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The Midwifery Stalemate and Childbirth Choice: Recognizing Mothers-to-Be as the Best Late Pregnancy Decisionmakers

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INTRODUCTION

Many believe that midwife-assisted home-births\(^1\) are as safe as hospital births for low-risk women, yet blanket government restrictions still prevent women from choosing this option in fifteen states.\(^2\) Since the 1970s, legal commentators have urged the case for the safety of midwifery\(^3\) and a woman’s constitutional right to choose

1. In this Note, “midwife” will be used to refer to direct-entry midwives (also known as “lay midwives” or “certified professional midwives”) and not to certified nurse midwives (“CNMs”). Direct-entry midwives practice primarily in non-hospital environments and provide woman-oriented, low-intervention prenatal, delivery, and postpartum care for low-risk births. CNMs are nurses with additional midwifery training who usually practice under the supervision of obstetricians and generally assist births in hospital or clinic environments. See Midwives Alliance of North America: Definitions, at http://mana.org/definitions.html (last visited Sept. 17, 2004). While obstetricians nearly always recommend a hospital setting for birth and routinely use technology,

\[\text{[t]heMidwivesModelofCareisbasedonthefactthatsub} \text{pregnancyandbirtharenormallifeevents}\ldots \text{[and]}\text{includes:monitoringthephysical,psychologicalandsocialwell-beingofthemothertroughoutthechildbearingcycle;providingthemothernewithindividuatededucation,counselingandprenatalcare,continuoushands-onassistanceduringlaboranddeliveryandpostpartum support; minimizing technological interventions; and identifying and referring women who require obstetrical attention. The application of this model has been proven to reduce the incidence of birth injury, trauma and cesarean section.}\]


3. E.g., Susan Cocoran, Note, To Become a Midwife: Reducing Legal Barriers to Entry Into the Midwifery Profession, 80 WASH. U. L.Q. 649 (2002). The infant mortality rate of the United States is one of the worst of developed nations and not because we lack a national health system. See Danielle Rifkin, Note, Midwifery: An International Perspective—The Need for Universal Legal Recognition, 4 IND. J. GLOBAL LEG. STUD. 509, 510 (1997) (arguing that infant mortality statistics from the USA and Canada, two nations that do not utilize midwifery care, are
among birthing options nearly twenty times. All midwifery advocates point to the significant public health and economic benefits that would result from greater access to midwife care: better outcomes for many mothers and babies at a much lower cost than obstetrical care. As our nation’s health crisis worsens, the policy arguments in favor of midwifery only gain in urgency: more and more women are without health insurance, and many birthing service providers must raise fees or close their doors due to astronomical malpractice insurance rates. Although several states have created licensing programs for direct-entry midwives, midwifery legislation faces entrenched comparably out of line with their economic power, despite the fact that Canada has a public health system.

4. One of the first constitutional arguments was made by Jennifer J. Tachera. Jennifer J. Tachera, "Birth Right": Home Births, Midwives, and the Right to Privacy, 12 Pac. L.J. 97, 106 (1980) (arguing for a fundamental right to choose home birth because the childbirth decision is an expression of family relationships as well as medical decisions). For the best early constitutional analysis, see Barbara A. McCormick, Note, Childbearing and Nurse-Midwives: A Woman's Right to Choose, 58 N.Y.U. L. Rev. 661, 692 (1983) (finding a fundamental right to make childbearing decisions based on personal autonomy, family autonomy, and bodily integrity). See also Dawn E. Johnsen, Shared Interests: Promoting Healthy Births Without Sacrificing Women's Liberty, 43 Hastings L.J. 569, 607–08 (1992) [hereinafter Johnsen, Shared Interests] (arguing outside of the midwifery context that restrictions and interventions targeting pregnant women should be viewed as equal protection violations); Dawn E. Johnsen, Note, The Creation of Fetal Rights: Conflicts with Women's Constitutional Rights to Liberty, Privacy, and Equal Protection, 95 Yale L.J. 599, 614 (1986) [hereinafter Johnsen, Fetal Rights]. But see John A. Robertson, Procreative Liberty and the Control of Conception, Pregnancy, and Childbirth, 69 Va. L. Rev. 405, 437 (1983) (arguing that once a woman has exercised her procreational liberty by deciding not to abort, her liberty to act in ways that would adversely affect the fetus is limited only by her right to bodily integrity).

5. Midwives generally charge fees that are about one-half of the amount an obstetrician would charge. The midwife’s fee, however, often includes complete prenatal care and postpartum checkups. Additionally, midwives have traditionally served rural or economically weak communities. See Rondi E. Anderson & David A. Anderson, The Cost-Effectiveness of Home Birth, 44 J. Nurse Midwifery 30 (1999) (finding the cost of the average, uncomplicated vaginal home birth to be 68% less than a comparable hospital birth); Rifkin, supra note 3, at 533 (opining in 1997 that $8.5 billion in health care costs might be saved yearly were midwives to deliver three out of four babies, as they do in Western Europe).

6. It was reported that in Texas, 152 of the state’s 254 counties have no obstetrician. Ralph Blumenthal, Yells Replace Yawns in a Texas Ballot Ritual, N.Y. Times, Sept. 13, 2003, at A11. Unfortunately, midwives carrying malpractice insurance are affected by this trend, too. Morning Edition: Birthing Centers Close Despite Popularity (NPR radio broadcast, Nov. 13, 2003), available at http://www.npr.org/ features/feature.php?w fid=1504365 (last visited Jan. 23, 2004). See also Rifkin, supra note 3, at 532 (finding it unfortunate that high malpractice rates prevent many midwives from practicing because “only six percent had ever been named in a malpractice suit, while sixty percent of obstetricians had been sued”).

resistance in other states. In fact, the home-birth rate overall has declined in recent years, instead of rising, as many midwifery advocates had expected.

While many legislatures have recognized the right to choose among safe childbirth alternatives, no court has yet recognized that the constitutional right to privacy encompasses childbirth choice. This produces the result in most jurisdictions that a


9. The American midwifery movement began in the sixties, and the first wave of commentary is from the late seventies and early eighties. While home-birth rates were on the rise in the early eighties, see Harry M. Caldwell, Bowland v. Municipal Court Revisited: A Defense Perspective on Unlicensed Midwife Practice in California, 15 PAC. L.J. 19, 30 (1983) (expressing confidence in the prediction that the trend to out-of-hospital births would continue), the nineties saw a rise in certified nurse midwife care but a decline in midwife-assisted home births. 4-22 MICHAEL G. MACDONALD, HEALTH CARE LAW § 22.05 (2003) (citing a 7% decline in the use of non-nurse midwives from 1989 to 1997).

10. See, e.g., CAL. BUS. & PROF. CODE § 4(b) (West 2000) ("Every woman has a right to choose her birth setting from the full range of safe options available in her community."); MONT. CODE ANN. § 37-27-102 (2003) ("The legislature finds and declares that . . . Montanans may exercise their right to give birth where and with whom they choose."); N.H. REV. STAT. ANN. § 326-D:1 (1982) ("It is the intent of the general court to preserve the rights of women to deliver children at home."); Katherine S. Yagerman, Comment, Legitimacy for the Florida Midwife: The Midwifery Practice Act, 37 U. MIAMI L. REV. 123, 140–43 (1982) (discussing FLA. STAT. ch. 467.002 (2003) ("The Legislature recognizes the need for a person to have the freedom to choose the manner, cost, and setting for giving birth.").

11. See generally Noralyn O. Harlow, Annotation, Midwifery: State Regulation, 59 A.L.R. Fed. 4th 929, §§ 3–6 (2003) (cataloging due process, vagueness, right of privacy, and equal protection claims). It should be noted that the legislation/litigation choice divides midwifery advocates, several believing that the courts are an inappropriate forum for achieving wider access to midwife care. See Cocoran, supra note 3, at 670–73; Suzanne Hope Suarez, Midwifery is Not the Practice of Medicine, 5 YALE J.L. & FEMINISM, 315, 360–61 (1993); Charles Wolfson, Midwives and Home Birth: Social, Medical, and Legal Perspectives, 37 HASTINGS L.J. 909, 938–39 (1986). These commentators feel either that the rights implicated do not rise to the level of constitutionally protected rights or that such public health matters are better handled by the legislatures. But see RAYMOND G. DEVRIES, MAKING MIDWIVES LEGAL: CHILDBIRTH, MEDICINE, AND THE LAW xvi (2d ed. 1996) (arguing that regulation has the effect of destroying the aspects of midwife care that distinguish it from the medical establishment). Still others believe strongly in the merits of privacy and equal protection arguments and feel that blanket restrictions on rights must be pierced if they are not lifted voluntarily. See Janet Gallagher, Prenatal Invasions & Interventions: What’s Wrong With Fetal Rights, 10 HARV. WOMEN’S L.J. 9, 13 (1987); Tachera, supra note 4, at 108; Kathleen M. Whitby, Choice in Childbirth: Parents, Lay Midwives, and Statutory Regulation, 30 ST. LOUIS U. L.J. 985, 1026–28 (1986); Joleen Susan Pettee, Note, Midwifery: Do Parents Have A Constitutional Right to Choose the Site, Process, and Attendant for the Birth of Their Baby?, 24 J.C.L. 377 (1998);
woman has the unfettered right to abort a fetus in the first trimester, the right to make most medical decisions for a child moments after birth, and the right to refuse medical treatment for herself in any other situation, but that she does not have the right to choose among safe childbirth alternatives for herself and her child. Thus, the law on midwifery is currently at odds with the law on abortion, child health decisionmaking, and much privacy doctrine. The project of this Note is to harmonize these areas of law, without jeopardizing Roe v. Wade. Late pregnancy is a unique condition where the rights of the mother-to-be and the developing child are intertwined. This Note concludes that given the strong privacy interests of a mother-to-be, including her parental rights as to the developing child, she, and not the state, is the most appropriate childbirth decisionmaker.


Although constitutional arguments have not been successful, several courts have legalized midwifery through statutory interpretation. If midwifery is held not to constitute the practice of medicine, it may be practiced with impunity, assuming that no other statutes stand in the way. E.g., Leggett v. Tenn. Bd. of Nursing, 612 S.W.2d 476 (Tenn. App. 1980). But see State v. Smith, 459 N.E.2d 401 (Ind. App. 1984) (holding that midwifery services do constitute the practice of medicine or nurse midwifery and are unlawful without a license). Additionally, statutory provisions have been found to be void for vagueness because they do not clearly indicate which acts constitute the practice of midwifery. See, e.g., People v. Jihan, 537 N.E.2d 751, 756 (Ill. 1989) (holding the previous version of the midwifery act unconstitutional as applied, but not reaching the revised version); cf. Peckmann v. Thompson, 745 F. Supp. 1388, 1394 (C.D. Ill. 1990) (holding the new statute vague on its face because it failed to indicate the current legality of the practice of midwifery when the vague references to "midwife" and "midwifery" were removed).

Even if the courts remain unwilling to address midwifery issues, some legislatures have been receptive to rights-based arguments, exercising their prerogative to interpret state and federal constitutions independently of the courts. For instance, California explicitly overruled the influential Bowland decision, holding that there was no constitutional right to choose a midwife because, following the trimester scheme in Roe, the state's interest in the welfare of the fetus reached its pinnacle at birth. Bowland v. Mun. Ct., 556 P.2d 1081, 1089 (Cal. 1977). California was followed by Kansas, see State Bd. of Nursing v. Ruebke, 913 P.2d 142, 162 (Kan. 1996), and Maryland, see Hunter v. State, 676 A.2d 968, 969 (Md. App. 1996). In 2000, the California legislature amended the Midwifery Act, finding that "[e]very woman has a right to choose her birth setting from the full range of safe options available in her community." CAL. BUS. & PROF. CODE § 2508 (West 2000); see Kathlyn Marie Happe, Review of Selected 2000 California Legislation: Health and Welfare Chapter 303: Is California Edging Toward a "Consultive" Relationship Between Midwives and Physicians, 32 McGEORGE L. REV. 713, 726 (2001); Harmon, supra note 8, at 129–30; see also Caldwell, supra note 9 (discussing the illogic of the Bowland decision as well as demonstrating that it had already been undermined by subsequent California decisions).


13. Throughout, I shall use the term "mother-to-be" for a pregnant woman and "developing child" to denote a late-term fetus. These terms are intended to reflect my attempt to take the unique situation of late-term pregnancy into account when balancing rights. Because the relationship between the two individuals in late-term pregnancy is fundamentally unlike their relationship during the first trimester of pregnancy and also distinct from the situation after birth, the terminology should signal that in-between state. I thank Professor Dawn Johnson for her insight into the polemic and descriptive significance of choosing these terms. See infra text accompanying note 59–60.
In Part I, I identify four reasons why the case for a privacy right encompassing childbirth choice has failed, which then suggest how the case can be bolstered. First, midwifery advocates must explain the political, philosophical, religious, and feminist dimensions of alternative understandings of birth; second, they must question the habitual deference to the judgment of doctors with regard to value-laden and personal health decisions; third, they must emphasize why midwifery is not about abortion; and fourth, they must both differentiate late pregnancy from early pregnancy and compare the parental relationship between the mother-to-be and developing child in late pregnancy with the parental relationship after birth.

Part II applies the numerous strands of privacy doctrine to the childbirth choice issue and demonstrates how midwifery is an issue that could unite advocates from left, right, and center, in contrast with the divisive abortion debate. Finally, Part III shows how midwifery law can and should be harmonized with the legal doctrines of abortion, forced caesarean, bodily integrity, and child health decisionmaking. First, late pregnancy should be recognized as a distinct phase during which a mother-to-be actively parents a developing child and during which both their interests and rights are uniquely intertwined. Second, given the woman's strong privacy interests in choosing the manner of childbirth as well as her status as mother-to-be of the developing child, she, and not the state, should be recognized as the most appropriate and competent health decisionmaker for both.

I. UNDERSTANDING WHY MIDWIFERY REFORM FAILED IS TO UNDERSTAND HOW IT CAN SUCCEED

One standard explanation for the stalemate on midwifery reform is that the powerful medical lobby seeks to preserve its economic share of the birthing business by preventing midwifery regulation and utilizing its traditional influence over courts.14 While this has been convincingly argued,15 there are other, more complex issues that underscore the midwifery debate and have consistently undermined efforts to achieve greater childbirth freedom.

In the first two Subparts, I demonstrate how midwifery advocates must effectively confront two misconceptions regarding their own attitudes toward birth. If personal preferences and safety concerns were the extent of the justification for home birth, there would not be a privacy right at stake, and rational basis review would likely come...
out in favor of the state.\textsuperscript{16} Rather, at the heart of the right to privacy are acts and choices that define the self.\textsuperscript{17} Therefore, advocates must communicate to courts the deeply held feminist, political, religious, and philosophical beliefs that support their alternative understandings of birth. Safety evidence is more complicated because midwifery advocates can argue both that midwifery is safer (an argument that does not support a privacy right, but would carry persuasive force nonetheless), and at the same time that it is they, not doctors, who should choose among medical treatment options. Here I place the struggle for childbirth choice in the context of the movements supporting the right to die, the rights of intersex people to remain untreated, and the rights of the disabled. All of these movements question the value judgments inherent in medical analyses and seek to reclaim the right to make fundamental health choices from doctors.

In the third Subpart, I note how the proximity of midwifery to the abortion issue has had an enormous effect on the way courts have handled, or rather avoided, the midwifery issue. To achieve midwifery reform, advocates must overcome the unwillingness of courts to face irreconcilable conflicts between the rights of the woman and the unborn in late pregnancy. This, as I argue in the final Subpart, can be done if late pregnancy is distinguished from early pregnancy, which it clearly can be when viewed not from the "outside" but from an "inside" perspective. I conclude that a centrist resolution to late pregnancy issues could help diffuse the abortion controversy without endangering the right to choose. This Part analyzes why the right to choose among safe childbirth alternatives has not yet been recognized and shows why it merits this status in order to lay the groundwork for the more doctrinal privacy arguments surveyed in Part II.

\textbf{A. Birth as Self-Definition}

Home-birth mothers believe that the choice about where and how to give birth is not a trivial decision that merely reflects personal, aesthetic preferences, such as dim lighting or background music.\textsuperscript{18} This Subpart will show how views about birth may express deeply held beliefs about nature and religion, and are often the product of parental, political, religious, and feminist choices. This Subpart is not an attempt to describe all of the alternative understandings of birth, a task that would exceed the scope of this Note. Instead, it seeks to relativize the medical model of birth by juxtaposing it with one alternative model of childbirth. The very incompatibility of

\textsuperscript{16} One could argue, however, that it is irrational for a state to outlaw midwifery where a significant number of counties are without obstetrical care or prenatal services. Given the Court's recent preference for overturning legislation on rational basis review as opposed to recognizing new fundamental rights (as in \textit{Romer} and \textit{Lawrence}), the rational basis review argument might be stronger than it appears at first blush. Such an argument was persuasive with the Arkansas legislature, which passed a bill legalizing midwifery in counties where 32.5\% of the population lived below the poverty level (six of seventy-five counties). Arthur English & John Carroll, \textit{Midwifery in Arkansas: The Delivery of a Bill}, 12 S. EXPOSURE 90 (1984).

\textsuperscript{17} See Smolin, \textit{supra} note 14, at 980--984 (identifying the existentialist belief that "human beings create and define themselves through their choices and acts" as the basis of the privacy right as understood by Justice Blackmun).

\textsuperscript{18} See infra note 29.
these views about birth demonstrates the significance of childbirth choices to the individual and the existence of a privacy right to childbirth choice. Indeed, birth might be considered the paradigmatic "sweet mystery" moment, thus meriting childbirth decisionmaking substantive due process protection.¹⁹

One description of an alternative world-view espoused by some midwifery advocates could be described as follows:

[T]he first precept of the alternative approach to childbirth is the notion that pain is not pathological, not something to be feared, and the conviction that women have the strength to endure it. In short, this approach rejects stereotypes of women as either weak and vulnerable or as dangerously irresponsible or hysterically out of control and instead affirms their strength and determination in the face of adversity.

[This] alternative approach to childbirth is revolutionary. It challenges fundamental beliefs and firmly entrenched distributions of power, raising questions about what constitutes male and female, science and superstition, order and chaos. Thus, efforts to employ this alternative approach can be seen as acts of resistance to the dominant order, acts informed by an alternative set of understandings of the world that medicine purports to know.²⁰

DeVries makes similar observations about the broad scope of the midwifery debate when he reflects on the reasons why midwifery reform has come so slowly:

In retrospect, it is clear that the kind of change we were seeking two decades ago was at least as radical as the changes demanded by the civil rights and antiwar movements. We were asking for a new view of our bodies, of our relation to technology, of our sense of 'home,' of gender, of family. We were asking not just for social change but for cultural change.²¹

Seen in this context, adherence to this alternative birth scenario comes close to a religious belief. Reading through Spiritual Midwifery, one of the midwifery "bibles" written by Ina Gaskin, a greatly revered midwife from The Farm community, it becomes clear that the practice of delivering babies can be an integral part, indeed an expression, of religious practice.²² In fact, a good analogy for the relation between the medical and alternative theories of birth would be the contrasting evolutionary and creationist views of the Earth's history. There is such a deep division between the medical and natural models of birth that neither can "convince" the other. The two models operate on different assumptions, and adherents to both the scientific and

¹⁹. See Planned Parenthood v. Casey, 505 U.S. 833, 852 (1992) ("At the heart of liberty is the right to define one's own concept of existence, of meaning, of the universe, and of the mystery of human life. Beliefs about these matters could not define the attributes of personhood were they formed under compulsion of the State."); see also Lawrence v. Texas, 539 U.S. 558, 574 (2003) (citing Casey).
²⁰. Ehrenreich, supra note 14, at 547, 549.
²¹. DEVRIES, supra note 11, at xvi.
religious views define themselves according to those assumptions. Just as the state may not impose religious viewpoints on citizens, the law should recognize multiple viewpoints in the birth context:

[T]his view of the reality of what happens in childbirth is as socially constructed as the view it means to supplant. But the mere presence of a coherent alternative to modern medicine casts doubt upon the convictions that drive society and the courts into accepting and enforcing one view of reproduction.

Birth is also a major personal milestone in the life of the woman. For many if not most women, giving birth is an extremely challenging and life-altering experience. It is an event that will take place only a few times in her life, and it marks an important moment in her transition from a single person, to a pregnant, dual person, and then to being a mother. Ina May Gaskin, one of the mothers of the midwifery movement, eloquently describes the role of the midwife in supporting a mother through this liminal event:

Many seeds for later actions and relationships are planted in the birth room. Marriages may be made or broken here, mothers form lasting ideas about their strengths or weaknesses, about their mate’s strengths and frailties and lasting impressions about the ‘personality’ of the newborn are created. The woman who is gently mothered by a midwife or nursed through her labor learns by absorption some of the most important skills she will need as a parent. When she is showered with sweetness and love, she is more likely to have a fund of generosity on which she can later draw when her patience is tested.

Reading through Ina Gaskin’s collection of birth narratives, the reader clearly understands that for these women, giving birth is one of the most amazing and transformative experiences of their lives.

No matter which alternative birth view a mother subscribes to, all would consider giving birth to be a highly significant event. Currently, substantive due process guarantees individuals the right to non-reproductive sex (by ensuring access to contraception) and the right to homosexual sex (by striking down anti-sodomy laws). Although some might believe that the cumulative effect of being able to choose consensual, non-reproductive sex is of even greater significance for the individual, it must be noted that these sexual encounters, viewed individually, may be fungible, and will seldom have the significance of a single birth event.

23. The weak point of the analogy is that both medical and alternative birth camps are deeply concerned with safety. See Ehrenreich, supra note 14, at 530, for an interesting discussion of how “privileged women’s role as good mothers includes the stricture that they be obedient to physicians.”

24. Ehrenreich, supra note 4, at 546. For a good summary in chart form of the medical and midwifery viewpoints, see id. at 548.

25. See infra Subpart II.G (discussing Lawrence v. Texas).

26. GASKIN, supra note 22, at 8.


B. Safety and the Growing Consensus: Doctors Please Don't Choose for Me

As explained above, many people are unaware of the personal, political, and religious significance of giving birth. However, there is another common misperception that similarly trivializes the motivations of home-birth mothers, namely that they put the aesthetic experience of birth over the safety of their children. Professor John Robertson, for instance, expresses what is surely the majority view in America that "[a] woman’s interest in an aesthetically pleasing or emotionally satisfying birth should not be satisfied at the expense of the child’s safety." In fact, as will be shown below, most home-birth mothers believe that their alternative understandings of birth have the added advantage of being safer for both mother and child.

In the following paragraphs I describe safety concerns regarding hospital births that have been reported by midwifery advocates time and again in the literature, but I repeat them here for several reasons. First, the safety data about midwifery and home births are still widely unknown. Second, these data form the basis of the bodily integrity arguments made later. Third, the outrage many alternative birth adherents feel at this unnecessary and disrespectful violence toward women partly explains their strength of conviction. And finally, after the data, I will discuss whether these data might not demonstrate something else entirely, namely, that since medical knowledge is not absolute and incorporates important value judgments, perhaps those value judgments should be the protected right of the individual as well.

But first, the data. Many mothers birth at home because they do not want to fall victim to our nation’s unnecessarily high caesarean section rate. This major surgery is performed on nearly 26.1% of American women, while the Dutch, for instance, who have a much lower infant and maternal mortality rate, perform it on less than 8% of their mothers. Home-birth mothers (who, it must be noted, have been prescreened by

29. Professor Nancy Ehrenreich reads this statement as belittling a woman’s concerns regarding childbirth options. See Ehrenreich, supra note 14, at 525–26. While Robertson does argue for more childbirth choice, he does not do so because of his confidence in mothers as the most informed and appropriate decisionmakers. Instead, as Ehrenreich notes, his stance is deeply suspicious of women as decisionmakers. Id. at 526–27. His mistrust is more directly expressed when he discusses outsider women who refuse doctor orders: "some may refuse because of religious beliefs, eccentric preferences, idiosyncratic weightings of the values at issue, fear of surgery, or desire not to have the child." Robertson, supra note 4, at 455 n.162 (citations omitted).

30. The primary purpose of this Note is not to restate the safety and economic arguments that should be influencing our legislators and have been convincingly made by others. See, e.g., supra notes 3, 5.


32. Rifkin, supra note 3, at 518–19. For newer, more complete information on caesarean section rates and infant mortality rates, see Diana Korte, Infant Mortality, Caesarean, and VBAC Rates, THE MAGAZINE OF NATURAL FAMILY PLANNING, at
midwives for risk factors) only require caesarean sections in 4–5% of cases. The maternal mortality rate of caesarean sections has been estimated to be between two and six times higher than the rate for vaginal deliveries, and Smolin estimates that there are between fifty and two hundred maternal deaths yearly due to unnecessary caesarean sections. Furthermore, caesareans have recently been linked to a nearly doubled risk of stillbirth after thirty-four weeks in a subsequent pregnancy.

Another reason women seek midwives is that many doctors still perform episiotomies routinely, while midwives almost never do. In 1983, it was reported that over 90% of new mothers received one. Recently, the overall rate dropped to 37.7% in 2000 from an average of 64% in 1980, though individual doctors still use the procedure routinely. Nearly all midwives, on the other hand, avoid episiotomies whenever possible and instead employ techniques that protect the perineum (stretching and supporting the tissue to promote elasticity and prevent natural tearing, avoiding the lithotomy position, etc.). These techniques result in much lower levels of birth injuries (both episiotomies and tearing). The World Health Organization has recommended against routine use of episiotomies. Indeed, infections from episiotomies account for 20% of maternal deaths, and approximately 10% of women with episiotomies report


33. See Carol Sakala, Midwifery Care and Out-of-Hospital Birth Settings: How do They Reduce Unnecessary Cesarean Section Births?, 37 SOC. SCI. MED. 1233, 1245 (1993) (citing a 4.4% rate in a study of data from freestanding birthing centers in the United States and a comparable rate from Dutch midwife-assisted births). Dutch studies of home-birth outcomes also show a much lower perinatal mortality rate (1.5% versus 18.9% for obstetrician-attended hospital births). Marjoire Tew, Safest Birth Attendants: Recent Dutch Evidence, 7 MIDWIFERY 55 tbl. 2 (1991).

34. Smolin, supra note 14, at 1007 n.169 (comparing this figure with the approximately seventy maternal deaths due to legal and illegal abortions performed in the year prior to Roe).

35. The Lancet published a study conducted at Cambridge University in November 2003. LANCET, Caesarean Delivery Could Increase Risk of Future Stillbirth (Nov. 2003), available at http://www.scienceblog.com/community/older/2003/F/20033611 .html (postulating additionally that the high infant mortality rate in some developed countries may be linked to the high caesarean section rates in those countries). These findings will very likely lead to a rethinking of obstetrical protocols.

36. An episiotomy is when an obstetrician cuts the vaginal opening to enlarge it and speed delivery. Episiotomies were thought to be better for the mother than a tear of the vaginal opening. However, 40% of episiotomies tear further, sometimes as far as the anus, resulting in serious injury, while only 5% of midwife-attended mothers tear at all. Rifkin, supra note 3, at 518. While episiotomies are more convenient than natural tears for the doctor to sew, they do not heal as easily for the mother.

Hospitals in Germany report episiotomy rates, allowing pregnant women to compare rates and make informed choices. Episiotomy data for individual institutions or doctors is much harder to come by in the United States.


39. Id.
fecal incontinence. Pain for months afterward and inability to enjoy sexual relations for months or years following the procedure are additional side-effects that have been less thoroughly studied.

Finally, mothers also seek to avoid injuries and distress to their infants. The “snowball effect” of interventions often causes fetal distress. Hospitals may insist on taking the baby away for routine “care” shortly after birth. Breastfeeding is also usually more difficult to establish after a caesarean delivery, and hospital nurses are often not able to give good breastfeeding advice. Because breastfeeding is “one of the most important contributors to infant health” that “improves maternal health, and contributes economic benefits to the family, healthcare system, and workplace,” the snowball effect of birth interventions can have far-reaching consequences.

40. Approximately 10% of women who received epistiotomies reported some degree of fecal incontinence three months after delivery. L. B. Signorello et al., Midline Episiotomy and Anal Incontinence: Retrospective Cohort Study, 320 BRITISH MEDICAL JOURNAL 86, 87–90 (2000). Avoiding damage to the anal sphincter is the major reason that many doctors now avoid routine epistiotomies.

41. A typical snowball of procedures would be the following: doctors may insist that labor be induced, induction may cause contractions that are too weak, pitocin may be administered to strengthen contractions, extremely strong contractions are painful and may cause fetal distress, an epidural anaesthetic may be administered for pain, the epidural may inhibit a woman’s ability to push, the doctor may need to pull the fetus out of the birth canal using a vacuum extractor, the woman will need a major episiotomy to insert the vacuum extractor, and the vacuum extractor will cause the infant to have a disturbing, bruise-like injury to the head. See Ehrenreich, supra note 14, at 544.

42. Laura Derrick writes:

I believe that what routinely happens to women (and their babies) birthing in hospitals with OBs borders on abuse. . . . Treatment of newborns might surprise a few people, too. It did me. My first child was born 3 1/2 years ago in Cedars Sinai Hospital in Los Angeles. My husband insisted on accompanying his newborn son to the nursery while he was bathed and checked over. First they pumped out his stomach—the colostrum from his first nursing experience went down the drain (and no, there was no meconium staining, this was just routine procedure). Next they stuck a tube up his butt, then injected him with vit K and stuck his heel and squeezed a while for his PKU test. All this time he was uncovered, flailing about on a tabletop and screaming. Finally, it was time for his first bath. The nurse held him under running water, all the while scrubbing his skin with a stiffbrush [sic]. He cried so hard that he stopped breathing three times, for which he was briskly slapped on the feet and buttocks and yelled at to take a breath. When my husband was near tears and finally protested, the nurse said, ‘I do this 20 to 30 times a day. It really doesn’t hurt them.’ What do YOU think? What would most new mothers think if they could see this?


Safety evidence played an undeniable role in swaying the Roe Court (i.e. that fewer women would die from illegal abortions if they were legalized and regulated). Similarly, although safety concerns are distinct from the deeply held convictions that midwifery advocates hold regarding birth, most midwifery advocates are convinced that home birth is better and safer for most mothers and babies. However, even though midwifery advocates can and do meet doctors on their own terms with safety data, many midwifery advocates do not believe that Western medicine is a scientific absolute or that it is the proper yardstick for measuring the acceptable risk or net benefit of a particular procedure. Rather, they note the existence of alternative approaches to healing, alternative beliefs about what level of risk and safety is good, and alternative ways of assessing the net benefit of any intervention.

Midwifery should be seen within the broader context of the debate on medical decisionmaking, where the tide has begun to turn on our nation’s long, unquestioning deference to doctors. The language of the Roe decision does sound “more like a doctors’ rights opinion than a women’s rights opinion,” but it is not. Our country’s healthcare spending is unsustainable over the long term, many procedures are of questionable utility, and medical benefits are unevenly and unfairly distributed among our citizens. But further, many groups are discovering that many of the decisions we have ceded to doctors must be reclaimed because they directly affect personal dignity and definitions of self. Advocates for the disabled are insisting that much of the assistance they require should not be considered medical care. Advocates for intersexed people are arguing that sex reassignment operations performed on babies are unethical and impose on the prerogative of those individuals to define themselves as

44. See Caldwell, supra note 9, at 23 (critiquing Bowland for failing to consider medical evidence whereas the Roe Court took judicial notice of safety evidence).
45. See supra text accompanying notes 31–43.
46. Smolin, supra note 14, at 1016 (citing Andrea Asaro, The Judicial Portrayal of the Physician in Abortion and Sterilization Decisions, 6 HARV. WOMEN’S L.J. 51, 53–55 (1983)); see Ehrenreich, supra note 14, at 567–68 (“even the foundational reproductive rights case really only gives the woman the right to have a doctor decide for her”) (citing Roe v. Wade, 410 U.S. 113, 163 (1973) (“[T]he attending physician, in consultation with his patient, is free to determine, without regulation by the State, that, in his medical judgment, the patient’s pregnancy should be terminated.”)).
47. “It is not by happenstance that we turn to cases involving sexual intimacy or the right to die with dignity when confronted by the pregnancy and birthing conflicts. In all of these contexts, government intrusion and medical hegemony affect not only the individual’s body, but the deepest core of her personal, spiritual identity.” Gallagher, supra note 11, at 57.
normal. Advocates for the elderly are attempting to demedicalize and reclaim death as an important personal event—the midwifery movement seeks to do the same for birth.

The bigger concern in all these contexts is not which choice is correct, but that given the fact that medical science has so often been wrong and that these choices are of such personal importance and value-laden, it is the individual who should choose, not the doctor. I argue here that the privacy right encompasses the right to choose among safe childbirth alternatives, but I am sure that one day we will be arguing instead that this right is but one aspect of a more broadly defined right to privacy that reserves to the individual all health decisionmaking that involves value judgments and affects personal dignity or autonomy.

C. Why Midwifery Is, and Is Not, About Abortion

Perhaps the most significant hurdle midwifery advocates face is the proximity of midwifery to the politically charged abortion debate. Roe decided the abortion issue by declining to recognize the unborn as a "person" under the Constitution but recognized the state's compelling interest in the "potential life." The result is that today, the abortion struggle in our society is now waged almost exclusively with reference to this legalistic question of when the baby becomes an individual. For example, during the recent debate on the Unborn Victims of Violence Act, liberal opponents of the bill argued that it was part of a strategy to undermine Roe because it used the term "unborn child" to denote a "fetus."

Liberals correctly note that according to the Roe doctrine, moving back the point at which a fetus becomes an individual would not only put the right to choose an abortion into question, but could also cast serious doubt on the resolution of other pregnancy issues such as the imposition of liability on pregnant women for neglecting their health during pregnancy, harming fetuses through the use of drugs, etc. For once the "fetus" becomes an "individual," courts are faced with the impossible task of deciding whose rights will have to be infringed upon. Many commentators fear that any balancing test

49. See, e.g., Susan F. Appleton, Transgender Tales: Jeffrey Eugenides's Middlesex and Other Stories of Popular Culture, Sex, and Law, 80 Ind. L.J. 391, 401 (2005) (citing "misguided medics," who counsel parents of intersexed children to sex reassignment surgery, may recommend drug therapy for ADHD, may seek forced caesarean section, etc.).

50. See generally Ehrenreich, supra note 14, at 515–24 (arguing that doctors act on and perpetuate the image of outsider women as irresponsible and dangerous when they order forced caesarean sections, and hence that outsider women can only reclaim their identity by throwing off the coercion of doctors).


52. Unborn Victims of Violence Act of 2004, 18 U.S.C.A. § 1841 (West Supp. 2004) (designating as a separate offense the "death of, or bodily injury . . . to, a child, who is in utero at the time . . . . injury or death occurred to the unborn child's mother").

53. Johnsen, Fetal Rights, supra note 4; Johnsen, Shared Interests, supra note 4.

54. This Note consciously refers to the pregnant woman as a "mother-to-be" and to the fetus or baby as the "developing child." This terminology is intended to denote the special characteristics of late pregnancy as well as to avoid the debate regarding whether a fetus is an individual.
for maternal and fetal rights would threaten a woman’s right to an abortion under Roe.\(^5\)

Indeed, perhaps in light of these pitfalls, the U.S. Supreme Court will likely remain extremely reluctant to take post-viability pregnancy cases. Lower courts too are extremely hesitant to tread into the uncharted waters of late-pregnancy. Recently, a Florida court described the potential scope of a case regarding the appointment of a guardian ad litem for the fetus of a retarded woman who had been raped:

If a fetus has rights, than all fetuses have rights. And, if a fetus is a person, than all fetuses are people, not just those residing in the womb of an incompetent mother. If we recognize a fetus as a person, we must accept that the unborn would have the rights guaranteed persons under the Constitutions of the United States and the State of Florida. While it is inviting to view this case as narrowly as Wixtrom suggests, it would be dangerous to do so when the potential for state intrusion into the lives of women is so significant.\(^6\)

However, there are several important reasons why midwifery should not be about abortion. First, midwifery is an issue both right and left can agree upon. Second, while it remains true today, as when Roe was decided, that there is no societal consensus about when life begins,\(^5\) this is much less true of late pregnancy. Fewer liberal politicians are willing to take the position today that no recognition of the fetus is tenable. In fact, the tide may have turned already, as evidenced by the recent passage of the Unborn Victims of Violence Act.\(^6\) Part of the Roe controversy, perhaps a large part, is that the law here has strayed too far from reality when it dictates that the unborn in the third trimester is not a “baby.”

I believe that the rights of a mother-to-be and developing child can be defined differently in late pregnancy than they are in early pregnancy or after birth. After birth, both mother and child enjoy full constitutional rights, although parents exercise considerable control over their children. In the first trimester, however, things are much different, because Roe says that the fetus is not yet a “person” under the

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\(^5\) E.g., Gallagher, supra note 11, at 11-14; Johnsen, Shared Interests, supra note 4, at 570; see also Robin P. Morris, Note, The Corneau Case, Furthering Trends of Fetal Rights and Religious Freedom, 28 NEW ENG. J. ON CRIM. & CIV. CONFINEMENT 89, 98-99 (2002) (analyzing the Corneau petition, where a pregnant cult member was placed in custody to insure that the mother received medical assistance at birth).

\(^6\) Wixtrom v. Dep’t of Children and Families (In re Guardianship of J.D.S.), 864 So. 2d 534, 541 (Fla. Dist. Ct. App. 2004) (Orfinger, J., concurring and concurring specially) (holding that Florida guardianship law does not address the appointment of a guardian ad litem for the unborn fetus of a mentally retarded woman raped in a group home).

\(^5\) “When those trained in the respective disciplines of medicine, philosophy, and theology are unable to arrive at any consensus, the judiciary, at this point in the development of man’s knowledge, is not in a position to speculate as to the answer.” Roe, 410 U.S. at 159.

\(^6\) 18 U.S.C.A. § 1841 (West Supp. 2004). During the debate, liberal opponents of the bill argued that it was prompted by a desire to undermine Roe, while President Bush asserted that “[p]regnant women who have been harmed by violence, and their families, know that there are two victims—the mother and the unborn child—and both victims should be protected by federal law.” Carl Hulse, Senate Outlaws Injury to Fetus During a Crime, N.Y. TIMES, March 26, 2004, at A1.
Constitution. Why should late pregnancy not also be unique, bearing some of the traits of the phases before and after? If we could compromise in late pregnancy, ceding the unborn some measure of rights by calling it a "developing child," while at the same time recognizing the decisionmaking authority of the "mother-to-be" as a parent, I believe we could not only achieve better outcomes but bring the law closer to reality. This is where it must be in order to be accepted.

In the next Subpart, I will attempt to show that a principled distinction may be drawn between the Roe framework for early pregnancy and the resolution of most late pregnancy issues. First, when applied to most late pregnancy conflicts, Roe does not reach the right result because the "outside" perspective of pregnancy is neither appropriate nor accurate for late pregnancy. Instead, late pregnancy should be viewed from the "inside," a perspective I explain in the next Subpart. The "outside" perspective is inappropriate both because it privileges a third-party decisionmaker over the mother-to-be, an "insider," and because it employs the methodology of conflicting individual rights instead of viewing the interests of mother-to-be and developing child as linked and connected. Additionally, the nature of most late pregnancy conflicts is different in magnitude from the Roe issue: late pregnancy conflicts purportedly involve exposure of the developing child to some measure of risk, whereas abortion, the primary early pregnancy issue, terminates the life of the fetus.

D. Pregnancy as Parenting

When a pregnant woman and the child are viewed from an "outside" perspective of someone thinking in the mode of individual rights, they may appear as nesting Russian dolls, two individuals who happen to be occupying the same space at the same time. Viewed from this outside vantage point, the rights of the woman and the baby will be seen to conflict when the woman considers abortion, neglects prenatal care, incurs a pregnancy-related health risk, etc. The "outside" decisionmaker, however, has no special knowledge with which to resolve a conflict and may be far removed from the woman's concerns (of a different sex, religion, socioeconomic status, or race).

Furthermore, no other situation will give the decisionmaker adequate guidance because "[t]he relationship between mother and her unborn child is unique among other types of biological, emotional, and legal relationships."  

60. Caldwell, supra note 9, at 23 (critiquing Bowland).
62. The most analogous situation described in the literature is that of conjoined twins, yet there are important differences too. See Eileen L. McDonagh, My Body, My Consent: Securing the Constitutional Right to Abortion Funding, 62 ALB. L. REV. 1057, 1113–14 (1999) (arguing that while conjoined twins each derive a benefit from the other, "[p]regnancy is a benefit to a fetus but a harm to a woman if she does not consent to it."). In my view, however, McDonagh's analysis does not capture the mutuality of the pregnancy relationship between mother and fetus. With twins, there is also no parental rights aspect and no disparity in maturity and decisionmaking ability as there is between mother and child. See also Morris, supra note 55, at 98–99 (noting that similar religious convictions often motivate parents objecting to both forced caesarean sections and operations to separate twins).
63. 4-22 Michael G. MacDonald, Health Care Law § 22.05(2)(a) (2003).
A legal discourse based on individual rights and autonomy artificially unravels the bonds between the mother-to-be and developing child, viewing them as separate individuals and imposing an artificial antagonism upon their protected parent-child relationship and linked medical concerns. As one commentator noted, "[w]hatever political value the notion of rights may have, the paradigm of conflicting rights seems singularly inappropriate to describe pregnancy, a condition of continuous connection and dependence."

The "outside" view of pregnancy may also correspond with what I would call a "male" view of pregnancy, while the "inside" perspective usually corresponds to a female, or feminist, view. The effect of a "male" view is that it privileges and emphasizes the acts of conception and birth but deemphasizes the "passive" phase of pregnancy. For Professor John Robertson, for instance, conception is important because it is the exercise of the "right of procreative freedom," whether by the usual means, through surrogate parents, in vitro fertilization, or other means. And birth is important because it marks when parenting begins, the other aspect of Robertson's idea of procreative freedom. During pregnancy, however, Robertson argues that because a pregnant woman has already chosen and exercised her freedom to procreate, she must bear the pregnancy passively: "Once she decides to forgo abortion and the state chooses to protect the fetus, the woman loses the liberty to act in ways that would adversely affect the fetus."

From a pregnant woman's "inside" perspective, however, the benchmarks that are potentially important milestones for the baby's "individuality" (conception, viability, or birth) are less determinative or important. Instead, motherhood is a continuum that can begin as early as conception, but usually begins later, after she learns of the

64. Radhika Rao, Property, Privacy, and the Human Body, 80 B.U. L. REV. 359, 428-29 (2000) ("Property theory severs the body from the person who owns it, whereas privacy theory maintains the two as indivisible and inextricably intertwined. . . . [B]odily privacy is generally inalienable and unassailable—it can neither be contracted away to private parties nor confiscated by the government.") (footnotes omitted).

65. Note, Rethinking (M)otherhood: Feminist Theory and State Regulation of Pregnancy, 103 HARVARD L. REV. 1325, 1341 (1990) (making an exception, however, for drug addiction, because "addictive behavior does not reflect the woman's overt consideration of potential consequences for the fetus"); see Johnson, Fetal Rights, supra note 4, at 599; Johnson, Shared Interests, supra note 4, at 569 (arguing that policies targeting pregnant women are ineffective in improving outcomes and should not withstand equal protection review).

66. Rethinking (M)otherhood, supra note 65, at 1337 (arguing that the regulation of pregnancy by means of drug and child abuse prosecutions deflected attention from needed prenatal care and drug treatment programs).

67. Robertson, supra note 4, at 437.

68. One woman writes:

When I got pregnant with our third child I knew pretty exactly the day I conceived. . . . [S]omewhere in the center of me I felt like a flash of energy just spark. It felt like my heart opening. Then it turned into a warm glowy feeling that spread up and down my body. It felt delicious, like falling in love. I lay there and thought, 'What is this?' After a while I found myself thinking. 'Wow, this feels just like being pregnant.'

Edine, Jenny Rose, in Spiritual Midwifery, supra note 22, at 98.
pregnancy and decides to carry the child to term. During pregnancy, the developing baby is the woman's constant companion, especially after quickening. They share the same blood, the same food, and the same experiences. Birth is a special moment in their relationship because the mother is able to see her baby for the first time in person and may discover its sex, if she has not already. However, birth marks a new phase in their relationship, not the beginning of that relationship.

What Robertson misses is that because the woman already parents the child in her womb, her pregnancy and birth health decisions should be respected as parenting decisions as well. The mother-to-be makes all of the nutritional decisions for the developing child and most medical decisions (for instance, whether to obtain prenatal care, whether to take vitamins, etc.). Robertson's model evinces a deep suspicion of the (sole) parenting contribution made by the mother during pregnancy. Yet, by his own token, "[t]o deny someone who is capable of parenting the opportunity to rear a child is to deny him an experience that may be central to his personal identity and his concept of a meaningful life."

When proper weight is given to the unique nature of pregnancy and the complex risk assessments involved in making pregnancy and birth health decisions, mothers (who have the "inside" perspective on their pregnancies) and not the state (with its "outside" perspective) should be regarded as the most appropriate and well-informed decisionmakers. Women are best informed as to their own religious beliefs, personal situations, risk-averseness, and pregnancies. And it appears that even compared with doctors, women are the best authority on what is best for the child in light of the nascent parent-child relationship. In one study the data showed that in six of fifteen court-ordered caesarean sections, doctors' predictions for imminent harm to the fetus were inaccurate. Though there is no representative study, some mothers faced with

69. I believe that the recent news story about Boris Becker's surprise third child caught the public's imagination precisely because it turned this typically male notion of active conception and passive wait on its head. Becker learned after the fact that Anna Ermakova, a Russian model, had impregnated herself by injecting sperm into her womb. The story went that Ermakova saved the sperm without his knowledge after giving Becker oral sex at a London restaurant. Becker experienced a passive, indistinct beginning of fatherhood but then, upon discovering the truth, was immediately confronted with a real, undeniable baby. See "Boris Becker blames Russian Mafia for Steal His Sperm After Closet Tryst", ON-LINE PRAVDA (Jan. 20, 2001), at http://english.pravda.ru/sport/2001/01/20/2107.html (last visited Jan. 23, 2004) (reporting that Becker's lawyers were investigating whether the Russian model and alleged mother of his illegitimate child, Anna Ermakova, had become pregnant by injecting herself with Becker's sperm following oral sex).

70. I believe that the wide use of ultrasound technology in prenatal exams has also had a profound effect on the way women experience their pregnancies. See infra note 152.

71. Robertson, supra note 4, at 410.

72. See Gallagher, supra note 11, at 13–14; Johnsen, Shared Interest, supra note 4, at 571.

73. See Johnsen, Shared Interests, supra note 4, at 598 (citing the AMA's position that given the uncertainty of obstetrical assessments, it would be inappropriate for any party other than the woman to make medical decisions).

74. See Veronica E.B. Kolder et al., Court-Ordered Obstetrical Interventions, 316 NEW ENG. J. MED. 1192, 1195 (1987).
court orders disobeys, flee the hospital, and deliver normally.\textsuperscript{75} As soon as the baby is born, the mother’s medical decisions for the child will be given broad deference, as long as the life of the child is not threatened.\textsuperscript{76} Questioning her judgement at the moment of birth, when she is better informed than anyone as to the well-being of the child, simply does not make sense.\textsuperscript{77}

Also, recognizing a woman’s right to parent an unborn child and to make her own health decisions, as well as those of the unborn child, places authority and responsibility on the shoulders of the pregnant woman. When a court orders a forced caesarean section against the will of a mother, it objectifies her, violates her rights, and disempowers her. When a legislature places blanket restrictions on a woman’s ability to birth as she chooses, it does the same things, though in a less obvious manner. The evidence has shown that courts are often wrong when they order caesarean sections, and studies also show that midwives often provide safer, gentler births for mothers and babies. Under either rule, whether the state decides or the mother decides, mistakes will be made. However, as a matter of public policy, empowering a pregnant woman as a mother, rather than disempowering her, objectifying her, and violating her

\textsuperscript{75} Dr. Helene Cole notes that “[c]onsiderable uncertainty can surround medical evaluations of the risks and benefits of obstetrical interventions,” and recommends against physicians overriding a pregnant woman’s evaluation of an acceptable level of risk as it “undermines the very concept of informed consent.” Helene M. Cole, \textit{Legal Interventions During Pregnancy: Court-Ordered Medical Treatments and Legal Penalties for Potentially Harmful Behavior by Pregnant Women}, 264 JAMA 2663, 2665 (1990). Furthermore, proceedings in court-ordered caesareans are usually procedurally inadequate. Often they are initiated shortly before birth or during labor, the mothers rarely testify directly, and misinformation is common. Gallagher, supra note 11, at 48–54. These medical and legal shortcomings are both illustrated by a recent case. Doctors in Philadelphia asked a judge to order a caesarean section for Amber Marlowe because her baby was expected to be thirteen pounds and they believed it was in imminent danger of death if the mother delivered vaginally. The doctors told the judge that the mother objected to a caesarean for religious reasons. However, the mother, told reporters that she did not want a caesarean because a friend had died from one and because she had delivered six other children, all of them vaginally, and some bigger. The judge ordered a caesarean section and appointed a guardian ad litem for the baby. The parents, however, did not return to that hospital but delivered the baby vaginally and without complications at another hospital. \textit{Hospital Faces Suit Over a Pregnancy}, \textit{Philadelphia Inquirer} (Jan. 19, 2004). Debacles like these should raise a red flag for any type of contested pregnancy health issue.

\textsuperscript{76} Courts generally require parents to consult doctors when their children’s lives are threatened; however, they are split as to whether medical treatment must be sought for non-life-threatening conditions. \textit{See generally} Barry Nobel, \textit{Religious Healing in the Courts: The Liberties and Liabilities of Patients, Parents, and Healers}, 16 U. Puget Sound L. Rev. 599, 639–51 (1993).

\textsuperscript{77} Similarly, parental decisionmaking was recently privileged over judicial decisionmaking in a little noted Supreme Court decision, \textit{Troxel v. Granville}, 530 U.S. 57, 75 (2000) (plurality opinion). The plurality in \textit{Troxel} held a Washington visitation law unconstitutional because it substituted the court’s judgment for the parents’ judgment as to whether granting visitation rights to third parties was in the child’s best interests.
constitutional rights, can only have positive effects for the developing child and might be the best long-term protection of his or her rights.\textsuperscript{78}

II. THE PRIVACY ARGUMENTS FOR MIDWIFERY
(FROM LEFT, RIGHT, AND CENTER)

Midwifery is a feminist issue, a rich person's issue, a right to life issue, a religious issue, a survivalist issue, and a poor people's issue. It cuts across all classes of people. It's everybody's issue.\textsuperscript{79}

Midwifery supporters are a broad and diverse group. Historically, nearly all births in America were attended by midwives until the late 1800s. Geographically, midwives deliver about 70% of babies in the European Union and are important birth attendants in nearly every other country.\textsuperscript{80} Politically, midwifery advocates come from the left as well as from the right.\textsuperscript{81} Many are members of formal religious groups, and many are not. While advocates from the left tend to rely more on personal autonomy arguments, advocates from the right may argue parental authority, family autonomy, religious freedom, and sanctity of the home.\textsuperscript{82} All, however, believe that women should have the freedom to make most childbirth decisions.

Numerous midwifery advocates have made privacy rights arguments, but no article to date has reviewed and gathered all of the different aspects of the privacy right in one place. Seen in their entirety, they reflect the diverse backgrounds of midwifery supporters, who use different but related reasons to justify the same thing. I believe that liberals should not balk at some of the more conservative arguments, and vice versa, because of the positive externalities that would result from legalizing midwifery. If the Court recognized that the right to privacy encompasses the right to choose any safe method of childbirth, on whatever rationale, not only will more women begin to exercise more freedom, but fewer resources will be expended on unnecessary procedures, and many mothers and babies will experience healthier outcomes. Furthermore, agreement by left and right on an inclusive issue such as midwifery

\textsuperscript{78} See Johnsen, Shared Interests, supra note 4, at 613 ("Policymakers who truly wish to foster healthy childbearing must understand that government, women, and their future children all have shared interests in taking the steps necessary to promote healthy births.").


\textsuperscript{80} Rifkin, supra note 3, at 511-12, 533.

\textsuperscript{81} E.g., Robertson, supra note 4, at 452-54; Smolin, supra note 14, at 1009-13.

\textsuperscript{82} Some also argue a form of conservative feminism. Smolin, supra note 14, at 1005 ("Contemporary anti-abortion women and men therefore usually do not use the term 'feminist' to describe their beliefs; nonetheless, they generally believe that their own anti-abortion position is more consistent with the equal worth and dignity of women than is the position of the National Organization for Women."). Smolin, for example, notes that attempting to achieve gender equality (defined as equal sexual freedom) through abortion rights exacts a heavy toll on women. Not only is the goal (being like men) intrinsically anti-woman, ignoring the unique experiential aspects of pregnancy and motherhood, but its pursuit causes many woman to abort, although they themselves consider abortion to be a killing. Id. at 1001-05.
would help resolve the divisiveness of the abortion debate, which has consumed so much energy that could have been used to address other social problems.83

A. Personal Autonomy

Personal autonomy goes to the heart of what many Justices feel is at the root of the privacy right. It is perhaps the most abstract or philosophical strand of privacy doctrine, as it is less about the right to do a particular thing as about the right to be let alone. For instance, in Eisenstadt, the Court stated, "If the right of privacy means anything, it is the right of the individual, married or single, to be free from unwarranted governmental intrusion into matters so fundamentally affecting a person as the decision whether to bear or beget a child."84 In Lawrence, it was not so much that the homosexual couple had a right to have sex as that the sodomy statute, in prohibiting a particular sexual act, reached too far—"touching upon the most private human conduct, sexual behavior, and in the most private of places, the home."85

Personal autonomy arguments can be made in favor of midwifery as well. For instance, Wolfson argues that childbirth decisions present "social, economic, and political, rather than merely medical, issues."86 McCormick reasons, "A woman's right to make procreative choices is protected because the decisions are intensely personal, and denial of the right would impose psychological, physical, social, and financial burdens upon the woman."87 One conservative midwifery advocate notes that it is inconsistent to allow abortion choice, with its heavy consequences for the fetus, while limiting childbirth choice, with its lesser risks for a fetus, when both trigger the autonomy rights of the mother.88 To prevail, however, midwifery advocates must clearly explain the feminist, political, religious, and philosophical dimensions of their alternative birth understandings. They must counteract the common misperception that childbirth choice is merely an aesthetic preference or a medical judgment call. Only when a fundamental right is at stake, such as privacy, will statutes be given strict scrutiny rather than rational basis review.

B. Bodily Integrity

Bodily integrity is the mainstay of any pregnancy-related privacy argument, including those made by midwifery advocates.89 As with all fundamental rights, the state must show a compelling governmental interest to justify a regulation challenged

86. Wolfson, supra note 11, at 941–42.
87. McCormick, supra note 4, at 686.
88. Smolin, supra note 14, at 980–85 (criticizing the Supreme Court for protecting abortion autonomy more assiduously than birthing autonomy).
89. E.g., McCormick, supra note 4, at 691 ("A woman's interest in controlling her body during childbirth involves not only direct physical control of her body but also exercise of that bodily control as an expression of her identity.").
on the ground that it infringed upon bodily integrity. In *Winston v. Lee*, for instance, the Court found that surgical removal of a bullet for evidentiary purposes would be a "virtual total divestment of respondent's ordinary control over surgical probing beneath his skin." 90 In *Rochin v. California*, the Court found a privacy right violation where a man's stomach was pumped in order to retrieve evidence. 91 However, in *Schmerber*, testing for blood alcohol level was held not to violate bodily integrity. 92

Clearly, piercing the woman's body to reach the unborn is a much greater bodily invasion than removal of a bullet or stomach pumping. Caesarean sections are major surgical procedures that are far more risky for the mother than vaginal delivery. The mother can also argue on behalf of her infant that the attachment of a fetal blood scalp monitor, the application of the vacuum extractor, or any other invasive procedure exceeds this standard. Midwifery advocates should argue that requiring hospital birth, doctor attendance, or imposing a higher risk of episiotomy or caesarean section (i.e. forbidding home birth) is also more like requiring surgery than requiring an alcohol blood test.

Seen theoretically, McCormick notes, there are two aspects of the privacy interest in controlling one's body: "one is freedom from interference with one's body . . . [t]he other is freedom to act with one's body, i.e., the right to exercise autonomous control." 93 Both of these aspects are implicated by currently routine obstetrical interventions. 94 Subpart I.B of this Note discussed how midwifery advocates object to unnecessary caesarean sections and episiotomies. The mother's freedom to act is implicated by mandatory use of fetal monitoring (which requires that the mother be attached to a machine and remain stationary during labor), prohibitions on eating or drinking during labor, and rules or expectations regarding the positions she may assume during the pushing stage. 95

Of course, the problem with protecting the woman's bodily integrity in pregnancy cases is that sometimes her right is seen to conflict with that of the fetus. When a baby's health lies in the balance, a mother's religious objections to treatment, or complicated risk assessment are often honored, but some object to this. 96 Many times a woman's decisionmaking is considered frivolous, or may not be respected because it reflects a different cultural background. 97 In such cases, Prof. Robertson argues for

93. McCormick, supra note 4, at 692 (emphasis in original).
94. Id.
95. It is common to require or expect the woman to take the so-called lithotomy position (on her back, often with her feet in stirrups) because this is the most convenient position for the obstetrician. It has been shown, however, that 95% of women would not assume this position unless directed to do so. Rifkin, supra note 3, at 517 (citing NANCY W. COHEN & LOIS J. ESTNTER, SILENT KNIFE 158 (1983)). The lithotomy position also increases the probability of cord compression. Additionally, an upright position enlarges the pelvic opening, allowing for easier passage of the baby and fewer forceps or vacuum deliveries. Id.
97. Ehrenreich, supra note 14, at 521–22 (noting that doctors associate bad decisionmaking with outsider women, and consequently attempt to upset the judgments of outsider women more often). The recent case of Melissa Ann Rowland is a good example. She
balancing the mother’s rights against those of the child as the New Jersey Supreme Court did when it required a pregnant Jehovah’s Witness to submit to a blood transfusion in order to save her own life and that of the unborn child. Similar balancing is presumably undertaken when lower courts order forced caesarean sections.

Midwifery advocates should object to any such balancing by the state. The common law is quite clear that when the bodily integrity of one individual is pitted against the needs of another individual, there is no duty to sacrifice oneself, even if the harm were minimal and the benefit to the other great. Opponents of forced caesareans argue that this no-duty rule should hold true, even where the supposed danger is to a fetus, and that strict scrutiny should be applied to government actions infringing on a mother’s bodily integrity. As Professor Janet Gallagher notes, “[t]he alternative adopts a brutally coercive stance toward pregnant women, viewing them as vessels or means to an end which may be denied the bodily integrity and self-determination specific to human dignity.”

If there must be balancing in late pregnancy situations, this Note argues emphatically in Part III that it should be done by the woman, and not by the state. Pregnancy, as discussed above, is a condition in which the bodies of the baby and mother are intimately connected, forming in essence one body together. Drugs must pass through her bloodstream to reach the baby, amniotic fluid can only be influenced by piercing the mother’s body, fetal surgery requires surgery on the mother, and birth, by whatever means, requires her participation. As will be discussed below, since her rights are affected in every case, a competent mother-to-be is in the best position to speak both for herself and the child; she, and not the state, is the best and most appropriate late pregnancy decisionmaker.

C. Right to Refuse Medical Treatment

Closely related to bodily integrity is the limited right to refuse medical treatment. Generally speaking, individuals have the right to make their own healthcare decisions unless third parties’ lives are threatened, or the patient is found to be incompetent.

was charged with murder after one of her twins was delivered stillborn. Associated Press, Murder Charged in Stillbirth (Mar. 14, 2004), at http://washingtontimes.com/national/20040314-121449-3356r.htm. Media reports emphasized Rowland’s alleged statement that she refused a caesarean because she did not want the scar. However, another quote in the article demonstrates the fact that she may not have been receiving the best medical advice: “[Rowland said that] doctors wanted to cut her ‘from breast bone to pubic bone.’” Id.


100. E.g., Johnsen, Shared Interest, supra note 4, at 583–84. 101. Gallagher, supra note 11, at 57–58 (footnotes omitted); see also Rao, supra note 64, at 410–14 (deploring the state’s appropriation of pregnant women as fetal incubators). 102. See supra Subpart I.D.

103. See In re A.C., 573 A.2d 1235, 1244–45 (D.C. 1990) (finding unconstitutional a court-ordered caesarean section performed on an objecting cancer patient who died, along with her baby, as a result; listing state, circuit, and federal district court cases).
The issue arises in pregnancy situations when doctors are faced with a woman who, for whatever reasons, does not accept their medical recommendations. Doctors sometimes seek the appointment of guardians ad litem for the unborn children and sometimes seek court-ordered medical procedures. Because of the nature of the proceedings, there is often no direct testimony from the woman, few appeals, and few written opinions. Midwifery advocates have asserted that women have the right to refuse medical birth assistance.

D. Parental Authority

Parental authority is the third important prong of the privacy argument, and midwifery advocates often emphasize the right of parents to make decisions regarding the upbringing of their children and family life. Some of the earliest privacy cases were parental authority cases. In *Meyer v. Nebraska*, parents protested a law prohibiting the teaching of foreign languages. *Pierce v. Society of Sisters* struck down a law requiring attendance at public rather than private schools. *Wisconsin v. Yoder* again privileged parental judgments in the context of education, where the family religion required private school attendance. In *Yoder*, Amish parents sought an exemption to state compulsory school attendance laws on the ground that it interfered with their ability to raise their children in the Amish faith, free of the influence of mainstream culture. The Court granted the parents the autonomy to decide whether to give their children alternative, community-based vocational education instead of public education, despite the Court acknowledging a possible risk that if the children left the Amish community later, they might be disadvantaged by their lack of education. But, only Justice Douglas's dissent considered this risk...
sufficiently important.\textsuperscript{113} Smolin argues that parents should be given the same latitude in birth decisionmaking as they are in educational decisionmaking: "[t]he issue of whether education is a matter of family or professional responsibility parallels the issue of whether birth is a matter of family or medical responsibility."\textsuperscript{114}

Moreover, parental authority is not limited to education and religion. In a recent case, \textit{Troxel v. Granville},\textsuperscript{115} the Court struck down a law that gave local courts the authority to grant visitation rights to third parties, holding that parents must be given deference as the primary balancers of their children's best interests, not the state.\textsuperscript{116} The plurality reasoned that "[t]he liberty interest in this case—the interest of parents in the care, custody, and control of their children—is perhaps the oldest of the fundamental liberty interests recognized by this Court."\textsuperscript{117} Further, "there is a presumption that fit parents act in the best interests of their children,"\textsuperscript{118} and "the court must accord at least some special weight to the parent's own determination."\textsuperscript{119}

Best interest calculations are notoriously complex, but no less so in birth decisionmaking than in visitation decisions or educational decisions. Just as \textit{Troxel} deferred to the parents' balancing of their children's best interests, so too should parents be accorded leeway to choose the circumstances of their children's births. Childbirth decisions involve not only family attitudes toward health and religion. Childbirth is also the very moment at which the family becomes a family, and the parents' wishes regarding this event should be given broad deference.

\textbf{E. Free Exercise and Hybrid Claims}

\textit{Yoder} involved free exercise rights as well, because the Amish parents were motivated by a desire to instruct their children effectively in the practice of their faith. \textit{Employment Division v. Smith}\textsuperscript{120} reinterpreted \textit{Yoder} as a so-called hybrid-rights case—that is, one that combines a free exercise with a privacy right. This line of reasoning, or this way of interpreting past precedent, is attractive in the midwifery context because, as this Part attempts to show, so many strands of privacy doctrine are implicated in childbirth decisionmaking. If the logic of \textit{Smith} (that two strands are stronger than one) holds, it would seem that childbirth choice would clearly be protected. However, \textit{Smith} is probably better understood as reaching only those privacy cases where a free exercise claim can be made as well, instead of "double" privacy cases.

Parents who can make free exercise arguments in the context of midwifery should do so, as it seems that in combination, a weaker privacy interest would suffice to

\begin{thebibliography}{99}
\bibitem{113} Id. at 245–46 (Douglas, J., dissenting).
\bibitem{114} Smolin, \textit{ supra} note 14, at 1022. \textit{See also} Gallaher, \textit{ supra} note 11, at 30 (citing Bowen v. Am. Hosp. Assoc., 476 U.S. 610, 628 (1986) for the proposition that parents are entitled to a strong presumption that they are acting in their child's best interests and arguing that fetal rights cases should be decided by the same standard).
\bibitem{115} 530 U.S. 57, 63–64 (2000) (plurality opinion).
\bibitem{116} Id. 63–64.
\bibitem{117} Id. at 65.
\bibitem{118} Id. at 68.
\bibitem{119} Id. at 70.
\bibitem{120} 494 U.S. 872, 881 (1990) (majority opinion).
\end{thebibliography}
override non-compelling government purposes. However, while centrist arguments will help dissipate the abortion controversy, showcasing religious objectors to medical treatment may ultimately hinder, rather than advance, the case of childbirth choice. The more reasonable home-birth advocates appear, the more likelihood they have of achieving real reform and respect for women's choices.

F. Privacy of the Home

The last privacy strand implicated by midwifery is the privacy of the home. The home is the locus of personal privacy, where citizens have the expectation of being let alone. Lawrence protected consensual sexual activity in the home. The Fourth Amendment confers special protection to the home from government intrusion. Historically, the home was the woman's realm, and most births occurred at home. Certainly, a law requiring a woman to leave home to give birth would have seemed the utmost affront to the wives of the founding fathers. Indeed, even when the

121. Duncan describes the test as follows:

First, what governmental purposes are being served by the restrictive law at issue? Second, does the law exempt or otherwise leave unrestricted secular conduct that endangers those governmental purposes in a similar or greater degree than the prohibited or restricted conduct of the party seeking the protection of the Free Exercise Clause? In other words, a law burdening religious conduct is underinclusive, with respect to any particular government interest, if the law fails to pursue that interest uniformly against other conduct that causes similar damage to that government interest.


122. For examples of commentators opposed to religion-based refusal of medical treatment see, e.g., Janna C. Merrick, Spiritual Healing, Sick Kids and the Law: Inequities in the American Healthcare System, 29 AM. J.L. & MED. 269 (2003) (advocating the protection of children threatened by religious minorities who fear or shun medical science); Miller, supra note 102, at 74 (arguing that "in situations like Corneau's the state's interest in protecting the life of the fetus takes precedence over any rights, including religious rights, the mother may have and that the fetus has a right to be protected by the state as soon as the fetus is viable or when a woman can no longer obtain a legal abortion"); Rita Swan, On Statutes Depriving a Class of Children of Rights to Medical Care: Can this Discrimination be Litigated?, 2 QUINNIPIAC HEALTH L.J. 73 (1998) (discussing the harm of religious exemption statutes).


125. I thank Professor Patrick Baude for this insight.
Fourteenth Amendment was enacted, “midwifery was universally legal and almost completely unregulated.”

Birth is one of the most private, intimate moments in a family’s life. The home is the most private, intimate sphere. It seems unreasonable both for the government to reach into the home with regulation and for it to forbid activities in the home that do not harm others. When there is no special risk to the developing child, the right to privacy protects both the parental decisionmaking as well as the locus of the home.

G. Recent Developments: Lawrence v. Texas Applied to Midwifery

Despite the plethora of possible privacy arguments described in Subpart A, significant hurdles remain when applying current substantive due process doctrine to the midwifery issue. The primary hurdle is, or was, the Court’s increasing reluctance to recognize “new” fundamental rights. The Court’s recent decision in Lawrence did show unexpected movement on the substantive due process front, but it is unclear whether Lawrence will actually help or hurt the midwifery cause.

On the positive side, Lawrence reemphasized the “sweet mystery” language of Casey, which appears on its face to be highly applicable to the moment of birth:

“These matters, involving the most intimate and personal choices a person may make in a lifetime, choices central to personal dignity and autonomy, are central to the liberty protected by the Fourteenth Amendment. At the heart of liberty is the right to define one’s own concept of existence, of meaning, of the universe, and of the mystery of human life. Beliefs about these matters could not define the attributes of personhood were they formed under compulsion of the State. Persons in a homosexual relationship may seek autonomy for these purposes, just as heterosexual persons do. The decision in Bowers would deny them this right.

A mother choosing a home birth usually does so because she wishes to be in charge of her birth—autonomous, experiencing the moment actively and freely—because she views birth as an extremely important moment in her personal development as well as one of the most important experiences she will share with her child. However, as Justice Scalia notes in his dissent, it is unclear whether the Casey language or the substantive due process talk in Lawrence are anything more than dicta because the majority also finds the Texas sodomy law unconstitutional on the grounds that it fails.

126. Smolin, supra note 14, at 1019; see also Robertson, supra note 4, at 452–53.
127. In Lawrence, the protected sexual activity also occurred in the home. The Lawrence majority, however, did make an exception to the government’s duty to stay out of private relationships—where there could be “injury to a person or abuse of an institution the law protects.” Lawrence, 539 U.S. at 567. Thus, home births might have to be limited to situations where the infant was not at risk. Midwifery regulation, where it exists, and general standards of good practice preclude home births in high-risk situations anyway.
129. Lawrence could have been decided more narrowly, as Justice O’Connor would have done, on equal protection grounds. This holding would not have required overruling Bowers v. Hardwick, 478 U.S. 186 (1986).
130. Lawrence, 539 U.S. at 574 (quoting Casey, 505 U.S. at 851).
rational basis review. If so, the Casey language, which Justice Scalia asserts to have been merely dictum in that case as well, may not play a rule in future substantive due process analysis.

We must also take careful note of the fact that the Court uses the wording “[p]ersons in a homosexual relationship” instead of referring to the protected nature of the relationship itself. This is significant because it may indicate that the Court was primarily moved to protect what Radhika Rao calls “personal privacy” instead of “relational privacy.” Personal privacy serves pure individual autonomy interests, while relational privacy encompasses the “right to include” some individuals by joining with them in close personal relationships. Probably the Court was motivated by a desire to avoid casting what Rao refers to as a “mantle of immunity” over homosexual relationships. Indeed, the majority opinion explicitly denies that it does, although Justice Scalia opines that Lawrence essentially removes all hurdles to gay marriage.

Because the birth situation involves only one individual who is capable of autonomous choice (the woman), childbirth choice must depend on both personal and relational privacy. The rule I advocate for in Part III recognizes that because the mother-to-be already parents the developing child and because of her own significant liberty stake in childbirth decisions, she should be authorized to choose midwifery for herself as well as for the child.

One aspect of Lawrence that bodes well for the midwifery issue is the fact that the majority in Lawrence takes the historical test for fundamental rights very seriously. The opinion goes into considerable detail describing the historical treatment of sodomy and analyzing how Bowers had been undermined because it was not based on historically accurate facts. Of course, if Scalia is right, and the majority does not, in fact, hold homosexual sex to be a fundamental right at all, then this historical analysis was not determinative. Nevertheless, it is clear that a historical analysis may hold great sway in establishing the case for a “new” fundamental right to a moderate or conservative court. Midwifery’s historical pedigree is, of course, as old as humankind itself. Certainly, in 1789, home birth was the norm, and to require a woman to leave the sanctity, privacy, and comfort of her home to give birth would have been unthinkable.

132. Lawrence, 539 U.S. at 586. See supra note 16 for an argument that outlawing midwifery should fail rational basis review under certain circumstances.
133. Id.
134. Rao, supra note 64, at 388–89.
135. Id. at 389.
136. Id.
137. The majority opinion stated “[Lawrence] does not involve whether the government must give formal recognition to any relationship that homosexual persons seek to enter.” Lawrence, 539 U.S. at 578. Justice Scalia, dissenting, wrote that “what justification could there possibly be for denying the benefits of marriage to homosexual couples exercising ‘the liberty protected by the Constitution?’” Id. at 605 (quoting the majority opinion).
138. See supra Subpart II.F.
139. Lawrence, 539 U.S. at 567–73 (conducting an extensive reevaluation of the historical evidence relied upon in Bowers).
140. See Smolin, supra note 14, at 1018–19 for a good analysis; see also supra text accompanying notes 124–26.
Similarly, the midwifery context compares favorably with the homosexual sex context because an individual birth event may be more meaning-laden for the individual than an isolated sexual encounter. On the other hand, Lawrence could, and perhaps should, be read to safeguard not the individual sex acts prohibited by the statute, but the right to express oneself through sexual orientation. If this is so, it is arguable that even highly significant, non-fungible events such as births are arguably not as protected if they affect the individual less fundamentally.

Finally, the Lawrence Court also seems to open the door to a comparative law analysis that could be utilized in the midwifery context. The majority opinion cites to a ruling by the European Court of Human Rights in building the argument that Bowers was wrongly decided from the start. Midwifery is the dominant model of birth in the European Union, and a directive requires all EU countries to recognize midwifery degrees (as opposed to nurse midwifery). The World Health Organization has also taken a strong position in support of the midwifery model of birth.

In sum, Lawrence is encouraging for midwifery advocates if for no other reason than that it demonstrated that there is currently a majority on the Court that is not dead-set against expanding the realm of substantive due process. Further, the Court relied on historical analysis as well as a comparative law approach, two arguments that can be made effectively for midwifery. More broadly, the Court seems to have reached a result that is compatible with the changing social norms and did not hesitate to overrule Bowers, a decision only seventeen years old. Given the fact that a majority of Americans may wish to recognize limited fetal rights in some form, midwifery might persuade the Court similarly.

III. HARMONIZING MIDWIFERY LAW WITH CURRENT LAW ON ABORTION, FORCED CAESAREAN SECTIONS, AND CHILD HEALTH DECISIONMAKING

The uniform, negative treatment of midwifery privacy claims in the courts is not in conformity with Roe, In re A.C. (the most famous forced-caesarean case), the bodily integrity cases, or the child health decision cases. This distinction is wrong because there is no logical reason (such as disproportionate risk) to treat the birth

141. Lawrence, 539 U.S. at 573. Since Lawrence, the Court has opened the door to comparative analysis a little wider. In overturning juvenile death penalty laws, the Court found "confirmation" for its Eighth Amendment holding in the unanimous jurisprudence of other states. Roper v. Simmons, 125 S. Ct. 1183, 1198 (2005).


143. Id. at 524. The World Health Organization website provides extensive resources aimed at both doctors and midwives. At http://www.who.int/topics/labour/en/ (last visited Apr. 2, 2005).

144. See supra text accompanying note 58–59.


146. 573 A.2d 1235 (D.C. 1990) (holding that a court-ordered caesarean section on a terminally-ill cancer patient who objected to and died as a result of the operation (along with the baby) was unconstitutional).

147. See supra Subpart II.B.

148. See supra notes 76–77 and accompanying text.
moment as different from any other health decision. These cases could all be harmonized by differentiating early pregnancy (when the woman and the fetus have no relationship) from late pregnancy (when the mother-to-be parents the developing child). As a woman and a parent, she should be entitled to exercise health decisionmaking for herself and the child, except perhaps where there is a showing of a clear danger to the life of the developing child or incompetence on her part.

When this limited recognition of fetal rights is properly allocated to late, rather than early pregnancy, and a mother-to-be’s parental rights are found to commence at the same time, the oppressive consequences commentators have predicted become much more unlikely. Additionally, this concession would help diffuse two conservative arguments. First, granting birthing choices to mothers who choose to bear their children instead of aborting refutes the conservative critique that courts currently grant broad rights to the minority (who abort) while largely ignoring the significant rights of the majority of women (who choose to birth). Second, acknowledging viable, third-trimester fetuses to be “babies” (or, in my terminology, “developing children”) more closely approximates the way most Americans view them.

149. The moment after birth, a parent may make decisions for the child that fall short of threats to the child’s life. Up until the moment before birth, the mother retains significant latitude to abort the child if her life or health is threatened. Most birth decisions involve complex risk calculations that are made even more opaque by the fact that the health of two individuals is at stake instead of just one. However, the same interests in bodily integrity, autonomy, and parental rights are at stake, and the increased complexity of birthing health decisions only lends more weight to the proposition that the individual should decide, not the state.

150. See Gallagher, supra note 11 at 42-43 (predicting prenatal negligence claims and noting that “[v]irtually all fetal rights proponents ultimately reject any ‘bright line’ limitation of maternal duties and liability to the period after viability”); Johnsen, Shared Interests, supra note 4 at 585-86 (discussing the possibility of prosecuting pregnant women for drug use or parental neglect, limiting work opportunities to non-risky jobs, etc.); Robertson, supra note 4 (advocating the same); see also Wixtrom v. Dep’t of Children & Families (In re Guardianship of J.D.S.), 864 So. 2d 534 (Fla. Dist. Ct. App. 2004). Judge Orfinger, in his concurring opinion, warned against opening the door to fetal rights because it “would be dangerous to do so when the potential for state intrusion into the lives of women is so significant.” Id. at 540-41 (Orfinger, J., concurring).

151. Smolin, supra note 14, at 1012 (“The judicial abandonment of a constitutional role in midwifery and women’s control over childbirth, contemporaneous with its constitutional activism in abortion, constitutes an arbitrary constitutional favoritism, as Justice Scalia described it, for the unconventional. Autonomy theory should equally protect both the conventional choice to give birth and the unconventional choice to abort.”).

152. See supra text accompanying notes 57-59. Regardless of how fetuses were viewed in the past, the advent of modern technology has given us a window into the fetus’s development. Mothers who see their babies squirming on the ultrasound screen or feel them kicking do not doubt that a fetus is, in the ordinary sense of the word, a baby. When legal doctrine strays so far from experience, the legitimacy of the courts is undermined. This has happened in the abortion context. See Robin Power Morris, Note, The Corneau Case, Furthering Trends of Fetal Rights and Religious Freedom, 28 New Eng. J. On Crim. & Civ. Confinement 89, 99-100 (2002) (arguing that technology has fostered identification with the fetus, which has, in turn, led to some placing the fetus’s rights on a par or above those of the
More importantly, however, taking the decisionmaking about how to birth back from the doctors and putting it in the hands of women will have a profound, if subtle, long-term effect on the dignity, autonomy, and self-respect of the women of this country. Midwifery is an important, core feminist issue, even if the violence of current obstetrical practices is usually non-lethal and generally goes unquestioned. \(^{153}\) Abortion rights currently dominate the feminist movement,\(^ {154}\) but this absolute commitment to that one issue has come at a cost.

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mother); see also Smolin, _supra_ note 14, at 1026–27 (noting that the Court’s legitimacy has also been undermined because of the way the abortion issue has affected the nomination process). \(^{153}\) See Ehrenreich, _supra_ note 14, at 553 (contrasting and connecting the outright violence of forced caesarean sections against outsider women with the hegemonic oppression of privileged women through obstetrical practices).

154. Neither the website of the National Abortion and Reproductive Rights Action League, at http://naran.org/ (last visited Oct. 15, 2004), nor the website of the National Women’s Law Center (“NWLC”), at www.nwlc.org (last visited Oct. 15, 2004), contained any references to midwifery or birthing choices (NWLC’s website did contain references to the availability of prenatal care). The National Organization of Women adopted a resolution in support of midwifery at its 1999 conference, but the website yields only one result for the topic in the years after that, and midwifery is not listed under the “Key Issues” section of the site. National Organization for Women, Key Issues, at www.now.org/issues/ (last visited Oct. 15, 2004). The 1999 N.O.W. resolution succinctly states the case for broader childbirth options:

EXPANSION OF REPRODUCTIVE FREEDOM TO INCLUDE THE MIDWIFERY MODEL OF CARE

WHEREAS, the National Organization for Women (NOW) has long supported reproductive freedom as a priority issue; and

WHEREAS, NOW believes that women should have complete authority over their reproductive lives; and

WHEREAS, reproductive freedom not only includes the ability to decide whether or when to bear children, but also the right to devise a birth plan with a medical provider of their choice in either a hospital or an alternative setting such as a freestanding birth center or private residence; and

WHEREAS, women have historically given birth with midwives; and

WHEREAS, the practice of midwifery has many benefits including lower costs, lower rates of premature births, higher rates of breastfeeding; and greater satisfaction with the birthing experience; and has been endorsed by the World Health Organization; and

WHEREAS, midwifery has a lower incidence of medical interventions during the birthing process, including the routine use of episiotomies and Caesarian sections; and

WHEREAS, women’s access to midwifery and traditional birthing practices many times is limited by restrictive laws and non-coverage by private insurance companies and state-subsidized funding;

THEREFORE BE IT RESOLVED, that NOW’s policy statements, brochures, and fact sheets concerning reproductive freedom include references to birthing choices, safe childbearing practices, midwifery; and

BE IT FINALLY RESOLVED, that NOW work in cooperation with state and national midwifery organizations to increase women’s access to midwifery and community awareness of childbirth, pregnancy, and early parenting choices.
CONCLUSION

Feminists and humanists are rightly angered by egregious examples of violence toward women such as forced caesarean and genital mutilation. Similarly, the right to choose an abortion will always be a vital aspect of reproductive freedom. Yet, when states outlaw midwifery and thus impose the medical model of birth on all childbearing women and their children, there are also costs to bodily integrity and to individual autonomy that, while perhaps less extreme, affect a large proportion of childbearing women.\(^{155}\)

This Note analyzed the factors that have blocked midwifery reform both in the legislative arena as well as in the courts. First, the medical lobby has a vested interest in defining birth as a medical event.\(^{156}\) Second, midwifery advocates have not communicated clearly the political, feminist, philosophical, and religious facets of their beliefs about the meaning of birth and their conviction that doctors should not make value-laden decisions that affect dignity and self-definition. Finally, we should abandon the “outsider” perspective of pregnancy as passive down-time, as a cake in the oven. Instead, pregnancy must be viewed from the “insider” perspective, as active parenting time during which the interests of mother and child are interconnected.

While the _Roe_ framework is appropriate for early pregnancy, in late pregnancy the individual rights of mother-to-be and developing child cannot, and should not, be artificially disengaged from each other and balanced by the state, because the state is not in the best position to accurately balance and assess the interests involved. Instead, absent a showing of incompetence, a mother-to-be should be authorized to make joint health decisions for herself and the developing child, as she would be moments after birth. Her decisionmaking for the developing child should be reviewable under the same standard as it would be after the child is born, subject, of course, to the maternal health-exception of _Casey_. Adopting this rule would harmonize midwifery doctrine with child health decisionmaking law, abortion doctrine, and the cases against forced caesareans.

Women have the right to give birth in accordance with their deeply held convictions about nature, women, parenting, and life. However, childbirth rights can only be recognized if the Court finally addresses the controversial legal issues raised by late pregnancy. Given the fact that midwifery supporters come from both left and right, it is a reproductive issue that is not programmed to divide us along pro-choice and pro-life lines. Instead, integrating midwifery decisions into a cohesive reproductive and parenting doctrine may help us move beyond the deep divisions and extreme positions wrought by _Roe_. Recognizing childbirth choice will bring important public health and economic benefits. But most importantly, by exercising childbirth choice, women will work long-term societal change, defining themselves, and in turn shaping society’s view of them as the most competent and appropriate pregnancy decisionmakers.

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155. The same harms occur when women are denied the option of giving birth vaginally after a previous caesarean section (“VBAC”), a distressing current trend. See Denise Grady, _Trying to Avoid 2nd Caesarean, Many Find the Choice Isn’t Theirs_, N.Y. TIMES, Nov. 29, 2004, at A1 (reporting that the VBAC rate has dropped dramatically from 28.3 in 1996 to 10.6 in 2003).

156. See supra note 14.