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Over-Medicalization and Criminalization of Birth In the United States: Exploring the Outcomes

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Abstract

This paper will examine the effects that over-medicalization and criminalization have had on the state of giving birth in the United States. It will attempt to offer insight on why the United States ranks near the bottom of countries that are considered "developed" in maternal mortality rates and infant mortality rates, despite spending the highest percentage of gross national product on health care. The paper will analyze: the history behind the medicalization of birth in the United States, different methods of over-medicalization, the impacts of unnecessary medical interventions, different incentives driving medicalization, the history of criminalization of pregnant women, the State intervention of women who are suspected of using illegal drugs while pregnant, narratives centered around the topic of medicalization and criminalization of birth and the pregnant body, and potential avenues for change to curve the over-medicalization and criminalization of birth. By examining these aspects of birth in the United States, it will provide insight into the adverse effects that many of these policies and practices are perpetuating. It will also demonstrate the need for change in the way that birth and pregnancy is viewed. It should be noted that these are not the only contributing factors that explain the state of giving birth in the United States, but what has been selected to be the primary focal points examined in this paper.

The History of Medicalization in the United States

The medicalization of birth in the United States has had several positive effects on birth outcomes. This paper will not be arguing that medicalization of birth is devoid of all benefit, instead it will focus on how the birth process has become technocratic and over-medicalized, to the point of producing adverse effects. There are times where medical interventions are completely necessary, however, the frequency of unnecessary medical interventions in the United States is rising. To understand the adverse effects that medicalization has on birth in the United States it is first important to understand the difference between medicalization and over-medicalization.

Medicalization, as defined by Emilia Kaczmarski, is "interpreting newer and newer aspects of reality, including human behavior, in medical terms, and treating them as medical problems rather than e.g. social, political or existential ones" (Kaczmarek, 2019). Therefore, according to definition, medicalization has occurred in the process of birth; a process once viewed as a physiological process or event, and something that occurred at home, has largely shifted to be viewed as a condition in need of treatment in a hospital. According to Kaczmarek, care can be deemed as over-medicalization when it leads to an "inadequate response to a problem means, first and foremost, unnecessary clinical interventions, which always entail certain health risks" (Kaczmarek, 2019). This is why I will argue that birth has not only been medicalized in the United States, but that it has become over-medicalized. The rates of medical interventions occurring in the United States are causing adverse effects.

Previously in the United States, before birth entered the hospital in the early 1900s, birth was seen as a process that was physiological. In 1900, about 5% of women gave birth in hospitals

(Suarez, Women's health and social control 10/30), meaning that most births were occurring at home with a midwife or with family members. This dynamic changed when male midwives became a profession; to give birth with the assistance of a male midwife, even though most had little hands on experience, was perceived as a marker of status. During this time period, giving birth in the hospital, specifically maternity hospitals, was viewed as a dangerous experience and was considered a last resort for many. Typically, maternity hospitals were only used by single, young mothers, and had very poor outcomes. In 1883, in Boston, 75% of patients presented with fever when birthing in hospitals due to dirty hands and tools, a rate which did not improve until the 1930s (Suarez, Women's Health and social control 10/30). Despite these risks, birth started moving to hospitals, because the viewpoint around birth and delivery had shifted. It became a demonstration of status to give birth in a hospital. By 1940, half of all births were occurring in hospitals, even though the cost of delivery in a hospital ranged from a quarter to one-third of a middle class income (Suarez, Women's Health and Social Control 10/30). This shift from the home to the hospital changed the process of giving birth in the United States permanently.

This shift in the way that people gave birth can largely be attributed to the standardization of delivery, which was a result of Dr. DeLee, a prominent obstetrician in the 1920s. He stated that labor was "pathogenic, meaning unhealthy, a procedure to be directed by a woman's physician. This was the philosophy of active management, and it shaped maternity care in the twentieth century" (Block, 2008, p. 21). Dr. DeLee started the wave of medical interventions and standardization of birth that is still in place in many hospitals today. He created the idea that childbirth should be viewed "as a procedure, an emergency rather than an emergence. If obstetricians were to be the legitimate providers of care in normal birth, birth could no longer be considered normal" (Block, 2008, p. 216). This meant that if labor was not occurring in a certain

amount of time, it should be induced, typically leading to additional, and what would otherwise be considered unnecessary, medical interventions. Labor induction has become standardized for a variety of reasons, including the decreased amount of birth time and the increased profits associated with the administration of a variety of pharmaceuticals.

Labor Induction

There has been a rise in the number of medical interventions since the 1990s. There are times in which medical interventions are lifesaving, when it is truly an obstetric emergency requiring professional medical care, however, they are oftentimes overused. A key component leading to the over-medicalization of birth in the United States is labor induction, which can result in unintended side effects for both mother and child. The observed uptick in rates of labor induction can be attributed to overall decreased labor time for hospitals, the ability of physicians to have more control over the labor, increased profits for obstetricians and hospitals, and obstetricians' convenience. Medical induction of labor has become standard protocol in many hospitals across the United States, however, inductions begin a cascade of interventions. Labor induction should not be viewed as an isolated act. The act of "inducing labor increases the odds of an emergency cesarean section, along with its attendant risks, without improving fetal outcome" (Block, 2008, p. 10). So why has there been an increase in labor inductions in the United States despite the known consequences?

The rate of medical inductions has "more than doubled between 1991 and 2006, from 10.5% to 22.5%," and coincided with a "13% increase in preterm births between 1991-2006" (MacDorman et al., 2010). A study was conducted on the correlation between preterm births and how they relate to medical inductions and C-sections. Preterm births have been identified as a

major risk, “because rates of death and disability are higher among preterm infants than among infants born at term” (MacDorman et al., 2010). The findings supported that the mother of a preterm infant was “88% more likely to have an obstetrical intervention in 2006 than in 1991”(MacDorman et al., 2010), and that “42% of singleton (one fetus in the womb) preterm infants were delivered via induction or cesarean birth without spontaneous onset of labor” (MacDorman et al., 2010). This data identifies a direct correlation between increased rates of medical induction of labor and the increased risk of preterm births and C-sections, both of which can pose potential health risks for the mother and the child.

It is important to understand that medically inducing birth can lead to a domino effect of other medical interventions. Labor can be medically induced using several different methods but the most common method is prescribing Pitocin, one of the primary drugs used to initiate the cycle of medical intervention. For example, with Pitocin comes, “amniotomy, internal fetal monitoring, immobilization, epidural, and urine catheter; oftentimes a blood sample will be taken from the fetus’s scalp to confirm a heart tracing, and an intrauterine pressure catheter will be inserted to measure the contractions’ strength within the womb” (Block, 2008, p. 139). Women are not informed that the use of Pitocin will likely lead to these further interventions. Pitocin is a form of synthetic oxytocin that can help to pharmacologically induce labor, as well as speed up contractions and make them stronger, but also more severe and painful. This is because they are chemically induced contractions, so they are more relentless without break, as opposed to physiological contractions which have brief pauses. This frequently can lead to the prescription of an epidural to numb the pain. However, the epidural can make Pitocin less effective, necessitating more Pitocin, which leads to even stronger contractions. Such artificially enhanced contractions can cause the baby to go into fetal distress, which doctors frequently address by

performing a cesarean section (C-section). When the child is delivered, the doctors are praised for "saving the baby," when the reality is, the series of medical interventions could have been the reason that the fetus went into distress.

In America, physiological birth has been framed as an inconvenience, leading many patients and doctors to prefer to conveniently schedule their births for greater control over the process. The life event of labor and delivery today, "has become one of timing, control, and convenience for both obstetrical providers and expectant women, with nearly two-thirds of all labor induction in the U.S. now initiated for nonmedical reasons" (Wilson, 2013). A pregnant woman's health, body size and type, age, number of previous births, and health and size of the fetus are all variable leading to an imprecise timing of a due date. With the use of Pitocin or similar drugs, the expecting mother and her obstetrician can schedule, to the hour, when labor and delivery will commence. In a study observing when births took place, they found it was not equally distributed throughout the week. The study found that babies "were much more likely to be born Monday through Friday. During the week, about 12,000 babies were born per day; on Saturdays and Sundays, the tally dropped to about 8,000" (Block, 2008, p. 3). Expecting mothers are oftentimes pressured to medically induce labor, which helps to explain this large discrepancy in the average of births per day of the week.

Because of this convenience factor, and the fact that medically induced labors bring in more profit, it is likely that the medical interventions are promoted to expecting mothers. It can be quite difficult to disagree with a doctor because of their medical authority. Patients, especially first time mothers, may rely heavily on "clinician guidance and input while making decisions and may not have or embrace evidence-based knowledge to inform their decisions" (Jou et al., 2015). Even if a woman does have the knowledge or desire to not have unnecessary medical

interventions, it can be challenging in the vulnerable position of laboring to question the doctor's authority. It has been found that "over one-fifth of women who gave birth in U.S. hospitals may perceive pressure from a clinician to induce labor or deliver by cesarean and women who perceive pressure from clinicians for induction of labor or cesarean have significantly higher odds of experiencing these procedures, even in cases without a definitive medical reason for the procedure" (Jou et al., 2015). This study supports that it is very common for a woman to feel pressured during labor by a clinician to have a medical intervention, and this pressure often results in a procedure.

The ethnicity of the expecting mother also strongly correlates with rates of inducing labor. It was found that, "More white patients underwent elective induction versus Black patients or Hispanic patients (56% versus 44% and 49%, respectively)" (Stephenson et al., 2015). It was hypothesized that these differences in demographics could be attributed to physician bias and differences in patient requests. Additionally, this study also found that "compared with white patients, Black patients were 75% and Hispanic patients were 22% more likely to undergo primary cesarean delivery" (Stephenson et al., 2015). The observed rates of C-section delivery by race seems to contradict the data suggesting that, elective induction increased the probability of a cesarean birth by 50%, and could demonstrate the blatant prioritization of white bodies over Black bodies within obstetrics (Wilson, 2013). The U.S. healthcare system seems to be making a statement of who has the privilege of being medically induced upon request. The common narrative of women of color being disregarded, silenced, overlooked, and experiencing racism within medicine is demonstrated here, and could be one possible explanation for the discrepancy in statistics. One might hypothesis, based on these statistics, since more white women are being induced, more white women would be having cesareans, but this is not the case. Rather, the data

is showing a clear racial disparity, that women of color experience less elective inductions, but higher rates of C-sections. This contraction in statistics cannot be attributed to one specific factor. It is likely the result of the healthcare system and society that has a long history of systemic racism, which results in poorer health outcomes for women of color. Looking at this data in combination with the finding that, "the magnitude of the association between pressure and procedure is actually higher for cesarean without medical reason. This suggests that the pressure women perceive from clinicians to have a cesarean may not be based entirely on medical necessity" (Jou et al., 2015). With these findings in mind, it is important to question who is being pressured to receive caesareans without medical reason. This coercion can help explain some of the ethnic disparities when it comes to what bodies clinicians are pressuring into procedures like the cesarean section.

Profits to be Made with Increased Medicalization

The more procedures completed and drugs prescribed lead to increased profits for doctors and hospitals. Therefore, it is necessary to see if cost incentives could also be contributing to the increased cesarean rates. According to WHO, "the proportion of cesareans should not exceed 15%, beyond that, the maternal injury and death consequent to major abdominal surgery begins to eclipse the lives and health saved" (Block, 2008, p. 49). In the United States around 33% of women have cesarean sections (Block, 2008). This is over two times the amount that WHO recognizes as appropriate, which means that other factors must also be influencing this rate. According to a study conducted on physician financial incentives, "Childbirth is the most common reason for hospitalization in the United States and cesarean sections (C-sections) are the most common inpatient surgery. Four million babies are born each year, resulting in $50 billion dollars in health care costs" (Johnson et al., 2016, p. 115). This demonstrates a huge market for

this operation, and many opportunities for doctors to perform them. This study not only evaluated financial incentives for performing cesarean sections, but it also examined the birth plans of physician mothers, to see if they chose the same treatment for themselves as their patients. The study found disparities, and "that physicians are less likely to get C-sections and have better health outcomes than comparable nonphysicians" (Johnson et al., 2016, p. 115). This discrepancy was rationalized by stating that physicians are more informed about the care they are receiving. Non physicians are typically less informed of appropriate levels of care. This allows "physicians to shift patient demand and move treatment quantity in the direction of their own interests because patients do not have the necessary medical knowledge to make independent decisions" (Johnson et al., 2016, p. 116). This is not to make the general statement that all patients are not informed of the proper level of care, and all doctors want to over-treat patients to drive up costs, but typically, even if patients might be aware of the proper level of care, they may risk adverse consequences advocating for themselves, or may simply not have the power and privilege to do so.

This study looked at the difference in cost between physicians and non-physicians delivering in the same hospital. It found that, "charges of physician-mothers and their infants are nearly 2.6 percent lower than those of non-physician mothers delivering in the same hospitals. If this reduction could be achieved in the broader US population, hospital charges would be reduced by $2 billion dollars per year. Over a third of these savings are attributable to the difference in delivery method in the two groups" (Johnson et al., 2016, p. 136). The difference in how the cost of giving birth varies, demonstrates who is valued in the healthcare system. The system has been created to benefit highly educated physicians who are likely in the upper middle class. It will cost them less to give birth and they will also be "7-9 percent less likely to have a C-

section than other highly educated patients" (Johnson et al., 2016, p.138). This study demonstrates that cost incentives may be driving high cesarean section rates.

This study also compared HMO-owned hospitals to other hospitals. The purpose of this was to see if financial incentives were playing a role in how physicians treat their patients. They found that "in HMO-owned hospitals C-sections are less financially favorable to physicians and to the hospital, because the hospital internalizes the costs of care and incentivizes the physicians it employs accordingly" (Johnson et al., 2016, p. 116). This means that doing a C-section is a more expensive procedure, and the hospital will likely have to absorb the cost of performing one. Therefore, it is less likely that a physician would perform one if it was not medically necessary. Unsurprisingly, the study found that "non-physician mothers delivering at HMO-owned hospitals have C-section rates that are almost 5 percentage points lower than nonphysicians delivering elsewhere" (Johnson et al., 2016, p.131). This statistic demonstrates that physicians may be over treating patients and performing cesarean sections when they are not medically necessary due to cost incentives. According to the study, "C-sections consume more hospital resources than vaginal deliveries. Hospital charges are $6,000 higher for a C-section and hospital costs associated with C-sections are estimated to be approximately $1,000 higher for uncomplicated deliveries and $3,000 higher for delivery"(Johnson et al. 2016, p. 116). Performing a cesarean section can be a lifesaving procedure, however when it is not medically necessary, or an emergency situation it should be considered to be a serious medical procedure that comes with its own set of risks. There is always a small amount of risk with any major medical procedure, and therefore performing cesarean sections when they are not medically necessary is putting birthing people in higher risk of facing adverse consequences then a vaginal birth might be.

The current healthcare system incentivizes overtreatment of patients because of increased profits and because of the consequences of undertreating a patient. According to Shannon Brownlee, who wrote a book on the overtreatment of patients in the United States, "malpractice fears drive defensive medicine, and then there is medical custom, which varies from region to region of the United States. But the most powerful reason doctors and hospitals over-treat is that most of them are paid for how much care they deliver, not how well they care for their patients. They get paid more for doing more" (Brownlee, 2008, p. 184). Not only is there financial incentive to give more medication and perform more procedures like cesarean sections, there is also the risk of being sued if they do not. If something goes wrong during a birth, cesarean sections are deemed to be a doctor doing everything they can, and it is very unlikely that they will be sued for doing one. This is in contrast to if a doctor fails to perform a cesarean section, which is grounds for a medical malpractice claim if the baby is injured. Therefore, doctors are not only financially incentivized to perform cesarean sections they also fear malpractice if they do not perform one.

How has the Law affected Medicalization

In the 1980s and the 1990s many states adopted tort reforms with the hopes to reduce the practice of defensive medicine. Defensive medicine is very closely tied with medicalization of childbirth, as it revolves around the idea that doctors must do everything medically necessary to save the infant. It is described as "the treatment decisions made by physicians primarily to avoid malpractice liability rather than benefit patients" (Montanera, 2016, p. 355). This practice of defensive medicine is very common, especially in modern Western medicine and is seen as one of the main contributors to the United States high healthcare costs and, "in some studies, 90% of physicians reported practicing positive defensive medicine within the past 12 months" (Minkoff,

2012, p. 390). Oftentimes, the court rules in favor of medical intervention. This means a doctor who performed C-section will typically hold up better in court than one who failed to perform a C-section, even if this is not necessarily evidence based medicine. It is difficult to navigate because, "when a damaged child is brought before a jury, the jurors are immediately subject to motivated reasoning because they try to find a way to provide whatever resources the family needs to provide for that child. Thus, if the child has cerebral palsy, the plaintiff's attorney may not have too much difficulty to get a lay jury to accept a (paid) expert's opinion that a squiggly line on a fetal heart tracing is ominous and to accept that the physician tarried in his obligation to effect a delivery" (Minkoff, 2012, p. 393). It becomes a very difficult process of holding someone accountable to try to mitigate increased expenses that this family has as a result of the child having cerebral palsy. However, it becomes even more difficult to determine if it is truly possible to hold anyone at fault.

Tort laws can lead to obstetricians over-attending to patients and taking extreme precautions, which can lead to negative outcomes. The goal behind tort laws and reforms is that these "reforms reduced the practice of defensive medicine arising from excess tort liability. We find that this does not appear to be true for a large and important class of cases of childbirth in the United States" (Currie et al., 2008, p. 796). Tort reforms have been an effective tool in decreasing defensive medicine in other aspects of medicine, but not obstetrics. Studies have suggested that "the recent runup in the rate of Caesarean sections in the United States (which reached 30% in 2004, up from approximately 20% in the 1980s) is driven primarily by fear of litigation,"(Currie et al., 2008, p. 796). Tort laws are necessary to ensure patient safety and to hold doctors accountable, however, in the area of obstetrics, it has created an excessive fear of liability, which has produced negative outcomes. It is a tricky balance to determine how much

liability doctors need to have to be responsible for their patients, but to also be practicing evidence based medicine and not over treating patients.

It is also important to take note of the way the media plays into this fear of being sued for malpractice and not performing a cesarean section. When speaking of the fear of litigation "one needs to look no further than a recent Detroit newspaper headline reporting a 140 million dollar award for failure to perform a cesarean section to find evidence in support of that supposition" (Minkoff, 2012, p. 390). It is unlikely that there will be headlines published about an obstetrician that refrained from performing a cesarean section when it was not medically necessary, but an obstetrician who failed to perform one, is newsworthy. Because of these fears, it is unsurprising that common rhetoric in obstetrics states, "the only cesarean section you will regret is the one that you don't perform." (Minkoff, 2012, p. 390).

These stories and associated mantra has created a culture that is operating under the pretense that it is better to be safe than sorry, "therefore, it is not surprising, that in the minds of many obstetricians, the performance of a cesarean section when there is any doubt about the baby's health, or even before there is any doubt, will have a salutary effect on their chance of being successfully sued" (Minkoff, 2012, p. 390). To them, the potential consequences of performing an unnecessary cesarean are much less than failing to perform one when it is medically necessary. However, there is little regard to the negative effects that can occur because of cesarean sections. It is constructed to be a procedure with minimal risks, and not as a major abdominal surgery that can come with severe complications. As demonstrated earlier in this paper, cesarean sections are a major medical procedure, which comes with its own set of risks. It is important to state that "unnecessary C-sections do entail risks to mothers and infants.

Common problems include sponges or other medical equipment left inside the patient, infections, and impairments to women's future fertility" (Currie et al., 2008, p. 803) and many more.

The rhetoric of better safe than sorry does not apply, because cesareans do pose risks. The law, specifically tort law, has had a major effect on the way that obstetricians deliver babies in the United States. Many believe that there needs to be additional tort reform to attempt to mitigate the practice of defensive medicine. However, the reality is that it is more complicated and there are many factors in play like "the likelihood of being sued, the harm of a suit, the effectiveness of a cesarean section to avoid suit, and any potential harm from cesarean sections. Because physicians often overestimate the likelihood of suit, largely agree that being sued is devastating, and often accept the supposition that a cesarean section may mitigate the chances of a successful suit" (Minkoff, 2012, p. 394). Therefore, it is not as simple as stating that tort reform would fix the problem, because it is complex and it is unlikely that a one-step solution would fix the problem. There needs to be a reframing of the actual risks associated with cesarean sections and a push towards practicing evidence based medicine because fear of malpractice suits are driving up cesarean section rates.

Reviewing the Statistics

Another aspect that is important to explore in relation to the state of giving birth in the United States are the statistics, which emphasize infant and maternal mortality rates. These statistics are used as a major indicator of the state of healthcare in a country and therefore by lowering these numbers the country will arguably look better on a global scale. One important factor to note about these statistics is that they do not account for morbidity or the actual lived experience of what it is like to give birth in the United States. However, because these statistics

are often one of the first categories reviewed with regards to birth in the United States, it is important to discuss them. According to the CDC, "in 2017, the infant mortality rate (IMR) in the United States was 5.8 deaths per 1,000 live births" (CDC, 2019), which is one of the highest among countries that are categorized as developed. Moreover, the IMR among Blacks is twice that among whites at 11.4 (CDC, 2019). In comparison to the other 36 countries included in the Organization for Economic Cooperation and Development (OECD), where the average infant mortality rate is 3.9 deaths per 1,000 live births (OECD, 2018). In an analysis of maternal mortality, "the United States ranks near the bottom for maternal mortality and life expectancy among the developed nations—despite ranking highest in the proportion of gross national product spent on health care. This suggests that factors other than health care contribute to the higher IMR and racial disparity in IMR" (Lorenz et al., 2016). As demonstrated earlier in this paper, increased spending and costs of treatment does not necessarily mean that people are receiving the treatment that is most beneficial for them. The assumption is that with increased spending comes better care and better health outcomes, however it is clear by looking at the statistics that this is not the case.

Not only does the United States spend the most on healthcare, but there is also a major discrepancy in the statistics of who has the best health outcomes. There is a huge racial disparity in the United States in relation to infant mortality. In comparison to whites, "infant mortality was also higher for infants born to American Indian or Alaskan Native mothers—7.61 deaths per 1000 live births. Infant mortality for infants born to Hispanic and Asian or Pacific Islander mothers—5.0 and 4.07 deaths per 1000 live births, respectively. In 2010 to 2013, the stillbirth rate was also higher among Black and American Indian or Alaskan Native mothers (10.53 and 6.22 per 1000 live births plus stillbirths, respectively)" (Lorenz et al., 2016). This vast inequality

demonstrated by the infant mortality rate is something that needs to be explored when discussing the state of birth in the United States. However, these statistics are complicated and it can be challenging to examine them holistically and give a full explanation for these disparities because of the complex structural systemic reasons for which they exist. Therefore, this section will only be a brief summary of the explanation behind these statistics and will mostly focus on the Black-White disparity in relation to the infant and maternal mortality rates.

An analysis of the Black-White disparities in pregnant women in the United looked at the risk factors that were associated with being a Black pregnant woman. The study was conducted because of the belief that by doing more research on the relationship between institutional racism and pregnancy risk factors that contribute to adverse pregnancy outcomes, "would help to "bridge the gap and add to the growing body of research to reduce the prevalence of LBW (low birth rate) babies" (Loggins et al., 2018, p. 655). LBW is one of the main adverse pregnancy outcomes and is a large contributor to infant mortality. Ultimately, this study found that "Black women who were pregnant had a lower socioeconomic status and experienced more measures of institutionalized racism compared to white women who were pregnant (e.g. inequalities in social factors, lower income levels, less employment, and less access to private health insurance)" (Loggins et al., 2018, p. 654). These are all factors that could likely contribute to the LBW of an infant, which is likely to be contributing to the Black-White disparity in the infant mortality rate.

This study also found that, "race, the widening gap between social class, and disparities in pregnancy outcomes are perpetuated by institutionalized racism. The stress caused by measures of institutionalized racism (e.g. inequalities in income, employment status, education) prior to the delivery of a child should be addressed to reduce the racial disparity and the

likelihood of LBW in pregnancy outcomes" (Loggins et al., 2018, p. 661). This study also had another very interesting finding in relation to risk factors. The study found that "while examining other factors in pregnant women that increased the risk of LBW, our study found that white women had higher levels of health-eroding behaviors such as smoking during pregnancy and the use of alcohol" (Loggins et al., 2018, p. 661). This is an interesting finding because smoking and using alcohol are oftentimes seen as major risk factors for pregnant women and there is a social stigma associated with these behaviors and pregnant women. However, despite these being some of the most well known risk factors associated with pregnancy, white women are able to participate in these activities and still have better health outcomes. In the study, it is noted that "white women can partake in more "self-inflicted" and damaging health-eroding behaviors (e.g. smoking cigarettes, consuming alcohol) and still have better maternal outcomes compared to Black women. Although Black women did not have control over most of the risk factors that are traditionally associated with LBW, the opposite effect existed for white women" (Loggins et al., 2018, p. 661). This is a very interesting finding because it demonstrates the white privilege that exists in the context of being pregnant. Even though white women actively participate in higher risk behavior, they still have better health outcomes then Black women because they are not subjected to the effects of institutional racism and racism in their daily lives.

Statistics as a Form of Control

There is a clear racial disparity that exists in the United States in relation to adverse birth outcomes. The healthcare system is a reflection of the United States as a whole and demonstrates the legacy of structural racism that exists and perpetuates how health care is administered. This affects how people of color are treated which can contribute to worse health outcomes. These

health statistics can give insight into the current state of giving birth in the United States, but they do not tell the entire story. These statistics allow for additional surveillance of the maternal body.

In a study that focuses on fetal death, it explores how fetal death has become tied to the idea of surveillance of the maternal body. The main method of surveying is through tracking statistics. The concept of vital statistics arose in the late 19th century and was immediately linked "with the administration of public health. The growth of this discipline was grounded in a notion of population as something that could be enumerated, measured, and controlled through interventions in public health" (Fordyce, 2013, p. 125). This process of tracking statistics created an awareness, which began the shift in thinking surrounding the causes of infant death. It shifted from, "biological to social, instigating large scale state interventions related to poverty, hygiene, housing, and nutrition" (Fordyce, 2013, p. 125). It allowed for the blaming of individuals for adverse pregnancy outcomes and for interventions and monitoring of the pregnant body in order to have better fetal and infant statistics. When "researchers and state public health organizations began tracking data about fetal death, we see a shift in prescriptions for pregnancy care and ideas about maternal responsibility as related to poor pregnancy outcomes" (Fordyce, 2013, p. 125). These measurements changed the notion of stillbirth to an inevitable aspect of life to something that could be intervened, tracked, monitored, with future hopes of prevention. Once the process of tracking birth, and statistics related to birth began, the concept of preterm birth arose. It instigated a, "need for closer clinical observation of women throughout the course of pregnancy and more through study of deviations from normal in order to obtain clues concerning factors which have deleterious effects on the fetus" (Fordyce, 2013, p. 129). This idea to prevent preterm births and stillbirths also contributed to the idea of intervention and "the early

assumptions that physicians are expected to intervene in and prescribe particular maternal behaviors as a means to prevent poor fetal outcomes" (Fordyce 2013, p. 126,). This belief that physicians are knowledgeable and in charge of the birth process consequently, contributed to regulation and what it meant to be a good pregnant person.

To achieve the status of being a good pregnant person, and to have a pregnancy with no adverse outcomes, the mother was supposed to participate in "routine visits with an obstetrician, who would counsel her on the appropriate behavior regarding such things as exercise, diet, bathing, clothing, and sexual intercourse"(Fordyce, 2013, p. 129). These methods still occur today and helped shape the concept of compliance and what it looks like to be a good patient. This process allowed the patients to be blamed if they were noncompliant and experienced an adverse pregnancy outcome. There is now an implicit belief tied to biomedical frameworks that ties individual responsibility for individual health. This means that poor fetal and infant outcomes are tied to maternal blame (Fordyce, 2013, p.130). These ideas of blame have become increasingly important in an era where legislation is introduced to award personhood rights to the fetus. This means that the links between the naturalization of maternal behavior, and fetal and infant health outcomes are increasingly tied to the criminalization of pregnancy (Fordyce,2013, p. 130). This allows for the regulation of the maternal body and can contribute to a loss of autonomy. The emphasis placed on statistics of the high infant and maternal mortality rate in the United States allows for increased monitoring, in attempts to lower this statistic. However, it is important to consider the balance between autonomy and better health outcomes. It is also important to analyze the rhetoric closely associated with fetal and infant deaths and examine the larger structural contexts in which they occur. However, this analysis does not always occur, which places maternal blame and maternal responsibility at the forefront of this conversation.

The History of Criminalization

The history of criminalization of drugs is very complicated in Western history. This is because "the criminalization of drugs cannot be separated from the relation of altered states of consciousness, imperialism, colonization, and subordination of women in Western history" (Boyd, 2004, p. 28). There can even be connections drawn between the history of witch hunts and how they served the purpose of regulation and subordination of women (Boyd, 2004, p. 28). Oftentimes, the people that were believed to be witches used plants that had hallucinogenic properties and those who were thought to be using hallucinogenic plants were condemned. Midwives and healers were prosecuted during this time period and "key elements that fueled the witch hunts were the control of female reproduction and sexuality and control of women's independence" (Boyd, 2004, p. 31). This regulation has continued throughout history although the ways in which females are regulated and criminalized has shifted.

Medical institutions and society situates women's bodies as always potentially pregnant and therefore subject to the same surveillance and behaviors as pregnant women (Fordyce, 2013, p. 129). However, the pregnant female body is subjected to hyper regulation and experiences increased monitoring in comparison to someone who is not pregnant. Regulation ties into medical and legal interventions, specifically in the relation to women who use illegal drugs. This is because women who use illegal drugs are assumed to be unfit parents and a danger to the fetus. Therefore, because women are regarded as always potentially pregnant this means that the stigma associated with women who use drugs is high. As Susan Boyd states "social attitudes about women's' illegal drug use are quite negative, especially in relation to women who are mothers" (Boyd, 2004, p. 76). Once a woman is pregnant she may face regulation from the State and from society because, Western society makes the pregnant body a public body. People

oftentimes feel the right to comment, critique and criticize the pregnant body. This is because the "state and the law have been concerned with the ownership of women's' bodies and what they produce" therefore "when women are suspected of using illegal drugs both surveillance and intervention increases"(Boyd, 2004, p. 80). This is an interesting concept because as demonstrated earlier, adverse pregnancy outcomes are blamed on the mothers, and women who use drugs are subjected to high rates of intervention, yet there is often little regard to societal factors like nutrition and poverty and good access to healthcare which have a major influence on health outcomes. This is one of the many double standards that exist in the ways that different female bodies are regulated based on race, socio-economic status, ethnicity, education status, and other demographics.

One double standard is the belief that infants born to mothers who use drugs will be a drain on society. This rhetoric began in the 1980s during the Regan era with the idea of the welfare queen. The welfare queen was depicted as someone who was ignorant, but also smart enough to finesse the system. This rhetoric was based on the idea that Black women do not make good mothers. This depiction made a statement about who was valued in society, and who should be reproducing. This was the era in which there was also a moral panic about "crack babies." Even though the evidence in which the myth of "crack babies" has been debunked, this harmful stereotype still perpetrates. The reality is the factors that lead to adverse pregnancy outcomes, which were initially blamed on crack cocaine, were actually related to poverty. This rhetoric still persists and allows for the persecution and criminalization of pregnant women who use drugs (Suarez, Women's health and social control 10/11/2019) despite the evidence proving that "crack babies" were likely the result of poverty, not drugs.

Illegal drug use allows for criminal prosecution, while the use of new reproductive drugs and technology is praised. However, this new technology is extremely expensive and the long term effects of using these drugs have not been explored. Oftentimes, fertility drugs can lead to multiple births. Women who use fertility drugs and have multiple births are "placed on a pedestal and those suspected of using illegal drugs like cocaine during pregnancy in prison" (Boyd, 2004, p. 83). The main argument behind placing these women who are using illegal substances is that they will be a drain on resources, however there is little criticism over how oftentimes these multiple births infants could face severe health problems. Many have to be birthed prematurely since a "women's uterus cannot physically hold five full-term infants, leaving them vulnerable to health problems such as visual disabilities and respiratory distress syndrome"(Boyd, 2004, p. 83). There is no push to criminalize these women, even though their infants are also facing adverse health effects. If the true concern were the fetal outcomes and adverse effects being a drain on society, fertility drugs would be further questioned. This demonstrates the discrepancy between who needs more regulation and what the root of criminalization of the pregnant body aims to achieve.

The State vs the Female Body

There has been a long history of criminalization of pregnancy. However, in the 1980s it shifted to a more conservative rhetoric that was rooted in general roles, personal responsibility, and family values (Boyd, 2004, p. 106). This era is one that drafted a plethora of legislation and bills that targeted women who used illegal drugs. These bills ranged from "forced sterilization, Norplant implantation, and involuntary detention" (Boyd, 2004, p. 106). These laws allowed for increased prosecution of pregnant bodies and different demographics were targeted differently. Of the women charged with criminal offenses between 1985 and 1992, "70 percent were women

of color. Biased reporting by media and initial, unconfirmed medical claims about harm to the fetus and unfitness of mothers who use illegal drugs were used by court prosecutors as facts rather than as social constructions" (Boyd, 2004, p. 107). This finding demonstrates how the State was pursuing women who fit a specific narrative. This statistic shows how harmful a false rhetoric can be, specifically to women of color. These new laws disproportionately affected women of color, because they were the targets of this legislation.

There are a great number of stories and cases that outline the punishment of women in relation to the fetus. The justification for these actions against these women is that they are a danger to the developing fetus; consequently, the actions taken by the State can cause more harm to the fetus. Some of the earlier cases demonstrate this wrongful targeting of specific populations for extra regulation and the extreme punishment of these females. One case specifically, Ferguson v. The city of Charleston, South Carolina 2001, describes the treatment of several women who came into a state hospital. The hospital had a very intrusive health policy that was created by police, the prosecutor, and the medical staff and raised several ethical and personal privacy issues. Essentially, the staff worked with the police for 5 years to search for any pregnant women or women that had recently given birth to see if there was evidence of drug usage (Boyd, 2004, p. 112). This search was done without the woman's consent and without any warrants. Another compounding issue with the policy was that it allowed medical personnel total control over who would be searched and given urine tests. If the test resulted in a positive result, it would provide evidence for criminal proceedings. Because of the selective searching "this program affected poor women, particularly Black women and all but one woman was African American. If evidence demonstrated that a woman had used drugs (specifically cocaine), she was arrested on the spot" (Boyd, 2004, p. 112). If the women were arrested they were oftentimes

subjected to horrible treatment. Some women were “shackled immediately after birth and escorted to prison in their hospital gown while still bleeding, in pain, and recovering from childbirth. Others were shackled to their beds prior to and after childbirth” (Boyd, 2004, p. 112). Clearly there was little regard for what is best for the newborn, since oftentimes they were immediately separated from their mothers.

Despite ten women challenging the State and suing them for violating their civil rights, the state ruled in favor of the hospital and deemed that it could be an exception, because it promoted health. Thankfully, when the case was brought in front of the Supreme Court, and the evidence surrounding legal sanctions and their lack of effectiveness in being a deterring factor was considered, it ruled in the women's favor; the Supreme Court recognized the right of these women to not be subjected to unreasonable searches. This example demonstrates how disproportionately these policies affect different women, specifically poor women of color, especially when medical personnel are given complete authority to determine who should be tested. The reality is that white women of higher economic status could have tested positive for illegal drugs, however because of a specific rhetoric and stereotyped target population, they were not as likely to be subjected to these tests.

In another case titled Starks v. State 2001, Julie Starks and the father of her unborn child were arrested because when she was approximately 7 months pregnant, she was on the site of an alleged methamphetamine lab. They were initially charged with manufacturing and possession of methamphetamine. The court later determined that her fetus was a deprived child because of these factors. Once they were arrested, Julie’s bail was set at $200,000 whereas the father of the unborn child was set at $25,000. This discrepancy is important because it demonstrates the harsher punishment to females, specifically if they are pregnant (Boyd, 2004, p. 111). They were

charged for the same thing, but the differences in the bail demonstrate how differently pregnant bodies are regulated and dealt with by the State. Julie was then ordered into foster care and ordered to submit random urine analysis and attend prenatal visits. However, one of the most interesting features of this case is that "Julie remained in jail for thirty-six days where she was fed an inadequate diet, developed a sinus infection, lost fourteen pounds, and became dehydrated. She went into premature labor and was rushed to the hospital. There she was given medication to stop her labor and she had to take the medication until a few days prior to her labor" (Boyd, 2004, p. 111). The irony of the entire situation is that Julie states that she never used drugs during her pregnancy, and she never tested positive for drugs besides the ones that she was forced to go on because of her premature labor, which was likely caused by her jail conditions.

This case demonstrates that the State is less interested in the health of the fetus, but instead, the regulation of the female body. If the State were concerned about the fetus they would not be subjecting Julie to conditions that likely caused her to go into labor prematurely. The end result is that Julie had far worse adverse health effects during her pregnancy due to the State's intervention, despite never testing positive for drug usage while pregnant. Julie's case is far from unique in terms of the conditions she experienced in jail. Julie's case demonstrates that the rhetoric the State is only doing what is best for the fetus is a false one. Between the years of 1973-2005, it was estimated that of the "413 cases where pregnancy was a necessary factor leading to attempted and actual deprivations of a woman's physical liberty, illicit drug use was mentioned in 348 (84%) of these cases"(Stone, 2015). Since 2005, there have been an "additional 380 cases identified" (Stone, 2015**)**. This is a large sum of women who have had their rights infringed upon by the State based on rhetoric that it is what is best for the fetus, counter to

any evidence demonstrating that legal sanctions are effective. It is very important to note that there is likely a "substantial undercount" of the number of cases "noting that the lack of searchable databases of cases, the confidentiality of family and juvenile court proceedings and civil commitment proceedings, the lack of media coverage of hospital detentions and compelled treatment, and lack of access to court records from Native American tribal courts. The record is also unfortunately out of date by almost a decade and, as the above-mentioned cases, court decisions, and legislative acts demonstrate, the arrests and prosecutions of pregnant and substance-using women continue" (Stone, 2015). This lack of an updated database demonstrates that the State does not view this infringement of female rights as a high priority issue. It is very important to observe that when a society does accurately research a topic, it demonstrates its value in that society. The lack of accurate data on this topic shows that tracking the cases, prosecutions, and arrests of pregnant women is not something that is not seen as important.

Even though the number of cases involving criminal prosecution of pregnant women are likely underreported, there are still a large quantity of them, despite little evidence that legal punishments serve as a deterring factor in drug usage while pregnant. According to studies "medical knowledge about addiction and dependency treatment demonstrates that patients do not, and cannot, simply stop their drug use as a result of threats of arrest or other negative consequences. This is one reason why threat-based approaches do not work to stop drug use or to protect children. Such approaches have, in fact, been shown to deter pregnant women not from using drugs but rather from seeking prenatal care and what little drug and alcohol treatment may be available to them" (Ehrlich et al., 2006). These findings demonstrate that not only is punishing pregnant women ineffective, it can actually have negative health effects. If the State is truly concerned with protecting the health of the fetus, different approaches need to be taken.

To have better health outcomes for the mother and the fetus, women should be able to go to their prenatal appointments without fear that their health providers will turn them over to the authorities. To feel safe going to her appointments, "the woman must trust her health care providers to safeguard her confidences and to stand by her while she attempts to improve her health, even if those efforts are not always successful. Transforming health care encounters into grounds for prosecution and turning health care professionals into agents of law enforcement destroys this all-important trust" (Ehrlich et al., 2006). Instead the current system has turned health care providers into mandatory reporters of the State and completely destroys this relationship. It has created more barriers to prenatal care, and the fear of imprisonment for seeking help. The system prioritizes punishing pregnant women, despite the adverse effects it could have on the fetus. The legal system views illegal drug use as criminal whereas the medical perspective views addiction as a disease. This can make treatment options difficult at times. There is a lack of access to treatment centers that help pregnant women and it is often not an option for children to accompany their mothers. As Boyd draws attention to "treatment is less accessible to women, especially the poor, because childcare is often not provided" (Boyd, 2004, p. 169). Many programs require women to stay from one month to a year and they offer few solutions for childcare. This is compounded by the fact that poor women "under the surveillance of social workers are fearful of child apprehension when entering drug treatment because their drug use, and quest for help, may be viewed by their workers as evidence of their maternal unfitness" (Boyd, 2004, p. 170). This can be a huge barrier to women who are trying to receive care and take the steps to stop using drugs as they fear being separated from their children making the decision to get treatment difficult. This seems very counterintuitive, because a main

reason that these women want to get clean is for their children, yet they risk being separated from their children for trying to do what they believe is best for them.

Treatment becomes even more complicated if a woman is pregnant, because "most programs in North America will not admit them (pregnant women), nor are service providers trained to work with them" (Boyd, 2004, p. 170). There is already a vast stigma attached to using illegal drugs, but this stigma becomes immensely magnetized if a woman is pregnant. However, this does not mean that there is not a need for comprehensive drug treatment centers to exist for pregnant women, "of pregnant women aged 15–44, 5% report current illicit drug use" (Stone, 2015). The issue is that there are penalties for using drugs while pregnant, but these females do not have the option of voluntary treatment because of State intervention. This turns the process into a more legalistic one where they are "subjected to State interventions in the form of apprehension of the fetus, imprisonment, and forced drug treatment" (Boyd, 2004, p. 170). This emphasizes the argument that the State views addiction very differently than the medical field does and treatment can be more complicated when it is mandated vs when it is voluntary.

This viewpoint of addiction treats different demographics of women who use substances while pregnant differently; a woman's socioeconomic status can be a large influencing factor in if she is able to get treatment. In this study of five different United States cities "the majority of outpatient and residential programs—ranging from 64% of all programs in Detroit to 100% of all programs in Albuquerque and Charleston—accepted pregnant women. Method of payment, however, proved to limit access significantly. While all the outpatient programs in Albuquerque and Charleston accepted pregnant women, fewer of these programs accepted pregnant women on Medicaid, 50% and 71%, respectively"(Breitbart, 1994, p. 1659). Not only is the availability of treatment facilities that accept pregnant women smaller, the number of facilities that accept

Medicaid is even fewer. This means that pregnant women of higher socioeconomic status are more likely to have the accessibility to receive treatment. Women who use drugs come from diverse class and racial/ethnic backgrounds. However, the consequences for using drugs are not the same, "poor women and women of color are most vulnerable to police profiling and arrest, social service intervention, and harsh treatment by the medical profession" (Boyd, 2004, p. 75). The consequences of using drugs, and the barriers to treatment are much greater for poor women. This is an interesting discrepancy because it demonstrates what women society believes are worthy of becoming substance free while they are pregnant. This is then tied deeply to ideas of who is considered to be worthy of reproduction.

Women are heavily surveilled when they are pregnant and suspected of using drugs, especially women of color and women in lower socioeconomic brackets. These women "may face arrest, prosecution, conviction and/or child removal" (Stone, 2015). This makes it easier to understand why women who are pregnant might not seek drug treatment, even if they know that it could be helpful to themselves and the unborn child. In a study analyzing the different barriers to care that pregnant women who use substances face, 30 pregnant women in a city of about 100,000 were interviewed. Through their narratives and interviews, common themes of the barriers to the care and treatment for these women were identified. One of the common barriers that was identified is that "73.3% reported that during their pregnancies they had been afraid of being identified as substance-users" (Stone, 2015). These women feared detection in the form of a positive result in a prenatal screening or even after delivery of the baby. There were several different strategies that these women used to try and minimize the potential consequences of their drug use while pregnant. The main methods were, honesty, social isolation, denial of pregnancy, and avoiding medical care, all of which can have various consequences.

It was found in the study that, “punitive policies have indeed had some chilling effect on women’s help-seeking behavior by discouraging women from accessing prenatal care or leading them to skip appointments, and by motivating women who did attend appointments to withhold medically relevant information about their substance use” (Stone, 2015). This creation of a culture of fear and stigma that surrounds pregnant women who use drugs has created an environment that results in negative health consequences and “these findings demonstrate that women are in need of more treatment options, better access to the treatment of their choice, and more support for staying in treatment. The women in this study revealed that in their searches for residential treatment centers they could locate only one facility that would accept pregnant women or women who needed to bring their children with them. This treatment facility is located more than a hundred miles from the study site, making transportation and visitation expensive and time-consuming” (Stone, 2015). This demonstrates that even when women are willing to face the potential consequences of separation from their existing children to receive treatment, they have to face additional barriers to receive this treatment. It is clear that existing treatment facilities need to be improved and more easily accessible.

Pregnant and Incarcerated

Pregnant women who use drugs are often punished very harshly which can lead to them being incarcerated while they are pregnant. The number of women in prisons has steadily increased, causing the number of pregnant women to increase as well. This is because “women represent the fastest-growing segment of the prison and jail population in the United States. Over the past 20 years, the number of women in state and federal prisons has increased more than six times and is growing at a faster rate than that of their male counterparts” (Ferszt et al. 2012, p.

557). It is also important to note that all women are not being affected proportionately by these increasing rates. This increase has been "dramatic for women and even more so for women of color: Black women are incarcerated at a rate 2.3 times that of white women, and Hispanic women are incarcerated at a rate 1.5 times that of white women" (Sufrin et al., 2015, p. 213). In the United States, a rise in incarceration rates is partially a response to the "war on drugs." In total the number of women that are pregnant when they enter correctional facilities is approximately 5–6% (Ferszt et al., 2012, p. 557). However, there are not standardized methods for testing for pregnancy when these women enter these facilities so the data representing the number of pregnant incarcerated women may be inaccurate.

Several studies surrounding the demographics of women who enter prisons while pregnant show that these women tend to come from impoverished backgrounds. Studies show that these women often are "undereducated, have poor work histories, come from nonwhite ethnic groups, and have significant histories of violence and abuse" (Ferszt et al., 2012, p. 558). They also tend to be incarcerated for "nonviolent crimes" (Ferszt et al., 2012, p. 558). These women have been subjected to hardships throughout their lives and are oftentimes the sole provider for their existing children. This creates great stress and a lack of other options. Therefore, this "lifetime of experiences of sexual victimization, prolonged disadvantage, and unrelenting stress often lead to drug and sex work-related crimes" (Ferszt et al., 2012, pg. 558). It is important to understand the underlying systemic reasons that can lead to these women's imprisonment.

It is common for women to be in poor health when they enter prisons. They suffer more serious diseases compared with women in the general population, including "HIV, sexually transmitted diseases, hepatitis B and C, hypertension, asthma, arthritis, diabetes, and dental

disease. The rates of psychiatric disorders are higher among incarcerated women compared with the general population" (Ferszt et al., 2012, p. 558). Incarcerated women are a particularly vulnerable population and therefore the health services that they receive while incarcerated are important to study. Women who are incarcerated tend to be a group that suffers more serious diseases, and therefore women who are pregnant and incarcerated are oftentimes deemed "high risk." Because of several physical and physiological stressors that these women experience either prior to incarceration or while incarcerated, "miscarriage, pre-term deliveries, spontaneous abortions, low birth weight infants, and pre-eclampsia are common complications"(Ferszt et al., 2012, p. 558). As a country that is very concerned with its neonatal and maternal mortality and morbidity rates, it is interesting that the healthcare these women receive while incarcerated is frequently inadequate. Although there have been attempts to improve the standard of care for pregnant incarcerated women by the National Commission on Correctional Health Care, there is no requirement that prisons follow these standards. The result is that "many state women's prisons fail to provide adequate prenatal care, nutritionally adequate diets or appropriate work assignments for pregnant inmates. The lack of adequate exercise, fresh air, and sanitary conditions also negatively affect both the pregnancy and the newborns. Furthermore, many facilities lack written policies for the management of pregnant women."(Ferszt et al., 2012, p. 558).

There is little information on how facilities handle the health care practices and treatment of pregnant women. Further research and reporting from prisons and jails are required to get a more accurate understanding. However, we can surmise from the limited data that the conditions of being pregnant and incarcerated are less than adequate and there tends to be little education or support for these women. This is compounded by the fact that pregnant incarcerated women have

"unique and complex psychosocial needs that can tax their ability to have successful pregnancies, psychosocial support and education are minimal if available at all. These women are confronted with numerous stressors including lack of childbirth preparation classes, choice of selecting their health care provider, education regarding pregnancy, labor, delivery, and the postpartum period" (Ferszt et al., 2012, p. 561). Oftentimes, they are immediately separated from their babies, and left with few resources to help them cope with this loss. This is quite different than in several other countries where prison nurseries allow for mothers to stay with their infants while they are incarcerated. However, the standards of these nurseries vary across countries. Unfortunately, "most prisons in the U.S. do not allow women to keep their babies with them during incarceration. As of 2008, nine states allowed some incarcerated mothers to keep their babies for 12–24 months" (Ferszt et al., 2012, p. 559). This means that a vast majority of states do not allow the infant to stay with the mother. Ideally, prison nurseries would exist across the United States; however, many prisons are already understaffed and lacking adequate resources. so nurseries would likely follow the same pattern. Oftentimes, these conditions are not fit for anyone to live in, especially not an infant.

In a study on the current conditions of incarcerated, pregnant women, surveys were sent to wardens of correctional facilities across the country with questions about their policies, procedures, and the conditions in which their pregnant prisoners lived. The findings of this study provided some very important insight and demonstrated that the "nutrition actually provided is inconsistent with the dietary recommendations for pregnancy, adequate rest is compromised, and two mattresses are rarely provided" (Ferszt et al., 2012, p. 565). It is interesting to examine this lack of adequate care these women receive. At a minimum, departments of corrections must develop policies ensuring that pregnant women have "two mattresses, are given lower bunks, and

meet with the nutritionist" (Ferszt et al., 2012, p. 565). It is especially interesting to contrast this to the cases where women are incarcerated because of their drug use potentially endangering their fetus. As outlined earlier, these women are imprisoned in order to protect the fetus, however once the woman is imprisoned she is often given inadequate nutrients which can lead to negative fetal outcomes.

Focus is also placed on nutrition when enrolling pregnant women for healthcare services through the Medicaid program. An in-depth study was conducted on the treatment of pregnant women enrolling for prenatal care through Medicaid at a hospital in New York City. In this program to be considered for the healthcare services, the women were required to meet with four different health professionals, including a nutritionist. In these meetings, the women were required to divulge very personal information surrounding every aspect of their lives. Specifically with the nutritionist, the women had to provide a full record of exactly what they are. It was found that most of these meetings ended with a "condemnation of their diet" (Bridges, 2011, p. 57) even though oftentimes patients appeared to have an "adequate diet and a healthy appetite" (Bridges, 2011, p. 55). There is a hyper regulation and scrutiny of these women's diets when they are in charge of their diet. It is interesting to compare this to incarcerated pregnant women. As noted above, many of these women are not receiving adequate nutrients when they are pregnant and incarcerated, and this is when the state is controlling what they are eating and what nutrients they are receiving. There is complete control over these women's lives yet, "prisons and jails are highly regimented institutions that control many aspects of women's daily lives, while frequently failing to meet their basic needs" (Sufrin et al., 2015, p. 213), like adequate nutrition for pregnant women. Pregnant women on Medicaid and those who are

incarcerated are oftentimes deemed high risk, yet the pregnant incarcerated population is less visible, and therefore the State is held less accountable to provide them with adequate care.

Reproductive Injustice for Incarcerated Women

One occurrence in the United States that affects some incarcerated pregnant women is the practice of shackling while they are giving birth. Although shackling pregnant women is banned federally, there are states that do not have any written policy banning this practice. Shackling has been deemed dangerous by numerous health professionals and organizations, yet it continues to happen. The practice of shackling includes the usage of anything from handcuffs, leg irons, waist chains or other restraints at any point in the pregnancy, this can "increase the risk of falls, which can lead to placental abruption (separation of the placenta from the uterus), hemorrhage and stillbirth. In addition, restraints interfere with health care professionals' ability to provide critical interventions when obstetric emergencies, such as seizures or fetal distress, arise during pregnancy or childbirth" (Sufrin et al., 2015, p. 216). Shackling pregnant women can be a major risk for their health and for the health of their fetus. Again, it is interesting to note that this practice occurs in a country that is very concerned about their infant mortality rate, yet the direct risk of shackling increases that rate. It demonstrates again that the State is more concerned with controlling these women then the actual health of the fetus. There needs to be a push to pass legislation in every state to ban the practice of shackling pregnant women. Currently, "only 21 states and the District of Columbia have passed laws to ban or limit shackling" (Sufrin et al., 2015, p. 216). As demonstrated, there needs to be major legislative changes to the way that pregnant incarcerated people are treated. As a country concerned with its infant and maternal

mortality rates, it is likely that the way that the State treats our incarcerated prisoners is at least contributing in a small way to these higher rates.

In addition to facing a potentially traumatic birth experience with additional adverse health effects, incarcerated women may also face the risk of having their parental rights terminated. “If a woman cannot arrange for someone she knows to care for her children, they will be sent to foster care. Under federal law, states are supposed to initiate proceedings to terminate a parent’s rights once a child has been in foster care for 15 months, a period shorter than many prison sentences” (Sufrin et al., 2015, p. 214). This process is irreversible in many states, and in the states where reversal is possible, if can be a very expensive and time consuming process.

There is no shortage of reproductive injustices that occur against pregnant incarcerated women. There is also no shortage of stories that highlight pregnant women being treated unjustly while in jail. In Texas, “a pregnant woman being treated with methadone was sent to a jail that subjects all people using opiates to immediate detoxification and withdrawal, despite evidence that this can lead to a miscarriage or stillbirth,”(Sufrin et al., 2015, p. 213). In another case, “women in Ohio and New York were forced to give birth inside jail,” (Sufrin et al., 2015, p. 213). In another story “a woman in Texas filed a lawsuit against a jail for ignoring her when she went into preterm labor. After 12 hours of pleading for help, she gave birth in a cell to a baby whose umbilical cord was wrapped around its neck; the jail nurse did nothing to revive the baby, who died before paramedics arrived” (Sufrin et al. 2015, p. 213). Unfortunately, these stories are not unique in nature, and all of them demonstrate the common theme of reproductive injustice occurring against these women.

Narratives Involving Medicalization and Criminalization

In this next section several different narratives centered around the topics of medicalization, informed consent, and criminalization will be highlighted. Although each narrative is unique, the general themes that occur in these narratives are similar. These narratives represent several real life examples of the different topics that were explored earlier in this paper surrounding medicalization and criminalization.

In one article written by a journalist for the New York Times outlines the story of a woman named Thea and her birth experience. Thea was experiencing a healthy, low risk pregnancy; however, when she went in for her checkup at 40 weeks she was informed that her "amniotic fluids were low, but the babies vital signs were strong" (Brooks, 2018). Once this was discovered the doctor told Thea that she would have to be medically induced immediately. Thea was unsure and questioned the doctor. She inquired about how successful inductions were and asked about the alternative option of a C-section. The doctor informed her that, "she had no choice." She realized that she would have to be medically induced and asked if she could return home to collect her things. The doctor then threatened her and told her if she left to go home she could be "arrested for endangering the life of a child"(Brooks, 2018). Ultimately, Thea endured 36 hours of Pitocin, which is a form of labor induction that speeds up contractions, and the end result was a cesarean. One side effect of Pitocin is that it can "increase the risk of postpartum hemorrhaging, And that's what happened a few minutes after her daughter was delivered. Thea bled for three hours and almost died" (Brooks, 2018). The journalist argues that the United States knows how to make childbirth safer but chooses not to. There has been a small push toward different types of maternal care, but not nearly as much as would be expected; however, "women know what they want when it comes to labor and delivery, and it turns out the things they want

(midwives, doulas, fewer unnecessary interventions and cesarean sections) are less expensive and produce better outcomes"(Brooks, 2018). There is a disconnect between those that are making the decisions and the desires of the patients and this neglect is having negative consequences on those who are giving birth.

As explored earlier, there are several different reasons why doctors may be making these decisions. The doctor's decision in Thea's situation could have stemmed from several different factors. As explored earlier in the paper the fear of malpractice suits is an influencer as well as the desire to perform more interventions to increase monetary compensation, which results in the over treatment of a patient. The doctor's statement that Thea had "no choice" could stem from a power complex that could be rooted in the medical hierarchy based on the way that medicine is set up. Doctors are at the top and therefore expect to be listened to and obeyed. This can lead them to disregard patients' voices and wishes, based on the premise that they are the experts, and therefore they know best. It can also lead to the punishment of women for questioning their authority, in this case, threatening Thea with police intervention if she did not listen to him. These are all important factors to consider, which could have contributed to Thea's traumatic birth experience. This narrative represents a general theme of disregarding patients' voices, over-medicalization them, and not informing them of the risks associated with the process of medical induction, as well as the constant threat of State intervention.

In another narrative, Leslie Driggers Hoard had a very different birth experience than what she was expecting. Her experience was "physically and verbally abusive, medically flawed, and deeply traumatic" (Tucker, 2019). Leslie signed a blanket consent form upon entering the hospital, which meant that the medical professionals did not discuss any decisions with her or ensure that she was aware of the risks or benefits of the different medical interventions. She was

given an IV without permission, Pitocin without consent, and was not allowed to drink water or use the bathroom. Although Leslie stated that her labor was progressing without complications or fetal distress, she was still told that the doctor was going to be performing a cesarean section. The doctor stated that, "this was not because he just wanted to finish his shift and go home,"(Tucker, 2019) which demonstrates the doctor was very aware of the stigma attached to cesareans that do not appear to be medically necessary. The doctor did not explain anything further about the surgery, and Leslie describes the experience as very traumatic; she believes that the cesarean section was not medically necessary. In the following months after the surgery Leslie was "not in a healthy place, and she struggled to breastfeed and bond with her baby" (Tucker, 2019). She experienced anxiety and a therapist suggested that she might be suffering from PTSD due to her experience. Leslie tried to report her experience to the hospital but was ignored and had difficulty filing a complaint. In the end, she was only given a letter stating that the hospital was truly sorry and that the staff would be better educated on informed consent in the future.

It has been found that one in six women in the United States experience abuse during pregnancy and childbirth. These rates are even higher for women of color, women giving birth in hospitals, and those with social economic, or other health challenges. These experiences of mistreatment ranged from, loss of autonomy; being shouted at, scolded, or threatened; and being ignored, refused, or receiving no response to requests for help (Vedam et al., 2019). There has been a recent push to bring attention to this abuse of women in childbirth. Leslie posted her story on the Birth Monopoly's Obstetric Violence Stories Map, which is a public database of abusive maternity care stories. Sights like this one have drawn attention to the many narratives and people who have had experiences like Leslies. She is one of over 250 women who have posted

on this map. The general themes cluster around lack of informed consent and ignoring women's voices. The medical system has created a culture that prioritizes control and convenience over the pregnant body, not one that prioritizes patients' best interests, consent, or the best outcomes. There is also a major focus on mortality rates in the United States, yet there is much less focus on patient morbidity. Mothers are told that because they have a healthy baby that they should feel happy and thankful. If infants do not experience permanent injuries, then it is very rare that lawyers will take up obstetric violence cases. There is little conversation surrounding traumatic birth experiences, and doctors hide behind the rhetoric that they need to take these measures to deliver a healthy baby. This idea needs to be challenged, evidence based medicine needs to be practiced, and informed consent needs to be a part of the equation at all times.

Another narrative is that of Jessica Roach's who gave birth to her second daughter at just 34 weeks and 5 days. She experienced dizzy spells, nausea, and food aversions during her pregnancy which eventually resulted in bed rest and her cervix dilating too early. Jessica's story is one that is very common for African American women in the United States who are "two to three times more likely than white women to give birth to a premature child. African American women are also four times more likely to die as a result of pregnancy and childbirth"(Perez, 2019). Jessica was very familiar with these statistics because at the time of the birth of her second daughter she was a nurse and believed she would not fall prey to this statistics because she had moved out of the projects, and had access to quality healthcare. She had addressed the major social determinants of health, which are oftentimes stated to be the reason for these statistics. Roach, who has since committed her career to supporting mothers like her, draws attention to the fact that these social determinants don't fully explain the stress of daily life for Black people. Roach describes how in her workplace she "had to perform at 120% whereas my

white counterparts only had to perform at 80%. Studies regarding the impact of stress on health during pregnancy show how such conditions can create the kind of outcomes that Roach faced" (Perez, 2019). This can explain why middle-class Black women face higher rates of infant mortality than low-income white women. Famous tennis player Serena Williams's, almost died giving birth in a hospital after a C-section. She experienced a blood clot in her lung and because the hospital staff did not listen to her, she had to advocate for the care that she needed. Women of color are oftentimes in a "materno-toxic zone" while giving birth because the people around them "perceive, respond and react in a way that puts their lives at risk" (Perez, 2019). This means that when they are forced to advocate for themselves, and oftentimes their voices are ignored.

Despite being aware of the statistics and working in a healthcare profession, Jessica gave birth to a preterm infant, which could have been a result of the racism she encountered in her daily life. There is a major Black/White disparity in maternal and infant health outcomes in the United States, yet efforts to address this disparity in a widespread way are lacking. Roach and other leaders have started programs to offer support to women of color during their pregnancy and have had very successful results. She describes the most important factor as, "comprehensive, consistent and accessible care, starting early in pregnancy and extending into the infant's early life. Another is the creation of a supportive environment – whether through prenatal clinic care or doula visits – and social and emotional support likely to buffer the daily stresses of racism"(Perez, 2019). As demonstrated earlier in this thesis, women of color's voices are often disregarded during the birthing experience, and they experience greater pressure from obstetricians during birth to have cesarean sections. Racism affects every aspect of the birthing experience, from the daily encounters of racism that can lead to adverse outcomes, to racism

from the hospitals and healthcare staff that ignores women of colors voices and pressures them to undergo more unnecessary medical procedures.

This next narrative deals with the criminalization of the pregnant body. This narrative is outlined in Susan Boyd's book and is about a women named Regina McKnight who was convicted of homicide by child abuse. She gave birth to a stillborn infant and was charged with homicide by child abuse and she was sentenced to twenty years. Regina Mcknight was an African American woman who did not receive a fair trial. According to Boyd's analysis of the court transcripts, "it is obvious that the state attempted to keep African Americans off the jury by using four of six strikes to eliminate them during the jury-selection process" (Boyd, 2004, p. 114). There were also several flaws in the evidence presented at trial. The first pathologist stated that three factors may have been the cause of death for the infant, those included the disease of chorioamnionitis or funisitis, or the presence of benzoylecgonine, which is a breakdown product in the metabolism of cocaine. It is important to note that the diseases of either chorioamnionitis or funisitis on their own could have been the cause of the infant's death, and women who do not use drugs can develop these diseases, which can result in stillbirths. It was never determined how the benzoylecgonine was in the stillborn's system and it was not established if that level found in the infant would have been sufficient to cause death. However, the State argued since it was "undermined, it must have been the cocaine which was introduced through the placenta" (Boyd, 2004, p. 114).

The State painted Regina to be a villain and the person who neglected her fetus. They stated that "Regina McKnight was sucking on a crack pipe. While most mothers would jump in front of a school bus to protect a young child, the crack pipe is still there" (Boyd, 2004, p. 114). The State used Western ideologies of the selfless mother, and constructed Regina to be in

opposition to this ideology. They framed Regina as a person whose "compulsion to use crack overrode her maternal instincts" (Boyd, 2004, p. 115), which they then attempted to state resulted in her fetuses' death. This rationale can have several negative implications for women who suffer from a miscarriage or a stillbirth. Regina was homeless and instead of receiving support after stillbirth, she was charged with a criminal offense because she was suspected of drug use. Placing the blame on the mother for this tragedy can be very traumatic and has several legal implications as well. It treats women as vessels that are potentially dangerous to the developing fetus (Boyd, 2004, p. 115). It also gives the legal rights of a born child to a fetus. Instead of providing support for women who are suspected of using drugs while pregnant, the State prosecutes them and punishes them. Instead of providing resources that could result in better health outcomes the State prioritizes punishment and control, despite evidence that this is not an effective way to prevent pregnant women from using drugs.

Thankfully this case was brought to court again and unanimously overturned. This case was overruled by relying on real science. They were able to prove that Regina's conviction was not based on scientific fact, since "unbiased scientific research has not found that prenatal exposure to any of the illegal drugs causes unique or even inevitable harm" (Paltrow et al., 2013). The entire case was based on the non-scientific claim that Regina's use of cocaine caused the stillbirth. In this case, the State relied on outdated studies that were biased and failed to call experts who could have testified about how, "recent studies showing that cocaine is no more harmful to a fetus than nicotine use, poor nutrition, lack of prenatal care, or other conditions commonly associated with the urban poor" (Stone, 2015). Instead, the State used these studies that perpetuate harmful stereotypes. This case shows that the State would rather wrongfully punish these women for the stillbirth, then use studies that are based on real scientific evidence.

This harmful rhetoric stems from the Reagan Administration's creation of the hysteria surrounding “crack babies” and shows how this false narrative started decades ago is still affecting women today.

Potential Avenues for Change: Addressing Over-Medicalization

As demonstrated in this paper, the way that pregnant women are treated in the United States is problematic. This is a very complex issue and stems from multiple conditions; therefore, there is no simple solution to help combat the issues that exist. These suggested avenues for change will not eliminate the problems that exist in relation to birth in the United States; however, they are a step in a direction to give pregnant women autonomy over their bodies, as well as reduce some of the mistreatment that occurs. This section will deal with potential solutions to help reduce the over-medicalization of the pregnant body. Suggested avenues for change will include: examining the American College of Obstetricians and Gynecologists (ACOGs) policies and recommendations and looking at the discrepancies that exist between recommendations and what is being practiced, practicing evidence based medicine, changing hospitals cultures, changing medical schools students education to reframe the way pregnancy is viewed, introducing more midwifery care, allowing Medicaid to cover midwifery care, and legalizing midwives. Some of these solutions are harder to enact than others but to have the greatest impact, all of these changes would have to be enacted.

To start, it is essential to examine ACOG'S recommendations for labor and birth. Many would be surprised to learn that ACOG has several different recommendations and opinion pieces on how to limit medical intervention and prevent cesarean sections. ACOG admits that C-sections are overused which demonstrates that use of the cesarean is not always best practice.

The reality is, “a woman giving birth by cesarean is more likely to die than a woman giving birth vaginally-four times more likely” (Block, 2008, p. 118). ACOG is well aware of these statistics, as well as the fact that 1 in 3 births in the United States, result in cesarean sections. The fact that ACOG is actively working to publish information on how to safely prevent cesarean sections is positive. It is essential that obstetricians are keeping current with the college's recommendations and practicing them. The goal behind ACOG is to recommend evidence based guidelines so that obstetricians can follow them. ACOG, managed care, and malpractice insurance control what methods and interventions are pushed, which is why evidence based obstetrics is essential.

ACOG gives several recommendations that seem to be in direct conflict with what is actually practiced. In many hospitals there are different protocols that require women to birth in certain positions. The most common of these being the supine position, or laying on the back. However, this position is one of the least optimal birthing positions. There is no gravity helping out the birthing person, and when the mother is laying down it is the baby's fragile frontal bones that have to bear the force against her sacrum. This position is “best for the birth attendants, but it does not appear to be in the best interest of mothers and babies” (Trevathan, 105). ACOG recognizes this, and states that, “the traditional supine position during labor has known adverse effects such as supine hypotension and more frequent fetal heart rate decelerations. Therefore, for most women, no one position needs to be mandated or proscribed” (ACOG, 2017). Hospitals often require this position because it is easier to control the birth, and can be required for liability reasons. However, this is an example of not practicing evidence based medicine, because it can cause adverse effects and there is no reason to require a woman to remain in this position while giving birth. This is an example of insurance and policy contradicting what is best for the women and baby. ACOG encourages frequent position changes as a way to enhance comfort, and as a

way to get the fetus into optimal position (ACOG, 2017). It is much harder to change the fetal positioning, if the mother is laying on her back and is not allowed to move herself. However, many hospitals do not have the staff to permit women to walk around during labor, especially if she has an IV or other interventions. Women need to be informed that with more medical interventions often comes more restricted policies because of liability risks. There needs to be a shift in hospital policy to make the birth experience best for the mother and the baby, not what is best for the obstetrician.

ACOG has published an article on the ways to limit intervention during birth and labor and these recommendations should be seen as a positive. One suggestion that ACOG states to minimize labor intervention is that "women with normally progressing labor and no evidence of fetal compromise, routine amniotomy need not be undertaken unless required to facilitate monitoring" (ACOG, 2017). Routine amniotomy is also known as breaking the water, which is often done to speed up the labor process. As outlined earlier in the paper, in the 1900's labor became a standardized process and protocols were put in place to make sure that every woman who was giving birth in a hospital was within these standardized numbers. Breaking the water oftentimes begins the cycle of medical interventions.

One standard policy in many hospitals is if a woman's labor does not occur within a certain timeframe, a cesarean section is necessary. This standard is loosely based on Friedman's Curve, which was presented as the standardization of the normal birthing timing. However, according to ACOG and more recent studies, certain phases or labor are slower than the standard rate derived from Friedman's work. This has caused ACOG to change some of their recommendations. For example the latent phase of labor, which is defined as the first stages of labor, when a woman first notices contractions, has previously been stated to be "prolonged" if it

lasts longer than 20 hours if the woman has never given birth before. Oftentimes, if this phase lasts longer than 20 hours, obstetricians take this as an indication for a cesarean section. However, ACOG states that a prolonged latent phase of labor should not be an indication for a cesarean delivery (ACOG, 2019). This also means that different definitions like labor dystocia need to be further examined, "because recent data show that contemporary labor progresses at a rate substantially slower than what has been historically taught"(ACOG, 2019). Although, redefining a word may not seem like significant change, a woman who would have been considered to have abnormally slow labor would likely have received a cesarean or other form of medical intervention under a different definition.

Labor induction is also performed for convenience and control. However, "inducing labor increases the odds of an emergency cesarean section, along with its attendant risks without improving fetal outcomes" (Block, 2008, p. 10). The practice of amniotomy is one method that is used to induce labor. However, as demonstrated this is not always in the best interest of the mother or the fetus and the tendency to "jumpstart labor has nothing to do with the women's bodies, its convenience" (Block, 2008, p. 14). Once the water is broken, most hospitals have a policy that the woman must go into labor within 24 hours. This means that once the water is broken the woman is on a deadline, which may lead to more medical interventions, like the use of Pitocin. When you induce labor, "the baby has not said, I am ready, I am mature, and states that induced labor is premature labor" (Block, 2008, p. 140). Medical interventions tend to increase the likelihood of a cesarean section and this is why they should be used when medically necessary, and patients should have informed consent and understand the risks that these medical interventions pose. ACOG states that, "multiple nonpharmacological and pharmacologic techniques can be used to help women cope with labor pain. Most women can be offered a

variety of nonpharmacological techniques. None of the nonpharmacologic techniques have been found to adversely affect the woman, the fetus, or the progress of labor" (ACOG, 2019). Instead of immediately pushing for epidurals or other medical interventions, different techniques should be offered as alternatives like, intradermal sterile water injections, relaxation techniques, acupuncture, transcutaneous electrical nerve stimulation, and aromatherapy, which may result in reduction of pain. There are times when pharmacological interventions are necessary; however, women need to be informed of the risks that are associated with these interventions. They should be offered alternative options to help cope with labor pain, especially since none of these interventions have been found to adversely affect the woman or the fetus, when medicalized interventions have been found to have adverse effects.

ACOG is very influential in the field of obstetrics and, "what ACOG says becomes the legal standard of care" (Block, 2008, p. 265). Their push for less medical interventions and recommending evidence based care is a positive progression. However, "a 2006 analysis of ACOG obstetric recommendations found that only 23% were based on good and consistent scientific evidence" (Block, 2008, p. 266). ACOG needs to endorse evidence based care and make recommendations that are not only in their best interest, but in the best interest of mother and baby. Although improvements can still be made, ACOG has begun the process of publishing information about decreasing unnecessary medical interventions which is an important step to help prevent the over-medicalization of birth. However, the field of obstetrics has been slow to follow their lead. This stems from the vast difference in hospitals' cultures across the country and the manner in which medical school students are being educated.

It is important to understand how doctors are being educated as it can heavily influence the way in which they practice medicine. Newer doctors are more likely to try new techniques,

which means it is important to teach them methods that involve less medical intervention. If an obstetrician is trained at a hospital where their attending is very likely to resort to a cesarean section when it is not medically necessary, it is likely that the resident will follow suit in their future career. The opposite could occur if a resident has an attending who is more likely to try other methods and positioning before using medical interventions. Because of the hierarchical structure in medicine, it can be challenging for a resident to question an attending or a nurse to question the obstetrician in the choices that they are making. This means that even if a resident was trained to use less medical intervention, it will have little impact if the culture of the hospital does not promote this. Individual hospitals have different policies and cultures that either incentivize less medical intervention, or that push for more medical interventions. There needs to be consistency across hospitals and a push to change hospital cultures to promote the best interest of patients.

This discrepancy across hospitals is important to pay attention to because only certain hospitals accept Medicaid and therefore a woman may not have a choice but to go to a hospital with a high cesarean section rate, even if she has the desire to have a physiological birth. The current viewpoint is that the female body has been constructed to be "essentially faulty; their reproductive bodies as potentially dangerous to babies; childbirth as so fraught with danger as to be unthinkable without biomedical surveillance and intervention" (Cheyney, 2011, p. 526). The media has also helped perpetuate these ideas. Most movies that have a birth scene show a woman hooked up to several machines lying flat on a bed screaming in pain. The United States has created a culture of fear surrounding birth that has convinced many women that they are not capable of giving birth without medical intervention. This framing creates the push for medical intervention immediately, without attempting non pharmacological methods, and without proper

informed consent. In many countries with better birth outcomes, this same culture of fear is less prominent. There should be a reframing of how pregnant bodies are viewed during the birthing process and that needs to be taught in medical school. This reframing will only occur if obstetrics pushes towards practicing evidence based medicine, and malpractice insurance allows this. Hospitals should have the ability to change their policies to do what is in the best interest of the mother, and allow for her to have autonomy over the birth process. This could mean that the mother is allowed to have a birth with several medical interventions, or one with no medical interventions. Women need to have autonomy over the process, and informed consent over what is being done, and policies need to reflect that.

Potential Avenues for Change: Looking to Midwives and Doulas

It is important to note that the United States is one of the few countries that have obstetricians in charge of the birthing process. In many countries, obstetricians are only called in when they are medically needed. Instead, midwives run the labor floors. Midwives are trained in several different methods and are less likely to use medical intervention. Medical intervention is viewed as a last resort and only used after several other methods are tried or when they are absolutely necessary. The threshold for performing cesarean sections is higher, which causes the percentage of women who undergo cesarean sections to be lower. Therefore, incorporating midwifery care is one suggested avenue for change to help prevent unnecessary medical intervention and help combat the over-medicalization of birth.

Currently in the United States, only 8.3% of US births are attended by midwives and since 94.3% of these births took place in a hospital setting, it is likely that the midwife coordinated with an obstetrician during the delivery process (ACNM, 2016). According to the

CDC, less than 2% of births take place outside of a hospital setting in the US (MacDorman, et.al, 2014). It is important to think about how the role of the obstetrician and the midwife differs, "obstetricians are surgeons, and know pathology, but they really suck at wellness. They are trained to sew up a tear, but not to prevent one" (Block, 2008, p. 176). Because obstetricians are trained to see pathology in their patients, this creates a stronger push to see pathology in pregnancy instead of seeing it as a physiological process. This is in contrast to the midwife who is trained less in pathology and more in wellness. This difference in training causes them to treat pregnancy and birth differently.

The United States has not adopted the practice of utilizing the midwife in the birthing process. However, there are several studies that demonstrate the importance of midwives and showed that, "integration was significantly associated with higher rates of spontaneous vaginal birth… as well as lower rates of obstetric interventions, preterm birth, low birth weight infants, and neonatal death" (Vedam et al., 2018). In an analysis of different countries' maternal health policies, "countries that had sustained a 20-year decrease in maternal mortality had increased country-wide access to health care through targeted investment in midwifery services" (Vedam et al., 2018). In the United States, midwifery care could be seen as a potential solution in communities where access to maternity care is scarce. Therefore, expanding access to midwifery care could serve as not only a way to help public health challenges but also a way to help the human health resource challenges (Vedam et al., 2018). Midwives help increase access to care and midwife integration promotes greater maternal and infant birth outcomes. They also save money at the population level (Vedam et al., 2018).

Midwives are associated with better birth outcomes, yet they face several barriers to practicing in the United States. A woman who chooses to have a midwife for her birthing process

may also face barriers as well. In many states there is a very low density of midwives, which can make finding them challenging. This challenge is compounded by the fact that "all midwives are not universally licensed to practice or integrated into regional health care systems. American midwives face multiple challenges to practicing, including numerous regulatory barriers and inability to secure third party reimbursement. As a result, women in many states cannot access midwives because of legal or payer restrictions" (Vedam et al., 2018, p. 2). Certified nurse midwives (CNMs) are legal in every state, but there is another type of midwife called the certified professional midwives (CPM) that is not recognized in all states. ACOG does not nationally recognize the CPMs as a practitioner, even though they have extensive training in the field of childbirth. There are 21 states in which CPMs are licensed, however even in the states where they are recognized, they face several barriers to reimbursement. They are trained, credentialed providers, which means that in these states they are entitled to Medicaid reimbursement by law, although many states do not comply (Block, 2008, p. 179). CPMs should not be facing these barriers to practice and Medicaid as well as private insurance should cover all forms of midwifery care. Midwifery models produce better outcomes and are less expensive and therefore it is counterintuitive that there is little integration in the United States. Studies have shown that a woman is more likely to have a positive birth experience when she feels she is in control (Block, 2008, p. 163). This means that women should have the autonomy to select the medical providers of their choosing to assist in the birthing process and midwives should be an option. Integrating midwifery care and removing barriers preventing midwives from practicing is an important step in helping in preventing over-medicalization of birth and in increasing access to care.

Another actor in the birthing process that is shown to be extremely beneficial is the doula. A doula is a person that offers continuous one-to one emotional support during the process. She is more than a hand holder or a cheerleader but also serves as an advocate, witness, and negotiator in the birthing process. They are currently the “most highly rated form of labor support in hospital settings, above doctors, nurses, partners and even nurse midwives" (Block, 2008, p. 154). Studies have shown that they help to decrease cesarean sections and other medical interventions. It was found that “among women who had doula support, there were half as many cesareans, one-third less use of forceps, and minimal request for epidural anesthesia -11% compared to 60% among the unsupported group” (Block, 2008, p. 155). Doulas have a difficult task at hand during the birthing process, especially in a technocratic hospital setting. They attempt to maintain a “protective bubble around their clients so that physiological labor can progress unheeded and unhurried” (Block, 2008, p. 157). It should be noted that doulas are typically not covered by insurance, and thus require out-of-pocket payments, making them mostly available for women of means. Increasing access to doulas for everyone is an important step to helping increase health equity under the current model of technocratic birth in the United States.

One important aspect about doulas is that they are instructed to support women's choices and not to give medical advice. They are not supposed to infringe on the roles of the nurse and the physician. The role of the doulas and childbirth educators is to help advocate for the woman during the birthing process and to help give them “unbiased” information so that they can make their own decisions about the birthing process. However, access to this unbiased information is not easy to find and many “doulas and childbirth educators often bite their tongues even when they have information that is crucial to a woman's decision making” (Block, 2008, p. 164). It is

still framed as a woman's responsibility to “do their homework” (Block, 2008, p. 164) on the cultures of the hospitals and the hospital's policies.

It can be hard to find information from reliable sources and women may not have the agency or ability and resources to access this information. This notion is individualistic and places the burden on the female. The idea that doulas are birth educators who are supposed to support the women's choices can be convoluted if there is not access to full information because, “freedom of choice does not exist without full information” (Block, 2008, p. 165). This makes the idea of informed consent very challenging to achieve since many women are not fully aware of what they are consenting to because there is not full access to information. There needs to be more transparency and access to information so that women are able to provide their informed consent.

Even in cases where women have access to information, desires about their birth experiences are often ignored. An episiotomy is one of the most common examples of a procedure that occurs during the birthing process without a woman's consent. Only “17% of women who got an episiotomy reported having a choice in the matter, and race was a strong determinant. A mere 4% of black women have a say in whether they were cut” (Block, 2008, p. 154). According to a survey by the Childbirth Connection in 2005, “80% of woman agreed that they should be informed of every possible side effect before consenting to a procedure, less than half could correctly identify the risks of induction, and less than one-third were familiar with the risks of cesarean sections” (Block, 2008, p. 154). Women need to be fully aware of all of the risks and side effects that come with all procedures so that they can have informed consent. In many cases, women do not provide their informed consent and experience a major loss of autonomy during the birthing process. Childbirth is a loss of control over the body, but in a

hospital setting the surrender is usually of the body to the provider because “women often lose control over what’s done to the body, rather than over what the body does” (Block 165). This has made the experience of birth a traumatic one for many women across the United States. Additionally, there is a lack of transparency over the facts of medical interventions in childbirth. The goal should be that every woman should provide informed consent in all aspects of her childbirth. The reality is that many women lack the agency and resources to have informed consent as it is complex and heavily tied to socioeconomic status and race. However, integrating midwifery care and increasing access to doulas is a step in the right direction to helping improve health outcomes and helping women regain autonomy over the birthing process.

Potential Avenues for Change: Adressing Criminalization

As demonstrated earlier in this paper the criminalization of pregnant women, and the treatment of women who are incarcerated and pregnant and give birth while incarcerated needs to be improved. Some of the potential avenues for change is increasing the number of pregnant women who use drugs access to treatment, stopping harsh sanctions for women who use drugs while pregnant, looking to other countries' maternity services as potential models, and providing doulas for incarcerated women.

As demonstrated earlier in this paper, a major challenge that women face is the lack of treatment facilities that will treat pregnant women. Women also need to not have the fear that going to these treatment facilities will end in the apprehension of their children by the State. Oftentimes when seeking support, women “have had their children apprehended, are denied privileges, medical care, and visits from family and friends; subjected to body searches, religious instruction, arbitrary rules and policy; experienced race, class and gender bias” (Boyd, 2004, p.

171). These can be major barriers and the model for drug services should be one that serves the needs of women and children. Increasing access to treatment facilities and providing a wide range of treatment programs in combination with other support services to change this narrative. There needs to be a shift of focus to the social factors that shape women's' drug use, instead of a prioritization of punishment of these women.

In addition to increasing access to treatment facilities for pregnant women, there needs to be a shift in the way the treatment facilities operate. Studies have shown that it is important to have a women-centered approach to OUD treatment because it can improve gender-specific outcomes, and may decrease barriers to treatment engagement in pregnancy (Krans et al., 2018). However, "despite the need to incorporate women-centered services during pregnancy, less than half of programs offer these services and fail to incorporate specific clinical pathways for pregnant and postpartum women" (Krans et al., 2018). Women-centered drug treatment is limited if it does not offer multiple avenues for stability and support. This treatment is not always fully comprehensive or inclusive and many existing programs are largely influenced by Christian rhetoric's. Most follow the 12-step program which has roots in Christian ideology. Boyd draws attention to how this can cause a barrier to Aboriginal women because the "services are developed by outsiders, which can be a barrier to reaching out for help" (Boyd, 2004, p. 170). The methods used in drug treatment can cause different racial/ethnic and religious conflicts and "Hispanic and Black women in drug treatment have criticized the confrontation techniques used in therapy" (Boyd, 2004, p. 170.) Clearly, access to drug treatment therapy needs to be more widespread and restructured to be more effective and more diverse in its ability to support women and their children.

Different models responding to illicit drug use by pregnant women have been used in other countries like Britain and Scotland. These countries provide services that ensure that women who use illegal drugs still have access to maternal care. This creates an environment that allows women who use drugs to have a similar birth experience to non-drug using women. These services allow "pregnant women non-judgmental prenatal and infant care without the threat of child apprehension. Despite high-risk categories, maternal outcomes have improved without legal and unwarranted medical intervention" (Boyd, 2004, p. 116). Some of the key aspects of the program is that random drug testing is not practiced and treatment is not coerced. The programs that are effective view drug use while pregnant as a manageable risk, and instead of using social workers as crisis interveners, they are used to provide economic and social support. These organizations recognize that "drug use by parents does not automatically indicate child neglect or abuse because automatic child abuse registration will deter parents from approaching drug dependence clinics for help" (Boyd, 2004, p.120). The approach provides voluntary maternal services which encompass a wide range of services from social, prenatal, and economic care to all women. As a result, "birth outcomes for women who use illegal drugs are similar to non-drug using women who use these services" (Boyd, 2004, p. 117). The primary reason stated for criminalizing pregnant women in the United States is rooted in the supposed adverse birth outcomes that accompany illegal drugs. However, this study demonstrates that by providing support and voluntary treatment, women in these programs have similar birth outcomes to women who do not use illegal drugs. Therefore, if the desire is to have better health outcomes in the United States, models such as this should be adopted and implemented.

However, as demonstrated earlier in this paper, in many states the exact opposite is occurring. Several states have enacted legislation to extend rights of the fetus to prosecute

pregnant women who use drugs. It is important to note that not all organizations are in agreement with this approach of persecution and punishment, including several prominent medical organizations. The ACOG states that "drug enforcement policies that deter women from seeking prenatal care are contrary to the welfare of the mother and fetus. Incarceration and the threat of incarceration have proved to be ineffective in reducing the incidence of alcohol or drug abuse" (ACOG, 2011). If the goal is to have better health outcomes, it is clear that punishment is not the solution. If a woman is seeking obstetric care it should not expose her to criminal or civil penalties, such as incarceration, involuntary commitment, loss of custody of her children, or loss of housing. These approaches treat addiction as a moral failing. However, addiction is a chronic, relapsing biological and behavioral disorder with genetic components (ACOG, 2011). This means that by making obstetricians mandatory reporters, it destroys the trust between doctor and patient. This is why ACOG encourages obstetricians and gynecologists to be aware of the reporting requirements in their states and to work with state legislators to change policy that punishes women for substance abuse during pregnancy. In states where there is "mandate reporting, policy makers, legislators, and physicians should work together to retract punitive legislation and identify and implement evidence-based strategies outside the legal system to address the needs of women with addictions" (ACOG, 2011). It is clear that policy change is necessary and new legislation drafted to stop the criminalization of women who are suspected of using drugs while they are pregnant.

There are organizations that have begun the process of protecting the rights of pregnant women and their children. The National Advocates for Pregnant Women (NAPW), has been at the forefront of arguing "that policy and laws that punish pregnant women and new mothers who use illegal drugs drive them out of the healthcare and social service system and endanger their

health" (Boyd, 2004, p. 121). The NAPW helped hold the state accountable in overturning Regina McKnight's case. They drew attention to the fact that the State used outdated studies and perpetuated harmful stereotypes. That policies, proposals, and laws impact poor women and women of color disproportionately and that these laws also ignore the fact that poverty negatively affects outcomes (Boyd, 2004, p. 122). Organizations like NAPW are helping to set a new precedent and drawing attention to the injustice occurring in the legal system. That the avenue for change is not through creating laws to punish, but instead in creating policy that supports.

Another potential avenue for change in achieving reproductive justice for incarcerated women is banning the practice of shackling not only federally, but across all states. Incarcerated women should also be allowed to utilize doulas. As demonstrated earlier in this paper, doulas are an effective tool to help advocate for women while they are giving birth. Allowing incarcerated women access to a doula would improve outcomes and increase agency. Pregnant incarcerated women are a very vulnerable population and many have extremely traumatic births. Facilities use restraints on pregnant incarcerated women and then many women must deal with the separation from their newborn immediately after giving birth. Therefore, having someone who emotionally can support them prenatally, during the birth, and in the weeks after the birth can be beneficial in helping birthing people recover from not getting to parent the newborn.

One program "developed, implemented and evaluated a multiagency, collaborative pilot program providing trained labor support (doulas) to pregnant women who delivered at a large teaching hospital while incarcerated in an urban jail facility" (Schroeder et al., 2005, p. 314). They offered this program to incarcerated women on a voluntary basis and were told that it would not affect their conditions in the jail or their cases in court. They found that no women

refused the service. These women met with the doulas several times before giving birth, and oftentimes the doulas were the only familiar face in the room when they delivered the baby. They interviewed these women who participated in the program and concluded this study demonstrated policy implications that doula birth support should be offered to all incarcerated pregnant women. Through the trial run, they demonstrated that "this program showed high feasibility and satisfaction and low costs, and every woman who participated said she would recommend the program to others. Long-term effects could be strengthened by building in a process of early intervention, harm reduction, and post release reunification"(Schroeder et al., 2005, p. 324). Pregnant women are a vulnerable population, and providing access to doula care is a way to help mitigate the trauma of being pregnant and incarcerated.

Ultimately, the criminalization of pregnant women who use drugs needs to be eliminated and prison and jail standards need to be improved. It has been demonstrated that it is not in the best interest of the fetus or the mother to punish them for using drugs while they are pregnant. By using methods that center around punishment and not supporting mothers, it is causing adverse health effects. If the end goal is to have the best health outcomes, different policies need to be enacted. Pregnant women who use drugs should have the option to receive treatment and the harsh sanctions for these women needs to stop. Finally, standardized levels of care for incarcerated pregnant women need to be followed and improved.

Conclusion

It needs to be addressed that the methods of examining ACOGs policies and recommendations practices, practicing evidence based medicine, changing hospitals' cultures, reframing how medical students are educated with reference to pregnancy, introducing more

midwifery care, allowing Medicaid to cover midwifery care, legalizing midwives, and stopping the criminalization of pregnant women, do not fully address one of the main systemic causes for adverse and maternal and infant outcomes, which is racism. This paper did not give potential avenues for change regarding how racism negatively affects women of color while they are pregnant and giving birth, but it needs to be noted that racism is one of the main causes of adverse effects. To be able to properly address this topic and provide appropriate suggested avenues for change is an entire thesis in itself; however, acknowledgement of its impact is necessary to understand the current state of giving birth in the United States.

There are several critiques that can be offered about the state of giving birth in the United States. The healthcare system in the U.S. incentivizes the overtreatment of pregnant women and high rates of medical intervention, which is contributing to negative maternal and neonatal birth outcomes. It is a very complex issue that does not have a simple solution. However, pushing for obstetrics to be evidence based, integrating midwifery care, and increasing access to doulas is a positive step towards helping curb the over-medicalization of birth in the United States. Reframing and creating policy that centers on best outcomes and the best interest of the mother and the infant, without infringing on her autonomy, should be the ultimate goal. The new policies should prioritize the mother and the infant, and not attempt to control them. All policies should be rooted in evidence and the punitive policies that center around the punishment of pregnant women for using drugs need to change. The state of giving birth in the United States is one that requires reevaluation and deep rooted change on a systemic level. The problems are extremely complex and deserve solutions that are equally as complex and inclusive. The goal should be to change the state of giving birth across the United States to be one that is better for all women.

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