Obstetric Racism and the Limits of Family Law Reform

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Colleen Campbell, Medical Violence, Obstetric Racism, and the Limits of Informed Consent for Black Women, 26 Mich. J. Race & L. 47 (2021).

This year, the law journals at the University of Michigan Law School published a collective joint special issue focusing on racism and the law. One essay included in the volume, selected and edited by the Michigan Journal of Race and the Law, was Colleen Campbell's *Medical Violence, Obstetric Racism, and the Limits of Informed Consent for Black Women*. Professor Campbell's essay concisely describes and explains how, as she puts it, "Black women are simultaneously overmedicalized *and* medically neglected" in obstetrics. Physicians see Black women as innately high-risk, so that they are overmedicalized by disproportionately common surgical interventions during pregnancy and birth. At the same time, racism that continues to devalue Black lives leads medical professionals to disregard Black women's choices and agency around their reproductive health. In both cases, the ability of Black women to determine or even consent to their medical treatment is undermined.

Professor Campbell's project is an ambitious one, as she traces treatment of Black women by the medical establishment in the context of obstetrics from the exploitation of enslaved women to higher rates of Black maternal mortality today, and she ably synthesizes the works of a wide range of scholars and literatures to do so. In the earliest days of "professionalized" gynecology, white male physicians took over a practice that had been largely conducted by women such as midwives. One way that the field became professionalized and masculinized was by greater reliance on surgical procedures. And a key, disturbing part of the development of surgical procedures was surgical experimentation on enslaved women, the most extreme example of medical violence in Campbell's account. Campbell points to the example of James Marion Sims, considered the father of modern gynecology through his surgical treatment of fistulas, who operated on conscious and unanesthetized enslaved women. Adding insult to unfathomable injury, Sims described enslaved women with no choice or control over what happened to their bodies as happily consenting to these procedures, and relied on the racist belief that Black people did not feel pain the way that white people did to justify not using anesthesia.

This blithe assumption of consent is also illustrated in Professor Campbell's discussion of mass sterilizations performed on Black women and other women of color in the early twentieth century, a more recent example of medical violence that inflicts surgical interventions in the absence of patient consent. Such practices grew from two racist beliefs: first, seeing women of color as hyper-fertile in a way that threatened white dominance, and second, physicians' willingness to perform life-altering surgery based on the judgment of a state agency or employee, which was deemed more important than the lack of consent of the actual Black woman or girl being operated on.

Demonstrating the weakness of the idea of informed consent anchors the final portion of Professor Campbell's essay. The concept of informed consent is that physicians must give their patients any information that a reasonable patient would take into account when deciding upon a course of treatment.[1] In practice, however, physicians are seen as objective experts while patients are expected to defer to medical knowledge. This dynamic is magnified in the context of obstetrics, which Campbell points to as one explanation for higher rates of c-sections performed on Black women, a subset of medical violence known as obstetric violence.

The intersection of obstetric violence, which many women experience during birth, is magnified by medical racism: where obstetric violence results from a belief that doctors know best about medical care, medical racism further asserts that Black women are incapable of directing their care so that their consent is even less necessary. As a result, Black women face worse health outcomes and experiences than White women, even if they hold other characteristics such as higher socioeconomic status that would typically correlate with better medical treatment. Professor Campbell bookends her essay with the example of Serena Williams, one of the most famous athletes in the world, who nearly died after giving birth to her daughter. The day after she gave birth, Williams correctly recognized symptoms of embolisms, which she had been treated for in the past. She immediately alerted hospital staff and requested the proper diagnosis and treatment protocol of a CT scan and blood thinner – but instead a nurse simply assumed that she was confused due to pain medication and delayed giving her the proper treatment for what turned out to be pulmonary embolisms, just as Williams had predicted. Williams had given birth by c-section, characteristic of overmedicalization, and then her well-informed medical knowledge and requests for care were ignored, characteristic of medical neglect.

Professor Campbell's focus is on the obstetric space, and her essay enriches a vein of recent scholarship into obstetric violence. Her broader analysis, however, is also relevant far beyond medical decisions around reproduction, as the tenuousness individual agency undergirding informed consent is pervasive throughout family law. Professor Campbell refers to the sterilization campaigns at the start of the last century, but incarcerated women – themselves disproportionately Black and Brown – are still subjected to sterilization procedures, and long-term birth control methods have been imposed as conditions of supervised release.[2] Yesterday's enslaved Black women exploited to refine surgical techniques later used to improve the lives of white women are today's home health care workers deprived of employment and health protections even as they are deemed essential workers who must continue working during the COVID-19 pandemic.[3] The lack of agency that Professor Campbell criticizes in the context of informed consent is the same lack of agency that criminalizes the choices of low-wage Black mothers. [4]

The essay is a welcome reminder, therefore, for family law scholars who focus on the promise of individual choice that not all people experience that choice in the same way. For all of the increased flexibility that family law can offer today – recognition of more relationships, more paths to parenthood, different ways to structure family life – the unequal history of American law means that flexibility is a tool of privilege. And even though some Black women and members of other historically excluded groups attain high economic or educational privilege, Professor Campbell points out that such status does not correlate with even as basic an improvement as better obstetric health outcomes. Meaningful reform of family law must take account of systemic racism and other prejudice that prevents theoretical change from having practical effect in the lives of all Americans.

1. Citing Canterbury v. Spence, 464 F.2d 772, 787 (D.C. Cir. 1972).
2. See Dara Purvis, *The Rules of Maternity*, 84 Tenn. L. Rev. 367, 431-34 (2017).
3. See Ruqaiijah Yearby & Seema Mohapatra, *Structural Discrimination in COVID-19 Workplace Protections*, HealthAffairs.org (May 29, 2020), https://www.healthaffairs.org/do/10.1377/hblog20200522.280105/full/.
4. See Ann Cammett, *Welfare Queens Redux: Criminalizing Black Mothers in the Age of Neoliberalism*, 25 S. Cal. Interdisc. L.J. 363, 370-75 (2016).

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