



Going solo: the law and ethics of childbirth during the COVID-19 pandemic

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I. INTRODUCTION

Among the many devastating effects of the coronavirus disease 2019 (COVID-19) pandemic has been its impact on reproductive health and rights. In particularly outrageous fashion, several states across the USA, including Ohio, Texas, Iowa, Alabama, and Oklahoma, saw the pandemic as an opportunity to curtail women's access to abortion care by trying to characterize these procedures as nonessential medical services, barring doctors from providing them until further notice.¹ In some states, such as Ohio and Alabama, abortion providers won temporary injunctions against these restrictions; but in Texas and others, abortions remain restricted.² Women have also faced reproductive restraints in their access to contraceptive care. This became a global concern after many countries imposed national lockdowns—disrupting the manufacturing of key components of contraceptive methods, delaying the transportation of such methods,

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1 Abigail Abrams, *COVID-19 Could Permanently Make Abortions Harder to Access Nationwide*, TIME (Apr. 7, 2020), <https://time.com/5816530/coronavirus-abortion-clinics-access/> (accessed May 5, 2020). See also N.Y. Times Editorial Board, *Make Abortion More Available During the Pandemic—Not Less*, N.Y. TIMES (Mar. 26, 2020), <https://www.nytimes.com/2020/03/26/opinion/abortion-law-coronaviru.html> (accessed May 5, 2020).

2 Abrams, *supra* note 1.

or shutting down clinics providing reproductive health services by deeming them nonessential.³

Yet, the spread of the novel coronavirus put a strain on another aspect of women's reproductive lives: childbirth.⁴ One illustrative example comes from New York, which has become the epicenter of the American coronavirus outbreak. On March 18, 2020, the New York State Department of Health issued an advisory for hospitals regarding visitation protocols. It advised hospitals to 'suspend all visitation except when medically necessary (ie visitor is essential to the care of the patient) or for family members or legal representatives of patients in imminent end-of-life situations.'⁵ As soon as they were made public, the guidelines prompted confusion, and then anger, among expecting parents and their families. Some feared going through this emotionally and physically demanding experience alone; others would miss the opportunity to witness the birth of their child or grandchild.⁶ In response to the outcry against the new guidelines, the state health department updated its initial advisory and clarified that the recommended visitation policy would advise hospitals to allow one support person 'in labor and delivery settings.'⁷

Nevertheless, in the days following this updated publication, at least two leading hospital networks in New York City decided to bar spouses, partners, and other family members, as well as professional support people such as doulas, from their delivery rooms. A petition, signed by more than 600,000 people, called for the hospitals to overturn these policies;⁸ but that would not happen until New York Governor Andrew Cuomo issued an executive order, applying to both private and public hospitals, requiring hospitals to allow at least one support person to be present during childbirth.⁹ While many cheered the executive order, some medical professionals criticized it for

3 Taylor Riley, Elizabeth Sully, Zara Ahmed & Ann Biddlecom, *Estimates of the Potential Impact of the COVID-19 Pandemic on Sexual and Reproductive Health in Low- and Middle-Income Countries*, 46 INT'L PERSP. ON SEXUAL & REPROD. HEALTH 73 (2020). See also Cara Anna, *Millions of Women Lose Access to Birth Control Due to Coronavirus Lockdowns*, TIME (Apr. 9, 2020), <https://time.com/5818412/coronavirus-s-lockdown-birth-control/> (accessed May 5, 2020).

4 This essay uses the word 'women' throughout the analysis, consistent with the sources used and cited in it. The author nevertheless acknowledges that not all birthing people identify as women.

5 New York Department of Health, *Health Advisory: COVID-19 Guidance for Hospital Operators Regarding Visitation* (Mar. 18, 2020), available at <https://coronavirus.health.ny.gov/system/files/documents/2020/03/covid19-hospital-visitation-guidance-3.18.20.pdf> (accessed May 5, 2020).

6 Christina Caron & Katie Van Syckle, *Some Pregnant Women in New York City Will Have to Deliver Babies Alone*, N.Y. TIMES (Mar. 24, 2020), <https://www.nytimes.com/2020/03/24/parenting/coronavirus-labor-birth.html> (accessed May 5, 2020).

7 New York Department of Health, *Health Advisory: COVID-19 Guidance for Hospital Operators Regarding Visitation Updated Guidance Regarding Obstetrical and Pediatric Settings* (Mar. 27, 2020), available at https://coronavirus.health.ny.gov/system/files/documents/2020/03/doh_covid19_obpedsvisitation_032720.pdf (accessed May 5, 2020).

8 *Safeguard the Right of All Laboring People to Have Support During COVID-19 Crisis*, Change.org, <https://www.change.org/p/andrew-m-cuomo-safeguard-the-right-of-all-laboring-people-during-covid-19-crisis> (accessed May 5, 2020).

9 (Executive Order [Cuomo] No. 202.12), available at <https://www.governor.ny.gov/news/no-20212-continuing-temporary-suspension-and-modification-laws-relating-disaster-emergency> (accessed May 5, 2020).

being ‘uninformed and unethical’, putting at risk labor and delivery hospital staff and their patients.¹⁰

Considering that many states and hospitals have faced and are likely to face similar decisions, this essay maps the ethical and legal issues raised by hospital visitation rules that require women to give birth alone. Section II begins by outlining the principal ethical argument in favor of the ban, namely, protecting the health and safety of obstetric care providers, patients, and newborn babies from COVID-19. It then discusses the countervailing ethical argument, that such bans can exacerbate difficulties already inherent in the experience of childbirth. These difficulties primarily appear in three areas: the emotional hardship that childbirth may impose upon women and their partners, the physical needs of women both during and after labor and delivery, and the complexities surrounding the medical decision-making process childbirth involves. Section III considers both national and international legal frameworks through which women’s birthing rights may be affirmed, also pointing out where they fall short. Section IV makes three recommendations for how women’s rights during childbirth, including the right to a support person, may be better addressed by different legal actors, including scholars, courts, and legislators.

II. ETHICAL CONSIDERATIONS

After it was discovered that two women were infected with the virus at the time they gave birth in one of their hospitals, the New York-Presbyterian hospital network instituted a new policy barring partners and other support people from labor and delivery rooms.¹¹ According to one report, the mothers’ conditions deteriorated soon after the babies were born, and they had to be admitted to the intensive care unit.¹² More than 30 health care workers were exposed to these two patients, who showed no signs of infection upon arrival, before they were diagnosed with COVID-19.¹³

Indeed, the principal argument in favor of banning partners and support people was that it was necessary in order to protect the health and safety of medical staff, obstetric patients, and newborn babies. Considering how little is known about the effect of the virus on pregnancy, an article recently published in the *American Journal of Obstetrics & Gynecology* MFM argued that ‘[i]t is reasonable to suspect that asymptomatic COVID-19 presentations are common and represent a substantial contribution to disease spread.’¹⁴ The authors presented their experience with seven cases of confirmed COVID-19 cases in pregnancy (including the two women discussed above),

10 Louise P. King & Neel Shah, *The Ethical Argument Against Allowing Birth Partners in All New York Hospitals*, HARV. L. SCH. PETRIE-FLOM CTR. BILL OF HEALTH (Apr. 8, 2020), <https://blog.petrieflom.law.harvard.edu/2020/04/08/new-york-coronavirus-birth-partners/> (accessed May 5, 2020). See also Emily Bobrow, *A Chaotic Week for Pregnant Women in New York City*, NEW YORKER (Apr. 1, 2020), <https://www.newyorker.com/science/medical-dispatch/a-chaotic-week-for-pregnant-women-in-new-york-city> (accessed May 5, 2020).

11 Christina Caron & Katie Van Syckle, *The Babies Were Delivered. No One Realized the Mothers Had the Virus*, N.Y. TIMES (Mar. 27, 2020), <https://www.nytimes.com/2020/03/27/parenting/nyc-coronavirus-hospitals-delivery.html?action=click&module=RelatedLinks&pgtype=Article> (accessed May 5, 2020).

12 *Id.*

13 *Id.*

14 Noelle Breslin, Caitlin Baptiste, Russell Miller, Karin Fuchs, Dena Goffman, Cynthia Gyamfi-Bannerman & Mary D’Alton, *COVID-19 in Pregnancy: Early Lessons*, 2 AM. J. OBSTETRICS & GYNECOLOGY MFM 1, 3 (Supp. 2020).

and concluded that ‘health care workers are a vulnerable population as it relates to viral transmission risk . . . due to their increased exposure to COVID-19 positive patients, both known and undiagnosed, as well as inadequate PPE [Personal Protective Equipment] supplies.’¹⁵ Obstetrical care providers are particularly at risk because of ‘long periods of interaction with patients during labor, multiple team members involved in patient care, and the unpredictable occurrence of sudden obstetrical emergencies with their potential for unanticipated intubations in women undergoing labor and delivery.’¹⁶ The limited availability of testing, as well as the variation in testing protocols regarding the minimal symptoms that should prompt such testing, present further difficulties in managing the risk to obstetric personnel presented by the coronavirus.¹⁷

The argument that the health and safety of medical staff and patients justify imposing a ban on birth partners was echoed by medical professionals on the front lines of the coronavirus fight. For example, two Boston-based obstetric gynecologists called Governor Cuomo’s executive order mandating that all New York hospitals allow birth partners, ‘uninformed and unethical.’¹⁸ They argued instead that it should be left for hospitals to make ‘difficult decisions’ in order to protect their health care workers, and that this ‘does not represent a failure to recognize the individual suffering faced by women giving birth without their partner of choice.’¹⁹ The authors highlighted the lack of adequate personal protective equipment, including N95 masks, which places labor and delivery providers at unique risk of infection.²⁰ Yet they also focused on the Governor’s decision to make an exception for pregnant women, when so many others require health care or are otherwise affected by the pandemic. The coronavirus outbreak has led to delays and cancellations of elective procedures, surgeries, and even cancer treatments that were deemed nonessential or nonurgent,²¹ all in order to free up medical staff, clear bed space, and conserve protective equipment, like gloves and gowns, for coronavirus patients.

These practitioners made a further, undeniable observation: ‘Just as there are heart-breaking stories of people birthing alone, there are heartbreaking stories of people dying alone.’²² Due to strict visitation policies implemented by medical facilities across the country, many people have lost the opportunity to be surrounded by their loved ones in their final moments. Friends and relatives have had to say goodbye over an ‘awkward’ Zoom videoconference, or through a phone placed in a plastic bag and held to the patient’s ear by a nurse.²³ For some elderly patients, even worse than the fear dying

15 *Id.*

16 *Id.*

17 *Id.*

18 King & Shah, *supra* note 10.

19 *Id.*

20 *Id.*

21 Daniel Boffa, *Will the Coronavirus Delay My Cancer Surgery?*, N.Y. TIMES (Apr. 15, 2020), <https://www.nytimes.com/2020/04/15/opinion/coronavirus-cancer-surgery.html> (accessed May 5, 2020).

22 King & Shah, *supra* note 10.

23 Jennifer Levitz & Paul Berger, *I’m Sorry I Cannot Kiss You’—Coronavirus Victims Are Dying Alone*, WALL ST. J. (Apr. 10, 2020), <https://www.wsj.com/articles/im-sorry-i-cant-kiss-you-coronavirus-victims-are-dying-alone-11586534526> (accessed May 5, 2020).

is the fear of ‘dying alone’, which ‘feels like missing a last chapter on a life’²⁴—one that they may have planned and prepared for years ago.

But as sobering as it is to learn about the tragic losses people have suffered, it is also crucial to fully understand what laboring people and their families are at risk of losing when they are required to give birth alone. The rest of this section therefore considers three interrelated issues that should inform the ethical debate over childbirth visitation bans: the emotional hardship that childbirth entails for women and their partners, the physical needs of women both during and after labor and delivery, and the medical decision making childbirth involves.

To begin, despite the physical and emotional hardship it entails, most people still perceive childbirth, first and foremost, as a joyful and exciting event. In recent years, however, there has been a growing recognition that many women around the world, including in the USA,²⁵ experience childbirth quite differently. Terms such as trauma and distress, and even violence and control are now being used to describe the experience of giving birth.²⁶ This growing awareness has led the World Health Organization (WHO) in 2014 to recognize that ‘[m]any women across the globe experience disrespectful, abusive or neglectful treatment during childbirth in facilities.’²⁷ In this context, research reveals that ‘[c]ommunication between women and health care professionals is sometimes inadequate and medical professionals give insufficient attention to women’s concerns’, with some reporting neglect or complete abandonment during childbirth.²⁸ These problems may result from staff shortages, constraints on necessary supplies, and problematic facility policies.²⁹ Consequently, while ‘[w]omen and their babies may survive childbirth [their] experience of facility-based care has left them traumatized.’³⁰

Indeed, labor and delivery are now recognized as having the potential to fulfill the ‘traumatic stressor criteria,’³¹ which explains why ‘[a]pproximately three to four per cent of women develop the full constellation of symptoms of posttraumatic stress disorder (PTSD).’³² Among the birth-related factors that can contribute to the development of postpartum PTSD are ‘perceived low control during birth or a negative gap between expectation and experience of the birth, a lack of support of partner or

24 John Leland, *At 89, She Fears Dying Alone More Than the Coronavirus Itself*, N.Y. TIMES (Apr. 7, 2020), <https://www.nytimes.com/2020/04/07/nyregion/dying-alone-coronavirus.html> (accessed May 5, 2020).

25 See, eg Elizabeth Kukura, *Obstetric Violence*, 106 GEO. L.J. 721 (2018) [hereinafter Kukura, *Obstetric Violence*]; Maria T. R. Borges, *A Violent Birth: Reframing Coerced Procedures During Childbirth as Obstetric Violence*, 67 DUKE L.J. 827 (2018); Farah Diaz-Tello, *Invisible Wounds: Obstetric Violence in the United States*, 24 REPROD. HEALTH MATTERS 56 (2016).

26 CHILD BIRTH, VULNERABILITY AND LAW: EXPLORING ISSUES OF VIOLENCE AND CONTROL 1 (Camilla Pickles & Jonathan Herring eds., 2019) [hereinafter CHILD BIRTH, VULNERABILITY & LAW].

27 World Health Organization, *The Prevention and Elimination of Disrespect and Abuse During Facility-Based Childbirth* (2014), available at https://apps.who.int/iris/bitstream/handle/10665/134588/WHO_RHR_14.23_eng.pdf?sequence=1 (accessed May 5, 2020).

28 Camilla Pickles & Jonathan Herring, *Introduction*, in CHILD BIRTH, VULNERABILITY & LAW, *supra* note 26, at 1, 1–2.

29 *Id.* at 2.

30 *Id.*

31 Antje Horsch & Susan Garthus-Niegel, *Posttraumatic Stress Disorder Following Childbirth*, in CHILD BIRTH, VULNERABILITY & LAW, *supra* note 26, at 49, 49.

32 *Id.* at 50.

staff, an emergency cesarean section (ECS), or an instrumental vaginal delivery.³³ The consequences of developing PTSD following childbirth include high levels of distress, suicidal thoughts, a loss of identity and sense of competency as a mother, and even the decision not to have further children.³⁴ Having a traumatic birth experience may impact not just the mother, but also the whole family, as ‘women may blame their partners for the events that took place’ or find it harder to develop strong bonds and secure attachments with their baby, who continues to be a reminder of traumatic experiences.³⁵

It is within this fuller context that the implications of requiring women to birth alone should be evaluated. Each of the above-mentioned factors, known to contribute to an environment in which women may experience a traumatic birth, can in some way be linked to the absence of a support person while giving birth. Having another person by one’s side during childbirth may mean, for example, a greater ability to voice and communicate the mother’s concerns to the medical staff; it may reduce the risk that the mother will be left alone during childbirth because medical staff are limited and/or overworked; and it may contribute to a greater sense of control over a situation that is rather chaotic in nature.

More importantly, the adverse effects of not having a support person present during childbirth are being exacerbated by general strains on the system caused by the current pandemic. Not only do pregnant women report feeling more stressed and anxious about the prospect of giving birth,³⁶ but hospitals are evidently already overworked, short staffed, and underequipped in ways that may directly affect their ability to tend to birthing women’s needs. This ethical argument, therefore, also includes a consideration of the harm that results from the practical consequences of giving birth without a support person when obstetrics care staff have a limited ability to tend the physical needs of patients during and after birth, such as helping them get on and off the bed, go to the bathroom, and feed their babies.³⁷

Admittedly, only a small portion of women develop PTSD following childbirth. However, a substantial number of women suffer from clinically significant PTSD symptoms, even though their symptoms remain below the diagnostic threshold level.³⁸ And a much greater number—up to one-third of women who have given birth—perceive their delivery as traumatic.³⁹

33 *Id.* at 54.

34 *Id.* at 55–56.

35 *Id.* at 56–57.

36 See, eg Kimiko de Freytas-Tamura, *Pregnant and Scared of ‘Covid Hospitals’, They’re Giving Birth at Home*, N.Y. TIMES (Apr. 21, 2020), <https://www.nytimes.com/2020/04/21/nyregion/coronavirus-home-births.html> (accessed May 5, 2020); Anna North, *‘The Babies Keep Coming’: What the Coronavirus Pandemic Means for People Giving Birth*, VOX (Mar. 25, 2020), <https://www.vox.com/2020/3/19/21183224/pregnancy-and-coronavirus-birth-covid-19-pregnant> (accessed May 5, 2020); Nadine Jolie Courtney, *I’m Terrified to Give Birth During the Coronavirus Pandemic*, GOOD HOUSEKEEPING (Apr. 7, 2020), <https://www.goodhousekeeping.com/life/parenting/a32064908/pregnant-giving-birth-during-coronavirus/> (accessed May 5, 2020).

37 *After Vaginal Delivery—In the Hospital*, MEDLINEPLUS (reviewed Sept. 25, 2018), <https://medlineplus.gov/ency/patientinstructions/000629.htm> (accessed May 5, 2020).

38 Horsch & Garthus-Niegel, *supra* note 31, at 52.

39 *Id.* at 51.

But beyond the trauma, when discussing the emotional impact of the ban, there also has to be an acknowledgment of the loss that may be experienced when birthing plans are thwarted by the pandemic and the new policies it has prompted. Pregnant women and their families spend months preparing for childbirth: they read pregnancy books and websites, take childbirth education courses, and hire doulas. Those hoping for a less medicalized birth are even encouraged to create a written birth plan.⁴⁰ To minimize the ‘pregnant women’s sense of loss of agency in the birth process’,⁴¹ these plans often allow the laboring person to detail their preferences regarding the use of an epidural, their desired birthing position, and the use of a fetal heart rate monitor.⁴² Even before childbirth moved to the hospital, ‘birth plans were made with the help of family and friends. Who will be with me? How will I cope with the pain of labor? When will the midwife come? What do I need for the new baby? Who will care for me after the birth?’⁴³ However, it was during the 1980s that the *written* birth plan was introduced in order to help women clarify their desires and communicate these to their caregivers in an ‘increasingly medicalized maternity environment’.⁴⁴ But even without a written document, and notwithstanding the fact that only few births actually go according to plan,⁴⁵ people’s vision of their birthing experience usually includes, at the least, their partner by their side.

Partners, and more specifically expectant fathers, have not always been part of the hospital birth experience. Indeed, ‘for most human history, childbirth was exclusively a woman’s event. When a woman went into labor, she “called her women together” and left her husband and other male family members outside.’⁴⁶ It was mostly during the twentieth century, when childbirth moved from the home and into the hospital,⁴⁷ that women became more vocal about wanting their husbands to stay with them through hospital labor and delivery.⁴⁸ According to one account, because of the ‘physical move from their own homes to the physician’s institutions’, women ‘missed the companionship that had been theirs at home, and they often felt alone and alienated by the sterile and impersonal hospital environment.’⁴⁹

This change was arguably a reflection of marriages becoming emotionally closer, but also of men’s growing interest in becoming involved in this reproductive event.⁵⁰

40 For a critical account of this phenomenon, see Amy Michelle DeBaets, *From Birth Plan to Birth Partnership: Enhancing Communication in Childbirth*, 216 *AM. J. OBSTETRICS & GYNECOLOGY* 31, 31–32 (2017).

41 *Id.*

42 See, eg *Creating Your Birth Plan*, AM. PREGNANCY ASSN., <https://americanpregnancy.org/labor-and-birth/birth-plan/> (accessed May 5, 2020).

43 Judith Lothian, *Birth Plans: The Good, the Bad, and the Future*, 35 *J. OBSTETRIC, GYNECOLOGIC & NEONATAL NURSING* 295, 295 (2006).

44 *Id.*

45 See, eg Cynthia D. Smith, *On Birthing Plans and Birthing Outcomes: Perspectives from a Physician-Patient*, in *OBSTETRICS AND GYNECOLOGY: A COMPETENCY-BASED COMPANION* 515 (Michael Belden ed., 2010).

46 JUDITH WALZER LEAVITT, *MAKE ROOM FOR DADDY: THE JOURNEY FROM WAITING ROOM TO BIRTHING ROOM* 22 (2009).

47 *Id.* at 32. ‘Birth moved into the hospital very unevenly in the early twentieth century. Although half of all American women delivered in a hospital by 1938, the numbers varied widely by race and geographic area.’

48 *Id.* at 35.

49 *Id.* at 34.

50 *Id.* at 46–47.

At the time women were giving birth alone, ‘men sat, also alone, a few rooms away, in maternity waiting rooms’—an experience an increasing number of them found ‘frustrating and unsatisfactory.’⁵¹ The expectant fathers found themselves ‘increasingly curious about what the women were doing, concerned about their suffering, and eager to share the experience with the women they loved.’⁵² Even the men who did not choose to join their wives in the delivery room appreciated the opportunity to decide for themselves.⁵³ Soon, even obstetrics physicians sought more flexible hospital policies, ‘as they saw the benefits to the hospital staff and to themselves of having the men in the labor rooms supporting their wives.’⁵⁴

Today, however, expectant fathers have ‘created unprecedented new roles for themselves to participate in a traditionally women’s event.’⁵⁵ By supporting their partners and witnessing the births of their children, expectant parents are able to bond with their families ‘in new and mutually beneficial ways.’⁵⁶ Even though the effects of fathers’ attendance during childbirth are relatively understudied and undertheorized, some studies indicate that the presence of a companion during labor ‘can reduce the pain, anxiety, and fatigue of the mother’, and even shorten the labor.⁵⁷ The presence of a father in the delivery room may even lead to greater involvement in his child’s life.⁵⁸

The doors of the delivery room are now open not just to husbands: ‘male lovers, lesbian partners, adoptive parents, and other friends, family members, and siblings, whom the woman had identified as necessary to her well-being’, are now invited in.⁵⁹ Of course, these doors did not open for everyone at once. For example, lesbian partners were historically left out and disregarded by health care providers, and their role in the childbirth experience is still often misunderstood or ignored.⁶⁰ Furthermore, ‘[w]hile most clinical environments are welcoming to doulas at this point in time’, they are still banned from attending some delivery rooms.⁶¹ ‘Because of the intermediary position doulas occupy, the negotiations they perform are often highly loaded exchanges that almost always involve some measure of both resistance to and accommodation of mainstream obstetric practice.’⁶² Although such obstacles remain, medical facilities are now built to accommodate several people in the delivery rooms, and medical students are being taught how to ‘manage a crowd’ around the delivery bed.⁶³ Indeed, family

51 *Id.* at 47.

52 *Id.* at 85.

53 *Id.* at 81.

54 *Id.* at 84.

55 *Id.* at 286.

56 *Id.* at 285.

57 Lars Plantin, Adepeju Aderemi Olukoya & Pernilla Ny, *Positive Health Outcomes of Fathers’ Involvement in Pregnancy and Childbirth Paternal Support: A Scope Study Literature Review*, 9 *FATHERING* 87, 96 (2011).

58 Jennifer L. Bellamy, Matthew Thullen & Sydney Hans, *Effect of Low-Income Unmarried Fathers’ Presence at Birth on Involvement*, 77 *J. MARRIAGE & FAM.* 647 (2015). See also Shefaly Shorey, Lina Ang, Esther C.L. Goh, Mihir Gandhi, *Factors Influencing Paternal Involvement During Infancy: A Prospective Longitudinal Study*, 75 *J. ADVANCED NURSING* 357 (2019).

59 LEAVITT, *supra* note 46, at 284.

60 Alison J. McManus, Lauren P. Hunter & Hope Renn, *Lesbian Experiences and Needs During Childbirth: Guidance for Health Care Providers*, 35 *J. OBSTETRIC, GYNECOLOGIC & NEONATAL NURSING* 13, 16 (2006).

61 Monica Reese Basile, *Reproductive Justice and Childbirth Reform: Doulas as Agents of Social Change 99* (May, 2012) (Ph.D. thesis, University of Iowa) (ProQuest).

62 *Id.*

63 LEAVITT, *supra* note 46, at 285.

members and other supports persons are considered by many hospitals as ‘an important and necessary role in helping patients recover.’⁶⁴ This is especially true for obstetric departments across the country that in pre-coronavirus days prided themselves in providing overnight accommodations for partners or support persons and family-centered environment for siblings and other family members, as well as welcoming doulas.⁶⁵

Another factor that contributed to the mid-twentieth century entrance of spouses into labor rooms is that medical treatments, interventions, and procedures had been carried out without the woman’s full knowledge and consent.⁶⁶ Even research from recent years indicates that informed consent, which requires that patients understand the benefits and risks of proposed procedures and provide their consent, is not consistently obtained during childbirth.⁶⁷ Although this requirement of informed consent ‘is deeply enshrined in both US moral and legal doctrine,’⁶⁸ women’s birth stories reveal that they have been induced and sedated, and have even undergone cesarean sections without having given consent.⁶⁹ The pervasiveness of the phenomena prompted several scholars to underscore the idea that childbirth, in and of itself, does not constitute a ‘medical emergency’ as defined in the informed consent doctrine,⁷⁰ and that despite the pain of labor, women do retain the capacity to give informed consent during childbirth.⁷¹

The importance of informed consent, specifically in the context of childbirth, provides therefore a third element of the ethical argument against requiring women to give birth alone. The presence of a support person may be able to ensure that the laboring woman’s medical autonomy is not violated. For those who must give birth alone, not only is the person they would usually confide in and turn to when making reproductive health decisions missing; there is also no one close by to ensure that they receive the care they have agreed to. This may affect routine birth-related decisions

64 *Your Care Partners*, LENOX HILL HOSP. NORTHWELL HEALTH, <https://lenoxhill.northwell.edu/patients-families-visitors/your-care-partners> (accessed May 5, 2020).

65 See, eg *Labor and Delivery*, VALLEY HEALTH SYS., <https://www.valleyhealth.com/services/labor-and-delivery> (accessed May 5, 2020); *Labor & Delivery Services at University Hospitals Birthing Center in Cleveland, OH*, UH CLEVELAND MED. CTR., <https://www.uhhospitals.org/locations/uh-cleveland-medical-center/services/childbirth> (accessed May 5, 2020); *Labor and Delivery Care*, STANFORD CHILD. HEALTH, <https://www.stanfordchildrens.org/en/service/labor-and-delivery> (accessed May 5, 2020).

66 Martin P. Johnson, *An Exploration of Men’s Experience and Role at Childbirth*, 10 J. MEN’S STUDIES 165, 166 (2002).

67 See generally Allison B. Wolf & Sonya Charles, *Childbirth Is Not an Emergency: Informed Consent in Labor and Delivery*, 11 INT’L J. FEMINIST APPROACHES TO BIOETHICS 23 (2018); Christine H. Morton, Megan M. Henley, Marla Seacrist & Louise Marie Roth, *Bearing Witness: United States and Canadian Maternity Support Workers’ Observations of Disrespectful Care in Childbirth*, 45 BIRTH 263 (2018); Borges, *supra* note 25.

68 Wolf & Charles, *supra* note 67, at 23.

69 Jessica Flanigan, *Obstetric Autonomy and Informed Consent*, 19 ETHICAL THEORY & MORAL PRAC. 225 (2016).

70 ‘One of the four major exceptions to a physician’s requirement to obtain express informed consent is in the setting of a medical emergency . . . [A] medical emergency occurs when the patient is incompetent to make medical decisions and immediate medical action is necessary to prevent significant harm or to save a human life.’ Hindi Stohl, *Childbirth Is Not a Medical Emergency: Maternal Right to Informed Consent Throughout Labor and Delivery*, 38 J. LEGAL MED. 329, 336 (2018).

71 *Id.* at 343. See also Wolf & Charles, *supra* note 67.

about induction, pain relief measures, episiotomy, artificial rupture of membranes, and whether to be admitted to the hospital in the first place.⁷² But it is even more critical for decisions about whether to undergo surgical delivery, or other types of emergency medical procedures.⁷³

Lastly, for each of these considerations within the ethical debate over banning partners and support people from being present at childbirth, it is important to acknowledge the disproportionate effect such regulations may have across race, class, and gender. In a 2013 survey of American women who gave birth in 2011 and 2012, 13 per cent of respondents indicated that they experienced discrimination due to race, ethnicity, language, or culture during their hospitalization for childbirth.⁷⁴ A more recent study found, *inter alia*, that ‘Black women who delivered by cesarean reported strikingly lower levels of shared decision making compared to White women’, and that the ‘decision making process leading up to cesarean delivery was more likely to be problematic for Black women.’⁷⁵ As one obstetric physician from California explained, with regard to the effect hospital policies may have on women of color and at-risk people: ‘The marginalized just become more marginalized when there is stress on the system.’⁷⁶

Underscoring the differential effects the pandemic may have on those giving birth, a recent *New York Times* article described how some expectant mothers who can afford to do so have chosen to leave the state and give birth in areas ‘with less besieged hospitals and fewer coronavirus cases.’⁷⁷ In a more recent article, a New York-based physician explained that ‘[t]he hospitals that have been most overwhelmed by the pandemic are the same hospitals that Black and brown women in New York City are predominantly giving birth in.’⁷⁸ It is within this social context of medical provision that any policy

72 Kathleen Rice Simpson, *Partnering with Patients and Families during Childbirth: Confirming Knowledge for Informed Consent*, 44 AM. J. MATERNAL/CHILD NURSING 180 (2019).

73 Assuming, of course, the laboring person is not incapacitated, in which case it may fall under one of the four exceptions of the informed consent doctrine.

74 Eugene R. Declercq, Carol Sakala, Maureen P. Corry, Sandra Applebaum & Ariel Herrlich, *Listening to Mothers III: Pregnancy and Birth*, CHILD BIRTH CONNECTION (2013), available at <https://www.nationalpartnership.org/our-work/resources/health-care/maternity/listening-to-mothers-iii-pregnancy-and-birth-2013.pdf> (accessed May 5, 2020).

75 Laura B. Attanasio, Katy B. Kozhimannil, Kristen H. Kjerulf, *Factors Influencing Women’s Perceptions of Shared Decision Making During Labor and Delivery: Results from a Large-Scale Cohort Study of First Childbirth*, 101 PATIENT EDUC. & COUNS. 1130, 1134 (2018). See also Laura B. Attanasio & Rachel R. Hardeman, *Declined Care and Discrimination During the Childbirth Hospitalization*, 232 SOC. SCI. & MED. 270 (2019).

76 Eileen Guo, *Coronavirus Threatens an Already Strained Maternal Health System*, N.Y. TIMES (Mar. 26, 2020), <https://www.nytimes.com/2020/03/26/us/coronavirus-pregnancy-maternal-health-system.html> (accessed May 5, 2020). See also KHIARA M. BRIDGES, *REPRODUCING RACE: AN ETHNOGRAPHY OF PREGNANCY AS A SITE OF RACIALIZATION* (2011).

77 Christina Caron & Katie Van Syckle, *Some Pregnant Women Who Can Afford to Are Fleeing New York City*, N.Y. TIMES (Apr. 1, 2020), <https://www.nytimes.com/2020/04/01/parenting/pregnant-women-nyc-coronavirus.html> (accessed May 5, 2020).

78 Emily Bobrow, *She Was Pregnant with Twins During COVID. Why Did Only One Survive?* N.Y. TIMES (Aug. 6, 2020), <https://www.nytimes.com/2020/08/06/nyregion/childbirth-Covid-Black-mothers.html> (accessed May 5, 2020). But as the article notes, ‘even when Black and Latina women gave birth in the same New York City hospitals as white women, and had similar insurance, they were still more likely to experience a life-threatening complication than white mothers’. *Id.* See also Elizabeth A. Howell, Natalia N. Egorova, Teresa Janevic, Michael Brodman, Amy Balbierz, Jennifer Zeitlin & Paul L. Hebert, *Race and*

meant to regulate the childbirth experience should be evaluated—understanding all of the potential harms before weighing them against the benefits.

III. LEGAL CONSIDERATIONS

In addition to the ethical issues raised by the decision to regulate women's labor and delivery experience, there are also legal considerations about the nature of the rights at stake and the laws that protect these rights. As mentioned above, in 2004 the WHO released a statement that helped bring much-needed global attention to the fact that women experience various forms of disrespect and abuse during childbirth.⁷⁹ In a more recent statement, the organization stressed that '[e]very woman has the right to the highest attainable standard of health, which includes the right to dignified, respectful health care throughout pregnancy and childbirth, as well as the right to be free from violence and discrimination.'⁸⁰ Such behaviors can 'amount to a violation of a woman's fundamental human rights, as described in internationally adopted human rights standards and principles.'⁸¹ These include such rights as autonomy, dignity, and bodily integrity.⁸² Guidelines issued by the WHO and other organizations, including the International Federation of Gynecology and Obstetrics, the White Ribbon Alliance, and the International Pediatric Association, have proposed several criteria for establishing mother–baby friendly birthing facilities, which include allowing 'all birthing women the comfort of at least one person of her choice (eg father, partner, family member, friend, and traditional birth attendant as culturally appropriate) to be with her throughout labor and birth.'⁸³

Indeed, in the days following the publication of hospital policies that responded to the pandemic by banning partners and support people from obstetric departments, many reports and commentaries have pointed out the fact that such policies may not conform with international standards of care.⁸⁴ In some countries, forcing women to birth alone could also violate national laws that safeguard women's rights at childbirth. Argentina, for example, in 2004 adopted a legal framework that 'introduced a human rights-based approach to childbirth that was meant to ensure to women a more dignified and respectful experience in facility-based childbirth.'⁸⁵ And in 2007, Venezuela passed a law protecting the 'right of women to a life free of violence', which included

Ethnicity, Medical Insurance, and Within-Hospital Severe Maternal Morbidity Disparities, 135 *OBSTETRICS & GYNECOLOGY* 285 (2020).

79 Camilla Pickles, *Leaving Women Behind: The Application of Evidence-Based Guidelines, Law, and Obstetric Violence by Omission*, in *CHILDBIRTH, VULNERABILITY & LAW*, *supra* note 26, at 140, 140.

80 World Health Organization, *The Prevention and Elimination of Disrespect and Abuse During Facility-Based Childbirth* (2015), available at https://apps.who.int/iris/bitstream/handle/10665/134588/WHO_RHR_14.23_eng.pdf?sequence=1 (accessed May 5, 2020).

81 *Id.*

82 Elizabeth Prochaska, *Human Rights Law and Challenging Dehumanisation in Childbirth: A Practitioner's Perspective*, in *CHILDBIRTH, VULNERABILITY & LAW*, *supra* note 26, at 132, 132.

83 Int'l Fed'n Gynecology & Obstetrics, Int'l Confed'n Midwives, White Ribbon Alliance, Int'l Pediatric Ass'n, World Health Org., *FIGO Guidelines: Mother – Baby Friendly Birthing Facilities*, 128 *INT'L J. GYNECOLOGY & OBSTETRICS* 95, 96 (2015).

84 See, eg Irin Carmon, *More Hospitals Are Banning Partners From Delivery Rooms*, *CUT* (Mar. 23, 2020), <https://www.thecut.com/2020/03/delivery-room-visitor-bans-are-confusing-patients.html> (accessed May 5, 2020).

85 Borges, *supra* note 25, at 829.

specific provisions addressing the problem of obstetric violence, placing it within the broader context of gender-based violence.⁸⁶ The term ‘obstetric violence’ is defined as ‘... the appropriation of the body and reproductive processes of women by health personnel, which is expressed as dehumanized treatment, an abuse of medication, and to convert the natural processes into pathological ones, bringing with it loss of autonomy and the ability to decide freely about their bodies and sexuality, negatively impacting the quality of life of women.’⁸⁷ Despite this broad definition, in practice, the term obstetric violence has been construed narrowly in Venezuelan jurisprudence to focus on the misuse of medical interventions and ensuring ‘a more humanized approach to childbirth that supports childbirth as a physiological process.’⁸⁸

In stark contrast, legislatures and courts in the USA have done very little to address maternal health care. To begin, the USA has often failed to comply with or even acknowledge international standards related to maternal care, including those set forth by the WHO. Consider, for example, maternal mortality, which continues to be a problem in the USA. Human rights groups around the world have been calling on the USA to do more ‘to keep its mothers from dying’ since 2008,⁸⁹ pointing out that this failure may in fact violate ‘a variety of human rights, including the right to life, the right to freedom from discrimination, and the right to the highest attainable standard of health’, all of which are guaranteed by international treaties the USA has ratified.⁹⁰ Furthermore, a ‘huge international effort’ to reduce maternal mortality rates has been in the works since 2000, when the United Nations included this among its Millennium Development Goals.⁹¹ Nevertheless, ‘[c]ompared with the huge efforts in most other countries, there was no large, nationwide effort to reduce US maternal mortality linked to the Millennium Development Goals during this period.’⁹² In particular, its failure to adopt the World Health Organization definition of maternal death has resulted in ‘seriously flawed US maternal mortality data in its data collection’, which in turn hinders ‘the ability of the USA to prevent these tragic deaths.’⁹³ Indeed, while maternal mortality declined by 44 per cent worldwide from 1990 to 2015, it had increased in the USA by 27 per cent during the same time period.⁹⁴

Among constitutional rights, those of reproductive autonomy and bodily integrity may intuitively seem to encompass women’s rights during childbirth—potentially even the right to have a support person present during delivery. Yet a deeper examination reveals that neither is able to effectively safeguard or even articulate these rights. The

86 *Id.* at 829–830.

87 *Id.*

88 *Id.*

89 Amy Roeder, *America Is Failing Its Black Mothers*, HARV. PUB. HEALTH (Winter 2019), https://www.hsph.harvard.edu/magazine/magazine_article/america-is-failing-its-black-mothers/ (accessed May 5, 2020).

90 *Id.* (quoting Nan Strauss & Rachel Ward, *A Human Rights-Based Approach to Maternal Mortality in the United States*, in *MATERNAL MORTALITY, HUMAN RIGHTS AND ACCOUNTABILITY* 66, 67 (Paul Hunt & Tony Gray eds., 2013)). Strauss and Ward identify in particular ‘the International Covenant on Civil and Political Rights and the International Convention on the Elimination of All Forms of Racial Discrimination.’ *Id.*

91 Marian F. MacDorman, *The Failure of the United States Maternal Mortality Reporting and Its Impact on Women’s Lives*, 45 *BIRTH* 105, 106 (2018).

92 *Id.*

93 *Id.* See also Priya Agrawal, *Maternal Mortality and Morbidity in the United States of America*, 93 *BULL. WHO* 135 (2015), <https://www.who.int/bulletin/volumes/93/3/14-148627/en/> (accessed May 5, 2020).

94 MacDorman, *supra* note 91.

constitutional right to reproductive autonomy developed through a series of Supreme Court cases dating back to 1942, which identified marriage and procreation as fundamental rights.⁹⁵ A 'zone of privacy created by several fundamental constitutional guarantees'⁹⁶ was found to encompass a right 'to be free from unwarranted governmental intrusion into matters so fundamentally affecting a person as the decision whether to bear or beget a child'.⁹⁷ However, these cases, while recognizing the right to reproductive autonomy, do not elaborate upon 'the legal rights of the pregnant mother, especially those of the laboring or birthing women'.⁹⁸

The constitutional right to bodily integrity similarly fails to articulate or protect women's rights in childbirth. Often framed as the right to refuse medical treatment, this right has been protected both by the Due Process Clause of the Fourteenth Amendment to the USA. Constitution⁹⁹ and by the common law.¹⁰⁰ Its development has occurred, inter alia, within court decisions resolving obstetric conflicts,¹⁰¹ ie cases in which medical staff seek judicial intervention to require that pregnant patients undergo treatment ostensibly in the best interest of the mother or the fetus or both.¹⁰² Such proposed interventions have included a blood transfusion, induction of labor, a forceps delivery, or, more commonly, a cesarean section.¹⁰³ Nevertheless, in most cases these decisions merely reiterate the principal that a 'pregnant woman has the right to decide whether or not to consent to medical treatment'.¹⁰⁴ Indeed, these cases not only fail to enumerate additional rights pregnant women may be entitled to before or at the time of delivery, but some courts have even found in favor of the medical staff, thereby undermining birthing rights and interests. As one author explained: 'If courts ignore a woman's interest in her birthing plan, doctors can do the same. By providing

95 See, eg *Skinner v. Oklahoma ex rel. Williamson*, 316 U.S. 535, 541 (1942) (holding that sterilization as punishment for stealing was unconstitutional).

96 *Griswold v. Connecticut*, 381 U.S. 479, 485 (1965). See also *Eisenstadt v. Baird*, 405 U.S. 438 (1972) (holding that both the Equal Protection Clause and the constitutional right to privacy guarantee unmarried couples the right to use contraception).

97 *Eisenstadt*, 405 U.S. at 453.

98 Stohl, *supra* note 70, at 330.

99 *Cruzan v. Dir., Mo. Dep't of Health*, 497 U.S. 261 (1990). See also Bradley J. Glass, *A Comparative Analysis of the Right of a Pregnant Woman To Refuse Medical Treatment for Herself and Her Viable Fetus: The United States and United Kingdom*, 11 *IND. INT'L & COMPAR. L. REV.* 507 (2001).

100 'No right is held more sacred, or is more carefully guarded, by the common law, than the right of every individual to the possession and control of his own person, free from restraint or interference of others, unless by clear and unquestionable authority of law.' *Union Pac. Ry. Co. v. Botsford*, 141 U.S. 250, 251 (1891).

101 See eg *Pemberton v. Tallahassee Mem'l Reg'l Med. Ctr., Inc.*, 66 F. Supp. 2d 1247 (N.D. Fla. 1999); *In re Madyun*, 114 Daily Wash.L.Rptr. 2233 (D.C.Super.Ct. July 26, 1986) (as reported in *In re AC 573 A 2d 1235 app.* at 1259–64 (D.C. 1990)); *Crouse Irving Mem'l Hosp., Inc. v. Paddock*, 485 N.Y.S.2d 443 (Sup, 1985); *Jefferson v. Griffin Spalding Cnty. Hosp. Auth.*, 247 Ga. 86 (1981); *Raleigh Fitkin-Paul Morgan Mem'l Hosp. v. Anderson*, 201 A.2d 537, 538 (1964). See also JOHN SEYMOUR, *CHILDBIRTH AND THE LAW* 7–32 (2000).

102 See generally SHEENA MEREDITH, *POLICING PREGNANCY: THE LAW AND ETHICS OF OBSTETRIC CONFLICT* (2016).

103 SEYMOUR, *supra* note 101, at 20–21.

104 *Id.* at 25. See also *In re A.C.*, 573 A.2d 1235, 1237 (D.C. 1990) ('In virtually all cases the question of what is to be done is to be decided by the patient—the pregnant woman—on behalf of herself and the fetus.' The court later qualified that it must abide by those wishes 'unless there are truly extraordinary or compelling reasons to override them'; thus leaving room for compulsory intervention on behalf of the fetus.)

a justification for forcing a woman to undergo an unconsented medical procedure, doctors, regardless of their true reasons, may ignore a woman's birthing plan if it is not in accordance with their recommendation, ultimately offering negligible deference to a woman's birthing plan.¹⁰⁵

Avenues that may be available through the common law—namely, the doctrine of informed consent and fiduciary law—fare no better in substantiating women's birthing rights, including the right to a support person during delivery. Application of the informed consent doctrine, which protects the right to bodily integrity by guaranteeing a patient's right to control medical decision making, is complicated by the physical and emotional elements of childbirth. These aspects of the experience have led some to conclude that birthing women inherently lack the competence to make decisions concerning their care.¹⁰⁶ The doctrine is further complicated by the presence of the fetus, especially in states where it is considered an independent legal entity.¹⁰⁷ Indeed, 'the fetus has become the dominant putative plaintiff in modern obstetric malpractice cases, distorting and diminishing the rights and remedies of birthing women as patients and as plaintiffs.'¹⁰⁸

Fiduciary law offers another potential legal framework for the regulation of childbirth. Because 'the moral themes of power, vulnerability, and dependence [are] at the heart of fiduciary law',¹⁰⁹ it can be a useful lens through which to analyze claims of mistreatment during childbirth, which violates a patient's trust and leads to physical, emotional, or psychological harms.¹¹⁰ Even though physicians were not originally recognized as fiduciaries, courts have subsequently found that fiduciary principles 'are at the heart of the doctor-patient relationship.'¹¹¹ However, fiduciary law, like the informed consent doctrine, has its limits when applied to maternity care and childbirth.¹¹² Courts hold physicians liable only when they breach their duties 'to keep information confidential, to disclose financial interests in medical research, and to refrain from abandoning patients, as well as the duty to obtain informed consent.'¹¹³ However, licensing boards and medical associations have not explicitly defined any further fiduciary duties owed by physicians or the legal consequences of violating such duties; this 'limit[s] the utility of fiduciary principles to address misconduct that is currently beyond the reach of tort law.'¹¹⁴

As this overview of US law suggests, not only are women's birthing rights not protected by the Constitution, but even doctrines from other areas such as tort and fiduciary law fail to provide recourse for patients who suffered an emotional or physical

105 Sarah D. Murphy, *Labor Pains in Feminist Jurisprudence: An Examination of Birthing Rights*, 8 AVE MARIA L. REV. 443, 467 (2010).

106 Stohl, *supra* note 70, at 339.

107 *Id.* at 331. See also Wendy Chavkin & Farah Diaz-Tello, *When Courts Fail: Physicians' Legal and Ethical Duty to Uphold Informed Consent*, 1 COL. MED. REV. 6 (2017).

108 Jamie R. Abrams, *Distorted and Diminished Tort Claims for Women*, 34 CARDOZO L. REV. 1955, 1958 (2013).

109 Elizabeth Kukura, *Obstetric Violence Through a Fiduciary Lens*, in CHILD BIRTH, VULNERABILITY & LAW, *supra* note 26, at 204, 208 [hereinafter Kukura, *Fiduciary Lens*]. See also Kukura, *Obstetric Violence*, *supra* note 25, at 790–792.

110 Kukura, *Fiduciary Lens*, *supra* note 109, at 208–222.

111 *Id.* at 204–205.

112 *Id.* at 222.

113 *Id.*

114 *Id.*

harm due to hospital policies like those that ban support persons. In this sense, part of the anger and confusion that many people experienced after learning of the new policies may have come from realizing that to date, there are no US laws that would prevent a hospital from forcing women to birth alone.

IV. A CHANCE FOR REFORM?

The COVID-19 pandemic has had overwhelming emotional, physical, and psychological consequences for people's lives, some of which have yet to be fully realized. But there is also room to consider the opportunities for reform that it creates. This part of the Essay makes three recommendations to better address the issue of women's rights in childbirth. First, it proposes the adoption of a more comprehensive approach in reproductive scholarship—one that views reproductive law as a *separate* legal field worthy of exploration and theorization. Second, it recommends that courts expand their application of the constitutional right to reproductive autonomy to include the right to control where and how women give birth. Lastly, this essay recommends that courts and legislators do more to legally recognize the various reproductive harms women constantly endure during childbirth.

Despite the growing attention to and focus on women's reproductive lives over the past few decades, the reproductive rights discourse in the USA has tended to focus on access to abortion and contraceptive care. Recently, women's rights *during* childbirth have received more scholarly attention, mainly in regard to the problems of forced cesarean sections and obstetric violence.¹¹⁵ However, this topic, and reproductive law in general, are often considered an offshoot or niche subset of such traditional areas as family law or constitutional law, which fail to account for the range of issues that this area of law entails. Taking a comprehensive approach to this subject—examining the larger relationship between law and reproduction, so that issues such as women's rights to be free from coercion, abuse, and violence, as well as to have a support person during childbirth, might be considered alongside more traditional issues such as abortion and contraception—would help to generate a more meaningful scholarly discussion of the hardships women regularly face during childbirth.

Additionally, courts have at least one ready tool to protect women's rights during childbirth: the constitutional right to reproductive autonomy. Developed primarily through cases addressing the use of contraceptives, the zone of privacy guaranteed by the Constitution is generally understood to encompass the right to procreate and the right not to procreate.¹¹⁶ But if the content and scope of this right were reconsidered, reproductive autonomy could arguably include decisions as to *where* and *how* to give birth—in addition to the decisions *whether* and *when*. '[The] freedom to control every activity related to procreation—to determine how conception will occur, to manage the pregnancy, to decide how, when, where, and with whom parturition occurs, or how the neonatal period will be managed—may be of great significance to individuals and may also deserve protection.'¹¹⁷ Of the two constitutional rights discussed above,

115 See Abrams, *supra* note 108, at 1958–59 n.7.

116 See eg I. Glenn Cohen, *The Constitution and the Rights Not to Procreate*, 60 STAN. L. REV. 1135, 1136–37 (2008).

117 See eg John A. Robertson, *Procreative Liberty and the Control of Conception, Pregnancy, and Childbirth*, 69 VA. L. REV. 405, 410 (1983).

an expanded interpretation of reproductive autonomy would have more potential to substantiate childbirth rights, including the right to a support person, than any attempt to try and make the constitutional right to bodily integrity fit onto issues of childbirth.

Nevertheless, even if reproductive autonomy were expanded to include women's rights during childbirth, the extent of those protections would still depend on how courts interpret and weigh each newly incorporated right. In the context of compelled cesareans, for example, courts have applied abortion jurisprudence to their analyses, balancing women's reproductive liberty against the state interest in protecting potential life.¹¹⁸ Some courts have explained their decision to apply this legal standard to childbirth as well by reasoning that, if 'the state's interest is sufficiently compelling to force a woman to carry to term an unwanted pregnancy, it certainly is enough to override her choice of childbirth procedure.'¹¹⁹ As a result, 'the reproductive liberty jurisprudence that has expanded women's ability to control when they become pregnant is often invoked to limit pregnant women's rights to make their own treatment decisions.'¹²⁰

Finally, maternal rights will be able to develop more fully within existing legal frameworks if there is more legal recognition of both physical and emotional reproductive harms. In assessing the potential for remedies through tort law, Professor Jamie Abrams notes that 'obstetric malpractice cases reveal fetal-focused consequentialist decision-making whereby, when the child is born healthy, . . . birthing women's rights to tort remedies are subsumed within the positive birthing outcome. Healthy babies negate maternal harms.'¹²¹ As a result, women 'rarely bring negligence cases for maternal harms.'¹²² One way to restore the balance, according to Abrams, is for more women to pursue damages for maternal harms, even if the awards are insignificant, which may 'push courts to consider more carefully the harms to mothers and perhaps influence the standard of care.'¹²³ Yet another option, which might be less taxing for plaintiffs, is for courts to apply the same fiduciary principles to medical and nonmedical contexts.¹²⁴ In such case, the plaintiff would only need to show a breach of duty relating 'to the maternal-doctor conflict . . . and various forms of coerced treatment,'¹²⁵ not any resulting physical or economic harm. Applying this rule could provide women with another avenue beyond the 'traditional tort framework to vindicate their rights.'¹²⁶

In order for tort law more generally to protect the right to a support person during childbirth, it would need to recognize not only physical or economical harms, but also emotional harms that women may endure while giving birth. Nevertheless, tort law—and medical malpractice or emotional distress actions in particular—rarely awards damages for 'standalone emotional harm.'¹²⁷ This legal vacuum has led Professor Dov Fox to develop a new cause of action for particular categories of reproductive harm resulting from the negligent provision of reproductive services by medical

118 Kukura, *Obstetric Violence*, *supra* note 25, at 794.

119 Borges, *supra* note 25, at 845.

120 Kukura, *Obstetric Violence*, *supra* note 25, at 793–794.

121 Abrams, *supra* note 108, at 1960.

122 *Id.* at 1995.

123 *Id.* at 1996.

124 Kukura, *Obstetric Violence*, *supra* note 25, at 791–792.

125 *Id.*

126 *Id.*

127 Dov Fox, *Reproductive Negligence*, 117 COLUM. L. REV. 149, 169 (2017). *See also id.* at 154.

professionals.¹²⁸ His work focuses on three types of reproductive wrongs: negligent behavior that (1) imposed unwanted pregnancy or parenting, (2) deprived people of the chance for wanted pregnancy or parenting, or (3) confounded efforts to have a child with particular genetic traits.¹²⁹ This cause of action would aim to redress injuries ‘to both autonomy and well-being that the disruption of reproductive plans inflict when it robs people of their legitimate expectations of control over whether, when, and how to undertake the life roles of pregnancy and parenthood.’¹³⁰ Legal recognition of such procreative interests could provide recourse to women who were denied delivery support and even promote a standard of care that goes beyond protecting women against coercion and violence, to guarantee their emotional and physical well-being during childbirth.

V. CONCLUSION

The pandemic is necessarily forcing people to make difficult decisions in response to truly pressing problems, including the risks COVID-19 poses to the health and safety of medical staff providing obstetric care. And yet, the potential for harm in the case of childbirth visitation bans must also be considered within a broader understanding of the devastating effects the pandemic has had on women’s reproductive lives. Reflecting on the challenges that women routinely face during childbirth in the USA allows us to realize more fully the implications such bans may have on the emotional and physical well-being of birthing women and their families. This contextualized analysis of the ethical and legal considerations explains some of the backlash such short-lived policies have prompted among expectant parents and professional support people. Greater recognition that there is a lot at stake for women and their families when hospitals attempt to regulate their childbirth experience also makes the need to articulate and codify women’s birth rights more pressing than ever before.

The public debate prompted by the COVID-19 visitation bans presents an opportunity not only to reconsider the role of law in protecting women’s rights during childbirth; it should also make us reconsider laws and policies that require some women to give birth alone, even outside of the looming threat of COVID-19. Incarcerated women are not permitted to have visitors or phone calls during their time in the hospital, and routinely give birth only in the presence of unfamiliar health care providers.¹³¹ We should also direct the public’s attention to the horrid conditions under which immigrant women give birth while held in Immigration and Customs Enforcement detention centers, and their implications for the mental and physical health of these women and their children.¹³²

128 *Id.* at 153.

129 *Id.*

130 *Id.* at 167.

131 Carole Schroeder & Janice Bell, *Labor Support for Incarcerated Pregnant Women: The Doula Project*, 85 PRISON J. 311, 312 (2005). See also Deborah Ahrens, *Incarcerated Childbirth and Broader ‘Birth Control’: Autonomy, Regulation, and the State*, 80 MO. L. REV. 1 (2015).

132 See, eg Mihir Zaveri, *Woman Delivers Stillborn Baby While in ICE Custody*, N.Y. TIMES (Feb. 25, 2019), <https://www.nytimes.com/2019/02/25/us/mother-birth-ice-custody.html> (accessed May 5, 2020).