Rights and Realities in U.S. Maternity Care

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Intro

The healthcare that women receive during pregnancy and childbirth implicates reproductive choice, bioethics, human rights, and feminism. The elimination of preventable maternal and neonatal mortality and morbidity requires not only that women can access skilled healthcare and emergency support for pregnancy, childbirth, and postpartum, but that the care women receive is culturally acceptable to them, and respects their dignity and autonomy. Women can experience labor and childbirth as a time of extreme vulnerability as well as extraordinary power. The way that they are treated during childbirth can amplify their vulnerability or their strength, and leave them feeling traumatized or empowered. In the last few years, grassroots groups in nations around the world have been organizing to speak out about pregnant people's experiences of maternal healthcare, catalyzing the emerging global recognition of the mistreatment of women in childbirth as a human rights issue.[1]

The recognition of preventable maternal mortality as a matter of human rights as well as public health led to the prioritization of maternal and infant health under the Millenium Development Goals, and investment in improving access to skilled health workers and emergency obstetric services, particularly in the developing world.[2] Yet without explicit recognition of the full range of human rights at stake in pregnancy and childbirth, including but not limited to the right to life and health, developing systems of care have implemented standards of practice that assume that the end goal of a live mother and live baby justifies the means by which that goal is achieved. The abuse and mistreatment of women in the process of facilitating a live birth is rendered invisible and irrelevant. In both developed and developing nations, systems of obstetric care have transformed in a generation, in a massive shift to pharmaceutically induced, augmented, and surgical deliveries. Women's options for supported physiological childbirth,[3] or even vaginal childbirth, have become limited in hospital settings.[4] Reports of forced interventions and abusive encounters with medical providers, and the political barriers to accessing midwifery support and safe out-of-hospital birth, are giving rise to an increasingly vocal feminist movement that calls for women's needs, rights and voices to be at the center of maternity care policies and practices.

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[1] World Health Org., *WHO Statement: The prevention and elimination of disrespect and abuse during facility-based childbirth*, 1 (2014); Bohren MA, Vogel JP, Hunter EC, Lutsiv O, Makh SK, Souza JP, et al. (2015) *The Mistreatment of Women during Childbirth in Health Facilities Globally: A Mixed-Methods Systematic Review*. PLoS Med 12(6): e1001847. doi:10.1371/journal.pmed.1001847

[2] Lozano R, Wang H et al. (2011) *Progress towards Millennium Development Goals 4 and 5 on maternal and child mortality: an updated systematic analysis*, The Lancet

[3] Gaskin, IM, *Ina May's Guide to Childbirth*, Bantam (2003)

[4] Leeman, L and Plante, L, *Patient Choice Vaginal Delivery?* Annals of Family Medicine, Vo. 4 No. 3 (2006)

Decision-Making in Childbirth

Many of the dysfunctions that women currently face in maternity care, including disrespect and abuse, could be eliminated through clarification that women's human rights are legal rights that remain in effect during pregnancy and childbirth. The right to autonomy, enshrined as informed consent and refusal, situates women as the central, authoritative decision-maker regarding their care, and yet this right is routinely ignored in maternity care. How much would change in the delivery room if it was understood by everybody present that nothing could be done to a birthing woman without fully and accurately informing her of her clinical condition, her healthcare options, and the risk and benefits of those options, and supporting her in making an uncoerced decision about how she wanted to proceed?[5] It would be transformative, in light of current dynamics in which women are told what is going to happen to them and showed where to sign, or not even told, but just acted upon, women have reported, like an "object" or an "animal."[6]

One in three women in the United States are now having their babies delivered by cesarean section. In the mid-1970s, the cesarean section rate was around 5%. There is no evidence that outcomes have improved as the result of obstetric culture's shift to the new era of surgical delivery, and in fact maternal mortality in the US is rising.[7] Cesarean section without a medical indication triples the mother's risk of dying in childbirth, and creates new forms of risk for her future pregnancies, including very serious conditions like placenta accreta.[8] The lowest cesarean section rates are reported for women who have prenatal care and good nutrition in pregnancy, integrated healthcare that includes both midwives and doctors, and continuous support through labor and birth.[9] The most significant variable that affects a woman's chances of giving birth by cesarean section is the hospital where she gives birth.[10]

A 2013 survey reported that 25% of women who had experienced an induction of labor or a cesarean section felt pressured to accept those interventions.[11] A 2014 study found that women who perceived pressure to have a Cesarean section were more than five times more

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[5] American Medical Association, *Opinion 8.08 – Informed Consent* (June 2006), http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion808.page?; American Medical Association, *Informed Consent* (Mar. 7, 2005), http://www.leg.state.nv.us/Session/77th2013/Exhibits/Senate/HHS/SHHS1054M.pdf

[6] Brief of Human Rights in Childbirth et al as *Amicus Curiae* in Support of the Plaintiff Rinat Dray, *Dray v. Staten Island Memorial Hospital*, Supreme Court of New York, Kings County, Index No. 500510/14. http://www.humanrightsinchildbirth.org/wp-content/uploads/2015/03/Amicus-Brief-Jan-2015.pdf

[7] Berg C, Callaghan W Et al., *Pregnancy Related Mortality in the United States, 1998-2005*, Obstetrics & Gynecology, Vol 116, Issue 6, p1302-1309; Blanchette, H, *The Rising Cesarean Delivery Rate in America: What Are the Consequences?*, Obstetrics & Gynecology, Vol 118, Issue 3, p 687-690 (2011).

[8] Digitale E, *Too Deeply Attached: The Rise of Placenta Accreta*, Special Report, Stanford Medicine, Fall 2013. http://sm.stanford.edu/archive/stanmed/2013fall/article4.html

[9] **The Farm Midwifery Center: Preliminary Report of 2,844 Pregnancies: 1970-2010,** http://www.thefarmmidwives.org/preliminary_statistics.html

[10] Haelle T, *Your Biggest C-Section Risk May Be Your Hospital*, Consumer Reports, April 13 2016

[11] Eugene R. Declercq, et al., *Listening to Mothers III: Report of the Third National U.S. Survey of Women's Childbearing Experiences*, Childbirth Connection, 35 (May 2013) [hereinafter *LtM III*], http://transform.childbirthconnection.org/wp-content/uploads/2013/06/LTM-III_Pregnancy-and-Birth.pdf.

likely to have a one, more than six times more likely to have one with no medical basis, and nearly seven times more likely to have an unplanned cesarean.[12] 59% of women who received episiotomies did not give consent at all.[13] Finally, 20-38% of women reported that the provider made the "final decision" about whether they would receive a planned cesarean surgery.[14]

Despite the commitment of the American College of Obstetricians and Gynecologists to supporting patient autonomy in childbirth, there exist significant gaps between the ethical principles expressed in their Ethics Committee Opinions and the way that informed consent plays out in reality.[15] This disconnect is fueled, in part, by providers' serious concern with perverse liability mandates that they fear make them legally vulnerable in the event that they support a woman's informed decision, but the birth results in a bad outcome.[16]

Reports on the role of liability pressure in obstetrics express a thematic assumption that providers can protect themselves from liability risk if they impose interventions, including cesarean surgery.[17] A liability rule that inclined doctors toward cesarean delivery might make sense if cesarean surgery carried no risks or costs, and vaginal birth were risky and dangerous. But that is not what the evidence shows. When cesarean surgery is medically needed, it can save lives. But when it is not needed, it carries a long list of risks and costs, including a significantly elevated risk of maternal death.[18] Women in US maternity care are giving birth in environments where providers claim that "liability" compels them to push for a surgical birth that happens to profit and convenience the hospital, but imposes risks on mother[19] and baby,[20]

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[12] Judy Jou et al., *Patient-Perceived Pressure from Clinicians for Labor Induction and Cesarean Delivery: A Population-Based Survey of U.S. Women*, Health Serv. Res. (Sept. 2014).

[13] *LtM III*, *supra* note 10, at 36.

[14] *Id.* at 38.

[15] American College of Obstetricians and Gynecologists Committee on Ethics, *Committee Opinion No. 664: Refusal of Medically Recommended Treatment During Pregnancy* (2016); American College of Obstetricians and Gynecologists Committee on Ethics, *Committee Opinion No. 321: Maternal Decision Making, Ethics, and the Law* (2005).

[16] Jeffrey Klagholz & Albert L. Strunk, *Overview of the 2009 ACOG Survey on Professional Liability*, 16 ACOG Clin. Rev. 13 (2009); Richard Hyer, *ACOG 2009: Liability Fears May be Linked to Rise in Cesarean Rates*, Medscape Medical News (May 20, 2009), http://www.medscape.com/viewarticle/702712.

[17] *See, e.g.*, Sakala, *Least Promising*, *supra* note 39, at e15.

[18] Catherine Deneux-Tharaux et al., *Postpartum maternal mortality and cesarean delivery*, 108 Obstetrics & Gynecology 541 (2006).

[19] *See* Henci Goer, *Do cesareans cause endometriosis? Why case studies and case series are canaries in the mine*. Sci. & Sensibility (May 11, 2009), http://www.scienceandsensibility.org/?p=147; Anne K. Daltveit et al., *Cesarean delivery and subsequent pregnancies*, 111 Obstetrics & Gynecology 1327 (2008).

[20] *See* James M. Alexander et al., *Fetal injury associated with cesarean delivery,* 108 Obstetrics & Gynecology 885 (2006); Anne K. Hansen et al., *Risk of respiratory morbidity in term infants delivered by elective caesarean section: Cohort study*, 336 Brit. Med. J. 85 (2008); March of Dimes, *Analysis shows possible link between rise in c-sections and increase in late preterm birth* (Dec. 16, 2008), http://208.74.202.108/24497_25161.asp.; Astrid Sevelsted et al., *Cesarean Section and Chronic Immune Disorders*, Pediatrics (2015).

up to and including the risk of death. Obstetric providers currently perceive a "liability" mandate that urges intervention and ignores informed consent and refusal, while failing to incentivize judicious decision-making or health care that optimizes maternal and infant health. Women are subjected to unnecessary surgical deliveries that increase the risks to themselves, their babies, and their future pregnancies, on the assertion that it would be too "risky" for providers or hospitals to support them in vaginal birth.

Obstetric providers recommend intervention on the basis of numerous non-clinical factors, including liability pressure and financial incentives; intervention rates therefore vary widely by provider. Empirical studies show - and doctors confess – that providers and hospitals steer women toward cesarean sections not only for clinical reasons, but also for non-medical reasons including financial gain, time convenience, and perceptions of liability pressure.[21] The fact that doctors perform unnecessary surgery for financial gain or time convenience does not prove their collective or individual moral turpitude, but rather their human response to economic incentives. When a provider decides whether to recommend an intervention for a given patient, financial considerations and time-convenience factors likely operate on a subconscious level. While higher costs and longer inpatient stays for surgical deliveries benefit hospitals more directly than individual doctors, these institutional economic forces can translate into imperatives that constrain doctors from providing individualized care, or into a medico-cultural argument that "this is the way we do it around here." On a macro level, these forces play out in significantly higher cesarean section rates in for-profit medical settings around the world.[22]

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[21] *See, e.g.*, Emmett B. Keeler & Mollyann Brodie, *Economic Incentives in the Choice between Vaginal Delivery and Cesarean Section*, 71 The Milbank Quarterly 365 (1993) (finding that pregnant women with private, fee-for-service insurance have higher C-section rates than those who are covered by staff-model HMOs, uninsured, or publicly insured); Jonathan Gruber & Maria Owings, *Physician Financial Incentives and Cesarean Section Delivery*, 27 RAND J. Econ. 99 (1996) (arguing that the 13.5% fall in fertility over the 1970-1982 period led ob/gyns to substitute from normal childbirth toward a more highly reimbursed alternative, cesarean delivery); H. Shelton Brown, 3rd, *Physician Demand for Leisure: Implications for Cesarean Section Rates*, 15 J. Health Econ. 233 (Apr. 1996); Joanne Spetz et. al, *Physician incentives and the timing of cesarean sections: evidence from California*, 39 Med. Care 535 (June 2001); David Dranove & Yasutora Watanabe, *Influence and Deterrence: How Obstetricians Respond to Litigation against Themselves and their Colleagues*, 12 Am. L. & Econ. Rev. 69 (2010) [hereinafter Dranove] (finding a short-lived increase in cesareans following the initiation of a lawsuit against obstetrician or colleauges); Lisa Dubay et al., *The impact of malpractice fears on cesarean section rates*, 18 J. Health Econ. 491 (Aug. 1999) [hereinafter Dubay] (finding that physicians practice defensive medicine in obstetrics, resulting increased cesarean sections).

[22] *See, e.g.*, Nathanael Johnson, *For Profit Hospitals Performing More C-Sections*, California Watch (Sept. 11, 2010), http://californiawatch.org/health-and-welfare/profit-hospitals-performing-more-c-sections-4069 ("women are at least 17 percent more likely to have a cesarean section at a for-profit hospital than at one that operates as a non-profit"); Elias Mossialos et al., *An Investigation of Cesarean Sections in Three Greek Hospitals: The Impact of Financial Incentives and Convenience*, 15 Eur. J. Pub. Health 288 (2005) ("[P]hysicians are motivated to perform CS for financial and convenience incentives."); Hannah G. Dahlen et al., *Rates of obstetric intervention and associated perinatal mortality and morbidity among low-risk women giving birth in private and public hospitals in NSW (2000–2008): a linked data population-based cohort study*, 4 BMJ Open e004551 (2014); Piya Hanvoravongchai et al., *Implications of Private Practice in Public Hospitals on the Cesarean Section Rate in Thailand*, 4 Hum. Res. Health Dev. J. (Jan.-Apr., 200-), *available at* http://www.who.int/hrh/en/HRDJ_4_1_02.pdf (concluding that care in a

Doctors' recommendations for intervention, including cesarean section, are colored also by their own perspective and values.[23] Studies show that obstetricians choose cesarean section deliveries for themselves in higher numbers than the general population,[24] and are more likely to undervalue physiological birth while considering cesarean delivery a good solution to "perceived labor and birth problems."[25] If providers believe that cesarean delivery is a good choice and vaginal birth is unnecessary and undesirable, their counseling of patients may be colored by the belief that the refusal of surgery is an unnecessary choice for the "procedure" of supported vaginal birth.

The multiplicity of factors that influence each obstetric provider's decision-making process are reflected in the significant variability of protocols and intervention rates across states, hospitals, and individual doctors. Studies show cesarean section rates ranging from 7.1 – 69.9% across U.S. hospitals.[26] These variations are not reflected in differences in maternal diagnoses or pregnancy complexity of individual patients.[27] Maternity care's variability of practice and ubiquitous overuse of interventions that benefit the provider at the patient's expense might reasonably lead an informed consumer to actively exercise her right to informed consent and refusal as she navigates the health care system. A birthing woman's legal right to authority in the decisions about her care is her only shield against variability and dysfunction in maternity care. All participants bring a constellation of issues, values, and experiences into their decisions, but informed consent and refusal means that the woman, like all health care patients, has the right to weigh all the factors at stake and make the final call. "Shared decision-making," though an admirable goal in the pursuit of patient-centered care, is misleading in its implication that the healthcare decision is shared. While the provider can share information, advice, and conversation with their patient, the decision about whether to accept a medical intervention belongs, legally, to the patient alone.

Just as providers and healthcare institutions bring a multiplicity of factors and priorities into shared decision-making, maternity care consumers make their healthcare decisions on the

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private hospital, which includes higher rates of intervention, associates with higher rates of neonatal morbidity and no evidence of reduction in perinatal mortality); Kristine Hopkins et al., *The impact of payment source and hospital type on rising cesarean section rates in Brazil, 1998 to 2008*, 41 Birth 169 (June 2014) (noting that publicly funded births in public and/or private hospitals reported lower c-section rates than privately financed deliveries in public or private hospitals).

[23] Cherniak D and Fisher J, *Explaining obstetric interventionism: Technical skills, common conceptualisations, or collective countertransference?* Women's Studies International Forum 31 (2008) 270-277.

[24] *See* Raghad Al-Mufti et al., *Obstetricians' personal choice and mode of delivery*, 347 Lancet 544 (Feb. 24, 1996).

[25] Michael C. Klein et al., *Attitudes of the new generation of Canadian obstetricians: how do they differ from their predecessors?*, 38 Birth 129-39 (June 2011).

[26] Katy B. Kozhimannil et al., *Cesarean Delivery Rates Vary Tenfold Among US Hospitals: Reducing Variation May Address Quality and Cost Issues*, 32 Health Aff. 527 (Mar. 2013).

[27] Katy B. Kozhimannil et al., *Maternal Clinical Diagnoses and Hospital Variation in the Risk of Cesarean Delivery: Analysis of a National US Hospital Discharge Database*, PLOS Medicine (Oct. 21, 2014), http://www.plosmedicine.org/article/info%3Adoi%2F10.1371%2Fjournal.pmed.1001745.

basis of many individual considerations and variables. Healthcare systems can expect that, given the diversity of cultural and religious values, financial circumstances, family support, and past experiences that each pregnant patient will bring to labor and delivery, they may see ten different women with similar clinical charts make ten different sets of choices with regard to pain relief, companionship for labor, induction, augmentation, or planned cesarean delivery. Decision-making in childbirth is more complex than it may be in some other areas of medicine, involving complex balancing of potential short and long-term risks, when it is often difficult to say with certainty whether an intervention is needed. The right to informed consent and refusal requires that systems anticipate the variability that women may bring to their decisions in childbirth, and be prepared to meet and support women's individual needs, instead of requiring women to compromise their right to be supported in their healthcare decisions by conforming to one-size-fits-all standards of care.

Human beings, like all mammals, need to feel safe in order to give birth.[28] The hormonal physiology, and the role of psychology, in labor and childbirth are not taught in medical or sex education, and are often unrecognized by the obstetric paradigm and therefore underserved and undervalued in facility-based birth. Childbirth as a physiological process is powered by hormones, including oxytocin, the hormone associated with love and human connection.[29] Those hormones are strongly affected by the birthing women's emotions, which are in turn affected by her perception of whether she is giving birth in a safe environment.[30] Women who give birth in circumstances that meet their mammalian needs for childbirth—circumstances that meet their needs for privacy and ensure that they feels safe, respected, and supported— have the best chance for an uncomplicated labor and birth.[31] In contrast, if a female mammal feels threatened, inhibited, or unsafe during labor, the release of adrenalin can slow or stop the progress of labor, giving rise to potentially dangerous complications.[32] After an un-medicated birth, mother and baby spike the highest level of oxytocin that the human mammal can produce, resulting in a feeling of bliss, euphoria, and love that ensures their bonding and the baby's survival.[33]

These facts about the psychology and physiology of childbirth cast the assumptions and practices of "normal" birth in the US and most of the world into serious question. Why do our obstetric systems of care ignore laboring women's mammalian needs, subjecting them instead to bright lights and many strangers? There is no reason why maternity care cannot be constructed in a way that meets each woman's needs to feel safe during birth. And yet, in systems around the world, women must sacrifice feeling safe, and even being safe, in order to access the safety that medical backup provides. Widespread reports of disrespect and abuse, dehumanized, traumatizing treatment, and violations of women's rights to privacy and dignity

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[28] Gaskin, IM, *Ina May's Guide to Childbirth*, Bantam (2003)
[29] Id.
[30] Buckley, S, *Hormonal Physiology of Childbearing: Evidence and Implications for Women, Babies and Maternity Care*, Childbirth Connection (2015)
[31] Id.
[32] Gaskin, IM, Id at 26.
[33] Id at 26 and 28.

show that women are giving birth in environments in which they cannot feel safe, because in fact, they are not safe.[34] In both the developed and developing world, some women avoid going to the hospital during childbirth, even if it is their only option for healthcare support, because they anticipate mistreatment or neglect.[35] As the risk of giving birth in the hospital rises, women are willing to accept a higher level of risk in giving birth outside the hospital, and women perceive disrespect and abuse as a salient risk factor.

The hormonal physiology of childbirth also suggests that a reason to pursue a normal physiological labor and birth isn't only to avoid unnecessary interventions and the risks they bear, but to access the physiological benefits of unmedicated childbirth. The postpartum spike of oxytocin, and the bliss described by women who give birth in circumstances that enable that spike,[36] suggest that giving birth without injections and intervention isn't just needless suffering and martyrdom, but holds a significant physiological reward that might even be critical to ensuring the strongest start to motherhood and avoiding postpartum depression.[37]

The history of obstetrics reveals that the protocols that many assume are necessary to safe childbirth, like giving birth on the back in stirrups, were not developed on the basis of women's needs. Women were put on their backs for the convenience of the provider, and on the basis of pre-feminist, colonialist assumptions that lithotomy was the position that "modest" women gave birth in, while only a "savage" woman would squat.[38] Obstetric technologies have evolved over time, from the common use of general anesthesia and twilight sleep to render women oblivious for delivery, to the age of the "awake and aware" epidural, planned surgical birth, and electronic fetal monitoring (EFM), but these technologies have generally been implemented without good evidence that they served mothers and babies or optimized healthy outcomes.

The universal use of EFM to monitor the baby's heart rate during labor is an example of how medico-legal dysfunctions operate to subject women to interventions without an evidence basis.[39] Despite consistent ongoing studies showing that EFM does not improve outcomes and triples the risk of cesarean section, EFM use has become ubiquitous in hospital settings, and many women are told that its use is "hospital policy" that they cannot refuse.[40] The imposition

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[34] Consumer-driven social media Break the Silence campaigns in the US and Italy: https://www.facebook.com/ImprovingBirth/photos/?tab=album&album_id=705655609507930; https://www.facebook.com/bastatacere/?sk=timeline&app_data.

[35] Abuya T et al, *Exploring the Prevalence of Disrespect and Abuse during Childbirth in Kenya*, PLOS One April 2015; Chattopadhyay S., *The Horrifying Sights and Sounds From the Labour Room of an Indian Public Hospital*, Quartz India June 11 2015; Freeze R, *Born Free: Unassisted childbirth in North America*, PhD (Doctor of Philosophy) thesis, University of Iowa, 2008. http://ir.uiowa.edu/etd/202.

[36] Gaskin, I.M., *Spiritual Midwifery*, Book Club Co., 4th Ed (2002)

[37] See e.g. Swain, J. et. al., *Maternal brain response to own baby-cry is affected by cesarean section delivery*, Journal of Child Psychology and Psychiatry 49(10) (October 2008)

[38] Murphy-Lawless, J, *Reading Birth and Death*, Indiana University Press (1999)

[39] Sartwelle, T, *Electronic Fetal Monitoring: A Bridge Too Far,* J Leg Med 2012 Jul;33(3):313-79; Block J., *Pushed: The Painful Truth About Childbirth and Modern Maternity Care*, Da Capo Press (2008)

[40] Dekker, R., *Evidence Based Fetal Monitoring*, July 17, 2012, Evidence Based Birth.

of EFM on birthing women is reinforced and justified by perverse liability incentives based on junk science and perpetuated by a multi-million dollar legal industry that profits from blaming cerebral palsy on the provider's failure to intervene and "deliver" the baby earlier.[41]

Only if courts hold providers liable for violations of women's right to informed consent and refusal in maternity care and, moreover, impose damage awards that recognize the individual and social significance of the harm, will doctor-patient dynamics in obstetrics be liberated from perverse incentives, and reorient toward woman-centered care. At the same time, with the consumer's right to informed consent comes responsibility for the decisions of care. Providers deserve assurance that their responsibility ends where the patient's rights begin. Legal reinforcement of informed consent and refusal must cut both ways: just as courts must find liability for violations of women's right to consent on the basis of information and advice, courts must also protect doctors and midwives from liability in cases where they are blamed for a woman's informed choice. Decisions that hold providers liable for a woman's informed decisions undermine the right to consent for all patients and leave doctors and midwives vulnerable for providing respectful support.[42] When practitioners share their knowledge of risks and benefits, and support women in the decisions at stake in their care, they must not later be found liable for the patient's decision on the theory that the patient lacked the expertise to assess and understand the risk, and shouldn't have been allowed to make the choice. Informed consent and refusal rests upon the assumption that, despite the esoteric nature of medical knowledge, ordinary people can assess their medical alternatives and make decisions about them—including the decision to go against their doctor's advice.

Reproductive Rights and Equality in Collaborative Maternity Care

Although the right of informed consent and refusal assures birthing people's rights to make the decisions about their medical treatment, and gives them the right to walk out of a hospital at any time, the right to say "no" doesn't ensure that active support that safe birth requires. The right to supportive healthcare for physiological birth, out-of-hospital birth, or even vaginal birth after cesarean, implicates the right to privacy and reproductive ethics.

In 2010, the European Court of Human Rights affirmed that the human right to private life includes the right to choose the circumstances of giving birth. In *Ternovszky v. Hungary*[43], the human rights tribunal made clear that this right includes the choice between giving birth with a midwife or with a doctor, at home or in the hospital. The Court held that governments violate this human right if they fail to regulate out-of-hospital birth in a way that legitimizes it as a healthcare choice and integrates it into the healthcare system, or if birth professionals cannot support women in their maternity care choices without fear of legal sanction. The birth professional with whom the mother in that case, Anna Ternovszky, fought for the right to give birth is Hungarian obstetrician-turned-midwife Agnes Gereb. Despite the Court's decision, the

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[41] Id.

[42] Steve Lash, *Hospitals: $20.6M Award Could Spur C-Sections*, The Daily Record (Dec. 7, 2014), http://thedailyrecord.com/2014/12/07/hospitals-20-6m-award-could-spur-c-sections/.

[43] *Ternovszky v. Hungary*, 67545/09, European Court of Human Rights, 2010.

Hungarian government kept Ms. Gereb on house arrest for three years for allegations associated with her support of out-of-hospital birth. The state finally released her under the strict condition that she was forbidden to talk to any pregnant woman.

The evidence is conclusive that achieving global targets for the reduction of maternal and perinatal mortality will require healthcare teams that include doctors, nurses, and midwives.[44] There is a growing call for, and movement toward, partnership and integration of midwifery and medicine in the care of pregnant women.[45] The picture of partnership and integration between medicine and midwifery is, however, a patchwork across Europe, across the United States, and around the world, in both law and practice. The maternity care systems with strong, supported midwifery professions that work with reliable backup from emergency obstetric providers have the lowest intervention rates and the best outcomes.[46] Systems without a supported midwifery profession, or where midwives' ability to provide midwifery care is severely circumscribed, increasingly resemble cesarean section assembly lines.[47] The human right described in *Ternovszky* is not yet a reality for most women around the world. On July 21, 2016, the Commissioner for Human Rights for the Council of Europe acknowledged receiving "disturbing reports of human rights violations in the context of maternity health care," and referenced both the *Ternovszky* holding and recent conclusions by the UN Committee on the Elimination of Discrimination Against Women (CEDAW) regarding the "need to ensure … respect for women's rights, dignity and autonomy during deliveries, expressing concerns in particular at reports that childbirth conditions and obstetric services unduly curtail women's reproductive health choices."[48]

Despite the best intentions of maternal health policy makers and providers to move toward the integration of midwifery in maternity care schemes and systems, such integration will be slow in coming without an overriding essential framework of equality and respect between the professions of medicine and midwifery. The fact that the idea of equality between doctors and midwives seems radical is a testament to how entrenched are the systems that have established medicine's dominance over midwifery. The current status of midwives, and

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[44] The Lancet Series on Midwifery, The Lancet, June 23 2014; National Institute for Health and Care Excellence. Intrapartum care for healthy women and babies. London (UK): National Institute for Health and Care Excellence; 2014.

[45] Int'l Federation of Gynecology and Obstetrics, Int'l Confederation of Midwives, World Health Organization et al., *Guidelines: Mother-Baby Friendly Birthing Facilities*, Int'l Journal of Gynecol & Obstet, 2015, 128:95-99; *Executive summary: Collaboration in practice: implementing team-based care.* American College of Obstetricians and Gynecologists. Obstet Gynecol 2016; 127:612-7.
Akileswaran C, Hutchison M, "Making Room at the Table. For Obstetrics, Midwifery, and a Culture of Normalcy Within Maternity Care," ACOG, Obstetrics & Gynecology; 2016.

[46] See The Lancet Series on Midwifery, Supra at fn44, and also "C-Section Rates "Vary Widely" Across Europe," BBC News, March 9 2015.; Daniel S., "Why Sri Lanka Beats India in Maternal Mortality Ratios," Al Jazeera, March 14 2016.

[47] "Greece Ranks First in the World in the Number of Cesarean Births,"GR Reporter, Dec 8 2011; Barros A, Santos I et al., "Patterns of deliveries in a Brazilian birth cohort: Almost universal cesarean sections for the better off," Rev Saude Publica, 2011 Aug; 45(4): 635–643.

[48] *Muižnieks N, "Protect Women's Sexual and Reproductive Health and Rights," The Commissioner's Human Rights Comments, Council of Europe, July 21 2016, http://www.coe.int/en/web/commissioner/-/protect-women-s-sexual-and-reproductive-health-and-rights*

the relationships between medicine and midwifery that underlie integration, cannot be understood without recognizing the systemic inequality between obstetric medicine and midwifery, awareness of its historical roots, and a commitment to dismantling that inequality[49] Whether women start birth with a midwife or with a doctor, they need access to emergency obstetric services in the event an emergency arises. Obstetric medicine has used its power to give or withhold emergency services to gain a monopoly over maternity care and to maintain dominance over midwives.

Since time immemorial, women have attended each other in childbirth. Some women developed such skill and expertise that they became the community midwife. Midwives often were the first line of healthcare for the community and tended to the full spectrum of women's reproductive healthcare needs. [50] Midwives held the knowledge of the local herbs and culturally rooted practices associated with fertility, healing, promoting health, and with minimizing the risk of pathology. It was for their knowledge of the herbs for contraception and abortion that midwives were defined as the primary target for the European witch hunts.[51] The torture and execution of midwives over three centuries led to the loss of that knowledge, and a population explosion that fueled many wars and the colonial settlement of the "New World."[52] With the midwives' knowledge of contraception went their knowledge of female sexuality and gynecology, including how to support women in childbirth. After the witch hunts, male doctors stepped in to attend women in childbirth, at first only in emergency cases, but then as the main providers for childbirth, a shift "promoted by the authorities but disliked by women."[53]

> "Up to the late 14th century midwives were entitled to practice without regulation. From this time onward [they] were downgraded from qualified and independent female healers… to mere assistants of the physician [who was] lacking any experience in obstetrics because through the Middle Ages no male was allowed to practice in gynecology."[54]

Despite the knowledge and skills that traditional midwives have always used to serve their communities, there were medical emergencies that could arise in childbirth that they could not solve. Antibiotics, anti-hemorrhagic medicine, assisted and surgical deliveries, and other medical technologies can prevent many of those deaths, and access to such technologies has saved many lives and massively reduced maternal and neonatal loss since their invention. But the terms on which these tools were offered to women, in the U.S. and many other places, created new forms of risk as all women were asked to place themselves in the care of medical professionals for pregnancy and birth, whether or not they needed medical treatment.

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[49] Fisch D, "Separated At Birth: A Historical and Legal Analysis of U.S. Birth Places and Attendants," Regents of the University of Michigan 2012.

[50] Ehrenreich B, English D, *Witches, Midwives and Nurses: A History of Women Healers*, The Feminist Press at CUNY, 2nd ed 2002

[51] Heinsohn G, Steiger O, "Witchcraft, Population Catastrophe and Economic Crisis in Renaissance Europe: An Alternative Macroeconomic Explanation," University of Bremen Discussion Paper, 2004

[52] Id, p.25.

[53] Id, p.23, and see also Ehrenreich B, Id at fn 51

[54] Id. p.22

In the U.S. and other industrialized nations, state authorities have worked in partnership with medical associations to drive the female population to give birth in hospitals, under the care of doctors.[55] Midwives were often disempowered both as professionals and as citizens, not only on the basis of sex, but also race, immigration status, or caste, in different combinations in different places and times[56]. After black midwives safely delivered generations of babies from both enslaved and free women in the United States, they were degraded through racist propaganda schemes to move women into the hospital, even as women of color in the U.S. had insecure access to hospital care.[57]

Although the subjugation and elimination of midwifery were historically built upon sex inequality, racial inequality, class and caste inequality, and colonial power, like most systems of domination and inequality, it eventually became primarily about capital. Obstetric medicine is a multi-billion dollar industry whose stakeholders include not only providers and hospitals, but pharmaceutical, insurance, and technology industries.[58] After generations of medical monopoly over childbirth, providers and the general public consider it obvious that doctors are superior to midwives, and should have the authority to determine when and how midwives will practice. Many people think that being cared for by a doctor is better than being cared for by a midwife, because that's what they've been always been told. In many places, people don't even know what a midwife is, or think that midwives are from "olden times," and this did not happen by accident.

In the last forty years, midwifery has re-emerged as a profession, in places where it had disappeared.[59] Regardless of how they are trained and where they work, midwives face powerful structural and systemic barriers to practice and integration. Doctors decide if they are allowed to practice in the hospital and if so, how they practice.[60] The state decides if they are allowed to practice outside the hospital, and often regulates their practice in a way that imposes medical standards on them and prevents them from providing evidence-based and culturally competent midwifery care that upholds their client's human rights.[61] In some places, midwives are still fighting for recognition that midwifery is even a profession.[62] Everywhere, midwifery is underfunded, and in many places, financially unsustainable. Underlying many of the ways that inequality can manifest is that hallmark of discrimination: Disrespect. When

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[55] Fisch D, "Separated At Birth: A Historical and Legal Analysis of U.S. Birth Places and Attendants," Regents of the University of Michigan 2012.
[56] Sadgopal M, "Can Maternity Services Open Up to the Indigenous Traditions of Midwifery?" Economic & Political Weekly Vol. XLIV 16, April 18, 2009.
[57] https://awakenmichigan.org/publications/graphic-and-fact-sheet-u-s-midwives-now-you-see-em-now-you-dont/
[58] Wagner M, *Born in the USA: How a Broken Maternity Care System Must Be Fixed To Put Women and Children First*, University of California Press (2008)
[59] See International Center for Traditional Childbearing, https://ictcmidwives.org/; Kline W, "Communicating a New Consciousness: Counterculture Print and the Home Birth Movement of the 1970s," Bulletin of the History of Medicine, Vol 89, 2015.
[60] Pascucci C, "Why Are We Asking Doctors If Women Should Have Midwives?" http://birthmonopoly.com/midwives/ Dec 19, 2014.
[61] Lusero I, "Making the Midwife Impossible: How the Structure of Maternity Care Harms the Practice of Home Birth Midwifery," 35 Women's Rights L. Rep. 406, 2014.
[62] http://pushformidwives.nationbuilder.com/cpms_legal_status_by_state

medical providers and systems assert dominance over midwives and midwifery, they treat them with disrespect. Not listening, condescending, dismissing, and talking down or rudely to people are all ways of expressing discrimination and disrespect.

What does collaboration based on equality look like, in relations between medicine and midwifery? It looks like mutual respect. In practice, it means that doctors and midwives recognize and respect each other's knowledge and expertise, remain in dialogue to better understand and learn from each other, and have equal voices at the table about maternity care policy. In law, equality requires the recognition of midwifery as an independent and valuable reproductive healthcare profession, and midwives as the authorities in their own standards of care. It also requires subjecting doctors and midwives to fair and equal legal oversight, and acknowledging the role that the law has played historically in marginalizing midwifery and giving medicine a monopoly over maternity care. In finance, equality looks like valuing midwives' role in maternal healthcare, and making sure that midwives and free-standing birth centers get paid as doctors and hospitals do.

The recognition of doctors and midwives as equal and complementary partners in reproductive healthcare would require respect for their relative fields of expertise. Midwives are the experts in physiological birth. Their training teaches them to work with the female body to help women give birth to their babies. As obstetric medicine increasingly relies on surgical delivery, midwives are often the only maternity care providers a woman can find who know how to support vaginal birth, let alone physiological birth, especially in the case of breech or twin deliveries.[63] Doctors' expertise focuses on using medical technologies and treatment to fight pathology and manage medical crises. Medical providers go to school for a long time to learn the complexities of pharmacology and the intricacies of surgery. However, in years of education and residency, an obstetrician might not learn how to support physiological childbirth. Modern obstetric doctors and nurses openly acknowledge that they may never see a woman give birth without intervention in either training or practice, let alone support a physiological breech birth.[64] Improved collaboration between doctors and midwives could operate not only to facilitate continuity of care, but can increase knowledge transfer and supported choices for women between planned cesarean delivery and vaginal or physiological birth.

Building respect and equality between medicine and midwifery will require investing in communication and building relationships. In order to evolve toward collaborative care teams, maternity care providers must prioritize time to simply sit and talk, with open ears and mutual respect, not only within collaborative hospital teams, but between the providers who work in hospitals and the providers who serve women to give birth at home, in birth centers, or in rural clinics. The quality of communication and trust between these professionals determines whether critical collaborative care moments go well or go poorly, and in an obstetric emergency, this can mean the difference between life and death. Integrated maternity care

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[63] Louwen F, Daviss BA et al., "Does breech delivery in an upright position instead of on the back improve outcomes and avoid cesareans?", Int J Gynecol Obstet 4 Nov 2016 Accepted Author Manuscript. DOI:10.1002/ijgo.12033 ,
[64] http://www.thebusinessofbeingborn.com/

systems promote mutual respect between doctors and midwives as collaborative professionals, which enables the transparency and continuity of care necessary to optimizing safety and quality of care.[65]

The need for integration based on equality is urgent, as perinatal studies for out-of-hospital birth have made clear that the systems that fail to respect the human right expressed in *Ternovszky* do not prevent the perinatal deaths associated with home birth, they cause them. In the maternity care systems that respect and integrate midwives and uphold women's human rights in childbirth, planned home birth is as safe as planned hospital birth.[66] In the systems where medicine still has a monopoly hold over childbirth and has failed to integrate midwifery, and the state enforces the status quo instead of women's human rights, the result is preventable perinatal mortality for out-of-hospital birth.[67] The only ethical and professionally responsible conclusion to draw from studies showing higher perinatal deaths in non-integrated systems is to work to improve integration, not to work to drive out-of-hospital birth and midwifery further underground.[68] Marginalizing midwifery and out-of-hospital birth as illegitimate, underground healthcare choices is unethical and irresponsible as a policy or a practice.[69] It is well known that it doesn't work to tell women that they are "not allowed" to make personal reproductive healthcare choices.[70] Women make their reproductive choices for reasons that are unique to their own circumstances and history, whether the "authorities" like those choices or not. When the state supports medical monopoly over childbirth by driving midwives underground or refusing to recognize out-of-hospital birth, or when states subject out-of-hospital midwives to unique legal persecution, the result is

- a lack of transparency between doctors, midwives, and their clients during prenatal care,
- a lack of transparency and communication between midwives and their backup professionals during labor,
- emergency medical services that lack the training and equipment for home birth transfers, but don't respect the midwives enough to let them help,

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[65] Ternus-Bellamy A, "Sutter Davis Birthing Center Boasts Lowest C-Section Rate in State," The Davis Enterprise, July 10 2016.

[66] De Jonge A, Geerts CC, Ven Der Goes BY et al., "Perinatal Mortality and morbidity up to 28 days after birth among 743,070 low-risk planned home and hospital births: A cohort study based on three merged national perinatal databases. BJOG. 2014; 122:720-728; Birthplace in England Collaborative Group, Brocklehurst P, Hardy P, et al. Perinatal and maternal outcomes by planned place of birth for healthy women with low risk pregnancies: The Birthplace in England national prospective cohort study. BMJ. 2011;343:d7400; Jannsen PA, Saxell L, Page LA, et al., "Outcomes of planned home birth with registered midwife versus planned hospital birth with midwife or physician, CMAJ. 2009; 181:377-383.

[67] Wax JR, Lucas FL, Lamont M, et al. *Maternal and newborn outcomes in planned home birth vs planned hospital births: a metaanalysis.* Am J Obstet Gynecol 2010;203:243.e1-8.**;** Snowden JM, Tilden E, Snyder J et al. Planned out-of-hospital birth and birth outcomes. N Engl J. Med. 2015;373:2642-2653.

[68] Tilden E, Snowden J, Caughey A et al, "Making Out-of-Hospital Birth Safer Requires Systems Change," Medscape, May 19 2016

[69] Chervenak F, McCullough L, *Planned home birth: the professional responsibility response*, . Am J Obstet Gynecol, 2013, Volume 208, Issue 1, 31-38.

[70] Haddad L, *Unsafe Abortion: Unnecessary Maternal Mortality*, Rev Obstet Gynecol, 2009 Spring; 2(2): 122–126.; Rosenthal E, *Legal or Not, Abortion Rates Compare*, NY Times Oct 12 2007

- communication breakdowns between midwives and hospital staff during transfer, and even
- punitive neglect of the birthing women who transfer in from midwifery care,

all of which predictably lead to perinatal, and even maternal, deaths that could have been prevented with timely medical treatment. Because violating *Ternovszky* causes perinatal death, rather than preventing it, no state government can legitimately claim that it optimizes public health by failing to integrate out-of-hospital birth. As an attorney working on cases involving home births, I have seen a pattern of cases in which preventable deaths occurred as a result of these factors of non-integrated care. In each case, the blame and fallout for these dysfunctions was laid squarely on the shoulders of the midwives. Focusing blame on the midwife diverts attention from the system dysfunctions and power dynamics that cause the bad outcomes. Systemic issues are sidelined, and the career and skills of another experienced provider are laid to waste.

It is time to put an end to the hierarchical, monopolistic maternity care systems that were constructed on socially and economically discriminatory systems of sex, race, caste, and of colonial oppression. These systems, and the millions of unnecessary surgeries currently imposed on birthing women, do not optimize maternal and newborn health. Integrated systems with strong midwifery professions as the first line for maternity care, in partnership and with reliable backup from medical professionals, are the most effective, and most efficient, strategy for optimizing the health of mothers, babies, and communities.[71] Healthcare systems are shifting from the old hierarchical models toward "team-based," "patient-centered" care, which is often called "woman-centered care" in the maternity context.[72] This shift reflects a movement away from the vertical model of care, in which doctors were at the top, and everybody else (including the patient) was below them, to a model in which the patient is at the center of a team of care providers, who are working on a horizontal plane, as equal and complementary partners, to provide care as needed for each individual. This transformation is achievable, but only with recognition of the role of power and entrenched inequality in the construction and dynamics of the current system.

Two Maternity Care Paradigms: US and The Netherlands

There is more than one way to understand childbirth, to approach it as a healthcare event, and to experience it as a birthing woman. I discovered this in 2007 when I moved from the United States to the Netherlands, when I was pregnant with my first child. The Dutch maternity care system developed on the model that childbirth is a normal physiological event, with the potential to become pathological or to require medical treatment in some cases. This paradigmatic concept of childbirth contrasted with the model of childbirth on which US maternity care was developed. US healthcare has long framed pregnancy and childbirth as medical events by definition, in which pathology is anticipated and can only be safely avoided

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[71] Daniel S., "Why Sri Lanka Beats India in Maternal Mortality Ratios," Al Jazeera, March 14 2016.
[72] Shah N. A NICE delivery—the cross-Atlantic divide over treatment intensity in childbirth. N Engl J Med 2015; 372:2181-3.

or treated through medical management and delivery.[73] The Dutch concept of childbirth as a normal physiological event gave rise to a strikingly different 20th century maternity care system, in which healthy women gave birth with midwives, usually at home, and were referred to doctors and hospitals only in the event that a medical issue arose during the pregnancy or labor. The Dutch system therefore maintained a strong, independent, well-trained midwifery profession, that has always worked in collaborative partnership with medical providers to serve the birthing population. In the United States, the American Medical Association conducted a concerted publicity campaign in the early 20th century to eliminate midwifery as a profession, and to put all women under the care of doctors, in hospitals, for childbirth.[74] Childbirth was framed as an event that is pathological in nature and that requires medical intervention—including pharmaceuticals, episiotomies, and instrumental deliveries— even in normal labors.[75] While healthy Dutch women were giving birth at home with midwives, and Dutch doctors were using their skills on the cases that required medical expertise, healthy US women were giving birth under general anesthesia or "twilight sleep," were routinely subject to instrumental deliveries, and were separated from their babies while they recovered from anesthesia and regained consciousness.

Despite the success with which Americans were convinced that giving birth at the hospital was itself critical to safe delivery and good outcomes, the Dutch home birth system has always had better birth outcomes than the US hospital birth system.[76] As the US model was exported to every other developed nation as authoritative and modern, the Dutch system has stood as an indictment of the narrative that hospital birth for all women is necessary to public health and safety. When a European study of perinatal outcomes in 2004, Peristat, indicated that the Netherlands ranked near (but not at) the bottom compared to 29 European nations, hospital birth proponents quickly and vocally declared that the home birth system was responsible for these outcomes. Dutch researchers then conducted the largest home birth study of all time, of over half a million births, to determine whether home birth was affecting its perinatal outcomes. The study proved conclusively that planned home birth, in the integrated Dutch birth system, had equal perinatal outcomes compared to planned hospital birth.[77] Further studies indicated that the causes of the Peristat rankings had more to do with differences in the point at gestation when the Dutch system would implement care for extremely premature babies, so that if 24 or 28 weeks were taken as the baseline instead of 22 weeks, the disparities disappeared. The next Peristat study in 2010 showed the Dutch outcomes to have moved toward the middle compared to other European nations. Nevertheless, media articles had so persistently and effectively drawn a link between Dutch perinatal outcomes and its home birth system that the Dutch home birth rate has fallen

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[73] See Block, J, *Pushed*, Supra, at fn37
[74] Id.
[75] Arnold, J, *Joseph Bolivar Delee and the Prophylactic Forceps Operation*, The Unnecesarean, Dec 6 2009.
[76] Infant Mortality Per Thousand Live Births in Six Countries, 1960-2008, OECD Health Data 2011. ; Infant mortality rates (number of infant deaths per 1,000 live births) in 2008 in selected OECD member countries. *Source*: OECD Health Data 2010 (April 2011 version) and WHO Global Health Observatory 2011. http://www.mdpi.com/1660-4601/10/6/2296/htm
[77] **de Jonge A et al.** ***Perinatal mortality and morbidity in a nationwide cohort of 529 688 low-risk planned home and hospital births.*** **BJOG 2009 10.1111/j.1471-0528.2009.0217**

significantly, and many people both within the Netherlands and abroad have the inaccurate impression that "studies show" that Dutch home birth kills babies.[78]

Until recently, the majority of Dutch women gave birth at home. Since the media campaign following Peristat, the percentage has fallen to somewhere between 15 – 25%, but this number still reflects hundreds of thousands more babies born at home than any other nation. If home birth increased the risk of perinatal death by three to ten times, as US obstetricians have asserted, the Netherlands would have long been famous for having many thousands more perinatal deaths than any other nation. Discussions of Peristat and its implications, which turn on the outcomes in 2-4 births per 1000, obscure this basic fact.

As a pregnant American woman planning to give birth in the Netherlands, I had a supported healthcare choice to give birth at home or in the hospital. If I chose to give birth at home, my mainstream health insurance company would not only pay for that choice, but would mail me a box of home birth supplies. I could rely on open, respectful communication between my midwife and the medical providers on whom I might have to rely if a medical problem arose. During my prenatal care, my midwife and our medical backup team would share records and plans transparently, and could get on a call and discuss how to collaboratively resolve any issue with my care in order to maximize safety for my baby and myself. I knew that if I needed to transfer to a hospital during labor, the ambulance services would be trained and equipped for assisting a woman in labor or postpartum, or for providing emergency care to a neonate. I didn't have to fear that hospital providers would impose their moral opprobrium for my choice to give birth at home by neglecting me, ignoring me, or mistreating me, or by refusing to work with my midwife. All of these factors, which come down to the willingness of the healthcare system and the medical profession to support and legitimize women's reproductive healthcare choices, are critical to ensuring safety for out-of-hospital birth. Because the Dutch maternal healthcare system had no political or economic investment in protecting a medical monopoly over maternal healthcare, I could safely choose to give birth at home, with a midwife.

Within a system that enabled the healthcare support for a free choice between giving birth at home or in a hospital, with a doctor or with a midwife, I could explore the clinical reasons for each choice. Like most women, my goal for the birth was to maximize my chance for a healthy outcome for my baby and myself. I wanted to give myself the best chance for a normal physiological birth, while ensuring that medical treatment would be available if the need for it arose.

I was privileged to receive consistent prenatal care and enjoy good nutrition during my pregnancy in the U.S. and after my move to the Netherlands, seven months into my pregnancy. Which of my healthcare options for labor and delivery would maximize my goal for a healthy, safe birth? While some women would feel safer laboring in a hospital, I anticipated that I would personally feel more relaxed in my home environment. In order to attempt an unmedicated birth, I would need to be able to move, vocalize, and behave as my body dictated during the birth. I knew that I would be less inhibited to do those things in my home, with a

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[78] Devries, R and Buitendijk, S., *Science, Safety and Place of Birth: Lessons from the Netherlands*

midwife I knew and trusted, than in a hospital room with on-call nurses and doctors. I wanted to avoid the imposition of EFM and its associated risks, and to minimize my risk of an unnecessary cesarean section. I would not mind having a cesarean section, or any other intervention, if it was necessary for my baby or myself, but I would mind having a cesarean section that I didn't need.

I gave birth at home with the support of my midwife, Laura van Deth, in 2007, and then again in 2010. In both of these births, my midwife offered me individualized support to overcome complications that could easily have resulted in cesarean sections in a hospital setting. Both times, I gave birth in the circumstances that I, personally, needed, including immersion in warm water that supported my body through the movements of labor and supported my perineum so that I didn't tear. My midwife handed my baby to me even as she supported it coming out of my body, and was peaceful and quiet around the baby, myself, and my husband as we all gazed on each other for the first time. I experienced the oxytocin bliss that I first read about in Ina May Gaskin's books[79]. The undisturbed minutes after the birth created a sacred memory for our family, and a peaceful initiation into life for my baby, and into parenthood for myself and my husband. Although I could have relied on the medical system to support us if we needed to transfer, we didn't need to go to the hospital during the labor or afterward. We got into bed and rested.

After the birth, I received another normal service of Dutch maternity care: a full time post-partum support nurse, in my home, for at least 8 days after the birth, and up to two weeks if the birth is complicated by something like a cesarean section or twins. This *kraamverzorgster* is a nurse who monitors the mother's recovery, measuring her fundus, checking her perineum, and charting her temperature, and also monitors the newborn, charting their conditions in a little book that they can share with their doctors and keep as a record of the postpartum period. She makes sure the mother is drinking and eating, grocery shops, cooks, and cleans—not only laundry and keeping things tidy, but disinfecting the toilet and shower and making the bed up fresh every day. The *kraamverzorgster* teaches a first-time mother everything about caring for a newborn, letting me lie in bed and watch her as I rested the day after the birth, and then adding one new thing that I could do myself, like hold the baby while bathing him without dropping him, until the last day I was doing it all, and she was watching me. As she did all these things for me, I wondered what my friends in the U.S. were supposed to do without such thorough postpartum support—or in many cases, any support at all? How are women without postpartum support supposed to learn all the things about newborn care that my *kraamverzorgster* had taught me—watch a Youtube video? Why wasn't post-partum care part of what they could expect from their healthcare system?

The cost of my home birth and 8 days postpartum support in the Dutch birth system—which was fully covered by mainstream health insurance, with no co-pays for our family—was around $7500. The cost of a vaginal hospital birth in the U.S. that left a woman with stitches and no postpartum support was usually at least twice that, and cesarean sections more

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[79] Id fn 26 and Gaskin, IM, *Spiritual Midwifery*, Book Pub Co, 4th Ed (2002)

expensive than that.[80] Maternal healthcare that meets the real physiological needs of women for labor and postpartum support is not an unaffordable luxury. It is a necessity that women have the human right to expect their healthcare system to be equipped to provide.

The radical implication of *Ternovszky* was that it required the state to dismantle legal and systemic inequality between medicine and midwifery, and to restrain medical monopoly over maternity care. Given the centuries that went into constructing the status quo of that monopoly, it is not surprising that this human right is not yet a reality. Similarly, the power dynamics in place between birthing women, providers, and medical institutions that undermine woman-centered care and informed consent and refusal are based on long histories of inequality, and are currently held in place by powerful economic forces. The human rights framework demands that entrenched systems built on human rights violations realign, or even dismantle, if necessary to fulfill the human right. Governments are obliged to move toward more perfect recognition and protection of human rights, even when doing so is inconvenient to prevailing interests. The evolving global awareness of human rights in maternal healthcare holds the potential to direct a new approach toward eliminating existing dysfunctions and optimizing the systems of support in place for pregnant women and babies.

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[80] Truven Health Analytics Marketscan Study, “The Cost of Having A Baby in the United States,” Truven Health Analytics, January 2013.