"The Land that Feminism Forgot": Birthzillas, Madwives, and the Politics of Chilbirth

Amber Vayo
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“The Land that Feminism Forgot”: Birthzillas, Madwives, and the Politics of Childbirth

A Dissertation Presented

by

AMBER VAYO

Submitted to the Graduate School of the University of Massachusetts Amherst in partial fulfillment of the requirements for the degree of

DOCTOR OF PHILOSOPHY

May 2023

Political Science
“The Land that Feminism Forgot”: Birthzillas, Madwives, and the Politics of Childbirth

A Dissertation Presented

by

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For Roselyn Abassah-Manu (1988-2022) whose friendship and faith always reminded me not to quit.
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It is impossible to acknowledge everyone who made this possible, but here is the highlight reel.

First and foremost, I would like to thank those who agreed to be interviewed for this dissertation. When I put out calls online that I needed help finishing my dissertation during COVID, fellow mothers from around Massachusetts filled my interview schedule in solidarity. I am forever grateful to them.

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“THE LAND THAT FEMINISM FORGOT”: BIRTHZILLAS, MADWIVES, AND THE POLITICS OF CHILDBIRTH

MAY 2023

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Directed by: Professors Rebecca Hamlin and Paul Collins

“The Land that Feminism Forgot” is an in-depth exploration of the politics of childbirth that draws together qualitative and quantitative evidence to theorize the connections between treatment in childbirth and maternal mortality. Situating the qualitative research in the larger national context, the second chapter offers a State Reproductive Autonomy Index that provides an overview of the reproductive policy landscape at the national level. The dissertation then explores the role of institutionalized childbirth, medical mistrust, and obstetric violence in the U.S.’s longstanding maternal mortality crisis and offers policy suggestions in key public health areas. Through 120 qualitative interviews with people who gave birth it examines the epistemic conflicts over whose knowledge and experience gets taken seriously during childbirth and how institutional policies can shape care. This dissertation finds that many of those who give birth felt ignored, marginalized, or fearful during their interactions with care providers. It also found that even when patients experienced events they did not want, a compassionate and communicative care provider left them with positive feelings about their interaction. The conclusion offers policy and social solutions that would address maternal mortality, medical mistrust, and shape a culture of childbirth that centers around health, wellness, and collaborative care.
PREFACE

It was over a decade ago when read *Pathologies of Power* by global health equity champion Dr. Paul Farmer. In his book I first read the term structural violence and began to see how researchers and policymakers can explicitly track the ways in which politics and power affect health. Dr. Farmer’s book opened up a world of research for me into the social determinants of health, and by the last line of his introduction, the course of my intellectual life had been irrevocably altered:

> When it is a matter of telling the truth and serving the victims, let unwelcome truths be told. Those of us privileged to witness and survive such events and conditions are under an imperative to unveil—and keep unveiling—these pathologies of power (Farmer, 2008, p. 22).

For too long the unwelcome truths of women’s intimate lives have been left out of historical narratives, policy discussions, and social consciousness. The research that follows gives space to those truths in their own words. The pathologies of power dealt with in the pages that follow are not those of multi-drug resistant tuberculosis (MDR-TB) in Peru, AIDS in Haiti, or cancer in Rwanda that Farmer studies; they are much closer to home and can be seen at the finest hospitals in one of the wealthiest states in the wealthiest nation in the world. Stepping into the labor and delivery wards and listening to the truths of those who give birth reveal pathologies of power and structural violence that are less deadly than MDR-TB, but no less important a matter of public health.

A doctoral dissertation is a massive undertaking. It is at once a summation of what you have learned, a key to show that you have the background knowledge to be in the scholarly club. It is also a contribution to the field, a duty to add something new; a charge I take seriously. As a scholar who started research in rhetoric and genocide
studies, then moved to international human rights law and legal epistemology, and only then came to political science and public health, this dissertation can look at first glance as disjointed as my journey to bring it to life. But weaving the threads of rhetoric, power, global and national health policy, and the political determinants of health together reveals the politics of childbirth in a way no single strand can on its own. It is my hope that revealing the politics of childbirth will provide a way for researchers, practitioners, and parents to change the culture of childbirth and create a habit of collaborative care that will save lives. The decades long maternal mortality crisis in the U.S., and our government’s continued restrictions on women’s reproductive liberty even at the expense of their lives may seem bleak, but in the words of Lt. General Romeo Dallaire when hope seemed impossible: “Peux ce que veux. Allons-y. Where there’s a will, there’s a way. Let’s go.”
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CHAPTER 1: INTRODUCTION

On a June night at around 11 pm, the incision site from Astrid’s cesarean section began weeping and she was experiencing a fever. Her husband and her doula\(^2\) had been recommending that she immediately seek care at an emergency room. But Astrid was hesitant because of how she felt treated by doctors and nurses during her VBAC\(^3\) attempt earlier that week. After a while, they convinced Astrid to seek care at another hospital where she was told that if she had waited 24 hours longer, she would have died. Astrid was put into a medically induced coma, given an emergency hysterectomy, and spent nine months physically recovering from necrotizing fasciitis\(^4\) as a result of post-operative infection.

Astrid’s story is not only tragic for her personally, it also part of a larger pattern of legal, social, and political issues that shape the U.S.’s maternity care system. The United States is currently experiencing a maternal mortality crisis so severe that the World Health Organization and Amnesty International (2012) have issued reports calling the U.S. the deadliest industrialized nation in which to give birth. According to the Center for Disease Control and Prevention (CDC, 2022), 53% of these deaths take place after the patient has left the hospital. A patient’s unwillingness or inability to return for follow-up care can depend on structural, economic, policy, and personal factors. If Astrid had not lived close to more than one hospital, if she had not had childcare for her newborn and

\(^1\) All names in this project have been changed and are the product of either participant choice or a random name generator.
\(^2\) Professional, individual labor support person
\(^3\) Vaginal Birth After Cesarean. After someone has had a cesarean section with a previous birth, any later births they deliver vaginally are referred to as VBACs or, if they are at home rather than in a hospital, HBACs (home birth after cesarean section).
\(^4\) Commonly called “Flesh-eating disease” it is a life-threatening bacterial infection.
toddler, if she had been taken off of public health insurance immediately after giving 
birth as has been policy in some states (CDC, “PRAMS,” n.d.), she would have died. 
Instead of being a maternal mortality statistic, she was one of what NPR calls “near 
misses” in its report showing that “for every person who dies in childbirth, seventy come 
close” (Montagne, 2018).

This dissertation seeks to understand people’s treatment in labor and delivery and 
how they experience that treatment (e.g., as “just the way it is,” an empowering 
experience, or a violation of their rights). This is integral to understanding the persistence 
of the maternal mortality crisis and the near-misses. People’s perceptions shape their trust 
in the medical industry and their willingness to seek follow-up care (Benkert, 2018; 
Bogart, et. al, 2021; Williamson and Bigman, 2018). Examining these individual 
perceptions also offers a view into the underlying political, structural, and legal elements 
of maternity care and childbirth in the United States—elements which together form the 
politics of childbirth. To understand the politics of childbirth this dissertation asks: what 
do people’s birth narratives, in their own words, reveal about how the politics of 
childbirth shape expectations and treatment in labor and delivery, especially when 
conflicts appear between patients’ autonomy and medical advice?

The Politics of Childbirth: Why Study Childbirth Experiences?

These politics of childbirth represent the unfinished work of the feminist 
movement that has focused on abortion and contraception with only rare forays into 
pregnancy (Cramer, 2021; Luna, 2020; Ross and Solinger, 2017; Solinger, 2013), 
childbirth (Cramer, 2021; Oparah and Bonaparte 2016; Solinger, 2013), and 
parenthood/motherhood (Briggs, 2017; Ross and Solinger, 2017). Feminist work is well-
placed to study childbirth for what it reveals about how power, social attitudes about
gender, and reproductive politics filter into labor and delivery in the same ways that these
power imbalances manifest in conflicts outside of the medical industry. When it comes to
including women’s voices and the voices and experiences of women and non-binary folks
in academic discourse, most feminist scholars have continually pushed academic
disciplines towards inclusion. However, even among feminists, childbirth appears to be,
in the words of activist Milli Hill (2019), “the land that feminism forgot.” This forgetting
has left an area ripe for study.

Understanding what makes people feel heard or respected in childbirth has
become more important in light of political factors that shape childbirth and medical
outcomes like maternal mortality. Politically, the overturning of Roe v Wade, the 1973
Supreme Court decision guaranteeing a woman’s constitutional right to an abortion,
makes it likely that more people will be giving birth. Medically, the United States is
experiencing a maternal mortality crisis, which will be discussed in more detail in the
following chapter. These factors relate in a concerning way: historically, states with
higher restrictions on abortion have also had higher maternal mortality. If these trends
continue, Stevenson et. al. (2022) estimate that they will result in a 21% increase in
maternal deaths, with a likely 33% increase among Black women. Further, research
shows that patients who have negative experiences are less likely to return for follow-up
care. With research also indicating that around half of maternal mortality occurs after
patients leave the hospital (CDC, 2022; Dembosky, 2022), understanding people’s
perceptions of their experiences in labor and delivery can offer new ways to mitigate the
maternal mortality crisis and medical mistrust broadly.
Within the interviews that form the basis of this dissertation, the politics of childbirth tended to manifest in different clusters that form the chapters of this dissertation: the feeling among women of not being listened to resulting in an epistemic injustice, the ways hospital structure and protocol curtail or expand a patient’s sense of reproductive autonomy, people who invoked the language of consent (from its presence or absence), and those who spoke of mistreatment or abuse in childbirth resulting in a mistrust of institutions and sense of betrayal by the medical industry broadly.

For people who have recently given birth, the opportunity to tell their ‘birth story’ is a major part of our culture and telling one’s birth story is a common cultural practice in other countries (Savage, 2001). But these stories can become fraught when things do not go smoothly and in the U.S.’s polarized culture even choices or preferences in childbirth can become lightning rods for criticism and hurt feelings. As epistemic justice scholars have pointed out, how someone experiences something matters. By virtue of their different motives, goals, and experiences, everyone in the labor room could have a different perception of events. But it is important to understand whose version of events is then considered valid and whose is ignored. Birth narratives where people complain are not just socially stigmatized, they are considered selfish as though people should be so grateful to have a baby that nothing else matters (Cramer, 2021; Hill, 2019). But, as we can see from the medical mistrust that comes up when people have bad experiences, it very much matters how someone is treated and how they believe they were treated. Even when considering whose version of events serves as the official retelling, gender-based power dynamics can become problematic because as Bell et. al. (2020) found, in a random survey of over 136,000 patients, 25% found errors in their medical records; ten
percent of which were considered “very serious.” Female patients were more likely to have errors in their charts than male patients (Bell, et. al., 2020). So, studying patient experiences in their own words, rather than through records or statistics, offers opportunity to see the patients’ view regardless of official records of events.

The competing narratives from multiple people in the labor and delivery space can be taken equally seriously without assuming either party is misrepresenting some objective truth of what has happened. Likewise, rather than deciding whose perception mattered more, social scientists can try to determine why there is a gap between the two realities. In labor and delivery, we can do this without tossing aside medical expertise by moving the frame to ask what experience shows about how navigating conflict can(not) decrease the distance between competing perspectives. The point is not that the birth giver’s narrative is the only or even primary source of information. Rather, it is that these narratives should be heard and integrated into our understanding of what the experience of childbirth entrails (the physical, medical, social, and personal elements all together).

Reproductive Politics and Birth Justice: Power, Community, and Care

With the exception of studies that explore the politics of midwifery licensure (Brodsky, 2008; Cramer, 2021), the economics and racial disparities behind unnecessary and high cesarean rates (Allin, et. al., 2015; Bailit, 2012; Bradly, 2018), and scholarship on racial disparities in maternal mortality and perinatal and intrapartum care broadly (Gurr, 2015; Nash, 2021), the experience of birth itself has been largely absent from reproductive politics discussions. Unpacking what reproductive politics is has been a long project for feminist scholars specifically regarding what should be included in the term. Reproductive politics are, at their core about law, policy, and power in the reproductive
arena. They include more familiar laws like fetal personhood laws and policies surrounding access to contraception and abortion, but they are also, as Laura Briggs notes, environmental laws, health care, welfare, and housing policies, and marriage and adoption laws. Taking a wide-angle lens, Briggs (2017) contends that “all politics are reproductive politics” because all of these politics and policies shape people’s decision and/or ability to have children and to be treated with respect as families under the law and in society.

This global lens of reproductive politics as a part of all policies is a scholarly frame compatible with the concept of reproductive justice. Reproductive justice is a scholarly and activist movement created by Black women in the wake of their marginalization and exclusion from both Bill Clinton’s health care plan (Luna 2020; Ross and Solinger 2017; SisterSong n.d.) and mainstream White liberal feminist movements (Nash 2021; Silliman et. al. 2019). Reproductive justice contends that reproductive autonomy encompasses as much the right to have children and raise those children as it does the right not to have them (Davis 2019; Ross and Solinger 2017; SisterSong n.d.). The reproductive justice framework has been challenging the individual and exclusionary focus on legal rights to prevent pregnancy that White liberal feminism promotes, at times to the detriment of non-dominant groups who do not experience the conditions necessary for a choice to be a truly free and fair choice between competing alternatives (Chrisler et. al. 2021; Ross and Solinger 2019). So, Briggs’ view of all politics being reproductive politics is steeped in this tradition, but even the wide-angle lens has left birth little discussed in favor of contraception and abortion.
Solinger, a reproductive justice scholar, takes a more birth-centered route by defining reproductive politics as “the question who has power over matter of sex-and-pregnancy and its consequences” (Solinger, 2019, p. 6). Birth being one of those consequences, should put it right into the discussion. Birth justice scholars are starting to fill this scholarly and activist gap by connecting not just reproduction generally but birth specifically to political and policy choices (Davis, 2019; Hill, 2019; Luna, 2020; Vayo, 2022). Building on the work of reproductive justice, birth justice shares a focus on the right to have children safely but puts at the forefront the tension among the medicalization of birth, for-profit medicine, and a person-centered, empowering view of childbirth. Birth justice, “exists when women and transfolk are empowered during pregnancy, labor, childbirth, and postpartum to make health decision” (Black Women birthing Justice, n.d.). This project contributes to both reproductive politics and to a larger extent, birth justice.

Birth justice and reproductive politics connect to mainstream political science and sociolegal issues in the following ways: they reveal the limits of law to protect patients’ right to consent, expose a lack of legal frame for understanding medical violence broadly, show the role policy and politics play in constructing reproductive freedom and birth outcomes, and unpack the ubiquity of the ways women’s lives are still shaped by hegemonic forces beyond their control. The patriarchal structures of power affect not only women, but those who are non-binary and those who are trans. The misogyny within a patriarchal system that shapes women’s treatment in childbirth affects those who do not identify as women who give birth, in some cases more strongly because they face not just sex-based ideologies about who birth looks like, but gender-based discrimination.
because of what a birth giver looks like (Wade, 2023). As the United States continues to restrict women’s full autonomy through fetal personhood laws (Guttmacher Institute, 2020) and revoking constitutional guarantees to bodily autonomy, particularly at the time when the U.S. is experiencing a maternal mortality crisis, it is important to understand what is happening in the birthing space and how scholars, activists, and practitioners can ensure birthing people are have the highest likelihood of positive, trust-building experiences. Social scientists have long contended that learning the history of institutions can help us understand how their roots are still shaping institutions and their outcomes today.

Talking about birth means considering the ways social expectations shape attitudes about and even the events of childbirth. Starting with the role of social attitudes, it should be clear that birth in the medical context is subject to any other sociolegal or political issues that happen in the medical industry broadly. While there is gender discrimination in healthcare and racial discrimination in health care, there is an intersection race-gender discrimination in birth that stems not just from race/gender but from what we think mothers are who is considered unfit or dangerous (Davis, 2020; Nash, 2021). How women are socially viewed shapes medical misogyny broadly, but how society views the role of mothers, what Adrienne Rich calls the “institution of motherhood,” adds another layer of complexity and bias towards those who give birth in ways that go beyond simply race, gender, or race-gender biases and call into question a system of knowledge.

In light of the maternal mortality crisis, and the history and culture that surrounds it, saying “birth is political” or that there is a politics of childbirth is not some new, so-
called woke statement meant to wade into a hyper politicized culture and politicize something that has not historically been political. To say that birth and reproduction are political issues, rather, is to acknowledge what has always been and draw attention to the ways that birth is influenced by political and social beliefs beyond partisan divides. While this is not politics in the sense of political parties or institutions, it is a matter of politics as understanding at the ground-level “who gets what, when, and how” (Lasswell, 1936).

The legacy of power, institutional violence, and social inequality in law and society is also present when it comes to childbirth. This legacy is especially so for Black women and Latinas who have faced legal and social forms of policing that are ubiquitous and speak to a history of reproductive coercion (the opposite of reproductive autonomy) that persists often through forms forced sterilization and other methods of interfering in the right to have children (Davis 2019; Gurr 2015; Luna 2020; Ross and Solinger 2017; Roberts 2017; Sundstrom 2015). These political practices shape social, and occasionally legal, attitudes about whose body can be controlled and for what purposes. Likewise, they shape ideas about who is “fit” to be a mother and who is “dangerous.” Due to the history of explicit racism in reproductive care, like slavery or mandating sterilization, it can be difficult to see how white women have also been constrained in birth choices and agency. Audre Lorde’s observation that “I am not free while any woman is unfree, even when her shackles are very different from my own,” is still relevant.

Likewise, who can be forced into pregnancy has roots in the denial of control, contraception, and abortion. This dynamic certainly persists today, with the March of Dimes and the Center for Disease Control and Prevention highlighting not just the absence of abortion and contraception protections, but the presence of rape-related
pregnancies. Both are state-sanctioned and interpersonal types of reproductive coercion (discussed more in Chapter Four). In states that still do not consider marital rape a crime, these rates of rape-related pregnancy may be higher. In states like Missouri, it is illegal to get divorced while pregnant, despite the American College of Obstetricians and Gynecologists and March of Dimes research showing that one in six women’s first experience with domestic violence happens during pregnancy (Intimate Partner Violence, 2012; March of Dimes, n.d.). Farther back, the history of enslaved people and forced servitude suggests that reproductive coercion and forced pregnancy have deeper meaning among the Black American population. Renowned enslaver Thomas Jefferson highlighted the forced pregnancy on which the early U.S. economy relied in the form of enslavement of Black people: “I know no error more consuming to an estate than that of stocking farms with men almost exclusively. I consider a woman who brings a child every two years as more profitable than the best man of the farm. What she produces is an addition to the capital, while his labors disappear in mere consumption” (Jefferson, 1820). Pregnancy for profit in this sense meant very literally the rape of enslaved people and the trafficking of their children.

This history cannot be disentangled from attitudes towards Black people and BIPOC folks generally as expendable especially in a time when the maternal mortality rate is 3–4 times higher among Black women than white women even with the same complications (Center for Disease Control, 2020; Declercq and Shah, 2018; Martin and Montagne, 2017; Sebelius and Thompson, 2021). Black infants are three times less likely to die when attended by Black physicians (CDC, 2020a); it is important to explore these

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5 Black, Indigenous, and People of Color
implicit biases and how they manifest themselves historically and politically in ways that shape public health. Likewise, for people in these demographics to enter the birthing space with mistrust about the institutions and the need for family or doula support, should not be a surprise.

Forced sterilization has been a persistent state-sponsored threat to reproductive autonomy and assaults on (primarily) non-white women and poor white women. From the 1930s to the 1970s, approximately a third of women in Puerto Rico were sterilized, many without consent (Luna 2020; Roberts 2017). By the 1980s, forced hysterectomies of Black women in the South were so common they became known as “Mississippi Appendectomies” (Davis 2020; Roberts 2017). Likewise, hundreds of Mexican women in the USC-Los Angeles County Medical Center in the mid-1900s were coerced into permanent sterilization during labor (Silliman et. al. 2004, p. 229). In 2020, the US border agency ICE was accused of forcibly sterilizing migrant detainees without consent (Treisman 2020). All of this state-sanctioned abuse flows from political power and reflects the historical roots of reproductive control over, primarily, women’s bodies (and will be discussed at length in Chapter Four).

Silliman et. al. (2004) note the long history of reproductive coercion on indigenous women and focuses on the forced removal and kidnapping of their children (P. 11). Likewise, Briggs (2021) links to the child protective services with reproductive coercion and forced removal of children as part of the foster care to prison pipeline for many socioeconomically disadvantaged families. The history of eugenics which lead to forced sterilization and medical mistreatment (Oparah and Bonaparte 2016; Roberts 2017; Washington 2006), play a part in some of these variables, as does the
understanding that foster care, adoption, and in-vitro fertilization are all ways to understand reproductive autonomy (Oparah and Bonaparte 2016). As Briggs notes, there is widespread political interference in foster care and adoption in terms of religious and LGBTQIA+ discrimination. These social and political factors filter into maternity care. A core element of reproductive coercion is disrespect and abuse in childbirth, commonly called obstetric violence.

The New “Problem without a name”: Centering the Role of Obstetric Violence

Though the term was first used in the medical journal *The Lancet* in 1827 (Blundell, 1827), obstetric violence is only now becoming recognized as a contemporary term. Chadwick (2021) compares the problem of naming obstetric violence to Betty Friedan’s groundbreaking book *The Feminine Mystique* (1963) which shattered the silence around women’s psychological un-wellness in the middle 20th century. Friedan described the loneliness, depression, and boredom of young mothers and women broadly; in so doing, she dared to name “the problem without a name,” and opened the door for floods of literature, social movements, and solidarity among women, helping to launch second wave feminism into the mainstream. Naming the problem became integral to addressing it and building solidarity among activists and community actors.

First used as a legal term in Venezuela in 2007, obstetric violence is there defined as:

the appropriation of women’s body and reproductive processes by health personnel, which is expressed by a dehumanizing treatment, an abuse of medicalization and pathologization of natural processes, resulting in a loss of autonomy and ability to decide freely about their bodies and sexuality, negatively impacting their quality of life” (República Bolivariana de Venezuela 2007).
Due to the sustained engagement and organizing of Latin American feminists Argentina, Brazil, Mexico, Uruguay, and Venezuela have codified into law protections against obstetric violence, which they view as an outcropping of gender-based violence (Quattrocci, 2019). Latin American feminists have been at the forefront of using the term obstetric violence as a legal term and centering it as the lens though which institutional and legal shift should happen (Quattrocci, 2019).

The utility of obstetric violence as a legal term in the U.S. legal system is unclear and is not the primary aim of this dissertation, but accepting the category as a type of violence that is different from other types of violence is an important part of understanding the politics of childbirth. Van der Waal et. al. (2022) note: “care workers such as obstetric nurses and obstetricians…see obstetric violence as an unnecessarily provocative term” (2). While naming obstetric violence as its own category of violence is sometimes controversial, it is an important element to understand the ways in which institutionalized childbirth can perpetuate within hospitals the same asymmetrical distributions of power that are reflected outside of the hospital. Reproductive violence could cover this, but that term also includes things such as rape, tampering with birth control, forced sterilization, among many other things that fail to capture the obstetric concept. Birth trauma or birth violence is an acceptable alternative, but it does fail to capture the violence during miscarriages and abortions that scholars have also studied (Assis and Erdman, 2021; Larrea, et. al., 2021). It is the context that matters most to what obstetric violence is: not just that it is in birth but that it is within an institution that was intended to care for the people within it.
While some may confuse the terms obstetric violence with targeting and blaming obstetricians, this misplaces the focus by moving the lens away from the people who give birth and their experiences. Likewise, viewing obstetric violence as being nothing different than medical malpractice or bad treatment neglects to account for the persistence of the violence despite decades long awareness\(^6\) of it. While liberal feminists in particular have had a more contentious time accepting the term obstetric violence (Oparah and Bonaparte, 2016; Ross and Solinger, 2017), feminists of the Global South have made enormous headway in explicating and cataloguing the problem. The different types of feminism that are coming into conflict with each other here should be addressed carefully and with racial privilege in mind (Hamad, 2021; Kendall, 2020; Zakaria, 2021).

In solidarity with feminists around the world including OBGYNs, this dissertation does accept the use of the term obstetric violence because the obstetric context is vital to understanding the ubiquity of the violence and the resistance to ending or even naming it.

Comparing to a concept more familiar to mainstream sociolegal scholarship in the U.S. might be useful in helping some scholars consider whether or not the term obstetric violence is useful. The concept of police brutality is a practical way of understanding the need for the term obstetric violence. Police brutality/violence is also intersectional violence that has been persistent and normalized. The term police violence itself creates significant backlash along the same lines of the term obstetric violence (e.g., being unnecessarily incendiary, targeting individuals and professions, the problem being a result of bad working conditions or some “bad apples” rather than a systemic problem).

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\(^6\) One of the earliest public awareness campaigns against violence on maternity wards came in the 1950s from *Ladies Home Journal* titled “Cruelty in the Maternity Ward” that sparked legal conversations and some policy but no cultural changes (Goer, 2010).
Like challenges to the notion of obstetric violence, challenges to the existence of police violence tend to breakdown along racial lines (Balko, 2020; Sanders, 2020). There are racial and class elements to police violence that are significant. But the fact that policing is meant to be a context of protecting a community is a significant factor of the violence and the trauma that results from it.

The context of it being police-protectors perpetrating the violence matters in the same ways that hospital staff-caregivers matters. As will be discussed later in this chapter, institutions which are meant to help but do harm, significantly alter the context of the harm (Smith and Freyd, 2014). Just as in police violence where the point is to focus on the structural and institutional conditions not to target individual police, obstetric violence is also meant to highlight the role of hospitals and obstetrics institutionally not individual obstetricians or institutional actors. In the same way there are those within either institution who deliberately perpetrate violence and those who knowingly fail to report perpetrators of violence, it is also true that in both groups the violence and its continued presence and public reactions against calling it out are matters of institutional and social feelings. Further, just as there are police officers and organizations that seek to address violence within the profession, there are obstetricians, nurses, and midwives who seek to address institutional violence (Dekker, n.d.; Dixon, 2015; Oparah and Bonaparte, 2016; Wagner, 2006).

Making clear the social and epistemological origins of obstetric violence as the following chapters will is vital because it is, in most cases, not doctors and nurses causing harm because they are bad people who want to hurt those under their care. Rather, it is the setup of the institutions and professions that determine who and what kind of
information is to be believed and what processes are to be followed based on these beliefs. It is law, policy, and institutional arrangements that set the conditions for obstetric violence (and police violence) and allow those individuals who do behave in a violence manner to continue. Refusing to acknowledge the systemic nature of obstetric violence obfuscates the role of hospital policy, economics, or power.

Within a cultural context that is still bound up in patriarchy, violence based on gender that plays out regardless of the gender of the care provider. Levesque and Ferron-Parayre (2021) concur, “obstetric violence is a manifestation of violence against women” (p. 1013) that is baked into institutional arrangements and social attitudes. As Villameera (2021) states, within patriarchal institutions:

Violence against women giving birth has become so normalised that it is still not considered as violence against women — almost as if its habitual nature renders the violence invisible… the recent 2019 UN Special Rapporteur's Report on Violence against Women in Reproductive Health Settings establishes obstetric violence as a violation of human rights. Obstetric violence, for which we now have data, statistics, and even laws, is one manifestation of gender violence which characterises patriarchy (n. p.).

Despite advances in the workplace and in society broadly, women are still not fully equal members of society, and that shapes how they are treated: “people are subject to epistemic injustice when they are insufficiently believed or improperly understood because they belong to a non-dominant social group” (Levesque and Ferron-Parayre, 2021, p. 1014). As Shabot (2021) describes in her research, “victims are not only disbelieved, but made to doubt their own knowledge” because they are pregnant (p. 636). Shabot (2021) links this to the very nature of birth being something that happens almost exclusively to women, and the historical medical mistrust of women’s bodies, especially their reproductive system (as discussed in Chapters Three through Six): “a birthing
woman’s knowledge is considered flawed precisely because she is in the process of birthing” (p. 637). Woollard (2002) offers a compelling argument that we should “flip the script” and believe women deliberately because “pregnancy is epistemologically transformative,” it is “an experience that brings you knowledge that you could not have acquired without having the experience” (n. p.). Understanding this knowledge and how people who give birth make sense of it helps to define the politics of childbirth.

Finding Patterns in the Difference: Engaging the Literatures

A difficulty in studying anything related to childbirth – from statistical evidence to individual stories – is that a multitude of different factors shape not just childbirth generally, but each person’s birth experience. These factors are social, legal, political, medical, and personal. To fully understand the non-medical factors that shape birth, we must start with two important and related scholarly and activist literatures: reproductive politics and birth justice. From these literatures, we can understand how institutions and professionalization have shaped birth culture and continue to do so. This dissertation also adds to the public health and medical sociology literatures that explains how people who experience negative treatment develop medical mistrust which leads to diminished compliance with care routines and not returning for follow-up care (Benkert, et. al., 2018; Bogart, et. al., 2021; Williamson, et. al., 2018). The strongest spaces where this work contributes to scholarly conversations, however, are in reproductive politics, law and society, and public health law.

Reproductive Politics and Health
As applied to reproductive politics, this means asking who has control over sex and its consequences (Solinger, 2013). By studying perceptions from the birth giver’s point of view, this dissertation contributes to reproductive politics and feminist health literature as well as the literature on medical sociology broadly, and in several areas of the socio-legal studies literature. There are many places in healthcare where patients complain about their treatment, and likewise, there are many areas where doctors and patients’ wish are constrained by legal, physical, technological, and economic limitations. Medical racism\(^7\) happens in all areas of medicine (Roberts, 2007; Washington, 2021; Washington, 2008). Likewise, medical misogyny—the lack of inclusion of women in medical studies, historic ideas of “hysteria,” and the “wandering womb” as the cause of women’s health problems happen in non-obstetric medicine. This dissertation takes steps to add in history and context of reproductive politics choices and in so doing contributes to literatures on reproductive politics and health.

It is impossible to enter into the fields of reproductive politics and health without also contributing to discussion of gender in medicine. Medical misogyny has most often been tracked when physicians prescribe pain medication more often for men than women for the same procedures because of the subconscious assumption that women are “overstating” their amount of pain while men are giving a rational assessment (Chen, et. al., 2008; Kaye, 2021). Likewise, medical gaslighting\(^8\) (Fraser, 2021; Katz, 2021) which

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\(^7\) This includes implicit bias stemming from social inequality but also encompasses historic attitudes towards non-white people, particularly Black people. It can range from attitudes that Black people have a higher threshold for pain to using more experimental treatments on Black patients without their consent (see Washington, 2021), to assuming Black and Latina patients will not comply with care regimens.

\(^8\) The practice of making someone question their own sanity or reality (Caron, 2022). A reference to the 1944 film noir *Gaslight* in which a husband slowly drives his wife insane by changing small details of their daily lives while assuring her that those changes are “only in her head” (Caron, 2022).
includes dismissive attitudes, constant interruption, condescending remarks, and subtle persuasion that a problem is “not that bad” or “all in your head” are common to women throughout medical areas (Chen, et. al., 2008; Katz, 2021; Kaye, 2021;). Abortion care, treatment of infants in the Neonatal Intensive Care Unit (NICU) (Davis, 2020) and women’s difficulty in getting tubal ligations and permanent sterilization offer places where the power of the medical establishment over women’s reproductive choices could be challenged. It is important to study birth specifically, in part because it has been understudied, and , and in part because policy and legal factors actually shape birth in substantial but often invisible ways.

Law and Society

This dissertation also contributes to discussions in the field of Law and Society related to the role of law as part of the cultural schema. Sarat and Felstiner (1995) remind scholars that to “acknowledge that law has meaning-making power then, is to acknowledge that social practices are unintelligible apart from the legal norms that give rise to them” (11). Through studying issues of consent and coercion, this dissertation steps into discussions of law’s meaning-making ability and the role of legalistic norms in individual decision-making processes. But as Albiston (2005) notes, “what counts as law depends not on some inherent truth, but rather on what we are trying to explain” (16), and some of the interviews that will follow, particularly around questions of consent relate strongly to this point. Albiston (2005) further contends that legal norms are themselves and are integral parts of “other institutionalized systems of meanings” (p. 12) which this dissertation considers in terms of institutional treatment and arrangements. Focusing on
the power of legal and cognitive frames that stem from institutions, Albiston (2005) also notes the ways in which institutions themselves have meaning-making capabilities.

In the same way Barnes and Burke (2006) explore how it was important that people seeking access to their rights found “the right person” when dealing with Americans with Disability Act compliance, interviews here that examine the role of care provider also find the right person in the room matters in childbirth. Lipsky (2010) discusses the role of “street-level bureaucrats” and how they “deliver benefits and sanctions [that] structure and delimit people’s lives and opportunities” (4). In many ways, there are bed-level bureaucrats in the form of doctors, nurses, midwives, and anyone who implements hospital policy without regard to patient’s wishes act through their sense of legality that comes from both law and society to form an understanding of how people should be treated in childbirth. But this is sometimes in conflict with how birth givers expect to be treated, setting the stage for conflicts.

Several additional important elements of law and society literature arise in this study, many of which will be dealt with more fully in each chapter. Legal pluralism (Merry, 1988) is an important point of understanding the competing legal and extralegal system surrounding childbirth. Likewise, the literature on rights consciousness (Engel, 2012; Ewick and Silbey, 1998), law’s role in meaning making (Marshall and Barclay, 2003) and identity formation (Engel and Munger, 2003), and the ways in which legal consciousness is experienced by different groups (Young and Billings, 2014). Likewise, the literature on law and social movements (McCann, 2006), law’s role in the policy making process (Levitsky, 2013), and procedural justice (Greenberg and Tyler, 1987). Likewise, the role of law in deciding what types of harm are justiciable (Sandefur, 2007)
or the ways in which some harms are categorized as violence that the law can address (e.g., interpersonal harms) and violence the law does not address (e.g., types of structural harms (McCann, 2014).

Public Health Law and the Role of Institutions

Focusing on the law is important, but so is Scheingold’s (2004) institutional view of law: “The law is real, but it is also a figment of our imaginations. Like all fundamental social institutions, it casts a shadow of popular belief that…we ordinarily associate with law” (3). As Ewick and Silbey (1998) note, this role of law in the culture leads to people adopting cognitive frames of law in daily life and giving legal meaning to things that may not have otherwise had them, leading to this sense of law-like thinking or legality. Legality “is a structural component of society. That is, legality consists of cultural schemas and resources that operate to define and pattern social life” (Ewick and Silbey, 1998, 43). Legality has long been a matter of study for law and society scholars, and as public health fields begin discussing law as both socially situated and an integral part of public health, this dissertation is poised to help bridge the fields.

The emerging field of public health law considers itself distinct from both law and public health as its own field (Gostin 2008). Public health laws are “any laws that have important consequences for the health of defined populations” (Goodman, et. al., 2006). Gostin (2008) offers a lengthy definition of public health law that focuses on studying the power of law, the state, communities, and policies to shape the health and wellness of communities (4). Gostin (2008) contends “the prime objective of public health law is
to pursue the highest possible level of physical and mental health in the population, consistent with the values of social justice” (4).

The focus through this dissertation considers what consent and coercion look like in labor and delivery, and what happens when there is a complaint. These are decidedly issues of public health law. Additionally, the role of institutions is important in considering the shape of childbirth within the contemporary context. This also includes looking at how birth givers view laws and policies that relate to their autonomy and the respond when they say they have been mistreated, in other words the legality around birth.

In her five-month ethnographic study of labor and delivery rooms in Sweden, Goldkuhl, et. al., (2022) found that labor was effected by many external processes like patient treatment and provider attitudes towards autonomy. Additionally, as a public health issue, childbirth may be a one-time event for an individual, but it has lasting implications on families because it affects postpartum mood disorders (Kukura, 2018), can create Post Traumatic Stress Disorder (Diaz-Tello, 2016), interfere with parent-child bonding (Taghizadeh, et. al., 2013), and lead to future infertility (Goer and Sakala, 2012) dramatically shaping people’s reproductive choices in the future. In other words, what is experienced in the hospital setting shapes willingness to receive future medical care.

Roadmap of the Book: Putting the Pieces Together

Where is the law in the politics of childbirth? As has been said before, it is all over (Sarat, 1990). Law is a constraining force (e.g., who may/may not legally practice medicine), a source of confusion (e.g., when is informed consent informed enough?), and
a source of fear (e.g., defensive medicine or making choices based on the fear of liability or litigation). Throughout all of this, law retains the symbolic force that has meaning making (Marshall and Barclay 2003; Sarat and Felstiner, 1995) that can allow patients to perceive their experiences as legal or systemic problems. Like other political issues, the politics of childbirth can expose how legal elements can shape personal experiences and a person’s perspective of their sense of fair treatment.

This introduction provides a wide-angle view of many pieces of a puzzle that is the politics of childbirth. Geared towards more fully theorizing the politics of childbirth, each chapter will illuminate one of these puzzle pieces more clearly so that it becomes easier to understand the mutually reinforcing relationship among law, society, and health. Birth is at an intersection of so many different fields. It is political, personal, medical, natural, and unique to each person and each experience. The chapters that follow will address relevant history, sociopolitical attitudes, institutional politics and policies, and experiences of those who have given birth to offer a more comprehensive understanding of the politics of childbirth. The conclusion will offer discussion of the policies that have been proposed to address the maternal mortality crisis and people’s treatment in childbirth.

Chapter Two begins the dissertation by outlining the policy landscape, exploring the role of legal pluralism throughout the fifty US states, and considering the ways in which it is difficult to implement policy when the policy landscape is so different. Drawing on seventy-five variables from each of the fifty states, this chapter creates an index of reproductive autonomy drawn from state policies. Relying on the reproductive justice frame, this chapter includes variables on abortion/contraception, birth choice,
parenthood and pregnancy, and the socioeconomic determinants of health to produce a nuanced landscape of the politics of childbirth in the U.S. This chapter offers a policy level look at the politics of childbirth by showing the ways legal and political choices shape birth experiences for individuals.

Chapter Three explains the maternal mortality crisis, the medicalization of birth, and the use of medical technology in the United States. Broadly, this chapter discusses where in the politics of childbirth we are and how we got here. The exploration of institutionalized childbirth explores historic use of law’s coercive force to restrict practitioners and shape the environment of labor and delivery. Today, law is looser in many respects: the opportunity to become a physician cannot be legally restricted by race or gender, all states license certified nurse midwives, and many states allow homebirth in some capacity. The different legal dispositions shape the contours of where childbirth happens, but there are still arguments about whether groups should have to turn to legal certifications as a means of legitimacy to practice labor and delivery care resulting in arguments among midwives (Cramer, 2021) and surrounding the free-birth movement.9 This includes the role of race, gender, and class in health outcomes and contextualizes the maternal mortality crisis and need to study childbirth. It grounds the reader in the ways the culture wars in broader reproductive politics shape the role of birth attendants. Additionally, it considers the United States’ position as an outlier in global maternal health care as a matter of policy decision rather than medical happenstance. Considering the social elements to the discussion, it further theorizes the connection between maternal

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9 Free birth is the process of giving birth outside of a hospital setting and without a birth professional (e.g., OBGYN, midwife, nurse) present.
mortality and obstetric violence and draws into the conversation the role of epistemic responsibility.

The following three chapters are based on interviews with 120 people who have given birth. These interviews illustrate the ground-level experience of the theoretical constructs each chapter discusses.

Chapter Four more fully discusses epistemic justice, which is a matter of who is believed and whose knowledge is ignored because of their social position, by considering its manifestation in labor and delivery. In the politics of childbirth, one thing we see clearly is the ability of law to shape discourse, from how we talk about consent to whose authority and credibility has the sanction of formal or legal certification behind it. In this chapter, epistemic justice it another way to understand law’s meaning-making power (Marshall and Barclay 2003; Sarat and Felstiner, 1995) in a medical setting. A key theme to all of the interviews, whether people described the experience in positive and negative terms was that “no one would listen to me.” This manifested in different ways from women not being believed that they had dilated so fast, doctors and nurses talking to people’s husbands/partners instead of them, to laboring people simply being told they did not know what they were talking about. This chapter considers the role of epistemology that underlies who gets trusted and believed during childbirth and includes interviews with those who discussed not being listen to, not being believed, having racism complicate their care, and how medical professionals can work to create epistemic peer models of care that are respectful and collaborative.

Chapter Five covers the role of coercion and consent in childbirth and engages with work on informed consent and betrayal theory. Interviews with birth givers
discussed in this chapter focused on the role of perceived coercion in childbirth and a lack of informed consent that proves harmful to patients regardless of their birth experience. Consent has some of the most tangible connections to law because as a legal term consent is one of the most proximate legal trappings in the delivery room. While consent forms are legally mandated, it is unclear the extent to which informed consent as a practice can be guaranteed to happen in a meaningful way. In some cases in my interviews, the obstetrician recommending the practice was enough for patients to feel informed, in others, patients refused to believe in the utility of interventions they did not want, and in a majority people just did not know they could ask follow up questions. The concept of institutional betrayal has wide-ranging theoretical use in political science, and in a medical setting particularly is very useful to understanding public health problems. Here it is discussed in terms of informed consent during labor and delivery and circles back to the question of epistemic justice and who is believed or respected in the labor and delivery room.

Chapter Six considers the role of perceived coercive care and how that can manifest into institutional betrayal. Institutional betrayal, or the sense that an institution you had to rely on for care has harmed you, can be considered as a matter of procedural justice. Additionally, this chapter expands the lens to the global conversation around treatment in childbirth, particularly disrespect and abuse. Thinking through the role of institutions in providing care, this chapter explores what happens when either accidentally or on purpose, those institutions fail to provide the care that patients expect. But there are also constraints on this because patients develop expectations from their families, television and other media, religious and cultural observations or beliefs, and
their own previous experiences. Perceived institutional betrayal can become understood through the lens of obstetric violence and as a larger pattern of systemic mistrust supported through the legal system in the form of difficult reporting processes or a lack of formal redress for grievances.

Finally, the conclusion offers pragmatic policy solutions that can be enacted through different levels of policy and professionalization in order to improve birth for many people. It also considers the implications of giving birth in a culture of misogyny and in an institution that prioritizes technological models of care and particular types of knowledge. The institutional constraints through geography, economic condition, and structures of power make it difficult to enact any change that requires more one-on-one care no matter how invested medical professionals are in this care. Indeed, without concurrent institutional, policy, and economic support, relying on more one-on-one care without increasing the maternal and perinatal health workforce could only lead to higher rates of physician and care-provider burnout. The dissertation is ultimately a hopeful one and contends that unmasking the misogyny and re-considering epistemic divides and how to approach difficult decisions through collaboration can overcome some medical mistrust. Social movements surrounding reproductive justice, obstetric violence, and maternal mortality might also create political will for policies that will give institutions the financial support to create conditions for such collaborative care.
CHAPTER 2: MAPPING THE POLITICS OF CHILDBIRTH: THE UNEQUAL LEGAL LANDSCAPE OF REPRODUCTIVE AUTONOMY

Drawing out the politics of childbirth, Zakiya Luna’s (2020) recent book on reproductive justice asserts “Reproduction is a biological and political project” (13). A quantitative snapshot of the policy landscape illustrates many ways the political aspect of the biological project is shaped. Legal pluralism is a defining feature of US federalism, and in few ways is this as apparent as the unequal legal landscape of reproductive rights. While the US Supreme Court may set a floor of equal protection under which states may not fall, each state interprets and approaches the floor differently, making meaningful comparisons across multiple jurisdictions incredibly difficult. Using methods from the field of public health law offers a way to study multifaceted socio-legal issues across making it well suited to explore the politics of childbirth. To illustrate the benefits of this method and the unequal policy landscape that shapes the politics of childbirth, this chapter offers the State Reproductive Autonomy Index, a measure of reproductive autonomy.

The politics of childbirth and reproductive autonomy are closely linked with reproductive autonomy shaping the parameters of the politics of childbirth and laying the conditions for institutionalized childbirth. Reproductive autonomy is defined as “having the power to decide about and control matters associated with contraceptive use, pregnancy, and childbearing” (Upadhyay et al. 2014). As Chapter One notes, a reproductive justice lens that focuses on the right to have and to raise children as much as the right to prevent or terminate pregnancy (Ross and Solinger 2017; Silliman et al. 2004; J. Nash 2021; SisterSong, n.d.) is vital to understanding the politics of childbirth more
specifically than reproductive politics generally. The State Reproductive Autonomy Index uses seventy-five variables from each of the fifty states, including abortion and contraception rights, rights related to pregnancy and parenthood, birth choice, and socioeconomic status. Studying these interlocking policies exposes the ways in which rights are constrained both from state intervention (for example, making abortion and contraception inaccessible) and from a lack of state intervention (for example, allowing discrimination in foster care and adoption), complicating our understanding of what it means to have a right by considering the ways in which some rights rest upon others or intertwine in ways that make it impossible to compare the policy and rights landscape without a broad focus.

While abortion tends to dominate the political discussion, it is important to keep one eye looking beyond traditional reproductive rights parameters to capture the full scope of constraints—through law and policy—on all reproductive choices (Ross and Solinger 2017; Luna 2020). Understanding the forms that these constraints take requires engaging with scholarship on legal pluralism (Merry 1988), with the work of reproductive justice scholars and activists, and with public health work on the legal determinants of health (Coggon 2020). Several measures of reproductive autonomy already exist, but their focus is narrowly tailored to exploring contraceptive autonomy (Senderowicz 2020), the attitudes of college students (Wright et al. 2018), women at family planning and abortion facilities (Upadhyay et al. 2014), and reproductive autonomy as it relates to policy (Vedam et al. 2018; Cramer 2021). A more encompassing measure—the Local Reproductive Freedom Index—evaluates reproductive health, rights, and justice policies in fifty US cities, highlighting the need and possibility for a socio-
legal approach to understanding how reproductive choices are shaped by legal forces (National Institute for Reproductive Health 2019). This State Reproductive Autonomy Index does not seek to replace local-level measures like the Local Reproductive Freedom Index, as ground-level understanding is invaluable to advocates and policy makers. What this measure offers is a way to supplement local and regional indices with broader sociolegal data that can be used by scholars, advocates, and policy makers to contextualize policy debates. Additionally, it provides a template for studying socio-legal issues that span the boundaries of multiple disciplines and jurisdictions and are constrained by different types of laws and policy.

The State Reproductive Autonomy Index offers three main contributions for scholars and policy makers. First, it integrates the reproductive justice framework with the mainstream academic socio-legal and public health law discourse. Second, it leads to a deeper understanding of the connections between the lived experience of rights and how legally plural environments shape those experiences through different uses of social and economic policies. Third, it shows the need for further engagement between the legal, political, and social science literatures and public health law methods. By taking an approach that considers the social determinants of health and looks to the “upstream” determinants of unequal access, or the “causes of causes” that precipitate legal and health disparities (Braveman and Gottlieb 2014), we can make visible the invisible force of the law governing many choices related to reproduction.

**Legal Mapping: A Transdisciplinary Method for A Multidisciplinary Field**

Reproductive justice scholars have repeatedly demonstrated the utility of an integrative approach to understanding reproductive autonomy that includes the lived
experience of policy, law, and economics (Ross and Solinger 2017; Davis 2019; SisterSong, n.d.) and while birth justice scholars are exploring the contours of the politics of childbirth, they have not been fleshed out in a quantitative measure before. The “transdisciplinary model” of public health law research provides a way to quantify this integrated approach without losing the crucial focus on the lived experience (Burris et al. 2016). There is incredible potential to unlock by integrating public health law methods into socio-legal studies in ways that are appropriate to our field. Along with methodological benefits of transdisciplinary research, similar questions about rights and law have emerged within the literature of public health, birthrights, and the social determinants of health. These questions have formed the basis for the selection of variables in this index.

This project uses a transdisciplinary method—the “true integration of theories, methods, and tools” from across disciplinary realms (Burris et al. 2016, n. p.)—adopted from public health law studies that are situated between legal mapping and legal epidemiology because there are the social, epistemological, institutional, and personal elements all embedded within the politics of birth. Traditional methods have a harder time capturing the ways in which law’s interactions with society shape politics, legal epidemiology offers a way to study law that centers both laws and their effects. Pulling from public health law methods, this method explores the role of three types of laws known as the three I’s: infrastructural (those that shape institutions and the environment), interventionist (specifically targeted toward policies and outcomes), and incidental (background conditions that are not intentionally related). While this type of method is suited to other transdisciplinary, highly charged, and seemingly intractable problems,
such as police violence and prison recidivism, reproductive autonomy is my starting point because the laws are so varied along the three I’s that success in measuring this concept will certainly offer pathways to look at other politically entrenched legal issues. For instance, in a study of police violence, one could explore the connection between police education requirements, recruitment, and salaries (infrastructural), the legality of chokeholds and other methods of restraint (interventionist), and the community-level rate of incarceration, poverty, and racism (incidental), among other variables, in order to provide a wide-angle lens on the scope, sources, and prevention strategies for violence. All of these things have a shaping effect on the politics of childbirth, particularly the as it relates to institutionalized birth.

The reason behind constructing the State Reproductive Autonomy Index is that the public health and socio-legal literatures do not appear to be speaking to each other, despite their clear links, and the literatures are not in conversation with the wider sociolegal work on rights. Bringing the literatures together offers a substantial contribution to theory and methods in sociolegal studies because it engages legal epidemiology’s work to measure “law’s strong determinative effects…on our social, governmental, commercial and physical environments” (Coggon 2020, n. p.). Sandra Levitsky (2013) stresses the need to study “law’s effects on social policy because state policy shapes our social lives” (34). Weaving interrelated legal categories together is crucial because “evaluation at the intersection of law and social science can yield meaningful insights into how broadly, deeply, and effectively policy makers efforts translate into public policy that achieves its objectives” (Tremper et al. 2010). Charles Tremper et al. (2010) also note “producing the most accurate measures requires close
attention to relationships among law and from different sources ::: and at different levels” (246). These different legal sources converge to shape the legal environment. This chapter illustrates a way to directly examine the law and its power as the underlying element in constructing health disparities through the lens of reproductive health and justice by using legal mapping to compare laws across multiple jurisdictions.

As partisan polarization takes on more explicit legal battles, law’s role as a social force calls us to explore the law in new and inclusive ways. As Michael McCann (2006, 21) notes, “legal constructs shape our very capacity to imagine social or political possibilities.” This capacity of law as meaning making is widely understood (Marshall and Barclay 2003; McCann 2006; Levitsky 2013). Anna Maria Marshall and Scott Barclay (2003, 618) contend that “law colonizes everyday existence” because it shapes what we think of as legitimate, acceptable, or possible. In legally plural environments, this creates systems where cultural or social practices may take precedence over law on the books, making rights in practice different than rights on paper (Merry 1988). Yet, as Sandra Levitsky (2013, 34) notes, even those rights based in law are often subject to litigation, which, in some senses, renders them in a constant state of flux—in reproductive autonomy, this can be seen in a sustained campaign of litigation over abortion and access to contraception. When law and rights are so different or inconstant across the fifty states, especially laws relating to bodily autonomy, we must ask whether we are living not only in legally plural environments but also in different socio-legal realities. As the United States continues to grow more polarized along partisan lines that target explicitly political issues (Rhodes and Vayo, 2019), socio-legal scholars should be poised to expose the ways in which widespread partisan polarization may be leading to
these different legal realities across state jurisdictions, calling into question the existence of rights at all. Legal mapping will provide a vital tool for this project.

**Why Reproductive Autonomy?**

Chapter One noted the debt this project owes to reproductive justice scholarship, but here too in the quantitative realm, this project is indebted to the immense work that reproductive justice scholars have done to expose the role that law, society, and politics play in procreation and their insistence that “reproductive decision-making is about the lived experience of individuals, including, for many persons, their drive to possess reproductive autonomy” (Ross and Solinger 2017, 7; emphasis in the original).

Reproductive autonomy is more than pro-choice rights discourse. As Jael Silliman and colleagues (2004) note, the very idea of a choice is premised upon autonomy—namely, sovereignty over one’s own body; the awareness of, and access to, alternatives; and the freedom from coercion. Studying autonomy exposes the ways in which law and policy shape what choices we have and what we think of as choices at all, filtering our “choices” in ways that are not captured by reproductive rights discourse. Autonomy is, on the one hand, freedom from state interference in reproductive choices (for example, midwife licensure), but, on the other hand, it also relies on a certain amount of intervention in order to protect freedom (for example, enforcing safety zones around abortion clinics). In their article, Kathryn Norsworthy, Margaret McLaren, and Laura Waterfield (2012, 67) explain “women’s reproductive choices must be framed within a broader social context that is characterized by gender discrimination and unequal access to basic health resources.” Unpacking what autonomy looks like complicates rights discourse because it
exposes the ways in which interlocking laws and policies shape widespread access to a right, while also calling for nuance in discerning when intervention is empowering or disempowering (Crenshaw 1991, 2012). But understanding reproductive autonomy allows us to explore the epistemic conditions that shape people’s choices and treatment in childbirth and the ways in which care providers believe they can/should interact with patients. Further, the role of obstetric violence and institutional betrayal stem from understandings of what or whether reproductive autonomy should exist for birthing parents.

The choice of whether, when, and how to procreate or establish one’s preferred family is fundamental to personal liberty. Understanding how law and politics shape these choices furthers our understanding of how law shapes all of our lives and choices. When talking about reproduction, law’s constraints on women’s full autonomy are normalized to the point of invisibility, making it seem as though people’s choices are personal and a matter of preference when, in reality, they are shaped and constrained by policy and legal parameters (Norsworthy, McClaren, and Waterfield 2012; E. Nash 2019). Using legal mapping to study reproductive autonomy allows us to look at a set of laws that govern one group differently than others, illustrating law’s pluralism (intentional or not) in terms of both state-federalism issues and in terms of treating different genders differently. Feminist scholars like Catherine MacKinnon (2005) have pointed out the need to study politics and law in a way that is explicitly conscious and critical of a system where men write laws that apply to women in ways that do not apply to other men, and reproduction is an obvious example of this pattern. Perhaps the most succinct explanation for the need to study reproductive autonomy through a multilayered
socio-legal lens that focuses on rights and power comes from the Black feminists who founded the Combahee River Collective (1977, n. p.): “[O]ur particular task the development of integrated analysis and practice based upon the fact that the major systems of oppression are interlocking. The synthesis of these oppressions creates the conditions of our lives.”

These interlocking systems of oppression and the way in which they are synthesized by and through law make it impossible to get an accurate understanding of reproductive autonomy by only focusing on one element of the system or on one element of autonomy, indicating the need for a sweeping measurement like the one presented in this chapter. Kimberle Crenshaw (1991, 2012) further exposes the need for a holistic study of the race, class, and gender dynamics that produce intersections of legal marginalization within these interlocking systems. These intersectional barriers push us to understand that, even in a single state or political culture, law affects differently situated groups in ways that cannot be unpacked into neat categories, and, in some cases, membership in one group (for example, race, gender, sexuality) can increase the risk of legal, social, or political violence (Crenshaw 1991). Rights look different depending on where you are as well as on who you are.

The State Reproductive Autonomy Index is necessary in itself because, while legal scholars have long contended that “there are fewer and fewer ‘zones of immunity’ from law” for all people (Friedman 1985, 22), women of childbearing age in the United States live their lives “in the shadow of the law” in a way that other groups do not (Currie 2009, 9). Women’s reproductive choices are policed through society and law—from the social phenomenon of strangers telling pregnant people they should not drink coffee
(Fox, Nicolson, and Heffernan 2009; Cramer 2015), to a federal court ordering a Florida mother to have a cesarean (Gluck 2014), to strangers asking women about their procreation plans. Once we expand our understanding of reproductive autonomy to include choices about pregnancy or raising children in a safe and healthy environment, as reproductive justice scholar-activists do (Ross and Solinger 2017; Davis 2019; Luna 2020; J. Nash 2021; SisterSong, n.d.), we complicate measures that attempt to quantify reproductive autonomy. But any measure that does so will be a more accurate representation of autonomy as it is experienced.

Reproductive justice contends that reproductive autonomy encompasses as much the right to have children and raise those children as it does the right not to have them (Ross and Solinger 2017; Davis 2019; SisterSong, n.d.). Created by a group of Black women as an activist movement in response to finding themselves left out of the mainstream feminist movement’s discourse on reproductive rights (Silliman et al. 2004; J. Nash 2021) and sidelined by President Clinton’s health-care plan (Ross and Solinger 2017; Luna 2020; SisterSong, n.d.), the reproductive justice framework has been challenging the individual and exclusionary focus on liberal rights to prevent pregnancy that white liberal feminism promotes, at times to the detriment of non-dominant groups that do not experience the conditions necessary for a choice to be a truly free and fair choice between competing alternatives (Ross and Solinger 2017; Chrisler 2012). It has thus created a more inclusive understanding of how we can and should talk about reproductive politics generally and about reproductive autonomy specifically.

Reproductive justice scholarship provides a framework for conceptualizing the ways in which law, politics, and society shape people’s constellation of choices.
throughout their reproductive years. Yet reproductive justice has been largely absent from mainstream social science and legal studies literature in favor of a reproductive rights discourse partly because of the ubiquity of liberal rights discourse and because it is more pragmatic to draw connections among specific, closely related policies. The State Reproductive Autonomy Index uses a reproductive justice frame and suggests that reproductive justice should be the dominant narrative through which scholars and advocates discuss reproductive politics (whether rights, law, or policy) despite (or because) it complicates rights discourse in a way that reflects the varied lived experiences of different groups. The State Reproductive Autonomy Index also exposes the contours of legal pluralism and uses legal epidemiology methods to measure reproductive autonomy in a way that is compatible with socio-legal scholarship, methods, and discourse.

Reproductive justice recognizes that reproductive struggles are essentially about power rather than choice itself (Ross and Solinger 2017, 11), and this is where a measure of reproductive autonomy becomes difficult. Some illustrative examples of policies where state power is targeted against autonomy can expose law’s constraints on women’s bodies and rights. In Texas, for instance, a law makes it illegal to disconnect a pregnant woman from life support even if her living will stipulates that she does not wish to remain on life support even while pregnant (Fernandez 2014). Another is the case of Jennifer Goodall who, in 2014, refused her hospital’s requirement to have a repeat cesarean. Attempting to coerce her compliance, the hospital threatened to call child services, and, when that did not work, they went to a Florida judge who court-ordered
Goodall to have a cesarean—major abdominal surgery that is not without risks—over her expressed consent (Jacobsen 2014).

Creating an even more pressing legal conundrum, Wisconsin allowed the state to appoint a lawyer as guardian to a fetus without the consent of its mother, Alicia Beltran, who disclosed a past history of pill addiction (National Advocates for Pregnant Women 2019). Reported by her doctor to the Department of Health Services, Beltran was arrested when she was fourteen-weeks pregnant; she appeared in court and was denied counsel herself but was told that her fetus had been assigned a lawyer and that it was on this authority that she was sentenced to a mandatory detention in a treatment center. Further, this case proceeded with no testimony from medical witnesses, and the treatment facility was suited to neither the type of drug treatment being sought nor prenatal care (Graham 2014; National Advocates for Pregnant Women 2019). This example brings up different questions about rights and state intervention. If a legal spokesperson can be appointed for a fetus with no input from the person carrying the fetus who is capable of making a decision, the question becomes who decides when and under what circumstances this is appropriate? When this is done either without or against medical advice, it is an even more invasive use of state power and calls into question what having a right to bodily autonomy means. The fact that some pregnant people, particularly Black people and Latinas, are subject to more social construction as bad or even dangerous mothers only increases the risks to reproductive autonomy in the form of state intervention (Norsworthy, McClaren, and Waterfield 2012; Oaks 2015; Davis 2019; J. Nash 2021).

Studying reproductive autonomy shows that even laws once meant as rights to protect women against domestic violence can be turned on their heads to punish women,
showcasing a legal-political, rather than a health-safety, power dynamic. Thirty-eight states have “feticide” laws on the books, many of which may be deployed with the discretion of a physician or law enforcement (National Abortion Rights Action League 2019). Christine Taylor of Iowa was charged with “attempted feticide” after the pregnant mother of two fell down the stairs, completely by accident. Bei Bei Shuai, who attempted suicide by swallowing rat poison, was charged by the state of Indiana with feticide when she survived but the fetus did not (Graham 2014). Feticide laws can also be used to criminalize miscarriage and stillbirth. Georgia law allows up to thirty years in prison for a miscarriage (Naftulin 2019). Michele Goodwin’s (2016, S19) research exposes the results of the criminalization of pregnancy, outlining the ways in which pregnancy is the catalyst for punishing women who “but for their pregnancies…would not have been prosecuted for doing something wrong.”

These stories represent only a fraction of the scope of reproductive constraints and offer a reason why reproductive autonomy should be a fundamental point of legal, social, and political studies about rights, health and wellness, and access to justice. These examples are often framed as an attack on the recently overturned 1973 case Roe v. Wade, however, understanding the individual anecdotes as connected through state commitment for or against reproductive autonomy can expose a much larger pattern of coercive power that extends beyond pregnancy through birth and into parenting and can be used in other areas to study how states police intimate areas of our lives (Center for Reproductive Rights 2020; Guttmacher Institute 2020a). Though this can be applied to other policies, especially the carceral state and broader welfare policies (Briggs 2017), reproductive autonomy is my starting point because simply by existing and being a
certain age women and people with uteri are governed by laws and policies that treat them as potential procreators, which is a burden men that do not share.

While the anecdotes above could produce their own papers on the legal and justice issues that arise from state power and the racial disparities in pregnancy policing (Roberts 2017), understanding the state’s commitment (or lack thereof) to reproductive autonomy helps explain the varied conditions under which these kinds of constraints on reproductive autonomy can arise and the backdrop against which policy makers would have to push to undo them. Unpacking the ubiquity of these constraints will be a useful tool in fully exposing how law is complicit in (de)constructing reproductive autonomy.

As McCann (2014, 251) notes, “classical liberal and neoliberal rights define mostly procedural rights that place selective limitations on arbitrary violence by discrete actors but do not limit routinized systemic violence…and require few positive mandates for social equality and redistribution of power.” The State Reproductive Autonomy Index includes variables to measure this systemic violence as well as its interconnectedness, particularly through legal pluralism in a federalist system.

**Measuring Reproductive Autonomy**

To develop the State Reproductive Autonomy Index, I categorized data for each of the fifty states based on seventy-five different variables. I tracked variables relating to abortion and contraception access (twenty-six variables), pregnancy and parenthood (thirteen variables), birth choice (fifteen variables), and background socioeconomic status data (twenty-one variables). For a full list of variables broken up by category, see Appendix 1. Variables are grouped together by subcategories to offer the
ways in which not only to compare reproductive autonomy generally but also to expose areas where incidental and infrastructural laws may be invisibly shaping reproductive autonomy. For example, seeing a state in the middle range overall could indicate a state with high abortion rights but low socioeconomic rights. While an aggregate measure would signal moderate reproductive autonomy, looking at the subcategories would show the ways in which some laws make other legal rights difficult to access. Public health law favors these methods because federal, state, and municipal laws all shape which public health measures are possible and affect the success of public health policy. Looking at reproductive autonomy through public health law methods allows us to conceptualize what is both a public health and legal issue in a new way. Other legal public health problems like gun violence, police violence, vaccine equity, disability justice, or environmental law could all benefit from this type of methodology, which explores interlocking laws and policies. Variables were selected from across multiple literatures that would benefit from engaging with each other and using the three I’s model. Considering how many laws and policies shape reproductive autonomy, it was important to choose those laws that could be both meaningfully compared across jurisdictions and that exemplify law’s presence in tipping the scales for or against autonomy, leading to a public health law/legal epidemiology model. Drawing these laws together in the manner of legal epidemiology helps capture how infrastructural laws (such as maternity care deserts or for-profit hospitals), interventionist laws (such as laws banning abortion or insurance funding for in vitro fertilization [IVF]), and incidental laws (such as welfare laws) all work together to form a reasonable expectation of reproductive autonomy. Using this strategy means exploring the conditions that shape institutions and
environments (infrastructural), laws specifically targeted toward, or related to, the subject at hand (interventionist), and background conditions that shape practical access to legal rights (incidental). Laws that were binary are coded one or zero (for example, is there a state law banning self-mediated abortion: a zero is for no; a one is for yes). When there are different degrees of severity in a law, the law is coded out of one, as a one represents a complete restriction. For example, in waiting periods for abortions, the highest level is seventy-two hours (coded as a one), the next is forty-eight hours (0.75), then twenty-four hours (0.5), then eighteen hours (0.25), and, finally, no waiting period (coded as zero). This is done rather than weighting the categories to make a comparison without judging which variables may be more important in a given space or for a given person.

Abortion and Contraception Variables

This category was the most obvious starting point because the choice to become/not become pregnant is a clear measure of reproductive autonomy. Abortion and contraception variables capture the ability of people to access reproductive services such as birth control and abortion by examining the multilevel issues of geographic, legal, and economic access to these services. Variables in this category include laws on abortion as well as barriers to access in terms of physicality (for example, no abortion facilities) and economics (for example, Medicaid policies), with the notion that, if you cannot access a right, you do not have it. These variables were chosen based on the legal and political literature surrounding reproductive rights. Abortion and contraception variables include infrastructural laws like the percentage of women who live in an abortion care desert because many women lack transportation (Pruitt and Vanegas 2015; E. Nash 2019;
National Abortion Rights Action League 2019; Guttmacher 2020a). They also include whether there are clinic safety laws in place to protect those who seek access, likewise, whether there is a birth control desert, which are areas in which birth control is inaccessible or unavailable (Planned Parenthood Federation of America 2012; National Abortion Rights Action League 2019; Guttmacher 2020a).

In addition, these variables include interventionist laws like whether there is a law that requires emergency room physicians to dispense emergency contraceptives (such as Plan B, commonly known as “the morning after pill”) because emergency contraception needs to be given within a short time frame in order for it to work, and a doctor who refuses to give it is denying a patient their right to reproductive autonomy (World Health Organization 2018; Guttmacher 2020a; Kaiser Family Foundation 2020). It is within these variables that we first see the difficulty in discerning how autonomy looks as it relates to the state because, in some ways, state intervention prevents accessing rights (that is, making something illegal) and, in other ways, it guarantees it (that is, mandating that pharmacists provide prescriptions). Further, this category helps illustrate the role that the three I’s play in shaping whether we can reasonably expect practical access to a right that exists on the books.

Abortion and contraception variables also include whether state law requires that abortion seekers are referred to crisis pregnancy centers, which are often against abortion and give false information (for example, that abortion is linked to breast cancer) (National Abortion Rights Action League 2019; Guttmacher 2020a). Forcing abortion seekers to take time to go to these places and be required to listen to non-medical evidence based on religious views is ideological coercion based on religious-political
preference. This is an important category, especially for women living in rural areas who are often burdened by reproductive rights policies; any extra waiting period, information session, or requirement is a barrier of time, transportation, and money to anyone seeking what is nominally a federally protected right (Pruitt and Vanegas 2015). To really expose the legal framing, variables include whether there are mandatory ultrasound requirements for abortions and whether state law criminalizes self-managed abortion (E. Nash 2019; Center for Reproductive Rights 2020). For some people living in religious areas or those in abusive relationships, the privacy of self-managed abortion is essential to personal safety (National Resource Center on Domestic Violence 2021). Likewise, the anti-abortion targeted regulations of abortion providers (TRAP) that each state supports can be separated into three categories (as broken down by their evaluating priorities: hospital admitting privileges, reporting requirements, and facility restrictions (Center for Reproductive Rights 2020; Guttmacher Institute 2020b). These regulations are regarded by medical and policy experts alike as being political interventions and not medically necessary (Guttmacher 2020b; Mukpo 2020). This measure also captures whether there are restrictions on procedures and facilities that go beyond the TRAP laws (E. Nash 2019; Guttmacher 2020b). Further, this category also includes whether a pre-abortion vaginal ultrasound is mandatory (a particularly traumatic process for sexual assault survivors and someone facing a rape-related pregnancy) (Center for Disease Control 2020b).

Because birth control and abortion decisions can be governed by economic circumstances, variables here also consider economic barriers as they relate to reproductive autonomy (Oaks 2015; J. Nash 2021). These data were taken primarily from
the Guttmacher Institute (2020a), the National Abortion Rights Action League (2019), and the Kaiser Family Foundation (2020) and include whether a state offers coverage for prescription birth control and under what circumstances they provide Medicaid for abortions. As the Guttmacher Institute (2020a, n. p.) reports,

12 states restrict coverage of abortion in private insurance plans, most often limiting coverage only to when the woman’s life would be endangered if the pregnancy were carried to term…33 states and the District of Columbia prohibit the use of state funds except in those cases…where the woman’s life is in danger or the pregnancy is the result of rape or incest. In defiance of federal requirements, South Dakota limits funding to cases of life endangerment only.

A self-managed abortion is any abortion that takes place outside of a medical setting and is most often pharmacologically induced via prescription medication.

These factors also include whether insurers must cover abortion through state insurance exchanges (Kaiser Family Foundation 2020) or whether state employees can buy abortion insurance through the state insurance exchange (Guttmacher 2020a). Variables here also include whether private insurers are required to offer abortion coverage (National Abortion Rights Action League 2019; Guttmacher 2020a); whether abortion coverage is banned and under what circumstances (Center for Reproductive Rights 2020; Guttmacher 2020a); what level of restriction exists through the state health-care exchange (Guttmacher 2020a); bans on public insurance coverage (Guttmacher 2020a); whether the state follows federal standards of only funding abortion in life-endangering situations or rape/incest (Kaiser Family Foundation 2020); and whether they only meet the lowest bar of federal minimum requirements.

Pregnancy and Parenting Variables
By looking at pregnancy and parenthood, variables in this category come from reproductive justice literature and include the right not only to have, but also to raise, a child. Taking the discussion beyond abortion/contraception is also crucial because, while the right to not be pregnant has been the primary struggle of white women, Black women and Latinas especially have faced legal and social forms of policing that are ubiquitous and speak to a history of reproductive coercion (the opposite of reproductive autonomy) that persists often through forms of forced sterilization and other methods of interfering in the right to have children (Gurr 2015; Sundstrom 2015; Roberts 2017; Ross and Solinger 2017; Davis 2019; Luna 2020).

The history of eugenics that has led to forced sterilization and medical mistreatment plays a part in some of these variables, as does the understanding that foster care, adoption, and IVF are all ways to understand reproductive autonomy (Washington 2006; Oparah and Bonaparte 2016; Roberts 2017). Pregnancy and parenting include IVF access and lesbian, gay, bisexual, transgender, queer, intersex, asexuality, plus (LGBTQIA+) access in adoption and foster care. As Marcin Smietana, Charice Thompson, and France Twine (2018) have stated, LGBTQIA+ families may require alternate routes to reproduction, including IVF, foster care, and adoption, but they are not routinely included in IVF health-care policies, and many states allow legal discrimination against LGBTQIA+ parents in both foster care and adoption (LGBTMap 2020). IVF is an important variable because, even though some insurance companies may cover it, this coverage is often sporadic and not equal across the board (Kaiser Family Foundation 2020). Such coverage is usually predicated on a history of unprotected heterosexual sex that has not resulted in conception (Kaiser Family Foundation 2020). This is an extra
burden on LGBTQIA+ families as well as intentionally single parents who intend to conceive. IVF variables are broken down according to states that require private insurance to cover some kind of fertility services or at least offer one plan to do so. There is another variable that includes whether Medicaid is required to cover or offer coverage for fertilization diagnosis, treatment, or both (Kaiser Family Foundation 2020). Together, these variables question the parameters of rights and the law’s neutrality in the wake of legal blindness to the broad scope of reproduction. Additionally, as abortion policies attempt to define conception as the beginning of life, this will continue to complicate IVF both with regards to the embryos that exist and to the potential for miscarriage that may necessitate abortions for the health of the gestational parent.

Drawing from reproductive justice and public health literature, pregnancy and parenting includes variables relating to incarceration, which could be considered both infrastructural and incidental. The rate of women in prisons in the United States rose 832 percent between 1977 and 2007; the United States currently incarcerates more women than any other country in the world (Goodwin 2020). Variables relating to rates of incarceration are included because mass incarceration has specific effects on women’s health and on infant mortality rates (Maxwell and Solomon 2018). Because Black women have become particular targets of mass incarceration, and many of these women are mothers, it has become an important focus of public health research (Goodwin 2020; J. Nash 2021). This is an autonomy issue both in terms of the treatment of pregnant incarcerated people and because it is often the case that an inmate who gives birth is forced to place their child in a foster care system immediately (Juvenile Law Center 2018). The fact that the United States opts to incarcerate pregnant women in the prison
system—where women already face a unique vulnerability to sexual abuse and increased risk of miscarriage (Just Detention International 2018; Goodwin 2020; Amnesty International, n.d.)—exposes a place ripe for legal intervention. This measure includes statistics such as whether there is a state law that requires prisons to report the outcome of pregnant inmates, whether there is a law requiring pregnant prisoners to be given federally required nutritional needs, whether pregnant prisoners can be forced to give birth in handcuffs, and whether prisons are following the National Commission on Correctional Health Care’s guidelines for pregnancy counseling in prisons (American Civil Liberties Union 2021). Incarceration variables are particularly illustrative of state commitment to reproductive autonomy because measuring the state policy landscape by what rights privileged people can access only captures a measure of privilege, while measuring a state on its commitment to the most vulnerable and least politically powerful group shows a real commitment to autonomy (Enns and Koch 2015).

Birth Choice

Birth choice is separate from pregnancy and parenting because, in this category, there are both legal and health factors that intertwine in ways that are fundamentally different (Hill 2019). Variables related to policies in childbirth\(^\text{10}\) such as treatment in labor and delivery, which affect not only maternal mortality (Bailit 2012; Johnson and Rehavi 2013) but also the mental health and wellness of families (Diaz-Tello 2016), expose the ways in which the invisible hand of law and policy shape choices within

\(^{10}\) These are the rights as defined by state law and policy, not those in practice in hospitals, which are virtually impossible to quantify.
health-care options. Synthesized from the public health and medical literature on childbirth (Johnson and Rehavi 2013; Vedantam 2013; Gurr 2015), maternal mortality (Goodman 2014; Ross and Solinger 2017; Declercq and Shah 2018; Villarosa 2018), and birth outcomes (Diaz-Tello 2016), these variables were selected to represent autonomy in childbirth.

Factors that affect birth choice include whether someone lives in an area defined by the March of Dimes (2020) as maternity care deserts—namely, places where there are so few birthing hospitals that there is no choice of provider. Birth choice has been overlooked likely because it is seen as being unimportant where someone gives birth or the rights that one has when they do give birth. While it may seem like one hospital is the same as any other, hospital culture plays a large role in birth outcomes (Johnson and Rehavi 2013; Vedam et al. 2018), particularly for Black women (Roberts 2017; Villarosa 2018; Luna 2020) and their babies (Davis 2019), with Black babies being three times less likely to die when cared for by Black doctors (Greenwood et al. 2020). The choice of a birth attendant as well as the place also features in the medical literature as having a significant bearing on maternal outcomes (Bailit 2012; Johantgen et al. 2012; Vedantam 2013; Graham 2014; Cramer 2021), including whether or not Medicaid covers doulas (labor support professionals and advocates) and midwives, both of which have consistent and positive effects on birth outcomes (Birth Place Lab 2015).

Research has repeatedly found “a strong association between midwifery-led care for pregnant women and reduced labor and birth interventions” (Johantgen et al. 2012; Raipuria et al. 2018, 387). Unpacking legal choice exposes the legal construction of birth choice. To capture the true preference, birth choice also includes whether or not a state
allows home birth midwifery and offers licensure to certified professional midwives and lay midwives and whether the state restricts Medicaid to certified nurse midwives and whether they license certified midwives (Birth Place Lab 2015). This is an imperfect variable, however, because as Renee Cramer (2021) notes, licensing midwifery does not necessarily indicate state support for it or consumer access to it, but it does open up access (and, therefore, autonomy) by allowing homebirths and for other midwives to be covered under state insurance exchanges and makes a stronger case for those appealing to private insurance for coverage. In particular, the relationship between positive health outcomes and the presence of midwives (Johantgen et al. 2012; Raipuria et al. 2018; Vedam et al. 2018) and doulas (Gruber, Cupito, and Dobson 2013; March of Dimes 2020), as well as the research from organizations like the March of Dimes (2020) calling for those birth workers to be reimbursed through Medicaid and other insurance plans, underpins the ability of law and policy to shape reproductive options and childbirth experiences.

Health indicators that appear in birth choice are from medical literature and sociolegal studies like Birth Place Lab’s (2015) Mapping Midwife Integration project and the Local Reproductive Freedom Index representing interventionist laws (National Institute for Reproductive Health 2019). The rates of cesarean section, induction, spontaneous vaginal birth, and vaginal birth after cesarean (VBAC) rates are included because research shows that cesarean rates and rates of induction are not reflective of

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11 Certified nurse midwives are licensed in all fifty states and primarily work in hospitals and go through formal and standardized training; certified professional midwives are licensed in some states and not in others and attend home births; training varies by state but includes both formal schooling and alternative practice-based paths; certified midwives, often known as lay midwives, are often not licensed and come to midwifery through apprenticeship and less formalized pathways.
women’s birth preferences (National Partnership for Women and Families 2006; Center
for Disease Control 2020a) and are influenced by for-profit hospital status (Johnson and
Rehavi 2013; Vedantam 2013; Goodman 2014), which is a legal position as some states
do not have for-profit hospitals (Kaiser Family Foundation 2020). Additionally, these
variables represent non-evidence-based legal determinants of health because some
hospitals have policies that deny all patients from having VBACs, despite the American
College of Obstetricians and Gynecologists and the National Institute of Health
recommending against such bans. VBAC bans are likely underestimated, and, while the
International Cesarean Awareness Network (2009) has completed a study showing that,
in some states, over 50 percent of hospitals have such bans, there is no way to know what
the actual numbers are. Many hospitals without official bans have de facto bans, or
doctors who refuse to work with VBAC patients, so it is virtually impossible to fully
quantify the actual number of bans (International Cesarean Awareness Network 2009). If
these hospitals are also listed under the variable of maternity care deserts (as they often
are), this becomes a way of legally coercing someone to have a cesarean. Because law
and policy do not forbid or punish such policies, they are within the realm of legality that
shapes what options are available, including allowing hospitals to coerce major surgery
against the recommendations of the leading professional medical associations.

Background Socioeconomic Status Variables

Background socioeconomic status primarily represents those incidental laws, or
the legal determinants of health, that “are factors that lie beyond the individual but effect
the community level health outcomes, including culture, the economy, and corporate
systems” (Oakes 2008, 1518). These variables include economic and social policies that “provide opportunities for public health intervention through policy” (1518). The theoretical reasoning is that these background socioeconomic status variables, while not specifically targeted toward those who give birth, are still going to shape reproductive autonomy by shaping economic choices, structural violence, living conditions, and rights generally (Martin 2001; Morgen 2002; Gurr 2015; Sundstrom 2015; Pascucci 2019). Again, we see that the “law is all over” not just in abortion but also in procreation more broadly (Sarat 1990). As Laury Oaks (2015) notes, the decision whether to keep a pregnancy or a child can rest on socioeconomic status factors such as money, domestic violence, and culture, and emotional and material support are all incidental and therefore often excluded from studies of reproductive rights. Additionally, background socioeconomic status factors affect family and people of reproductive age, creating an environment where law is allowed to intervene in bodily autonomy and the family realm (Morgen 2002; Roberts 2017; Ross and Solinger 2017).

As the social determinants of health and reproductive justice literatures both contend, health equity and reproductive freedom are affected by social determinants, but it is important to point out that these variables are not just social but also legal in nature; emphasizing the legal nature of these determinants is a reminder that they are not accidental or unchangeable. These variables could include taxation policies and any number of economic and legal factors that might affect the health of populations (Putnam and Galea 2008) and generally concern the role of different parts of the political system (Galea 2007). As Jennifer Nash (2021), Loretta Ross and Rickie Solinger (2017), and Sillman and colleagues (2014) note, the connection between reproductive autonomy and
economics must be made clear, especially when considering economic assistance and tax policies that prioritize certain types of families.

Background socioeconomic status variables are the largest crossover between public health and socio-legal literature, and they comprise a necessary intervention to understand the scope of law and policy’s ability to affect what it means to have a reproductive right (Martin 2001; Morgen 2002; Diaz-Tello 2016; Upadhyay et al. 2014; Gurr 2015; Sundstrom 2015; Goodwin 2016; Roberts 2017; Ross and Solinger 2017; Declercq and Shah 2018; Pascucci 2019; Wright et al. 2018; Senderowicz 2020). The percentage of women in state legislatures is included because studies show that states with more women in government are more likely to consider “women’s issues” such as reproductive rights, family leave policies, and domestic violence legislation (Didi 2020) and how the state matters (Luna 2020), and it also reminds us that not only do the laws themselves matter but also the lawmakers as shapers of reproductive choices (National Conference of State Legislatures 2019).

Likewise, exploring the state’s role in constructing vulnerability, socioeconomic status variables explore the role of power imbalances with regard to domestic violence. Thus far, studies of the effects of domestic violence on reproductive autonomy have been primarily focused at the medical or individual level (Planned Parenthood Federation of America 2012; Center for Disease Control 2020b; Saravi 2020), but this becomes more valuable as more studies connect public and political violence to a history of intimate partner violence (Bosman, Taylor, and Arango 2019; Martin and Epstein 2021). The State Reproductive Autonomy Index uses socioeconomic status variables to explore the power of states in signaling their (un)willingness to protect domestic violence survivors,
which relates directly to reproductive autonomy. Exposing the failure of states to take
male violence, especially violence against their partners, seriously speaks to much of the
literature on intersectionality, privilege, and the law. If male partners can harm women
with impunity, then women can rightly see themselves as lacking in state protections and
not as full rights-bearing citizens with the same level of legal protections under the law
that is needed for reproductive autonomy to flourish. The ability of partners to leave
complicates this situation, especially when there are no protections to keep people from
being fired due to domestic abuse (for example, women being fired for being stalked at
work or for former partners showing up and threatening them). The ability to say “no” to
your partner regarding reproductive decisions and not to have the legitimate expectation
of violence against you is fundamental to reproductive autonomy. States that ignore this
element of protecting people, while restricting abortion and contraception access,
demonstrate in practice, whether intentionally or not, a commitment to male sovereignty
and female disempowerment.

Addressing the ability of women to leave an abusive relationship directly affects
reproductive autonomy because, according to the Center for Disease Control (2020b),
“almost three million women in the US will experience rape-related pregnancy during
their lifetime,” most often from intimate partner violence. Additionally, “of the women
who were raped by an intimate partner, 30% experienced reproductive coercion by the
same intimate partner. Specifically, about 20% reported that their partner had tried to get
them pregnant when they did not want to or tried to stop them from using birth control”
than 320,000 women are abused by their partners during pregnancy” each year. Further
the American College of Obstetricians and Gynecologists reports that one in six women first experience domestic violence during pregnancy. Likewise, in Louisiana, “domestic violence [that is, male partners] kills more pregnant women each year than any other cause” (Woodruff 2020, n. p.), and, elsewhere in the United States, it is in the top causes of death of pregnant women (National Institute of Health 2020; Woodruff 2020; Planned Parenthood Federation of America 2012). The uniquely vulnerable position of those individuals surviving domestic violence is exacerbated by the precarious economic position of pregnancy and motherhood, especially for mothers with young children (Planned Parenthood Federation of America 2012; Saravi 2020). As Norsworthy, McClaren, and Waterfield (2012, 65) state, gender-based power imbalances, especially in economics, are significant drivers of reproductive coercion, making seemingly incidental laws fundamentally important background conditions.

Further it is crucial to unpacking the politics of childbirth to understand the role of power and violence in the lives of women, several variables explore gun rights as they relate to reproductive autonomy, including where there is a gun ban for those under domestic violence protective orders, those convicted of misdemeanor domestic violence, sex crimes, or stalking and whether there is a firearm surrender order for those convicted of misdemeanors or specific incidences of domestic violence. These variables were included because one in seven women (and one in eighteen men) have been stalked to the point where they consider themselves fearful that they will be harmed or killed (National Coalition against Domestic Violence 2020; National Resource Center on Domestic Violence 2020).

With a reminder that domestic violence, intimate partner violence, and partner rape are often underreported (National Coalition against Domestic Violence 2020).
Violence 2021), and intimate partner violence accounts for half of all female murder victims (National Coalition against Domestic Violence 2020).\(^\text{13}\) This rate of murder is higher in pregnancy and failure to curtail the ability of known domestic violence perpetrators from access to weapons is another example of states protecting the right to commit violence over the right of family safety (Woodruff 2020).\(^\text{14}\) According to the National Coalition against Domestic Violence (2020), “most intimate partner homicides are committed with firearms…Abusers’ access to firearms increases partner femicide at least five-fold. When firearms have been used in the most severe abuse incidents, the risk increases 41-fold.” These variables measure the ability of women to experience autonomy (in this case, freedom from violence) in ways that affect reproduction. The diverse factors here flush out the contours of state commitment to reproductive autonomy and their willingness to intervene (or not) on behalf of vulnerable groups.

Understanding the position that economic freedom has in the choices that one makes, which are part of the background socioeconomic status variables, makes up more specific economic measures. These include whether there are employment protection or unemployment insurance benefits for survivors of domestic violence because states that protect domestic violence survivors are promoting autonomy (to leave the abusive relationship) and providing a legal safety net for parents and children to do so. In addition to interpersonal violence, this measure also includes institutional violence that keeps vulnerable populations vulnerable. Whether the state has a higher or lower average of women living in poverty or families with children headed by women living in poverty

\(^{\text{13}}\) Statistics were not easily available for trans or non-binary people, but trans people are subjected to higher rates of violence than the general population (National Coalition against Domestic Violence 2020.)

\(^{\text{14}}\) Additionally, the commonality among almost all mass shooters in the United States is a history of domestic violence (Bosman, Taylor, and Arango 2019; Martin and Epstein 2021).
indicates whether states prioritize family wellness and shapes a person’s choices with regard to having a child, carrying a pregnancy to term, or raising rather than giving up a child (Oaks 2015). Additionally, the gender wage gap and an above average number of women workers in the lowest quartile of wage earners, and whether or not the state has policies for pregnancy and birth-related family leave, indicates the autonomy to have a child and maintain economic security (Status of Women 2015). What socioeconomic status variables also do is complicate the discourse about reproductive autonomy by widening the field to include factors that create the background conditions for autonomy to exist and flourish. To add to the difficulty of political discussion, having reproductive autonomy is not as simple as saying “autonomy from state interference” since sometimes to have reproductive autonomy requires restrictions or tipping the scales in favor of one policy or another. Ultimately, this is why this dissertation takes no normative position on interventionist or non-interventionist states and prefers to consider how to determine the substantive effects of intervention on autonomy.
Figure 1: Barriers to Reproductive Autonomy by State.

Exploring the Reproductive Autonomy Landscape: States of Inequality

If there is a “floor” of constitutional rights, then what falls below that floor is unequal access to that which citizens are entitled. This type of legal mapping, with its emphasis on interventionist policies as well as incidental and infrastructural laws across related policy areas, exposes the ways in which states choose to approach the floor, and how they do so can mask a lack of access to rights and justice. The State Reproductive Autonomy Index offers a way to visualize inequality between states on matters of reproductive autonomy. Looking at the wide difference of reproductive autonomy among the states, we see 21 percent of barriers to autonomy in the lowest scoring state (California) and 87 percent in the highest (Mississippi). The substantial scope of inequality suggests that something very dramatic is going on with the distribution of reproductive autonomy and warrants a broad structural inquiry into how equal rights can
exist so unequally, which brings us back to conversations on legal pluralism and what it means for equal rights. Looking at the measure in aggregate, as Figure 1 does, allows us to look at the subnational variation across the reproductive autonomy landscape. Figure 1 represents the aggregate total of all categories within the State Reproductive Autonomy Index based on variables between 2019 and 2021 (all data were taken from the most recent year available). Because a lower number indicates fewer barriers and more autonomy, a lower score equals a more autonomous state. States are color-coded with darker states having more barriers (and less autonomy) and lighter states having fewer barriers (and more autonomy).

### Table 1: Typologies of States

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<th>Very Restrictive</th>
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Drawing attention to the wide range between neighbor states brings us back to legal pluralism and questions about what this means for access to rights (31 percent in Washington versus 33 percent in Oregon; 72 percent in Idaho versus 40 percent in New Mexico; and 77 percent in Texas versus 80 percent in Oklahoma). Figure 1 shows that, in
some ways, traditional blue states (most of New England and the West Coast) have fewer barriers to autonomy, while traditionally red states (Mississippi and Texas) have more. This is not unexpected in terms of reproductive autonomy, but it does also call into question the false dichotomy of calling some states “nanny”—or intervention heavy—and some libertarian states because those labels do not appear to show libertarian “hands-off” policies in conservative states or nanny-esque meddling in liberal states. The ideology for or against restricting personal liberties used in typical polarized discourse is not evident here (Rhodes and Vayo 2019); rather, we are seeing a matter of which—and whose—liberties are restrictable in each state, and those with higher percentages show a willingness to restrict autonomy when it comes to reproduction.

To show which states are restricting whose rights, Table 1 offers typologies based on where each state fell when measuring the disaggregated subgroups (abortion and contraception, pregnancy and parenthood, birth choice, and socioeconomic status). When looking at the totals in the subgroups, very restrictive states are in the fourth quartile three or more times, restrictive states are in the third or fourth quartile three or more times, and toss-ups are split evenly between the second and third quartile. Open states are in the first or second quartile three or more times, and very open states appear in the first quartile three or more times. Five states are listed as wild cards, meeting none of the criteria above and showing a wide range across the variables (for example, South Dakota is in the second quartile on background socioeconomic status and birth choice, but in the fourth quartile on abortion and contraception and pregnancy and parenthood). Table 1 offers a companion way of looking at the national map because it exposes the ways in which some states have higher or lower numbers in aggregate because of particular policy
parameters; the typologies break through this portrayal and show the larger patterns that can be masked by the aggregate.

Abortion and Contraception

Figure 2: Abortion and Contraception Barriers by State.

An obvious driver of high percentages in many states, the abortion and contraception variables range tremendously from 3 percent in California to 81 percent in Texas, Louisiana, Oklahoma, and South Dakota. What is concerning about this from a legal pluralism standpoint is that abortion and contraception variables represent those most litigated in state and federal courts and those covered by federal law, illustrating Sandra Levitsky’s (2013) concern that constantly litigated rights may not be rights at all. Many of the other variables relate to social policies typically reserved for the state governments to decide; however, abortion and contraception are supposed to be governed by some level of federal floor, but what Figure 2 shows is that this is not the case.
When exploring the connection between legal pluralism and rights, this part of the findings even more than others highlights the way in which law is used to deny rights or expand them based on the political climate and questions whether federalism can sustain such inequality. Further, Figure 2 exposes some of the dangers that much on the country will face if the US Supreme Court overturns Roe v. Wade. Figure 2 is the map of abortion and contraception barriers when there are laws in place guaranteeing access to these rights; without a federal law to even nominally limit state ability to restrict them, this map could look far more unequal. One could look at access in some of these states as matters of geographical difficulty where larger states and rural states in the West and South have a harder time creating abortion clinics to serve rural and sparsely populated areas, but, given that rural states in New England, like Maine, and states that are geographically large and also have rural, sparsely populated areas like New York, California, and Oregon, it would indicate that abortion clinic deserts and lack of access to abortion and contraceptive care are policy choices where political will, rather than geographical constraints, matter more. This is especially obvious in neighbor states like Montana that share some politically conservative values and geography-population barriers to policy with North and South Dakota, but Montana has only 31 percent of barriers and North and South Dakota have 81 and 77 percent respectively. Neither widespread political values, states’ rights ideologies (Enns and Koch 2015), or geographical conditions appear to be driving the differences (in fact, the neighboring states are similar in all other subcategories); instead, it appears to be attitudes about abortion and contraception particularly.

Pregnancy and Parenthood
Looking at pregnancy and parenthood reveals many barriers to becoming parents. The pregnancy and parenthood variables raise questions about what it means to be a “family values” state and, indeed, how willing states are to regulate what counts as a family. The pregnancy and parenthood totals indicate that those states that regulate abortion and contraception so thoroughly do not appear to support parenthood and are also likely to restrict autonomy in pregnancy and parenthood. This lends credence to the feminist argument that restrictions on abortion and contraception are about controlling bodies, choices, and autonomy and not about valuing families and children. If states were pro-child and pro-family, the path to parenthood would be clearer and more accessible, including IVF and in foster and adoption care, but as Dorothy Roberts (2017) and Harriet Washington (2006) have pointed out—from eugenics and sterilization to welfare policies (Briggs 2017)—states have a history of using laws to decide which groups are “fit” to
become parents and get support (Oaks 2015; Oparah and Bonaparte 2016; J. Nash 2021)—either positively (access to economic/insurance help IVF) or negatively (denying access to birth control or abortion).

As Laura Briggs (2017) and Julia Oparah and Alicia Bonaparte (2016) explain, reproductive autonomy in pregnancy and parenthood takes many different forms and are shaped by social factors from community engagement to economic policies. When those policies exclude some parents from IVF based on income, that is the state declaring that poor people do not deserve to reproduce and people with means do. Likewise, as Zakiya Luna (2020) contends, the right to have a child is a human right, but that right has been strictly controlled by who has access to money, medical technologies, and the benefit of the law. Figure 3 reveals that some states have developed a strong policy of excluding families, particularly those seeking financial help in conceiving and those who are LGBTQIA+. Looking at Figures 2 and 3, we can see that, in states where abortion is regulated and adoption is seen as a suitable alternative, adoption itself is still regulated by who the state sees as “fit.” States like Mississippi (100 percent use of barriers) and Alabama (92 percent use of barriers) are very restrictive in their typology and are in the higher states when it comes to abortion and contraception and are among those that use the rhetoric of family values, but when looking at those states that use fewer barriers to parenthood, we see the more liberal states of Connecticut (23 percent use of barriers) and California, New York, and New Jersey (31 percent use of barriers) among those providing benefits to families. This data empirically challenges the rhetoric of family values as evidence of policies that value families.
Birth Choice

**Figure 4:** Barriers to Birth Choice by State.

Figure 4 shows the situation with barriers to birth choice. Birth choice is an area that closes the inequality gap among states because most states are restrictive in some way. In this group, no state is in the bottom quartile, and almost all states use 50 percent of the barriers or more, meaning that, even in politically liberal states, which use fewer barriers overall, birth is still regulated and restricted at higher levels. This is an area that showcases the ways in which politics, and not medicine, shape access to rights and autonomy in childbirth. Even a state like California, which has made a sustained effort to end maternal mortality and lower cesarean rates, uses 50 percent of the barriers. States where we see higher maternal mortality rates like West Virginia, Kentucky, and Mississippi all use 90 percent of the barriers to autonomy in childbirth, supporting both the social determinants of health contention that non-clinical factors shape health outcomes (Goodman 2014; Diaz-Tello 2016; Ross and Solinger 2017; Declercq and Shah...
2018; Villarosa 2018) and reproductive justice theories on the role of state policy and attitudes toward those who give birth as effecting health outcomes broadly (Ross and Solinger 2017; Davis 2019; Luna 2020; J. Nash 2021).

For birth choice to be this regulated brings all states up in the final calculation of barriers, so even typically low states like California get a bump in the aggregate. More than any other group, birth choice variables illustrate why it is important to explore the disaggregated categories. California is generally in the bottom five of the barriers in each category, but here they are closer to the median restrictive state, highlighting the need to disaggregate the data when one is looking at particular policies. Conversely, Florida is often in the top quartile, but is relatively low here. State priorities in policy to support reproductive autonomy as judged by the other three groups but lacking here indicate that birth choice is an even more invisible category than other barriers.

Background Socioeconomic Status
**Figure 5:** Background Socioeconomic Data.

A key component of understanding the landscape against which reproductive autonomy happens is the background socioeconomic status. Figure 5 identifies background socioeconomic status and exposes the ways in which social and economic policies in each state can shape reproductive autonomy. Socioeconomic status barriers create conditions that affect health and wellness (Putnam and Galea 2008; Maxwell and Solomon 2018; Coggon 2020), exacerbate racial disparities in maternal care and parenting (DeClercq and Shah 2018; Roberts 2017; Kawachi, Daniels, and Robinson 2005), and shape economic conditions that affect access to abortion.

Drawing from reproductive justice theorists on the role of reproductive rights as human rights (Ross and Solinger 2017; Luna 2020) and the role of welfare policies (Briggs 2017), this group of variables captures the conditions that make reproductive autonomy possible. These variables are ones that could be most clearly identified as those that value families, where the state literally values families by providing financial benefits or protections and values families in terms of protecting them from the threat of violence. Not only do the totals on this map suggest that families are valued very differently across states but that those states known for using the rhetoric of family values in abortion and contraception are not using the policies of family values in socioeconomic status factors. Because so much of this measurement includes socioeconomic data, it makes sense that poorer states would score as using higher barriers (because they would lack the money to provide social safety nets), though those states could access federal funding for many of the variables measured. However, states that also have shown resistance to the Affordable Care Act score lower in this category as well, showing that political will surrounding
particular issues as well as political mood generally can shape state choices for or against reproductive autonomy (Enns and Koch 2015). The inclusion of domestic violence and gun violence variables are not explained by economics but, rather, by ideology. States that have higher gun rights ideology and lower economic ability, score very high on background socioeconomic status overall, like Mississippi (93 percent), Idaho (86 percent), and Kentucky (89 percent). However, states like Texas (68 percent) manage to be pro-gun without being scoring a high number of barriers because there are a number of protections on other metrics.

**Conclusion: The Politics of Childbirth and Rights in Disarray**

In one of his last skits before his death, comedian George Carlin references Japanese internment during the Second World War, saying that this event proved “there’s no such thing as rights :::: rights are an idea, they’re imaginary.” Using legal mapping to visualize the extent to which legal pluralism results in wildly different legal realities and access to rights, one wonders whether the famously cantankerous comedian is correct. The State Reproductive Autonomy Index provides a comprehensive view of the state variation in access to reproductive autonomy across the United States as well as a more nuanced understanding of the landscape as it shapes access to rights in specific reproductive areas. Legal pluralism where customary law or norms collide with law on the books is a matter for societies to navigate as part of the life course of law and does not necessarily represent a lack of rights; however, within a single constitutional federal republic, when there appears to be no floor of equal protection, legal mapping can cause

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15 Affordable Care Act, March 23, 2010, 124 Stat. 119
us to ask whether legal pluralism is the guise for denying rights to people in areas that
governments simply do not want to allow.

With this larger politics and policy landscape in mind, Massachusetts can be seen
both as a fairly typical state (it falls in the median range on most measures of
reproductive autonomy) and an atypical one (being less religious, more politically liberal,
and more open economically). The ways in which different elements of reproductive
autonomy play out offer us some context into understanding the qualitative experience
more fully. Similar interviews in politically states might produce similar results, but in
more religious state or states that are more comfortable using religion to make political
decisions attitudes about childbirth would likely be different. This makes a quantitative
context a starting point for choosing comparative case study sites for future research.

The State Reproductive Autonomy Index allows us to calculate what equality
looks like at the state level, offering a way to compare states on interlocking policies and
explore the limits of legal pluralism’s inequality. Creating state profiles gives policy
makers and activists in each state a context and scope for discussion. While the method is
useful to scholars as a roadmap to pull out the interlocking structures of other persistent
and widespread political-legal issues, this index is also useful to social scientists broadly
because reproductive autonomy is a crucial part of a person’s rights. Reproductive
autonomy shapes the lives of every person on the planet—because even those who do not
give birth are born—and all people who present as women and anyone with a uterus must
live in a context that may regulate their choices during their presumed reproductive years.
Using the State Reproductive Autonomy Index itself will be a way for researchers to
categorize the status of women and families in any given state.
Understanding the role of the politics of childbirth and institutionalized birth is a massive undertaking that requires multiple perspectives, methods, and ways of seeing the problem. As epistemic justice scholars remind us, how we see a problem is determined by what we are trained to see. Seeing reproductive autonomy is one step in seeing the role of institutionalized childbirth. But it is also important to understand that any policies which seek to address epistemic collaboration, institutional betrayal, obstetric violence, or any of the barriers to reproductive autonomy will have to contend with the context in which they are situated.
CHAPTER 3: INSTITUTIONALIZING BIRTH: MATERNAL MORTALITY, MEDICAL MISTRUST, AND CULTURAL HEALTH CAPITAL

As a continual outlier in maternal health and wellness, the U.S. approach to childbirth has come under scrutiny from national and international organizations for the past decade. The persistence of the maternal mortality crisis despite longstanding evidence that it exists and can be prevented is a significant feature of the politics of childbirth, which at its core is a matter of public health. Before the subsequent chapters which rely on individuals’ perceptions of their experiences, this chapter outlines the background social and institutional dispositions that shape the public health and policy elements of the maternal mortality crisis, how people are treated in pregnancy, and how that filters into shaping the contours of the politics of childbirth. Because understanding the structures of power helps us to understand the agency of actors within that structure, this chapter offers a brief history of the institutionalizing childbirth. Starting with a history of paternalistic attitudes towards pregnancy and birth and then moving into a history of the institution of childbirth, this chapter grounds the problem of the politics of childbirth historically.

This chapter explore the institutionalization of childbirth and how the setup of the U.S. maternity care system has specific effects on childbirth. Legal pluralism shapes the different policies and laws that are in place in reproductive autonomy, but institutionalized childbirth interacts with law and policy differently than homebirth or out of hospital births. As law’s pluralism moves through different states and policy realms, it also moves through different childbirth settings. Concerns about liability and litigation can shape all birth environments, with birth centers and homebirth midwives often having
to refuse patients who are considered in higher risk categories. But within the context of hospitals versus birth centers or home birth, out of hospital birth environments are often set up with more one-on-one patient provider care (especially homebirth where there can frequently be more than one midwife and only one patient). Who can birth where and under what circumstances are shaped by legal guidelines, whether certifications for medical professionals or health and safety regulations. The governing laws become more difficult to interpret with parents who prefer a more anarchist style of giving birth known as freebirthing. While there is an assumed risk to give birth entirely unattended by medical professionals and it is not illegal in the United States, there is in a grey area if there were negative outcomes involved. The maternal mortality crisis alone raises questions about the state of its perinatal care broadly. Currently, the Centers for Disease Control and Prevention (CDC) terms the U.S. as having severe maternal morbidity which: “includes unexpected outcomes of labor and delivery that result in significant short- or long-term consequences to a woman's health.” In the U.S., “more than 50,000 American women are severely injured as a result of childbirth on an annual basis” (Declercq and Zephyrin, 2020.; Sebelius and Thompson, 2021; Young, 2021). As of 2011, the US was “among just 23 countries to see an increase in maternal mortality” (Amnesty, 2011, p. 3), and this trend has not stopped despite decades-long awareness of the issue (Chmielewska, et. al., 2021; Declercq and Zephyrin, 2020). Repeated studies from state maternal mortality commissions have confirmed that over half of these deaths could have been avoided; in fact, the Tennessee Department of Public Health reported that up to 85% of maternal deaths in Tennessee were preventable (Tennessee Department of Public Health, 2018). In 2022, NPR cited a CDC study saying 4% of maternal deaths
are preventable, particularly those in the “fourth trimester” (Dembosky, 2022). An NPR study found that “for every woman who dies in childbirth in the U.S., 70 come close” (Montagne, 2018).

**Life, Death, and the Maternal Mortality Crisis**

In *Deadly Delivery*, Amnesty International confirmed what non-hospital-based birth workers as well as concerned obstetricians, nurses, nurse-midwives, and parents have been reporting for years: the US is a dangerous place to be a pregnant person (Bradley 2018; Goodman, 2014). In fact, “although the US spends more than any other country, it ranked 41st (at the time of publication) in terms of maternal death…[and] Half of these deaths are preventable.” These maternal mortality rates are three to four times higher for Black women (Declercq and Shah, 2018; Martin and Montagne, 2017; Sebelius and Thompson, 2021; Villarosa, 2018). As NPR reports:

American women are more than three times as likely as Canadian women to die in the maternal period…six times as likely to die as Scandinavians. In every other wealthy country, and many less affluent ones, maternal mortality rates have been falling…But in the U.S., maternal deaths increased from 2000 to 2014. In a recent analysis by the CDC Foundation, nearly 60 percent of such deaths are preventable (Martin, 2018).

The United States is quantifiably the most dangerous wealthy democracy in which to give birth (Amnesty International, 2012; DeClercq and Shah, 2018), and it has the highest rate of maternal deaths in the industrial world.

Understanding why this preventable crisis keeps happening and might be getting worse can offer pathways to stave off these increases. It is important to remember that many of these deaths are preventable and that the U.S. is an outlier to comparative countries. Birth is not without risk and even under perfect conditions, not all maternal and
neonatal deaths can be prevented. As importantly, the maternal mortality crisis and the
fact that it is preventable are a widely known issue and enjoys perennial press and social
media attention when a famous person like Serena Williams or Beyonce describe their
own experiences. Williams’ interviews on both television and in print brought wide
attention to the issue of maternal mortality, especially because she is in remarkable
health. As she discussed in the interview, her medical history of blood clots was on file
with her doctors, but despite her health, wealth, and medical history, she was still forced
to self-advocate in order to prevent blood clots in her post-partum time in the hospital
(Williams, 2022). It is not a lack of knowledge about the problems that allows the
problem to persist.

Scientists and medical researchers have proposed policies and practices that can
save lives in childbirth, but judging by the continued maternal mortality crisis there is
something missing from these solutions. Medical researchers and social scientists have
implicated law, politics, and society:

discrimination; financial, bureaucratic, and language barriers; lack of information
about maternal care and family planning options; inadequate staffing and quality
protocols; inadequate postpartum care; and a lack of accountability and oversight
(Amnesty, 2012, p. 3).

These barriers are reproductive politics and the politics of childbirth in action; they are
created and shaped through law and policy in ways that are unmistakable. How hospitals
are allowed to staff (e.g., patient to provider ratios), whether some types of birth are
restricted (e.g., bans on vaginal birth after cesarean section), whether postpartum care is
accessible economically through insurance, and accountability and oversight, all factors
that are shaped by law.
“Proof of Male Potency”: How Attitudes Towards Pregnancy Shape the Politics of Childbirth

Studying narratives of birth is important for what they reveal about attitudes towards birth, including whether birth is a natural event or process that occasionally needs medical or technical intervention, or whether it is a medical and potentially dangerous event that should take place under the care of professional with quick access to technology or something in between where patient and provider can collaborate on the amount of technology and interventions. Likewise, studying from the ground up offers a way to see who really has the last word on what interventions will be used in labor and delivery and how treatment of patients can shape outcomes. Given that patients who have negative health experience are less likely to seek follow-up care (Perrotte, et. al., 2020; Wudneh, et. al., 2022), understanding how people perceive their treatment in labor and delivery can offer insights into ground-level solutions to maternal mortality and expose how the lived experience of childbirth can affect the maternal mortality crisis.

Figure 1 illustrates why it is important to consider patient experiences when talking about maternal mortality. As the CDC (2022) notes, over half (53%) of maternal deaths occur outside of the hospital. As Benkert (2018), Bogart, et. al, (2021), and Williamson and Bigman (2018) note, people’s willingness to return for follow-up care is shaped by their trust in the medical industry. Thinking about this role of medical trust in shaping people’s decisions offers more complex way to understand public health issues in general, and birth specifically. In the simplistic view, the process is that someone has postnatal complications so they go to the hospital. But public health research repeatedly indicates that health problems are not sufficient conditions for attempting to access or
accessing health care. What the social determinants of health told us is that there are other necessary conditions for people to access health care. While postpartum distress would be a sufficient cause for accessing care, within the health care system there are mediating variables that shape that access. These include which include geography (does someone live in a maternity care desert?), law and economics (does this person have health insurance?), and social support (Is there child care available?).

![Diagram](image.png)

**Figure 6:** The Role of Trust in Healthcare Decision Making

What the experience-conscious model adds is that even if all of the necessary conditions are met through law, policy, and society, there is still the barrier to trust. People will go to the hospital if they think it will benefit them. If they do not trust the
hospital or feel the hospital will cause more harm, then trust becomes a barrier is that even if we take into account all of those social determinants one of the most important, mediating variables is that people have trust. That they think going to the hospital is not going to do them more harm (Benkert, 2018; Bogart, et. al, 2021; Williamson and Bigman, 2018). Knudson-Martin and Silverstien (2009) track how social attitudes towards motherhood prevents people from reporting postpartum depression and increases maternal fear of losing their children if they do report their depression. This was especially high among lesbian mothers (Alang and Fotomar, 2015) and Black woman (Harp and Bunting, 2019; Sampson, et. al., 2017). When parents mistrust medical institutions or medical professionals, it increases the risk that, even when the social determinants of health are equitable, they may not access life-saving care. As in other areas of health care, notably, vaccines. Despite vaccine equity programs, distribution, and economic incentives, those who mistrust medical systems even when the structural barriers are removed will still not access potentially lifesaving care.

Understanding the social role of pregnancy and the politics of childbirth helps to illustrate the factors that are not medical as they shape childbirth and people’s choices. In few places are attitudes about motherhood more revealed than discussions around abortion. Legal until the late 1800s, the arguments to make abortion illegal relied on two arguments: white women were not having enough children compared to other races and women could not be trusted with the decision because male doctors understood the female body better than women (Abdelfatah and Arablouei, 2023; Ross and Solinger, 2017; Washington, 2008). The case against abortion was also linked to sexual purity and morality/religion in order to garner more support (Abdelfatah and Arablouei, 2023), but
the key feature was a mistrust of women and a desire to keep them from exercising autonomy. These attitudes about what pregnancy is filter into how pregnant people are treated (and regulated) including in childbirth.

In more recent history, in 1970, Dr. George S. Walter summed up the anti-woman sentiment at the core of the anti-abortion argument in his piece for the Journal of Obstetrics and Gynecology:

the pregnant woman symbolizes proof of male potency and if the male loosens the right to dispose of that proof when they want to, the men then feel terribly threatened lest woman can, at will, rob them of their potency and masculinity (Walter, 1970).

Walter’s article did not cloak itself in morality as do contemporary arguments that ensoulment\textsuperscript{16} occurs at fertilization. Walter expressed a straightforward belief that giving women reproductive autonomy was a problem because it challenged male supremacy in the reproductive arena. That this statement was published in a leading professional medical journal could seem like a relic of life before women’s liberation, but attitudes of male supremacy and female passivity are still thriving in many discussions of reproduction and cannot be disentangled from the institutionalization of childbirth. Such attitudes shape the politics of childbirth, so they warrant some discussion here.

Examples of this male supremacist ideology include the 2014 comments Virginia Representative Steve Martin posted on Facebook referring to: “the child's host (some refer to them as mothers)” (Hill 2019). Likewise in 2017 Oklahoma lawmaker Justin Humphrey saying, “what I call them is, is you’re a ‘host’” (Hill 2019) referring to

\textsuperscript{16} The time at which a human being develops a soul; the time is defined differently across and within religious beliefs (Gowri, 2013).
mothers. In 2019, Florida representative Jose Oliva further serves as a reminder that Walter’s primitive ideas about women’s bodies persist: “there’s a host body and that host body has to have a certain amount of rights because at the end of the days it is that body that carries this entire other body to term” (Hill 2019).

The notion of woman as host has real-world consequences for pregnant people. Pregnancy in the U.S. is policed at extreme levels\(^\text{17}\) (Cramer, 2021; Nash, 2021; Woolsey, 2015). At least thirty-eight states have “feticide” laws on the books (NARAL 2019), many of which may be deployed with physician or law-enforcement discretion to criminalize miscarriage. Cramer (2021) notes that much of the surveillance and power politics that shape the politics of childbirth begin in policing pregnancy. The pervasive belief that women should have fewer rights to bodily autonomy while of reproductive age is entrenched in this host ideology where women are passive participants. These beliefs shape institutionalized childbirth because they were the foundational beliefs about moving childbirth from care of female providers (midwives) to male providers (OBGYNs) and remain undercurrents in many hospital policies (Cramer, 2021; Hill, 2019). Further, the host ideology reinforces the historic stereotype of women (especially pregnant woman) as not rational, and it gives people in positions of power opportunity to determine who is a fit or safe parent based on the women’s level of compliance (Briggs, 2017; Nash, 2021).

As the field of obstetrics becomes, in some places, majority female, it will be interesting to view the shifts in practice and response to practices. While female

\(^{17}\text{More on this in Chapter Two.}\)
OBGYNs are become the majority in the field itself, “women are still underrepresented in department leadership roles” and most positions that would allow them to train future practitioners (Ricciotti, et. al., 2017). However, there are geographical differences in this, for instance, in the West women are overrepresented in positions of department and academic leadership, while the are underrepresented most in the South and slightly in the Northeast (Ricciotti, et. al., 2017). It is unclear how much this will change patient experiences and expectations, though because while a majority of women first request a female OBGYN, according an ACOG study, they view men as more technically competent and women are 47% less likely to be rated highly on their skills (Tobler, et. al., 2016). While Bacon’s (2008) study reported that patients prefer women because they believe women are less likely to suggest surgery and intervention, gendered attitudes shape how patients are choosing and interacting with physicians.

The institutionalization of childbirth paired with the prevailing winds of reproductive politics that delimit women’s autonomy do not create an environment of collaborative care which is related to maternal mortality. The US is facing a maternal mortality crisis that is neither comparable to other industrialized democracies nor explainable by ill health of the US population (Amnesty, 2012; Declercq and Zephyrin, 2020). Further, the politics of childbirth are exacerbating the maternal mortality crisis and, attitudes like Humphrey and Olivia’s that confine women to hosts rather than autonomous adults, are creating conditions that make it difficult to implement solutions to the crisis.

Public health data exposes the scope of the maternal mortality crisis, and into that research stream, this chapter adds an understanding of how the US is an outlier in global
health practice and outcomes. Through discussion of the historic forces that have shaped the current moment, this chapter offers a look at the institutionalizing of birth over time, then links this institutionalization with a mistrust of women broadly while pulling out how both that mistrust and the institutionalization of birth shape the maternal mortality crisis. The role of midwives and technology and the uncertain access to collaborative care in maternity practices will be a key feature of this chapter, which will lay the foundation for the rest of the dissertation.

**Patriarchy, Technology, and the Institutionalization of Childbirth**

Institutions have been defined as groups of rules and practices (either formally in law or informally as norms), that are intended to shape (often constrain) the behaviors of individuals and groups (Grief and Laitin, 2004; Knight, 1992). Laws and social conventions are in themselves institutions (Knight, 1991). It is through these institutions and practices that social customs and power are preserved throughout generations (Bourdieu, 1979). Looking at childbirth through its historical development offers a way to understand how the institutionalizing childbirth has become difficult to challenge.

**Women in the Field: Midwives, Doulas, and Nurses**

In birth, surveillance and control are closely linked with the history of bringing birth from home/midwives to hospitals/obstetricians. Understanding the history of childbirth and the role of midwives over time exposes several important things: the role of politics and economics in childbirth policies, the historic and contemporary marginalization of women in the birth profession, and the outsized role that technology and an institutionalization of birth have on the experience of childbirth. The history of
midwife exclusion and the political fights about their re-emergence (Cramer, 2021) are a microcosm of social-political issues in childbirth today.

While bringing birth into hospitals was a public health intervention that decreased infant and maternal mortality, the move towards institutionalizing perinatal care under the primarily male dominated field of obstetrics was also a political choice meant to increase profits for obstetricians and remove birth from the control of women dominated practitioners, who were predominantly midwives (Cramer, 2021; Hill, 2019; Leavitt, 1986; Wagner, 2016). Consider that a fully patient-centered shift to hospital birth would have included the knowledge, authority, presence of midwives, as practiced in other countries that still experience lower maternal mortality and have midwives integrated into their health care system. But instead in the US, midwives were systematically excluded and, in some cases, criminalized (Cramer, 2021; Leavitt, 1986; Wagner, 2006). While today’s doctors likely do not have this history in mind, the history shapes institutional practice and professional expectations in scope of responsibility and who has authority in a room. The longstanding attitudes towards hierarchy in the field, the decades-long exclusion of midwives from practicing in hospitals, and the reliance on medical technology rather than patient reports of their progress stem from this institutional and professional history.

As Cramer notes, “By 1913, the AMA (American Medical Association) had created the Propaganda Department, which helped to develop, by the 1920s, a campaign to eliminate midwifery…doctors launched a vicious smear campaign to delegitimize the practices of African American and immigrant midwives. They were called ‘dirty’ and ‘disease-laden’” (p. 46). The idea of midwives as dirty still persists among those who do
not consider homebirth midwives to be educated medical professionals (Cramer, 2021). Ironically, these anti-midwife or “Mad-wives” attitudes persist despite the prevalence of doctors who choose home birth. This conceptualization of midwives as incapable, dirty, dangerous, and uneducated paved the way for their exclusion from professional birth work shaping attitudes that still persist about midwives, patient-centered care, and medical technology.

In 1930, the American Board of Obstetricians and Gynecologists (ABOG), formalized the connection between the previously separate obstetrics and gynecology\textsuperscript{18} fields (Wolf, 2018). As a first move, the ABOG relegated certification to attend births to their specific group, angering not only midwives but general practitioners (Wolf, 2018). Yet, these primarily male general practitioners, were able push the ABOG to create and offer a certificate in family practice so they were able to continue attending births, even while the all-female midwives were directly targeted and shut down (Wolf, 2018). This move is a strong indication that the issues at hand was rooted in misogyny as much as economics or health and safety. Into the mid- to late 1900s, the ACOG (American College of Obstetricians and Gynecologists, as the ABOG changed its name) continued to push to limit and discredit midwifery and consolidate power under what was, until recently, a male-dominated field. Formalizing the field in such a way was intended to secure status, promote economic benefits/provide new clients, and legitimize the obstetrics industry (Brodsky, 2008; Drife, 2002), which by the 1950s had a considerable lobbying power (Wagner, 2006). The attitudes that left women’s experiences out also

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\textsuperscript{18} Gynecologists handle a much broader scope of care for women and those who are assigned female at birth. Gynecologists for instance, will handle fibroids, infections, routine tests, and such. Obstetricians are more specialized in their care of pre-conception, pregnancy, childbirth, and immediate postpartum care.
resulted in policies and practices that tried to control birth and paved the way for medicalization and technological intervention that significantly shapes birth in the US still.

Ehrenreich and English (2010) note that, as doctors began attending births, they wanted to “man the field” and remove midwives from it, and ideology that still persists today in the U.S.’s conspicuous dearth of midwives compared to other OECD countries (Tikkanen, et. al., 2020). Indeed, even in early training, nurses were not welcomed into the field by male doctors early in their professional development (Ehrenreich and English, 2010). Nurses in training were told to earn physicians’ trust by not doing anything, including helping dying patients, without the specific permission of the doctor; and it was this docility that finally allowed doctors to accept women nurses into their field (Ehrenreich and English, 2010), a compliance that midwives did not share (Cramer, 2021; Wagner, 2006; Wolf, 2018).

The doctor-nurse hierarchy is baked into the professional history and still exists in medicine, and in hospitals, through practice, habit, and professionalization. But today it takes the shape of policies that require even certified nurse midwives and nurse practitioners,19 to practice under the guidance of OBGYNs. Yet, nurses and certified nurse midwives are still seen as lower on the hierarchy than doctors in hospital policy and scope of practice (Wagner, 2006). For instance, in some hospitals nurses are not allowed

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19 Certified Nurse Midwives, or CNMs, are hospital-based midwives who receive specialized and nationally standardized training after receiving a bachelor’s degree in nursing (Cramer, 2021). All fifty states license them to practice, and they are rarely allowed to attend home births as a scope of their practice (Cramer, 2021). In most states, they must practice under the direction of an OBGYN (Cramer, 2021). A Nurse Practitioner is a high-level clinician who, in some states, can prescribe medications, and in many areas, particularly rural areas that cannot attract enough primary care physicians, Nurse Practitioners fill similar roles to general practice doctors (Cramer, 2021).
to catch babies\textsuperscript{20} even if the doctors are not in the room, which has resulted in incredible trauma with nurses holding in an infant’s crowning head into its mother’s birth canal until the doctor arrived causing the mother a lasting injury, which even lawyers had a difficult time categorizing under the law as malpractice, assault, or something not covered by legal protection (Lawson, 2019).

Further conflicts can enter the labor space with the addition of doulas. The mistrust of doulas, professional labor support hired by the pregnant person who stays with them throughout labor and delivery, despite widespread evidence of their benefits is an example of both status-consciousness of the field and a mistrust of women (a vast majority of doulas identify as women) (Dekker, n.d.; Hill, 2019). As advocates for patients, doulas and midwives are in a space to offer support to patients and help explain OBGYN recommendations and answer patient questions in plain language. But the role of doula-advocate is also complicated for several reasons. Not all doulas consider themselves advocates and it does not require any special training to become a doula. While the research indicates that there are many benefits to doulas who are well trained, doctors must contend not only with differing views on what the patient wants but whether or not the patient is receiving quality advice from a doula who may or may not be properly trained.

As will be discussed shortly, the medical mistrust that can develop complicates this process even further because in some doula practices doulas are trained to be skeptical of medical intervention broadly without the same type of medical familiarity

\textsuperscript{20} Midwives often used the term “catch babies” rather than “deliver” them to put the emphasis on the person who is birthing/delivering the baby as the one doing the work.
doctors, midwives, and nurses have; in addition, the mistrust on the side of a patient may mean they are listening to bad advice from the doula and wrongly dismissing good medical advice from the doctor based on mistrust from previous medical encounters or mistrust broadly. Simply putting more people in the room them might cause more confusion and more harm leading patients to feel even more negatively.

Institutional Birth: Obstetricians, Technology, and the Power of Specialized Knowledge

A long history of framing birth as a medical event that requires hospitalization creates a social consensus that hospitalization and technological interventions are necessary, and hospitals are the only safe option. Because hospitals are associated with medical technology, “safe” birth becomes associated with this institutionalized, technology-reliant model of care. This medical institutionalization gives rise to negative views of those who call for changing the institutional mindset away from reliance on technology and medicine. Despite the scientific evidence that supports lowered use of technology and interventions in most births (WHO) the criticism of “crunchy granola” or “Birthzilla” types permeates attitudes who seek lower intervention and less technological models of care (Cramer, 2021; Hill, 2019). Midwives who use this model, especially homebirth midwives, are also regarded as “mad”-wives (Hill, 2019).

This trajectory of professional development along with a rise in technology and the specialized knowledge that technology requires manifests itself in the U.S. reliance on obstetricians for what midwives refer to as “normal,” low risk, or uncomplicated birth. This manifests in the institutionalization of birth as something that requires hospitalization and an OBGYN’s care. The prevalence of OBGYNs is a policy decision so ubiquitous that it becomes invisible, people consider a medicalized view of birth as
“just the way it is” rather than a choice or political at all. Yet, the US maternity care system is a significant outlier and is almost alone (aside from Canada) when compared to other industrialized democracies. In most OECD countries, midwives outnumber obstetricians at least severalfold, but in the U.S. obstetricians outnumber midwives almost 3 to 1 (Tikkanen, et. al., 2020). The prominence of obstetricians shapes the structure of perinatal care system because it results in a costlier health system which may contribute to maternity care deserts\(^\text{21}\) and the closing of maternity wards (March of Dimes, 2020). Likewise, hospital policies and professional attitudes that carve out a diminished professional role (e.g., scope of practice, legality) of midwives by mandating they practice under the supervision of OBGYNs undercuts the ability of hospital and policy to offer more patient support, post and prenatal care, especially in rural areas.

Understanding how much the U.S. is an outlier helps to illustrate the role that policy rather than medical necessity plays in maternity care, particularly because the U.S. is also an outlier in maternal mortality. According to data from an OECD\(^\text{22}\) study, the perinatal care workforce in the United States is noticeably different from similarly situated countries.\(^\text{23}\) According to Tikkanen et. al. (2020) in The Commonwealth Fund report, in the US, there are 11 obstetricians and 4 midwives per 1,000 live births which makes for around 15 care providers per 1,000 live births. The only country with a lower number of workers per 1,000 live births is Canada with a total of 12 workers (8 OBGYNs to 4 midwives) with the next nearest country the Netherlands with 35 workers per 1,000

\(^{21}\) Areas where access to maternity care is limited or non-existent
\(^{22}\) The Organization for Economic Cooperation and Development represents the governments of 37 countries that have market-based economies and are considered democracies.
\(^{23}\) There is data from eleven countries: Australia, Canada, Germany, France, the Netherlands, New Zealand, Norway, Sweden, Switzerland, the United Kingdom, and the United States.
live births (which is more than twice the number in the US, with 10 OBGYNs to 25 midwives a reversed ratio to midwives) (Tikkanen et. al., 2020). The Commonwealth Fund Report (Tikkanen, et. al., 2020) also notes that remaining countries all outpace the US in both number of birth workers and almost all do so in ratio of midwives to OBGYNs. Germany and Switzerland have similar number of OBGYNs and midwives (27 to 30 in Germany; 22 to 32 in Switzerland), but both still have more midwives and more workers (Tikkanen et. al., 2020). The country with some of the best birth outcomes in the world is Sweden, which has the highest number of birth workers to births (78 care workers to 1,000 live births, more than 5 times that of the US) with 66 midwives and 12 OBGYNs per 1,000 births a ratio of about 5 to 1 (Tikkanen et. al., 2020). The above data would indicate that due to the structure of US medical systems, there are simply not enough care workers from either model.

The (Over)use of Technology

Technology in childbirth exists in a duality: it is life-saving but can be deadly; it was liberatory, freeing women from pain, but can be used to shame or disregard those who want non-pharmacological pain management; it offers women greater control over when and how to give birth, but it can be used to override consent and silence the preferences of the birthing person; and it can catch problems early on to prevent injury and death, but it can also be used to overreach and pathologize normal variability during labor and delivery (Amnesty, 2012; Morgen, 2002, Thielking, 2015; Wagner, 2006). Whether technology is a blessing or a curse depends on the institutional role of the technology and whether those who rely on it give precedence, though policy or practice, to the technology over the patient’s wishes or even let the patient know they have another
choice. When the personal connection is overridden by the mediating role of monitors and the authority of technology despite its proven fallibility then the role of technology can become harmful (Hill, 2019; Thielking, 2015; Wagner, 2006).

Morgen (2002) and Hill (2019) both note the original feminist and liberatory role of technology in childbirth, particularly for pain relief. The belief that pain in childbirth was the “curse of Eve” kept some practitioners from allowing it (Morgen, 2002). But as it became more commonly accepted, practices like the use of Twilight Sleep (Leavitt, 1986; Wolf, 2018) and the forcing of interventions became so ubiquitous that in 1958, Ladies Home Journal wrote a stunning expose on what it called “Cruelty in Maternity Wards” (Goer, 2010, Schultz, 1958). The report rang true with so many mothers that they mobilized to push through policies to protect maternal wellness across several states (Goer, 2010; Schultz, 1958). Today, questions about overuse of technology, whether in the form of obstetric violence or standard practice comes from both the epistemic authority given to the technology and to the lack of care providers throughout the maternity care workforce. World Health Organization calls for a decrease in technology in birth across the board, suggesting a reliance on technology result in unnecessary interventions in low-risk birth. Technology such as fetal heart monitoring for example is known to trigger other interventions:

“Without any evidence at all to suggest continuous fetal monitoring improves outcomes, it has become a standard of care,” said Dr. Terrie Inder, a neonatologist at Brigham and Women’s Hospital in Boston ...“And when there’s a blip in the reading — if a baby’s heart rate goes up or down — that can trigger a C-section, even if it’s not clear the baby is truly in distress” (Thielking, 2015).

The role of technology becomes problematic when the technology dictates the reality and the person giving birth does not. In Chapter Four, this will be discussed as a matter of
epistemic authority—whose knowledge gets to “count” as valid. The special knowledge that technology requires—for instance, reading and understanding heart monitors—can serve to marginalize those who do not have the knowledge as it does to shape the institutions of birth.

The epistemic authority can create conflicts around whose knowledge gets to be trusted. In a space where medical science is highly valued there is going to be specialized knowledge. When technology rather than interpersonal conversations become the mediator between special knowledge and what becomes the patient’s knowledge if there are conflicts between intervention and autonomy that can create mistrust. The reliance on technology has been a lightning rod in recent years in the cultural fights around childbirth. Some doctors and patient advocates have begun to shy away from routine monitoring due to its association with higher rates of intervention. However, when discussing birth centers, midwives, and homebirth, attitudes still persist that technology and interventions is safe while going without them is risky. The underlying issue is that technologies like fetal monitoring offers necessary surveillance—and early warning system— and anyone who would forego this surveillance early warning by trusting in natural processes is dangerous.

Like other contemporary fault lines in the politics of childbirth, there is an institutional history that develops creating mistrust. Understanding the overreliance on interventions through the history of “twilight sleep” offers some insights into the difficulties in changing established procedure within an institution. For decades even after it was illegal in other countries women in the U.S. were given twilight sleep a combination of morphine and scopolamine which produced a semi-conscious amnesiac
state during childbirth and produced blue and lethargic babies and mothers who did not remember giving birth (Leavitt, 1986). Even after it was widely known that twilight sleep was dangerous to mothers and infants, doctors continued to use it to streamline the childbirth process for themselves (Leavitt, 1986; Wolf, 2018). Given a long history of conflict over who has power in the birthing room that has often marginalized women as patients and providers, it is understandable that there are undercurrents of mistrust among those who give birth that they will be taken seriously.

**Medical Mistrust and Institutionalized Birth**

It is important to note that the history of institutionalizing childbirth and its concomitant increase in technology also parallels questions about what counts as authoritative practices in birth. Care providers from different schools of thought will view higher or lower interventions as stemming from the best research, not just midwives versus OBGYNs but even among different midwives or different OBGYNs. Standard practice is not standard because it is only practice supported by current research, it is standard because that is what is done (Dekker, n.d.; Wagner, 2006; Wright, et. al., 2011). Care providers must also contend with institutional norms and protocols as well as navigating each case at hand.

Underlying arguments about policy changes including midwifery, birth centers, and access to homebirth is the idea that hospital births with an OBGYN is necessarily safer, which depending on the risk assessment in an individual case may be true (Cramer, 2021; Hill, 2019). Likewise, underlying some of the culture war arguments is that patients who request fewer or no interventions are behaving dangerously in a way that might injure their child (“birthzillas” and “madwives” who support them) or that those
who request interventions are “control freaks” or “too posh to push” (Weaver and Magill-Cuerden, 2013). While the right to refuse intervention is one element of autonomy, the right to request intervention is another. As two sides of the same coin, requests for intervention can stem from the same fear and mistrust that refusal of intervention does. In my own interviews there were stories that were concerning, included a young mother who requested a cesarean because she wanted to “stay tight” for her boyfriend. Just as overuse of intervention against patient wishes is harmful, it may be just as harmful to refuse an intervention a patient wants. In either case, there is a conflict between what the patient wants and what the medical professional sees as best that is an opportunity to develop trust or mistrust.

The institution of birth shapes how patients are cared for. With so few providers of any model of care in the U.S., patient have more technology, less relationship (Tikkanen, et. al., 2020). This can shape development of trust broadly. It is important to note that mistrust is not simply the absence of trust, it is far more complex than that and as such can create problems with mindset when meeting conflict. Medical “mistrust is not merely the opposite of trust…mistrust often refers to the belief that the entity that is the object of mistrust is acting against one’s best interest or well-being” (Jaiswal, 2019; Jaiswal and Halkitis, 2019).

Like the reliance on technology, the framing of birth as medical event that needs to be managed by professionals shapes social understanding of what birth is and who gets to claim authority in deciding what birth should look like. This results in social clashes—culture wars—about what birth is, what it means (to doctors, to those who give birth), when someone choses a certain path, and is another manifestation of our polarized
culture. A particularly illustrative example of the ways in which women’s autonomy and choice are not valued in childbirth was the American College of Obstetricians and Gynecologists making fun of Duchess Meghan Markle for considering a home birth (Truong, 2019). This included an envoy from the Royal College of Obstetricians and Gynecologists in the UK, a renowned physician, Dr Timothy Draycott, snidely remarking, “Meghan Markle has decided she's going to have a doula and a willow tree” (Truong, 2019). Whether Markle was an appropriate risk level for home birth is not the issue, as Draycott was not commenting on Markle’s particular medical case nor risk factors that preclude some patients from a safe homebirth; he was mocking her choice in a room full of other physicians who also mocked her choice. Speaking about the risk associated with homebirth, especially among older mothers and first time mothers would have been seen as antagonistic from some people, but publicly mocking someone’s birth choices can be harmful to patient-provider trust. These attitudes towards those who consider non-hospital birth practices or increasingly common practices like having a doula, are present when doctors are treating laboring patients. These kinds of comments matter because as Law and Society scholars have spilled a lot of ink demonstrating, judges do not automatically shed their prejudices and implicit biases when they put on their black robes (Segal and Spaeth, 2002; Yates and Coggins, 2009). Similarly, there is little reason to believe that doctors shed their attitudes and implicit biases or outdated practices when they put on their white coats, a concern that received widespread public

24 Which has been repeatedly demonstrated to have positive effects (Greiner, et. al, 2019; Gruber, et. al, 2013; March of Dimes, 2019).

25 Likewise, patients do not shed their identity biases when they enter a medical space offering interesting research opportunities exploring whether medical mistrust is also related to the increasing majority of women in medical fields, including obstetrics (Bacon, 2008; Jefferson and Maynard, 2015; Kramer, et. al., 2022).
confirmation when some of the most renowned physicians in the world were caught making fun of a pregnant celebrity’s birth choices.

Draycott’s derision of Markle’s homebirth hopes is particularly dismissive when you consider myriad studies indicating that, among low-risk gestational parents, home birth is as safe as hospital birth (Brocklehurst et. al., 2011; Hutton, et. al., 2019; Janssen, et. al., 2009). While the safety varies depending on geography (hospital and region the birthing parent lives in) (Grünebaum, et. al., 2020), if midwifery is legal and well-integrated into the hospital system (Hoope-Bender, et. al., 2014; Grünebaum, et. al., 2020), as it is in the UK, it is widely regarded as safe. In the United Kingdom, midwifery is a part of the National Health Service, and this includes home birth. It is also worth noting that Draycott’s comments were not about the safety of Markle or her pregnancy, but strictly derogatory for making choices about her birth. For Markle’s preferences to be met with “raucous laughter” by leading physicians at ACOG’s meeting brings to surface negative attitudes about women who want some agency in childbirth and can themselves lead to mistrust.

Derision of birth choices is not limited to gossip about famous women, American obstetrician Amy Tuteur, known online as the Skeptical OBGYN has referred to women with birth plans as “birth-zillas.” Her recent book blames feminism and expectations of bodily autonomy in birth for negative birth outcomes with no evidence to support those conclusions. Tuteur’s book is just one example of the kinds of public discourse that shames perinatal choices and the people who make them. Likewise, Irish OBGYN Aoife Mullally contends that “middle-class Birthzillas” are causing themselves trauma for not trusting physicians and having their own birth plans. This kind of name calling reinforces
that mistrust on the side of patients that doctors do not value their perspective, and the mistrust can go both ways. When doctors and patients are coming into the situation with different expectations about what birth is and (sometimes) competing perspectives on what the “best” thing to do is it creates conflicts. The result of institutionalizing childbirth becomes naming and shaming those who resist such institutionalization, which leads to more difficulty establishing medical trust in institutions.

**Doxa and the Role of Cultural Health Capital**

Bourdieu spends a good deal of time discussing the way fields are organized around certain practices that become socially legitimized. A field is defined as a space where people with different social positions interact (Bourdieu, 1979; 1977) using rules that are specific to that place; the “proper” deployment of these rules or conformity to them indicates someone’s “cultural capital.” Cultural capital can be considered both a sense of how well someone fits within a social class or hierarchy within a field, and where in the field that is (the more capital you have the higher your standing) (Shim, 2010). Shim (2010) discusses Bourdieu’s’ use of capital, in this case adding cultural health capital, as an illustration of how these fields shape the rules of social interaction through a specific cultural capital that relates to health. Within the medical industry there are specific types of knowledge (empirical, science-based), certain belief systems (about biology, health, and medicine), and ways of speaking that can mark someone as in the club or out of it (Shim, 2010). The institutionalization of childbirth has led to such views of birth and types of communication to be more valued, sometimes at the expense of those who give birth either because they have different ideas about birth (e.g., a non-medical event) or they lack the ability to communicate in in expected ways. Those with
higher cultural health capital can expect better care because they speak the language and the culture of the health care system; and this is born out in studies showing that mothers who are physicians have lower rates of cesarean sections for no apparent medical reasons (Johnson and Rehavi, 2016). Questions about the use of interventions that come from outside the medical field, either from patients or doulas and midwives then, are disregarded out of hand because the people who ask lack the cultural health capital to be heard.

Bourdieu offers ways to understand the role that power-practice-habit-and belief have on shaping authority and trust (Young and Billings, 2014). As will be discussed at length in Chapter Five, who is to be believed, whose knowledge is considered valuable, who is considered unreliable: none of these questions are answered in isolation. As Shim (2010) notes “cultural capital is deeply relational, it refers to the power of dominant social groups not only to shape institutional arrangements but to define the kinds of activities, resources, and behavior that culture values in these context” (p. 4). These values: credibility, authority, and knowledge are socially (re)constructed through law, politics, and social interactions.

When authority is questioned and the doxa breaks, patients express doubts whether based on previous experience or their own uncertainty about events. This doubt is an opportunity for doctors and patients to confer together through conversation, but when a patient’s doubt is met with dismissal or derision, that only furthers medical mistrust (Hill, 2019; Washington, 2006). Wagner (2006) notes, “when doubt is expressed by a patient, it is all but intolerable. You can’t imagine how upset many doctors become when a patient asks for a second opinion” (p. 15). The reflex to shame and blame birth
givers for their mistrust rather than consider its origins stems from the institutionalizing of birth where women are passive participants, and their cultural health capital renders them in a place where they are not seen as having the authority to ask such questions. Institutionalizing birth shapes it into a Bourdieusian field, complete with its own specific protocol, expectations, and cultural capital wars. In this arena the role of woman and mother is carved out to make questioning the institution not only unwelcome but borderline negligent.

This is another reason why it is shocking that feminist political and social scientists have not studied widely in this arena: these are the kinds of gender constraints levied by patriarchy that concern equality. Additionally, those who give birth and do not identify as women are trapped in the same gender role problem because they are not women and birth is something that is seen as happening to women patients, while trans and non-binary folks face added discrimination (Besse, et. al., 2020). Birth givers are not wrong to question the conscious or subconscious motives of hospital policy. The rise of the maternal mortality crisis has prompted public health, economic, and policy scholars to develop substantial quantitative research on birth, and what they found was that non-medical factors shape childbirth. These factors include the role falling birth rates and profit motives have on the rising rate of cesareans (Gruber and Owings, 1996; Johnson and Rehavi, 2013), staffing patterns and physician preference have in shaping which options are available to patients (Bailit, 2012; Oner et. al., 2015), physician pay structures affect all interventions including cesarean rates (Vedantam, 2013), and for-profit hospital have on increasing use of medication, interventions, and cesarean rates (Gruber, et. al., 1999; Johnson and Rehavi, 2013).
Against Their Own Bodies, In Their Own Words Epistemic Injustice and Pathologizing Resistance to Institutionalization

There are studies of how outside sociolegal forces filter into day-to-day life and interactions with people in education (Jindal, et. al., 2022), policing (Drakulich, 2023;; Sewell, 2020; Sheptycki, 2020), and institutions broadly. With a focus on institutionalization, it is important to expose the ways in which institutionalization creates epistemic winners (who are believed) and losers (who are disbelieved). This includes pathologizing resistance to the institutionalization of birth by calling people “birthzillas,” “madwives,” “granola types” and other derogatory names. Likewise, refusing to acknowledge the proven benefits of midwives and doulas as part of a professional culture of birth workers stems from their resistance to institutional dogma. On the opposite end of the spectrum are those who denigrate people who do prefer interventions as being less “empowered” or “too posh to push” (i.e., either too lazy or unconcerned to go through physiological birth). Just as denying the importance of midwives and doulas on the one side, the refusal to acknowledge medical expertise or question doula training on the other side. Socially, those who give birth are pulled in either direction complicating the ability to have dialogue in the labor and delivery space, especially if there was no time to establish rapport with care providers.

While the use of the term epistemic injustice is fairly new, first being coined in 1999 (Pohlhaus, 2017), the need for such a term was heavily anticipated in scholarly literature. Political theorist Vivian May (2014) links the philosophical formation of epistemic justice to Black liberationist Ann J. Cooper in the early 1890s whose work called attention to the deliberate silencing and ignoring of Black women’s voices. Others
place the founding on postcolonial26 feminist scholar Spivak and her seminal text “Can the Subaltern speak?” Spivak’s (1988) exploration of the role race, gender, geography, and class play in determining who gets heard/believed was groundbreaking. Her article also considered this a matter of who has the words to describe their experiences and an audience willing to take them at those words.

Fricker coined the phrase “epistemic injustice” to includes both the kind of injustice that frames certain groups as inherently lacking credibility/believability ("testimonial injustice") and the injustice that results from an inability to conceptualize or verbalize a social and cultural experience of marginalization ("hermeneutical injustice") that underlies Spivak’s work (Fricker, 2007, 2). Testimonial injustice stems from the harm done by ignoring or not believing someone’s experiences based on a part of their identity (e.g., race, class, country of origin, gender) something we see throughout the politics of childbirth.

Medina has suggested that more specific attention to the role of credibility and authority through the lens of epistemic justice (2011) and to including more voices in the conversation broadly (2012). In birth, epistemic injustice manifests itself in the way women and birthing people suffer from a credibility gap or “negative identity prejudice” (Medina, 2011, p. 16) while medical technology and protocols and are given “excessive attribution of credibility” (Medina, 2011, p. 18). Medical authority is seen as the only authority acceptable within institutions resulting in a gap of cultural health capital. The role of credibility matters a good deal because being believed is a fundamental part of

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26 Though she has had mixed responses to being called postcolonial.
building trust, but “those who have an underserved (or arbitrarily given) credibility excess are judged comparatively more worthy of epistemic trust” (Medina, 2011, p. 20). As Medina (2011) notes, “under conditions of oppression, social disparities often result in differential presumptions of epistemic authority and credibility” (p. 22). Medina’s (2011) point is that status outside hospitals can translate to lesser status in it. The question of whose authority is valued leads to an understanding of why institutions are set up to prioritize certain knowledges and types of authority.

There is a connection between institutions and the stories of the people caught up in them. Anderson (2012) says “hermeneutic injustice is always structural” and considering what role institutions can take to create more “epistemic virtuous” systems. These systems are built to encourage dialogue and epistemic justice, including having protocols and organizations that share knowledge. Sociolegal philosopher Boaventura de Sousa Santo’s (2017) “sociology of absences” and claims that global justice is not possible without cognitive justice. In his *Epistemologies du Sud* (“Epistemologies of the South), Santos outlines what he sees as the neoliberal, capitalist, western hegemony creating absences or stories and thought. He contends that some stories are not naturally absent but that their absence is create by dominant cultures to silence, ignore, and obfuscate connections between different groups, struggles, and understandings (2017). These absences are intended to divide communities and leave out certain types of perspectives in order to keep at bay resistance to the dominant social order (2017). These absences can amount to “epistemicide” or the destroying of knowledge and experience of certain groups (2017).
Freeman (2015) more fully pulls out the nature of epistemic injustice specifically related to birth, when she explains:

claims that pregnant women make about their bodies are not taken seriously; when their desires and requests are systematically undermined, overlooked, or ignored; when their agency fails to be recognized and when, as a result of being unheard and ignored, they are demoted to occupy a position of powerlessness (p. 45).

Freeman’s (2015) article discusses the epistemic credential and injustice as a matter of the “panoptics of the womb” ideology. Relating to the institutionalization and technologization from the previous chapter, the concept of “panoptics of the womb” was a way to control labor, delivery, and pregnancy at large. The panoptics of the womb was intended to be a positive thing under patriarchal medicine, because of “the kind of epistemic power that it grants to medical practitioners,” but it becomes problematic when general knowledge of birth is valued within the system at the expense of the knowledge of “women’s lived body experiences” (Freeman, 2015, p. 55).

Underlying notion of panoptics, something that is constantly observable, is the belief that women’s bodies could not be trusted unless observed by an outside force. Freeman (2015) offers an alternative for those who give birth to be “epistemic peers” where they balance the medical expertise of the doctors, midwives, and nurses with the priorities, requests, and embodied knowledge of the birthing person. Epistemic peers allow the birthing person to use their embodied knowledge in conversation with medical staff’s broader general knowledge to shape patient care.27 This reframes cultural health capital by giving weight to people’s understanding of their experiences as part of the

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27 This is not a radical position, as the “midwife model of care” that integrates patient knowledge and preferences, highlights informed consent, and prioritizes the relationship between provider and patient over a hierarchy (Hill, 2019) could be considered a model for epistemic peers in childbirth.
health dialogue. Interviews show that this model can improve patients’ perception of their care and experiences and epistemic justice within the institutions themselves (Anderson, 2012). Meeting conflict with dialogue offers epistemic peer models of care that does not discount expert medical advice but integrates patient concerns and knowledge into part of the patient care process.

The matter of whose credibility counts within a medical context is a political and legal matter. As Wagner (2006) notes, by professional acculturation and the construction of the medical field, doctors do not like being second-guessed. Even in perfectly egalitarian social conditions, this would lead to a conflict in epistemic authority, and we are not in perfect egalitarian social conditions. As Shabot and Korem (2018) call attention to the role of institutional power structures in creating conditions for epistemic injustice claiming that hospital “staff merely perpetuate the violence of the existing structure.” Conflict met with coercion is not thought of as violence because it is not thought of at all, it is simply a pattern of behavior that is replicated through training and is considered objective due to its formality and longevity. Understanding epistemic injustice then, demands new ways to think about how we think about childbirth, and that includes a model which considers the embodied experience of birthing parents.

Shabot (2021) links this to the very nature of birth being something that happens almost exclusively to women, and the historical medical mistrust of women’s bodies, especially their reproductive system: “a birthing woman’s knowledge is considered flawed precisely because she is in the process of birthing” (p. 637). Woolard (2002) offers a compelling argument that we should “flip the script” and believe women deliberately because “pregnancy is epistemologically transformative,” it is “an experience
that brings you knowledge that you could not have acquired without having the experience” (n. p.).

**Conclusion: Institutionalizing Birth and Pathologizing Resistance**

The politics of childbirth shape the original reproductive politics question: “who has power over sex and its consequences” (Solinger, 2013) by looking at the ways in which law determines who has power over the consequences of sex. Law adds legitimacy to institutions through certifications and licensure and to certain practices through liability and malpractice laws. But relying on law to make medical decisions can be a hinderance as has been seen in the post-\textit{Roe} concerns with doctors asking “when is death imminent enough” for them to act or being unclear what the law allows them to say to patients (Simmons-Duffin, 2022) or Cuba’s policy that restricts cesareans in order to keep rates down but winds up increasing rates of maternal mortality (Cueto, 2020). But in areas like staffing patterns, maternity care deserts, and hospital ownership/economic constraints, law can useful in shaping childbirth experiences in a positive way.

Studying birth in this context illustrates that there is sometimes a feedback loop between the institutionalization of childbirth and a mistrust of women and their bodies, that it has historic roots, and that it is shaping birth experiences. Those who lack to cultural health capital to be taken seriously when they raise questions about the system or within the labor space face marginalization because of institutionalized beliefs about what people who give birth are supposed to be, do, and look and act like. This is a kind of epistemic injustice—a harm done to a group because of their membership in a group that allows others to mistrust them or think badly of them (Fricker, 2007)—as part of living in a patriarchal society where, no matter what legal hegemony happens that will still be
done in concert with patriarchal mores. The link between feminist thought and public health is a vital one, and this dissertation contributes to a feminist theory of public health scholarship. As Rich (1986) says,

patriarchy is the power of the fathers: a familial-social-ideological political system in which men—by force, direct pressure, or through ritual, law, and language, customs, etiquette, education, and the division of labor, determine what part women shall play or not play (p. 57).

Likely within this contentious and in some ways legally plural culture, how do women make sense of their birth experience? My interviews show a wide range of attitudes, beliefs, and practices. Epistemic justice and reflexivity are key concepts in some research circles, but through quantitative and qualitative social science research, this dissertation offers a look at how those theoretical concepts can be turned into policy and professionalization goals and deployed to create substantive changes.

Birth shapes and is shaped by sociolegal and political forces. While this chapter explored the history to situate some of the context of childbirth as an institution, the role of medical technology, and the interpersonal professional conflicts, the following chapter zooms out. Chapter Four explores epistemic authority and how these assumptions of authority are constructed through the institution of birth. These facts paired with the historical evolution of birth as an institution show the ways that the polarization that produces the broader culture wars has direct effects on the institution of childbirth.
CHAPTER 4: “I’M THE EXPERT HERE”: EPISTEMIC JUSTICE, MISTRUST, AND IDENTITY IN A MEDICAL SETTING

In 2017, California mom Kimberly Turbin settled out of court what had been an intense legal case surrounding (mis)treatment in childbirth (Allers, 2020; Greenfield, 2017; ImprovingBirth, 2017). In 2015, Turbin sued her obstetrician Dr. Alex Abbassi for assault during the birth of her child in 2013 (ImprovingBirth, 2017; Pascucci, 2018). Abbassi cut Turbin’s perineum28 12 times while she screamed for him to “stop! Don’t cut me.” When Turbin asked why Abbassi was performing the procedure, he yelled, “What do you mean ‘why?’…Listen: I am the expert here!” and provided no further information or justification (ImprovingBirth, 2017; Pascucci, 2018). What is most surprising about this case is not that the incident took place, episiotomies—incisions near the vagina intended to facilitate childbirth—are still common despite the American College of Obstetrician and Gynecologists’ recommendation against their routine use (“Ob-Gyns can Prevent”, 2016; Wiener, 2016a; Wiener, 2016b; Willyard, 2020). Likewise, mistreatment that ranges from disrespect to obstetric violence are a global problem (Declercq, et. al., 2013; Diaz-Tello, 2016; Pascucci, n.d.; Tucker, 2018). What is surprising is that the case went to court at all. Despite the video evidence of what Turbin alleges as battery, it still took two years for her to find a lawyer (ImprovingBirth, 2017; Pascucci, 2018). Most lawyers were unsure whether a crime had been committed and were even less sure they could convince a jury (Pascucci, 2018) because no one was certain what rights a birthing person has to refuse procedures, where the law can constrain physicians, or the parameters of consent-based care this confusion stems from

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28 The female perineum is the area between the anus and the vulva.
the institutionalization of birth and highlights the epistemic tensions that arise when naming mistreatment in birth.

The politics of childbirth and their connection to law are at their most amorphous when talking about epistemic justice. The meaning-making powers of law and the effect that has on social institutions plays out in epistemic justice. What counts as evidence, who gets authority in birth, and who gets their voices heard are shaped more noticeably by society than law. But if we consider the role of law to sanction certain types of knowledge and knowing, then it becomes more clear that the weight of law can tip the scales of epistemic justice. In order to practice medicine in hospitals, OBGYNs, nurses, CNMs, and other practitioners must go through formally and legally sanctioned training, certifications protocols, and licensure requirements. Hospitals and OBGYNs must hold these credentials in order to practice and in order to have insurance, which is also a matter of law. In itself, these processes lend authority through law to the epistemic credibility of medical professionals. The role of law is also a current front in the battle over whether or not to certify and license professional midwives in all states. Some midwives are against licensure because they do not want formalized knowledge hierarchies sanctioned by law and others in favor of licensure because it confers the medical credibility (through the law) on their field (Cramer, 2021).

When examining the maternal mortality crisis, institutionalized childbirth, and the social construction surrounding people who give birth, it is important to note that the current epistemic conflicts in childbirth in the U.S. are not necessarily deliberate nor intentional (e.g., doctors are not conspiring in an underground lair to maintain control over birthing people). The institutionalization of birth, as discussed in the previous
chapter, started as a combination of professional gatekeeping and control, economics, mid-century infatuation with technology, and a feminist desire for freedom from “the curse of Eve” (pain in childbirth) (Morgen, 2002). But the over-medicalization and reliance on technology persist in ways that can leave patients feeling undervalued and left out of decisions-making about their own bodies; these epistemic conditions help to normalize institutional arrangements that favor intervention, technology, and protocols that may not include collaborative decision making. Likewise, the institutional arrangements that normalize the host ideology discussed in the previous chapter (where the mother is simply a vessel through which the child passes) or those that do not allow reproductive autonomy to reinforce the perception of birth as something that should be institutionalized or medicalized rather than seen as an event that sometimes needs intervention.

The institutionalization of birth leads to a path dependency in the institutions and risk aversion by some doctors in the form of defensive medicine.29 Institutionalizing childbirth creates the social cognition that birth is an inherently medical event, which leads to the preeminence of certain types of authority being valued more than others and run into conflicts with cultural health capital as discussed last chapter. As the previous chapter noted, epistemic authority shapes who is believed and that authority can become a matter of doxa—common and habitual practices that is almost invisible. This chapter continues the discussion of epistemic authority in childbirth as a matter of cultural health

29 Defensive medicine is the practice of ordering extra tests or interventions that are not medically necessary out of a fear of a malpractice lawsuit; in the medical literature, it is offered by physicians themselves when asked to explain higher rates of interventions (Hankins et. al., 2016; Frakes, 2012; Currie and MacLeod, 2008).
capital by showing the ways in which individuals experience childbirth and how or when they felt heard.

By taking an epistemic (in)justice frame, this chapter offers an understanding of how certain knowledge and knowers are valued in different childbirth settings, how that shapes and is shaped by outside forces, what that looks like from the perspective of a sample of those experiencing labor and delivery, and how law and policy changes offer pathways towards collaborative communication in the labor space. This chapter brings in interviews, explains the methodology of the study, and considers the role of epistemic justice and credibility in terms of medical gaslighting and medical racism.

This chapter considers the way social attitudes towards women broadly shape birth-givers’ perspectives of how willing providers are to listen to and trust people in labor. Epistemic injustice and credibility relate directly to whose perception of events is taken for granted and whose is not (Medina, 2011). When someone’s beliefs about identity groups create conditions that marginalize and silence minoritized communities, they result in epistemic injustice, which Fricker (2007) defines as “a wrong done to someone specifically in their capacity as a knower” (1). This “knower” capacity echoes medical misogyny where women’s descriptions of their conditions are not taken seriously, as well as medical gaslighting, where people are pressed to question their own reality of the situation. The lack of inclusion of birth narratives in mainstream studies is a manifestation of this testimonial injustice. As the previous chapter notes, maternal mortality happens frequently after someone has left the hospital, so understanding how someone experiences labor and delivery can shape maternal mortality because if they are not going back because there are geographical or logistic problems that can be solved.
with certain policies, if they are not going back because they felt unsupported in labor that can be solved through policy interventions.

**Inside the Labor Room: Method and Purpose**

This chapter and those that follow were shaped by semi-structured qualitative interviews which took place via Zoom over the course of five months from February to June 2021, with most being between April and May. I interviewed 116 people who gave birth in Massachusetts. As discussed in more detail below, Massachusetts offers some comparative opportunities because it is fairly representative of public health data on childbirth. Participants were recruited through a survey that was sent out via email and posted on websites and social media including multiple Facebook and Twitter posts targeted towards mothers in Massachusetts. The COVID-19 pandemic eliminated options for more public postings of recruitment materials and engagement with people without internet and meant I was relying on social media as well as the social networks of those who participated for recruitment.

Participants were interviewed in either a one-on-one format or in a small group (from two to nine people). I offered this choice for two reasons. Those who had traumatic birth experiences or who feared judgements from other parents (often those who had either planned homebirths or planned cesareans) often selected one-on-one, likewise, with pandemic-related remote schooling burdens falling primarily on mothers, many picked one-on-one interviews for scheduling reasons. Those who identified as LGBTQIA+ also tended to prefer one-on-one interviews.
All interviews began with the same question: “What were your expectations of childbirth?” I often followed up by asking “where did you get these expectations?” In large groups, following up on particular experiences was not always possible, but I did follow-up one-on-one conversations with 4 participants. Follow-ups were selected on a volunteer basis (participant volunteered) and if time permitted within the months of interviewing. Eleven participants indicated a willingness to do follow-ups interviews, but due to time constraints, I could only schedule six (four were interviewed, two had last minute scheduling changes). When having to choose for time constraints, I chose those who had not had a chance to speak as much in the group interviews. In one-on-one interviews, it was easier to ask follow-up questions like, “why did you choose [place of birth]?” or “what made you decide to explore midwives?” These questions proved fruitful.

Initial Stages: Transcribing and Coding

Since the interviews were conducted via Zoom, I used that platform to record and transcribe them. The Zoom-provided transcript was then downloaded and stored into an excel file until all interviews were completed. At the conclusion of the interviews, all the transcripts were double-checked for accuracy and then coded multiple times. In order to not bias my interview questions based on what previous participants said, I chose to wait until the conclusion of all interviews to transcribe any interviews. Once all interviews were complete (on June 2, 2021) I began to check the transcripts for accuracy.

While there was no particular deadline for the interviews beyond the time my funding for participant incentives ran out, I chose to stop scheduling them at the end of May because there were too many to continue. At the time of discontinuing interviews, I turned away approximately 70 people. There were an additional 40-50 more who were in my scheduling pool but were unable to find a good time to meet. This was due to my own limitations of time to transcribe and process the data for a timely dissertation.
This process involved listening to the recorded interviews while following along with the transcript, which were mostly accurate except for medical (e.g., cervix) and pharmaceutical terms (e.g., Pitocin). Once a transcript was accurate, it was saved to an excel file the recording of the interview was deleted, per my IRB protocol. At this time participants were assigned a pseudonym of their choosing or one chosen at random which became the file name and therefore the participant name for the remainder of the research. During this process, I kept notes of phrases that were repeated over time (e.g., “no one would listen”) and themes that occurred often (e.g., nurses were very important to many participants).

After the interviews were transcribed, each excel sheet was uploaded to NVivo and each person’s comments were filed as an individual case. When participants were in a group, each person from that group was coded to their own case file. For the first round of coding I included method of birth (e.g., vaginal, cesarean, VBAC, emergency), place of delivery (e.g., hospital, birth center, home), and birth attendant (e.g., OBGYN, certified nurse midwife, nurse, midwife). Included in this original coding set were any specific references to law or legal concepts (e.g., law, rights, malpractice, lawyers, consent). Because I did not intend to explore institutional betrayal or medical mistrust, these things were not in the original coding set.

The second round of coding was line-by-line to review the interviews for more implicit references to law and politics. These included looking for references to hospital policy, bodily autonomy, and when a participant said they should have the “choice to” or “should have been able to” (or conversely “should not have the choice” or “should not be able to”). On the third read through of the interviews that produced this addition to the
coding I also turned NVivo’s auto-coded themes. These themes included birth/birthing person, care, consent, decisions, health, and interventions. With the exception of health, these were already on my list of themes. NVivo’s auto-coding of sentiment found that there were 38 references that were very positive, 109 that were moderately positive, 183 that were negative, and 92 that were very negative. There was no indication that people selected into the study simply to share negative birth experiences, and many shared positive experiences. Among those who had particularly salient discussions of mistrust, two participants did seem motivated to share mistrust and advocate for alternative birth choices (Agnes who chose five homebirths) and hospital policy changes (Amanda, a physician who had two negative, one positive, and on neutral experience). Because this was during COVID lockdown, it is possible that a large number of participated simply to talk to someone else. Additionally, many noted this was their first time sharing their birth story, which leads me to believe that the biggest predictor of selecting into the study was not positive or negative experience but desire to share the experience at all. More common than sharing a particular negative experience was the need to be heard about any birth experience. I went through these codes as the start of my “Emotions” node and corrected for some of the auto-coding mistakes (words like “best” and “worst” were used literally by auto-coding but contextually would not fall properly into the sentiment). It was at this point I noticed a bulk of these emotional responses were involved in participants discussing whether they felt trust or mistrust. Upon further reading, it became clear that mistrust and trust were referring to both institutions and interpersonal interactions, so I began to code them separately. These would eventually become the codes for medical mistrust and institutional betrayal.
I was not aware of the concept of institutional betrayal at the time of my interviews (a shortcoming of the interview questions that will be rectified in future research), but the code was derived from the data itself. It was not until a colleague shared this information with me that it appeared to describe the auto-coded theme of decision and my own node of hospital policy that made sense as a category for understanding what I was seeing. Likewise, I was not intending to use the concept of medical mistrust because I did not expect to find discussion of it, but since it was a significant minority of comments, it became part of the broader themes.

One commonality was the sense of “not being listened to” that compares with the sense of epistemic injustice, particularly testimonial injustice. In every interview someone talked about not being believed that they had dilated quickly, that their water had broken, or that their epidural did not work. I did not start by looking at birth through a lens of epistemic justice. It was only after the interviews were complete and I began to transcribe and code them that I started to see what looked to me like patterns of feelings as though they were not being taken seriously, and on further reflection realized it spoke to specific patterns of epistemic injustice. Epistemic injustice manifested itself in ways described by Medina (2011) about credibility and both Medina (2011) and Freeman (2015) about the need for a peer model of care. As Sim (2010) noted the lack of cultural health capital can be a determining factor in patient experience, especially within a culture of medical racism and hierarchy.

Distribution of Codes and Choosing Interviews to Include

The selection of themes into the dissertation chapters was driven by the data, with the more common codes forming the theoretical basis of each chapter. The choice to
include stories that spread broadly into three categories—not being listened to/epistemic justice, consent and mistrust, institutional betrayal and trauma—came in two stages. One was the prevalence of these codes in the data, and the other was the salience of the issue among those who participated as judged by the number of times a person or group mentioned the subject being coded.

To highlight that there is no fixed view of childbirth, reproductive autonomy, or reaction to events, I also approximated a matched case study method by including multiple perspectives from within the examples, including those who had been exposed to similar interventions, treatments, and processes but reported different (more positive or more negative) feelings. For each interview included that discusses a coded issue, there is also one included that explores a similar event that a patient viewed differently. For example, when there is a discussion of institutional betrayal, there is added an interview where there was a similar situation but no sense of betrayal. This is to explain the personal attitudes and feelings that cannot be separated from birth, to avoid overly generalizing that a certain procedure or solution will guarantee any outcome, and to highlight the control that medical professionals and institutions have in mitigating harm through explanation, interaction, and communication. Indeed, most people (77%) referred to their birth attendant: 46% discussed their OBGYN, 28% their CNM, 9.5% a CPM, 25% a doula, 43% a nurse, and 20% their anesthesiologist.\(^{31}\) When discussing both hospital policy and care provider 10% of people mentioned the importance of a shift change on their feelings of care (e.g., a midwife or OBGYN that they preferred came on

\(^{31}\) All but one comment about anesthesiologists were negative, including the ones from the two anesthesiologists in the study.
shift and things were better, they felt pressured that they would be pushed by new care providers, comfort that their nurse or OBGYN stayed to introduce the new shift to them).

There were 116 interviews in total, but because participants had between 1 and 9 children, the number of labor and delivery experiences discussed is higher. Using the codes to determine what people talk about when asked about the experiences in labor and delivery I found that 73% mentioned some kind of emotions from happy or safe (14%) to shame (16%) to fear (30%) to ‘birth is scary’ (1%). Two people mentioned “white coat syndrome (<1%) but others in the group agreed. With regards to those saying they did not feel as though they could trust in institutions, 33% mentioned medical mistrust.

Around 41% of participants mentioned rights in some capacity. Most common was informed consent (40%) and implied words about rights (“should be able to”) (22%). With regards to sentiment drawn from NVivo, 36% discussed some kind of negative feeling about the way they were treated via hospital policy, with 11% using the word trauma explicitly, 1 person using the terms “obstetric violence,” and 1 using “birth assault.” Whether by discussing its importance, presence, or absence, 36% referred to autonomy in birth. Many specifically used to word autonomy, others used phrases like “allowed to” and “my choice.” In discussing labor and delivery, 34% specifically mentioned not being listened to or heard and needing to listen more about birth. When broken down by race, 27% of those who identified as White and 55% of BIPOC participants reported feelings of mistrust. Table 1 below shows the breakdown among racial groups by major coding area.

Approximately 19% mentioned institutional betrayal with regards to processes that they felt were “more important than me” or when discussing that they wanted to
complain about a process, policy, or treatment but could find no way to do it.

Approximately 15% of White identifying participants reported these feelings, while 32% of BIPOC respondents did. Differentiated from mistrust, this category only included those who mentioned that these complaints had a long term (beyond the single incident) effect on their trust in the institution. For example, if someone switched hospitals or care providers because they felt they could not trust the previous hospital due to a policy, if someone lodged or attempted to lodge a formal complaint and were denied that, or if they explicitly said that their experience made them mistrustful but pointed to hospital or the policy rather than a person it was coded as institutional betrayal. People who complained about policy but did not attribute their treatment to any structural issue or those who say their treatment as part of “just the way it is” and did not develop mistrust were not included in the institutional betrayal code (though some were used as matching cases to explore when this kind of betrayal occurs and what can be done to mitigate it).

The salience of the different topics was what lead me to prioritize those codes and topics as chapters. So, while 73% discussed emotion of some kind, there were 102 reference to it, 33% reported fear but there were 68 references to fear, and while 33% of people discussed mistrust, there were 64 references to it. The salience of the topic to those who discussed it was an important point of inclusion.

The prevalence and salience of these codes made them the major codes to use in the dissertation, illustrated in Table 1: Major Codes by Race. Many of the other codes were demographic (e.g., method of birth, place of birth) while a few were only mentioned by a single or small number of people (e.g., stillbirth, interventions, or postpartum issues). While the sample set is too small to make many generalizations about
race, there are racial breakdowns in those who were coded into the major codes, as Table 2 shows.

Table 2 presents the percentage of participants who were in the total code, the breakdown of the major codes by race, and the percent of each racial group in the study (discussed more in the demographic section). While there is not enough individual information to make claims within racial demographics, looking at the last two columns allows comparisons for BIPOC and the entire study population. With the exception of bodily autonomy, BIPOC participants were more likely to report one of the major coding groups, medical mistrust, concern about hospital policies, and feeling not listened to. When compared to people who specifically identified as white the numbers are also conspicuous.

“No One Would Listen to Me!”

The comments that most informed this chapter came from a phrase that appeared over and over in the transcripts that was “no one would listen to me.” This phrase had several iterations (“no one listens to moms,” “it’s my body, but what would I know, right?” and “why don’t they just listen, I’m right here”). The chapters that follow were
also taken from common complaints that were group largely into consent. These were
chosen when someone specifically used the language of consent (“I have a right to”) or
the word consent itself. Situations that involved people not being allowed to eat or drink,
have a cesarean, include a support person, or see their newborns were also included here.
The last interview chapter codes developed due to the emphasis several mothers placed
on the hospitals and policies and how those made them feel with regards to follow up
care. These codes became the institutional betrayal codes that includes things like parents
having filed formal complaints but being ignored, feeling as though they could not trust
hospitals due to interactions with hospital policy (e.g., the hospital called the department
of child and family services on them) or people they could not trust (e.g., perceived
unprofessional or hostile staff).

Each participant was given an intake survey which asked about method of
delivery (e.g., cesarean, vaginal), place of birth (e.g., home or hospital, name of hospital),
age, and race. All answers were optional, so in many cases participants did not disclose
all of the demographic data, a limitation I accepted because I wanted to promote a culture
of consent that included what participants wanted to disclose. Participants ranged in age
from 26 to 60+ (their response), with the most in their 30s (67 participants) and 40s (26
participants). A majority of births in the study were vaginal births (85). There were at
least 30 cesareans, with some people writing “cesareans” but not putting the number of
them, and 11 emergency cesareans. There were also 4 vaginal births after cesareans
(VBACs). According to the Massachusetts Department of Public Health statistics on the
method of delivery, homebirths were over-represented, with 11 homebirths in the study, 4
births at birth centers, and the rest were hospital births.
Table 3 offers a demographic view by race. The second column provides information on interview subjects and the third column reports information on Massachusetts residents based on 2021 Census Bureau information. Since not all participants disclosed their race, the demographics are based on who reported (82 participants in total). The total percentage of BIPOC participants was 19%. Asian, Black, and White groups appear overrepresented, among those who disclosed their race, and Latina/Hispanic population was underrepresented. As previous chapters have noted, racial disparities in health happen across the board, but they are glaring in maternal mortality, particularly among Black women. It was important to me that this project be as diverse as possible, but the limitations of the COVID lockdown also meant that it was harder to establish rapport with participants and limited opportunities for recruitment and participation.

<table>
<thead>
<tr>
<th></th>
<th>Number of participants (percent of survey of those who identified)</th>
<th>Percent of Massachusetts population according to the 2021 census bureau</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asian</td>
<td>7 (6%)</td>
<td>7.2%</td>
</tr>
<tr>
<td>Black</td>
<td>8 (6.9%)</td>
<td>6.5%</td>
</tr>
<tr>
<td>Hispanic or Latina</td>
<td>6 (5%)</td>
<td>12.6%</td>
</tr>
<tr>
<td>Immigrant/Refugee (self-described)</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Mixed Race</td>
<td>1 (1.2%)</td>
<td>4.7%</td>
</tr>
<tr>
<td>White</td>
<td>55 (47.4%)</td>
<td>67.6%</td>
</tr>
<tr>
<td>Did not Identify</td>
<td>37</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>116</td>
<td></td>
</tr>
</tbody>
</table>
Looking at cases in Massachusetts offers some generalizability. When looking at multiple measures of childbirth from the State Reproductive Autonomy Index (Vayo, 2022) to the Birth Place Lab’s Midwife Integrations Study (2015) to the CDC yearly data reports, Massachusetts is fairly average across maternal health and wellness, birth choice, and access to midwifery, hospitals, and homebirth. Massachusetts has a slightly higher percent of midwives attending births (16.4 to the national 10.3%), a slightly higher percent of spontaneous vaginal births (54.4% to the national 49.2%), and lower rates of induction (18.1% to the national 23.2%). These indicate that there is some more autonomy for birthing people in the state and a culture of care that relies less heavily on interventions (e.g. spontaneous birth means there is less intervention to induce, midwives tends towards lower rates of medical technology usage) though as in other states the variation in hospital policy is significant (Vayo, 2022), but none of these are significant enough to make Massachusetts an outlier. The state has comparable rates of vaginal birth after cesarean rates (13.4% to the national 11.3%) and rates of cesarean sections (31.7% to nations 32.2%). The method of birth in this study was fairly representative of the statistics in Massachusetts and nationally. While Massachusetts is an outlier in higher educational attainment (Fitzgerald, 2022; McCann, 2022) and liberal politics (PEW, 2014), those cultural elements do not seem to have a much of an effect on childbirth culture broadly.

Since the state had no maternity care deserts, some people had the ability to choose from multiple options, but this was constrained by geography in western and central Massachusetts and on the South Shore, and by insurance companies in central and

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32 At the time of the interviews.
eastern parts of the state. So, while on paper it might have looked as though Massachusetts was an outlier, the geographical distribution of the hospitals makes it much more similar to other states that have maternity care deserts. Though home birth is over-represented the lack of birth centers was a complaint from multiple participants (some who chose home and some who chose hospital) who wanted to choose a birth center for their birth were not able to do so because there are so few in the state and none in central Massachusetts, a common complain nationally as the Listening to Mother II (2006) survey showed. Overall, while the socio-political factors make Massachusetts an outlier in some respects, it is fairly average on what birth looks like demographically.

**Findings: Feelings of Gaslighting, Mistrust, and Invisible Women**

The findings were fairly broad as is to be expected when talking about childbirth. Most participants noted that this was the first time they had spoken of their birth experience, especially those who gave birth during the COVID pandemic so, there was some processing people were doing as they were telling the stories that might look different upon later reflection. A common theme was about the lack of a conversation about birth in the broader culture reflecting the absence of dialogue around birth. I started interviews by asking “what were your expectations” as a way to get people talking in their own words about the treatment they expected and whether there was a gap between that and what they experienced. The conversation usually flowed naturally for them to discuss in their own words how they felt about that gap, if one exists. Many participants described the difficulty, pain, and fear of childbirth, but even in light of that, a majority of people who spoke did speak of their birth in positive terms. The narratives themselves do offer some patterns in terms of conflict and cooperation with parents describing
when/why they felt conflicts had occurred and how/if they felt it had been met with cooperation or coercion.

One common factor was for people to talk about an experience they did not want, but also talk through how their doctor or nurse guided them through the difficulty. This was a powerful part of the discussions, showing that care providers in the room have the ability to shape perspectives even under difficult circumstances. When coding interviews I chose to code narratives based on how patients felt about them, so there were several times when patients had an outcome they did not want or that could be considered traumatic (e.g., emergency cesarean, hemorrhage) but they described the interaction with their provider as positive because they felt cared for and supported, so they were coded as positive. Even when they used the language of mistrust, many parents wanted to be able to trust professionals. For most patients the desire for trust was very strong, even among those who came in with a sense of mistrust. There were some commonalities among all participants whether they spoke positively or negatively about their experienced which included not being listened to, not being taken seriously and being treated differently based on race.

Not Being Listened To

Not being listen to or allowed to speak is a key element of testimonial injustice (Fricker, 2007) and is part of medical gaslighting, as discussed in Chapter One, where patients feel they are being made to question their own reality. Among the comments I heard in interviews included many who said they did not feel listened to or heard. The testimonial injustice links very closely to the institutionalization of birth and the history shaping the institution of childbirth. Institutionalizing birth leads to the commodification
of birth-related medical expertise (previously shared by midwives in birth practice, and through communities in discussion). This commodification becomes a part of cultural health capital, and when patients cannot access the knowledge in ways institutional actors expect, there is an epistemic conflict. Hospital policies that are built to center protocols and process put barriers in place that can prevent conversation and cooperation. As experts on birth generally, the body of knowledge that doctors offer is valuable to be able to catch early signs of when conditions are becoming emergent, to know how to mitigate certain problems, and to make some birth givers feel comfortable. But when all hospital policies are seen as objective and what patients want is seen as inferior to that, then it becomes an epistemic clash. The construction of what counts as objective are part of the process of creating epistemic authority and becoming epistemological peers (Freeman, 2015). Protocols that value generalized knowledge about bodies broadly but not embodied knowledge in the specific experience, or generalized knowledge at the expense of embodied knowledge, can make patients feel invisible and unheard, creating situations where people are epistemic peers can create lasting bonds between patient and increase medical trust.

Shelly, a mother of two, discusses not being believed when her water broke, a common complaint of the participants. Likewise, she was not believed when she said that she was in active labor. Shelley pointed out that in her previous labor she dilated quickly but despite that, the nurses were unwilling to check how far dilated she was because they felt she had not been in labor long enough. Shelly said, “I was just kind of shocked that

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33 In this sense embodied knowledge is the experience of those who are giving birth and their knowledge of the process. While this may translate to a patient preference it may contribute to or drive preference for or against interventions like pain medication, cesareans, or induction.
she didn't listen” and when she asked the nurse “can I get checked again?” the nurse ignored her. Finally Shelly said, “I was like...I want somebody in here to check me and she stood there, while I got checked, and I was at 10 centimeters and I want to be like [gives middle finger to imaginary nurse].”

Shelly, a middle-class white women had the cultural health capital to complain in a way that allowed her to be heard. Interestingly, Eudora, a middle-class Black mom and postpartum nurse almost did not make it to the hospital on time because she said, “I was like, no, I’m not that far along, I haven’t been in labor long enough.” In Eudora’s case, her doula and husband encouraged her to go into the hospital, where she realized she was in active labor. She noted later that the focus on process and what labor was “supposed to look like” was so engrained for her that even in her own body it was difficult to get away from what she called the “clock mindset” that labor was supposed to progress a certain way.

The role of hospital culture played a part in both stories. Eudora was encouraged to come in and did so because of her community support, relying on the professionalism of her doula and those at the hospital. Shelly felt there were inter-staff conflicts that eroded her confidence in the professionalism of those around her. Likewise, Shelly’s interaction with disbelief and what she described as bad staff show the role hierarchy can play in how patients feel valued or able to trust in their care. Shelly had the physical experience—contractions and dilation—and without checking, the nurse assumed that because she did not follow the textbook rules for labor, she was not far enough along:

He [the resident] came in and was very rude about [imitating him] “where was the nurse” and “where did she go” …He whips off his gloves [big gestures like miming his behavior] he, like threw them in the trash and stormed out, and I was
just like “oh, ok. Um. I’m having a baby here, can we like take it down?” So, there was some unprofessionalism that I was not expecting in my first labor. I didn't expect it to go that way, it was a little bit hostile.

Multiple participants expressed concern when they saw doctors and nurses not listening to each other, fighting, or acting in unprofessional ways. Overall, when patients had these experiences, it made it difficult for them to fully trust the interventions they were given because they did not trust their professionals. Given staffing rates and burnout among hospital workers, a qualitative view of the need for more staff can show the consequences of these problems that quantitative studies have exposed.

While annoyed with what happened to her in labor, Shelley offered some important insights about the role of medical trust. She had lower trust in the labor and delivery nurses but that did not extend to her obstetrician. Because her personal experience with her OB, Shelly was able to compartmentalize the mistrust so when she needed postpartum care, she had trust. This example centers the importance of relationships and the human connections. Her obstetrician noticed that she had symptoms of postpartum depression and helped her seek care. His care of her in this way, including taking her complaints seriously and addressing them in what she saw as a positive and non-judgmental manner, won Shelley’s trust and respect. She complied with her care regimen and sought out the same OBGYN for her subsequent pregnancies, and she also recommended him to “everyone I know!”

Shelly was able to keep her high trust because the care she found problematic was only part of a larger pattern of care. Overall, she saw a trend of good care and the bad care that happened was a fluke. Nora, on the other hand saw a pattern of problematic care that she felt did not prioritize her.
Nora had three children in three different states. Her comment: “I kind of went in expecting to not be listened to and being frustrated from the get-go which might have been a little unfair, but I don't think so.” Entering with a mindset of mistrust shaped how Nora approached interaction with medical systems. She describes feeling condescended to at her first birth because she was young, and then throughout the rest of her pregnancies:

basically [I] went the whole time not being listened to at all because well, [with her first at 22, in Illinois] “You don't know, you're young.” And then the second one, who was in Ohio, “well, you don't know how far along you actually are, you're not as far as you say so he's a preemie.” Which he wasn't…. No one ever listens to me; I’m already going in [to the third birth] angry going “you're not gonna listen to me. I’m gonna make you listen to me.” And they still didn't listen to me! …By that point I just knew… this is going to suck, let's just get it over with.

This was in a group discussion, and the other eight mothers were nodding agreement.

There were verbal indications of support and familiarity when Nora also pointed out, that the doctors and nurses were asking her husband questions about her needs, “I was like ‘Hi. I'm here. Just listen to me’.” This is the essence of the feeling of epistemological injustice faced by laboring people: They are physically present and yet invisible.

Nora’s story was interesting for what it showed about how mindset of mistrust raised stress level, but also how previous interactions that confirmed Nora’s expectations lead to a higher level of mistrust/resignation. The sense of not being listened to and not being heard and the sense of testimonial injustice that came up were intertwined. What all of the mothers had in common was a sense of how they were treated by looking at patterns in their own care. The culture of the hospital, the institutionalization of birth, and their own ideas about the culture of healthcare shaped how they determined whether to trust healthcare providers. If they felt they had received poor care, then mistrust and
anger developed, especially if that care was part of a pattern of poor care. With Shelly and Eudora, bad feelings about care were a glitch in the system, with Nora, it was a feature. For others, similar patterns of trust and mistrust arose in patterns around being believed in the form of hierarchies of knowledge and whose knowledge was valued.

Knowledge Hierarchies: Epidurals, Credibility, and Conflict

A common theme throughout the interviews regarded the use of epidurals in labor. A key to getting interviews going or getting stalled interviews moving forward was sharing my own experiences. In some ways, it appears that mutual sharing of experiences is the coin of the realm when discussing childbirth. Capitalizing on my own experience of not being listened to when I had an epidural, leading me to feel the first incision of my cesarean section, I asked others if they had similar experiences. Multiple participants said they did feel at least some part of their cesarean, and many said their epidural did not work, did not work fully, or stopped working before delivery. Almost all remember being met with disbelief by the medical professionals in the room.

Sharing what she describes as a harrowing experience with an emergency cesarean, Adele describes having her arms strapped down and “freaking out.” She was not sure the epidural had worked because she could feel some pressure and movement, and when she asked about it, she felt it was not explained to her adequately. Because the cesarean needed to happen so quickly, her husband was unable to be with her, and Adele felt “completely alone.” Not having had a prior discussion about how a cesarean feels, she was unsure what to expect, and:
I remember like wiggling my toes and you can feel everything. So, there you know you can feel them like put your intestines on your chest...but they numbed my chest, so I couldn't feel myself breathe...I remember asking someone, [was I] breathing? Probably anesthesiologist, and he was super annoyed with me. Like the look on his face was like eye roll like “yeah you're breathing.” And I, one of the nurses in the periphery like ran over and was comforting me because it was like his attitude was horrible.

In the moment, this kind of (un)professional behavior can be jarring for patients. When staff are acting in this way or perceived to be, it creates mistrust among patients.

Failing to take seriously the distressed patient’s fear of death is an invalidating experience could result in feelings of gaslighting and testimonial injustice. Adele’s case is difficult because with emergency cesareans, there is little time to discuss options, but at the same time, patients are already in heightened levels of medical distress. Despite this, Adele did trust the physician doing the surgery to save her and her baby. Her bigger concern was actually the anesthesiologist.

Lacey, a 26-year-old mother who gave birth during a nurses’ strike at a hospital describes not being listened to regarding the nurses and the epidural:

My epidural for my second one [child] didn't work, and the traveling nurses didn't believe me...When they gave me my epidural it dropped my blood pressure too low. So they had to give me like epinephrine, but it spiked me and the baby's heart rate too high, so they had to like decrease it... And [they] didn’t believe me when I told them ...the epidural didn't work. So she's lucky that I was holding my husband's hand because she [the nurse] almost got punched in the face.

Lacey spoke in a small group of parents from the same small city, and they all were nodding in agreement with her comments. Lacey was responding to similar comments about not being believed. But also, the legal and political conditions around her birth are something to consider. She did not trust the visiting nurses, and several of those who

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This experience was not reported by anyone else who had had a cesarean, which makes this an example of how difficult it can be to understand larger patterns in childbirth and treatment when each experience is very different.
gave birth in that hospital spoke negatively of the so-called strike teams, some of the comments were matters of mistrust of the nurses specifically for being the teams that go in when other nurses are on strike and some were that they did not trust the nurses whom they felt did know them or their community. Additionally, the nurses’ strike was about low staffing patterns and nurse-to-patient care ratios. This is a legal issue, and in other areas of the hospital, many states regulate the patient-to-nurse ratio in intensive care units. Staffing ratios are a matter of law, which means that to some extent the political environment has an affect on patient care. Within that framework are also matters of hospital culture that arise from staffing levels and institutional frameworks.

Veronica, a nurse who would not deliver her children at her own hospital, complained about the way anesthesiologists interact with patients who say the epidural did not work. Veronica said, “like it's really funny how many people, [the anesthesiologist says to] ‘Oh, have you ever been told you have scoliosis?’…[they] have a difficult place placement or like it suddenly isn't working [and they] blame it on anatomy.” The blame on anatomy echoes back to the very blame on and mistrust of women’s bodies that was used to move birth from home to hospital and sense that women’s bodies are just non-compliant (Cramer, 2021; Leavitt, 1986; Wagner, 2006). Blaming patients for epidurals not working invites women to view their own bodies as inherently problematic—an idea with deep roots in a patriarchal culture. Further, faith in

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35 This is how one of the nurses referred to the visiting nurses who are trained specifically to go in to hospitals where nurses are on strike.
36 California is the only state that regulates nurse to patient ratios generally. Massachusetts and a handful of other states regulate this care in intensive care units. A majority of states have no regulations in place.
37 Which was my experience with my first birth, a cesarean.
technology outweighing evidence to the contrary including the person’s own reports of their pain, is sometimes being dismissed in ways that suggest medical misogyny.

When I asked Veronica why anesthesiologists seemed hesitant to believe patients she echoed Wagner (2006) and Luna’s (2020) claims about professionalism and the status hierarchy in medical fields:

I feel like Anesthesia [referring to anesthesiologists and their department], I don't know if they take it as like a personal affront. Like they always want to tell you, like “well…are you having pain or pressure, because we can't take the pressure away.” And I’m like she's [patient] having pain. I’m bolusing her!”…But, yeah a lot of times I feel like Anesthesia doesn't believe the nurse, the patient, and you're like yeah this is not a good epidural.

Veronica’s sentiment was echoed by another mother who was herself an anesthesiologist who works at a busy urban hospital and chose midwives for her second birth. This mother explained the role of not just hospital culture but the culture of institutionalized birth. An interesting element of Veronica’s story is that it reveals quite a bit of the hierarchy within the delivery room that patients do appear to be picking up on and that authors like Shabot (2021) link to gender-based discrimination within professions that filter down: doctors and anesthesiologists (who are more likely to be men) are at the top of the hierarchy of belief, then nurses (who are primarily women), then the birthing patient (who is almost always a woman). Epistemic authority flows upward with a doctor whose “objective” knowledge of the situation is privileged via policy and political to the person embodying the experience or the intermediate person with medical expertise who is closer to the patient (the nurse or midwife). The ways in which concerns were handled are a result of

38 A bolus is a single dose of medication, usually through IV, but can be administered orally. In this case, it was likely “topping off” the epidural. Some labor wards allow the patient to bolus themselves using a device that allows an appropriate release of the medication, others require staff to do it.
hospital protocol and culture when hospital culture is one of epistemic injustice, it leads to conflict. When the hierarchy is lessened into collaboration, it can lead to cooperation.

Aliyah illustrated the difficulty epistemic hierarchy creates in the labor space and the way it prevents epistemic peer cooperation. She articulates how the tension between doctors and nurses can lead to bad experiences for the patients, complicates communication, and contributes to patients feeling not believed:

And I know people don't know how to ask for those questions [about interventions] so that's a scary thought. And I needed, we needed to advocate for ourselves. Like we told our nurse, our nurses were really great about advocating for us as well, because even at the time when I was ready to push the resident wasn't even around. like the nurse kept saying, “She was in a meeting,” and I said “No, we need somebody now. It’s happening!” And finally, she [the resident] came in…but it just could have been avoided if, if, like the doctors had listened. You know, like the nurses listen, so why aren’t the doctors listening to the nurses? If they're saying, “you need to come here and check this person.” And so that part was really frustrating.

The credibility and communication issue here is part of the social issues earlier with cultural health capital and hierarchy. Witnessing the interprofessional conflict was part of the issue. The interprofessional conflict left Aliyah wondering about her care.

The role of doubt and uncertainty was significant. Veronica, who took an out of hospital birth class before the birth of her first child, has also begun to question some of the role of interventions in birth. Her comments are illustrative of the role professionalization and acculturation play in creating birth experiences, and the ways in which training and continuing education can be used to mitigate mistrust. When talking about institutionalized birth, Veronica said,

As a labor and delivery nurse, it's like, you think you're saving people like rushing to the O.R., but it's like did we caused the problem in the first place? Did we pit them to distress? Like did we convince them to augment their labor when they would have spontaneously gone into labor within 24 hours of their water
breaking? ...Did we C section them because we monitored the baby and, like every baby has dips, and it's all done to increase the C section rate.

After her own experiences giving birth at a hospital that focuses on low intervention and a cooperative model of care, Veronica is considering seeking employment at a different hospital. As an insider witness to the ways in which treatment can vary, Veronica’s experience shows the importance of professional culture and how different knowledge into the system when met with epistemic humility can alter a provider’s response to protocols that might leave out patient perspectives.

Veronica also spoke about the importance of hospital culture as a determining factor for her choice of where to give birth. Speaking about why she did not wish to birth at her own hospital:

It’s just that mentality is very medical, huge medical model there …One of the midwives got a lot of flak behind her back because she was very [non medicalized approach]…Forget intermittent monitoring, nobody there is comfortable intermittent monitoring…One of the OBs retired that would openly say, she was super… she had three C sections herself, and was, like “everyone should be cut, there's no reason, any babies have to come out of the vagina.”

So, in addition to the hospital culture broadly, the physicians on duty to have effects on birth outcomes and types and rates of intervention which is supported by public health data (Bailit, 2012; Gruver, et. al., 1999; Gruber et. al., 2013; Gruber and Owings, 1996; Johnson and Rehavi, 2016; Oner, et. al., 2015 Vedantam, 2013). What Veronica also shows is that the patient’s perception of hospital culture can shape the extent to which they feel their perspectives were valued.

Similarly, Erika’s familiarity with medical culture broadly shaped her ability to trust the systems of her care. Erika, a Black mother of two who works in health insurance

39 Sometimes called the midwife model of care (Cramer, 2021; Hill, 2019; Wagner, 2006).
management echoed the problem of doctors not listening and patients having to self-advocate. Erika describes being sent home despite being in labor because medical staff did not believe her: “I’m in full blown labor, whether you believe it or not. Just because the numbers don't look like they should to you doesn't mean that you know, like you're, you're downplaying my situation right now.” She also noted that because she was under supervision for a previous medical condition, she had expected the hospital to take her concerns more seriously. Like all other Black women in the study with only one exception, Erika was conscious of the maternal mortality crisis among Black women. This distress resulted in her mistrusting the hospital and being even more conscious of the risk of maternal death, already high among Black women:

The mortality rate for me in my situation was way higher than it would have been for someone without my blood condition. So not only did you not listen to me, you didn't read my chart or you would have known you had to keep me. What I never would have, God forbid, something that happened to her, my daughter. …I would have lost it. I would have lost it if something happened to her. Because the risk is more for me than her. I had a risk of hemorrhage…So just, the whole not, no one realizes, not listening could literally mean life or death for mom, for baby, or both. You know um, just seeing how much you feel like you don't matter, when you should matter the most.

Putting the emphasis on listening, Erika’s comments reflect the epistemological injustice patients can feel when they believe their concerns are not being heard, in particular the ways in which women are mistrusted when they complain about something that challenges what is considered objective truth (like charts for labor progression).

The importance of being clear with patients when and why an intervention is happening rather than “they just do it” approach, is seen in Leslie’s birth story. Leslie, a Black mom wanted home birth partly for fear of the maternal mortality rate among Black

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40 Nia was 13 years old when she gave birth, and it was in the 1990s.
women and because she had professional familiarity with the hospital system and was worried about being forced into interventions. She describes being transferred to the hospital and her treatment that resulted from being considered a “failed homebirth” as “an ordeal.” After transferring to the hospital, Leslie had to fight against getting an epidural so that she would be free to labor in different positions. Because she did not have the epidural, she felt her baby crowning. The homebirth midwife, who had accompanied her to the hospital, as her doula, went to get the nurse-midwives or doctor. They did not believe the baby was coming so quickly, so they did not rush necessitating the homebirth midwife/doula to rush back into the room and catch the baby, despite it being illegal for her to do so.41 Because of how the staff did not believe her, Leslie came to believe her perineal tear was due to their inaction. Though perennial tears are common her anger and mistrust from the staff not reacting (what she believed to be) fast enough was folded into Leslie’s feeling about requiring stitching from the tear. It was this experience that pushed Leslie over the line from feeling like it was an unpleasant and unwanted experience to something more traumatic:

The nurse midwife and the doctor had both like really bad bedside manner. So the doctor stitched me up… And you know as he's finishing up his stitching …the last thing he ended up, he ended with was um, “So if you're ever thinking about having children again, um you need to come see me because you can only have C sections.” And I was like, I looked at my husband, I was like “what? did you hear what he said to me? Like how dare you?” And then and then [midwife/doula] like “Do not listen to him, you're okay. Don't listen to him.” And I was it was upsetting. And so I was like, what are you doing sewing everything shut.

Here there are several layers to the professionalism. There is the obvious issue of the hospital staff not responding quickly to catching the baby (because they did not

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41 A common problem with the law is that only doctors or certain certified nurse midwives are allowed to catch the baby as it is born.
believe Leslie’s knowledge of her body or the knowledge of the experienced midwife),
but there is the conflict between the obstetrician and the midwife. Telling the patient she
could only have cesareans without offering any explanation why, left Leslie worried that
she was given the “husband stitch”\(^{42}\) and mistrustful of the hospital broadly. Both layers
of conflict and mistrust here represent the epistemic injustice of obstetric violence in that
it is again a matter of whose knowledge is valued and who gets to decide what
information another person gets (in this case, the doctor decided which information
Leslie got about what was being done to her body, while simultaneously disbelieving her
knowledge of when her baby was crowning). Further, with absolutely no redress for this
trauma, it is a type of institutional betrayal (as discussed further in Chapter Five).

Erika discusses the need for better training in listening as a way to combat some
the problems in medical care. Like Nora, her experiences were shaped by medical staff
not believing her about her physical-embodied knowledge because it conflicted with their
expectations of what childbirth should look like:

I think, the one thing I just kind of wanted to touch on which my experience with
my oldest. Being a first-time mom, I think there needs to be more of an emphasis
on just listening, you know we always get told, I know I got told, quite a few
times. “Well, you never been through this before you don't know how this feels,
you don't know what you're going to experience.” But when I’m telling you I feel
this way or this feels like this, you need to listen. You know, because there were
times, especially during the middle of my pregnancy…I had a preterm labor scare
around 26 weeks. I told my doctor, I said “something doesn't feel right, I want to
be checked out.” She's like, “oh no that's normal, it's stretching your body's just
getting bigger and expanding.”

\(^{42}\) An extra stitch put in to make the vagina “tighter” which causes pain and infection and is not an
approved medical procedure. It is sometimes performed by doctors who joke about it (Murphy, 2018), or is
requested by husbands (Rupe, 2018), and represents some of the more horrifying dynamics of obstetric
betrayal from both partner and profession, highlighting the ways in which misogyny and sexualization of
women’s bodies for male pleasure shape women’s medical treatment.
After arguing with the doctors, Erika threatened to go to the emergency room in order to get checked out. She went through “two or three” doctors the office with her threat before they finally decide to just check her: “And lo and behold, my cervix was starting to open. If I wasn't checked within probably that day or so it would have been a bad situation.”

Erika also believes she experienced a phenomenon called “Pit to distress” in her labor (a process that Veronica also mentioned seeing happen as a labor and delivery nurse). She argued with the doctors that the Pitocin was up too high and that she wanted them to turn it down. The refused telling her that it would stall her labor. Erika, who did not have an epidural at the time, told them that she could feel both the Pitocin contractions and the regular contractions, and that she wanted them to turn the Pitocin off (thereby revoking her consent to be given the medication). It was not until she told them, “Turn it down or turn it off, if you don't, I’m going to take the IV out. And it took me saying that to this nurse, and she looked at me mortified, and I had my hand on the IV like I’m not playing, turn it down. I don't like the way it's making me feel” that they finally turned it down. By that time, she says it was “too late” and she developed a condition called preeclampsia43 while she was in labor, which she attributes44 to the presence the Pitocin.45 She sums up her anger with the institutions this way:

43 Preeclampsia is a potentially fatal high blood pressure condition.
44 There is not an abundance of medical literature on pre-eclampsia developing in labor after Pitocin use, but the literature that exists does not find a strong correlation; however, because a regular google search lists “the dangers” of Pitocin in most of the top references, it is likely that Erika’s mistrust in Pitocin and her experience were shaped through the lens of mistrust more broadly than through scientific research.
45 There is interesting future research to be done on patient perspectives about Pitocin. Throughout my interviews, at least 20 people spoke about Pitocin in negative ways, many citing the movie The Business of Being Born as their primary source of information on Pitocin. Because I was not trying to steer the conversation towards specific interventions, I do not have robust data on the feelings about Pitocin, but given the polarized responses online from mothers responding to the current Pitocin stories, this seems like another place where attitudes are vehemently formed in ways that may be harmful if an individual actually needs Pitocin.
Why not just listen? If I’m telling you something, I’m not telling you for no reason, like there's a reason I’m telling you what I’m saying. And yeah, especially with, with pregnancy, labor, and delivery there's just so much. I’ve heard so many stories of just women not being listened to. Because we don't know what we're talking about, or when you're in active labor they're like “Oh well, it's just the medicine,” or “it's just your body telling you things are making you think things.” I’m like no, that's not what it is.

A feature of treatment in childbirth seems to be a feeling of medical gaslighting, the psychological violence of pitting a pregnant person against their own perception of reality. There are times in labor and delivery where it is difficult to make decisions -- as one mother said, “I just wanted the nurse to tell me what to do” -- but this is why having a birth plan and having open communication before that point are crucial to allowing pregnant people to trust their care providers at this difficult time. Several parents refer to what is known as “Laborland,” usually the transition between active labor and birth (when dilation is between 8 and 10 cm), as a space where they just wanted to be able to rely on a nurse, doctor, or midwife, and those who felt heard and valued during the labor leading up to this point felt safe and confident with whatever recommendation or intervention, including to cesarean sections, that doctors or midwives proposed during this time.

Medical Racism: Authority, Credibility, and Status

The history of medical racism in general (Roberts, 2017; Washington, 2008) and in the reproductive arena particularly (Nash, 2021; Ross and Solinger, 2017) has been heavily researched by reproductive justice activists, Black feminists, and public health scholars. As a white woman discussing birth experiences, I was mindful that race is a factor that shapes treatment in childbirth and would prevent some parents from wanting to share their experiences with me. There is a history of reproductive violence against
non-white women in general and Black women specifically, that white women have been a part of (Nash, 2021; Roberts, 2017; Ross and Sollinger, 2017). I mentioned to Gabriella, a Jamaican-Hispanic mother who was also a doula, that while recruiting and discussing birth with participants, I understood that “some moms aren’t going to want to share with a random white lady.” We discussed the importance of what she called a “consciousness” of these issue when talking about or engaging in birth work. Yet, listening to mothers, many patients felt a lack of this consciousness on the part of some medical professionals. While Erika connects her story more to a general pattern of not being listened to, she also acknowledges that she felt there was an element of racism in her experience. It was not just that Erika was a young woman or a young first-time mother, it was that she was a young Black woman that shaped the parameters of her care. In addition, being conscious of the higher maternal mortality rates among Black women, Erika went in prepared to self-advocate.

Grace, a 32-year-old mother from Ghana who gave birth in the United States, experienced a lack of racial and cultural consciousness:

I feel that, again, you know racism plays out everywhere um you know, [the staff] are like “the Black African girl, well, whatever she is, just like push, you know push her out.” …But you know very, very thin and subtle. Grace felt experienced this racism in many ways throughout her labor and pregnancy. This includes her wish for a low intervention birth, with respect to her religious and cultural beliefs. The atmosphere became so difficult during labor and delivery that her mother, who had traveled from Ghana for the birth, left the labor room. Additionally, Grace and her husband felt the medical care providers did not explain procedures in a way that made them feel confident:
[The doctor] she didn't let me know what it [the problem] was, I didn't know whether it was [baby’s] heart rate or whatever, but no one told me exactly what it was. But I feel that his heart rate might have been a little bit slow, but he was okay. So [they] broke my water rush me along. [They said]… “We would have to perform a C section.”

When I asked how they talked to her about breaking her water she said, “There was no informed consent, they did not ask.” When she refused the cesarean, Grace said,

They give me some medicine and immediately, they give me that medicine …[and the baby’s heart rate began] dropping and dropping, and dropping and dropping and it was like, we were like “nope, we have to get him out right, we have to get a baby out right now, we have to get the baby right now.” And that's when they rushed me, to you know the cesarean section.

Notice that she did not know what the medicine was or why they gave it to her his speaks to the lack of communication. Whatever doctors said or did not say, communication did not happen, and that left Grace feeling mistrustful. Like the epistemic injustice and epistemic authority issues more broadly, cultural health capital is part of a schema of who is believed and for Grace, she felt as though she did not have the health capital necessary to feel heard and cared for.

As well as the helplessness she felt shape Grace’s response and caused her severe postpartum depression and other physical ailments for which she was later hospitalized:

Then I became very depressed after having him, you know I felt … it makes me a little bit emotional, very upset. But I felt that you know that …the mother-child, you know bond was taken away from me, I was rushed. And I really my, I didn't enjoy my birth at all, I did not enjoy the experience. I didn't know who the doctors were. I don't know who the hell was in my room, like people would just come and go. Nobody introduced themselves to me. I never saw my doctor once or any of the doctors I had seen any of my OBs, I never saw any of them.

The impersonal nature of institutionalized birth, paired with a lack of cultural understanding shaped Grace’s perspective on childbirth. The institutionalization itself leads to a pathway of mistrust because of the lack of flexibility to meet patient needs.
Isabel, a 35-year-old mother from Spain spoke of her experiences with a previous childbirth in North Carolina during her PhD program where she felt unsupported generally and recalled several racist comments towards her and her husband, who is from Mexico. To avoid this, she chose to have her second child, who was due during the COVID-19 pandemic, at home. Since she did not have childcare for her toddler and was afraid of giving birth alone if her husband were to stay home with the older child, this made sense. But she was still not sure about it until a colleague who was a doctor confided that she had also had homebirth; a choice common among some doctors (Goldstein, 2015). For Isabel, the choice of homebirth was so extreme that she did not tell her family about it until almost the end of her pregnancy, but she chose it deliberately to be treated with respect and care in childbirth after doing prenatal care with obstetricians.

Isabel’s experience captures much broader themes in the birth that, even when situations are difficult, feeling met with respect and care allows patients to give their trust more easily to the medical provider:

I had a cervical lip; the pushing phase was horrible because I had to push with a midwife like pushing the lip…it was super painful… Then I had, I had a hemorrhage…Then my blood pressure was still very low, so the older [midwife] figured out that there was something going on, and she put Pitocin and everything, so you know they were I had an IV, you know they were prepared for this emergency and then I expelled the rest of the membranes, and I was fine. So I lost, I lost more blood during this process, which was kind of stressful. I was totally calm totally, I felt completely safe, you know I don't know like it was it was an amazing experience.

Even in the midst of an emergency Isabel and her husband believed that things were safe and felt calm. This is a prime example of the epistemic peer model and the ways in which it provides trust and increases the ability of patients to accept recommendations.

46 This is not to say that only midwives can be epistemic peers. As Aliyah’s story illustrates earlier, her OBGYN talked her through a difficult decision and procedure in what is an epistemic peer model.
The flexibility of the midwife model of care paired with the personal connection available because of the lower patient-provider ratios. Isabel attributes these good feelings, despite pain and discomfort, to her trust in her midwives, a trust that came from mutual respect:

Knowing the management of the emergency of the postpartum hemorrhage I always felt, I was [in charge]. She asked me like “do you want me to…I think you need Pitocin at this point because…” I said “yeah, yeah go ahead.” You know? But I made that decision. They were asking all the time, you know how midwives are, you know, like you know they're all trained like they were asking for consent for every single thing you know, and I just said, “stop asking me if you can listen to the baby, of course you can listen to the baby.”

This is a point to be considered when discussing patient trust: the more agency the patient feels they have seems to make it easier for them to accept medical care provider guidance. Likewise, while there are polarized attitudes about which model of care or care provider are best, it appears that a provider someone trusts makes the most difference, regardless of model of care.

The connection with her provider was crucial to Isabel’s sense of well-being. As she observed, the experience with her obstetrician’s office left her worried that she would not be able to trust her provider if something went wrong, even as she admitted that if her midwife had told her to transfer to the hospital, she would not have questioned it. The good faith the is created through good communication and mutual trust was made impossible by the dismissive treatment she experienced from her obstetrician’s office. In the story both the structural and institutional levels are here because doctors are not

Likewise, not all midwives are epistemic peers. That is why this research suggests an epistemic peer model is a more useful way to conceptualize the false “midwife versus medical model” of care dichotomy that posits midwives are always patient centered while OBGYNs are never patient-centered, or that OBGYNs are medical and midwives are not.

With homebirth midwives it is between one and three midwives per laboring patients.
available as easily for patient questions, but also, institutional protocols do not support the “soft skills” necessary to build relationships and cooperation.

I had a horrible visit…with the OBs. The doctor was there for five minutes again she told me that the baby was transverse, and I said, “let's get an ultrasound, you know and and check it out, because I do think the head is…down.” And she's like “no we’ll get it in two weeks, and if it's, if it's still transverse transverse then we'll schedule” one of these things where they rotated… “If not if it doesn't work then C-section.” And I would come crying, you know.

When she asked for more information about her condition she recalled racist treatment:

I called again. The nurse was like awful with me like really, really, really awful like “maybe you don't understand because English is not your first language, but…” You know blah blah blah these kind of things. And I felt so bad, so I called again. I complained, I was crying…And this bullying is horrible and you know. I have a PhD, I’m an educated person and everything, and I’m still, I felt super vulnerable that I couldn't say anything, you know.

Consciously concerned about medical racism, Gabriella, a bi-racial doula, wanted a homebirth partly because she did not like institutional birth but also because of the maternal mortality crisis. Due to her living situation and her family’s resistance to homebirth, she began her prenatal with an obstetrician’s office. After being treated in what she describes as a “stale” environment, Gabriella and her husband decided to transfer to a local birthing center. There, they had a mostly good experience, but Gabriella noted that who is in the room and the way they treat the patient is important:

To tell my [sarcasm] darling midwife [end sarcasm] that you know I had concerns and then to be laughed at was like, what?! You know um yeah very different. So she ended up, for one reason or the other, and I think this is really why it was two days off when I got to the birth center and had started contraction she was there. But my son decided to prolong it a little bit longer. Maybe I decided to.
Gabriella attributes her son’s delayed birth to her being uncomfortable with her providers in this case, her midwife. This is an assertion shared by many other mothers in my sample.

When Gabriella had a different midwife, she felt more comfortable relaxing in labor,

Our communication styles were different, which is fine, but I could tell like you know, her end goal and mine matched. In terms of you know, good vibes, positive feelings. She did actually end up being the midwife to deliver my second son. That when I felt like it was very much like I am woman hear me roar which was awesome is very empowering.

Like other mothers in this chapter, especially Nora and Felicity, Gabriella’s story shows how easily trust-mistrust can change as quickly as who is in the room. Her original discomfort may have been exacerbated by previous experiences, but the midwife whose “vibes” aligned with what Gabriella wanted was able to walk through that to provide comfort.

The empowering birth experience and the importance of mindset were also present for Eudora, a Black mother of one who is a postpartum nurse who also chose to give birth at a birthing center instead of a hospital. Like Gabriella, Eudora wanted a home birth, but “due to financial and logistic reasons it was out of reach.” Eudora notes the stress that medical racism can put on people and that while she did not experience it during her pregnancy, it was a chronic backdrop in conversations about pregnancy and labor. From her friends and family, she was reminded of the maternal mortality crisis. For both women, the birthing center provided a space for them to give birth in a way they felt

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48 This again highlights the need for more than a midwife–medical model of care dichotomy. Mistrust can be created by any provider and can be mitigated by providers. The epistemic peer understanding of birth providers highlights the need for open communication rather than relying on a certain model of care to increase trust.
was safe, empowering, and accessible but also where they would be heard, seen, and treated with respect as knowledgeable about their own bodies and people who care about their children. Eudora credits her successful birth with having a positive mindset and being able to choose where to birth among people she trusted. While the institutional culture in birth centers may make it easier to have autonomy, several of those who gave birth in hospitals also noted the importance of having a positive mindset as part of their experience. The role of trusted care providers in hospitals especially centered around nurses, with ten participants mention “Labor land” (a space where they “just wanted to be told what to do”) and feeling comfortable entering that space because there was a nurse they trusted guiding them through it.

**Conclusion: Listening our way to change**

Epistemic authority is not a problem law can solve, but it is an area where organizations are currently trying to use law (through certification, re-licensure, training) to mitigate implicit biases and increase cultural competencies. Whether midwife licensure and (even more contentious) doula licensure would allow more types of evidence in the room to increase the epistemic credibility of all involved remains to be seen. Understanding pregnancy as an epistemologically transformative experience (Woollard, 2002) and each pregnancy as different can help patients and providers become epistemic peers through collaborative partnerships and decision-making. Valuing both types of knowledge—the embodied and the clinical—can render even a difficult experience less traumatic, providing a healthier atmosphere and sowing the seeds of future trust. But the perception of women as less believable or less rational, especially when they are pregnant, creates the conditions for epistemic injustice in ways that may not be easily
eradicated from practice. The hospital policies that promote institutions and technology over interaction matters. The habit of not believing women or social norm of seeing women’s bodies as unwieldy. Likewise, the epistemic authority granted to medical professionals over the embodied experience of the patient makes it difficult to find ways to challenge the institutionalization of birth.

Birth justice scholars have focused on the importance of a positive birth experience as a matter of health and justice (Oparah and Bonaparte 2016). But through institutionalized birth and the reliance on interventions and technology, people’s birth experiences are shaped in ways that are not often discussed even in birth justice, and there appears to be the tacit understanding that any birth in a hospital will be a fight. Indeed, as Black mom Felicity said, “I felt like I was going into battle.” But, if birth justice does not make space for positive hospital birth experiences, then the movement and scholarship run the risk of alienating allies and falling into the same epistemic traps that marginalize out of hospital birth as less safe because it is not “medical” care. The knowledge hierarchies that Aliyah and Veronica observed cannot be addressed by policies specifically, even policies meant to rely less on technology. Cultural health capital, which an important element to understanding treatment in childbirth is intertwined with an epistemic credibility gap that negatively impacts women.

Eudora, Gabriella, and Erika discuss the ways that epistemic credibility is shaped by race. Their stories connect back to a much wider literature on medical racism, but they also illustrate the difficulties overcoming cultural health capital barriers for Black women even if they are familiar with the medical industry. All three of them have some familiarity with medical terminology of childbirth and some professional familiarity with
hospital settings and language, Eudora as a postpartum nurse, Gabriella as a doula, and Erika as a health management professional. If the ability to speak professionally about childbirth or understand hospital and medical vocabulary and protocols were enough, all three of them would have had high cultural health capital. But that was not the case for Erika and was only partly the case for Gabriella. Even among those who should have objectively high cultural health capital, medical racism diminished their epistemic credibility within the institution.

The knowledge hierarchies that shaped Nora and Shelly illustrate the role of doxa, the common practice, in marginalizing women from their own experiences. Both women experienced labor and were told that because their experiences did not match what was expected (as in Shelly’s case) or that they were too young (as in Nora’s case), both were disregarded. Nora’s frustration with the doctors speaking to her husband rather than her illustrates what Reyes-Foster (2021) calls “maternal vanishing” or the ways in which the person in labor is ignored as a feature of hospital policy and protocol. This vanishing can also appear as a result of hospital staff who behave in ways that patients’ perceive as unprofessional or hostile to maternal wishes. As Aliyah and Shelly noticed, when hospital staff have a conflict in front of patients or do not treat each other with respect, the patient has less confidence in the professional even if they are making the right decision from the medical and health standpoint. For Aliyah and Shelly, there were moments when they felt “vanished” because they believed their input was lost amid the inter-professional clashes.

Veronica’s story offers insights into the role that hospital policy and the institutionalization of birth have on those who work there. Her mindset before seeing other hospitals was one she describes as seeing interventions in heroic lights. When she
recognized that her own hospital might not allow her to birth vaginally due to the preference of the head of obstetrics, she chose a different hospital. Even with the cultural health capital of a labor and delivery nurse who works at that hospital, she was mistrustful of the hospital itself. Her choice to seek employment in a different place rather than try to change the institution from within illustrates the difficulty of any single actor being able to change institutional policies.

As will be discussed more in Chapter Seven, one pathway to increasing epistemic justice is through training. Training requirements as part of continuing education credits for licensure renewal could provide professionals a place to reflect on their practices and integrate models of care that balance their expertise with patient experience as implicit bias trainings have done. Organizations such as Evidence Based Birth and VBAC Facts are engaged in this work already and are able to offer continuing education credits to nurses and doctors in some states. Examining their data seeing whether or not the outcomes and hospital culture shift, would be a way to test whether this intervention is useful enough to enact at a state or national level. While a wide-scale social reimagining of the status of women in order for them to have greater autonomy and agency seems unlikely, but making explicit the ways in which misogyny meets medicine through non-hospital prenatal classes, social education programs, on the part of consumers could provide pre and postnatal support.

Through a mixture of professionalization and hospital culture there are ways offering critical history of medicine (Armicida et. al., 2021; Berrig, 2018; Jones, et. al

49 For certain professional licensures, continuing education credits are a part of re-certification requirements and promote the learning of new skills and practices.
2014), particularly about the ways structural racism and misogyny still pervade the field (Davis, 2021; Luna, 2020; Ross and Solinger, 2017; Washington, 2008). Using medical curriculum to center the role of medicine as a social field could help professionals guard against some of these epistemic biases.

Those who shared their stories here were interested in improving the culture of birth. As Amanda, the physician and mother of four said after several difficult experiences, “I have to believe that it can change because, I can't imagine my two daughters having babies in this type of climate. I don't want that for any other little girls or women.” Ultimately, those who have undergone the epistemic transformation not just of pregnancy but of labor and delivery, provide a valuable source of knowledge for policymakers and advocates, childbirth educators, and doctors and nurses because they have lived the experience of politics and policies. Changing the culture of patriarchy necessitates making visible the spaces where patriarchy is still present, and institutionalized childbirth can be one such place. To change how those who labor and deliver are seen and treated would have wide ranging positive outcomes throughout the health and welfare of entire families and communities. But that change must start by listening to those who give birth for what their stories reveal about how communication is important on the ground.

The next chapter moves from importance of listening as a tool to overcome epistemic conflict and to take concepts of how institutionalization of childbirth contributes to some people articulating institutional betrayal as a result of what they see as policies that caused them harm. This chapter will take us from the importance of understanding mindset and epistemology to how these mindsets shape institutions in a
way that can cause lasting harm.
CHAPTER 5: “YOU’RE NOT ALLOWED TO NOT ALLOW ME”: LEGALITY AND THE SUBTLE COERCION OF (MIS)INFORMED CONSENT

A shock went through the birth justice community when Caroline Malatesta won a $16 million lawsuit against an Alabama hospital for her treatment during childbirth (Lee and Cline, 2021). Some viewed this rare victory as a sign that birth justice activists were achieving their goal of raising awareness and getting legal redress for obstetric violence, a term that includes coercion, mistreatment, bullying, or assault during childbirth (Chadwick, 2016; Chattopadhyay et al., 2017; Diaz-Tello, 2016; Kukura, 2018). Malatesta suffered permanent damage during the birth of her child when a nurse forced her on her back and another held her baby’s crowing head into the birth canal for six minutes (Faulk, 2018; Lee and Cline, 2021; Pascucci, 2018; Tucker, 2018). Aside from the excruciating pain she suffered in the moment, Malatesta developed pudendal neuralgia, a chronic pelvic pain that makes it impossible for her to have vaginal or anal intercourse or more children (Faulk, 2018; Pascucci, 2018; Tucker, 2018). For this, a jury awarded her $10 million for the nerve damage, and also awarded $1 million to her husband for “loss of consortium”\(^{50}\) (Faulk, 2019; Lee and Cline, 2021; Tucker, 2018). The jury also awarded Malatesta $5 million dollars for “reckless fraud” on the part of the hospital which had marketed itself as promoting “natural birth” and being intervention free (Faulk, 2018; Pascucci, 2018; Tucker, 2018). Malatesta’s experience sparked out-
pourings of sympathy and stories online with many pointing to her treatment as (what they believe is) evidence of a harmful medical culture in the United States.

This chapter considers the two inter-related issues of epistemic justice from Chapter Four and the role of institutions in Chapter Three. In addition, it adds to a wider discussion on the construction of legality and how that becomes legal hegemony in a medical setting. Thinking about Malatesta’s case in the course of this study allows us to see an example of the ways in which legal hegemony and the legalistic trappings of institutionalized birth can result in reproductive coercion. This chapter deals with several closely related elements of reproductive coercion—the opposite of the reproductive autonomy discussed in the previous chapter—that involve around the legality and legal hegemony of hospital policy within institutionalized childbirth. Legal hegemony can be described as law’s invisible role in legitimizing and, in some cases codifying, structures of power that are constantly reinforced through day-to-day interactions in such a way as to render them natural interactions, masking their presence as choices (Silbey, 2005).

As contemporary conversations around campus sexual assault note, consent is a more difficult concept to understand in all settings. It is not always clear when consent is freely given, when it is informed enough, or when it is revoked without explicitly saying so. Communications styles and personality types can create clashes in consent without being malicious, and law alone cannot fully flesh out all of these grey areas. The confusion around consent creates problems for patient trust in childbirth because consent is the most proximate legal protection for patients and consent forms or “consenting” (getting consent) are touchstones of all medical culture in the U.S. Hospitals must get consent for any procedure. When a patient cannot give consent because they are
unconscious or are not legally able to do so, there are protocols and laws in place that guide medical decision making. But it is not always clear when that consent is truly informed. For some patients, relying on doctors, nurses, and midwives will be enough to feel informed, for others clarifying questions will help, but some will not know they can ask or will not feel as though they can even if they are allowed. Still there are some patients who will never feel fully informed because they have their minds set against an intervention and there is not changing it. This puts care providers in a legal conundrum: they legally need consent forms but patients may be refusing medical care from misinformation. Within the context of birth this is more complicated because, while an adult can refuse care for themselves, it is unclear how much risk a fetus is expected to assume on behalf of its parent.

Because there are legal elements like consent forms and insurance issues some of which have the actual power of law on the books behind them, all hospital policies become imbued with the trappings of legality people think all hospital policy is law and there will be some form of consequence if they do not follow it. Particularly drawing attention to the interaction between hospital policy, legality, and the ways in which informed consent can be deployed to coerce patients in an institutional setting. This chapter uses interviews of those who gave birth to show their perceptions of informed consent. Exploring legal hegemony and the “language of demands” (Hill, 2019) through interviews reveals a sense of misinformation, coercion, and doubt. This chapter draws together the theoretical elements of epistemic violence in Chapter Four and the ability of policy to shape reproductive autonomy in childbirth outlined in Chapter Two. Hospital policy shapes knowledge and choices when epistemic authority is granted to hospital
policy because of the epistemic credibility of those who implement the policy (doctors, nurses, and nurse-midwives).

**Law without law: Legality becomes Legal Hegemony in Institutionalized Childbirth**

A cornerstone of law and society research is the acknowledgement that law is not just a social construction but part of a wider social process. Law on the books is a part of this process but so are expectations, norms, rules, and customs that ordinary people imbue with the authority of law. In hospitals, the belief that hospital policy as law comes from the grey zone between law and legality—what is law and what is law-like—especially when it comes to questions about the limits of consent for those in labor. There are not firm guidelines on what risks laboring people may take during birth by refusing interventions, and as Chapter Two notes, the policies and laws vary widely across and within states. Through unpacking the legality at work, this chapter explores the way the legality inherent in informed consent forms creates a subtle coercion during childbirth. While consent forms are legal documents, informed consent is less clear: when is it fully informed? When is it actual consent? In short, consent forms do not mean that consent has been informed nor that it has been given freely (Donovan, 2014; Ozhan, 2014). Patients believe they must fill out the forms and that the forms mean they have given their consent, but they do not always feel as though they can revoke their consent, understand what it most important, or that they could have refused to sign the forms (Donovan, 2014; Ozhan, 2014) because of the sense of legal hegemony. When consent forms are conflated with signing away a legal right, patients feel as though the law supports whatever hospital policy says.
Silbey’s (2018) recent work suggests looking at legality as “an analytic term rather than a socially approved state of affairs” (n. p.) noting that legality and law are often interrelated. Legality is both an interpretive framework and a set of resources for people to understand their social world (Silbey, 2018). Silbey (2018) refers to legality and legal consciousness as being demonstrated when “ordinary citizens invoke legal concepts and phrases as part of their accounts of situation” (n. p.). In the interviews that follow, participants referred often to consent and choice and what they were “allowed” to do, invoking some level of this discursive legality. Silbey (2018) also notes that “legality is hegemonically present in … institutional forces” (n. p.).

Legality within hospitals turns into a sense of legal hegemony when hospital policy and insurance company preferences are used to deny birthing people their right to choose how their children come into the world and how their own bodies are treated in the process. Likewise, hospital administrators and risk managers make policies that consider law, including those that might curtail patients’ rights or knowledge in order to avoid lawsuits against the hospital (Fiumara and White, 2016). The legalistic nature of the process becomes routinized to the point of invisible reliance on these trappings of legality to produce a sort of legal hegemony where what people think is law is used as the basis for their decision-making. As Silbey (2005) notes:

> hegemony is produced and reproduced in everyday transactions in which what is experienced as given is often unnoticed, uncontested, and seemingly not open to negotiation…[and the] burdens and costs, in these transactions are relatively invisible (330-31).

Understanding how we come to think of who has what authority in institutionalized childbirth can expose the legal hegemony of hospitals and the ways in which this
hegemony shapes understanding of consent because patients may think a legally preferred intervention is actually a medically preferred option.

Levitsky (2014) contends that there is a need to study these expectations in relation to policy or policy discourse, especially in areas overlooked as sites of legal hegemony. Legality is the meaning that people give to things they think are legal; it is “how people make sense of the law and legal institutions and how people give meaning to their law-related experiences” (Hoffmann, 2005, 692-93). Because of this meaning-making capacity, it is important to understand the ways in which legality meets epistemic credibility in areas that are not even considered legal—such as familial care giving (Levitsky, 2014) and birth (Cramer, 2021).

Listening to those who have given birth, it becomes clear that law, legality, and epistemic authority have a profound effect on what happens in labor and delivery. The use of consent forms and the language of demands, what patients may not do, form a legal hegemony where the idea of law-based rules becomes an important way of understanding how one is expected to behave in labor. By observing this hegemony in practice through listening to birth narratives, this chapter offers a contribution to understanding the continual (re)construction of legitimacy via social processes, and adds the importance of epistemic authority. In other procedures, patients may refuse and reasonably expect that refusal to be heeded, but in birth doctors often take the “two patients in one body” approach (Lyerly, et. al. 2008; “Refusal,” 2016), where they view the fetus as a separate patient who is equal to or even entitled to more consideration than that of the gestational parent. This two-patients-in-one-body model is concerning because it indicates that doctors’ preferences or beliefs about the mother take precedence over the
birthing person because it presupposes an antagonist relationship where the doctors are acting to protecting the fetus from the mother’s decisions rather than making decisions with the birthing person to protect gestational parent and fetus.

In her article on the need to study law and health policy Levitsky (2013) illustrates hegemony and how it works in a medical setting:

When people understand certain social structures or practices as natural, normal, or just the way things are, they are less likely to believe that these constructs can be challenged or changed. The project of demonstrating the ways in which social structures and practices are not inevitable, but instead the product of social and political action, is thus directly relevant to public health scholars interested in the dynamics of health policy reform (p. 43).

Levitsky’s (2013) point is quite salient in birth. In my interviews, I found the normalization that Levitsky speaks of is reflected across age, race, and economic status, making my research important in understanding not only what/whether people think of rights during childbirth but where they say these perceptions come from. Going into the delivery room allows us to study places where “the presence of law is neither obvious nor visible” (Levitsky, 2013, p. 35), and legal hegemony goes unnoticed (Silbey, 2005) as hegemony. Hernandez (2010) likewise notes the wide scope of attitudes towards law even in similar situations. She describes the polyvocality of low-income mothers and how the multiple perspectives and ideas shape understanding of law the reaction to legality.

The Language of Demands: The Subtle Coercion of Informed Consent

Despite the law and legality of hospital policy, a hospital setting is not its own special legal zone where hospital protocol supersedes laws on bodily autonomy and consent, yet institutional policies often do just that. Weinberg (2016) notes that there are
some ways in which consent to violence or harm in hospitals is understandable, for instance, if it is in the course of treatment (e.g., breaking ribs during CPR chest compressions) and the harm happens in order to repair a greater harm. But, in birth, patients are not always aware of what they are consenting to. Law on consent “operates as the cultural frame that shapes a person’s expectations, attitudes, and beliefs” (Weinberg, 2016, 28), so when patients’ consent is violated during the course of birth, many will assume that this is appropriate and acceptable due to the legality of forms. Like the meaning-making power of law in general, “Consent operates as a script that individuals use to make sense of their reality” (Weinberg, 2016, 12) and when that consent is violated without recourse, legal hegemony is revealed and institutional betrayal happens.

While positive autonomy (the right to request a procedure) is less explored through the literature and law, negative autonomy (the right to refuse even in the case of life-threatening harm) has a long history in U.S. law. As explained in Union Pacific Railroad v Botsford (1891) with the U.S. Supreme Court holding: “No right is held more sacred, or is more carefully guarded by the common law, than the right of every individual to the possession and control of his own person, free from all restraint or interference of others.” Negative autonomy is continually articulated through cases, notably, in Cruzan v Director of Missouri Department of Public Health (1990): “A competent person has a liberty interest under the Due Process Clause in refusing unwanted medical treatment.”

These laws also shape stated ethical principles of major healthcare professional organizations in the U.S. The American College of Obstetricians and Gynecologists and
the American Academy of Pediatrics both espouse that bodily autonomy of the
gestational parent\textsuperscript{51} is of paramount concern even despite physicians’ personal beliefs to
the contrary (Cramer, 2021; “Refusal” 2016). The hospital or medical staff may not
provide every requested procedure, depending on facility conditions, economic/insurance
issues, and other considerations, but they are legally and ethically bound to respect a
patient’s declination of treatment. Talking to people who have given birth shows there are
a wide range of attitudes towards what is an acceptable level of personal autonomy or
even self-advocacy at the patient level and from how they are treated by professionals in
the room. This variation in willingness to claim or even acknowledge a threshold of
bodily autonomy for birthing people is formed from ideas about law and rights as well as
ideas about parenthood, especially motherhood. This is particularly evident when it
comes to social attitudes about motherhood as inherently self-sacrificing (Hill, 2019;
Nash, 2021; Sadler et. al., 2016) and the belief that a “healthy baby is all that matters”
(Diaz-Tello, 2016; LTM II, 2006, Pascucci, n.d.; Taghizadeh, et. al., 2013), which leaves
the unstated premise that mothers do not matter and their injury or trauma is an
acceptable price for a baby\textsuperscript{52}.

But consent is more than a yes/no dichotomy, it is a practice and a process
(Weinberg, 2016, 85-86) that can be difficult to negotiate over the course of a labor and
delivery. This difficulty is due not just to institutional or professional attitudes, but the
hospitals are understaffed—as discussed in Chapter Three—meaning that doctors and
nurses do not have the time to fully explain interventions and options to the person in

\textsuperscript{51} They use the term woman.
\textsuperscript{52} Despite research that shows the effect of trauma on family, including breastfeeding, bonding, and
postpartum depression.
labor, especially if that person lives in a maternity care desert and did not have adequate access to discuss procedures through the course of prenatal care. Looking at the number of professionals per birthing person in the U.S. compared to other industrialized democracies, we see that the U.S. ranks very low in the patient to care giver ratios (Tikkanen, et. al., 2020) which undercuts multiple levels of quality care, including the time needed for longer discussions about interventions.

Understanding the contours of informed consent, when a patient feels properly consented, and how medical professionals can best present information in an understandable way have all been the subject of recent scholarship. Exploring a history of informed consent cases, particularly around sterilization and cesarean procedures, Curran (2012) calls informed consent a “right without a remedy” because “the informed consent doctrine fail[s] to ensure the fundamental right to bodily integrity” in childbirth (136). Curran (2012) offers guidelines for states to recommend informational guidelines to provide more pathways to redressing a lack of informed consent. Director of Perinatology and Medicolegal Chair at Harbor-UCLA Hindi Stohl has written extensively about the limitations of informed consent on patients’ access to VBACs (2017) as well as the general need for more clarification on how informed consent protocols in labor can be applied (2018).

Wade and Anup (2019) found that women who receive information at 36 weeks gestation and while in labor have a higher likelihood of understanding and giving informed consent than women who receive information only once labor has started. Their study also calls for further study on the capacity of informed consent to be standardized in prenatal and intrapartum care. Sturgeon, et. al.’s (2021) Scottish study
illustrated that psychological trauma can result from emergency procedures in birth when patients do not fully understand what they are consenting to. Their study illustrates a general lack of fully informed consent and explores a protocol to help inform patients about risks and benefits. Valente, et. al. (2022) study of 1200 women in labor found that informed consent was lacking in many cases, with cesareans being a notable exception. Their findings align with previous evidence showing that consent request practices during childbirth need to be largely improved. More research is needed to investigate effective strategies for improvement” (Valente, et. al., 2022).

One of the ways to get consent forms without consent is to not offer a choice. Using the “language of permission” as a starting point, Hill analyzes the public discourse surrounding women who give birth as a way of understanding how the commonality of discursive violence lays the conditions for the structural violence. Phrases used to disempower patients, such as “I’m going to give you an exam” versus “May I give you an exam” (Hill, 2019, 20). This language of permission/demands includes things like telling the patient that something will be done to them rather than asking for permission to do it. It also includes medical staff saying they “cannot allow” the patients to do certain things, like labor standing up or eat and drink. Likewise, with VBACs the doctor will “let you try” is a disempowering use of language.

In addition to the interpersonal language use is the broader social context of misogyny as discussed in Chapter Three which lays the groundwork for epistemic

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53 Hospitals had previous banned VBACs because of the staffing costs of keeping OBGYNs and anesthesiologists (in the event of a cesarean) fully available (Dekker, n.d.). Likewise, hospitals and the ACOG had relied on studies that falsely inflated the risks of uterine rupture and maternal or fetal death, with ACOG revoking its support for VBAC bans in 2017 (Dekker, n.d.; Wagner, 2006).
injustice which marginalizes women. Hill (2019) lists comments made by obstetricians about “floaty dressed middle-class mums,” women who “think they’re the only person ever to give birth,” “bloody difficult women,” and other disparaging remarks made publicly by professional OBGYNs and contends that it is impossible to separate structural and institutional misogyny from contemporary practices. Regardless of whether Hill is right that these comments reflect a broad culture of medical misogyny, her perception that this is the case was common among my interview participants especially those who felt unheard. The history of misogynist practices is also reflected in the subconscious shaming of women’s bodies resulting in practices like shaving the pubic hair because it is seen as “dirty” (Block, 2007; Greer, 1999; Wolf, 2018), to episiotomies or cesareans to keep vaginas “firm” (Block, 2007; Greer, 1999; Wolf, 2018), and the policing of women’s intimate areas in many cases for the benefit of men, such as the “husband stitch.” Hill considers attitudes towards birth givers as a manifestation of medical misogyny, but she believes that “a vast majority of medical staff do not knowingly perpetrate obstetric violence” (p. 54).

Findings: Doubt, Misinformation, and Fear

In a number of interviews parents discussed not feeling informed enough to give meaningful consent and feeling as though they had no choices. This did not bother all parents. Many were happy to do what the doctors and nurses advised them to do if they trusted staff, hospitals, and medical providers in general. Those who had prior negative experiences with the medical industry or in birth specifically, however, expressed how the miscommunication or not feeling meaningfully “consented” left them with doubts about their care in a way that increased their mistrust in the medical system. All used
language of consent in some way and talked about policies in hospitals. There was some sense of a legal hegemony when they discussed what you are “allowed” to do. Several categories arose in discussion that illustrated the consent-legal hegemony issue: lack of communication to feel informed, mental and emotional coercion, and the role of ableism and disability in shaping mistrust.

Lack of Communication: Demand versus Consent

The language of demands played a role in the feelings of some families who felt a sense of mistrust later on. The language of demands was a common talking point from interview participants: the feeling that if you do not give the patient an option, they do not know they can refuse. Astrid found this out when the nurse approached her to start Pitocin without asking her about it or telling her what was in the IV bag that was being hooked up. She had explicitly said she did not want to start Pitocin early in her labor and the nurse responded that it was “standard procedure” and continued to hook up the IV. Like Astrid, Aliyah, also had concerns because of the language of demands. As her labor progressed she was alarmed to be told she needed a cesarean. She notes: “That was frustrating…because…it's like they come in, and they're like hey you need a c section, and they don't, they didn't tell me any of that they didn't prepare me or tell me like the alternatives.” Aliyah’s response was to ask medical professionals to explain themselves. A short conversation did not change her mind about wanting a cesarean, but the respect for her concerns allowed her to feel comfortable accepting it. A social worker, Aliyah also pointed out that she and her husband were equipped not just to ask the questions they needed to feel safe and comfortable ultimately accepting the cesarean, but to know they
could ask which was not the case for all parents. Aliyah pointed out that others who lacked their education, professional status, and other privileges might not feel capable, comfortable, and even aware of the ability to try and be epistemic peers.

Laurel, a college student and mother of three, was hoping for a VBAC when we spoke. When she was 17, her first child was born attended by midwives. She describes that birth as easy, until the end when she had a perineal tear that required extensive repair. After a considerable recovery period, her second child, two years later was also born vaginally. Despite the difficulty and physical trauma from those two births, it was when Laurel had a cesarean with her third child almost a decade later that she reports the most negative feelings about consent and the process. Her third labor progressed, when her contractions stopped, she was told she would need a cesarean:

Oh I didn't even really have, I didn't have a choice they had mentioned it prior…they were just like, nope, C-section. And I like literally didn't, I really don't … I don't even recall saying yes or no, I think I was just like oh. Like I just remember crying. I remember crying, and, and I think at that point, I was just like okay, well do what you gotta do.

Laurel fears that needing a cesarean could have been a matter of the previous stitching from her other two births, but it was not explained to her at the time or even asked follow-up questions postpartum, leaving her to question the cesarean because it she felt she did not have enough information. It is this sense of the unknown and the lack of information she feels entitled to that causes Laurel such discomfort that she wants home birth for her next baby. Additionally, she felt not informed because no one would explain the reason for her cesarean after the fact. This made her suspect that it was not medically necessary. She was triggered by this even later when she learned about the low rates of VBAC. Her experience here mirrors the broader literature of women not being informed
about the increased risk of follow-up cesareans when they are presented for with the option for one (Herlacher, 2022).

Because this study did not look at medical records, it is not possible to discern the medical motives for any intervention, but the fact that patients do not feel that it was explained properly and participants have trouble getting their records, engenders mistrust and continues a sense of incomplete information for those I spoke with. If there is an information vacuum, considering cultural health capital another concern regarding medical mistrust is that those with lower cultural health capital are more comfortable asking friends or looking on the internet for explanations rather than pressing doctors or nurses for them. This information vacuum could then be filled with out of date information, cultural beliefs, or anti-science information from online. I interviewed two mothers who had what is known as a “stat section” which is, as one described, “even more emergency than an emergency c-section” in which there is absolutely no time for discussion because mother and/or baby are moments from death. Situations like these arise in any medical setting, and require firm communication beforehand so that when they do happen, the trust is already built into the relationship between provider and patient. The amount of discussion and time to plan around Laurel’s case suggests that this was not a stat section, and she was not familiar with the term. So, there were discussion, but none revolved around helping her understand the nature of the medical decisions enough for her comfort, which left her concerned and considering a home birth with her fourth child.

When asked why she might consider a homebirth, Laurel said:
[the doctors] really didn't give me, I didn't have like a choice. Like they didn't hear me. Even if I said no, they just didn't hear me. … you know so at that point. I just felt like something was just being taken away from me… but I think that's why, I think afterwards it affected me so bad for months because, like, I felt like I did not fight hard enough for that moment, you know I did not fight hard enough.

Throughout our interview, she repeated that she “did not have a choice,” and it was clear that this was something distressing to her, a fact she remarked on after. The idea that there was some other option to “fight for” and that she did not feel she had fought hard enough is a result of her not feeling her consent was given freely or that she was fully informed. Not feeling included in the decision-making process resulted in a coercion by lack of information that left residual mistrust. Additionally, not knowing the reasons for the previous cesarean puts her at a disadvantage when accurately weighing the safety of home birth. Laurel could be unnecessarily endangering herself with a home birth without knowing it because of her lack of communication from medical professionals during and after her third birth.

Whether this was a lack of communication or something else, Laurel believed her consent was not given freely because she was not informed in the moment and no one took time to explain during her follow-up questions. This was similar to Astrid and other mothers many of the women felt they had signed consent forms and therefore could not revoke consent nor question interventions. The legality here leads to the legal hegemony via the language of demands. Aliyah was able to get beyond this by asking because she

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54 Like most people I spoke with, I was either the only person or one of a handful of people, including friends and family, that people had talked to about this, so many were still processing and reflecting as they told their stories.

55 This is not to contend that homebirth is unsafe. As studies suggest, homebirth can be as safe as hospital birth (Brocklehurst et. al., 2011; Hutton, et. al., 2019; Janssen, et. al., 2009;), but in some cases a hospital birth is the safest course of action.
knew she could. While it is not possible to explain every benefit, risk, and side-effect of every procedure or refusal of procedure, the consent forms alone are not enough to guarantee that patients feel their rights are being respected or they are informed.

A similar consent-legality concern happened with Denise. After her Pitocin kicked in, Denise protested that she felt the contractions were too intense. The nurse assured her the contractions were no stronger than normal contractions and that she was fine. Denise, a 44-year-old social worker, complained about Pitocin and was told that it does not cause stronger contractions, information Astrid also received, which is not based in evidence (Lothian, 2006; Tillet, 2011). Denise said she had the Pitocin up so high she “thought about throwing [my]self out the window.” Both she and her sister, who was supporting her in labor, were repeatedly ignored before the staff eventually turned off the Pitocin. Denise credits the lack of discussion about her care with her postpartum depression and the intensity of the Pitocin contractions with her fear of having another child. Voluntary infertility (choosing not to have more children) due to fear of what happened in labor and delivery is reflected in the scholarly literature (Goer and Sakala, 2012; Kukura, 2018). Without access to her medical chart, it is impossible to say, but Denise believed she had experienced the practice of “pitting to distress,” or the overuse of Pitocin to speed up labor that leads to fetal distress necessitating a cesarean delivery (Chopra, et. al., 2015; Tillet, 2011).

56 Mentioned earlier, the drug used to speed up or induce labor despite not being FDA approved for that purpose.
57 Too much Pitocin leads to hyper-stimulation of the fetus where the fetus can be deprived of rest or oxygen due to the increased stress of the contractions, so saying that inductions can be used to avoid other interventions like cesareans is not necessarily clear because the cesareans that are necessitates for “failure to progress” (in which Pitocin is used to hurry labor along) are often failing to progress along the timeline of the hospital policy rather than a biological timeline (cite).
Gaslighting and Emotional Appeals

The subtle coercion of misinformation in childbirth can range from unintentional like doctors and nurses engaging in standard procedures without explaining them to the patient or doctors and nurses who themselves do not have the most current information, to more explicit threats (Morris and Robinson, 2017; Pascucci, 2018) or physical acts as in Turbin’s case from Chapter Four. Misinformation and coercion also result through gaslighting bringing this back to an issue of epistemic justice, particularly the testimonial injustice discussed in Chapter Four. A prime example of this was Astrid who, when seeking a vaginal birth after cesarean (VBAC), was told by a nurse that an episiotomy\textsuperscript{58} heals better than a natural tear despite evidence against this (Jiang, et. al., 2017; Weiner, 2016) so she should not be worrying about it. She was also assured by the nursing staff that an epidural\textsuperscript{59} would make her completely numb; and when it did not, the same nurse who had assured her that some patients were so numb she had to tell them when it was time to push, said, “well, I don’t know who told you [you wouldn’t feel anything], but they lied to you.” Astrid described serious emotional distress from being not believed nor allowed to labor without an IV as she had asked. Additionally, while she felt the obstetrician was honest with her, the nurse and particularly the nurse midwife behaved in a way she found to be gaslighting (which she described not as “telling me one thing and then telling me they didn’t tell me that”). Her disappointment in her midwife was particularly difficult for her to address because she had trusted her midwife—after whom

\textsuperscript{58} A surgical incision at the base of the vagina intended to make the birth opening wider for the baby.
\textsuperscript{59} Pain medication, administered around the spinal cord, intended to numb feeling from the waist down.
she had named her first child—and had done a majority of her prenatal appointments with this midwife.

Herlacher (2022), who works for a venture capital health organization, recounts her own experience of medical gaslighting. Herlacher (2022) points out the connection between not listening and maternal health as well as maternal trust in the health care system over the life-course of an entire family. Families refused to go back to hospitals, not just doctors. Coercion can also take a stronger emotional threat, which multiple mothers in the study called the “dead baby card” where they were told their baby would die if they did not consent to certain procedures but were not told why. Hill (2019), Pascucci (n.d.), Nash (2021), Shabot (2021) and many others point out that “the dead baby card” is often used as a means to silence mothers and to accuse them of selfishness and prioritizing themselves over the welfare of their babies. This shows the multifaceted nature and scope of obstetric violence as more than a matter of obvious physical assault. Complaints about obstetric violence challenge the idea that a healthy baby, while admittedly the goal, is the only measure of success. None of the mothers I spoke with in this study would say that a healthy baby was not a top priority, but many pointed out that when they complained about their treatment were met with some variation of “at least your baby is healthy.” Moving the conversation to from centering on a healthy baby to accepting the dual priorities of a healthy baby and a health gestational parent is an essential part of creating an epistemic peer model of care. Acknowledging that those who want agency in their labor experience also want the best outcome for their child is the basis of collaborative care.
Understanding the role that the culture of childbirth had on how people are treated is a useful lens. Willow, who had children in the US and in the UK offered some important comparative contexts. Willow had her first baby in England. It was an attempted homebirth using the National Health Service midwives which are an integrated part of the UK’s health care system. From volunteering to lead support groups for new parents, Willow was able to hear many birth stories from parents in both countries. She offered some interesting observations on the different cultures of childbirth, many of them exhibiting coercion and misinformation within an institutionalized and profit-driven maternity care system. She noted the legalistic nature of the US maternity care system in both conversations about consent and what is “allowed” (she had a homebirth in the US) and in terms of what insurance companies covered. Within that she spoke about how in the United States birth culture is different. In the US she said she felt pressured towards interventions through emotional coercion.

One thing that's interesting is the whole, the role of like coercion and threats...the whole “your baby's gonna die, you're gonna let your baby die? We have to the C-section, right now.” Instead of like, “here's the percent, like you're a person and here's like what we see in women in this circumstance, like there's a 40% chance that this situation might not.” You know?

To combat fear, Willow advocates for labor and birth support, particularly in the form of doulas as a way of information and empowerment. Drawing on her own experience with a doula, Willow said:

[Having a doula] can't be overstated, I think, having somebody who is an independent well they're, they're your advocate, the woman's advocate right... If there's a complication the doulas...might be able to say, “well you know because you're doing it like this, [this] is the intervention, they want to do.” ...This has happened with me actually with my doula like “they want you to transfer the hospital, it doesn't go according to what I’m seeing. It doesn't seem necessary right now like, but you, you can make a choice.” ...So instead of like the panicked medical professional who's like worried...she's like “okay [homebirth
midwife’s name], thank you for that information. I’m going to talk to my client now.”

This role of doulas is supported by evidence which says they provide care and support and their presence increases positive birth outcomes (Greiner, et. al, 2019; Gruber, et. al, 2013; March of Dimes, 2019), but nurses and doctors tend to resist their presence (Neal, et. al., 2019) something that has not changed very much over time (Papagni and Buckner, 2006). To Willow’s mind, doulas, through both their prenatal rapport building and their one-on-one labor support, are a guard against some forms of coercion. However, laws that would allow doulas in the room as an extra support person might be controversial because doulas are not required to be certificated. If such laws were to take effect they could be paired with requiring only doulas certified through certain trainings which would likely result in similar legal, policy, and social activism as midwife licensure (Cramer, 2021) making doulas even more controversial.

While issues of open and free communication and taking patients seriously can be seen as “bedside manner” and “soft skills”, such interpersonal communications issue they are reflective of larger research trends that show a culture of deliberate or accidental coercion that is a systemic problem. As a problem of professionalization and hospital culture, it is more than interpersonal – it is institutional. How doctors and nurses act is shaped by hospital culture (Mannion and Davies, 2018), through the trappings of legality that structures the kind of legality working in hospitals which in turn creates the institutional culture patients find themselves in. Patients believe doctor and nurses are observing hospital policy and that hospital policy is the law. The epistemic credibility of doctors is transferred onto the policies and at the same time, the social and legal authority
of law also shared with policies creating institutional childbirth as an event seen through legality.

Fear, Protocol, and Power

Several participants with difficult births or who had disabilities felt the hospital treated them differently because of ableism. These feelings of being pressured by hospitals left them afraid that they would not receive life-saving care because they had refused medical advice or made decisions the doctors disagreed with.

Interestingly, Indian mom Sujata challenged her hospital’s policy when they told her she would not be allowed skin-to-skin contact with her infant in the first twenty-four hours. Sujata’s second child was born during the COVID pandemic. She left her husband at home with her older child and went with her doula for a scheduled cesarean. For Sujata, a mother in her mid-40s with a child waiting at home, she felt more comfortable scheduling the cesarean than having an induction. Her doula went with her for this and the recovery period. As a medical researcher herself, Sujata went in with a high rate of knowledge about what to expect, so when the medical staff told her she could not do skin-to-skin immediately, she pushed back. She and her doula pulled up the research on her phone and told the staff that if they wanted to stop her from doing skin-to-skin they would have to provide her with evidence not to. After a while, the staff sent in her obstetrician whom she said admitted that it was a hospital policy based on an infant loss that had happened a few weeks earlier and was not supported by evidence. Because the baby was roomed with her due to COVID guidelines, she never stopped doing skin-to-skin but was concerned to learn that they had pushed so hard for a policy that was potentially harmful by all known standards of newborn care because they were afraid of
liability As Frakes (2012) notes, fear of legal and financial liability is a driver of some hospital policies and medical decisions.

Elizabeth, a Latina mom, had a different experience. As a child and young adult, Elizabeth had a medical condition that required repeated abdominal surgeries. Her first child was induced in central Massachusetts, and the baby was sent to the NICU where she was not allowed to visit. This was a result of institutional policies related to staffing: there were not enough nurses to take Elizabeth, who had had a cesarean, to the NICU floor where her baby was. While there are staff to patient ratios in Intensive Care Units, the law does not require similar low nurse or staff to patient ratios in maternity care. She felt immensely distrustful and there was no process to file a grievance. So, when it came time to have her second child, she chose a different hospital.

Elizabeth’s second child was born at a hospital in western Massachusetts via emergency cesarean. Because she had had so many surgeries growing up, Elizabeth was not responding to cesarean recovery in the way the hospital expected (she was not in as much pain). While at this hospital she was able to visit the NICU to see her second child, when she did, she found a note altering her that the baby was not allowed to go home wither due to a pending DCF (Department of Children and Families) investigation. At first no one would tell her why this investigation had been opened, but it turned out to be about her pain tolerance. She was suspected of being a drug user and was tested repeatedly for drugs in her system. Elizabeth says,

It would say “DCF has been called because mother reacted to pain differently than most parents.” Please don't like let child go home with mother until it's cleared. And it made me feel so bad because it's like, I’m a hard-working individual, never done drugs in my life. Never. Don’t even drink much, and I have another child at home, and DCF’s never been involved. And it's like, it just it was
like basically, like a scarlet letter on my chart saying that there’s something wrong with me.

This left her with enormous stress. She was worried that DCF would take not only her newborn, but her child at home as well. Just as with her first birth, there was no recourse and no one at the hospital apologized to her for this stress.

River, a masculine presenting trans person chose homebirth not only because they were trans but because of a history mistrust from other people. River’s mistrust of the role of protocol over patients stemmed their older sister’s difficult cesarean and follow-up cesarean (this was over a decade ago when there was even less choice than now). Adding to their mistrust was a sense of anger when the OBGYN told River to take insulin for gestational diabetes rather than see a nutritionist. Like Grace from the previous chapter, River refused the insulin and used food to control their diabetes. Both Grace and River tested well on blood sugar and had no problems. Because they had both been told this was impossible and to take the insulin (which Grace bought but did not take), they were immediately mistrustful of forced protocols. While these decisions could have been legally motivated (a fear of liability) they were experienced by the patients not as the hospital trying to protect them or even itself but as meaningless interventions that were matters of protocol. River considered it a part of what they saw as fat-shaming in medical culture. While both people went for follow-up appointments and were able to observe their conditions, there gestational diabetes is a medical complication that could have been problematic if they had simply ignored the insulin out of mistrust for the process.

Additionally, River’s mistrust came from a history of attending births with friends in the LGBTQIA+ community. One story they relayed was that of a young Black mother who River said was pushed into interventions and when the patient or support people
asked, they were treated badly by staff despite the fact that they had at least three support people who were allowed in the room. River’s characterization of the situation shows a mistrust of the medical system broadly that seems to be foundational to developing a sense of mistrust surrounding whether they would be treated with informed consent.

Viewing the hospital protocols through the lens of mistrust, Reiver described the story this way:

And then ultimately being a MassHealth recipient, when her admission came to 24 hours and she had been admitted and in her room for 24 hours, all of a sudden. We were outnumbered there was 16 medical professionals in the room, they were wheeling her out, they were taking her for an emergency C-section… And we just kept making eye contact and being like look, this is their stuff like they’re adrenaline junkies. The clock is up and so they’re acting like there’s a need. But nothing has changed with your baby from five minutes ago to right now. It’s just that their time limit of letting you labor is up. And they were very angry, that we were saying those things…So they ended up wheeling her out and they were so rushed, and doing so that they actually like started wheeling her while her bed was still plugged in so then she liked [mimes being pulled backwards] rubber banded back against the wall and we were like “yo, you guys need to slow down like you’re taking her down the hall” … And then, on the way out, they like bumped her bed against the door jamb they were just like in such a rush, and so you know in their adrenaline and so she ended up having a C-section.

River’s characterization of this interaction signals an awareness of racial and institutional issues in birth. Their perception of the interventions as stemming unnecessary interventions that were driven by protocol and discrimination was amplified by what they describe as the doctor’s being angry with them. River’s framing of the story and subsequent choice to do a homebirth show a person who is very aware of legal and political marginalization against themselves and their community; the interactions with

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60 River is making the assumption that means-based insurance recipients receive less quality care but this is not supported by some studies (Paradise and Garfield, 2013) with some suggesting that birth outcomes with Medicaid as compared to uninsured are better (Bauchner and Maddox, 2019). But mothers with Medicaid are at a higher risk for site infection from cesarean (Lagasse, 2019) and cesarean section rates increased among Medicaid recipients once Medicaid began covering them.

61 No one River was with was a medical professional, so it is not clear these interventions were unnecessary.
medical professionals were seen through this lens. But the interaction was also formative in making River feel as though they would have no access to informed consent because either the protocols were not explained while River was in the room or in a way River felt adequate. Throughout our interview River referred to doctors as “adrenaline junkies” who were just “tied to their clocks” meaning that they were focused on protocols and hospital-based timelines.

So, it was not only the concerns about trans discrimination that shaped River’s choice but wanting a sense of control over the process: “as a queer person, as a trans person, like I really wanted to give birth at home, where I felt most comfortable and surrounded by my community where I felt understood.” The epistemic issue is obvious in their statement about wanting to feel understood, but what is also interesting was the continued sense of not having choices, not being allowed to consent or refuse consent, and a general fear of being harmed through protocol. This sense of care, support, and trust, appear throughout high rights consciousness as they relate to homebirth. But they also appear in high rights consciousness of those who choose hospitals, including those who have elected cesareans who also want control over their experiences.

**Conclusion: Consent and Mistrust**

In some of these narratives patients saw consent as a useful frame that made them feel protected or included (epistemic peers) in the decisions-making process. In others, they saw consent as lacking or as performative, which made them feel anything from resigned or angry. Many did not think of consent at all, assuming that because they had

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62 Possibly because they were not explained to River at all because the doctors had no obligation to do so, but also because River may have found their explanations unsatisfactory as read through the lens of the original mistrust, seeing the explanation as justification rather than actual explanation.
signed the forms the doctors and nurses were engaging in appropriate procedures and they did not have to worry about it. It is impossible to predict completely how every pregnancy will go, just as it is impossible to predict who will end up with postpartum depression. Risk factors are helpful but not perfect. Likewise, understanding who will develop mistrust and the extent of that mistrust is not easy. High profile cases like Turbin and Malatesta are clear, as are cases like Leslie’s who was not only afraid her doctors had been treating her with retribution but that they had interfered with her ability to have children in the future. But if informed consent is to be more than a buzzword or coercive tool, there must be more conversations about what real consent is and how its lack can lead to mistrust in the future. Likewise, patients should take their own roles more seriously and become educated in what to expect in childbirth and be prepared to ask questions if they are not sure about something.

As more childbirth education classes add sections on informed consent, groups like Birth Monopoly and Evidence Based Birth focus on handouts and policies saying “you’re not allowed to not allow me.” As organizations that work with doula training and childbirth educator training organizations around the country, it is important to consider the ways in which this will manifest in the actual labor space. Perhaps for those who lacked agency to discuss consent, these kinds of slogans will help patients feel empowered to step into their legal consenting rights to information in the labor space. But as with any intervention, it runs the risk of overcorrecting and setting patients up with a mindset of conflict before they arrive in the labor space, shutting down pathways towards epistemic peer models from the patient side. Consider the patients like Felicity who said
she felt as though she was “going into battle” or Agnes who had five homebirths because “why bother they’re not going to listen to me anyway?”

One of the reasons that the politics of childbirth are politics at all and not simply a matter of hospital policies is that they have the undercurrent of legal authority. Who is a fit or good parent, who is behaving dangerously by disobeying or questioning policy, and who has the last word in a fight are all social and political elements. But when you add hospital policies and the ability for hospitals to call upon child services or, in some cases, courts to order interventions (as discussed in Chapter Two), then hospital policy carries with it the authority of law. This legal hegemony that imbues policy with the trappings of legality is significant for those who lack the social and cultural capital to challenge it.

The language of demands is itself a form of epistemic injustice serving to invalidate someone’s preferences. While this epistemic problem stems from the same patriarchal and social epistemic credibility gaps discussed in previous chapters, it plays out in birth in a dangerous way. The language of demands invalidates informed consent. While hospital policies are a matter of legality, consent forms are a matter of law. When the consent form is signed, if it is not fully informed, then the politics of childbirth presents a legal problem not just in terms of obstetric violence but in baseline consent and bodily autonomy. The way that the language of demands (Hill, 2019; Pascucci, n.d.) frames options in birth is a strand of the discursive problems that stem from epistemic authority pregnant people. Consider the ways in which childbirth is discussed, centering the physician as the one who allows people to try for VBAC. This creates a gap between patient and physician power. Likewise, referring to the hospital staff as the people who deliver the baby rather than the person who births it are subtle discursive frames that
shape how power is disbursed, including giving subtle cues about who can request or refuse interventions. Through this discursive framing a pregnant person is a vessel who carries a baby, not an active participant who builds and births one, returning to the host ideology discussed in Chapter Three. Because patients feel as though they have less agency, some develop have less certainty about their experiences.

Laurel and Densie have lingering mistrust because they do not feel the consent they gave was fully informed. This lack of information left them feeling like they should have asked more questions. They blame themselves for not asking, but they also blame the institutions that they feel harmed them. This has serious real-world implications since both were pregnant at the time we spoke, and neither were comfortable with the idea of future hospital births. If either of them chooses homebirth or freebirth out of fear, they could risk serious, even deadly complications. While homebirth is associated with positive outcomes for low-risk birth, it is not the safest choice for every person. But since the institutions they were giving birth in coerced rather than consented them, other care providers will have to spend time building trust in order to do their jobs.

Sujata and Elizabeth both entered the delivery room as second time moms, giving them some level of authority and understanding of what was going on and to be expected, but likewise, both of them faced pushback. When Sujata was told of a policy that she knew violated evidence, she had the confidence to ask about it. Because of her conversation with the doctor and her look at the research, she was able to hold her newborn immediately, but she still felt mistrustful that they had tried to coerce her away from her child based on bad evidence. Elizabeth, on the other hand, had no recourse. She
felt deep shame for being labeled a danger to her child. Her child did not show any signs of a parent who had used drugs; however, because Elizabeth did not respond in the way the hospital staff expected, she was singled out as a danger. Calling DCF on a parent could have lifelong consequences for the whole family, these could be economic (as a social worker mother in Elizabeth’s group pointed out, if she had had DCF called on her, she would have lost her job) and psychological. Such an intervention that carries with it a high risk of trauma should not be undertaken lightly.

River’s retelling of their friend’s story was an interesting window into the ways that secondary mistrust can develop. I did not get the indication that River or any of their friend’s labor support partners was a medical professional, but they were convinced that nothing had changed with the friend or her baby. River and their companions’ beliefs in the ways hospitals treated Black mothers, poor mothers, and public health recipients shaped their ability to trust the medical professionals in the room. The mistrust developed from not feeling listened to as well as the anticipation of being coerced shaped River’s friend’s ability to trust her care providers and River’s choices when it came time to have their own child.

River’s acknowledgement of “the clock” was something that many people throughout this study mentioned. Parents felt as though they were parts of a process rather than individuals who were having an experience. Those who felt as though their autonomy and individuality were given less priority than hospital policies that were impersonally applied reported mistrust not only with regards to their own situation but of other situations as well, creating a wide-ranging mistrust.
The kinds of policies that have the potential to create lasting harm are part of a structural violence known as institutional betrayal, to be discussed at length in the next chapter. Such institutional betrayal can leave a lasting sense of trauma for people caught up in circumstances. Creating stronger organizations that focus on people over policy and allow the voices of those who give birth to return to labor and delivery can help mitigate some of the negative results of such violence, and that can start with having truly informed consent. Taking the language of demands out of the conversation might be a good starting point. If patients understand through language that they have the ability to ask for things and have a say in their care, this might open up the pathway to questions about other elements of their care. But, as Chapter Four notes, good intentions alone and the ability to speak are not enough to combat entrenched epistemic injustice. Likewise, institutional hegemony through standard operating procedures or through using law and law-like elements of consent to coerce patients into certain behaviors are not going to go away with a policy. A cultural shift that values the epistemic peer model will ensure a more informed informed consent and offer ways for those who give birth to feel some agency. This agency could mitigate some of the fears that lead to mistrust, voluntary infertility, and other negative feelings towards hospitals and doctors.
CHAPTER 6: MORE THAN BAD LUCK: INSTITUTIONAL BETRAYAL IN CHILDBIRTH

Through news stories and original interviews, the narratives in this dissertation have been an exploration of part of the culture of institutionalized childbirth in the United States. As with any institution, some aspects are positive and some negative, but all are responding in some way to cultural and institutional understanding of what birth looks like. The previous chapters have fleshed out the contours of maternal mortality and its connection to epistemic justice and the role of institutional culture through the lens of coercion and consent. This chapter offers an important intervention by considering the effects of institutional culture on patients. This chapter explores the ways in which disrespect and abuse in childbirth and obstetric violence can lead to feelings of institutional betrayal among those who felt they could not rely on their care providers or the institutions in which they received the care; and in some cases that institutional betrayal becomes viewed through the language of obstetric violence. Underlying all is the important sociolegal elements of law and perception as forming institutional culture in health and maternity care.

This chapter looks at specific policies and responses to them to consider how institutional arrangements can create the conditions for conflict and exploitation through law and policy parameters and a sense of legality (as discussed in the previous chapter). Like the exploration of legal pluralism from Chapter Two will show, the laws and policies on which practices are acceptable, standard, and legal in maternity wards varies greatly by state and even by hospital (Birth Place Lab, 2015; Vayo, 2022). Through highlighting the social and epistemic conditions that shape attitudes about birth and birth
givers and illustrating the legal and policy role of consent and other practice, the previous chapters have outlined a law-society connection to the politics of childbirth. Building on that understanding, this chapter considers institutionalized childbirth by centering the patients’ views of the institutions themselves as drivers of mistrust.

This chapter builds on the sociolegal framing of childbirth, including the role of communication and collaborative care by looking at the way in-hospital actors can be constrained by policy and how policies can erode patient’s trust in their care. Institutional betrayal has radiating effects that can cause people not just to mistrust one institution but many. In Amanda’s story, she not only mistrusted the hospital for how they treated her but the hospital protocol for not taking her seriously and the state Department of Public Health for “brushing me off.” As a physician who also worked at the hospital, it was a personal blow but also one where Amanda felt the law would not protect her. As much as law has meaning-making power to increase feelings of inclusion in full citizenship, it also has the opposite power. When legal remedies are not available or institutions appear to be protecting themselves rather than people who rely on them (Smith and Freyd, 2013) this is not just a general matter of mistrust, it erodes faith in whole parts of the legal system and any semblance of procedural justice. Drawing on interviews from more parents, this chapter considers how the institutionalization of birth leads birthing people vulnerable to problems that arise in other institutions, including problems with epistemic authority, discrimination, and the role of bureaucracy in causing harm. Further, it offers deeper understanding of obstetric violence as a problem of both interpersonal and institutional practices.
Using an institutional betrayal framework, this chapter considers how hospital policy, staff behavior, and professionalization can produce mistrust between patient and provider. Institutional betrayal results from harm caused, intentionally or not, by an institution that someone had to rely on for care (Smith and Freyd, 2013). The concept has rarely been applied to treatment by hospitals, with research often focusing instead on college response to sexual assault (Gomez, 2022; Smith and Freyd, 2013), sexual trauma in the military (Kelly, 2021), and childhood abuse by parents or caregivers generally (Smith and Freyd, 2014). Bringing institutional betrayal into mainstream political science discourse is an important intervention because when we are considering policy fixes to social and political problem or the way laws and society interact a sense of betrayal or mistrust may complicate solutions to intractable problems. Further, institutional betrayal is a theory that has wide applications across areas as different as redlining, police violence, toxic waste dumping, and propaganda. Institutions are arranged through law in different ways and bringing institutional betrayal more fully into sociolegal concepts will be an important bridge to understanding the future of American democracy in a highly polarized time that is marked by mistrust and misinformation especially around the rule of law and its uses. Using betrayal theory in discussions of childbirth also helps to further theorize the concept of obstetric violence as an institutional problem rather than personal one. This frame can also help physicians and policymakers to understand the move towards alternative birth practices (Chadwick, 2016; Chattopadhyay et al., 2017; Diaz-Tello, 2016; Kukura, 2018; Pascucci, 2018; and Tucker, 2018).

**Trauma Studies and Betrayal theory**
In the early 1990s, two books were released that moved trauma studies towards exploring the role of systemic and institutional violence, pushing the field far beyond single-incident and interpersonal trauma. Judith Herman’s *Trauma and Recovery* (1992) linked political violence to individual trauma and outlined the ways in which sexual violence and domestic violence were interrelated with social standing of women as types of political violence. Jonathan Shay’s *Achilles in Vietnam* (1994) illustrated the role the U.S. government’s actions had in shaping and potentially increasing post-traumatic stress disorder (PTSD) among combat troops. Shay’s work with Vietnam veteran groups allowed him to develop an understanding of how those who were told they were fighting for certain principles developed greater incidence of complex and treatment-resistant PTSD if they perceived the government had betrayed its own principles (and by extension, them and those who died). Both books are foundational texts in studying what would later be known as institutional betrayal (Smith and Freyd, 2013).

Looking through the lens of betrayal theory (Freyd, 1994, 1996; Freyd et al., 2007); Smith and Freyd (2013) showed how interpersonal trauma, particularly trauma related to a person or institution that was supposed to be in a caregiving or protective capacity, can have long lasting effects beyond the original traumatic experience. Smith and Freyd (2014) define institutional betrayal as, “trusted and powerful institutions (schools, churches, military) acting in ways that visit harm upon those dependent on them for safety and well-being” (p. 575). An institutional betrayal framework has been used to discuss issues like complex posttraumatic stress disorder in childhood abuse cases, military sexual trauma (Kelly, 2021), the Department of Defense’s former “Don’t ask, don’t tell” policy (Bloeser, et. al., 2021), states requiring teachers to disclose students’
gender identity and other laws that target LGBTQIA+ school children (Smidt and Freyd, 2018), and college and university responses to sexual assault (Gomez, 2022; Smith and Freyd, 2013). As a result, it is suited to examining pervasive problems across different institutional levels.

The lens of betrayal theory can clarify ground-level responses to institutions with a history of real or perceived violence, like hospitals, schools, organized religion, and the police, by focusing on the specific type of trauma that results from “traumas that include a violation of trust and safety at the hands of a caregiver or person on whom the survivor is dependent for survival or significant needs” (Freyd, 1996 qtd in Kelly, 2021). Due to the persistence of structural violence, it is important to consider that institutional betrayal can include deliberate acts, but it can also include acts of omission or negligence or generalized apathy and “just following protocol” (Smidt and Freyd, 2018; Smith and Freyd, 2013) all of which are categories of obstetric violence. Protocols can result in a codified violence that becomes unrecognizable as violence because it is just “the way it is.” In the case of childbirth, this betrayal is seen in hospital policies that violate bodily autonomy and allow hospital staff to work without informed consent from the patient (Annborn and Finnbogadottir, 2022; Cohen Shabot, 2021; Pascucci, 2018) as discussed in Chapter Five as well as policies that force certain interventions as discussed in Chapter Three. Institutional betrayal takes many forms, and Bachem, et. al. (2020) explains that in addition to being accidental, even a matter of perceived betrayal on the part of the patient can still have negative effects on health outcomes and future trust in institutions.

Within institutions, medical mistrust may be shaped by any number of variables (Roelofs and Spinhoven, 2007; Vermeir, et. al., 2021), including media attention to issues
like health disparities, maternal mortality, or other institutional problems, these in turn can shape a view patients have of doctors and institutions (Smith, 2017). Medically unexplained symptoms (Roelofs and Spinhoven, 2007; Vermeir, et. al., 2021) as a result of PTSD can create problems with medical mistrust (Jaiswal, 2019; Rosen, et. al., 2019) and this happens more so with women than men (Claréus and Renström, 2019). Medical anthropologists study the “epistemic tension” when illness is not widely known, studied, or taken seriously (Dumes 2020), as happens with women due to the lack of medical research on how issues effect women and the lack of reflexive protocols in women’s treatment (Morgen, 2002). Likewise, iatrogenic conditions—those caused by medical exams or treatments (Sadler, et. al., 2016)—can result in and from obstetric violence. Bloeser, et. al. (2021) note in their study of military sexual trauma this can lead to institutional betrayal. Likewise, treatment by medical professionals themselves can also create mistrust, which is particularly problematic because patients who trust physicians are more likely to comply with care regimens (Smith, 2017), so mistrust can result in ill health. Institutional betrayal is associated with higher fear and mistrust in government institutions as well, particularly during the COVID-19 pandemic (Bachem, et. al., 2020).

In health care generally and childbirth specifically, one area where institutional betrayal manifests itself is in practitioners’ failure to recognize the existence of previous negative experiences or the rationality of medical mistrust by some patients (Bloeser, et. al., 2021). Acknowledging context, whether medical, racial, or historical is important to providing quality care and preventing feelings of mistrust that might lead to trauma: “Our findings support the notion that historical context is an essential part of the patient-provider relationship, especially in the case of contested illness” (Bloeser et. al., 2021, p. 187).
6). A critical component of institutional betrayal is when institutional policy makes it difficult or impossible for victims to report the harm by lacking transparent complaint processes (Smith and Freyd, 2013). Understanding institutional betrayal through the lens of epistemic injustice helps to explain why people in positions of medical authority may find the histories and lived experiences of non-dominant groups to be unimportant for what is seen as objective and value neutral science of medical decision making despite evidence that holistic approaches to patient care produce better results (Bloeser et. al., 2021).

**Findings: Unresolvable Conflicts, Coercive Policies, and a Sense of Institutional Distrust**

The interviews turned up several different ways in which institutional betrayal manifested itself. Here, we look at three distinct ways in order to unpack the diverse nature of the problem (see Table 2). The first is a particular point of institutional betrayal, the lack of protocols for redress of grievances (Smith and Freyd, 2013). As in cases of church or military sexual abuse, victims found themselves with nowhere to turn and felt re-victimized by the system that had failed to protect them and then failed to avenge them (Smith and Freyd, 2013). Next is through coercive hospital policies. Two of the most coercive policies are intertwined: the denial of cesareans and the mandating of them. VBAC bans, blanket bans on vaginal birth after previous cesarean birth, are against the recommendation of the ACOG. Patients who are coerced into these surgeries because they have no choice experience a sense of institutional betrayal. And lastly, those who experience medical mistrust in previous conditions are fearful of retribution if they are not following medical advice.
In my interviews, this was particularly salient with mothers who had disabilities or those who had refused to terminate pregnancies where the fetus had a disability. Table 4 provides an overview of patterns of institutional betrayal. The interviews revealed three types of institutional betrayal: lack of protocol for redress, coercion through policy, and fear of retribution. This table defines each of these categories and provides examples that are elaborated below.

**Table 4: Patterns of Institutional Betrayal**

<table>
<thead>
<tr>
<th>Category</th>
<th>Definition</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lack of meaningful protocol for redress. Protocols are in name only, unresponsive, or cumbersome (Smith and Freyd, 2013)</td>
<td>There are no policies or institutional supports for seeking redress of harm (Freyd and Smith (2013).</td>
<td>Amanda, a physician filed a complaint with the state Board of Health but was ignored.</td>
</tr>
<tr>
<td>Coercion through policy</td>
<td>Coercing patients into interventions that hospitals deem mandatory regardless of patient’s wishes or without adequate consent</td>
<td>Florence’s sister had to receive special permission to have a vaginal birth despite being fully dilated because of hospital policy and was told “we don’t do that [VBACs] here.”</td>
</tr>
<tr>
<td>Fear of retribution</td>
<td>Patients who feel they cannot speak up for fear of retribution or who fear retribution based on their previous refusal of medical advice.</td>
<td>Leah was afraid the hospital would not save her child because she refused their advice to have an abortion.</td>
</tr>
</tbody>
</table>

Lack of Redress for Violations

One key element to institutional betrayal is not being able to get follow-up care or even complain about a harmful event or process. This was a hallmark of several of the stories that I had heard, which mothers felt they could not complain out of fear of
retribution or because there was no way to complain. Several also tried to lodge complaints and nothing happened. Literature on procedural justice contends that people respond better and see law and processes more fairly if there is some kind of procedural fairness baked into the system (Greenberg and Tyler, 1987; Tyler, 2003). Looking at institutional betrayal in part as a lack of procedural justice explains some of the sense of unfairness aimed at protocols that appear vague, pro forma, or cumbersome.

The clearest story of obstetric violence was from Amanda, an anesthesiologist who described the birth of her fourth child as “obstetric violence.” Her story is an interesting case study in how agency and interpersonal understandings can shape experience of both obstetric violence and institutional betrayal. During her fourth birth experience she describes being forcibly held down by the medical staff, at the hospital where she was employed and having her baby:

And she [the obstetrician] reached in, and started yanking on my baby, and they wouldn't let me go, and I kept saying “I can't push like this; I can't push I can't push like this.” And they, my husband was saying it, I mean both of us were pleading. They wouldn't let go of me; she wouldn't let me move to different position. …I was struggling to breathe…I need to put my legs down [due to a limited range of motion in her hips, which was causing her pain], and they wouldn't let me put my legs down. Probably because they knew I could move then … And I realized very quickly that they weren't going to stop until I just got the baby out, so I realized, I had to just get the baby out or they wouldn't stop. It was excruciating because I could feel everything, no epidural. I mean it was so painful what she was doing to me. And um, it was it was horrible to be assaulted during childbirth, and as after she was born I just felt so disappointed so defeated [by this time her voice had changed to a dissociative monotone]. I knew is our last baby, it was really hard.

While Amanda’s fourth birth is a very explicit example of traumatic childbirth, she also demonstrates how difficult it can be for someone to name mistreatment in birth when the trauma is less explicit and forceful. Amanda’s second child was a vaginal birth
after a prior cesarean section (VBAC), and she described the male doctor as “old school” in his approach. She speaks of her VBAC that required a vacuum extractor birth:

Needless to say, I was you know, tears are streaming down my face, [but] “I’m like all right, I need to do this, let's do this.” And so I had a vaginal birth, but he did do an episiotomy and then tore me to yank the baby out.

When I followed up asking “Did they ask before they did the episiotomy?” Amanda said, “No.” Her voice cracked quite a bit at this point, and I offered to switch topics, but she felt it was important to continue. She then described the experience:

After he did the vacuum twice, he did, the episiotomy, tore me, and pulled the baby out. There was, yeah, there wasn't really talking about it. Um [voice heavy] But I kind of think that's sort of how old school practice is. They just do it.

This framing of some doctors as “old school” shows us a few things. One is that even despite traumatic experiences, there are many ways in which people will rationalize their treatment and that even during a bad labor experience, patients are still able to tell the difference between an outcome or procedure they did not want, or a person whose attitude or demeanor they did not like, and a traumatic experience. This shows that people are not simply claiming “obstetric violence” in response to the normal course of childbirth difficulties, pains, and stresses as others have noted (Hill, 2019; Pascucci, n.d.). The claiming of obstetric violence has many parallels to those who report sexual assault (i.e., they know the difference among bad sex, sex they regret, and rape). Speaking to the issue of institutional betrayal, Amanda considers only her fourth birth an instance of obstetric violence, and she and her husband filed a formal complaint to the hospital board.

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63 I have been told and read in other literature’s stories of patients being “torn” without surgical tools (i.e. physician’s hands), but given Amanda’s level of trauma, I did not follow up in this interview to determine what exactly “torn” meant in this regard. After this story, I asked about her third birth, which she had described as perfect.

64 Indicating on some level that reports of obstetric violence may be underreported.
and the state Board of Public Health. Likewise, when she looked at her own medical chart later, there was misinformation on the chart itself, which despite being illegal, is something multiple parents have spoken about.

As others have noted, a component of institutional betrayal is not having pathways to rectify or redress grievances. For Amanda, even as a physician she was not able to call upon her field experience to get a policy change. This made the whole situation look far more systemic to her than simply a bad experience. She closed our interviews by expressing worry for her daughters and saying that she did not want anyone to give birth in our current maternity care culture.

A similar case of lacking redress for obvious mistakes is Donna. Donna’s case offers a look at someone who did not believe there was a process for complaining about the system because she lacked the cultural health capital to do so. Donna felt that she was treated condescendingly for being young. Donna, a white, 30-year-old mother of one, was 19 when she had her child but said she looked younger. She conceived her baby deliberately, but during many of the prenatal appointments, doctors and nurses assumed her baby was unintentional because of her age and because she lived in a low-income area. Donna chose her hospital because she did not have a car and could walk there when she was in labor. Comments that she remembers doctors and nurses making about her age shaped her trust of the hospital system. This was more lack of trust than distrust because as she went in for her scheduled induction, she was hopeful it would be quick and did not have any other expectations: “I just expected to hold her right away, that was all I wanted.” But that is not what happened.
Donna’s daughter was sent to the nursery, and Donna, who was recovering from a cesarean, was unable to see her for over 24 hours. This illustrates the role that law and policy play in shaping what happens in childbirth because, the nurses said the hospital was not staffed well enough to provide a nurse to escort her up to the nursery or to bring her baby to her. Donna was denied the “golden 24 hours” in which skin to skin bonding is meant to be a prioritized because of hospital staffing patterns not medical necessity. Staffing patterns and patient-provider ratios are a matter of legal policy as well as hospital policy. After a “miserable” hospital experience, Donna was sent home, but she later developed complications from the staples in her cesarean incision site. When she called to “tell them I looked like Frankenstein and it was red and itching” and to ask the hospital when to get them out, they told her she should have had them taken out before she left and, Donna felt, they derided her for not knowing that before she left the hospital and was offered no apology for the mix-up. The cultural health capital lens can help explain some of what Donna faced in terms of how she was spoken to and how she was treated, but it is also worth noting that that hospital was known in the area as being problematic and their maternity ward did later close. But for Donna there was nowhere she felt she could complain about her treatment or the infection in her cesarean scar.

The impact of having a grievance process is important and can help mothers feel as though they have used their bad situation as part of meaningful change. Natalie, a white mother of five, was sent home from her prenatal appointment while she was in active labor. With her first child, Natalie went to the hospital when her contractions were only two minutes apart, but because the machine read-out did not indicate she was in labor, she was told to drive 45 minutes home. Two hours later, her mother called an
ambulance because the contractions were so intense, Natalie could not walk down the front steps into a car. The EMTs could not make it to her preferred hospital and she ended up giving birth at another one closer to her home. Natalie half-jokes that her biggest fear was being stuck in Red Sox traffic and having to give birth on the side of the road, something many Boston area moms laughed at but admitted to worrying about.

I was so scared …because the day after I had my baby, he was born at 6:25 in the morning. That day in the Boston Globe on the front page was about moms getting sent home from the hospital and dying from like childbirth at home because, like you know being sent home prematurely whatever that could have happened to me.

Highlighting a positive impact that a complaint process can have, Natalie complained to the hospital by writing a letter to the CEO about her story because she wanted to “to change the policy for the hospital, as far as like sending people home.”

It just so happened that in the same group was Ivy, who had recently had a similar experience at the same hospital. The hospital tried to send her home despite being six centimeters dilated (6 cm is considered to be in “active labor”). But, due to a policy change, they were unable to send her home, and she was able to stay at the hospital and safely deliver her baby two hours later.

Florence, a mother of six who had given birth in birth centers and at home spoke about how she felt like she could not complain, though her midwife had been too rough at the end of her labor. When asked why she chose birth center and then homebirth, Florence said it was on the advice of her obstetrician when she asked a lot of questions about standard protocol. She considered home birth, but her husband was against it. Florence describes midwives being “gentle” with her when sending her to the birth-center affiliated hospital after 48 hours of labor. She refused Pitocin, but doctors suggested cervadil and they gave her half a pill.
I said all right well I'm not familiar with that one, print something out and bring it to me, so I can read about it. And they were like “really?” Yeah really. So, yeah they printed out the you know the paperwork they brought it to me, I read through it, she said, look we'll give you a half a pill to start….She's like you know, it's kind of your only option at this point, you we don't there's not a lot of places to go from here unless you want to talk about a C-section. And I was like, “oh well, we're not talking about that.”

The intervention worked and she was transferred back to the birthing center in time to give birth, but said she was “traumatized” by the way the midwife retrieved her placenta when it was not coming out fast enough:

Oh, and she just went in there…[mimics pain]…And I am screaming…I mean it was not gentle in any way …It was bad. And that was really like traumatizing to me like that's …not okay. With kind of no warning, you know it was just like I’m about to do this. Give me a minute to get that placenta out myself, thank you, and maybe if you haven't tugged on it.

But despite describing it as trauma, she does not self-describe her issue as obstetric violence like Amanda does. She did, however, feel betrayed by the hospital staff and the staff at the birth center. Her treatment prompted her to have homebirths for her next two children.

I had done so much research, and I was so prepared and what not. But I wasn't prepared for that. And, and I felt bad about it for a while, like. And you know, but ultimately my, the baby was fine, I was fine…you know so it's like oh it's fine, nothing you know, it wasn't bad, it was a great experience you know and that's what people say and it's like yeah. [makes a wishy-washy face] kind of yeah um. So when I got pregnant, the next time … [husband] was like, “You know, okay…that's what's comfortable for you like, being at home.”

Especially in her mind was the sense that it is inevitable that something bad will happen based on stories she had heard, and there is nothing you can do about it. On her fourth pregnancy when we spoke, her sense of betrayal was still strong even when she was recommended to give birth at a hospital due to gestational diabetes. Already
mistrustful, the nature of the recommendation, coming from her doctor’s office but not her doctor himself, made her feel as though they were not going to give her individualized care in her own birth and increased her hesitance. Within her concerns are both the sense of institutional betrayal and problems with the language of demands discussed in previous chapters: “The nerve of her to even ask me if I wanted to schedule something right now you're not even my doctor. yeah and I’m only 20 weeks along. Like, no thank you I’m good.”

Part of Florence’s concern came from the culture of birth she found in hospitals which did not allow her to complain or seek redress, but also when contacting other parents, she felt as though she was facing hate from expressing her anti-hospital opinions. The reaction to her comments is similar to reactions against notion of obstetric violence in general. On the language of demands:

Just makes me cringe it's like [people say] “oh my doctor is only going to let me go to 37 five.”...You know it's like your doctor can't let you do anything. It's your pregnancy. I don't like you know, and I, and I always comment that on people's things like “Oh, what do you think?” You know, and I get so much like hate for that. It's like...“you shouldn't tell people to go against medical advice.” And I’m like, I’m just telling you what my opinion is. You know, doctors are people too, they have their own biases and you know.

Florence’s reaction to other people’s comments and subsequent responses to hers illustrate the difficulty in having conversations about birth in public spaces. Individual cases should be dealt with individually and people want the one-on-one recommendations, but decisions on risk profiles and interventions also have to be made by studying general trends. Both types of information—individual and general—are
important and can be merged when talking with a trusted care provider, but when released into the polarized discussions, some resulting from a place of medical mistrust, these kinds of conversations can start as an uphill battle.

While the previous chapter explored the role individual perception has on mistrust, this next part of this chapter engages with the role of institutions and their policies. When individuals are already mistrustful or are on the border of trust/mistrust it is not just individual stories that can shape their feelings. When they view institutions as set up to “push me though” rather than help them, then they can come in skeptical of institutional actors regardless of the interpersonal relationships.

Coercive Policies: VBAC bans and Cesarean Refusals

One of the most pervasive coercive policies is blanket bans on VBACs. It is legally permissible for a hospital to ban patients from having a vaginal birth after a previous cesarean section, ultimately forcing them into major abdominal surgery (a cesarean) despite laws on bodily autonomy that should provide patients the right to refuse a surgical birth. It is legally permissible because hospitals have the legitimate expectation that they will not be sued. In some states over half of all hospitals have such bans (ICAN, 2009; Vayo, 2021) and when those hospitals are in reproductive care deserts, law and policy directly relate to a hospital’s ability to push its preferences on patients rather than assess individual cases. Blanket bans on VBAC are not necessary for protecting health (ACOG, “Refusal,” 2016; Evidence Based Birth, n.d.; VBACFacts, n.d.), and while

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65 An example of this would be a doctor’s recommendation of something like bed rest, induction, or cesarean section (among others) based on how an individual looks compared to similar (general) cases.
individuals may require a repeat cesarean for their health, the health of their pregnancy, or the ability to have children in the future, the US has an extremely low number of VBACs, even when compared to other countries (Birth Place Lab, 2015; Reyes-Foster, 2021; Vayo, 2021, 2022). Reyes-Foster (2021) refers to VBAC policy in Florida as a matter of “maternal vanishing” or “the ways mothers describe experiencing feelings of being dismissed, disempowered, and disengaged by their medical providers when giving birth” (2) and becomes institutional culture that creates violence conditions. Recognizing the need for a case-by-case evaluation rather than a general rule, the American College of Obstetrician and Gynecologists issued statement on medical ethics recognizing the importance of patient consent and that it does not support VBAC bans (ACOG, “Refusal”, 2016). With hundreds of hospitals in the country having these bans despite the evidence of their harm and the recommendation against doing so from their professional organization, hospitals are not violating rights for the sake of health and safety or professional responsibility but are proscribing patients’ rights for non-health related reasons. This creates scenarios where there is not just an ambivalence about trust but an active mistrust where patients are fearful or harm.

Geography and institutional culture play a significant role in people’s treatment towards childbirth and can shape mistrust for the patient as well as those close to them. Florence learned this when her sister, Felicia, attempted to have a VBAC in Nevada. Because her first child was breach, Felicia had a cesarean. She and Florence were pregnant at the same time for the first and second pregnancies, so they were in communication throughout the process about expectations, how they felt treated, and whether or not they were supported. Florence’s reaction to her sister’s VBAC story
showcase two things: 1) how people’s mistrust can be shaped or reinforced by other people’s stories; and 2) the role of hospital culture in determining VBAC (and patient treatment broadly):

There's only one hospital in the entire Las Vegas area that will allow VBACs. One hospital, one doctor…She did get in to see him, and, he was a, he's a jerk but he you know. he's the only one that will allow you to try a VBAC. And I’m just grrrrr…just do a home birth, but her husband would never ever in a million years agree to that…Of course, her doctor was on vacation [when she went into labor]…But like skiing or whatever, when she was in labor, [but] he was, like “all right, go to this hospital, I called ahead, I let them know you're my patient, they need to allow this.”

But when they arrived, the nurses refused to listen to her, and despite being very close to labor (having labored at home for as long as she could), “the nurse looks over and says, ‘we’re going to section this one.” When her sister said she wanted a VBAC, the nurse reportedly responded with “we don't do that here.” Her doula called the vacationing doctor who spoke to the staff and “accepted responsibility” for the VBAC, at which point they did allow her sister to have birth non-surgically. But her sister felt as though she was treated harshly for going against the staff’s wishes:

She's like, “but I had my VBAC. I don't know how I’m supposed to feel about it. … you know my husband came to like stand and they were like you might want to go stand over there, he was like oh Jesus Christ. Like you know, just almost make sure that it was it was horrific. I’m butchered.”

Because Florence and her sister were often pregnant at the same time and both wanted big families, when Florence announced her third pregnancy everyone expected her sister to announce, but she said she was too afraid to have any more children and by the time Florence was having her fourth child, her sister had still not tried to conceive again. This
voluntary infertility does have support in medical literature as a result of obstetric violence (Goer and Sakala, 2012).

Florence mentioned feeling guilty that she had not warned her sister more of what she saw as the difficulties in hospital birth but refraining from telling people negative experiences was a common thread in the discussions. In one group discussion, Tori, herself a home birth midwife, stressed the importance of learning through telling each other stories. Indeed, most people said they got their expectations from television, family members, or friends. Few of those people considered anything about complications.

Emma, a young, Asian mother, was an exception. She said she scared all her friends by asking about the worst-case scenario. When she became pregnant, she wanted a cesarean and had no desire to birth vaginally, but her hospital refused to schedule one.

Emma said,

I didn’t go in knowing a whole lot, that I had options. I like I never talked to a doctor about having a midwife, I didn’t. I just went to the doctors like I was supposed to, and they just pushed me along and then yeah, I was saying about a C-section only because I, getting, information from movies or TV or friends telling me like childbirth is awful and all the movies, like the woman’s like with her legs up screaming. And I’m like, No I’d rather just like have a nice little surgery where like I have like anesthesia.

Emma’s is an unusual case because even with gestational diabetes, her doctor was insistent that she go to 40 weeks. His refusal to allow her a cesarean, though brings up a problem not often addressed by the birth justice or obstetric violence activists, which is that when someone who is properly informed requests a cesarean, giving them one is birth justice and reproductive justice. Refusing them one is not only interfering with their autonomy, but doing so in a way that will cause then a lot of physical, if not emotional and psychological, distress. But her doctors repeatedly refused her:
The doctor that I got at [Boston area hospital] was like the head of medicine there…but he was one of the ones like at the beginning that he was like laughing at me. I was like, no if I could like schedule a C section now that'd be great he's like no. And then, even when the baby was having complications, I was pretty far along and he was like no we're going to get you to 40 weeks. And then at like 36 I’m so uncomfortable and I’m big, and I’m like if you want to take the baby now. he's like nope you're going to go to 40 weeks, and I was like no I can't. I can't make it he's like no, we will 40 weeks.

She notes that she was in a well-renowned teaching hospital and believes that the many interventions she received were part of the doctor’s preference to keep his own cesarean rate low (another complication of measuring the quality of hospitals or physicians by their statistics alone) and at least in part to demonstrate interventions to students and observers.

So I went for my last ultrasound on a Friday…scheduled me on Monday to be induced… Finally, the emergency C-section happens because, like his heart rate is dropping. They checked him out, right after he’s born.

Emma describes a four-day ordeal with different doctors telling her to prepare for cesarean and then others coming on the next shift telling her they were not going to do it.

As someone who wanted the cesarean from the beginning, she was happy she had one, but felt mistrustful that she had to go through 35 hours of labor and extra weeks of pregnancy that she did not want to only to end up with the cesarean she requested that they told her she could not have.

Institutional Betrayal and Mistrust: Termination, Disability, and Fear

When talking to participants, two strands of disability rights came up: one was mothers who had disabilities and how this shaped their care, the other those who had pregnancies where the newborns were expected to have disabilities. Several mothers
disclosed disabilities, many so-called invisible disabilities of ADHD, PTSD, and anxiety. Two disclosed physical disabilities that shaped the scope of their care.

Barbara, a white mother with attention deficit disorder, who had her second child during the COVID pandemic said that she needed warnings about risks to be conveyed differently because she did not understand them. She took responsibility for not asking follow-up questions, but also held resentment against her hospital for it. Barbara wanted an induction rather than a cesarean, but felt that she did not realize how difficult that would be due to the placement of her placenta. Illustrating the complexities of birth experiences, Barbara both holds herself accountable for not following up with questions and has resentment towards the medical staff despite. During her induction, after several rounds of Pitocin, during which she was primarily alone due to COVID protocols, Barbara believes she blacked out, though she had no medical documentation of this. When she regained consciousness, she saw a team of doctors in her room who were trying to help her avoid a cesarean. At one point, she felt her daughter’s hand slip through the birth canal, at which point the umbilical cord prolapsed and she was rushed in for an emergency cesarean. When she regained consciousness after her cesarean, her daughter had been rushed to another hospital for the NICU.

The treatment surrounding her daughter’s stay in the NICU stressed Barbara out. She felt as though her concerns about her daughter were “brushed off” as attributable to post-partum depression. While there, she also was concerned that they doctors were not taking her concerns seriously because she requested a DNR (do not resuscitate) order on her daughter she believed they thought she was unfit. During this time, her cesarean scar opened up repeatedly and she was rushed away from the NICU to her own surgeries.
The next story is that of Scarlett, a middle-class white mother who gave birth to twins by emergency c-section. As someone who had gone through in vitro fertilization for almost a year and had become pregnant, Scarlett was prepared for a medical model of birth. She had planned a cesarean, but was concerned about her care because due to her spina bifida “nothing in my body is where it should be.” She had done several prenatal meetings with her medical team in Boston as she says, “drawing them a map” to come up with a plan for the cesarean. But, while visiting her parents in central Massachusetts, she began to feel unwell. A doctor’s visit showed a prolapsed cord, with one of her twins becoming unable to get oxygen. Because there is no hospital in central Massachusetts equipped for the level of maternity care she needed, she was rushed by ambulance to Boston. She remembers telling the doctors about her anatomical anomalies, but felt they dismissed her. Her twins were safely delivered by emergency cesarean and rushed to NICUs. But Scarlett was unable to join them because her bladder and several internal organs had been cut in the process of her cesarean. Scarlett does not hold mistrust towards the system for this any longer but admits at the time it was very difficult for her. The response of the hospital in helping her recover was vital in rebuilding a sense of trust in the institutions because of pervious issues in her own disability care.

Not just a problem in labor itself, disability concerns also appeared in terms of people feeling that the hospital wanted them to terminate certain pregnancies. These feelings of being pressured by hospitals left them afraid that they would not receive life-saving care because they had refused medical advice to end their pregnancies. Leah told me her story, punctuated by following her children around, about her son who was the second smallest baby to survive in a Boston-area NICU. She describes herself as being
“worried that the hospital wouldn’t do everything they could do to save the baby because I had felt, I have felt all along that they had been pressuring me to terminate. Like there was a lot of pressure, starting at like 21 weeks.” This pressure came because Leah had received a kidney transplant in 2013 and they doctors were afraid she would lose her kidney. Leah discussed the hospital’s repeated attempts to convince her to terminate her pregnancy and her reluctance to do so:

So on the day that they told me that he needed to come out, they said “so we can induce you and just let him pass.” And I said no…my husband wasn’t even at the hospital…because we didn’t think anything crazy was happening … They said, “well, we can put you under general anesthesia and remove him.” And I said no, because I want my husband to be there. Because I was so scared that if my husband was not in the room, they weren’t going to save him…It was terrifying and then they brought me in and they had trouble getting me numb enough…So they gave me the spinal, and I was only numb from my belly button down, it’s supposed to be from nipples down.

In addition to the fear of losing her baby if he was born without her husband there, Leah had been shocked to learn that she was being scheduled for a cesarean at all. The support she felt made her feel comfortable.

When I asked how they approached her about scheduling the cesarean, Leah said,

They had put me on food restriction without telling me what was going on, and I was like what’s happening …And so I asked the nurse like why “Why is my food restricted?…Am I having an more tests?”…She’s like, “oh they’re going to take you for an ultrasound and then they’re going to decide if you need to deliver today.” And I was like what? So they took me for the ultrasound and they realized that he hadn’t grown into two, in two weeks. So they’re like “okay it’s time for him to come out.” And then they’re just like, these are your options basically…they said he’s not 24 weeks, yet so we can terminate the pregnancy. Or we can induce you and let him pass…or you can have an emergency C-section, but if he lives he’s going to have poor quality of life, he’s probably never going to talk or walk or do anything. Basically it’s how they sold it to us.
She later describes a harrowing experience of being the NICU and being worried that they were not going to save her son.\textsuperscript{66}

Kelsey a mother of 3, likewise reported misgivings about proper medical care. Her first child was born when Kelsey was a teenager and in an abusive marriage. She describes her first pregnancy as a “forced pregnancy, a rape.” Being both young and Latina, she remembers being treated badly at the hospital, including being asked if she took drugs, which she did not. This perceived mistreatment, especially as she was dealing with physical and sexual abuse at home, left a distrust of hospitals for her. Two decades later, when she was pregnant with her second child she found a strong advocate in her obstetrician. She wanted a vaginal birth, but began to sense that something was wrong, and when she told her obstetrician that, “the pain is too much, this is not normal” and that she might want a cesarean, the medical team listened. Because of this, they realized the baby was in a breech position\textsuperscript{67} and gave Kelsey an emergency cesarean to which she immediately consented. Because this was all explained to her and done with great care despite the need to be quick about it, she describes the birth as difficult but positive. It was this team she returned to with her third pregnancy, and she repeatedly noted how supportive they were. When they found out her third child would have Down’s Syndrome, multiple medical professionals either asked or assumed that she was going to terminate her pregnancy, and this worried her about what to expect from prenatal care and labor, but when she returned to the trusted OBGYN she felt safe and supported.

\textsuperscript{66} She admits that this was not a rational fear, and this dissertation is also not suggesting that the hospital \textit{would} have ignored life-saving care. But, understanding how the patient felt in the time and what lead to those feelings is important to understanding the scope of obstetric violence, institutional betrayal, and how to prevent them. It was the lack of communication and compassion in general that gave rise to and exacerbated her fears.

\textsuperscript{67} While breech babies can be born vaginally, it is uncommon because many practitioners are not trained to
Reflecting the power institutional actors have to mitigate or cause trauma, it is important to note that while Kelsey did not want either cesarean with her second or third child, the team around her, especially her obstetrician, were key players in helping her decide on and feel comfortable about a course of action that was best for her wellness.

Institutional Mistrust: Systems and Economics

Institutional betrayal and feelings of mistrust emerge throughout discussions of childbirth. Like Florence speaking about her sister’s VBAC and feeling mistrustful broadly, Marcia, a white mother who worked in hospital administration, also signaled mistrust in institutions with her comments about her friend’s attempted VBAC,

I think some of it, they try to keep their numbers appropriate. That does a lot for funding so. [Private, religious hospital in central Massachusetts] won't deal with heart people that could potentially ruin their numbers, so they'll tell them they won't do surgery because they're too high risk. They could do the surgery, but they choose not to because the, the risk of the potential of that person dying or having complications would make them no longer number one for heart care. So my guess is, to some degree that's fueling a lot of this because we all know that the healthcare industry is based on how much money they can make, and if they’re top ranking they're going to make more money…I’ve had my own similar experiences to some degree, is that no one listens to mothers…that's, the main reason why Black mortality is as high as it is, is because we don't listen to mothers, and notoriously we don't listen to Black mothers.

Her belief that interventions or their lack were driven by a numbers game of some kind as something I had heard from several patients with regards to wanting or not wanting a cesarean. None of those parents looked at the number of the hospital in question in comparison to other hospitals in the area but they were convinced that the institution was tipping the scales in favor of its own numbers over patient wishes regardless.

Since they were in the same group, Bella, a white mother of four agreed with Marcia:
I completely agree with Marcia about there's a lot of numbers stuff that goes on behind the scenes, when I was fresh-faced and perky boobs and without gray hair and I was coming up on this idea of having our first child and I interviewed our first OB, I said “tell me what the C-section numbers are here”, and she[told me.] And I said that's astounding and it's “frankly unacceptable…tell me why you think they're so high.” And she said, “well let's face it, you know, I have a mortgage. I have, I have a family, I have expenses I couldn't possibly run the risk of running myself into financial ruin.” I said, thank you very much for your time. That was when I switched to a midwife service and never looked back.

Bella also noted that she has professional familiarity with liability concerns through her job as a social worker.

I understand about liability, I understand, about professional risk, and I understand how we want to limit that because our rates go up for malpractice insurance and we don't want to have action taken against our licensure. And so I think some of that is that play.

When discussing why some hospital policies exist that her groupmates brought up (this group focused on cesareans and malpractice, likely because several of the mothers in the group were birth workers or worked in the medical field, and there were several young, pregnant mothers who were asking other group members what they could do in labor).

Bella continued with issue of diversity as problematic of institutions and mistrust:

But every single time we're trying to have those conversations [about making policy changes] they're taking place in rooms, full of elderly white men. So until those groups are more representative, not only of the people who are doing the birthing, not to exclude male partners in this or female partners in this, or anybody's partners in this, but until that room is more representative of the people who are experienced what we’re talking about here, I don't expect that much would change.

Linking the issue to epistemic injustice, Bella also noted that hospital policies made her feel as though there was a gatekeeping of knowledge and the ways in which women are not trusted as knowledgeable peers nor as having the best interest of their baby at heart:
Well, otherwise the implication is that as birthing mothers we're not concerned with the life and livelihood of our offspring, which evolutionarily would be just wildly so far left to center to say that. And and and then and then again, I think it's also calling into question our capacity to educate ourselves and our capacity to make informed decisions. And I think that, that is also a problem right like how are we able to educate ourselves and maybe that was a good question that you asked about.

To general acclaim of her group, Marcia also pointed out the betrayal that comes from being not only shuffled into interventions but feeling ignored at the same time especially linking to those same epistemic issues as discussed in Chapter Four. Marcia said,

And they were like “Oh, we think it's just your anxiety,”…They give me a nebulizer. My mom was a nurse…came back that night and I couldn't breathe. And she was like “this isn't normal, like I know my daughter,” and it turned out that my lungs were filling with fluid from my blood pressure being so high, and they had to do an emergency C-section. Because they don't listen, like no one's listening to me, and had she not gone to get a resident, because it was at [hospital in the Worcester area], I probably wouldn't have survived in either with my daughter…My second daughter was at [same hospital]…she had health issues, so I knew that her pregnancy was going to be challenging And then she didn't end up surviving much beyond her birth…And my third pregnancy, I was pregnant with twins and my high risk OB was like “Okay you're already like creating issues for me here so. If you come in and like there's a baby like working its way out of your vagina then like yes, you can try and have a vaginal birth, but otherwise we're not playing that game. It's too like risky you've already had to C-section.” So I think that they made an individual decision for me, but if I had gone in and been told, like, “You don't have a choice or an option we're not going to have this discussion” [I would have been upset].

Also linking to Reyes-Foster’s (2008) maternal vanishing, Marcia says, of her immediate postpartum care, that

All four of my children spent time in the NICU. So like, I was in the NICU, they were watching me, they saw that I was having trouble breathing nobody did anything. Nobody asked, “do you need something?” No one checked. And I think that that historically is what happens to women, they leave you.
Almost all of the mothers reported feeling as though hospitals attention vanished for them after the baby was born. There was one hospital in the Boston area and one in the Metro-West area that were notable exceptions. Only one birth center mother said this, and around ten percent of homebirth mothers did. But parents’ perceptions of why this happened were varied. Some mothers believed that the attention was rightly focused on the baby, other felt they were just ignored because “that’s how it is,” others felt they were happy to be left alone and “not have to deal with anyone,” and still other felt they were deliberately ignored due to some systemic issue (e.g., racism, sexism, ability status). This raises some future research questions about the role of institutional practices in the immediate postpartum moments in cultivating positive relationships and de-escalating any negative feelings of maltreatment and about why some people assign systemic issues to their treatment and others do not.

**Conclusion: Culture of Birth**

The stories in this chapter center the role of institutions in the process of childbirth and ask questions about how true consent can be achieved under conditions of imperfect information. What many of those here have added is that their mistrust regarding institutions could be mitigated by responsive institutions or institutional actors. This offers one of the clearest pathways to legal forces that can increase medical trust. With policies in place that are clear and well-articulated, those who have complaints could have the opportunity for some level of procedural fairness, even if they do not have the outcome they want, though more research is needed in this area. Policies that are rooted in evidence collaboration and communication would have made a good
deal of difference for Felicia or Marcia. The shuffle into interventions that people did not understand was a product of policy and hospitals making choices that do not center the gestational parents. As Florence notes, this can lead to a growth of mistrust not just for the parties involved, but those in their social networks.

Florence was already cynical about hospitals and medical culture, but her sister’s story made her even more so. This could be problematic in the future, as Florence has gestational diabetes with her current pregnancy. She says she will go to the hospital to deliver her baby if she feels there is enough reason, but her ability to make this judgement is clouded by the bad experience she had and the traumatic experiences of her sister. The kinds of medical mistrust that lead to maternal health problems are shaped here by the anti-VBAC policies at Felicia’s hospital.

When obstetric violence happens institutional unwillingness to provide redress is a re-traumatizing experience (Freyd and Smith, 2013). But other protocols could prove useful as Amanda suggests. When the situation is harmful, hospitals could take complaints more seriously and offer a way to rebuild trust. Some hospitals and risk managers are already working on this solution as a way to build patient trust (Fiumara and White, 2016), and it is a promising avenue for mitigating institutional betrayal when there is already trauma. The legal remedy for a sense of institutional betrayal does not have to be malpractice or liability lawsuits, and in fact, protocols for admitting mistakes or conflicts or opinion in medical practice have been a substantial study for medical ethicists not because they are intended to shame medical professionals but because these processes can mitigate medical mistrust.
Some of the larger patterns of not listening that lead to mistrust in institutions broadly as shown by Marcia. Like the narratives in Chapters Four, the mothers in this chapter felt that they were not being listened to. For those narratives in this chapter, the feelings of epistemic injustice developed more fully from personal annoyance with their doctor or hospital to wider sense of mistrust in the maternal care industry or the medical industry more broadly. Though the chapters mothers like Marcia, Erika, and Amanda who had more familiarity with the medical industry also appeared to have more mistrust in it. For those caught up in situations where they feel they do not know where to turn like Donna or have nowhere to turn like Barbara, they are left feeling unsupported and vulnerable at a time when they may still be facing pregnancy and birth related medical complications.

One of the dangers of institutionalizing childbirth is that the institutions in which childbirth takes place can develop the same negative identity prejudices (Medina, 2011) or path dependencies as other institutions, codifying out-of-date practices or dangerous habits. What research on institutional betrayal and obstetric violence show is that institutions often fail to take seriously violence that is seen from the ground up because they do not recognize it as violence. When the institutional intransigency is added to the social institutionalization of pregnancy and birth that delimits women’s epistemic capabilities, there comes an added layer of difficulty unpacking bad practices or even having the language to speak about them.

Childbirth is difficult, but when trauma comes from both the experience and the institutional response there are lasting consequences. Like medical mistrust broadly, institutional betrayal sets the stage for a much larger pattern of mistrust by patients and
can lead into the same systemic mistrusts that discourage patients from returning to the hospital for follow-up care. Moving away from the personal view of the politics of childbirth, the following chapter explores the policy landscape of the U.S. and how those politics are shaped.
CHAPTER 7 CONCLUSION: TALKING BIRTH, TALKING POLITICS

Many stories have appeared in this dissertation. Voices with positive and negative experiences, and narratives from women, non-binary, and trans folks have all shared their varied expectations and experiences with the institution of childbirth. Across gender and racial lines people told stories that on the outside look so disparate as to have no meaningful basis for comparison, but while you could ask a million people about their births and hear millions of stories, what all of these stories show is that childbirth is shaped by the invisible hand of policy, law, and society in the form of institutionalized childbirth. The previous chapters have explored the ways that the politics of childbirth are shaped by legal and social forces from our beliefs about birth and birthing people to law and policy at the hospital and national levels. To conclude, this chapter explores the global movement against obstetric violence in order to draw out policy solutions that will improve the culture of childbirth and make the politics of childbirth something that encourages collaborative care and saves lives. Law underlies the politics of childbirth through legal, policy, and sociolegal factors, but this chapter considers the global scope of some of law and policy debates and solutions about treatment in childbirth.

This dissertation has offered a connection between maternal mortality and treatment in labor and delivery through the kinds of mistrust that develop from institutional betrayal and epistemic injustice. It has put forth a quantitative policy snapshot that allows scholars and advocates to compare state policies on the ground while providing a policy-level view of legal pluralism, and how to bring reproductive justice and politics to the forefront of mainstream political science studies. Qualitatively, this dissertation has talked about childbirth as an institution allowing readers to consider the
role of using an institutional betrayal lens when evaluating policies and the persistence of negative outcomes that are well known and preventable. Throughout it all, whether in terms of epistemology or contending with definitions of obstetric violence, it has called for more reflexivity of institutions and those within them. It is crucial to becoming more reflexive in evaluation, application, and revision of policies and practices to remember that what we believe shapes out interactions with the world around us. This dissertation renders those epistemic commitments front and center and assesses how they work to form childbirth as an institution and practice as much as biological process or life event.

This dissertation has been a long journey through the ways law and society, both separately and through their intersections, shape policy and affect care around childbirth. As Chapter Three explained, we do know better about maternal health than our policies and health outcomes would suggest. Understanding the institutionalizing of birth, the role of consent, and the view from the patient-level can offer pathways towards pragmatic social and policy solutions to some institutional issues. Some things, like the epistemic injustice of not believing women or BIPOC folks because of these aspects of their identity, cannot be solved with a policy. However, policies can emerge that mitigate biases and foreground the importance of believing the birthing person but if there is no institutional support there is no reason to believe that works. This dissertation is not suggesting that people stop trusting doctors just because some mistakes are made. Rather, it is to unpack the assumption that a birth giver who questions or refuses interventions is always hysterical, controlling, or difficult and consider the role that such social framing may have on a birthing person’s experience. For conflict to become cooperation, it needs to be met with reflexivity.
The politics of childbirth are shaped by individuals’ perceptions of what birth is, clashes in ideology about the extent to which people who give birth should have autonomy, unclear answers about who should have authority when there is a conflict between medical advice and patient preferences, and a host of legal, policy, and structural elements discussed throughout these chapters. These factors shape the institutionalization of childbirth and are, in turn, shaped by the institutionalization of childbirth. The reinforcing relationship between belief and practice has been the centerpiece of the qualitative portion of this project, but underlying that was the role of institutionalized birth in shaping the response to the maternal mortality crisis. There are programs nationally and internationally that address maternal mortality, obstetric violence, and mistreatment in childbirth in order to improve birth culture. Drawing from the evidence, interviews, and ideas presented in this dissertation, the conclusion explains how policies can work to improve birth for many people. Changes can be broken into three major areas: Recognition of the problem, Institutional Change, and Social Science Contribution. This conclusion explores some options that have potential for legal and social policy changes within attitudes about birth and then considers the ongoing role social sciences could have the would be useful.

**Recognition: A Problem with a Global Scope**

While this dissertation has largely focused on the United States due to its outlier position in maternal mortality, it is important to recognize that the politics of childbirth and who gets treated with respect are part of a global context of women’s health. Understanding the global scope of the problem as well as the national and transnational activism and research offers the U.S. some pathways through policy and social activism.
to creating a more intersectional conversation which can improve childbirth for more people. As noted in Chapters One and Two, the reproductive justice movement and birth justice movements are particularly illustrative of the ways different worldviews and different views of what law and politics should do are central to understanding the diverse struggles of reproductive autonomy even within the same country (Ross and Solinger, 2017; Vayo, 2022).

As discussed in the introduction, there is resistance to the term obstetric violence, but to fully understand the politics of childbirth, the term must stand alongside other concepts used to understand reproductive autonomy. As Chadwick (2021) notes, naming any violence runs the risk of alienating people within structures of power, accusations of overlooking or minimizing other types of violence, disempowering those who would be considered “victims” of violence, and being accused of being incendiary (2-3). She also writes of not just the risk of backlash to the terms as distracting from the issues at hand, but of the problem of misrecognition (Chadwick, 2021, 3) where ordinary discomfort or disagreement becomes labeled a type of violence, therefore depriving the term of any meaning at all. Ultimately, Chadwick (2021) supports the use of the term:

in daring to openly name as violence that which is often seen as ‘normal’ or acceptable, we risk being seen as bias, extreme, and overly hostile. This can become a basis for dismissing our work…[as] too “subjective” or “inflammatory” (3).

As sociolegal scholars, weighing in on what is violence in a legal context or stemming from law is fraught, especially when considering the legal underpinnings and normalization of institutional behaviors (e.g., informed consent policies, scope of practice, malpractice laws). Additionally, “defining violence is never a neutral act, but it is deeply contested and political” (Chadwick, 2021, 3). Further, because obstetric
violence is a “feminist concept meant to name institutional violence from the point of view of the victims” (Van der Waal, 2022, 2) it challenges power in ways that are going to be considered problematic, even accusatory, by some. The term obstetric violence, like any new term to describe a type of routinized or accepted violence against marginalized groups or that takes on taboo violence, face the same criticism as the terms domestic violence (Snyder, 2019), date rape (Warshaw, 1994), microaggressions (Gomez, 2015), sexual assault (WCSAP, n.d.), sexual harassment (Garcia-Navarro, 2017), marital rape (Warshaw, 1994), and even movements like #MeToo have. But at the end, to address the violence, one must have a name for it.

In response to the growing awareness of disrespect and abuse during childbirth, the World Health Organization has repeatedly issues guidelines and engaged in studies on the “prevention and elimination of disrespect and abuse in facility-based childbirth” and calling respectful treatment in childbirth a human right (2015). Using WHO data, Boren, et. al. (2019) published in *The Lancet* a four-country cross-sectional study and community-based observation analysis that contended “structural violence” against women in labor and mistreatment of people in childbirth was common, with more than a third of people in their study experiencing it. In 2022, the World Health Organization outlined the growing indications that mistreatment and poor care in childbirth leads to long-term medical mistrust. This mistrust is revealed in the U.S. in ways that prevent follow-up care for those who experience postpartum complications. Recognizing the scope of violence against women and people who give birth and naming it is essential to mitigating the harms that many people are facing. Castro and Savage (2019) note:
Obstetric violence is an urgent issue that affects women giving birth in clinical settings throughout the world and needs to be understood and addressed as a key driver of inequitable maternal and child health outcomes. The term “obstetric violence”—also labeled dehumanized care, disrespect and abuse, or mistreatment during childbirth (in text citations removed) (p. 123).

This urgent issue should be viewed as institutional and social factors that relate to epistemic credibility and the ways in which women’s experiences generally are marginalized.

An important future project would be to tighten the concept of obstetric violence in a way that links it more clearly to reproductive autonomy and allows scholars to meaningfully compare problems and solutions that they research. In India, Shrivastava and Sivakami (2020) created a study that explored seven different elements of obstetric violence in order to clearly delineate the term. From their results, they offer support for a rigorously and comprehensively designed framework for understanding obstetric violence, which they refer to as “this normalized public health issue” and call for “a multi-pronged, rights-based framework…that addresses the social, political and structural contexts of ‘obstetric violence’ in India.” Following this framework in the U.S. to address treatment of those in socioeconomically disadvantaged groups would be a good start for providing quality maternity care.

Bringing healthcare providers into this discussion is a vital way of getting qualitative and quantitative understandings of the scope of the politics of childbirth and how they manifest in healthcare settings. Midwives in Mexico have worked with OBGYNs to explore the connection between violence in obstetric settings to violence in society broadly (Dixon, 2015) in a way the highly polarized United States might benefit from. Wendland (2007) draws in the concept of the “vanishing mother” to help explore
the ways women are treated in institutional childbirth as the process is continually more medicalized and geared towards relying on technology, as discussed in Chapter Three. Engaging with the crosscutting and global intersectionality, Wolf (2022), connects the forced hysterectomies of immigrant detainees in Georgia by the US organization ICE, as part of a larger pattern of obstetric violence as an immigrants justice issue looking at US and Colombia.

This first step of recognizing and accepting that this type of violence exists is part of a consciousness-raising project. While not costly in the same way other policy suggestions are, this is not without difficulty. As previous chapters have discussed, the polarization that marks the U.S. political culture is also part of any social discussion, including childbirth. Getting widespread buy in on the term obstetric violence could be very difficult from people who do not or do not want to categorize their negative experience as violence. Likewise, in a culture where women are given less epistemic credibility and those parts of culture that have the host-body ideology with regards to those who give birth, it is not likely that the concept of obstetric violence will take root with everyone. Even within the interviews here some participants claimed “you have no rights” when it comes to what to expect during childbirth.

There is promise for engaging in the ground-level acceptance of the term as doulas, out of hospital childbirth classes, and physician-advocates become more prevalent (Dekker, n.d.; Hill, 2019; Oparah and Bonaparte, 2016). More popular media sources like Vice, NPR, and NBC news address the dual problem of maternal mortality and treatment during labor and delivery. As organizations like Birth Monopoly, Evidence Based Birth, and VBACFacts as well as state-level organizations like the California Maternal Quality
Care Collaborative, the New York Doula Project, and the Bay State Birth Coalition work to ensure better birth practices and raise awareness of disparities these are the foundations for more social activism and awareness in the future. Much of the work on obstetric violence in North America, especially Canada (Birth Place Lab, 2015; Fraser, 2021; Janssen, et. al., 2009; Vedam, et. al., 2018) and Mexico (Dixon, 2015). Loreto, et. al. (2022) found that among older doctors there was little acknowledgement of and some hostility to the term obstetric violence and considerations of patients’ rights/autonomy, but that there was awareness and willingness to use it among residents at much higher rates. Even in interviews for this dissertation, physicians themselves used the term, one to describe her own experience in labor. There does appear to be space between physician resistance to the term and a growing social acceptance of it to hope that more conversations could help engage physicians. As the introductory chapter noted, the same conditions that shape professional resistance to obstetric violence as a term shape that resistance to police violence as a term. Through normalizing the terms at the social level, they may become more amenable to people in general.

**Institutional Change**

Chapters Three through Six explored the role institutions have in shaping experience and expectations. Rather than engaging in broader fights about “madwives” and birthzillas, or the midwife versus medical model of care, hospitals could seek an epistemic peer model of care that prioritizes mutual respect and collaboration. From those chapters several institutional policies and practices arise that could shape the ability of providers and patients to engage in the epistemic peer model of care. Creating these models would include, incorporating doulas and midwives into the medical system
through access and insurance practices. As Chapter Two shows, there is a wide disparity in the ability to access quality care, and that even in states where there is relatively high rates of reproductive autonomy choices in childbirth are limited by policy, law, and geography. Increasing access to perinatal care options through insurance access to Certified Professional Midwives and birth centers, and state policies that promote alternatives to maternity care deserts, and collaborative care among physicians institutions could increase maternal health and wellness.

“Let’s Midwife [and Doula] the system!”

Attitudes about midwives (madwives) and those who might use them (birthzillas) has been a feature of this discussion. It is then only fitting that a strong place in policy is to break down the conditions that give rise to the pejorative labels of birthzilla or madwife by reassessing how we think of birth and those who care for birth.

The Birth Place Lab’s (2015) massive study that mapped midwife integration across all fifty US states was an important moment for reproductive politics and public health. The map of midwife integration remains a ground-breaking example of how public health law methods can be harnessed by social sciences to explore the role of law and policy on public health. The Birth Place Lab’s continued research in Canada has offered data on respectful treatment in maternity care and how to achieve what in Canada is called “Obstetric Justice,” both the presence of respectful maternity care and the absence of obstetric violence/injustice. The Birth Place Lab’s Midwife Integration Scores put forth the important role that midwives have in patient care and creating a positive climate of birth, Additionally, the Midwife Integration Scores show how continuity of
care is a vital metric to maternal and infant health. They suggest a higher rate of midwives and access to doulas as matters of maternal health and wellness.

Greater access to midwives should be a central policy to improving health and harnessing the institution of childbirth as one that works for those who give birth. Or as maternal health blogger Romano says, a solution through both law and policy would be to “midwife the system” (Romano and 2019). Increasing the availability and presence of midwives and doulas would be a way to balance the need for more providers and those who are committed to lower technology and interventions (Vayo, 2021). Renfrew et. al. (2014) found that on 56 measures of maternal and infant health, midwives are associated with better results. Dozens of studies have repeatedly show patients with midwives have better birth outcomes (Janssen, et. al., 2009; Martin, 2018; Raipuria, et. al., 2018; Vedam, et. al., 2018). According to the Lancet, “integrating midwives into the health care system could prevent more than 80 percent of maternal and newborn deaths worldwide” (qtd in Martin, 2018, n. p.). Midwife integration will especially help Black women and Latinas who are experiencing higher rates of maternal and infant mortality rates of white women (Vedam et. al., 2018).

Current “research findings support strong association between midwifery-led care for pregnant women and reduced labor and birth interventions” (Raipuria et. al., 2018). Research has repeatedly found “a strong association between midwifery-led care for pregnant women and reduced labor and birth interventions (internal citations omitted)” (Raipuria et. al., 2018) making birth safer and less expensive. Additionally, “women cared for by certified nurse midwives have fewer cesareans”68 and more autonomy in

68 Measuring people who start labor with certified nurse midwives, not just measuring the fact that midwives do not perform cesareans.
labor and delivery (Gorman, 2019). Certified nurse midwives (CNMs) rely less on technology and “achieve similar or better outcomes” (Johantgen et. al, 2012) likely because increased use of technology and interventions across low-risk births. As Chapter Three points out, midwife exclusion was not about health benefits and their continued marginalization in U.S. maternity care is also not about health outcomes. Countries with better maternal mortality and infant mortality have higher midwife integration into their healthcare systems (Martin, 2018; Vedam et. al., 2018). To re-integrate midwives would correct their exclusion and bring the U.S. in line with other comparable countries on its perinatal care workforce. Homer, et. al. (2014) find that integrating midwives in the maternity care system could “eliminate 83% of all maternal deaths, stillbirths, and neonatal death” and call for a collaborative care that values midwives and specialists working together to provide the best care for families.

Integrating midwives can also be a matter of continuity of care. Continuity of care can be vital when a homebirth patient needs to transfer to a hospital. Reproductive autonomy would require access to homebirth with qualified midwives to be an option for parents in all states, but even states that are reluctant to legally sanction homebirth can still improve by allowing CPMs to bring clients into the hospital and stay with them as non-professional support partners. States where homebirth midwifery is legal, midwives are not usually allowed to accompany their clients into hospitals should something necessitate a transfer (Vedam, et. al., 2018). Allowing wider access for homebirth midwives to accompany their clients to the hospital (with an understanding that their role as the patient’s primary medical professional ends at the hospital door) would allow for a continuity of care even if the midwife were no longer the primary medical professional in
the room. This would possibly be met with resistance by physicians, but doctors in hospital do not need to have professional conflict with midwives, as scope of practice rules and guidelines can be agreed to allow midwives to attend their client even as that client is also the patient of a doctor.

Collaborative care already exists across the practice of medicine, so its absence in birth is conspicuous. Collaborative care practice is becoming more common in orthopedics (DiGioia, 2017), pediatrics (Levitt, 2023), mental health fields (Goodrich, et. al., 2013) and in complex medical-psychiatric cases (Ivbijaro, et. al., 2014). Drawing on his work treating patients who had heart failure and depression Callahan (2021) suggests that collaborative care should be the dominant model of practice for the wellness of the patient and to allow physicians to focus on their own specialties and combining expertise. Collaborative care is common across oncology where multiple specialists often work together (Coniglio, 2013; Courtnage, et. al., 2022), especially when including mental health and depression that occur throughout cancer treatment (Li, et. al., 2017).

D’Alton, et. al. (2019) note the lack of collaborative care in maternal fetal medicine, particularly in care that collaborates with patients, as a driver of race-based maternal mortality and “preventable harms and adverse outcomes” (p. 311). Carmona, et. al., (2018) observed the positive effect of WhatsApp and the ability to have real time collaborative care between maternal and fetal medicine and obstetrics. Collaborative care works in maternity care just as well as other areas of medicine (Watkins, et. al., 2022), and it is unclear whether it is professional gatekeeping or a matter of views of women and childbirth that shape resistance to more collaborative models.
Along with and increased role of midwives, support of doulas can be vital to patient success (Greiner, et. al, 2019; Gruber, et. al, 2013; March of Dimes, 2019). Increasing the availability of doulas through insurance programs and hospital-based programs would also aid in patients having the one-on-one support. One of the common concerns among those I interviewed was that they did not know about the interventions they were subject to and they felt they did not have time to talk to their providers about it. The lack of conversation left lasting doubts and can sew mistrust. Even the best prenatal class is likely not able to prepare patients for the risk/benefits or reasons for every intervention. Having a trusted person who has professional familiarity with birth interventions and is trained to speak about them in plain language can break down some of the cultural health capital barriers. Well trained doulas spend time learning how to talk to patients in “plain language”; this plain talk might not be first-hand practice for doctors and nurses by the time they have completed years of education and professional training that rewards clinical and exact language. With doulas and or midwives to bridge the conversation gap, this opens up the epistemic peer models and increases the cultural health capital of those in labor. In hospitals where doctors, nurses, and CNMs are taking care of multiple patients at a time, having a doula for constant one-on-one support makes space for these difficult conversations with (usually) enough time for patients to feel as though they are getting their questions answered (Hailes and Spivak, 2020). Likewise, doulas educate patients in advance (Hailes and Spivak, 2020; Hill, 2019). The presence of doulas can help patients feel as though they had “buy in” on the interventions making their care feel more representative of their wishes.
California, New York, and Massachusetts have all begun expanding access to doulas through state health care exchanges. Massachusetts’ Birth Equity and Support through the Inclusion of Doula Expertise (BESIDE) Investment Program awarded one hospital in the eastern section of the state and one in the western section of the state just under $195,000 each to offer doula access to patients. Other cities and states nationally are experimenting with doula access for the poorest patients as well. These funds are meant to help doula access for economically disadvantaged people. To have Medicaid expand access to doulas would be an important intervention, and there is reason to believe that despite the cost, it would save more money in the long run. O’Neil, et. al, (2021) estimate the “maternal morbidity [outcomes related to pregnancy or delivery] costs for all U.S. births in 2019 to be $32.3 billion [from birth until age five]…This amounts to $8,624 in additional costs to society for each maternal–child pair.” They find that the costs of medical expenses, hospitalizations, lack of economic productivity, and increased reliance on social services during this first five years as a result of pregnancy or delivery and also suggest these numbers are under-estimated since parents rely on families, spouses, or do not go to the doctors (O’Neil, et. al., 2021). Participants in my interviews mentioned economic and social difficulties after they had experiences they perceived as bad. This included one who broke her tailbone during labor, another who required a surgery that she did not disclose, and another whose home visit nurse called her cesarean section “the easy way out.” These women and others I spoke to had fallout from a difficult birth experience in other areas of their lives.

Access to Birth Centers and Ending Maternity Care Deserts
Chapter Two notes the wide range of accessibility to midwifery care, doulas, and birth centers. This is a disparity that quantitative data can help flush out and one that policies are suited to solve. Doula and midwifery access are also important parts of maternity care in the face of growing maternity care deserts. As New York and California’s doula pilot programs showed, doulas offered fundamental prenatal service to help pregnant people understand their risks and options in childbirth and to increase perinatal wellness. As discussed in Chapters One and Two, the March of Dimes (2020) reported on the state of maternity care deserts, areas where access to maternity care is limited or unavailable. There are many areas around the country where perinatal care is difficult to find or absent, especially in rural and sparsely populated areas and in economically depressed areas of large cities (March of Dimes, 2020). Gallardo and Martin (2017) note this is particularly concerning in rural areas of the country, bringing in a health risk when mothers must travel long distances while in labor and either arrive at the hospital too early (and risk having interventions to “speed up” labor) or too late (and give birth unattended on the way to the hospital).

Despite awareness of the deadly repercussion of maternity care deserts, their presence is ever expanding. As of the writing of the State Reproductive Autonomy Index (Vayo, 2022), Massachusetts did not have any maternity care deserts, now it has at least one with another on the horizon. Since the last birth center in Eastern Massachusetts and a maternity ward in Falmouth, Massachusetts (“Falmouth,” 2020) both closed, what few resources there were to women who wanted a less institutionalized model of birth have been dramatically curtailed. When closing the maternity ward in Falmouth, the Massachusetts Department of Public Health referred to this move as “dangerous” to the
public health and called the maternity ward “essential” to the public health (”Falmouth, 2020). Yet, the state could do nothing to stop the closing of this maternity ward. Nor could the state stop hospital owner, Cape Cod Health, from following up the creation of a maternity care dessert with even more cuts to the maternity care workforce at its other facility, Cape Cod Hospital, by cutting training programs and availability of midwives in the hospitals (Bentley, 2020). This lack of power to protect the public health against the medical industry is a problem for many states.

While the Cape Code Healthcare group is not-for-profit (KFF, “Hospitals,” 2021), the entire medical system in the United States operates within the profit motive of hospitals, insurance companies, and other health-related organizations. The presence of a for-profit health care system cannot be mitigated by individual hospital and state decisions, thought there are five US states that do not have for-profit hospitals (Hawaii, Minnesota, New York, Rhode Island, and Vermont). Birth centers are cheaper to maintain and offer more flexibility for people who live in population sparse regions (Allsbrook and Ahmend, 2021; Vayo, 2019). Likewise, birth center deliveries are cheaper to patients and insurance companies (Allsbrook and Ahmend, 2021; Cullen, 2016). When the Affordable Care Act (ACA) increased insurance reimbursements to birth centers, birth center births grew by 55% (Allsbrook and Ahmend, 2021; Cullen, 2016). These centers may not be appropriate for all pregnancies, but for low-risk (“normal”) pregnancies birth centers are a viable option that is more affordable to families. Increasing birth centers around the country could offset maternity care deserts providing the pre- and postnatal support for good birth outcomes and to decrease the maternal mortality trends.
Beyond birth centers doctors and activists in maternity care deserts around the county are trying to create pathways to wellness. With the looming OBGYN shortage which is expected to increase to 22,000 fewer OBGYNs than needed by 2050 (Kramer, et. al., 2022) recruiting and retaining OBGYNs is one step in the process of continuing good care. Given the role individualized care and rapport building has on patients’ feelings, having an OBGYN shortage could be catastrophic to medical trust. But, as the field becomes more “feminized” and predominated by women, OBGYNs are experiencing the same devaluation of their profession that other fields do: when women start to dominate a field, wages stagnate or go down (Levanon, et.al., 2009). This makes recruiting and retaining OBGYNs even more difficult given that among female OBGYNs 23% are already having to cut their hours at work due to childcare responsibilities (Bacon, 2008). An ACOG study found that 64% of all OBGYNs report experiencing burnout and almost a third (31%) agreed with the statement “I want to quit.” Hostetter and Klein (2021) suggest building satellite networks of OBGYNs, which has worked in several states to reduce maternal mortality. Minnesota, Missouri, Montana, New Mexico, Texas, and West Virginia have received $21 million in federal funding as part of strategies to develop regional and satellite networks of OBGYNs in order to decrease maternal mortality in rural areas (Hostetter and Klein, 2021). Insurance companies also play a role in mitigating the crisis (Kozhimannil and Zimmerman, 2020). In 2009, Blue Cross and Blue Shield of Tennessee gave a $1.8 million grant a maternal-fetal medicine specialist in Chattanooga’s Regional Obstetric Consultants who created a telemedicine program intended to help Tennessee and Appalachian high-risk pregnancies (Hostetter and Klein, 2021). The Solutions to Obstetrics in Rural Counties (STORC) now covers
areas in Alabama, Georgia, North Carolina, and Tennessee. STORC founder Dr. Adair has worked to find the balance between much needed access among high-risk patients and the importance of maintaining populations in rural hospitals for the sake of the communities themselves (Hostetter and Klein, 2021).

Lewis, et. al., (2019) note the role Medicaid could plays in maternity care deserts to help keep these rural hospitals open and financially solvent. In rural areas, Medicaid pays for over half of all births, but because it reimburses hospitals less than private insurance and rural hospitals cannot expect to offset costs with money from private insurance companies, economics become a reason hospitals close (Lewis, et. al., 2019). As medical care costs have risen across the board, Medicaid reimbursements have not kept up, putting rural hospitals even more behind (Kozhimannil and Zimmerman, 2020; Lewis, et. al., 2019). Like other studies Lewis, et. al. (2019) support the increased training for non-clinical practitioners like doulas and midwives, but they also add a need for rural hospitals to train nurses to go out into the area to help with prenatal and postnatal care. Further, they recommend collaborative partnerships with area universities, teaching hospitals and satellites as Hostetter and Klein’s (2021) research supports (Lewis, et. al., 2019).

There are economic and policy ways through changes in Medicaid and government grants to rural hospitals that will help to reduce maternity care deserts and increase maternal and neonatal wellness. Considering that midwives are less expensive to patients and insurance companies their use in hospitals in rural areas would be a benefit, especially if the scope of practices were changed so that midwives did not require the supervision of OBGYNs. These policies are important elements to undoing the damage
of hospital closures. But it is important to note the policies that also suggest increased use of doulas, midwives, and other community health workers (like nurses) to engage with prenatal and postnatal patients. But it is important to see that these patients must also be able to go into institutions that are able to support them and create conditions of collaborative care.

Social Sciences

Social scientists have an important role to play in helping catalogue the politics of childbirth and promote policies that will reduce harm in maternity care. Such programs exist in smaller forms throughout the US that could be drawn on to shape changes in the institution of childbirth. Yet, as each birth narrative and experience differs, it is the same that each hospital and area are different. This means that a “one size fits all” solution will likely not work. Having a monitoring system like the CDC’s PRAMS (Pregnancy Risk Assessment Monitoring System) (n.d.) is useful for gathering vital statistics. The Birth Place Lab (2015) model in Canada and Birth Monopoly in the U.S. (Pascucci, n.d.) have been useful in aggregating stories of birth experiences, exploring policies, and promoting respectful maternity care. Likewise, California’s Maternal Quality Care Collective has integrated state policies and hospital to improve birth outcomes. But it is in the City Health Dashboard project and the Midwife Integration Score that we can see the real power of data-driven social science coming to bear on re-shaping institutions and political conditions.
Created by legal epidemiologists, City Health Dashboard is a massive project using public health law methods to bring useful data to the public. The City Health Dashboard offers data on over 40 different measures in over 900 cities. Such measures include Clinical Care (e.g., insurance status, prenatal care rates), Health Behaviors (e.g., smoking, binge drinking), Health Outcomes (e.g. firearm homicides, breast cancer deaths), Physical Environment (e.g., air pollution, lead exposure), and Socioeconomic Factors (e.g., income inequality, children in poverty). By categorizing these data, cities are awarded medals based on the number of positive factors they have. This data set is available to the public and is updated regularly. The publicity of it has caused some change in city policies (Impact Stories, 2023) as cities have a specific goal (increasing their medal) and the aggregate of information online makes it easier for advocate and residents to point to specific policy areas. Because the City Health Dashboard also included specific texts of laws and policies, this empowered local citizens and activists to interface with local policymakers to increase health outcomes.

While hospitals might not be motivated in the same publicity campaigns that shape the City Health Dashboard’s medal program, policies that are framed as consumer choice do find traction with hospitals and healthcare systems (Cramer, 2021; Hill, 2019; Wagner, 2006). Creating a program like City Health Dashboard that could categorize hospital level data about interventions, method of birth, and other health factors would also fill a gap for consumers and researcher because that information is not widely available. City Health Dashboard is not an exact template for a maternal wellness index, but it is a useful model for the ways in which the social sciences can harness the power of data and analysis to empower concerned citizens.
Working with reproductive justice scholars to expand the State Reproductive Autonomy Index in Chapter Two, and continuing on with the Birth Place Lab’s midwife integration scores (Vedam., et. al., 2018), and expanding on the Listening to Mothers Surveys (National Partnership for Women and Families, 2006) all offer ways for social scientists to collect qualitative and quantitative data to drive public health policy recommendations that could help with staffing, access, and other aspects of the individual experience. While they do not offer the ease of finding specific law and policy that City Health Dashboard does, the Midwife Integration Score has been a starting point for research around the U.S. and has been used as data by activists to support a broader role of midwifery (Cramer, 2021). The Listening to Mothers Surveys through the National Partnership for Women and Families (2006) have been invaluable to crafting and advocating for policies that center patients and their wellness, including calls for more midwife and doula involvement (Cramer, 2021; Wagner, 2006). These measures that are qualitative and quantitative as well as local, regional, and national are all important because the conditions across the U.S. are so different. But each offers a way for data to be put into the hands of activists and policymakers to improve birth.

Additionally, having information about maternity care and policies that is publicly available is not only something patients want (National Partnership for Women and Families., 2006) but it can allow a consumer-level push for better policies and outcomes (Cramer, 2021; Wagner, 2006). This data could allow patients to make arguments to insurers about out of network hospitals and providers and even in areas where alternatives are not possible, it allows patients to see specific issues and address policymakers and social activists.
Conclusion:

The maternal mortality crisis is the most visible manifestation of the politics of childbirth in the U.S. Its persistence and the failure of institutions and policymakers to solve the problem illustrate its intractability as well as the fact that attitudes about people who give birth shape what policymakers and individuals think about how birth should look. People who view women as hosts for pregnancies or those who believe women do not and should not have autonomy in reproductive choices, including childbirth, are not going to take seriously a social movement that prioritizes childbirth or those who give birth. For many, even those who identify as feminists, they term “those who give birth” (Hill, 2019) is contentious. Building solidarity around the politics in childbirth means engaging with not just policymakers and institutions but social and individual attitudes. Those epistemic conditions create significant barriers to change. Those who view negative childbirth outcomes or experiences as individual problems not structured by any outside forces such as racism, misogyny, or politics, are not going to jump to spend time and money changing institutions they do not feel are broken.

A starting point to addressing the politics of childbirth, whether maternal mortality, institutional betrayal, obstetric violence, or maternity care deserts is to address the role institutions have in shaping the narrative around birth and childbirth experiences. Institutions are powerful. Whether they were constructed deliberately or grew out of a path dependency of doxa and social practices, they have staying power in our laws and imaginations. Changing the institutions of birth to be more responsive to individuals requires political, legal, and social solutions. But, more than that, it requires changing the narrative of what birth is, who has power over it, and how that power can be shared.
Changing the story can change the story. But to do that, we must listen to those who gave birth and take their stories seriously.

Those who shared their stories with me did so out of a sense of not being listened to. Even those who had good experiences had rarely had a chance to talk about what their birth was like. As long as these stories remain rarities and people who give birth do not have space to talk about it, institutionalized childbirth will continue to dominate the view of what childbirth is and how it should look. Amanda, the anesthesiologist who described her experience as “obstetric violence” ended our interview with concern about her two daughters growing up in a culture that does not take care of them when they are vulnerable. As the U.S. moves towards restricting the right to prevent or end pregnancy, Amanda’s concerns are going to become even more important to families throughout the country. Family health and wellness should be national priorities, but at a time when the rest of the developed world continues to shake its head at the U.S.’s repeated failure to address maternal mortality, it is clear that those are not priorities. The lives at stake are not just the people who die giving birth, they are the families, friends, and communities to which those people belong. If the stories throughout this dissertation accomplish anything, it should at the least be that behind every statistic is a story. And behind almost every story of maternal mortality is a person that we knew how to save, but a system that was not set up to prioritize them. The national and international research has offered pathways to better birth, the only question now is whether we have the political and social will to take them.
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### APPENDIX A: ALL VARIABLES BY CATEGORY

<table>
<thead>
<tr>
<th>Variable Name</th>
<th>Score</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abortion and Contraception Variables</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Percent of counties without a known clinic</strong></td>
<td>1 = 75%+; 0.75 - 50-74%; 0.5 =26-50%; 0.25 = 1-25%; 0=0</td>
<td>Guttmacher (2020); NARAL (2019)</td>
</tr>
<tr>
<td><strong>Mandatory Delay/Waiting Period</strong></td>
<td>1= 72 Hours; 0.75 = 48 Hours; 0.5 = 24 Hours; 0.25 = 17 Hours;</td>
<td>KFF (2021); CRR (2020); NARAL (2019)</td>
</tr>
<tr>
<td></td>
<td>0 = None</td>
<td></td>
</tr>
<tr>
<td><strong>Refer Women to Crisis Pregnancy Centers</strong></td>
<td>1 = Does refer; 0 = Does not</td>
<td>Guttmacher (2020)</td>
</tr>
<tr>
<td><strong>No Clinic Safety Access</strong></td>
<td>1 = Does not have; 0 = Has</td>
<td>CRR (2020); NARAL (2019)</td>
</tr>
<tr>
<td><strong>Birth Control Desert</strong></td>
<td>Percent of zip codes listed as birth control deserts: 1 = 75%+;</td>
<td>PowertoDecide.org (2019)</td>
</tr>
<tr>
<td></td>
<td>0.75 - 50-74%; 0.5 =26-50%; 0.25 = 1-25%; 0=0</td>
<td></td>
</tr>
<tr>
<td><strong>Emergency room Required to Dispense Emergency Contraception</strong></td>
<td>1 = No law requiring; 0 = Law requiring</td>
<td>KFF (2021); Guttmacher (2020)</td>
</tr>
<tr>
<td><strong>Counseling and Referral ban on State Health Advocates</strong></td>
<td>1 = Has a ban; 0 = Does not have a ban</td>
<td>CRR (2020)</td>
</tr>
<tr>
<td><strong>Laws Supports Crisis Pregnancy Centers</strong></td>
<td>1 = Law supports; 0 = No law/No support</td>
<td>Guttmacher (2020)</td>
</tr>
<tr>
<td><strong>Law on the Books Forces Women to Crisis Pregnancy Centers</strong></td>
<td>1 = Has law; 0 = Does not have law</td>
<td>Guttmacher (2020)</td>
</tr>
<tr>
<td><strong>Criminalize Self-Managed Abortions</strong></td>
<td>1 = Criminalizes; 0 = Does not criminalize</td>
<td>CRR (2020)</td>
</tr>
<tr>
<td><strong>Mandatory Ultrasound</strong></td>
<td>1 = Has law; 0 = Does not have law</td>
<td>CRR (2020)</td>
</tr>
<tr>
<td><strong>Reproductive Rights Access</strong></td>
<td>1 = Extremely Restrictive; 0.75 = Highly Restrictive; 0.5 =</td>
<td>NARAL (2019)</td>
</tr>
<tr>
<td></td>
<td>Moderate Restriction; 0.25= Low Restrictions; 0 = Very Low Restrictions</td>
<td></td>
</tr>
<tr>
<td><strong>State Law Guarantees Birth Control Prescriptions Filled</strong></td>
<td>1 = Lacks law; 0 = Has law</td>
<td>NARAL (2019)</td>
</tr>
<tr>
<td><strong>State Constitutional Protections</strong></td>
<td>1 = Lacks protection; 0 = Has protection</td>
<td>Guttmacher (2020); NARAL (2019);</td>
</tr>
<tr>
<td><strong>State Statutory Protections</strong></td>
<td>1 = Lacks protection; 0 = Has protection</td>
<td>Guttmacher (2020)</td>
</tr>
<tr>
<td><strong>Targeted Restriction on Abortion Providers (TRAP) laws: Three types of TRAP laws: Location or Facility (LF); Admitting Privileges (AP); Reporting</strong></td>
<td>1 = Has all three types; 0.66 = Has two types; 0.33 = Has 1 type; 0 = Has none</td>
<td>Guttmacher (2020); CRR (2020)</td>
</tr>
<tr>
<td><strong>Restrictions on Practitioner and/or Facility May Practice</strong></td>
<td>1 = Substantial; 0.66 = Moderate; 0.33 = Minor; 0 = None</td>
<td>NARAL (2019)</td>
</tr>
<tr>
<td><strong>Medicaid Coverage of Multi forms of Contraceptive</strong></td>
<td>1 = Lacks coverage; 0 = Has coverage</td>
<td>KFF (2021)</td>
</tr>
<tr>
<td><strong>State Requires No Cost Contraceptive Coverage</strong></td>
<td>1 = Lacks coverage; 0 = Has coverage</td>
<td>KFF (2021)</td>
</tr>
<tr>
<td><strong>State Requires Coverage of Prescription Contraception</strong></td>
<td>1 = Lacks coverage; 0 = Has coverage</td>
<td>KFF (2021)</td>
</tr>
<tr>
<td><strong>Abortion Coverage Required by Private Insurance</strong></td>
<td>1 = Lacks coverage; 0 = Has coverage</td>
<td>Guttmacher (2020); NARAL (2019)</td>
</tr>
<tr>
<td><strong>Private Coverage Banned</strong></td>
<td>1 = Banned; 0.66 = Banned with exception of life endangerment; 0.33 = Banned with exception of life/health endangerment and case of rape/incest; 0 = not banned</td>
<td>Guttmacher (2020)</td>
</tr>
<tr>
<td>Variable Name</td>
<td>Score</td>
<td>Source</td>
</tr>
<tr>
<td>---------------</td>
<td>-------</td>
<td>--------</td>
</tr>
<tr>
<td><strong>Restriction on Insurance through State Health Exchange</strong></td>
<td>1 = No coverage/ban; 0.66 = Life/health endangerment exception; 0.33 = Life/health endangerment exception or rape/incest cases; 0 = No restriction</td>
<td>Guttmacher (2020); NARAL (2019)</td>
</tr>
<tr>
<td><strong>Prohibitions for Public Employees to use Health Insurance for Abortion</strong></td>
<td>1 = Only in life endangerment; 0.5 = Rape/incest and endangerment; 0 = No restriction</td>
<td>Guttmacher (2020); NARAL (2019)</td>
</tr>
<tr>
<td><strong>Follows Federal Standard, Funding Only Cases Involving Life Endangerment, Rape and Incest</strong></td>
<td>1 = Follows; 0 = Goes beyond</td>
<td>KFF (2021)</td>
</tr>
<tr>
<td><strong>Offers Fund for All or Most Medically Necessary Abortions, Exceeding Fed Requirements</strong></td>
<td>1 = Does not offer; 0 = Offers</td>
<td>KFF (2021)</td>
</tr>
</tbody>
</table>

**Pregnancy and Parenthood**

<table>
<thead>
<tr>
<th>Variable Name</th>
<th>Score</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>IVF Coverage Private Insurance</strong></td>
<td>1 = Nothing; 0.5 = Some option; 0 = Mandate to cover</td>
<td>KFF (2021)</td>
</tr>
<tr>
<td><strong>IVF Coverage Medicaid Insurance</strong></td>
<td>1= Nothing; 0.5 = Some diagnostic; 0 = Some treatment and diagnostic</td>
<td>KFF (2021)</td>
</tr>
<tr>
<td><strong>LGBT Foster Protections</strong></td>
<td>1 = State permits discrimination; 0.66 = No explicit protections; 0.33 = prohibits discrimination on gender identity only; 0= State policy/statute/regulation prohibits discrimination in foster care based on sexual orientation AND gender identity</td>
<td>LGBTMAP (2020)</td>
</tr>
<tr>
<td><strong>LGBT Adoption Protections</strong></td>
<td>1 = State permits discrimination; 0.66 = No explicit protections; 0.33 = prohibits discrimination on gender identity only; 0= State policy/statute/regulation prohibits discrimination in foster care based on sexual orientation AND gender identity</td>
<td>LGBTMAP (2020)</td>
</tr>
<tr>
<td><strong>Shorter than 2-week Safe Haven Period</strong></td>
<td>1 - Shorter than 2 weeks; 0 = More than two weeks</td>
<td>National Safe Haven Alliance (2021)</td>
</tr>
<tr>
<td>State Requirement for Appropriate Nutrition to Pregnant Inmates</td>
<td>1 = Lacks requirement; 0 = Has requirement</td>
<td>ACLU (2020)</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>Requirements for Prisons to Keep a List of pregnancies and Outcomes</td>
<td>1 = Lacks requirement; 0 = Has requirement</td>
<td>ACLU (2020)</td>
</tr>
<tr>
<td>Follows National Commission on Correctional Health Care Guidelines for Pregnancy Counseling Including Abortion</td>
<td>1 = Does not follow; 0 = Follows</td>
<td>Status of Women (2015)</td>
</tr>
<tr>
<td>States Offers Paid Family Leave</td>
<td>1 = Does not offer; 0 = Does offer</td>
<td>NARAL (2019)</td>
</tr>
<tr>
<td>State Law Requires Reasonable Accommodations for Pregnant Workers</td>
<td>1 = Lacks law; 0 = Has law</td>
<td>NARAL (2019)</td>
</tr>
<tr>
<td>No Workplace lactation rights (CRR)</td>
<td>1 = No Lactation Rights; 0 = Lactation Rights</td>
<td>Center for Reproductive Rights (2019)</td>
</tr>
<tr>
<td>Expanded Family and Medical Leave Act</td>
<td>1 = No Expanded FMLA; 0= Expanded</td>
<td>Center for Reproductive Rights (2019)</td>
</tr>
<tr>
<td>Medicaid income limit for pregnant women is at least 200% of the poverty line</td>
<td>1 = limited; 0 = higher limit</td>
<td>Center for Reproductive Rights (2019)</td>
</tr>
</tbody>
</table>

### Birth Choice

<table>
<thead>
<tr>
<th>Variable Name</th>
<th>Score</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maternity Care Deserts</td>
<td>1 = Has; 0 = Does not have</td>
<td>March of Dimes (2020)</td>
</tr>
<tr>
<td>LAMC (Limited Access to Maternity Care)</td>
<td>1 = Has LAMC; 0 = Does not have</td>
<td>March of Dimes (2020)</td>
</tr>
<tr>
<td>Restricts Medicaid to Certified Nurse Midwives</td>
<td>1 = Restricts; 0 = Does not</td>
<td>The Birth Place Lab (2016)</td>
</tr>
<tr>
<td>States Medicaid Not Covers Doulas</td>
<td>1 = Not covered; 0 = Covered</td>
<td>The Birth Place Lab (2016)</td>
</tr>
<tr>
<td>----------------------------------</td>
<td>------------------------------</td>
<td>---------------------------</td>
</tr>
<tr>
<td>Lacks Certified Professional Midwife License</td>
<td>1 = Lacks licensure; 0 = Has licensure</td>
<td>The Birth Place Lab (2016)</td>
</tr>
<tr>
<td>Official Vaginal Birth After Cesarean (VBAC) Bans in hospitals</td>
<td>Percent of hospitals in state with VBAC bans: 1 = over 50%; 1 = 0.5- 50%; 0 = none</td>
<td>The Birth Place Lab (2016)</td>
</tr>
<tr>
<td>Lacks License Certified Midwife</td>
<td>1 = Lacks licensure; 0 = Has licensure</td>
<td>The Birth Place Lab (2016)</td>
</tr>
<tr>
<td>Restricts Certified Professional Medicaid</td>
<td>1 = Restricts; 0 = Does not</td>
<td>The Birth Place Lab (2016)</td>
</tr>
<tr>
<td>Restricts Certified Midwife Medicaid</td>
<td>1 = Restricts; 0 = Does not</td>
<td>The Birth Place Lab (2016)</td>
</tr>
<tr>
<td>Above Average Cesarean (CS) Rate</td>
<td>1 = Above average CS rate; 0 = Below average</td>
<td>The Birth Place Lab (2016); CDC “Stats” (2018)</td>
</tr>
<tr>
<td>Above Average Induction Rate</td>
<td>1 = Above average; 0 = Below average</td>
<td>The Birth Place Lab (2016)</td>
</tr>
<tr>
<td>Below Average Spontaneous Vaginal Birth</td>
<td>1 = Above average rate; 0 = Below average</td>
<td>The Birth Place Lab (2016)</td>
</tr>
<tr>
<td>Below Average Rate of Vaginal Birth After Cesarean</td>
<td>1 = Above average rate; 0 = Below Average</td>
<td>Birth Place Lab (2016); Osterman, (2020)</td>
</tr>
<tr>
<td>Maternal Mortality Review Board Established</td>
<td>0= Established; 1 = Not established</td>
<td>Center for Reproductive Rights (2019)</td>
</tr>
<tr>
<td>State Law Allows the Use of Restraints on Pregnant/Laboring Inmates</td>
<td>1 = Allows; 0 = Does not allow</td>
<td>ACLU (2020)</td>
</tr>
</tbody>
</table>

**Socioeconomic Background Factors**

<table>
<thead>
<tr>
<th>Variable Name</th>
<th>Score</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percent of Women in the State Legislature avg 28</td>
<td>1 = up to 15; 0.75 = 15.1-25; 0.5 = 25.1-35; 0.25 = 35.1 to 49; 0 = 49.1 and above</td>
<td>NCSL (2019)</td>
</tr>
<tr>
<td>Above Average Rate of Incarcerated Women (per 100,000 women)</td>
<td>Average rate is 140 per 100,000. 1 = Rate of 231, 000+; 0.5 = 140-230, 000; 0 = Below average</td>
<td>US Bureau of Justice Statistics (2019); Prison Policy.org (2020)</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>Gun Possession Bar on Individuals Subject to Domestic Violence Protection Orders</td>
<td>1 = No bar; 0 = Has bar</td>
<td>Status of Women (2015)</td>
</tr>
<tr>
<td>Gun Possession Bar on Individuals Convicted of Misdemeanor Domestic Violence Crimes</td>
<td>1 = No bar; 0 = Has bar</td>
<td>Status of Women (2015)</td>
</tr>
<tr>
<td>No Gun Possession Bar on Individuals Convicted of Misdemeanor Sex Crimes</td>
<td>1 = No bar; 0 = Has bar</td>
<td>Status of Women (2015)</td>
</tr>
<tr>
<td>Gun Possession Bar on Individuals Convicted of Misdemeanor Stalking Crimes</td>
<td>1 = No bar; 0 = Has bar</td>
<td>Status of Women (2015)</td>
</tr>
<tr>
<td>Bar for Misdemeanor Domestic Violence Crimes, including &quot;Dating Partners&quot;</td>
<td>1 = No bar; 0 = Has bar</td>
<td>Status of Women (2015)</td>
</tr>
<tr>
<td>Required Surrender of Certain Firearms by Persons Convicted of Misdemeanor Domestic Violence Crimes</td>
<td>1 = No surrender; 0 = Surrender order</td>
<td>Status of Women (2015)</td>
</tr>
<tr>
<td>Required Removal of Certain Firearms at Specified Domestic Violence Incidents</td>
<td>1 = Lacks removal; 0 = Requires removal</td>
<td>Status of Women (2015)</td>
</tr>
<tr>
<td>Category</td>
<td>Scale Description</td>
<td>Source/Reference</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------</td>
<td>-----------------------------------------------------------------------------------</td>
<td>---------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Above average number of days per month of poor mental health among women, Days avg 4.3</td>
<td>1 = Higher than Average; 0 = Below Average</td>
<td>Status of Women (2015); IWPR Behavioral Risk Factor Surveillance System (2013)</td>
</tr>
<tr>
<td>Employment Rights Law for Victims of Domestic Violence</td>
<td>1 = Lacks law; 0 = Has law</td>
<td>Status of Women (2015)</td>
</tr>
<tr>
<td>Law Provide Unemployment Insurance Benefits to Domestic Violence Victims</td>
<td>1 = Lacks law; 0 = Has law</td>
<td>Status of Women (2015)</td>
</tr>
<tr>
<td>Marital Rape Loophole</td>
<td>1 = Loophole for spousal rape; 0 = No loophole</td>
<td>Quinn (2019)</td>
</tr>
<tr>
<td>Women Aged 18 and Older Living Below Poverty Line</td>
<td>1 = Higher than average; 0 = Lower than average</td>
<td>Status of Women (2015)</td>
</tr>
<tr>
<td>Percent of Female Headed Household with Children Living Below the Poverty Line</td>
<td>1 = Higher than average; 0 = Lower than average</td>
<td>Status of Women (2015)</td>
</tr>
<tr>
<td>Percent of All Women Living in Poverty</td>
<td>1 = Higher than average; 0 = Lower than average</td>
<td>Status of Women (2015); IWPR (2015)</td>
</tr>
<tr>
<td>Gender Wage Gap</td>
<td>Average – 79.2 cents to a man’s dollar</td>
<td>Status of Women (2015)</td>
</tr>
<tr>
<td>Women’s Share of Workers with Earnings in the Lowest Quartile</td>
<td>1 = Higher than average; 0 = Lower than average</td>
<td>Status of Women (2015); IWPR (2015)</td>
</tr>
<tr>
<td>Women’s Share of Workers with Earnings in the Highest Quartile</td>
<td>1 = Above average; 0 = Below average</td>
<td>Status of Women (2015); IWPR (2015)</td>
</tr>
<tr>
<td>Family Receiving TANF can keep child support collected on their behalf</td>
<td>1 = Cannot Keep; 0 = Keep</td>
<td>Center for Reproductive Rights (2019)</td>
</tr>
<tr>
<td>Waiting Period for children to enroll in CHIP</td>
<td>1 = Waiting Period; 0 = No Waiting Period</td>
<td>Center for Reproductive Rights (2019)</td>
</tr>
<tr>
<td>---------------------------------------------</td>
<td>------------------------------------------</td>
<td>---------------------------------------</td>
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274
### Descriptive statistics

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## APPENDIX C: ALL TOTALS BY STATE

All totals by state

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