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The Relationship Between Demedicalization and Criminalization in Reproductive Health

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THE RELATIONSHIP BETWEEN DEMEDICALIZATION AND CRIMINALIZATION IN REPRODUCTIVE HEALTH

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CONTENTS

I. INTRODUCTION

On March 21, 2023, Temecia Jackson, a Black woman living in suburban Dallas, gave birth to baby Mila at home with a midwife licensed by the state of Texas.[1] When the family's pediatrician diagnosed the baby with jaundice at a scheduled "newborn checkup" on March 24, Temecia and her husband Rodney opted for phototherapy treatment at home under their midwife's guidance, rather than having the baby admitted to the hospital.[2] After learning of this decision, their

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1. Kerry Breen, *Texas Couple Who Had Home Birth Say Their Child Was Wrongfully Taken by Department of Family and Protective Services*, CBS NEWS (Apr. 8, 2023, 8:34 PM), https://www.cbsnews.com/news/mila-temecia-rodney-jackson-texas-home-birth-taken-department-family-protective-services/ [https://perma.cc/JS7A-EC2R].

2. *Id.*

pediatrician, Dr. Anand Bhatt, called and texted the parents several times, including once at 11 p.m., to warn the Jacksons that he would report them to the Department of Family and Protective Services (DFPS) if they did not comply with his recommendation for hospital-based treatment.[3] According to Temecia, Dr. Bhatt had initially counseled them about options for either hospital-based or in-home treatment for jaundice, though his "tone changed" subsequently and he later discouraged the idea of in-home treatment with continuing care by their midwife.[4] Although the Jacksons had begun phototherapy at home, Dr. Bhatt followed through on his threat, reporting them to DFPS on March 25, noting "their distrust for medical care and guidance."[5]

Five hours after the pediatrician's late-night text, a DFPS investigator and two police officers arrived at the family's home.[6] Rodney Jackson refused to speak with them, but they returned an hour later, around 5:00 a.m., with a fire truck and ambulance to transport Mila to the hospital.[7] Rodney Jackson again refused to open the door.[8] Five days later, on March 30, members of the Dallas County Constable's office came to the Jacksons' house with a warrant, waited for Rodney to return home, and arrested him; while he was detained, the constables took his keys, entered the house, and removed Mila from

3. *Id.*

4. Candice Norwood, *Texas Newborn Is Headed Home After Custody Fight Involving Race, Midwifery and the Child Welfare System*, THE 19TH (Apr. 20, 2023, 1:20 PM), https://19thnews.org/2023/04/texas-newborn-mila-jackson-parents-reunite-foster-care/ [https://perma.cc/2HNJ-ZJ42] [hereinafter *Texas Newborn Headed Home*]; Excerpt from Texas Department of Family and Protective Services Report (on file with author).

5. Excerpt from Texas Department of Family and Protective Services Report, *supra* note 4; Jadriena Solomon, *Texas Family Demands CPS Return Their Newborn Daughter Taken Over Concerns About Jaundice*, THE SHADE ROOM (Apr. 7, 2023), https://theshaderoom.com/texas-family-demands-cps-return-their-newborn-daughter-taken-over-concerns-about-jaundice/ [https://perma.cc/R62B-HV2Y]. Dr. Bhatt's report to DFPS of a "Priority 1 referral of Medical Neglect" was received at 1:43AM. *See* Harriet Alexander, *Texas Couple's Newborn Is Taken Into Foster Care After Social Workers Showed Up With Paperwork Bearing the Name of Another Mom Who Is Criminal: Couple Said Midwife Could Treat Infant's 'Dangerous' Jaundice*, DAILY MAIL (Apr. 8, 2023, 1:00 PM), https://www.dailymail.co.uk/news/article-11951467/Social-workers-remove-Texas-newborn-parents-said-theyd-use-midwife-treat-jaundice.html [https://perma.cc/4QHX-G4FD].

6. Breen, *supra* note 1.

7. *Id.*

8. *Id.*

Temecia's care while she was alone with the baby.[9] Mila was placed in foster care, and a hearing was scheduled for April 6—then postponed until April 20.[10] The Jacksons were allowed a few supervised visits with the baby (one two-hour visit each week at the DFPS office in the presence of police officers), though, according to press reports, their attempts to deliver breast milk or otherwise care for Mila were unsuccessful.[11] The Jacksons were particularly fearful about the loss of their baby because the legal documents used to remove Mila named the wrong people, and they had not yet filed for Mila's birth certificate because she had been born at home.[12]

Dr. Bhatt, who had cared for the Jacksons' two older children for twelve years, wrote in his letter to DFPS that the "[p]arents are very loving and they care dearly about their baby."[13] Nevertheless, he initiated an investigation that resulted in the removal of the newborn from her family at a critical time for bonding, breastfeeding, and postpartum adjustment. News accounts reported that upon learning about the 5:00 a.m. police visit put in motion by his letter, Dr. Bhatt communicated to the family he was ending the patient relationship.[14] After three weeks, DFPS recommended dismissal of the case, and the

9. *Id.* According to court documents, Rodney Jackson was charged with possessing drug paraphernalia and preventing the execution of civil process. *Id.*

10. *Id.* After removing Mila from the Jacksons' care, DFPS placed her with strangers, despite federal law's prioritization of placements with relatives in order to "maintain[] family connections and cultural traditions that can minimize the trauma of family separation." CHILD WELFARE INFORMATION GATEWAY, PLACEMENT OF CHILDREN WITH RELATIVES 1 (2022), https://cwig-prod-prod-drupal-s3fs-us-east-1.s3.amazonaws.com/public/documents/placement.pdf?VersionId=XjIVY8dqAGq68GeI.zVwKiGzNcCB9JI6 [https://perma.cc/T6GD-EF25].

11. Candice Norwood, *A Black Texas Couple Chose Their Midwife's Care Over a Hospital. Now Their Newborn Is in Foster Care*, THE 19TH (Apr. 17, 2023, 10:26 AM), https://19thnews.org/2023/04/black-texas-couple-home-birth-midwife-newborn-foster-care/ [https://perma.cc/Q6JU-8U2F] [hereinafter *Black Texas Couple Chose Midwife*]; Kylie Cheung, *Black Couple Says Texas Authorities Seized Their Newborn Because They Chose a Midwife Over a Hospital*, JEZEBEL (Apr. 6, 2023, 9:30 PM), https://jezebel.com/black-couple-says-texas-authorities-seized-their-newbor-1850309498 [https://perma.cc/874X-5UUP]. The Jacksons told reporters that during their visit with Mila in early April, they "noticed some irritation in and around her genitals." When they raised this concern with DPFS workers, they were told that the foster family—who had been caring for Mila when the irritation began—would "handle this, and [the Jacksons] weren't permitted to take Mila to get care." *Id.*

12. Breen, *supra* note 1.

13. Solomon, *supra* note 5.

14. Cheung, *supra* note 11.

Jacksons were reunited with Mila.[15] A local organization, the Afiya Center, advocated for the Jacksons during the period when they were fighting to have Mila returned to the family.[16]

This essay explores the relationship between demedicalization[17] and criminalization in the context of reproductive health care, focusing on childbirth and using the Jacksons' story to illustrate how childbearing people are punished (or threatened with punishment) when perceived as challenging the authority of mainstream medicine.[18] The

15. *Texas Newborn Headed Home*, *supra* note 4; Nicquel Terry Ellis, *A Texas Family Fought for Weeks to Regain Custody of Their Newborn. Experts Say the Case Shows How Black Parents Are Criminalized*, CNN (Apr. 24, 2023, 11:14 PM), https://www.cnn.com/2023/04/24/us/texas-family-newborn-removed-reaj/index.html [https://perma.cc/R32L-XRZ3].

16. Cheung, *supra* note 11.

17. There is extensive social science literature on the concepts of medicalization and demedicalization, which reflects disagreement over both descriptive and normative facets of these phenomena. *See infra* Part III. Political scientist Lauren Hall provides a useful starting point for understanding medicalization as "the process by which human experiences or conditions come to be treated as illness or diseases." LAUREN K. HALL, THE MEDICALIZATION OF BIRTH AND DEATH 7 (2019). Some forms of medicalization entail the medical profession asserting its power and authority to determine the appropriate response. *See* PAUL STARR, THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE 3–6 (1982). This essay understands demedicalization as a phenomenon that often reflects concern about, resistance to, or the dismantling of physician control that excludes other forms of knowledge about and approaches to managing health. *See generally* IVAN ILLICH, LIMITS TO MEDICINE—MEDICAL NEMESIS: THE EXPROPRIATION OF HEALTH (2010).

18. While the nature of punitive state action related to childbearing may vary depending on whether law enforcement scrutiny arises during pregnancy, labor, or postpartum, it nevertheless makes sense to analyze postpartum punitive action in conjunction with pregnancy prosecutions given that they are both rooted in the desire to control the behavior of childbearing people. As a descriptive matter, it is also appropriate to analyze punitive regulation of the entire childbearing cycle collectively, as clinicians and researchers include up to the first year postpartum in determining clinical practice guidelines and analyzing perinatal health outcomes. *See* AGENCY FOR HEALTHCARE RESEARCH AND QUALITY & PATIENT-CENTERED OUTCOMES RESEARCH INSTITUTE, POSTPARTUM CARE UP TO 1 YEAR AFTER PREGNANCY: A SYSTEMATIC REVIEW AND META-ANALYSIS 1 (2023), https://www.pcori.org/sites/default/files/PCORI-AHRQ-Postpartum-Care-for-Women-up-to-One-Year-After-Birth-Systematic-Review-Report-June-2023.pdf [https://perma.cc/B6P6-RF6W] (noting risk of maternal mortality and morbidity extending up to 365 days postpartum); Sarudzayi M. Matambanadzo, *The Fourth Trimester*, 48 MICH. J. L. REFORM 117, 117 (2004) (applying the concept of the fourth trimester, extending three to six months postpartum, to anti-discrimination law). In this article, discussion of the punitive regulation of pregnant people includes those

demedicalization-criminalization dynamic in childbirth is an example of the broader phenomenon of using criminal law to address social problems (or perceived problems).[19] As the birth justice movement[20] and consumer advocacy aimed at improving maternity care services continue to grow,[21] spurring interest in community birth, midwifery care, doula support, and other alternatives to the dominant, medicalized approach to birth in the United States, we can expect to see continued, and perhaps increased, reliance on criminalization to discipline pregnant people who resist medicalized childbirth. Punitive action is likely to target vulnerable populations disproportionately, especially Black and Indigenous women, poor women, and pregnant people who are young, disabled, queer, or gender non-conforming.[22]

Furthermore, the demedicalization-criminalization dynamic is not unidimensional. Criminalization of pregnant people due to health care decision-making or pregnancy outcomes can reinforce the desire among pregnant people to seek out demedicalized approaches to childbirth, which invites further criminalization to preserve the status quo and

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who face punishment during the postpartum period for their medical decision-making.

19. Criminalization may be an attractive solution to social problems to the extent it sends a strong message intended to deter future conduct without having to invest resources in addressing the root causes of the social problem requiring attention. *See, e.g.*, Maria Foscarinis et al., *Out of Sight—Out of Mind?: The Continuing Trend Toward the Criminalization of Homelessness*, 6 GEO. J. POVERTY L. & POL'Y 145, 146–47 (1999) (homelessness); Risdon N. Slate, *Deinstitutionalization, Criminalization of Mental Illness, and the Principle of Therapeutic Jurisprudence*, 26 S. CAL. INTERDISC. L. J. 341, 348 (2017) (mental illness).

20. *See generally* JULIA CHINYERE OPARAH ET AL., BIRTHING JUSTICE: BLACK WOMEN, PREGNANCY, AND CHILDBIRTH (Julia Chinyere Oparah & Alicia D. Bonaparte eds., 2016).

21. *See, e.g.*, EVIDENCE BASED BIRTH, https://evidencebasedbirth.com/ [https://perma.cc/38DN-UD2Q]; BIRTH MONOPOLY, https://birthmonopoly.com/ [https://perma.cc/54SJ-P9GP].

22. In certain places, this essay refers to pregnant and childbearing people as women, but it is important to recognize that some men and nonbinary people also get pregnant and give birth. *See, e.g.*, Heidi Moseson et al., *The Imperative for Transgender and Gender Nonbinary Inclusion: Beyond Women's Health*, 135 OBSTETRICS & GYNECOLOGY 1059, 1061–62 (2020); Elizabeth Kukura, *Reconceiving Reproductive Health Systems: Caring for Trans, Nonbinary, and Gender-Expansive People During Pregnancy and Childbirth*, 50 J. L., MED & ETHICS 471, 471 (2022). For accuracy, this essay will use the terms "pregnant people" or "birthing people" in general discussion and "women" when discussing particular examples, explicitly gendered aspects of childbirth-related care, or research involving only women, even though the research findings may be applicable to all pregnant people.

then drives people further away from mainstream medicine.[23] Whether the rejection of mainstream medical care leads to positive or negative health outcomes may depend on context. For someone who receives inferior, even harmful, care in a hospital due to bias and discrimination, pursuing an alternative form of care may be health-promoting. For someone who develops a life-threatening complication requiring medical intervention, the deterrence function of criminalization is likely to be health-harming. Either way, it is important to understand that by criminalizing the decision to seek care outside mainstream medicine, medical and law enforcement authorities who distrust the pursuit of demedicalized alternatives may achieve an outcome at odds with their underlying goal.

Part II returns to the Jackson family to analyze their story through the lenses of demedicalization and criminalization, identifying how each played a role in shaping Temecia's (and Mila's) birth and postpartum experiences. Although we do not know all the details that influenced this particular family's childbearing decisions, their story provides a helpful starting point for understanding the complex factors driving efforts by individuals, organizations, and social movements to demedicalize childbirth by different means. The Jackson family's story also illustrates how families experience child removal as punishment, highlighting how family policing is a form of criminalization that allows health care providers to assert control over patient decision-making and causes serious harm to families subjected to severe, and often arbitrary, invasions of their private lives. Race and class are central to family policing as a mechanism of social control, both as a threat used to coerce pregnant people to accept unwanted medical interventions and, more

23. Prominent medical organization have long recognized the risk that criminalization will deter pregnant people from seeking medical care in settings where they may be exposed to law enforcement scrutiny. *See Statement of Policy, Opposition to Criminalization of Individuals During Pregnancy and the Postpartum Period*, AM. COLL. OBSTETRICIANS & GYNECOLOGISTS (Dec. 2020), https://www.acog.org/clinical-information/policy-and-position-statements/statements-of-policy/2020/opposition-criminalization-of-individuals-pregnancy-and-postpartum-period [https://perma.cc/RS48-JYKR] ("Policies and practices that criminalize individuals during pregnancy and the postpartum period create fear of punishment that compromises this relationship and prevents many pregnant people from seeking vital health services."); Helene M. Cole, *Legal Interventions During Pregnancy: Court-Ordered Medical Treatments and Legal Penalties for Potentially Harmful Behavior by Pregnant Women*, 264 JAMA 2663, 2667 (Nov. 28, 1990) ("Pregnant women will be likely to avoid seeking prenatal or other medical care for fear that their physicians' knowledge of substance abuse or other potentially harmful behavior could result in a jail sentence rather than proper medical treatment.").

generally, as a way to shift responsibility to poor people for society's failure to provide adequate support for childrearing.[24]

Next, Part III contextualizes the Jackson family's attempt to demedicalize birth with a brief introduction to existing scholarship on medicalization and demedicalization. The essay shows how analysis of these concepts has deepened over time to account for the complexities of medicalizing and demedicalizing forces that may occur simultaneously, and which are better understood as evolving processes rather than static descriptive categories. It then applies these theoretical insights to the example of childbirth to highlight some of the fault lines in public discourse about midwifery in the perinatal health care system and in U.S. childbirth culture more generally.

Part IV then weaves together the discussions of demedicalization and criminalization in the context of reproductive health care. It highlights the mutually reinforcing quality of the demedicalization of childbirth and the criminalization of pregnant people's decision-making. Specifically, when punitive state action causes trauma and other harms, some people will be more likely to seek demedicalized options for care in future pregnancies and when managing their health more generally. While receiving care outside of mainstream medicine may be empowering and health-promoting for some people, others will miss out on necessary medical attention due to their distrust of medical providers and institutions. Finally, Part V concludes by arguing that people who care about reproductive rights and reproductive justice must pay close attention to the demedicalization-criminalization dynamic in reproductive health. In particular, increased reliance on medication abortion in a post-*Dobbs* legal environment,[25] where self-managing abortion with pills outside of a medical setting may be the best—or only—option available to many, will make more people with the capacity for pregnancy vulnerable to criminalization for their reproductive choices and pregnancy outcomes.[26]

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24. *See generally* JANE M. SPINAK, THE END OF FAMILY COURT: HOW ABOLISHING THE COURT BRINGS JUSTICE TO CHILDREN AND FAMILIES 1–6 (2023); DOROTHY ROBERTS, TORN APART: HOW THE CHILD WELFARE SYSTEM DESTROYS FAMILY FAMILIES—AND HOW ABOLITION CAN BUILD A SAFER WORLD (2022); Shanta Trivedi & Matthew Fraidin, *A Role for Communities in Reasonable Efforts to Prevent Removal*, 12 COLUM. J. RACE & LAW F. 29, 29 (2022); DOROTHY ROBERTS, SHATTERED BONDS: THE COLOR OF CHILD WELFARE vi (2001).

25. Dobbs v. Jackson Women's Health Org., 597 U.S. 215, 231 (2022) (overruling five decades of precedent to find that the Constitution does not protect the right to abortion).

26. *See* David S. Cohen et al., *Abortion Pills*, 76 STAN. L. REV. 317 (2024) (discussing changes in abortion provision in the United States due to increased access to medication abortion).

II. UNDERSTANDING THE JACKSON FAMILY'S STORY

The Jackson family's experiences surrounding the birth of their daughter Mila reflect the dual—and often dueling—dynamics of demedicalization and criminalization. Here, skepticism about, or hostility to, midwifery care fueled the machinery of family policing, which disproportionately targets Black families. It is instructive to disentangle the parents' decision-making from actions taken by medical and state authorities involved in the case, and to understand how both medical and legal power get deployed (or resisted) in service of protecting children.

A. Through the Lens of Demedicalization

The Jacksons opted to receive care outside mainstream medical institutions both for Temecia's pregnancy and delivery, and when addressing Mila's jaundice in the first week of her life—two bundles of health care decision-making that reflect their pursuit of demedicalized care. As discussed in Part III *infra*, demedicalization is best understood as a process that occurs along a spectrum, rather than a static state that is either achieved in full or completely absent. This perspective on demedicalization as a process aligns with the idea that physicians may assert authority over a patient's care to greater or lesser degrees, depending on the circumstances, and that such assertions of professional power can be analyzed along different axes.

1. Demedicalizing Perinatal Care

Midwifery care is not available to all pregnant people in the U.S.; rather, access varies depending on where someone lives.[27] In some areas, pregnant people can choose what type of midwife to seek care from and whether to give birth at home, at a freestanding birth center (FBC), or in a hospital. Temecia Jackson's midwife, Cheryl Edinbyrd, is a Certified Professional Midwife (CPM) who is licensed by the state of Texas.[28] The CPM is one of three distinct credentials a midwife can obtain in the United States, signifying the type of training they received and the organization responsible for overseeing satisfaction of national

27. *See* Elizabeth Kukura, *Rethinking the Infrastructure of Childbirth*, 91 UMKC L. REV. 497, 528–34 (2023) [hereinafter *Rethinking the Infrastructure of Childbirth*].

28. *See Black Texas Couple Chose Midwife*, *supra* note 11. Credentialing and licensing are distinct processes, though states may rely on credentialing administered by private organizations in their licensure requirements.

standards.[29] CPMs are autonomous, direct-entry midwives, meaning they pursue midwifery training directly without the requirement of prior education as a nurse.[30] CPMs train to attend births in community settings, either at home or in FBCs.[31] Their credential is granted by the North American Registry of Midwives (NARM), which requires education through formal programs accredited by the Midwifery Education Accreditation Council or through a portfolio evaluation process (PEP).[32] NARM administers a national exam for all CPM applicants and also monitors the completion of continuing education.[33] Thirty-eight states (plus D.C.) currently license CPMs.[34] As of October

29. *See* Elizabeth Kukura, *Better Birth*, 93 TEMP. L. REV. 243, 272 (2021) (discussing the educational requirements, credentialing bodies, and numbers of midwives practicing with each credential).

30. *Id.* By contrast, Certified Nurse Midwives (CNMs) become registered nurses before receiving specialized midwifery education; although they can train to attend births in both hospitals and community settings, the vast majority of CNMs work in hospitals. *Id.* at 272–73. CNMs are the most common type of midwife and are licensed in all fifty states. *Id.* The third midwifery credential is the Certified Midwife (CM), another type of direct-entry midwife who is credentialed by the same organization that oversees the CNM; like CNMs, CMs can train to attend births in hospitals or community settings, but they primarily work in hospitals. *Id.* at 273. Only eleven states (plus D.C.) grant licenses to CMs. *Certified Midwife Credential*, AM. COLL. OF NURSE-MIDWIVES, https://www.midwife.org/certified-midwife-credential [https://perma.cc/49Z9-EDWJ].

31. *Id.* Because the Jacksons chose home birth, this essay does not discuss freestanding birth centers (FBCs) in detail other than to say that FBCs—as distinct from hospital-based birth centers—expand access to demedicalized childbirth by providing an opportunity for community birth for pregnant people who do not consider home birth a comfortable option. For more on FBCs generally, as well as the barriers to increasing the number of FBCs in the United States, see *Rethinking the Infrastructure of Childbirth*, *supra* note 27, at 534–42; Jill Alliman & Kate Bauer, *Next Steps for Transforming Maternity Care: What Strong Start Birth Center Outcomes Tell Us*, 65 J. MIDWIFERY & WOMEN'S HEALTH 462, 462–64 (2020).

32. NORTH AMERICAN REGISTRY OF MIDWIVES, CERTIFIED PROFESSIONAL MIDWIFE (CPM) CANDIDATE INFORMATION BOOKLET 6, narm.org/pdffiles/CIB.pdf [https://perma.cc/YV8K-4BND] (listing educational pathways to securing the CPM credential). NARM will also issue the CPM to CNMs, CMs, and midwives licensed in certain jurisdictions outside the United States. *Id.*

33. *Id.* at 5, 29–30.

34. Press Release, New Law Makes Iowa 38th State to Regulate Midwives, ICAN of Central Iowa (June 2, 2023) (on file with author).

2020, there were 2,500 CPMs with active certification in the United States.[35]

Different types of credentialed midwives vary in terms of whether they focus their practice on hospital birth or community birth, as well as in what types of regulations states impose regarding scope of practice, physician supervision requirements, and malpractice insurance coverage, but they all must document sufficient training in order to obtain their credential. Importantly, they commit to practicing according to the Midwives Model of Care, which prioritizes individualized support during pregnancy and childbirth and minimizes technological interventions.[36] Midwives are deliberate about distinguishing midwifery from the practice of medicine.[37] It is midwifery's embrace of physiologic birth, enabled by a low-intervention approach, use of non-pharmacologic methods of pain relief, and continuous labor support, that represents an effort to demedicalize the birthing process.[38]

The history of midwifery in the United States, including its evolving relationship to the medical profession, provides context that explains why choosing midwifery is an act that furthers demedicalization. Midwives have assisted women in childbirth throughout U.S. history—initially as the primary birth attendants (and community healers) in early American history, then in peaceful coexistence with an emerging but still largely unskilled class of physicians, and later pushed increasingly to the margins of childbirth by the medical profession as it concentrated power over scientific and medical knowledge, while

35. E-mail from Ida Darragh, CPM, LM, Member of N. Am. Registry of Midwives Bd., to author (Oct. 23, 2020, 8:30 PM) (on file with author).

36. *See The Midwives Model of Care*, NACPM, https://www.nacpm.org/midwives-model-of-care [https://perma.cc/J3Q3-NHWM] ("The Midwives Model of care includes: [m]onitoring the physical, psychological and social well-being of the mother throughout the childbearing cycle[;] [p]roviding the mother with individualized education, counseling, and prenatal care, continuous hands-on assistance during labor and delivery, and postpartum support[;] [m]inimizing technological interventions[; and] [i]dentifying and referring women who require obstetrical attention.").

37. *See* Suzanne Hope Suarez, *Midwifery Is Not the Practice of Medicine*, 5 YALE J. L. & FEMINISM 315 (1997); *see also* Kukura, *Better Birth*, *supra* note 29, at 271 (discussing differences between prenatal and intrapartum care with a midwife as opposed to typical obstetric care).

38. *See* Robin Kanak Zwier, *Taking Back Birth: De/Medicalization and the Rhetoric of the Santa Cruz Birth Center*, 84 WESTERN J. COMMC'N 1, 5 (2020). National midwifery organizations define physiologic birth as "one that is powered by the innate human capacity of the [pregnant person] and the fetus." *Supporting Healthy and Normal Physiologic Childbirth: A Consensus Statement by ACNM, MANA, and NACPM*, 22 J. PERINATAL EDUC. 14, 15–16 (2013) (identifying practices that support and interfere with physiologic birth).

attempting to neutralize possible competition in the market for patients.[39] Physicians successfully asserted authority over childbirth in the late nineteenth and early twentieth centuries, attracting a growing number of women to deliver in hospitals instead of at home, mounting propaganda campaigns against the largely Black and immigrant midwives who continued to care for pregnant women, and initiating hostile legal and regulatory action against prominent midwives in order to deter their continued practice.[40]

Midwifery's modern resurgence began in the 1970s, as the predominantly White women's health movement "rediscovered" the practices and traditions of Black "grand" midwives, some of whom were still quietly practicing midwifery in southern states.[41] In subsequent decades, midwifery care has become more prevalent in the United States, as a large body of research has shown that midwifery care is safe,[42] cost-effective,[43] and linked with positive health outcomes,

39. *See* Kukura, *Better Birth*, *supra* note 29, at 281–83; Stacey A. Tovino, *American Midwifery Litigation and State Legislative Preferences for Physician-Controlled Childbirth*, 11 CARDOZO WOMEN'S L. J. 61, 64 (2004); JEAN DONNISON, MIDWIVES AND MEDICAL MEN: A HISTORY OF THE STRUGGLE FOR THE CONTROL OF CHILDBIRTH 44–45 (1988); STARR, *supra* note 17, at 49–51; RICHARD W. WERTZ & DOROTHY C. WERTZ, LYING-IN: A HISTORY OF CHILDBIRTH IN AMERICA (1977).

40. *See* Kukura, *Better Birth*, *supra* note 29, at 282–83. For an example of a leading advocate for modern obstetrics as an elite medical specialty and the use of medical interventions to prevent harm in childbirth, see *infra* Part III. B.

41. *See generally* Zwier, *supra* note 38; INA MAY GASKIN, SPIRITUAL MIDWIFERY (4th ed. 2002); Nina Renata Aron, *Meet the Unheralded Women Who Saved Mothers' Lives and Delivered Babies Before Modern Medicine*, MEDIUM (Jan. 12, 2018), https://medium.com/timeline/granny-midwives-birthed-rural-babies-and-saved-lives-33f12601ba84 [https://perma.cc/GZR4-A9WW]; SUZANNE ARMS, IMMACULATE DECEPTION: A NEW LOOK AT WOMEN AND CHILDBIRTH IN AMERICA (1975).

42. *See*, *e.g.*, Katy Sutcliff et al., *Comparing Midwife-Led and Doctor-Led Maternity Care: A Systematic Review of Reviews*, 68 J. ADVANCED NURSING 2376, 2384 (2012); Melissa Cheyney et al., *Outcomes of Care for 16,924 Planned Home Births in the United States: The Midwives Alliance of North America Statistics Project, 2004 to 2009*, 59 J. MIDWIFERY & WOMEN'S HEALTH 17, 26 (2014); *see also* Kukura, *Better Birth*, *supra* note 29, at 275–78 (discussing research on midwifery's safety record).

43. *See, e.g.*, Molly R. Altman et al., *The Cost of Nurse-Midwifery Care: Use of Interventions, Resources, and Associated Costs in the Hospital Setting*, 27 WOMEN'S HEALTH ISSUES 434, 438–40 (2017); Embry Howell et al., *Potential Medicaid Cost Savings From Maternity Care Based at a Freestanding Birth Center*, 4 MEDICARE & MEDICAID RSCH. REV. E1, E1, E7 (2014); MIDWIFERY LICENSURE AND DISCIPLINE PROGRAM IN WASHINGTON STATE: ECONOMIC COSTS AND BENEFITS, HEALTH MGMT. ASSOCS. (2007), https://www.washingtonmidwives.org/uploads/1/1/3/8/

including reduced need for intervention.[44] Despite these benefits, midwifery's role in perinatal care continues to be suppressed by the medical profession.[45] The status of midwifery in the United States is strikingly different from Canada, Australia, and many countries in Western Europe where midwives are the primary providers of maternity care for people experiencing low-risk pregnancies and work in collaborative teams with obstetricians and other specialists to care for pregnant people with more complex needs.[46]

The midwifery profession in the United States is fragmented into subgroups shaped by the various credentials and each subgroup's resulting cultural-philosophical orientation toward childbirth in the U.S. health care system.[47] The first training program for nurse-midwives began in 1932, after concerns about the lack of access to maternity care for poor women in rural areas prompted recruitment of nurses to fill this gap, and the American College of Nurse-Midwives (ACNM) was established in 1969.[48] Nurse-midwifery emerged amidst "rancorous opposition," as the "autonomy that midwives had was sacrificed for credibility and access to the health care system."[49] Ultimately, proponents concluded that locating midwifery as a clinical specialty within nursing "retained health care system access and acceptance at a time when the word 'midwife' conjured up, albeit unfairly, derogatory images."[50] Nurse-midwives operated under physician supervision,

113879963/midwifery_cost_study_10-31-07.pdf [https://perma.cc/EF53-VU2T].

44. *See, e.g.*, Robin P. Newhouse et al., *Advanced Practice Nurse Outcomes 1990-2008: A Systematic Review*, 29 NURSING ECON. 230, 243 (2011) (referencing Table 5b); Denis Walsh & Soo M. Downe, *Outcomes of Free-Standing, Midwife-Led Birth Centers: A Structured Review*, 31 BIRTH 222, 225–27 (2004); *see also* Kukura, *Better Birth*, *supra* note 29, at 275–78 (discussing research on midwifery's health benefits).

45. *See* Kukura, *Better Birth*, *supra* note 29, at 281–92.

46. *See generally* BIRTH MODELS THAT WORK (Robbie Davis-Floyd et al. eds., 2009).

47. *See generally* Judith P. Rooks, *Unity in Midwifery?: Realities and Alternatives*, 43 J. NURSE-MIDWIFERY 315 (1998).

48. *See* Nancy Schrom Dye, *Mary Breckinridge, The Frontier Nursing Service and the Introduction of Nurse-Midwifery in the United States*, 57 BULL. HIST. MED. 485, 488 (1983); Katy Dawley, *Origins of Nurse-Midwifery in the United States and Its Expansion in the 1940s*, 48 J. MIDWIFERY & WOMEN'S HEALTH 86, 88 (2003).

49. Helen Varney Burst, *The History of Nurse-Midwifery/Midwifery Education*, 50 J. MIDWIFERY & WOMEN'S HEALTH 129, 129 (2005).

50. *Id.* (noting that physicians preferred that nurse-midwives be called "obstetric assistants," continuing to advocate for this language until the 1960s).

reserving for physicians the ultimate authority over where and how midwives practiced.[51] Compromises made by early nurse-midwifery leaders have shaped subsequent developments in U.S. midwifery, and early struggles to "make [nurse-midwifery] acceptable to the mainstream health care system (i.e., nursing and medicine)" continue to echo in disagreements among different types of midwives[52] and in spaces where the relationship between midwives and mainstream maternity care remains contested.[53]

As nurse-midwifery grew throughout the twentieth century, navigating its uneasy relationship with mainstream medicine, direct-entry midwives continued to practice in community settings and began to professionalize. In 1994, after lengthy study and consultation, the CPM was launched, adopting a uniform national standard for the training of direct-entry midwives who opted to pursue the credential.[54] While the professionalization of direct-entry midwives increased the profession's alignment with other providers of childbirth services in nursing and medicine to the extent that it standardized training requirements and imposed a minimum set of competencies on all participants, this development should be understood as distinct from medicalization. CPMs retain autonomy over their internal standard-setting, continue to promote a non-interventionist model of care, and attend births only in community settings. To the extent that state law imposes a physician supervision requirement on CPMs, it is typically adopted over the objections of midwives.[55]

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51. *See* Dawley, *supra* note 48, at 88; Burst, *supra* note 49, at 129 ("The [nurse-midwife] profession was allowed to come into being only attached to nursing and under the auspices of medical supervision and control.") (emphasis in original). *See also* Kukura, *Better Birth*, *supra* note 29, at 283 (discussing how the nature of nursing as a largely female helping profession made nurse midwives less threatening to physicians than direct-entry midwives who practiced autonomously).

52. *See* Rooks, *supra* note 47, at 315 (discussing efforts to "bridge the chasm" that divides nurse-midwives and direct-entry midwives in the United States).

53. Burst, *supra* note 49, at 129.

54. *History of the Development of the CPM Credential*, NARM, https://narm.org/ about/the-cpm-credential/history-of-the-development-of-the-cpm-credential/ [https://perma.cc/PJW3-Q47N]. During the same period, the ACNM developed its own credential for direct-entry midwives, with the first CM credential granted in 1997. *Certified Midwife Credential*, *supra* note 30. Currently, the CM is recognized by only eleven states (and D.C.) and a small minority of credentialed midwives are CMs. *Id.*

55. *See* Kukura, *Better Birth*, *supra* note 29, at 286–87 (discussing how collaborative agreement requirements suppress the growth of midwifery). *Cf. State Regulations For CNM'S [sic]: States that Allow CNMs to Practice and Prescribe Independently vs Those that Require a*

Significantly, NARM also maintains a path to the CPM credential though apprenticeship rather than training through a degree-granting institution.[56] This preserves a traditional aspect of midwifery practice, while ensuring that CPMs develop necessary competencies through observing, assisting, and serving as the primary caregiver all under the guidance of a NARM registered preceptor.[57] Some commentators criticize credentialing and licensure for displacing traditional forms of knowledge and practice around birth in an exercise of power akin to colonization, echoing critiques of the medicalization of childbirth more generally.[58] In this sense, maintaining apprenticeship as a model for CPM training represents a compromise between those who want to preserve traditional birth practices and those who consider standardization necessary for expanding access to midwifery care by growing the midwifery workforce.[59]

There are various reasons why pregnant people might choose midwifery care over physician-attended birth. Temecia Jackson had delivered her two sons by cesarean and "believed working with a midwife and team of doulas would be a safer, more comfortable process after she endured two difficult C-sections."[60] Indeed, pregnant people commonly cite the desire to avoid unnecessary medical intervention as

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Collaborative Agreement, MIDWIFESCHOOLING.COM, https://www.midwifeschooling.com/independent-practice-and-collaborative-agreement-states/ [https://perma.cc/KXV2-BZV7] (noting opposition of the American College of Nurse-Midwives and the National Council of State Boards of Nursing to collaborative agreement requirements for certified nurse midwives).

56. *NARM Supports the Portfolio Evaluation Process!*, NARM (Oct. 30, 2018), https://narm.org/2018/10/narm-supports-the-pep/ [https://perma.cc/8F7M-VVXM].

57. ENTRY-LEVEL PEP, NARM, http://narm.org/pdffiles/AppForms/PEP-ELInstructions.pdf [https://perma.cc/YF9A-VALY].

58. *See* Bentley Portfield-Finn, *What Does It Mean to Decolonize Birth?*, MOTHERLOVE, https://www.motherlove.com/blogs/all/what-does-it-mean-to-decolonize-birth [https://perma.cc/T46E-KXJB] (discussing licensure and credentials as colonizing practices that exclude "various cultural traditions surrounding birth and postpartum" and replacing them "with a tightly regulated hospital environment"); Christy Kollath, Reinterpreting Reproduction: An Ethnography on Discourses, Ideologies, and Practices Among Midwifery Participants in South Carolina (2012) (Ph.D. dissertation, University of South Carolina) (discussing divisions within midwifery community about the costs and benefits of professionalization, especially to the extent that "professionalization [is] antithetical to midwifery because it aligns midwifery with medicine").

59. *But see NARM Supports the Portfolio Evaluation Process!, supra* note 56 (noting that individual states may not accept PEP for the purposes of state licensure).

60. Breen, *supra* note 1; *Texas Newborn Headed Home*, *supra* note 4.

their reason for choosing midwife-attended birth in a community setting, reflecting concern that delivering in the hospital will preclude their ability to decide whether to choose a medical intervention or concern that they will be pressured to do so.[61] This concern may be particularly salient for a pregnant person with a history of prior cesarean delivery under circumstances where the birthing person doubted its medical necessity or felt pressured into accepting surgery.[62]

Concern about unnecessary medical intervention during hospital birth—and the potential of being pressured to accept unwanted care—is appropriate given the exceedingly high rate of cesarean deliveries and other medical interventions in U.S. childbirth,[63] along with significant rates of pregnant people reporting coercion by their perinatal care providers.[64] Fear of ceding control over decision-making during childbirth, particularly decisions that involve weighing the potential risks and benefits of medical intervention, arises against the backdrop of a maternal health crisis in the United States. Women die in childbirth in the United States at significantly higher rates than in other industrialized nations, with Black and Indigenous women between three and four times more likely to die from pregnancy-related causes than White women.[65] Approximately 60,000 people each year experience life-

61. Debora Boucher et al., *Staying Home to Give Birth: Why Women in the United States Choose Home Birth*, 54 J. MIDWIFERY WOMEN'S HEALTH 119, 121–22 (2009).

62. *See TheUnnecesarean.com: Pulling Back the Curtain on the Unnecessary Cesarean Epidemic*, https://www.cesareanrates.org/the-unnecesarean-a-brief-history [https://perma.cc/T9TA-Y793].

63. Michelle J. K. Osterman et al., *Births: Final Data for 2021*, 72 NAT'L VITAL STATS., REPS. 1, 6 (2023) (reporting cesarean rate of 32.1% in 2021, an increase from 31.8% in 2020); *Appropriate Technology for Birth*, 326 LANCET 436, 437 (1985) ("There is no justification for any region to have a rate higher than 10–15%."); Martha Bebinger, *Study Suggests 19 Percent Could Be Benchmark C-Section Rate*, WBUR (Dec. 1, 2015), http://www.wbur.org/commonhealth/2015/12/01/benchmark-cesarean-section-rate [https://perma.cc/2PFU-P66D] (discussing recent research suggesting that a 19% cesarean rate is an appropriate benchmark for the United States); Eugene R. Declercq et al., *Major Survey Findings of Listening to Mothers(SM) III: Pregnancy and Birth*, 23 J. PERINATAL EDUC. 9, 10 (2014) (summarizing data regarding frequent use of various interventions during childbirth).

64. *See* Rachel G. Logan et al., *Coercion and Non-Consent During Birth and Newborn Care in the United States*, 49 BIRTH 749, 750–51 (2022); Saraswathi Vedam et al., *The Giving Voice to Mothers Study: Inequity and Mistreatment During Pregnancy and Childbirth in the United States*, 16 REPROD. HEALTH 1, 1-8 (2019).

65. *See Pregnancy Mortality Surveillance System*, CTRS. FOR DISEASE CONTROL & PREVENTION, https://www.cdc.gov/reproductivehealth/maternal-mortality/pregnancy-mortality-surveillance-system.htm [https://perma.cc/G7AA-YGZM] (reporting, based on data submitted to

threatening complications from pregnancy or childbirth.[66] People may also choose community birth with midwives because they have experienced mistreatment or bias during a previous hospital birth, or while seeking non-pregnancy related medical care.[67] Prior bad experiences with the medical system prompt them to seek alternatives in an attempt to avoid discriminatory or dehumanizing treatment.[68]

Some people decide midwifery better aligns with their values than physician-led, hospital-based care.[69] They may prioritize autonomy and want to play an active role in decision-making about their care during pregnancy and childbirth.[70] Or they may feel safer giving birth at home or in a freestanding birth center, where they have control over who is present during childbirth and what kind of support is available.[71] Choosing midwifery for these reasons reflects a reaction to the medicalization of hospital-based birth, which has been theorized as a "technocratic" model of birth due to the high degree of standardization and reliance on medical intervention to manage labor and delivery as if childbirth were a pathological, not normal, process.[72]

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the CDC for 2016–2018, a death rate of 41.4 per 100,000 live births for Black non-Hispanic women and 13.7 deaths per 100,000 live births for White non-Hispanic women); *see also* Myra J. Tucker et al., *The Black-White Disparity in Pregnancy-Related Mortality from 5 Conditions: Differences in Prevalence and Case-Fatality Rates*, 97 AM. J. PUB. HEALTH 247, 247 (2007) ("For the past 5 decades, Black women have consistently experienced an almost 4-times greater risk of death from pregnancy complications than have White women.").

66. Nina Martin & Renee Montagne, *The Last Person You'd Expect to Die in Childbirth*, PROPUBLICA (May 12, 2017), http://www.propublica.org/article/die-in-childbirth-maternal- death-rate-health-care-system [https://perma.cc/N2J7-CJC6]; Eugene Declercq & Laurie Zephyrin, *Severe Maternal Morbidity in the United States: A Primer*, COMMONWEALTH FUND (Oct. 28, 2021), https://www.commonwealthfund.org/publications/issue-briefs/2021/oct/severe-maternal-morbidity-united-states-primer [https://perma.cc/YZ7L-SCFS].

67. *See* Boucher et al., *supra* note 61, at 119; Nicholas Rubashkin, *I'm an Obstetrician. Stop Stigmatizing Home Births*, SLATE (Mar. 9, 2021, 9:00 AM), https://slate.com/technology/2021/03/home-birth-obstetrician-stigma.html [https://perma.cc/FRK7-KV33].

68. *See* Ellis, *supra* note 15 (noting that "many Black women are choosing midwives because they have lost trust in doctors and hospitals," according to reproductive justice leader Monica Simpson).

69. *See* Boucher et al., *supra* note 61.

70. *Id.*

71. *See* Elizabeth Kukura, *Birthing Alone*, 79 WASH. & LEE L. REV. 1463, 1473–79 (2022).

72. *See* Robbie E. Davis-Floyd, *The Technocratic Model of Birth*, *in* FEMINIST THEORY IN THE STUDY OF FOLKLORE 297 (Susan Tower Hollis et al. eds., 1993).

Community birth represents a small fraction of the approximately four million births in the United States each year, but the last two decades have seen a notable increase in the number of births taking place outside a hospital. From 2004 to 2017, out-of-hospital births increased 85%, and the home birth rate increased 77%.[73] More recently, demand for midwives and community birth increased during the COVID-19 pandemic as pregnant people sought to avoid hospitals and became familiar with midwifery care as an alternative.[74] Between the maternal health crisis and the pandemic, the number of people of color choosing community birth has increased significantly. A recent report from the National Partnership for Women and Families on the number of community births from 2019-2020 showed marked increases among Black (30%), Indigenous (26%), and Latinx (24%) people.[75] The authors concluded these increases were likely tied to "the higher risk of maternal mortality and morbidity [people of color] face and the impact of discrimination and structural racism in hospitals that result in lower-quality care."[76] Interest in demedicalized birth in community settings is growing not only on the demand side, but with eleven states (plus D.C.) having passed licensure for CPMs in the last decade, legalized practice creates more opportunities to increase the midwifery workforce and extend the option for demedicalized birth to more pregnant people.[77] It seems likely that Temecia's decision to have her baby at home with a midwife reflects a growing trend across the United States in demand for the option of demedicalized childbirth.

2. Demedicalizing Newborn Care

Temecia Jackson recounts her home birth as an exceedingly positive experience, but her continued pursuit of demedicalized care in the postpartum period to address Mila's jaundice invited unwanted attention from Dr. Bhatt and from DFPS, resulting in the newborn's

73. Marian F. MacDorman & Eugene Declercq, *Trends and State Variations in Out-of-Hospital Births in the United States*, 2004–2017, 46 BIRTH 279, 280 (2019).

74. *See* Elizabeth Kukura, *Seeking Safety While Giving Birth During the Pandemic*, 14 ST. LOUIS U. J. HEALTH L. & POL'Y 279, 281–83 (2021).

75. *More People Giving Birth at Home and In Birth Centers*, NAT'L P'SHIP FOR WOMEN & FAMS., https://nationalpartnership.org/news_post/more-people-giving-birth-at-home-html/ [https://perma.cc/46DC-J4TD].

76. *Id.*

77. *See* LICENSURE FOR CERTIFIED PROFESSIONAL MIDWIVES: STATE TRENDS, BIG PUSH FOR MIDWIVES, https://pushformidwives.org/wp-content/uploads/2023/09/The-Big-Push-for-Midwives_State-Regulation-Push Map_SEPT-2023.pdf [https://perma.cc/SW8E-J6RY]; Press Release, New Law Makes Iowa 38th State to Regulate Midwives, *supra* note 34.

separation from her family for over three weeks.[78] Jaundice is a common condition in newborns caused by the buildup of bilirubin, a naturally occurring substance produced by the breakdown of red blood cells.[79] Some infants need phototherapy, which applies light directly on the baby's skin to help break down the bilirubin until the liver is mature enough to process it on its own.[80] Babies can lie under the lights wearing protective goggles or be wrapped in a blanket containing the light source, or both. Phototherapy can be administered either in a hospital or at home; in fact, Kaiser Permanente offers instructions on how to obtain and use a biliblanket to treat jaundice at home.[81]

There are various reasons why parents may want to avoid a hospital admission for their newborn. Infants hospitalized in a neonatal intensive care unit (NICU) face the risk of infection due to exposure to medical devices and various other sources of potential infection.[82] When infants are admitted to the NICU, their parents are not admitted to the hospital with them and may face formal restrictions on when they are permitted to be with their babies or informal restrictions on visiting due to staff changes or other operational concerns, interfering with postpartum bonding and increasing the risk of postpartum depression.[83] Parents may need to leave the infant alone in the NICU to care for other children at home. Such constraints can also impede the successful establishment of breastfeeding; pumping to supply breast milk in a bottle to a baby hospitalized in the NICU may be less effective for establishing milk supply than giving a baby who can nurse directly the

78. *See Black Texas Couple Chose Midwife*, *supra* note 11 ("It was a beautiful experience.").

79. *Infant Jaundice*, MAYO CLINIC (Jan. 6, 2022), https://www.mayoclinic.org/diseases-conditions/infant-jaundice/symptoms-causes/syc-20373865 [https://perma.cc/5ZNZ-QJMM]; *Jaundice in Newborns*, CLEV. CLINIC, https://my.clevelandclinic.org/health/diseases/22263-jaundice-in-newborns [https://perma.cc/U67N-AJQH] ("Up to 60% of full-term babies develop jaundice during their first week of life.").

80. *Home Phototherapy Patient Instructions for Parents*, KAISER PERMANENTE, https://thrive.kaiserpermanente.org/care-near-you/northern-california/sanjose/wp-content/uploads/sites/7/2018/11/BiliBlanket-FAQ-Parent-12-12-002.pdf [https://perma.cc/2Z3W-52RK].

81. *Id.*

82. *See* Li Wang et al., *Risk Factors of Nosocomial Infection for Infants in Neonatal Intensive Care Units: A Systematic Review and Meta-Analysis*, 25 MED. SCI. MONITOR 8213 (2019).

83. *See, e.g.*, Natalie V. Scime et al., *The Effect of Skin-to-Skin Care on Postpartum Depression Among Mothers of Preterm or Low Birthweight Infants: A Systematic Review and Meta-Analysis*, 253 J. AFFECTIVE DISORDERS 376, 376–77 (2019) (discussing research on maternal-infant separation and poor outcomes, including postpartum depression).

opportunity to do so.[84] For all of these reasons (and others), it is reasonable for parents to want to avoid hospitalization of a newborn.

The Jacksons' pediatrician may himself have recognized the potential benefits of avoiding hospitalizing Mila by doing phototherapy at home as, according to Temecia, Dr. Bhatt initially counseled them on both in-home and hospital-based treatments for jaundice.[85] Evidently, he later changed his mind, urging the Jacksons to have Mila admitted to the hospital for treatment and even "reserv[ing]" her a bed at Children's Medical Center of Dallas.[86] The Jacksons had the advantage of continued support by their midwife, who agreed to provide guidance for addressing Mila's jaundice.[87] It is typical after a home birth to have multiple visits with the midwife for maternal and well-baby care during the first six to eight weeks postpartum.[88] It may be that the midwife's involvement prompted the change in Dr. Bhatt's position on phototherapy treatment, perhaps because he was unfamiliar with the training of CPMs, which includes newborn care, or assumed that Cheryl Edinbyrd would be unable to provide suitable support.[89] When Dr. Bhatt expressed concern about whether they would use phototherapy correctly, the Jacksons explained their treatment plan, including ordering a biliblanket for use at home and supplementing breastmilk with formula, which is often recommended to help clear the bilirubin

84. *See* Catherine Crider, *What's Best for You? Exclusively Breastfeeding or Pumping?*, HEALTHLINE (Jan. 28, 2021), https://www.healthline.com/health/breastfeeding/breastfeeding-vs-pumping [https://perma.cc/ZZD4-KM46] (comparing the effectiveness of breast pump suction relative to a baby's mouth at drawing milk from the breast).

85. *Black Texas Couple Chose Midwife*, *supra* note 11.

86. Ellis, *supra* note 15.

87. Breen, *supra* note 1.

88. AM. COLL. OF. NURSE-MIDWIVES, COMPARISON OF CERTIFIED NURSE-MIDWIVES, CERTIFIED MIDWIVES, CERTIFIED PROFESSIONAL MIDWIVES CLARIFYING THE DISTINCTIONS AMONG PROFESSIONAL MIDWIFERY CREDENTIALS IN THE U.S. (2017).

89. *Id.*; Regardless of their familiarity with the midwives model of care, some doctors perceive midwives as a threat to their financial livelihood and take action to undermine individual midwives or midwifery practice more generally, whether by opposing efforts to license and integrate midwives or by interfering with relationships between patients and their midwives. When doctors counsel their patients to avoid midwifery care, concerns about the safety of midwifery may serve as a pretext for economic protectionism. *See, e.g.*, Anemona Hartocollis, *Doctors' Group Fights a Bill That Would Ease Restrictions on Midwives*, N.Y. TIMES (June 17, 2010), https://www.nytimes.com/2010/06/18/nyregion/18midwives.html [https://perma.cc/4J6C-3RP4] (noting opposition of American Congress of Obstetricians and Gynecologists to midwifery liberalization bill on the basis that it was "a ploy to allow midwives to expand their turf and directly compete with doctors.").

from the body faster by producing more urine output.[90] They also gave Dr. Bhatt their midwife's contact information.[91] However, he chose to report the Jacksons to DFPS rather than to communicate with the midwife and help facilitate successful phototherapy at home according to the parents' wishes.

In his letter to DFPS, Dr. Bhatt noted that he made ten attempts "to appeal to the family through phone calls, text messages, and leaving voicemails as they did not pick up the phone."[92] These ten attempts occurred within a short time span, as less than twenty-four hours elapsed between Mila's appointment and the transmission of Dr. Bhatt's report to DFPS. Instead of allowing for the possibility that the family was busy caring for their newborn, including the administration of phototherapy, along with their two older children (and Temecia's postpartum recovery), the pediatrician concluded that his inability to reach the family reflected their disrespect for his medical advice. He decided to leverage the power of the state to enforce his current view that hospital admission was the only suitable approach to addressing Mila's jaundice. To the extent that Edinbyrd's involvement in Mila's care may have prompted skepticism and hostility by Dr. Bhatt, such reactions reflect the medical profession's long history of asserting superiority over midwives and other health care providers, even when no particular medical expertise is necessary or when someone else might even be better positioned to provide certain forms of care than a physician.[93] Racial bias can also influence how health care providers respond when patients do not follow their advice; research shows that Black patients are more likely than non-Black patients to be described by doctors as "noncompliant" or "non-adherent."[94] Furthermore, the

90. Solomon, *supra* note 5; *see also* Meredith L. Porter & Beth L. Dennis, *Hyperbilirubinemia in the Term Newborn*, 65 AM. FAM. PHYSICIAN 599, 602 (2002) (discussing potential need for supplementation in breastfed babies with jaundice).

91. Solomon, *supra* note 5.

92. *Id.*

93. Notably, Temecia reported that Dr. Bhatt never actually examined Mila; rather she was seen only by a nurse practitioner (and was deemed healthy other than the jaundice). *See* Alexander, *supra* note 5. For an example of the medical profession's opposition to advance practice nurses and physician assistants filling expanded roles in the health care system, see Andis Robeznieks, *How Scope of Practice Expansion Efforts Were Defeated in New York*, AMA (Sept. 6, 2023), https://www.ama-assn.org/practice-management/scope-practice/how-scope-practice-expansion-efforts-were-defeated-new-york [https://perma.cc/444X-UUNG].

94. Roni Caryn Rabin, *Doctors Are More Likely to Describe Black Patients as Uncooperative, Studies Find*, N.Y. TIMES (Feb. 16, 2022), https://www.nytimes.com/2022/02/16/health/black-patients-doctor-notes-diabetes.html [https://perma.cc/YDR6-XDQM]. *See also* Alice

fact that Edinbyrd is a Black woman may have compounded Dr. Bhatt's negative reaction to the Jacksons' preference for ongoing midwifery care, given the research showing Black physicians report high rates of workplace discrimination, including by their health care provider colleagues.[95]

When physicians hold biases against midwives, are unfamiliar with midwifery care, or misunderstand the qualifications of midwives, they can make misguided and harmful assumptions about people who choose midwifery care.[96] For example, jaundice is more common in breastfed newborns than formula-fed newborns, and babies born outside a hospital are more likely to be exclusively breastfed; nevertheless, jaundice among babies born at home may be "alarming" for pediatricians who are unfamiliar with the care provided by the attending midwife or with the role that breastfeeding can play in producing elevated, but easily treatable, levels of bilirubin in newborns.[97] When a health care provider is unfamiliar with the evidence supporting no- or low-intervention practices in childbirth, they may misrepresent the quality of care provided by a midwife or accuse someone pursuing demedicalized childbirth of engaging in harmful practices when, in fact, the opposite is true. For example, the DFPS allegation of medical neglect quotes language from Dr. Bhatt's referral describing the Jacksons' decision to practice delayed cord clamping (DCC), which is the act of allowing additional blood flow from the placenta to the newborn immediately after birth before cutting the umbilical cord:

> "A lot of times, the placenta is clamped so there is not too much blood going to the baby. This is considered standard care. Mother and father have the belief that the more placenta, the more stem cells, and immune cells will go to the baby; however, if it's not

Abrokwa, *Too Stubborn to Care for: The Impacts of Discrimination on Patient Noncompliance*, 77 VAND. L. REV. ___, at Part II (forthcoming 2024) (discussing the role of stereotypes in driving noncompliance biases among health care providers).

95. Amarette Filut et al., *Discrimination Toward Physicians of Color: A Systematic Review*, 112 J. NAT'L MED. ASS'N 117, 119 (2020) (noting that "Black physicians consistently encountered discrimination at higher rates than any other group").

96. *Black Texas Couple Chose Midwife*, *supra* note 11 (noting that Temecia was aware of "discomfort about her home birth" during the initial pediatrician visit and "felt the doctor did not have a good understanding of midwifery care").

97. STEPHANIE BRATTON ET AL., BREAST MILK JAUNDICE (2024) ("Neonatal hyperbilirubinemia has a higher frequency in breastfed infants compared to formula-fed infants."); *Black Texas Couple Chose Midwife*, *supra* note 11 (quoting Florida midwife Audrey Luck).

> done in a controlled manner, too much blood goes to the baby. This can cause blood cells to pack, decrease blood flow and can result in complications like stroke and brain damage."[98]

Contrary to Dr. Bhatt's assertion about the standard of care, major medical organizations, including the American College of Obstetricians and Gynecologists, the American Academy of Pediatrics, and the World Health Organization, have endorsed guidelines recommending DCC for at least 30-60 seconds or up to five minutes after birth to increase hemoglobin levels in term infants and iron stores in the first months of life, which is believed to positively impact infant development.[99] Some research has found a slightly increased incidence of jaundice requiring phototherapy after DCC, while other studies have found no difference, which may be explained by increased blood flow to the liver due to higher blood volume. Ultimately, experts consider the benefits to outweigh any increased risk of jaundice.[100]

DCC is a return to a long-standing practice whose early advocates included Erasmus Darwin and Aristotle.[101] Starting in the early twentieth century, as the medical model of physician-led, hospital-based birth began to predominate, early cord clamping immediately after birth was promoted for efficiency and to avoid any impact of newly-employed anesthesia or other medications on the infant.[102] With extensive research documenting the benefits of DCC in recent decades, advocates have promoted DCC and patients have increasingly requested that providers follow this evidence-based practice. As DCC requires physicians to abstain from early intervention into the natural blood flow from placenta to infant, the move from early to delayed cord

98. Alexander, *supra* note 5 (quoting DFPS document included in photos accompanying news report).

99. *See* Chelsea K. Bitler et al., *Evaluating the Evidence Behind Umbilical Cord Clamping Practices in At-Risk Neonatal Populations*, 47 SEMINARS PERINATOLOGY 1, 2 (2023); *Committee Opinion No. 684, Delayed Umbilical Cord Clamping After Birth*, 136 Obstetrics & Gynecology e5, e6 (2020), https://www.acog.org/-/media/project/acog/acogorg/clinical/files/committee-opinion/articles/2020/12/delayed-umbilical-cord-clamping-after-birth.pdf [https://perma.cc/3P72-SWSQ] [hereinafter *ACOG, Opinion No. 684*]. For preterm infants, DCC improves circulation and establishment of red blood cell volume, while decreasing the need for blood transfusions and the likelihood of complications like necrotizing enterocolitis. *Id.* at e100. Research does not support an association between DCC and stroke or brain damage.

100. *ACOG, Opinion No. 684*, *supra* note 99, at e5.

101. *See* Balaji Govindaswami et al., *A Narrative Review of Delayed Cord Clamping 2020—Who, What, When, Where, Why and How?*, 3 PEDIATRIC MED. 1, 2 (2020).

102. *Id.* at 2; Tonse N. K. Raju & Nalini Singhal, *Optimal Timing for Clamping the Umbilical Cord After Birth*, 39 CLINICS PERINATOLOGY 1, 1 (2012).

clamping—now adopted in over 80% of health care institutions as the standard of care—reflects a form of demedicalization in perinatal care.[103] Not only did the pediatrician's report misrepresent the standard of care, but it appears to provide incorrect information about the health impacts of DCC. This may reflect the physician's discomfort with or resistance to the parents' pursuit of demedicalized care during pregnancy, birth, and postpartum.

B. Through the Lens of Criminalization

It is not uncommon for physicians and patients to weigh the risks and benefits of medical treatment differently, sometimes reaching conflicting decisions about the care to be provided, but both law and medical ethics guard against health care providers forcing their preferences on their patients.[104] Understandably, it can be challenging for a provider who believes strongly that a particular approach declined by the patient will best serve the patient's health; such situations may prompt an internal conflict between one's professional obligation to respect patient autonomy and the provider's personal values.[105] When health care providers threaten legal action to convince a patient to accept unwanted treatment, they violate their professional obligations to the patient, leveraging state power to assert their own priorities over the patient's decision. If the state gets involved, through investigation by either law enforcement or child welfare authorities, patient decision-making becomes criminalized.

In the Jackson family's case, state involvement was triggered by Dr. Bhatt's report of alleged medical neglect to DFPS. Starting in the 1970s, states established dedicated agencies to implement procedures for investigating suspected child maltreatment, as required by federal law.[106] Over the decades, the reach of child welfare agencies has expanded significantly, such that "[o]ne in three children in the US will be part of a child welfare investigation by age 18."[107] In 2019 alone,

103. Bitler et al., *supra* note 99, at 2.

104. *See, e.g.*, *Committee Opinion No. 664, Refusal of Medically Recommended Treating During Pregnancy*, AM. COLL. OBSTETRICIANS & GYNECOLOGISTS 1, 1 (June 2016, revised January 2022), https://www.acog.org/-/media/project/acog/acogorg/clinical/files/committee-opinion/articles/2016/06/refusal-of-medically-recommended-treatment-during-pregnancy.pdf [https://perma.cc/733G-VCP7].

105. *See id.* (acknowledging the difficulty of such conflicts for medical professionals).

106. *See* John E. B. Myers, *A Short History of Child Protection in America*, 42 FAM. L. Q. 449, 454, 456–57 (2008).

107. *US: Child Welfare System Harms Families—Disproportionate Separation in Black, Indigenous Communities*, HUM. RTS. WATCH (Nov. 17, 2022,

agency hotlines received calls about almost eight million children suspected of being maltreated, resulting in three million investigations.[108] Research suggests that race and class bias drives interactions with state agencies charged with investigating child neglect and abuse allegations.[109] In 2021, Black children constituted 22% of children in foster care even though they are only 14% of the nation's youth population, reflecting the disproportionate targeting of Black families.[110] Researchers found that between 2003-2014, 53% of Black children were subjects of investigations by the family regulation system, compared to only 28% of White children.[111] Given the documented harms of child removal,[112] and this use of the state's authority to criminalize Black and Indigenous parents, many scholars and advocates have adopted the terms "family policing system" or "family regulation system" in favor of "child welfare system."[113]

12:01 AM), https://www.hrw.org/news/2022/11/17/us-child-welfare-system-harms-families [https://perma.cc/5VT3-PK67].

108. *Id.* (noting that 80% of complaints were found not to involve abuse or neglect). Even when investigators conclude a complaint is unfounded, research shows the investigation alone can cause trauma to children, parents, and families). Julia Hernandez & Tarek Z. Ismail, *Radical Early Defense Against Family Policing*, 132 YALE L. J. FORUM 659, 665 (2023).

109. *See* '*If I Wasn't Poor, I Wouldn't Be Unfit': The Family Separation Crisis in the US Child Welfare System*, HUM. RTS. WATCH (Nov. 17, 2022), https://www.hrw.org/report/2022/11/17/if-i-wasnt-poor-i-wouldnt-be-unfit/family-separation-crisis-us-child-welfare [https://perma.cc/ZJL8-TY5C] (noting that "Black children are almost twice as likely to experience investigations as white children and are more likely to be separated from their families") [hereinafter, HRW, FAMILY SEPARATION CRISIS]; Shereen A. White et al., *Help Not Hotlines: Replacing Mandated Reporting for Neglect With a New Framework for Family Support*, 1 FIJ QUARTERLY 132, 132 (2022) (analogizing mandated reporting for child neglect to "stop and frisk" policing practices in the way both constitute a "tool of omnipresent surveillance and devastation").

110. *Black Children Continue to Be Disproportionately Represented in Foster Care*, ANNIE E. CASEY FOUNDATION (Apr. 13, 2020), https://www.aecf.org/blog/us-foster-care-population-by-race-and-ethnicity [https://perma.cc/M3FL-WVJT]. In contrast, White children are 49% of the U.S. population of children but represent only 43% of youth in foster care. *Id.*

111. Hyunil Kim et al., *Lifetime Prevalence of Investigating Child Maltreatment Among US Children*, 107 AM. J. PUB. HEALTH 274, 277 (2017).

112. *See generally* Shanta Trivedi, *The Harm of Child Removal*, 43 NYU REV. L. & SOC. CHANGE 523 (2019).

113. *See* ROBERTS, TORN APART, *supra* note 24; Jayla Whitfield-Anderson, '*A Nightmare': Texas Parents Say Their Baby Was Taken by CPS After They Used Midwifery Care for Jaundice*, YAHOO NEWS (Apr. 12, 2023), https://news.yahoo.com/a-nightmare-texas-parents-say-their-baby-was-taken-by-cps-after-they-used-midwifery-care-for-jaundice-191528392.html

Reporting by a health care professional that triggers involvement with the family regulation system raises concerns about patient privacy and respect for patient autonomy in medical decision-making. Certain health care providers are required by state law to report suspected child maltreatment.[114] Yet, research suggests that confusion exists among professionals about the circumstances under which reporting is mandatory, resulting in unnecessary reporting that initiates unwarranted scrutiny and surveillance of families' lives.[115] Many people come in contact with the family regulation system in their professional or personal lives; when this prevalence combines with a lack of understanding about the scope of reporting laws and the impact of resulting investigations, bias can lead people to report for reasons unrelated to child neglect or abuse.[116] In the context of perinatal care, bias against parents who choose community birth with midwives—perhaps driven by misunderstandings of midwifery care and home birth—may influence what a medical professional perceives to be medical neglect or other harm to a child, prompting a complaint to the state agency.[117]

[https://perma.cc/QR4V-563Q] (quoting law professor Dorothy Roberts on why the "family policing system" is more appropriate language than "child welfare system").

114. *See* Joel M. Geiderman & Catherine A. Marco, *Mandatory and Permissive Reporting Laws: Obligations, Challenges, Moral Dilemmas, and Opportunities*, 1 J. AM. COLL. EMERGENCY PHYSICIANS OPEN 38, 38 (2019). *But see* White et al., *supra* note 109, at 135–36 (arguing for repeal of the mandated reporting requirement imposed by the Child Abuse Prevention and Treatment Act of 1974 (CAPTA)).

115. *See, e.g.*, Tonya Foreman & William Bernet, *A Misunderstanding Regarding the Duty to Report Suspected Abuse*, 5 CHILD MALTREATMENT 190, 190 (2000); Mical Raz, *Calling Child Protective Services Is a Form of Community Policing That Should Be Used Appropriately: Time to Engage Mandatory Reporters as the Harmful Effects of Unnecessary Reports*, 110 CHILD. & YOUTH SERVS. REV. 2 (2020). Research also suggests that bias plays a role in who gets reported by their health care providers for suspected abuse or neglect. For example, Black patients are more likely to be screened and reported for substance use during pregnancy than White patients, although Black patients do not test positive at higher rates. Marian Jarlenski et al., *Association of Race With Urine Toxicology Testing Among Pregnant Patients During Labor and Delivery*, 4 JAMA HEALTH F. 1, 3 (2023).

116. *See* Krista Ellis, *Race and Poverty Bias in the Child Welfare System: Strategies for Child Welfare Practitioners*, AM. BAR ASS'N (Dec. 17, 2019), https://www.americanbar.org/groups/public_interest/child_law/resources/child_law_practiceonline/january---december-2019/race-and-poverty-bias-in-the-child-welfare-system---strategies-f/ [https://perma.cc/QLR9-EF6L] (discussing impact of bias in driving child removals).

117. *See Black Texas Couple Chose Midwife*, *supra* note 11 (summarizing University of Chicago professor Darcey Merritt's research findings that

Reporting on the Jackson family's case suggests a point of confusion about the role physicians play in reporting suspected medical neglect. Dr. Bhatt's letter to DFPS said, "I authorized the support of CPS to help get this baby the care that was medically necessary and needed."[118] The idea that a physician can authorize the state agency to act is a curious interpretation of the physician's role, or assumed role as a mandated reporter, in relation to the state agency that has jurisdiction to investigate child maltreatment allegations.[119] The language seems to suggest that the medical professional making a report has authority over the state agency, which is not how power is allocated in the system, although in practice it is often the case that investigators defer to the opinions of medical professionals even in the face of contrary evidence or evidence that suggests further inquiry is warranted before removing a child.[120] Furthermore, reference to the "support of CPS to help get this baby . . . care" obscures the reality of family policing, which is that children are often removed from their families in a rush and without explanation, leading to lengthy separations and trauma—not "support" and "care."[121] Notably, media coverage of the Jacksons' experience indicates that while Mila was removed from her parents on March 28, she was not taken to the hospital for treatment until April 4.[122] This lack of urgency suggests that Dr. Bhatt's report—and Mila's subsequent removal—were more about punishing the parents for choosing care outside the mainstream medical system than about the risk to Mila's well-being.

Finally, there is another way that the Jackson family's story reflects criminalization and bias against people impacted by the criminal legal system, who are disproportionately people of color. The affidavit that DFPS provided as the legal basis for removing Mila listed the names of two strangers as the infant's parents.[123] The woman named as Mila's

"what someone perceives to be danger or neglect could be influenced by bias").

118. Excerpt from Texas Department of Family and Protective Services Report, *supra* note 4.

119. *See* White et al., *supra* note 109, at 133–35 (describing the history of mandated reporting and physicians' role in the system).

120. *See* DIANE L REDLEAF, THEY TOOK THE KIDS LAST NIGHT: HOW THE CHILD PROTECTION SYSTEM PUTS FAMILIES AT RISK (2018).

121. *See generally* ROBERTS, *supra* note 24; White et al., *supra* note 109, at 138.

122. *Black Texas Couple Chose Midwife*, *supra* note 11.

123. Breen, *supra* note 1; *see also* Solomon, *supra* note 5 (quoting Temecia: "I felt like they had stolen my baby as I had a home birth, and they were trying to say my baby belonged to this other woman.").

mother has a criminal history and prior CPS involvement,[124] which suggests that an initial clerical error in identifying the child's mother may have contributed to the agency's conclusion that Temecia posed a risk to Mila because they had incorrectly attributed another individual's history of DFPS involvement to Temecia. Media coverage noted that a department spokesperson was "unable to explain why a different woman with a criminal history" was named on the affidavit.[125] In addition, other documents listed Rodney Jackson as Mila's "alleged father," which may reflect racist assumptions about the childbearing decisions of Black parents and, in particular, the involvement of Black fathers in their children's lives.[126] The lack of accountability for such mistakes in light of the harm and trauma caused by removing a newborn from her family is characteristic of how family policing operates—adopting an "act now, check later" mentality to child removals. It left the Jacksons traumatized and feeling like they had "been treated like criminals."[127]

III. DEMEDICALIZATION IN CONTEXT

Medicalization as a feature of modern life is visible in the degree to which people turn to licensed medical professionals for assistance managing their bodies and health, the array of technologies and medications developed to address common conditions, and the vast resources consumed by medical treatments unimaginable a century ago. While some people embrace these developments as progress, others resist the medicalization of problems that might have solutions that lie elsewhere. This Part places the examples of demedicalization identified in the Jackson family's story into theoretical context, starting first with key concepts from the scholarly literature on medicalization-demedicalization and then examining how demedicalization of childbirth might be understood in the current perinatal health care landscape of the United States.

124. Solomon, *supra* note 5; Whitfield-Anderson, *supra* note 113. In 2020, the woman listed on the affidavit supporting Mila's removal had a three-month old child briefly removed from her custody "after a domestic violence incident" and was also listed as being arrested in 2016 for criminal trespass. Bekah Morr, *Legal Document Used to Take Dallas Newborn Had the Wrong Family's Name*, KERA (Apr. 7, 2023, 5:41PM), https://www.keranews.org/news/2023-04-07/newborn-baby-taken-child-protective-services-dallas [https://perma.cc/EK4J-ETCF].

125. Solomon, *supra* note 5.

126. Alexander, *supra* note 5.

127. Solomon, *supra* note 5.

A. Defining Demedicalization as a Social Phenomenon

In order to understand efforts to demedicalize, it is important to start with the concept of medicalization, which sociologist Peter Conrad explains consists of "defining a problem in medical terms, using medical language to describe a problem, adopting a medical framework to understand a problem, or using a medical intervention to 'treat' it."[128] As noted above, Lauren Hall identifies medicalization as "the process by which human experiences or conditions come to be treated as illness or diseases."[129] Conrad identifies various forms of perceived deviance or natural life processes that were not always understood as medical issues but which became medicalized, either historically or currently, including alcoholism, homosexuality, opiate addiction, hyperactivity and learning disabilities in children, child abuse, compulsive gambling, infertility, sexuality, menstrual discomfort (PMS), childbirth, child development, menopause, aging, and death.[130] Often medicalization includes an expectation that the medical profession will assume responsibility for treating the problem, granting medical professionals authority over both the problem's definition and resolution.[131]

The scholarly literature on demedicalization tends to define the concept simply by reference to medicalization—as its opposite[132]—though some scholars have explored the distinctions between medicalization and demedicalization more robustly. Historian Janet Golden suggests that demedicalization is marked by "the diminishing cultural authority of medicine and the yielding of the power to diagnose social ills to other professions and authorities."[133] She points to various

128. Peter Conrad, *Medicalization and Social Control*, 18 ANN. REV. SOCIO. 209, 211 (1992).

129. HALL, *supra* note 17, at 7.

130. Conrad, *supra* note 128, at 213.

131. Conrad notes, however, that medicalization as a "sociocultural process [] may or may not involve the medical profession, lead to medical social control or medical treatment, or be the result of intentional expansion of the medical profession." *Id.* at 211. This seems to suggest that while medicalization concentrates power in the medical profession, the phenomenon extends more broadly beyond the profession of medicine itself.

132. Drew Halfmann, *Recognizing Medicalization and Demedicalization: Discourses, Practices, and Identities*, 16 HEALTH 186, 187 (2011); *see* Conrad, *supra* note 128, at 224 (identifying demedicalization as achieved when the "problem is no longer defined in medical terms and medical treatments are no longer deemed to be appropriate solutions.").

133. Janet Golden, *"An Argument That Goes Back to the Womb": The Demedicalization of Fetal Alcohol Syndrome, 1973–1992*, 33 J. SOC. HIST. 269, 271 (1999). Her definition of medicalization similarly focuses on the

drivers of demedicalization in the 1970s, as the emergence of bioethics, new government regulation, and patient activism reduced physician authority concurrent with changes in health care delivery and finance prompted by the introduction of the Medicare and Medicaid programs in 1965.[134] Golden highlights the agency of patients in the demedicalization process, spurring demedicalization of a particular diagnosis "by those rejecting the sickness designation given to them."[135] In this sense, demedicalization must be understood as a political and social process.[136] Overall, however, scholars have dedicated less attention to demedicalization than to medicalization.[137]

One of the most prominent commentators associated with demedicalization is Ivan Illich, whose book *Medical Nemesis* argues that "the medical establishment has become a threat to health," with increasing reliance on the delivery of health care services by professionals leading to less health across the population.[138] In her commentary on Illich's thesis, sociologist Renée Fox highlighted the "increase in the numbers and kinds of attitudes and behaviors that have come to be defined as illnesses and treatment of which is regarded as belonging within the jurisdiction of medicine and its practitioners."[139] Medicalization may be driven in part by the development of more sophisticated treatments and technologies to address conditions that were previously accepted as incurable or unavoidable due to aging or

acquisition of power by physicians to define problems as medical in nature and to shape how conditions defined as medical are treated. *Id.* at 270.

134. *Id.* at 271.

135. *Id. But see* Ruth Colker, *Overmedicalization?*, 46 HARV. J. L. & GENDER 205, 214–15 (2023) (arguing that "[d]emedicalization is not the solution to overmedicalization" in the context of disability justice, given "that medical categories sometimes help explain the lived experiences of some disabled people" even while "the disability community has often been critical of the role of medicine in policing disability categories.").

136. Golden, *supra* note 133, at 271 (noting that demedicalization "reflect[s] the interests of particular groups in returning definitions of deviance to the legal arena, the moral realm, and the court of public opinion").

137. Halfmann, *supra* note 132, at 187; Jennifer M.C. Torres, *Medicalizing to Demedicalize: Lactation Consultants and the (De)Medicalization of Breastfeeding*, 100 SOC. SCI. & MED. 159, 160 (2014) (noting the minimal attention scholars have paid to demedicalization relative to medica lization).

138. ILLICH, *supra* note 17. The 2010 version of Illich's books updates the original, which was published in 1975.

139. Renée C. Fox, *The Medicalization and Demedicalization of American Society*, 106 DAEDALUS 9, 11 (1977); *see also* Peter Sedgwick, *Illness: Mental and Otherwise*, 1 HASTINGS CTR. STUD. 19, 37 (1973) (identifying "the progressive annexation of not-illness into illness").

genetics.[140] It may also reflect the gradual secularization of society, as the diminished moral authority of religious leaders led problems that were once considered "sins" to be understood as "crimes" and eventually reframed as "medical" problems in an era dominated by the pursuit of scientific knowledge.[141] In short, the "medical profession plays a vastly more important role than it once did in defining and regulating deviance and in trying to forestall and remedy it."[142]

Fox identifies the countertrend of demedicalization as a reaction to the changes brought about by medicalization and particularly the negative social implications of embracing medical understandings (and solutions to) an increasingly wide range of social problems.[143] Important examples of demedicalization emerged in the 1970s, as advocates helped bring about the American Psychiatric Association's decision to declassify homosexuality as a mental disorder and elsewhere, feminists critiqued physicians' "over-attribut[ion of] psychological conditions to their female patients" and their tendency to manage pregnancy as an illness and "childbirth as a 'technologized' medical-surgical event."[144] As commentators called for the demedicalization of American society, feminist and gay rights activists were able to secure changes that were embraced as welcome forms of demedicalization.[145]

More recent scholarship has criticized analysis of medicalization "as a category or state rather than a continuous value," suggesting that earlier writings had "miss[ed] occasions where medicalization and demedicalization occur simultaneously" because they employed an overly narrow conception of medicalization at the outset.[146] Sociologist

140. Sedgwick, *supra* note 139, at 37 ("*The future belongs to illness:* we just are going to get more and more diseases, since our expectations of health are going to become more expansive and sophisticated.").

141. Fox, *supra* note 139, at 11 (providing examples of this sin-crime-medical trajectory such as hyperactivity in children or addictive disorders like alcoholism or compulsive gambling).

142. *Id.* at 15.

143. *Id.* at 17 (noting that subjective nature of categories such as health and illness).

144. *Id.* at 18.

145. *See generally* ILLICH, *supra* note 17; RICK J. CARLSON, THE END OF MEDICINE (1975); Leon R. Kass, *Regarding the End of Medicine and the Pursuit of Health*, 40 PUB. INT. 11, 11–13 (1975).

146. Halfmann, *supra* note 132, at 186. Other studies have highlighted how medicalization and demedicalization can occur simultaneously. *See, e.g.*, Mary C. Burke, *Resisting Pathology: GID and the Contested Terrain of Diagnosis in the Transgender Rights Movement*, 12 ADVANCES MED. SOC. 183, 185 (2011) (gender identity disorder); June S. Lowenberg & Fred Davis, *Beyond Medicalisation-Demedicalisation: The Case of Holistic Health*, 16 SOCIO. HEALTH & ILLNESS 579, 579 (1994) (holistic medicine).

Drew Halfmann notes that understanding medicalization as a category can obscure ongoing increases and decreases in the medicalization of a problem that may be significant but not momentous enough to "produce a categorical change."[147] He argues that it makes more sense to understand medicalization "in terms of an increase or decrease rather than a presence or absence," which avoids the pitfall of assuming a certain threshold must be achieved before a problem can be classified as medicalized.[148] The insight that medicalization and demedicalization can be simultaneous processes suggests that observers are wrong to conclude that "medicalization is ubiquitous while demedicalization is rare."[149] It is important, Halfmann argues, to perceive "crosscurrents and interstices in which change runs in the opposite direction," as they might present openings to "resist medicalization" that are not immediately apparent if one views medicalization as a static category.[150]

Building on the idea of medicalization and demedicalization as continuous processes that may occur simultaneously, sociologist Jennifer Torres observes, in the context of lactation consultants, that some degree of medicalization in the form of asserting medical control in a specific domain may serve the ultimate goal of demedicalization.[151] The role of lactation consultant emerged from the women's health and natural childbirth movements—both of which are associated with efforts to demedicalize—but because medical professionals have come to see the value of promoting breastfeeding through medical management, lactation consultants have taken positions as lactation specialists within hospitals.[152] In doing so, Torres suggests, lactation consultants accept medicalization of breastfeeding at the institutional level in order to promote demedicalization of breastfeeding in their work with patients at the individual level.[153] The notion of "medicalizing to

147. Halfmann, *supra* note 132, at 189.

148. *Id.*

149. *Id.*

150. *Id.* Likewise, such "crosscurrents and interstices" between medicalization and demedicalization may "disguise medicalization by suggesting that change is moving in many directions at once and things are not quite as bad as they seem." *Id.*

151. Torres, *supra* note 137, at 159.

152. *Id.* at 160–61 (noting how the "contemporary medicalization of breastfeeding created an opening for lactation specialists" to act as "clinical managers of breastfeeding" within hospitals, while also serving as advocates for pro-breastfeeding changes in hospital policies).

153. *Id.* at 162–65 (discussing examples of medicalizing to demedicalize in the areas of medical control over breastfeeding, pathologization of breastfeeding, and use of medical technologies by lactation consultants).

demedicalize" allows for further complexity and nuance in understanding the different forms that demedicalization can take.[154]

Other scholars have approached the study of demedicalization from the perspective of social movements. Sociologist Naomi Braine identifies autonomous health movements as those developing around a health practice that "involves de-medicalization through community use and control of medical knowledge and technology," where the "process of de-medicalization results in significant shifts in power relationships . . . in ways that enhance autonomy and self-determination of the marginalized."[155] She examines social movement organizing around self-managed abortion in Latin American jurisdictions where abortion is criminalized, finding that autonomous health movements engaging in demedicalizing practices "challenge mainstream cultural and public health assumptions that medical safety lies within institutional systems."[156] Such movements reflect the power of demedicalization as a challenge to the hegemony of medical authority and mainstream medical practices.

B. Demedicalization in Childbirth

Scholars have argued that the use of rigid categories to study medicalization and demedicalization obscures the prevalence of demedicalization, which can occur at the same time as medicalization and may lessen the overall impact of medicalization. Halfmann's insight about the continuous nature of both medicalization and demedicalization, along with the possibility for simultaneous processes, has particular salience in the childbirth context. He criticizes commentators who argue that demedicalized childbirth requires the

154. *Id.* at 165.

155. Naomi Braine, *Autonomous Health Movements: Criminalization, De-Medicalization, and Community-Based Direct Action*, 22 HEALTH & HUM. RTS. J. 85, 86, 91 (2020). Braine analyzes self-managed abortion in Latin America and harm reduction measures such as syringe exchanges and overdose prevention in the United States as social movement-driven practices that demedicalize forms of health care in the face of criminalization.

156. *Id.* at 92. In analyzing self-managed abortion as demedicalization, Braine describes how "women take control of knowledge and technologies that enable safe abortions." *Id.* at 91. This includes developing methods to procure medications outside of the formal medical system, learning how to administer them safely and effectively, and becoming educated about how to monitor symptoms for signs of complications. *See* Rishita Nandagiri & Lucía Berro Pizzarossa, *Transgressing Biomedical and Legal Boundaries: The 'Enticing and Hazardous' Challenges and Promises of a Self-Managed Abortion Multiverse*, 100 WOMEN'S STUD. INT'L FORUM 1, 6 (2023) (discussing SMA as a challenge to the centrality of legal and bio-medical paradigms in abortion); Cohen et al., *supra* note 26, at 329.

complete absence of doctors and hospitals, "a very high threshold."[157] This all-or-nothing approach ignores mid-twentieth century changes in childbirth that moved away from "twilight sleep" to induce amnesia among laboring women and routine episiotomies, enabled women to deliver in birthing rooms with their partners present, and increased the presence of midwives in maternity units—all of which represent less medicalized approaches to managing childbirth in hospital settings, even as the final decades of the twentieth century saw skyrocketing cesarean rates and the widespread adoption of continuous electronic fetal monitoring.[158] One result is that consequential forms of demedicalization are made invisible by the dominance of medicalized practices.[159]

Researchers have documented how childbirth in the United States was transformed from a social event that took place at home with the birthing person surrounded by other women to a medical event managed by doctors and other health care professionals in a hospital.[160] Medicalizing practices developed and applied to childbirth throughout the twentieth century include the use of "twilight sleep"; administration of morphine and other medications to minimize pain, including the now-routine use of epidural analgesia; routine use of Pitocin to induce or augment labor; common use of episiotomy to widen the birth canal; use of instruments like vacuum extraction to aid vaginal deliveries; regular use of cesareans; the long-dominant (but since debunked) belief that a prior cesarean required surgery for all subsequent births; the introduction of continuous electronic fetal monitoring (EFM) and its widespread use despite dubious benefits; and internal fetal monitoring using electrodes implanted in the baby's scalp.[161]

Importantly, many of these practices were adopted by physicians with minimal research on their safety or effectiveness and promoted as optimal maternity care even though they interfered with physiologic birth, caused physical harm to birthing people, and ultimately increased the cost of childbirth.[162] For example, Dr. Joseph DeLee was a

157. Halfmann, *supra* note 132, at 189.

158. *Id.*

159. *Id.*

160. *See generally* THERESA MORRIS, CUT IT OUT: THE C-SECTION EPIDEMIC IN AMERICA (2016); Heather A. Cahill, *Male Appropriation and Medicalization of Childbirth: An Historical Analysis*, 33. J. ADV. NURSING 334 (2008); DONNISON, *supra* note 39; WERTZ & WERTZ, *supra* note 39.

161. *See, e.g.*, ROBBIE DAVIS-FLOYD, BIRTH AS AN AMERICAN RIGHT OF PASSAGE 109, 117, 129, 135 (3d ed. 2022); HALL, *supra* note 17, at 24.

162. *See* Elizabeth Kukura, *Contested Care: The Limitations of Evidence-Based Maternity Care Reform*, 31 BERKELEY J. GENDER L. & JUST. 241, 246–64 (2016).

prominent early twentieth-century obstetrician who developed the technique of an episiotomy—a surgical incision to widen the vaginal opening—and, without researching its efficacy or risks, successfully encouraged colleagues to use the intervention to save women from "'the evils' that are 'natural to labor . . . .'"[163] He also advocated for prophylactic use of forceps by specialist obstetricians, promoting a protocol that included use of scopolamine to sedate pregnant women, cutting an episiotomy, and using forceps to remove the fetus.[164] The historical record suggests that DeLee was genuinely motivated to address the high incidence of maternal mortality and morbidity at the beginning of the twentieth century and also advocated "training physicians in elementary noninterventionist practices" for use in home-based obstetrics practices serving low-income women in Chicago.[165] At the same time, he had a strong personal and professional interest in advancing his philosophy of modern childbirth. DeLee was one of ten children in an immigrant family who cemented his reputation as a "titan" and "formidable force" in modern obstetrics, authoring leading textbooks, giving interviews with reporters, providing inspiration for a book and movie popularizing his work, and cultivating influence over fellow physicians through dozens of articles and public appearances.[166] As part of a "medical specialty striving to prove itself," he was motivated to advance the interests of obstetricians, alongside what he perceived as advancing the interests of pregnant women.[167] With his "complete—if somewhat naive—faith in the power of medicine" and active opposition to midwives, DeLee played an important role in asserting physician control over childbirth practices and the liberal use

163. JUDITH PENCE ROOKS, MIDWIFERY AND CHILDBIRTH IN AMERICA 25 (1997) (citation omitted).

164. Judith Walzer Leavitt, *Joseph B. DeLee and the Practice of Preventive Obstetrics*, 78 AM. J. PUB. HEALTH 1353, 1354 (1988).

165. *Id.* at 1355–56.

166. *Id.* at 1353–55.

167. *Id.* at 1357 (noting DeLee's philosophical choice of medicine over midwifery, looking away from the immigrant experience he shared with many midwives toward his "new identity group, the profession of medicine," whom he considered the "'experts'" in childbirth). Leavitt details how DeLee strategically linked medical and public health discourses in pursuit of safer hospital-based maternity care to "help the cause of the developing obstetric specialists" as "obstetricians were elevated to the status of surgeons." *Id.* at 1358. Ironically, research shows that "the increased use of operative procedures in hospital obstetrics led . . . to maintaining high maternal mortality" in the 1920s and 1930s, the opposite of DeLee's goals; however, DeLee's efforts were successful in "upgrad[ing] the status of the [obstetrics] specialty and [gaining] it a place in the increasingly competitive world of twentieth century medicine."). *Id.*

of obstetrical interventions, a form of medical authority over childbirth that persists today.[168]

Against the backdrop of medicalized childbirth under the authority of physicians, advocates for less intervention and more patient-centeredness have nevertheless achieved some of their goals. Demedicalizing practices advocated and adopted in recent decades include the professionalization of midwifery and acceptance of nurse-midwives into many hospital settings; abandonment of "twilight sleep" and recognition that women should be able to be active participants in the delivery; the creation of birthing suites for delivery (rather than in operating rooms) and elimination of rules barring husbands and partners from being present during delivery; recognition of the benefits of continuous labor support provided by doulas; use of birthing balls, showers and baths, massage, and mobility to provide unmedicated forms of pain relief; availability of intermittent auscultation instead of continuous EFM in some hospitals; adoption of immediate skin-to-skin and delayed cord clamping practices; promotion of vaginal birth after cesarean (VBAC) as an alternative to automatic elective repeat cesarean; the increasing acceptance of "gentle" cesareans, which enable the birthing person to hold the baby and have skin-to-skin contact immediately after birth while the surgery is completed; water birth; and the establishment of freestanding birth centers and promotion of home birth as alternatives to hospital-based delivery.[169] While some of these demedicalizing practices occur only or mostly in community settings, others relate to care provided in hospital settings.[170] In other words, it is not necessarily the location or type of birth attendant that establishes whether childbirth is medicalized/demedicalized. Rather, what matters is the extent to which medical interventions predominate and the degree to which physicians (and the staff they supervise) have asserted authority over the birthing process, such as by excluding patients from medical decision-making or by representing to patients that interventions are standard or mandatory practices instead of treatment subject to informed consent (or refusal) by patients.

Not only have some of these medicalizing and demedicalizing trends occurred simultaneously, but a single pregnant person can make choices that reflect both medicalized and demedicalized approaches to childbirth, such as choosing midwifery care for a hospital-based delivery. Demedicalization can be meaningful without being absolute. For example, someone may spend hours in labor at home or at a birth

168. *Id.* at 1355–56 (noting DeLee's "bias in favor of elite education and notions of expertise," which was "undoubtedly self-serving").

169. *See* DAVIS-FLOYD, *supra* note 161; HALL, *supra* note 17, *passim*.

170. *See, e.g.*, *Water Birth*, INSPIRA HEALTH, https://www.inspirahealthnetwork.org/services-treatments/pregnancy-and-childbirth/midwifery/water-birth [https://perma.cc/MYK8-BMZU].

center, benefiting from the support for physiologic birth practices available in a community setting with midwives, but later decide to transfer to a hospital to receive Pitocin augmentation or an epidural. Indeed, the Jackson family embraced demedicalization in their midwife-attended home birth but then chose to take Mila to the pediatrician for a routine newborn visit, rather than relying solely on well-baby care provided by their midwife.

In some instances, the demedicalization of childbirth means stripping away the label "medical care" from a form of care that is provided during labor and delivery but is not exclusively medical in nature, despite the fact that obstetricians perform the task and consider it part of their practice of medicine.[171] For example, obstetricians assess labor progress with cervical exams as part of attending patients on the labor floor, but midwives may also use cervical exams to determine the extent of cervical dilation and effacement.[172] Obstetricians consider the exam part of the medical care they provide to pregnant patients, but it is not exclusive to the domain of medicine. Boundaries drawn to delineate medical practices can be artificial or blurry; the medical profession may try to enforce strict boundaries in order to promote their economic interest or professional status, but efforts to demedicalize childbirth continue to challenge mainstream medicine's dominance over pregnancy- and childbirth-related care.[173]

The static, categorical approach to medicalization and demedicalization criticized by Halfmann risks obscuring the meaning of changes in the rates of community birth attended by midwives, particularly home birth. While community births still represent a very small percentage of the approximately four million births in the United States each year, the 85% increase in out-of-hospital birth relative to hospital births from 2004 to 2017 may generate important insights

171. *See* State Bd. of Nursing v. Ruebke, 913 P.2d 142, 150 (Kan. 1996).

172. *See Script: Painful Cervical Exams During Labor*, FEMINIST MIDWIFE (Oct. 24, 2021), https://www.feministmidwife.com/fmblog/feministmidwifescriptspainfulcervicalexamsduringlabor [https://perma.cc/W8QK-U7U7] (reflecting on midwives' use of cervical exams to check labor progress).

173. The futility of trying to impose strict boundaries around certain forms of childbirth-related care as "medical care" reflects the blurry overlap between medical care and health care. There are many ways people care for their health that do not require involvement of a licensed medical professional and, indeed, where physicians would prefer that people self-manage their care, such as treating cuts or mild burns with products available at the drug store. Other forms of care may involve tasks that physicians would prefer to oversee (and bill for) but over which they cannot claim exclusive authority, whether because those tasks could also be performed by nurses or physician assistants or because they can be managed at home without the involvement of a health care professional. I'm grateful to David S. Cohen for highlighting the medical care/health care distinction in the context of self-managed health care.

about the ability of mainstream medicine to meet the needs of birthing people.[174] Likewise, while the number of obstetricians significantly dwarfs the number of midwives currently practicing in the United States, recent legislative victories for midwifery advocates have increased the number of states that license direct-entry midwives, creating new avenues for expanding access to demedicalized childbirth in the form of midwifery care. Such legal changes, though often resulting in compromises on scope of practice or other regulatory issues, represent state validation of alternatives to medicalized childbirth that is the result of consumer demand and public support.[175] Dismissing the idea of demedicalization in the childbirth context because the overall numbers of midwives and home births are small misses an important part of the picture.[176]

Finally, it is important to note that identifying a particular practice as constituting demedicalization in childbirth may itself be contested. The Midwives Model of Care reflects various aspects of demedicalized childbirth, such as non-interventionist approaches to pain relief and support for vaginal delivery. But some observers have questioned whether midwives who practice in hospitals do in fact practice midwifery in a way that reflects demedicalization, or if they are even able to given the medical spaces in which they work and institutional constraints that shape how hospital-based midwives practice.[177] Some suggest that the term "medwife" is a more appropriate way to refer to hospital-based midwives, and that one must look to community-based midwifery to find practices that truly represents the demedicalization of birth.[178] Others argue that despite the compromises necessary to be part of mainstream medical institutions, hospital-based midwives are able to promote forms of demedicalization from within those institutions by pursuing policy changes regarding VBAC, non-pharmacological forms of pain relief, and intermittent fetal monitoring,

174. Marian F. MacDorman & Eugene Declercq, *Trends and State Variations in Out-of-Hospital Births in the United States, 2004-2017*, 46 BIRTH 279, 280 (2019) (reporting that the home birth rate increased by 77% during the same period).

175. *See generally* Kukura, *Better Birth*, *supra* note 29.

176. Halfmann, *supra* note 132, at 189 (critiquing Peter Conrad's 2007 book, *The Medicalization of Society: On the Transformation of Human Conditions into Treatable Disorders*).

177. *See* Kathleen E. Zenith et al., *Midwives and Medwives: An Analysis of Technology Use Among Canadian Midwives*, 18 CAN. J. MIDWIFERY RES. & PRAC. 35, 36 (2019) (discussing perceived medicalization of midwives who employ range of technologies during hospital-based birth); Kollath, *supra* note 58, at vi (summarizing ethnographic research on how midwifery participants' "practical accommodation of medicine has transformed ideologies and practices of midwifery").

178. *See* Kollath, *supra* note 58, at 15–16.

or by supporting individual patients in their pursuit of less medicalized hospital-based deliveries.[179] In this sense, the midwife/medwife debate within the midwifery profession may reflect what Torres calls "medicalizing to demedicalize."[180]

IV. DEMEDICALIZATION AND CRIMINALIZATION IN REPRODUCTIVE HEALTH

As social phenomena, both demedicalization and criminalization have long and contested histories, with advocates, social movements, professional experts, and the state advancing different visions of how best to manage our health, well-being, safety, and security in a democratic, pluralistic society. Scholars have theorized the underlying values that justify different approaches, collecting and analyzing data on the benefits and costs of more or less medicalization (or more or less criminalization), and advancing arguments calling for alternative applications of medical authority or the criminal law in order to promote human flourishing.[181] Some scholars have explored the intersections between these two phenomena, especially to the extent that certain social problems have come to be medicalized after previously having been understood as crimes.[182] But in the context of pregnancy, the use of criminalization as a tool of social control has been too easily dismissed as occurring only at the margins in exceptional cases with unsympathetic facts.[183] Although scholars and advocates

179. *See* Robert Forman, *Midwifery Review: Adding Care by Midwives Improves Birth Outcomes*, YALE SCH. MED. BLOG (Aug. 15, 2023), https://medicine.yale.edu/news-article/the-value-of-midwives-during-prenatal-care-and-birth/ [https://perma.cc/Z8D7-SM3E] (discussing the roles midwives play as educators and advocates within hospitals, noting that "midwives often play a role in demonstrating 'here's what normal physiologic birth looks like'"); *see also* Robbie Davis-Floyd, *Some Thoughts on Bridging the Gap Between Nurse- and Direct-Entry Midwives*, *originally published in* MIDWIFERY TODAY (Mar. 1999) (criticizing the denigration of nurse-midwives as "medwives").

180. Torres, *supra* note 137, at 159.

181. For arguments about the social value of medicalization and demedicalization, see ILLICH, *supra* note 17; CARLSON, *supra* note 145; Kass, *supra* note 145. Many books and articles address the use of criminal law to address poverty, drug use, and other social problems. *See, e.g.*, ELIZABETH HINTON, FROM THE WAR ON POVERTY TO THE WAR ON CRIME: THE MAKING OF MASS INCARCERATION IN AMERICA (2017); MICHELLE ALEXANDER, THE NEW JIM CROW: MASS INCARCERATION IN THE AGE OF COLORBLINDNESS (2010).

182. *See* Fox, *supra* note 139, at 11.

183. *See*, e.g., Azi Paybarah, *Judge Dismisses Murder Charge Against California Mother After Stillbirth*, N.Y. TIMES (May 20, 2021), https://www.nytimes.com/2021/05/20/us/chelsea-becker-stillbirth-

have extensively documented the policing of pregnancy and the criminalization of pregnancy outcomes long before *Dobbs*—explaining the harm of criminalization as a matter of constitutional rights violations, an abandonment of respect for autonomy and self-determination in matters of health care decision-making, and from a public health perspective as a driver of poor outcomes—the public has not shown much appetite to oppose the criminalization of pregnancy.[184]

In the context of childbirth specifically, the relationship between demedicalization and criminalization has been largely invisible in public discourse. When a pregnant person's attempt to demedicalize childbirth has led to scrutiny by law enforcement or the family policing system, cases are typically understood and assessed on the basis of their individual facts rather than as a reflection of a broader social phenomenon that make certain families more vulnerable to harm due to their race, class, or other marginalized identity. This failure to recognize the systemic nature of such punitive reactions may be changing, as the growing movement to abolish family policing educates the public about the harms of family policing and how the threat of child removal, even when temporary, is a powerful tool of coercion.[185] At the same time, demand for midwifery care in community settings is growing, which makes the potential for criminalization of demedicalized birth a matter of wider concern.

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murder-charges-california.html [https://perma.cc/TAB8-8RKX] (discussing murder charge against woman who consumed methamphetamine while pregnant); New Jersey Div. of Youth & Fam. Servs. v. V.M., 974 A.2d 448, 449–50 (N.J. Super. Ct. App. Div. 2009) (per curiam), *cert. to N.J. denied*, 983 A.2d 1113 (N.J. 2009), *cert. to U.S. denied*, 561 U.S. 1028 (2010) (upholding the termination of parental rights of a woman who declined cesarean and subsequently delivered a healthy baby vaginally where court was aware of woman's previous mental illness diagnosis when evaluating her decision to decline recommended intervention). *See also* Elizabeth Kukura, *Obstetric Violence*, 106 GEO. L. J. 721, 747–48 & n.173 (2018).

184. *See generally* WENDY A. BACH, PROSECUTING POVERTY, CRIMINALIZING CARE (2022); Khiara M. Bridges, *Race, Pregnancy, and the Opioid Epidemic: White Privilege and the Criminalization of Opioid Use During Pregnancy*, 133 HARV. L. REV. 770 (2020); Grace Howard, *The Pregnancy Police: Surveillance, Regulation, and Control*, 14 HARV. L. & POL'Y REV. 347 (2020); Lynn M. Paltrow & Jeanne Flavin, *Arrests of and Forced Interventions on Pregnant Women in the United States, 1973-2005: Implications for Women's Legal Status and Public Health*, 38 J. HEALTH POL. POL'Y & L. 299 (2013); JEANNE FLAVIN, OUR BODIES, OUR CRIMES: THE POLICING OF WOMEN'S REPRODUCTION IN AMERICA (2009); April Cherry, *The Detention, Confinement, and Incarceration of Pregnant Women for the Benefit of Fetal Health*, 16 COLUM. J. GENDER & L. 147, 152 (2007).

185. *See generally* SPINAK, *supra* note 24; ROBERTS, TORN APART, *supra* note 24; Trivedi, *supra* note 112.

There are many reasons to care about the demedicalization-criminalization dynamic in pregnancy and childbirth. The risk of punitive state action—even where community-based midwives are licensed by the state, as in Texas—stifles midwifery practice, whether by encouraging midwives to stop attending births or to limit their practice, discouraging new midwives from entering the profession, or making pregnant people fearful of choosing community birth with midwives.[186] Research shows that midwifery is a health-promoting and cost-effective form of care. Thus, criminalization undermines important health goals in the face of a maternal health crisis, maternity care workforce shortages, and lack of access to care due to maternity care deserts.[187] Criminalization of demedicalized birth also infringes patient autonomy, as legal risks impose external constraints on pregnant people's ability to exercise self-determination in their medical decision-making. Respect for patient autonomy is a central value of law and medical ethics.[188] Targeting demedicalized choices for law enforcement or family policing scrutiny appears to carve out pregnant people as an exception to physicians' obligations to promote patient autonomy.[189] Furthermore, because both general policing and family policing disproportionately impact racialized minorities, the criminalization of demedicalized birth perpetuates the harmful effects of racial bias (and other forms of bias) in health care, subjecting certain people to poorer outcomes because of where and how they choose to give birth. As birth justice advocacy encourages more pregnant people to insist on shared decision-making and their right to decline treatment, we can expect that physicians who understand patients to be challenging their medical authority will seek ways to reassert their power, including by reporting patients to the state for their perinatal health care decisions.

The demedicalization-criminalization dynamic is particularly troubling to the extent that these processes can feed each other. When

186. *See* Alexa Richardson, *The Legal Infrastructure of Childbirth*, 134 HARV. L. REV. 2209, 2222–24 (2021) (discussing impact of prosecutions on midwifery practice); *Midwives*, TEX. DEP'T LICENSING & REGUL., https://www.tdlr.texas.gov/midwives/midwives.htm [https://perma.cc/W6BJ-GL4C].

187. *See Rethinking the Infrastructure of Childbirth*, *supra* note 27, at 521.

188. Elizabeth Kukura & Nadia N. Sawicki, *From Constitutional Protections to Medical Ethics: The Future of Pregnant Patients' Medical Self-Determination Rights After Dobbs*, 51 J. L. MED & ETHICS 528, 531 (2023).

189. *See* Wendy Mariner, *'We See Pregnant Women Lose Their Right to Bodily Integrity'.*, BU SCH. PUB. HEALTH (Mar. 1, 2019), https://www.bu.edu/sph/news/articles/2019/we-see-pregnant-women-lose-their-right-to-bodily-integrity/ [https://perma.cc/8Y74-4LG9]; *see also* Lynn M. Paltrow & Jeanne Flavin, *Pregnant, and No Civil Rights*, N.Y. TIMES (Nov. 7, 2014), https://www.nytimes.com/2014/11/08/opinion/pregnant-and-no-civil-rights.html [https://perma.cc/HPA8-UBK5].

someone pursues demedicalized childbirth, they may be vulnerable to state scrutiny of their choices and subsequent punishment—whether after community birth with midwives or resulting from decision-making about medical intervention during hospital-based care. Being threatened with legal action, including child removal, or facing punishment for refusing an intervention or giving birth outside a hospital can lead to subsequent distrust of health care providers. Such distrust may prompt a patient to seek further demedicalization in future pregnancies, which can heighten the risk of state scrutiny and additional criminalization. Furthermore, when the criminalization of demedicalized choices leads to distrust in health care professionals, patients may forego care for other health conditions that would require interacting with the same types of physicians, nurses, and hospital administrators who initiated a punitive response previously.

Whether one's sympathies lie with the medical model of childbirth or efforts to demedicalize birth (or neither or both), it seems clear that the mutually reinforcing nature of the demedicalization-criminalization dynamic heightens the risk of harm. People who feel safest giving birth at home with a midwife but then find their choice criminalized— as the Jacksons did when the state deprived them of their newborn daughter—may experience trauma and other adverse health consequences. In situations where a newborn is removed from the family, interruption of breastfeeding, lack of maternal-infant bonding, and poor postpartum adjustment can have longer-term impacts on both parent and child. Likewise, in situations where punitive treatment by health care providers prompts patients to seek care elsewhere—or forego perinatal care entirely in a subsequent pregnancy—patients may be reluctant to reengage with mainstream medical providers if complications arise that necessitate medical intervention in order to protect the life and health of both the pregnant person and baby.[190]

For the Jacksons, being reunited with Mila after three weeks can seem like a victory at first glance, given the much lengthier separations some families experience before a legal determination is made that there was no harm to the child.[191] But this outcome is far from good news. Not only did the Jacksons endure trauma due to the loss of Mila and have their early postpartum bonding interrupted, but the state—with the assistance of the reporting physician—has signaled that it is skeptical of the choice to demedicalize birth, especially when exercised by Black women, who are already subject to heightened scrutiny of their reproductive decision-making. Potential criminalization for

190. *See* Whitfield-Anderson, *supra* note 113 (quoting National Black Doulas Association CEO Tracie Collins on child removal in circumstances like the Jackson family's: "This is trauma . . . This is only going to push [Black families] away from Western medicine.").

191. *See* Trivedi, *supra* note 112, at 561–62.

childbirth decision-making—and even just the threat alone—can cause significant harm to patients seeking demedicalized care.

V. CONCLUSION

Beyond the Jackson family's experience, it is important to understand what the relationship between demedicalization and subsequent criminalization reflects about the current landscape of reproductive health and reproductive rights. In the aftermath of *Dobbs*, as state restrictions limit reproductive autonomy and public awareness of reproductive control grows, this is a critical time to see—and challenge—the use of criminal law to constrain how people exercise autonomy in managing their reproductive health, whether in pursuit of parenthood or when looking to avoid having a child. While the surveillance and criminalization of certain conduct during pregnancy are not new phenomena, post-*Dobbs* legal changes mean that many more people are vulnerable to criminalization related to their reproductive health.[192]

In the United States, abortion has been medicalized and demedicalized to varying degrees throughout history, as changes in law, social norms, and the professional interests of doctors influenced where abortion care was provided, on what basis women could access abortion, and the rhetoric employed to describe acceptable use of abortion to manage reproduction.[193] As Halfmann notes, the medicalization and demedicalization of abortion throughout history sometimes occurred simultaneously. For example, in *Roe v. Wade*, the Supreme Court articulated a model for legal abortion with physicians playing a central role in abortion decision-making—a reflection of increased medicalization of abortion.[194] At the same time, in *Roe*'s parallel case *Doe v. Bolton*, the Supreme Court struck down Georgia's requirement that abortions be performed solely in hospitals with the approval of a hospital abortion committee, thus clearing the way for freestanding clinics to become the dominant site where people obtain abortion care—a example of the demedicalization of abortion in certain respects.[195]

192. *See* David S. Cohen et al., *The New Abortion Battleground*, 123 COLUM. L. REV. 1, 9–12 (2023).

193. *See* Halfmann, *supra* note 132, at 192–201 (identifying various instances of medicalization and demedicalization of abortion during key historical periods from 1860–1900 and 1960–73).

194. Roe v. Wade, 410 U.S. 113, 164–66 (1973) ("The abortion decision in all its aspects is inherently, and primarily, a medical decision, and basic responsibility for it must rest with the physician.").

195. Doe v. Bolton, 410 U.S. 179, 197–98 (1973); *see also* Halfmann, *supra* note 132, at 197.

Ever since *Dobbs* gave states the green light to pass criminal prohibitions on abortion, attention has focused on medication abortion.[196] Medication abortion enables access to care even where state law makes it illegal for physicians to perform abortions, while also increasing the challenge faced by abortion-hostile states that want to prevent people from accessing pills online and through the mail.[197] The availability of abortion pills—through telehealth, from online pharmacies that deliver by mail, and through informal channels, as well as through traditional prescription and provision at clinics—means that many more pregnant people can terminate a pregnancy outside of medical spaces and without the involvement (or with minimal involvement) by licensed health care providers.[198] To the extent that medication abortion enables self-managed abortion (SMA), it represents a form of demedicalization in reproductive health care.[199] SMA is threatening because it "positions women as persons with the knowledge and authority to make decisions about their own bodies, sexuality, and reproduction, which continues to be a contested claim even in contexts where abortion is legal."[200] To enforce an abortion prohibition under these circumstances, the state must extend the reach of the criminal law into people's lives—not just into their reproductive decision-making but also into private spaces of the home, where medication abortions often take place.[201]

196. *See* Cohen et al., *supra* note 26, at 353–57.

197. *Id.* at 38–39.

198. *Id.* at 11–14.

199. *See* B. Jessie Hill, *De-Medicalizing Abortion*, 22 AM. J. BIOETHICS 57 (2022); Nisha Verma & Daniel Grossman, *Self-Managed Abortion in the United States*, 12 CURRENT OBSTETRICS & GYNECOLOGY REPS. 70 (2023). The term "self-managed abortion" is imprecise, given that it may refer to different methods of obtaining abortion pills, to varying degrees of clinician involvement, or even to other methods employed to end a pregnancy, including self-harm, *see id.* at 70–71, an array of choices that may lead patients to experience abortion as a medicalized or demedicalized process. I use "self-managed abortion" here in a narrow sense to mean the termination of a pregnancy without physician or clinic involvement, such as obtaining pills through a website or through personal networks and completing the abortion at home, thus reflecting a version of demedicalized pregnancy termination.

200. *See* Braine, *supra* note 155, at 91; *see also* Nandagiri & Pizzarossa, *supra* note 156, at 4.

201. *See generally* Yvonne Lindgren, *The Doctor Requirement: Griswold, Privacy, and At-Home Reproductive Care*, 32 CONST. COMMENT. 341 (2017) (analyzing the privacy implications of reproductive health care at home, including under the Fourth Amendment protections against search and seizure).

Those who have historically experienced the brunt of pregnancy policing are people who use drugs during pregnancy, who disagree with their doctors and decline treatment, or who transgress norms of "good mothering," whether due to being poor or relying on public benefits, race or ethnicity, their youth, or their mental health status.[202] Since *Dobbs*, many people have learned that seeking abortion in certain jurisdictions could result in prosecution under new (or newly enforceable) criminal abortion laws.[203] Certainly, some jurisdictions had used existing laws to criminalize pregnancy outcomes before *Dobbs*, even in the absence of explicit criminal prohibitions on terminating a pregnancy; but enforcement of post-*Dobbs* abortion bans require more extensive pregnancy policing for states that want to ensure people are not circumventing the law by accessing abortion medication online, by mail, or through other informal channels. The demedicalizing of abortion makes other categories of people vulnerable to criminalization, as pregnant people who lose a wanted pregnancy through miscarriage or stillbirth may be investigated and prosecuted because someone in a position of medical or legal authority suspects them of having taken medication to induce an abortion.[204]

The expanding reliance on criminalization in response to the demedicalization of reproductive health care in both the abortion and childbirth contexts threatens a widening circle of people with punishment for their reproductive decision-making. In the post-*Dobbs* era, people who care about reproductive rights and justice must resist the demedicalization-criminalization dynamic in order to protect and promote reproductive autonomy for all.

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202. PURVAJA S. KAVATTUR ET AL., THE RISE OF PREGNANCY CRIMINALIZATION: A PREGNANCY JUSTICE REPORT (Sept. 2023); *see* Kukura, *Obstetric Violence*, *supra* note 183, at 738–50.

203. *See* Cohen et al., *supra* note 192, at 7; David Dayen, *The Inevitable Prosecutions of Women Who Obtain Abortions*, AM. PROSPECT (Jan. 16, 2023), https://prospect.org/health/2023-01-16-prosecution-women-mifepristone-abortion-alabama/ [https://perma.cc/EW73-YT3A].

204. *See* Robert Baldwin III, *Losing a Pregnancy Could Land You in Jail in Post-Roe America*, NPR (July 3, 2022, 5:27 AM), https://www.npr.org/2022/07/03/1109015302/abortion-prosecuting-pregnancy-loss [https://perma.cc/6U5Q-CNAN]; Devin Dwyer & Patty See, *Prosecuting Pregnancy Loss: Why Advocates Fear a Post-Roe Surge of Charges*, ABC NEWS (Sept. 28, 2022, 5:02 AM), https://abcnews.go.com/Politics/prosecuting-pregnancy-loss-advocates-fear-post-roe-surge/story?id=89812204 [https://perma.cc/CR64-EYE7]; Patrick Adams, *In Poland, Testing Women for Abortion Drugs Is a Reality. It Could Happen Here*, N.Y. TIMES (Sept. 14, 2023), https://www.nytimes.com/2023/09/14/opinion/abortion-pills-testing-poland.html [https://perma.cc/4X5Z-ZXHS].