 *CLINICAL PERINATOLOGY* 293, 293 (2008) [hereinafter MacDorman et al., *Cesarean Birth*].

18. Benjamin, *supra* note 11, at 978.

19. *Id.* (describing the need for cultural humility to redress power imbalances and paternalism in the patient-physician relationship); see also Carolyn Johnson & Phil Drechsler,

ism's continued impact on Black women's navigation of obstetrics care. Using the frameworks of obstetric racism²⁰ and dehumanization, it examines the critical failure of the law to protect Black women from overmedicalization and medical violence.

I. HISTORY OF MEDICAL EXPLOITATION

A. *Antebellum Reproductive Politics*

Slavery institutionalized Black women's loss of bodily and reproductive autonomy.²¹ Professor Dorothy Roberts explains that slavery relied on "the dehumanization of Africans on the basis of race and the control of women's sexuality and reproduction."²² Early colonial statutes, for example, attempted to enlarge the slave labor pool through the use of Black women's bodies.²³ Legislatures established the legal doctrine of *partus sequitur ventrem*, which guaranteed that Black women's children inherited the status of their mother.²⁴ This contravened the common law principle that citizenship status was based on patrilineal descent.²⁵ The law thus ensured that Black women's children were considered slaves and legal property even if they were born to white slave owners.²⁶

Antebellum laws such as these enforced Black women's essential functions within slavery as reproductive and productive labor. Enslaved women were thus "bred" no differently from domesticated animals.²⁷ For example, some masters employed "special breeding techniques" to pro-

After His Wife Died, Man Pushing to Change Laws to Protect More Women from Pregnancy-Related Deaths, NBC L.A. (July 16, 2020), <https://www.nbclosangeles.com/investigations/wife-died-giving-birth-change-laws-to-protect-more-women-pregnancy-related-deaths/2395401/> [https://perma.cc/RUT9-368T] (noting how his race and gender filtered his ability to advocate for his wife, Kira Johnson's husband stated, "if I lost my temper if I yelled, if I slammed my fist on the nurse or on the nurses station that is as an African-American man I would be seen as a threat").

20. The term "obstetric racism" was coined by Dána-Ain Davis. Dána-Ain Davis, *Obstetric Racism: The Racial Politics of Pregnancy, Labor, and Birthing*, 38 MED. ANTHROPOLOGY 560, 561 (2019) [hereinafter Davis, *Obstetric Racism*].

21. DOROTHY E. ROBERTS, *KILLING THE BLACK BODY: RACE, REPRODUCTION, AND THE MEANING OF LIBERTY* 23 (Vintage Books 1st ed. 1999).

22. *Id.*

23. *Id.*

24. Camille A. Nelson, *American Husbandry: Legal Norms Impacting the Production of (Re)Productivity*, 19 YALE J.L. & FEMINISM 1, 18-19 (2007).

25. *Id.* ("The notion that legal status was inherited from the mother directly contradicted traditional English law, but was consistent with the laws governing animal husbandry and the rearing of livestock.").

26. *Id.*

27. *Id.*

duce lighter-skinned women who were more valued as sexual partners.²⁸ Moreover, pregnant enslaved women and those with infant children were forced to perform productive agricultural work without reprieve from harsh labor conditions.²⁹ Some Black women resisted these conditions, however, by aborting their babies, choosing not to give birth under these conditions.³⁰

Ideological constructs about their sexuality and reproduction were used to justify Black women's exploitation.³¹ Sociologist Patricia Hill Collins coined the term "controlling images" to describe the hegemonic ideas used to legitimize violence against Black women.³² In particular, the jezebel archetype depicts Black women as hypersexual beings who want and deserve sexual attention.³³ This ideological construct also justified masters' unfettered sexual access to enslaved women's bodies.³⁴

But sexual violence against Black women has never been merely a gendered phenomenon; it was also a form of racial violence.³⁵ According to Kimberlé Crenshaw, who developed the framework of intersectionality, Black women's systematic sexual exploitation was a form of racial subordination as well.³⁶ Therefore, "[w]hen Black women were raped by white males, they were being raped not as women generally, but as Black women specifically."³⁷ This is key to understanding Black women's intersectional reproductive domination.

Because Black women's sexual exploitation satisfied America's economic needs and preserved its racial hierarchy,³⁸ "[t]heir femaleness made them sexually vulnerable to racist domination, while their Blackness ef-

28. Ehrenreich, *supra* note 12, at 514-15.

29. ANGELA Y. DAVIS, *WOMEN, RACE AND CLASS* 9-10 (Vintage Books 1st ed. 1983).

30. *Id.* at 171.

31. See PATRICIA HILL COLLINS, *BLACK FEMINIST THOUGHT: KNOWLEDGE, CONSCIOUSNESS, AND THE POLITICS OF EMPOWERMENT* 5 (Routledge 2d ed. 2000).

32. *Id.*

33. *Id.* at 81 ("Jezebel's function was to relegate all Black women to the category of sexually aggressive women, thus providing a powerful rationale for the widespread sexual assaults by [w]hite men typically reported by Black slave women. Jezebel served yet another function. If Black slave women could be portrayed as having excessive sexual appetites, then increased fertility should be the expected outcome.")

34. *Id.*

35. Kimberlé Crenshaw, *Demarginalizing the Intersection of Race and Sex: A Black Feminist Critique of Antidiscrimination Doctrine, Feminist Theory and Antiracist Politics*, U. CHI. LEGAL F. 139, 158-59 (1989); see also Osagie K. Obasogie, *Anything But a Hypocrite: Interactional Musings on Race, Colorblindness, and the Redemption of Strom Thurmond*, 18 YALE J.L. & FEMINISM 451, 482 (2006).

36. Crenshaw, *supra* note 35, at 158.

37. *Id.*

38. Ehrenreich, *supra* note 12, at 514-15.

fectively denied them any protection.”³⁹ The damaging stereotypes against Black women—as presumptively promiscuous, hypersexual, dysfunctional, and disorderly—therefore justified the systematic sexual violence.⁴⁰ This pervasive violence against Black women by white men was replicated in medicine.⁴¹

B. *Early American Gynecology*

As legal property, enslaved women could neither consent to nor refuse the imposition of white men on their bodies. While the law thus created a permissive legal environment for Black women’s medical exploitation, the logic of biological race fueled this dehumanization, naturalizing that exploitation in order to advance the medical field.⁴² History of medicine scholar Rana Hogarth explains that slave hospitals in this era existed to facilitate the production of biomedical knowledge about Blackness and normalize the idea that Black bodies were physiologically distinct—and fundamentally inferior.⁴³ More specifically, medicine constructed Black bodies as medical “super bodies” and impervious to pain.⁴⁴ For example, as legal scholar Khiara Bridges observes, it was widely believed that Black women possessed “obstetrical hardiness,” or a “primitive pelvis.”⁴⁵

It was common practice to test new therapies on Black bodies before applying them to white bodies⁴⁶ and slaves were particularly suscep-

39. Crenshaw, *supra* note 35, at 158-59.

40. COLLINS, *supra* note 31.

41. DEIRDRE COOPER OWENS, *MEDICAL BONDAGE: RACE, GENDER, AND THE ORIGINS OF AMERICAN GYNECOLOGY* 7 (2018).

42. *Id.*; see generally Todd L. Savitt, *The Use of Blacks for Medical Experimentation and Demonstration in the Old South*, 48 J. S. HIST. 331, 331-48 (1982); Colleen Campbell, *Racial Inclusivity in COVID-19 Vaccine Trials*, PETRIE-FLOM CTR.: BILL OF HEALTH BLOG (Sept. 22, 2020), <https://blog.petrieflom.law.harvard.edu/2020/09/22/racial-inclusivity-covid19-vaccine-trials/> [https://perma.cc/MTF4-47DV]; RANA A. HOGARTH, *MEDICALIZING BLACKNESS: MAKING RACIAL DIFFERENCE IN THE ATLANTIC WORLD* (2017).

43. HOGARTH, *supra* note 42, at 163; see generally OWENS, *supra* note 41 (discussing this normalization).

44. OWENS, *supra* note 41, at 7; KHIARA BRIDGES, *REPRODUCING RACE: AN ETHNOGRAPHY OF PREGNANCY AS A SITE OF RACIALIZATION* 117-18 (2011).

45. BRIDGES, *supra* note 44, at 117-18.

46. Savitt, *supra* note 42, at 341 (“When new techniques or treatments required experimentation doctors tested them on readily available and legally silent slave or free black patients.”).

tible to exploitation because of their lack of legal protection.⁴⁷ Black bodies therefore “found their way to dissecting tables, operating amphitheatres, classroom or bedside demonstrations, and experimental facilities.”⁴⁸ As property, they could not legally give consent to their bodies. But even if they could conceivably consent legally, without the right to refuse, informed consent was meaningless.⁴⁹ Slaves therefore became prime fodder for medical schools and physicians, who capitalized on their legal and political vulnerability.

Death was no respite from these indignities either, as medical students often employed professional ‘resurrectionists’ to raid graves for anatomical material.⁵⁰ They did so with the approval of their institutions, both in the North and South.⁵¹ In fact, dead slaves were especially coveted by medical schools; one flyer proclaimed the local slave population “furnish[ed] ample materials for clinical instruction.”⁵²

The burgeoning American medical profession “needed bodies to advance the field and to recognize formal medicine as legitimate.”⁵³ Gynecology particularly needed to assert its dominance over a previously feminized practice that had been dominated by midwives and Indigenous healers, especially in the Black community.⁵⁴ The development of surgical expertise through “[p]ioneering gynecological surgical procedures, many of which were initially performed on enslaved women and later on poor immigrant women” ultimately facilitated the field’s “rapid advancement.”⁵⁵

It is now well known that James Marion Sims, considered the “father of modern gynecology,”⁵⁶ developed his surgical procedure to repair

47. *Id.* at 332, 337. “Blacks were considered more available and more accessible in this white-dominated society: they were rendered physically visible by their skin color but were legally invisible because of their slave status.” *Id.* at 332.

48. *Id.* at 331.

49. *See generally* Benjamin, *supra* note 11.

50. Savitt, *supra* note 42, at 337.

51. Ivy Wang, *A Grave Offense*, THE NEW J., Nov. 1, 2005, <http://www.thenewjournal.atyale.com/2005/11/a-grave-offense/> [<https://perma.cc/G6Z6-P7YJ>] (describing these practices at Yale Medical School).

52. RANDI HUTTER EPSTEIN, *GET ME OUT: A HISTORY OF CHILDBIRTH FROM THE GARDEN OF EDEN TO THE SPERM BANK* 41 (illustrated ed. 2011) (describing medical treatment for slaves advertised as health care as “dubious treatment under the direction of inexperienced medical students”).

53. OWENS, *supra* note 41, at 11; KRISTEN LUKER, *ABORTION AND THE POLITICS OF MOTHERHOOD* 17 (2008).

54. OWENS, *supra* note 41, at 5; LUKER, *supra* note 53, at 17.

55. OWENS, *supra* note 41, at 5.

56. *E.g.*, Durrenda Ojanuga, *The Medical Ethics of the ‘Father of Gynaecology’, Dr J Marion Sims*, 19 J. MED. ETHICS 28 (1993).

vesico-vaginal fistula by experimenting on enslaved women.⁵⁷ This technique solidified his international reputation and that of the profession.⁵⁸ Betsey Harris, Anarcha Westcott, and Lucy Zimmerman were all identified as research subjects at his facility in Alabama.⁵⁹ He performed multiple surgeries on these women—and many unnamed others—between 1845 and 1849 when he eventually perfected his technique.⁶⁰

Although Victorian sensibilities at the time meant it was generally frowned upon for white women to be exposed to the opposite sex, medical professionals had no issue visiting the surgical theatre to watch Sims's surgeries.⁶¹ Consider Lucy's surgery: While she was positioned on her hands and knees, twelve doctors gazed upon her exposed body, watching as she endured agonizing surgery for an hour.⁶² Black women's bodies at once satiated medicine's institutional needs as well as the male medical gaze.

It is plausible that Sims may have actually caused Anarcha's fistula.⁶³ Anarcha was in labor for thirty-six hours with a slave midwife when Sims was called to tend to her birth.⁶⁴ Despite having minimal experience in instrumental delivery, Sims nevertheless delivered Anarcha's baby with forceps.⁶⁵ With only a year and a half of medical training, he had lost two patients and confessed he “had no more idea of what to do than if I had

57. This severe complication of obstructed childbirth results when pushing creates a hole between the vagina and bladder or bowel, and was common in the nineteenth century. OWENS, *supra* note 41, at 36 (explaining that Sims entered the gynecology field because of the “plethora of reproductive ailments” women faced at the time). For enslaved women, this condition rendered them useless to masters as both reproductive and productive labor. *Id.*

58. See MICHELE GOODWIN, *POLICING THE WOMB: INVISIBLE WOMEN AND THE CRIMINALIZATION OF MOTHERHOOD* 53 (2020) (“His innovations earned him a statue in New York's famed Central Park. Only recently has it been removed.”).

59. OWENS, *supra* note 41, at 36; WASHINGTON, *supra* note 16, at 65–66; *see also* Shankar Vedentam, Maggie Penman, Jennifer Schmidt, Tara Boyle, Rhaina Cohen & Chloe Connelly, *Remembering Anarcha, Lucy, and Betsey: The Mothers of Modern Gynecology*, NPR: HIDDENBRAIN PODCAST (Feb. 7, 2017), <https://www.npr.org/2017/02/07/513764158/remembering-anarcha-lucy-and-betsey-the-mothers-of-modern-gynecology> [hereinafter Vedentam et al.] (Professor Vanessa Gamble suggesting the phrase “Mothers of Modern Gynecology” as a means of reframing these women as not mere victims of medicine).

60. Nelson, *supra* note 24, at 28–31.

61. WASHINGTON, *supra* note 16, at 64; *id.* at 24 (“Victorian norms of prudery and decency were inapplicable to slave women and girls and would not serve to protect them.”).

62. Ojanuga, *supra* note 56, at 29.

63. WASHINGTON, *supra* note 16, at 64–65.

64. *Id.* at 63.

65. Nelson, *supra* note 24, at 32. Forceps had emerged as one of the early tools used to medicalize obstetrics. Richard Johanson, Mary Newburn & Alison Macfarlane, *Has the Medicalisation of Childbirth Gone Too Far?*, 324 *BRITISH MED. J.* 892, 892 (2002).

never studied medicine.”⁶⁶ Medical ethicist Harriet Washington therefore speculates that, in addition to her age and malnutrition, Anarcha’s fistula may have resulted from Sims’s lack of technical proficiency in forceps delivery.⁶⁷

Sims also intentionally depicted the women in a manner that capitalized on racist tropes in order to legitimize his experiments. For example, he described them as submitting to the operations “not only cheerfully but with thanks.”⁶⁸ This absurd intimation that these women plausibly consented, or possessed a minutiae of medical agency in the ordeal, strains credulity at best.⁶⁹ “Informed consent did not exist for slave patients.”⁷⁰ They were certainly not free medical agents.

Sims exploited another racist belief—that Black Americans did not feel pain the same way whites did⁷¹—when he operated on these women without anesthesia, despite its availability at the time.⁷² This fraught attempt to obscure the suffering of slave women is further belied by Sims’s own accounts: “Lucy’s agony was extreme,” he admitted: “She was prostrated and I thought that she was going to die.”⁷³ It was months before Lucy recovered entirely from the effects of the operation.⁷⁴ Despite promulgating sanguine images of consenting research subjects, Sims’s own assertions betrayed him.

Finally, while Sims depicted himself as a savior to the wider medical community, he did not provide reparative therapy to all of the women on whom he operated. According to Harriet Washington, it was Sims’s former assistant who actually closed some of the women’s fistulas after Sims left the Alabama facility.⁷⁵ Any ethical justification Sims offered based on the therapeutic value of these surgeries was undermined by this fact alone.

These early experimental surgeries marked Black women’s bodies as expendable clinical material for medicine. Enslaved women rarely bene-

66. WASHINGTON, *supra* note 16, at 61.

67. *Id.* at 64. Additionally, Sims’s medical assistant claimed Sims created a fistula while removing bladder stones from a nine-year-old enslaved girl. *Id.* at 67.

68. J. Marion Sims, *Two Cases of Vesico-Vaginal Fistula Cured*, 5 N.Y. MED. GAZETTE & J. HEALTH 1, 1 (1854).

69. Nelson, *supra* note 24, at 32.

70. OWENS, *supra* note 41, at 108.

71. Vedentam et al., *supra* note 59.

72. WASHINGTON, *supra* note 16, at 65.

73. *Id.*; see also Ojanuga, *supra* note 56, at 29 (describing how Lucy “became extremely ill with fever resulting from blood-poisoning” after surgery and nearly died due to Sims’s experimental use of a sponge to drain urine away from the bladder).

74. J. MARION SIMS & H. MARION-SIMS, *THE STORY OF MY LIFE* 239 (H. Marion-Sims ed., 1884).

75. WASHINGTON, *supra* note 16, at 67.

fited from the therapies that were developed on their bodies. Instead, medicine relied on the logic of biological race and a legal environment stripping them of their agency to exploit them. In post-slavery America, medical violence against Black women persisted well into the twentieth century, with gynecology continuing to play a key role.

C. Sterilization Abuse

The twentieth century witnessed continued gynecological abuse in the form of mass sterilizations of Black women and other women of color.⁷⁶ Though the early twentieth century saw sterilization institutionalized as part of the eugenics movement, in the latter part of the twentieth century, state family planning programs became weaponized as a source of anti-natalist reproductive policy against poor women of color.⁷⁷ Political discourse amplified the stigmatization of Black and Brown women and constructed them in biologized terms as hyper-fertile bodies that drained the state's resources.⁷⁸ Similarly, public figures cast Black women as inherently bad mothers whose children constituted "an embryonic 'criminal class.'"⁷⁹

Relf v. Weinberger exposed nationwide sterilization abuses and widespread clinical experimentation on Black bodies and poor people by government-funded clinics.⁸⁰ The family planning clinic in the *Relf* case administered the then-experimental birth control therapy Depo Provera on young women and children in public housing.⁸¹ The clinic began its unsolicited administration of the therapy to Katie Relf (17) without her parents' consent shortly after the Relfs moved to public housing; eventu-

76. See generally ROBERTS, *supra* note 21 (examining the compulsory sterilizations and reproductive subordination of Black women).

77. *Id.*

78. See generally REBECCA M. KLUCHIN, *FIT TO BE TIED: STERILIZATION AND REPRODUCTIVE RIGHTS IN AMERICA, 1950-1980* (Rima D. Apple & Janet Golden eds., 2011) (examining the compulsory sterilizations of poor women in the post-eugenics era).

79. Khiara M. Bridges, *Quasi-Colonial Bodies: An Analysis of the Reproductive Lives of Poor Black and Racially Subjugated Women*, 18 COLUM. J. GENDER & L. 609, 610-11 (2009) (arguing that the "problematization of poor Black women's fertility . . . ought to be understood as a form of contempt for Black women's reproductive rights"); see also DANIEL P. MOYNIHAN, *THE NEGRO FAMILY: THE CASE FOR NATIONAL ACTION* (1965).

80. *Relf v. Weinberger*, 372 F. Supp. 1196, 1199 (D.D.C. 1974), *vacated*, 565 F.2d 722 (D.C. Cir. 1977).

81. The facts from the case are taken from the Civil Action Complaint at 5, 8-10, *Relf v. Weinberger*, 372 F. Supp. 1196 (July 17, 1973) (No. 73-1557) [hereinafter *Complaint*], <https://www.splcenter.org/seeking-justice/case-docket/relf-v-weinberger> [<https://perma.cc/Q6SH-MW6W>].

ally it targeted the younger Relf siblings, Mary Alice (12) and Minnie (14)—one of whom was mentally disabled—for the same drug.⁸²

In June of 1973, a family planning nurse picked up Mrs. Relf and the two younger Relf sisters and brought them to a hospital.⁸³ Mrs. Relf was told the children would be administered the same shots they had been receiving and asked to put her “mark” on a consent form before being escorted home.⁸⁴ Only later did Mrs. Relf, who could not read or write, learn she had consented to surgical sterilization.⁸⁵ Fourteen-year-old Minnie was asked to sign a consent form stating she was twenty-one years old and consented to the same procedure.⁸⁶ She too did not understand what she was signing and never spoke to the doctor before she was surgically sterilized.⁸⁷

Relf drew national attention to the widespread sterilizations across the U.S., as an estimated 100,000 to 150,000 poor persons were sterilized annually under federally funded programs.⁸⁸ The National Welfare Rights Organization brought a class action lawsuit challenging the Department of Health, Education and Welfare’s (HEW) authorization to sterilize persons “incompetent under state law to consent . . . because of minority or mental deficiency.”⁸⁹

Several key principles informed the court’s decision that HEW could not legally authorize the sterilizations of minors and disabled persons.⁹⁰ An examination of these principles, however, illustrates the stark discrepancy between the law and the medical experiences of poor and Black women.

First, the court noted that informed consent “clearly precludes the existence of coercion or force.”⁹¹ Yet, poor Black women, especially those relying on public assistance or a state health care policy, were often

82. See Complaint, *supra* note 81, at 8 (“[T]he agency sought out the Relf children as good experimental subjects for their family planning program.”).

83. *Id.* at 8-9.

84. *Id.* at 9.

85. *Id.*

86. *Id.*

87. *Id.*

88. *Relf*, 372 F. Supp. at 1199. These numbers exceed the over 60,000 sterilizations carried out under eugenic sterilization statutes. Alexandra Minna Stern, *Sterilized in the Name of Public Health: Race, Immigration, and Reproductive Control in Modern California*, 95 AM. J. PUB. HEALTH 1128, 1128 (2005).

89. *Id.*, 372 F. Supp. at 1201.

90. *Id.*, 372 F. Supp. at 1204-05. As a result of this case, there are now more stringent consent procedures to protect persons relying on state family planning services, including voluntary sterilization. *Id.* For example, it is now mandatory that individuals seeking sterilization are *orally* informed that no federal benefits can be withdrawn because of a refusal to consent to sterilization. *Id.*

91. *Id.*, 372 F. Supp. at 1202.

pressured to be sterilized under the threat of losing their state benefits.⁹² Poor pregnant women commonly encountered explicit threats of reprisal by state and even private medical providers for refusing to be sterilized.⁹³

Second, the *Relf* court explained that consent requires the “voluntary, knowing and uncoerced consent of” competent individuals.⁹⁴ This in turn requires that individuals have access to adequate information that can facilitate their appreciation of the significance of a medical decision. Some poor women could not meaningfully provide consent, however, as the intentionally deceptive manner in which medical providers procured Mrs. Relf’s consent illustrates. Given her limited literacy, her consent certainly did not meet this standard. The *Relf* court also noted it was a “universal common law and statutory rule that minors and mental incompetents cannot consent to medical operations.”⁹⁵ As such, the Relf sisters and others targeted for sterilization could not have legally consented to the procedure.

Sterilization abuse emanated in part from the eugenic philosophy that some bodies and reproduction are more expendable than others. That logic confirmed that racist medical violence against Black women continued throughout the twentieth century. The state engaged in systematic medical neglect and deployed sterilization to discipline poor Black women, a practice that began in the antebellum era.⁹⁶ Indeed, many state actors, including individual social workers and medical providers, subscribed to the dominant political images of Black mothers as

92. See *Cox v. Stanton*, 529 F.2d 47, 49 (4th Cir. 1975). Eighteen-year-old Nial Ruth Cox was sterilized under North Carolina’s eugenic sterilization statute. *Id.* Her mother, a recipient of public assistance, consented to Cox’s sterilization after a social worker threatened to strike the family from the welfare roll. *Id.* North Carolina authorized eugenic sterilizations well into the latter part of the twentieth century. Angela Davis, *The Historical Context: Racism, Birth Control and Reproductive Rights*, 4 RACE, POVERTY & ENV’T 21, 22 (1993). While the stated purpose of these operations was to prevent reproduction by “mentally deficient persons,” about 5,000 of the 7,686 persons who were sterilized were Black women. *Id.*

93. See *Walker v. Pierce*, 560 F.2d 609, 611 (4th Cir. 1977). In this case, Virgil Walker sued her obstetrician for coercing her into a sterilization procedure because she had multiple children and received public assistance. *Id.* At trial, he admitted this was his policy and that he dismissed patients, who often had no other access to an obstetrician, who refused. *Id.*; see also *3 Carolina Doctors Are Under Inquiry in Sterilization of Welfare Mothers*, N.Y. TIMES, July 22, 1973, at 30.

94. *Relf*, 372 F. Supp. at 1201-02.

95. *Id.*, 372 F. Supp. at 1202.

96. See ALONDRA NELSON, *BODY AND SOUL: THE BLACK PANTHER PARTY AND THE FIGHT AGAINST MEDICAL DISCRIMINATION* 132-33 (2011). For a general discussion on how Medicaid is still an instrument for enacting control over poor women’s lives by depriving poor mothers of their right to privacy and autonomy, see BRIDGES, *supra* note 44.

the dregs of the state.⁹⁷ This stigmatization also materialized in private medical settings, where a lack of meaningful choice of providers often precluded poor Black women from fully exercising their reproductive agency.⁹⁸

Moreover, despite the growing twentieth century embrace of bioethical articulations of patients' right to self-determination, the protections of principles like informed consent eluded Black women. Physicians—in concert with state actors—habitually threatened non-compliant women with dismissal when they refused sterilization.⁹⁹ Private medical spaces therefore effaced Black women's bodily and reproductive agency and legitimized their dehumanization.

The next Part centers overmedicalization in obstetrics to illustrate how medicine remains a site of profound biomedical racialization and power differentiation. This, in turn, sheds light on the continuity of medical violence against Black women enabled by the failure of enshrined bioethical principles to protect them.

II. RACISM, NOT RACE, AS RISK FACTOR

The overmedicalization of Black women in obstetrics is a continuation of a long history of medical violence that impedes Black women's reproductive autonomy. This overmedicalization results, in part, from the presumption that Black bodies are inherently more at risk for adverse health outcomes and from physician bias. This Part considers disparities in cesarean sections, which are implicated in negative reproductive health outcomes, to examine the consequences of this racialization.¹⁰⁰

This Part does not reduce Black women's maternal health outcomes to overmedicalization. Independent of the disparities in surgical interventions, there are underlying disparities in health that are socially determined. Indeed, these underlying health conditions may increase the need for C-sections. Yet as this Part will illustrate, Black women's overmedicalization is not commensurate with or merely reflective of underlying health profiles. Black women's disparate exposure to medically unnecessary high-risk surgical interventions constitutes an independent health risk factor that must be centered in reproductive health discourses.

97. See generally, e.g., *Walker*, 560 F.2d 609; *Cox v. Stanton*, 529 F.2d 47 (4th Cir. 1975).

98. See generally, e.g., *Walker*, 560 F.2d 609; *Cox*, 529 F.2d 47.

99. E.g., *Walker*, 560 F.2d 609.

100. Vanessa L. Jacoby, Victor Y. Fujimoto, Linda C. Giudice, Miriam Kuppermann & A. Eugene Washington, *Racial and Ethnic Disparities in Benign Gynecologic Conditions and Associated Surgeries*, 202 AM. J. OBSTETRICS & GYNECOLOGY 514, 514-21 (2010).

While C-sections are sometimes medically necessary and potentially lifesaving, a C-section is a major surgery that poses greater fetal and maternal health risks than vaginal birth.¹⁰¹ In fact, C-sections are associated with extensive adverse perinatal and neonatal outcomes.¹⁰² For this reason, the World Health Organization states “[t]here is no justification for any region to have a rate higher than 10–15%.”¹⁰³ At over 30%,¹⁰⁴ the C-section rate in the U.S. is generally concerning from a public health standpoint.

C-sections are also the most commonly performed surgical procedure in the U.S.,¹⁰⁵ which sees a comparatively high maternal morbidity and mortality rate vis-à-vis its wealthier counterparts.¹⁰⁶ One of the many causes for the high C-section rate is physician pressure to undergo the surgery. Physicians routinely coerce women into having medical interventions such as labor induction and C-sections.¹⁰⁷ Additionally, the constant specter of malpractice liability;¹⁰⁸ widespread bans on vaginal birth after C-section (VBAC);¹⁰⁹ variation in hospital practices;¹¹⁰ and subjective, as opposed to objective, clinical indications are all identified as causal

101. Katy Backes Kozhimannil, Michael R. Law & Beth A. Virnig, *Cesarean Delivery Rates Vary Tenfold Among US Hospitals; Reducing Variation May Address Quality and Cost Issues*, 32 HEALTH AFFS. 527, 527 (2013) [hereinafter Kozhimannil et al.]; MacDorman et al., *Cesarean Birth*, *supra* note 17.

102. Darios Getahun, Daniel Strickland, Jean M. Lawrence, Michael J. Fassett, Corinna Koebnick & Steven J. Jacobsen, *Racial and Ethnic Disparities in the Trends in Primary Cesarean Delivery Based on Indications*, 201 AM. J. OBSTETRICS & GYNECOLOGY 422.e1, 422.e6 (2009) [hereinafter Getahun et al.].

103. World Health Org., *Appropriate Technology for Birth*, 326 LANCET 436, 437 (1985).

104. Michelle K. Osterman & Joyce A. Martin, *Trends in Low-Risk Cesarean Delivery in the United States, 1990-2013*, NAT'L VITAL STATS. REP. 1-2 (Nov. 5, 2014).

105. MacDorman et al., *Cesarean Birth*, *supra* note 17, at 293.

106. Marian F. MacDorman, Eugene Declercq, Howard Cabral & Christine Morton, *Recent Increases in the U.S. Maternal Mortality Rate: Disentangling Trends from Measurement Issues*, 128 AM. J. OBSTETRICS & GYNECOLOGY 447, 447, 453 (2016) [hereinafter MacDorman et al., *Recent Increases*] (“Despite the United Nations Millennium Development Goal for a 75% reduction in maternal mortality by 2015, the estimated maternal mortality rate for the U.S. increased from 2000 to 2014; the international trend was in the opposite direction.”).

107. Judy Jou, Katy B. Kozhimannil, Pamela Jo Johnson & Carol Sakala, *Patient-Perceived Pressure from Clinicians for Labor Induction and Cesarean Delivery: A Population-Based Survey of U.S. Women*, 50 HEALTH SERVS. RES. 961, 971 (2015).

108. See generally THERESA MORRIS, CUT IT OUT: THE C-SECTION EPIDEMIC IN AMERICA (2013) (examining the role of the malpractice system in high rates of C-sections).

109. Elizabeth Kukura, *Choice in Birth: Preserving Access to VBAC*, 114 PENN ST. L. REV. 955, 971 (2010) (discussing the impact of widespread VBAC bans on increased risk of medical interventions such as C-sections).

110. Kozhimannil et al., *supra* note 101, at 531.

mechanisms in the excessive rates of C-sections.¹¹¹ In other words, non-obstetric risk factors account for much of the general rise in overmedicalized births.¹¹²

For example, one study concluded that recent “increases in primary cesareans in cases of ‘no indicated risk’ have been more rapid than in the overall population and seem to be the result of changes in obstetric practices rather than changes in the medical risk profile or ‘maternal request.’”¹¹³ Plainly put, it is not that mothers have become unhealthier over the years and are in greater need of C-sections, nor can the rates be explained by a greater patient preference for the procedure. If the high rates of C-sections are not medically indicated, then, they constitute an independent increased risk factor for adverse maternal health.¹¹⁴

But the surgical burden and risks of overmedicalization have not been borne equally by all women. Indeed, there are stark racial and socioeconomic disparities in C-section deliveries, with Black women experiencing higher rates of the procedure and its associated health risks.¹¹⁵ These disparities remain even when comorbidities and social demographic background factors are accounted for.¹¹⁶ One study of New York City data found racial disparities in C-sections even after accounting for insurance status, pre-pregnancy weight, maternal age, education, parity, birth weight, gestational age, medical complications, and pregnancy complications, with rates of C-sections for Hispanic Caribbean women and African American women still greater compared to the rates for white women.¹¹⁷ Importantly, the disparity is visible even for low-risk pregnancies, i.e., those pregnancies for which there is no medical complication.¹¹⁸ In other words, perfectly healthy Black women who do not need a C-

111. See Emma L. Barber, Lisbet S. Lundsberg, Kathleen Belanger, Christian M. Pettker, Edmund Funai & Jessica L. Illuzi, *Indications Contributing to the Increasing Cesarean Delivery Rate*, 118 AM. J. OBSTETRICS & GYNECOLOGY 29 (2011).

112. See, e.g., Kozhimannil et al., *supra* note 101, at 527; Eugene Declercq, Fay Menacker & Marian MacDorman, *Maternal Risk Profiles and the Primary Cesarean Rate in the United States, 1991-2002*, 96 AM. J. PUB. HEALTH 867, 867 (2006).

113. MacDorman et al., *Cesarean Birth*, *supra* note 17, Abstract, <https://pubmed.ncbi.nlm.nih.gov/18456070/> [<https://perma.cc/L3L9-DDCH>].

114. *Id.* at 302 (noting the nexus between increased risk for neonatal and maternal mortality and medically elective cesareans compared with vaginal births).

115. Azad A. Kabir, Gabriella Pridjian, William C. Steinmann, Eduardo A. Herrera & M. Mahmoud Khan, *Racial Differences in Cesareans: An Analysis of U.S. 2001 National Inpatient Sample Data*, 105 AM. J. OBSTETRICS & GYNECOLOGY 710, 710 (2005) [hereinafter Kabir et al.].

116. *Id.*

117. T. Janevic, E. Lofffield, D.A. Savitz, E. Bradley, J. Illuzzi & H. Lipkind, *Disparities in Cesarean Delivery by Ethnicity and Nativity in New York City*, 18 MATERNAL & CHILD HEALTH J. 250, 250-57 (2013) [hereinafter Janevic et al.].

118. *Id.* at 252-53.

section are also receiving this major surgery, thereby increasing their risk of negative health outcomes.

Several reasons have been articulated for these disparities. First, patients' preferences, specifically Black women's preferences, are often alluded to.¹¹⁹ For example, a study in the *Journal of Obstetrics and Gynecology* opined that "Black women may have been more agreeable to primary cesarean delivery than others."¹²⁰ This amounts to a cultural proxy for race. In essence, this assumption summarily reduces Black women to a homogenous group with a preference for overmedicalization without further inquiry.

This rationale is not only counterintuitive—insofar as it is unlikely that Black women alone may prefer medically unnecessary, invasive interventions that expose them to greater risks—but it has also been rejected, especially when considering that the disparities exist among first-time and low-risk pregnancies.¹²¹ Instead, it is more likely that healthy Black women are not being presented with freedom of choice when it comes to delivery.¹²²

Another particularly harmful explanation is biological racial differences, which implicates Black women's bodies in the etiology of underlying risk factors that cause C-sections. In the same *Obstetrics and Gynecology* study, researchers controlled for over twenty clinical risk factors, yet Black women still experienced disproportionately high rates of medically unnecessary C-sections.¹²³ Underlying health profiles did not fully explain the disparate C-section rates. Thus, the clear implication is that *healthy* Black women are likely having unnecessary C-sections, exposing them to harmful medical risks and adverse outcomes affecting their health.

The study's authors attempted to explain the disparities by framing Black women as somehow biologically different. They suggested Black women may have a higher rate of "unreported or uncommon medical complications," prompting physicians' decisions for C-sections.¹²⁴ It is not clear why Black women alone would experience complications not captured by a list of common clinical complications, and in numbers that result in significantly higher C-section rates.

This untenable assumption is characteristic of medicine's failure to confront the reality of racism as a risk factor. It represents a common

119. *E.g.*, Kabir et al., *supra* note 115, at 716.

120. *Id.*

121. Allison S. Bryant, Sierra Washington, Miriam Kuppermann, Yvonne W. Cheng & Aaron B. Caughey, *Quality and Equality in Obstetric Care: Racial and Ethnic Differences in Cesarean Section Delivery Rates*, 23 *PAEDIATRIC & PERINATAL EPIDEMIOLOGY* 454, 460 (2009) [hereinafter Bryant et al.]

122. *See id.*

123. *See* Kabir et al., *supra* note 115, at 716.

124. *Id.*

mode of framing Black women's bodies as biologically predisposed to complication. Applying this logic then justifies subjecting Black women to increased risk management practices; simultaneously, it elides how physician and institutional racism construct and frame risk to overmedicalize women generally and Black women especially.¹²⁵ As a result of this durable logic, providers approach clinical encounters with "preconceived notions of risk of adverse maternal or neonatal outcomes for women of different races and ethnicities"—risks they then attempt to mitigate through increased interventions.¹²⁶

By continuing to mark Black women's bodies as distinct and deserving of differential medical treatment, biomedicine evidences a remarkable "lack of attention to social theory [because of] the persistence of implicit notions of race."¹²⁷ Indeed, epidemiologists continue to embrace a "theory of race that has been rejected in adjacent disciplines."¹²⁸ Case in point, Blackness is still considered a genetic risk factor for preeclampsia, which is indeed higher among African Americans.¹²⁹

Furthermore, in addition to preexisting biological racial beliefs, provider bias is also an important contributor to the overmedicalization of Black women.¹³⁰ This phenomenon must therefore be understood as a

125. See BRIDGES, *supra* note 44, at 112 ("[W]hen physician racism is invoked in studies of racial disparities, it is never by that name and it is usually done through a 'rhetoric of exculpation' and with 'euphemizing vocabulary' in which physicians are excused for the racial biases they may harbor and put into practice.").

126. Bryant et al., *supra* note 121, at 460.

127. Carles Muntaner, *Invited Commentary: Social Mechanisms, Race, and Social Epidemiology*, 150 AM. J. EPIDEMIOLOGY 121, 123 (1999).

128. *Id.* at 122.

129. Annetee Nakimuli, Olympe Chazara, Josaphat Byamugisha, Alison M. Elliott, Pontiano Kaleebu, Florence Mirembe & Ashley Moffett, *Pregnancy, Parturition and Preeclampsia in Women of African Ancestry*, 210 AM. J. OBSTETRICS & GYNECOLOGY 510-20.e1, 514 (2014); J.M. Roberts & D.W. Cooper, *Pathogenesis and Genetics of Preeclampsia*, 357 LANCET 53, 54 (2001) ("The list of predisposing factors" for pre-eclampsia "includes hypertension, diabetes, increased insulin resistance, increased testosterone, [B]lack race, and increased blood homocysteine concentration." (emphasis added)).

130. BRIDGES, *supra* note 44, at 111-12 (emphasizing the importance of naming physician racism in reproductive health discourse); INST. OF MED. COMM. ON UNDERSTANDING & ELIMINATING RACIAL & ETHNIC DISPARITIES IN HEALTH CARE, UNEQUAL TREATMENT: CONFRONTING RACIAL AND ETHNIC DISPARITIES IN HEALTH CARE 11 (Brian D. Smedley, Adrienne Y. Stith & Alan R. Nelson eds., 2003) (citing Kevin A. Schulman, Jesse A. Berlin, William Harless, Jon F. Kerner, Shyrl Sistrunk, Bernard J. Gersh, Ross Dubé, Christopher K. Taleghani, Jennifer E. Burke, Sankey Williams, John M. Eisenberg & José J. Escarce, *The Effect of Race and Sex on Physicians' Recommendations for Cardiac Catheterization*, 340 NEW ENG. J. MED. 618, 624-25 (1999) [hereinafter Schulman et al.] (acknowledging the role of physician bias in disparities in quality of care and outcomes); Janevic et al., *supra* note 117, at 256.

function of both underlying processes of racialization and physician racism.

Biological race has been discredited as lacking any meaning beyond its social and political geneses.¹³¹ Yet, as this Essay illustrates, it has remained powerful in shaping Black women's disparate exposure to surgical procedures in obstetrics, where Black women are paradoxically simultaneously overmedicalized and medically neglected. Biological race, in turn, operates as a justification for Black women's adverse health outcomes. As the next Part will illustrate, the discourse on overmedicalization is not only crucial for interrogating racialization in obstetrics but power differentiation as well.

III. THE LIMITS OF INFORMED CONSENT

Clearly, one needn't look to history to confirm that anti-Black racism forecloses to Black Americans full access to the panoply of bioethical rights—"autonomy, justice, beneficence, and nonmaleficence"¹³²—traditionally enjoyed by others. This Part first examines the doctrine of informed consent, its preoccupation with protecting patient autonomy, and how it operates in actual medical practice. It then deploys the frameworks of obstetric racism¹³³ and dehumanization to explore the intersectional dynamics of obstetrics that specifically impair Black women's reproductive autonomy.

A. *Informed Consent*

Informed consent protects patients' well-being and enshrines respect for their bodies and the right to self-determination.¹³⁴ When operational-

131. See generally DOROTHY ROBERTS, *FATAL INVENTION: HOW SCIENCE, POLITICS, AND BIG BUSINESS RE-CREATE RACE IN THE TWENTY-FIRST CENTURY* (2011) (discussing the resuscitation of biological race in the form of race-based drugs and genetic testing).

132. Osagie K. Obasogie & Marcy Darnovsky, *Introduction* to *BEYOND BIOETHICS: TOWARD A NEW BIOPOLITICS* 1, 6-7 (Osagie K. Obasogie & Marcy Darnovsky eds., 2018).

133. See Davis, *Obstetric Racism*, *supra* note 20.

134. See *Informed Consent*, AMERICAN CONGRESS OF OBSTETRICIANS & GYNECOLOGISTS' COMMITTEE ON ETHICS: COMM. OP. NO. 439, Aug. 2009, at 1, <https://www.acog.org/-/media/project/acog/acogorg/clinical/files/committee-opinion/articles/2009/08/informed-consent.pdf> [<https://perma.cc/HG4P-RD5Q>] [hereinafter *ACOG Committee Opinion*]; *Canterbury v. Spence*, 464 F.2d 772, 781 (D.C. Cir. 1972) (discussing the relationship between informed consent and the physician's duty to exercise reasonable care for the safety and well-being of the patient); see also *Cobbs v. Grant*, 502

ized, it is a *process* of communication between provider and patient that produces either affirmative consent or refusal.¹³⁵ A physician ideally makes certain disclosures about the risks and benefits of a particular treatment course and responds to patient needs.¹³⁶ In other words, informed consent is more than simply signing a consent form—it is the “mutual sharing of information” between the clinician and patient to facilitate the patient’s active engagement in their treatment.¹³⁷

Justice Cardozo’s early articulation of the principle reflected informed consent’s core concern—procuring individual autonomy: “Every human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient’s consent, commits an assault, from which he is liable in damages.”¹³⁸ The doctrine of informed consent shifted throughout the twentieth century, beginning first with the professional or physician-based standard, which measured the disclosure requirements from the perspective of a reasonable medical practitioner under the same or similar circumstances.¹³⁹ The standard was later criticized for its “excessive paternalism” and the immunity it effectively granted to physician defendants in malpractice cases.¹⁴⁰

Lawmakers later expanded the consent requirement’s protections by demanding that disclosure be premised on the informational needs of the reasonable patient.¹⁴¹ Approximately half of the nation’s jurisdictions now adopt a reasonable patient standard due to “broad skepticism that practitioners can adequately police their own professional standards.”¹⁴² To sat-

P.2d 1, 9–11 (Cal. 1972) (analyzing the duty of a medical practitioner to obtain a patient’s informed consent for surgery).

135. *ACOG Committee Opinion*, *supra* note 134, at 6.

136. *Id.* at 5.

137. *Id.* at 1; *see also* Benjamin Moulton & Jaime S. King, *Aligning Ethics with Medical Decision-Making: The Quest for Informed Patient Choice*, 38 J.L. MED. & ETHICS 85, 89 (2010) (describing consent as a process of communication whereby the physician and patient use “*unbiased and complete information* on the risks and benefits” of treatment alternatives (emphasis added)).

138. *Schloendorff v. Soc’y of N.Y. Hosps.*, 105 N.E. 92, 93 (N.Y. 1914).

139. *Schloendorff*, 105 N.E. at 93 (stating informed consent is required “except in cases of emergency where the patient is unconscious, and where it is necessary to operate before consent can be obtained”); *Natanson v. Kline*, 350 P.2d 1093, 1104 (1960).

140. Lars Noah, *Informed Consent and the Elusive Dichotomy Between Standard and Experimental Therapy*, 28 AM. J.L. & MED. 361, 367 (2002).

141. *See Canterbury v. Spence*, 464 F.2d 772, 780 (D.C. Cir. 1972).

142. Heather Joy Baker, *We Don’t Want to Scare the Ladies: An Investigation of Maternal Rights and Informed Consent Throughout the Birth Process*, 31 WOMEN’S RTS. L. REP. 538, 545 (2010); Noah, *supra* note 140, at 368 (“A few other courts opt for a more subjective test, which inquires about the perhaps idiosyncratic prior knowledge and preferences of the particular patient.”).

isfy the requirements of informed consent, physicians must now disclose information that a reasonable patient would take into account when making medical decisions, or else they may face liability.¹⁴³

The leading case on informed consent, *Canterbury v. Spence*, illustrates this reasonable patient standard. In that case, a physician advised a patient to undergo a laminectomy to alleviate back pain.¹⁴⁴ However, the physician did not advise him of the well-known 1% chance of becoming paralyzed, believing this might cause the patient to reject the treatment.¹⁴⁵ Following the procedure, the patient fell from his hospital bed and was paralyzed.¹⁴⁶ The patient sued the physician for failing to inform him of the risks associated with the procedure.¹⁴⁷

The D.C. Circuit held that physicians would be liable if their conduct was not “reasonable under the circumstances,” but centered that inquiry on the disclosure requirements from the requirements from the reasonable patient’s position, not the physician’s.¹⁴⁸ This objective standard asks whether a reasonable person in the patient’s position would be likely to attach significance to the risks associated with a particular therapy.¹⁴⁹ In other words, it assesses the informational needs from the perspective of a reasonable patient under similar circumstances.

The preceding discussion of Black women’s medical exploitation as experimental subjects and their contemporary overmedicalization illustrates, inter alia, a failure of informed consent to protect Black women from medical violence. Despite an emphasis on ‘patient-centered’ care,¹⁵⁰ law in practice is often not commensurate with the spirit or letter of the law. This disjuncture is referred to as the “informed consent gap,”¹⁵¹ which emanates from “the physician-patient relationship, the tort law system, and an increasingly cost-conscious health care delivery system.”¹⁵² In obstetrics for example, physicians often practice medicine defensively, that is, with the constant specter of malpractice liability distorting medical

143. *Canterbury*, 464 F.2d at 787.

144. *Canterbury*, 464 F.2d at 777.

145. *Canterbury*, 464 F.2d at 777.

146. *Canterbury*, 464 F.2d at 777.

147. *Canterbury*, 464 F.2d at 778.

148. *Canterbury*, 464 F.2d at 785.

149. Baker, *supra* note 142, at 545.

150. Moulton & King, *supra* note 137, at 89-90 (arguing that shared medical decision-making addresses some of the challenges of balancing patient-centered care with autonomy). For further discussion on the importance of shared decision-making in ensuring informed consent, see Bryan Murray, *Informed Consent: What Must a Physician Disclose to a Patient?*, 14 AM. MED. ASS’N J. ETHICS 563 (2012).

151. Peter H. Schuck, *Rethinking Informed Consent*, 103 YALE L.J. 899, 903-05 (1994).

152. *Id.* at 905.

treatment recommendations.¹⁵³ This accounts for much of the rise in invasive interventions such as C-sections, which result from women receiving clinical advice from providers without being informed of the non-medical factors behind these recommendations.¹⁵⁴ This not only impairs patients' decisional capacities, it exposes them to medically unnecessary and high-risk interventions primarily to reduce physicians' legal liability. This contributes to the pervasive obstetric violence that routinely exposes women to mistreatment and abuse.¹⁵⁵ The informed consent gap therefore renders obstetrics a precarious terrain for women.

Finally, physician paternalism often renders informed consent illusory. Physicians are presumed to not only know what is best, but also to be unbiased and objective in their expertise.¹⁵⁶ Patients are likewise socialized to trust medical authority and to be 'good' patients by placing deferential trust in physicians.¹⁵⁷ As a result, providers may influence medical decisions without necessarily making an explicit recommendation. Yet, despite their claims to objectivity, physicians are not free from the general biases of society.¹⁵⁸ This is because medicine is a microcosm of wider society, where race, gender, and class controls are routinely enacted. These are the forces that contribute to obstetric violence.

B. Obstetric Racism

Obstetric violence is pervasive and adversely impacts the reproductive agency of all pregnant persons. It is increasingly being recognized as gender-based violence as women continue to report mistreatment and

153. See generally MORRIS, *supra* note 108 (discussing the role of the legal malpractice system in the C-section epidemic).

154. Lisa L. Chalidze, *Misinformed Consent: Non-Medical Bases for American Birth Recommendations as a Human Rights Issue*, 54 N.Y. L. SCH. L. REV. 59, 60 (2010). For more on how VBAC bans contribute to this issue, see Kukura, *supra* note 109, and L. Indra Lusero, *Challenging Hospital VBAC Bans Through Tort Liability*, 20 WM. & MARY J. WOMEN & L. 399 (2014) (examining the feasibility of tort claims against hospital VBAC bans).

155. Farah Diaz-Tello, *Invisible Wounds: Obstetric Violence in the United States*, 24 REPRODUCTIVE HEALTH MATTERS 56, 57 (2016).

156. Benjamin, *supra* note 11, at 978 (describing the false dichotomy in the expert-layperson duality that "demeans the competency of so-called lay people, while ignoring the subjectivity and biases of experts").

157. Karin A. Martin, *Giving Birth Like a Girl*, 17 GENDER & SOC'Y 54, 54 (2003) (describing how white, middle-class, heterosexual women often worry about "being nice, polite, kind, and selfless in their interactions during labor and childbirth").

158. See generally BRIDGES, *supra* note 44, for a discussion of the effects of racism on reproductive health. See also John M. Hoberman, *Medical Racism and the Rhetoric of Exculpation: How Do Physicians Think About Race?*, 38 NEW LITERARY HIST. 505, 512 (2007).

coerced medical interventions during birth.¹⁵⁹ The naturalization of physician authority is key to this phenomenon.

Physicians are generally presumed to possess a monopoly on expertise and their medical authority is rarely questioned.¹⁶⁰ Because of physician paternalism, they are presumed to be better suited to make healthcare decisions for patients.¹⁶¹ At the same time, women are socialized to distrust their own bodily knowledge and to place deferential trust in physicians to act in their best interest.¹⁶² Indeed, “[p]roviders acknowledge that this power differential exists and will persist.”¹⁶³

Thus, providers can determine *how* to frame risk, including what information is shared, controlling how some patients understand their options.¹⁶⁴ As a result, informed consent becomes vacuous, representing more of “an illusion of autonomy rather than the real thing,” as providers can guide women’s decision-making by the mere framing of treatment options and choices.¹⁶⁵ In other words, physicians are powerful in shaping patient’s choices, which in turn creates a fertile space for obstetric violence.

As an analytical lens, obstetric violence illuminates the gendered violence that all women experience; but it does not fully account for “the contours of racism that materialize during Black women’s medical encounters” with physicians.¹⁶⁶ Professor Dána-Ain Davis thus offered the theoretical framework of obstetric racism to account for the full effects of medical racism *and* obstetric violence.

There are several points that distinguish Black women’s medical experiences from others. Modern American medicine is anchored in the medical exploitation of Black women and African Americans.¹⁶⁷ This his-

159. Diaz-Tello, *supra* note 155, at 57 (citing Eugene R. Declercq, Carol Sakala, Maureen P. Corry, Sandra Applebaum & Ariel Herrlich, *Major Survey Findings of Listening to Mothers III: Pregnancy and Birth*, 23 J. PERINATAL EDUC. 9 (2014)). Moreover, most women (63%) who had a primary C-section, for example, identified their provider as the decision-maker. *Id.*

160. Benjamin, *supra* note 11, at 979.

161. Molly R. Altman, Talita Oseguera, Monica R. McLemore, Ira Kantrowitz-Gordon, Linda S. Franck & Audrey Lyndon, *Information and Power: Women of Color’s Experiences Interacting with Health Care Providers in Pregnancy and Birth*, SOC. SCI. & MED. 7 (2019) [hereinafter Altman et al.].

162. See Ehrenreich, *supra* note 12, at 493 (illustrating women’s reactions to medical care are based on their prior experiences, which are in turn shaped by race).

163. Altman et al., *supra* note 161.

164. *Id.*

165. *Id.*

166. Davis, *Obstetric Racism*, *supra* note 20, at 561.

167. See generally OWENS, *supra* note 41 (recounting the history of gynecology and its basis in medical experiments on enslaved women); WASHINGTON, *supra* note 16 (re-

tory cannot be disconnected from Black women's medical exploitation today. Indeed, this is a key feature of Black women's negotiation with obstetrics. The discourse of obstetric racism thus engages with this distinct history and the continuity of reproductive subordination.¹⁶⁸

The discussion above, for example, illustrates that Black women's overmedicalization is an extension of biomedical racialization that began with enslaved women. As physiologically distinct "clinical material," their bodies were expendable then to the emerging surgical needs of gynecology. Similarly, today, the 'unexplained' racial disparities in rates of C-sections are attributed to "uncommon" biological risk factors specific to Black women alone. Put otherwise, the "dystopian past" is "not *just* the past."¹⁶⁹

At the same time, scientific discourses often obscure the significance of institutional practices such as overmedicalization in reproductive health. Instead, they overemphasize Black women's bodily characteristics as a site of pathologization.

Consider the racial disparities in primary C-section deliveries, for example. While African American women are more likely to receive C-sections than white women,¹⁷⁰ researchers emphasize explanations implicating Black women's individual bodily characteristics, including higher rates of obesity and diabetes.¹⁷¹ As this and the previous Part confirm, Black women's disparate exposure to the surgical scalpel is connected to the logic of biological race and ongoing medical racism—that is, the distinct causal pathways of obstetric racism that are unique to Black women.¹⁷²

Additionally, Black women are not simply harmed by racism; they also do not experience the positive reproductive health gains that are traditionally associated with class mobility. Intersectional analyses, for example, illustrate the inability of class mobility to militate against the harmful

counting the history of Black Americans' mistreatment as unwitting subjects in medical experiments).

168. See Davis, *Obstetric Racism*, *supra* note 20; Dána-Ain Davis, *Reproducing While Black: The Crisis of Black Maternal Health, Obstetric Racism and Assisted Reproductive Technology*, 11 REPRODUCTIVE BIOMED. & SOC'Y ONLINE 56 (2020) [hereinafter Davis, *Reproducing While Black*].

169. DÁNA-AIN DAVIS, REPRODUCTIVE INJUSTICE: RACISM, PREGNANCY, AND PREMATURE BIRTH 13 (2019).

170. See Getahun et al., *supra* note 102.

171. *Id.*

172. Davis, *Reproducing While Black*, *supra* note 168, at 60. The other two dimensions are "critical lapses in diagnosis" and "being subjected to neglectful, dismissive or disrespectful treatment." *Id.*

health effects of racism.¹⁷³ To that end, Black women still fare worse than their similarly situated white counterparts in maternal morbidity and mortality rates even after accounting for socioeconomic class.¹⁷⁴

The picture becomes more complex, however, when considering maternal health disparities are not simply between educated Black women and their similarly educated white counterparts. Rather, *educated* Black women fare comparatively worse than *non-educated* white women.¹⁷⁵ The mortality rate for Black women with a college education or higher is about 1.6 times greater than that of white women with less than a high school diploma.¹⁷⁶ The positive health effects of advanced socioeconomic status thus do not accrue to Black women as they do to white women and other ethno-racial groups.

Race has thus been described as an independent organizing principle; although it interacts with other systems of domination, it has independent effects beyond class and gender.¹⁷⁷ In the realm of maternal health, therefore, Khiara Bridges argues that “race has everything to do with why Black women are more likely to die in the path toward motherhood—and not simply because race follows class closely in the United States.”¹⁷⁸ Indeed, the disparities in maternal health outcomes reflect the residual effects of racism that cannot be explained by class. It is therefore *racism*, not *biological race*, that principally drives Black women’s negative health outcomes.¹⁷⁹

Overmedicalization is an important tool for interrogating Black women’s negative maternal health outcomes. For Black women especially, the problem of disparities in maternal health must also be understood as a problem of racism intersecting with high-risk *practices*, not simply the problem of high-risk *populations*.¹⁸⁰ Nevertheless, Black women’s bodies are often framed as a site of difference, and, by necessity, brokenness. By

173. Cf. Emily E. Petersen, Nicole L. Davis, David Goodman, Shanna Cox, Carla Syverson, Kristi Seed, Carrie Shapiro-Mendoza, William M. Callaghan & Wanda Barfield, *Racial/Ethnic Disparities in Pregnancy-Related Deaths—United States, 2007-2016*, 68 MORBIDITY & MORTALITY WKLY. REP. 762, 763 (2019).

174. Cf. *id.*

175. *Id.*

176. *Id.*

177. Eduardo Bonilla-Silva, *Rethinking Racism: Toward a Structural Interpretation*, 62 AM. SOCIO. REV. 465, 474-75 (1996).

178. BRIDGES, *supra* note 44, at 109.

179. See generally Jo C. Phelan & Bruce G. Link, *Is Racism a Fundamental Cause of Inequalities in Health?*, 41 ANN. REV. SOCIO. 311 (2015) (“[T]he connection between race and health outcomes endures largely because racism is a fundamental cause of racial differences” in health outcomes.).

180. Schulman et al., *supra* note 130, at 618 (finding that the race and sex of a patient independently influence how physicians manage chest pain).

emphasizing biological race as a risk factor—or worse, shaming Black women for having higher body mass index, hypertension, or being unhealthy—these pathologizing strategies divert attention away from medical racism and overmedicalization in producing disparate outcomes.

This discussion on obstetric racism illustrates how medical violence harms Black women's reproductive agency and their health. However, with its emphasis on individual agency, the doctrine of informed consent does not protect against medical harm to disempowered social groups. This is a key critique of the doctrine. As sociologist Ruha Benjamin explains, “[t]oo often, biomedical and scientific culture and Euro-American values of autonomy and free choice elude interrogation.”¹⁸¹ To that point, its overemphasis on individual choice “can cloud, even obscure and divert our attention away from group harms and the vulnerabilities of collectives and communities.”¹⁸² The following discussion on dehumanization further demonstrates the inadequacy of modern bioethics to protect Black women from medical violence.

C. Dehumanization

Black women's overexposure to the scalpel also implicates another axis of obstetric racism—dehumanization. Dehumanization effectively reduces patients to clinical objects.¹⁸³ It does so by depriving them of their agency and denying their capacity for full human experiences.¹⁸⁴ Thus, it assails the body and will.

Psychoanalytic studies of dehumanization suggest that it is distinct from traditional prejudice or racism.¹⁸⁵ Prejudice is a broad intergroup attitude that may prompt one to discriminate against a job candidate, for example; dehumanization, by contrast, “is the route to moral exclusion” and the “denial of basic human protections to a group.”¹⁸⁶ Dehumanization has, for example, been identified causally in studies on police use of force against Black boys who are denied the protective innocence of

181. Benjamin, *supra* note 11, at 978.

182. Troy Duster, *Foreword* to BEYOND BIOETHICS: TOWARD A NEW BIOPOLITICS, *supra* note 132, at xiii; *see also* Obasogie & Darnovsky, *supra* note 132, at 5, 6–7.

183. Omar Sultan Haque & Adam Waytz, *Dehumanization in Medicine: Causes, Solutions, and Functions*, 7 PERSPECTIVES ON PSYCH. SCI. 176, 176 (2012).

184. *Id.* at 177–78.

185. Phillip Atiba Goff, Marthrew Christian Jackson, Brooke Allison Lewis Di Leone, Carmen Marie Culotta & Natalie Ann DiTomasso, *The Essence of Innocence: Consequences of Dehumanizing Black Children*, 106 J. PERSONALITY & SOC. PSYCH. 526, 527 (2014).

186. *Id.*

childhood: Because they are more likely to be perceived as adults, they lose the protections generally afforded to other children.¹⁸⁷

It also manifests as apathy to outgroup violence and “decreased concern for harm inflicted on the dehumanized individual or groups.”¹⁸⁸ Consider one study of white participants who were subliminally primed with images of apes (a traditional mode of dehumanization for Black Americans in the U.S.) before watching a video of police beating a Black man: The participants were more likely to endorse the beating, despite the extremity of the violence, after viewing the dehumanizing images.¹⁸⁹ However, the participants did not endorse the same beating when the suspect was white or when they had not been primed with the image.¹⁹⁰

Dehumanization is a critical aspect of Black women’s medical experiences. Denying Black women’s capacity to feel pain has been a common form of dehumanization that deprives them of “a critical human experience based on an arbitrary group marker.”¹⁹¹ Increased awareness of the hegemonic perception within medicine that Black Americans feel pain differently has exposed the perverse ways in which biological racism continues to distort medical practice and perpetuate medical violence.¹⁹² This form of dehumanization emanates from the “super-humanization” or medical super-body trope¹⁹³ that continues to legitimize the differential treatment of Black bodies.

Overmedicalization might well reflect physician bias or traditional prejudice. Indeed, physicians may be more prone to racial animus, and as a result, less likely to refer Black women to less invasive or therapeutic treatments. The increased surgical attention to Black women’s bodies may therefore reflect conscious stereotyping or bias, but it is also a mode of dehumanization because it displays apathy to Black women’s physical pain and trauma.

187. *Id.*

188. Vani A. Mathur, Theresa Morris & Kelly McNamara, *Cultural Conceptions of Women’s Labor Pain and Labor Pain Management: A Mixed-Method Analysis*, SOC. SCI. & MED. 8, 8 (2020) [hereinafter Mathur et al.].

189. Phillip Atiba Goff, Jennifer L. Eberhardt, Melissa J. Williams & Matthew Christian Jackson, *Not Yet Human: Implicit Knowledge, Historical Dehumanization, and Contemporary Consequences*, 94 J. PERSONALITY & SOC. PSYCH. 292 (2008).

190. *Id.*

191. Mathur et al., *supra* note 188, at 8.

192. See generally Kelly M. Hoffman, Sophie Trawalter, Jordan R. Axt & M. Norman Oliver, *Racial Bias in Pain Assessment and Treatment Recommendations, and False Beliefs About Biological Differences Between Blacks and Whites*, 113 PNAS 4296 (2016) (documenting a study showing that medical students and residents believe that there are biological differences between Black and white patients, including differences in the experience of pain, which affects treatment for pain).

193. See *supra* Part I.

This Part thus sheds light on the institutional forces that mire Black women's navigation of medicine. In particular, biological racism and the law have always dictated Black women's incorporation within biomedicine as objects of power and subordination. These forces continue to account for the divergence of bioethics principles as imagined in the law and as they materialize in practice.

CONCLUSION

Serena Williams's experience reveals a sobering truth about childbirth in the U.S.—that is, how obstetrics can silence and dismiss Black women, exposing them to reproductive harm and medical violence.¹⁹⁴ Insofar as scientific discourses continue to frame Black women through the lens of biological race and as a high-risk population, this Essay counters the problematization of Black women's bodies. Instead, it argues that medical institutional practices and medical racism are material to Black women's health outcomes.

While Williams had a pre-existing medical condition, which placed her arguably in a high-risk category, it was her providers' refusal to listen to her that increased her risk of an adverse maternal outcome. It was this inability to critically engage with providers—to effectively talk back to medical authority—that nearly proved fatal. Had she not been insistent, she would likely have been among those women who do not survive childbirth. It is this silencing that renders childbirth a fatal terrain for many Black women.

Williams's ability to successfully push back at all speaks to the exception that confirms the rule. Williams had considerable resources at her disposal compared to the average person giving birth—both material and informational. These resources matter because they affect one's ability to challenge physician authority and engage in informed refusal at a moment of profound vulnerability. Williams was thus able to push back against the weight of an oppressive medical apparatus—the hegemony of physician paternalism, normalized obstetric violence, and the marginalization of women's bodily expertise. For Black women, this calculus includes a history of dehumanization, pathologization, and distrust.

Being legally and bioethically empowered means being able to push back against these edifices that continue to mar Black women's bodies. For some, this might require nothing short of herculean fortitude—an untenable and cruel expectation considering the demands on the body and will during childbirth. More than anything, the 'problem' of Black

194. Elizabeth A. Howell, Natalia Egorova, Amy Balbierz & Jennifer Zeitlin, *Black-White Differences in Severe Maternal Morbidity and Site of Care*, 214 AM. J. OBSTETRICS & GYNECOLOGY 122.e1 (2016).

women's reproductive health and agency must be understood as that of a defective health care system and a legal apparatus that is ill-equipped to cure such defect—not defective bodies. Indeed, this discourse must be situated within the context of the forces of overmedicalization and obstetric racism, which preclude Black women from accessing not only informed consent, but the full spectrum of reproductive rights.

