OBSTETRIC VIOLENCE

by

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Preface

I. A Problem With No Name

The questions that became this project began bobbing around in the back of my mind when my friends started having children. I was reading intensely about medicine, law, and how pregnant people are dehumanized in these institutions, desperately searching for a dissertation topic.

Visiting a friend with a newborn is like an anthropological expedition into heteronormativity. Stacks of crisply folded but unused onesies in garishly gendered colors lurk at the edges of every room. Often, my friends do not even use whatever room I helped paint or decorate with whatever color is trending for newborns.[1] Mostly, we sprawl together on the most comfortable couch in the house, in the middle of a nest with every little thing that either mother (it is always mother) or child could possibly need in arm's reach. It forms a kind of forcefield between my friends and me, an armored carapace to shield them from all the demands of the outside as they try to find a new rhythm to their irrevocably changed world.

Exhausted people can't make small talk other than about the needs of the infant that is, hopefully, contentedly nestled into the warmth of their arms. I cannot stand to be idle.

[1] Over the last decade, it has gone from Martha Stewart pops of pastels, to grays, to yellow, to red and black buffalo check, back to pastels. I have dutifully sewn, or knit, or crocheted depending on the trends in handicrafts blankets and stuffed animals and on one notable occasion a lamp with a mobile of felted zoo animals to match the decor. There are times in one's life when being "crafty" is a blessing, and times when it is a curse.

So I ask what housework needs done. Sometimes, after a brief silence because no one has yet asked them this question, when a flood of answers comes out, I just pick up a broom or dish sponge and get to it.

In those moments when I was mopping, or vacuuming, or scrubbing dishes, or folding laundry, something else started coming out of my friends' mouths. Alarmingly, almost no one is given advice on how to heal their own body, or what to do about their health in the wake of the expulsion. Doctors and nurses hadn't really listened to them during labor and delivery, just soothed them into a quiescent lithotomy position whenever possible.

One nurse said a headache was really normal postpartum, and gave my friend a Tylenol instead of taking her blood pressure. This friend has a heart condition. She knew how dangerous it was. Just like Serena Williams, I instantly thought, when she went to give birth and almost died. My friend's blood pressure was normal by the time she returned home, to her testing equipment, which was behind her on the long narrow console table.

One nurse shouted at my friend when she didn't want to be touched after a long and traumatic birth and rejected skin to skin time, which apparently is supposed to help with "bonding" and constitutes "child abuse" if it is rejected. So my friend, feeling like her skin was about to leap off her body with tears streaming down her face, held her baby. It took her weeks and weeks to become comfortable holding her baby, because her whole fight or flight reaction went off every time she tried. She never tried to breastfeed.

One friend stepped on a landmine in the war between nurses with different opinions about breastfeeding, and the baby was repeatedly snatched away without actually asking my friend what she wanted. She told me that one nurse (older, possibly past retirement age) felt strongly that formula was best, and actually took her pump out of the room while lecturing about how long milk was good for when pumped, and how to sterilize the bottles since my friend was so intent on "killing" her baby.

One doctor called a friend "hysterical" when she asked why he was demanding to perform a C-section. She demanded copies of her medical chart after a (healthy) vaginal birth, and the word "non-compliant" was plastered all over it. A chill ran down my spine. I had done a pilot project about the criminalization of pregnancy, and one case continues to haunt me. A couple in New Jersey came very close to having their parental rights terminated for refusing what turned out to be an unnecessary C-section.

That couple was not allowed to take their child home from the hospital, because refusing (unnecessary) medical treatment was taken as evidence that they were unfit parents.[2] The Division of Youth and Family Services pursued the termination of their parental rights all the way to the New Jersey Supreme Court, which apologized to the couple in their decision and ordered that immediate and full custody without condition be restored to them. This process took two years. Two years of notes from a case worker that only visited with a police officer in uniform with the child, because the parents could not

[2] DYFS v. V.M. and B.G. In the Matter of J.M.G., A Minor. (2009) 408 N.J. Super. 222, 974 A.2d 448

understand why their child had been “kidnapped.” The use of the word “kidnapped” by the mother of the child was listed as evidence of her delusions of persecution. When the child’s father refused to intervene and insist on a C-section, the caseworker labeled the delusions as a “folie à deux.”

I did not tell my friend this. As a sociologist, I am often the thief of joy in conversations. My closest friends research eating disorders, homelessness, political violence on the Christian right, and suicide. I have had to learn how to moderate my inclination to absolute and incredibly detailed honesty. Only the morbidly curious press past my polite deflections at parties these days. There was no need to frighten my friend about custody of her adorable newborn. She was actively rewriting the events into a crazy story of the whirlwind birth, digesting it into the family lore. Her tone was indignant, and little chuckles and scoffs punctuated her disbelief.

It had happened *to her*, and she still didn’t quite believe it.

One friend told me she had no warning when a doctor she didn’t know “needed” to do a vaginal exam. He didn’t ask for consent and he didn’t close the door or the curtain. My friend was concerned about passing staff and patients seeing her “hooha.” She laughed about it while she fed her infant and I addressed thank you notes from her baby shower, which had happened only two weeks before she gave birth due to a series of communications mishaps and a slightly early baby.

I thought, "that meets the legal definition of assault. She's describing a crime to me. Does that guy assault his patients often? Does he not know it is illegal?"

I came across more than one case that could be seen as criminal behavior by doctors in my pilot project. Kimberly Turbin, in spite of informing her medical team that she experienced PTSD as a rape survivor and minutely reviewing consent before giving birth, had her perineum cut by her doctor twelve times during birth. He later voluntarily surrendered his medical license after he admitted that he knew what he had done was wrong and violated the ethics of his profession (Grant 2018). Catherine Skol's doctor told her as he selected a needle that it was too large to stitch a periurethral tear and that he would not give her anesthesia because "pain is the best teacher."[3] He wanted her to submit to an episiotomy which she refused. He sent all the other medical staff out of the room to perform the surgery while she was still unable to walk after an epidural. He knew what he was doing was wrong. A jury awarded Catherine Skol punitive damages.

Both Turbin and Skol won in court. Rinat Dray lost. After the hospital counsel overrode her desire to give birth vaginally, she begged her doctor not to perform the surgery throughout her C-section. Her case was dismissed because there was no injury to the infant, even though Rinat Dray's ability to have more children may have been permanently damaged.[4] The doctor in the case said that she had already had "enough"

[3] Catherine Skol v Dr. Scott Pierce 08L-13805 Tried Feb. 17-Mar. 1, 2012

[4] Dray v. Staten Island Univ. Hosp., No. 500510/2014 (N.Y. Sup. Ct. Kings County)

children, so what he did was not harmful since it saved both the fetus and Ms. Dray's life. None of these cases were criminal charges against doctors for assault, but civil malpractice lawsuits.

My friends felt deeply distressed because of how they were treated. They distrusted both doctors and their own instincts, so they minimized their complaints after birth. They only talked to me about it because I was there when they were trying to process. I had been avoiding going into detail about my research for months–in part because I wasn't quite sure what my dissertation would be about, and in part because none of my pregnant friends needed to hear the gruesome details fueling my outrage before giving birth. They had a vague notion that I did "pregnancy stuff," as one friend put it. One friend said, "put that in your dissertation," though she laughed.[5]

I assume they thought I might believe and understand their pain and anger–unlike our friends who had good experiences. Or their own mothers. My friend who had endured the shouting nurse said her mother had angrily shaken a finger at her and told her to "stop whining," and "focus on your baby."

My friends healed. They developed a rhythm. They got on with the process of living, and tried to put their experiences behind them.

Not one of my friends could name what had happened to them. They felt that it was inappropriate. One used the word, "violated." Another, "shattered." A third,

[5] I didn't include her story here, though I am grateful for her openness. This process has taken so long that my friends have had *a lot* of babies in that time. There isn't space for all of their stories.

“overwhelmed.” I think that underlying those descriptions was a deep, personal sense of shame. That they had not been up to the task. That they could not cope, in some cases, with their feelings in the wake of trauma. I think that, in the words of C. Wright Mills, they lacked the sociological imagination to frame their experiences (Mills 2000[1959]).

The legal cases that so appalled me in my pilot project involved the exact same behaviors of doctors and issues with birth that my friends experienced. They are probably not going to be counted in any government survey of negative birth experiences, such as the Center for Disease Control’s Pregnancy Risk Assessment Monitoring Survey (PRAMS). They aren’t running out to hire lawyers. Their stories are not going to be on the local news at ’Ix, and no newspaper is going to interview them. They probably won't ever really talk about it again.

It feels true that’the legal cases I cited above are the same phenomenon as what my friends experienced. The resonance made it very difficult to keep my mouth shut, and not ruin my friends’ joy. The thought though, that so many problems and violations are not even recognized by medicine or law raises my heart rate.

How can you solve a problem if you can’t see it? How can we argue that a problem is serious, if not one is counting it? How can we know if we are experiencing the same thing, if we don’t name or define it?

Does it exist at all if no one acknowledges it?

II. How can everything go so wrong when everyone means so well?

At the private defense of my dissertation proposal, one committee member commented, “OK, we get it. Simple story. Bad doctors do bad things.”

Out loud, I hedged. In my head, I panicked.

As appealing as the Bad Apple Thesis is, I do not think it is so simple. I didn’t see how what I had written could be interpreted that way. I was, however, in no position to argue. I had no idea why the narrative made me so uneasy.

A very close and dear relative is an obstetrician. I knew her before she went to medical school, and have watched her career with some interest. In the lull between formal Family Events, patterns emerged to me in the way she talked about her work.[6]

The first thing that I think is really poorly understood by most Americans is that pregnancy is not safe. There is a tendency to assume that one pregnancy equals one baby, and that anything other than a good outcome is rare. I could, and I certainly shall in other chapters, cite a number of statistics supporting this assertion. Doctors may not have the minutiae of statistical trends on the tip of their tongues, but they know exactly how dangerous birth is. It is actually their job to be calm, reassuring, and give patients the information they need to make choices about their care quickly. It is not infrequently a matter of life and death.

[6] I have asked her to comment on this introduction, since her stories were personal venting and not in any way part of my research design. She is most worried about coming off as a bit of an asshole; I don't think she does, but that might be because I'm a bit of an asshole myself.

One story that she shared with me involved a surgery that had to happen fast. News of a drop in fetal heartbeat and the danger and urgency are incredibly emotional. It is the job of a doctor to act quickly. Sometimes, my relative says, patients are not engaging productively in their own care. They are shocked, they are heartbroken, they are traumatized. Conversations happen on the way into surgery and in other less than ideal circumstances that might correctly be labeled "coercive."

In this particular story, she told me that once they had scrubbed in for surgery, she did not breathe until the infant was out and (fortunately) crying–not limp and cold and dead. She remembers that breath, because she had to remind the resident shadowing her in surgery to breathe too. She saw her own terror mirrored on the face across from her, and began an internal mantra. Breathe, the baby's out. Breathe, and take a breath and then get back to work to save mom.

She closed this story by saying she didn't know what she could have done differently or better, and that haunted her. She was sure that she had caused some trauma to that patient. It was hard to argue with the result though.

Many people feel that knowledge of negative medical outcomes is itself coercive–like doctors are trying to bully or scare them into accepting treatment they do not want and do not need.[7] The knowledge of all the terrible things that can and do go wrong is like

[7] I am not one of these patients. During my recent cancer care, my surgeon tried to make me promise not to "Google it." I said I would do no such thing, and that I intended to make an annotated bibliography. She chuckled and replied, "oh right. You're a scientist. OK, here's what you need to know."

Bluebeard's room full of dead wives. They can live with the knowledge in relative peace, so long as it remains vague and locked away. So long as they are not actually confronted with the gravity of their choices.

My relative shared with me stories about pregnant patients in the ICU during waves of COVID outbreaks. In early waves, the data was inconclusive about the safety of the vaccine for pregnant people specifically. But in later waves, by the time we knew that the vaccine was safe for pregnant people, patients were still declining the vaccine. Pregnant patients were intubated, on ventilators, or undergoing emergency C-sections. She got a wave of questions from ICU teams about establishing milk supply by putting pumps onto the comatose patients. She felt it was weird and creepy, but they had no idea if the pregnant patient would wake up, in some cases. They hadn't had that conversation before they had lost the ability to consent. And you can't go back and establish a milk supply later if it dried up. She actually had to ask patients these questions in the emergency department when they were being admitted, and it became part of the COVID vaccine conversation she had with patients. Which is definitely better in a less urgent situation, but still felt coercive to my relative.

It certainly wouldn't help to have a panicking obstetrician in a high risk situation. All doctors are, to some extent, trained to treat patients as a technical object to be worked on– to detach the normal, visceral reaction we have as humans to illness and injury.[8] My

[8] Screaming, bleeding people are hard to work on. I myself could never do it. I cried when I had to pull out a particularly gnarly splinter. It didn't even hurt. There was no blood. It offered no resistance. When I had a

relative says she often feels patronizing, or brusque, or blunt. She also says it feels like a light in the darkness when one of her patients tells her that her calm and confidence made what could have been a very traumatic experience into one they can live with.

She once told me the story of a patient having a panic attack on the way to her C-section. She was just a trainee, and her supervisor stopped the anesthesiologist from administering anesthesia without the patient's consent. The patient understood the necessity of a C-section. She suffered from PTSD. In this case, the fetal heart rate was concerning but they had time to talk it out with the patient. I don't know all the details and I'm certainly not a doctor, but that was probably better for the patient than being anesthetized while having a panic attack.

Not every pregnancy ends in a healthy baby. Not every pregnant person survives. Medical care can increase the odds of good outcomes, but it cannot eliminate the bad. My relative has confided in me about cases that haunt her. Even when no harm occurred that was caused by her actions.

My relative is a good doctor. She does not want to harm her patients. She does not allow others to harm patients. She is also human. She has moments of frustration. She worries about taking her feelings out on patients, and the people around her.

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larger surgery, sealed by staples, I couldn't look at them. Even in the shower, I scrubbed dutifully with the post-surgical wash around them and rinsed with the showerhead with closed eyes, working by sight and sting alone.

My own uneasiness with the simple narrative aligns with my relative's sense of uneasiness about particularly difficult cases. C. Wright Mills notes that a strong sense of moral injury, coupled with the conviction that the injured individual has no other choices, is a giant red flag for social problems (Mills 2000[1959]).

The Bad Apple Thesis is, in my mind, a failure to understand the structural and institutional constraints surrounding obstetric care. It pins all the responsibility for the problem on individual Bad Doctors. Certainly, such doctors exist; the True Crime Podcast industry is rife with salacious examples.

Evidence that either supports or undermines the Bad Apple Thesis is hard to find. About 1 in 5 medical personnel in the United States and Canada report that they have seen their colleagues performing medical procedures explicitly against the wishes of their patient during labor and delivery (Morton et al 2018). Even studies that suggest a large minority of medical staff have observed violations of patients during labor and delivery assert that such instances are vanishingly rare (Khosla et al 2016).

Pregnancy Justice[9] is one of the few organizations trying to quantify violations of pregnant peoples' rights. They focus on criminal arrest and prosecution of pregnant women, primarily for crimes against their fetuses. The number of these cases has risen dramatically since the 1970s, when the problem first arose; by the mid 2000s, there were about 25 to 30 criminal arrests of pregnant women for crimes against their fetuses or

[9] Formerly the National Advocates for Pregnant Women.

forced medical interventions against pregnant people in a year (Paltrow and Flavin 2013). In 2005, 4,138,349 births were registered in the United States (Martin et al 2007). The math works out to approximately .0007% of live births that included this violation of the pregnant person's consent.

If these violations are so vanishingly rare, why do so many of my (privileged, mostly white, mostly college educated) friends tell me these stories? Why do so many medical personnel report seeing them? How can everything go so wrong sometimes, when everyone means so well?

And why is it so hard to find actual data measuring pregnant people's negative experiences of medical care?

III. Obstetric Violence

I was first drawn to outrageous, sensational headlines about lawsuits that describe what I would call fundamental violations of pregnant peoples' rights. Their right to refuse consent to medical treatment; their right to bodily autonomy; their right to liberty. A systematic study of a sample of these cases was my pilot project for this dissertation. There have certainly been case law review articles that examine them (See Kukura 2018). Attorneys working on these cases are most concerned with legal precedent–that is, with lawsuits or criminal prosecutions which have actually happened, and the way that decisions reached in those cases help interpret the law going forward.

After reviewing the legal scholarship, I found myself unable to answer basic questions in which attorneys have little interest. In a precedent based system such as the United States, research into the frequency of such violations is almost irrelevant. The law is notoriously blind to basic sociodemographic data, which the Chief Justice of the United States Supreme Court has infamously referred to as "sociological gobbledygook" (Flaherty 2017). It is difficult to say which pregnant people experience these types of violations–what racial groups may be overrepresented; the socioeconomic status of birthing people who have these experiences; or in some cases, their age. Case law contains a consistent record of geographic data at least, but most researchers and activists have not been interested in identifying hotspots of activity. Finally, it is unclear how a small number of exceptional lawsuits and prosecutions align with the general experience of giving birth in the United States.

It was not even clear from a review of the medical or legal scholarship about the rights of pregnant people what I should call the problem I want to study.

A term that has rapidly gained popularity to describe the abuse of pregnant people during labor and delivery is obstetric violence. I had not heard it by the time I started this project; the title of my dissertation prospectus is a torturous series of clauses and qualifiers that offer little clarity in spite of the high level of precision.[10] The term does not appear to have existed before 2004, when it was included in a Spanish-language statute

[10] "Forced Medical Intervention During Pregnancy, Labor, and Birth in the Contemporary United States."

passed in Argentina (Vacaflor 2016). Obstetric violence is now used widely in activist feminist circles, legal scholars here in the United States, international scholars of human rights, and the popular press.

The definition is almost contained in the term itself: harm that comes to pregnant people when they are giving birth. It feels simple. It seems clear that it describes at least some of the cases that have so disturbed me.

The popularity of the term is a double edged sword. Different groups using the term obstetric violence use definitions that vary wildly in scope and approach the problem from at times opposing intellectual frameworks. It has become a kind of catchall for any case of Bad Things Happening to Pregnant People.

When I encountered the term obstetric violence (without definition) for the first time in the wild, I felt a little thrum. It was in a policy brief from the National Advocates for Pregnant Women,[11] outlining a disturbing trend in legal cases (Diaz-Tello 2016). A woman forced to have a C-section for no medical reason and against her will, or face arrest. A woman actually arrested and forced to have a C-section. Threats shouted by one doctor about calling child protective services if his patient did not immediately submit to surgery for a "suspected large baby." The story of Rinat Dray, that I discussed above.

Tantalizingly, the brief ended with the assertion that viewing these cases individually was insufficient to the task of ending the problem. That the Bad Apple Thesis was both

[11] Now known as Pregnancy Justice.

incorrect and inadequate. The brief stopped short of offering any estimate as to how widespread the problem (again, not defined, merely asserted via a series of case studies to include unconsented surgery) is in the contemporary United States, or for how long it has been a problem, or even who the problem is most likely to impact or where.

This lacuna, this void of information is what I encountered over and over again in my widening search on obstetric violence. These questions are difficult to answer, to be sure, because no one has historically collected data about them. This dissertation's main goal is to try and build a bridge over the gap.

IV. Summary of Dissertation

In this dissertation, I want to answer very basic questions about obstetric violence.

Part I focuses on the more concrete empirical questions. What is obstetric violence? How often does it happen, and to who? Where does it happen in the United States? Is the problem getting worse?

The first task of this study is to hash out what exactly is encompassed by the term obstetric violence. Chapter 1 explores who is using the term, what they mean by it, and offers a working definition to set the scope of my inquiry. Chapter 2 outlines why I have chosen to try and answer basic demographic questions about obstetric violence with a combination of case law and survey data, including an explanation of my own epistemological orientation to the field of sociology. In particular, I focus on the image of

an iceberg–which is quite popular in medical sociology for explaining how exceptional cases are often signifiers of a larger, unseen problem.

The final three chapters of Part I pick apart the layers of that iceberg. Chapter 3 contains an analysis of legal cases involving pregnant people–the tip of my iceberg. Chapter 4 analyzes secondary survey data from Listening to Mothers III. In some ways, this is the mirror image of the legal cases: I know exactly who these women are in a sociodemographic sense, but have no access to the minute by minute facts of their experience. Chapter 5 merges the case law data together using maps. While general conclusions from these maps should be drawn only cautiously, seeing the data together in this way is certainly incredibly suggestive for new avenues of research.

Part II focuses on understanding the broader context of obstetric violence as a social problem. How did this happen? Or rather, how did institutions which enable obstetric violence get built? What do the answers to the questions in Part I–or the frustrating inability to answer some of them very clearly–tell us about social problems?

Medicine and Law are the institutions, broadly construed, most responsible for the definition of the problem. Chapter 6 sketches the history of birth in the United States, with a particular focus on the way that the treatment of pregnant people in both medicine and law has changed as the fetus has emerged as a legal and medical person.

Finally, I conclude with a reflection on the sociological theory of institutions in chapter 7. Institutions are often defined and envisioned as competing for and colonizing

new areas of social experiences for exclusive authority. I draw from a diverse array of theoretical traditions to argue that my study of obstetric violence illuminates how institutions can collaborate, and how individuals caught between them can fall through the cracks and become invisible.

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I particularly want to thank my committee chair, Brian Gran. He was unflaggingly patient, never missed a deadline, and came to sit with me during chemotherapy (and not just because he was procrastinating).

I also want to acknowledge my darling, my dove, the person who has heard me complain about this for years in my sleep: thank you for believing in me, and thank you for feeding me on this whole journey.

Obstetric Violence

Abstract

by

ELIZABETH NALEPA

The term obstetric violence has become popular in recent years in feminist activist, journalistic, legal, and academic circles to describe a constellation of mistreatment, medical negligence, and negative birth experiences. There has been no systematic effort to measure obstetric violence in the United States.

In Part I of this dissertation, I define and measure obstetric violence using several methods. Obstetric violence as the violation of pregnant people's rights by medical staff during labor and delivery. I measure obstetric violence through a combination of qualitative archival analysis of case law and quantitative analysis of a nationally representative survey of people who have recently given birth. Finally, I map the resulting cases and explore the geographic distribution.

My primary finding is that while obstetric violence is rare, it is not evenly distributed. In regions with poor protections for reproductive rights and poor reproductive health care, obstetric violence occurs more regularly. Moreover, marginalized people were much more likely to report obstetric violence. Hospitals are institutions where a great deal of power resides. This power is often organized in ways that protect medical staff, making it difficult to remedy mistreatment. Rather than competing for authority over

pregnancy, courts and hospitals have an interest in cooperating to keep the system running smoothly.

In Part II, I explain the historical context of obstetric violence and my contribution to sociological theory. I first lay out the historical context of how medicine and law have grown together as institutions. They have an elective affinity to control reproduction. In my final chapter, I explore the theory of institutions, social problems, and intersectionality to explain how a widespread if rare problem is practically invisible.

Taken together, this project provides diverse stakeholders the tools that they need to address the problem of obstetric violence. The first tool is a strategy to measure the problem using multiple different methods. The second is a theory of how cracks between institutions form, and why particular people fall into them. This dissertation advances the study of social problems in the tradition of sociologists who seek to hold power to account.

Part 1: Measurement

This project falls into two distinct sets of questions: questions about measurement and questions about context. The division isn't quite as neat as that in my mind. Broadly speaking, though, this section asks and answers concrete, empirical questions about obstetric violence.

Chapter 1 investigates the origins and various definitions of the term obstetric violence, and defines the scope of my inquiry. While obstetric violence originated as a descriptor used by feminist activists and remains popular with them, legal institutions and medical researchers globally have also grappled with the term. I trace back citations to the scholars who have tried to define obstetric violence–which are, fortunately for me, relatively few–and synthesize a definition of obstetric violence. For my dissertation, I define obstetric violence as: the violation of a pregnant person's legal rights or bodily autonomy by medical staff during labor and delivery.

In Chapter 2, I make a case for combining different methods to answer my questions. The problem with measuring obstetric violence is that no one is really trying to do it directly. I have a somewhat unique perspective on social inquiry, which I use to justify my choice of data sources. In particular, I explain why a qualitative study of case law should be paired with a more traditional quantitative analysis of survey data in order to draw a more complete picture of obstetric violence.

Chapter 3 turns to an actual investigation of the case law data. Case law offers a gold mine of information about how pregnant people who feel that their rights have been violated seek remedies. Most legal decisions include a detailed summary of the facts of the case that are not in dispute as well as a summary of the legal issue. On the other hand, case law generally does not include detailed sociodemographic information about individual plaintiffs or defendants. These cases are also outliers–fairly extreme ones, in some notable examples. It is dangerous to draw generalized conclusions from cases that so clearly deviate from a more typical experience. They are the tip of the iceberg. Exploring the details of these cases gives a complete picture of *how* obstetric violence unfolds and how often it occurs. The key finding of this analysis is that institutions such as hospitals use their resources to protect powerful participants in them, like doctors. In life and death situations and the years-long tail of sorting out legal liability and other consequences of split second decisions, this places patients at a serious disadvantage.

To identify more about who the victims of obstetric violence are, I turn to an analysis of survey data in Chapter 4. These data are the submerged iceberg–the mirror image of the case law that I analyze in Chapter 3. There is enough information in the dataset to be reasonably confident that what the survey operationalizes as "mistreatment" is actually a less severe form of obstetric violence. The full clinical and legal details of the respondents' experiences are missing, but unlike the legal cases I have complete sociodemographic data. This chapter answers questions about *who* the victims of

obstetric violence are, and a better estimate of how extensive the problem is throughout the United States. Students of sociology and intersectional feminists will not be shocked to learn that the results of my analysis align with previous research: marginalized people are much more likely to report that they experience obstetric violence.

Chapter 5 compares the geographic information from Chapters 3 and 4. Risk is not generally evenly distributed. Chapter 4 underscores the risk of obstetric violence that marginalized people face in medical settings is higher. Chapter 5 takes a different approach to understanding danger and risk of violence in medical settings. Different states have different laws and layers of protection for pregnant people. Understanding how obstetric violence aligns with these protections provides valuable insight into protecting pregnant patients.

Part II focuses on more abstract, contextual questions. There are more chapters in Part I, each with a smaller scope than the expansive ruminations of Part II. Think of Part I as the positivist foundation from which to launch a kind of weather balloon measuring something different about obstetric violence as a whole.

Chapter 1: Defining Obstetric Violence

Early in the process of turning my work into an actual dissertation, I received very frank feedback. A reader told me she thought it was very clear that I was writing about something important, but she had not understood a word of what I had written. Or even, she continued, what it was I wanted to write about–aside from Bad Things Happening.

I was mortified at the time. I thought that by honing my language to needle-point precision I could brute force a difficult project into submission.

The more I dug in, the more I realized my writing wasn't the problem. I had such a hard time finding the term obstetric violence in the first place that I had not examined it too closely when I did. Different groups use the term obstetric violence more broadly or narrowly, for at times competing purposes. Doctors and lawyers, in particular, have very distinct definitions that align with their own institutional biases. For every author evangelizing with the zeal of the convert, there were also naysayers insisting that the term was harmful and inaccurate.

Very, very few people offered an attempt to define obstetric violence. There were a great many scholars out in the wilderness as I had been, using polite labels such as "mistreatment" and less polite ones such as "negligence" or "abuse" to try and measure negative birth experiences. Also, often, without definition beyond a reference to a statute book.

Obstetric violence is the right term for this project. It does, however, require an examination of who uses it and what kinds of experiences are included or excluded to proceed with an attempt to measure the problem. In this chapter, I want to focus on what people are trying to measure, and what their major concern is when they are using the term obstetric violence.

In this chapter, I first outline the creation and history of the term obstetric violence (Section I). Then, I list and deconstruct the unique attempts to define obstetric violence in English language scholarship (Section II), and further hone the definition through cases which are NOT included (Section III). After a brief aside to address critics of the term (Section IV), I offer my own definition of obstetric violence that guides this project (Section V).

I. A New Term for an Old Problem

The term obstetric violence does not appear to have existed before 2004 (Betron et al 2018, Rubashkin & Minckas 2018, Vacaflor 2016). A 2004 Argentinian law calling for humanized birth used the term in 2004; a second Argentinian law expanding the definition of specifically protecting against obstetric violence passed in 2009. There is some confusion in English-language scholarly literature about this point. They cite the wrong country (Venezuela passed a law in 2007 using very similar language, see D'Gregorio 2010); they cite the wrong year, using the year Argentina's statute was first translated, or the passage of the second law because it expanded the definition. From

South America, the term spread first to English scholarship, then to French; the first article in France itself appeared in about 2010, and a resolution regarding obstetric and gynecological violence was adopted by the Conseil de L'Europe on October 3rd, 2019 (Azcué and Tain 2021). Medical doctors, attorneys, ethicists, journalists, and activists around the globe now use the term obstetric violence in their work. A simple internet search will turn up hundreds of results. Many use the term interchangeably without attempting a definition (see for example, Sadler et al 2016).

By far the most common definition simply reproduced the same English translation of the definition offered in Argentinian law in 2009. The statute defines obstetric violence as "[v]iolence exercised by health personnel on the body and reproductive processes of pregnant women, expressed through dehumanizing treatment, medicalization abuse, and the conversion of natural processes of reproduction into pathological ones..." (Vacaflor 2016:66) Vacaflor also offers a list of different instances of abuse and violence that the law is intended to prevent, offering specific instances of legal cases in Argentina that document the occurrence of these abuses:

> A woman, experiencing her first pregnancy, undergoes an unconsented episiotomy during childbirth which, as a result of poor care, leads to loss of sphincter control. A woman experiencing a healthy pregnancy is given oxytocin for easier labor management during six hours without monitoring, consequently the fetus is harmed. A woman, pregnant as a result of rape, is denied access to an abortion by a physician who demands prior judicial authorization. (Vacaflor 2016:65)

This format—a definition, explained by a series of real examples—is common to almost all of the legal advocates and researchers.

Obstetric violence in this definition encompasses a few distinct problems, ranging from too much intervention to too little. The first example is a clear violation of informed consent. The patient is not given information about the risks of the procedure, and does not agree to it. She suffers lifelong issues because of it. The second example outlines a very serious case of negligence or malpractice. The patient is given standard care, but without appropriate risk monitoring. The third and final example seems at first like it doesn't fit with the other two. The patient does not want to be pregnant at all, but she is denied access to care because of legal hurdles that require her to prove she was raped in order to obtain an abortion.

What these examples have in common is that the patient is not in control of her body or her reproductive capacity. The patient is not exercising their right to voluntary and informed consent, or choosing the risks she will take with her body. Also noteworthy is that the structural inequality beyond the hospital itself and the interference of other institutions with medical care is explicitly labeled as obstetric violence. Also included is a focus on access to a broad range of reproductive health services, including but not limited to abortion and birth control.

II. Differing Perspectives

The meteoric rise in popularity of the term obstetric violence has not led to a unified definition. Broadly speaking, aside from feminist activists that pushed for legal protections in South America, there are two other groups of stakeholders that use the

term: legal advocates and medical professionals. In order to produce a clear definition of my own, I want to explore the way legal and medical scholars use the term obstetric violence.

I include English-language academic and law review articles that define obstetric violence. I searched the academic literature in English after its creation in 2004 up to the present day. The term first began to be translated from Spanish to English and French scholarly articles in approximately 2010 (Vacaflor 2016, Azcué and Tain 2021). Before 2013, I found only two articles attempting to define the term in English. In articles published after 2018, I found only references to earlier work and no new attempts at a typology. So here, I focus on the period between 2013 and 2018.

The first half of this section is dedicated to comparing and contrasting disparate definitions. The second half compares the examples and typologies that different authors include. Where foreign-based research articles are included, they either focus on the United States exclusively, include the United States in their analysis, or are cited by authors that include the United States.

Table 1 gives a list of unique definitions. Not all the works include one unified, specific definition of obstetric violence; some mentioned the term as an alternative to their work (e.g., Bohren et al 2015), or used it, but did not define it—instead, they reproduce the same English translation of the definition proposed by Argentine statute (e.g., Vacaflor 2016). The categorization above reflects my best understanding of what

each piece means by the term obstetric violence as well as the broadly defined disciplinary affiliation or perspective of the authors.

Table 1: Definitions of obstetric violence

Source	Professional affiliation or perspective	Definition
Diaz-Tello 2016 (pp56)	Legal researcher and advocate	"bullying and coercion of pregnant women during birth by health care personnel, known as obstetric violence."
Kukura 2018(pp727)	Legal researcher and advocate	"... mistreatment during childbirth, including, but not limited to, violations of the rights to informed consent and bodily autonomy, which lead to both physical and emotional harms. Mistreatment during childbirth may be perpetrated by physicians or nurses, as well as other professional staff present during labor and delivery."
Vacaflor 2016, citing statutory definition, pp66; Borges 2018; Betron et al 2018; Sen, Reddy, and Iyer 2018 citing same definition	Legal researcher and Medical researchers	"[v]iolence exercised by health personnel on the body and reproductive processes of pregnant women, expressed through dehumanizing treatment, medicalization abuse, and the conversion of natural processes of reproduction into pathological ones... the legal concept of obstetric violence seeks to shed light on the ongoing lack of state oversight of the provision of maternal health services in both the public and private health sectors." "
Bohren et al 2015	Medical researchers	pp 21 " These experiences can be active (such as intentional or deliberate physical abuse), passive (such as unintentional neglect due to staffing constraints or overcrowding), related to the behavior of individuals (verbal abuse by health care providers against women), or related to health system conditions (such as a lack of beds compromising basic privacy and confidentiality).

It is easy to see how these branches have grown from the same root. Some use exactly the same language as the Argentinian statute. These definitions rely on concrete examples to explain what they mean by their very broad scope. Diaz-Tello's article (2016) is

entirely composed of case studies; Kukura's law review article (2018) similarly focuses on the scope of case law, using real examples to illustrate each individual type of case in effort to create a full typology. A mix of legal and medical researchers use Vacaflor's translated definition directly (2016), but all use illustrative examples to justify fitting the data they have (or collected) to the definition. Bohren et al (2015) do the most work to expand the criteria of the original definition. Their project is to create a complete typology of obstetric violence through a mixed-method review of the medical) literature.

All the researchers attempting to define obstetric violence above focus more narrowly than the Argentinian statute on the actual moment of labor and delivery–on obstetrics, rather than gynecological care more broadly. They do not include, as the Argentinian statue did, abortion and birth control access, or the way that medical care can exacerbate the harms of violent crimes such as rape.

Table 2 lists, with citations, the full range of practices that are included in discussions of obstetric violence in the medical and law review articles described at the beginning of Section II. These are the types of violence that I will include in my collection and analysis of legal cases involving obstetric violence and that the authors think of as obstetric violence. There is a rough patterning of the different conversations that use the term obstetric violence: the original statute and international human rights law; legal advocates and researchers; and medical researchers. I discuss their frames separately.

Table 2: Examples of Obstetric Violence	
Example	Sources
Forced Surgery (C-section, episiotomy, etc)	Kukura 2018; Diaz-Tello 2016; Vacaflor 2016; Borges 2018
Unconsented medical procedures or forced compliance	Betron et al 2018; Kukura 2018; ACOG 2016; Diaz-Tello 2016; Borges 2018
Physical Restraint	Kukura 2018
Sexual Violation	Kukura 2018; Bohren et al 2015
Physical Abuse	Betron et al 2018; Kukura 2018; Bohren et al 2015
Verbal Abuse	Betron et al 2018; Kukura 2018; Bohren et al 2015
Coercion by Judicial Intervention	Kukura 2018; Diaz-Tello 2016; Vacaflor 2016
Coercion by VBAC restriction	Kukura 2018
Coercion by Child Welfare Intervention	Kukura 2018; Diaz-Tello 2016
Coercion by witholding treatment, manipulating information, or applying emotional pressure	Kukura 2018; Diaz-Tello 2016; Vacaflor 2016
Disrespect (exposing genitalia, addressing partner for decisions, etc)	Betron et al 2018; Kukura 2018; ACOG 2016 ; Vacaflor 2016
Discrimination and stigma	Betron et al 2018; Bohren et al 2015
Failing to meet professional Standards of Care (ie neglect or inadequate care)	Betron et al 2018; Vacaflor 2016; Bohren et al 2015

1. Legal researchers and advocates

The authors that I categorize as legal researchers and advocates in Figure 2 share a close association with the authors and translators of the Argentine statute, but with a narrower lens on birth itself. They are more focused on the actual process of labor and delivery. These articles focus less on crimes against women that lead to the need for medical intervention, such as rape, or the long term consequences of unwanted surgical

intervention. These authors see medical institutions—and in particular doctors as the actors with the most power in those institutions—as the problem. Doctors do not think events such as forced C-sections can even occur, for example, and so obstetric violence remains largely invisible in hospitals (Diaz-Tello 2016).

This group of authors also views legal proceedings as inadequate to offer a remedy to women who experience obstetric violence. Legal standards of voluntary and informed consent (Kukura 2018), tort reform (Borges 2018), and anti-discrimination law (Diaz-Tello 2016) are inadequate to the task of preventing or remediating obstetric violence.

These authors do not include abortion access or birth control in their definitions, nor violence against women such as domestic abuse, sexual assault, or rape. Their definitions largely focus narrowly on the birth process, rather than the full term of a pregnancy. Finally, they focus on interpersonal relations between doctors and patients, excluding the structural realities of hospitals and medical care almost entirely. In this last characteristic, the conception of these legal researchers and advocates largely matches that of medical doctors and researchers themselves.

2. Medical doctors and researchers

Medical doctors and researchers on the whole do not use the term obstetric violence, though they often acknowledge that they are discussing very similar conduct as researchers studying obstetric violence. This group of authors prefer terms such as the "mistreatment of women" because it is more neutral than "violence" and less likely to be

off-putting to doctors (Sen, Reddy, & Iyer 2018, Bohren et al 2015). Others use terms such as “forced compliance,” “coercion,” and “duress” (American College of Obstetrics and Gynecology 2016). In some cases, a definition of obstetric violence is offered as an aside or in a footnote (Betron et al 2018). Indeed, rather than accept blame from legal advocates, doctors tend to focus on structural issues (Bohren et al 2015).

However, like legal advocates, medical researchers tend to focus narrowly on birth, labor, and delivery of babies in their definitions of obstetric violence. Other reproductive health issues and forms of violence associated with pregnancy are not even mentioned.

III. Honing the Scope: Exclusions

There are some instances of violence, abuse, or neglect that I explicitly exclude from consideration for this project though other researchers include them. I share the narrow focus on the labor and delivery process of both medical and legal researchers, rather than the broad, systematic vision of feminist activists embodied in the Argentinian statute. I'm also not going to include legal cases that occur without the input of medical professionals, even when they involve labor and delivery. Finally, there are some medical interventions such as end of life care and advanced directives that are regulated by the state in ways that produce violent outcomes, but that I would not consider to be *obstetric violence*.

In this section, I want to explore a few famous cases that are cited by researchers that I think should be excluded from a definition of obstetric violence. Any definition that includes them is, I think, too broad to be useful.

1. Crimes committed while pregnant

Consider Kemba Smith. She was convicted of conspiracy related to the sale, distribution, and production of controlled substances. Her crime was, essentially, being pregnant while knowing that she was in the presence of drugs.[12] Her arrest was unrelated to medical treatment but was made possible because Ms. Smith was pregnant. Criminal arrests of pregnant women for reasons not relating to their health and wellbeing or that of the fetus are not cases of obstetric violence, even though they may in some cases violate the rights of women and *lead to* obstetric violence.

2. Crimes against fetuses

Consider Martina Greywind. She was arrested while approximately 12 weeks pregnant for endangering her fetus by inhaling paint fumes.[13] The district attorney declined to continue court proceedings against her when she obtained an abortion—not because she was innocent, but because it was "no longer worth the time or expense to prosecute her" (Paltrow and Flavin 2013). Ms. Greywind first came to the attention of the law when she appeared in an emergency room for symptoms related to her drug use and

[12] United States v. Smith, 113 F. Supp. 2d 879 (E.D. Va. 1999) US District Court for the Eastern District of Virginia - 113 F. Supp. 2d 879 (E.D. Va. 1999) August 4, 1999
[13] State v. Greywind, No. CR-92–447 (N.D. Cass County Ct. Apr. 10, 1992).

exacerbated by her homelessness. Because she was pregnant at the time, additional sanctions were applied. While the hospital and medical personnel certainly participated in her prosecution, they did not direct or control the process.

I *would* include cases where a court order for medical treatment was obtained with the object of protecting a fetus until birth, even if labor and delivery does not result. In such a case, medical personnel would be the ones actually *carrying out* the sanctions.[14]

I do not include cases of "illegal abortion." For example, Jennie Linn McCormack obtain an abortifacient and then used it to induced an abortion which would have been legal in the state of Idaho if she had undergone the procedure under the supervision of a doctor; because of the ease of obtaining medication abortion via telemedicine in Utah, she did not visit a clinician.[15] While troubling that a woman would be prosecuted for a perfectly legal procedure, typically these cases come before the court because a woman did not seek medical attention, but rather because like McCormack they self-administered an abortifacient. Some advocates might include such cases, since lack of access to abortion is included in some calls to eliminate obstetric violence (see Vacaflor 2016 on the scope of Argentina's 2009 law). However they do not generally meet my definitional criteria because they do not involve medical personnel or birth.

[14] For example, the case of Alicia Beltran. Alicia was forced to undergo medical treatment for opioid addiction while pregnant, with no testing or legal recourse for more than a week (Eckholm 2013).
[15] McCormack v. Hiedeman, 694 F.3d 1004 (9th Cir. 2012)

3. Inhumane treatment of incarcerated pregnant women

Some people incarcerated while pregnant endure truly horrific treatment. There are some truly disturbing reports of women being shackled even while giving birth (American Civil Liberties Union 2012), women being denied care unless they consent to sterilization—both in the past as a formal, state sponsored eugenics program[16] and informally as late as 2010 (Johnson 2013), and being denied access to abortion care while in federal custody.[17] The expanded detention of pregnant, undocumented women make this kind of violence more likely to occur. One Georgia doctor was dubbed "the Uterus Collector" by detainees who claim he performed a staggering number of unconsented or unexplained hysterectomies on immigration detainees (Ibbetson 2020).

Some of these abuses might be accurately labeled obstetric violence, such as forced sterilization. The practice of shackling patients is often included, but in every case I have encountered, it is prison or carceral staff that commits the offense. Doctors often immediately order shackles to be removed and participate in the process of lawsuits for the long-term consequences of these abusive practices. In short, doctors are separated from patients by the incarcerating institution, and are not in a position of power in some of these cases. These are not cases of obstetric violence.

[16] Madrigal v. Quilligan, 639 F.2d 789 (9th Cir. 1981)
[17] Garza v.Hargan, 874 F.3d 735, 2017 U.S. App. LEXIS 20911 (D.C. Cir., Oct. 24, 2017)

4. End of life care and advanced directives

Finally, I exclude legal cases involving the refusal to implement advanced directives or the invalidation of a living will because a patient is pregnant. The case of Marlise Munoz is illustrative of why such cases might be considered for inclusion. Marlise was a pregnant EMT, mother of one, and had a living will which gave instructions for advanced directives. When she was found by her husband—also an EMT— on the floor of the kitchen in the middle of the night, he administered CPR because he did not know how long she had been unconscious. It became clear after she was revived that her brain had been deprived of oxygen for too long to save her life. However the hospital declined to enact her advanced directives and disconnect her life support because she was pregnant. Ultimately, after a protracted legal battle, her wishes were respected (for a summary, see Fernandez 2014). Clearly, the explicitly documented wishes of Marlise and her family were overruled by medical providers. Such cases are a troubling representation of "mission creep" in the state's mandate to protect potential life (Fox 2014) in that the pregnant person is quite literally nothing more than a container in which a fetus is grown.

While this case involves medical doctors and hospitals carrying out the will of the state against the wishes of the patient, who was pregnant, I don't think it is a case of obstetric violence. The risks of pregnancy in this case had tragic consequences. Doctors were the agents that carried out the will of the state against the wishes of the patient.

They also advocated *against* state intervention, and ultimately worked to ensure that the state never again interpreted the statute in this way. It was Texas, so their success was dubious and quickly subsumed by fresh horrors, but they tried.

IV. A Note on the word "violence"

Along with growing popularity of the term *obstetric violence* is growing pushback. Popularizing the term obstetric violence, one review author writes, “will do far more violence to the relationship of physician and their patients, than the harm that already comes to all parties in the handful of cases discussed” (Dinerstein 2018). Obstetric violence as an alternative term may “galvanise women but may be less helpful when it comes to conducting research or investigating the problem with providers” (Sen, Reddy, & Iyer 2018: 3). This has led some researchers to search for a “broader, more inclusive term that better captures the full range of experiences women and health care providers have described in the literature” (Bohren et al 2015).

Indeed, doctors in the United States seem inclined to believe “Coercion in these instances are not moments when a patient is tied down by the staff in the labor and delivery room and subjected to medications and procedures against her will – no health professional coerces a patient in this manner” (Dinerstein 2018). When asked for comment by the media, one doctor stated, “If that woman says, ‘No way, I refuse to have a C-section,’ then you cannot take that person to the operating room” (Diaz-Tello 2016). Some researchers assert that the term *obstetric violence* is a "misnomer," and that abusive

or neglectful treatment "...can sometimes result from systemic issues, lack of training, or misunderstandings rather than intentional violence" (Chervenak et al 2023).

Yet women report that precisely these things—physical restraint to force compliance, being wheeled into an operating room for a C-section while verbally protesting—do happen to them, in the United States, today. Jennifer Goodall protested her arrest and continued to verbalize her objection and lack of consent even as the physician cut open her abdomen and uterus to extract her baby (Diaz Tello 2016).

I agree that hyperbole serves no one, and may damage the arguments of advocates for the rights of pregnant people. Yet I am not sure that either softening the language that describes the phenomenon or allowing doctors to make clearly false statements about the occurrence of involuntary coerced care is a viable or palatable alternative. One doula who witnessed “disrespectful care” describes “The amount of times I have to say, ‘She’s saying no, and you have your hand in her vagina. You need to take it out’ is unreal” (Tucker 2018).

One recent and infamous legal decision against a doctor involved irreparable and permanent nerve damage to Caroline Malatesta because medical staff held the head of her baby inside of her uterus for approximately six minutes while they attempted to locate the doctor on call. While there was no injury to her son during the birth, Malatesta

experiences constant, severe pain and may never be able to have sex or give birth to another child again.[18]

The less recent but infamous case of Angela Carder involved a court order to deliver via C-section a fetus that was approximately 26 weeks old and may have been brain dead already. Angela was undergoing medical treatment for a recurrence of cancer thought to be terminal— treatment meant to prolong her life long enough to deliver her child. Premature intervention resulted in the death of both Angela and the baby.[19]

The haunting case of V.M. out of New Jersey[20] underscores the point that sometimes, the treatment that is forced upon women is not medically necessary. Because she refused fetal monitoring, V.M.'s physician insisted that she have a C-section to protect the child, J. M. G. The key evidence that the hospital considered was that their refusal of medical care endangered their child. In the summary of the case before the court:

> When Dr. Mansuria stressed the need for V.M. to consent to a C-section, V.M. stated that she understood the risks, but she did not want the procedure. Dr. Kurani then made a critical finding. Although he acknowledged that V.M. was very anxious, Dr. Kurani concluded that V.M. was not psychotic and had the capacity for informed consent with regard to the C-section. At no time did anyone seek judicial intervention or the appointment of a special medical guardian. After Dr. Kurani left, the staff requested a second psychiatric opinion from Dr. Jacob Jacoby. Before Dr. Jacoby's evaluation was completed, V.M. gave birth vaginally to J.M.G. without incident. (Emphasis in original)[21]

[18] Malatesta v. Brookwood Medical Center a/k/a Brookwood Women's Center; Tenet Healthcare Corporation (Ala.Cir.Ct.) 2016

[19] In re A.C., 573 A.2d 1235 (D.C. 1990) (en banc)

[20] DYFS v. V.M. and B.G. In the Matter of J.M.G., A Minor. (2009) 408 N.J. Super. 222, 974 A.2d 448.

[21] Ibid.

The legal case that actually came before the state supreme court was a civil action to terminate the parental rights of V.M. and B.G., her partner, to J.M.G., aged two, so that the child could be adopted by parents that were more suitable. The court rejected the grounds for termination and restored custody of J.M.G. immediately though it offered no other remedy for the two year separation.

These instances are violent. Women are treated as though they are not human beings with a free and independent will, and as though their rights are superseded by the rights of a fetus–which has neither its own body nor mind, and which under more conventional English common law would not be considered to be a person with rights at all. Worse still, in acting on behalf of fetuses, the state and medical providers sometimes coerce pregnant people to undergo medical procedures that are not necessary and may in fact injure or kill fetuses.

Labeling these cases as violence is not hyperbolic. It is, clearly, unpalatable to medical practitioners, particularly doctors. Yet in a recent survey of medical providers in the United States and Canada, about two thirds of participants reported that they witnessed doctors often or occasionally performing medical procedures without giving women time or the option of considering to consent; nearly twenty percent of respondents reported that they witnessed doctors administering care that was explicitly and directly against the stated wishes of patients (Morton et al 2018).

In order to promote more just obstetric practices, we must acknowledge the injustices that pregnant people experience in very explicit terms. If this seems to take an inappropriately biased "tone" (Dinerstein 2018), it is because research into immoral practices is not—can not, should not—be impersonal or neutral. Such a stance does not produce objectivity. It reproduces and reinforces systematic injustice and allows perpetrators of violence to continue committing violence.

V. A Synthesized Definition

Different groups promote (or attempt to discard) the term obstetric violence. They impose their own meanings in the absence of a unified definition. They approach the term from their own professional perspectives, with their own internal biases. Feminist activists are concerned with how mistreatment impacts the life and ability of all people to control their own bodies. Legal scholars share this framework, but focus specifically on a framework of human rights and locate power in the hands of doctors and the institutions of medicine. Medical researchers and doctors have, on the whole, been skeptical that obstetric violence exists. When they try to measure it, they seem most interested in how to improve communication with patients by being honest about when they have failed.

It is worth noting again that there really are not that many people interested in synthesizing a definition or creating a typology of obstetric violence. It is impossible to say without actually looking how common or rare obstetric violence is, how severe it is, or which patients are most likely to experience it. In order to try and measure obstetric

violence, I conclude this chapter by synthesizing a definition out of the exploration above.

I define obstetric violence as the violation of a pregnant person's legal rights or bodily autonomy by medical staff during labor and delivery. In this section, I examine each element of this definition individually: patient's rights, the victims of violations, perpetrators of obstetric violence, and the temporal focus of my work.

1. What are the legal rights of a patient to bodily autonomy?

I focus on how doctors themselves, as a profession, say that pregnant patients ought to be treated. The standards of medical care broadly and of obstetric care specifically tell patients what kind of care they should expect. Courts defer to the way that doctors regulate themselves in disputes, so it also offers a useful frame for understanding the law.

The American Medical Association views it as the duty of physicians to respect the rights of patients (AMA 2016). In the full code of Medical Ethics, consent is the right most rigorously examined across different situations (AMA 2016). Patients have a right to voluntary informed consent to medical care, free of coercion and fundamentally exercising the right to bodily autonomy.

The American College of Obstetricians and Gynecologists officially endorses that these rights are not nullified by pregnancy (ACOG 2016). The current guidelines produced by the ethics committee use the term "forced compliance" to mark behavior by doctors that violates the standard of informed and voluntary consent, and offer this

process for managing pregnant patients who refuse recommended treatment that is designed to continue to engage with and treat patients with emergency medical needs in a way that aligns with the standard of informed and voluntary consent (ACOG 2016).

The opinion of the ethics committee is succinct at 8 pages, and seems designed to obviate any gray areas in medical practice. The use of coercion:

> "... is not only ethically impermissible but also medically inadvisable because of the realities of prognostic uncertainty and the limitations of medical knowledge. As such, it is never acceptable for obstetrician–gynecologists to attempt to influence patients toward a clinical decision using coercion. Obstetrician–gynecologists are discouraged in the strongest possible terms from the use of duress, manipulation, coercion, physical force, or threats, including threats to involve the courts or child protective services, to motivate women toward a specific clinical decision" (ACOG:2)

Clearly, doctors themselves in general and obstetricians in particular view the right to bodily autonomy as central to their practice. The right to patient consent that is voluntary and informed ist the primary way that doctors protect this right. Finally, pregnant people are the patients of doctors, not their fetuses, and so it is the rights of pregnant people that doctors are tasked with protecting.

Though the conservative legal movement has attempted to establish something called "fetal personhood," a fetus is generally not understood to have rights separate from those of the pregnant person. Legal interventions directed against pregnant people create space to infer such rights and force medical interventions in the interest of a fetus–with the goal of achieving a birth. However, medical standards of ethics and care explicitly reject this construction.

2. Who is the victim of Obstetric Violence?

Pregnant people whose rights are violated are the victims of obstetric violence. My definition grounds obstetric care in constitutional rights, and implicitly includes all medical treatment that violates best practices and the rules of informed consent without coercion. This may include too much or too little treatment; treatment without consent; coercion and threats to obtain consent, sometimes legal threats; and the invalidation of women's clear, stated intentions for their bodies.

It is the right of a person to refuse medical intervention, even if it may cause the patient harm except in very narrow circumstances (See Borges 2018, pp843 footnote 91 for a discussion). The question of whether or not pregnant persons can actually exercise this right[22]–which the American College of Obstetricians and Gynecologists holds is not abridged for their patients (ACOG 2016)–is separate from the question of whether or not certain medical interventions are necessary or even medically indicated. C-sections, for example, are performed at approximately three times the recommended optimal rate in the United States (Morris 2013). That is, for every C-section that probably saves the life in the United States, there are two more performed that probably were not necessary. Distinguishing these cases is difficult and fetal monitoring technology is almost no help at all (Morris 2013). Instead of wading into whether or not in a particular case medical

[22] Certain courts have held that pregnant people cannot refuse treatment without balancing the interest of the potential life of their fetus, see Fox 2014.

intervention would be beneficial, I think it best to rely on the stated wishes of patients in individual cases because under the American Medical Association's own code of ethics (AMA 2016), a patient's refusal of treatment ought to be respected.

My definition leaves out the question of which pregnant people are more likely to experience obstetric violence. Native American women, Latinas, poor women, and women living in rural areas or the South are more likely to experience legal interventions against their person when they come into conflict with medical systems (Borges 2018, Diaz-Tello 2016, Paltrow & Flavin 2013). The purpose of this dissertation is to gather the information needed to understand which people, if any, experience obstetric violence more often.

3. Who perpetrates Obstetric Violence?

Pregnancy is largely medicalized—that is, it is recognized as a condition over which medical personnel have the authority to make decisions and enforce rules intended to ease or prevent suffering (Conrad 2007). Upwards of ninety-eight percent of births in the United States take place in a hospital (MacDorman and Declerq 2019).

Chief among medical personnel are doctors. Doctors are the most highly trained, and take on the most legal responsibility for medical procedures. However, births in hospitals might also involve a wide variety of other medical and medical adjacent staff: nurses, midwives, doulas, and various others that have the responsibility of caring for patients' rights.

A definitional focus on medical staff is appropriate because these are the individuals committing acts of violence, but such a limited focus elides other crucial institutional actors. Legal institutions such as courts also participate in the commission of obstetric violence and the enforcement of patient compliance. The history and development of cooperation between medicine and law will be explored in Chapter 6.

4. When does Obstetric violence occur?

My definition potentially reproduces the weaknesses of the medical conception of illness and causality, namely an acute temporal focus. Rather than the long-term consequences of obstetric violence, the definition focuses on the actual occurrence. This is not to say that obstetric violence does not cause more obstetric violence, or that the institutional frameworks leading to or subsequent consequences of obstetric violence do not matter (see Krieger 2008). For instance, Vaginal Birth After C-section (VBAC) is highly discouraged in the US medical system, so one C-section tends to beget more C-sections during subsequent pregnancies, whether or not it is medically indicated; this is sometimes referred to as a "cascade" of interventions (Declercq et al 2013).

Conclusion

My definition of obstetric violence—the violation of a pregnant person's legal rights or bodily autonomy by medical staff during labor and delivery—is an attempt to build on the strengths of other attempts to define the scope of my inquiry. It includes all of the

most consistent elements of other definitions: a legal framework (a patient's right to bodily autonomy and consent), who commits violence (medical personnel, primarily doctors), who experiences violence (pregnant women), and the temporal frame of this violence (the time leading to the separation of a gestating person and a fetus, that is, birth). It is limited enough in scope but flexible enough to produce workable criteria for the study. It also allows me to consider both legal cases as well as argue for the inclusion of instances of "discriminatory" or "disrespectful" care in surveys of women—that is, it allows me to unify different data sources under one definition.

Chapter 2: Methodology

In the substantive chapters of my dissertation, I want to explore both exceptional events–as represented by case law–and more ordinary, or less severe cases–as represented by surveys of birthing people. While the data will not be directly comparable, studying both rare events and more run of the mill reports in the same time period offers insight into the broader landscape. It offers a chance to zoom in on the uniquely unhappy cases, as well as offer a broad overview of the phenomenon. I will explain my methods alongside my substantive analyses in the remaining chapters of Part I.

This chapter is something a little different. This dissertation is a bit different than most, and I feel that my approach requires explanation. I know of only a few colleagues who use archival data as a primary source. In spite of the fact that I will use more conventional quantitative methods to analyze a secondary dataset, I view this project as largely qualitative. I will study individual cases, using somewhat conventional case coding methods. I do not view myself as contributing primarily to theory with this project, though I do think that advancing theories through a grounded, constructivist framework is the best approach to social science more generally. I think disruptions, ruptures, or breaks in the functioning of institutions are the best places to look under the hood and see how they work.

As I prepared to write this dissertation, I kept encountering stories from my friends that mirrored cases in the news. Something seemed different about the pregnant people

being threatened with prosecution or bringing lawsuits against hospitals and doctors. The more I dug in, the more I became convinced that the only thing that separated the more quotidian experiences of my friends from the horror stories being repeated in the media was chance. The exceptional cases and the more invisible personal stories are two sides of the same coin. Or rather, the tip of the iceberg and the submerged mass of the iceberg.

I have already explored who is using the term obstetric violence, for what purposes, and what they meant by it, as well as my own synthesized definition and the criteria for inclusion in my analysis Chapter 1. This chapter explains why I chose a particular time period and particular methods to measure obstetric violence. I want to explain here my philosophical approach (Sections I), as well as the guiding image of how the data I chose are linked (Section II). I also explore what data are available, what information can be gleaned from them, and the limitations of combining my analyses (Section III).

I. A Brief History of Several Hundred Years of Sociological Inquiry

It is always difficult to know where to start a story. I want to talk about ethnomethods and inconvenient witnesses in this section. To do that, we must turn back to what problems more contemporary theorists built their methods to correct.

Sociologists, in my experience, have a bottomless capacity for navel-gazing to soothe their anxiety about being a *real* science. We are all natural materialists in orientation–we must be able to *observe* real things–even and perhaps especially the real existence of individual understandings of human society. We like to document extensively the steps

we took to produce and analyze data, whether qualitative or quantitative, in the hopes that if someone wanted to, they could reproduce our findings or restate our inquiries as falsifiable hypotheses that are built up into a body of theories.[23]

The last time any of us really seemed to *agree* on anything, though, was in the 1800s.[24] So we trot out the classical theorists to forge some sense of being engaged in the same project.

I'm no different. I rail about the genteel conservatism of Durkheim every time I work through a problem of structure and function. I'm not infrequently upset all over again at Weber's insistence that a social scientist should not take a position on their area of study, and stick to the facts–and in Weber's case, allow his social research to be used to construct an apartheid colonial state on behalf of his imperial overlords. As much as I sympathize with Marx, I struggle with maintaining either as much optimism or as much rage about the human condition that suffuses his work. Whenever I sit down with a new project, I journal about all three of our Founding Fathers and the way that I am connected to our shared disciplinary past.

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[23]Sociology is certainly not unique among the sciences. Much ink has been spilled detailing the crisis of reproducibility in science more broadly, and the attendant crisis of scientific fraud. The most recent example of a lie running around the world before the truth has got its boots on is various fraudulent studies of the novel coronavirus COVID 19. Retracted articles on COVID 19 are *still* dramatically more likely to be cited in the scientific literature than more rigorous articles that do not rely on fabricated data or articles that make more modest, well founded claims. See Taros et al, 2023.

[24] I acknowledge that our classical theorists were contentious in their time. The benefit of 100 years or more of hindsight is that some kind of consensus has been reached, for better or worse.

For what it's worth, here's my understanding of where my project falls in the sociological tradition of scientific inquiry.

1. We Are All Positivists Now

The discipline of sociology germinated from the seeds planted by Enlightenment. From Auguste Comte onwards, the positive social science blossomed from a reaction against philosophical idealists.[25] Without *evidence*, science cannot proceed. Even philosophers no longer proceed from closed, deductive systems devoid of empirical observation.

Karl Marx rejected the idealism of his teachers to engage with the material, historically contingent, empirically measurable conditions of human life (Tucker 1978[1972], see especially *The German Ideology* pp. 146-186). Max Weber wrote that sociology is "…the science whose object is to interpret the meaning of social action and thereby give a causal explanation of the way in which the action proceeds and the effects which it produces" (Weber 1978, p.7). In other words, while we might be studying thoughts, feelings, or opinions, sociologists ought to do this by measuring the actions people take.

[25] I'm slightly envious of the days when anyone who was charismatic or convincing enough could write down whatever they liked and have it be taken seriously as a form of rational inquiry. I would have earned a doctorate much more quickly in medieval times, my gender aside.

Émile Durkheim is the theorist most closely associated with positivist thought in contemporary sociology. For him, sociology was the study of "beliefs and modes of behavior instituted by the collectivity" (Durkehim and Lukes 1982, p45), that is, the study of institutions. Institutions of society, in his view, act on individuals to produce behavior, and so can and should be studied as we would study the laws of the natural world.

Durkheim's view–or at least, the naive positivist structural functionalism that evolved from his view–dominated American sociology until the mid-twentieth century.

2. The Problem with Structural Functionalism

The most glaring issue in much positivist work is the assumption that an objective reality exists external to the individual. Furthermore, it is possible to study this reality objectively. The knowledge produced by sociologists in this framework is viewed as an unbiased, rational interpretation that exists independently of social meanings attached to the individual experience of reality. Durkheim calls these social facts *sui generis*–in Latin, literally "of their own kind," and having an existence independent of individual interpretations of reality.

My favorite example of the problem with this assumption is Durkheim's anthropological aside contained in *The Division of Labor* (2013[1933]).[26] In the first

[26] My second favorite example of the glaring problems with this paradigmatic orientation to "facts" is Kingsley Davis's (1937) article in the second issue of the *American Sociological Review* entitled "The

chapter, after discussing the function of law and the difference between different types of solidarity, he lays out the “objective” evidence that modernity has weakened women, both physically and mentally. Women’s skeletons seem to diverge from men’s in size as we approach modernity, and in particular, their cranial circumference and presumably capacity declines. Durkheim argues though (in a very Benthamite utilitarian way) that the dramatic social benefits of modernity outweigh the harm done to women. In other words, we must simply accept that women will be weaker and stupider as part and parcel of the wonders of modernity. Implicit in his conclusion, while situated in historical time to be sure, is the universality and inevitability of the consequence (effect) of the transformation of society (cause).

Like many positivists after him, Durkheim failed to recognize that alternate interpretations of these "facts" exist. Or that the measurement of skeletal structure was highly contested, even in his own time. He did not interrogate his own biases or the social structures which may have generated the "facts." Women–or people viewed as women, since sex and gender were not well understood at the time Durkheim was writing– were not permitted to attend much formal education, thus kept deliberately ignorant and dependent. Childbirth strains the body and weakens the bones because modern diets contain fewer micronutrients after the transition to a settled agrarian lifestyle (For an

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Sociology of Prostitution” which underscores how prostitution enables men to tolerate the constraints marriage places on their “natural” promiscuity, an assumption recently called into question by more complicated interrogation of biological “facts,” see Wlodarski, Manning, and Dunbar 2015.

overview, see Harper and Armelagos 2010). These deficiencies are exacerbated by toxic exposures common in industrial societies and felt most keenly by marginalized people who live near environmental hazards; lead is one of the most common, which impacts brain function (Drum 2016).

Durkheim uses “objective” and “rational” criteria to justify unequal and unjust treatment of women, and fails to consider the smaller, micro-interactional implications of larger structural restrictions in the every-day performance of social roles. For instance, an intelligent outspoken woman in Durkheim’s time could look forward to a life of spinsterdom or prostitution but almost assuredly not marriage (unless she was wealthy). Declining to challenge these "facts" about women in the modern era had then as it has now social utility. Jane Ward dubs the silence and mistrust that stretches between heterosexual couples attempting to navigate social rules that dictate people of different sexes should have no common perspectives "the tragedy of heterosexuality" (Ward 2020).

3. Working Across Levels

It is incredibly tempting to repeat this error with quantitative and statistical analyses. There isn't much space in journal articles. Cramming in detailed coding and methodological descriptions is difficult enough. *Finding* datasets that actually contain information about social problems like obstetric violence is daunting enough, without interrogating who made them, and why. Quantitative work just feels more "scientific"

and "objective" than qualitative work; the author of the data is hidden away behind a curtain, and we are not supposed to notice that choices were made to produce the work. In a discipline that does not have laboratories with bubbling beakers and wild-haired maniacs shouting "Eureka,"[27] the temptation to focus very narrowly on the trappings of science without engaging in deeper debates about what kind of knowledge we are producing, and what kinds of theories that explain that knowledge is sometimes too much to resist.

Post-positivists still tend to be searching for causal relationships, though they for the most part frame causality probabilistically rather than dichotomously (See Cresswell 2012, who self identifies as a post-positivist: 23-24). Post-positivists maintain that generalizability and reproducibility—both more traditional measures of validity—have led to an emphasis on "rigorous" data collection. Their reports tend to look like a standard "scientific" report and many qualitative researchers find themselves constrained to this format due to the demands of funding agencies. Post-positivists don't believe in a single, objective *interpretation* of the truth: indeed, Cresswell stresses that they work with multiple points of view. Nevertheless, they situate their work in a frame that

[27] I paid for my undergraduate education working in a genetics laboratory doing cancer research. There weren't bubbling beakers. There *were* carefully labeled refrigerators, radioactive isotopes, and people shouting out their frustrations when someone turned off the double distillation filter or the autoclave too early *again*. It takes a very particular kind of person to collect virgin fruit flies at 3AM in the pursuit of knowledge about cancer while navigating the other, *very* particular people around them. It probably says something about me that I thrived in that environment, and look back on that time with fondness.

advances scientific knowledge by adding to and testing previous theories, even if (as Cresswell notes of his own work) they occasionally dabble in other paradigms.

Guba and Lincoln (2005) explore the ontology and epistemology of post-positivists rather than their methodology. Post-positivists still believe in a reality "out there," in spite of our flawed ability to perceive it (ibid 269). Empiricists/positivists tend to reject the subjective human experience as "knowable" and focus on objective facts—that is, for the most part, numbers. I think this assertion is misleading in terms of qualitative positivist work, but that as Schwandt (2000) argues, post-positivists can mostly be classified as interpretivists. Post-positivists certainly believe that value neutral knowledge is possible to generate while incorporating the meaning of action into sociological work. That is, they empirically observe what people do, and ask why people say they do it, to come to an understanding of the facts.

In order to fit qualitative work into an empiricist, theory-generating frame, qualitative post-positivists sought a way to rigorously analyze qualitative work, to check intuition against "objective" criteria such as probability or proportion, and to continue to build a base of knowledge that had validity external to itself. Grounded Theory is probably the most influential and systematic strategy to emerge (See Glaser and Strauss 1999[1967], Charmaz 2013). Grounded theory is post-positivist in orientation toward micro-level empirical evidence that explicitly aims to create "theories of the middle range" (á la Merton, see Charmaz 2014) rather than grand narratives or a strict focus on micro-

interaction. Without discarding an analysis tied to empirical evidence in the positivist tradition, grounded theorists attempt to legitimate qualitative evidence as sufficiently empirical and rigorously gathered and analyzed to count as "scientific."

Grounded theory as promoted by Glaser and Strauss is that they still treat texts and information produced by researchers as objectively true and independent of interpretation. That is, they still privilege the researcher's perspective above that of the researched. To echo Foucault, such an orientation toward the generation of knowledge ensures the privileged place of the researcher in the regime which silences and dehumanizes marginalized people (see Ladson-Billings & Donnor 2005).

Kathy Charmaz promotes constructivist grounded theory to address this critique. The addendum "constructivist" has two meanings. To Charmaz, a theory is (very positivistically), "either explaining the relationships between concepts or offering an abstract understanding of them" (2013: 300). She believes in the need for theory construction in order to advance knowledge. The second meaning is a shift in the epistemology of method to encompass more pragmatist or relativist ontological orientations toward reality (ibid, 305). Using "abductive" reasoning researchers simultaneously build from the ground up (inductive) and seek to explain findings in the midst of the research process by connecting them to existing theories and possibly refining those theories (deductive) (ibid 295).

The lack of distinct stages in the process of research makes the logic of research practice more open to new understandings constructed in conjunction with the research participants and new theories fitted to the realities with which the researcher engages. While agnostic on the question of grounded theory proper, Emerson, Fretz, and Shaw write the simplest and clearest analogy of the method that Charmaz describes. Finding questions, collecting data, and analyzing it is like "... a carpenter alternately changing the shape of a door and the shape of the door frame to obtain a fit" (1995: 144).

Embracing the fuzziness of the edges and boundaries is exactly what Fine and Weis call for researchers to do with their conception of "oscillation" in "compositional studies" (2008). They define the latter as "ethnographic inquiry designed to understand how global and national formations, as well as relational interactions, seep through lives, identities, relations, and communities of youth and adults, ultimately refracting back on the larger formations that give rise to them to begin with" (ibid: 69). As examples, they cite Paul Farmer, Patricia Hill Collins, and Franz Fanon. Similarly, and also alluding to the allegory of light through a crystal, Laurel Richardson (1997) calls for a transgressive, postmodern take on validity that move back and forth between perspectives and across levels much like light "...can be both waves *and* particles. Crystallization, without losing structure, deconstructs the traditional idea of 'validity'...and provides us with a deepened, complex, thoroughly partial understanding of the topic" (ibid:92)

II. Measuring What We Cannot See

Social problems by their nature defy generalization. Individuals have a tendency to see larger structural or historical patterns through the frame of their own experience; we experience structural issues as particular personal complaints rather than general societal ills (Mills 2000 [1959]). We resist the urge to generalize our troubles–in part because we internalize the failures of society as our own, and failure is shameful. To paraphrase the famous opening of *Anna Karenina*, every happy life is the same, but every unhappy life feels unhappy in its own way.

Obstetric violence is uniquely positioned to be difficult to study as a social problem. Childbirth straddles institutions in a way that makes it difficult to find recorded data–both due to the intensely personal nature of pregnancy and birth as well as limits placed on scientific research using pregnant people as subjects. There are no large-scale data projects that directly measure individual instances of obstetric violence, and only one that has asked directly about negative birth experiences over several waves.[28]

Another way of thinking about social problems theory is that it focuses on the weak points in social structures. Imagine that institutions are the tectonic plates of society. They float slowly across the molten core of society, occasionally ramming into each other

[28]As I completed my penultimate draft of this project, the CDC announced the results of their analysis of the Porter Novelli View Moms survey, which asked about "mistreatment" of pregnant people by medical staff (Mohamoud et al, 2023). Plans to include questions in the Pregnancy Risk Assessment Monitoring Survey (PRAMS) moving forward are underway, though again, "mistreatment" in this study seems to mean "discrimination," and it isn't clear how they will alter the survey to directly measure obstetric violence.

and causing new mountains, new tectonic plates, or natural disasters such as earthquakes. Sometimes, the process of widening the distance or rubbing gently alongside each other creates cracks. Sometimes these cracks are big enough to swallow people whole.

1. Breaks in reality

One trick in the sociologist's arsenal is knowing where to look to find these fissures.

The constructivist turn of the 1970s gave rise to a number of interpretivist approaches and scholars that focused on the micro-level of interactions who not coincidentally draw on Weberian notions of Verstehen and interpretivism. The most popular of these are the phenomenological stylings of Erving Goffman's performance theory and Garfinkel's ethnomethodology (Schwandt 2000). They, like Weber before them, seek to interpret action and contextualize it within the *lebenswelt* as part of a system of making meaning out of everyday experiences.

Goffman's fundamental insight is that all the world is a stage, so to speak, and all the men and women merely players who in their time play many parts (Goffman 1959 in O'Brien 2010).[29] He expands role theory beyond the structural-functionalist perspective by focusing on interaction between individuals as the basic building block of the social order. These small, everyday rituals and scripts that individuals use to navigate social

[29] Paraphrased from *As You Like It* by William Shakespeare.

interaction are actually what produces a stable sense of external reality and the internal self.

Goffman (1959 in Grusky and Pollner 1981) sees the self as ".... not the property of any one person to whom it is attributed, but dwells rather in the pattern of social control that is exerted in connection with the person himself and those around him..." In other words, the self is an illusion constituted by the social pressure of various institutional arrangements. This spawns a very passive rather than active notion of social control, but one that fits in well with the everyday experience of reality as performance. The goal of any individual in an interaction is generally to create a kind of working consensus to get through without much friction.

Harold Garfinkel is also incredibly fun to read.[30] In the classic work *Studies in Ethnomethodology* (Garfinkel 1984 [1967]), he extends the argument that individuals create a stable sense of the world through small, everyday interactions. Merely reproducing these interactions is not, however, going to make the rules by which they proceed clear. Garfinkel asserts that we can best expand our understanding of stable social rules by looking for breaks in our sense of a stable social world–or by deliberately causing them. Garfinkel taught students to do this in small ways, such as standing backwards in an elevator or sending them home with instructions to pretend to be angry.

[30] Though I'm not sure I would have enjoyed his company. He seems like the kind of prankster one could never take seriously, and simultaneously like the sort of person who could reliably recite *exactly* what you said while drunk ten years ago.

Examining the reactions of other people, and the ways they attempt to restore a stable world illuminate the edges of the break in reality, like the flickering light of a road flare over broken glass after a car accident.

This project does not examine the project of the self, as such. Nor did I conduct an ethnography of obstetric practices. Obstetric violence represents a break in reality. My friends never wound up in court over their mistreatment, certainly. I can't imagine that their medical records contain any mention of mistreatment. I know at least one of them and I suspect that several more were labeled "noncompliant." They did not submit to the social pressure to interact smoothly. Interactions between them and their medical provider broke down. The edges of their interactions remain sharp, and emotionally painful. Studying this rupture is an opportunity to see more clearly the institutions that structure these interactions.

2. Self-repairing institutions

Emile Durkheim wrote in *The Division of Labor in Society* that the purpose of legal action by the state corresponds to the type of social solidarity to which a particular law or set of laws corresponds (Durkheim and Simpson 2013).

Pre-modern societies that function on the basis of mechanical solidarity require repressive laws. Durkheim argues that the problems of pre-modern societies revolve around offense to the collective consciousness, to the communal sense of justice and order. Repressive sanctions which remove an individual from her function in order to

appease the communal sense of injustice do not interrupt the workings of a society where one person is much the same as the next. Even if repressive laws did interrupt the workings of the economy or political life of a society, they would satisfy the bloodlust of the offended collective conscience and be permitted to persist.

Modern societies which rely on an organic solidarity stemming from the division of labor require the law to focus on restitution. Since every role is highly specialized, society cannot afford to lose a single person. Their contracts and activities must continue to be performed. The role of the state is to restore social order and redress imbalances so that society may function. The laws of such a state are meant to offer restitution and repair the break in the social order so that the wheels of the larger social order continue to turn.[31]

Case law is a record of these attempts to heal the breach. Judicial opinions give a history of facts that are not in dispute, the way the court interprets the dispute, and a ruling on how disputes will be resolved. In short, in a precedent based system like that of the United States, the body of various public documents produced by the court system give an excruciating amount of detail about breaks in reality. The attempt to build bridges

[31] I hate it when Durkheim is right, though there are some caveats to the above. Durkheim's ideal types do not represent the full complexity of society. Organic solidarity has not replaced mechanical solidarity, though it becomes difficult to distinguish the two in practice. A murder both offends the collective moral sensibility of a community and interrupts its functioning if it removes a highly specialized actor within the community. It logically follows that for Durkheim, the murder of a doctor or businessman is more notable than the murder of an unskilled laborer. Contained within this vision of the law, in other words, is the means by which inequality is reproduced.

across gaps, and keep society going. They are a great place to look in order to understand social problems, institutions, and social control.

3. The Iceberg

Recall that using the extremely rough estimate of thirty cases that rise to legal attention in a year (Paltrow and Flavin 2013) and the number of live births matched to the time period (Martin et al 2007) works out to approximately .0007% of live births. Observing obstetric violence directly would be an ideal method to understand more about it. With such a low rate of the kind of dramatic, exceptional case, however, I might just as well try to get a clear picture of antimatter using a polaroid camera. It might be theoretically possible, but in practice it is extremely unlikely that I would produce valuable data using that method.

Cases of obstetric violence that garner a great deal of legal and journalistic attention are illuminating. However studying only these cases will not answer more general questions about how often obstetric violence is committed and against whom.

Somewhat extensive and precise records of these cases exist. Court documents were at one time laborious to access. Some still are. But federal courts, state courts, and various appellate courts in the United States have largely digitized the body of their decisions. Accessing the totality of cases involving pregnant women in the history of the

United States (at least, those that rise to a certain level) is as easy as honing one's search terms.[32]

The question then becomes how to understand the extreme outliers in the context of a broader social phenomenon. Some oscillation between levels is necessary to contextualize them, and gain fuller insight.

In the introduction, I used the image of an iceberg as a metaphor to underscore that cases visible to mainstream society are often just a small fraction or special cases of a much more widespread phenomenon. These cases may be unique or shocking in some way that draws attention or produces action. A different set of cases may remain invisible.

A classic example of the iceberg in medical sociology is mortality associated with heart disease compared to the long-term morbidity of heart disease (Verbrugge 1985). Men who suddenly have a massive coronary incident resulting in death take up a large share of attention in early diagnosis, screening, and treatment of vascular disease–in particular middle aged white men. Women are no less likely to experience heart disease, but face hurdles in obtaining early screenings, diagnoses, and treatment. In one study designed to test bias in diagnosis, women along with non-white people and elderly people presenting the same symptoms in pre-recorded patient vignettes were not screened at the same rate as middle aged white men; did not receive the same amount of recognition of

[32] This is like saying, "things could be worse: it could be raining." Honing search terms was not easy.

their symptoms as concerning as white men; and were not recommended for more aggressive treatment at the same rate as white men (Welch et al 2012). In other words, disproportionate attention is given to dramatic and easily recognizable problems that fit preconceived biases while ignoring the broader context of health inequalities.

III. Data Selection

In order to study such a phenomenon that appears both as dramatically, easily recognizable events and more subtle instances that often pass unremarked and unrecorded, I must gather information about both. In the case of obstetric violence, I want to study two main data sources: legal cases and the opinions of pregnant people. I will study them over the same ten-year period to explore how more severe, visible cases of obstetric violence are related to under or unreported cases.

1. The Tip of the Iceberg: Case Law

Case law offers a rich source for qualitative study, particularly judicial opinion. With respect to race and class, the deficiencies of case law and legal proceedings are well known and recorded (see especially Roberts 1998). Across jurisdictional lines, statutory law gets blurry. Judicial opinions, however, always include a set of agreed upon facts that offer a basis to compare cases of obstetric violence.

A search of case law from the perspective of a sociologist rather than an attorney would certainly yield a different picture than law review articles (Borges 2018, Kukura

2018). As noted by Dorothy Roberts (1998), judicial opinions and other court documents are often frustratingly bereft of basic information like the race and socioeconomic status of individuals.[33] They do not offer a complete picture of patients impacted by obstetric violence. I am also interested in the geographic distribution of cases. Basic location information which will be contained in any judicial opinion.

2. Caveat: Justice is Blind

I started this project wanting to know the answers to some very basic questions about *obstetric violence*. For example, how often does it happen? Are there places where it is more likely to occur–or possibly more accurately, places where instances of obstetric violence are recorded more regularly? Which people are more likely to be victims? Women of color, women with disabilities, younger or older pregnant people, women of low socioeconomic status? Are there more demographic categories that matter here–such as religion or immigration status?

As for case law, do examples of *obstetric violence* found here represent the phenomenon more generally, or is there something different? If they are the "tip" of the iceberg, is there some discernible reason that they rise to public attention? Are they more severe–or do they involve individuals with more resources and privilege to pursue their claims?

[33] Michelle Alexander (2012) notes that this blindness to color allows courts to maintain a willful blindness to their disparate impact on the black community.

At certain stages in the project, I felt like I wasn't *really* doing sociology at all. Sociology tends to focus on levels of analysis above the individual. As Mills (1959[2000]) puts it, to understand that personal troubles are sometimes public issues. This "sociological imagination," as Mills calls it, strives to see both the forest and the trees. We should be interested in systems, structures, institutions. All I was doing was trying to figure out a way to count.

The problem with using case law as a way to count is that a great deal of very pertinent information is largely absent because it is considered irrelevant to the law.[34] Noted jurist John Roberts, current Chief Justice of the Supreme Court of the United States, once referred to basic demographic information about the disparate impacts of law as "sociological gobbledygook" (Flaherty 2017). Lawyers and judges are largely uninterested in measuring how the law functions in this way–though recent trends in critical race scholarship and in a liberal interpretation of originalism give some hope to frustrated social scientists. Nevertheless, hundreds of years of case law are simply missing any way to measure things like race or class.

For example, the Citing Slavery Project was founded to help the legal profession reckon with its role in the system of American enslavement (Treisman 2023). Slavery touches a huge swath of American law–and in a precedent based system, some cases that

[34] A very old joke is that the goddess of Justice is depicted as blind because her sword will hit whoever kneels before her, and she cannot tell if her own scales are balanced. The English of the nineteenth century liked to claim that famous, clever Romans originated it, but I have never been able to source the quote. I think it is such an apt description that it isn't actually funny.

include slaves are still cited today without acknowledging who the contested property was. You can investigate a map of primary cases and cases that cite them at the project's website <https://www.citingslavery.org/>. Justin Simard, a lead scholar on the project, has successfully advocated to update the Bluebook citation rules for cases involving slaves (Triesman 2023).

Dorothy Roberts has traced this peculiar blindspot of the law over time with regards to black women's reproduction. In *Killing the Black Body* (1998), Roberts artfully traces this empty space in the law to understand how laws racially neutral on their face are used to control black women's bodies, their reproductive choices, and their children. As Peggy Cooper Davis notes, the experiences of black women in particular were critical to the formulation of what it would really mean to be a free citizen and the case law surrounding black women's reproduction was foundational to the drafting of the Reconstruction Amendments (1997). Central to Roberts' argument is the deliberate erasure of demographic information that would contextualize black women's experiences in the body of case law. By treating cases as "colorblind," legal scholars reify racism by making it impossible to measure (Roberts 1998).

In their study of criminal cases against pregnant women and forced medical intervention, Paltrow and Flavin (2013) painstakingly searched for court cases in local newspapers, rather than legal databases. In part, this is because they wanted to find information about the sociodemographics of pregnant people that are not included in

legal cases. They found that black women and native American women were dramatically more likely to face criminal charges. In part this is because no legal databases existed at the time the study was completed that included a complete record of all local municipal and county courts. The situation is now somewhat improved in terms of data access, but would still require straddling multiple databases or state level archives to complete a search of *every* court.

A much more fundamental problem with using case law as a data source exists, however. Previous legal scholarship (for example, Diaz-Tello 2016) documents how even the threat of legal action is enough to coerce compliance out of pregnant patients. Courts may be asked to intervene, but the problem becomes moot before that intervention takes effect leaving only a collection of ephemera and no published opinion. The threat alone of reporting a non-compliant patient to law enforcement authorities is sometimes enough to remove the need for actual, recorded intervention. Such a case would meet the definition of obstetric violence outlined in Chapter 1, but it is very hard to *measure* these cases, and they certainly would not appear in the public legal record.

There is danger in repurposing historical and archival documents for purposes that they were not created to fulfill. Scholars must be very careful drawing general conclusions from such data. The information contained in these cases is incomplete, though there are tantalizing hints here and there[35]. I focus on what information is

[35] I don't expect that Medicaid patients, for example, are wealthy or privileged from a class perspective. I don't think someone with the surname "Cardenas" (*Cardenas v. Jerath*, 180 P.3d 415 Colorado Supreme

available, and supplement my understanding of case law by comparing it to a large secondary dataset in the next chapter [6]. While these two avenues of investigation are also not directly comparable, including both captures the richness of case law and matches it to parallel experiences that help to fill in sociodemographic data.

What kind of cases–criminal, civil, the plaintiff (such as, a doctor or a patient)–is available for the entire dataset. I can map where, and when, these cases are decided. I analyze whose claims are successful in court, and what kind of compensation the parties receive. Crucially, since these cases include a narrative of agreed upon facts, we can understand in the narrative of events the way that institutions deploy their power.

3. The Submerged Iceberg: Listening to Mothers

There is no single large-scale survey of pregnant people or recent birthing parents that actually measures OV as defined in Chapter 1. There *is* one wave of a long running survey that asks questions of new mothers about mistreatment at the hands of medical staff, and focuses on soliciting negative birthing experiences: Listening to Mothers.

The nonprofit group Childbirth Connection has administered all three waves of the survey since 2002, as part of their longstanding project to improve childbirth in the

Court (2008) would classify herself as a non-hispanic white woman, or that an infant named "Dishean" (*Heard v. Morehouse Parish Health Unit*, 917 So. 2d 652 Louisiana Court of Appeal (2005)) would be identified as white. As even these hints are not available for all cases, comparing this dataset consistently by race and socioeconomic status is impossible.

United States. All of their data is publicly archived at Odum Institute Data Archive at the University of North Carolina.

In 2002, the first wave of the Listening to Mothers Survey was conducted. It was then the *only* national survey of women who had recently given birth. The goal was to understand childbirth experiences. All 1,583 survey participants had given birth to a single baby within twenty-four months of the time of the survey. Wave II included 1,573 women who had given birth to a single baby in a hospital in 2005. Waves I and II included a small minority of women who were given an interview to fill out the survey by phone, though the overwhelming majority of respondents completed an online questionnaire.

Listening to Mothers III was released in 2013. As in the other two waves, women had to have given birth in the last year. The third wave eliminated the telephone response option. Participants had to be able to participate online in English, and be willing to answer questions about their experiences, their interactions with healthcare providers throughout the pregnancy, their feelings about their pregnancy, a limited amount of medical information, and basic demographic information. Women were given the opportunity to answer open-ended questions in their own words about their experiences. The survey included 2400 respondents from all 50 states and the District of Columbia.

All mothers were asked the same questions about their retrospective experiences of pregnancy, childbirth, and early motherhood. They could choose to answer the open-

ended questions soliciting a narrative of their experiences. Almost all of the mothers answered at least one of these questions. Results suggest that many mothers reported pressure to submit to medical procedures, difficulties with postpartum pain management and recovery, problems obtaining explanations of procedures and risks, and an inability to refuse consent to medical procedures (Declerq et al 2013). What is less clear from the report analyzing the data is how these problems align with one another, how they align with intersecting categories of advantage and disadvantage, and how they are distributed geographically.

I am most interested in the way this longitudinal study contextualizes the exceptional cases in the tip of the iceberg. Where case law does not consistently include demographic information, Listening to Mothers does. Where case law includes particular information about the mechanism of escalation and the way that hospital function, as an institution, the Listening to Mothers survey provides general information about how patients felt they were treated. The two sources complement each other in a way that will offer a fuller, more nuanced picture than either alone.

Conclusion

Sociology is a strange sort of science. We often study institutions that have no material existence, but are very real in their consequences. Social problems theory in particular focuses on marginalized people, who are invisible to broader society. I don't know many sociologists who don't have any opinions at all about solving society's

problems.[36] Most of us want, on some level, to improve the world with the information we uncover.

I hope I have made clear my own personal biases about doing sociology. We are all positivists now, in that we seek to produce *evidence* and measure the real, material world. The real challenge, I think, is trying to measure the parts of the world that are invisible. How we find the cracks in reality that allow us to see it more clearly; whose perspectives we elevate as trustworthy; and how we conceive of different levels in our inquiry can make all the difference in telling a sociological story.

I have outlined here why I want to include in this project data sources that are not directly comparable. The case law and survey data are mirror images of each other. Case law provides a rich, deep understanding of the particular circumstances of instances of obstetric violence, but is missing basic sociodemographic information. Survey data makes it easy to understand trends and analyze linkages between the characteristics of pregnant people, though a deeper understanding of individual cases isn't possible. Together, these two sources sharpen the picture of *obstetric violence* in different ways.

The rest of Part I focuses on the analysis of the two data sources outlined above. Chapter 3 explores the legal cases included under the study criteria. Chapter 4 analyzes the Listening to Mothers data. Chapter 5 offers a comparison of the two by mapping out the data to see where instances of obstetric violence align with broader measures of

[36] Well, I've met one sociologist who *claims* that he, personally, has not developed opinions about social problems, and I think he's lying.

mistreatment. Part II returns to the question of context and sociological theory, and why I think *obstetric violence* is a useful window into understanding social reality.

Chapter 3: The Tip of the Iceberg

This chapter presents the first piece of my substantive investigation. In it, I treat the case law produced between 2002 and 2012 with regards to birth, specifically, as an archive of documents to be analyzed through a sociological lens.

By comparing court cases to survey data that measures negative birth experience in Chapter 4 and mapping the cases in Chapter 5, I hope to sketch the iceberg of *obstetric violence* completely, if imperfectly. These cases are a snapshot of the medical reaction to shifting legal realities. I will outline the growth of the consensus between legal and medical institutions in Chapter 6–and what these institutional arrangements mean for marginalized people in Chapter 7.

Section I describes how I produced this set of court cases. Section II describes how I processed and coded these cases into a dataset, and gives a general overview of the contents of the dataset. Section III gives a detailed analysis of the themes that emerged, with specific examples from the cases that highlight the nuances of these themes.

I. Sources and Methods

1. Data source: Harvard Caselaw Access Project (CAP)

I waited exactly long enough to finish the project that someone built an Application Programming Interface (API) code to compile all state and federal case law

in the United States into one searchable database.[37] It saved me from doing it myself, [38] and significantly expanded my ability to compare case law to secondary survey data.

The project was largely completed between 2013 and 2018 by the Harvard Law School Library. The database includes all state courts, federal courts, and territorial courts for American Samoa, Dakota Territory, Guam, Native American Courts, Navajo Nation, and the Northern Mariana Islands. Two distinct operations created the database. The first and most important part of this project is an API that compiled electronic records from federal and state court reporters around the country. Some, like the Supreme Court of the United States, have their own electronic archive that includes cases as old as 1793. Others have digitized cases into the mid-20th century, or much more recently.[39] The second part which may be of interest to other scholars is the scanning of older court cases. Over the initial five-year period of the project, over 40 million pages of court decisions were digitized. While the project is now transitioning away from their original

[37] What an API does is allow applications with different "languages" to talk to one another directly. A substantial barrier to making a single database of any kind from different sources is that different applications are built at different times with different programming languages and for different purposes. They can't directly give instructions to one another, or match up particular data types. APIs bridge the gap, and duct tape together all the massive datasets and applications undergirding, for example, financial systems. Every insurance company, bank, subscription service, or ordering system built before 1980 uses CBL. The task of programmers post 1980 is to make newer coding systems and applications talk to the old mainframe–many of which have been running since the 1960s. It's very cool, but also, the idea that your bank account almost certainly depends on a machine built before the Cold War *really* took off should maybe alarm you a bit.

[38] I have no doubt that I *could*, but I'm not a particularly good programmer. Only marginally competent, and that begrudgingly.

[39] Alabama's judicial system was still using typewriters in the early 21st century, and the archive on their state Supreme Court website only runs to 2013. (Alabama Judicial System 2024)

API tool, they continue to update new cases in all of the state and federal court reporters as they are published. (Caselaw Access Project 2024) [40]

2. Search criteria and results

I conducted a pilot project in the Spring of 2015 to see how feasible my idea of using case law as an archival dataset was. The project focused more on the criminalization of pregnancy than *obstetric violence*. I used the archived cases from Pregnancy Justice[41] to create a dataset of cases. The cases spanned the years 2006 to 2013. While my research focus shifted between the pilot project and this dissertation, this smaller dataset was useful to validate my search criteria in the Caselaw Access Project. I added some additional very famous cases from earlier in the 2000s decade that are frequently cited by legal and medical researchers. That is, if any or all of these pilot project and exemplar cases were missing, I did not consider my search terms or the resulting collection of cases returned to be complete.

The first search I used spanned cases decided between 2000 to 2015, and used the terms "pregnant" or "labor and delivery" or "birth" or "maternal injury" or "fetal injury." I extended the date range beyond that of this dissertation because I wanted to pick up

[40] The archives of the Caselaw Access Project are now housed at Court Listener (<https://www.courtlistener.com/>), from the Free Law Project. Searches from the old CAP API now return only Court Listener results. The search engine is a little clunkier, but it returned exactly the same set of cases from my search criteria. I tested it when I was double checking my citations and completing the full draft of my dissertation in March and April of 2024.

[41] Formerly the National Advocates for Pregnant Women (NAPW).

absolutely any hint of the example cases. Legal cases that make their way into a state or federal level appellate court tend to leave a long trail of various motions. Some of these are short and contain no references to the case history or findings of facts, but others debate issues of evidence or procedure in ways that lead back to a larger case. If there was any chance of my search terms resonating with these threads, I wanted to give the test enough of a range to work on.

This first search yielded too narrow a field, even specifying "or" not "and."

For the second search, I used "labor and delivery" alone, since I was interested most in the moment of birth. This search of cases decided over 2000 to 2015 yielded too wide a range of cases, but it did include all the example cases that I was looking for. It also captured instances of the same case working out legal issues across various courts, as I expected.

I decided that this was acceptable. I could prune non-pregnancy related cases and consolidate cases that involve the same legal issues.

It is worth noting that the date range searched is when the case was decided, or recorded. This is not when the events *occurred*. As noted in Chapter 2, the case law dataset is not directly comparable to the Listening to Mothers longitudinal survey data. Even less so because there is some lag time in case law data.[42] Still, the overlay of

[42] It would be better, of course, to compare the set of cases originating over the time period 2002-2012 to the Listening to Mothers survey over the same time period. This set of cases was not as easily located as the cases decided in this time. Some of the children mentioned in these cases were born in the 1980s–one, as

activity illuminates the legal landscape and how legal understandings operate on the ground in the same time period.

I understand, and explain, the ways in which case law is inadequate to the task. I also understand the distinction between cases *decided* in the decade of interest versus cases *originating* in the decade of interest. It would be ideal to compare the latter to the Listening to Mothers data, but I have settled for the former in this project as a matter of practicality. Legal databases are generally searchable by and cite the year in which the case was decided. Searching the year in which the legal dispute occurred is technically possible, but much more prone to error.

The final search conducted in the CAP database was for any cases including the phrase "labor and delivery" over the date range 2002-01-01 to 2013-01-01. This search returned 405 cases. When duplicate cases were consolidated, there were 378 unique cases represented. Appendix [C] offers a full listing of these cases, with citation data and their coding in the study.

II. Dataset

Chapter 2 describes the reasons that I wanted to use case law to answer basic questions about obstetric violence, and the limitations of such a data source. I have described above how I actually conducted the search and initially sorted the data for

early as 1982 (*Cangemi v. Advocate South Suburban Hospital*, 364 Ill. App. 3d 446 (2006)). It is beyond the scope of this project to build such a dataset.

unique cases that meet the basic criteria for inclusion. In this section, I explain how I coded the cases that it produced. I will also present some basic distribution information about the cases, before turning to a deeper analysis of the themes that emerged from coding.

1. Coding for Obstetric Violence

The cases were separated first into Not Applicable (NA, or excluded), Yes (Y, or *obstetric violence*), and No (N, or not *obstetric violence*). I coded 126 cases NA of the 378 unique cases, representing about 33% of the cases.[43] These cases either did not involve pregnancy and birth or were excluded from my definition of obstetric violence (see Chapter 1). Appendix C offers a brief exploration of these cases, including why some of them were picked up in the search and what they say about the legal landscape of pregnancy and birth.

Of the remaining 252 cases, I coded 72 of them "Yes" for obstetric violence, or about 28% of the remaining cases.

Cases were coded "no" if there was not enough information in the record about the circumstances of the case. My coding therefore represents the smallest possible set of cases of obstetric violence that could be construed from this dataset. Wherever possible, when the case in my data lacked details, I traced it back through lower courts until I was

[43] Not a very *precise* search, but extremely *accurate.* It is better to be sure nothing is missing, in my opinion.

able to fill in the details. In some appeals, there is only a judgment entered about the technical grounds of the appeal, and searching for cases that led to the appeal or that proceeded from it yielded no further information. For example, in Klippel v. Rubinstein (2012),[44] the pregnant patient was admitted under the care of a particular physician, but the question is about whether the hospital is liable for actions that led to the death of the pregnant patient taken by different physicians answering an emergency page. This suggests that one of them is responsible for her wrongful death, but the issue is whether or not the hospital is liable. I included this case as potential *obstetric violence,* but coded it "No" because the information is incomplete.

I used similarly conservative estimates in other areas of coding as well. I coded cases that included only injuries to the fetus or infant as not obstetric violence–especially in cases where some problem was diagnosed late in pregnancy. Cases that involved some sort of concealment or actively promoting misinformation, though, were coded Yes. Cases that seemed like simple medical errors I also coded not obstetric violence. The only thing that distinguishes them from any other error is that a pregnant person is involved.

After reading all of the cases and coding them for obstetric violence, I reread the cases and coded for what kind of legal claim undergirded the court document and by themes that emerged.

[44] *Klippel v. Rubinstein* 300 A.D.2d 448, 751 N.Y.S.2d 553 (2012)

The majority of the dataset involved cases that originated before the passage of the Affordable Care Act (ACA). As Theresa Morris (2013) notes, before the passage of the ACA in particular the insurance system for Obstetricians and Gynecologists incentivized lawsuits. Children born with injuries could be considered to have pre-existing conditions that health insurance companies used to deny them health insurance for the rest of their life. Morris (2013) describes cases in which patients know their doctor didn't make an error and were not negligent, but they sued for malpractice anyway in order to pay for future medical costs. In this dataset, the tail for malpractice suits is long. It is impossible to say from these cases how many patients would or would not have sued if they had another way to pay for medical treatment.

2. Types of cases

All of the 253 cases coded for obstetric violence were civil suits. Table 3 shows the distribution of underlying causes of action of these lawsuits.

Table 3: Underlying Legal Issue of Cases Coded for Obstetric Violence	
Malpractice or Negligence	223
Malpractice or Negligence, combined with Wrongful Death	10
Wrongful Death	10
Employment Disputes	4
Constitutional Rights or Federal Law violation	3
Wrongful Life	1
Intentional Infliction of Emotional Distress	1
Unfair or Deceptive Practices	1

Overwhelmingly, these cases involve the assertion of malpractice or negligence, sometimes in combination with wrongful death. There were no criminal charges in this dataset.[45] This is not all that surprising. The most famous cases of women actually holding medical personnel or hospitals liable for obstetric violence–such as *Malatesta*[46] or *Skol*[47]–are civil suits as well. There are four criteria that must be met to prove negligence: (1) the doctor had a professional duty owed to the patient which (2) they breached, resulting in (3) injury as a result and (4) an account of the resulting damages that the courts can offer some remedy for (Bal 2009). The plaintiff–that is, the person claiming an injury–bears the burden of proof.

[45] There were some criminal cases in the cases coded NA, see Appendix C for a fuller explanation.

[46] Malatesta v. Brookwood Medical Center a/k/a Brookwood Women's Center; Tenet Healthcare Corporation (Jefferson County, Ala. August 2016).

[47] Catherine Skol v Dr. Scott Pierce 08L-13805 Tried Feb. 17-Mar. 1, 2012

Medical negligence and malpractice are a matter of civil law in the United States, and doctors have vigorously and strenuously argued against the criminal prosecution of doctors. To quote the American Medical Association's policy, "The AMA opposes the attempted criminalization of health care decision-making especially as represented by the current trend toward criminalization of malpractice; it interferes with appropriate decision making and is a disservice to the American public" (American Medical Association 2022). The American Bar Association agrees, noting "Because criminalizing human errors in healthcare does not correct or prevent these causes, it does not protect society and the patients who entrust their care to healthcare systems. In fact, it has the opposite long-term effect" (Dickinson 2022).

Still, there are circumstances in which medical negligence can be prosecuted as a crime. The fifth element that distinguishes such cases is the state of mind of the perpetrator, or "mens rea" (Bae 2019). If the medical provider had a depraved indifference to human life; did not respond in a timely manner; or recklessly endangered the patient, then they may have committed a criminal act. Opponents of criminally prosecuting doctors (see AMA 2022, Dickinson 2022) will often propose the Bad Apple Hypothesis, citing (as Bae 2019 does) lurid examples of opioid overprescription where a doctor met patients in the parking lot with briefcases of pills, or a surgeon so indifferent to the wellbeing of his patients that he earned the nickname "Doctor Death."[48] It seems to

[48] Season one of the Podcast series, hosted and reported by Laura Beil, follows the story of one Christopher Duntsch, who performed spinal cord surgeries while visibly intoxicated and did permanent

me though that the real problem is that everyone assumes doctors are acting in good faith. The system could not operate if we didn't. But in cases where this is clearly not true, there are no systems in place to remove bad faith actors. I address this further in Section 7 below.

I do not make a distinction between cases in which the pregnant patient, the fetus, or the infant died. Generally speaking, cases in which a pregnancy was not carried to term successfully and the fetus was stillborn or miscarried are not among the wrongful death suits in this set of cases.[49] These cases are a minority of the dataset, but a much more substantial minority than any other type of lawsuit.

I coded several cases as labor disputes. In these cases, the hospital that employs a nurse (in two cases) or doctor (in two cases) is either attempting to sever the employer-employee relationship or already has. In all of these cases, the employee asserts that they were wrongfully terminated. These cases appeared in my search because the underlying legal issue is that the employer of these medical personnel cite their handling of labor and

damage to 31 patients, killing a further 2. There are two more seasons following different doctors, and a TV series as well.

[49] In some states, fetuses are considered persons for the purpose of wrongful death. This seems to me to contradict precedent in torts–specifically, that damages are unrecoverable unless the fetus is born alive. Ever since Justice Blackmun listed all the ways in which fetuses are not people in *Roe v Wade* (1973), it has been the dearest wish of those attempting to overturn the precedent to count fetuses as people and bring wrongful death suits and have them counted in the census, and so forth. The past twenty years or so have seen many successes in this slowly creeping agenda (Fox 2014). Indeed, in the recent Alabama case *LePage v. Center for Reproductive Medicine, P.C. (2024)*, two couples whose embryos were accidentally destroyed successfully sued the clinic for wrongful death for a fertilized but unimplanted fetus. Words fail me about how absolutely insane it is to consider a cluster of cells to be a child, but this is the world we live in after *Roe*.

delivery as the reason for their termination or contract non-renewal. For some, it had to do with a pattern of behavior; for others, one specific incident.

Generally, malpractice or negligence claims are not brought in federal court, with a few exceptions. Several pregnant people, for example, accused a hospital at which they gave birth of violating the Emergency Medical Treatment and Labor Act (EMTALA). While state courts do have jurisdiction over federal laws like EMTALA, plaintiffs often choose to file in federal court first. Inmates in federal prisons also often assert that their constitutional rights are violated when they are denied access to medical treatment, instead of filing malpractice claims in state courts.[50] Other federal cases in the dataset involve incidents that happen on army bases or military hospitals. While the underlying issue in these cases is malpractice or negligence, the suit itself is a dispute about whether or not the pregnant person or the child is eligible for medical coverage. I coded these cases both as medical malpractice, insurance disputes, and constitutional rights violations in the dataset.

One case involved a lawsuit for wrongful life.[51] In it, there was significant evidence early in the pregnancy that the fetus was not developing normally. Not only did the doctor not inform the pregnant patient of these abnormalities, but he also refused to contemplate referring the patient for an abortion. The doctor testified that he would never

[50] The majority of these cases are explored in Appendix C because they do not involve medical staff. However, some are included in this dataset.
[51] *Ermoian v. Desert Hospital,* 152 Cal. App. 4th 475 (2007)

recommend anyone with a viable fetus for an abortion, because it would be immoral. The patient was seeking compensation for the crushing financial burden of a profoundly disabled child thirteen years later. The fact that nurses and doctors simply lied to the patient throughout her pregnancy led me to code the case as obstetric violence. The judgment in my dataset affirmed a lower court's finding in favor of the defendants.

There was only one case that involved the intentional infliction of emotional distress without an underlying malpractice suit.[52] In it, the hospital cared for the pregnant patient but the emergency room nurse failed to locate and remove the intact fetus inside her clothing. The patient discovered the fetus still in the amniotic sac at home later, when she began to wash her clothing. I coded the case "yes" because the couple asserts that the medical staff was totally unresponsive and "rude" over multiple phone calls about what to do with the fetal remains. The court dismissed the case–or rather, upheld the granting of summary judgment from a lower court.

One unique case involved a lawsuit alleging unfair or deceptive practices, and was later amended to add a charge of fraud.[53] Essentially the plaintiffs are suing the author of an academic article and Elsiver, the publisher, for publishing a study that is commonly cited and taught but which relies on fraudulent data. The study represents itself as a case study of a doctor that did not use traction during the delivery of the baby and in which the

[52] *Roddy v. Tanner Medical Center, Inc.*, 262 Ga. App. 202, 585 S.E.2d 175 (2003)
[53] *Gorbey ex rel. Maddox v. American Journal of Obstetrics & Gynecology,* 849 F. Supp. 2d 162 United States District Court for the District of Massachusetts (2012)

baby did not experience shoulder dystocia (ie, the baby's shoulder getting caught or stuck on the pregnant patient's hip bone) *but* in which the baby still suffered an injury to the brachial plexus (a nerve bundle that controls motor function in the arm[54]). It is often cited in cases of malpractice as evidence that such an injury could arise without traction or dystocia. The plaintiffs allege that the author did not actually read the case notes for his study and that he had harmed a lot of people by setting back medical training standards and helping protect doctors from malpractice suits. The court is not persuaded that they have a case; the suit is dismissed and the request to add "fraud" to the lawsuit is denied. It certainly *feels* like the doctors publishing an (allegedly) fraudulent article are contributing toward violence in the birthing process, but I ultimately coded it as not obstetric violence.

The underlying cause of action is different from the legal question that the court is being asked to answer in any given filing. For example, defendants are given the opportunity to challenge expert testimony or present conflicting testimony. The Daubert rule[55] which gives the court guidelines about what kind of expert or scientific testimony is permissible, is frequently mentioned in motions generated by malpractice suits.

Another common ruling sought is about the timeliness of suits. States have different rules about how long after adverse medical events the victim has to file suit, which are

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[54] Fun fact: Kaiser Wilhelm probably had a brachial plexus injury which led to his notably shorter, weaker left arm and lifelong problems with balance. The way that this was treated in the nineteenth century medicine was *not fun* and I do not recommend any readers looking up the details. Suffice it to say, I'm so glad modern medicine has advanced beyond covering a child in freshly dead animal to hope that their "essence" makes a child strong.

[55] *Daubert v. Merrell Dow Pharmaceuticals, Inc.*, 509 U.S. 579 (1993)

also separate from the time limits for federal suits. In one case[56], the plaintiff was born in February 2005, but the injury or the liability of the clinic was not discovered until December 2005, when plaintiff was advised to seek additional diagnosis for what was likely a birth injury. Though the case may have had merit, the suit was not filed until April of 2008. This was outside the two year time limit set out by the Federal Tort Claims Act (FTCA). The appeal was dismissed on this basis.

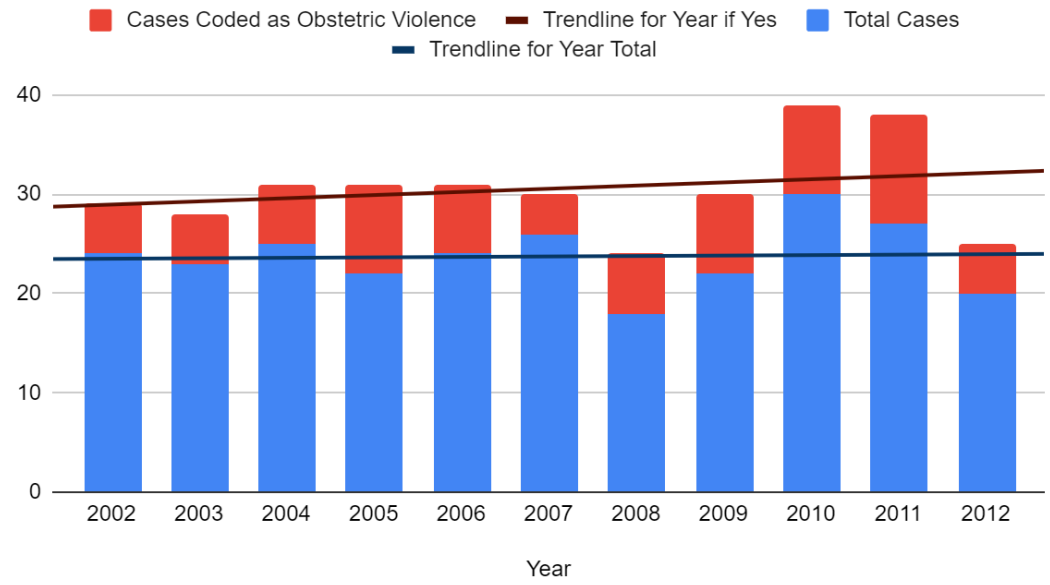
A subset of the malpractice claims originating in Florida[57] is almost entirely made up of cases about whether or not a particular patient injured at birth is eligible to receive compensation from the Birth-Related Neurological Injury Association (NICA). The question in these cases is slightly different. Generally, the fact that an injury occurred at birth is not in question. Rather than pay enormous premiums for obstetric insurance (see Morris 2013), Florida experimented with a novel risk pool modeled after the National Vaccine Injury Compensation Program. There is no finding of fault associated with the acceptance that an injury occurred, and the patient is compensated if they are eligible. In practice, doctors and hospitals sue patients to prevent them from accessing this compensation frequently enough that they appear in this project.

[56] *A.Q.C. ex rel. Castillo v. United States,* 656 F.3d 135 United States Court of Appeals for the Second Circuit (2011)
[57] And one from a similar plan in Virginia.

3. Distribution over time

The only thing especially notable about the distribution of cases over time is that it remains fairly even. Over the ten year period of this study, there is no massive upswing in cases of pregnant people appearing in federal and state courts. Figure 1 shows the distribution of all cases coded for obstetric violence over the study period, with cases coded "yes" in red. The blue section of the stacked chart represents the cases included in the study but coded "no," so that the bars represent all the cases in the dataset from that particular year. The dark blue trend line represents the average number of cases in a year, and the dark red trend line represents the average number of cases coded yes. There is a

Figure 1: Cases of Obstetric Violence as a Proportion All Cases



very slight upward trend in the number of cases of obstetric violence compared to the total cases which is statistically significant, but not substantively robust.

One notable feature of this dataset is how long it takes to settle these cases–or even to file them. On average, the length of time from the birth or other events to the present case is approximately 5 years. The longest lag time in the dataset involves a child that was born in *1982* for a case resolved in *2006*.[58] Some of the original doctors were dead by the time the patient filed suit in 2003, and a large chunk of this case revolves around whether or not the statute of limitations should apply from the date of injury or the date of discovery. The patient gave birth in Chicago but lived in Texas, and only requested medical records of her son's birth to help with his case for medical accommodations in the Texas university system. If she hadn't, she would never have known that her son was stillborn and required resuscitation.

While our study periods only partially overlap and the phenomena under study are not the same, it is noteworthy that Paltrow and Flavin (2013) found that there were very few cases before 1989 (five or fewer a year on average), a massive spike in the early 1990s (an average of 40 a year between 1989 and 1991), followed by a steady case load in the later years of the study (about 20 a year on average between 1992 and 2005). This is consistent with my findings in terms of the temporal distribution of cases.

[58] *Cangemi v. Advocate South Suburban Hospital*, 364 Ill. App. 3d 446 (2006)

III. Themes

1. Informed consent

The standard practice of medicine in the United States requires that patients consent to treatment, with a few notable exceptions. In order to consent, patients must understand their treatment options fully (ie, they must be informed) and they must be free from coercion (ie, consent must be voluntary). In Chapter 1, I explained in depth the standards of consent published by the American College of Obstetricians and Gynecologists (ACOG). The patient is the pregnant person, not the fetus, according to ACOG, and any coercion to gain consent for treatment that the patient has declined is *never* acceptable (ACOG 2016).

There were many, many cases in which doctors did not meet the standard of voluntary and informed consent. Doctors in these cases often withheld or failed to disclose extremely crucial information from patients.

In some cases, this took the form of a failure to communicate. In *Harvest v. Craig,*[59] the doctors monitoring the case did not communicate either with each other or with the patient. Ms. Harvest was experiencing pain severe enough to present at the emergency room in Arizona, though her regular obstetric care was in Las Vegas, Nevada. The ER doctor diagnosed her bleeding as the beginning of labor, sometimes known as a "bloody

[59] *Harvest v. Craig,* 202 Ariz. 529, 48 P.3d 479 (2002)

show" because the expulsion of the mucus plug from the cervix is theatrical. He consulted on the phone with her regular physician, who was more aware of the patient's history and noted that there was a risk for a serious complication known as placental abruption. The ER doctor didn't note this or communicate with the patient. Neither did her regular obstetrician, who just told Ms. Harvest to come in. Because of his misdiagnosis and the failure to communicate with the patient, the ER doctor allowed her to be discharged and attempt to drive to the hospital across state lines to be seen by her regular physician. Somewhere in transit, the fetus died.

This case also highlights that patients are not experts, and have no idea what symptoms, risk factors, or information is relevant. The power of knowledge and responsibility for communication disproportionately rest on medical staff. Ms. Harvest was aware of her long history of risk factors that might have changed the ER doctor's decision. She failed to communicate any of them, from her history of substance use during pregnancy to her history of previous early labors and prior abortions.

In other cases, doctors and medical staff deliberately withheld very critical information. When she delivered, Ms. Smalling was told that her daughter died within minutes of her birth.[60] Ms. Smalling later discovered evidence in her medical records that her daughter in fact survived for several *hours* during which she was concealed from Ms. Smalling. Ms. Smalling was deeply distressed at the thought of her daughter dying alone

[60] *Smalling v. Gardner*, 203 S.W.3d 354 Texas Courts of Appeals (2005)

without having had the chance to hold her. The doctor who delivered the baby thought it was probably best, since the child was not compatible with life, to save Ms. Smalling from the distress of watching her die. There is a kind of misguided nobility in this case. The heroic doctor and medical staff take on the burden of caring for a dying patient. They take the pain of knowledge–a pain with which anyone with a career in medicine knows intimately. Ms. Smalling claims that this violated her right to informed consent for the treatment of her child. Though the court dismissed the case (because it was not filed in a timely fashion), it is hard to argue that Ms. Smalling is wrong about that. Her doctor lied to her because he thought it was best, and violated her rights.

Examples of situations where doctors simply omit critical information abound. In *Gingerich v. Kline*[61] the doctor not only failed to inform the plaintiffs that a vaginal birth after C-section (VBAC) had a higher risk to the patient of uterine rupture, but also failed to inform them of his own personal history of having more than one other patient whose uterus ruptured. In *McQuitty v. Spangler*[62], the doctor correctly diagnosed that a partial placental abruption[63] had occurred, but didn't inform the patient of the risk of placental abruption worsening when he scheduled her for a C-section 39 days later. The case in my dataset is actually about whether or not a doctor in the state of Maryland can be found to

[61] *Gingerich v. Kline*, 75 S.W.3d 776 Missouri Court of Appeals (2002)
[62] *McQuitty v. Spangler*, 410 Md. 1, 976 A.2d 1020 (2009)
[63] Premature separation of the placenta from the uterine wall. This can be fatal to the fetus or the pregnant person as the fetus' oxygen supply is cut off, or as in this case, cause severe birth defects.

have violated a patient's consent in the absence of physical injury or battery. Thankfully, the answer in this case was yes.

In *Arrabal v. Crew-Taylor*[64], the patient alleges that not only should the doctor have known to immediately deliver the triplets upon diagnosing fetal distress, but also, the patient and her partner should have been informed about the fetal distress immediately. A whole host of interventions to save the third baby were undertaken without actually telling the patient why, or what risk waiting posed to her or the other two triplets. Lest this be misconstrued as heat of the moment mistakes, it took the doctor two *days* to order a C-section after the patient was admitted. It is very possible that this met the standard of care, and that the doctor made the correct decision. The patient presented earlier than full term, and delivering multiple pregnancies before term is much riskier. The point though, is that the doctor and medical staff at no point told the patient any of this information.

Where patients are unaware of their medical information–either through lack of clear communication or through active concealment–they cannot consent to medical procedures. It is a very clear violation of the ethical standards of medical care *not* to ensure that the patient understands what their condition is, what it means, and what their care options are.

[64] *Arrabal v. Crew-Taylor,* 159 Md. App. 668, 862 A.2d 431 (2004)

2. Hospitals control all the records

The Health Insurance Portability and Accountability Act (HIPAA) was passed in 1996. It governs the privacy and security of patient records, among other things. It gives very detailed rules about who may access patient information, how records must be maintained and secured, and what information is considered to be private (United States Department of Health and Human Services 2024). The legislation was supposed to empower patients to control their personal health information. In an insurance regime where any pre-existing conditions from the moment of birth might bar an individual from ever being able to purchase private health insurance (see Morris 2013), patient control over private information is particularly important.

In practice, however, I found that HIPAA was often cited to deny patients access to their own medical records. Specifically, the fact that the hospital produced and owned the records, and was obligated to protect the records was used to deny patients access to their own records. This prevented patients from understanding the extent of any injury or medical malpractice that may have occurred. It also makes it very difficult to demonstrate those injuries in court.

For example, in *Cardenas v Jerath,*[65] Cynthia Cardenas attempted to obtain her own medical records and that of her daughter Isabelle when a birth-related neurological injury was diagnosed near Isabelle's second birthday. The only investigative report that the

[65] *Cardenas v. Jerath,*180 P.3d 415 Colorado Supreme Court (2008)

hospital claims to exist (contrary to their own policy) is that of their attorney. The case revolves around whether or not the hospital's attorney notes are discoverable–that is, whether or not they can be entered into evidence for the trial. In this particular case, the hospital spent years claiming that no medical investigative report existed, and that they had turned over all the patient's medical records. Their legal claim was that Cardenas, the patient, had been attempting to discover records that "simply do not exist." Cynthia was required by the courts to disclose all her medical records for her own medical treatment five years prior to Isabelle's birth and all of Isabelle's medical records to the hospital by the court, but had to execute individual waivers of her doctor-patient privilege as required by HIPAA for each visit by date and including the names of all the doctors involved to obtain her records from the hospital. Each attempt to obtain factual records by Cardenas spiraled into a tedious bureaucratic process to deny that such records existed or that Cardenas should have access to them; it took about two years to obtain the documents before the suit could proceed.

The disclosure of patients can be a double-edged sword. Hospitals are incredibly prepared to use evidence that a patient is suffering from mental illness to claim that the patient is not a reliable witness, even if the mental illness has nothing to do with their suit. For example, the doctors in the case *Harvest v Craig*[66] described above entered medical records of the patient's psychiatric diagnoses to support his assertion that the

[66] *Harvest v. Craig*, 202 Ariz. 529, 48 P.3d 479 (2002)

patient was incoherent. The actual case that was returned in my data set was a motion by the patient to exclude her medical records from years ago at a different healthcare facility as irrelevant. It took eight years for the courts to churn through all the objections and processes in that case–including the patient obtaining medical records from the hospital in the first place.

Birth produces–or is supposed to produce–a wide variety of medical records. Many hospitals have a very, very long-term record retention policy for records of labor and delivery in particular. These records range from fetal heart rate monitoring tapes, to the pre-operative conditions reports of C-sections, to regular reports about the progress of labor. In several of these cases, the records simply don't exist. The reasons given by the hospital vary. In some cases, such as *Gotto v. Eusebe-Carter*[67], the technology was faulty; the hospital policy was to retain fetal heart rate monitoring strips on CD-ROM, but the transfer of those records to CD was discovered to have not worked in a huge swath of their records, and so they could not produce the disputed record for the court. In others, such as *Bustos v Lenox Hill Hospital*[68], the hospital used HIPAA and privilege rules to argue that the patient was not entitled to access records that the hospital claimed were not relevant, such as the physical layout of the birthing suite.

[67] *Gotto v. Eusebe-Carter,* 69 A.D.3d 566, 892 N.Y.S.2d 191 (2010)
[68] *Bustos v. Lenox Hill Hospital,* 29 A.D.3d 424,816 N.Y.S.2d 24 (2006)

Hospitals are also typically responsible for administrative investigations of medical malpractice. As Elizabeth Anderson (2017) notes, agencies responsible for monitoring compliance with federal law generally have the power to approve policies and procedures that private corporations say they will follow. Once those policies and procedures are approved, courts are reluctant to review whether or not those policies and procedures are actually likely to work for their stated aims, only whether or not they were followed. Anderson (2017) argues that this essentially turns every corporation with a Diversity, Equity, and Inclusion policy into the arbiter of justice for people who enter into its fiefdom.

In the context of hospitals, this "private government" (Anderson 2017) takes many forms. If a nurse or doctor whose malpractice insurance is purchased through the hospital deviates from the standards of care that the hospital has adopted, she can be sued individually. Nurses and doctors who make mistakes or suffer too many adverse patient outcomes are shuffled out the door in order to protect the hospital from further liability. This is most visible in my dataset in the labor dispute cases. For example, in *Williams v. Woodhull Medical & Mental Health Center*[69], the doctor was first reassigned, then never added back to the labor and delivery schedule, then had her contract terminated after a labor that resulted in uterine rupture when the patient repeatedly declined a C-section.

[69] *Williams v. Woodhull Medical & Mental Health Center*, 891 F. Supp. 2d 301 United States District Court for the Eastern District of New York (2012)

The doctor claims that these actions were retaliatory and violated her civil rights under New York law.[70]

Finally, sometimes medical records are incomplete–either deliberately or incidentally. Patients are often not in a position to directly witness their care. They have only their medical records to tell them what happened if they fell asleep or were anesthetized and their medical care team either cannot or will not disclose what happened. During labor and delivery specifically, if an epidural is administered, patients often are not aware of injuries that occur because they cannot feel what is happening to them. In *Rosales-Rosario v. Brookdale University Hospital & Medical Center*[71], for example, the patient was heavily sedated and was administered an epidural. She suffered a burn injury at some point during her labor and delivery, though she has no memory of when due to the sedation and the epidural. The hospital does not dispute this fact, but claimed that the proposed theory of how the patient was burned could not have been true. Since the patient's proposed theory could not have been true, the hospital claims that they cannot be liable for her injury. The patient proposed that, during a vaginal examination, the surgical lamp was pulled too close to her right thigh and left there for too long. The

[70] I had to read this particular case several times, because it was complicated. The document I cite here was really messy; the doctor initially filed her lawsuit pro se, which means that she represented herself. She resisted when the court assigned her an attorney, but when she hired her own attorney a lot of the original claims were amended. Let this be a lesson to the reader, just because you are an expert at one thing doesn't mean you are an expert at everything. Also, a lawyer who represents himself has a fool for a client.

[71] *Rosales-Rosario v. Brookdale University Hospital & Medical Center,* 1 A.D.2d 496, 767 N.Y.S.2d 122 (2003)

medical record is incomplete on whether or not the surgical lamp was used, probably because such a level of detail is not normally relevant.

In all of these cases, whether the hospital intended to derail the lawsuit deliberately or not, one thing is the same: the hospital was in total control of virtually all of the pertinent records, or even telling the patient (or other plaintiffs) what records existed. In some cases, they used laws like HIPAA to deny patients access to their own records or used the courts to access damaging medical records themselves. In some cases, they claimed records didn't exist or weren't discoverable. In all cases, there was an enormous power imbalance in terms of access to information.

3. Medical Professionals Don't Always Listen to Patients, or Act in Good Faith

The problem of communicating symptoms in a medical context is acute. Patients are not doctors. They do not know how to describe their pain. They often leave out extremely pertinent information about risk factors. Not to mention, labor and delivery are a "bloody show." Doctors are familiar with the various gobs and horrors that the body endures to give birth. Patients often are not, and their emotional reactions are sometimes unpredictable. It can be very hard to diagnose a patient under these circumstances.[72]

[72] I am reminded of one particular case review exercise for young midwives that I watched for an ethnography project. They read the facts of the very real case and make differential diagnoses, then are fed another chunk of case history. Several of these cases stick out in my mind, but the one that haunts me is a case in which the fetus was far, far too small to be the age reported by the pregnant patient. The ultrasound technician merely corrected the gestational age to match the fetus's size, and no one followed up on why there was such a stark mismatch. The patient in reality suffered a miscarriage that turned septic, and she did

Consider *Lawson v United States.*[73] The patient, Lawson, had a birth defect known as the chiari malformation, in which part of her brain protruded from the base of her skull. She lived a normal, healthy life and gave birth to one child in a fairly normal pregnancy. She complained of very intense headaches and vertigo during her second pregnancy, and was no longer able to perform household tasks unassisted. Indeed, she could no longer lie flat or stand still without experiencing extreme vertigo. She wasn't actually diagnosed with the chiari malformation until after the (healthy, normal) delivery of her second child, when a doctor prescribed her physical therapy for a diagnosed compression of the nerve controlling her left leg. It's difficult to imagine how doctors could have diagnosed the patient with an issue she was unaware of herself; indeed, I coded this case as not obstetric violence. It is noteworthy though that all her medical providers did not take her extreme symptoms during her second pregnancy especially seriously even though she has a documented history of extreme headaches of about 20 years. It was only after her pregnancy when the symptoms persisted (for *years*) that deeper investigations began.

What I found in cases of obstetric violence goes beyond a mere failure to communicate. Doctors and nurses in these cases ignored patients' pain. They refused to perform examinations. The became exasperated when women complained of troubling

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not survive. The lesson was supposed to be that you should always take patient information seriously, and ask questions when it doesn't make sense.

[73] *Lawson v. United States,* 454 F. Supp. 2d 373 United States District Court for the District of Maryland (2006)

symptoms, and failed to monitor patients at high risk for complications. More than once, they sent a pregnant person home alone, with dire results.

Demanding to be seen and examined often resulted in being pointedly ignored, or told to calm down. When Latarsha Creekmore's partner[74] demanded at about midnight that a nurse take her blood pressure and measure her urine output–symptoms he had been instructed to watch for after a C-section to treat her preeclampsia–the nurse noted that the patient was "resting comfortably" and did not respond to his calls again until 2 AM. The nurse administered fluids to raise her rapidly dropping blood pressure, but declined to examine the patient further. By 3:30 AM, Latarsha had lost approximately half her blood volume and suffered a massive, entirely preventable stroke. The court's record notes that as soon as medical staff lifted the patient to take her to a surgical suite (without answering her partner's questions), they could all see "a significant amount of blood on her sheets and gown."

Many of these cases in particular revolve around a failure to take action promptly. The facts in *Phelps v. Physicians Insurance Co.*[75] are specifically noted as "not in dispute." A jury had already found the physician negligent; this case was brought to determine whose insurance was liable. The pregnant woman, Mrs. Phelps, awoke in the early morning after being hospitalized for a high-risk twin pregnancy that doctors already

[74] *Creekmore v. Maryview Hospital*, 662 F.3d 686 United States Court of Appeals for the Fourth Circuit (2011)
[75] *Phelps v. Physicians Insurance Co.*, 282 Wis. 2d 69, 698 N.W.2d 643, 2005 WI 85 (2005)

determined would be delivered via C-section. When she awoke in constant pain, it took the on-call physician about an hour to arrive. It took a further hour and a half to rule out several possible diagnoses–not unreasonable, given that both twins had normal heart rates. Then the doctor on call, a first-year resident, said he would consult the senior resident. He never did, and he cannot account for his whereabouts for two and a half hours. He only re-entered the medical record when the patient asked for help to the bathroom, feeling the urge to defecate, only to feel "toes extending from her." The twin that the resident had already diagnosed as possibly experiencing placental abruption[76] was unable to be revived.

The other side of this coin is that patients sometimes do not understand how *urgent* a situation is. Even in cases where doctors are complying with patient wishes, they can be held legally liable for poor outcomes. They are the experts. It is apparently up to them to convince adamantly reluctant patients to consent to treatment. Consider *First National Bank v. Glen Oaks Hospital & Medical Center.*[77] The plaintiffs wanted a totally natural birth with no medication or external monitoring. The doctor attempted to comply, using nipple stimulation instead of pitocin to induce contractions, though he insisted on a fetal heart rate monitor. Labor took days. By the time she was ready to deliver, the baby had

[76] Basically and non-technically, the placenta separates from the wall of the uterus too soon, and may get kinked like a hose or block the cervix, preventing birth. A fetus experiencing abruption may suffocate to death from its own weight. It is rare, but extremely serious. Generally, if the suspected abruption is bad enough, immediate preparations to remove the fetus surgically ensue.

[77] *First National Bank v. Glen Oaks Hospital & Medical Center*, 357 Ill. App. 3d 828 (2005)

his hand in his face and umbilical cord partially wrapped around his shoulder. An episiotomy and forceps were required to deliver. The jury did not find the doctor to be liable, but they did find the hospital to be negligent.

It is true that medical staff are the experts. It is true that they see a lot of very urgent cases. It is also consistently true in these cases that they just don't believe patient reports of pain–at least, not enough to act on them. Medical training and practice requires the patient to shed the self and become a "technical object" to be acted upon (Emerson 2011). The danger of constructing a patient as only worthy of care when they are compliant or passive receivers of care is that their symptoms may be ignored until it is too late.

4. Injuries Are Not Always Obvious, and Discovery Takes a Long Time

The problem with the body, from the perspective of the law, is that it actively works against the preservation of evidence. Often, as in the case of a stroke, the evidence that something terrible has occurred can still be observed. The patient cannot speak clearly, or walk unaided. However, once the blood clot has dissolved, the blood volume has refilled, the liver has processed medication, the uterus contracts and resumes its normal, unassuming and slender profile in the abdomen,[78] the source of the original medical problem cannot be traced.

[78] My oncologist used the phrase "a hot mess" to describe a pregnant uterus when we were discussing long-term care options post cancer.

Take *Huss v. Gayden.*[79] The doctor prescribed a medication off-label to delay the onset of labor. An "off label" prescription means that the medication is being used for something it is not approved to treat, or in any way that is not indicated in the labeling such as dosage or for different medical conditions.[80] The patient in question had a lot of risk factors, including continuing to smoke while pregnant, that would normally have prevented the prescription. No edema or swelling around her heart or irregular heartbeat was recorded before she developed preeclampsia. Subsequent to the prescription, she developed congestive heart failure. Was the medication what caused the damage to her heart, or her smoking? Any tests that might have determined the answer to that question, however dubious their results even under the best of circumstances, could not be performed until it was too late for them to yield conclusive results. In the end, the court decided to grant the plaintiffs a new trial because the trial court had excluded evidence that she had not been given information sufficient to meet the standards of informed consent; she had not understood the risks of her medication when she began to take it.

In *Crawford v Sorkin*[81] the issue is similar. The pregnant patient was walking steadily after her C-section, but complained of pain in her hip. In this case however, the doctors immediately took her pain seriously. They performed four tests documented in the court

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[79] *Huss v. Gayden,* 571 F.3d 442 United States Court of Appeals for the Fifth Circuit (2009)

[80] This is actually how activists in Brazil identified misoprostol as an effective and safe abortifacient; the contraindication label warning pregnant patients against taking it led activists to buy the cheap, safe, widely available drug that could be purchased over the counter and use it to induce wanted abortions (Brooke 1993).

[81] *Crawford v. Sorkin*, 41 A.D.3d 278, 839 N.Y.S.2d 40 (2007)

record, including one that indicated a low magnesium content in her blood that would explain bad reflexes and difficulty walking–symptoms that were alleviated with treatment. The issue didn't clear up after she left the hospital, though. It got worse. The patient alleges she has femoral nerve damage–which the court notes would be a very rare complication of a surgery like a C-section. Because the patient cannot document that the injury existed while she was under care in the hospital or account for how the injury occurred–she thinks it was while she was anesthetized for surgery–the court does not allow her to renew her suit.

In many of these cases, the problem is greater than the simple miracle of healing. It can be extremely difficult to diagnose neurological injuries to babies when they are born. Sometimes, in dramatic births where resuscitation or intubation are required, it is easy to establish that neurological injury is likely the result of the circumstances of birth. In other instances, the infant may seem to have suffered few if any ill effects from the excitement until much later, when they begin to miss developmental milestones. The underlying issue in a lot of these cases is that the statute of limitations for a lawsuit expired years previously. The plaintiff must establish special circumstances–often, an argument that the statute of limitations clock should begin at the discovery of the injury, not the date of the injury.

Sometimes, medical personnel are clearly aware that there is a potential injury. They may not disclose their knowledge directly to the patient, but they make comments like

"get that arm checked out."[82] When questioned directly though by the pregnant patient Stapleton, no one at the hospital would explain what was wrong with the infants' arm, or even acknowledge that it was hanging limply. The doctor, meanwhile, had noted that the infant suffered a shoulder dystocia and brachial plexus injury in the medical records.[83]

As noted in Chapter 1, I'm not primarily interested in injuries to fetuses or infants. The majority of these cases revolve around injuries to the fetus or infant, not the pregnant person. Even if these cases involve negligence, it isn't necessarily true that they met my criteria to be labeled as obstetric violence. What characterized the cases that I did code as obstetric violence was concealment, and dishonesty. Patients are not told about medical procedures, such as resuscitation. Their questions are not answered. Years later, they discover that the evidence of the infant's injuries was there the whole time.

In *Azizi* [84], the plaintiff alleges that she did not suspect that anything was wrong with her daughter until just after her first birthday. She began to exhibit cognitive delays at around this time–or at least, this is when the child's family first *noticed*. The plaintiffs show that they "... requested [their daughter] Izabelle's medical records from MacDill AFB Hospital shortly after Izabelle's first birthday in August 1991, and annually thereafter, but that Izabelle's records were not provided until an attorney requested the

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[82] *Stapleton v. Moore*, 403 Ill. App. 3d 147 (2010)

[83] The case before the court is actually about whether or not the now believed to be falsified journal article mentioned in Section II, part 2 above to explain the single lawsuit for "Unfair or Deceptive Practices" should have been admitted as evidence.

[84] *Azizi ex rel. Azizi v. United States*, 338 F. Supp. 2d 1057 United States District Court for the District of Nebraska (2004)

records sometime after April 1998…. The government has not controverted that assertion." The first part of the United States's argument that this case should be dismissed was that it had dramatically exceeded the statute of limitations on malpractice suits. Indeed, by the time this particular set of issues was decided, the child was *fourteen years old*. The plaintiffs were not able to review her medical records until she was already eight years old, when they discovered that the doctors at the MacDill Airforce Base Hospital suspected she had suffered placenta previa, but had not offered additional treatment or information.

In a case that was ultimately dismissed, the plaintiffs in *Plaza v. New York Health & Hospitals Corp.*[85] filed a late claim "without leave of the court." That is, they did not seek the permission of the court to waive the time limit on filing, which is normally quite short in administrative law.[86] They had not become aware of the injury at birth until two years later. The case was dismissed in part because the infant was recorded as doing well both after resuscitation and in the Neonatal Intensive Care Unit (NICU), so the parents were not notified that the child had ever stopped breathing. When the child later developed neurological difficulties, the 90-day limit had long since expired.

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[85] *Plaza v. New York Health & Hospitals Corp.*, 97 A.D.3d 466, 949 N.Y.S.2d 25 (2012)

[86] The reader may require a more precise answer than "quite short." In the cases that adjudicated particular issues or appeals in my dataset, the time limit is often between 30 and 90 days. It is impossible to summarize here the ways in which different states with different plans have set this time limit. States that have adopted a plan like Florida's Birth-Related Neurological Injury Compensation Association (NICA) have wildly different standards of proof and filing deadlines than states like New York, which has so many malpractice cases that the pipeline is well greased and unlikely to grant exceptions.

Patients often have no thoughts of questioning their medical doctors, because they assume they would at least be notified if something terrible had occurred. The kinds of neurological injuries common at birth due to lack of oxygen or shoulder dystocia are a ticking time bomb. Many of the pregnant patients only found out much, much too late that their child or they themselves had suffered an injury during labor and delivery. Combined with the point that hospitals control all the records and information–and sometimes, are extremely poor stewards of those records–it's easy to see why so few suits are filed, so late after birth.

5. Heroic medicine

There is an idea that doctors must exhaust every treatment option. That if a doctor does not act quickly or drastically enough or is unwilling to perform surgery, then they are somehow failing in their duty of care. The roots of this idea lay in the primordial origins of the profession. In the 18th and 19th centuries, at a time when surgery was a desperate last resort only worth the risk in a dire minority of cases (Fitzharris 2017). Doctors who push the boundaries of technology and medicine to prolong life are still treated as heroic. This is in spite of the fact that in repeated surveys of medical doctors over the past 30 years, many say they would not choose aggressive resuscitation or cancer treatment for themselves (For a summary of current academic research attached to a longer journalistic article, see Span 2023). This has even extended into the growing field of fetal surgery (Casper 2017).

Patients feel like doctors should go to heroic lengths. More than one case in my data stems from a feeling that doctors did not offer a C-section quickly enough. Or, as in *Madrigal v Mendoza*[87], the plaintiff claims that the doctor deviated from the standard of care by allowing a trial of labor when there was every indication that the fetus had grown too large to be born vaginally. The case was dismissed because the expert witness for the plaintiff did not meet the federal rules of evidence, and there was no other evidence that the doctor had deviated from the standard of care.

It isn't only patients that feel doctors should intervene aggressively. Doctors too feel that they should not stop until all avenues for care have been exhausted–sometimes, against the express wish of their patients. It is clear from the repeated use of words such as "extraordinary" when listing the plaintiffs claims in *DeJesus v. Mishra*[88] that the author of the opinion does not find the lawsuit to be credible. A great deal of time is spent laying out which facts are not in dispute–such as the fetus was alive, with a heartbeat when the plaintiff arrived at the hospital–and those which are in dispute–such as the exact timing of the discovery that the fetus was in distress. The doctor, Mishra, ordered a C-section to be performed against the express wish of the patient, who felt that there was nothing to be done for a fetus that had no heartbeat and did not want to endure the risk associated with surgery. The court finds the idea that a C-section is risky to be beside the

[87] *Madrigal v. Mendoza,* 639 F. Supp. 2d 1026 United States District Court for the District of Arizona (2009)
[88] *De Jesus v. Mishra,* 93 A.D.3d 135, 939 N.Y.S.2d 403 (2012)

point, and seems to justify any intervention with the chance of saving a fetus–though not one *without* any chance of saving a fetus–whether the pregnant patient consents or not.[89]

Doctors and hospitals are stuck between a rock and a hard place though. Recall *First National Bank v. Glen Oaks Hospital & Medical Center*.[90] The doctor in question was not found liable for following the patient's wishes for a totally natural birth, without intervention, but the hospital *was* found liable for a failure to meet the standard of care. Because the standard of care is this kind of heroic interventionism, doctors who don't meet it risk penalties.

In some cases where doctors lack urgency, it is clear *why* the standard is extreme interventionism. *Morin v. Eastern Maine Medical Center* is the kind of case that was rare before *Roe v. Wade* was overturned. The plaintiff accuses the hospital of violating EMTALA. The patient was sixteen weeks pregnant and experiencing contractions when she arrived in the emergency room. The doctor noted that there was no fetal heart rate, and that the pregnancy was no longer viable. The patient's husband became agitated when she was discharged, asking what to do if his wife miscarried at home. The physician declined to make any referral or treatment plan aside from "tylenol 3" since the patient appeared to be in stable condition. She delivered the dead fetus alone at home about nine

[89] Recently, in response to state level abortion bans, miscarriage management of any kind has essentially become illegal in states like Louisiana. A recent report found that C-sections are being performed to prevent the appearance of an abortion being performed. The author of the report found this to be "ludicrous, absolutely ludicrous" because of the risk of complications to future pregnancies and the risk of the surgery itself (Westwood 2024).

[90] *First National Bank v. Glen Oaks Hospital & Medical Center*, 357 Ill. App. 3d 828 (2005)

hours later. While the facts of the case are heartbreaking, there really was not much else the doctors could do and they were correct that the patient was at no immediate risk. She presented at the Emergency Room on Saturday morning, and had a follow up appointment first thing Monday morning.

The expectation that doctors will intervene at all costs underpins many of these cases. This is not a reasonable social standard, but it is one tied to medical practice from the earliest days of the modern sense of the profession. In these cases, the judgment of the medical doctors is called into question over and over again, whether they respect patient consent, or not; whether they act decisively and swiftly, or not. The result of an inhuman standard of action and judgment is that doctors are more inclined to be very interventionist.

6. Liability is Complicated

In these cases, it is alarming how often the *facts* are not in dispute, but the liability is. In one example, the hospital appears to have been sold *multiple times* over the course of the lawsuit, and the original entity no longer exists.[91] The hospital argues that this should mean that no one is liable, even though the same doctors are still practicing in the same physical location doing the same work as when the plaintiff was injured.

[91] *Craig v. Oakwood Hospital,* 471 Mich. 67 (2004)

Often, even if the facts of a case are not disputed, whose insurance should pay is. For example, when Mrs. Vargas-Colon[92] asked to be seen for pain by her obstetrician, he performed a very minimal examination. He sent her home with a drug to delay the onset of labor–though it is not clear from the record whether the patient knew what it was. When she came back very early the next day, the doctor sent her to the hospital for immediate delivery. The physicians at the hospital noted "... the baby clearly had an infectious process in the uterus when Mrs. Vargas visited the offices of [her obstetrician], the day prior to the admission at Hospital Damas." The question in the case is not, however, whether or not negligence occurred. It is whether the hospital should share liability with the doctor's office.

The two cases I have cited directly here don't stand out in terms of duration from the other cases. Still, *years* after the fact that a jury found the medical staff to be negligent or to have committed malpractice, the patients have not received the awarded damages. This is certainly not unique to medical malpractice cases; many civil suits are settled rather than endure the litigation of each appeal or objection. Many of the families in this data set are suing because they have a profoundly disabled child that requires expensive care. Increasing consolidation and complexity of medical organizations has increased the difficulty for patients seeking a legal remedy to the harms they have suffered.

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[92] *Vargas-Colon v. Hospital Damas, Inc.*, 597 F. Supp. 2d 290 United States District Court for the District of Puerto Rico (2009)

7. Hospitals Treat Doctors With Enormous Care and Deference

Employment disputes were one category of case I had not expected to find. They constitute a small minority of my sample, but a very interesting one. It is, of course, dangerous to draw general conclusions from such a small collection of cases. I think that these cases illuminate something very interesting about all the others.

In all of the above sections, I noted that hospitals acted to protect medical staff, and particularly doctors. Doctors may, and often do hire separate attorneys to represent themselves in lawsuits because they have separate legal interests from their employer. Doctors and nurses *do* benefit from the enormous amount of power and resources that hospitals have at their disposal, however. In this section, I want to discuss a small subset of cases where that is simply not true.

These cases are interesting because in them, the hospitals are *not* marshaling their resources to protect doctors. Rather, they are attempting to sever the relationship with "bad apples" to limit their liability for future injuries. Once the hospital is *aware* of a problem with a doctor and written records exist, not doing something about it may expose the hospital to future liability. What kinds of records are viewed as bad enough to sever that relationship, and how the hospitals proceed with them illuminate in the above cases just how much deference doctors in particular get.

Of the four cases coded as only employment disputes, one plaintiff was a nurse and three were doctors seeking recourse for what they view as wrongful termination. Only the

nurse was actually terminated immediately following the incident. The nurse[93] was fired after she left to get dinner but failed to ensure that anyone was monitoring the fetal heart rate strip. All three doctors in these cases were quietly shuffled around until the opportunity to quietly not renew their contract came up. Obviously, a doctor may have a difficult time seeking employment elsewhere if the reason that their contract was terminated is listed; they have every incentive to initiate a legal process to defend their reputation.

One of the doctors[94] also was reassigned and then her contract was not renewed following a single incident. The patient repeatedly declined a C-section and was later treated for uterine rupture. In spite of the fact that Dr. Williams was trying to respect patient autonomy and consent, her lack of action was taken as evidence that she had poor judgment and failed in her duty of care when she treated the extended labor of two days only with antibiotics, even as the fetal heart rate fell. It's hard to argue with that conclusion, though this seems like a very Scylla and Charybdis situation for doctors to be in. On the one hand, the patient may sue if forced to undergo an unwanted surgery. On the other, the hospital may terminate employment or threaten the license of a doctor who won't.

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[93] *Smith v. Wesley Health System, LLC,* 47 So. 3d 742 Mississippi Court of Appeals (2010)
[94] *Williams v. Woodhull Medical & Mental Health Center,* 891 F. Supp. 2d 301 United States District Court for the Eastern District of New York (2012)

The other two cases coded as labor disputes involve the hospital establishing that the doctor had a pattern of ignoring protocol or unexplained negative outcomes. In *Ritten v. Lapeer Regional Medical Center*[95], during a review for the renewal of his contract, Dr. Ritten's patient injury rates and complaints were astonishingly high. He accounted for about one fifth of *all* patient complaints by himself, and his rate of "trauma"–that is, of injuring pregnant patients or infants, though it isn't clear from the court records how that distinction is drawn–during vacuum extraction was slightly more than double that of his colleagues. Finding these facts, the hospital declined to renew his contract. The case that appeared in my dataset did not resolve the issue. It was difficult to code, because the court recorded a complex decision about the suit, but allowed it to go forward.

Perhaps the most disturbing of the labor dispute cases was *Bauman v. Mount Sinai Hospital.*[96] Dr. Bauman was accused of inducing labor using misoprostol by inserting the tablet vaginally. The FDA, the court record notes, has issued explicit guidance that this method of induction results in a high rate of uterine rupture because of the violence of the contractions. While explicitly banned by the hospital after the FDA guidelines were updated, this was apparently common enough practice that other doctors recognized the tablets during vaginal examinations of two patients; one even admitted in court that she had induced labor this way herself. What makes the case disturbing though is that the

[95] *Ritten v. Lapeer Regional Medical Center.*, 611 F. Supp. 2d 696 United States District Court for the Eastern District of Michigan (2009)
[96] *Bauman v. Mount Sinai Hospital,* 452 F. Supp. 2d 490 United States District Court for the Southern District of New York (2006)

patients were totally unaware that Dr. Bauman had attempted to induce their labor. They both returned to the hospital a few days or hours after a gynecological examination with Dr. Bauman complained of sudden, painful contractions that they were worried about because they could not explain why it was happening. The hospital issued a letter, suspended him, and attempted to sever their relationship immediately after the second incident. His suit to reinstate his privileges at the hospital was dismissed, in part because his self-filed complaint and amendments did not comply with the Federal Rule of Civil Procedure.[97]

Some malpractice cases used administrative investigations done by the hospital to show that allowing a doctor to continue treating patients is in and of itself negligent. One case in particular stands out from the rest. In *Manning v. United Medical Corp.*[98], the Manning family is attempting to hold the hospital responsible for allowing the doctor that delivered their child to continue to practice. The details of the report are not contained in this particular judicial opinion, but references to the report and the testimony of other doctors against Dr. Golden are. The plaintiffs discovered after their initial suit that the hospital reinstated Dr. Golden's certification after it had been revoked by the state. The

[97] The opinion notes that rather than a "a short and plain statement," the amended complaint was 150 paragraphs and included 23 additional exhibits, including the full 244-page transcript of his disciplinary hearing. Not following the rules in a hearing in part about Dr. Bauman ignoring protocol and doing whatever he liked while a delightful example of man's hubris was not, in the end, effective.
[98] *Manning v. United Medical Corp.*, 902 So. 2d 406 Louisiana Court of Appeal (2005)

reason is not specified here, but the referenced testimony mentions that Dr. Golden repeatedly violated the standard of care.

One final note: the employment dispute cases are generally resolved relatively quickly.[99] They stand out as remarkably short in the context of the other cases. On average, the malpractice cases take between 5 and 8 years to resolve. These cases are filed promptly. The average length across the four cases was three years–with *Bauman v. Mount Sinai Hospital* being dismissed in just under a year. I'm sure it helps that the cases themselves are less complex–fewer expert witnesses or exhibits, as such witnesses are required in many states to sustain a malpractice claim, with a limited scope. It feels significant though that professionals with grievances get their answers in court long before a patient should expect to.

Conclusion

In the cases that occurred between 2002 and 2012, it does not appear that obstetric violence is increasing or decreasing. Nor does this sample indicate that lawsuits involving

[99] Particularly when, as in all three of the cases involving doctors cited above, the plaintiff is representing themselves *pro se* and file documents containing no legal arguments that are not in compliance with procedure. Only Dr. Bauman continued his entire suit without representation by an attorney. While Dr. Williams did eventually retain an attorney who attempted to amend her complaint to the satisfaction of the court, she continued to question her own attorney's judgment up until the moment her complaint was dismissed. Dr. Ritten found an attorney relatively quickly as is noted in the procedural history. While correlation is not causation and this is a *very* small sample size, he is the only doctor whose case cleared the first hurdle toward reinstatement.

pregnant patients are increasing. Cases of *obstetric violence* do appear to be geographically concentrated in large population centers and the Southern United States.

I'm not qualified to make either medical or legal judgments in these cases. I cannot say whose claims have merit, and I wouldn't venture to evaluate whether or not any particular case was rightly decided. Some distinct patterns emerged during my analysis.

The biggest theme in these cases is how institutions exercise their power. Hospitals and doctors have basically all the power and authority in their relationship with patients. They have all the medical knowledge, and choose when to disclose information. Rules meant to protect patient interests, like the Health Insurance Portability and Accountability Act (HIPAA), are routinely used to deny patients access to the information necessary to make claims in court. Because doctors are so central to the system, hospitals may be slow to act and deploy all of their resources to protect medical professionals. While it is a small sample size, the employment dispute cases add an interesting caveat to note how careful hospitals act when they want to sever their relationship with doctors. Finally, in some cases the lack of examinations and in others the abundance of interventions is generally taken as evidence in favor of doctors–irrespective of how appropriate or helpful these actions would have been.

This underscores the incredible barriers to change that patients face. Taken together, the opinions of the judges that author case law seems to be that any incidents of patient harm are isolated, rather than systemic. That some doctors or nurses are "bad apples," and

all the remedy that is required is to remove them from the barrel. If courts find that individual diseased trees are the problem, it is because they aren't looking at the forest.

These legal cases are exceedingly rare compared to how commonly people give birth. They are troubling. There are some clear patterns in how power is used to protect institutions, and who has success in navigating them.[100] If they were the only instances of obstetric violence in the United States, they might be easily dismissed as unfortunate but rare instances created by peculiar circumstances particular to each individual case.

These are particularly grotesque trees. They invite us to stop and gawk. In the next chapter, I would like to examine the forest. Or rather, to return to the image of an iceberg, to examine the ice that is lurking beneath the surface. A *lot* is missing from this analysis. Most fundamentally, who are these pregnant people? Demographic data is almost totally absent from the factual case histories. We could make very educated guesses and fill in the gaps of age, race, socioeconomic status, ability in a number of them, but not in a consistent and reliable way across the whole dataset. Chapter 4 examines this question using the Listening to Mothers Wave 3 data.

In Chapter 2, I outlined how these two data sources are related. They are mirror images of each other. The cases I analyzed in this chapter are rich, complex, and offer a great deal of information about how institutions function to defend themselves. In

[100] Again, *don't be your own lawyer*.

Chapter 4, I turn to the Listening to Mothers data to understand more about who the pregnant patients are.

Chapter 4: The Submerged Iceberg

This project boils down to a few very basic questions that have not really been answered by legal scholars, medical researchers, and activists for reproductive rights and justice. Chapter 1 defined obstetric violence. Chapter 2 laid out how I propose to study it. Chapter 3 offered some insight into the institutional processes that enable obstetric violence. This chapter turns to the question of who is at risk.

I agree in principle that one case of obstetric violence is one too many. In practice, though, risk is not distributed equally. Understanding which patients are most likely to experience obstetric violence is crucial to doing something about it.

It isn't entirely fair to say that no one at all is interested in demographics. Medical researchers have largely focused on surveying doctors to understand the institutional problems, rather than patients (see for example Morton et al 2018). Legal scholars have defined and measured the issue via detailed case studies of examples, which they often note disproportionately involved non-white women, poor women, and have been geographically concentrated in the South though not exclusive to it (see for example Diaz-Tello 2016, Paltrow and Flavin 2013).

In Chapter 3, I explored the set of legal cases over a ten-year period.[101] There were no criminal proceedings in them at all,[102] against either pregnant women or against doctors and medical providers. Even civil suits were somewhat rare–though as noted, much more common in some areas of the country than others. Civil suits involving obstetric violence have among the highest settlement awards as a remedy.[103] Those that are successful involve egregious, clear, and repeated violations of women's consent or rights.[104] Some involve a woman losing custody of her child or children.[105] Such cases increased in frequency suddenly and dramatically in the United States in the early 1990s, they seem to have leveled off at a higher but stable rate in the early 2000s (Paltrow and Flavin 2013). They still account for only a tiny sliver of births in a year. My analysis in Chapter 3 aligns with these conclusions.

If these cases are the tip of the iceberg or outliers, then how do more mundane, ordinary, or regularly occurring cases unfold? As other scholars have noted, the potential for even serious cases to yield little to no record in the courts is high (Diaz-Tello 2016).

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[101] This was originally intended to parallel the Listening to Mothers complete dataset. I was *promised* that the same questions were asked in each wave. The questions I used to operationalize my dependent variables of interest *were not asked in waves I and II*. I still think a larger sample of cases makes for more interesting analysis in Chapter 3 even if I am personally frustrated at being deprived of interlocking time periods.

[102] Not in the dataset coded for *obstetric violence*, at least. See Appendix C for a full explanation of what criminal cases were returned in the initial search of the database, and why they were not included.

[103] See for example Malatesta v. Brookwood Medical Center a/k/a Brookwood Women's Center; Tenet Healthcare Corporation (Ala.Cir.Ct.) 2016.

[104] See for example Alicia Beltran's case (Eckholm 2013) or Catherine Skol's (*Catherine Skol v Dr. Scott Pierce* 08L-13805 Tried Feb. 17-Mar. 1, 2012)

[105] See for example DYFS v. V.M. and B.G. In the Matter of J.M.G., A Minor. (2009) 408 N.J. Super. 222, 974 A.2d 448

The relationship between these two kinds of cases is like an iceberg. Thinking of the outliers (the part visible at the surface) and the less visible, less recorded instances of obstetric violence (the part of the iceberg beneath the surface) as parts of the same phenomenon offers more clarity to both. I describe in detail in Chapter 2 how the data sources mirror each other.

In this chapter, I analyze survey data from Wave III of the Listening to Mothers project. It is the only wave that asked respondents specifically about poor treatment during labor and delivery, and ties that treatment to race, ethnicity, socioeconomic status, and a willingness to disagree with or disobey healthcare providers. I will first describe how I constructed the variables included in my analysis, and the way I modeled them (Section I). I will then give the results of the logistic regression models created to understand the relationship and distribution of answers.

I. Data and Methods

1. Listening To Mothers Wave 3

Listening to Mothers III is the third wave of a nationally representative survey of new mothers (Declercq 2013). The nonprofit group Childbirth Connection has administered all three waves of the survey since 2002, as part of their longstanding project to improve childbirth in the United States. All of their data is publicly archived at Odum Institute Data Archive at the University of North Carolina. To qualify, the respondent had to have

given birth in the last year, be able to participate online in English, and be willing to answer questions about their experiences, their interactions with healthcare providers throughout the pregnancy, their feelings about their pregnancy, a limited amount of medical information, and basic demographic information. Women were given the opportunity to answer open-ended questions in their own words about their experiences. The survey included 2400 respondents from all 50 states and the District of Columbia. For a more detailed discussion of why this survey in particular was chosen, and the limits of the available data, see Chapter 2.

2. Dependent Variable of Interest: Poor Treatment

The Listening to Mothers 3 Survey (Declercq et al 2013) specifically asked questions about being treated poorly because of the pregnant person's race or ethnicity; her insurance status; or because she disagreed with a doctor. These are all listed as Question 1375 in the original questionnaire. Table 4 gives the distribution of the answers as a percent of the responses received. In each of the three categories separately, between 15 and 20 percent of respondents answered that they were treated poorly at least some of the time.

"Poor treatment" can mean a lot of things. Not all of the survey respondents answered the prompts to clarify or offer additional information. Those who did explained that "poor treatment" meant everything from being shouted at by staff; to being refused treatment; to hearing jokes about their race being told by nurses; to being pressured to the point of

Table 4: Distribution of Answers About Discriminatory Treatment in Original Listening to Mothers III				
During your recent hospital stay when you had your baby, how often were you treated poorly because of …?	Never	Sometimes	Usually	Always
Your race, ethnicity, cultural background, or language	86%	8%	3%	3%
Your health insurance situation	84%	8%	5%	4%
A difference of opinion with your caregivers about the right care for yourself or your baby	80%	11%	6%	3%
Adapted from Declercq et al 2013, page 27				

tears to accept treatment (Declercq et al 2013). Respondents also explained that they didn't really understand the reasons for their treatment–in particular, C-sections–and felt that they had no option of saying no. For example, one woman who answered that she had been treated poorly because of disagreements about her care explained:

> The attending doctor claimed the baby was stuck. Everything was very rushed. To this day *I don't know if this baby was really stuck*. I don't know if everything was so rushed because they really were concerned about the baby or they just really refused to do a vaginal birth [after cesarean] no matter what. (Declercq et al 2013, emphasis added)

It seems unlikely that medical personnel would simply lie to achieve the result that they desired, or that they would simply prefer one method of delivery over another so strongly that they coerce women to undergo a particular surgery. In my personal experience, doctors in particular are highly motivated to go to any lengths to treat their patients. I have no context to judge whether this respondent is correct in her assessment that the emergency was not clear. The relevant point, though, is that this respondent did not trust

her medical providers to tell her the truth. She felt that she did not have a choice about her care.

These instances of "poor treatment" meet the criteria laid out in Chapter 1 to be considered obstetric violence. So, I shall.

3. Operationalizing the Dependent Variable for Binary Logistic Regression

To operationalize these three questions for logistic regression, I created four variables. Each of these variables is the dependent variable of one of the four binary logistic regression models. I am most interested here in answering two questions. First of all, which respondents are more likely to not experience obstetric violence at all? Second, which respondents are most likely to report that they experienced the most obstetric violence?

Model 1 answers the first question: which respondents are more likely to not experience obstetric violence at all? The dependent variable was coded 1 if the respondent answered “never” to all three parts of the question (logical and). This creates the smallest possible set by excluding all respondents who ever reported being treated poorly, for any reason, at any frequency.

The other models answer the second question: which respondents are most likely to report that they experienced the most obstetric violence? The dependent variable for Model 2 was coded 1 if a respondent answered that she was "always" treated poorly because of her race, ethnicity, cultural background, or language. The dependent variable

for Model 3 was coded 1 if a respondent answered that she was "always" treated poorly because of her health insurance situation. Finally, the dependent variable for Model 4 was coded 1 if a respondent answered that she was "always" treated poorly because of her differences of opinion about the right care for herself or her baby.

I did not model the responses "sometimes" or "usually." In my dissertation as a whole, I have made the case that charting the extremes offers us the most information. I chose to continue that thrust here. The less clear, squishier responses that are difficult to operationalize, and muddy the waters. I am fairly certain that if a respondent does not think she was poorly treated at all, she probably didn't experience obstetric violence. If a respondent ever thought that they were always treated poorly, then chances are good that her experience meets my definition of obstetric violence.

4. Independent Variables

This dataset was chosen to hold up a mirror to the legal cases investigated in Chapter 3. They offer less context or explanation about the events, but much richer information about the demographics of the pregnant people. I include in all for binary logistic regression models all of the independent variables that describe the respondent's race or ethnicity; educational attainment; income; age; experience (whether or not this child was their first); relationship status; nativity (that is, whether or not the respondent was born in the United States); insurance status; and geographic location.

Table 5 gives more detailed information about the demographics of the respondents. These largely reflect the general demographics of the United States at the time the survey was done, and form a random, representative sample. It is noteworthy that respondents

Table 5: Demographics of Listening to Mothers III by Race or Ethnicity				
Variable	Overall %	White%	Black%	Latina %
Age 18-19	4.58%	2.98%	7.12%	8.85%
Age 20-24	20.46%	14.74%	32.36%	29.42%
Age 25-29	26.83%	27.06%	23.95%	26.99%
Age 30-34	28.83%	33.36%	20.06%	19.69%
Age 35-39	14.04%	16.26%	10.36%	10.62%
Age 40-44	4.71%	5.67%	5.50%	3.98%
Age 45 and up	0.54%	0.62%	0.65%	0.44%
Percent Below 200% Poverty	29.96%	22.35%	44.01%	46.90%
Married	66.96%	76.54%	37.54%	55.75%
Unmarried with a partner	26.42%	19.03%	47.90%	36.06%
Unmarried with no partner	5.88%	3.74%	13.92%	7.52%
High Schools Education or Less	19.42%	16.82%	20.71%	29.20%
More than a High School Education	24.21%	22.42%	30.42%	28.32%
College Degree	40.00%	41.59%	36.89%	32.08%
More than a College Education	16.38%	19.17%	11.97%	10.40%
First Birth	52.33%	43.88%	54.05%	51.55%
Born in US	93.04%	98.06%	96.12%	81.64%
Private Insurance	54.88%	65.74%	34.63%	34.29%
Medicaid or CHIP Insurance	30.25%	22.98%	48.54%	44.25%
Paid out of pocket	4.63%	2.77%	5.50%	7.52%
All Other Insurance	10.25%	8.51%	11.33%	13.94%
Northeast	14.50%	15.92%	7.77%	15.27%
Midwest	26.13%	30.93%	22.01%	16.81%
South	36.71%	33.22%	61.17%	32.52%
West	22.67%	19.93%	9.06%	35.40%
Total Number	2,400	1,445	309	452

who identified as white were slightly older than the other racial categories.[106] White respondents also had a slightly higher educational attainment and a higher rate of private insurance, which strongly indicate that they have an overall more privileged economic status. Finally, while other respondents are more evenly distributed geographically, it is worth noting that nearly two-thirds of respondents who identified as black are from the South.

In the rest of this section, I explain the coding decisions and criteria that I made to operationalize the survey responses for analysis. Since I chose a binary logistic regression model, these variables are in general operationalized as binary values, where 1 represents that the respondent possesses this characteristic and zero means that they do not. The gold standard for clarity in modeling is to create exhaustive and mutually exclusive categories. That is, each respondent fits into exactly one of the coded categories.

A. Race or Ethnicity

My analysis focuses on the differences between non-Hispanic White women, non-Hispanic Black women, and Hispanic women of any race.[107] These categories were created from two questions about the race and ethnicity of respondents in the original

[106] I did not include several smaller categories here because the sample is so small. I did include all other races in the logistic regression models in order to get a clearer picture of the other responding racial and ethnic categories. I explain coding criteria and selection further in the Independent Variable section.

[107] I am well aware of the difference between Hispanic or Spanish-speaking peoples and Latina or Latin American peoples. This survey does not really distinguish between the two, probably in order to be more inclusive. The majority of respondents who indicated that they were Hispanic or Latina also responded that they sometimes speak Spanish, so I will use the term "Hispanic" to refer to them.

survey, Q477 and Q480. “White” was used as a reference category in the regression models. A fourth category in the overall regression contained all of the women that could not be placed into these three categories. Q480 included the categories Asian, American Indian, Alaskan Native, and Native Hawaiian or Other Pacific Islander, as well as an optional space for the respondent to fill in "other." These racial and ethnic categories combined comprised under 200 respondents total, or about 7.5% of the unweighted sample. Separating them out in a large regression analysis is unlikely to yield reliable results, but they must be included to help clarify other categories.

B. Education

The original survey item, Q2205, listed 9 different levels of education or educational outcomes. To decide how to divide the responses and operationalize this variable, I conducted a series of t-tests to model distinctions between different levels of education on the dependent variable. I settled on four categories: high school graduates or less, more than high school, college graduates, and more than college. I used the lowest level of educational attainment as the reference category.

C. Income

Household income was solicited on a scale in increments of about $8000 in Q520. A pre-coded variable was available that separated respondents living at or below 200% of the federal poverty line from those living above it. This is a somewhat standard dividing

line in statistical analysis because it is the level of income to which so many federal benefits are tied. To check that this was reasonable in my analysis, I coded Q520 responses as a series of binary variables and ran a regression on the dependent variables. Across all 4 models, a change in sign on the coefficient occurred at about 200% poverty. I included the pre-coded variable, which assigned 1 to individuals reporting a household income of above 200% of the poverty line and 0 to individuals reporting a household income at or below 200% of the poverty line.

D. Age

The age of respondents was calculated from the respondents year of birth using the year the survey was administered (Q105). Neither of these was included in the public dataset, which reported age as a binary variable along different ranges. I used these categories directly as they were the only available data. I used the lowest age range as the reference category.

E. First birth

Whether or not the respondent has given birth before impacts patient perceptions of medical care. Certainly, in examples of the free responses, patients frequently compared their birth experience to past experiences (Declercq et al 2013). I included in the models a dichotomous variable that indicates whether this birth was the woman's first child or not.

F. Relationship Status

There were three categories of relationship status available in the survey from Q1915: married with a partner, unmarried with a partner, and unmarried with no partner.[108] These categories represent various degrees of vulnerability and support that may impact how medical staff treat patients. I included each as a dichotomous variable, and omitted "married with a partner" as a reference category.

G. Insurance Status

Given that insurance status is a pretty consistent indicator of economic status and one of the dependent variables is centered on poor treatment because of insurance status, I chose to include it in addition to measures of educational attainment and income. Q1845 asked what the primary source of payment was for all of the respondent's maternity care. I included the largest response categories as a dichotomous variable: Medicaid or CHIP; Private Insurance; and Paid out of pocket. I also created a fourth category for all other insurance arrangements (for example, VA benefits or federal health coverage). I omitted Private insurance as the reference category.

[108] Only about 1% of respondents declined to answer.

H. Geographic Location

Obstetric violence is not evenly distributed around the United States in previous studies (Paltrow and Flavin 2013). My findings in Chapter 3 add support to this conclusion. I mapped out the responses by individual states to demonstrate their distribution. Chapter 5 compares the map of case law to the geographic distribution of the Listening to Mothers wave III data.

It would be unworkable to include all fifty states and DC separately in the model. Instead, I created dichotomous variables to divide the states by census region.[109] In the Northeast, I included: Connecticut, Maine, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island, and Vermont. In the Midwest,[110] I included Illinois, Indiana, Iowa, Kansas, Michigan, Minnesota, Missouri, Nebraska, North Dakota, Ohio, South Dakota, and Wisconsin. In the South, I included: Alabama, Arkansas, Delaware, the District of Columbia, Florida, Georgia, Kentucky, Louisiana, Maryland, Mississippi, North Carolina, Oklahoma, South Carolina, Tennessee, Texas, Virginia, and West Virginia. In the West, I included: Alaska, Arizona, California, Colorado, Hawaii, Idaho, Montana, Nevada, New Mexico, Oregon, Utah, Washington, and Wyoming.

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[109] For a full explanation of all levels of census designations, see "Geographic Levels," United States Census Bureau, <https://www.census.gov/programs-surveys/economic-census/guidance-geographies/levels.html> Last accessed 4/23/2024.

[110] For Chicagoans in particular, I am not interested in debating whether or not Ohio is a Midwestern state. Take it up with the census bureau, but also, *of course it is*.

I. Results

1. Binary Logistic Regression Model: Explanation and Overview

After operationalization and coding, I created binary logistic regression models using R (R Core Team 2021). Table 6 reports the results of the binary logistic regression models as odds ratios. Binary logistic regression was chosen because the dependent variables were best operationalized as binary outcomes–either yes, or no. It is entirely a coincidence that the independent variables are also all binary. In some cases, as described above, that is because while the questions (such as age) were asked as a continuous variable, the public use dataset only includes deidentified categorical data. While it is completely possible and reasonable to model data with a binary outcome on a continuous independent variable, I find the results of binary models easier to interpret.

When interpreting this table, the reader should note that the number reported is the ratio of the original regression model output to the reference category. I have noted the reference categories parenthetically, which all have an odds ratio of 1.[111] These are the denominator categories, to which the other binary variables are being compared. An odds ratio of less than 1 indicates that respondents in that category are less likely than the

[111] Because the reference category is both the numerator and the denominator of the fraction. In the full regression model, they would be omitted, and some much more complex math is required to understand what they mean. Reporting the full regression model also gives insight into things like model fit and specification.

reference category to report the modeled dependent variable answer. Likewise, a response of greater than one indicates that they are more likely.[112]

Table 6: Results of the Binary Logistic Regression Model, Reported as Odds Ratios				
Variable	Model 1: Never Experience Poor Treatment	Model 2: Always Treated Poorly Because of Race, Ethnicity, or Culture	Model 3: Always Treated Poorly Because of Insurance	Model 4: Always Treated Poorly Because of Disagreement
Race: White (reference)	1.00	1.00	1.00	1.00
Non-Hispanic Black or African American	0.87	2.2827519*	3.013661**	2.547586*
Hispanic or Latina	0.7283016*	1.69	1.16	1.14
All Other Races	0.6381529*	1.47	2.525345 .	2.06
Education: High School or Less (reference)	1.00	1.00	1.00	1.00
More Than High School	0.97	0.65	0.4570753 .	0.61
Completed Associate or Bachelor's Degree	0.77	0.97	0.3686019*	0.55
More Than a College Degree	0.72	1.56	0.72	1.01
Income: Greater than 200% Federal Poverty Line	0.97	2.4740155*	2.660755*	1.826111 .
Age 18-19 years	1.00	1.00	1.00	1.00

[112] I am well aware of the problem with prioritizing statistically significant results without fully understanding what they mean, or why they matter. A p-value is actually the probability that the true population value falls outside of the confidence interval; most statistical software packages default to reporting the smallest possible p-value that defines a confidence interval that does not cross zero. See Ziliak and McCloskey 2008, who likened including only statistically significant results or placing too much weight on statistical significance to a cult. I scrupulously avoid the problem they call "the sizeless stare," that is, saying that something is statistically significant without considering the effect size or contextualizing what that means. The reader may judge whether or not my analysis makes sense in real world terms.

(reference)				
20-24	1.5210351 .	0.340424*	1.23	2.66
25-29	2.3690218***	0.3839487 .	0.73	2.15
30-34	2.4123794***	0.2044162**	0.59	1.02
35-39	3.7321923***	0.38	0.83	1.77
40-44	1.67	0.96	2.88	6.520556*
45 and up	0.93	1.64	0.00	0.00
First Live Birth	0.7414853*	0.90	0.75	1.59
Marital Status: Married (reference)	1.00	1.00	1.00	1.00
Unmarried With a Partner	0.92	0.88	0.62	0.62
Unmarried, No Partner	0.6205714*	1.23	0.95	0.74
Born in the United States	0.73	1.08	0.84	1.22
Insurance: Private (reference)	1.00	1.00	1.00	1.00
Medicaid or SCHIP	0.6723193**	2.9159125**	2.580484*	3.882769***
Pay Out of Pocket	0.2471302***	5.8775422***	3.361557*	5.265127**
All Other Insurance	0.5386923***	0.67	3.4579**	2.773568*
Region: Northeast (reference)	1.00	1.00	1.00	1.00
Midwest	1.08	0.59	0.88	1.00
South	0.98	1.33	1.10	1.32
West	1.04	0.85	1.06	1.97
Significance codes[113]: 0 ‘***’ 0.001 ‘**’ 0.01 ‘*’ 0.05 ‘.’ 0.1				

[113] Students of statistical analysis may be searching for other measures of fit and specification aside from the noted p values. In terms of binary logistic regression, the intercept is largely irrelevant. In this particular case, the intercept of the binary logistic regression was statistically significant at the .001 level in all four models. It was positive in Model 1 and negative in Models 2-4. What does that mean? *Not a lot* since I'm

For example, in the "Model 1" column, the logistic regression indicates that Non-Hispanic Black respondents were slightly less likely (at .87, about 13% less likely) than Non-Hispanic White respondents to report that they never experienced poor treatment. This difference is not, however, statistically significant. That means that the model cannot reliably distinguish between the two groups. It could be that Non-Hispanic Black respondents are less likely to respond "never," but this model does not support that hypothesis. Interestingly, in Model 1 both the group of Hispanic people and All Other Races show a measurable difference from White respondents. They are both less likely to respond "never" than their white counterparts by a large margin, and that difference is statistically significant (which really just means that we can be pretty sure that the relationship is real, and depending on the size of the confidence interval defined by the p-values, the value given is probably close).

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working with no continuous variables at all. Did I map the residuals to check for symmetry? No. If you care about any particular measure of model fit, I have given you everything you need here to reproduce my results. Go check for yourself.

Several measures of model fit have become particularly popular after the rise of Large Language Models, sometimes called Artificial Intelligence (This is a misnomer). The Akaike Information Criterion (AIC) is not really appropriate or meaningful here as I am not comparing these models to one another. The Bayesian Information Criterion (BIC) makes a bit more sense. In this instance, it is more of a measure of how many criteria are used to achieve the model fit. In models that are over specified, the statistical significance of any particular variable, dependent or independent, is an artifact of the fact that the variance has been parceled out too much. BIC measures the tradeoff between a smaller, less specific model and a larger, more specific model.

I hope this footnote underscores that I know what I'm talking about at least well enough to be a little dangerous even if I haven't included every single measure of model fit along with its mother. They are, by and large, simply not relevant here. To paraphrase the late, great E. P. Box, *all models are false* but some models are useful. I think that these models are useful enough to answer my questions, and nothing more elaborate needs to be done to them since at the end of the day, they are still false. The question any serious social scientist should ask is not, "how close to reality can my model be?" but rather "how false can my model be before it ceases to be useful? "

2. Model 1: Who is most likely to report no poor treatment at all?

The dependent variable of Model 1 is coded 1 for all respondents who answered that they "never" experienced poor treatment for any of the three reasons listed in the Listening to Mothers 3 Survey.

White respondents compared to all other races were the most likely to report that they never experienced poor treatment. Respondents between the ages of 25 and 40; married respondents; and respondents with private insurance were also more likely by large and statistically significant margins to respond that they "never" experienced poor treatment. are the mWhite women; women with a HS or less education; women between the ages of 25 and 40; women married with a partner; and women with private insurance are the most likely to respond “never.”

There does not appear from this model to be any relationship between the region a respondent lived in across all four models. Just looking at the map, though, is highly suggestive. Chapter 5 explores this further, comparing the distribution of survey respondents to the distribution of legal cases from Chapter 3.

Several groups stand out among the least likely people to respond "never." There was not much less likelihood that Black respondents answered "never," but Hispanic respondents of any race and all other racial categories were substantially less likely than White respondents to answer "never." Though the difference is not statistically significant, and we cannot say for certain this relationship exists, college graduates and

respondents with more than a college education are less likely to respond "never." The tail ends of the age distribution were less likely to respond "never," as well. Unmarried respondents with no partner were substantially less likely than their married peers to respond "never." Finally, while all respondents that did not have private insurance were less likely to respond "never" than their peers with private insurance, there was no real difference between respondents living above or below the poverty line in Model 1.

3. Models 2, 3, and 4: Who is most likely to report being treated the worst?

Models 2, 3, and 4 considers the respondents who reported that they "always" experienced poor treatment because of their race, ethnicity, cultural background, or language (Model 2); because of her health insurance situation (Model 3); or because of her differences of opinion about the right care for herself or her baby (Model 4).

Black respondents were more likely to answer “always” across all three categories. So are all other races and ethnicities compared to white women, though the odds ratio is smaller and not statistically significant in all models. Black women are between 228% to 354% more likely to respond "always."

The signifiers of economic well-being returned somewhat mixed results. Women living above the poverty line were more likely to respond always. On the other hand, respondents with any form of insurance other than private insurance were more likely to respond always across all categories. One might expect the effect to line up on model 3, where the dependent variable is always treated poorly because of insurance status, but the

effect size is actually larger for Medicaid or SCHIP and Pay out of pocket in models 2 and 4. Finally, compared to people with a high school degree or less, across all the models more highly educated respondents were less likely to respond always. With the notable (though not statistically significant) exception of the more than college category in Model 2 and Model 4.

Across all models, being born in the United States and age were not, in general, a very large effect size and not statistically significant. The notable exception is the large effect size of Model 4 and Age 45 and up. 650% more likely to report poor treatment due to disagreements about their care. In Model 2, 20-34 years older were much, much less likely to report always being treated poorly than younger respondents because of their race, ethnicity, language, or culture–from 33% less likely to 80% less likely. It isn't clear why that might be the case.

III. Discussion

1. Privilege and Marginalization

On the whole, respondents who said that they "never" experienced poor treatment (Model 1) were more likely to be members of privileged groups than their peers. Respondents who answered that they "always" experienced poor treatment (Models 2, 3, and 4) were more likely to be members of marginalized groups. There are some notable caveats.

Black women in particular were more likely to say that they "always" experienced poor treatment in all three categories, not just because of their race. It is worth examining who a typical Black respondent to this survey is. [Table y] above outlines the distribution of demographic characteristics by race. Black respondents made up the largest share of 18 and 19 year olds giving birth, and skewed notably younger than other racial groups. They had the most individual respondents whose income was 200% of the federal poverty line or below; the highest share of Medicaid or SCHIP recipients; and the lowest share of higher education. Black respondents were disproportionately unmarried overall, and had the highest share of respondents with no partner. Finally, Black respondents disproportionately lived in the South–a full 60% of Black respondents, when only slightly more than a third of respondents overall were from a Southern state.

Marginalization is better understood as a system of interlocking oppressions than individual categories (Collins 2009). Understanding Black people as marginalized in medical systems and as the victims of reproductive injustice without considering the intersectionality of that marginalization lets institutions off the hook (Price 2011).

Consider the general demographic characteristics of White respondents. About 60% of these respondents were between the ages of 25 and 34–the age at which infant mortality is the lowest across (almost) all racial categories (Cohen 2016). They had the lowest share of respondents living at or below 200% of the federal poverty line, the highest share of college graduates, and nearly double the rate of private insurance as

other racial groups. Three quarters of them said that they were currently married. If the intersecting marginalization of Black respondents pushed down on them, then certainly the intersecting privileges of White respondents lifted them up. These women were the most likely to report that they never experienced poor treatment.

The other largest category of distinction was insurance status. It is unsurprising that insurance status was associated with reporting discrimination due to the type of insurance that a woman carried. However, the effect was statistically significant for Model 2 (poor treatment because of race/ethnicity) and Model 4 (poor treatments because of disagreements with doctors) as well. That is to say, there was a detectable and distinct difference between individuals with private insurance and all other forms of insurance, with the latter much, much more likely to report always being treated poorly. The odds ratios were much larger than any other category, even the difference between women living above the poverty line and those not. Insurance may have more functional value in the hospital setting; income doesn't really determine the ability to pay in the same way that insurance coverage does in American hospitals, and so it is possible that income itself does not impact access to care in the same way.

2. The Institutional Environment of Hospitals

There is very little evidence that any of the respondents to the Listening to Mothers Wave 3 Survey experienced obstetric violence as severe or with such long lasting consequences as the pregnant people in Chapter 3. For one thing, respondents who did

not leave the hospital with a live baby were not included in the final dataset (Declercq et al 2013). While I do think that women experiencing "poor treatment" in the ways outlined by the survey are experiencing a form of obstetric violence, I would not expect any of the respondents in this survey to sue their providers or the hospital where they gave birth. They don't have permanent physical injuries, they have babies that were born alive, and those babies don't have long term illnesses. They have no grounds to pursue legal action.

It's very possible that the respondents themselves would not interpret what happened to them as a structural problem, but as a personal trouble. Understanding mistreatment and disrespectful care as a structural problem–indeed, understanding it as obstetric violence–is critical to actually addressing the underlying structural issues (Sadler et al 2016). That neither doctors nor patients seem to possess what Mills (2000[1959]) termed the sociological imagination to do so is hardly surprising. It is a classic problem of measuring social behavior that individuals resist broader identity labels. For example, that is why most population health surveys of sexual behavior ask if male respondents have ever had sex with other men, not if they identify as homosexual. The former elicits honest responses that help demographers, epidemiologists, and other social scientists and policy makers. The latter, a lot of denial. Patients tend to personalize their experience. Doctors reject being labeled as bad for participating in institutions that have structural problems.

Saying that because there is no permanent physical injury to the respondent does not mean that there is no harm done. One of the most harmful consequences of obstetric violence and poor treatment is that patients are silenced not only in the present moment but in their future care (Chadwick 2020). Patients who are abused for disagreeing learn that in order to be cared for, they must at the very least remain silent and hope that their silence is interpreted as consent.

It is worth underscoring that a small minority of survey respondents answered that they "always" experienced poor treatment–about 3 or 4%. A much larger percentage responded that they were "sometimes" or "usually" treated poorly. In some categories, as many as 15% of the respondents felt that they were treated poorly at least some of the time. This aligns with the findings of surveys of medical staff. In one survey conducted in North America, about two-third of nurses say that they have witnessed disrespectful care; one in five nurses say they have witnessed doctors administering care that directly violates the patient's wishes (Morton et al 2018). In international studies, as many as a third of women reported disrespectful treatment that centered around the moment of birth (Bohren et al 2019).

Conclusion

Chapter 3 explored the case law of labor and delivery for a ten-year period. It isn't exactly a novel finding that medical institutions had a great deal of power, or that some medical providers are not acting in good faith or complying with informed consent rules.

How they used that power when they had to interact with the courts, however, is my unique contribution. They controlled the records, which were created or destroyed; produced or failed to be produced; pertained strictly to the case at hand or used the medical records of patients against them. They were better able, in general, to navigate the legal system than their patients.

There was not a lot of information about who the individuals were in the cases of Chapter 3; the United States Legal System, in general, does not record this kind of demographic information as it is irrelevant to the case.[114] In this chapter, I turned to a survey of new mothers to fill in this gap. I modeled the most extreme answers to a question about poor treatment as the dependent variables to see who is more likely to report that they never experienced poor treatment, compared to those who report that they always experienced poor treatment. Respondents who never experienced poor treatment were more likely to be White; between the ages of 25 and 34; living above 200% of the federal poverty line; have graduated from college; and have private insurance. Respondents who identified as any race other than white were more likely to respond that they always experienced poor treatment. Black respondents in particular responded they were likely to be treated poorly across all four specific reason models.

[114] For a strong critique, see Crenshaw 1989 or Roberts 1998. I will return to the question of intersectionality, the colorblindness of the law, and how relevant demographics are for understanding the impact of the law in Chapter 7.

While no direct comparison between these two data sources is possible, in the next chapter, I map all of the data to understand how these two data sources align and where they diverge.

Chapter 5: Charting the Sea

This is the last chapter of Part 1, which rounds out the empirical attempt to answer my questions. I began my research journey with what I thought would be very simple questions to answer. How often does obstetric violence happen–and to whom? Chapter 1 defined the term *obstetric violence* and set the scope of my analysis. Chapter 2 explained what kind of empirical data I would gather to answer these questions, and why. Chapter 3 analyzed court cases to understand the context of obstetric violence and attempt to estimate its occurrence–how often. Chapter 4 explored data from wave three of the Listening to Mothers survey to answer my questions about who the victims of obstetric violence are.

One question that remained unanswered in those chapters was where. *Where* are these incidents occurring? What does that context reveal about who is likely to experience obstetric violence? What kind of legal regimes at the state level are associated with proportionally more cases? In other words, I turn to maps.

In an ideal world, I would be able to collect directly comparable data. I would have all the demographic information about the legal cases, and the entire case history about *why* survey respondents felt they were treated well, or poorly.[115] Anyone well-schooled in methodology will begin shouting at the idea of drawing general conclusions from very

[115] I would also have several assistants to code all of my data, feed me regularly, and clean my house.

different types of information, epistemologically speaking, analyzed using very different methods. The data that I used in Chapter 3 and Chapter 4 is operating at the same scale: each one concerns information primarily about once instance of labor and delivery. One pregnant patient, one fetus on its way to becoming a baby.[116]

In this chapter, I will convert the raw numerical data into population rates and map them for both the court cases from Chapter 3 and the survey data from Chapter 4. I want to explain a little bit about the history of maps in social science and epidemiology, and why I think this is an important tradition in sociology. I then turn to the maps. While I am mindful that drawing general conclusions from these comparisons is fraught, I do think that this comparison is *highly suggestive* of an underlying causal relationship. Certainly, looking at data this way has stirred a lot more questions that could be answered with further research. I hope that readers too will be convinced that seeing is believing.

I. A History of Maps in American Sociology

Maps have a long tradition in the social sciences of being used to unite disparate information. Epidemiology was possibly the first of the nascent 19th century social

[116] There are a few notable cases in which this is not true. All of the *Listening to Mothers* respondents had given birth and currently had a live infant at home. Multiple births were excluded, see Declercq et al 2013. Most of the legal cases had given birth, whether the infant survived or not, and there were very few recorded instances of a multiple birth in these cases. In instances where there was more than one pregnancy involved, it was mostly labor disputes. For example, *Bauman v. Mount Sinai Hospital*, 452 F. Supp. 2d 490 United States District Court for the Southern District of New York (2006). Dr. Bauman did not tell his patients he was inserting a misoprostol tablet into their vagina with the purpose of inducing labor, and then tried to represent himself in court with the defense of, essentially, we have all been doing this for decades, what's the fuss? Reader, I cannot stress enough that you should *never represent yourself in court*.

sciences to recognize the value of maps for understanding social problems and solving them. In his quest to understand and contain cholera epidemics in Victorian London, John Snow[117] mapped which water service companies drew water from downstream of London, where they pumped it to, and who got sick–though it was his walking-radius map that demonstrated everyone who got sick in the 1854 outbreak probably drew water from the same pump that finally convinced his colleagues to turn off the pump (Johnson 2007).

In the early 20th century at the height of both the first wave of the women's movement in the United States and eugenic or hygienic public health policies, social problems were treated like diseases and mapped epidemiologically.[118] Risk is generally not distributed evenly across a population. Fundamental Cause Theory posits that marginalized people–particularly people with low socioeconomic status–are most vulnerable to negative health outcomes (Link and Phelan 1995, Phelan et al 2010).

Chicago Sociologists Robert Ezra Park and Ernest Watson Burgess are largely credited with popularizing the method in American Sociology. Their influential text *An Introduction to the Science of Sociology* codified the work that they and their graduate students had been doing in the city to map its social contours into a central part of urban

[117] Not *that* John Snow; this one knew a great many things.

[118] Some of the social problems *were*, of course, conditions in slums that spread diseases. Which, as McKinlay and McKinlay (1977) argue, social reformers were much more successful at solving than medical doctors. Virtually all of the great reductions in mortality from disease of the 20th century happened *before* vaccines were invented (McKinlay and McKinlay 1977).

sociology (1921). In part, this stems from the split in American Sociology and Social Work in the early 20th century. More activist women such as Jane Addams–who refused to take a faculty position, founding Hull House and Social Work to support her reform movement instead–collected the data that more theoretically oriented men of the Chicago School analyzed (Deegan 1990).[119]

Maps have also been an official tool of marginalization and oppression in the United States. "Redlining" refers to the way that neighborhoods were categorized for the purpose of assessing loan risk. A literal red line was drawn around "unstable" neighborhoods–and the federal government defined neighborhoods with a mix of white and black residents, or that was gaining black residents too quickly as "unstable." This became a self-fulfilling prophecy when banks refused to loan money or invest money in those neighborhoods. Richard Rothstein (2017) lays out the argument that this was a deliberate (and forgotten, though still impactful) project of the federal government to keep neighborhoods racially segregated.

My project is not nearly as granular as the work of the Chicago School. Graduate students mapped everything, from the distribution of families receiving some kind of assistance, to the distribution of different dwelling types (houses, apartments, single

[119] Jane Addams also consistently refused to take a position in the Sociology department at the University of Chicago. She viewed her work more broadly than the narrow academic focus of the university men and thought that a formal post would hinder it rather than enhance it. If I had a time machine, I would love to sit in on lectures and seminars at Hull House.

rooms, and so forth), to the distribution of motion picture theaters.[120] I'm not even interested in mapping at the level of census tract, as the federal government so often does. The best and most complete level of measurement that I have for my project to compare my two data sources is the state.

II. Maps of Case Law

Chapter 3 outlined how I found and coded case law data to measure the occurrence of obstetric violence. To review briefly, I used the Harvard Caselaw Access Project (CAP) to find all of the legal cases at the appellate court or higher involving "labor and delivery" between 2002-01-01 to 2013-01-01. This search returned 405 cases. After consolidating cases that are not unique and removing cases that did not meet my criteria[121], there were 252 remaining cases. I coded 73 of these as instances of obstetric violence. There were a small number of cases that did not contain enough information and were coded as Not Obstetric Violence, though they were clearly within the criteria set for inclusion. As such, this coding represents the smallest possible set of cases of obstetric violence in the case law search.

To map this data to the United States, I counted the total number and transformed this information into a simple percent. Figure 2 maps the distribution of all the cases in

[120] There is a permanent catalog of these maps at the University of Chicago Library, and many of them have been digitized after a 2015 exhibit. Information about the exhibit and a portal to the digital records can be found at <https://www.lib.uchicago.edu/collex/exhibits/mapping-young-metropolis/>

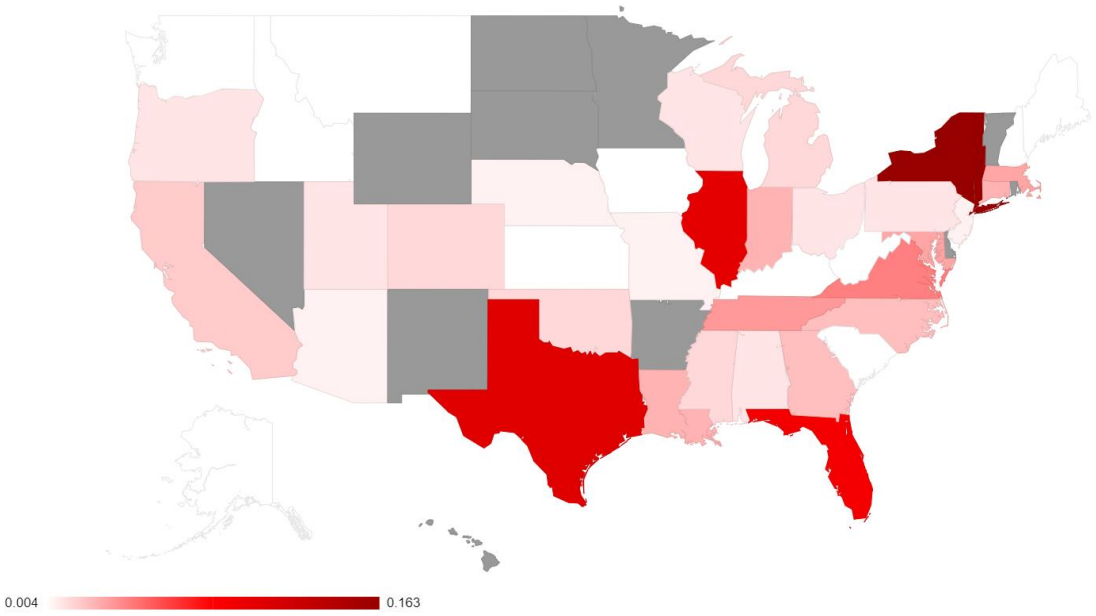
[121] See Appendix B for an explanation of excluded cases and Appendix A for a full listing of unique cases and their coding.

the final dataset. The numerator of the percent is the number of cases in that state, and the denominator is the overall number of cases (252). States that are gray have no cases at all in the dataset. States that are white have a very small number of cases. For example, Montana has one case, or .4% of all the cases.

To create figure 3, I mapped only those coded as instances of obstetric violence as a percentage of other cases in that state. The numerator of the fraction is the count of obstetric violence, and the denominator is the count of overall cases *in that state*. States that appear in gray have no cases at all, so they obviously also have no cases of obstetric violence.[122] States shaded pink or white have a small proportion of cases, and states that appear red have a high volume, proportional to the number of cases in that state.
It is hardly a surprise that New York and Illinois as two of the most populous states carry a high proportion of cases. New York, indeed, had both the most cases involving birth (42 of 253, or 16%) and the highest number of cases coded as obstetric violence (11 of 72, or 15%). However, compared to other states, New York has a relatively low percentage of cases of obstetric violence. Only about a quarter of the cases in New York (42) were coded as obstetric violence (11). Texas too has a large population and a high proportion of cases (27 of 253, or 10%) and a large share of cases coded as obstetric

[122] It is not possible to divide by zero in the real numbers. Telling a statistical software to do it will make it crap itself in panic. There are mathematical systems in which this is possible. They are carefully and painstakingly constructed to make this operation possible. Mathematicians are strange, and not to be trifled with, lest they divide *you* by zero.

Figure 2: All cases coded for OV, expressed as a percent :



violence (6 of 72, or 8%). As a proportion of the Texas cases, only about 22% of the cases were coded as obstetric violence.

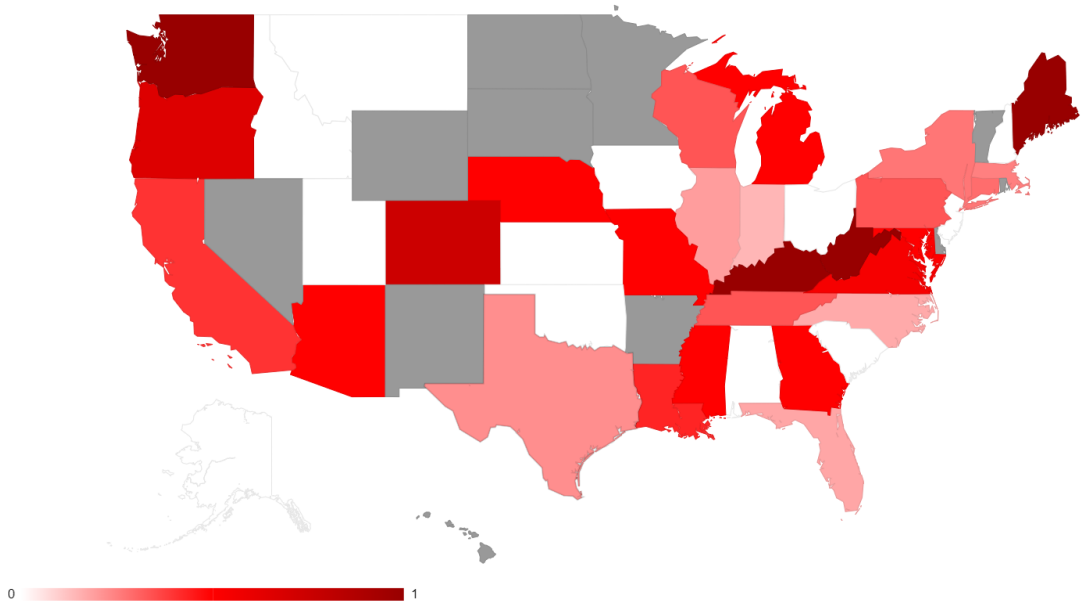
Compare this to a state like Kentucky or Colorado. Kentucky only had one case in the overall dataset, which was coded as obstetric violence–or, 100%. Colorado had four, three of which were coded as obstetric violence–or 75%.

Figure 2 shows that court cases overall are concentrated in the Southeastern United States disproportionately to their share of the population. This aligns with other research findings documenting that arrests of pregnant people with the goal of forcing them to undergo medical intervention are concentrated in the south (Paltrow and Flavin, 2013). More than half of the cases in this study were located in the southern United States

(Paltrow and Flavin 2013). In particular, ten states accounted for two thirds of the documented cases of criminal arrests and forced medical interventions that Paltrow and Flavin documented between 1973 and 2005: in descending order of frequency South Carolina, Florida, Missouri, Georgia, Tennessee, Wisconsin, Illinois, Nevada, New York, and Texas (Paltrow and Flavin 2013). With the exception of South Carolina and Nevada, these findings map closely onto mine. It appears that women in the South are much, much more likely to find themselves in court over obstetrics care.

Figure 3 underscores that obstetric violence is everywhere. It may seem a bit skewed to compare a state that only has one case that was also coded as obstetric violence (or 100%) like Washington to California. California, in spite of being another very populous state, had a very small proportion of cases with five cases or about 2%. Two of those five cases were coded as obstetric violence, or about 40%. It *is* a bit skewed. This is not a random or representative sample. It is not a sample at all–it is all of the cases that

Figure 3: Cases Coded Yes as a Percent of state cases:



reached a certain level in this ten-year period. I am alarmed that states like Colorado and California which have strong reproductive healthcare protections look, but this measure, worse than Alabama–a state where a fetus has long been considered a person.

Not pictured on this map are US territories and the District of Columbia. The only territory of the United States that appeared in this search was Puerto Rico. Eight cases originated in Puerto Rico, but only two were coded as obstetric violence. That's a higher proportion of cases coded as obstetric violence (25%) than either New York or Texas, even if it is on the lower end of all cases. Only three of the cases coded for obstetric

violence[123] were in the District of Columbia Court of Appeals, all of which were coded as not obstetric violence.

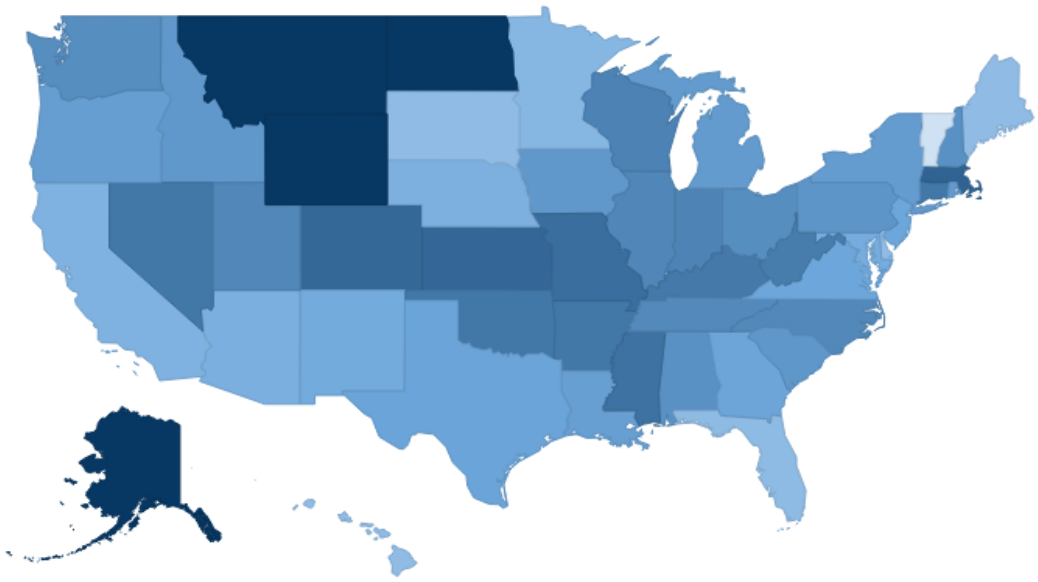
III. Maps of Survey Data

The statistical models and my overall analysis focuses on respondents at the extreme ends of the spectrum. On the one hand, the majority of respondents indicated that they were not treated poorly for any of the reasons listed in Question 1375. We can be fairly certain that they did not experience obstetric violence. The other end of the spectrum is respondents who answered that they *always* were treated poorly because of their race, ethnicity, cultural background, or language; their health insurance situation; or a difference of opinion with their caregivers about the right care for either the respondent or their baby. These respondents answered additional questions that indicated their experience would meet the criteria outlined in Chapter 1 as *obstetric violence* (See Declercq et al 2013).

Recall how the dependent variables were constructed. For Model 1, I constructed a binary variable using the logical "and" function to analyze all the respondents who answered "never" to all three parts of Question 1375. For Models 2, 3, and 4, I constructed a series of binary logistic variables to isolate respondents who had answered "always" for each of the individual parts of Question 1375. To map all of these

[123] A further six were in the NA cases, see Appendix B for more information.

Figure 4: Cases that all responded “never” to all 3 dependents as a percent



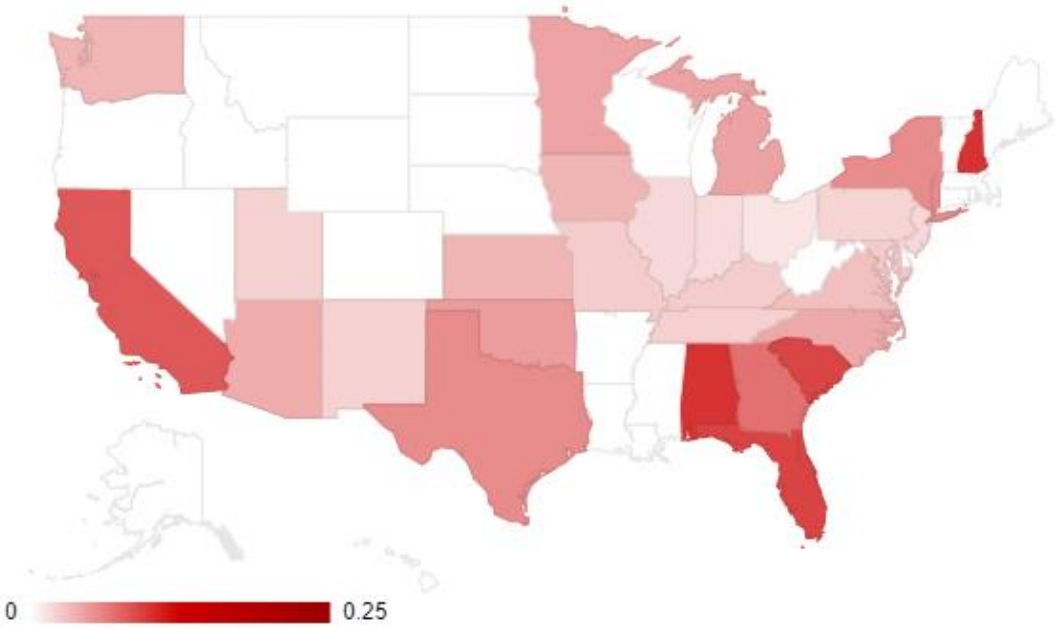
respondents together, I created one last variable using the logical “or” to capture all the women who had responded "always" to any of the questions.

Similar to the case law maps, I then normed these raw counts using the count of respondents within the state. Alabama for instance had 30 respondents. Only three (10%) responded always at least once, and twenty-four (80%) responded never for all three questions. That's a relatively high rate of both "never" responses and "always" responses. Florida, for example, had an "always" response rate of 9.15% but a "never" response rate of 66.9% or only two thirds. Washington D.C. was the only geographic area with a higher proportion of "always" responses–one of the four respondents, or a full quarter (25%).

Three of the respondents in Washington D.C. (75%) responded "never" for all three questions.

Readers following along and adding up the percentages will note that only the example of Washington D.C. adds up to 100. These are all the respondents who answered somewhere in between "never" on all three questions and "always" for at least one. I have chosen not to analyze this particular gray area. There are pros and cons to this analytic choice. To create a clearer analysis, and separate out the signal from the noise, I have chosen this restricted subset of respondents that are very different from the others. To paraphrase once more the late, great E.P. Box (1979), all models are false, but some models are useful. I would be fascinated to see other ways of solving my problem, using

Figure 5: Cases for which at least once response was “always” as a percent



my own data coding choices from Chapter 4. There's a *lot* of variance in the data not measured by these maps.

Figures 4 and 5 show the distribution of these cases as a percentage of the total cases in that state. With the exception of states that had very few respondents (Vermont, for instance, had only 2, one of which responded that she “always” experienced negative treatment for at least one question), the “nevers” seem to be concentrated in the West while women responding always at least once are concentrated in the south.

1. A note on demographics

Recall from Chapter 4 that overall respondents who said that they "never" experienced poor treatment were more likely to be members of privileged groups than their peers. Respondents who answered that they "always" experienced poor treatment were more likely to be members of marginalized groups. In particular, black women were much more likely to respond "always" across all three questions–not just the question about race or ethnicity.

Part of what this map shows is the distribution of the black population in particular and the non-white population more broadly. Part of what it shows is the distribution of the population living in poverty. Montana, for example, was recorded as 89.4% white in the 2010 census (United States Census Bureau 2012a).[124] The single largest other racial group was American Indian or Alaskan Native (6.4%). About 15.3% of the overall

[124] I am aware of the 2020 decennial census. I am using the most complete census data closest to the collection of the Listening to Mothers III dataset.

United States population was recorded as living in poverty in 2010, while Montana recorded a poverty rate of 12.6% (United States Census Bureau 2012b). Alabama, by comparison, was recorded as 66.5% White and 26.2% Black or African American in 2010 (United States Census Bureau 2012c), and a poverty rate of 19% (United States Census Bureau 2012b). A careful reader might assume that, based on this information alone, Montana would have more "never" respondents and Alabama more "always."

The regional variable was not statistically significant in any of the models in Chapter 4. Dividing up the data in that way was clearly both false and not particularly useful for increasing understanding. These maps are, however, *highly suggestive* that something distinguishes the southeast from the rest of the country in terms of birth experiences.

Conclusion

This is the last section of Part I. Part I offers answers to my more empirical questions about obstetric violence. Chapter 1 defined the problem of obstetric violence for the purposes of my study. Chapters 2 outlined the methodology of how I would measure obstetric violence in the United States, and why I chose these methods. Chapters 3 and 4 explored the two main empirical data sources. If obstetric violence is like an iceberg, then the flashy, outrageous legal cases are like the visible tip. The more quotidian, less severe cases in the survey data are the submerged iceberg lurking below the surface.

This chapter maps out a little bit more context. Severe cases occur everywhere in the United States, though court cases involving pregnancy overall are concentrated in the

south. There is no one place where cases of obstetric violence are more concentrated as a proportion of court cases. This supports broadly my assertion that legal cases are a visible tip. The mirror image, the Listening to Mothers survey, adds more context. When mapped out like this, it is easy to see that many states in the South have a high proportion of women who report extremely negative birth experiences and mistreatment. More homogenous, more prosperous states outside of that region have a higher percentage of women reporting that they never experienced mistreatment.

In Part II, I move to a different kind of sociological inquiry. Now that I have offered some answers about who, what, where, and how often, I want to know more about the *why* of obstetric violence. Chapter 6 gives more context about the history of obstetrics in the United States and how it is intertwined with the law. I then conclude with a theoretical statement about institutional arrangements and social invisibility in Chapter 7.

Part II: Reflections

This project began with two sets of questions. Part I answers the more basic, concrete questions. What is obstetric violence? Who are the victims of obstetric violence, and how often does it happen? And finally, where does it happen?

Part II turns to the other questions. How does this happen? Or more precisely, what are the institutional arrangements that enable obstetric violence?

The answers to this question, while rooted in historical facts, are less empirically driven. I'm not building or mining datasets. I do not need to describe my methodology.[125] Rather, I want to understand in a sociological sense how the institutional arrangements that allow obstetric violence to occur have developed. How is it that pregnancy came to be understood as a medical problem, or which doctors in particular have a great deal more moral and legal authority than patients? How did pregnancy come to be understood as a public issue or social problem? Finally, what does this history of these institutional arrangements illuminate about institutions, more broadly?

Part II is composed of two chapters. The first is a sociological inquiry into the history of medicine and law, in the tradition of Max Weber. The second is an exploration of the sociological theory of institutions and marginalization. Considered together, these chapters underscore a weakness in the theory of social problems: how is it that such a dire problem remains largely invisible?

[125] Though, a keen reader will I trust be unsurprised when I do.

Chapter 6 tells the story of the tightly interwoven institutional history of medicine and law. As one advances their knowledge and framework, the other must react. There is a resonance, or in Weberian terms, an elective affinity between these two institutions which makes disentangling that history a delicate task. I think it is a worthwhile one to put Chapter 7 into perspective.

In the final chapter of my dissertation, I draw from three strands of sociological theory to explain how institutions work together to render marginalized people invisible. By bringing together classical social problems theory; a theory of institutions and institutionalization; and intersectionality, I explain more fully how marginalization and privilege operate to produce extremely negative outcomes.

Chapter 6: The Institutionalization of Pregnancy

Historical analysis has fallen out of fashion in sociology. In its place, theories of the middle range (Merton 1949 [1968]) that link empirical work–largely though not exclusively statistical analyses–directly to small advances in theoretical understanding dominate our disciplinary journals.

This dissertation is in some ways a part of that tradition. I do have very simple empirical questions to answer, now that I have outlined a definition for *obstetric violence*: how often, where, and to whom does this happen? The process of arriving at that definition has made clear that there are two major institutions that claim authority over pregnancy: medicine and law.

These institutions have their own histories and structures that give context to measurements taken of them. Every amateur historian is tempted to read the present backward into history–to impose their own moral understanding of the world on the past, through the lens of the present state of human knowledge. Sociology is no different. Though, I think we are sometimes too forgiving of the faults of our own Founding Fathers.

Pregnancy has not meant the same thing in all times, and all places. My project is to measure *obstetric violence* in the contemporary United States. This chapter chronicles three related, intertwining transformations that began in the mid-nineteenth century that have had dramatic consequences for pregnancy and birth. The first is the medicalization

of pregnancy. The second is the right of the state to control reproduction. The final is the personhood or potential personhood of fetuses, and the interest of the state in potential life.

The right to privacy is fundamental to the regulation of pregnancy in the United States. Before the 20th century, births occurred most often at home–in private–and were not attended by medical professionals. Distinct from other forms of illness or medical concerns, women frequently stopped writing in journals during the period of "confinement" preceding a birth, as the possibility of death, injury, or miscarriage were considered too personal even to write in a private journal (Wertz and Wertz 1977).

As intensely private as the troubles of childbirth are, there is also a long history of considering them a public issue. From Malthusian concerns about overpopulation; to the popularization of eugenic thought on who should or should not be allowed to reproduce; to the appropriateness and availability of birth control; pregnancy has been a central issue of public debate.

In the last half of the 20th century, the public issue of pregnancy expanded in the United States. In the war of *Roe v Wade,*[126] debate about the state's interest in potential children and their rights under the law rose under the banner of the fetal personhood movement. This was a radical departure from traditional conceptions of personhood. The implications for medical practice are still hotly contested.

[126] Roe v. Wade, 410 U.S. 113 (1973)

This chapter tells the story of how pregnancy and birth, previously deemed extremely private acts to be overseen by pregnant people themselves, became institutionalized in the United States in both a medical and legal sense. This has led to increasing external regulation of women's bodies by the state with the cooperation of medical institutions.

Over the course of the nineteenth and twentieth centuries, the regulation of pregnancy has been construed as benefiting either private individuals or the collective public health. In the nineteenth century, hospitals were largely built with a Victorian understanding of morality: public charitable institutions that cared for persons deemed otherwise incurable or disabled, and sometimes those too poor to care for themselves. Even at this time, the law did not understand a fetus to be a person until birth, and the pregnant person remained most responsible for monitoring and reporting the progress of a pregnancy. Contrast this to the contemporary United States. Pregnancy has been thoroughly medicalized. The overwhelming majority of births occur in hospitals, monitored by doctors and other trained medical staff. Pregnancy is no longer understood to be a dangerous or even a private endeavor, and the expectation is that every pregnancy will end in the birth of a healthy baby.

The chapter opens with a classical sociological model of examining grand historical transformation (Section I), then proceeds roughly chronologically through different periods of medical and legal practice. The first is the initial professionalization of medicine itself, and the claims that doctors made over childbirth during the late

nineteenth century (Section II). During this period, oversight and management of birth was contested. Section III explores two historically significant medical doctors treated very differently for practicing obstetrics to underscore the turning point.

During the late nineteenth and the early 20th centuries, the United State government, social reformers, and medical doctors all asserted the power of the state to control reproduction for the public good. Section IV puts together all the pieces of this eugenic argument that we tend to treat separately in the modern context. Additionally, this period was characterized by framing pregnancy as dangerous, and separating the interests of a pregnant person from that of a fetus. Advances in medical imaging technology in the late twentieth century launched pregnancy even further into the realm of public concern. Section V tells the story of how the ability to see a fetus changed the narrative around abortion and pregnancy related care. Section VI concludes the chapter with an explanation of the rise of fetal personhood. Fetal personhood subverts the interests and legal rights of pregnant people, which in turn enables the use of state power to control pregnant people.

I. A Note on Historical Complexity

1. Elective Affinities

Sociology, at its heart, is the study of social systems. I think if you asked ten sociologists, you would get ten very different (and in some cases antagonistic) answers about what that means, or why they care.

Personally, I am interested in understanding social problems so that we can solve them, in the tradition of Marx, translated through C. Wright Mills. Their project was to understand the contemporary problems caused by institutional arrangements, and help individuals develop the ability to see and understand their problems as more than personal. Marx called it class consciousness. Mills insisted that personal troubles had to be reframed to be seen as public issues. One rallying cry of the second wave feminist movement was that the personal is political (Hanisch 1969), very much in line with this school of thought.

I also think that understanding how institutional arrangements have come to be–how particular institutions have grown up together, in either supportive or competitive relation to one another–is critical to understanding how they create problems for the people navigating them.

The classical example for sociologists approaching historical analysis is Max Weber's *The Protestant Ethic and The Spirit of Capitalism* (Weber and Kahlberg 2001[1920]). Much early sociological work is concerned with understanding the systems and problems

of modernity. Max Weber's project is distinct from many of his contemporaries. He does not want to explain the functioning of contemporary institutional arrangements. Instead, he focuses on the way these arrangements came to be. He tells a complex, interwoven narrative about how shifts in the moral understanding of work intersected with and enabled the growth of a modern, global economic system.

Weber does not say that mass conversion to Protestantism *caused* modern industrialization. Rather, he argues that a loosening of rigid institutional arrangements enabled by a cultural shift away from traditional, Catholic norms realigned all the systems around it. Americans contemporary to Weber no longer even recognized the moral claims embedded in this cultural shift though they were the apotheosis and chief prophets of them. Weber opens the book by quoting noted deist Benjamin Franklin's purportedly secular proverbs that encourage hard work to make more money. The religious origins of these now trite aphorisms were perhaps invisible even to Franklin, in Weber's mind, and certainly to Americans who quoted them a century later.[127] Weber spends the rest of the book explaining the almost certainly religious origins of these cultural attitudes, and the structural shifts that they enabled.

History from this perspective is not experienced as a series of causal relationships so much as a series of shifts in institutional arrangements. It is not so much a list of begats,

[127] Though I very much doubt it. Franklin was nothing if not a rational capitalist, and if I had to guess I would say he merely thought that stripping Poor Richard's Almanack of overtly religious content would make it a more popular seller.

or dates of important battles, but an attempt to understand the customs and lived experience of the foreign country that is the past.[128] This makes history particularly difficult to study, but essential to understanding the nature of social structures. Social understandings may seem fixed or absolute to individuals experiencing the world, but they shift in relationship to each other over time in ways that individuals often do not consciously recognize. Weber calls organic relations between ideas that feed off of one another and amplify or complement one another in largely unrecorded ways to alter institutional arrangements *elective affinities*.[129]

2. Elective Affinities of Childbirth

The institutionalization of pregnancy was facilitated by several large shifts in the moral understanding of personhood, and privacy. This chapter explores them in more detail. It is worth taking a moment to untangle some of the cultural shifts that enabled the growth of new institutional arrangements.

The first is the creation of the profession of medicine. Doctors are now thought of as having the knowledge and authority to make the best decisions about medical care for

[128] L.P. Hartley's opening line of his 1953 novel *The Go Between* is immensely quotable and underrecognized: "The past is a foreign country: they do things differently there."

[129] This is not dissimilar to Marx's reliance on a Hegelian dialectic in understanding class struggle. Whereas Marx understands the means of production as the fundamental building block of society and all struggles as class struggles, Weber suggests that history is much more complex and subtle. Marx believes the superstructure of culture is a mask to hide the real relations; Weber makes space for the idea that cultural understandings effect changes to the base of social relations. In other words, people's beliefs about what they are doing are just as important as the underlying relations of production, because they sustain otherwise intolerable institutional arrangements.

pregnant people. Their authority in obstetrics is now recognized and enforced by the law. It is difficult to imagine for contemporary Americans, but the most reliable witness in a court of law of the health and wellbeing of a fetus used to be the gestating person. Doctors were not trained, as gentlemen, in "women's complaints" and it was not considered decent for a man–even a doctor–to observe a woman's genitalia for *any* purpose.

Perhaps the most significant shift is the understanding of pregnancy as a public issue rather than a private trouble. This shift began with the growth and popularity of eugenics in the late 19th century. Understanding poverty as a moral failing was nothing new. However, understanding disease, poverty, and criminality as potentially genetic conditions that could be removed from the human race is a radical and fundamental shift in western culture. It was not Darwin, after all, but Herbert Spencer who coined the term "survival of the fittest," which was specifically used to describe the fitness of human societies and the different "races" (Falk 2020). Medical doctors played a central role in promoting institutional arrangements that supported this goal. By no means was the medical profession alone in institutionalizing reproduction as a public issue. Legal professionals were critical to ensconcing the right of the state to sterilize individuals against their will in the early 19th century United States (Cohen 2016).

Another important shift is the understanding of the fetus as a person. English common law, which guides American legal institutions,[130] hold that a person is a body matched with a mind. There are some circumstances in which persons can be compelled to accept medical treatment against their will, and they almost all align with some defect in body or mind. The ability of the state to compel medical intervention for children, persons with mental illnesses, or to compel medical treatment for suspected criminals is still limited. Throughout the 20th century, new medical technologies had allowed us to literally see the fetus. Cultural understandings have shifted from warning women that pregnancy is dangerous and the fetus is a parasite to imagining that every pregnancy, without interference, will result in a live birth (Barker 1998). A technocratic conception of medicine as heroically saving "preborn" babies undergirds much of the legal movement to give fetuses the same rights as persons (Dubow 2011, Casper 1998, Davis-Floyd 1992).

The institutionalization of medicine, medical standards of ethics, fetal personhood, the medicalization of birth, and the medicalization of pregnancy are separate but deeply interrelated histories. This chapter approaches this history partially chronologically and partially by topic area. It begins with a narrative of what pregnancy and birth was like in

[130] Some might say to our detriment. *Dobbs v. Jackson Whole Women's Health Organization* (597 U.S. (2022)) cites the legal code of Henry the First of England, dating back to 1115 C.E, which notes that the penalty to a pregnant person for killing a quick child was then death. There is no examination in *Dobbs* of what a "quick" child means, either in the context of the *Leges Henri Primi* or the long tradition of "quickening" serving as the first dividing line in American legal precedent. See below in this chapter for a full explanation, with appropriate citations.

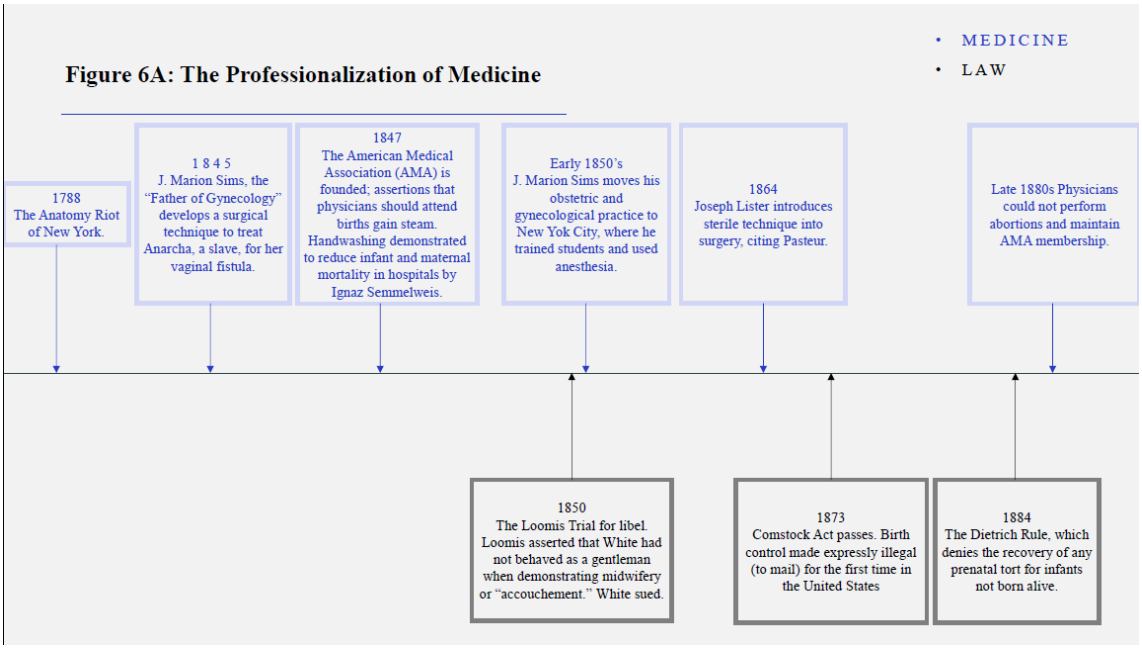
the early 19th century for American women, follows the contours of large institutional changes and landmark controversies and legal cases, and ends with an exploration of current debates in the legal precedent of fetal personhood and the criminalization of pregnancy.

II. The Professionalization of Medicine

In the early 19th century, medical doctors did not have a profession in the modern sense of the word. There was no centralized system of training, no dominant understanding of medical standards of practice or ethics, and birth was largely the realm of women, in their private homes (Dubow 2011, Leavitt 1986).

While it was a crime to conceal a birth in many parts of the United States[131] (and still technically is in some states, the statute never having been repealed), abortion was not

[131] It was illegal to conceal a pregnancy in many parts of early modern Europe, see Lewis 2016 for an exploration of the prosecution of young women for this crime in early modern Germany. Often, these young women were prosecuted for infanticide in what we might today recognize as a spontaneous abortion or miscarriage. It is truly shocking and disturbing to see such unscientific medieval nonsense as "the lung test" making a comeback in contemporary forensic examinations of miscarriages, but they certainly have (Lewis 2015).



understood as a medical procedure or particularly restricted (Reagan 1997). The moral claims of physicians as they institutionalized medical practice led to increasing public interest in the private reproductive lives of women.

Under English Common Law, fetuses were not considered to be eligible for legal protections of any kind until "quickening," that is, until the pregnant person was able to detect movement. Under English common law, injuries to fetuses could not be remedied by a tortious claim unless the fetus was born free of injury–a precedent reaffirmed in 1884 by the Dietrich Rule.[132] The *right* of a fetus to be born free of injury if born alive was not seriously debated again until 1946.[133]

132 Dietrich vs Northampton, Inhabitants of, 138 Mass. 14 (1884)

133 Bonbrest v. Kotz, 65 F. Supp. 138 (D.D.C. 1946

1. Medical Sects

During this period, doctors in the United States and other medical professionals had no uniform system of training. Often, medicine was learned as other trades: by apprenticeship, in the field. Part of the reason for this was that doctors were frequently trained using classical manuals in the 17th and 18th centuries, leading to ineffective and harmful remedies being widely promoted (Drachman 1979). When presented with clear evidence that doing something could be worse than doing nothing, many patients and aspiring physicians searched outside of formal training at medieval universities.

Doctors also had bitter arguments over the causes of and cures for diseases, some of which resulted in public health disasters. For example, before the germ theory of disease became widely accepted, the miasma theory of disease dominated institutional thinking. Public cemeteries inside cities, open sewers, and industrial waste were presumed to cause disease not through infection with a "germ" or bacteria, but through injury to a person's lungs and entry into their body–more like a poison.[134] In Victorian London, this led to the replacement of miasmatic open sewers and cesspits–and the elaborate system of shifting

[134] In some ways, the miasma theory of disease is correct. Industrial waste of the nineteenth century in particular contains toxins, such as heavy metals, that *do* poison and sicken people exposed to them, rendering individuals immunocompromised or causing neurological disorders. Under the miasma theory of disease, air could be "bad," but light and air circulation would dissipate the negative effects. This is the origin of the charming Parisian tradition of the lunch hour, strictly observed and eaten away from the workplace to minimize negative effects. The miasma theory undergirded the Progressive call to redesign cities in the late 19th and early 20th centuries. The triumph of the germ theory of disease actually by some tellings is *not* responsible for the reduction of disease mortality in the early 20th century (see McKinlay and McKinlay 1977), and may have significantly set back public health efforts by grinding these reforms to a halt.

human waste out of the city–with a vast network of water pipes and companies pumping water out of the Thames. As John Snow observed in his elaborate tracing of cholera outbreaks in the capital, homes serviced by water companies that drew their water downstream of sewage outlets were associated with more incidents of cholera than those that did not. It would take nearly ten more years for him to demonstrate that cholera was waterborne. (Johnson 2007)

Popular discoveries such as the action of electricity on the nervous system led to strange conclusions. Mesmer's theory of mental illness was that "animal magnetism" could be misaligned by electrical forces, and realignment was necessary to cure the attendant mental and physical symptoms of disrupted nerves. This sometimes took the form of communal treatment with the feeling of a ritual, including magnets passing overhead or "ethereal" music from the glass harmonica to induce hypnotic trance. (Raz 2014)

Patent medicines claiming to cure everything from baldness to warts were advertised openly in newspapers. Treatments that promised to or "restore blocked menses," that is, to eliminate an unwanted pregnancy, were advertised openly in the late nineteenth century (Reagan 1997: 8, Mohr 1978). The food and drug administration, a body regulating the advertisement of supplements and medical treatment such as abortifacients, would not be founded until 1906–nearly 60 years after the founding of the American Medical Association.

2. The Founding of the American Medical Association

Medical doctors had begun the process of professionalization before the founding of the American Medical Association (AMA) in 1847. The founding of the AMA cemented certain practices and moral claims as central to the profession of medicine. Other medical professionals, such as surgeons (Fitzharris 2017) and nurses (Bingham 1979) followed suit much later, though advances in surgery and antisepsis promoted the construction of larger and larger institutions throughout the 1860s and 1870s (Fitzharris 2017, Starr 1982).

Of particular interest here is how the burgeoning profession viewed its relationship to pregnancy and childbirth. Male physicians had, even before the founding of the AMA, begun to displace female midwives. In 1763, Dr. William Shippen was the first and only physician in the American colonies to advertise his skills with the forceps and professional knowledge of anatomy to shorten a difficult labor; by 1815 the city of Philadelphia listed twenty-one women and twenty-three men as practicing midwifery (Starr 1982: 49-50). By 1824 only six women remained listed in the city directory as professional midwives (Starr 1982: 50).

Whether this was a passive transformation or an active claim of moral authority for physicians is an area of some historical debate. There is a somewhat romanticized vision of running for the doctor in Georgian or Federalist times, when the situation is dire. Wertz and Wertz (1979) have argued that there is a kind of elite trendsetting that

occurred in this period. For wealthy women, the argument goes, the gentlemen consulted other gentlemen physicians in times of trouble, overruling the women who normally dealt with birth. This is incredibly difficult to document, precisely because pregnancy was so private; women were expected to stop writing in their journals and remain fully clothed for any kind of physician's examination, which was done entirely by touch and not sight[135]. I personally find it hard to fathom given what is known about the history of gynecology in the United States, see Section III below.

I find Leslie Reagan's argument (1997) much more convincing: that doctors used the American Medical Association to institute licensing for midwifery, then aggressively denied female midwives licenses and insisted on the prosecution of practicing medicine without a license. This drove women who could not afford private physician visits to their home into public maternity hospitals. Similar transformations occurred in many countries throughout Europe. Some of the most well-documented examples of the Medical Sect debates about germ theory in Continental Europe and the United States involved obstetric practice. Ignaz Semmelweis discovered *in 1846* that hand washing before delivering babies was the key difference driving a drastically high rate of maternal mortality in the General Hospital between patients seen by doctors and those seen by midwives (Davis 2015). It would take another 30 years for Louis Pasteur and Joseph Lister's combined efforts to get doctors to *wash their hands* (Fitzharris 2017).

[135] Imagine maintaining eye contact through that vaginal exam!

As doctors aggressively sought to stamp out and replace the private, feminine craft of midwifery, anatomical knowledge and surgical skills of the medical profession grew. While the founding of the American College of Surgeons was a half century after the AMA (1913) and the American College of Obstetricians and Gynecologists more than a century (1951), the growth of a body of common knowledge and a stock of common tools to assist in labor led to many positive results in assisting childbirth. They also led to a disastrous uptick in deaths after physicians attempted abortions: male physicians often were not trained in the use of common surgical tools to perform abortions, and the rate of complications, mistakes, and deaths was high (Reagan 1997).

One of the first major pieces of legislation that the AMA pushed after its founding in 1847 was a ban on abortions performed by untrained members of the "medical sects" (Conrad and Schneider 2008). Medical doctors closely aligned themselves with social workers and considered public health to be a professional duty (Conrad and Schneider 2008, Starr 1982). They aimed to promote public health primarily through pushing regulations of the urban environment and the individual behaviors of the poor (Conrad and Schneider 2008, McKinlay and McKinlay 1977). The crusade against abortion in this period was understood by doctors not only as rooting out their professional competition (as regular members of the AMA could not perform abortions and maintain their status as members by the late 1880s, see Reagan 1997) but also as protecting vulnerable women from risks to their health.

Medical doctors campaigned successfully to make practice of medicine by anyone but doctors illegal, and abortion was one of their first and most successful such attempts to weaponize the state (Reagan 1997). By 1907, a report to the New York City officials suggested that "the term midwife is synonymous with the term abortionist" (Reagan 1997: 90), and to be either was a crime.

Birth control methods first became expressly illegal in 1873, when the United States Congress passed the Comstock Act. It included prohibitions against obscenity in the form of providing birth control.[136] The act is somewhat unique in that Anthony Comstock, as a private citizen with no interest in social welfare or training in medicine, drafted the Act himself and presented it to Congress (Reagan 1997). Comstock thought that even distributing medically accurate information about birth control or anatomically accurate information about human reproduction was obscene. At the time, this position was popular in the AMA. States rapidly followed suit, passing a barrage of laws that remained enforceable until the middle of the 20th century.

III. Crossing the Boundaries of Decency

By the middle of the 19th century, medical doctors were staking a widely accepted claim to the practice of obstetrics. Female midwives, lacking formal training but

[136] Obscenity laws are still used to control sexual behavior among vulnerable or marginalized groups, such as the queer community. Reinstating Sodomy Laws has been a key campaign issue for the governor's race in states like Virginia since at least 2010, where sodomy is defined in the medieval sense as any sexual contact that does not have procreation as its main object. I plead the fifth on whether or not I was a felon while I lived in Virginia.

often possessing more practical experience than physicians, had difficulty maintaining a practice increasingly dominated by male physicians, collectively lobbying via the AMA. Middle and upper class women preferred to hire men to attend on them during birth as a status symbol, and their preferences made the task of prosecuting non-physicians a much simpler proposition (Reagan 1997).

Obtaining specialized training in birthing practices remained difficult for male physicians. Doctors who crossed the boundaries of decency often faced social and legal consequences for their actions. This section explores one illuminating example and underscores how the "father of modern gynecology" J. Marion Sims successfully crossed the boundaries of decency to found a successful surgical practice. To obtain the experience necessary to claim expertise and attract wealthy white patients, doctors like White and Sims took advantage of the lack of power of poor or black women.

1. The Loomis Trial

The Loomis Trial of 1850 was widely publicized in contemporary newspapers, and produced a flurry of letters and articles in the press. It illuminates the tensions within the burgeoning medical profession. On the one hand, more rigorous training was vital to the claims of professional legitimacy. Better care and better outcomes would dramatically aid members of the AMA in the prosecution of experts such as midwives practicing without a license.

On the other hand, young men in training to become physicians had to fight to be recognized as respectable. The 1788 Anatomy Riot in New York was perhaps the most dramatic instance in the United States of medical professionals being held responsible for criminal acts. Because the growing profession required dissection specimens to train its newest members in anatomy and so few were available, doctors often resorted to paying grave robbers to obtain subjects. A riot broke out when a young medical student waved the arm of his cadaver at a group of young boys to frighten them away.[137] The reputation of physicians had recovered somewhat by the middle of the 19th century, but professionals frequently accused each other of indecency in flamboyant public displays of virtue. Male birth attendants were "...expected to act simultaneously as doctors and gentlemen" (Drachman 1979:70).

Having trained in Europe as an "accoucheur" (a birth attendant similar to but distinct from a midwife in that the focus of expertise was in particular techniques to assist with birth), Dr. James Platt White gave a public demonstration to medical students of how to manage labor in January of 1850. Specifically, Dr. White wanted to show students how to properly support the head of a crowning baby without hurting the laboring patient. He obtained permission from his patient to remove certain items of her clothing to demonstrate the technique for a group of about twenty students of the Buffalo Medical

[137] With perhaps the worst case of bad luck, the student had teased "This is your mother's arm, I just dug her up" to a young boy whose mother had actually just died and been buried in a pauper's grave.

College. It was the first such demonstration ever allowed in the history of the United States.

An anonymous colleague, later identified as Dr. Horatio Loomis, wrote a letter to a commercial newspaper calling such demonstrative midwifery "medically unethical, pedagogically unnecessary, and professionally unsound" (Drachman 1979). Dr. White sued "L" for libel after Loomis began circulating copies of the paper among wealthy patrons of the college.

Crucially, White offered a very specific justification for his breach of feminine modesty and ungentlemanly conduct. While middle and upper class women in private practice would never be used as technical objects at the college, the patient in question was an unwed woman, recently immigrated from Ireland. Despite the testimony of students that her genitals were covered during the actual delivery, her status as a woman in need of charity rendered her less worthy in the eyes of both the medical and legal professions. Her care was provided for free on the understanding that she was obligated to assist in the educational mission of the college and its hospital.[138]

In spite of that, Dr. Loomis was found not guilty of libel. The American Medical Association, after commissioning a study through the Education Committee rather than the Committee on Obstetrics, declined to endorse demonstrative midwifery as an appropriate educational tool.

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[138] Rebecca Skloot explores a more contemporary and consequential example of the long life of this view of medical ethics in *The Immortal Life of Henrietta Lacks.*

2. The Father of Modern Gynecology

Poor and marginalized women, though not used as technical objects for demonstrative midwifery in the nineteenth century, were nevertheless viewed as having an obligation to submit to examinations and more private demonstrations in public hospitals. The invention of ether rendered the demonstration of pelvic examinations more palatable to students and patients alike: an unconscious patient is incapable of interaction, or crying out in pain, or protesting rough treatment. To this day some physicians feel that it is easier to teach techniques for vaginal examination when the patient is unconscious, whether patients have consented or not (See Goldberg 2020).

Black women in particular bore the brunt of medical charity in the middle and later 19th century United States (Owens 2017). Before the Civil War and the passage of the Civil War Amendments, black women with obstetric complaints could be bought and sold in many states without any concern for either their modesty or their consent.

One particularly enterprising physician in the arena of gynecological surgery was James Marion Sims. Gynecology and obstetrics had long been considered a surgical speciality because birth required attendants to manipulate areas inside of the patient. Actual surgery, however, was rare and often fatal. In a time before the astonishing dual discovery of sterile techniques by Joseph Lister and Louis Pasteur, surgery of even the most minor kinds was a last resort.

Sims had long been a doctor primarily to enslaved people on plantations in Alabama. He recorded his theories about illness among the enslaved that were very typical of the proto-eugenics and Victorian morality of the day. Illness among enslaved people, in his mind, was caused by intellectual inferiority and laziness (Washington 2006:62). A common theory about the intellectual inferiority of black people was that their skulls fused too early as infants, stunting the growth of their brains.[139] Sims conducted experiments meant to keep the skulls of black infants from fusing, thus improving their value. When the infants died, he blamed the inherent intellectual inferiority and unwomanly nature, rather than the material conditions of slavery such as malnutrition and physical abuse (Washington 2006:63).

In 1845, a patient presented to Sims with a very common birth injury: the vaginal fistula. A fistula is a medical term meaning a hole which connects the internal organs to the outside world, generally in muscle tissue whose action prevents healing.[140] Because the vagina is made up of smooth muscle, the strain of long labor can easily cause such a tear. Due to the nature of the muscles in question, tears did not heal cleanly or easily, if

[139] The smallness of marginalized people's skulls and phrenological justifications for eugenics were cutting edge anthropology of the mid 19th century. Emile Durkheim writes of how modernity makes women weaker and less intellectually capable based on what was at the time cutting-edge forensic anthropological evidence from it in *The Division of Labor in Society* (Durkheim and Simpson 2013).

[140] Louis XIV famously suffered from a fistula in his perineum. Similar to J. Marion Sims, the French physician called on to treat the monarch required a year to test his theories of how to proceed on seventeenth century French peasants before he would dream of operating on the king. Speculation about how this injury came about was rampant at the time, but King Louis' preference for only the finest of white breads and cakes was probably a contributing factor to his extreme difficulty in producing regular stool.

they closed at all. Many women of all stations experienced painful and embarrassing problems for the rest of their lives due to the complex nature of the injury.

In the antebellum period, slave owners could not import a fresh supply of labor but demand for cash crops was rising ever higher. Chronic malnutrition among enslaved women and the lack of surgical techniques to aid in difficult births led to debilitating injuries of black women. Black women often had no choice in their reproductive lives because they represented such a valuable commodity, and were forced to bear more children by their enslavers (Owens 2017, Washington 2006).

Sims took great delight in, as he put it, seeing "everything as no man had seen before" (Washington 2006: 64). Though ether had been discovered and was commonly used for surgeries, Sim refused to give the eleven fistula patients any anesthesia. Over the course of approximately four years, Sims perfected his technique. By the early 1850s, Sims had moved his practice to New York City and founded the country's first hospital for women. He administered ether and morphine to his patients there, who were often middle or upper class white women. When he wrote papers describing his techniques or gave lectures, he omitted the information that he had conducted medical experiments on enslaved women (Washington 2006).

Today, the ethical breaches of Sims are clear and legion. He continued to practice surgical techniques in the south on captive slaves for many years. He actively concealed how he had acquired his experience, and implied that he had the consent of poor white

women to practice his surgeries, as would have been acceptable at the time. He created a distributional injustice by developing experimental surgical techniques on marginalized people, then profiting from that research in clinics for the wealthy and on the lecture circuit abroad. (Washington 2006)

Sims pioneered surgical techniques. He also pioneered the expansion of medical authority over reproduction. He did it in the same way as Dr. White before him: using his power to render marginalized women as technical objects for study. In the post-Civil War Era, Dr. Sims was a staunch eugenicist that advocated for the forced sterilization of the kinds of women he had formerly experimented on (Owens 2017). By the early twentieth century, the model of pregnancy as a public concern that Dr. Sims advocated was widely accepted by his peers–even for the wealthy white women whose privacy and modesty Sims had advocated.

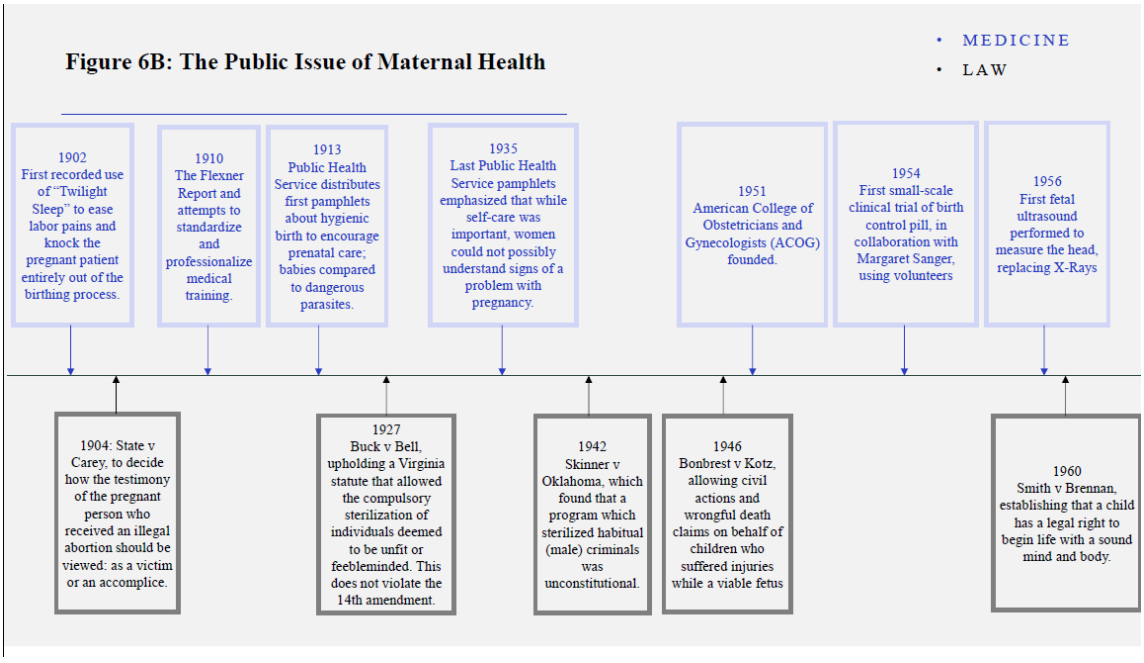
IV. The Public Issue of Maternal Health

1. Prenatal Care

Once medical doctors successfully marked birth as their purview and demonized midwives, their attention expanded. In the early 20th century, the American Medical Association collaborated with government officials at the national and state level to medicalize not only healthy delivery of babies but also the healthy gestation of babies.

This involved reconceptualizing pregnancy as a public rather than a private concern as well as dangerous rather than natural–in fact, as an illness.

At the turn of the century, no formal program of prenatal care existed (Barker, 1998). However, by the time the Flexner report was published in 1910 and medical schools became more tightly regulated, the AMA had solidified its understanding of pregnancy as an illness that should be monitored by medical authorities both before and after the actual event of giving birth (Conrad and Schneider, 2008). The utilization rates of prenatal care remained stubbornly low among women; while no firm data exists, Kristen Barker (1998) estimates that less than 5 percent of women sought out prenatal care–and then, only in the case of extreme complications.



Doctors had difficulty convincing the public of the necessity of prenatal care for all without help.[141] They enlisted two different kinds of help. They united forces with social workers and practical sociologists such as Jane Addams to combat maternal and infant mortality among poor, urban women (Reagan, 1997). Addams was herself convinced by medical doctors that midwives were responsible for disproportionately high infant and maternal mortality rates in spite of the fact that among both "professional" physicians and midwives, the outcomes of births and abortions varied dramatically by training and experience (1997, see especially Chapter 2).

One example of the tensions at play in the time period is the Connecticut Supreme Court case *State v. Carey.*[142] Rather than prosecute the patient who obtained an abortion for the crime, it targeted the person who had provided it. Indeed, the issue in the case was how the testimony of the pregnant person should be viewed: as a victim or an accomplice. Most state abortion statutes of the time targeted the provider rather than the pregnant person, and were used to criminalize midwifery (See Reagan 1997).

The AMA also solicited the help of government officials from the Public Health Service to create and distribute pamphlets directly to women that promoted a biomedical

[141] Note that some public health and hygiene measures were actively opposed by progressive feminists. For example, when vaccinations were not evenly applied annually, they were not effective. Some feminists argued that of course only the black and the poor carried disease, and so only they ought to bear the risk of vaccination. Others underscored how ineffective and unjust such a policy was, and argued that unless and until all persons would submit to vaccination the forced vaccination of black and poor citizens was unjust and should not be permitted, see Leavitt in Reverby and Rosner, 1979.

[142] State v. Carey, 76 Conn. 342 (1904)

understanding of pregnancy and urged women to seek prenatal care (Barker, 1998). By the time the first pamphlet was distributed in 1913, the AMA had successfully promoted gynecological and obstetrical care among rich women, but prenatal care rates were still incredibly low. These pamphlets framed pregnancy as a public health problem not because the state had an interest in protecting potential life, but because the developing baby was a danger to the person gestating it. The fetus was a parasite, something that could harm the mother. This is a far cry from having legal rights, but it does mark the beginning of official government involvement in promoting the idea that fetuses have separate interests from pregnant people. In early versions of this publication, the focus was on encouraging women to care for themselves and seek medical advice as a precaution, or when they felt it was necessary.

However by 1935 (the last publication of these pamphlets), the focus had shifted. They emphasized that while self-care was important, women could not possibly understand the signs that something might be wrong with their pregnancy. Barker (1998) also argues that the focus had shifted from protecting the pregnant person to protecting her fetus–that is, the major concern was not the injury *caused by* the fetus any longer, but injury *done to* the fetus, even by inattention. By the latter half of the 20th century, the concern of public health professionals had transformed from protecting women from the "parasites" and "tumors" growing in their bodies (Barker 1998, Oakley 1987) to protecting the public from the cost of "unhealthy" or "abnormal" fetuses (McKeown,

1976). That is, the conception of a fetus as a separate entity with separate concerns transformed the understanding of how health during pregnancy impacted society and how women should and could responsibly monitor the health of their fetuses.

2. Promoting Hygienic Birth

Medical doctors had long made moral claims about who should and should not be giving birth, and which women should be treated with modesty and dignity. The AMA crusade against midwives and abortionists was not only a matter of individual health and safety, but also of the health of society as a whole. Many prominent public health advocates from Margaret Sanger to Dr. Harry J. Haiselden were eugenicists to varying degrees.[143] In practice, the policies championed by eugenicists ranged widely. Undergirding them all was a fundamental belief that the birth of injured or "defective" infants was a public issue rather than a private concern, and that the state had the (patriarchal) authority to control the reproductive lives of citizens.

This was enabled by the gradual shift in viewing pregnant people themselves as the primary expert in giving birth to medical doctors as experts in manipulating technical objects. Pregnancy in this period shifts from being conceived of as a natural process to a mechanical process–and women are machines in this process (Tone 2012). Even

[143] Modern critics of Planned Parenthood, founded by Sanger in 1916 to meet the needs of women desperate for family planning and birth control, note with glee that Sanger was a eugenicist. In fact she saw abortion as a barbaric practice and likely helped in the prosecution of midwives. Her advocacy for birth control was most steadily aimed at eliminating genetic defects such as Down's Syndrome rather than at achieving racial purity. See Gandy 2015.

prominent feminist Ellen Key described motherhood as "the natural *function* of women" (Miller 1979, emphasis added).

Pain management during labor and delivery became a primary concern of physicians in this period–not only because physicians sought to increase their authority through the increased adherence to technocratic regimes, but also because women themselves advocated for access to the advances of medical science (Wolf 2009, Miller 1979). Suffragists and feminists were often middle class or wealthy white women–the ideal women to be giving birth in the minds of many civic minded physicians (Pernick 1999). Their concerns were heard, their tastes and self conceptions catered to in the management of labor and delivery (Wolf 2009).

The "twilight sleep" became a popular demand in the 1910s to ease the suffering of labor. The first recorded use of a combination of two powerful narcotics (morphine and scopolamine) was in 1902. Early medical texts that mention the technique use words such as "dangerous" or "unnecessary" to describe it (Miller 1979). Yet women asked to be given drugs that would render them unconscious for the process of birth. This practice continued into the midcentury, and produced many photographs that to a more contemporary observer appear macabre: women lying still, minutes after giving birth with their hair perfectly coiffed and a full face of makeup, eyes closed and unable to support their infants alone (Wolf 2009).

Hygienic birth also encompassed the administration of postnatal care to premature babies. In an era before NICU and when "weakness" was considered hereditary, prominent eugenicists advocated that it was immoral to give care to babies who were, in their minds, clearly unfit (Pernick 1999). Dr. Harry Haiselden went so far as to very publicly advocate for the withdrawal of care from such infants. He produced and starred in a film that was distributed by the National Health Service in various forms for forty years that dramatized these events (Pernick 1999).[144]

Hygiene encompassed a wide variety of popular practices with little scientific merit. Indeed, breastfeeding was viewed as less hygienic than the use of formula (Wolf 2001). Wealthy and middle class women had begun to reject breast feeding in favor of the use of wet-nurses in the mid to late 19th century. Queen Victoria of the British Empire famously rejected becoming a "cow" for her children.[145] It seems that this fashion among wealthy, white women was adopted by the medical profession as infant formula became available, rather than any scientific evidence that the more "hygienic" use of formula improved infant or maternal health (Wolf 2001).[146]

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[144] Interestingly, as Martin Pernick notes in *The Black Stork*, Haiselden was such a staunch believer in hygienic marriage and the procreation of children that he never married. History is silent on what Haiselden's particular disqualifying defect was, but no one can accuse him of hypocrisy on that account.

[145] Victoria also infamously loathed the state of pregnancy almost as intensely as she enjoyed the physical act of procreation. Her dislike of breastfeeding is particularly ironic since extending breastfeeding is a semi-reliable form of birth control which might have decreased the number of children she bore during her child-bearing years–nine in total.

[146] This is particularly deplorable in light of the scandalous promotion of formula in Africa by the Nestle corporation, which led to the death by malnutrition or from infection due to the use of contaminated water of thousands of infants.

Finally, hygienic birth was promoted among the wealthy, socially prominent class of women by continuing the crusade to outlaw abortions.

3. Preventing Unhygienic Birth

The foundational Supreme Court decision that enshrined the authority of the state to prevent pregnancy was *Buck v Bell* (1927). Even casual scholars of legal history are probably familiar with the words of Justice Oliver Wendell Holmes, who penned the 8-1 opinion: "Three generations of imbeciles are enough."[147] The court upheld a Virginia statute that allowed the compulsory sterilization of individuals deemed to be unfit or feebleminded, finding that the statute did not violate the the 14th Amendment.

It is worth exploring what the terms "unfit" or "feebleminded" meant in this case. Carrie Buck was the daughter of a woman committed to the Virginia State Colony for Epileptics and Feebleminded near Charlottesville, Virginia. The only "mental defect" recorded of Carrie's mother was that she suffered a "peculiar mental defect" and "lacked moral sense" to prevent her from committing the crimes of vagrancy and prostitution (Cohen 2016:22, citing court records). She was committed involuntarily to the colony, and Carrie was taken in as a servant. The colony may have been kinder than prison, but Carrie's life became dramatically worse. In 1923, Carrie was raped by the nephew of her adoptive family. She was committed to the colony along with her mother until she

[147] Buck v. Bell, 274 U.S. 200 (1927)

reached the age of 18. She was separated from her child, and sterilized against her will before her release. (Cohen 2016)

The legal case was specifically designed to secure the rights of medical doctors to act as the enforcers of state power over the reproductive capacity of "unfit" persons. Dr. Albert Priddy, then the superintendent of the colony, was chosen to spearhead the effort from among the prominent Virginia eugenicists (Cohen 2016). Their goal was to secure the right to protect the (white) race by securing the right to prune the branches of the evolutionary tree. Francis Galton, nephew of Charles Darwin, was a staunch advocate for these policies, along with sociologist Herbert Spencer. Eugenic sterilization found a welcome home in the United States at a time when progress meant securing the future for only a particular class of people and their tastes: white people able of body and mind.

Notably, *Buck v Bell* was weakened slightly by the court's decision in *Skinner v. Oklahoma* (1942).[148] The court found that a program which sterilized habitual (male) criminals was unconstitutional. While the Americans with Disabilities Act of 1990 lends some protection, *Buck v. Bell* is still considered to be a valid legal precedent. As Dorothy Roberts notes, the regulation of disabled bodies in this way is problematic because "Locating the problem inside the disabled body rather than in the social oppression of disabled people leads to eliminating these bodies as the chief solution to impairment" (Roberts in Kirkland and Metzl 2010:66). In other words, advances in technology that

[148] Skinner v. Oklahoma 316 U.S. 535 (1942)

focus on the fetus as defective–or indeed, defective people gestating fetuses–ignores evidence that health is socially determined and rooted fundamentally in social conditions of inequality (Link and Phelan 2010, Marmot 2005, Link and Phelan 1995).

4. Two Edges of the Same Sword

Sterilization and banning abortion seem diametrically opposed. One prevents births, while the other forces them to occur. The fact that the AMA was advocating for both underscores the ways in which doctors successfully used their status as experts to promote a particular legal agenda. Eugenics was not particularly controversial in the United States before World War II. Indeed, the National Health Service created and circulated motion pictures that promoted "hygienic" marriages and births beginning in about 1915 (Pernick 1999).[149]

Promoting childbearing among middle and upper class white women was the purpose of criminalizing abortions. Sterilizing mentally infirm, physically disabled, poor, or otherwise "unfit" people prevented the "wrong" people from having babies. Promoting prenatal care to ensure that babies were born healthy and free from defect also expanded the role of doctors in choosing who was fit to bear children.

[149] You can still find many of these gems from the 1940s and 1950s on YouTube, including the original Reefer Madness. They often don't mention contraception, but try to discourage 18 year olds from getting married because babies are such a *drag* and make you poor.

These three interrelated legal battles of the AMA cemented the position of doctors as experts in maternity and obstetrics care. By using the courts to wage these battles, doctors of the AMA also turned pregnancy and birth from a private issue into a public one.

V. Seeing is believing: Public View and Fetal Personhood

By the middle of the 20th century, infant and maternal mortality rates had begun to decline. Public health measures promoted by doctors and social crusaders of the early decades of the century had caused a steep decline in childhood diseases, and vaccines against them were in active development (McKinlay and McKinlay 1977). Public health, and in particular nutrition, had advanced so much that the prospect of delivering a healthy baby from any given pregnancy was more certain than ever.

This period is often seen as a kind of golden age for the profession of medicine (McKinlay and Marceau 2002). Professional authority of medical doctors had reached its zenith. Advances in technology and an economic boom in funding for medical practice brought about a proliferation of specialties and subspecialties. The American College of Obstetrics and Gynecology, for instance, was founded in 1951. As a younger generation of physicians came into practice, the moral compass of the profession shifted decidedly. Rather than collaborate with the state and social activists, medical doctors as a whole staked out new areas of practice to claim moral authority and promote the prestige of their profession (Starr 1982).

The baby boom of the post World War II era was preceded by the enforcement of laws prohibiting birth control even for married couples. Laws preventing unsuitable persons from becoming married had become popular as part of the eugenics movement in the late 19th century, but were becoming unpopular. Indeed, more and more doctors had begun to object to the idea of the state intruding in private matters. In the wake of the revelation that many medical doctors had actively participated in Nazi atrocities, physicians closer to home were scrutinizing the standards of ethics and practice around them.

1. Fetal Imaging technology

The history of seeing the fetus as an individual separate from a pregnant person is also the history of doctors coming to see the fetus as a patient with needs that sometimes conflict with the needs of the pregnant person. As medical technology has helped to overcome the boundary between the inside and outside of the womb, the fetus is easier to conceptualize as a person. Certainly, the social and legislative push for personhood was aided when we saw how life-like the fetus was (Ginsburg, 1989). Indeed, deploying medical technologies that permeate the womb have become an arsenal in the anti-abortion crusade; if women could only see their babies, then perhaps abortions could be avoided (ibid).

The transformation of pregnancy into a medical and technical problem required a new regime of measurement. In the early 19th century, pregnancy was measured largely by

pregnant people. Doctors rarely wrote notes about pregnancy because they were rarely called to visit pregnant patients; female diarists often, as was custom at the time during illness, did not document birth either (Wolf 2009, Leavitt 1986). The legal standard for tortious claims for damage to a fetus was the "quickening," measured by when a woman felt a fetus moving or "taking root" (Bordo 2003). By the middle of the twentieth century, startling advances had been made in safely performing C-sections (Wolf 2018). By the late 20th century, imaging technology had advanced so much that we could so accurately measure fetal distress that surgery to a fetus in utero had become possible–the last, heroic frontier in the minds of some doctors (Casper 1999).

Corresponding to this transformation in our ability to see inside a womb (though not always to accurately utilize the information, see Morris 2013 on the harm caused by fetal heart rate monitoring) is an extension of the power of doctors, who control the knowledge production and imaging technology that is considered to be the most accurate way of knowing a fetus.

Reliance on medical technologies and expert opinions above the direct observations of patients distances the subjective experiences of women. As Oakley points out, "Once it is believed that the machine is less fallible than the woman then the woman does not need to be asked anymore" (Oakley 1987: 51). The regularization of medical standards of practice superseded first the pregnant person's perception of the "quickening" and then dismissed their experience entirely by replacing the important turning point of pregnancy

from the “quickening” to “viability” (Dubow 2011). “Viability” appears in the legal lexicon as a rigidly defined medically controlled point in the pregnancy, though such a claim is dubious at best.

Furthermore, the understanding that medical technology is “scientific” and “objective” is deeply contestable. As Oakley (1987) points out, medical technologies such as X-ray and ultrasound were originally applied to pregnancy almost accidentally, on the understanding that fetuses were similar to a tumor (ibid, 44). Technologies for fetal imaging, like many medical technologies, were not evaluated extensively for safety before being put into use. X-rays were later found to significantly (both substantively and statistically) increase risks for fetal complications. The first RCT of ultrasound for effective detection of problems and therefore better pregnancy outcomes was not published until nearly 20 years after it became widely used.

Even after regulations were passed in the United States requiring doctors to record precisely which technologies they used during delivery and which medical procedures were performed, no rules existed about recording antenatal examination technology– which serves to preserve the power of doctors as the interpreters of truth. As Bordo puts it, this “...has required that the body’s meanings be utterly transparent and accessible to the qualified specialist (aided by the appropriate methodology and technology) and utterly opaque to the patient herself” (1993: 66). Indeed, even when the production of reproductive technology is marketed as giving women “control” over their knowledge of

their bodies–such as home pregnancy tests–these instead come to serve as the indicators of when women should submit to external control (Tone 2012).

Dubow (2011) argues that a medicalized understanding of pregnancy transformed the embodied experience of pregnant people into an irrelevant detail; doctors no longer relied on women to tell them that the baby had "quickened" –not inconsequentially the point at which common law had previously held that a fetus was commonly criminalized.[150] The doctor takes control of diagnosing and treating fetal illness and the pregnant person is expected to passively accept expert opinions. Rather than pregnancy being a process of two subjects being embodied together as a set of subjective observations, technological advances purport to be objective facts (Bordo 1993).

A telling example of the ways that the medical professional maintains control of pregnancy is the invention of the at-home pregnancy test. A reliable, fast, and technically simple test to determine pregnancy was created in 1967 (Tone 2012). Doctors in particular had long desired this technology for their own practices. They fought against releasing it to the public. The consequences of allowing untrained people to discover, for themselves, what was happening inside their bodies reopened old wounds. What, doctors argued, would young people do if they had access to inconvenient information in the privacy of their own homes? The answer they feared was that young people would

[150] Dietrich vs Northampton, Inhabitants of, 138 Mass. 14 (1884)

engage in risky sexual behavior and then risky or immoral actions to deal with the consequences of that behavior, such as illegal abortions.

It undermined the ability of doctors to control the choices their patients made to allow them to find their own information. This underscores that controlling information and patient choice was especially important to physicians of reproduction.

2. The Right to Privacy

In addition to technological advances in literally seeing the fetus, there were advances in birth control technology in the middle of the 20th century. Margaret Sanger spearheaded both a long campaign to repeal Comstock laws and an effort to create a safe, effective, reversible birth control method that could be taken as a pill in the privacy of the home. The cause gained traction in the medical profession as time went on, as well as the campaign to legalize abortion (Reagan 1997).

The first hormonal birth control pill was put on the market in 1950. It would take another fifteen years for a successful challenge at the Supreme Court of the United States to recognize the right to the private use of contraception by married couples.[151]

It is noteworthy that many of the clinical trials conducted before the commercial release of the first hormonal birth control were conducted under the guise of a "fertility study," and without the full voluntary and informed consent of patients. Dr. John Rock

[151] Griswold v. Connecticut, 381 U.S. 479 (1965)

conducted a small trial in collaboration with Margaret Sanger in 1954. The first large-scale clinical trial began under the direction of Dr. Gregory Pincus in Puerto Rico in 1956, again without the informed and voluntary consent of the largely impoverished residents of a public housing project (Liao and Dollin 2012).

The legal precedent most closely associated with the right to make private medical decisions is *Roe v. Wade.*[152] The decision of the Supreme court also established in legal precedent the understanding of pregnancy as entirely medicalized–that is, as being a medical problem or illness whose symptoms are diagnosed and managed by medical providers. In *Roe,* doctors are the experts. The right to privacy in the relationship between the patient and provider underscores that pregnancy falls under the institutional authority of medicine. I will explore further in Chapter 7 what sociologists mean by institutionalization and illness. This is known as the viability standard, which ends the legal right to abortion at the point in a pregnancy when a fetus is capable of surviving outside of the uterus. There is widespread disagreement about the precise point in pregnancy when a fetus becomes viable, and it is the source of ongoing efforts to regulate and eliminate access to abortion. Generally, 24 weeks gestation is recognized as the point of viability because the chance of survival of the fetus rises above zero percent.

[152] Roe v. Wade, 410 U.S. 113 (1973)

Abortion and pregnancy were further ensconced as a medical procedure firmly under control of medical authority in *Planned Parenthood v. Casey.*[153] The decision strikes down the spousal notification restriction, but upholds all the rest of regulations. That is, it held that the state of Pennsylvania could and in some ways, had a duty to regulate abortion like all other medical procedures and personnel. This finding paved the way for Targeted Regulation of Abortion Provider (TRAP) laws that attempt to make it impossible for free-standing abortion clinics to meet the regulatory requirements to operate.

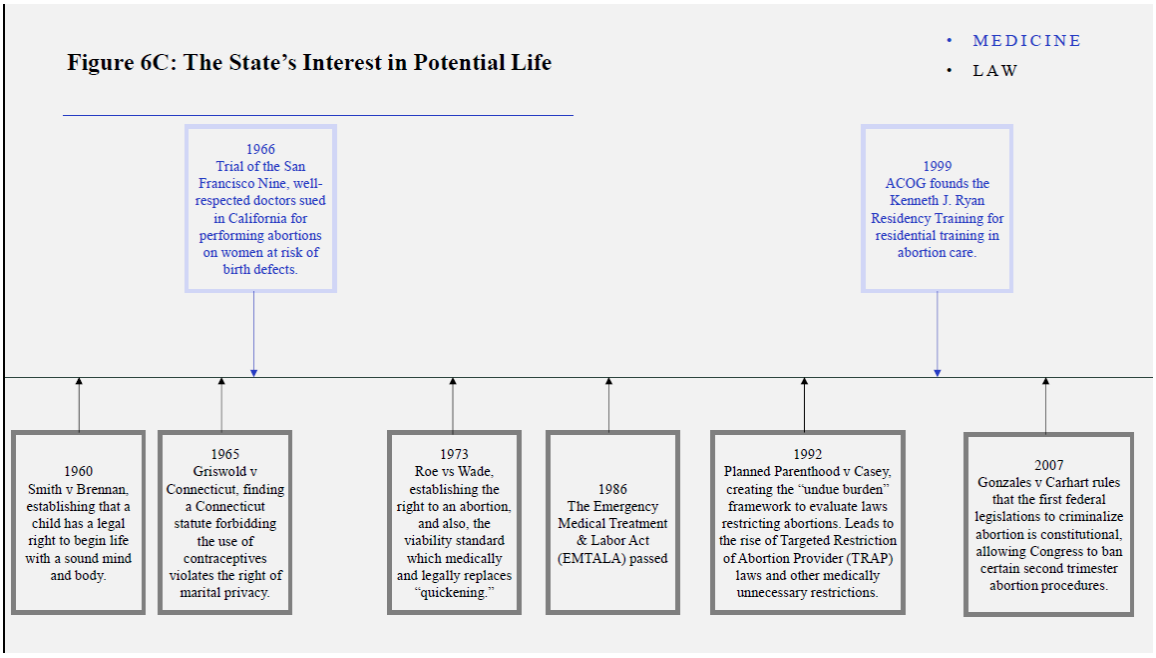
VI. The State's Interest in Potential Life

Much of the legal precedent in the last 50 years surrounding the bodily autonomy and constitutional rights of pregnancy is tied to cases involving abortion, rather than cases involving a pregnancy that ends in the birth of a child. A great deal of case law surrounding medical practice and pregnancy is also tied up in the state's interest in potential life–an idea that is tied directly to Roe v. Wade (1973) and the viability standard. In this section, I examine the legal definition of personhood, the development of case law surrounding fetal personhood and viability, and the way that the doctor becomes the valid legal expert.

[153] Planned Parenthood v. Casey, 505 U.S. 833 (1992)

1. When can we violate the rights of people?

The definition of personhood most often cited by those who oppose applying the label of personhood to fetuses is: a mind paired with a body (Fox 2014, Bordo 1993). Medical intervention against the wishes of individual persons is generally approved by courts when the definition of personhood is violated in some way and aims primarily to preserve the mind or body until the individual in question can once again make their own decisions. There are three main categories of individuals that violate the standard definition of personhood which courts have ordered medical treatment for: mentally ill or insane persons, who have a body but who are figuratively "out of their minds"; children, whose minds are not yet developed, making them legally incapable of consenting to medical procedures and whose parents may take action against the interest of their health;



and pregnant people, who are persons themselves but have two bodies and only one mind (Cherry 2004, Bordo 1993).

2. Can we prosecute crimes against fetuses?

It is only recently that women have begun to be successfully prosecuted for crimes against their fetuses. When the question of prosecuting crimes against or recovering damages for harms done to fetuses first arose in 1884, the Dietrich rule was proposed which held that damages to fetuses are not recoverable separately from damages to the pregnant person.

The earliest case to consider indirectly the question of prosecuting women was *State v. Carey* (1904).[154] The Connecticut Supreme Court found that a pregnant person who obtained an abortion was a witness to a crime, but not an accomplice in it. This did not rule out the prosecution of pregnant people for crimes committed against their fetuses, though it did not actually open the door to such prosecutions either. The contemporary interpretation of the significance of Carey is found in *State v. Ashley.*[155] In Ashley, the pregnant person attempted to kill herself and the state found that the mother could not be prosecuted for the death of her (viable) fetus.

[154] State v. Carey, 76 Conn. 342 (1904)
[155] State v. Ashley, 701 So. 2d 338, 340 (Fla. 1997)

Additionally, two other contradictory cases stand out in the recent legal catalog: *State v. Gray,*[156] which held that the moment of birth is the moment that a fetus becomes a child, and it is inappropriate to prosecute women for harm they caused to their fetuses before birth, and *Whitner v. State,*[157] which finds that child abuse statutes apply to viable fetuses and women can be prosecuted. The issue is not privacy or protection from intervention, or rights of doctors to practice medicine, or the rights of individuals to receive or seek out medical care. The issue under consideration is the extent of medical intervention that violates informed and voluntary consent or legal action against pregnant people that is permissible to protect potential persons. Gray holds that fetuses are, for the purposes of the child endangerment statute, not commonly understood to be children. Whitner on the other hand holds that some fetuses are different from others–that is, once past viability, a fetus is so close to being a person that the distinction is immaterial–and criminal action against individuals who harm them is permissible, implicitly compelling medical intervention.

Recall that in 1884, the injury of the fetus was not held to be recoverable separately from injury to the mother (Dietrich rule (1884)). In Bonbrest v. Kotz (1946), that changed; a fetus that was viable–that is, capable of sustaining life outside the womb–was, in the court's mind, now a separate legal entity, who can be legally wronged. The author

[156] State v. Gray, 584 N.E.2d 710 (Ohio 1992)
[157] Whitner v. State of South Carolina, 492 S.E.2d 777, 780 (S.C. 1997)

of the decision writes in the strongest terms that "The absence of precedent should afford no refuge…," and that viability, rather than birth, should be the standard for separately recoverable damages (Bonbrest v. Kotz 1946).

Smith v. Brennan (1960) pushes this further. It established that "a child has a legal right to begin life with a sound mind and body," and like the Bonbrest ruling it relied on a subsequent live birth. Smith v. Brennan is incorporated into the broad understanding of the "state's interest in potential life (Fox 2014). Perhaps this is, as Susan Bordo so eloquently concludes, "The slippage here, from a live-born child's right to bring action against injuries suffered when in the fetal state to the right of the fetus to force its mother to accept treatment against her will, is profound and pernicious" (1993, 87). It is, in other words, a known legal pitfall that contradicts the finding that women cannot be held liable for unsuccessful medical treatment.

Perhaps the most successful assault on the legal precedent set out in the Dietrich Rule has been in the War on Drugs. From imprisoning women without due process for the mere suspicion of drug use (Eckholm 2013) [158]; to prosecuting a woman for using drugs while pregnant *after* she had obtained an abortion[159] ; to being pregnant in the presence of drugs,[160] the criminalization of pregnancy has broken down the distaste for prosecuting a pregnant person for crimes against the fetus she is gestating.

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[158] Beltran v. Strachota, Case No. 13-C-1101 (E.D. Wis. Sep. 30, 2014)
[159] State v. Greywind, No. CR-92–447 (N.D. Cass County Ct. Apr. 10, 1992)
[160] United States v. Smith, 113 F. Supp. 2d 879 (E.D. Va. 1999) US District Court for the Eastern District of Virginia - 113 F. Supp. 2d 879 (E.D. Va. 1999) August 4, 1999

Conclusion

This chapter traces the path of pregnancy from being conceived as intensely private concern to being a public issue. The medicalization of pregnancy grew hand in hand with the regulation of pregnancy by the state for public aims. From an event so private that women even stopped writing in their diaries, and so dangerous that women wrote letters to their children when they entered confinement in case they did not survive, advances in medical technology have turned birth into something routine and which *feels* certain, even if it remains one of the most dangerous things a person can do with her body that is totally legal.

The first stage of this transition was allowing medical doctors, almost exclusively men in the nineteenth century, access to the more taboo parts of women's bodies. The second step was to envision the survival of individual women and healthy babies as a public concern. This is the first time that the health, safety, and legal rights of pregnant people were widely constructed in opposition to those of fetuses. The balance from protecting pregnant people from their fetuses to protecting fetuses from their gestational carriers occurred in the latter half of the twentieth century, largely as a backlash to the legalization of abortion.[161]

There are of course many positive outcomes of this transformation that should not be downplayed. In spite of the "epidemic" of C-sections (Morris 2013), advances in surgery

[161] I tried *so hard* not to write a dissertation about abortion. And yet.

have delivered dramatic reductions in infant and maternal mortality–though it should be noted that black women in particular have not benefited equally from these advances (Bridges 2011). Medical monitoring of fetal health has even enabled surgery on fetuses to reduce common causes of miscarriage and stillbirth (Casper 1998).

Technological advances have also had their drawbacks. Increased surveillance of pregnancy by medical doctors has proved an incredibly effective tool for criminalizing behaviors of pregnant women labeled as deviant (Medina and McCranie 2011). Furthermore, the mission creep of the state's interest in protecting potential life has reinforced the state's authority to invade the privacy and invalidate the consent of pregnant people (Bridges 2017, Fox 2014). Worst of all, pregnant people's concerns for their bodies are routinely dismissed when they seek relief for mistreatment (Diaz-Tello 2016).

I have told a story in this chapter of *elective affinity.* Medicine and law had different reasons for advancing pregnancy as a public issue. At various times throughout this story, they have move together and at others, in opposition. They have been moving toward the same end, though: control of pregnant people. It's hard to say now that the cultural idea that "the most dangerous place for a baby is in the womb"[162] has really taken root, it doesn't really matter which institution is more responsible for that transformation.

[162] A simple search of the internet will return thousands memes and op eds in local papers and right-wing think tank pieces with this exact phrase. Its origin is in the racist attacks against Planned Parenthood (See Gandy 2015), though I very much doubt the people using it to oppose abortion know its history. See, for

In my final chapter, I want to zoom out once more into the realm of sociological theory. I asserted in my methodology chapter (Chapter 2) that the spaces where reality breaks, between institutions, is the best place to look in order to understand social reality. I think what my dissertation has revealed is a kind of crack in the sidewalk. A crevasse in the icefield, at the risk of overstretching the metaphor of an iceberg, that certain people have a high risk of falling into. Who those people are, and why no one seems all that alarmed (if they notice at all) is what I would like to explain.

example, the top search result in Google when you type it in: "Most dangerous place for children is the womb," an op ed by Evalyn Finney published June 1st of 2019 in the Bonner County Daily Bee.

Chapter 7: The Invisibility of Social Problems

Throughout the process of completing this project, I was consistently surprised by how perplexed even the most well-meaning listener was about my dissertation topic. In the days before I found people using the term *obstetric violence*, I would give a very, very long and detailed description of what I wanted to study. Almost invariably, the reaction was either "well, how big of a problem can *that* be, really?" or "aren't there more important things to worry about?" Audiences were extremely split (and very *intense*) about whether or not I should just write a dissertation about abortion and be done with it.

Not everyone meant well. One particular old, white, male visitor to our department told me while interrupting my sentence that he was sure my dissertation was going to be "very trendy" because I had "managed to include the word violence" in my title.[163] Sneering reactions of this sort were invariably some version of "why do women always overreact to the smallest things?"

I thought as I dug deeper into my research I would come up with some answer to the question of why no one thought this was a big deal. "Misogyny" is probably the correct answer on some level, but that's not a very sociologically interesting one.

[163] He also was convinced that a fellow graduate student and I were one and the same when she habitually wore ten times as much makeup as me, was half a foot shorter, and bears no physical resemblance to me whatsoever. I think the guy might have a problem with women, but maybe that's just me.

How could even people in theory who have trained to develop a sociological imagination simply dismiss this problem? Only after sitting down to actually write out the findings of this project did something incredibly obvious strike me. The constant confusion and dismissal is actually the perfect demonstration of how social problems are rendered invisible.

In this, my final chapter, I want to advance a theoretical perspective about how privilege operates to render social problems invisible.

My argument has a few different strands. Throughout this dissertation, I have cited C. Wright Mills' foundational work on social problems. In Chapter 6, I made a case that pregnancy and childbirth are now envisioned primarily as public concerns–as social problems. In Section 1, I want to dig a little bit further into the specifics of social problems theory, and underscore Mills' work on how individuals internalize social problems. The very first challenge with understanding social problems is that individuals tend to view them through the context of their own lives, and not with what Mills' terms a "sociological imagination." Mills (2000 [1959]) describes this as an ability to envision your own personal troubles as social issues instead–issues that you did not cause, and you cannot solve through individual action, and that there is a great deal of social pressure to keep to yourself. Without this imagination, the roots of social problems are invisible even to the person experiencing them.

I have also discussed institutions and institutional frameworks throughout this dissertation, though I have played somewhat fast and loose with what that *means*. I dedicate Section 2 to explaining what sociologists mean when we use the word *institution*. This cuts to the very heart of the origins of our discipline's foundational attempts to understand industrial modernity. Institutions are classically envisioned as competing for exclusive authority over particular areas of social life, or particular social problems. I argue that while this is sometimes the case, more often they reach a cooperative equilibrium. This is particularly true of institutions that regularly produce legal issues. As Durkheim put it, the law as an institution has a very particular function: to eliminate obstacles to the smooth operation of society (Durkheim 2013). As these institutions have hardened into their current arrangement, they have formed increasingly deep fissures that vulnerable people fall into.

The final strand of my argument in Section 3 is the feminist legal theory of Intersectionality. Intersectionality is a theory that explains how social positions are greater than the mere sum of their parts. It grew from the work of black feminist scholars that observed gains made by white women in society were not available to black women in the same way. I have committed knowingly the same sin as many other quantitative researchers and separated out the strands of social vulnerability to understand their effects, particularly in Chapter 4.[164] Statistical analysis is a hammer, and the problem of

[164] Hinze, Lin, and Andersson (2012) explore a novel method to incorporate intersectional analysis into quantitative methods. They create separate variables to parcel out the variance and analyze as a group

understanding how these social positions intersect is not a nail. Refusing to acknowledge intersecting social vulnerabilities is one more way that social problems are rendered invisible.

When considered together, these three strains of social theory–the limits of our own individual perspectives; the way that institutions such as law and medicine function to assert social control; and the way that social vulnerabilities intersect–outline the ways in which some social problems are generally invisible.

I. What is a Social Problem?

1. Millsian Analysis

Social problems are at the heart of the discipline of sociology. Every budding young sociologist reads excerpts from Karl Marx, Max Weber, and Émile Durkheim. That Marx was concerned with problems of collective action is well understood. He focused on the looming cliff of capital's assumption of endless growth, and the way that vulnerable people pay the numerous costs of economic institutions that prized money above all other values. Weber and Durkheim too were concerned with what we might now label as social problems. *The Protestant Ethic and The Spirit of Capitalism* (Weber and Kalberg 2001)

survey participants who fall into multiple dependent variables of interest. This method is promising and illuminating, though in smaller samples partitioning up the variance runs the risk of over specifying the model and rendering conclusions deeply suspect. Recall the late great George E. P. Box (1979): all models are wrong, but some models are useful. I think this method is extremely useful for answering some questions, but inappropriate to my dataset.

can be read as an explanation of how Protestantism solves the problem of excess labor capacity among young women. Durkheim's *Suicide* (Durkheim and Spaulding 1951) is an exploration of how particular social arrangements produce more negative social outcomes. Suicide in this frame is in fact a *social* problem. Indeed, I explained in Chapter 2 that Durkheim viewed the law as an institution meant to repair problems with the social organization without disrupting the functioning of society–that is, as an institution that *solves social problems*.

Contemporary sociologists most often turn to C. Wright Mills' classical definition of social problems. Mills defines a social problem as one caused by collective action or shifts in institutional arrangements (Mills 2000[1959]). Individuals no more cause these problems than they control the weather with their minds. Trying to solve social problems as an individual is about as likely to be effective as thinking hard thoughts at a cloud in order to make it rain.

At the heart of Mills' understanding of social problems is a narrow perception of personal experience. A narrow perception of individual *troubles* tends to lead to a narrow conception of blame. If public issues or social problems are understood to be personal and private troubles, then collective solutions are unlikely to be sought. Individuals bear the blame and shame for unrecognized social problems.

Mills envisioned sociology as a way of seeing the world that revealed truths beyond individual perception. A critical component of his definition was that individuals

experience reality in a way that conceals the origin and nature of social problems even from the individual experiencing the problem. A "sociological imagination" is the first step to solving these problems–that is, developing the capacity to see social problems clearly, and understand personal troubles and public issues (Mills 2000[1959]).

Setting aside for the moment the issue of defining institutional arrangements or institutions, Mills asserts first that cultural unease about the state of cherished values or indifference about the suffering of others is a symptom of crisis. The future becomes uncertain, and "cherished values" are undermined by conditions beyond individual control or even perception. This sense of unease about the world, then, Mills takes as an indication of crisis which sociologists are particularly well-positioned to illuminate. In this (Marxian) framework, individuals are not trained to perceive systems and structures that impact their lives outside of the immediate environment.

2. Foundational Examples

Mills offers several examples in *The Sociological Imagination* (Mills 2000[1959]). It is worth examining them more closely to understand the limits of individual perception; what Mills means by a "cherished value" or the "indifference" of the public; and the call to collective action.

If an individual working in a factory loses his job, that is a personal trouble and “for its relief, we properly look to the character of the man, his skills, and his immediate opportunity” (ibid: 9). On the other hand, if all of the factories of a particular industry

close at once and a quarter of the people in town are suddenly unemployed, the problem is outside of the control of individuals to either have caused or offer solutions for it; it is a public issue.

The United States in particular is a country that values hard work. Max Weber cites the earliest foundations of the country as evidence that the Protestant Ethic has moved beyond a religious concern of salvation and to a general public value in the United States (Weber and Kahlberg 2001). Phrases such as the "right to work" (generally connected with anti-union legislation and opposition to government regulation) and the "dignity of work" (generally connected with pro-union legislation and government oversight) permeate the political and social landscape.

The idea that hard work may have no bearing on success--that one can toil for years at a factory and find their pension fund dissolved, lack access to adequate medical care for the damage done to the body by this labor--causes a deep sense of uneasiness that the social contract has been breached. Arlie Russell Hochschild explores just this sense of injustice and betrayal in her instant classic *Strangers in Their Own Land* (2018) and again in *Stolen Pride* (2024). What is really striking about the merry band of right-wing environmentalists that Hochschild (2018) follows is that they do not make the connection between government regulation and the incredible devastation that the oil industry has wrought on some of the most ecologically fragile land in the world. They completely and utterly refuse to imagine environmental contamination as a collective problem, so much

as an individual inconvenience that is driving them into penury via the impact on their property.

Another recent example that has dominated the news is per- and polyfluoroalkyl substances (PFAS).[165] Consumers cannot solve the problem of environmental contamination by refusing to buy products that contain them. So long as they remain legal, someone will make them. As products like teflon pans and waterproof mascara inevitably enter the water supply, we will all continue to be exposed to known carcinogens and endocrine disruptors.[166]

Mills also asks us to consider the fact that, by the late 1950s when he wrote the book, half of all marriages were ending in divorce. Each new divorce feels like a personal failure to maintain what politicians on both right and left call the basic unit of our society. Yet if so many marriages are failing, it speaks to more than individual absent husbands or inattentive wives.

Individuals are not positioned well to understand the structural or historical forces that produce social problems. In the case of the former, we generally do not experience structural forces directly. The Institution of Marriage is not calling individuals women

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[165] Just one of the horrific classes of forever chemicals currently disrupting human endocrine systems and causing us all higher rates of a host of diseases like cancer. The most tragic part of PFAS being in everything from waterproof mascara to frying pans is that *there are cheap alternatives to most of them that actually biodegrade* and do not, as one notable ongoing disaster downstream of a Dow Chemical factory demonstrated, turn cows green and cause huge swaths of the local wildlife to bubble up with cancer inside (Bilott and Shroder 2020).

[166] I have a hunch this is just one of the reasons for the recent, massive spike in people under 50 being diagnosed with cancers, especially gastrointestinal and reproductive cancers. People like myself. See Zhao et al 2023.

Bad Wives. *Individuals* enforce their understanding of marriage through social controls.[167] In the case of the latter, none of us were there when history happened. For example, it is a bit of a sticky question when it even became a sacrament rather than a legal contract in the Catholic Church; certainly by the 1184 Council of Verona, though some historians say it was not recognized by canon law until the Council of Trent in *1563*. It simply is not true that marriage has always been a sacred institution, or even the foundational building block of a society; no one cared who villains and serfs married because they didn't own anything, so they usually didn't even bother.

Digging into the historical roots of marriage as a sacrament with someone who is unaware of this history underscores the way that individuals experience social reality. My father, a devout Catholic, was absolutely appalled, shocked, *horrified* that I would think something so obviously untrue as marriage *not* being sacred. He thinks that people who have children without getting married are "not nice people." When I told him I planned to elope to Las Vegas, he nearly ran into a mailbox and started sobbing hysterically about how much he had failed me as a father. My husband and I sort of helplessly endured the intense anxiety of all the well-meaning people around us convinced that our marriage would fail if it wasn't in a church, and I wasn't dressed in white.[168]

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[167] I'll explore a little bit the difference between a Parsonsian structural-functionalist perspective and a social constructionist perspective in the *Institutions* section.

[168] We are still married as of the completion of this project, having just passed our 15th wedding anniversary.

3. Common Pitfalls in Understanding Social Problems

I have always found Mills' view of social problems particularly prescient. Contained within his very simple, visceral definition of a social problem is a deep understanding of power, privilege, and marginalization as structural issues. Mills says we can identify social problems through our individual structural inability to fix them, and the intense anxiety that they engender in the public consciousness. If a subject is taboo or evokes a visceral reaction from members of the public, chances are good there is a social problem lurking nearby.

I think one of the more common failures of a sociological imagination is blaming marginalized or oppressed people for their own private troubles. Even sociologists are extremely guilty of this. Eduardo Bonilla-Silva's brilliant and important work *Racism Without Racists* (2010)[169] lays this out extremely clearly. He flips the script when discussing the problem of racism in contemporary America. Rather than studying the way that increasing racial segregation in the twenty-first century marginalizes racial minorities, he studies how privileged, white, suburban people understand their culpability in creating oppressive systems. The lens is not on the victims of the social problem of institutional racism, but on the perpetrators. Or, as the title of the book suggests, the

[169] I was briefly excited that he had cited Charles W. Mills in his introductory chapter, only to find that this is a *totally different Marxian scholar* than C. Wright Mills. The former is a black philosopher who coined the term "racial contract" who recently passed away. The latter is an extremely white sociologist, who has been dead a long time–which probably has something to do with the fact that in virtually every picture of him, he is smoking a cigarette.

beneficiaries of the institutional arrangement that do not feel personally culpable for the marginalization of communities of color even as they maintain the systems that reify that social order.

Fundamentally, Mills' views social problems as a "...crisis of institutional arrangements" (Mills 2000[1959]: 9). In the first section of this chapter, I underscored that what allows social problems to fester is a of failure of imagination. Individuals have trouble understanding problems caused by collective action as *social problems.* They don't have a clear vision of the historical context of these problems either, making it difficult to understand their origins. Mills also notes that individuals are often not well positioned to articulate clearly the social expectations of institutions that they have to navigate.

Mills envisions institutions as ever shifting, like any good Marxian.[170] As institutional arrangements shift, and institutions crash against each other or push apart, crack emerge. In Chapter 2, I discussed the sociological reasons that we would look for breaks in reality to understand its structure. I also, without defining what sociologists mean by "institutions" argued that institutions act to maintain social order. Powerful institutions, as Durkheim discussed in *The Division of Labor In Society* (2013), tend to have the power to pave over these breaches and maintain their authority.

[170] One of Marx's most famous quotes from the communist manifesto reads: "All that is solid melts into air, all that is holy is profaned, and man is at last compelled to face with sober senses his real conditions of life, and his relations with his kind" (Tucker and Marx 1978). I take it that Marx is *not a fan.*

Durkheim is letting privileged people off the hook. Marginalized people are *not* more likely to be oppressed by institutions through the luck of the draw. Nor are actors within institutions absolved of their moral culpability because they are simply following the rules. Institutional arrangements don't just *happen*. They are built by people, with personal goals and biases. We accept the terms of those institutions when we participate in them–or, as the case may be, walk inside with a can of gasoline to make sure the house burns down. Make no mistake though. The people who are harmed, the people who become social problems, did not cause their circumstances.

II. Institutions

The question of invisibility, inequality, and marginalization within and across institutions requires an explanation of what sociologists mean by institutions, and how medical and legal institutions make claims to authority. Part of the reason I have resisted a fuller description of what an institution *is*, in a sociological sense, is pure cowardice. No matter what I write or who I agree with, someone is going to be upset. You're generally safe with Marx, Weber, and Durkheim, even if you are insulting them.[171]

Rather than merely define an "institution," I want to first expand my critique of structural functionalism from Chapter 2, Section 1. Then, I want to offer and explain a popular alternative: Social Constructionism, which spawned the New Institutionalist line

[171] I do so love to insult Durkheim.

of thinking (Section 2). Finally, I offer a theory of institutional cooperation that aligns with the historical narrative of Chapter 6 (Section 3).

1. A Note on the Function of Institutions

While C. Wright Mills spent a great deal of time and energy unpacking what defines a social problem, he was not breaking a new trail. He was following in a tradition that orients the field of study toward solving problems created by large structural changes to the foundations of society. I explained in the introduction to this section the roots of the study of social problems in the discipline of sociology; I trotted out Marx, Weber, and Durkheim again.

A different founding father of sociology is central to much of medical sociology: Talcott Parsons. If you share war stories with sociologists of a certain age, they will invariably describe diligently trying to memorize one or more of his great tomes. Parsons was a structural- functionalist. His life's work appears to have been describing in great detail the specific roles that individuals could take within contemporary institutions. I will discuss the Sick Role later in this section. It is just such a useful concept that it is hard to throw out the baby with the bathwater.

Some caution is necessary though. Structural-functionalism has fallen out of favor in broader sociological circles because it is built around two particularly glaring logical flaws. The first is assuming that the existence of an institutional arrangement indicates that it offers a benefit to society, and reasoning forward from this assumption. The second

is that collective benefits gained from maintaining oppressive institutional arrangements outweigh the costs to individuals.

Emile Durkheim is the founding father of sociology most closely associated with the structural functionalist orthodoxy of positivist sociology. Much of Durkheim's work rests on the assumption that an objective reality exists external to the individual. Furthermore, this reality is presented as a singular, unbiased, rational object that exists independently of social meanings attached to the individual experience of reality.

For example, consider Durkheim's anthropological aside contained in The Division of Labor (2013[1933]). In the first chapter, after discussing the function of law and the difference between different types of solidarity, he lays out the "objective" evidence[172] that modernity has weakened women, both physically and mentally. Women's skeletons seem to diverge from men's in size as we approach modernity, and in particular, their cranial circumference and presumably capacity declines. Durkheim argues though that the dramatic social benefits of modernity outweigh the cost--that is, harm done to women.

In other words, if you want the omelet, you must break eggs. Women are the eggs in this equation, while all the wonders of industrial modernity are the omelet.

There are a number of implicit assumptions in the chain of logic that links the initial positive observation (that sexual dimorphism appears to become more pronounced in

[172] Even in his own time, Durkheim's contemporaries contested these observations and the conclusions that he drew from them.

human skeletal remains over time) to the conclusion (that modernity, in the form of the division of labor, is harmful to women). It is quite a leap of logic to assume that a smaller skull leads to a smaller cranial capacity which leads to a lower intelligence. It is quite a leap to observe that women seem to have smaller skeletons and therefore they are weaker. Other conclusions might be drawn, such as the epidemiologic transition to agrarian forms of living resulted in nutritional deficiencies that impacted the health and wellbeing of women in particular (see Olshansky and Ault 1986, Omran 1977, and Omran 1971).

In *Suicide,* Durkheim reaches much the same conclusion (Durkheim and Spaulding 1951). Durkheim compares suicide rates across different countries in Europe. He pays particular attention to the dominant religion of the country, and the legal regime governing divorce. It is a very detailed analysis that draws some interesting conclusions about who benefits from marriage–forgive the brevity of my summary. In situations which women have difficulty obtaining divorce, their rate of suicide is much higher. In certain circumstances where divorce is easy to obtain and not stigmatized, the rate of suicide for *men* is higher. Durkheim rejects, though, the idea that we should try to alter institutional arrangements to obtain better outcomes for all. Marriage, in Durkheim's mind, is a natural and necessary part of society. So we must accept that women pay with their lives–in childbirth, they die and in being trapped in a gilded cage, they choose suicide. This is the price of nice things, and Durkheim is lined up to pay it.

Consider another example. Kingsley Davis's (1937) article in the second issue of the American Sociological Review entitled "The Sociology of Prostitution." The article underscores how prostitution enables men to tolerate the constraints marriage places on their "natural" promiscuity. Davis begins with the observation that prostitutions still exists in the world in spite of numerous attempts to stamp it out via criminalization. He works backwards from that assumption to his conclusions, based on a "fact" sui generis that men are more promiscuous than women.[173]

It is possible to study the structure and function of institutions without falling into these traps. As an example, I offer the recent work of Alex Vitale, *The End of Policing* (2017). Vitale argues throughout the book that though the institution of policing has multiple origins in the United States, the function of contemporary police forces has converged in such a way that the explicitly racist origins of policing as a mechanism of domination and control have been obscured.[174] Institutions in Vitale's view are organized to maintain themselves and protect their existence by continually reinforcing social order. In Vitale's view, the fact that many Americans now see the outcomes of policing--mass incarceration, violence, and the creation of a persistent underclass through the drug war to name a few that Vitale tackles--as threatening the cherished American values of liberty and justice for all is not because policing has changed. Rather, it is because we now

[173] An assertion called into question by more complicated interrogation of biological "facts," see Wlodarski, Manning, and Dunbar 2015.
[174] The structure of the book is very Weberian, a la The Protestant Ethic and the Spirit of Capitalism (Weber and Kahlberg 2001).

understand that these institutions have a historical context. They were designed to function in this way.

2. Social Constructionism and the New Institutionalists

There is an alternative vision of what an institution is, and how it constitutes reality.

Berger and Luckman define an institution as the stable product of the ongoing "reciprocal typification of habitualized actors by types of actors" (1966[1967]: 54). Society is, in their view, a set of such institutions that evolved from inherited habituated action. As individuals lack direct knowledge of how institutions arose and have no access to the original meaning of institutions, "It, therefore, becomes necessary to interpret its meaning to them in various legitimating formulas" (ibid: 61-62) This set of habituated actions and the legitimating formulas or normative rules form what we call institutions.

Furthermore, "Since this knowledge is socially objectivated as knowledge, that is, as a body of generally valid truths about reality, any radical deviance from the institutional order appears as a departure from reality." (ibid: 66) Institutions such as "medicine" are, in this social constructionist view, a set of ideas about how to behave and recurring individual compliance to these ideas.[175]

[175] This is different from a Parsonsian model where society is nothing but a matrix of fixed roles that people slot into; individuals often have ideas about how they ought to behave that take on a fixed character via repeated interactions.

While institutions and social structures have no existence outside of individuals, individuals *act as though they do.* As noted by other theorists, individuals often learn the most about the rules of social order by breaking them (especially Garfinkel 1984, but also Goffman 1968 and Goffman 1986). Berger and Luckman (1966[1967]) focus on how socialization into new institutions works as an *interactive process* that we engage in *every day*.[176] We build social reality together, and then keep building it.

Individual actors either validate a shared reality and the systems of oppression and power within it, or they do not–and face the consequences. That is, individuals who deviate from expected roles are sanctioned. Deviance is, however, often in the eye of the beholder.

> ... deviance is not a simple quality, present in some kinds of behavior and absent in others. Rather, it is the product of a process which involves responses of other people to the behavior. The same behavior may be an infraction when committed by one person, but not when committed by another; some rules are broken with impunity, others are not. In short, whether a given act is deviant or not depends in part on the nature of the act (that is, whether or not it violates some rule) and in part on what other people do about it. (Becker 1997 [1963]: 14)

That is, some actors are not sanctioned when they deviate from shared institutional understandings. Shared, cherished values may come into conflict, and individuals must navigate the challenge this presents to social order. Or individuals inhabiting multiple roles encounter a problem in fulfilling expectations. Or some people, by virtue of their position, expect that only certain rules apply to them.

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[176] As others have before them, though not quite so clearly distinctly from the structural-functionalist school of thought. For other examples in American sociology, see Mead 1934 and Cooley 1983.

The process by which an institution is formed is, in fact, a form of social control by limiting the imagination of reality. In this conception punishment is *not* the primary form of social control. The definition of reality controls behavior rather than the sanctioning of deviants. Berger and Luckmann use the example of incest. The primary form of social control is the definition of incest as repulsive; "beheading certain individuals" (1966[1967]: 55) for violating the taboo against incest is only necessary when primary social control–that is, instilling a disgust for incestuous relationships–fails.

In this vision, an institution is a set of normative rules, legitimating formulas, and habituated actions or routines of behavior that have a relatively stable existence. Individuals themselves act to recreate and stabilize what we experience as external social reality. Roles are reinforced through routine social interaction. When rules are violated, individuals with authority punish deviance to reinforce the definition of reality.

3. The New Institutionalists

Social Constructionism is all very thrilling. It gives the study of social reality a bit of a dangerous edge. We as sociologists wander around looking for the tender spots to poke in society, trying to make someone yelp. Social Constructionism gives one a strong sense that the world is malleable, and that such sore spots are easy to find.

One particular problem with this way of thinking is that some institutions actually *are* just sets of rules and sanctions. For example, Parsonsian analysis and the old structural-

functionalism describes formal law *extremely well*. There is a reason that citing Durkheim–a man writing a century ago in France–still resonates with sociologists.

Moreover, some institutions have such a stable existence, and exert such serious consequences for violating the social order, that they might as well have an existence outside of our heads. Paul Farmer writes very eloquently about how "noncompliance" inside hospitals is basically a way of removing moral culpability from doctors for patients who face a great many barriers to care (Farmer 2001). When doctors withdraw attempts to treat noncompliant patients, it is often a matter of life and death. Death is an *extremely* serious consequence for not participating in the institution of medicine in the correct way.

Social construction theory and a theory of social interaction spawned new ways of thinking about institutions that attempt to navigate this tension. Philip Selznick is generally recognized as one of the founding scholars of what has come to be called New Institutionalism.[177] Selznick

> …advanced a perspective on the manner in which authoritative systems of rules, analogous to formal laws proclaimed by the state, developed within private organizations. Private organizations, Selznick showed, develop their own normative structures to which the participants of the organization are expected to conform and for which sanctions can be applied in the case of rule violation. (Deflem 2008: 147)

[177] He is in part so influential because he spent most of the 1950s and 1960s writing definitional sections in textbooks, encyclopedia entries, and promoting his view of the sociology of law in journals of *other* disciplines–including management. One of his most cited works, *Leadership in administration: a sociological interpretation* (2007[1957]) has this quote on the jacket cover: "Beautifully describes organizational character, competence, institutional values, and leadership…basic to the success of the excellent companies." Max Weber would be proud, Karl Marx probably less so. I can also confirm, having received my MA from the University of Virginia, that Donald Black is *still really mad about it*.

In some sense, these "authoritative systems" operate parallel to formal law. Private organizations of the kind Selznick was analyzing are almost all for profit, large companies. They are highly sensitive to both the context of the free market and formal legal systems. Deflem (2008) offers the example of safety rules. Formally, such organizations have safety rules. Manufacturers are often regulated by agencies such as the Occupational Safety and Health Administration (OSHA).[178] Normatively, such rules are often treated as onerous and unreasonable on the ground in workplaces.

My husband, an industrial engineer by training, loves to tell stories about how workers at one of the plants he designed had circumvented all the safety protocols he had installed to ensure they kept all their fingers and toes. All the buttons, they told him, made everything too slow. So they just taped blocks of wood on three of the four buttons required to operate the machine and carried on. Because the company had all the required safety rules and OSHA posters, it would be difficult to hold anyone actually legally responsible for workplace injuries that resulted from noncompliance. Indeed, Selznick notes that this is often the function of such a body of formal policies: to shield the corporation from liability.

Elizabeth Anderson (2017) takes this insight a step further. I explained in Chapter 3 how hospitals function as "private governments," in Anderson's sense of the word.

[178] Hilariously, one of the companies that my husband contracted with remotely early in his career actually interpreted these rules as being required to be posted in his workspace in our home. They sent us a copy of and required photographic proof that he had hung his OSHA poster on the wall.

Hospitals require formal compliance with procedure in order for employees to access liability insurance coverage. Other medical institutions, such as United Nations vaccination and treatment programs, require compliance with formal protocols before they will approve funding for additional medical treatment. Farmer (2001) notes that this means doctors on the ground must waste precious time and resources treating what they *know* is multi-drug-resistant tuberculosis (MDR-TB) in order to access treatments that will actually work. Employees, patients–everyone within these systems are ruled by authoritarian systems against which they have limited recourse.

Corporations and other institutions that maintain a body of state-sanctioned (or required) formal rules become what I think of as little mill traces–little streams with controlled entries and exits that run parallel to the formal economy, but shield people within it from external pressures. Little river loops that turn the millwheels of the economy in tiny closed circuits insulated from change. They are armored against external forces–for better and for worse. They have a tendency, as Elizabeth Anderson (2017) notes, toward rigidity, authoritarian control of the most minute details of worker's lives while on the job, and toward aggressive self-protection.

In some ways, hospitals and other medical institutions are much the same as any other private employers in this respect. With one crucial distinction: patients, who in other corporations might be considered customers and exempt from rules of order, also fall under these regimes.

4. Medicine as an institution

I now turn to the institution at the heart of this project: medicine. I argued in Chapter 6 that medicine and law have an elective affinity. In the Weberian sense, they have a reciprocal relationship of attraction and influence. The law recognizes doctors as experts and medical facts as critical to mediating disputes. Doctors, in turn, advocate for changes to formal statutes as well as how those statutes are interpreted by the courts. It is medical understandings of what an illness is and how patients should behave that take on outsized meaning in legal institutions.

I close this section with a brief discussion of how problems come to be understood as medical (medicalization). Contained in the definition of illness is expectations for how patients behave. Chapter 6, reframed slightly, is actually the history of the medicalization of pregnancy. I close with a brief explanation of The Sick Role[179] and how pregnancy is a poor fit for medicalization.

Medicalization is the process by which human experiences come to be defined as illnesses, subsumed under the authority of doctors (Conrad 2007). Peter Conrad (2007:, 4-5) defines medicalization as "a process by which nonmedical problems become defined and treated as medical problems, usually in terms of illness and disorders … That is, a problem is defined in medical terms, described using medical language, understood

[179] Even having so maligned Talcott Parsons in the preceding paragraphs, his definition of how medical institutions understand their obligation to a patient remains central to how doctors understand their work.

through the adoption of a medical framework, or 'treated' with a medical intervention." Much of this scholarship has focused on the way that medicalization, intended to reduce human suffering by naming problems and seeking to treat them, has marginalized and isolated individuals with chronic or incurable diseases, disabilities, or mental illnesses (Conrad & Schneider 1992, Conrad & Potter 2000, Conrad & Barker 2010, Rier 2010).

As problems become illnesses, individuals take on the role of being sick in order to interact with medical practitioners. Following Parsons' (1975) definition of the sick role, a sick individual is obligated to seek medical authority and comply with treatment in order to return to health. Only the fulfillment of both these duties absolves the individual of other responsibilities and blame; when these duties are not performed, illness becomes a deviant act. Individuals are blamed for their absence from their other roles, and blamed for not getting better—that is, for the perceived negative outcomes of their illness. Doctors label these deviants as malingerers in extreme cases, which excuses doctors from fulfilling their role to listen to the problem and prescribe treatment. Malingerers are typically expected to "get over it" and return to their normal lives or may be compelled to accept treatment by legal means if they "choose" to continue to be sick.

Parsons first coined the idea of the Sick Role at a time of high modernity in the realm of medicine, when confidence in the profession and prestige was at the pinnacle and doctors were much stronger gatekeepers to the privileges associated with the sick role (McKinlay and Marceau 2002). The sick role remains a key component of

medicalization: physician authority is legitimated when patients come to understand their problems as an illness and accept that medical treatment holds the answer to their problems. As Frank notes, "Whether or not the sick role describes the experience of being ill, and most agree it does not, it remains a powerful narrative of what medicine expects from the ill person and what other social institutions expect from medicine" (1997: 83). For some illnesses—acute illness, especially of a critical nature which is not disabling—the sick role is an adequate description and moreover a relief from the worry and sudden disjuncture of illness (Rier 2000).

The real crux of the matter is that the Sick Role is an imperfect fit for pregnancy. Pregnancy is not an "illness" in the traditional sense, certainly not an acute infectious illness. While it can be life threatening and the delivery of babies itself is an arduous and "acute" task, there is no returning to a life before the birth of a child for a pregnant person. Pregnant people do not "get over it" and return to their normal lives; their lives are altered permanently and in some cases dramatically after giving birth even though the "illness" has passed.

Aspects of pregnancy, birth, and motherhood have certainly been increasingly medicalized. The dangers of giving birth and being pregnant are well recognized, and it is now normatively expected to give birth in a hospital. Breastfeeding has come to be viewed as a medical problem with trained and certified medical practitioners to assist new mothers to follow medically acknowledged best practices, though as Torres (2014)

notes the goal of many lactation consultants is to support adequate breastfeeding so that medical intervention and monitoring are less necessary.

The advancing technocratic health regime of childbirth has become increasingly complex and requires intensive monitoring, expensive machinery, and has every promise of continuing to expand (Davis-Floyd 1994), though much like other increasingly technocratic regimes of care (such as cardiac disease, Waitzkin 1979) these changes have so far failed to yield dramatic improvements (Morris 2013). Conrad, Mackie, and Mehrotra (2010) estimate that the cost of newly medicalized illnesses topped $77 billion dollars in 2005—about 3.9% of the total health expenditures in that year. The manufacturers of the technologies which treat medicalized illnesses are the primary beneficiaries of that spending rather than patients--for whom new technology has not decreased infant and maternal mortality—or even hospitals—which have spent enormous amounts of money for few tangible results. It is no accident that the cost of childbirth-related expenditures alone accounts for about $18 billion dollars of increased health spending in 2005, or slightly less than a quarter of Conrad, Mackie and Mehrotra's (2010) estimated total.

Pregnancy also violates Western philosophical traditions defining personhood. I outlined this strain of argument in Chapter 6. Standards and practices of medicine make very clear that the pregnant person is the patient NOT the fetus (ACOG 2016), legal arguments for the state's interest in potential life have steadily expanded since Roe v

Wade (Fox 2014), and its recent overturning is unlikely to improve that state of affairs. In practice, medical personnel constantly argue that they have a moral obligation to a fetus before birth in the same way that they have an obligation to the pregnant person.

The most problematic part of conceptualizing pregnancy in a Parsonsian frame is the duty to recognize that it is bad to be sick. As noted above, some pregnant people *are* viewed as bad, wrong, or dangerous when they become mothers, and their children are viewed as social problems. Above all other messages about the fitness of some pregnant people to become mothers, pregnant people are both morally and socially obligated to finish the pregnancy to term. In other words, individuals must leave the pregnant state correctly under medical scrutiny and, crucially, with a healthy baby. When pregnant people fail to fulfill their obligation as a sick person to comply with treatment as prescribed by doctors, they are accused of harming their child—even if the state of medical evidence for that advice is dubious (Lee, Sutton & Hartley 2016, Oster 2014).

III. Intersections

I have said throughout this project that risk is not evenly distributed. I noted above in Section 1 that one of the more common errors in thinking about institutions is a very human tendency to assume they treat all people equally. It is more of a hope that all persons are equal before the law than an actual fact.

A structural-functionalist vision of how institutions operate is very formulaic, and a bit simplistic. One person walks in the door. Other people within the institution apply the

rules that align with the role they take on inside the institution. There is a reason that in the movies, people can just steal a white jacket and be treated like a doctor. Even a Social Constructionist view lacks a capacity for complexity in understanding how more concrete institutions like Medicine interact with more ephemeral cultural institutions like Race or Gender. As compelling as I find the New Institutionalist perspective, they don't really solve this problem either. Quite the opposite. Elizabeth Anderson sets out to explain why it is that the roles within private institutions are so rigid, simple, and resistant to change.

In spite of the fact that this captures something essential about medical institutions, it doesn't really help explain the uneven distribution of risk. One person who takes on the Sick Role is not the same as any other person. For example, Hinze et al (2009) found that pain relief is overprescribed to "deserving" patients in the emergency room, and underprescribed to patients who somehow fail to appear "deserving." Opioid pain medication is not prescribed for more difficult to diagnose problems; for patients whose behavior is stigmatized; or for patients belonging to marginalized groups (Hinze et al 2009).

In order to explain the unequal outcomes recorded in Chapter 6 and 7, I need a theoretical framework that accounts for the context of individual differences, as well as complexity in how institutions interact with each other. In this section, I explain with intersectionality meets that need.

Much like defining obstetric violence itself, defining intersectionality will be difficult. It means different things to different people, not all of whom approach the use of terminology with precision. This untidiness has both benefits and drawbacks. I do not intend to give a full accounting of the history here. I want to note instead how intersectionality underscores and enhances our understanding of the invisibility of social problems.

The kernel of the idea that became intersectionality began as a movement within a movement, with one simple observation: white feminists did not see or address the specific needs of black feminists.

This tension in prioritizing the needs of some marginalized people over others is certainly nothing new in social justice movements. Frederick Douglass and Susan B. Anthony, lifelong neighbors and collaborators, somewhat famously and angrily disagreed over whether or not to include women's suffrage in the reconstruction amendments. In the end, Douglass' incrementalism won the day and women had to wait another fifty years for the nineteenth amendment. Somewhat ironically, the suffragettes were keenly aware of the optics of including black women in their organizations, and excluded them from many marches for fear of jeopardizing the passage of the amendment.

In this section, I want to give a foundational example of intersectional analysis, and how intersectionality exposes the cracks inside of institutions. I then explain what characteristics sociologists look for when they say that their work is intersectional.

Finally, I return to the question of institutional collaboration to understand how marginalized people fall through the cracks between institutions.

1. Blind Spots of the Law

Though her work should be understood more as a synthesis of existing strains of feminist thought than a creation whole cloth (Hancock 2016; Collins 2015), Kimberle Crenshaw's seminal article is widely noted as the first to use the word *intersectionality* to describe a way of seeing the world and formulating methodological approaches to correct for institutional blindness. Crenshaw's use of the term was also specifically an attempt to theorize how and why black women are invisible in anti-discrimination law in the United States, and therefore their claims are often denied.

In her original article on the subject, Crenshaw (1989) analyzes three different cases in employment law that refused to consider the intersection of black women's identities as relevant to whether or not the women had been discriminated against. The clearest of these is DeGraffenreid *v. General Motors*, a lawsuit against a car manufacturer for employment discrimination against black women. The manufacturer hired women to work in the office, but not black people; the company hired black men to work on the factory floor, but not women. Black women categorically were refused employment in either the office or on the factory floor. However, the claim of employment discrimination was not successful because the categories protected by law were

considered separately, not jointly. That is, the court reasoned that since General Motors hired black people and women, they could not be discriminating against black women.

This underscores the way that individuals might experience discriminatory outcomes but be unable to seek legal remedies, and the way that institutions defend themselves against claims of discrimination. They simply render black women invisible.

2. What makes an analysis intersectional?

No matter how you define intersectionality or where you pinpoint its origins, someone is likely to get very upset. For those interested in the intellectual history of intersectionality, I direct you to the incredibly well-researched and very detailed work of Ange-Marie Hancock, who spans the globe, social movements, and academic work (Hancock 2016).

I tend to follow the approach of Collins and Bilge (2016) in my own work. Rather than adhering rigidly to a specific definition, the authors distill six key characteristics that distinguish intersectional work: *(i) social inequality, (ii) power, (iii) relationality, (iv) social context, (v) complexity, and (vi) social justice*. These characteristics "...provide guideposts for thinking through intersectionality" (ibid: 25). I think of them as a fast track for developing what Mills (2000[1959]) called a *sociological imagination*.

Intersectionality is centered on the idea of systems. *(i) Social inequality* in this framework is understood as a collective characteristic rather than an individual difference. This translates into a broad interest in exploring outcomes of social systems

via rates and along the lines of categories of difference, not individual cases. Intersectionality adds to single category analyses the understanding of the ways in which individuals experience inequality as a consequence of multiple forms of marginalization.

Intersectionality posits that *(ii) power* relations form the basis of the ways that systemic discrimination is maintained. Institutions that exert power over individuals are also mutually constituting and self-perpetuating–that is, individuals exert the power of institutions in ways that maintain their power and reproduce systematic inequalities. This understanding adds depth to both the social constructionist perspective and the structural-functional perspectives explored above. Particular social actors exert more influence on the construction of reality, and their power within institutions tends to be exerted within the context of institutions in ways that protect that power.

Single cause explanations (either/or) tend to be insufficient to fully explain inequality or differential outcomes of systems. Exploring the ways that systems of domination relate to each other–the *(iii) relationality* of such systems–is critical to understanding the marginalization and oppression of individuals along all axes of difference.

Intersectionality also focuses on the general sociological problem of perception: *(iv) context* is often absent from individual perception. That is, intersectionality seeks to explain "...how different people can be in the same general social context and yet have different interpretations of it" (ibid: 28). Put differently, intersectionality seeks to explain the invisibility of systems of oppression outside of the experience of marginalized

persons. This is sometimes referred to as privilege--the idea that systems which are built for a particular group, to serve its needs and function on its behalf. In context, privilege becomes invisible to members of dominant groups that benefit from systems built to serve them.

The project of intersectional analysis also embraces *(v) complexity*. Simple explanations for social phenomena may be satisfying, but rarely expand our understanding of systems of oppression and marginalization. A willingness to search for complex, interdependent explanations of inequality is particularly suited to understanding problems that span institutions and axes of difference.

Finally, implicit in the understanding of inequality is a normative claim that the world should be different. Merely producing knowledge or describing the world is insufficient to achieve the ends of intersectional analysis. Work that pursues *(vi) social justice* actively pursues the changes suggested by research. Or, in academic work, framing specific areas of analysis where change is needed.

I think this project exemplifies all of these areas of concern. My work is framed by my intense personal calling to do justice work. I stumbled into sociology as a field when I got lost looking for meaning as a mathematician. I have stayed with it because I think that better research will produce better public policy, though I personally feel called to much more direct justice work. Certainly, the conclusions of Part I highlights how institutions such as medicine produce unequal outcomes (Chapter 4) and how institutions exercise

power (Chapter 3). I have also taken great care to lay out the larger context (Chapter 6) of obstetric violence, and seek complex answers to relatively simple questions.

What I have not done especially well in the rest of this project is explain how the interrelationship between institutions produces the highly skewed negative outcomes that I documented in Part I.

3. Collaboration Between Institutions

In Section II of this chapter, I explained several different theories of institutions and institutionalization, broadly defined. I am most persuaded by a Social Constructivist perspective, filtered through the lens of the New Institutionalists. The definition of institutions provided above--as sets of habituated actions and the legitimating formulas or normative rules that give some individuals power to sanction deviance–generally leads us to conceive of institutions as separate and independent entities that compete to make moral claims.

This is certainly sometimes the case. If a person steals a candy bar while under the delusion that they own the world, for instance, is their action a symptom of illness or a crime? A judge would not attempt to prescribe medication. That would be practicing medicine without a license. Similarly, a doctor would not make a very good attorney,[180] and would almost certainly be prosecuted for practicing law without a license.

[180] See Chapter 3, particularly section III part 7. Again, *do not* ever represent yourself in court.

How is it then that judges make decisions to order a patient to accept a C-section (Diaz-Tello 2016)? How is it that doctors send police officers to arrest patients who refuse to comply with treatment recommendations (Diaz-Tello 2016)?

When it comes to pregnancy and birth, I have argued that there is a kind of elective affinity of aligned interests that grew over time between medicine and law (Chapter 6). I propose here that what is actually going on is *not* that medicine and law are making competing moral claims. Rather, I think the more reasonable explanation is that these two institutions, broadly construed, are cooperating to sanction deviant patients.

This isn't so strange in the history of medicine and law. Indeed, in psychiatric treatment, layered social control and multi-institutional management of social problems has become increasingly common (See Medina and McCranie 2011). Partially, this is due to the fact that mental illness is an incredibly poor fit with the Sick Role (See Rier 2000). Mental illnesses are generally chronic. They are not so much cured as managed well. The norm in the late nineteenth through the mid twentieth century for managed severe mental illness was indefinite involuntary confinement. It should come as no surprise to readers that groups viewed as social problems, such as middle-aged depressed housewives or young black men, have at different times been over diagnosed with serious mental illnesses (Metzl 2009).

The classical example of the medicalization of deviance is homosexuality (Conrad and Schneider 1992 [1980]). Homosexuality has historically been viewed as a social

problem that violated cherished norms of "family values,"–namely, that the only legitimate families were heterosexual married couples that intended to produce children.[181] Homosexuality is also often conflated with predatory pedophilia, which violates the cherished value of the innocence of children. A familial or romantic relation that explicitly rejected these norms posed a threat to social order, then as now (though in the contemporary United States, moral outrage tends to be reserved for intentionally childless couples rather than homosexual couples).

Medicalization as an alternative to criminalization of homosexuality was viewed in the mid twentieth century as better and more compassionate than criminalization. While medical doctors have made an attempt to "treat" or "cure" homosexuality through such means as electroshock therapy, chemical castration, or conversion therapy, it is law enforcement and the judiciary that opened the door for the medicalization of homosexuality by mandating medical treatment for criminal violations.

Obstetric violence occurs at the intersection of two institutions: medicine and law. Thinking more broadly, however, the separateness of institutions creates a tidy and if not simple at least predictable set of institutional interconnectedness. A smoothly operating

[181] Indeed, state support of "families" often has meant state support of white, heterosexual, married couples who have or intend to have children. For example, it is well understood that the explicit terms of a federally-backed mortgage loan to move to the suburbs in the 1950s included racial exclusion for the resale of homes. Less well known is that the loan program also excluded single or childless people (Rothstein 2017).

social order gives each individual a clear sense of what to do, and what the boundaries of reality are.

I argued above that hospitals act more like private governments in Anderson's (2017) sense of the term. They are isolated institutions that make and enforce their own rules. The result can be a kind of funhouse mirror. In highly stressful life and death situations, boundaries of reality break down. Institutional values come into conflict. Medical staff act, and sort out the legal consequences later. This is compounded by the way that legal institutions of various kinds–police officers, courts, youth and family service organizations–collaborate to enforce social rules.

Recall the examples in the preface to this project. Rinat Dray wishes to attempt a vaginal birth after repeat C-section, and she is wheeled protesting into the surgical theater, and continues throughout the procedure. No charges were brought against her doctor, and she lost her civil suit. The parents of young J. M. G. fought for *two years* to have their infant child returned because their refusal to submit to an (unnecessary) C-section was taken as evidence of their unfitness.

In some rare cases, such as that of Kimberly Turbin and Catherine Skol, sanctions are leveled against doctors. There were some doctors who lost their licenses in my own data (Chapter 3). I think my work does make clear that the majority of sanctions are leveled at pregnant people, rarely against medical personnel. The legal institutions cooperate with medical authorities to a great extent in order to secure compliance of patients.

Conclusion: Social Invisibility

In Part I, I attempted to measure obstetric violence in various ways using different methods: its frequency, geographic distribution, and social distribution. My findings align with previous research. Obstetric violence is, even in my own data, rare. My analysis of case law in Chapter 3 underscored how much power hospitals in particular have, and how they use that power in ways that protect medical staff at the expense of patients. My work also demonstrates that *obstetric violence* is not random. My analysis of the Listening to Mothers III data in Chapter 4 showed that pregnant people who are vulnerable or marginalized were more likely to report that they *always* experienced poor treatment, while pregnant people who were more privileged were much more likely to report that they *never* experienced poor treatment. Chapter 5 maps out the cases that I analyzed. Readers of the news about obstetrics care were surely shocked, *shocked* to find that obstetric violence was highly geographically concentrated as well, particularly in states that prioritize fetal personhood over maternal health care.

Part II of my dissertation lays out the case of how obstetric violence came to be distributed in this way. I argued in Chapter 6 that pregnancy as a public issue was institutionalized across two very distinct institutions: medicine and law. This chapter has laid out the theoretical elements of why obstetric violence is so widespread but remains so invisible. It is the nature of social problems to engender shame and stigma, and an unwillingness to admit personal trouble or moral failings publicly (Section I). The way

that institutions operate to enforce social order and the way that individuals act to construct social reality together creates the environment for obstetric violence to occur–partially as a form of social control, or sanctions for violating the norms of the institution of medicine (Section II). Finally, an intersectional understanding of individual sociodemographic characteristics explains how institutions cooperate or collaborate to exclude marginalized people (Section III).

This is how power and privilege operate. The normative order that grows out of the relationship between institutions becomes an "iron cage"[182] of its own that leads straight to a meat grinder. In spite of the fact that ideologies of misogyny and racism are not *functional*, and have no root in the current institutional arrangements of society, they have taken on a life of their own. We must have babies to support ailing social welfare systems built on the assumption that the Baby Boom would last forever–just not too many babies who aren't white. If economic conditions require women to work to support families and push birth later and later into life, just pay to freeze the good eggs. So that women may fulfill their "biological destiny." And so, even at the expense of the lives of pregnant people, even against the recommendations of medical institutions such as the

[182] I am aware of the controversial translation of "stahlhartes Gehäuse" by Talcott Parsons. More literally, Weber's words mean something like "a housing as hard as steel." In spite of being a consummate weirdo, Parsons apparently had poetry in his soul. Iron cage sounds better, and is a pretty good translation of the metaphor. Though, my German is atrocious so who am I to judge?

American College of Obstetricians and Gynecologists,[183] the pressure to treat fetuses as children has taken on a life of its own.

I suspect that sociologists who read my research questions at the beginning of my dissertation–and many savvy readers with a well-developed sociological imagination–are unsurprised by my findings. I hope that this chapter offers a new way to think about how inequality and marginalization is reproduced. I hope my dissertation opens the door to thinking about social invisibility in new ways.

My final hope for this project is that it will be useful to people trying to *do something about obstetric violence.* It is happening in a community near you. Doctors who are trying to do their best, and who are not themselves racist or sexist or ableist nevertheless are working within a system that oppresses marginalized people in ways that are invisible to the broader public. I hope that people in a position of authority within these systems are interested enough to read the whole thing, and that a few seeds are planted. I hope that we may build together newer, better systems that treat even people with no power well.

[183] Recall that in Chapter 1, I explored ACOG's explanation of the rights of pregnant patients. The fetus is never a patient, in their eyes; the patient is the pregnant person, whose rights to refuse treatment must be respected.

Afterword: The Future of Women's Rights

I took too long to write my dissertation.

In my defense, a fascist takeover of the American government and a global pandemic happened. *Roe v. Wade* was overturned, making a lot more work for those of us working in both political organizing and abortion.

Then I got cancer.

Which was strangely, surreally relevant to the larger issues within my dissertation.

I. Roe's demise is so much worse than anyone seems to know

Until my cancer diagnosis, I went to the only local hospital–which happens to be Catholic–for all my healthcare needs. For a low-risk patient like myself who has never given birth, all gynecological care is funneled through the Women's Center.

If I was ever confused about what the Women's Center at a Catholic hospital is for, there are definite clues. Every exam room has a different picture of a pregnant person or a breastfeeding infant. None of these pictures of women's bodies have heads. The center of the image is the belly or the baby. There is a crucifix at the foot of every exam table over the sink, positioned so that the agonized eyes of a bleeding Jesus are staring straight up the center of the stirrups. At every visit, I had to say that I wasn't trying to conceive at this time. The response was always "maybe soon" or "someday!" Not one single provider at the Women's Center ever discussed birth control with me, and I do not recall it being on the pre-visit questionnaire.

In order to receive care at a regular gynecology visit, you are required to provide a urine sample. The nursing staff won't tell you what it's for. Consent forms are not posted and cannot be produced on request. If you refuse to pee in the cup, then you are denied access to care and billed for it anyway.

The last straw for me was a pap smear. I refused consent to have my vaginal exam observed, and the certified nurse midwife waited until she had inserted and set the speculum to assure me that it would only be a quick peak, and invited the resident in anyway.

I swore to myself that I would never, ever go back there for any reason.

Then a mass began developing in my abdomen. I was measuring myself to tailor a suit to defend my dissertation when I noticed how many inches I was gaining in my waist. At the same time I was losing weight.

My primary care physician palpated my abdomen and said, "you're getting an ultrasound today. Right now. I'm personally calling around until we get you a spot."

The ultrasound tech tried to make a joke about how worried I was.

"It's not a baby," she cracked.

In a family with a history stretching three generations of abdominal cancers, that was definitely not what I was worried about, even after the demise of Roe. What worried me is that the first technician could not find the edge of whatever she was looking for. She

called for backup, who had me empty my bladder and told jokes. She also ran the probe all the way up my abdomen and over my rib cage, and all the way down to my pelvis.

I was at the radiology department for a total of seven hours. I had another ultrasound, and a CT scan. My primary care physician told me that I had what looked like a giant ovarian cyst that would probably have to be surgically removed along with the ovary to be biopsied. Then she referred me to the Women's Center.

The same woman who has repeatedly violated my consent is who opened my chart. Well, she eventually opened my chart. It took her five days. I started getting phone calls to schedule a lot of unnecessary tests before I actually spoke to her. The scans could not be scheduled for another six weeks at least, probably more like eight to ten. When I finally spoke to her on the phone, she tried to convince me to save my ovary while they removed the mass. I argued that it didn't sound like a maximally invasive surgery was in my best interest. I asked to speak to a surgeon before making a decision.

The certified nurse midwife, exasperated, finally said, "removing your ovary would be the moral equivalent of providing you with an abortion. And we don't have to do that any more."

I hung up. I called the same close relative that I referred to in the preface of this dissertation. I told her how I hated to do this, but I really needed help and advice. I managed to screenshot one of my scans and bypass the download blocker. She talked me through all my options. I did not mention the absolute insane thing the nurse midwife had

said to me. She texted me a list of surgeons that she would trust with her life, and told me to use her name as my referral.

About three weeks later, I had an outpatient laparoscopic surgery to execute the traitor. It was still a shock somehow, when the biopsy came back as cancer.

My surgeon tried to make me promise not to google it, which is not exactly *reassuring*. When I said I was absolutely going to, she replied, "oh yeah. You're a scientist." She explained what I needed to know before I read too much. My surgeon assured me that she saw no evidence of gross disease. I was stage 2 at worst. But I was definitely getting an exploratory laparotomy and chemotherapy.

"You don't have anything in common with the majority of cases of this type of ovarian cancer. You should not pay attention to the general prognosis."

I'm glad she told me that. It's pretty grim. The five year survival rate is just under 30%. This is mostly because it grows so quickly. Nearly 90% of cases are diagnosed at stage three or four. The median survival time for someone diagnosed at stage 4 is 20 months. The time it takes to go from stage one to stage four is six months on the low end, and twelve months on the high end.

All I could think when I read this, is that the certified nurse midwife nearly killed me.

II. Brittany Watts

The same hospital system betrayed the trust of another woman this year. They debated for over 8 hours whether or not they could induce labor for Brittany Watts'

miscarriage. She visited the same ER three times in one week before she miscarried in a toilet at home. When she went back a fourth time, a nurse (presumably, a good Catholic nurse) reported her to the police.

Criminal charges were filed, though they were eventually dismissed. I very much doubt anyone will ever prosecute the doctors who failed to treat her for their gross negligence. No one is even arguing that the fetus would have lived. The fetus died inside of Brittany, days before she expelled the fetal remains–weighing in at just under a pound.

I feel my blood pressure rising every time someone calls the pound of flesh that could have killed Brittany a baby, or the remains of it a corpse. A fetus is not a person. It has neither a body nor a mind. Fetal remains are medical waste, in the eyes of the law–or at least, they should be.

If that feels uncaring or cold when you read it, you should know that the same nurse who tried to pressure me into saving my ovary called me approximately four times on what I think was her private cell phone to beg me not to harm my future children, not to have the surgery to remove my ovary. She refused to release my medical records to a different hospital. I had to make the request directly to the records office and take a CD ROM of my CT scan and ultrasound results to Cleveland with me. She harassed me while I was recovering from surgery and navigating oncological care.

I don't have standing to sue because I got care somewhere else, and I am not going to die. I lived in terror of experiencing complications from my chemotherapy or my 4

abdominal surgeries and having to present at my local hospital. Would they treat me if it meant removing the other ovary? Would they give me antibiotics without testing my urine to see if I was pregnant? Would they call the police? Would I have to see that woman in person again–and would she tell me I had behaved immorally by saving my life?

I am immensely privileged. I had health insurance that covered all six doses of my chemotherapy. All four of my abdominal surgeries, no questions asked. My husband's work was perplexed about how anxious he was about all the time off he had to take to drive me almost two hours one way to receive chemotherapy. One of his coworkers–a survivor herself–finally said, "your wife has *cancer*. We have *unlimited time off*. Of course you will take care of her."

Brittany couldn't miss work. She had to leave the emergency room. She wasn't going to go back when she passed the fetal remains into her toilet. She looked so ill that her friend begged her to go.

It should not shock anyone who has read my whole dissertation that Brittany is black. She is not married. She has at least one other child at home. She is working class. She had no one to take her to the emergency room—not even the friend who begged her to go, who had work herself. It isn't clear what happened to her child when she was arrested and taken into custody, but I heard through the legal grapevine that she had to fight a bit to get custody back.

I see a red mist when I think of how many women like us are going to have to actually die before the hospital is held accountable. How many women like Brittany are going to have to go to prison before someone punishes the doctors for their negligence. There is nothing separating the reality of women in Texas from those in El Salvador. People who can become pregnant and can only turn to the local Catholic hospital have worse health care access than a third world country. Eventually, we are going to start dying.

III. Without the right to ourselves, we have no rights.

In my capacity as the President of the local chapter of the League of Women Voters, I was invited to give a talk about the importance of voting to a Planned Parenthood student chapter at the local university. This was just before the *Dobbs* decision was leaked. The speakers were all older professors and activists. The mood among the college students was cheerful if tired–free Chik-fil-A! Among the presenters, it was smolderingly enraged.

I had a whole speech prepared. It was a good speech. About gerrymandering and voter purging and how we don't really live in a democracy if there are people who cannot cast a ballot and expect it to be counted. We don't really live in a democracy if our legislators refuse to follow the law in redistricting. We don't really live in a democracy if money is all it takes to buy the legislation that you want. We don't really live in a democracy if suffrage is not one of the rights of citizenship.

The students were not into it.

I veered off script and spoke from the heart. I had been reviewing and revising my history chapter. It was all very fresh.

"Listen, this isn't just about abortion. This is about your right to privacy. It's in the penumbra. You don't have an explicit right to control your own body."

I explained what that meant in terms of constitutional law. I even got the quote about penumbras and shadows right on the fly, though I would have to reread *Griswold* now.

"Are you all familiar with Griswold v. Connecticut?"

Some were. One girl who opened the evening by declaring she would like to be a turtle for a day[184] explained to the others about legally accessing contraception.

"That's done if you don't have a right to privacy. Obergefell v. Hodges?"

They knew that one. I didn't know that about two months later Alito would cite it in his draft opinion overturning *Roe*. The dissenters, he argued, were not taking seriously the state's obligation to protect fetal life. This seemed, to him, "...designed to stoke unfounded fear that our decision will imperil those other rights" (Dobbs v Jackson Women’s Health 2022).

"Done, gone. Same with Lawrence v. Texas."

[184] It was an icebreaker, I hate that nonsense, don't judge her

I had to explain what a sodomy law was. When I lived in Virginia, Ken Cuccinelli[185] was running for governor and desperately wanted to reinstate the felony sodomy law even if it was unconstitutional. Sodomy was defined in the medieval sense of the word dating from the 14th century, meaning any sex act at all that could not result in procreation.[186] It is still on the books, even though *Lawrence* had rendered it unenforceable.

"What about Loving v. Virginia?"

A nice young man who I know to be a member of the local Democratic Socialists of America chapter explained the case which invalidated anti-miscegenation laws.

"Buck v. Bell is still good law, anyone familiar?"

In an earlier draft of this dissertation, one of my committee members expressed skepticism that *Buck v. Bell* was going to come back to haunt us. It *does* seem crazy to think that involuntary sterilizations would make a comeback as formal policy. I only know about the case because I fell in with a strange crowd of Libertarians in Virginia. They were all pretty upset because they had heard their further-right friends talking excitedly about reinstating the precedent–set right there in Albemarle County! I was horrified when I read the decision myself. My sense of dread only grew when I read the excellent book *Imbeciles* (Cohen 2016) that I cited in Chapter 6, many years later.

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[185] You know, the guy whose career highlights include a stint at DHS in which he tried to rewrite the Emma Lazarus poem to make sure indigent immigrants couldn't come to the United States and who masterminded both remain in Mexico and family separations for Donald Trump? *That guy.*

[186] I plead the fifth over whether I had committed felony sodomy in the state of Virginia when I lived there.

I concluded by admonishing the assembled students that if they didn't know what their rights were, how could they expect to protect them? I joked about how old I sounded when I said it, but I really believe that we have a civic duty to educate ourselves. I also confessed that I have, for years, read amicus briefs for fun for a lot of major Supreme Court decisions. It doesn't make me a lawyer, but it does really put into perspective the *stakes* of shifting legal precedent.

I had no idea that a year later, *my* life would be on the line. That *I* wouldn't be able to access healthcare. That women like Brittany would start getting arrested for miscarriages. I really should have known though. I really, really *should have*.

I have no hope that our Congress will magically become functional enough to pass legislation that protects the right to abortion nationwide. They can't even pass legislation to reduce infant and maternal mortality, or protect voting rights.

I expect the birth rate to plummet further. A dear friend recommended that every woman of her acquaintance go and reread Lysistrata since we won't have access to birth control. Women will be prosecuted for homicide and feticide. Women will have medical procedures performed on them, including surgical procedures, without their consent.

Eventually, someone is going to die because doctors and hospitals will not remove a nonviable fetus. Indeed, I had to update this afterword before finalizing my dissertation. The day after I submitted the penultimate draft to start the countdown to freedom, ProPublica released a report on the first two known death of a pregnant person directly

attributable to Dobbs (Surana 2024). The hospital investigation had taken two years. They published the story almost immediately—only to have the state commission that investigate the incident disbanded die the impropriety of “leaking” the information (Yurkanin 2024).

People are getting C-sections instead of D&E's, and hysterectomies when their miscarriage that isn't managed goes wrong. I just spent several hundred pages explaining how the violation of pregnant people's rights is often virtually invisible. It took two years to record the deaths associated with Dobbs. Then the commission has *stopped recording*. I have no doubt that the number is far, far greater than two whether it is reported or not, particularly given the proliferation of private Christian hospitals. In underserved rural, poor, or Black communities, there is a higher density of hospitals that are not for profit. It’s like watched a train barrel down the tracks on a woman that has been tied down. Much like a silent movie, we are all out here screaming but no one seems to hear.

I don't even know how a preventable death from untreated cancer would be recorded. Make no mistake though, the *Dobbs* decision nearly killed me. I wonder how many other women out there are dying right now from preventable, treatable cancers because to some medical providers, an unfertilized, immature oocyte is the moral equivalent of a baby.

If it had not happened to me, I would not believe it.

Obstetric violence seems small potatoes in the face of so much pain and death that lours over the blackened horizon. Yet with no clear picture of the scope or scale of the

problem, I fear it will grow rapidly and unchecked. I hope I have contributed in some small way to illuminating the issue, which to me seems simple: women are not commonly understood as people.

There is no longer any check on the power of the state or the power of doctors over pregnancy. Freedom from violence is at the heart of the 14th Amendment, as is the freedom to choose whether or not to have children. Black women fought for that recognition in the 19th century, because they knew a pain modern people have forgotten. Forced birth, the theft of their children, and yes, even violence committed by doctors working for their enslavers.

Women cannot be full and equal citizens without these freedoms. We cannot ever live in a democracy without equality. I would like to live in one someday, and I will fight every day of my life to make it happen.

Appendix A: The Full Dataset of Cases

Case	Decision Date	Citation	Court	Obstetric Violence
A.Q.C. ex rel. Castillo v. United States	2011-09-08	656 F.3d 135	United States Court of Appeals for the Second Circuit	N
Abilene Regional Medical Center v. Allen	2012-11-29	387 S.W.3d 914	Texas Courts of Appeals	N
All Children's Hospital, Inc. v. Department of Administrative Hearings	2011-02-18	55 So. 3d 670	Florida District Court of Appeal	N
Allen v. Methodist Healthcare Memphis Hospitals	2007-04-02	237 S.W.3d 293	Tennessee Court of Appeals	N
Amodeo v. Cumella	2007-06-05	41 A.D.3d 396, 838 N.Y.S.2d 152	New York Supreme Court, Appellate Division	N
Anderson ex rel. Anderson v. Helen Ellis Memorial Hospital Foundation, Inc.	2011-08-19	66 So. 3d 1095	Florida District Court of Appeal	N
Anderson v. Gonzalez	2010-04-22	315 S.W.3d 582	Texas Courts of Appeals	N
Anderson v. Medical Center, Inc.	2003-03-26	260 Ga. App. 549, 580 S.E.2d 633	Court of Appeals of Georgia	N
Ater ex rel. Ater v. Follrod	2002-09-17	238 F. Supp. 2d 928	United States District Court for the Southern District of Ohio	N
Azizi ex rel. Azizi v. United States	2004-09-28	338 F. Supp. 2d 1057	United States District Court for the District of Nebraska	N
B.J. ex rel. E.J. v. Shultz	2009-07-21	351 Mont. 436,214 P.3d 772,2009 MT 245	Montana Supreme Court	N
Bailey v. Haynes	2003-10-10	856 So. 2d 1207	Louisiana Supreme Court	N
Bennett v. St. Vincent's Medical Center, Inc.	2011-07-07	71 So. 3d 828	Florida Supreme Court	N
Bergman v. Kelsey	2007-08-02	375 Ill. App. 3d 612	Illinois Appellate Court	N

Berry v. West Suburban Hospital Medical Center	2003-03-24	338 Ill. App. 3d 49	Illinois Appellate Court	N
Borges v. Serrano-Isern	2010-05-03	605 F.3d 1	United States Court of Appeals for the First Circuit	N
Bravo v. United States	2005-11-30	403 F. Supp. 2d 1182	United States District Court for the Southern District of Florida	N
Brown ex rel. Brown v. St. Vincent's Hospital	2004-10-08	899 So. 2d 227	Alabama Supreme Court	N
Brown ex rel. Brown v. United States	2006-09-08	462 F.3d 609	United States Court of Appeals for the Sixth Circuit	N
Bryant v. LaGrange Memorial Hospital	2003-12-17	345 Ill. App. 3d 565	Illinois Appellate Court	N
C v. St. Luke's-Roosevelt Hospital Center	2007-06-18	16 Misc. 3d 688, 58 P.3d 78	New York Supreme Court	N
Callistro v. Bebbington	2012-04-03	94 A.D.3d 408, 941 N.Y.S.2d 137	New York Supreme Court, Appellate Division	N
Cartagena v. New York City Health & Hospitals Corp.	2012-02-09	93 A.D.3d 187, 938 N.Y.S.2d 77	New York Supreme Court, Appellate Division	N
Central Virginia Obstetrics & Gynecology Associates, P.C. v. Whitfield	2004-01-13	42 Va. App. 264, 590 S.E.2d 631	Court of Appeals of Virginia	N
Cham v. St. Mary's Hospital	2010-04-27	72 A.D.3d 1003, 901 N.Y.S.2d 65	New York Supreme Court, Appellate Division	N
Chau v. Riddle	2008-05-16	254 S.W.3d 453	Supreme Court of Texas	N
Chicago Hospital Risk Pooling Program v. Illinois State Medical Inter-Insurance Exchange	2010-01-26	397 Ill. App. 3d 512	Illinois Appellate Court	N
Christiansen v. Providence Health System of Oregon Corp.	2006-12-27	210 Or. App. 290, 150 P.3d 50	Oregon Court of Appeals	N
Cload v. West	2002-04-03	328 Ill. App. 3d 946	Illinois Appellate Court	N

Coffey v. Virginia Birth-Related Neurological Injury Compensation Program	2002-01-29	37 Va. App. 390, 558 S.E.2d 563	Court of Appeals of Virginia	N
Cole v. Raut	2008-06-09	378 S.C. 398	Supreme Court of South Carolina	N
Coleman v. Putnam Hospital Center	2010-06-15	74 A.D.3d 1009,903 N.Y.S.2d 502	New York Supreme Court, Appellate Division	N
Commonwealth v. Bakke	2005-09-27	46 Va. App. 508, 620 S.E.2d 107	Court of Appeals of Virginia	N
Cousart v. Charlotte-Mecklenburg Hospital Authority	2011-01-18	209 N.C. App. 299	North Carolina Court of Appeals	N
Craig v. Oakwood Hospital	2004-07-23	471 Mich. 67	Michigan Supreme Court	N
Crawford v. Sorkin	2007-06-21	41 A.D.3d 278, 839 N.Y.S.2d 40	New York Supreme Court, Appellate Division	N
Crocker v. Roethling	2011-11-15	217 N.C. App. 160	North Carolina Court of Appeals	N
Crutcher v. Williams	2008-03-14	12 So. 3d 631	Alabama Supreme Court	N
Csiszer ex rel. Csiszer v. Wren	2010-08-06	614 F.3d 866	United States Court of Appeals for the Eighth Circuit	N
D'Angelis v. Buffalo General Hospital	2003-12-31	2 A.D.3d 1477,770 N.Y.S.2d 553	New York Supreme Court, Appellate Division	N
Darby v. Chelouche	2003-07-21	48 Conn. Supp. 138	Connecticut Superior Court	N
De La Cruz v. New York City Health & Hospitals Corp.	2004-12-09	13 A.D.3d 130, 786 N.Y.S.2d 52	New York Supreme Court, Appellate Division	N
Descant v. Herrera	2004-12-22	890 So. 2d 788	Louisiana Court of Appeal	N
Dias v. Brigham Medical Associates, Inc.	2002-12-23	438 Mass. 317	Massachusetts Supreme Judicial Court	N
Drake v. Bingham	2011-09-27	131 Conn. App. 701	Connecticut Appellate Court	N

Duss ex rel. Regions Bank v. Garcia	2012-01-06	80 So. 3d 358	Florida District Court of Appeal	N
Earlington v. Anastasi	2009-08-25	293 Conn. 194	Connecticut Supreme Court	N
Enea ex rel. Jones v. Linn	2002-06-18	256 Wis. 2d 714, 650 N.W.2d 315, 2002 WI App 185	Wisconsin Court of Appeals	N
Estate of Ford v. Eicher	2011-03-21	250 P.3d 262	Colorado Supreme Court	N
Estate of Hagedorn v. Peterson	2004-12-17	690 N.W.2d 84	Iowa Supreme Court	N
Farishta v. Tenet Healthsystem Hospitals Dallas, Inc.	2007-01-25	224 S.W.3d 448	Texas Courts of Appeals	N
Faughn v. Perez	2006-12-05	145 Cal. App. 4th 592	Court of Appeal of the State of California	N
First National Bank v. Glen Oaks Hospital & Medical Center	2005-05-17	357 Ill. App. 3d 828	Illinois Appellate Court	N
First National Bank v. Lowrey	2007-06-29	375 Ill. App. 3d 181	Illinois Appellate Court	N
Fisher v. Lindauer	2012-11-15	904 F. Supp. 2d 750	United States District Court for the Western District of Michigan	N
Florida Health Sciences Center, Inc. v. Division of Administrative Hearings	2007-12-19	974 So. 2d 1096	Florida District Court of Appeal	N
Furey v. Kraft	2006-03-07	27 A.D.3d 416, 812 N.Y.S.2d 590	New York Supreme Court, Appellate Division	N
Garbowski v. Hudson Valley Hospital Center	2011-06-07	85 A.D.3d 724, 924 N.Y.S.2d 567	New York Supreme Court, Appellate Division	N
Gardner v. Brookdale Hospital Medical Center	2010-05-25	73 A.D.3d 1124, 901 N.Y.S.2d 680	New York Supreme Court, Appellate Division	N
Garley v. Columbia LaGrange Memorial Hospital	2004-06-30	351 Ill. App. 3d 398	Illinois Appellate Court	N
Gelsthorpe v. Weinstein	2005-03-02	897 So. 2d 504	Florida District Court of Appeal	N

Gilbert v. Miodovnik	2010-03-18	990 A.2d 983	District of Columbia Court of Appeals	N
Gomes v. Hameed	2008-01-22	184 P.3d 479	Oklahoma Supreme Court	N
Goolsby v. Qazi	2003-04-11	847 So. 2d 1001	Florida District Court of Appeal	N
Gorbey ex rel. Maddox v. American Journal of Obstetrics & Gynecology	2012-03-16	849 F. Supp. 2d 162	United States District Court for the District of Massachusetts	N
Gotto v. Eusebe-Carter	2010-01-05	69 A.D.3d 566, 892 N.Y.S.2d 191	New York Supreme Court, Appellate Division	N
Hall v. University of Maryland Medical System Corp.	2007-03-21	398 Md. 67, 919 A.2d 1177	Court of Appeals of Maryland	N
Hankla v. Jackson	2010-07-14	305 Ga. App. 391, 699 S.E.2d 610	Court of Appeals of Georgia	N
Hayes v. Chartered Health Plan	2004-03-11	360 F. Supp. 2d 84	United States District Court for the District of Columbia	N
Hernandez ex rel. Telles-Hernandez v. United States	2009-10-16	665 F. Supp. 2d 1064	United States District Court for the Northern District of California	N
Hey v. University of Virginia Health Services Foundation	2010-05-24	80 Va. Cir. 360	Charlottesville Circuit Court	N
Hinojosa v. Columbia/St. David's Healthcare System, L.P.	2003-05-08	106 S.W.3d 380	Texas Courts of Appeals	N
Holt v. Wesley Medical Center, LLC	2004-03-19	277 Kan. 536, 86 P.3d 1012	Kansas Supreme Court	N
Iaccino v. Anderson	2010-12-03	406 Ill. App. 3d 397	Illinois Appellate Court	N
In re Raja	2006-07-27	216 S.W.3d 404	Texas Courts of Appeals	N
Indiana Patient's Compensation Fund v. Butcher	2007-03-16	863 N.E.2d 11	Court of Appeals of Indiana	N

Jackson v. Buck	2005-12-08	77 Pa. D. & C.4th 404	Dauphin County Court of Common Pleas	N
Jensen v. IHC Hospitals, Inc.	2003-11-14	82 P.3d 1076, 2003 UT 51	Utah Supreme Court	N
Johnson v. United States	2006-08-09	460 F.3d 616	United States Court of Appeals for the Fifth Circuit	N
Jordan ex rel. Jordan v. Deery	2002-11-22	778 N.E.2d 1264	Supreme Court of Indiana	N
Kenyon v. Handal	2003-03-10	122 S.W.3d 743	Tennessee Court of Appeals	N
Kesterson v. Jarrett	2010-12-01	307 Ga. App. 244, 704 S.E.2d 878	Court of Appeals of Georgia	N
Khomyak ex rel. Khomyak v. Meek	2011-08-02	214 N.C. App. 54	North Carolina Court of Appeals	N
Klippel v. Rubinstein	2002-12-16	300 A.D.2d 448, 751 N.Y.S.2d 553	New York Supreme Court, Appellate Division	N
Lambadarios v. Kobren	2002-02-05	191 Misc. 2d 86, 739 N.Y.S.2d 549	New York Supreme Court	N
LaSalvia v. Johnson	2003-01-21	15 Mass. L. Rptr. 622	Massachusetts Superior Court	N
Lawson v. United States	2006-10-02	454 F. Supp. 2d 373	United States District Court for the District of Maryland	N
Lewis v. United States	2003-07-24	290 F. Supp. 2d 1	United States District Court for the District of Columbia	N
Linton v. Davis	2008-06-03	887 N.E.2d 960	Court of Appeals of Indiana	N
Livingston v. Montgomery ex rel. Colter	2009-02-27	279 S.W.3d 868	Texas Courts of Appeals	N
Long Beach Memorial Medical Center v. Superior Court	2009-03-26	172 Cal. App. 4th 865	Court of Appeal of the State of California	N
Lopez v. Northwestern Memorial Hospital	2007-07-26	375 Ill. App. 3d 637	Illinois Appellate Court	N
Lownsbury v. VanBuren	2002-02-20	94 Ohio St. 3d 231	Supreme Court of Ohio	N

Lyons v. Vassar Bros. Hospital	2006-06-13	30 A.D.3d 477, 818 N.Y.S.2d 124	New York Supreme Court, Appellate Division	N
M.D.P. v. Houston County Health Care Authority	2011-11-03	821 F. Supp. 2d 1295	United States District Court for the Middle District of Alabama	N
Madrigal v. Mendoza	2009-07-23	639 F. Supp. 2d 1026	United States District Court for the District of Arizona	N
Manhardt ex rel. Manhardt v. Tamton	2002-09-04	832 So. 2d 129	Florida District Court of Appeal	N
Maradiaga v. United States	2012-05-08	679 F.3d 1286	United States Court of Appeals for the Eleventh Circuit	N
Matteini v. Florida Birth-Related Neurological	2006-12-08	946 So. 2d 1092	Florida District Court of Appeal	N
McCarty v. Sanders	2004-04-07	805 N.E.2d 894	Court of Appeals of Indiana	N
McGowen v. Mau-Ping Huang	2003-10-22	120 S.W.3d 452	Texas Courts of Appeals	N
McIntyre v. Ramirez	2003-06-26	109 S.W.3d 741	Supreme Court of Texas	N
McKellar v. Cervantes	2012-04-18	367 S.W.3d 478	Texas Courts of Appeals	N
McLeod v. Mt. Sinai Medical Center	2006-05-04	166 Ohio App. 3d 647	Ohio Court of Appeals	N
McNamee v. Sandore	2007-06-07	373 Ill. App. 3d 636	Illinois Appellate Court	N
McShane v. Bay Area Healthcare Group, Ltd.	2005-10-06	174 S.W.3d 908	Texas Courts of Appeals	N
Mendez v. Bhattacharya	2007-03-30	15 Misc. 3d 974, 838 N.Y.S.2d 378	New York Supreme Court	N
Mensah v. Goedken	2006-04-04	21 Mass. L. Rptr. 6	Massachusetts Superior Court	N
Miller ex rel. Miller v. Dacus	2007-08-17	231 S.W.3d 903	Tennessee Supreme Court	N
Morrell v. Finke	2005-11-03	184 S.W.3d 257	Texas Courts of Appeals	N
Motley v. United States	2002-07-05	295 F.3d 820	United States Court of Appeals for the Eighth Circuit	N

Mussemann v. Villarreal ex rel. Elizondo	2005-08-25	178 S.W.3d 319	Texas Courts of Appeals	N
Nagy v. Florida Birth-Related Neurological Injury Compensation Ass'n	2002-03-13	813 So. 2d 155	Florida District Court of Appeal	N
Nassar v. County of Cook	2002-08-08	333 Ill. App. 3d 289	Illinois Appellate Court	N
Neal v. Yang	2004-09-30	352 Ill. App. 3d 820	Illinois Appellate Court	N
New Hampshire Insurance Guaranty Ass'n v. Elliot Hospital	2006-12-20	154 N.H. 571	New Hampshire Supreme Court	N
Nolen v. Boca Raton Community Hospital, Inc.	2004-06-18	373 F.3d 1151	United States Court of Appeals for the Eleventh Circuit	N
Northern Trust Co. v. Burandt & Armbrust, LLP	2010-07-27	403 Ill. App. 3d 260	Illinois Appellate Court	N
Northern Trust Co. v. University of Chicago Hospitals & Clinics	2004-12-23	355 Ill. App. 3d 230	Illinois Appellate Court	N
O'mara ex rel. Reavis v. Wake Forest University Health Sciences	2007-07-03	184 N.C. App. 428	North Carolina Court of Appeals	N
Orlando Regional Healthcare System, Inc. v. Florida Birth-Related Neurological	2008-10-31	997 So. 2d 426	Florida District Court of Appeal	N
Orlando Regional Healthcare v. Alexander	2006-06-30	932 So. 2d 598	Florida District Court of Appeal	N
Pagés-Ramírez v. Hospital Español Auxilio Mutuo de Puerto Rico, Inc.	2008-05-14	553 F. Supp. 2d 108	United States District Court for the District of Puerto Rico	N
Pagés-Ramírez v. Ramírez-González	2010-05-19	605 F.3d 109	United States Court of Appeals for the First Circuit	N

Pediatrix Medical Group of Florida, Inc. v. Falconer	2010-04-07	31 So. 3d 310	Florida District Court of Appeal	N
Pediatrix Medical Group, Inc. v. Robinson	2011-10-31	352 S.W.3d 879	Texas Courts of Appeals	N
Pedro v. Goldfarb	2011-09-13	28 Mass. L. Rptr. 559	Massachusetts Superior Court	N
Petryshyn v. Slotky	2008-07-29	387 Ill. App. 3d 1112	Illinois Appellate Court	N
Pilecki v. Cromwell	2002-12-30	300 A.D.2d 1007, 755 N.Y.S.2d 142	New York Supreme Court, Appellate Division	N
Pope ex rel. Pope v. Cumberland County	2005-07-19	615 S.E.2d 715	Court of Appeals of North Carolina	N
Pounds v. Mississippi Department of Health	2006-06-20	946 So. 2d 413	Mississippi Court of Appeals	N
President v. Jenkins	2003-02-06	357 N.J. Super. 288, 814 A.2d 1173	New Jersey Superior Court, Appellate Division	N
Preston v. Meriter Hospital, Inc.	2004-02-26	271 Wis. 2d 721, 678 N.W.2d 347, 2004 WI App 61	Wisconsin Court of Appeals	N
Price v. Wolford	2010-06-17	608 F.3d 698	United States Court of Appeals for the Tenth Circuit	N
Quiroz ex rel. Quiroz v. Covenant Health System	2007-03-08	234 S.W.3d 74	Texas Courts of Appeals	N
Reagan-Dailey v. McNichol	2003-10-02	309 A.D.2d 1221, 765 N.Y.S.2d 105	New York Supreme Court, Appellate Division	N
Robertson v. B.O. ex rel. Ort	2012-10-31	977 N.E.2d 341	Supreme Court of Indiana	N
Rodas v. SwedishAmerican Health System Corp.	2009-01-29	594 F. Supp. 2d 1033	United States District Court for the Northern District of Illinois	N
Rodríguez-Rivera v. Federico Trilla Regional Hospital	2008-07-02	532 F.3d 1	United States Court of Appeals for the First Circuit	N

Roesler v. TIG Insurance	2007-10-12	251 F. App'x 489	United States Court of Appeals for the Tenth Circuit	N
Royal v. Tyree	2012-01-17	91 A.D.3d 744, 937 N.Y.S.2d 268	New York Supreme Court, Appellate Division	N
Saade v. Villarreal	2009-02-26	280 S.W.3d 511	Texas Courts of Appeals	N
Salvant v. State	2006-07-06	935 So. 2d 646	Louisiana Supreme Court	N
Sandmann v. Shapiro	2008-07-08	53 A.D.3d 537, 861 N.Y.S.2d 760	New York Supreme Court, Appellate Division	N
Santos v. Rosing	2009-03-17	60 A.D.3d 500, 875 N.Y.S.2d 59	New York Supreme Court, Appellate Division	N
Scalisi v. Oberlander	2012-04-19	96 A.D.3d 106, 943 N.Y.S.2d 23	New York Supreme Court, Appellate Division	N
Schaner v. Mercy Hospital	2005-02-04	15 A.D.3d 997, 789 N.Y.S.2d 561	New York Supreme Court, Appellate Division	N
Shipman v. Mount Sinai Hospital	2002-01-15	290 A.D.2d 294, 736 N.Y.S.2d 338	New York Supreme Court, Appellate Division	N
Smith v. Wesley Health System, LLC	2010-11-16	47 So. 3d 742	Mississippi Court of Appeals	N
Somoye v. Klein	2004-06-08	349 Ill. App. 3d 209	Illinois Appellate Court	N
St. Vincent's Medical Center, Inc. v. Bennett	2009-08-21	27 So. 3d 65	Florida District Court of Appeal	N
Staggs v. United States ex rel. Department of Health & Human Services	2005-10-04	425 F.3d 881	United States Court of Appeals for the Tenth Circuit	N
Steen v. Professional Liability Insurance Co. of America	2007-06-27	962 So. 2d 470	Louisiana Court of Appeal	N
Sullivan v. Edward Hospital	2004-02-05	209 Ill. 2d 100	Illinois Supreme Court	N
Taber v. Roush	2010-06-17	316 S.W.3d 139	Texas Courts of Appeals	N
Tenet Hospitals Ltd. v. De La Riva	2011-06-29	351 S.W.3d 398	Texas Courts of Appeals	N

Thao Chau v. Riddle	2006-09-28	212 S.W.3d 699	Texas Courts of Appeals	N
Torres v. Sarasota County Public Hospital Board	2007-04-13	961 So. 2d 340	Florida District Court of Appeal	N
Torretti v. Main Line Hospitals, Inc.	2009-09-02	580 F.3d 168	United States Court of Appeals for the Third Circuit	N
Trowbridge v. United States	2010-03-05	703 F. Supp. 2d 1129	United States District Court for the District of Idaho	N
TTHR Ltd. Partnership v. Moreno	2011-07-07	401 S.W.3d 163	Texas Courts of Appeals	N
University of Maryland Medical System Corp. v. Gholston	2012-02-10	203 Md. App. 321, 37 A.3d 1074	Court of Special Appeals of Maryland	N
Valdez ex rel. Donely v. United States	2008-02-29	518 F.3d 173	United States Court of Appeals for the Second Circuit	N
Velazquez v. Jiminez	2002-05-29	172 N.J. 240, 798 A.2d 51	Supreme Court of New Jersey	N
Viera v. Cohen	2007-08-07	283 Conn. 412	Connecticut Supreme Court	N
Vincent v. Essent Healthcare	2007-01-18	470 F. Supp. 2d 140	United States District Court for the District of Connecticut	N
Vitro v. Mihelcic	2004-01-23	209 Ill. 2d 76	Illinois Supreme Court	N
Ward v. Glover	2006-06-02	206 S.W.3d 17	Tennessee Court of Appeals	N
Washington v. City of Evanston	2002-12-19	336 Ill. App. 3d 117	Illinois Appellate Court	N
Weeks v. Florida Birth-Related Neurological	2008-01-31	977 So. 2d 616	Florida District Court of Appeal	N
Welch v. Scheinfeld	2005-09-20	21 A.D.3d 802, 801 N.Y.S.2d 277	New York Supreme Court, Appellate Division	N
Wetherell v. Hospital Interamericano De Medicina Avanzada, Inc.	2009-03-31	609 F. Supp. 2d 186	United States District Court for the District of Puerto Rico	N
Williams v. Woodhull Medical & Mental Health Center	2012-08-27	891 F. Supp. 2d 301	United States District Court for the Eastern District of New York	N

Wilson v. IHC Hospitals, Inc.	2012-07-20	289 P.3d 369, 2012 UT 43	Utah Supreme Court	N
Wilson v. Robertson	2012-02-13	29 Mass. L. Rptr. 484	Massachusetts Superior Court	N
Wolfe v. Virginia Birth-Related Neurological Injury Compensation Program	2003-05-20	40 Va. App. 565, 580 S.E.2d 467	Court of Appeals of Virginia	N
Wood v. University of Utah Medical Center	2002-12-31	67 P.3d 436, 2002 UT 134	Utah Supreme Court	N
Young v. Villegas	2007-04-03	231 S.W.3d 1	Texas Courts of Appeals	N
Zhumi v. County of Suffolk	2009-12-01	68 A.D.3d 775, 889 N.Y.S.2d 670	New York Supreme Court, Appellate Division	N
Adeyemi v. Guerrero	2010-12-07	329 S.W.3d 241	Texas Courts of Appeals	Y
Apence v. Julian	2011-10-26	201 Md. App. 562, 30 A.3d 220	Court of Special Appeals of Maryland	Y
Arrabal v. Crew-Taylor	2004-12-03	159 Md. App. 668, 862 A.2d 431	Court of Special Appeals of Maryland	Y
Bauman v. Mount Sinai Hospital	2006-09-29	452 F. Supp. 2d 490	United States District Court for the Southern District of New York	Y
Baumgart ex rel. Baumgart v. DeFries	2008-03-20	888 N.E.2d 199	Court of Appeals of Indiana	Y
Brown v. Bauman	2007-07-26	42 A.D.3d 390, 841 N.Y.S.2d 229	New York Supreme Court, Appellate Division	Y
Burless v. West Virginia University Hospitals, Inc.	2004-06-30	215 W. Va. 765, 601 S.E.2d 85	Supreme Court of Appeals of West Virginia	Y
Bustos v. Lenox Hill Hospital	2006-05-18	29 A.D.3d 424,816 N.Y.S.2d 24	New York Supreme Court, Appellate Division	Y
Butler v. Joy	2003-03-20	116 Wash. App. 291	Washington Court of Appeals	Y
Cangemi v. Advocate South Suburban Hospital	2006-03-06	364 Ill. App. 3d 446	Illinois Appellate Court	Y
Cardenas v. Jerath	2008-03-17	180 P.3d 415	Colorado Supreme Court	Y

Castle v. Lester	2006-11-03	636 S.E.2d 342	Supreme Court of Appeals of Virginia	Y
Clifton v. Eubank	2006-03-08	418 F. Supp. 2d 1243	United States District Court for the District of Colorado	Y
Cooper v. Adler	2004-11-16	44 Va. App. 268,604 S.E.2d 747	Court of Appeals of Virginia	Y
Cooper v. Tabb	2010-12-22	347 S.W.3d 207	Tennessee Court of Appeals	Y
Creekmore v. Maryview Hospital	2011-12-08	662 F.3d 686	United States Court of Appeals for the Fourth Circuit	Y
Daniels v. Durham County Hospital Corp.	2005-07-19	171 N.C. App. 535	North Carolina Court of Appeals	Y
De Jesus v. Mishra	2012-03-01	93 A.D.3d 135, 939 N.Y.S.2d 403	New York Supreme Court, Appellate Division	Y
DiGeronimo v. Fuchs	2011-08-04	33 Misc. 3d 206, 927 N.Y.S.2d 904	New York Supreme Court	Y
Dixon ex rel. Atkinson v. Crete Medical Clinic, P.C.	2007-08-17	498 F.3d 837	United States Court of Appeals for the Eighth Circuit	Y
Ermoian v. Desert Hospital	2007-06-22	152 Cal. App. 4th 475	Court of Appeal of the State of California	Y
Estate of McCall v. United States	2009-09-30	663 F. Supp. 2d 1276	United States District Court for the Northern District of Florida	Y
Fernandez v. Moskowitz	2011-06-21	85 A.D.3d 566, 925 N.Y.S.2d 476	New York Supreme Court, Appellate Division	Y
Florida Department of Health v. Dinnerstein, M.D., P.A.	2011-12-14	78 So. 3d 26	Florida District Court of Appeal	Y
Foley v. Fletcher	2005-09-19	361 Ill. App. 3d 39	Illinois Appellate Court	Y
Fort Worth Osteopathic Hospital, Inc. v. Reese	2004-08-27	148 S.W.3d 94	Supreme Court of Texas	Y
Garhart ex rel. Tinsman v. Columbia/HealthOne, L.L.C.	2004-06-28	95 P.3d 571	Colorado Supreme Court	Y
Gingerich v. Kline	2002-03-12	75 S.W.3d 776	Missouri Court of Appeals	Y

Gonzalez v. United States	2002-04-01	284 F.3d 281	United States Court of Appeals for the First Circuit	Y
Harvest v. Craig	2002-05-30	202 Ariz. 529, 48 P.3d 479	Arizona Court of Appeals	Y
Havard v. Puntuer	2009-01-22	600 F. Supp. 2d 845	United States District Court for the Eastern District of Michigan	Y
Heard v. Morehouse Parish Health Unit	2005-12-14	917 So. 2d 652	Louisiana Court of Appeal	Y
Hooks v. Humphries	2010-03-30	303 Ga. App. 264, 692 S.E.2d 845	Court of Appeals of Georgia	Y
Howerton v. Mary Immaculate Hospital, Inc.	2002-06-07	264 Va. 272	Supreme Court of Virginia	Y
Huss v. Gayden	2009-06-10	571 F.3d 442	United States Court of Appeals for the Fifth Circuit	Y
Jenkins ex rel. Branum v. Best	2007-09-28	250 S.W.3d 680	Kentucky Court of Appeals	Y
Johannesen v. Salem Hospital	2003-12-26	336 Or. 211, 82 P.3d 139	Oregon Supreme Court	Y
Johnson v. Ingalls Memorial Hospital	2010-06-29	402 Ill. App. 3d 830	Illinois Appellate Court	Y
Johnson v. Morehouse General Hospital	2011-05-10	63 So. 3d 87	Louisiana Supreme Court	Y
Jones v. United States	2011-04-25	789 F. Supp. 2d 883	United States District Court for the Middle District of Tennessee	Y
Lanphier v. Avis	2008-01-10	244 S.W.3d 596	Texas Courts of Appeals	Y
Livingstone v. Greater Washington Anesthesiology & Pain Consultants, P.C.	2009-08-27	187 Md. App. 346, 978 A.2d 852	Court of Special Appeals of Maryland	Y
Lopez v. Contra Costa Regional Medical Center	2012-10-10	903 F. Supp. 2d 835	United States District Court for the Northern District of California	Y
Manning v. United Medical Corp.	2005-04-20	902 So. 2d 406	Louisiana Court of Appeal	Y

Marcano Rivera v. Turabo Medical Center Partnership	2005-07-15	415 F.3d 162	United States Court of Appeals for the First Circuit	Y
McCall v. United States	2002-11-13	310 F.3d 984	United States Court of Appeals for the Seventh Circuit	Y
McGovern ex rel. McGovern v. Brigham & Women's Hospital	2008-11-05	584 F. Supp. 2d 418	United States District Court for the District of Massachusetts	Y
McNeary v. Baptist Memorial Hospital	2011-03-14	360 S.W.3d 429	Tennessee Court of Appeals	Y
McQuitty v. Spangler	2009-07-24	410 Md. 1, 976 A.2d 1020	Court of Appeals of Maryland	Y
Mejia-Arevalo v. Inova Health Care Services	2008-08-08	77 Va. Cir. 43	Fairfax County Circuit Court	Y
Morin v. Eastern Maine Medical Center	2011-03-25	779 F. Supp. 2d 166	United States District Court for the District of Maine	Y
Murphy v. United States	2010-06-17	383 F. App'x 326	United States Court of Appeals for the Fourth Circuit	Y
Neuhaus v. Decholnoky	2006-10-03	280 Conn. 190	Connecticut Supreme Court	Y
Northwest Medical Center, Inc. v. Ortiz	2006-02-15	920 So. 2d 781	Florida District Court of Appeal	Y
Phelps v. Physicians Insurance Co.	2005-06-22	282 Wis. 2d 69, 698 N.W.2d 643, 2005 WI 85	Wisconsin Supreme Court	Y
Plaza v. New York Health & Hospitals Corp.	2012-07-17	97 A.D.3d 466, 949 N.Y.S.2d 25	New York Supreme Court, Appellate Division	Y
Ramsay v. Good Samaritan Hospital	2005-12-19	24 A.D.3d 645, 808 N.Y.S.2d 374	New York Supreme Court, Appellate Division	Y
Reilly v. Ninia	2011-02-22	81 A.D.3d 913,917 N.Y.S.2d 652	New York Supreme Court, Appellate Division	Y
Ritten v. Lapeer Regional Medical Center	2009-03-11	611 F. Supp. 2d 696	United States District Court for the Eastern District of Michigan	Y
Roddy v. Tanner Medical Center, Inc.	2003-07-08	262 Ga. App. 202, 585 S.E.2d 175	Court of Appeals of Georgia	Y

Rosales-Rosario v. Brookdale University Hospital & Medical Center	2003-11-17	1 A.D.2d 496, 767 N.Y.S.2d 122	New York Supreme Court, Appellate Division	Y
Simons v. Beard	2003-06-26	188 Or. App. 370, 72 P.3d 96	Oregon Court of Appeals	Y
Smalling v. Gardner	2005-03-10	203 S.W.3d 354	Texas Courts of Appeals	Y
Special v. Baux	2010-06-23	52 So. 3d 682	Florida District Court of Appeal	Y
Stapleton v. Moore	2010-06-11	403 Ill. App. 3d 147	Illinois Appellate Court	Y
Texas Tech University Health Sciences Center v. Ward	2008-08-06	280 S.W.3d 345	Texas Courts of Appeals	Y
Torres v. Ashmawy	2009-03-26	24 Misc. 3d 506, 875 N.Y.S.2d 781	New York Supreme Court	Y
University of Mississippi Medical Center v. Foster	2011-12-13	107 So. 3d 155	Mississippi Supreme Court	Y
University of Texas Medical Branch at Galveston v. Kai Hui Qi	2012-04-24	370 S.W.3d 406	Texas Courts of Appeals	Y
Vargas-Colon v. Hospital Damas, Inc.	2009-02-12	597 F. Supp. 2d 290	United States District Court for the District of Puerto Rico	Y
Whitmyer v. Power	2004-09-22	68 Pa. D. & C.4th 506	Lancaster County Court of Common Pleas	Y
Wilkins v. Connecticut Childbirth & Women's Center	2012-05-22	135 Conn. App. 679	Connecticut Appellate Court	Y
Wilson v. Obstetrics & Gynecology of Atlanta, P.C.	2010-05-21	304 Ga. App. 300, 696 S.E.2d 339	Court of Appeals of Georgia	Y
Analla v. Secretary of Health & Human Services	2006-03-08	70 Fed. Cl. 552	United States Court of Federal Claims	NA
Anderson v. Unum Life Ins. Co. of America	2006-02-13	414 F. Supp. 2d 1079	United States District Court for the Middle District of Alabama	NA

Brintley v. St. Mary Mercy Hospital	2012-11-16	904 F. Supp. 2d 699	United States District Court for the Eastern District of Michigan	NA
Britell v. United States	2002-05-29	204 F. Supp. 2d 182	United States District Court for the District of Massachusetts	NA
Carhart v. Ashcroft	2004-09-08	331 F. Supp. 2d 805	United States District Court for the District of Nebraska	NA
Kaiser Foundation Hospitals v. Superior Court	2005-04-04	128 Cal. App. 4th 85	Court of Appeal of the State of California	NA
National Abortion Federation v. Ashcroft	2004-08-26	330 F. Supp. 2d 436	United States District Court for the Southern District of New York	NA
Northland Family Planning Clinic, Inc. v. Cox	2007-06-04	487 F.3d 323	United States Court of Appeals for the Sixth Circuit	NA
Pellicer v. St. Barnabas Hospital	2009-07-23	200 N.J. 22, 974 A.2d 1070	Supreme Court of New Jersey	NA
People v. Strawbridge	2002-11-07	299 A.D.2d 584, 751 N.Y.S.2d 606	New York Supreme Court, Appellate Division	NA
Richmond Medical Center for Women v. Hicks	2004-02-02	301 F. Supp. 2d 499	United States District Court for the Eastern District of Virginia	NA
Roe v. Crawford	2008-01-22	514 F.3d 789	United States Court of Appeals for the Eighth Circuit	NA
State v. Burden	2002-05-24	30 Kan. App. 2d 690, 46 P.3d 570	Kansas Court of Appeals	NA
Szewczyk v. Department of Social Services	2005-09-20	275 Conn. 464	Connecticut Supreme Court	NA
Webb v. Jessamine County Fiscal Court	2011-08-05	802 F. Supp. 2d 870	United States District Court for the Eastern District of Kentucky	NA
Willingham v. Hudson	2005-07-07	274 Ga. App. 200, 617 S.E.2d 192	Court of Appeals of Georgia	NA
Brawley v. Washington	2010-05-03	712 F. Supp. 2d 1208	United States District Court for the Western District of Washington	NA

In the Interest of Doe	2002-10-18	100 Haw. 20, 58 P.3d 78	Hawaii Intermediate Court of Appeals	NA
Jones ex rel. heirs of Jones v. Minnesota Department of Corrections	2008-01-09	512 F.3d 478	United States Court of Appeals for the Eighth Circuit	NA
Lugo v. Beth Israel Medical Center	2006-07-21	13 Misc. 3d 681, 819 N.Y.S.2d 892	New York Supreme Court	NA
Nelson v. Correctional Medical Services	2008-07-18	533 F.3d 958	United States Court of Appeals for the Eighth Circuit	NA
Paehl v. Lincoln County Care Center, Inc.	2004-03-26	466 F. Supp. 2d 1249	United States District Court for the District of New Mexico	NA
People v. Portellos	2012-11-13	298 Mich. App. 431	Michigan Court of Appeals	NA
Rogers ex rel. Rogers v. Saunders	2008-03-05	309 Wis. 2d 238, 750 N.W.2d 477, 2008 WI App 53	Wisconsin Court of Appeals	NA
Tarpon Springs Hospital Foundation, Inc. v. Anderson	2010-04-21	34 So. 3d 742	Florida District Court of Appeal	NA
Villegas v. Metropolitan Government	2011-04-27	789 F. Supp. 2d 895	United States District Court for the Middle District of Tennessee	NA
Abraxis Bioscience, Inc. v. Navinta LLC	2010-11-09	625 F.3d 1359	United States Court of Appeals for the Federal Circuit	NA
Abraxis Bioscience, Inc. v. Navinta, LLC	2009-08-03	640 F. Supp. 2d 553	United States District Court for the District of New Jersey	NA
Allender v. Raytheon Aircraft Co.	2004-04-02	220 F.R.D. 661	United States District Court for the District of Kansas	NA
American Home Assurance Co. v. Plaza Materials Corp.	2005-07-07	908 So. 2d 360	Florida Supreme Court	NA
Avery v. Joint Township District Memorial Hospital	2008-07-01	286 F. App'x 256	United States Court of Appeals for the Sixth Circuit	NA

Avery v. Joint Twp. Dist. Mem'l Hosp.	2007-05-25	504 F. Supp. 2d 248	United States District Court for the Northern District of Ohio	NA
Bakare v. Pinnacle Health Hospitals, Inc.	2006-08-24	469 F. Supp. 2d 272	United States District Court for the Middle District of Pennsylvania	NA
Barber v. Catholic Health Initiatives, Inc.	2007-04-30	174 Md. App. 314, 921 A.2d 811	Court of Special Appeals of Maryland	NA
Beasley v. Hillcrest Medical Center	2003-10-09	78 F. App'x 67	United States Court of Appeals for the Tenth Circuit	NA
Belle View Condominium Unit Owners' Ass'n v. Drytech, Inc.	2004-06-24	65 Va. Cir. 169	Fairfax County Circuit Court	NA
Berger Enterprises v. Zurich American Insurance	2012-01-11	845 F. Supp. 2d 809	United States District Court for the Eastern District of Michigan	NA
Blue Ridge Environmental Defense League v. Nuclear Regulatory Commission	2012-02-17	399 U.S. App. D.C. 202, 668 F.3d 747	United States Court of Appeals for the District of Columbia Circuit	NA
Brown v. Luebbers	2004-06-15	371 F.3d 458	United States Court of Appeals for the Eighth Circuit	NA
BWK, Inc. v. Department of Administrative Services	2009-09-30	231 Or. App. 214, 218 P.3d 156	Oregon Court of Appeals	NA
Bygrave v. New York City Housing Authority	2009-09-01	65 A.D.3d 842, 884 N.Y.S.2d 724	New York Supreme Court, Appellate Division	NA
Cancellieri v. Northeast Hospital Corp.	2008-06-17	24 Mass. L. Rptr. 625	Massachusetts Superior Court	NA
Chandler ex rel. Estate of Chandler v. Wackenhut Corp.	2012-02-21	465 F. App'x 425	United States Court of Appeals for the Sixth Circuit	NA
Chapman v. Health & Hospitals Corp.	2005-03-24	7 Misc. 3d 933, 796 N.Y.S.2d 876	New York Supreme Court	NA
Colozzi v. St. Joseph's Hospital Health Center	2011-03-08	275 F.R.D. 75	United States District Court for the Northern District of New York	NA

Communications Workers of America v. Ector County Hospital District	2006-10-05	467 F.3d 427	United States Court of Appeals for the Fifth Circuit	NA
County of Kern v. State Department of Health Care Services	2009-12-17	180 Cal. App. 4th 1504	Court of Appeal of the State of California	NA
Cruz v. Mo. Department of Social Services	2012-12-04	386 S.W.3d 899	Missouri Court of Appeals	NA
Dalton v. State	2003-02-20	115 Wash. App. 703	Washington Court of Appeals	NA
Dennis v. Columbia Colleton Medical Center, Inc.	2002-05-16	290 F.3d 639	United States Court of Appeals for the Fourth Circuit	NA
Dennis v. DeJong	2011-09-30	867 F. Supp. 2d 588	United States District Court for the Eastern District of Pennsylvania	NA
Devers-Scott v. Office of Professional Regulation	2007-01-12	181 Vt. 248, 918 A.2d 230, 2007 Vt. 4	Vermont Supreme Court	NA
Diaz v. Division of Social Services	2004-09-07	166 N.C. App. 209	North Carolina Court of Appeals	NA
Equal Employment Opportunity Commission v. Greater Baltimore Medical Center, Inc.	2011-01-21	769 F. Supp. 2d 843	United States District Court for the District of Maryland	NA
Flinchum v. ESTOVA Health System	2012-06-19	84 Va. Cir. 530	Fairfax County Circuit Court	NA
Gaines v. Comanche County Medical Hospital	2006-06-13	143 P.3d 203, 2006 OK 39	Oklahoma Supreme Court	NA
Galvin v. Eli Lilly & Co.	2007-06-08	488 F.3d 1026	United States Court of Appeals for the District of Columbia Circuit	NA
Garnett v. Commonwealth	2007-04-10	49 Va. App. 524, 642 S.E.2d 782	Court of Appeals of Virginia	NA
Gilster v. Primebank	2012-08-14	884 F. Supp. 2d 811	United States District Court for the Northern District of Iowa	NA

Goslin v. State Board of Medicine	2008-05-23	949 A.2d 372	Commonwealth Court of Pennsylvania	NA
Greer v. Greer	2006-01-17	624 S.E.2d 423	Court of Appeals of North Carolina	NA
Grogan v. Women's & Children's Hospital, Inc.	2008-04-16	981 So. 2d 162	Louisiana Court of Appeal	NA
Haines City HMA, Inc. v. Carter	2007-02-09	948 So. 2d 904	Florida District Court of Appeal	NA
Hedgepeth v. Whitman Walker Clinic	2011-06-30	22 A.3d 789	District of Columbia Court of Appeals	NA
Hill v. Billups	2005-09-07	92 Ark. App. 259, 212 S.W.3d 53	Arkansas Court of Appeals	NA
Hoffman v. United States	2009-01-07	593 F. Supp. 2d 873	United States District Court for the Eastern District of Virginia	NA
Houston v. Phoebe Putney Memorial Hospital, Inc.	2009-01-26	295 Ga. App. 674, 673 S.E.2d 54	Court of Appeals of Georgia	NA
In re Juvenile Detention Officer Union County	2003-12-11	364 N.J. Super. 608, 837 A.2d 1101	New Jersey Superior Court, Appellate Division	NA
Independent Contractors Research Institute v. Department of Administrative Services	2006-07-26	207 Or. App. 78, 139 P.3d 995	Oregon Court of Appeals	NA
Kaiser Foundation Hospitals v. Wilson	2011-12-05	201 Cal. App. 4th 550	Court of Appeal of the State of California	NA
Kessel ex rel. Swenson v. Stansfield Vending, Inc.	2006-03-16	291 Wis. 2d 504, 714 N.W.2d 206, 2006 WI App 68	Wisconsin Court of Appeals	NA
Knox v. City of Portland	2008-03-05	543 F. Supp. 2d 1238	United States District Court for the District of Oregon	NA
Kochert v. Greater Lafayette Health Services, Inc.	2004-12-29	372 F. Supp. 2d 509	United States District Court for the Northern District of Indiana	NA
L.T. v. W.L.	2009-11-06	47 So. 3d 1241	Alabama Court of Civil Appeals	NA

LeDonne v. Workers' Compensation Appeal Board	2007-08-13	936 A.2d 124	Commonwealth Court of Pennsylvania	NA
Lindsay v. Barnhart	2005-05-04	370 F. Supp. 2d 1036	United States District Court for the Central District of California	NA
Luna v. Division of Social Services	2004-01-06	162 N.C. App. 1	North Carolina Court of Appeals	NA
Malcolm v. Mount Vernon Hospital	2003-10-30	309 A.D.2d 704, 766 N.Y.S.2d 185	New York Supreme Court, Appellate Division	NA
McNabb v. Barnhart	2003-12-03	347 F. Supp. 2d 1085	United States District Court for the Middle District of Alabama	NA
Medina v. Division of Social Services	2004-07-20	165 N.C. App. 502	North Carolina Court of Appeals	NA
Morris v. Department of Professional Regulation	2005-02-18	356 Ill. App. 3d 83	Illinois Appellate Court	NA
Murff v. Pass ex rel. Pass	2008-03-28	249 S.W.3d 407	Supreme Court of Texas	NA
Northeast Hospital Corp. v. Sebelius	2010-03-29	699 F. Supp. 2d 81	United States District Court for the District of Columbia	NA
Peachtree Fayette Women's Specialists, LLC v. Turner	2010-07-08	305 Ga. App. 60, 699 S.E.2d 69	Court of Appeals of Georgia	NA
Philadelphia Construction Services, LLC v. Domb	2006-07-19	903 A.2d 1262	Superior Court of Pennsylvania	NA
Powers v. CSX Transportation, Inc.	2002-01-29	188 F. Supp. 2d 857	United States District Court for the Southern District of Ohio	NA
Ricci v. Secretary of Health & Human Services	2011-10-26	101 Fed. Cl. 385	United States Court of Federal Claims	NA
Richardson v. Cornes	2004-05-18	905 So. 2d 620	Mississippi Court of Appeals	NA
Roe v. Crawford	2006-07-18	439 F. Supp. 2d 942	United States District Court for the Western District of Missouri	NA
Rural Water District No. 3 v. Owasso Public Works Authority	2007-02-07	475 F. Supp. 2d 1108	United States District Court for the Northern District of Oklahoma	NA

Salazar v. City of Albuquerque	2011-03-28	776 F. Supp. 2d 1217	United States District Court for the District of New Mexico	NA
Scanlon v. Jeanes Hospital	2009-04-01	319 F. App'x 151	United States Court of Appeals for the Third Circuit	NA
Scottsdale Healthcare, Inc. v. Arizona Health Care Cost Containment System Administration	2002-05-07	202 Ariz. 365, 45 P.3d 688	Arizona Court of Appeals	NA
Scottsdale Healthcare, Inc. v. Arizona Health Care Cost Containment System Administration	2003-08-20	206 Ariz. 1, 75 P.3d 91	Arizona Supreme Court	NA
Sherman v. Sherman	2004-11-09	160 S.W.3d 381	Missouri Court of Appeals	NA
Slivka v. Camden-Clark Memorial Hospital	2004-02-19	215 W. Va. 109, 594 S.E.2d 616	Supreme Court of Appeals of West Virginia	NA
Soldo v. Sandoz Pharmaceuticals Corp.	2003-01-13	244 F. Supp. 2d 434	United States District Court for the Western District of Pennsylvania	NA
Spring Creek Management v. Department of Public Welfare	2012-06-08	45 A.3d 474	Commonwealth Court of Pennsylvania	NA
St. Dominic-Jackson Memorial Hospital v. Mississippi State Department of Health	2005-09-15	910 So. 2d 1077	Mississippi Supreme Court	NA
State ex rel. W.H.V. v. J.A.V.	2002-02-27	811 So. 2d 189	Louisiana Court of Appeal	NA
State v. Chapman	2012-02-07	218 N.C. App. 428	North Carolina Court of Appeals	NA
Stinson v. Stinson	2004-10-25	161 S.W.3d 438	Tennessee Court of Appeals	NA
United States v. Guy	2003-08-22	340 F.3d 655	United States Court of Appeals for the Eighth Circuit	NA
United States v. Jim	2012-06-22	877 F. Supp. 2d 1018	United States District Court for the District of New Mexico	NA

United States v. Peshlakai	2007-11-16	618 F. Supp. 2d 1295	United States District Court for the District of New Mexico	NA
United States v. Utah Medical Products, Inc.	2005-10-21	404 F. Supp. 2d 1315	United States District Court for the District of Utah	NA
United States v. Washington International Insurance	2005-05-12	29 Ct. Int'l Trade 511, 374 F. Supp. 2d 1265	United States Court of International Trade	NA
Warner v. Workman	2011-08-31	814 F. Supp. 2d 1188	United States District Court for the Western District of Oklahoma	NA
Washington Hospital Center v. District of Columbia Department of Employment Services	2002-01-24	789 A.2d 1261	District of Columbia Court of Appeals	NA
West Boca Medical Center, Inc. v. Marzigliano	2007-09-12	965 So. 2d 240	Florida District Court of Appeal	NA
Whisenant v. Arnett	2011-05-05	339 S.W.3d 920	Texas Courts of Appeals	NA
Young v. District of Columbia Department of Employment Services	2007-03-15	918 A.2d 427	District of Columbia Court of Appeals	NA
Young v. State	2012-01-10	358 S.W.3d 790	Texas Courts of Appeals	NA
Arellano v. Department of Human Services	2010-06-16	402 Ill. App. 3d 665	Illinois Appellate Court	NA
Damas v. Valdes	2011-04-12	84 A.D.3d 87	New York Supreme Court, Appellate Division	NA
Heitman v. Heartland Regional Medical Center	2008-04-29	251 S.W.3d 372	Missouri Court of Appeals	NA
In re Temple	2007-11-08	239 S.W.3d 885	Texas Courts of Appeals	NA
McInnis-Misenor v. Maine Medical Center	2003-02-11	319 F.3d 63	United States Court of Appeals for the First Circuit	NA
State v. Lamy	2009-04-08	158 N.H. 511	New Hampshire Supreme Court	NA
Thomas v. Crawford	2007-09-26	966 So. 2d 786	Louisiana Court of Appeal	NA

Thompson v. Patton	2008-10-10	6 So. 3d 1129	Alabama Supreme Court	NA
Viasana v. Ward County	2009-03-05	296 S.W.3d 652	Texas Courts of Appeals	NA
Vincent v. Essent Healthcare of Connecticut, Inc.	2005-05-12	368 F. Supp. 2d 181	United States District Court for the District of Connecticut	NA
Weininger v. Siomopoulos	2006-06-02	366 Ill. App. 3d 428	Illinois Appellate Court	NA
State v. McKnight	2003-01-27	352 S.C. 635, 576 S.E.2d 168	Supreme Court of South Carolina	NA
In re JHG	2010-05-25	313 S.W.3d 894	Texas Courts of Appeals	NA

Appendix B: The NA Cases

The best and easiest source for this project was the Harvard Caselaw Access Project (CAP). My initial search in the database was narrowly tailored. As described in Chapter 3, this resulted in too few cases. By widening my search criteria in the Harvard Case Law Access Project database, I almost certainly captured all of the cases I was looking for. Certainly, simplifying the search term to "labor and delivery" over the full text of the opinions returned all the cases from the first search and several hundred new ones. I also captured a number of other cases that are not directly relevant to this study. Of the 406 cases originally returned, I first consolidated cases with multiple rulings during the time period. Of the 378 unique cases, I excluded 126 of them entirely.

There is no question as to whether or not a firm of laborers who failed to deliver on a contract have committed obstetric violence. Some cases occurred within a hospital L&D ward, but they are disputes about the employment of nurses, not about any of the patients.

Some of these cases, while not obstetric violence as such, tell an interesting story about pregnancy in particular and medicine in general during the ten-year period under study. As noted in Chapter 6, the time period leading up to and immediately after the Carhart decision is interesting because Carhart exploded long-standing precedent about what entities constitute a person. I would draw a direct line from *Gonzalez v. Carhart*[187]

[187] Gonzales v. Carhart. 550 U.S. 124 (2007)

to recent rulings out of Alabama that claim a fertilized embryo is an "extrauterine child" (Godoy 2024). It is worth examining them briefly here.

I categorized the cases using standard qualitative coding methods. Table 7 gives a simple distribution. Readers will notice that this adds up to more than 126 cases. I took less care in generating mutually exclusive and comprehensive coding categories as they are not part of the main inquiry. Some of the cases fall in multiple categories. Other categories are so broad and involve such disparate cases that they would not be useful in a more serious inquiry. Appendix B contains a full list of all the cases returned by the Harvard Case Law Access project, with duplicate cases condensed. All the final coding decisions, including these "NA" cases, are listed there. I'm very certain that some of these would be considered OV under more expansive definitions. The original Argentine statute includes the

Table 7: Summary of Cases Coded NA	
Type of Case	Count
Non-hospital related administrative and labor disputes	14
Hospital related administrative and labor disputes	30
Medical Technologies	3
Custody Disputes and Divorces	10
Insurance Liability	22
Criminal Cases	20
Constitutional Rights of Prisoners	7
Abortion	6
Malpractice and Torts	30
Other Medical	7

refusal to perform abortion by doctors as a form of obstetric violence (see Vacaflor 2016). My own definition, which synthesizes that of lay activists, medical professionals, and legal scholars, is: the violation of a pregnant person's legal rights or bodily autonomy by medical staff during labor and delivery (For more details, see Chapter 1).

In this appendix, I want to define the categories that I generated from the data, largely by using examples. I conclude with some thoughts about what information and context these cases give us. I. Cases Not Involving Pregnancy or Birth

1. Administrative or Labor Disputes

Together, administrative and labor disputes make up almost a third of these NA cases.

In both the category "Non-hospital related administrative and labor disputes" and "Hospital related administrative and labor disputes," none involve a pregnant person giving birth. They range from an insurance company not paying customs duties[188]; to a water rights dispute that happened to serve a hospital with a Labor and Delivery ward[189]; to a lawsuit claiming the non-compete clause of a gynecology and obstetrics practice contract is unenforceable[190]; to various accusations of employment discrimination on the basis of race, sex, or gender in both hospitals and jails[191]. One notable suit involved the

[188] *United States v. Washington International Insurance,* 29 Ct. Int'l Trade 511 (2005); combined with 374 F. Supp. 2d 1265

[189] *Rural Water District No. 3 v. Owasso Public Works Authority,* 475 F. Supp. 2d 1108 United States District Court for the Northern District of Oklahoma (2007)

[190] *Peachtree Fayette Women's Specialists, LLC v. Turner,* 305 Ga. App. 60, 699 S.E.2d 69 (2010)

[191] *Knox v. City of Portland,* 543 F. Supp. 2d 1238 United States District Court for the District of Oregon (2008); *In re Juvenile Detention Officer Union County,* 364 N.J. Super. 608, 837 A.2d 1101

systematic sexual harassment of a bank employee, but cited the evidentiary precedent set by class action brought against a hospital for the systematic sexual harassment of the Labor and Delivery nurses[192].

There are no patients here represented, except as incidental to staff capacity or service areas. Because the United States Government provides service for utilities and in some cases, medical care (such as on Native American Tribal Lands and Reservations), actions that might close facilities or move their location are subject to judicial scrutiny.

2. Medical Technologies

These cases are lawsuits against the manufacturers of medical devices or medications, with one patent infringement case. I find the scope of use of these devices fascinating. In one case[193], the Utah Medical Products corporation manufactures disposable, extruded plastic devices and components that are used in "... labor and delivery, neonatal intensive care, gynecology, urology, electrosurgery and blood pressure monitoring." Because the company does business both across state lines and internationally, the federal court system is the entity holding it liable for faulty and nonsterile[194] manufacturing practices.

(2003); *Haines City HMA, Inc. v. Carter,* 948 So. 2d 904 Florida District Court of Appeal (2007); *Slivka v. Camden-Clark Memorial Hospital,* 215 W. Va. 109, 594 S.E.2d 616 (2004)

[192] *Gilster v. Primebank,* 884 F. Supp. 2d 811 United States District Court for the Northern District of Iowa (2012)

[193] *United States v. Utah Medical Products, Inc.*, 404 F. Supp. 2d 1315 United States District Court for the District of Utah (2005)

[194] Yikes!

It's not exactly taking a literary tour to see how sausage is made, but it does underscore the need for regulation.

3. Custody Disputes and Divorces

These cases are split between disputes between parents about custody and cases of the state attempting to remove custody. The cases of divorce run the gamut in terms of legal issues. Some examples are child support calculations[195]; the distribution of marital assets[196]; and claims of abuse made during a divorce impacting employment[197]. One case uses lack of contact–from the moment of birth–to deny the child's father access to any part of the settlement from a wrongful death lawsuit[198].

The most upsetting cases to me are attempts of the state to remove custody or terminate parental rights. There just are no good outcomes. If the state is wrong about there being cause to suspect a child will come to harm, then they have dragged these families through the courts for nothing. If they are right, then it might be the right decision to remove a child from the custody of their parents but it remains gut wrenching all the same.

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[195] *Sherman v. Sherman*, 160 S.W.3d 381 Missouri Court of Appeals (2004)
[196] *Stinson v. Stinson*, 161 S.W.3d 438 Tennessee Court of Appeals (2004)
[197] *Salazar v. City of Albuquerque*, 776 F. Supp. 2d 1217 United States District Court for the District of New Mexico (2011)
[198] *Richardson v. Cornes*, 905 So. 2d 620 Mississippi Court of Appeals (2004)

For example, the state uses the behavior of a mentally disabled couple at the time of Baby Doe's birth in *In the Interest of Doe*[199] to attempt to remove custody, for fear that the child may come to harm if left in their custody. In another, the state suspects abuse, but the parents claim the child's skull was malformed when they were born, causing the seizures more typically seen in abuse cases[200]. In one, the patient did not know she was pregnant, and her "flat affect" about the birth of her child was used to begin the proceedings to remove custody[201]

Michelle Goodwin (2020) uses the word "complicity" to describe interactions between law enforcement, hospitals, medical providers, and the courts with respect to custody and prosecuting pregnant people for crimes against their fetuses. The word makes me uncomfortable. It implies that there is a collaboration or conspiracy. I don't think that there is, in an active sense–though I do think that courts and law enforcement are more likely to take a doctor's word over their patient's. The idea that anyone's behavior in such a stressful time as giving birth could be used as evidence of unfitness also makes me uncomfortable. So does the idea that a child might die because no one was willing to protect their life in deference to parental rights.

What makes me most uncomfortable is the idea of the state deciding who has the right to a child, and who doesn't. We've been down that road before, during the height of

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[199] *In the Interest of Doe*, 100 Haw. 20, 58 P.3d 78 (2002)
[200] *Dennis v. DeJong,* 867 F. Supp. 2d 588 United States District Court for the Eastern District of Pennsylvania (2011)
[201] *In re JHG,* 313 S.W.3d 894 Texas Courts of Appeals (2010)

the eugenics movement. In these cases, the courts are an instrument of the assertion that some people should not be allowed to parent children. As noted throughout my dissertation, the court records are largely silent about demographic information. I would not bet money that the majority of the parents having their children removed by the states are Black. In spite of the fact that the legal actions of former slaves to build their citizenship included protections for raising their families without interference from the state (See Cooper-Davis 1997 for an exhaustive catalog of these lawsuits and arguments), it feels like very little has changed.

3. Insurance Liability

Some of these cases involve pregnancy, and some do not. Universally though, the legal question is whether or not a particular insurance company is liable. These break down broadly into two groups. The first is insurance companies suing each other. The second is patients suing their insurance companies.

In the first type of case, the parties all accept that malpractice or abuse occurred. Most of them do not even involve pregnant people. The legal question is whose insurance is liable. Consider *Rogers ex rel. Rogers v. Saunders*[202]. The type of malpractice in prenatal care is not discussed in the ruling because the facts are not at issue. The lawsuit is one insurance company, that covers the hospital, suing another insurance company, which

[202] *Rogers ex rel. Rogers v. Saunders*, 309 Wis. 2d 238, 750 N.W.2d 477, 2008 WI App 53 (2008)

covers the nurses supplied through a staffing agency. Because the nurse is not technically employed by the hospital, the hospital's insurance company claims that they should not be liable for her malpractice and is suing the company that insures the staffing agency to recover payment.

The second kind of case universally involves Medicare and Medicaid. This is a particularly interesting time period with respect to Medicare and Medicaid. The Emergency Medical Treatment And Labor Act (EMTALA) was passed into law in 1986. The law was offered to hospitals as a kind of carrot-and-stick approach to making sure that individuals without insurance could access medical care. The stick is that the federal government requires hospitals to provide emergency medical care if they accept Medicare or Medicaid funds. The carrot is that the federal government will foot the bill through those programs if there really is no other way for the patient to pay.

In these cases, however, the dispute is whether or not EMTALA applies. Take the case of Zbigniew Szewczyk, an illegal alien from Poland[203]. He was diagnosed with cancer. He had no health insurance, but the hospital began treatment. I can attest personally that cancer treatment of any kind is incredibly expensive, so it isn't a wonder that it is worth the time and expense of trying to get out of paying. The dispute is whether or not his cancer constitutes an "emergency." He absolutely would not survive without treatment, even if he was not actively trying to shuffle off his mortal coil when he

[203] *Szewczyk v. Department of Social Services*, 275 Conn. 464 (2005)

presented in the emergency room. A huge swath of the opinion is dedicated to Webster's dictionary, and the ways that lower courts have adjudicated the plain meaning of the word "emergency." The dissenting jurist thinks that the court has adopted an "incorrect and unworkable" standard in saying that cancer constitutes an emergency, and offers argument with evidence that Congress meant the law to be construed more narrowly.

These cases set the precedent that courts have the authority to decide what constitutes a medical emergency. This is not a desirable state of affairs in that courts tend to take a long time to decide things, and emergencies require quick action. It is also not a desirable state of affairs because in many cases that are not immediately life threatening, doctors are refusing to act for fear of legal action *until* the patient might actually die. After the fall of *Roe v. Wade* (1973), courts are now litigating what the word "emergency" means in case after case involving states that have banned abortion with an exception for "emergencies" or to save a pregnant person's life.

Jaci Statton reported that when she presented at an Oklahoma hospital with a molar pregnancy–a birth defect resulting from an abnormal number of chromosomes which is never viable and may develop into a form of cancer–that doctors refused to help her. She recalls, "They said, 'The best we can tell you to do is sit in the parking lot, and if anything else happens, we will be ready to help you. But we cannot touch you unless you are crashing in front of us or your blood pressure goes so high that you are fixing to have a heart attack'"(Simmons-Duffin 2023).

This is an appalling state of affairs. If doctors wait until a patient with a non-viable pregnancy could die to intervene, eventually some patients will–for fetuses that I cannot stress enough are *never coming out as babies*.

It isn't all grim, dark news though. Pennsylvania's state supreme court recently jammed its foot in the door to argue that Medicaid funding for abortions could be broadened in states, because EMTALA cannot discriminate based on sex and must be applied equally (Associated Press 2024).

4. Criminal Cases

I didn't really expect there to be any criminal cases in my search of case law. I'm no attorney, but it seems to me that the bar for charging doctors with criminal negligence is high. This is probably as it should be, since patient outcomes are not always good. As Theresa Morris notes (2013), even when patients know that their doctor is not responsible for their bad pregnancy outcomes, they sometimes sue because there is no other way to pay for their care. Charging a doctor with potential crimes committed in the course of medical treatment seems to fall almost entirely under the realm of criminal negligence, and it is incredibly rare. The criteria that separates malpractice from criminal negligence is, as noted in Chapter 3, the state of mind of the medical professional. It is incredibly difficult to prove someone's state of mind or intentions.

Yet even where there is a direct statement from a doctor that they intend to inflict harm on their patient, criminal prosecution remains elusive. Recall the case of Catherine

Skol from the introduction[204]. She was awarded punitive damages by a jury at her trial after her doctor told her he would teach her a lesson by refusing to administer anesthesia and using a needle that was too large to suture the tear in her perineum resulting from childbirth. The trial was, however, not a criminal case of assault nor an action rooted in the physical harm done to Catherine Skol, a "highly decorated Chicago Police Officer" giving birth for the fifth time. It was a civil suit for "Emotional Abuse of a Patient During Childbirth."

Still, a number of criminal cases were returned, all of which actually mentioned childbirth in the text of the case. *A warning to the reader*: these are quite graphic and disturbing.

Several of these cases mention labor and delivery only as an explanation of legal precedent. For example, in one case the testimony and qualifications of an expert witness is challenged. The court cites a standard set by the testimony of a labor and delivery nurse[205].

The majority of these cases are prosecutions of rape. Not the rape of pregnant people, though many of the woman had given birth. Victims were frequently asked to compare the pain of the rape to childbirth by the defense. The argument they are trying to build is essentially that if the rape did not hurt, then they had to have consented on some level.

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[204] *Catherine Skol v Dr. Scott Pierce* 08L-13805 Tried Feb. 17-Mar. 1, 2012

[205] *Gaines v. Comanche County Medical Hospital,* 143 P.3d 203, 2006 OK 39 (2006)

This is both appalling and inaccurate. Defense attorneys attempted to minimize the crimes in other ways as well. One attorney used the fact of the alleged victim having given birth to argue that, biologically speaking, this meant that the alleged rapists hands were too small to reach her cervix and therefore he was not physically capable of hurting her as badly as she claimed[206].

As noted above, several of the custody cases also involve criminal prosecutions of the custodial parents for crimes allegedly committed against the child. One was a homicide prosecution for the death of one foster child, combined with the removal of other children from the home, though the legal issue in the case that I encountered was whether or not doctors had failed in their duty to report suspected child abuse[207].

This is also the era in which the use of DNA evidence began to rise precipitously to solve cold cases. One of these cases was the prosecution of a man in 2006 for a rape and homicide he committed in 1979[208].

Several of these cases are prosecutions of homicide. The time period of this project is, thankfully, before attempts of some states to revive feticide laws and prosecute pregnant women en masse for miscarriages,[209] though there are a few. One is the case of an

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[206] *State v. Burden*, 30 Kan. App. 2d 690, 46 P.3d 570 (2002)

[207] *Dalton v. State*, 115 Wash. App. 703 (2003)

[208] *Chandler ex rel. Estate of Chandler v. Wackenhut Corp.*, 465 F. App'x 425 United States Court of Appeals for the Sixth Circuit (2012)

[209] See Lewis 2015, "The Dire 17th-Century Origins of the Purvi Patel Feticide Verdict" for an in depth explanation of the literally medieval origins of these laws, which seem more akin to prosecuting witches than doing justice. Though we have done that in the United States too. In Ohio, our only known witch trial

intellectually disabled woman giving birth alone and hiding the baby, which later died[210]. In the other, a woman miscarried very late in her pregnancy, and the stillborn fetus tested positive for cocaine metabolites[211]. The latter case is often cited as setting a legal precedent that the *presence* of cocaine is sufficient evidence that the cocaine caused the stillbirth–a dubious claim at best. One other case prosecutes a woman for a stillbirth, using her expressed desire for an abortion as evidence that the baby was born alive; evidence of significant fetal abnormality incompatible with life was presented at trial[212]. At least one case uses the evidence of the alleged murderer's injuries as birth which caused him lifelong intellectual disabilities to argue for more lenient sentencing[213].

In one especially gruesome case, a man was convicted of raping his own 11 month old infant, who later died of her injuries[214]. The procedural record starts with the child's birth. She was born after an unexpected premature labor, during which the medical staff reported there was substantial evidence of physical abuse on her mother's body. The list of moments for intervention–many of them documented by medical professionals and reported to law enforcement–is truly horrifying. It led me to suspect that the victims were

occurred in 1803, an artifact of importing English Common Law directly and wholesale into our state constitution, see Knight 2023.

[210] *People v. Portellos,* 298 Mich. App. 431 (2012)

[211] *State v. McKnight,* 352 S.C. 635, 576 S.E.2d 168 (2003)

[212] *People v. Strawbridge,* 299 A.D.2d 584, 751 N.Y.S.2d 606 (2002)

[213] *Brown v. Luebbers,* 371 F.3d 458 United States Court of Appeals for the Eighth Circuit (2004)

[214] *Warner v. Workman,* 814 F. Supp. 2d 1188 United States District Court for the Western District of Oklahoma (2011)

not white, and indeed, a quick search of the internet confirmed that Charles Frederick Warner, a black man, was executed for his crimes against his daughter.

These cases are some of the easiest to find more information about online. Many of them made national news complete with mugshots and victim tributes. They are the kind of exceptional cases that break reality. Journalists and other commentators have tried to make sense of them at length, or draw meaning from the advances in technology that enable us to locate and prosecute perpetrators from crimes committed decades ago. I wish the rest of the dataset was so easy to fill in the blanks on.

II. Cases Involving Pregnancy or Birth

1. Constitutional Rights of Prisoners

When I was first trying to locate a definition of *obstetric violence* and then writing my own, one issue I kept encountering was the rights of female prisoners–particularly those in federal custody. The expansion of federal drug offenses in the 1980s and 1990s dramatically increased the number of women in federal prison. In more recent years, the intensification of border detention has ballooned the number yet again. With is has come a number of fresh hells for people who can become pregnant in federal detention, from tracking the menstruation of children–and failing to prosecute their guards when their menstruation ceases, as well as preventing them from accessing contraception or abortion care (Wright 2019; Messing, Fabi & Rosen 2020) –to one doctor performing so many

elective hysterectomies that detainees dubbed him "The Uterus Collector" (Ibbetson 2020, Jennings 2021).[215]

Though the issue is serious and disturbing, it seemed fundamentally different to me than medical staff in a hospital violating their patients. I noted in Chapter 1 that I would specifically exclude cases of shackling because it is not medical providers committing the violence. Medical personnel are often advocates for patients when they are granted access. They have the authority to both do something about the inhumane treatment they see and testify about it later in court[216].

There are several cases involving a prisoner that are included in the main dataset, and coded as obstetric violence[217]. In *Clifton v Eubank* (2006) the patient is incarcerated and eight months pregnant. She begged for help for more than a day, certain that something was wrong. The duty nurse of the jail refused to even attempt to use the fetal heart rate monitor–she claims, because she didn't know how to use it. The nurse labeled the distress a "false alarm" and sent the patient back to her cell–where her baby died. This case is

[215] I am reminded of the practice of prisons and jails in the south, most notably Florida, of housing black prisoners in mixed-gender cells, then taking the profits from the sale of any children that were born because of it (for brief overview and additional sources, see Bauer 2020). Eugenics is dead, long live eugenics.
[216] Though their testimony is not always in favor of the pregnant person; see *Villegas v. Metropolitan Government*, 789 F. Supp. 2d 895 United States District Court for the Middle District of Tennessee (2011). One doctor testifies that shackling is unlikely to have increased the likelihood of the specific complications that Juana Villegas experienced, while another directly contradicts him. The court granted in part her motion for summary judgment and dismissed the rest without prejudice.
[217] *Clifton v. Eubank*, 418 F. Supp. 2d 1243 United States District Court for the District of Colorado (2006); *Havard v. Puntuer*, 600 F. Supp. 2d 845 United States District Court for the Eastern District of Michigan (2009)

different from the NA cases because the medical staff was in the jail with direct access to the pregnant woman ignored her distress and denied her care.

The majority of these cases (4 of 7) are of shackling during labor and delivery. Two additional cases were of a prisoner seeking an abortion and suing because she was denied, and one involved a woman denied access to medical care upon admission to the prison even though she was in obvious distress. In all of these cases, the jail acts as a barrier to pregnant people seeking medical care.

In all the cases of shackling, prison staff are the ones applying restraints for transportation, and medical staff are the people trying to care for patients. In a deposition submitted with one case[218], the (male) officer stated: “deal with it, because [he’s] not going anywhere" when a nurse balked at having a male officer escorting an obviously laboring patient. In another, the jail staff formed an impenetrable barrier between the inmate and medical care; they refused, flat out, to take a patient who was nine months pregnant and complaining of back pain and vaginal discharge to a hospital[219].

There is no doubt that these cases are examples of gender based violence, and reproductive injustice. Other definitions would probably include them as *obstetric violence* (See Chapter 1). I do not, because of my focus on who is committing the violence.

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[218] *Brawley v. Washington,* 712 F. Supp. 2d 1208 United States District Court for the Western District of Washington (2010)

[219] *Webb v. Jessamine County Fiscal Court,* 802 F. Supp. 2d 870 United States District Court for the Eastern District of Kentucky (2011)

Lost in a lot of these cases are the crimes for which the prisoners are being detained. In one, a woman was in custody after agreeing to be deported voluntarily after being arrested for driving without a valid license[220]. The case history described her intense fear that her child would suffocate because she could not open her legs to deliver the baby while they were shackled. The procedural history of the case extends forward beyond the time period defined by this study, though it mostly focuses on whether or not she and her husband were legally detained by ICE in the first place[221]. In the end, the court declines her request to acknowledge that she was tortured in state custody because the statutes that her case cite only apply to torture outside of the United States, but grants her application for a visa to remain in the United States[222]. There is no further procedural history attempting to hold anyone accountable for the intense emotional distress and physical harm she experienced.

2. Constitutional Rights: Abortion

The time period of the study was chosen because there was data available to answer my research questions. Over the ten year period in question, I could link two available datasets to examine different levels of *obstetric violence*. Right at the beginning of the

[220] *Villegas v. Metropolitan Government*, 789 F. Supp. 2d 895 United States District Court for the Middle District of Tennessee (2011)
[221] *Daniel Renteria-Villegas v. Metropolitan Government of Nashville and Davidson County*, 382 S.W.3d 318 (Tenn. 2012)
[222] *Villegas v. Metropolitan Government*, 907 F. Supp. 2d 907 (M.D. Tenn. 2012)

timeline, the Partial Birth Abortion Ban Act was passed (2003). There is some overlap in this category with criminal prosecution and the rights of prisoners, but the majority of these cases attempt to litigate the ban leading up to the United States Supreme Court case *Gonzales v Carhart* (2007). *Gonzales* finds that the ban did not pose an undue burden, and therefore did not violate the standards set by *Planned Parenthood v Casey* (1992). Furthermore, the court upheld in *Gonzales* that Congress's assertion that a "partial-birth abortion" is *never* medically necessary–in spite of a lot of expert testimony that this is nonsense.

These lawsuits are a snapshot of the death by a thousand cuts approach taken to restricting abortion. In one case, the state of Massachusetts argued that it did not have to pay for abortions using Medicaid funds, even if they were medically necessary[223]. In this case, the fetus in question was gestating without a head and the pregnant person was developing other complications from being pregnant; she could not, however, afford an "elective" abortion.

Half of these cases are lawsuits directly challenging doctors for their practices in performing abortions, or direct challenges of state-level laws by doctors. *Gonzales* (2007) would later uphold the assertion of Congress that a partial birth abortion was never medically necessary as a fact. States variously tried to introduce novel legal definitions, or broadly interpret the law, or engage in a wide variety of chicanery and shenanigans to

[223] *Britell v. United States*, 204 F. Supp. 2d 182 United States District Court for the District of Massachusetts (2002)

make abortion illegal. In one of these cases, the state of Michigan passed a law that created a novel legal term "perinate," meaning a fetus of which any living part had passed out of the uterus[224].

Overall, these arguments sweep under the rug the idea that birth is *dangerous*. Undergirding a lot of the courts' assumptions is the notion that without medical intervention, one pregnancy = one birth. This is of course nonsense. While the rate of induced abortions has been falling for years, the rate of stillbirth and spontaneous abortion has remained low but steady (MacDorman 2013, Fordyce 2013).

3. Malpractice and Torts

As Theresa Morris points out in her book *Cut It Out* (2013), the system of private insurance in the United States before the passage of the Affordable Care Act (2010) incentivized women to sue their doctors for any injuries or defects that could be related to birth. Morris notes that this makes insurance for medical obstetrics a complex and extremely expensive market, which puts a great deal of pressure on labor and delivery wards–an *already* extremely expensive specialty, due to the staffing needs, and the fact that babies arrive on their own schedule.

The "tail" of this issue of insurance is long; as long as the person in question is still a child, they can sue for issues related to their birth. In this dataset, these cases include

[224] *Northland Family Planning Clinic, Inc. v. Cox*, 487 F.3d 323 United States Court of Appeals for the Sixth Circuit (2007)

examples such as vaccine injury (See for example Analla v. Secretary of Health & Human Services 2006); a failed surgical correction of spina bifida (See for example Pellicer v. St. Barnabas Hospital 2009). They also include a number of cases involving birth defects not caused by doctors, but which may nevertheless entitle the child to compensation under plans created by states meant to relieve the burden on the insurance industry and pool the risk appropriately (See especially Florida, for example Tarpon Springs Hospital Foundation, Inc. v. Anderson 2010)

In some cases, the tail is even longer. As noted in the section on criminal cases above, some defendants use injuries at birth to excuse or explain their emotional dysregulation and mitigates their crimes. On woman filed suit against the manufacturer of a synthetic hormone because she claimed her exposure to their product in utero caused her infertility as an adult; she was born in 1965, and the case concluded in 2007[225].

Many of the cases in this category do not involve birth or pregnancy at all, merely cite case law and precedent that mentions labor and delivery. Some cases are about injuries to fetuses born alive. There are more than a few cases involving car accidents that caused premature labor (see for example, Damas v. Valdes 2011).

[225] *Galvin v. Eli Lilly & Co.,* 488 F.3d 1026 United States Court of Appeals for the District of Columbia Circuit (2007)

4. Other Medical Rights Questions

It is difficult to summarize the issues in this category. It is a pile of leftovers clearly medical in nature but that are not malpractice or torts.

For example, in one case a woman sued her local hospital to ensure that for the birth of her second child, they would have a wheelchair accessible room for her[226]. This is clearly a medical issue, and definitely related to the plaintiff's past experience giving birth. A broad definition like that of the Argentine statute (see Chapter 1) might include this as a form of structural violence against pregnant people. It definitely is not compatible with ideas of reproductive justice and reproductive rights. The plaintiff claims that it violates the rights asserted by the Americans with Disabilities Act (ADA). Reproductive justice advocates argue that all people who want to give birth should be able to do so, without restrictions and with appropriate access to medical treatment. I coded it as "NA" because the current case does not directly involve anything that happened to her in labor and delivery. Her standing to sue is rooted in the fact that she is pregnant again, and the local hospital will be responsible for her care. It does not, however, meet my criteria for inclusion.

Another case uses the fact that a 21 month old is experiencing severe lead poisoning as evidence that the New York City Housing Authority is violating federal law by not

[226] *McInnis-Misenor v. Maine Medical Center,* 319 F.3d 63 United States Court of Appeals for the First Circuit (2003)

remediating the lead paint in its units[227]. This is a medical issue, and an issue of the rights of tenants and responsibilities of landlords. It came up in my search of the database because before the infant was born, the child's mother tested for high blood lead levels. Several cases involve injuries inside hospitals to the older children of pregnant people that occurred while they were in labor (see for example Kessel ex rel. Swenson v. Stansfield Vending, Inc. 2006).

[227] *Bygrave v. New York City Housing Authority*, 65 A.D.3d 842, 884 N.Y.S.2d 724 (2009)

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