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ABSTRACT

In recent years, the scholarly literature, the journalistic press, and even pop culture have begun to grapple with the many ways in which prison life works to degrade and dehumanize female prisoners, particularly pregnant women and new mothers. These voices are drawn – quite understandably – to the worst abuses, to practices (such as the shackling of laboring women) that underscore the dichotomy between the brutality of prison life and the allegedly autonomous norms governing pregnancy and parenting in the outside world. This Article supplements – and in crucial places challenges – the narrative implicit in those depictions by, first, placing practices such as shackling in the context of the many less dramatic ways in which prison policies and norms strip autonomy from pregnant and laboring women, and, then, by exploring the substantial overlap between the restrictions placed upon incarcerated pregnant women and those faced by non-incarcerated women. The Article concludes that the constraints and indignities imposed on pregnant prisoners are an outgrowth not only of patterns of social control of prisoners but also of patterns of social control of pregnant women more generally. Like our criminal sanctions regime, these pregnancy-specific patterns of control reflect and reinforce complicated ideas about race, class, and gender, and offer important insights into our culture's values and preoccupa-

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tions. Critically reading the experiences of women who are pregnant or laboring behind bars requires appreciation that their treatment stems from two distinct, though often overlapping, matrices of social control.

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INTRODUCTION

Criminal justice has been dominated by male defendants. The majority of persons prosecuted for crime historically have been men, and the overwhelming majority of persons jailed and incarcerated following criminal convictions have been men as well.[1] Those figures are in flux: over the past several decades, as the population of persons convicted and imprisoned has ballooned, the growth in the incarceration rate for women has outpaced that for men,[2] in part because the War on Drugs led to prosecution and incarceration for low-level drug offenders.[3] A common critique of criminal courts and prisons is that, based on these historical populations, the distinct and particular needs of women have been elided or ignored.[4] Parenting issues are one

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1. During 2011, the state and federal incarceration rate for men was more than fourteen times the rate for women. *See* E. Ann Carson & William J. Sabol, *Prisoners in 2011*, BUREAU JUST. STATS. 7 (Dec. 2012), http://www.bjs.gov/content/pub/pdf/p11.pdf (stating that the rate for women was 65 per 100,000 and for men was 932 per 100,000). The federal figures alone are even more stark: as of January 2015, the weekly tally of prisoners jailed under the authority of the Federal Bureau of Prisons was 93.3% male. *See Statistics: Inmate Gender*, FED. BUREAU OF PRISONS http://www.bop.gov/about/statistics/statistics_inmate_gender.jsp (last updated Jan. 24, 2015). As discussed *infra* note 2, the current statistics actually reflect something of a convergence; historically, men have been incarcerated at rates twenty or thirty times greater than the rates for women. For a full set of statistics for the years 1925 to 2012, showing the annual rates of incarceration for men and women, see *Sourcebook of Criminal Justice Statistics*, STATE U. OF N.Y. U. AT ALBANY, www.albany.edu/sourcebook/pdf/t6282012.pdf (last visited Mar. 3, 2015).

2. From 1980 to 2012, the incarceration rate for women increased 572% while the incarceration rate for men increased by "only" 330%. *Sourcebook of Criminal Justice Statistics*, *supra* note 1. The trend has been consistent from year to year, with the female prison population increasing at roughly 1.5 times the increase in the male population on an annual basis. *Id.*

3. *See, e.g.*, Kim Shayo Buchanan, *Impunity: Sexual Abuse in Women's Prisons*, 42 HARV.C.R.-C. L. L. REV. 45, 51-54 (2007) (discussing the impact of drug laws and enforcement policies on the growth of female prison populations and on the demographics of that population); Natasha A. Frost, Judith Greene & Kevin Pranis, *Hard Hit: The Growth in the Imprisonment of Women, 1977-2004*, COMMON SENSE FOR DRUG POL'Y 21 (May 2006), http://csdp.org/research/HardHitReport4.pdf (discussing the impact of the War on Drugs, particularly mandatory sentencing policies, on women and noting that, while only 21% of male prisoners were serving time for drug offenses in 2002, 32% of female prisoners were, up from 11% in 1977).

4. *See, e.g.*, INVISIBLE PUNISHMENT: THE COLLATERAL CONSEQUENCES OF MASS IMPRISONMENT 79 (Marc Mauer & Meda Chesney-Lind eds., 2003) ("[L]ittle or no thought was given to the possibility of a female prisoner until she appeared at the door of the institution. It was as though crime and punishment existed in a world in which gender equaled male."); Ronald L. Braithwaite et al., *Health Disparities and Incarcerated Women: A Population Ignored*, 95 AM J. PUB. HEALTH 1679 (2005), *available at* http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1449417/ (noting that the historical underrepresentation of women in the criminal justice system has generated

locus for such critique; while both men and women who are incarcerated are likely to be parents,[5] women are more likely to be the primary caregivers for minor children and are therefore more likely to be affected by prison policies that impact parenting.[6]

Pregnancy and childbirth are specific aspects of parenting only experienced by women. In the past decade, there have been a number of academic articles and interest-group reports that document the problems that women who are pregnant and birthing face while incarcerated, and those articles and reports have focused in particular on the practice of shackling women who are pregnant during transportation, court appearances, and, most sympathetically, labor.[7] This spotlight on the practice of shackling women during labor

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a system "created by males for males in which the diverse needs of women are forgotten and neglected" and arguing that this is particularly true in the area of medical needs and reproductive health); Stephanie S. Covington & Barbara E. Bloom, *Gendered Justice: Women in the Criminal Justice System*, *in* GENDERED JUSTICE: ADDRESSING FEMALE OFFENDERS 2 (Barbara E. Bloom, ed., 2003), *available at* http://www.stephaniecovington.com/assets/files/4.pdf ("Until recently, criminological theory and research focused on explaining male criminality, with males seen as the normal subjects of criminology.").

5. The most recent Bureau of Justice Statistics study on incarcerated parents found that, in 2004, 61.7% of women incarcerated in state prisons and 51.2% of such men were parents to minor children. *See* Laura E. Glaze & Laura M. Maruschak, *Parents in Prison and Their Minor Children*, BUREAU OF JUST. STATS. 3, http://www.bjs.gov/content/pub/pdf/pptmc.pdf (last updated Mar. 30, 2010). The statistics for federal prisoners were of a similar magnitude, though, interestingly, they did not show a similar gender disparity. *Id.*

6. Over 64% of women incarcerated in state prisons lived with a minor child in the month before arrest or immediately before incarceration versus 46.5% of men. *Id.* at 4. Moreover, approximately two-thirds of those women living with children (41.7% of all incarcerated women) were raising them in single-parent homes. *Id.* Among the men, the great bulk of residential fathers lived in two-parent homes. *Id*.

7. For some of the leading pieces in the academic literature on shackling, see Elizabeth Alexander, *Unshackling Shawanna: The Battle Over Chaining Women Prisoners During Labor and Delivery*, 32 U. ARK. LITTLE ROCK L. REV. 435 (2010); Geraldine Doetzer, *Hard Labor: The Legal Implications of Shackling Female Inmates During Pregnancy and Childbirth*, 14 WM. & MARY J. WOMEN & L. 363 (2008); Claire Louise Griggs, *Birthing Barbarism: The Unconstitutionality of Shackling Pregnant Prisoners*, 20 AM. U. J. GENDER SOC. POL'Y & L. 247 (2011); Pricilla A. Ocen, *Punishing Pregnancy: Race, Incarceration, and the Shackling of Pregnant Prisoners*, 100 CAL. L. REV. 1239 (2012); Dana L. Sichel, *Giving Birth in Shackles: A Constitutional and Human Rights Violation*, 16 AM. U. J. GENDER, SOC. POL'Y & L. 223 (2007); Dana Sussman, *Bound by Injustice: Challenging the Use of Shackles on Incarcerated Pregnant Women*, 15 CARDOZO J. L. & GENDER 477 (2009). Advocacy groups have also played a significant role in drawing attention to the issue. *See, e.g.*, *Abuse of Women in Custody: Sexual Misconduct and Shackling of Pregnant Women*, AMNESTY INT'L, http://www.amnestyusa.org/pdf/custodyissues.pdf (last visited Mar. 5, 2015) (detailing the practice of shackling); Emily P. Walker, *AMA: House of Delegates Backs Ban on Shackling Inmates in Labor*, MEDPAGE TODAY (June 15, 2010), http://www.medpagetoday.com/MeetingCoverage/AMA/20692 (describing the prac-

has been important and productive. In addition to focusing attention on particularly troubling practices, this focus on shackling has helped underscore the degree to which practices that are theoretically gender-neutral – women are shackled based on non-gender-specific prison administrative regulations that require restraints during transportation and medical procedures for all prisoners – can impose gender-specific indignities on female prisoners.[8] In large part because of the attention that has been drawn to the problems posed by restraining pregnant prisoners, a number of jurisdictions now have legislation or administrative regulations that limit the practice of shackling pregnant women during transportation and labor,[9] and a number of courts have begun to take seriously constitutional challenges to the indiscriminate shackling of pregnant and birthing mothers.[10]

While this focus on shackling has been useful and has prompted helpful policy changes, it has not – thus far – translated into a broader appreciation for the challenges and constraints encountered by incarcerated pregnant women and birthing mothers.[11] Those challenges and constraints are consid-

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tice of shackling as "barbaric"); *cf. Conclusions and Recommendations of the Committee Against Torture*, U.N. Comm. Against Torture on its 36th Sess., May 1-19, 2006, ¶ 33, U.N. Doc. CAT/C/USA/CO/2 (July 25, 2006), *available at* http://daccess-dds-ny.un.org/doc/UNDOC/GEN/G06/432/25/PDF/G0643225.pdf?OpenElement (determining shackling constitutes torture under international law).

8. Sussman, *surpa* note 7, at 477-78.

9. As of 2012, ten states and the Federal Bureau of Prisons had adopted statutes or policies banning the shackling of pregnant women. Dorothy E. Roberts, *Prison, Foster Care, and the Systemic Punishment of Black Mothers*, 59 UCLA L. REV. 1474, 1494 n.122 (2012); *see also* Mary Nicol Bowman, *Engaging First-Year Law Students Through Pro Bono Collaboration in Legal Writing*, 62 J. LEGAL EDUC. 586, 597 (2013) (reporting on a project by Seattle University law students that led to the passing of a statute banning routine shackling of pregnant prisoners during labor in Washington State).

10. *See, e.g.*, Nelson v. Corr. Med. Servs., 583 F.3d 522, 533-34 (8th Cir. 2009) (holding that routine shackling of prisoners is a clearly established violation of the Eighth Amendment); *see also* Alexander, *supra* note 7 (narrating the events in *Nelson*, 583 F.3d 522, an important and complicated case).

11. There are a few academic articles and advocacy reports that deal more broadly with the problems of pregnant prisoners, though even those tend to focus disproportionately on shackling and access to abortion. *See, e.g.*, Robin Levi et al., *Creating the "Bad Mother": How the U.S. Approach to Pregnancy in Prison Violates the Right to Be a Mother*, 18 UCLA WOMEN'S L.J. 1 (2010) (discussing, from a human rights perspective, barriers faced by pregnant women in U.S. prisons, while focusing significant attention on shackling); Rachel Roth, *Obstructing Justice: Prisons as Barriers to Medical Care for Pregnant Women*, 18 UCLA WOMEN'S L.J. 79 (2010) (discussing a variety of issues related to pregnancy in prison, albeit while roughly half the article discusses issues of access to abortion); The Rebecca Project & The Nat'l Women's Law Center, *Mothers Behind Bars: A State-by-State Report Card and Analysis of Federal Policies on Conditions of Confinement for Pregnant and Parenting Women and the Effect on Their Children*, NAT'L WOMEN'S L. CENTER (Oct. 2010) [hereinafter *Mothers Behind Bars*], *available at* http://www.nwlc.org/sites/default

erable. Court cases, advocacy reports, and news accounts paint a troubling – albeit necessarily anecdotal – portrait of a prison-industrial complex that is ill-equipped to deal with the complicated logistical, medical, and emotional consequences of incarcerating increasing numbers of pregnant women. As this Article demonstrates, incarcerated pregnant women face challenges that range from convincing prison officials that they are pregnant or are in labor to obtaining sufficient nutrition or necessary prenatal care. Once birth approaches, they often face a series of constraints and indignities ranging from loss of control over the timing and method of delivery to the prohibition of ordinarily-available pain medication and the micro-managing of who may be present in the delivery room.

Bringing these constraints to the forefront in the academic discussion helps to flesh out a complete picture of the degree to which the prison industry disempowers, stigmatizes, and generally fails pregnant women. Understanding the issues faced by pregnant prisoners is a worthy goal in itself. Highlighting these issues, however, also helps to draw out an important connection obscured by the literature's focus on shackling, namely the similarities – in kind, if not always in degree – between the constraints faced by incarcerated and non-incarcerated women when making decisions about their pregnancies and birthing experiences. While prisoners generally operate under comprehensive restrictions, such that even dramatic restraints may seem predictable albeit concerning, women outside of the prison context are not usually viewed as subject to such direct and complete state control. When many of the same issues faced by incarcerated women arise outside of prison walls, it becomes less plausible that constraints solely reflect incarcerative status.

This is why the focus on shackling has obscured the more universal nature of constraints. Shackling is something generally foreign to non-incarcerated pregnant and laboring women – women outside of prison are not physically restrained while pregnant and are not dramatically held in metal shackles during labor. Because it is so different than what is experienced by non-incarcerated women, the focus on shackling creates two conceptual difficulties. First, to some extent, the shackling focus conceptualizes the problem of the regulation of pregnant prisoners as a subset of the problem of how we generally treat prisoners.[12] While there is much to be said for critically read-

/files/pdfs/mothersbehindbars2010.pdf (offering assessment of state laws on a variety of issues of concern to incarcerated pregnant women and mothers, including shackling as one of four major subjects); *see also* Kelly Parker, *Pregnant Women Inmates: Evaluating the Rights and Identifying Opportunities for Improvements in Their Treatment*, 19 J. L. & HEALTH 259 (2004-05) (discussing the health care issues raised by being pregnant in prison and legal mechanisms for ensuring adequate care); *cf.* Hum. Rights Program at Justice Now, *Prisons as a Tool of Reproductive Oppression*, 5 STAN. J. C.R. & C. L. 309 (2009) (documenting a variety of ways in which prisons are destructive of the reproductive capacities of female inmates).

12. The literature on how our culture degrades and disempowers individuals charged or convicted of crimes, and in particular prisoners, is voluminous. *See, e.g.*,

ing the practice of shackling pregnant prisoners as a particularly objectionable iteration of our culture's persistent quest to racialize, stigmatize, and dehumanize those accused or convicted of crimes,[13] in this case it is only part of the story.

Second, this conceptualization distracts us from the broader issue of how our culture regulates and constrains women in pregnancy and childbirth, not just inside but also outside of the penal context.[14] Exploration of the specific complaints and horror stories voiced by women in prison reveals striking similarities and connections between the kinds of issues women face birthing in prison and those faced by many women outside of prison.[15] These similarities are particularly marked when it comes to non-incarcerated women of color, poorer women, and members of other stigmatized demographic groups.[16] Moreover, in assessing the dynamics of social control imposed

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MICHELE ALEXANDER, THE NEW JIM CROW: MASS INCARCERATION IN THE AGE OF COLORBLINDNESS (2012) (exploring the degree to which the modern prison system functions as a comprehensive system of racial othering); DAVID GARLAND, THE CULTURE OF CONTROL: CRIME AND SOCIAL ORDER IN CONTEMPORARY SOCIETY (2001) (describing and exploring the reasons for the rise of a particularly punitive modern penal order); Sharon Dolovich, *Cruelty, Prison Conditions, and the Eighth Amendment*, 84 N.Y.U. L. REV. 881, 894 (2009) (discussing doctrinal ramifications of the fact that "the structure and culture of the contemporary American prison often operate to dehumanize prisoners"); *cf*. MICHELLE ALEXANDER, *Foreword* to INSIDE THIS PLACE, NOT OF IT: NARRATIVES FROM WOMEN'S PRISONS (Robin Levi & Ayelet Waldman, eds.) 11, 12-13 (2011) ("Our nation is awash in punitiveness, for reasons that have stunningly little to do with crime or crime rates. . . . Collectively, our nation has turned away with cruel indifference, leaving the millions of people behind bars out of sight and out of mind.").

13. *See, e.g.*, Ocen, *supra* note 7 (finding that the popularity of shackling pregnant prisoners derives from a long cultural tradition of constraining, degrading, and criminalizing sexuality and reproduction of African-American women). Ocen's work, and other similar views of shackling, draw heavily on the important work of other scholars who have focused their attention on the racialized nature of the modern mass incarceration state, *see, e.g.*, ALEXANDER, *supra* note 12, and on the persistent pattern of regulation and criminalization of the sexuality of African American women, *see, e.g.*, DOROTHY E. ROBERTS, KILLING THE BLACK BODY: RACE, REPRODUCTION, AND THE MEANING OF LIBERTY (1997).

14. *See generally infra* Part II and works cited therein.

15. *See generally infra* Part III.

16. As lawyers, doctors, and theorists have consistently observed, social norms, professional hierarchies, and threats of legal coercion have worked to constrain the choices and experiences of pregnant women writ large, but have applied greater constraints and imposed higher dignity and autonomy costs upon those already marginalized by race, class, marital status, or disability. For one particularly insightful examination of these intersections, see Lisa C. Ikemoto, *The Code of Perfect Pregnancy: At the Intersection of the Ideology of Motherhood, the Practice of Defaulting to Science, and the Interventionist Mindset of Law*, 53 OHIO ST. L.J. 1205 (1992). For the strongest voice on the particularly onerous ways in which law regulates African-American pregnancy, see the works of Dorothy Roberts including Roberts, *supra* note 13, and

upon pregnant women, it is worth noting that the categories of incarcerated and non-incarcerated pregnant women are themselves porous; as I describe below, the choices that pregnant and laboring women make at times expose them to criminal prosecution and incarceration.[17]

This Article tells a story about the regulation of pregnancy and childbirth in the era of mass incarceration – a story that will connect scenes shot inside prisons with those captured in ordinary hospitals, doctors' offices, and homes. Part I describes the various categories of administrative policies, sentencing conditions, and other obstacles that pregnant women face while housed in jail or prison. Part II catalogues the constraints that non-incarcerated women face when making decisions about continuing their pregnancies and giving birth, paying particular attention both to those constraints backed by the explicit or implicit threat of legal sanction and to the demographics of women threatened with the most coercive mechanisms of control. Part III argues that the story of regulated pregnancy and childbirth both in and out of prison is rooted in how we construct motherhood and, in particular, how we conceptualize mothers from disadvantaged groups and constrain their choices. Incarceration is not, this Article argues, the status that authorizes control – it is the broader social status of women that authorizes control, particularly the status of poor and minority women, constructed as "bad mothers" who should not be pregnant or birthing in the first place.

This Article does not so much challenge the existing literature on the social meaning of restrictions on the reproductive freedom of incarcerated women as augment it. The constraints and indignities imposed on pregnant prisoners are an outgrowth not only of patterns of social control of prisoners (and other unfree labor)[18] but also of patterns of social control of pregnant women more generally. Like our criminal sanctions regime, these pregnancy-specific patterns of control reflect and reinforce complicated ideas about race, class, and gender, and offer important insights into our culture's values and preoccupations. Critically reading the experiences of women who are pregnant or laboring behind bars requires appreciation that their treatment stems from two distinct, though often overlapping, matrices of social control.

Dorothy E. Roberts, *Punishing Drug Addicts Who Have Babies: Women of Color, Equality, and The Right of Privacy*, 104 HARV. L. REV. 1419 (1991).

17. *See infra* notes 33-41, 167-176 and accompanying text; *see also* Lynn M. Paltrow & Jeanne Flavin, *Arrests of and Forced Interventions on Pregnant Women in the United States, 1973-2005: Implications for Women's Legal Status and Public Health*, 38 J. HEALTH POL. POL'Y & L. 299 (2013) (collecting and analyzing incidents when the choices that pregnant and laboring women make expose them to criminal prosecution and incarceration).

18. *See* Ocen, *supra* note 7, at 1258-74 (discussing the legacy of slavery, chain gangs, and convict leasing in setting the stage for shackling of imprisoned women of color).

I. INCARCERATED PREGNANCY AND IMPRISONED CHILDBIRTH

A. The Scope of the Affected Population

The number of women who are affected by jail and prison policies related to childbirth has exploded in the past several decades as the general population of incarcerated women has grown dramatically. Since 1983, there has been an eight-fold increase in the female incarcerated population in the United States,[19] and, since 1985, the rate of incarceration for women has increased about twice as much as the rate for men.[20] The overwhelming majority of women who are incarcerated – approximately two-thirds of those in state prisons – are incarcerated for nonviolent offenses.[21] Women of color make up the bulk of incarcerated women: nearly half of incarcerated women are African-American, and approximately two-thirds of incarcerated women are members of minority groups.[22] The number of women who are detained for civil immigration violations also has increased markedly during this period, and many women detained for immigration violations are held in the same jails used to house women who are awaiting disposition of criminal cases or who are serving sentences for criminal convictions.[23]

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19. *See Sourcebook of Criminal Justice Statistics*, *supra* note 1 (showing total number of women incarcerated for each year).

20. *See Women in the Criminal Justice System: Briefing Sheets*, SENTENCING PROJECT (May 2007), http://www.sentencingproject.org/doc/publications/womenincj_total.pdf; *see also Sourcebook of Criminal Justice Statistics*, *supra* note 1 (calculating that, since 1980, the rate of female incarceration has increased at about one and a half times the rate of male incarceration).

21. *See* Greene & Pranis, *supra* note 3.

22. The exact figures are a matter of dispute. For the last study by the Bureau of Justice Statistics, which is over a decade old, see Lawrence A. Greenfeld & Tracy L. Snell, U.S. DEP'T OF JUST. (2000), http://www.bjs.gov/content/pub/pdf/wo.pdf (black women represent 35% of federal prisoners, 48% of state prisoners, and 44% of inmates of local jails; Hispanic women account for 32% of federal, 15% of state, and 15% of local prisoners; white women constitute 29% of federal, 33% of state, and 36% of local prisoners; women of other races make up 4% of federal, 4% of state, and 5% of local prisoners).

23. In this Article, I primarily focus on women who have been detained in jail or prison based on criminal prosecution or conviction. Many women who are suspected of civil immigration violations are also held in jails at various points of the proceedings, and may face issues similar to those criminally charged. *See* Dan Frosch, *Report Faults Treatment of Women Held in Immigration Centers*, N.Y. TIMES, Jan. 21, 2009, at A23 (stating that over 3,000 women are held in immigration detention centers every night and discussing a report that details problems faced by such women, particularly with regard to pregnancy and birth). Indeed, the vast majority of authorized federal detention facilities are local jails with which the Department of Homeland Security has a contractual relationship. *See* Jonathan Simon, *Refugees in a Carceral Age: The Rebirth of Immigration Prisons in the United States*, 10 PUB. CULTURE 577, 579 (1998); *see also Detention Facility Locator*, U.S. IMMIGR. & CUSTOMS

Pregnancy is not an uncommon experience for women who are incarcerated. It is unsurprising that many women enter jail and prison pregnant – demographically, female prisoners generally are of childbearing age,[24] and the majority of them are mothers to minor children.[25] Women with young children are, in fact, the fastest growing incarcerated population.[26] It is difficult to get a handle on exactly what percentage of women enter prison pregnant, as states are not required to maintain data about pregnancy and birth in jails and prisons. Forty-nine states, in fact, do not report incarcerated women's pregnancies or their outcomes,[27] but the best estimates put the incoming pregnancy rate at somewhere between five and ten percent.[28] A small additional percentage of women become pregnant while incarcerated.[29] Some

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ENFORCEMENT, http://www.ice.gov/detention-facilities/ (last visited Mar. 4, 2015) (providing a full list of facilities in which detainees are held). The treatment of pregnant women in these facilities has recently drawn some attention because, while the Federal Bureau of Prisons bans shackling of pregnant prisoners, federal immigration detainees held in state prisons are subject to whatever protocols the local facility utilizes. *See, e.g.*, Cristina Constantini, *It's Still Legal to Shackle Women During Childbirth in America*, ABC NEWS (June 25, 2013), http://abcnews.go.com/ABC_Univision/News/legal-shackle-women-childbirth-immigration-detention/story?id=19481909. Senators Patty Murray and Mike Crapo recently introduced legislation to prohibit the shackling of such prisoners. *See id.*

24. More than half of women who are held in jail or prison are under the age of thirty-five. *See There Are Over 97,000 Women in Prison Today. They Are . . .*, WOMEN'S PRISON ASSOC. 1 (Dec. 2003), http://66.29.139.159/pdf/Focus_December2003.pdf (reporting that the median age for female prisoners is thirty-four). As of 1999, the average age of women in federal prison was thirty-six; in state prison, thirty-three; and in jail, thirty-one. *See* Greenfield & Snell, *supra* note 22, at 7.

25. *See supra* notes 5-6 and sources cited therein (calculating that approximately 64% of imprisoned women lived with minor children in the months before their arrest or imprisonment and that roughly two-thirds of those lived in single-parent households).

26. *See* Carrie Golus, *Research: Investigations: Moms Behind Bars*, U. OF CHI. MAG., June 2003, at 10.

27. *See Mothers Behind Bars*, *supra* note 11, at 6.

28. *Compare* Tracy L. Snell, *Survey of State Prison Inmates, 1991: Women in Prison*, U.S. DEP'T OF JUST. 10 (1999), http://www.bjs.gov/content/pub/pdf/SOSPI91.PDF (estimating 6% of women entered prison pregnant in 1991) *with* Diana J. Mertens, *Pregnancy Outcomes of Inmates in a Large County Jail Setting*, 18 PUB. HEALTH NURSING 45, 45 (2001) (estimating 10% of female inmates enter prison pregnant).

29. While discussion of the pervasive problem of sexual assault in prisons and jails is beyond the scope of this Article, it is worth underscoring the degree to which such assaults multiply and magnify the difficulties of providing adequate reproductive and mental health services to women in prisons. Over the last two decades, scholars and commentators have produced sophisticated and insightful literature on the complicated issues related to sexuality and sexual assault in the prison context. For some of the significant works dealing with these issues, particularly in the context of sexual contact between female prisoners and male employees, see Cheryl Bell et al., *Rape*

percentage of incarcerated women terminates pregnancies electively.[30] While the figures, again, are imprecise, it seems that about two thousand babies are born to incarcerated women each year.[31]

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and Sexual Misconduct in the Prison System: Analyzing America's Most "Open" Secret, 18 YALE L. & POL'Y REV. 195 (1999) (discussing abuse of women in prison); Buchanan, *supra* note 3, at 56 (detailing the pervasiveness of the problem of sexual assault in prisons and offering doctrinal modifications to help provide legal redress); Kim S. Buchanan, *Our Prisons, Ourselves: Race, Gender, and the Rule of Law*, 29 YALE L. & POL'Y REV. 1, 23-46 (2010) (discussing the issue of sexual assault in prisons with special attention to racial dimension); Angela Davis, *Public Imprisonment and Private Violence: Reflections on the Hidden Punishment of Women*, 24 NEW ENG. J. ON CRIM. & CIV. CONFINEMENT 339 (1998) (finding that the issue stems from deeper pathologies of the modern prison system); Brenda V. Smith, *Sexual Abuse of Women in United States Prisons: A Modern Corollary of Slavery*, 33 FORDHAM URB. L.J. 571 (2006) (describing the sexual abuse of female prisoners in a historical context); Brenda V. Smith, *Rethinking Prison Sex: Self-Expression and Safety*, 15 COLUM. J. GENDER & L. 185 (2006) (engaging with complicated questions related to autonomy and sexuality of female prisoners); Brenda V. Smith, *Watching You, Watching Me: Cross-Gender Supervision of Prisoners*, 15 YALE J.L. & FEMINISM 225 (2003) (offering vivid descriptions of problems of sexual violence and harassment in prison and discussing underlying problems posed by cross-gender supervision).

Over the same timeframe, government officials and watchdog groups have paid increased attention to the problems of sexual violence behind bars and lawyers and advocates have, with at least some success, pursued litigation and legislation to prevent or ameliorate sexual assault in prisons. *See generally* Prison Rape Elimination Act of 2003 §§ 1–9, 42 U.S.C. §§ 15601–15609 (2012 & Supp. 2013) (federal legislation acknowledging problem and taking some steps to ameliorate it); Women Prisoners of the D.C. Dep't of Corr. v. District of Columbia, 877 F. Supp. 634, 665 (D.D.C. 1994), *vacated in part*, *modified in part*, 899 F. Supp. 649 (D.D.C. 1995) (groundbreaking class-action lawsuit achieving at least some relief for inmate victims of sexual assault and harassment); *Abuse of Women in Custody: Sexual Misconduct and Shackling of Pregnant Women*, *supra* note 7; *All Too Familiar: Sexual Abuse of Women in U.S. State Prisons 1996*, HUMAN RIGHTS WATCH (1996), http://www.hrw.org/reports/1996/Us1.htm; *Report on Sexual Victimization in Prisons and Jails*, U.S. DEP'T OF JUST. (Apr. 2012), http://www.ojp.usdoj.gov/reviewpanel/pdfs/prea_finalreport_2012.pdf (monitoring the problem and providing data). Even to the narrow extent that this Article deals with the sexual activity of prisoners and the implications for their reproductive and mental health, it does not engage with the complicated theoretical issues related to prisoner sexuality or gender identity, *see, e.g.*, Russell K. Robinson, *Masculinity As Prison: Sexual Identity, Race, and Incarceration*, 99 CAL. L. REV. 1309 (2011), or to the dynamics of consent and coercion in a correctional environment, *see, e.g.*, Smith, *Rethinking Prison Sex: Self-Expression and Safety*, *supra*.

30. Other authors have written thoughtfully about abortion access for incarcerated women and have noted that women who are incarcerated often have difficulty accessing elective pregnancy termination, as they generally are poor; may be required to pay for the procedure itself as well as transportation and other services incidental to access; and may otherwise be required to navigate (without legal counsel) prison and/or court processes in order to obtain an abortion. *See* Thomas M. Blumenthal &

That many women enter prison pregnant and/or give birth while incarcerated is not just a function of the fact that women of childbearing age make up the bulk of incarcerated women. Pregnancy behavior can itself be a trig-

Kelly M. Brunie, *The Absence of Penological Rationale in the Restrictions on the Rights of Incarcerated Women*, 32 U. ARK. LITTLE ROCK L. REV. 461 (2010) (discussing dignity-based rationales for protecting the right to abortion); Elizabeth Budnitz, Note, *Not a Part of Her Sentence: Applying the Supreme Court's* Johnson v. California *to Prison Abortion Policies*, 71 BROOK. L. REV. 1291, 1294 (2006) (focusing on degree to which access to abortion turns on informal policies and personal whims of prison officials and discussing the split results in cases arguing that these obstacles violate the Constitution); Claire Deason, Note, *Unexpected Consequences: The Constitutional Implications of Federal Prison Policy for Offenders Considering Abortion*, 93 MINN. L. REV. 1377 (2009) (focusing on federal administrative policies that place obstacles in the path of inmates seeking an abortion); Mark Egerman, Comment, Roe v. Crawford: *Do Inmates Have an Eighth Amendment Right to Elective Abortions*?, 31 HARV. J.L. & GENDER 423 (2008) (discussing prisoner abortion rights as an Eighth Amendment issue); Avalon Johnson, Note, *Access to Elective Abortions for Female Prisoners Under the Eighth and Fourteenth Amendments*, 37 AM. J. L. & MED. 652 (2011) (reviewing the literature and case law); Diana Kasdan, *Abortion Access for Incarcerated Women: Are Correctional Health Practices in Conflict with Constitutional Standards?*, 41 PERSP. ON SEXUAL & REPROD. HEALTH 59 (2009) (presenting results from nationwide survey of correctional health care providers describing abortion access and barriers); Angela Thomas, Note, *Inmate Access to Elective Abortion: Social Policy, Medicine and the Law*, 19 HEALTH MATRIX 539 (2009) (proposing reforms to increase access to abortions for prisoners).

While the Supreme Court has never addressed the abortion rights of prisoners, a number of cases have reached appellate courts. The majority of courts have held that prisoners possess a constitutional right to terminate their pregnancies at their own expense, striking down, for example, requirements that prisoners get a court order to obtain an abortion or blanket policies prohibiting their transfer off-site for such a procedure. Other courts have determined otherwise, applying strong deference to prison regulations that make elective abortions difficult or impossible. *Compare* Roe v. Crawford, 514 F.3d 789 (8th Cir. 2008) (holding that the policy of prohibiting transportation of pregnant inmates off site to receive elective, nontherapeutic abortions is unconstitutional), *and* Monmouth Cnty. Corr. Institutional Inmates v. Lanzaro, 834 F.2d 326 (3d Cir. 1987) (policy requiring court order for inmate abortion unconstitutional) *with* Victoria W. v. Larpenter, 369 F.3d 475 (5th Cir. 2005) (no constitutional right), *and* Gibson v. Matthews, 926 F.2d 532 (6th Cir. 1991) (holding that prison officials are entitled to qualified immunity from an inmate's claim that the Fifth, Eighth, and Ninth Amendments protect pregnant inmates' right to elective abortions and that the officials' conduct in this particular case in question did not amount to a constitutional violation). While I focus in this Article on women who are continuing pregnancies and experiencing childbirth, rather than on access to elective abortion care, I wanted to note that some subset of incarcerated women who are pregnant and/or who give birth might make different choices about continuing their pregnancies if they were not incarcerated, and do not suggest that all such pregnancies are welcome or chosen.

31. *See* Adam Liptak, *Prisons Often Shackle Pregnant Women in Labor*, N.Y. TIMES (Mar. 2, 2006), http://www.nytimes.com/2006/03/02/national/02shackles.html ?pagewanted=all (citing figures calculated by the Sentencing Project).

ger for criminal prosecution and incarceration. Where women have engaged in behavior that plausibly might cause or might have caused harm to a developing fetus, women have been criminally prosecuted under various criminal statutes and pursuant to varying theories of liability.[32] Most of these cases have involved women who ingested illegal drugs during their pregnancies, although many have involved other behaviors.[33] The fact that pregnancy and childbirth choices are subjected to criminal prosecution, in fact, is part of why Part II of this Article argues that the constraints faced by pregnant women are not confined to the prison setting, but, rather, may introduce them to it.

Even where women are not prosecuted for offenses that involve fetal harm, the fact that a woman is pregnant may affect sentencing decisions after conviction.[34] While health care experts do not consider prison a healthy setting for pregnancy,[35] and while, as discussed below,[36] prisons have been sued

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32. *See infra* notes 167-176 and accompanying text. I explore this issue further in Parts II and III.

33. *See, e.g.*, State v. McKnight, 576 S.E.2d 168 (S.C. 2003) (permitting a woman to be prosecuted for homicide by child abuse where she had used cocaine during pregnancy and fetus was stillborn); Whitner v. State, 492 S.E.2d 777 (S.C. 1997) (permitting child endangerment prosecution where pregnant woman ingested cocaine); Ferguson v. City of Charleston, 532 U.S. 67 (2001) (finding Fourth Amendment violation in program that drug tested women at hospital to give birth and arrested those who tested positive for drugs). I discuss the issue in more depth and provide more citations in Deborah Ahrens, *Methademic: Drug Panic in an Age of Ambivalence*, 37 FLA. ST. U. L. REV. 841, 855 n.68 (2010); *see also* LAURA E. GOMEZ, MISCONCEIVING MOTHERS: LEGISLATORS, PROSECUTORS, AND THE POLITICS OF PRENATAL DRUG EXPOSURE (1997); Ellen Marrus, *Crack Babies and the Constitution: Ruminations About Addicted Pregnant Women After* Ferguson v. City of Charleston, 47 VILL. L. REV. 299, 301-02 (2003); Paltrow & Flavin, *supra* note 17; Loren Siegel, *The Pregnancy Police Fight the War on Drugs*, *in* CRACK IN AMERICA: DEMON DRUGS AND SOCIAL JUSTICE (C. Reinerman & H. Levine, eds., 1997). These prosecutions have often occurred in the face of tenuous evidence of a relationship between illicit drug use and fetal harm, as those prosecuted tend to be poor, lack prenatal care, and have other high-risk pregnancy factors that one would expect to lead to poor pregnancy outcomes. *See* Ahrens, *supra*, at 855 n. 66. For the more limited use of creative strategies to prosecute mothers who used methamphetamine while pregnant, see *id*. at 883-84. For one of the most controversial attempts to prosecute a pregnant woman for conduct that harmed a fetus, see Carrie Ritchie, *Indy Woman's Suicide Attempt, Baby's Death Sparks National Cause*, INDY STAR ONLINE (Jan. 5, 2013), http://www.indystar.com/article/20130105/NEWS02/130105015/Indy-woman-s-suicide-attempt-baby-s-death-spark-national-cause (discussing prosecution of woman for suicide attempt that killed fetus).

34. This is especially true with regard to women who judges believe have a substance abuse problem. *See* Siegel, *supra* note 33, at 250-51.

35. *See, e.g.*, Brief of Medical, Public Health, and HIV Experts as Amicus Curiae, U.S. v. Quinta Layin Tuleh, No. 09-19-B-W (1st Cir. June 15, 2009), *available at* http://advocatesforpregnantwomen.org/Brief.pdf, at 7 ("The American Medical Association, the American College of Obstetricians and Gynecologists, the American Academy of Pediatrics, the March of Dimes, the National Association of Public Child

repeatedly for failure to provide adequate medical care, some judges determine that a pregnant woman and her fetus will have access to a safer environment or better health care in jail or prison.[37] Most cases where a judge has taken pregnancy into account in augmenting a sentence are unpublished or unpublicized.[38] In one case that garnered substantial media attention, Quinta Layin Tuleh, an HIV-positive pregnant woman, was convicted in federal court for possessing false immigration documents.[39] While the federal sentencing guidelines, the Assistant United States Attorney prosecuting the case, and the defense attorney all recommended time served for the defendant, the judge sentenced her instead to a term of 238 days specifically to ensure that she would be incarcerated for the duration of her pregnancy, arguing,

> My obligation is to protect the public from further crimes of the defendant, . . . and that public, it seems to me at this point, should likely include that child she's carrying. I don't think the transfer of HIV to an unborn child is a crime technically under the law, but it is as direct and as likely as an ongoing assault.[40]

Welfare Administrators, the American Nurses Association and the Center for the Future of Children, the National Perinatal Association, and the American Psychiatric Association all oppose attempts to protect or improve fetal health by incarcerating pregnant women." (citations omitted)); Jenni Vainik, Note, *The Reproductive and Parental Rights of Incarcerated Women*, 46 FAM. CT. REV. 670, 677-78 (2008) ("Prison healthcare consistently falls below federal and professional standards because it fails to address inmates' specific needs in regard to pregnancy, as well as substance abuse, abuse by corrections officers, and HIV/AIDS.").

36. *See infra* notes 150-156 and accompanying text.

37. *See infra* notes 150-156 and accompanying text.

38. *Cf.* Paltrow & Flavin, *supra* note 17, at 304 ("In general, it is not possible to identify and document cases that have not resulted in published court opinions and that were neither reported by the media nor brought to public attention by clients, counsel, or other concerned parties."). In conversations among defense lawyers, particularly lawyers who have extensively represented low income clients, discussions of such anecdotes are commonplace. During my time in practice, I remember vividly one instance in which a judge explicitly ordered a client into custody solely for the purpose of ensuring that she would be incarcerated for the remainder of her pregnancy. One similar story is recounted in Debra Cassens Moss, *Pregnant? Go Directly to Jail*, 74 A.B.A. J. 20 (Nov. 1, 1988) (describing judge who sentenced pregnant woman to jail on check forging charges over a prosecutorial recommendation of probation because she had tested positive for cocaine, commenting "I'll be darned if I'm going to have a baby born that way").

39. *See, e.g.*, Lynn Harris, *Jailed For Her Child's Own Good?, District Judge Orders Woman To Give Birth in Federal Prison*, SALON (June 3, 2009, 12:04PM), http://www.salon.com/2009/06/03/bangor_judge/.

40. *Id.* (internal quotation marks omitted).

In this particular case, the First Circuit reversed the sentencing judge and the defendant ultimately was sentenced to time served,[41] but the impulse to sentence a pregnant defendant to an incarcerative term for the good of the fetus is one that has driven similar sentences.[42]

B. Prison-Based Pregnancy and Birthing Issues

That pregnant and birthing women experience issues accessing appropriate health care during incarceration should not be surprising. Scholars, advocates, and medical professionals have offered broad and scathing critiques of prison health care provision,[43] and innumerable lawsuits have challenged correctional health care, either directly or as part of larger systemic complaints.[44] Many such lawsuits have identified particular concerns with health services provided to women.[45] As noted above, a substantial number

41. *See* Judy Harrison, *Judge Resentences HIV-Positive Woman to Time Served*, BANGOR DAILY NEWS (Aug. 4, 2009, 2:09PM), http://bangordailynews.com/2009/08/04/news/judge-resentences-hivpositive-woman-to-time-served/. A brief filed at sentencing on behalf of twenty-eight public health experts, advocates, and organizations, as well as a declaration from a prison expert, agreed that prison was not an appropriate or healthy environment for the defendant's pregnancy and delivery. *See* Brief of Medical, Public Health, and HIV Experts as Amicus Curiae, *supra* note 35. After filing an appeal, the defendant successfully moved for release on bail pending appeal and was provided with community health care upon release. *See* Harrison, *supra*.

42. Deborah L. Rhode, *The Terrible War on Pregnant Drug Users*, NEW REPUBLIC (July 7, 2014), http://www.newrepublic.com/article/118681/law-protect-fetuses-actually-punishes-minority-women.

43. *See, e.g.*, Elizabeth Alexander, *Prison Health Care, Political Choice, and the Accidental Death Penalty*, 11 U. PA. J. CONST. L. 1 (2008); Amy Vanheuverzwyn, Note, *The Law and Economics of Prison Health Care: Legal Standards and Financial Burdens*, 13 U. PA. J.L. & SOC. CHANGE 119, 120 (2010); G. Nicholas Wallace, *The Real Lethal Punishment: The Inadequacy of Prison Health Care and How It Can Be Fixed*, 4 FAULKNER L. REV. 265 (2012); John J. Gibbons & Nicholas de B. Katzenbach, *Confronting Confinement: A Report of the Commission on Safety and Abuse in America's Prisons*, VERA.ORG (2006), http://www.vera.org/sites/default/files/resources/downloads/Confronting_Confinement.pdf.

44. The Supreme Court has held that prisoners suffer a constitutional deprivation where a prison acts with "deliberate indifference to serious medical needs" of a prisoner. Estelle v. Gamble, 429 U.S. 97, 106 (1976). Allegations of improper or inadequate prison-provided health care comprise one of the four largest categories of inmate lawsuits. *See* Margo Schlanger, *Inmate Litigation*, 116 HARV. L. REV. 1555, 1571 (2003). The highest profile constitutional challenge to inadequate prison health care over the last decade has been the massive class action lawsuit against California's prison system that has resulted in the release of thousands of prisoners. *See generally* Brown v. Plata, 131 S. Ct. 1910 (2011) (upholding remedial order requiring release of prisoners as remedy for ongoing Eighth Amendment violations related to inadequate prison health care).

45. *See, e.g.*, Women Prisoners of the D.C. Dep't of Corr. v. Dist. of Columbia, 93 F.3d 910 (D.C. Cir. 1996) (alleging, *inter alia*, that the District had not provided

of recent law review articles have addressed the specific issue that women who are pregnant are often shackled, either during transportation for medical care and court proceedings or while actively laboring.[46] (Health concerns attach to all such shackling but particularly to shackling during labor, which often includes being shackled to a hospital bed and/or having one's legs shackled to one another, in violation of medical guidelines and human rights standards.)[47]

Beyond shackling, however, there are a number of other, less publicized challenges and constraints that pregnant and laboring women face while incarcerated. While some of these problems and limitations are the inevitable outgrowth of the general loss of liberty that accompanies incarceration, others are the result of particular prison policies born of callousness or ignorance or of the particular limitations and biases of correctional administrators and employees. Similarly, while a few of these dangers and constraints are in some ways reflective of broader concerns about the manner in which we manage the modern prison system, others are unique to female prisoners, women of child-bearing age, or pregnant women more specifically.

While it is impossible to develop an exhaustive list of the ways in which incarceration imposes costs and limitations upon pregnant women, the following pages attempt to catalog some of the problems that appear to be most common or most concerning. As data collection in the prison context is often difficult, data collection with regards to female prisoners is doubly difficult,[48] and data collection with regard to pregnant prisoners is barely even attempted.[49] Most of what follows is, of necessity, drawn from anecdotal reports, press coverage, and litigation papers.[50] These issues do, however, arise with sufficient frequency that they most likely reflect systemic problems or common occurrences rather than isolated incidents.

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adequate medical care for female prisoners, and that, specifically, care for gynecological needs, sexually transmitted diseases, and prenatal care were deficient, and that use of restraints on pregnant prisoners during transportation was inappropriate); Todaro v. Wood, 431 F. Supp. 1129 (S.D.N.Y. 1977) (first action challenging female health care under Eighth Amendment); *see also* Boswell v. Sherburne, 849 F.2d 1117 (8th Cir. 1988) (individual action involving pregnant woman); Archer v. Dutcher, 733 F.2d 14, 15 (2d Cir. 1984) (individual action involving pregnant woman).

46. *See* sources cited *supra* note 7. As also noted *supra*, a smaller number of recent law review articles and advocacy reports have also begun to develop broader critiques of the health care ramifications of being pregnant or giving birth while incarcerated. *See* sources cited *supra* note 11.

47. *See* Sichel, *supra* note 7, at 239.

48. *See generally* Braithwaite et al., *supra* note 4, at 1679 (discussing lack of focus on solving public health problems specific to women in prison).

49. *See Mothers Behind Bars*, *supra* note 11, at 6 (noting that most states do not even keep track of the number of births and pregnancies in prison).

50. In addition to case reports and newspaper accounts, academic articles written by those who have done extensive interviews with female prisoners have proven to be an excellent source of anecdotal information. *See, e.g.*, Levi et al. *supra* note 11.

1. Establishing Pregnancy

First, women who are pregnant may have difficulty persuading correctional officials that they are pregnant in the first place. For women who are not incarcerated, determining pregnancy status can be complicated and emotionally freighted, but pregnancy outside of an incarcerative setting at least involves processes and materials that can be accessed autonomously. Non-incarcerated women may, for example, absent financial or social capital constraints, obtain and utilize home pregnancy tests, communicate with medical personnel, and visit medical facilities in order to obtain services to confirm a pregnancy. An incarcerated woman who is unsure whether she is pregnant or not (or is entirely unaware of the possibility but experiencing troubling symptoms), in contrast, must rely on correctional officers and prison procedures to obtain the necessary care and confirmation. Some facilities perform routine physical or gynecological exams as part of their admitting procedures, but many do not perform perfunctory exams that are likely to discover pregnancies.[51] Nor do such exams assist women who may have become pregnant while incarcerated.[52]

Even if a woman knows or strongly suspects that she is pregnant, she must still rely on the assistance of others to access prenatal care or otherwise have her pregnancy officially acknowledged. Securing access to health care often requires that a woman convince an individual correctional official that she is pregnant, a step that is often surprisingly difficult given the incentives of the parties and the general lack of trust between the detained and detainee.

The case of Imka Pope provides a worst-case illustration of why this feat may be more difficult than it might seem. Pope was booked into the King County Jail in Seattle after she had been arrested by police for sleeping on a city bus stop bench.[53] While she told corrections officers at the jail that she was pregnant, corrections officers believed her to be mentally ill and to be either deluded about the existence of a pregnancy or feigning the existence of her pregnancy.[54] As it turned out, she was both mentally ill and pregnant, and, after a week in custody, corrections officials discovered their error when they heard an infant crying from her cell, where she had given birth on the floor.[55]

While it may be rare for an incarcerated woman's claim of pregnancy to be disbelieved long enough to result in the birth of a baby, particularly in the

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51. *See, e.g.*, Women Prisoners of the D.C. Dep't of Corr. v. Dist. of Columbia, 877 F. Supp. 634, 643-44 (D.D.C. 1994*), vacated in part, modified in part*, 899 F. Supp. 649 (D.D.C. 1995) (detailing failure to perform exams at intake).

52. *See* discussion *supra* note 29 and accompanying text.

53. Christine Clarridge, *Jury Gives $975K to Woman Who Gives Birth Alone on Floor in Jail Cell*, SEATTLE TIMES (Feb. 4, 2012), http://seattletimes.com/html/localnews/2017419232_inmatebaby04m.html?prmid=obinsource.

54. *Id.*

55. *Id.* Pope was awarded $975,000 in damages pursuant to her Section 1983 suit against King County. *Id.*

context of convicted women serving prison sentences, delays in establishing pregnancy are more common and may have significant health consequences for the woman and/or the fetus.[56] For example, the failure to acknowledge an inmate's pregnancy may result in the denial of prenatal care,[57] inadequate nutritional support,[58] continuation of unsafe work assignments,[59] or limitations on a prisoner's ability to terminate an unwanted pregnancy.[60]

2. Accessing Appropriate Prenatal Care

Second, women who are incarcerated while pregnant may have difficulty accessing appropriate prenatal care. While jails and prisons are constitutionally obligated to provide sufficient medical care to prisoners,[61] the availability of particular services – even necessary services – varies from facility to facility. The availability of obstetric and gynecological services is particularly touch and go.[62] Until recently, many facilities with large female populations lacked onsite (or reasonable offsite) access to obstetricians, gynecologists, or physician's assistants/nurses with appropriate obstetric or gynecological training.[63] While the staffing of larger women's facilities has improved to some degree,[64] largely in response to litigation,[65] most jails and

56. *See, e.g.*, Goebert v. Lee Cnty., 510 F.3d 1312 (11th Cir. 2007) (describing incident in which baby was stillborn after mother was allegedly denied medical care by guards who doubted her pregnancy); Norton v. Greene Cnty., No. 2:11-CV-157, 2012 WL 729837, at *1 (E.D. Tenn. Mar. 6, 2012) (describing incident in which woman had miscarriage after being denied prenatal care by officials who disbelieved her claim of pregnancy).

57. *Cf. infra* notes 66-80 and accompanying text.

58. *Cf. infra* notes 84-88 and accompanying text.

59. *Cf. infra* note 92 and cases cited therein.

60. The current constitutional regime regulating abortion places great weight on the gestational age of the fetus. *See generally* Planned Parenthood v. Casey, 505 U.S. 833 (1992). Thus, even short delays in acknowledging a pregnancy may have big consequences for a prisoner's reproductive rights.

61. *See generally* Estelle v. Gamble, 429 U.S. 97 (1976) (establishing that constitutional duty not to inflict pain on prisoners requires prisons to provide health care to alleviate pain caused by injury or illness).

62. *See Appendix III: Forms of Violence Against Incarcerated Women, Part II: Lack of Adequate Healthcare*, *in* INSIDE THIS PLACE, NOT OF IT: NARRATIVES FROM WOMEN'S PRISONS *supra* note 12 ("Access to obstetrical and gynecological care, a key element of comprehensive healthcare for all women, is at best inconsistent in U.S. women's prisons.").

63. *See, e.g.*, Parker, *supra* note 11, at 280-81 (discussing earlier practices in California prisons).

64. *See, e.g.*, Levi et al., *supra* note 11, at 28 ("Our research suggests that the majority of pregnant people in California's women's prisons are receiving prenatal appointments at medically acceptable intervals."); Parker, *supra* note 11, at 280-81 (discussing agreement by which California has now made onsite gynecological and obstetric care available to inmates at its women's prisons).

many smaller and medium-size prisons continue to offer no access or insufficient access to such professionals.[66]

Even when routine prenatal care is offered on a roughly adequate schedule, women with high-risk pregnancies, other underlying medical conditions exacerbated by pregnancy, or pregnancy complications often are denied the additional services required to ensure care that is adequate in their individual circumstances.[67] To some extent, the failure to adapt schedules and policies to meet the medical needs of individual pregnant women is an inevitable consequence of the standardization and sheer size of the modern mass incarceration state, but other factors – including lack of knowledge, lack of concern, and lack of resources – are also clearly at play in some of the most heart-wrenching narratives.[68]

While inadequate access to prenatal care might be a problem even in an otherwise unremarkable pregnancy,[69] lack of adequate prenatal care is particularly troubling for incarcerated women, who are much more likely than women generally to experience high-risk pregnancies because they are more likely to be poor,[70] to have a history of limited health care and health care

65. The unavailability of such care has been a major issue in most class action litigation involving women's prison conditions. *See, e.g.*, Women Prisoners of the D.C. Dep't of Corr. v. Dist. of Columbia, 877 F. Supp. 634, 648 (D.D.C. 1994), *vacated in part, modified in part*, 899 F. Supp. 649 (D.D.C. 1995); Ellen Barry, *Bad Medicine: Health Care Inadequacies in Women's Prisons*, 16-SPG CRIM. JUST. 38, 40 (2001) (discussing settlement of major lawsuit against California prisons, *Harris v. McCarthy*).

66. *See, e.g.*, Parker, *supra* note 11, at 269 ("The quality of care a pregnant woman will receive is probably dependent on where she serves her sentence. . . . To date, the problems of adequately addressing the needs of pregnant women in correctional facilities remain only somewhat improved."); *Appendix III, supra* note 62, at 235-36 ("Access to obstetrical and gynecological care, a key element of comprehensive healthcare for all women, is at best inconsistent in U.S. women's prisons.").

67. *See, e.g.*, Levi, et al., *supra* note 11, at 28-29.

68. For example, one California prisoner was told by a nurse that her abnormal first-trimester bleeding was normal, was denied access to a doctor until her regularly scheduled exam, then after further complications was brought to a doctor who declined to even examine her after finding out that she had previously birthed seven children. *See* Levi et al., *supra* note 11, at 37 (reporting the story of Michelle Rawson). She subsequently lost the child and had to undergo emergency surgery to protect her own health. *Id.*; *see also id.* at 38-39 (reporting stories of women whose claims of emergency were downplayed or ignored but were later found to be suffering from serious medical conditions such as tubal pregnancies, kidney disease, and bladder infections, in many instances causing serious harm to the mother and/or fetal death).

69. *See* Office on Women's Health, *Prenatal Care Fact Sheet*, WOMENSHEALTH.GOV, http://www.womenshealth.gov/publications/our-publications/fact-sheet/prenatal-care.html (last visited Mar. 5, 2015) (outlining necessity of and timetable for prenatal care in ordinary pregnancy).

70. *See* Parker, *supra* note 11, at 263 (discussing rates of poverty for women in prison and consequences for their health).

access,[71] and to have health problems (such as sexually transmitted diseases and substance abuse) that can create pregnancy complications.[72] The failure to provide adequate prenatal care to high-risk women, a problem in itself, also acts synergistically with other problems in prison health care to substantially increase the likelihood of catastrophic outcomes. Most concretely, high-risk pregnancies are more likely to lead to birthing complications, which, for reasons this Article will discuss shortly, may create particular problems in a prison environment.[73]

Even when women see doctors at appropriate intervals, the quality of care may be poor. Medical personnel, either on their own or under pressure from correctional officials, may feel the need to downplay concerns in order to limit costs, simplify the logistics of treatment and monitoring, and avoid the prescription of medication that might be diverted into the prison economy or might trigger consequences for prisoners with histories of substance abuse.[74] By all reports, similar incentives and structures limit the time medical personnel spend with pregnant patients, shift patients from caregiver to caregiver preventing the formation of stable doctor-patient relationships, and discourage medical personnel from providing inmates with sufficient information about their pregnancies and their impending labor.[75] There is little doubt that the economics and psychology of the modern prison state make the relationship between pregnant inmate and state-supplied physician particularly challenging.[76] Later sections explore the degree to which similar con-

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71. *See* M. Katherine Maeve, *Adjudicated Health: Incarcerated Women and the Social Construction of Health*, 31 CRIM. L. & SOC. CHANGE 49, 51 (1999) ("[H]ealth care for women in prison is largely an effort to 'catch up' in that considerable effort is most often necessary to raise women's health status to legally mandated, acceptable levels.")

72. *See* Parker, *supra* note 11, at 263 (reporting substance abuse statistics); American College of Obstetricians & Gynecologists, Comm. on Healthcare for Underserved Women, *Committee Opinion: Reproductive Health Care for Incarcerated Women and Adolescent Females* 1 (Aug. 2012), *available at* http://www.acog.org/~/media/Committee%20Opinions/Committee%20on%20Health%20Care%20for%20Underserved%20Women/co535.pdf?dmc=1&ts=20130711T1304186944 (reporting statistics on sexually transmitted diseases).

73. *See infra* Part I.B.3.

74. In one case, jail records provided startling evidence of such cost-consciousness, as officials in two different facilities tried desperately to avoid fiscal responsibility for the health care of a pregnant inmate. *See* Boswell v. Cnty. of Sherburne, 849 F.2d 1117, 1123 (8th Cir. 1988).

75. *See* Levi et al., *supra* note 11, at 29, 33-34 (discussing generally, and via reference to specific anecdotes, rushed provision of services, failure to establish consistent doctor-patient relationship, poor attitudes of medical personnel, and lack of trust between doctors and pregnant patients).

76. One article by the authors of a thorough survey of pregnant inmates boldly concludes that "[d]riving all of these abuses is a glaring – and dangerous – lack of concern on the part of medical and non-medical prison staff for the health and well-being of pregnant people." Levi et al., *supra* note 11, at 29.

straints degrade the autonomy and threaten the health of non-incarcerated women.[77]

In addition to their inability to access appropriate medical care, incarcerated women face many other challenges in ensuring an appropriate prenatal environment. For example, incarcerated women may also have difficulty obtaining adequate nutrition to support a pregnancy.[78] While many facilities have policies that permit pregnant women to access additional food and/or provide prenatal supplements,[79] those policies differ from facility to facility and jurisdiction to jurisdiction and depend on the good faith of correctional personnel.[80] Moreover, the underlying quality and, at times, quantity of prison food is so poor that merely providing proportionate increases above the baseline rations does little to ensure sufficient prenatal nutrition.[81] Anecdotal evidence suggests that pregnant prisoners are routinely served food of dangerously poor nutritional quality, dubious food safety, or both.[82] As a result

77. *See infra* Part II.

78. Levi et al., *supra* note 11, at 30-32.

79. *See, e.g.*, *id.* at 31-32 & accompanying notes (describing extra milk, snacks, and vitamin supplements pregnant women receive in California prisons).

80. For example, while California policy requires that pregnant inmates receive additional milk, many other facilities refuse to provide any milk to pregnant women. *See, e.g.*, Patterson v. Carroll Cnty. Detention Ctr., No. 05-101-DLB, 2006 WL 3780552, at *6 (E.D. Ky. Dec. 20, 2006) (alleging that insufficient nutrition, including failure to provide milk contributed to premature stillbirth at local jail); *see also* Olivia Hamilton, *Olivia Hamilton*, *in* INSIDE THIS PLACE, NOT OF IT: NARRATIVES FROM WOMEN'S PRISONS, *supra* note 12, at 25, 30 (narrating how doctor ordered pregnant inmate to eat fresh fruit but local jail did not have and would not supply fruit).

81. The California Department of Corrections spends about half the amount of money per prisoner feeding women as it does men. *See* Laura Gottesdiener, *California Women Prisons: Inmates Face Sexual Abuse, Lack of Medical Care and Unsanitary Conditions*, HUFFINGTON POST (June 30, 2011), http://www.huffingtonpost.com/2011/06/03/california-women-prisons_n_871125.html. One California prisoner complained that pregnant women were served the same inadequate diet as other prisoners plus one apple, carrot, and some milk per day – not nearly enough to meet her nutritional needs. *See* Levi et al., *supra* note 11, at 31 n.164.

82. *See, e.g.*, Levi et al., *supra* note 11, at 31-32; Sheryl Pimlott & Rosemary C. Sarri, *The Forgotten Group: Women in Prisons and Jails*, *in* WOMEN AT THE MARGINS: NEGLECT, PUNISHMENT, AND RESISTANCE 55, 77 (Josefina Figueria-McDonough et al., eds. 2003) (reporting on routinely poor nutrition and occasionally spoiled food and contaminated water served to pregnant inmates); Dan Weikel, *Report Assails Conditions at State Prison for Women: Drug Dealing by Inmates and Staff, Frightful Medical Care, Sexual Abuse and Crowding Among Problems Cited by Legislative Panel*, L.A. TIMES (Apr. 11, 1990), http://articles.latimes.com/1990-04-11/news/mn-979_1_prison-conditions (reporting on a legislative committee report on prison conditions that documented a host of indignities including spoiled food); sources cited *supra* note 11 (describing poor quality and spoiled food served to women prisoners, including one incident in which spoiled fish and fruit cocktail was served to pregnant women).

of these factors, one survey of pregnant prisoners in California concluded that "[n]early every person with whom we spoke raised concerns about her prenatal diet."[83]

Pregnant prisoners may have even more difficulty in accessing simple accommodations necessary for prenatal health that fall outside of the areas of medical care and nutrition. Though litigation is, as discussed below,[84] difficult with respect to medical care and nutritional support, there are at least clearly established standards in precedents in those areas that provide some guidance and incentives to correctional officials.[85] More idiosyncratic requests for relief from conditions that endanger a fetus or impose unnecessary suffering on a pregnant inmate are often met with bureaucratic confusion or indifference, even if they involve accommodations as simple as the provision of a slightly more padded mattress[86] or a transfer from a physically overtaxing or chemically toxic environment.[87]

3. Dealing with Complications and Emergent Deliveries

Perhaps the biggest physical dangers associated with birthing in jail or prison stem from the difficulties inmates face in obtaining prompt and adequate care for serious pregnancy complications and emergency deliveries.[88] To begin with, just as women who are in custody have difficulty convincing corrections officers that they are pregnant, they have trouble persuading corrections officers that they are in labor. While correctional facilities generally

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83. Levi et al., *supra* note 11, at 30.

84. *See infra* notes 150-156 and accompanying text (discussing doctrinal and statutory barriers to effective litigation over these issues).

85. The opinions, standards, and guidelines offered by medical professional organizations, *see* sources cited *infra* notes 144-148, also help standardize expectations when it comes to medical care and nutrition. *See generally* Laube v. Campbell, 333 F. Supp. 2d 1324, 1258 (M.D. Ala. 2004) (approving consent decree with Alabama prison system requiring the provision of prenatal medical care and nutrition according to standards established by professional organizations).

86. *Cf.* Patterson v. Carroll Cnty. Detention Ctr., No. 05-101-DLB, 2006 WL 3780552, at *6 (E.D. Ky. Dec. 20, 2006) (alleging that stillbirth resulted, in part, from requiring pregnant woman to sleep on unpadded mattress on hard concrete floor).

87. *See* Levi et al., *supra* note 11, at 29-30 (detailing stories of Carol Perez, who could not get reassigned from a heavy-lifting job as a porter, and Kara Graham, who could not get reassigned from a cosmetology job filled with noxious chemicals without giving up work credits and delaying her release); *see also* Gerald Austin McHugh, *Protection of the Rights of Pregnant Women in Prisons and Detention Facilities*, 6 NEW. ENG. J. ON PRISON L. 231, 236-37 (1980) (noting resistance of prison guards to requests by pregnant women that they be given work assignments appropriate to their stage of pregnancy on assumption that women were simply shirking more arduous work).

88. For examples of prisons' failure to treat emergent situations, see *supra* note 68. For examples of prisons' failure to respond adequately to early labor, see *infra* notes 92-107 and accompanying text.

have policies that require that laboring women be transported to hospitals during labor,[89] transportation will occur only if a correctional officer orders it.[90] The failure to convince a corrections officer of a pregnancy may delay or deny prenatal care; the failure to convince a corrections officer of labor means that the prisoner is forced to labor in a prison cell without adequate medical care, pain relief, personal support, or hygiene, and in some cases leads to the birth of a baby in a cell.[91]

While labor symptoms may seem easily recognizable and universally understood to require immediate medical attention, there are an astounding number of reported incidents in which correctional officials refused to accept that a pregnant woman was in labor, either delaying transfer for substantial periods or denying it altogether. Many such cases have resulted in litigation. In *Webb v. Jessamine County*, for example, the plaintiff was booked into jail and promptly informed the deputy jailer that she was nine months pregnant.[92] Shortly after booking, she told the corrections officer that she was experiencing pain and vaginal discharge and felt the urge to use the bathroom; a little while later, she told the officer that she was cramping and continued to feel that she needed to use the bathroom.[93] In response, the corrections officer gave her an aspirin substitute.[94] She subsequently took off her clothes, at which point a second corrections officer told her to put her clothes back on and to stop lying and acting like a child.[95] A half an hour later, Webb told the corrections officer that her water had broken; in response, the corrections officer told her to put her wet pants back on and to stop urinating on herself.[96] An hour later, she notified the corrections officer that she believed the baby to be crowning, at which point the corrections officer contacted emergency

89. *See* Rachel Roth, *Justice Denied: Violations of Women's Reproductive Rights in the United States Prison System*, PRO+CHOICE FORUM (Sept. 2004), http://www.prochoiceforum.org.uk/psy_ocr10.php ("For at least twenty-five years, advocates have been reporting that many jails and prisons do not initiate the process to transfer a pregnant woman to an outside hospital until she goes into labor.").

90. *See* McHugh, *supra*, note 87.

91. *See infra* notes 92-107 and accompanying text; *see also* Tom Held, *Two Nurses Fired for Failing to Help Pregnant Inmate*, MILWAUKEE J. SENT., May 26, 1999, (reporting on incident in which prison nurses refused to visit a full-term pregnant woman who said she was in labor because they disliked her and thought she was a "liar" thereby resulting in the birth of a baby in her cell).

92. *See* Webb v. Jessamine Cnty. Fiscal Ct., 802 F. Supp. 2d 870, 875 (E.D. Ky. 2011).

93. *See id.*

94. *See id.* at 875-76.

95. *See id*. at 876.

96. *See id.*

medical services.[97] Webb blacked out and regained consciousness to find that Emergency Medical Services was delivering her (healthy) baby.[98]

Other similar cases abound, each with its own disturbing details: a guard who delayed transfer to complete a headcount;[99] a nurse who did not know how to use a fetal monitor so used the presence or absence of amniotic fluid as the sole criterion for determining if a woman was in labor;[100] a jail that did not recognize the symptoms of pregnancy then, after waiting hours, sent the pregnant woman to a hospital thirty miles away rather than to a much closer facility;[101] a woman who lost an early-term baby that might otherwise have been saved after multiple shifts of jail guards refused to seek medical assistance for her or contact her doctor and instead informed her that she could seek medical assistance after she posted bail.[102] While in some cases the delay in medical care has not led to permanent damage or disability to mother or child,[103] other cases have ended less felicitously. In several reported cases, prisoners had difficulty persuading corrections officers that they were in labor and required medical care and then experienced fetal or infant demise.[104] All of these cases obviously generated physical and emotional distress for the laboring woman.

Even when officials believe that prisoners are in labor or suffering severe complications, there are often substantial delays before prisoners receive the necessary emergency care. Guards routinely prioritize other tasks, become confused as to protocols, or dither inexplicably.[105] Sometimes the per-

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97. *See id.*

98. *See id.* The correctional officers moved for summary judgment in part on the theory that the birth of a healthy baby precluded liability. *See id.* at 881 n.6. The judge denied summary judgment, holding that the healthy baby reduced damages but did not preclude liability, noting, "At the end of it all, Plaintiff delivered a healthy baby and suffered no physical injuries during the delivery, but she was, however, embarrassed and humiliated by the experience." *Id.* at 876; *see also id.* at 881 n.6 (analyzing issue).

99. Pamela Clifton Dep. 19:3-5 (Nov. 13, 2001), No. 00–CV–2555–JLK, Clifton v. Eubank, 418 F. Supp. 2d 1243, 1244 (D. Colo. 2006).

100. *Eubank*, 418 F. Supp. 2d at 1244 (D. Colo. 2006).

101. *See* Patterson v. Carroll Cnty. Detention Ctr., No. 05-101-DLB, 2006 WL 3780552, at *2 (E.D. Ky. Dec. 20, 2006).

102. *See* Boswell v. Cnty. of Sherburne, 849 F.2d 1117, 1119-20 (8th Cir. 1988).

103. *Webb*, 802 F. Supp. 2d at 876.

104. *Boswell*, 849 F.2d at 1120; *Patterson*, 2006 WL 3780552, at *2; Michael P. Buffer, *DA's Office Probes Baby's Death in County Prison*, CITIZEN'S VOICE, Feb. 14, 2002, *available at* 2012 WLNR 3155165 (reporting story of woman who delivered twins at seven months while in county jail, one of whom died after guards delayed notifying nurse); Jill King Greenwood, *Woman Whose Baby Died in Jail Sues*, TAMPA TRIB., Dec. 10, 2004, *available at* 2004 WLNR 18498382 (reporting story of woman whose baby died of a lung infection before making it to the hospital after nurse allegedly ignored complaints of labor pains for ten to twelve hours).

105. *Eubank*, 418 F. Supp. 2d at 1244 (D. Colo. 2006); Richard Gazarik, *Westmoreland Inmate Delivers Baby in Jail*, PITTSBURG TRIB. REV., Oct. 25, 2011, *availa-*

sonnel and resources necessary to transport or care for the laboring or suffering expectant mother are diverted to another emergency or are otherwise unavailable.[106] In facilities with medical personnel on-site, valuable time is often spent determining whether prisoners can be treated at the facility or must be transported to the hospital.[107] To some extent, prison officials and inmates facing difficult pregnancies are caught between a rock and a hard place when it comes to medical staffing decisions: if a facility invests in significant onsite medical care for obstetric patients, prisoners with healthy pregnancies may be well served but those with complications may receive suboptimal care; on the other hand, if the facility decides instead to provide most obstetric care offsite, prisoners with complications may suffer pain, injury, and fetal death while the prison machinery mobilizes for transfer.[108]

4. Autonomy and Safety During Labor

For women outside the correctional context, preparing to deliver a child is an exercise in planning, requiring the expectant mother to make dozens of decisions large and small. While these choices are, as discussed below,[109] often constrained or coerced and are always contingent upon the progress of the pregnancy, they are central to the birthing experience and essential for the maintenance of autonomy and control.[110] As a general matter, pregnant inmates enjoy comparatively less control over their birthing experience. For most inmates, questions of how and when they give birth are dictated by correctional policies and/or the decisions of individual correctional and medical

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ble at 2011 WLNR 21906308 (guard ignored complaints of pain and delayed calling ambulance for no discernible reason; baby born in jail).

106. Ellen M. Barry, *Pregnant Prisoners*, 12 HARV. WOMEN'S L.J. 189, 189 (1989) (discussing case of Louwanna Yeager, who labored alone for three hours and gave birth on a mat outside a prison clinic after being told that she had to wait because no medical staff members were available); Parker, *supra* note 11, at 260 (discussing case of Louwanna Yeager).

107. *See, e.g.*, Coleman v. Rahja, 114 F.3d 778, 781-84 (8th Cir. 1997) (involving complicated case in which seven-months-pregnant prisoner was repeatedly bounced back and forth between a prison doctor and nurse and a local hospital and ultimately labored in her cell before being transported to the hospital moments before birth); Michael P. Buffer, *DA: Prison Officials Followed Procedure During Twin Births*, CITIZENS' VOICE, Apr. 25, 2012, *available at* 2012 WLNR 6681473 (reporting on results of inquiry into death of twin born to mother in county jail who was not transported to hospital with sufficient promptness; report exonerated facility because it "followed protocols," but protocols involved repeated assessments by onsite nurse and guards as to whether to treat on-site or transport to hospital).

108. *See generally* Parker, *supra* note 11, at 263-70.

109. *See generally infra* Part II.

110. For a discussion of the importance of developing a birthing "plan" in the modern literature on managing pregnancy, see MARSDEN WAGNER & STEPHANIE GUNNING, CREATING YOUR BIRTH PLAN: THE DEFINITIVE GUIDE TO A SAFE AND EMPOWERING BIRTH (2006).

officials.[111] This subsection catalogs a number of the crucial birthing decisions that are routinely stripped from pregnant women. Some of the loss of autonomy reflected in the items below is unsurprising given the nature of incarceration and the logistical constraints faced by the state. Other items are more surprising in their lack of necessity, their pettiness, and/or their cruelty.[112]

a. The Timing and Method of Delivery

Women who have given birth while incarcerated persistently complain that correctional administrators and health care providers made decisions for them about when and by what method they would give birth.[113] Evidence suggests that correctional facilities routinely schedule inductions and Cesarean sections ("C-sections")[114] for prisoners that have neither been requested nor deemed medically necessary.[115] To some extent, these decisions are motivated by altruistic or, at least, understandable goals. For example, as discussed above,[116] women who go into labor unexpectedly in their jail cells sometimes face logistical difficulties that may delay transport and threaten maternal and fetal health;[117] scheduled deliveries reduce the likelihood of such a dangerous episode. Similarly, planned deliveries ensure the availability of necessary security, transportation, and medical personnel and resources, protecting health and limiting costs. Despite those considerations, inmates consistently report that officials make these decisions haphazardly and impe-

111. *See generally* Parker, *supra* note 11, at 263-70.

112. *See generally* Hamilton, *supra* note 80.

113. *E.g.*, Wendy Harris, *Policy Keeps Shackles on During Labor*, POST-CRESCENT, Jan. 15, 2006, at 13A (discussing woman whose labor was induced without her prior knowledge or consent).

114. Cesarean has two different accepted spellings: this one, and "Caesarean." *Caesarean Section*, MERRIAM-WEBSTER, http://www.merriam-webster.com/dictionary/cesarean%20section?show=1 (last visited Mar. 7, 2015).

115. *See, e.g.*, Hamilton, *supra* note 80 at 32-34 (narrating the story of the birth of her child while serving six-month prison sentence: state scheduled induction, administered Pitocin, and ordered C-section all without obtaining consent and left her shackled during entire episode). Even when women are allowed to exercise their agency and decline a voluntary induction, they are often subject to repercussions and threats to their safety in retaliation. *See, e.g.*, Doe v. Gustavus, 294 F. Supp. 2d 1003, 1006 (D. Wis. 2003) (woman who declined induction was placed in segregated confinement, then examined only through a door slot when she began to manifest signs of labor, and ultimately delivered in her cell); Levi et al., *supra* note 11, at 45 (reporting on case where pregnant woman declined induction and was "patronized by a nurse and locked in a holding cell for hours without food").

116. *See supra* notes 92-104 and accompanying text.

117. Indeed, one of the complaints commonly lodged against the prison obstetric care during the first wave of lawsuits was that prisons often did nothing to prepare to transfer a pregnant inmate until after labor had started. *See* McHugh, *supra* note 87, at 244.

riously, without sufficient warning or consultation and with disdain for their health and psychological concerns.[118]

Prison officials and medical personnel also routinely schedule C-sections for pregnant women who might be able to labor and deliver vaginally.[119] In particular, prison officials and engaged medical personnel are likely to schedule such procedures for women who have previously delivered a child via C-section.[120] While medical resistance to vaginal births after C-sections ("VBACs") is common with regards to all women,[121] the dynamics of decision making in the prison context bring added pressures to bear on the expectant mother. While prisons probably lack the authority to order a woman to undergo a medically unnecessary C-section if she refuses,[122] pregnant inmates are unable to shop around for sympathetic facilities and providers, often lack the information necessary to make an informed choice, and face potential disciplinary consequences for challenging authority in ways that might be deemed confrontational.[123] This Article discusses the pressure towards C-sections for non-incarcerated women in Part II, demonstrating that while incarcerated women may face some bureaucratic obstacles that non-incarcerated women do not, C-sections are an issue for women generally, not incarcerated women specifically.

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118. In one such case, a woman who was thirty-eight weeks pregnant was informed by corrections officers that she was being transported for a doctor's appointment. Harris, *supra* note 113, at 13A. Instead, she was taken to hospital labor and delivery, where a doctor ruptured her amniotic sac in an attempt to start her labor. *Id.* When that did not work, she was given Pitocin. *Id.* This news article actually focused on the fact that the woman had been shackled during labor and provided her case as an example of the possible problems with the practice of shackling laboring women; the other details were offered in the article in passing. *Id.*; *see also* Hamilton, *supra* note 80, at 33 (doctor examined inmate and said there were no signs of the baby coming anytime soon, but jail officials nevertheless ordered induction – and ultimately a C-section – the next day because Memorial Day weekend was about to start).

119. *See, e.g.*, Levi et al., *supra* note 11, at 44 (detailing the story of Kate Long, who was denied a vaginal birth after C-section and forced into another C-section in California).

120. *Id.*

121. *See generally* Elizabeth Kukura, *Choice in Birth: Preserving Access to VBAC*, 114 PENN. ST. L. REV. 955 (2010) (discussing modern trend discouraging or limiting VBACs and reproductive justice implications of those trends); *see also infra* Part II.C (discussing issue).

122. For a discussion of the right to refuse a C-section and its limitations, see *infra* Part II.B; *see also* Ikemoto, *supra* note 16, at 1240-46 (narrating a significant number of cases before 1992 in which courts ordered C-sections, mostly, though not always, out of claims of medical necessity).

123. *See* Levi et al., *supra* note 11, at 43-44 (discussing the implications of continued correctional control of pregnant prisoners' ability to negotiate the details of their deliveries).

b. Pain Relief

Correctional personnel and affiliated medical staff often make decisions for prisoners about their ability to access pain relief during labor. A variety of pain relief options are available to laboring women, ranging from natural childbirth pain relief methods; to narcotic pain-relief medications, such as Stadol; to epidural anesthesia.[124] Medical staff and/or corrections officials may determine for a woman whether or not she will be permitted to access various forms of pain relief despite the patient's contrary wishes.[125] Decisions are primarily made in the direction of denying access to pain medication for women who have documented histories of substance abuse, on the theory that it is inappropriate to expose a woman with a substance abuse history to pain-relief methods that include narcotic drugs.[126] As a significant percentage of female prisoners have a history of substance abuse and/or are incarcerated for drug offenses,[127] many prisoners face constraints on their ability to determine whether they will access pain relief and what forms they will access. These constraints not only limit the autonomy of pregnant prisoners but also force them to endure intense, preventable pain.

c. Access to the Delivery Room

Pregnant women often carefully limit access to the rooms in which they labor and deliver, inviting in supportive people who might enhance their experience and excluding those who might unsettle them or invade their privacy. While, outside of prison, women may not be able to include all wanted people; may face scheduling or policy constraints that limit access to supportive persons; and may not be able to exclude all unwanted visitors, incarcerated women are often entirely denied autonomy in these matters. Incarcerated women who give birth generally are not permitted to have supportive people of their choice present while they labor and deliver.[128] Those supportive people may include the biological father/partner/spouse of the laboring

124. *See generally Using Narcotics for Pain Relief During Delivery*, AM. PREGNANCY ASS'N (July 2011), http://americanpregnancy.org/labornbirth/narcotics.html (discussing pain relief option).

125. *See* Levi et al., *supra* note 11, at 70.

126. *See Using Narcotics for Pain Relief During Delivery*, *supra* note 124 (discussing levels of narcotics present in various pain-relief options, including a small amount of narcotics present in most epidurals).

127. *See* Parker, *supra* note 11, at 263 (reporting substance abuse statistics).

128. *See* Levi et al., *supra* note 11, at 43 (narrating stories of women denied sympathetic presence, often rudely). At least one federal court has held that under some circumstances prisoners have a legal right to have a non-incarcerated spouse present during their delivery. Turner v. Wilkinson, 92 F. Supp. 2d 697, 699 (S.D. Ohio 1999).

woman; other relatives and friends; doulas;[129] or a physician or midwife that the woman has herself selected.[130] She may also not be permitted to inform any of those persons that the birth is about to take place, or that it has just taken place.[131] Even when prison policy allows women to inform such people of a pending birth or even invite them into the delivery room, pregnant inmates are dependent on correctional officials or medical personnel to communicate their wishes, an obligation that is often ignored or mishandled.[132]

While a laboring woman who is incarcerated may not be able to have the persons present that she wishes to have present, she may be saddled with audience members whom she did not invite. Corrections officers, including opposite-sex corrections officers, often remain in the room during labor and delivery, at great cost to the woman's privacy and autonomy and with little if any marginal gain in security.[133] In some instances, such guards have engaged in loud, distracting, or uncivil behavior which the laboring prisoners have had little ability to control.[134] In one notable incident, a woman had a guard next to her bed during childbirth who was watching NBA basketball, cheering and yelling at the TV.[135] Despite repeated requests to leave or turn off the television, he refused to do so, remaining in the room until the baby was crowning.[136]

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129. Over the last decade, one of the bright spots with regard to the health care of incarcerated pregnant women has been the growth of a small but significant number of prison doula programs, permitting laboring women access to nonmedical, supportive labor personnel. *See* Levi et al, *supra* note 11, at 45-46 (discussing program at Valley State Prison for Women in California); *The Birth Attendants: Prison Doula Project*, PARTNERSHIP FOR SAFETY AND JUST., http://www.safetyandjustice.org/node/881 (last visited Mar. 6, 2015) (discussing successful program in Washington State prisons). In the absence of formal programs, women are routinely denied the assistance of doulas. In addition, formal programs do not guarantee access, as prisons routinely suspend or cancel such programs with little warning.

130. Hannah Dahlen, *The Ideal Birth Support Person: Everything You Have Always Wanted to Know*, PREGNANCY BIRTH & BEYOND, http://www.pregnancy.com.au/resources/topics-of-interest/labour-and-birth/the-ideal-birth-support-person.shtml (last visited Mar. 6, 2015).

131. *See* Levi et al., *supra* note 11, at 43-44.

132. *See* Levi et al., *supra* note 11, at 43-44 (narrating stories of women denied sympathetic presence, often rudely).

133. *See, e.g.*, Colleen Mastony, *Childbirth in Chains*, CHIC. TRIB. (July 18, 2010), http://articles.chicagotribune.com/2010-07-18/news/ct-met-shackled-mothers-20100718_1_shackles-handcuffs-labor (discussing case of Melissa Hall).

134. *See id.*; *cf.* Levi et al., *supra* note 11, at 50 (detailing story of guard who remained in room for length of hospital stay, playing action movies on a DVD player, at volumes so loud that "[w]hen the shooting started . . . the baby woke up and started crying.").

135. *See* Mastony, *supra* note 133.

136. *See id.*

5. The Experience After Birth

Finally, women who give birth while incarcerated face a variety of problems in the aftermath of the birth. Those problems begin immediately, as some mothers are denied the ability to nurse the newborn, stay with the newborn for any length of time, or introduce the newborn to other family members.[137] Once a baby is safely delivered, some prisons become less conscientious in meeting maternal health needs and deny access to breast pumps, postpartum counseling, and follow-up health care.[138]

In the medium and long term, the problems persist. Outside of a small number of programs, incarcerated mothers are denied ongoing access to their infants.[139] Moreover, they are often denied postpartum placement counseling and are limited in their ability to make choices as to who might raise their children in their absence.[140] At some point, the problems of those who give birth behind bars then merge into the broad and overwhelming problems of incarcerated parents, including the difficulty of maintaining relations with their children,[141] the operation of laws and policies that push to strip parental rights,[142] and the lack of programs to facilitate post-release reunification of mothers with children through housing or other services.[143]

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137. *See, e.g.*, Levi et al., *supra* note 11, at 47 (discussing limitations on breastfeeding imposed on some California prisoners while still in hospital).

138. *See id.* at 50-54 (detailing stark deficiencies in postpartum care); Brandon Gee, *Nashville Prisoner Sues Metro for Millions After Having Miscarriage*, TENNESSEAN, Nov. 26, 2011, *available at* 2011 WLNR 24516456 (discussing case of Juana Villegas, who was denied the use of a breast pump).

139. *See Mothers Behind Bars*, *supra* note 11, at 7 (demonstrating that only thirteen states offer any kind of prison nursery program and that most of those are limited in availability and duration); Levi, et al., *supra* note 11, at 59-63 (discussing limitations of programs).

140. *See, e.g.*, Levi et al., *supra* note 11, at 53-54.

141. *See, e.g.*, Women in Prison Project, *When "Free" Means Losing Your Mother: The Collision of Child Welfare and the Incarceration of Women in New York State*, CORRECTIONAL ASS'N. OF N.Y. ix, ix-x (Feb. 2006), http://www.correctionalassociation.org/wp-content/uploads/2012/05/When_Free_Rpt_Feb_2006.pdf (noting that an incarcerated mother's difficulties include "limited visiting and family reunification services, inadequate or non-existent legal representation in Family Court, and insufficient coordination between corrections departments, child welfare agencies and the courts").

142. *See generally id*. at 15. Chief among the legal obstacles to maintaining parental rights is the Adoption and Safe Families Act of 1997, a federal statute that pushed states to initiate proceedings terminating the parental rights of the parents of children who have been in foster care for fifteen of the last twenty-two months. *See* 42 U.S.C. §§ 673b, 678, 679b (2012 & Supp. 2013).

143. *See generally* Women in Prison Project, *supra* note 141, at 26.

C. The Medical and Legal Context

These difficulties and constraints faced by those who are pregnant behind bars do not occur for lack of standards for obstetrical and gynecological care for prisoners. There are, in fact, specific professional guidelines for pregnancy-related health care in prison. The National Commission on Correctional Health Care,[144] the American Congress of Obstetricians and Gynecologists,[145] and the American Public Health Association[146] all publish specific standards for pregnancy-related health care in prison. These professional guidelines include standards requiring risk assessments, mental health screening, dietary supplements, special housing, "sensitive and dignified" exams, the training of health care staff in prisons in case of emergency, and ongoing access to newborns after delivery.[147] There is no requirement, however, that incarceration facilities comply with any of these standards, and, to the extent that information is available about prison pregnancy and birth at all, it appears that only a minority of jurisdictions even purport to follow professional guidelines for care.[148]

Efforts to compel prison officials to follow readily available standards for inmate care often of necessity take the form of lawsuits.[149] After-the-fact suits, seeking compensation for the consequences of degrading and substandard obstetrical care have, on occasion, been successful,[150] but such lawsuits face substantial doctrinal obstacles including the doctrine of qualified immunity,[151] the requirement that there exist a policy or practice of constitutional violations before a municipality can be held liable,[152] and the underly-

144. *See generally State Standards for Pregnancy-Related Health Care and Abortion for Women in Prison – Map*, ACLU, http://www.aclu.org/maps/state-standards-pregnancy-related-health-care-and-abortion-women-prison-map (last visited Mar. 6, 2015) (summarizing the National Commission on Correctional Health Care standards).

145. *See generally id.* (summarizing the American Congress of Obstetricians and Gynecologists standards).

146. *See generally id.* (summarizing the American Public Health Association standards).

147. *See id.*

148. *See id*.

149. *See generally Mothers Behind Bars, supra* note 11, at 28.

150. *See* Coleman v. Rahija, 114 F.3d 778, 788 (8th Cir. 1997); *see also* Clifton v. Eubank, 418 F. Supp. 2d 1243, 1253-54 (D. Colo. 2006).

151. *See* Harlow v. Fitzgerald, 457 U.S. 800, 800, 818 (1982) (establishing the doctrine and shielding public officials from liability for constitutional violations when the right in question is not "clearly established"). Because of the particular contours of the substantive right at issue in prison medicine cases (which requires violations of established norms to establish a substantive violation), the doctrine of qualified immunity does not act as an independent bar as often as it does in other civil rights contexts.

152. *See* Monell v. Dep't of Soc. Servs., 436 U.S. 658, 694 (1978). Even when constitutional harm can be shown, suits against facilities and municipalities for the

ing standard for liability for violations of the Cruel and Unusual Punishment Clause of the Eighth Amendment, which requires "deliberate indifference" to known harms.[153] As one Court described the law when dismissing a sympathetic action, "A prison official cannot be found liable under the Eighth Amendment for denying an inmate humane conditions of confinement unless the official knows of and disregards an excessive risk to inmate health or safety."[154] While at one point, groups of female inmates achieved some success in class actions seeking declaratory and injunctive relief against prison practices that threatened their reproductive health and safety,[155] such lawsuits have, more recently, been hampered by the strictures of the Prison Litigation Reform Act ("PLRA").[156]

II. PREGNANCY AND BIRTHING CONSTRAINTS ON NON-INCARCERATED WOMEN

A few of the constraints faced by incarcerated pregnant women are entirely peculiar to the modern prison system, a fact underscored by the attention that has been lavished on the distressing practice of shackling pregnant and laboring women that continues to be prevalent in many state systems.[157] Many of the constraints that incarcerated women face in childbirth are less peculiar, however. Women who are not incarcerated also experience limits

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denial of medical services to pregnant prisoners may be dismissed for failure to show such a pattern or practice.

153. *See* Estelle v. Gamble, 429 U.S. 97, 106 (1976). Claims that pre-trial detainees were denied necessary medical care technically fall under the Fourteenth and Fifth Amendments' Due Process Clauses, but the Supreme Court has held that a jail's obligations to pretrial detainees are at least as broad as those to people convicted of crimes, and parties routinely litigate claims against jails under the Due Process Clause utilizing the same standards and precedents as under the Eighth Amendment. *See* City of Revere v. Mass. Gen. Hosp., 463 U.S. 239, 244 (1983) (quoting Ingraham v. Wright, 430 U.S. 651, 671-72 n.40 (1977)) ("Eighth Amendment scrutiny is appropriate only after the State has complied with the constitutional guarantees traditionally associated with criminal prosecutions.").

154. Farmer v. Brennan, 511 U.S. 825, 837 (1994).

155. *See, e.g.*, Women Prisoners of the D.C. Dep't of Corr. v. Dist. of Columbia, 877 F. Supp. 634, 679 (D.D.C. 1994), *vacated in part, modified in part,* 899 F. Supp. 649 (D.D.C. 1995); Barry, *supra* note 65 (discussing settlement of major lawsuit, *Harris v. McCarthy*, against California prisons).

156. *See generally* Parker, *supra* note 11, at 282-84 (summarizing some of the challenges raised by the PLRA); *see also* Amy Petre Hill, *Death Through Administrative Indifference: How the PLRA Allows Women to Die in California's Substandard Prison Healthcare System*, 13 HASTING'S WOMEN'S L.J. 223, 237-38 (2002). The PLRA has many hurdles, some of which also apply to individual suits for compensation. However, physically injured pregnant prisoners have had some luck in protecting their claims from dismissal under the PLRA. *See, e.g.*, Clifton v. Eubank, 418 F. Supp. 2d 1243, 1245 (D. Colo. 2006).

157. *See* sources cited *supra* note 7.

on pregnancy and birthing choices and behaviors, and those limits are often enforced by the threat (or application) of criminal sanctions.[158] This Part focuses on some of the constraints and limits imposed on non-incarcerated women: describing them, drawing parallels where appropriate to the limitations on incarcerated women described in Part I, and beginning to explore their roots and social meaning.

Some of the constraints imposed on non-incarcerated women have either involved the application of formal legal force on the choices of pregnant women[159] or involved situations in which pregnant women have had to seek the aid of formal legal processes to vindicate their choices.[160] Those episodes of conflict have produced a substantial public record and this Part describes many such cases.[161] This Part pays attention to challenges to constraints placed on particular pregnant and birthing women who disagreed, or whose partners or families disagreed, with decisions made by physicians or hospital administrators. These cases highlight a striking similarity between the plight of incarcerated and non-incarcerated pregnant women: the willingness of the state and the medical profession to override their preferences and undermine their autonomy,[162] particularly in situations where the woman's demographics or life circumstances do not comport with notions of appropriate motherhood.[163]

These cases also, however, serve as an interesting window into a second level of constraint imposed on non-incarcerated pregnant women – constraints that might be called "sublegal."[164] "Sublegal" restrictions involve the common – indeed common-place – situation in which hospitals or doctors give pregnant women directives that are not legally enforceable, or that at least are of untested legal durability, but that nevertheless operate as both functional and moral constraints on pregnancy and birthing choices. While a full treatment of the psychological and cultural mechanisms that functionally constrain women in these situations is beyond the scope of this Article, this Part fleshes out a number of such constraints.[165]

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158. *See generally* Levi et. al., *supra* note 11.

159. *See, e.g.*, *infra* notes 184, 189, 191, 203 and accompanying text.

160. *See, e.g.*, Fitzgerald v. Porter Mem'l Hosp., 523 F.2d 716, 717-18 (7th Cir. 1975) (involving constitutional challenge to public hospital's policy barring fathers from delivery room).

161. *See* discussion *infra* Part II.B.

162. *See infra* notes 218-222 and accompanying text.

163. *See* discussion *infra* Part II.A.

164. *See generally* Ikemoto, *supra* note 16, at 1221-22 (describing restrictions on reproductive liberty).

165. *See* discussion *infra* Part II.C (discussing issues of induction, involuntary C-sections, and limitations on midwifery and non-hospital births).

A. The Uneven Resort to Legal Constraint

Attempts to impose formal legal constraints upon the medical and lifestyle choices of pregnant women are much more likely to fall on those who live in poverty, belong to marginalized racial groups, or otherwise mark themselves as outside of the mainstream.[166] Probably the set of constraints most familiar to criminal law scholars are those that affect women who use or are suspected of using illicit drugs during pregnancy. The *Ferguson* case,[167] for example, drew attention to a program wherein women at the Medical University of South Carolina who were suspected of drug use were tested after childbirth; several women who tested positive were immediately arrested and prosecuted.[168] While the Supreme Court's ultimate invalidation of the program on Fourth Amendment grounds[169] meant that other localities did not rush to develop similar programs,[170] individual women had been prosecuted less systematically prior to *Ferguson*, and individual prosecutions have continued its wake, in both cases that do and do not involve negative pregnancy outcomes.[171] While most women who have been criminally prosecuted based on behavior that they engaged in while pregnant have been accused on various criminal law theories of exposing their fetuses to illicit drugs, at least a few have been prosecuted for other behavior during pregnancy, including attempted suicide.[172]

The *Ferguson* case drew attention for a variety of reasons and was ultimately resolved on other grounds,[173] but one central aspect of the story was the taint of racial discrimination hanging over the litigation.[174] Both the design of the program – from its location in particular public hospitals to the

166. *See generally* Ikemoto, *supra* note 16, at 1207.

167. Ferguson v. City of Charleston, 532 U.S. 67 (2001).

168. *Id.* at 70-71.

169. The Supreme Court found that this particular testing program was designed to ferret out ordinary criminal wrongdoing, rather than to meet the special needs the state may have outside of law enforcement; the Court was particularly troubled by the degree to which prosecutors were involved in designing the program, and the use of arrest and prosecution to enforce its goals. *Id.* at 79-86.

170. Because of the fact-specific nature of the *Ferguson* decision, it is possible that programs similar to that adopted in Charleston might be constitutional if, for example, they were focused more on treatment or education, made more use of medical personnel, and relied more heavily on individual consent. *See id.* at 79-81. Nevertheless, localities do not seem to have tested the waters with similar but less prosecution-oriented testing programs.

171. *See* sources cited *supra* note 33 and accompanying text.

172. *See* Ritchie, *supra* note 33 (discussing prosecution of woman for suicide attempt that killed fetus).

173. Ferguson v. City of Charleston, 532 U.S. 67, 79-86 (2001) (discussing the case's Fourth Amendment holding).

174. Bryony J. Gagan, Note, Ferguson v. City of Charleston, South Carolina: *'Fetal Abuse,' Drug Testing, and the Fourth Amendment*, 53 STAN. L. REV. 491, 498-99 (2000).

amount of discretion it gave to individual medical personnel – and its implementation operated to create widely racially disparate consequences: of the thirty women who were ultimately prosecuted, all but one were African-American; the lone exception had an African-American partner whose race was noted on her medical file.[175] Statistics from other formal legal interventions involving parenting women present similar patterns of racial, ethnic, and class distrust.[176] For example, one study of cases in which women were forced to undergo C-sections found that all or nearly all have been on public assistance, about eighty-one percent have been members of minority groups, and about twenty-five percent have been non-native English speakers.[177]

The racial, ethnic, and class disparities with which legal and medical authorities seek to impose formal legal constraints upon non-incarcerated pregnant women is a lead story, not a footnote.[178] It demonstrates continuity between the constraints imposed on incarcerated and non-incarcerated women, offers a layer of explanation for the magnitude of the restrictions imposed in the prison context, and provides some validation for the narrative of scholars and activists who have treated the shackling of pregnant prisoners as the exemplifying technology in their critique of the modern prison system's degradation of pregnant women. There is much truth both to the common observation that our law and culture are fixated on categorizing pregnant women and mothers as either "good" or "bad" mothers and imposing limitations and sanctions accordingly,[179] and to the corollary that that process of line-drawing is heavily enmeshed in narratives of race and class.[180]

B. Legal Constraints on Pregnant Women Writ Large

While the line between "good" and "bad" mothers is one often drawn according to perceived demographics, the drive to regulate and constrain the pregnancy choices of expectant mothers transcends issues of race and

175. *Id.* at 498, n.40.

176. *See generally* Paltrow & Flavin, *supra* note 17.

177. *See* Nancy Ehrenreich, *The Colonization of the Womb*, 43 DUKE L.J. 492, 521 (1993).

178. *See* Gagan, *supra* note 174, at 498, n.40.

179. *See, e.g.*, Ikemoto, *supra* note 16, at 1219-20, 1304 (discussing historical roots of "good" mother stereotypes); *id*. at 1223-43 (discussing how modern medicine works to differentiate "good" mothers from "bad" mothers based on their pregnancy choices); Levi et al., *supra* note 11 (discussing limitations on pregnant prisoners' rights through prism of ways in which our laws create category of "bad" mothers deserving of greater regulation); *cf.* Ada Calhoun, *The Criminalization of Bad Mothers*, N.Y. TIMES MAG., Apr. 29, 2012, at MM30, *available at* http://www.nytimes.com/2012/04/29/magazine/the-criminalization-of-bad-mothers.html?pagewanted=all&_r=0.

180. *See* Ehrenreich, *supra* note 177, at 498; Ikemoto, *supra* note 16, at 1208; Roberts, *supra* note 16, at 1435-45.

class.[181] To begin with, a surprising number of women have experienced direct civil legal action taken by the state to direct pregnancy treatment.[182] For example, some women whose health care providers have recommended hospital bed rest because of pregnancy complications have been court-ordered to undertake that rest against their wishes.[183] In one such case, *Burton v. State*, a doctor notified the local state attorney that Burton was refusing medical treatment.[184] In response, the state attorney sought a court order to force Burton to submit to hospital confinement to be followed by a C-section.[185] In granting the order, the trial court found that there was a "substantial and unacceptable" risk of severe injury or death to the fetus if Burton did not follow the prescribed course of treatment.[186] While the reviewing court ultimately determined that the trial court had inappropriately used a "best interests of the child" standard in granting the order, and that the correct standard would have recognized that the state required a compelling interest to override Burton's fundamental constitutional right to refuse medical intervention,[187] appellate court review did not come until after Burton was confined and received a C-section.[188] In other similar cases, courts have ordered women confined to receive blood transfusions,[189] substance abuse treatment,[190] mental health counseling,[191] or to undergo minor surgical procedures.[192]

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181. Ehrenreich, *supra* note 177, at 512.

182. Over the last three decades, a number of scholars have documented this trend, particularly with regards to C-sections. *See, e.g.*, Erin P. Davenport, *Court Ordered Cesarean Sections: Why Courts Should Not Be Allowed To Use a Balancing Test*, 18 DUKE J. OF GENDER L. & POL'Y 79, 83-86 (2010); Lidia Hoffman & Monica K. Miller, *Inconsistent State Court Rulings Concerning Pregnancy-Related Behaviors*, 22 J.L. & HEALTH 279 (2009); Ikemoto, *supra* note 16, at 1235-61; Paltrow & Flavin, *supra* note 17, at 304-05; Nancy C. Rhoden, *The Judge in the Delivery Room: The Emergence of Court-Ordered Cesareans*, 74 CAL. L. REV. 1951, 1951 (1986); Charity Scott, *Resisting the Temptation to Turn Medical Recommendations into Judicial Orders: A Reconsideration of Court-Ordered Surgery for Pregnant Women*, 10 GA. ST. L. REV. 615, 624-27 (1994).

183. Burton v. State, 49 So. 3d 263, 264 (Fla. Dist. Ct. App. 2010).

184. *Id.*

185. *Id.* at 265.

186. *Id.*

187. *Id.* at 266.

188. *Id.* at 264.

189. *See, e.g.*, *In re* Jamaica Hospital, 491 N.Y.S.2d 898, 900 (N.Y. Sup. Ct. 1985).

190. *See* Paltrow & Flavin, *supra* note 17, at 307 (discussing the case of Rachel Lowe, a twenty-year-old pregnant woman, who was held against her will after voluntarily seeking treatment for Oxycontin addiction).

191. *See, e.g.*, *In re* Steven S., 178 Cal. Rptr. 525, 526-27 (Cal. Ct. App. 1981).

192. *See, e.g.*, Taft v. Taft, 446 N.E.2d 395 (Mass. 1983).

As *Burton* demonstrates, women may be directed by judges to give birth by C-section against their will.[193] The highest-profile of these cases was probably *In re A.C.*, a legal dispute that played out publicly a quarter-century ago.[194] In that case, a woman who had been battling cancer for a dozen years became pregnant and wanted to carry her baby to term.[195] By about twenty-six weeks into her pregnancy, however, her cancer had become terminal, and her doctors suggested that she have a C-section to maximize the chances that her fetus would survive, although the C-section might hasten her death.[196] She did not consent, and the hospital sought a court order to perform the C-section.[197] After the court ordered the C-section, it was performed; the baby died quickly, and she died several days later, aware that her baby had died.[198]

While the case was criticized by health care providers, advocates, and academics and was reversed by the full court (albeit after A.C. died),[199] women have continued to be taken to court:[200] pregnant women in at least eleven states have been the subject of court orders that have mandated that they give surgical birth by C-section;[201] in fact, in about eighty-six percent of cases where physicians or hospitals have sought court orders, those orders have been granted.[202]

In some instances, a woman's desire to avoid an unwanted C-section or induction has led her to attempt to avoid hospital birth altogether and spawned a legal dispute as to whether she may be detained or forcibly transported for hospital birth.[203] Once again, a high profile court case provides an excellent example. In *Pemberton v. Tallahassee Memorial Regional Medical Center*, Laura Pemberton, a white woman who had previously given birth by C-section wanted to give birth vaginally.[204] The hospital where she was to

193. 49 So. 3d at 265.

194. *In re* A.C., 533 A.2d 611 (D.C. 1987), *reh'g granted*, 539 A.2d 203 (D.C. 1988), *vacated*, 573 A.2d 1235 (D.C. 1990).

195. *In re A.C.*, 533 at 612.

196. *Id.* at 612-13.

197. *Id.* at 613.

198. *In re A.C.*, 573 A.2d at 1238.

199. *See, e.g.*, *Id.* at 1235; Ikemoto, *supra* note 16, at 1245-46; Terry E. Thornton & Lynn Paltrow, *The Rise of Pregnant Patients: Harder Case Brings Bold Policy Initiatives*, 8 HEALTH SPAN, No. 5 (1991), *available at* http://advocatesfor pregnant-women.org/articles/angela.htm.

200. *See, e.g.*, *In re* Baby Boy Doe, 632 N.E.2d 326 (Ill. App. Ct. 1994); Paltrow & Flavin, *supra* note 17, at 325 (discussing the case of Rebecca Corneau).

201. *See* V.E. Kolder et al., *Court-Ordered Obstetrical Interventions*, 316 NEW ENG. J. MED. 1191 (1987).

202. *Id.*

203. *See, e.g.*, Pemberton v. Tallahassee Mem'l Reg'l Med. Ctr., Inc., 66 F. Supp. 2d 1247, 1248-49 (N.D. Fla. 1999); Jefferson v. Griffith Spalding Cnty. Hosp. Auth., 274 S.E.2d 457, 459-460 (Ga. 1981); B. Flanigan, *Mom Follows Belief, Gives Birth in Hiding*, DET. FREE PRESS, June 28, 1982, at 3A.

204. 66 F. Supp. 2d at 1249; Paltrow & Flavin, *supra* note 17, at 306.

give birth told her that because she had received a C-section before, she would be required to give birth again by C-section and would not be permitted to have a trial of labor with an attempt at a vaginal birth.[205] Because she could not have the birth she thought appropriate, she attempted to circumvent an unwanted C-section by giving birth at home.[206] When she became dehydrated during labor at home, she decided to go to the hospital, where medical personnel informed her that she would only be treated if she consented to a C-section.[207] After nurses informed her that the hospital was in the process of seeking a court order for surgery, Pemberton left the hospital and went home.[208] The hospital convened a hearing before a state judge who ordered a sheriff to go to her home to take her into custody and return her to the hospital.[209] Once back at the hospital, the judge gave her an opportunity to be heard but then ordered a C-section against her will.[210] After undergoing the surgery, she filed a federal civil rights suit seeking damages against various state officials, but a federal judge determined that the hospital had acted properly.[211]

It is difficult to determine exactly how many women in the modern United States have been subject to similar direct legal control or sanction for their pregnancy and delivery choices. Scholars and journalists have written extensively about several dozen representative cases,[212] but, until recently, no one has attempted a systematic study.[213] A few years ago, Lynn Paltrow of National Advocates for Pregnant Women and Jeanne Flavin of Fordham University attempted to identify all the incidents between 1973 and 2005 where there was some sort of court-ordered intervention that deprived a pregnant woman of her liberty in response to the choices she made during her pregnancy or was contemplating for her delivery.[214] The study identified 413 cases in which pregnant women were arrested, detained, or forced to submit to medical interventions.[215] As the authors explained, however, even that number drastically undercounts the number of such cases, as the study could not identify women who were nominally sentenced on other charges but only faced

205. 66 F. Supp. 2d at 1249.
206. *Id.*
207. *Id.*
208. *Id.*
209. *Id.* at 1250.
210. *Id.*
211. *Id.* at 1252-54 (analyzing and dismissing all complaints, largely based on deference the court felt was owed to the medical testimony). For a more complete version of the facts that puts the case in context, see JENNIFER BLOCK, PUSHED: THE PAINFUL TRUTH ABOUT CHILDBIRTH AND MODERN MATERNITY Care 249-51 (2007). Pemberton delivered twins via VBAC in 1999 at a secret location that she refused to reveal to Block. *Id.* at 249.
212. *See generally* works cited *supra* note 179; Block, *supra* note 211.
213. Paltrow & Flavin, *supra* note 17, at 299.
214. *Id.*
215. *Id.* at 303.

prison time because of their pregnancies,[216] women who were prosecuted as juveniles or faced civil actions in sealed juvenile proceedings, or women whose hospital detention or forced medical interventions produced neither a published court opinion nor media coverage (likely a substantial majority of such cases).[217] So while it is difficult to know the exact number of women who have faced direct, formal legal sanction or control based on pregnancy choices, the number is appreciable.

As others have observed,[218] the rhetoric and reasoning in these reported cases works to "other" the women who are subject to formal legal constraints or sanctions for their pregnancy choices. As argued above,[219] many of the women who are subject to such constraints are already marginalized because of their race, class, ethnicity, marital status, or chemical dependence. Because these women belong to groups whose mothering skills traditionally have been denigrated, the legal and medical establishments have found it comparatively easy to conceptualize them as "bad" mothers unworthy of liberty or autonomy,[220] and this places these cases in the broader narrative of how the reproductive decisions of women of color are distrusted and degraded.[221] However, this "othering" or distancing process operates even in cases where the mother in question faces few, if any, such markers. As Lisa Ikemoto concluded after analyzing the major cases involving forced interventions, the very act of resisting the combined weight of the legal and medical establishments marks a woman as deviant in the eyes of most judges, a "bad mother" against whom "we should and can intervene to protect the innocent fetus."[222]

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216. *Cf. supra* notes 40-47 and accompanying text (discussing a few such incidents).

217. *See* Paltrow & Flavin, *supra* note 17, at 303-04.

218. *See generally* Ikemoto, *supra* note 16.

219. *See supra* Part II.A.

220. *See, e.g.*, Ikemoto, *supra* note 16, at 1245-46 (discussing how modern medicine seeks to differentiate "good" mothers from "bad" mothers based on their pregnancy choices); Levi et al., *supra* note 11 (discussing the limitations on pregnant prisoner rights through a prism of ways in which our laws create a category of "bad" mothers deserving of greater regulation); Calhoun, *supra* note 179.

221. *See, e.g.*, ROBERTS, *supra* note 13.

222. Ikemoto, *supra* note 16, at 1246; *see also id.* at 1245 ("Underlying the court's . . . language is a set of assumptions – that a normal woman would do anything for the sake of her unborn child even if it endangered her own life; that there must be something wrong with the woman who refuses consent; that doctors and lawyers who call for intervention speak with authority and know better than the woman who refuses consent . . . .").

C. Sub-Legal Coercion: On the Limits of Autonomy in Ordinary Pregnancies

Bringing the incidents detailed in the section above into the discussion of the treatment of pregnant prisoners broadens and complicates that story and locates our treatment of pregnant prisoners in a broader context in which our society is surprisingly quick to bring the forces of cultural condemnation and legal sanction down on women whose pregnancy choices disturb or frighten. As incidents of forced legal coercion play out across demographic lines but are substantially more likely to occur when the woman in question is poor or a woman of color,[223] it is possible to reconceptualize the specter of direct legal regulation of one's pregnancy choices as something that hovers over all women but becomes more likely and potentially more severe as one moves further towards the social margins. Prisoners – who are marginalized because of their demographics[224] and then remarginalized by their very construction as "criminals" or "prisoners"[225] – are, in this telling, simply the end points, the worst case scenario, in a broader system of dehumanization.

Even telling the story that way, however, misses some of the crucial dynamics at play in the regulation of modern pregnancy. After all, incidents of forced legal intervention in pregnancy choices, while more common than might make us comfortable, remain the exception rather than the rule. If our focus is limited to such situations, then the kind of coercion imposed on pregnant prisoners remains atypical, a deviant set of practices subject to challenge based on the norms of liberty and autonomy that ostensibly exist in (the great bulk of) non-incarcerative pregnancies.

However, as many critics and commentators have noted over the last few decades,[226] the dynamics of health care and decision making for most pregnant women in the United States are more fraught than that picture would imply. Doctors, hospitals, insurance companies, and government regulators operate in a variety of ways to constrain the choices open to pregnant women and challenge their decisions when those decisions do not conform to narrow pre-existing norms.[227] While affirmative legal coercion may be exceptional, the absence of formal legal process does not guarantee, or even suggest, autonomous decision making.

Power dynamics and cultural expectations, often presented in the form of a "rule" and sometimes backed by the threat of legal sanction, influence

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223. *See supra* Parts II.A-B.

224. *See generally* Greenfeld & Snell, *supra* note 22.

225. Regarding the construction of the "criminal" as an all-encompassing identity used to mark those convicted of crimes as marginal others, see generally Deborah Ahrens, Note, *Not in Front of the Children: Prohibition on Child Custody as Civil Branding*, 75 N.Y.U. L. REV. 737 (2000).

226. *See, e.g.*, BLOCK, *supra* note 211; Ehrenreich, *supra* note 177.

227. Jennifer Block's book, *Pushed: The Painful Truth About Childbirth and Modern Maternity Care* (2007), seems to be the most complete single work documenting these trends. *See* BLOCK, *supra* note 211.

the choices that pregnant women make on matters ranging from whether to deliver in a hospital and whether to engage a doctor or midwife[228] to whether to undergo an induction or C-section[229] to what kinds of pain relief, if any, they wish to receive. These kinds of sub-legal restraints and pressures define the experience of pregnancy and delivery for many, perhaps most, women in the contemporary United States.

These sub-legal forms of coercion play out in a variety of ways. Sometimes they take the form of formal policies imposed by hospitals or physicians.[230] At other times, they manifest in the decision of a doctor to schedule a procedure, like an induction, as if it had already been agreed or as if there was no choice in the matter, relying on inertia and the authority his position conveys to guide the patient's choice without ever really ascertaining her autonomous preference.

Other women may not face policies that contradict their preferences or doctors who are quite as aggressive with their scheduling, but instead find themselves formally consenting to procedures that they might not have consented to if provided with all of the information they are medically and legally entitled to.[231] Such women may have their pregnancy and childbirth choices constrained in the sense that they may not be provided with all of the information that they need in order to make appropriate decisions about their maternity care. The litigation record here is instructive: while there are relatively few formal, court-ordered C-section or detention cases, there are many more cases in which a woman claims that she was not given legally required information to consent to procedures, whether those procedures are C-sections, vaginal births, inductions, or other surgical interventions.[232] In many such cases, women allege that doctors withheld information in order to encourage a particular course of action or treatment. While these cases do not represent situations where a woman has been court-ordered to unwanted sur-

228. *See infra* notes 254-262 and accompanying text.

229. *See infra* notes 235-253 and accompanying text.

230. *See, e.g.*, *2011 Oregon Hospital VBAC Policies*, ICAN PORTLAND, http://www.icanofportland.com/birth-stats--vbac-hospital-policies.html (last visited Mar. 7, 2015) (containing link to document detailing survey conducted by International Cesarean Awareness Network of Portland concluding that in 2011, 28 of 52 hospitals surveyed had a formal ban on VBACs).

231. Kukura, *supra* note 121, at 957 ("A 2002 study . . . which surveyed over 1,500 women about their recent birth experiences, found that only 62% of respondents said they had fully understood their right to receive complete explanations of any procedure, drug, or test offered to them during pregnancy and childbirth, and only 66% of respondents said they had fully understood their right to refuse any procedure, drug, or test offered.").

232. More of these cases, in fact, involve women who consented to vaginal birth when they did not wish to give birth vaginally for various reasons. *See, e.g.*, Lawrey v. Kearney Clinic, P.C., No. 8:11CV63, 2012 WL 5839516 (D. Neb. Nov. 16, 2012); Klutschkowski v. PeaceHealth, 311 P.3d 461 (Or. 2013); Fernandez v. Moskowitz, 925 N.Y.S.2d 476 (N.Y. App. Div. 2011).

gery or denied care if she refuses consent, they do represent real restrictions on the ability of pregnant women to obtain appropriate care.

Finally, and in probably the hardest category to document empirically, women may be persuaded, coerced, or manipulated (depending on how normative and negative we wish to construct this) into procedures under circumstances where they are not court-ordered to a particular treatment path and where they are provided with legally sufficient information to make medical decisions, but where, nevertheless, the expectant mother is pressured into an undesired course of action.[233] In some cases, the "persuasion" comes close to direct coercion – a woman may be told that the doctor may transfer her care if she does not agree with the doctor's suggested course of treatment; may be told that she does not care about the baby or will be a bad mother if she does not follow the suggested course of treatment; or may be told that she needs to make a decision within a specific, time-pressured framework.[234]

Though these mechanisms of sub-legal coercion are presented abstractly above, they recur so often in the literature on modern maternity care that they come to seem almost archetypal. To make them more concrete, however, all one needs to do is look at how these dynamics play out in several common scenarios. Take, for example, the rate of C-sections performed. As has been widely reported, the rate of C-sections in the United States has grown rapidly over the last two decades and currently sits at somewhere around one-third.[235] Many factors likely contribute to the substantial increase in surgical births, but incentive structures that reward doctors and hospitals for undertaking the more expensive surgical procedure[236] and put them at litigation risk if anything goes wrong in a vaginal delivery[237] are two of the key components.[238]

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233. *See infra* Part II.

234. *See* Ikemoto, note 16, at 1239-40 ("Doctors who feel strongly that the woman's choice is wrong may do more than seek authorization – they may attempt to persuade her to change her mind in ways that amount to coercion. For example, the doctor may tell the patient, very frankly, that by not consenting she places the doctor in a bind, and that to escape the bind the doctor will get a court order. This may influence the patient by intimidating her. Or, it may persuade her that the doctor's opinion bears great weight. In either case, she would not be giving informed consent, but acceding to authority. In some instances, the woman changes her mind when literally faced with authority – when confronted by the judge or when the court order has issued.")

235. *See* Luz Gibbons et al., *The Global Numbers and Costs of Additionally Needed and Unnecessary Caesarean Sections Performed Per Year: Overuse as a Barrier to Universal Coverage*, WORLD HEALTH ORG. 21 (2010), http://www.who.int/healthsystems/topics/financing/healthreport/30C-sectioncosts.pdf.

236. For an excellent, albeit vitriolic, discussion of the role of professional groups in establishing the C-section rate, see Michael J. Myers, *ACOG's Vaginal Birth After Cesarean Standard: A Market Restraint Without Remedy?*, 49 S.D. L. REV. 526 (2004).

237. *See* BLOCK, *supra* note 211, at 59-64 (discussing the influence of litigation risk on C-section rates).

As others have pointed out, individual women are often given only limited choice in determining whether to deliver via C-section or attempt a course of labor.[239] Anecdotes abound of doctors and other personnel who have harangued patients who have been unwilling to give immediate consent to C-sections or offered exaggerated accounts of the medical risks of labor in order to induce consent.[240] More commonly, medical personnel utilize their position of authority and the knowledge gap that exists to steer patients towards C-sections, either as an initial matter or at the first sign of distress during labor.[241] While some – or even many – of the additional C-sections performed in this country may be medically beneficial,[242] many decisions to undertake the procedure are made in a manner that raise serious questions about whether they reflect the autonomous desires and the considered reflection of the women in question.

Many of these issues of subtle coercion and sub-legal constraint often come to a head when women who have previously undergone Cesarean deliveries request the opportunity to deliver vaginally. Many hospitals and doctors have grown increasingly reluctant to even attempt labor under such circumstances.[243] In rare instances, such as the *Pemberton* case described above, stand-offs between medical personnel who refused to perform VBACs and patients who refuse to consent to C-sections have provoked legal battles.[244] Few hospitals, however, need to go to the extreme of seeking a court order for a C-section delivery. Many hospitals, such as the one where Pem-

238. The desire to deliver at a set time, extreme parental caution, concern about the physical effects of vaginal delivery, and the over-use of inductions are also often cited as contributing causes. *See generally id*. at 50-59 (cataloging these reasons).

239. *See, e.g.*, *id.*; Kukura, *supra* note 121.

240. *See, e.g.*, BLOCK, *supra* note 211, at 91-95 (section entitled "The 'Exploding Uterus' Card").

241. Regarding the construction of medical knowledge as authoritative and its consequences for the power dynamics between doctors and pregnant patients, see Susan Irwin & Brigitte Jordan, *Knowledge, Practice, and Power: Court-Ordered Cesarean Sections*, 1 MED. ANTHRO. Q. 319 (1987).

242. For example, planned C-sections have the advantage of scheduling deliveries during hours where medical professionals are more alert, while emergency C-sections preserve infant health and safety in at least some situations. *See* Cullinane et. al., *The 2003 Report of the Confidential Enquiry into Perioperative Deaths*, NAT'L CONFIDENTIAL ENQUIRY INTO PATIENT OUTCOME & DEATH (2003), http://www.ncepod.org.uk/pdf/2003/Datasupplement2003.pdf.

243. *See* sources cited *infra* note 245 (discussing the trend and noting that as many as 30% of all hospitals may have policies precluding VBACs). *See generally* BLOCK, *supra* note 211, at 86-93 (discussing trend).

244. *See, e.g.*, Pemberton v. Tallahassee Mem'l Reg'l Med. Ctr., Inc., 66 F. Supp. 2d 1247 (N.D. Fla. 1999); Jefferson v. Griffith Spalding Cnty Hosp., 274 S.E.2d 457, 460 (Ga. 1981); Flanigan, *supra* note 203, at 3A; *see also* BLOCK, *supra* note 211, at 251-53 (detailing situation in which woman gave birth vaginally only because baby all-but fell out while she was asserting her rights and doctor was preparing to force her into a C-section).

berton gave birth, have blanket policies that require women who have given birth by C-section before to deliver all subsequent babies by C-section.[245] Due to their formality and rigidity, such policies speak authoritatively and convince a substantial number of women to refrain from requesting or pursuing a VBAC.[246] Even if women are not convinced, the absence of hospitals with different policies in a particular geographic region and the barriers imposed upon non-hospital or non-physician-assisted births[247] may leave women with little choice but to accede to subsequent C-sections. Those who are able to pursue VBACs at more accommodating hospitals or through non-traditional birthing options may be forced to compromise other aspects of their birthing plan – such as accessibility to other family members whose presence may be desirable or the preference for physician-assisted birth – in order to achieve that objective.[248]

Similar dynamics play out when it comes to inductions. In many practices, policies encourage or require women to schedule induced labor once they pass specific chronological targets, often quite early ones.[249] Even in the absence of such formal rulemaking, women are scheduled for inductions for reasons other than medical necessity – such as for the convenience of the delivering obstetrician, who may not wish to deliver in the middle of the night or on a weekend.[250] Court cases abound in which women allege that doctors scheduled inductions without obtaining their consent, without inform-

245. Regarding the growth of hospital policies precluding VBACs and the possible legal challenges to such policies, see Kukura, *supra* note 121; Krista Stone-Manista, *In the Manner Prescribed by the State: Potential Challenges to State-Enforced Hospital Limitations on Childbirth Options*, 16 CARDOZO J.L. & GENDER 469 (2010). As of 2009, approximately 28% of all hospitals had policies banning VBACs. *Id.* at 470.

246. The authoritativeness of such policies is further reinforced by the fact that such policies rely on official practice "standards" released by professional organizations, such as the American College of Obstetricians and Gynecologists. *See, e.g.*, AMERICAN COLLEGE OF OBSTETRICIANS & GYNECOLOGISTS, VAGINAL BIRTH AFTER CESAREAN, PRACTICE BULLETIN #5 (July 9, 1999) (establishing standards for attempting VBACs that are prohibitive in many circumstances, including the presence for the entire trial of labor of a medical doctor prepared to perform an emergency C-section).

247. *See supra* notes 244-246; *infra* notes 252-264.

248. *See* Elizabeth Cohen, *Mom Won't Be Forced to Have C-Section*, CNN (Oct. 15, 2009), http://www.cnn.com/2009/HEALTH/10/15/hospitals.ban.vbacs/index.html (describing a mother of three who planned to temporarily relocate 350 miles from her family's home in order to deliver her fourth child at the nearest hospital that would allow VBACs).

249. *See* BLOCK, *supra* note 211, at 5-6 (collecting data showing that anywhere between 30 and 60% of pregnancies are induced, that many more are "augmented" with Pitocin, and that as many as 65% of pregnant women have their water broken manually); *id.* at 11 (discussing inductions based solely on estimated length of pregnancy).

250. *See id.* at 14-17 (discussing inductions for the convenience of doctors).

ing them of the medical costs and benefits of the procedure, or through use of other forms of coercion.[251]

Even in cases where women's physicians are supportive of their desire to enter labor spontaneously the behavior of other officials may combine with structural factors to limit or foreclose that option. In particular, the lack of available health care facilities in close proximity to where people who need services reside may lead to scheduled inductions. In one notable case, the American Civil Liberties Union ("ACLU") filed a complaint in 2010 alleging that Indian Health Services had failed to provide adequate obstetrical and other medical care to residents of the Cheyenne River Sioux Reservation in South Dakota, alleging that, despite ongoing plans to build a birthing unit, Indian Health Services had not done so, leaving women in the position that they needed to travel ninety miles to a health care center for labor and delivery at a time chosen by their doctor to be medically induced.[252] In some cases, inductions might be scheduled without advance notice to the patient, even though family members are far away and now will not be in a position to attend the birth and to provide desired support.[253]

One of the most significant axes of coercion faced by pregnant women in the contemporary United States is the pressure they face to deliver in a hospital attended by a medical doctor.[254] While the current norm in most countries and the historical norm in this country is that trained midwives attend most "normal" (low-risk) births while obstetricians handle higher-risk and emergency deliveries,[255] the expectation in the contemporary United States is that children will be born in a hospital and delivered by a doctor.[256] Many others have traced the development of this expectation, tying it both to honestly-held but ultimately overstated concerns about safety, to concerns about malpractice litigation, to the medical profession's desire to entrench its authority, and to financial incentives for surgical intervention.[257] The norms of hospital delivery by obstetricians contribute to a particular model of preg-

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251. *See, e.g.*, Tiffany Ellis, *Verdicts & Settlements, November 21, 2011: Parents of Child with Cerebral Palsy Settle with Doctor, Hospital*, MO. LAWYERS MEDIA, Nov. 21, 2011.

252. Complaint for Petitioner at 1-2, ACLU v. Indian Health Servs. (2010), *available at* http:// https://www.aclu.org/files/assets/2010-9-27-ACLUvIHS-Complaint.pdf.

253. *Id.* at 2.

254. *See* BLOCK, *supra* note 211, at xx (reporting that 99% of American women give birth in hospitals).

255. For an explanation of the historical norms in the United States and the transition to the modern model, see, for example Ikemoto, *supra* note 16, at 1243-44, 1246-47. For an explanation of the divergence of the American and European experience, see BLOCK, *supra* note 211, at 65.

256. *See* BLOCK, *supra* note 211, at xx (reporting that 99% of American women give birth in hospitals).

257. *See generally,* RAYMOND G. DE VRIES, REGULATING BIRTH: MIDWIVES, MEDICINE, & THE LAW (1985).

nancy that some have come to call the "medical model."[258] Under the norms of the medical model, women are conceptualized as relatively passive patients who need to be "treated" and delivery has come to be encumbered by expensive new technology, excessive interventions, and the expansive use of drugs to assist in labor and mute pain.[259]

While many women are comforted by the technology and expertise arrayed to assist them and many might choose to give birth in exactly the same way if given a full and fair choice, even today, a substantial number of women express a preference for an untraditional birth outside of a hospital, assisted by someone other than an obstetrician, or both.[260] For those who so choose, such birth is ordinarily possible, but the legal landscape is variable. Many states heavily regulate midwives,[261] some states prohibit midwives from attending deliveries without the supervision of a medical doctor and/or prohibit direct-entry midwives (midwives who are not trained as nurses and certified as nurse midwives) from attending deliveries all together,[262] and insurance companies routinely force midwives out of business by failing to fight malpractice claims or raising fees astronomically after a single bad outcome.[263] Moreover, both the number of women who consider such a delivery and the number who ultimately select one are drastically reduced by the same combination of norms, unspoken assumptions, subtle pressure, and overt coercion discussed above with regard to delivery method and timing.

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258. For discussions and critiques of the medical model within the legal literature, see Ehrenreich, *supra* note 177, 525-26; Kukura, *supra* note 121, at 996. Those works in turn draw upon a rich sociological and anthropological literature. *See, e.g.*, EMILY MARTAIN, THE WOMAN IN THE BODY (1992); BARBARA K. ROTHMAN, IN LABOR: WOMEN AND POWER IN THE BIRTHPLACE (1991).

Moreover, academic work in this area draws heavily on the sophisticated advocacy work of groups such as Our Bodies, Our Selves, formerly the Boston Women's Health Book Collective. *See generally About Us*, OUR BODIES, OUR SELVES, http://www.ourbodiesourselves.org/about/ (last visited Mar. 7, 2015).

259. *See* BLOCK, *supra* note 211, at 249-51; DE VRIES, *supra* note 257.

260. *See* Sheila M. Eldred, *More Women Using Midwives*, DISCOVERY NEWS (June 27, 2013), http://news.discovery.com/human/midwives-birth-120627.htm (noting that use of midwives was up to 7.6% as of 2009).

261. Scholars and advocates have produced a massive amount of literature on the legal regulation of midwifery and possible legal challenges that might be brought against it. For a thorough treatment of the literature, see Amy F. Cohen, *The Midwifery Stalemate and Childbirth Choice: Recognizing Mothers-to-Be as the Best Late Pregnancy Decisionmakers*, 80 IND. L.J. 849, 850-53 (2005); *see also* Pamela Laufer-Ukeles, *Reproductive Choices and Informed Consent: Fetal Interests, Women's Identity, and Relational Autonomy*, 37 AM. J. L. & MED. 567, 587 n.144 (2011) ("Fifteen states in the U.S. prohibit direct-entry midwives and home births, although certified nurse midwives may practice in hospitals under a physician's control.").

262. *See* Laufer-Ukeles, *supra* note 261; *see also* BLOCK, *supra* note 211, at 180-83 (discussing "complicated" legal landscape for midwives).

263. *See generally* Gail A. Robinson, *Midwifery and Malpractice Insurance: A Profession Fights for Survival*, 134 U. PA. L. REV. 1001 (1986).

There are many reasons to be critical of the particular practices and norms that characterize the modern American way of birth. However, one need not fully embrace that normative critique to appreciate the empirical point that non-incarcerated women navigate pregnancy and delivery through a complicated set of norms, practices, legal constraints, and sub-legal pressures that limit their autonomy in complicated and substantial ways.

III. CONSTRAINT AND COERCION IN MULTIPLE CONTEXTS: OBSERVATIONS TOWARDS A FULLER ACCOUNT OF INCARCERATED CHILDBIRTH

In recent years, activists and scholars have begun to focus some attention on the problems faced by women who are pregnant and give birth in jails and prisons.[264] Their work has focused public attention on practices that are particularly jarring – such as the shackling of pregnant prisoners and the limited contact most incarcerated mothers are allowed with their newborns.[265] The focus on these particular indignities are well-chosen to raise the ire of sympathetic segments of the non-incarcerated population, as these limitations and abuses are in conflict with the birth experiences of the vast majority of non-incarcerated women and are dramatic and sensational.

The focus on practices like shackling provides substantial insight into the nature and meaning of our current regime of incarcerated childbirth and motherhood. As these scholars and activists have demonstrated, the restrictions and challenges imposed on pregnant prisoners embody and reflect deep-seated attitudes about both the role of the prison in contemporary American society and our cultural attitudes towards the demographic groups who predominantly fill our jails and prisons.[266] Moreover, this focus on prisoner-specific practices like shackling helps to underscore the reality that the kinds of constraints that women face when they are pregnant and in correctional facilities are more serious than those that women face outside of an incarcerative setting. This is not surprising – prisoners exercise much less control over their day-to-day environments than do women who are not prisoners, and prisoners lack political power.[267] The fact that the policies imposed on wom-

264. *See* Alexander, *supra* note 7, at 436.

265. *See id.*

266. *See* Ocen, *supra* note 7 (finding that the popularity of shackling pregnant prisoners derives from a long cultural tradition of constraining, degrading, and criminalizing sexuality and reproduction of African-American women).

267. *See Felony Disenfranchisement Laws in the United States*, THE SENTENCING PROJECT (Sept. 2008). http://legaltimes.typepad.com/blt/files/fd_bs_fdlawsinus.pdf (prisoners are formally disenfranchised in forty-eight out of fifty states at least for the duration of incarceration). This inability to directly affect elections, however, is probably not the main reason why prisoners lack political power, nor is the inability to organize probably the major impediment to influence. Rather, in the past several decades, the law and order movement has vastly expanded the prison state, shifted the

en who give birth in the prison setting are broader in scope and more inflexible in application than birthing women would expect outside of a prison is such a natural outgrowth of the modern penal mindset that it borders on a truism.

However, those observations notwithstanding, this Article has illustrated that most of the constraints imposed on pregnant and laboring prisoners differ in degree rather than in kind from those imposed on non-incarcerated women. While it is tempting to focus on practices such as shackling and conclude that the problems women face when pregnant or giving birth in prison are simply a subset of problems that incarcerated persons generally experience, a broader survey of the obstacles and constraints faced by women giving birth inside and outside of prison complicates that narrative. When it comes to crucial matters like choosing the time and method of delivery, avoiding unwanted surgery, and negotiating the details of pain relief, constraints on the autonomy of pregnant women are relatively common outside of a prison setting[268] and reflect broader themes of social control that are directed towards pregnant and parenting women.[269]

Reading the problems of autonomy and control for pregnant prisoners in conjunction with the problems non-incarcerated women experience in these areas provides insight on a number of levels. First, it allows us to focus on the permeability – and at times circularity – of those categories of regulated women. As I have illustrated,[270] by becoming pregnant, a non-incarcerated woman puts herself in danger of incarceration, as prosecutors and judges have developed creative mechanisms for prosecuting and detaining pregnant or recently pregnant women who engage in or fail to engage in particular pregnancy and parenting behaviors. The threat of criminal prosecution hangs over pregnant women, even those not yet – or not currently – in custody.

Second, by looking at the two populations side-by-side, we notice that similar dynamics of race, class, and mental illness or substance addiction influence the restraints imposed on pregnant and laboring women inside and outside of prison. The kinds of women who experience legal and sub-legal constraints outside of a prison setting are those who most closely resemble the population of women that is incarcerated. Most women who are incarcerated, as this Article has noted, are poor and/or dependent on public support, and the majority are women of color.[271] Many cases involve drug-addicted women, for whom resources both in and outside of prison are sparse.[272] Most

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focus of imprisonment from rehabilitation towards retribution, imposed increasingly punitive sanctions, and construed the incarcerated as dangerous others.

268. Complaint for Petitioner, *supra* note 252.

269. *See generally* BLOCK, *supra* note 211.

270. *See supra* notes 33-34 and accompanying text.

271. For demographics of female offenders, see generally Greenfeld & Snell, *supra* note 22; *see also supra* notes 5-6, 19-23.

272. *See* Parker, *supra* note 11, at 263 (reporting substance abuse statistics for prisoners); Paltrow & Flavin, *supra* note 17, at 310 (noting substance abuse statistics for women subjected to formal pregnancy interventions).

of the cases of formal civil legal constraints similarly involve poor women who are predominantly from minority groups.[273] The population of women subject to civil sanction is also centered geographically in the heavily incarcerative southern states,[274] is disproportionately mentally ill,[275] and is highly likely to have a history of or face an allegation of substance abuse.[276] At a fundamental level, the lack of respect for the reproductive autonomy of incarcerated women mirrors the lack of respect those same women were likely to face (and sometimes did face), based on their demographics, outside of prison walls.

Third, focusing on issues like forced inductions and the refusal to perform VBACs rather than exclusively on issues like shackling allows us to see both how difficult and how essential it is to establish reproductive justice and autonomy in the prison context. To the extent that we conceptualize the problem of incarcerated childbirth in terms of aberrational practices like shackling, we tempt ourselves into thinking that justice and autonomy can be achieved, either completely or in large measure, by convincing people of the deviance of such practices and rooting them out. However, to the extent that we instead survey the full spectrum of prison-based pregnancy constraints and challenges, we discover that the problems of incarcerated childbirth are much more deeply embedded, implicating broader conceptions about the dignity and moral agency of the regulated women. Moreover, by identifying similar patterns in the treatment of non-incarcerated women,[277] and by relying on the literature that has already analyzed and critiqued such restrictions,[278] we begin to understand the degree to which those troubling assumptions about maternal dignity and autonomy transcend the prison context.

Relying on that literature and on side-by-side comparisons between incarcerated and non-incarcerated childbirth also allows us to understand the full spectrum of coercion at play in the prison setting. Pregnant prisoners are often subject to constraints that take the form of formal prohibitions and requirements, but they are also often the subject of less formal mechanisms of manipulation and control, including foot-dragging, hectoring, and manufactured consent.

Ultimately, the greatest benefit from exploring the similarities between incarcerated and non-incarcerated childbirth may relate to our understanding of the experiences of non-incarcerated women. To the extent that the problems of incarcerated childbirth are but a symptom of our broader dehumanization of prisoners (or of women of color), then non-incarcerated childbirth is the golden other, the free alternative to the soul-deadening institution of in-

273. *See* Paltrow & Flavin, *supra* note 17, at 310-11.

274. *See id*. at 310 (noting that 56% of cases arose in the South).

275. *See id.*

276. *See id*. (noting that 84% of cases involved mention of an illicit substance); *id*. at 311 (noting that 43% of women were formally charged with a drug crime).

277. *See supra* Parts I-II.

278. *See supra* Part II.C.

carcerated childbirth. But reproductive autonomy is more than freedom from shackles; it involves full information, free choice, and interactions with personnel who respect your dignity and moral agency. These are values that are often ignored or given only passing lip service in the pregnancy and birth experiences of women both inside and outside of prison.[279]

While the prison setting brings the capacity for control into sharp focus because incarcerated women are not conceptualized as free actors, women outside of correctional control historically have faced, and continue to face, the possibility that their decisions about pregnancy and childbirth will be made by other people. There are power dynamics non-incarcerated women face in navigating and negotiating the pregnancy and birthing experiences they want. Formal legal constraints may directly dictate choices. The shadows of those formal legal constraints may also shape choices – even if a pregnant woman is not prosecuted or subject to court order, the knowledge that those options are available may prompt her to agree to an undesired medical course. The women who face or are threatened with formal sanctions are often women from disadvantaged groups who may not have the educational background to effectively advocate for themselves in court or in a medical setting. The power imbalance based on race, class, gender, education, profession, and information contributes to the constraint on choice. While anyone in a medical setting may find themselves in a difficult position, laboring women are in a particularly poor place from which to negotiate.

CONCLUSION

The constraints that incarcerated women face when pregnant or giving birth thus may at first seem a subset of the general problems that prisoners face: prisoners may be denied access to adequate living standards and health care; there are women in prison who are pregnant; and, therefore, women who are pregnant and in prison may be denied adequate living standards and health care. As prisons have less experience dealing with specific needs of female prisoners, and as only female prisoners will be pregnant, perhaps the problems that pregnant and birthing women experience in prison could simply represent the ordinary problems of prisoners compounded by an incarcerative system that is not adept at addressing women's issues. This Article argues otherwise.

While a smattering of academic articles have addressed separately the issues of pregnancy and birthing constraints in jails and prisons (generally focusing on shackling and arguing that shackling demonstrates that gender-neutral policies impact women negatively) and on discrete issues faced by non-incarcerated women during pregnancy and childbirth,[280] this Article draws together the articles and cases involving both sets of women. This

279. *See supra* notes 106-118 & 177-218 (narrating stories).

280. *See* BLOCK, *supra* note 211, at 249; Ehrenreich, *supra* note 177, at 525-26; sources cited *supra* note 7.

Article has documented that incarcerated women face considerable restrictions on their ability to choose the conditions of their pregnancy and birth, and to have a healthy pregnancy and birth regardless of any choices they might make.[281] This Article has also demonstrated that women who are not incarcerated can face criminal prosecution for their pregnancy and birthing choices;[282] civil court orders to direct their pregnancy and birth activities;[283] formal medical policies that limit their ability to make decisions;[284] and sub-legal policies and pressures that shape pregnancy and birth in directions the mother may not desire.[285]

While the regulation of incarcerated pregnancy and birth is more severe in degree than that experienced by non-incarcerated women, and while some of those restrictions are different in kind than those experienced by non-incarcerated women, the parallels between the experiences of incarcerated and non-incarcerated women are striking. We see that women who are not perceived to be good candidates for motherhood in the first place – women who are poor, who are from minority groups, who do not speak English, and/or who are mentally ill – are much more likely to find themselves incarcerated, to find themselves subject to pregnancy and birthing constraints when not incarcerated, and to become incarcerated based on pregnancy and birthing choices. The kinds of experiences that women have while incarcerated are therefore similar to the kinds of experiences women have who are not incarcerated – the experiences that pregnant women have in prison stem in part from their incarcerated status, but also in part from their status as women whose race, class, mental health, or similar factors make them targets for social control.

281. *See supra* Part I.
282. *See supra* notes 33-34.
283. *See supra* Parts II.A-B.
284. *See supra* Part II.C.
285. *See supra* Part II.C.