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The Patient Protection and Affordable Care Act and Choice in Childbirth: How the ACA's Nondiscrimination Provisions May Change the Legal Landscape of Childbirth

Caitlin McCartney

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THE PATIENT PROTECTION AND AFFORDABLE CARE ACT AND CHOICE IN CHILDBIRTH: HOW THE ACA'S NONDISCRIMINATION PROVISIONS MAY CHANGE THE LEGAL LANDSCAPE OF CHILDBIRTH

CAITLIN MCCARTNEY*

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INTRODUCTION

The vast majority of births in the United States take place in a hospital setting.¹ Trends over the past decade suggest, however, that the number of hospital births has been declining. Between 2004 and 2013, there was a 56 percent increase in non-hospital births in the United States.² Most of these non-hospital births took place at home or in a birthing center³ and were attended by a midwife.⁴ There are many factors that may be influencing this upswing in non-hospital births—these include grassroots advocacy by groups promoting home birth, efforts to expand access to midwifery through state legislatures,⁵ and growing awareness of the high number of medical interventions that often occur in hospital births.⁶ Women desire meaningful options concerning care and medical intervention during childbirth, and this interest is not confined to whether the birth will occur in the hospital. Women also often want to have the final say over other decisions regarding their pregnancy and labor—for example, the decisions to take medication, to agree to certain invasive tests, or to give birth vaginally or through cesarean section.

Yet there are various legal obstacles to the exercise of such choices, both at home and in the hospital. These include state licensure laws that restrict the practice of midwifery; the failure of courts to recognize constitutional protections for midwives, their clients, and pregnant women who experience unwanted medical interventions during childbirth; and the narrow scope of malpractice remedies for individuals, compared with hospitals’ interest in limiting possible malpractice liability.

1. See MARIAN F. MACDORMAN ET AL., NATIONAL CENTER FOR HEALTH STATISTICS, TRENDS IN OUT-OF-HOSPITAL BIRTHS IN THE UNITED STATES, 1990–2012 (2014), <http://www.cdc.gov/nchs/data/databriefs/db144.htm#x2013;2012> [hereinafter MacDorman et al., 2014].

2. See *id.*

3. See *id.*

4. See *id.*

5. See e.g., State Resource Center, AM. C. OF NURSE-MIDWIVES, <http://www.midwife.org/State-Resource-Center>; CPMS Legal Status by State, THE BIG PUSH FOR MIDWIVES, <http://pushformidwives.org/> (last visited Apr. 20, 2015).

6. See e.g., Grassroots Advocacy, AM. C. OF NURSE-MIDWIVES, <http://www.midwife.org/Grassroots-Advocacy> (last visited Apr. 20, 2015).

Recent developments in the U.S. health care system have created new legal protections that may increase women's access to choice in birth. Two provisions of the Patient Protection and Affordable Care Act of 2010 (ACA) prohibit discrimination against providers and patients, respectively.⁷ Section 2706(a) of Title XXVII of the ACA [hereinafter "Section 2706(a)"], which went into effect in January 2014, prohibits health insurance issuers from discriminating against "any health care provider who is acting within the scope of that provider's license or certification under applicable state law."⁸ This prohibits insurance companies that participate in the healthcare marketplace from refusing coverage of midwifery services in states where midwives are licensed providers. Section 1557 of Title XLII [hereinafter "Section 1557"] of the ACA prohibits discrimination by health care providers against certain patients.⁹ This law is the first civil rights provision to protect women from sex-based discrimination in healthcare; it also prohibits discrimination on the basis of race, color, national origin, age, or disabilities.¹⁰

This paper explores how the ACA's nondiscrimination provisions may increase women's ability to make crucial choices about pregnancy and childbirth, ranging from choosing where to give birth, choosing whether to use the services of a midwife, and deciding which medical interventions are desired—and when they are necessary. Part I offers a background of choice in birth, explaining trends in childbirth historically, in the United States today, and in other developed countries. It also clarifies the difference between midwives and physicians, explains the arguments for and against home births, and explains several issues women sometimes face in hospital births. Part II discusses the legal obstacles to home birth, including state licensure laws and the failure of courts to recognize constitutional, antitrust, and other legal arguments as protecting unlicensed midwives and their clients; it then describes how the nondiscrimination provisions of the ACA may increase access to home birth, birth at a birth center, and midwifery services. Part III explains the legal obstacles women face when they experience emotional trauma or injury at the hands of an obstetrician or other medical staff during childbirth and argues that the recently passed civil rights law may be more effective than tort law at systematically addressing forced detainment and medical treatment of

7. 42 U.S.C. § 18001 et seq. (2012).

8. 42 U.S.C. § 300gg-5 (2012).

9. 42 U.S.C. § 18116 (2012).

10. *Section 1557 of the Patient Protection and Affordable Care Act*, U.S. DEP'T OF HEALTH & HUMAN SERVS., <http://www.hhs.gov/ocr/civilrights/understanding/section1557/> (last visited Mar. 7, 2016).

pregnant women by medical personnel, as well as holes in informed consent with pregnant patients. Part IV concludes.

I. CHOICE IN CHILDBIRTH

A. History of Midwifery and Childbirth in the United States

As the Introduction notes, home birth in the United States has gained steam rapidly over the course of the last decade. In 2012, 1.36 percent of births occurred outside of a hospital.¹¹ This is a small percentage of births—but it is up from 87 percent of births in 2004, which marks a 56 percent increase after several decades of very low rates of out-of-hospital births.¹² In several states, the percentage of births occurring outside of the hospital is even higher than the national average, ranging from 3 to 6 percent of all births.¹³ About two-thirds of non-hospital births in the United States take place at home, while one-third occur in a birth center.¹⁴

The sudden increase in home births is something of an anomaly in the modern-day United States, but is not so unusual when compared to modern-day childbirth norms in other developed countries¹⁵ or even the history of childbirth in the United States. Childbirth was not considered a “medical” event for much of U.S. history,¹⁶ and from colonial times until the Great Depression, most births were attended by a midwife.¹⁷

Several social and medical changes, beginning with the use of anesthesia during childbirth in the Victorian period, led to the gradual medicalization of childbirth—and the movement of childbirth from the home to the hospital.¹⁸ Milestones such as the invention of penicillin and the

11. See MacDorman et al., 2014, *supra* note 1.

12. See *id.*

13. See *id.* (“In 2012, out-of-hospital births comprised 3%–6% of births in Alaska, Idaho, Montana, Oregon, Pennsylvania, and Washington, and between 2% and 3% of births in Delaware, Indiana, Utah, Vermont, and Wisconsin.”).

14. See *id.* (defining a birth center as a homelike healthcare facility staffed by midwives).

15. See *infra* Part I (iii).

16. See LAUREL THATCHER ULRICH, *A MIDWIFE’S TALE: THE LIFE OF MARTHA BALLARD, BASED ON HER DIARY, 1785-1812* 183 (1991).

17. See JUDITH WALZER LEAVITT, *BROUGHT TO BED: CHILD-REARING IN AMERICA, 1750-1950* 12 (1986).

18. See Richard B Clark, *Fanny Longfellow and Nathan Keep*, AMERICAN SOCIETY OF ANESTHESIOLOGISTS http://anestit.unipa.it/mirror/asa2/newsletters/1997/09_97/FannyLongfellow_0997.html (last visited Feb. 26, 2016) (stating the first known recipient of anesthesia during childbirth in the United States was Fanny Longfellow, the wife of Henry Wadsworth Longfellow. After the birth, Fanny praised the anesthesia, writing to friends that she

dissemination of information on sanitation actually ended a trend of hospital births having higher fatality rates than home births, which was due to the spread of infection in hospital wards.¹⁹ In 1900, there were still relatively few births taking place in hospitals.²⁰ By 1950, more than 80 percent of births took place in the hospital, under the care of a physician, rather than a midwife;²¹ by 1969, the percentage rose to 99 percent of births.²²

1. *Childbirth Today: United States*

Until 2004, the rate of hospital birth for U.S. women hovered around 99 percent.²³ Beginning in 2004, until 2012, the last year for which data is available, the rate of hospital births declined. In this time period, most home births were to non-Hispanic white women. In 2012, the rate of planned home births remained below 1 percent for African American, Hispanic, American Indian, and Asian/Pacific Islander women, while 2.05 percent of births to non-Hispanic white women occurred outside of the hospital.²⁴ There are higher rates of out of hospital births in the northwestern states: Washington, Montana, Oregon, Idaho, and Alaska all have out of hospital birth rates of 3 percent or more.²⁵ There is also evidence that home birth has become safer over the past decade. Between 2004, and 2012, the percentage of out-of-hospital births resulting in preterm babies declined from 6.7 percent to 4.4 percent, and the proportion born at low birth weight declined from 4.8 percent to 3.2 percent.²⁶ In 2009, most home births were attended by midwives—about 62 percent.²⁷

felt “like a pioneer to less suffering for poor, weak womankind); *see also* Charles B. Pittinger, Letter to the Editor, *The Anesthetization of Fanny Longfellow for Childbirth on April 7, 1847*, 66 ANESTHESIA & ANALGESIA 368, 369 (1987).

19. *See* JACQUELINE H. WOLF, DELIVER ME FROM PAIN: ANESTHESIA AND BIRTH IN AMERICA (2011); Chris Hafner-Eaton & Laurie K. Pearce, *Birth Choices, the Law, and Medicine: Balancing Individual Freedoms and Protection of the Public Health*, 19 J. HEALTH POL. POL’Y & L. 813, 815 (1994).

20. *See* MARIAN F. MACDORMAN ET AL., NATIONAL CENTER FOR HEALTH STATISTICS, HOME BIRTHS IN THE UNITED STATES: 1990-2009 1 (2012), <http://www.cdc.gov/nchs/data/databriefs/db84.pdf> [hereinafter MacDorman et al., 2012].

21. WALZER LEAVITT, *supra* note 17, at 12.

22. *See* MacDorman et al., 2012, *supra* note 20, at 1.

23. *Id.*

24. MacDorman et al., 2014, *supra* note 1, at 2.

25. *Id.*

26. *Id.*

27. *Id.*

About 7 percent of hospital births are attended by midwives,²⁸ and over 90 percent of hospital births are attended by a physician—over 90 percent.²⁹

There has been an increase in midwife attendance to women in hospital births.³⁰ Because the percentage of midwife-attended hospital birth is relatively low, at just over 7 percent,³¹ there is not reliable data about whether midwife care in hospital births affects ultimate outcomes in births. This information would be especially significant in cases of women who are at-risk for poor childbirth outcomes due to factors such as health conditions, race and socioeconomic status, or chronic stress. Data suggests that Certified Nurse Midwives attending hospital birth may perform more robust screenings of certain risk factors, such as domestic violence.³² This information would be significant—and especially relevant today. The U.S. maternal and infant mortality rates³³ have been rising over the past decades.³⁴ Since 1990, the United States has experienced a larger increase in infant mortality than any developed country,³⁵ and more than forty countries have lower maternal mortality rates than the United States.³⁶

28. See generally MacDorman et al., 2012, *supra* note 20, at 3; see also *Fact Sheet: CNM/CM – Attended Birth Statistics in the United States*, AM. C. OF NURSE-MIDWIVES, http://www.midwife.org/ACNM/files/ccLibraryFiles/FILENAME/000000004002/CN-M-CM-AttendedBirthStatistics2014_FINAL.pdf (last updated March 2014).

29. See MacDorman et al., 2012, *supra* note 20, at 3.

30. See *CNM/CM-attended Birth Statistics*, AM. C. OF NURSE-MIDWIVES, <http://www.midwife.org/CNM/CM-attended-Birth-Statistics> (last updated June 2015).

31. See *id.*

32. See Carolyn M. Sampselle et al., *Prevalence of Abuse Among Pregnant Women Choosing Certified Nurse-Midwife or Physician Providers*, 37(4) J. MIDWIFERY & WOMEN'S HEALTH 269, 273 (1992); see also Marian MacDorman & Gopal K. Singh, *Midwifery Care, Social and Medical Risk Factors, and Birth Outcomes in the USA*, 52 J. EPIDEMIOLOG. COMMUNITY HEALTH 310, 316 (1998) (explaining that CNMs tend to spend more time with patients in prenatal visits, compared with physicians).

33. These indicators measure the number of women who die annually from causes related to pregnancy and childbirth, and the number of infants who die annually in the first year of life. The maternal mortality rate is measured per 100,000 live births, and the infant mortality rate is measured per 1,000 live births.

34. See Nicholas J. Kassebaum, *Global, Regional, and National Levels and Causes of Maternal Mortality During 1990-2013: A Systematic Analysis for the Global Burden of Disease Study 2013*, 384 THE LANCET 98-1004, 990, 998-99 (2014), [http://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(14\)60696-6/fulltext](http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(14)60696-6/fulltext).

35. See generally *id.*

36. See The World Factbook, Central Intelligence Agency, Country Comparison: Maternal Mortality Rate, <https://www.cia.gov/library/publications/the-world-factbook/rankorder/2223rank.html> (last visited Apr. 18 2015); AMNESTY INTERNATIONAL, MATERNAL HEALTH IN THE U.S., <http://www.amnestyusa.org/our->

Ethnic and racial disparities in these rates have existed for more than one hundred years³⁷ and continue today. The infant mortality rate for black women is more than double that of non-Hispanic white women.³⁸ Racial disparities persist even when factors such as socioeconomic status, recreational drug and alcohol use, and education level are controlled for.³⁹ Many factors may contribute to rising maternal and infant mortality rates, including: health conditions; lifestyle choices, including drug or alcohol use; age; quality of medical care and facilities; and overall wellbeing, including stress level.⁴⁰

Because the high percentage of hospital births in the United States does not seem to correlate with comparatively low rates of maternal and infant mortality, further studies are necessary for understanding whether aspects of midwifery care, including emphases on the family unit, physical and

work/campaigns/demand-dignity/maternal-health-is-a-human-right/maternal-health-in-the-us (last visited Apr. 15, 2015).

37. See generally SAM SHAPIRO ET AL., *INFANT, PERINATAL, MATERNAL AND CHILDHOOD MORTALITY IN THE UNITED STATES* (1968) (noting that in the United States, racial disparities have been found in childbirth outcomes since data was first collected).

38. See Marian F. MacDorman & T.J. Matthews, NAT'L CTR. FOR HEALTH STATISTICS, *UNDERSTANDING RACIAL AND ETHNIC DISPARITIES IN U.S. INFANT MORTALITY RATES 1* (2011), <http://www.cdc.gov/nchs/data/databriefs/db74.pdf> (noting that the infant mortality rate in 2007 was 2.4 times higher for non-Hispanic black women than for non-Hispanic white women).

39. See Richard E. Behrman & Adrienne Stith Butler, *Sociodemographic and Community Factors Contributing to Preterm Birth*, in *PRETERM BIRTH: CAUSES, CONSEQUENCES, AND PREVENTION* (2007), <http://www.ncbi.nlm.nih.gov/books/NBK11362/> (“Conventional wisdom often regards race as a proxy for condition, and some believe that socioeconomic factors (often measured in terms of educational attainment, household income, or occupational status) explain differences in preterm birth rates by race. [. . .] However, in most studies the differences in preterm birth rates, [. . .] birth weights [. . .] and infant mortality rates [. . .] between African American and white women persisted after adjustment for (measured) socioeconomic differences. Furthermore, socioeconomic condition does not confer equal protection across racial-ethnic groups.”); see also L.F. Beck et al., *Prevalence of Selected Maternal Behaviors and Experiences, Pregnancy Risk Assessment Monitoring System (PRAMS), 1999*, 51 *SS02 MORBIDITY AND MORTALITY WKLY REP.* 1, 27 (2002) (finding that black women are less likely than white women to report smoking during pregnancy); M. Serdula et al., *Trends in Alcohol Consumption by Pregnant Women, 1985 through 1988*, 265 *JAMA*, 876, 879 (1991).

40. See generally Charles J. Homer et al., *Work-Related Psychosocial Stress and Risk of Preterm, Low Birthweight Delivery*, 80 *AM. J. OF PUB. HEALTH*, 173, 177 (1990), <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1404615/pdf/amjph00215-0037.pdf> (finding that women working during pregnancy in jobs characterized by high demand and low control were twice as likely to deliver a low birthweight, preterm infant, compared with women working in less stressful jobs).

psychological health both before and after the birth; and the provision of individualized education and counseling may be useful in combating these rising mortality rates and other adverse outcomes in birth.⁴¹

2. *Childbirth Today: Europe*

Several European countries provide interesting counterexamples to the United States, due to higher rates of home birth and higher rates of midwife-attended births. In the Netherlands, which has an official system for home birth, hospital birth is not the standard but is one of several accepted alternatives. In 2010, more than 16 percent of births in the Netherlands took place in the home and more than 11 percent took place in a birthing center.⁴² Several other European countries have rates of home births that exceed that of the United States but that do not reach the Netherlands' rates. In Wales, 3.7 percent of births occur at home; in England, 2.7 percent; in Iceland, 1.8 percent.⁴³ In Germany, Denmark, and Belgium, home births account for between 1 and 2 percent of all births.⁴⁴

In addition to having higher rates of home births, several European countries also see an extremely high percentage of hospital births attended by midwives. In Denmark and France, midwives attend nearly all births, whether they take place at home or in the hospital.⁴⁵ More than 70 percent of births are attended by midwives in England, Ireland, and Germany.⁴⁶ In the United States, midwives attend just 7 percent of hospital births.⁴⁷

The maternity care customs in the European countries mentioned above, while not identical, share several characteristics, which may shed light upon both why women in the United States wish to seek midwifery services and a home birth, and also the motivations of governments that promote midwifery and home birth. First, as evidenced by the high rates of midwives attending both home and hospital births, these countries tend to incorporate midwives into standard maternity care.⁴⁸ They also promote home birth as safe.⁴⁹ For a recent example, Britain's national health

41. *Midwives Model of Care*, CITIZENS FOR MIDWIFERY, <http://cfmidwifery.org/mmoc/define.aspx>.

42. EURO PERISTAT, EUROPEAN PERINATAL HEALTH REPORT, HEALTH AND CARE OF PREGNANT WOMEN AND BABIES IN EUROPE IN 2010 19 (2010), http://www.europeristat.com/images/doc/EPHR2010_w_disclaimer.pdf.

43. *See id.*

44. *See id.*

45. JUDITH PENCE ROOKS, MIDWIFERY AND CHILDBIRTH IN AMERICA 406 (1997).

46. *See id.*

47. *See* MacDorman et al., 2012, *supra* note 20.

48. *See* PENCE ROOKS, *supra* note 45, at 394.

49. *See e.g., id.* at 401 (explaining that in most European Union countries,

service, the National Institute for Health Care and Excellence, issued guidelines in December 2014 advising women that for low-risk pregnancies, it is safer to give birth in the home or in a birthing center than in a hospital, due to the lower risk of a medically unnecessary intervention.⁵⁰ Finally, the costs associated with childbirth are considerably lower in countries that integrate midwifery services into maternal healthcare.⁵¹ Healthcare systems that integrate midwifery services show that these are safe, cost-effective, and provide women with an alternative to physician-led care during pregnancy and childbirth.

For many women in the United States, unfortunately, choosing to have a home birth—or even to use the services of a midwife in a hospital birth—is simply not a meaningful option, as it is in several other developed countries. Yet increasing interest in home birth over the past decade reflects an important demand for this option. In light of rising maternal and infant mortality rates in the United States, it is especially important that further studies are conducted about midwives' potential to positively impact outcomes. It is also important that legislatures, in regulating access to midwifery, inform their decisions with facts, rather than rely solely on the discourse of risk.

B. *Midwife v. Physician*

1. *What Midwives Do*

There are several types of midwives that practice in the United States. These vary in the extent and type of training and education they receive, as well as in their level of licensure, regulation, or restriction in various states. This paper discusses three categories of midwives: Certified Nurse Midwives (CNMs), who obtain a degree in nursing as well as specialized training in midwifery; Certified Professional Midwives (CPMs), who are trained and certified by a national organization; and Lay Midwives, who train primarily by apprenticeship and are regulated by the fewest number of states—and actually statutorily barred from practicing in ten states and the District of Columbia.⁵²

midwives play significant roles even in pregnancies with complications).

50. See Katrin Bennhold & Catherine Saint Louis, *British Regulator Urges Home Births Over Hospitals for Uncomplicated Pregnancies*, N.Y. TIMES, Dec. 3, 2014, http://www.nytimes.com/2014/12/04/world/british-regulator-urges-home-births-over-hospitals-for-uncomplicated-pregnancies.html?_r=0.

51. See ROBBIE DAVIS-FLOYD, BIRTH MODELS THAT WORK 300 (Robbie E Davis-Floyd et al. eds., 2009); PENCE ROOKS, *supra* note 45, at 386-89.

52. See JENNIFER BLOCK, PUSHED: THE PAINFUL TRUTH ABOUT CHILDBIRTH AND MODERN MATERNITY CARE 180 (2007) (noting that these states are: Alabama, Illinois, Indiana, Iowa, Kentucky, Maryland, Missouri, North Carolina, South Dakota, and

2. *Arguments for and Against Home Birth*

Today, there is debate over the role midwives and physicians should optimally play in childbirth. Proponents of midwifery argue that midwives and physicians have different approaches to childbirth.⁵³ Midwives consider childbirth a normal process. Pregnancy and labor are only a part of their wider focus; in addition to helping women with the biological aspects of conception, pregnancy, childbirth, and breastfeeding, midwives are also concerned with the impact of the birth on others in the household, the infant's adjustment to life outside of the womb, and other "social, cultural, spiritual and ceremonial aspects of pregnancy and childbirth."⁵⁴ Women who want to give birth at home or in a birth center, attended by a midwife, often prefer the comfort of a home or home-like setting. At home, women have the opportunity to surround themselves with friends and family during the labor.⁵⁵ They can also move freely and are able to eat, drink, or do anything else that would make them more comfortable.⁵⁶

Supporters of midwifery and home birth are not only concerned with the benefits of giving birth under the care of a midwife—they also often have reasons for wanting to avoid hospital birth. Women who give birth in hospital settings are far more likely to undergo unnecessary medical interventions, including electronic fetal monitoring, anesthesia, induced labor, and cesarean section.⁵⁷ In addition to being costly, these interventions are often unnecessary for a pregnancy with no complications. They also have risks of their own, including making additional medical interventions necessary.⁵⁸ Cesarean sections, like any other surgery, can be

Wyoming).

53. See e.g., Laura D. Hermer, *Midwifery: Strategies on the Road to Universal Legalization*, 13 HEALTH MATRIX 325, 336–37 (2003); Jill Cohen, *The Homebirth Choice*, MIDWIFERY TODAY (2008), <http://www.midwiferytoday.com/articles/homebirthchoice.asp#Types>.

54. PENCE ROOKS, *supra* note 45, at 395.

55. See *id.* at 481–82.

56. See *id.* at 481.

57. See Kenneth Johnson & Betty-Anne Daviss, *Outcomes of Planned Home Births with Certified Professional Midwives: Large Prospective Study in North America*, 330 BRIT. MED. J. 1416 (2005); NK Lowe, *Context and Process of Informed Consent for Pharmacologic Strategies in Labor Pain Care*, 49 J. MIDWIFERY & WOMEN'S HEALTH 250–59 (2004).

58. The "Cascade effect" is a phenomenon in which one intervention may cause a need for the next; for example, fetal monitoring can slow labor; an induction administered to speed up delivery may lead to increased pain; increased pain can lead to an epidural; an epidural can distress the fetus and make a C-section necessary. See HENCI GOER, *THE THINKING WOMAN'S GUIDE TO A BETTER BIRTH* 96 (1999); see also M. Sara Rosenthal, *Socioethical Issues in Hospital Birth: Troubling Tales from a*

risky, and maternal mortality rates are two to six times higher in women who undergo this procedure; yet during the last decade, rates of cesarean section reached an all-time high in the United States, at 32 percent of all births.⁵⁹ Many advocates of midwifery and home birth point to this as an example of physician focus on the diagnosis and management of pregnancy as a pathological process—rather than a normal life event. Other issues women who give birth in a hospital sometimes face include lack of informed consent and the feeling that they are not in control of the labor and delivery.⁶⁰ While physicians might be motivated by the convenience of a quick childbirth, the pay that comes from ordering additional medical tests or procedures, or the fear of liability for anything that could go wrong during the birth, midwives make an effort to prioritize the pregnant or laboring woman's comfort and instincts.

Of course, there are two sides to this argument. Medical groups in the United States, including the American College of Obstetricians and Gynecologists (ACOG) and the American Academy of Pediatrics (AAP), have issued guidelines asserting that childbirth is safest when it takes place in a hospital, under the care of a physician.⁶¹ The American Medical Association (AMA) has published a resolution asking state legislatures to pass legislation prohibiting home birth.⁶² There are many medical problems that can arise during childbirth—both for the laboring woman and her fetus or the newborn child.⁶³ Physicians believe that these risks make hospitals the safest place for labor and delivery. When emergencies occur, hospitals are equipped to quickly intervene surgically or

Canadian Sample, 49 SOCIOLOGICAL PERSPECTIVES 369, 372 (2006) (“Once the first intervention is introduced, the laboring woman has the sense that she has lost control of the experience and that she is at the mercy of the hospital staff.”).

59. See FAY MENACKER & BRADY E. HAMILTON, U.S. DEPT. OF HEALTH AND HUMAN SERVS., RECENT TRENDS IN CESAREAN DELIVERY IN THE UNITED STATES 1 (2010), <http://www.cdc.gov/nchs/data/databriefs/db35.pdf> (showing an increase in Cesarean sections from 21 per 100 births in 1996 to 32 per 100 births in 2007).

60. See e.g., Sarah R. Baker et al., “*I Felt as Though I’d Been in Jail*”: Women’s Experiences of Maternity Care During Labour, Delivery and the Immediate Postpartum, 15 FEMINISM & PSYCHOLOGY 315, 315–42 (2005).

61. See Amie Newman, *Bad Medicine: AMA Seeks to Outlaw Home Births*, RH REALITY CHECK (June 16, 2008, 3:28 PM), <http://rhrealitycheck.org/article/2008/06/16/bad-medicine-ama-seeks-to-outlaw-home-births/>.

62. *Id.*

63. See AM. COLL. OF OBSTETRICIANS & GYNECOLOGISTS, COMMITTEE ON OBSTETRIC PRACTICE, PLANNED HOME BIRTH (2011), https://www.acog.org/Resources_And_Publications/Committee_Opinions/Committee_on_Obstetric_Practice/Planned_Home_Birth [hereinafter ACOG COMMITTEE OPINION].

pharmaceutically. Moreover, obstetricians are specialists who have years of medical training.⁶⁴ Hospital resources and trained personnel minimize risks and optimize preparation for emergencies.⁶⁵

Additionally, some proponents of hospital birth cite the costs of an integrated home birth system as a concern. The costs of maintaining home birth as a safe and widely available option include the costs of a transfer system in case of emergencies; personnel, especially where there are shortages; and the legal costs and care costs associated with injuries or disabilities incurred by women and children in emergency situations.⁶⁶

3. *Safety of Home Birth*

In addition to continuing debate about the benefits of midwifery care versus physician care for pregnant and laboring women, there is debate about the relative safety of home versus hospital births. Several studies of planned home births⁶⁷ have shown no increased risk to the woman or child.⁶⁸ These have largely taken place in areas ripe for safe transfers or widespread use of home birth.⁶⁹ Other studies have shown elevated risks to babies born at home.⁷⁰ While there is no consensus among the medical community whether home birth is as safe—or safer—than hospital birth, it is noteworthy that the United States has higher infant and maternal mortality rates than countries that have either higher rates of home birth or higher rates of births attended by midwives, in addition to physicians.⁷¹

64. *Id.* See also *Become an OBGYN: Education Requirements and Career Information*, http://study.com/become_an_obgyn.html (last visited Feb. 26 2016).

65. See ACOG COMMITTEE OPINION, *supra* note 63.

66. See Kelly Fitzgerald, *Home Birth Not As Safe, Cost Effective Or Satisfying As Previously Reported*, MED. NEWS TODAY (Nov. 13, 2012), <http://www.medicalnewstoday.com/articles/252753.php>.

67. Studies that compare the safety of home births with hospital births, but which include unplanned home births, may skew statistics and not fully represent the safety of planned home births. Judith Lothian, *Home Birth: The Wave of the Future?*, 15 J. Perinatal Educ. 43, 44 (2006) (citing Benedetti et al., *Outcomes of Planned Home Births in Washington State: 1989-1996*, OBSTETRICS & GYNECOLOGY 101, 198-200 (2003)).

68. See *id.*; Kenneth Johnson & Betty-Anne Daviss, *Outcomes of Planned Home Births with Certified Professional Midwives: Large Prospective Study in North America*, 330 BRIT. MED. J. 1416 (2005); Janssen et al., *Outcomes of Planned Home Births Versus Planned Hospital Births After Regulation of Midwifery in British Columbia*, 166 Can. Med. Ass'n J. 315, 315 (2002); Murray Enkin et al., A GUIDE TO EFFECTIVE CARE IN PREGNANCY AND CHILDBIRTH 250-51 (3rd ed. 2000).

69. See ACOG COMMITTEE OPINION, *supra* note 62, at 3 (examining planned home births in Washington State, the Netherlands, and British Columbia.).

70. *Id.*

71. See World Factbook, *supra* note 35; Amnesty International, *supra* note 36;

II. HOME BIRTH: LEGAL OBSTACLES TO ACCESS

Several components of the U.S. healthcare system pose potential barriers to women who wish to give birth at home or in a birthing center—and the midwives whose services they use. First, state licensure of midwives and birth centers varies, leaving women with different options for childbirth depending on their state. Second, insurance plans do not always cover midwives and birthing centers. Midwives and others who turn to the legal system in an attempt to overcome these barriers face difficulties there, as well. This section focuses on how midwives, their clients, and their prospective clients are affected by these structural barriers to midwifery access.

A. State Licensure

States have the power to regulate the medical licensing of midwives. There are several different classifications of midwives, which require different levels and types of training, and which have various degrees of recognition and regulation in different states. The primary categories of midwives are Certified Nurse Midwives, Certified Professional Midwives, and Lay Midwives.

1. Certified Nurse Midwives

Certified Nurse Midwives (CNMs) are required to have a nursing degree and to obtain additional education in midwifery through an accredited nurse-midwifery program.⁷² The American College of Nurse Midwives certifies CNMs,⁷³ and CNMs usually work in hospitals or birth centers.⁷⁴ Few CNMs assist in home births, because to do so they must collaborate with a physician.⁷⁵ CNMs are licensed in all states, but several states only license CNMs and not other types of midwives.

Connecticut is one example of a state that licenses CNMs but not other types of midwives.⁷⁶ In Connecticut, CNMs seeking licensure must hold current certification by the American College of Nurse Midwives; be

Shapiro, *supra* note 37.

72. *Become a Midwife*, AM. C. OF NURSE-MIDWIVES, <http://www.midwife.org/Become-a-Midwife>.

73. *Id.* See also Medline Plus, Certified Nurse-Midwife, NATIONAL INSTITUTES OF HEALTH/U.S. NATIONAL LIBRARY OF MEDICINE (2013), <http://www.nlm.nih.gov/medlineplus/ency/article/002000.htm>.

74. *Id.*

75. Cohen, *supra* note 53.

76. *Midwife Licensure Requirements*, Conn. Dep't OF PUBLIC HEALTH (2015), <http://www.ct.gov/dph/cwp/view.asp?a=3121&q=389420> (last visited Feb. 14, 2016).

eligible for registered nurse licensure in Connecticut; and have successfully completed thirty hours of education in pharmacology for nurse-midwifery.⁷⁷ Because Connecticut has no law regulating—or making illegal—lay midwifery, a woman in Connecticut seeking a home birth may find and use the services of a lay midwife. She might, however, have trouble getting an insurance company to cover these services. Insurance providers are not required to cover the services of unlicensed medical actors. Moreover, even though Connecticut neither regulates nor restricts the practice of midwives who are not CNMs, certified professional midwives and lay midwives remain at risk of prosecution for the unlicensed practice of nursing or medicine in states that only regulate CNMs.

Although this legal landscape is not ideal for a woman who wishes to use the services of a midwife but not in a hospital setting, a woman in Connecticut would face fewer obstacles in pursuit of a home birth than a woman in a state that has enacted a prohibition on the practice of lay midwifery. The practice of lay midwifery is unlawful in eleven jurisdictions, including the District of Columbia.⁷⁸ North Carolina is one such state.⁷⁹ The only legal option for a woman seeking a home birth in North Carolina would be to use the services of a CNM under the supervision of a physician. Statutory bans on midwifery have not entirely stopped women from choosing to have their babies at home; instead, they have sent pregnant women and midwives underground.⁸⁰ Although there are lay midwives who will break the law in order to assist in home births—especially when the alternative is a woman giving birth without any medical assistance—these births may be riskier. It may be more difficult for a midwife practicing illegally to make the decision to transfer to the hospital, given her personal stakes in not being detected.⁸¹

2. *Certified Professional Midwives*

Certified Professional Midwives (CPMs) are certified by the North

77. *Id.*

78. See Block, *supra* note 52, at 180.

79. N.C. GEN. STAT. § 90-178.3 (2015).

80. Sara Patterson, *Underground Midwives Flout N.C. Law to Give Moms-to-be More Choices*, CREATIVE LOAFING (Jan. 8, 2014), <http://clclt.com/charlotte/underground-midwives-flout-nc-law-to-give-moms-to-be-more-choices/Content?oid=3298788>.

81. *Id.* (“Every time a midwife is working illegally, there is going to be hesitation about going to a hospital if it becomes necessary,” says Joelle Ceremy, a certified midwife who is licensed to attend home births in South Carolina. “Most of these women have kids themselves, so they’re concerned about their own freedom.”).

American Registry of Midwives (NARM).⁸² To qualify for certification, CPMs train through a combination of education and supervised clinical experience.⁸³ CPMs can only work legally in states that recognize and regulate their profession. About half of the states regulate CPMs through requiring licensure, certification, or registration with the state.⁸⁴ CPMs usually work in birth centers and/or in the home setting.⁸⁵ California is one example of a state that licenses CPMs. In California, CPMs may apply for California midwifery licensure after passing NARM training and certification examination.⁸⁶

3. *Lay Midwives*

A final group of midwives are known as lay midwives.⁸⁷ Compared with CNMs and CPMs, lay midwives generally have less formal training.⁸⁸ Lay midwives generally learn necessary skills through apprenticing with more experienced midwives and assist in home births.⁸⁹ States regulate lay midwifery to various degrees. About half of the states neither regulate nor prohibit lay midwifery. Lay midwifery is unlawful in ten states and the District of Columbia.⁹⁰ Several states explicitly permit lay midwives to practice and have laws regulating aspects of the practice.⁹¹ For example, the Arkansas “Licensed Lay Midwife Act” authorized the Arkansas Department of Health to create rules and regulations for the licensing of lay midwives who wish to practice in the state.⁹² The Department of Health then created guidelines detailing safety protocols for antepartum, intrapartum, postpartum, and newborn care, as well as requirements for

82. *How to Become a CPM*, NORTH AMERICAN REGISTRY OF MIDWIVES, <http://narm.org/certification/how-to-become-a-cpm/> (last updated 2016).

83. *Id.*

84. See *CPMS LEGAL STATUS BY STATE*, THE BIG PUSH FOR MIDWIVES, http://pushformidwives.nationbuilder.com/cpms_legal_status_by_state (last visited Feb. 17, 2016).

85. Medline Plus, *supra* note 73.

86. See *Midwives Application for Licensure*, THE MED. BOARD OF CAL., <http://www.mbc.ca.gov/Applicants/Midwives/> (last visited Feb. 14, 2016).

87. Lay midwives are also known as “direct entry” midwives. Cohen, *supra* note 53.

88. *Id.*

89. *Id.*

90. See BLOCK, *supra* note 51, at 180.

91. Donna M. Peizer, *A Social and Legal Analysis of the Independent Practice of Midwifery: Vicarious Liability of the Collaborating Physician and Judicial Means of Addressing Denial of Hospital Privileges*, 2 BERKELEY WOMEN’S L.J. 139, 176 (2013), <http://scholarship.law.berkeley.edu/cgi/viewcontent.cgi?article=1012&context=bglj>.

92. Licensed Lay Midwife Act, Ark. Code Ann. § 17-85-101 (1987).

emergency situations and transfers.⁹³

Because most states do not regulate lay midwifery—and some states even prohibit it—most women in the United States who desire a home birth may face uncertainty when seeking and financing midwifery services.

4. Birth Centers

Birth centers, defined by the American Public Health Association as “Any health facility, place, or institution which is not a hospital or in a hospital and where births are planned to occur away from the mother’s usual residence following normal, uncomplicated pregnancy,”⁹⁴ are increasingly being used by women who do not wish to give birth at a hospital—but also do not want to give birth at home.⁹⁵ They are often designed to be home-like facilities. The American Association of Birth Centers, which advocates for increased access to and use of these facilities, states that birth centers are guided by “prevention, sensitivity, safety, appropriate medical intervention, and cost effectiveness.”⁹⁶ At birth centers, women are cared for by midwives, with the possibility of transfer to a hospital.⁹⁷

Birth Centers are licensed in forty-one states and operate in eight states that do not license them.⁹⁸ This means that most women can theoretically use a birth center if they choose to; however, insurance coverage can provide a barrier to access. Fifteen percent of women who use birth centers use a form of self payment; about 50 percent use private insurance; 24

93. See generally, *Rules and Regulations for Governing the Practice of Lay Midwifery in Arkansas*, ARK. STATE BOARD OF HEALTH (Apr. 2007), <http://www.healthy.arkansas.gov/aboutadh/rulesregs/laymidwifery.pdf>.

94. *Guidelines for Licensing and Regulating Birth Centers*, AMERICAN PUB. HEALTH ASS’N, <http://www.apha.org/policies-and-advocacy/public-health-policy-statements/policy-database/2014/07/10/13/29/guidelines-for-licensing-and-regulating-birth-centers> (last visited Feb. 25, 2016).

95. MacDorman et al., 2014, *supra* note 1, at 2 (finding that, like home births, birth center births have been rising since 2004 but continue to constitute fewer than 0.5 percent of all U.S. births).

96. *What is a Birth Center?*, AM. ASS’N OF BIRTH CTRS. (2014), http://www.birthcenters.org/?page=bce_what_is_a_bc (last visited Feb. 13, 2016).

97. *Birth Center Results*, AM. ASS’N OF BIRTH CTRS. (2010), https://web.archive.org/web/20130702233946/http://www.birthcenters.org/open-a-birth-center/birth-center-experience/birth-center-results_

98. See Letter from Am. Ass’n of Birth Ctrs. to Mr. Donald S. Clark, Sec’y, FTC 2 (Apr. 30, 2014) (on file with Federal Trade Commission), https://www.ftc.gov/system/files/documents/public_comments/2014/04/00171-90023.pdf.

percent use Medicaid; 2 percent use Medicare; and 3 percent have military coverage.⁹⁹

B. Insurance Coverage

Insurance providers in the United States vary in coverage of midwifery services and birth centers, but legislative changes over the last several years suggest that providers are moving in the direction of greater coverage.

The ACA mandated Medicare coverage for licensed midwives and birth centers.¹⁰⁰ It also prohibited private insurance providers that participate in the Healthcare Marketplace from discriminating against licensed providers, including midwives.¹⁰¹ Medicare has covered midwifery services and birth center births in accordance with state licensure for more than two decades, but the ACA also made positive changes to Medicare coverage by increasing reimbursement for CNMs.¹⁰² Women who are seeking midwifery services states that prohibit or do not license CPMs, lay midwives, and/or birth centers, continue to face obstacles to paying for such services.

C. Legal Obstacles

A variety of circumstances have led midwives to bring legal action defending their right to practice—these have included situations in which midwives were protesting state laws prohibiting midwives from practicing outside of the scope of state licensure¹⁰³ or were disciplined for practicing without a license or enjoined from such practice.¹⁰⁴

There have been many cases in which midwives have put forward constitutional arguments that state statutes restricting or regulating midwifery, or state action disciplining midwives for practicing outside the

99. Rebecca Dekker, *New Evidence Confirms Birth Centers Provide Top-Notch Care*, AM. ASS'N OF BIRTH CTRS. (Jan. 31, 2013), <http://www.birthcenters.org/?page=NBCSII>.

100. *Payment for Certified Nurse-Midwife (CNM) Services*, CTR. FOR MEDICARE & MEDICAID SERVS. (Dec. 7, 2012), <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/mm7005.pdf>.

101. Amy N. Moore, *ACA Prohibits Discrimination Against Licensed Providers, Inside Compensation* (July 31, 2014), <https://www.insidecompensation.com/2014/07/31/aca-prohibits-discrimination-against-licensed-providers/>.

102. See *Payment for Certified Nurse-Midwife*, *supra* note 100.

103. See *Lange-Kessler v. Dep't of Educ. of the State of N.Y.*, 109 F.3d 137, 139 (2d Cir. 1997).

104. *E.g.*, *Leigh v. Bd. of Registration in Nursing*, 481 N.E.2d 1347, 1349 (Mass. 1985); *People ex rel. Sherman v. Cryns*, 786 N.E.2d 139, 144 (Ill. 2003).

scope of state licensure, violate midwives and pregnant women's due process and equal protection rights.¹⁰⁵ Largely, these arguments have been unsuccessful in court. No U.S. court has held that the decision where to give birth is encompassed by the right to privacy, which is considered a fundamental right under the Constitution.¹⁰⁶ Instead, courts have tended to rely on the framework laid out in *Roe v. Wade* and its progeny.¹⁰⁷ In *Roe*, the Supreme Court recognized that at the point of viability, the State has a legitimate interest in the life of the fetus.¹⁰⁸ The Massachusetts Supreme Court, in validating a statutory scheme in which CNMs were licensed, while lay midwives were not, declared that statutes requiring midwives to be licensed according to state law are "adopted precisely to protect this interest [in the health and safety of the fetus and woman]."¹⁰⁹ Other courts have similarly found that the right of privacy, while encompassing some reproductive and procreative choices, does not include the choice to give birth at home with the assistance of an unlicensed midwife.¹¹⁰ Because midwives have not successfully argued that the ability to choose the circumstances of birth should be encompassed as a fundamental privacy right, their constitutional arguments have been limited.

In determining whether state action that does not impinge upon a fundamental right violates the Fourteenth Amendment, a court looks to whether there is a "rational basis" for the state action.¹¹¹ If there is a rational basis for the state action, a court will not find that it unconstitutional. Constitutional claims by midwives that challenge state licensure schemes which exclude midwives, or disciplinary action toward a midwife who has acted outside of such licensure, generally have not been successful because of state interests in protecting the health of women and children. The Second and Third Circuits have both issued such rulings in denying due process claims;¹¹² as the Third Circuit explained, a training

105. *E.g.*, *Lange-Kessler*, 109 F.3d at 139; *Leigh*, 481 N.E.2d at 1349.

106. *See, e.g.*, *Griswold v. Connecticut*, 381 U.S. 479, 484 (1965) (finding a fundamental right to privacy in marital relationships); *see also* *Lawrence v. Texas*, 539 U.S. 558, 564-66 (extending the right to privacy to consensual, homosexual activity).

107. *See generally* *Roe v. Wade*, 410 U.S. 113 (1973).

108. *Id.* at 163.

109. *Leigh v. Bd. of Registration in Nursing*, 506 N.E.2d 91, 93-94. (Mass. 1987).

110. *E.g.*, *Sammon v. N.J. Bd. of Med. Exam'rs*, 66 F.3d 639, 645 (3d Cir. 1995); *People v. Rosburg*, 805 P.2d 432, 437 (Colo. 1991); *State v. Kimpel*, 665 So.2d 990, 994 (Ala. Ct. App. 1995); *Bowland v. Mun. Court*, 556 P.2d 1081, 1088-89 (Cal. 1976); *Hunter v. Maryland*, 676 A.2d 968, 975 (Md. Ct. Spec. App. 1996).

111. *See generally* *United States v. Carolene Prods. Co.*, 304 U.S. 144 (1938).

112. *See* *Lange-Kessler v. Dep't of Educ. of the State of N.Y.*, 109 F.3d 137, 141 (2d Cir. 1997); *Sammon*, 66 F.3d at 645.

requirement was not irrational “given [State] interests in both the technical competence of the entire population of midwives and the health of the entire population of midwife consumers,”¹¹³ and adding that “it is for the legislature, not the courts, to balance the advantages and disadvantages of the . . . requirement.”¹¹⁴ Equal Protection arguments have been defeated under the same rational basis analyses.¹¹⁵

Midwives have also brought legal challenges to midwifery restriction under the Sherman Act, which provides, “[e]very contract, combination . . . or conspiracy, in restraint of trade or commerce among the several States . . . is declared to be illegal.” 15 U.S.C. § 1 (1982). However, courts have held that several actions, including state licensure of midwives,¹¹⁶ the restriction of midwifery practice to licensed facilities,¹¹⁷ and physicians acting with hospitals to limit the admitting privileges of midwives,¹¹⁸ do not constitute restraint of trade.¹¹⁹

D. Section 2706(a) of the ACA and Access to Midwifery

Section 2706(a) of the ACA, which prohibits private insurers from extending coverage to licensed providers, went into effect in 2014. While the statute’s protection is limited to midwives who are acting within the scope of state licensure, it provides a cause of action for licensed midwives and patients when health insurance companies refuse to cover midwifery services. For CNMs and their patients, the law is likely to significantly expand access to midwifery services to those who cannot afford to pay out-of-pocket.

Prior to the passage of the ACA, only thirty-three states had laws in

113. *Sammon*, 66 F.3d at 646.

114. *Id.* (citing *Williamson v. Lee Optical of Oklahoma, Inc.*, 348 U.S. 483, 483 (1955)).

115. *E.g., Rosburg*, 805 P.2d at 439 (explaining that the classification of licensed nurse-midwives versus lay midwives is rational and reasonable. Testimony at trial revealed that nurse-midwives practicing in Colorado are required to be registered nurses, must have an additional year of midwifery training and also must participate in continuing education. The state’s expert in pediatrics and obstetrics testified that the state’s certification of nurse-midwives and prohibition of lay midwifery was ‘very reasonable and rational.’).

116. *Leigh v. Bd. of Registration*, 506 N.E.2d 91, 94 (Mass. 1987).

117. *Id.*

118. *Nurse Midwifery Assocs. v. Hibbett*, 918 F.2d 605, 614 (6th Cir. 1991) (“With respect to the allegations that HCH and SHH conspired with their respective medical staffs, for the reasons stated above, we conclude that the members of the medical staff were acting as agents of the hospital and that, therefore, the intracorporate conspiracy doctrine is controlling.”).

119. *Leigh*, 506 N.E.2d at 94.

place requiring private insurers to cover midwifery services, and insurers were only required to reimburse CNMs for all maternity services in fifteen states.¹²⁰ One study of eighteen private insurers found that the majority of insurers sampled did not offer coverage of midwifery and noted that the factors that made insurers most likely to cover complimentary or alternative medical care were “consumer interest, demonstrable clinical efficacy, and state mandates.”¹²¹ A 1992 study found that less than 20 percent of total payments to CNMs derived from commercial insurance companies.¹²² In 2013, in response to a New York Times article on the costliness of childbirth in the United States, dozens of women penned frustrated responses, which detailed stories of private insurance companies refusing to cover midwife care.¹²³ One woman described her insurer’s refusal to pay for medical care in a birth center, which was cheaper than a hospital birth, and noted, “If I had used a medical doctor, medications and had a C-section with a hospital stay of one week, my coverage would have been 100 percent.”¹²⁴

If CNMs or other midwives licensed by state statute are discriminated against by an Section 2706(a) of the ACA, they now have the right to state enforcement in accordance with guidelines set out by the state; if the state does not enforce the law, enforcement falls to the U.S. Department of Health and Human Services (HHS).¹²⁵ Unfortunately, § 2706(a) does not help—and may even hurt—women seeking the services of unlicensed midwives. While the ACA contains several provisions that are friendly to unlicensed providers of complimentary and alternative medicine (CAM)¹²⁶

120. See Elizabeth Rosenthal, *Getting Insurance to Pay for Midwives*, N.Y. TIMES, July 3, 2013, http://well.blogs.nytimes.com/2013/07/03/getting-insurance-to-pay-for-midwives/?_r=0; E.R. Declercq et al., *State Regulation, Payment Policies, and Nurse-Midwife Services*, 17 HEALTH AFF. 2, 193 (1998).

121. Kenneth R. Pelletier et al., *Current Trends in the Integration and Reimbursement of Complementary and Alternative Medicine by Managed Care, Insurance Carriers, and Hospital Providers*. 12(2) AMERICAN J. HEALTH PROMOTION 112, 122 (1997).

122. Anne Scupholme et al, *Nurse-Midwifery Care to Vulnerable Populations Phase I: Demographic Characteristics of the National CNM Sample*, 37(5) J. NURSE MIDWIFERY 341, 345 (1992).

123. Rosenthal, *supra* note 120.

124. *Id.*

125. 42 U.S.C. § 18041 (2012).

126. 42 U.S.C. § 256a-1 (2012) (“The Secretary of Health and Human Services [. . .] shall establish a program to provide grants to or enter into contracts with eligible entities to establish community-based interdisciplinary, interprofessional teams (referred to in this section as “health teams”) to support primary care practices, including obstetrics and gynecology practices, within the hospital service areas served by the eligible entities.”).

and even establishes interprofessional health teams¹²⁷, the exclusive language of § 2706(a) allows insurers to deny coverage to any unlicensed professional. Moreover, it may incentivize state legislatures to repeal current licensure of midwives, or refuse to establish new licensure provisions, and thus avoid reimbursing midwives at 100 percent of the rate of their fee, which is now required for Medicare and Medicaid reimbursements.

III. HOSPITAL BIRTH AND THE LAW: LEGAL OBSTACLES TO REMEDIES

A. Background

The previous section explained the structural and legal barriers that prevent women from choosing to use a midwife or give birth at home. This section explores issues that can occur in hospital births, where physicians often balance the woman's interests and rights against risk to the fetus, regardless of whether such balancing is lawful. Physicians sometimes prioritize the wellbeing of the fetus over the wellbeing of the woman, or her decisions about her medical care, and perform forced medical interventions or do not provide the requisite informed consent. When subjected to such mistreatment by the physician—or even other forms of misconduct, such as emotional abuse during labor—women often face legal barriers to recourse. When the labor and delivery result in a healthy baby, judges and juries, and accordingly, lawyers, are unlikely to view physician transgressions as yielding significant, if any, damages.

A recent example that has been discussed in the media is the case of “Kelly,” a California woman whose forced episiotomy was caught on video

127. See Louis Jacobson, *Did the Health Care Law Give 'Elevated Legitimacy' to Alternative Medicine?*, POLITIFACT: PUNDITFACT, Feb. 24, 2015, <http://www.politifact.com/punditfact/statements/2015/feb/24/jonah-goldberg/did-aca-give-elevated-legitimacy-alternative-medic/> (noting that the following provisions of the ACA create legitimacy for non-licensed providers of alternative treatments: Section 4001, which “establishes the National Prevention, Health Promotion and Public Health Council and, in turn, an advisory group on prevention, health promotion, and integrative and public health issues”; Section 4206, which “creates a pilot program to provide at-risk individuals who use community health centers with ‘individualized wellness plans’ designed to reduce risk factors for preventable conditions, including integrative health techniques”; Section 5101, which “creates a National Healthcare Workforce Commission and expands the definition of the health care workforce to include integrative health care practitioner, licensed complementary and alternative medicine provider, and doctors of chiropractic”; and Section 6301, which “establishes the Patient-Centered Outcomes Research Institute to fund research that determines which medical techniques work best, [...] funding studies of ‘relaxation and mindfulness exercises,’ massage, yoga, meditation, and breathing exercises.”).

and who has been unable to find a lawyer to represent her.¹²⁸ Kelly and advocacy organizations working on her behalf have spread Kelly's story and raised over \$6,000 to cover Kelly's legal costs.¹²⁹ In the video of Kelly's birth, after the baby crowns, the doctor states that he will perform an episiotomy.¹³⁰ Kelly has only pushed once at this point and repeatedly says, "No." The nurse tells Kelly she will not feel it; the doctor maintains he is preventing a possible tear.¹³¹ There is no evidence that Kelly's baby was in distress, or that the episiotomy was medically necessary.¹³² In response to Kelly's protests, the doctor states, "Listen. I am the expert here. [. . .] You can go home and do it. You go to Kentucky."¹³³ He then performs the episiotomy, without consent.¹³⁴

In 2013, Lynn Paltrow and Jeanne Flavin reported the results of a thirty-two year study of pregnant women who were forcibly confined or given medical treatment.¹³⁵ The report details more than 400 cases in which pregnancy "was a necessary factor leading to attempted and actual deprivations of a woman's physical liberty."¹³⁶ The original study examined cases beginning in 1973, the year *Roe v. Wade* was decided, and ending in 2005.¹³⁷ In a follow-up article, Paltrow and Flavin observed that there has been a significant increase in the frequency of these cases since 2005 with 380 identified between 2005 and 2014.¹³⁸ Many of these cases involved forced transfer to and confinement at the hospital, and several involved forced medical procedures, including cesarean section.¹³⁹

Emotional abuse at the hands of medical staff can also be a problem for

128. *Forced Episiotomy: Kelly's Story*, Human Rights in Childbirth, (Aug. 27, 2014), <http://www.humanrightsinchildbirth.org/kellys-story/> [hereinafter *Kelly's Story*].

129. IMPROVING BIRTH'S FUNDRAISER, CROWDRISE, <https://www.crowdrise.com/kellygoestocourt/fundraiser/improvingbirth> (last visited Feb. 27, 2016).

130. *Kelly's Story*, *supra* note 128.

131. *Id.*

132. *Id.*

133. *Id.*

134. *Id.*

135. 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. OF HEALTH POL., POL'Y AND LAW, 299 (2013).

136. *Id.*

137. *Id.*

138. See Lynn M. Paltrow & Jeanne Flavin, *Pregnant, and No Civil Rights*, N.Y. TIMES, Nov. 7, 2014, http://www.nytimes.com/2014/11/08/opinion/pregnant-and-no-civil-rights.html?_r=0.

139. See Paltrow & Flavin, *supra* note 135, at 299.

women in childbirth. In 2014, Catherine Skol received a verdict of 1.4 million dollars from the Chicago hospital where she gave birth in 2008.¹⁴⁰ During Skol's childbirth, her obstetrician, Dr. Scott Pierce, denied Skol pain medication and told her, "Pain is the best teacher"; refused to answer her questions; told her, "Shut up, close your mouth, and push"; artificially ruptured the membrane in order to induce her water to break without consent; and told a nurse, who attempted to show Skol the Fetal Heart Monitor, "No, do not help her."¹⁴¹ After the delivery, Dr. Pierce refused to allow either Skol or her husband to hold the baby.¹⁴²

Although Skol was successful in bringing charges against the physician in her case, women who experience abuse or other violations during childbirth may not think they have recourse—especially if they and their baby are healthy afterward. Yet there are severe consequences of trauma during childbirth—and trauma during childbirth may be more common than discourse would suggest. Research has found that between 1.5 and 6 percent of women suffer symptoms of Post-Traumatic Stress Disorder (PTSD) following childbirth.¹⁴³ One study has suggested a correlation between PTSD and high levels of medical intervention.¹⁴⁴ The women interviewed described their childbirth experiences as making them feel "powerless," and "stripped of their dignity."¹⁴⁵

Informed consent is another important issue in hospital births, and the extent of informed consent established may impact whether unwelcome medical interventions occur during birth and whether a woman experiences

140. See Roy Strom, *Kathleen Zellner: The Rescuer*, CHI. LAWYER, (Dec. 1 2014), <http://chicagolawyermagazine.com/Archives/2014/12/Kathleen-Zellner.aspx>; see also Skol v. Pierce, *The Verdict*, JOURNEY TO A BETTER BIRTH (Feb. 1, 2014), <https://partusmelior.wordpress.com/2014/02/01/skol-v-pierce-the-verdict/>.

141. *Lawsuit Details Painful Delivery*, CHI. TRIBUNE, (Dec. 16, 2008), http://articles.chicagotribune.com/2008-12-16/news/0812160129_1_suit-pain-hospital.

142. *Id.*

143. Cheryl Tatano Beck, *Post-Traumatic Stress Disorder Due to Childbirth*, 53 NURSING RES. 216, 217 (2004), <https://www.elpartoesnuestro.es/sites/default/files/public/documentos/posparto/PTSD.pdf>; see also Clare Goldwin, *Libby Didn't Know Whether her Newborn Baby was Alive for SIX HOURS and Needs Post-traumatic Stress Counselling Over the Birth Experience . . . So What IS Going Wrong in Britain's Labour Wards?*, DAILY MAIL (Jan. 30, 2013), <http://www.dailymail.co.uk/femail/article-2270941/Birth-trauma-Libby-ORourke-Toni-Harman-Julie-Hainsworth-traumatic-labours-Britains-hospital-wards.html> (referencing a study from Tel Aviv University that found that one in three women who give birth experience symptoms of PTSD); I. Shlomi Polachek et al., *Postpartum Post-Traumatic Stress Disorder Symptoms*, ISRAEL MEDICAL ASS'N JOURNAL, 347, 347-53 (2012).

144. Beck, *supra* note 143, at 217.

145. *Id.*

feelings of powerlessness or frustration during and following the birth. Federal regulations and professional guidelines state pregnant women's right to accurate and comprehensible information.¹⁴⁶ There are many benefits that stem from women participating in their maternity care decisions and feeling in control of the birth, including increased patient satisfaction,¹⁴⁷ shorter recovery periods,¹⁴⁸ fewer post traumatic stress symptoms after the childbirth,¹⁴⁹ and increased levels of bonding between the woman and newborn child.¹⁵⁰ Comprehensible informed consent may be lacking in many childbirths, however. Studies of first-time mothers show that they often walk away from their birth without having understood the risks of common procedures, such as induction and cesarean section.¹⁵¹ While 75 percent reported knowing they had the right to refuse treatment, 18 percent of women who had episiotomies reported no participation in

146. See generally Holly Goldberg, *Informed Decision Making in Maternity Care*, 18(1) J. PERINATAL EDUC. 32, 32–40 (2009), <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2667301/#bib25>; see also *The Patient Care Partnership*,

THE AM. HOSP. ASS'N (2003), <http://www.aha.org/advocacy-issues/communicatingpts/pt-care-partnership.shtml>; AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS, *INFORMED CONSENT* (2009), <http://www.acog.org/Resources-And-Publications/Committee-Opinions/Committee-on-Ethics/Informed-Consent>.

147. See Wendy Christiaens & Piet Bracke, *Assessment of Social Psychological Determinants of Satisfaction with Childbirth in a Cross-National Perspective*, 7 BMC PREGNANCY AND CHILDBIRTH, 26 (OCT. 2007); Josephine M. Green & Helen A. Baston, *Feeling in Control During Labor: Concepts, Correlates, and Consequences*, 30 BIRTH, 235–47 (Dec. 30, 2003), <http://www.ncbi.nlm.nih.gov/pubmed/14992154>.

148. Green & Baston, *supra* note 147, at 235.

149. See Julie J. Jomeen, *The Importance of Assessing Psychological Status During Pregnancy, Childbirth and the Postnatal Period as a Multidimensional Construct: A Literature Review*, 8 CLINICAL EFFECTIVENESS IN NURSING 143, 143–55 (2004).

150. J.M. Green et al., *Expectations, Experiences, and Psychological Outcomes of Childbirth: A Prospective Study of 825 Women*, 17(1) BIRTH 15, 15–24 (1990).

151. EUGENE R. DECLERCQ ET AL., *LISTENING TO MOTHERS II: REPORT OF THE SECOND NATIONAL U.S. SURVEY OF WOMEN'S CHILDBEARING EXPERIENCES I*, 6 (2006), http://www.childbirthconnection.org/pdfs/LTMII_report.pdf; see also Jennifer M. Torres & Raymond G. De Vries, *Birthing Ethics: What Mothers, Families, Childbirth Educators, Nurses, and Physicians Should Know About the Ethics of Childbirth*, 18 J. PERINATAL EDUC. 12, 18 (2009), <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2667293/> (“Inundating parents with pages of information, standardized and presented in medical and statistical terms unfamiliar to laypeople, may meet the letter of the ethical requirement to respect autonomy, but it fails to provide the knowledge parents need to make an informed choice.”).

making the decision.¹⁵²

There are many components of hospital-based maternity care that can lead to traumatic outcomes for women, even when ultimately, both the woman and the baby are healthy. Part III discusses legal recourses for these women and explains how they are often inadequate.

Physicians and medical staff who perform medical interventions or procedures against a woman's will generally have a variety of reasons. On one end of the spectrum are interventions that the physician deems necessary for the survival of the woman and/or the fetus. On the other end of the spectrum are interventions performed where there is no significant risk to either the woman or the fetus—perhaps performed for convenience or for physician preference. In the middle of the spectrum are procedures that may or may not improve the wellbeing of the woman and fetus.

B. Legal Barriers: Constitutional Law

The right to self-determination in medical treatment is an important aspect of autonomy.¹⁵³ Two rights typically fall under this umbrella: the right to informed consent and a corollary right to refuse medical treatment. Both state common law and the U.S. Constitution provide a basis for these rights.¹⁵⁴ Although there are limited exceptions to the right to refuse medical treatment, including state interest in the protection of life and state interest in the protection of third parties,¹⁵⁵ a state generally cannot compel medical treatment of one individual to benefit or even save the life of a third party.¹⁵⁶ Yet courts have routinely found it lawful to compel medical

152. DECLERCQ, *supra* note 151, at 6-7.

153. Margo Kaplan, "A Special Class of Persons": *Pregnant Women's Right to Refuse Medical Treatment After Gonzales v. Carhart*, 13 U. PA. J. CONST. LAW 145, 163 (2010); *see also* Reva B. Siegel, *Dignity and the Politics of Protection: Abortion Restrictions under Casey/Carhart*, 117 YALE L.J. 1694, 1754-56 (2008).

154. *See Cruzan ex rel. Cruzan v. Mo. Dep't of Health*, 497 U.S. 261, 278 (1990) (finding a Constitutional right to refuse medical treatment: "The Fourteenth Amendment provides that no State shall 'deprive any person of life, liberty, or property, without due process of law.' The principle that a competent person has a constitutionally protected liberty interest in refusing unwanted medical treatment may be inferred from our prior decisions"; and noting the state interests that may override a patient's right to refuse treatment at common law: the prevention of suicide; the preservation of life; the protection of third parties; and the preservation of the ethical integrity of the medical profession).

155. *Id.* at 271.

156. *See generally* *McFall v. Shimp*, No. GD78-17711, 1978 Pa. Dist. & Cnty. LEXIS 70, at *71 (C.P. of Allegheny Cty. Jul. 26, 1978) (refusing to order one man to donate bone marrow to save the life of his cousin).

treatment in the case of pregnant women.¹⁵⁷ In doing so, they have typically cited *Roe* and its discussion of state interests in fetal life. It is unclear whether these cases point to an additional exception to the common law right to refuse medical treatment—the state’s interest in protecting fetal life—or whether they extend state interests in preserving life and protecting third parties to potential life.¹⁵⁸

Orders to compel medical treatment have generally been upheld only in circumstances in which the procedures would protect the life of both the viable fetus and the pregnant woman.¹⁵⁹ This is in line with the emphasis on women’s health in *Roe*, which created an exception to state’s ability to proscribe abortion in the third trimester if the pregnancy or childbirth would endanger the life of the woman. Importantly, decisions overturning court orders have come too late for some women—a particularly tragic case is *In re A.C.*, in which doctors received a court order to perform a cesarean section on a terminally ill woman in her twenty-sixth week of pregnancy. The surgery resulted in the death of both the preterm child and the woman.¹⁶⁰

Although women have succeeded in challenging compelled medical treatment, especially when it would only benefit the fetus, they have also failed. Several factors contribute to the continuing precariousness of

157. See, e.g., *In re Madyun Fetus*, 114 Daily Wash. L. Rep. 2233, 2240 (D.C. Super. Ct. 1986) (finding that a state can override a patient’s religious reasons for refusing a Cesarean section); *Pemberton v. Tallahassee Mem’l Reg’l Med. Ctr.*, 66 F. Supp. 2d 1247, 1252-53 (N.D. Fla. 1999) (finding that a risk of uterine rupture of between two and 6 percent constituted an unacceptable risk to a fetus and warranted an order compelling a pregnant woman to submit to a cesarean section); *Jefferson v. Griffin Spalding Cnty. Hospital*, 274 S.E.2d 457, 460 (Ga. 1981) (ordering a pregnant woman to submit to a sonogram and cesarean section); *In re Jamaica Hospital*, 491 N.Y.S.2d 898, 899 (N.Y. Sup. Ct. Spec. Term 1985) (ordering a pregnant woman to submit to a blood transfusion and acknowledging that the pregnancy was the reason for intervening).

158. Kaplan, *supra* note 153, at 167; Eric M. Levine, Comment, *The Constitutionality of Court-Ordered Cesarean Surgery: A Threshold Question*, 4 ALB. L.J. SCI. & TECH. 229, 278-87 (1994).

159. In cases involving a fetus that was not viable, or where the medical treatment would risk the life or health of the woman carrying the fetus, courts have refused to issue or overturned court orders compelling medical treatment. See *In re A.C.*, 573 A.2d 1235, 1235 (D.C. Cir. 1990) (overturning a court order of a cesarean section that increased the chances of survival of the fetus but would be dangerous to the woman); *In re Baby Boy Doe*, 632 N.E.2d 326, 326 (Ill. App. Ct. 1994) (refusing to order a Cesarean section for the “sole benefit” of the fetus because the surgery would increase risk to the woman’s health and increase her recovery time); *Taft v. Taft*, 446 N.E.2d 395, 395 (Mass. 1983) (refusing to order a procedure in the second trimester that would improve the chances of survival for the fetus).

160. See Paltrow & Flavin, *supra* note 135, at 319.

pregnant women's right to refuse medical treatment. The determination of whether a procedure or lack thereof poses risk to the woman or fetus is often uncertain.¹⁶¹ Questions remain as to what constitutes a woman's "health," and whether this encompasses physical health; psychological health; future psychological health; survival, simply; or a combination of these.¹⁶² One scholar has argued that recent abortion jurisprudence has abandoned the primacy of women's health and will potentially pave the way for courts to compel medical treatment of pregnant women where treatment would benefit the fetus, regardless of whether it would benefit the health of the woman.¹⁶³

Interestingly, *Roe* and its progeny did not explicitly extend the state interest in fetal life to any context other than proscribing abortion. Because courts have routinely used these cases to analyze the constitutionality of forced medical interventions, it is unlikely that there will be a significant backslide; indeed, recent decisions such as *Gonzales v. Carhart* and an upswing in legislative attempts to restrict abortion¹⁶⁴ threaten to continue to strip away at women's right to refuse medical treatment during pregnancy. Medical professionals and the judiciary, in determining these cases, should continue to emphasize the importance of the woman's health laid out in *Roe*. Moreover, when analyzing the health of the woman, decision-makers should look to a more expansive analysis of health that also includes the woman's psychological health and well-being at the time of the prospective medical intervention. Federal legislation tailored to the right to refuse

161. See Kaplan, *supra* note 153, at 170.

162. *Id.* at 171-72 ("Roe provides that, while the state's compelling interest in fetal life allows it to proscribe abortion in the third trimester, it may not proscribe abortion when doing so would endanger the life or health of the mother. Health must be broadly construed, encompassing not only physical well-being, but also psychological and emotional well-being. Even after viability, when a state's interest in fetal life becomes "compelling," states may not pursue this interest at the expense of a woman's health. In subsequent cases, the Court has reaffirmed that the state cannot sacrifice maternal health for the sake of preserving fetal life.").

163. See *id.* at 176-77 (explaining that "in medical treatment cases, the state's interest in fetal life is not as compelling as in abortion cases: such treatment cases involve risk to the fetus's life or health, but not the termination of fetal life at issue in abortion," and suggesting: "Fetal life is implicated far more in these cases than in Carhart, which concerned the method of abortion rather than whether a fetus would be aborted. Courts may determine that, if the state's interest in fetal life justifies state intrusion into women's medical decisions in Carhart, it is an even stronger justification for intrusion into the medical treatment decisions in cases where there is evidence that a fetus may live or die depending on a chosen course of medical treatment.").

164. See Paltrow, *supra* note 138 (noting that an increase in forced interventions on pregnant women has coincided with a "seismic shift" in the number of states with laws hostile to abortion rights.").

medical treatment in pregnancy would best outline such guidelines. Part III(d) explores how the ACA's prohibition on discrimination strengthens the public policy argument that pregnant women have the same rights as people who are not pregnant and is a step in the right direction for protecting the right to refuse treatment.

C. Legal Barriers: Tort Law

Women continue to have tort remedies available to them as a recourse for tortious acts, including negligence and intentional infliction of emotional distress, that occur during childbirth. While tort claims are common in cases of fetal harms or injury to the fetus, women rarely sue for personal harms.¹⁶⁵ This is possibly due to low dollar value even for claims of physical harm, for example an unwanted cesarean section.¹⁶⁶ Cultural expectations that motherhood is an exclusively joyous occasion also may dilute women's willingness to pursue claims of negligence or emotional distress connected with the childbirth.¹⁶⁷ A 2010 study on cruelty in maternity wards relays more than a dozen stories of emotional abuse inflicted by medical staff during childbirth and notes:

"Women, of course, could complain afterwards—and some do—but most abuse victims are likely to be recovering from surgery, and all have a newborn to care for. Traumatized women [must] cope with their symptoms and function as new mothers. Few [. . .] have the physical or emotional energy to do other than try to put events behind them and carry on. For those who do complain, the system that predisposed to abuse in the first place ensures that complaints will fall on deaf ears."¹⁶⁸

Indeed, when women do bring malpractice claims for maternal harms, courts often "villainize" maternal conduct, finding that factors like the woman's age, weight, health, and sexual history impact the physician's liability.¹⁶⁹ When women prevail on malpractice claims encompassing

165. Jamie R. Abrams, *Distorted and Diminished Tort Claims for Women*, 34 CARDOZO L. REV. 1955, 1979 (2013).

166. *Id.*; see also Clarke T. Edwards, *The Impact of a No-Fault Tort Reform on Physician Decision-Making: A Look at Virginia's Birth Injury Program*, 80 REV. JURID. U.P.R. 285, 291 (2011) (explaining that the injuries of a forced cesarean section include the cost of the procedure and the extended recovery time).

167. Abrams, *supra* note 165, at 1980.

168. Henci Goer, *Cruelty in Maternity Wards: Fifty Years Later*, 19 J. PERINATAL EDUC. 33, 42 (2010), <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2920649/>.

169. Abrams, *supra* note 165, at 1982 (offering examples of such cases, including *White v. Edison*, 361 So. 2d 1292, 1294, 1296 (La. Ct. App. 1978) (which emphasized that the woman was "exceptionally young" and suggested that her abscesses might

their own physical and emotional injuries, these claims often accompany fetal harm claims.¹⁷⁰ A myriad of factors explains a comparative absence of maternal malpractice claims, including women not feeling like they can bring claims, not wanting to bring claims, or being unable to find lawyers to take their claims to court, where damages may not be significant. The following section describes how the ACA can be used to obtain remedies for women subject to adverse actions motivated by sex discrimination, and to more generally transform obstetrics into a practice that puts more emphasis on women's autonomy.

D. The ACA's Prohibition of Sex-Based Discrimination in Healthcare

The ACA's civil rights provision embodies the first declaration that patients are not to be discriminated against by health care providers based on sex. Section 1557 is the first civil rights statute in health care.¹⁷¹ It is a broad mandate, which explicitly refers to other, similar civil rights statutes, including Title VI of the Civil Rights Act of 1964, Title IX of the U.S. Education Amendments of 1972, and the Age Discrimination Act of 1975.¹⁷² Both the protected characteristics and the enforcement mechanisms of these enumerated civil rights statutes apply to § 1557 of the ACA. Thus, it is likely that the statute gives rise to both disparate treatment and disparate impact theories of discrimination.¹⁷³ Health care providers might violate the statute with respect to sex discrimination in two ways: first, through intentionally treating individuals unfavorably on the basis of sex; and second, through having facially neutral policies or practices that result in adverse, gender-based outcomes.

Section 1557 went into effect in January 2014, and very few cases have been decided under the statute, so far. This is likely due to its newness—and the options it offers in terms of enforcement mechanisms. Section 1557 creates a private right of action but also creates an administrative remedy. Individuals who believe they have been discriminated against may file a complaint with the Office for Civil Rights (OCR) of the U.S.

have been due to prior venereal disease); *Powell v. Mullins*, 479 So. 2d at 1120, 1123 (Ala. 1985) (emphasizing that the plaintiff's obesity complicated the analysis of causation in a case that involved a sponge left in the plaintiff's abdomen).

170. *Abrams*, *supra* note 165, at 1980.

171. 42 U.S.C. § 18116 (2012).

172. *Id.*

173. *Id.*; *see, e.g., McDonnell Douglas Corp. v. Green*, 411 U.S. 792, 792 (1973) (laying out the analysis for disparate treatment under Title VII); *Griggs v. Duke Power Co.*, 401 U.S. 424, 428 (1971) (establishing that there is a disparate impact theory for liability under Title VII); *Franklin v. Gwinnett Cnty. Pub. Sch.*, 503 U.S. 60, 61 (1992) (finding a private cause of action for intentional discrimination under Title IX).

Department of Health & Human Services (HHS) within 180 days of the discriminatory action.¹⁷⁴ The OCR will then investigate the complaint and issue a finding.¹⁷⁵ If discrimination is found, the discriminatory actor will be given a time period in which to correct the discrimination or create a plan of correction.¹⁷⁶

Individuals who have been discriminated against may also file a complaint in court, without first filing an administrative complaint.¹⁷⁷ Very few discrimination cases have been brought under Section 1557. In 2015, a federal district court in *Rumble v. Fairview Health Services* found that a transgender complainant sufficiently alleged sex discrimination under the disparate treatment theory of Section 1557 and denied the defendant's motion to dismiss.¹⁷⁸ The court found that the physician's hostile treatment of the plaintiff, which involved asking him embarrassing and aggressive questions, as well as administering an "assaultive" physical examination, "plausibly demonstrate[d] . . . discriminatory intent" prohibited by Section 1557.¹⁷⁹ Several particulars of this court's interpretation of Section 1557 may illuminate its potential protections for women seeking the care of a midwife or seeking to give birth in a birth center. Procedurally noteworthy were the court's willingness to find a private right of action under Section 1557,¹⁸⁰ its finding that Section 1557 applies to any healthcare provider that receives any federal assistance,¹⁸¹ and its attempt to determine liability, causation, and a standard of proof through looking to agency regulations, which are currently nonexistent.¹⁸² Substantively, the court broadly interpreted sex discrimination as encompassing adverse actions in connection with sex stereotyping, in line with cases brought under Title VII and Title IX.¹⁸³

If courts continue to interpret sex-based discrimination broadly, pregnant

174. *Office for Civil Rights*, U.S. DEP'T. OF HEALTH & HUMAN SERVS., <http://www.hhs.gov/ocr/office/>.

175. *How Does OCR Investigate a Civil Rights Complaint?*, U.S. DEP'T OF HEALTH & HUMAN SERVS., <http://www.hhs.gov/ocr/civilrights/faq/Procedures/303.html>.

176. *Id.*

177. 42 U.S.C. § 18116 (2012) ("The enforcement mechanisms provided for and available under such title VI, title IX, section 504, or such Age Discrimination Act shall apply for purposes of violations of this subsection.").

178. *Rumble v. Fairview Health Servs.*, No. 14-CV-2037 SRN/FLN, 2015 WL 1197415, at *31 (D. Minn. Mar. 16, 2015).

179. *Id.* at *18.

180. *Id.* at *11.

181. *Id.* at *12.

182. *Id.* at *31.

183. *Id.* at *2.

women may have a cause of action for adverse actions rooted in not only animus toward women, but also notions of how pregnant women and mothers should act.¹⁸⁴ Moreover, under both Title VII and Title IX, sex-based harassment, whether verbal or involving un-consented to touching, that produces to a “hostile environment,” is encompassed within the definition of sex discrimination.¹⁸⁵ Under these analyses, a woman who is pressured into or forcibly subjected to a procedure that is not necessary to protect her life and health, as well as that of the fetus, but which simply lessens a small risk to the fetus,¹⁸⁶ may have a § 1557 claim against a physician and the medical facility, if it does not have policies in place regarding nondiscrimination toward pregnant women. Another example of disparate treatment based on sex might involve derogatory comments made by medical staff during childbirth toward the woman about her behavior or her right to make medical decisions—like the remarks of the physician in the case of the forced episiotomy discussed in Part III.¹⁸⁷ An example of a policy that might give rise to a disparate impact claim would be an informed consent process that does not adequately inform women of the risks of certain procedures, such as Cesarean Sections, VBACs, or episiotomies, or through which women waive the right to object to such procedures once they are admitted to labor and delivery. Such forms would not be facially discriminatory, but would disproportionately subject women

184. See, e.g., *Nevada Dep’t of Human Res. v. Hibbs*, 538 U.S. 721, 736 (2003) (recognizing that actions based on stereotypes about mothers, rather than on actual performance, constitute sex-based discrimination: “Stereotypes about women’s domestic roles are reinforced by parallel stereotypes presuming a lack of domestic responsibilities for men [. . .] These mutually reinforcing stereotypes created a self-fulfilling cycle of discrimination that forced women to continue to assume the role of primary family caregiver, and fostered employers’ stereotypical views about women’s commitment to work and their value as employees.”).

185. *Sexual Harassment Guidance 1997*, U.S. DEP’T OF EDUC. OFFICE FOR CIVIL RIGHTS, (<http://www2.ed.gov/about/offices/list/ocr/docs/sexhar01.html> (last updated Oct. 16 2015)); *Revised Sexual Harassment Guidance*, U.S. DEP’T OF EDUC. OFFICE FOR CIVIL RIGHTS, (Jan. 19, 2001), <http://www2.ed.gov/about/offices/list/ocr/docs/shguide.html>.

186. This was the case in *Pemberton v. Tallahassee Mem’l Reg’l Med. Ctr.*, 66 F. Supp. 2d 1247 (N.D. Fla. 1999) in which the risk of uterine rupture was debated by experts, but was between 2 and 6 percent. After the patient in this case was forced to undergo a VBAC (vaginal birth after Cesarean), she went on to have two more children vaginally, which suggests the birth in question also would have been successful absent the Cesarean.

187. Prior to performing the episiotomy without consent, the medical staff in Kelly’s case said, ““We’re not going to feel it, remember? And you have the epidural,” and “Listen: I am the expert here [. . .] But why can’t [you] try [to push]? You can go home and do it. You go to Kentucky.” *Kelly’s Story*, *supra* note 128.

to procedures without full informed consent or a right to refuse treatment, creating the implication that pregnant women cannot be trusted to make rational decisions about their bodies and about risks to the fetuses they are carrying.¹⁸⁸

Under Title VII and Title IX jurisprudence, employers and educational institutions that discriminate based on sex may raise limited affirmative defenses—these include cases of safety,¹⁸⁹ cases in which there was a “legitimate, nondiscriminatory reason” for the adverse action,¹⁹⁰ and cases in which plaintiffs failed to make use of institutional reporting procedures.¹⁹¹ Significantly, Title VII cases have explored whether protecting fetal life is an interest that may warrant discrimination.¹⁹² Courts have held that protecting an unborn fetus does not fall under the umbrella of the safety-based affirmative defense for employers that discriminate.¹⁹³ This particular analysis is unlikely to extend to discrimination against women in childbirth. Courts are likely to continue to use the balancing test in *Roe* to weigh women’s rights of self-determination in medical care against state interests in fetal life. Decisions under Title VII and Title IX have laid a strong groundwork, however, that treating women adversely due to their sex or pregnancy is unlawful except in rare circumstances. If courts or HHS create an exception to Section 1557 in line with the state’s interest in fetal life, they should ensure that this is a narrow exception, which prioritizes the autonomy, health, and wellbeing of the pregnant woman, in line with the spirit of the nondiscrimination provision and other civil rights statutes.

CONCLUSION

Many barriers continue to frustrate women’s attempts to make informed choices about childbirth. Legislatures and courts alike have exaggerated risks to fetal life in order to proscribe professional or lay midwives and thus limit access to home birth; insurance companies have refused to cover the

188. See *Gonzales v. Carhart*, 550 U.S. 124, 129 (2007) (considering the potential future harm to women who would later regret their decision to have an abortion).

189. *Int’l Union, United Auto., Aerospace & Agr. Implement Workers of Am., UAW v. Johnson Controls, Inc.*, 499 U.S. 187, 201 (1991).

190. *McDonnell Douglas Corp. v. Green*, 411 U.S. 792, 792 (1973).

191. *Burlington Indus. v. Ellerth*, 118 S. Ct. 2257, 2270 (1998); *Faragher v. Boca Raton*, 118 S. Ct. 2275, 2293 (1998); *Gebser v. Lago Vista Indep. Sch. Dist.*, 118 S. Ct. 1989 (1998).

192. *Int’l Union*, 499 U.S. at 219 (“The Court’s narrow interpretation of the BFOQ defense in this case, however, means that an employer cannot exclude even *pregnant* women from an environment highly toxic to their fetuses.”).

193. *Id.*

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services of a midwife or the costs of a birth at a birth center; physicians, in an effort to reduce all possible risks to the fetus, have gained court orders to compel medical treatment—even when it has put the life of the woman at risk.

By prohibiting discrimination against licensed providers and sex-based discrimination against patients, the ACA has made modest strides toward increasing women's control over components of childbirth. The remedies under § 2706(a) and § 1557 are promising—especially for licensed midwives and their clients, and women subjected to mistreatment by medical staff during childbirth. Yet there remain significant hurdles for women; these largely depend on their state—whether it licenses professional and lay midwives; whether it licenses birth centers; whether its courts are likely to issue a court order and have it overturned, rather than risk harm to the fetus; whether its courts find that some risk to the woman's health is sufficient to outweigh the state interests in fetal life, or whether, even in a life-or-death scenario, the court will prioritize fetal rights.

The ACA's potential to remedy systematic discrimination against pregnant women has not yet been tested, and if the statute will produce results, it may be years before guards of women's rights are embodied into medical practice. In order to promote choice in childbirth even further, it will be important for legislatures to continue to expand licensure and regulation for midwives and birth centers and to create state laws that bolster the ACA's prohibition of sex-based discrimination in healthcare.