

Obstetric Violence

ELIZABETH KUKURA*

Maternity care in the United States is in a state of crisis, characterized by high cesarean rates, poor performance on various mortality and morbidity measures, and a steep price tag. There are many factors that impede access to high-quality, evidence-based maternity care for certain women. Grassroots organizers have raised awareness about the extent to which giving birth in the United States has become overly medicalized. Perhaps less widely known, however, is the extent to which women experience abuse, coercion, and disrespect while giving birth.

Inspired by activists in Latin America, advocates in the United States have begun to adopt the language of “obstetric violence” to describe and condemn such mistreatment. However, the existing research on obstetric violence is limited, which complicates the task of defining the problem and identifying solutions. To that end, this Article explores the profound mistreatment that some women experience during childbirth at the hands of their health care providers. It identifies various types of provider behavior that qualify as obstetric violence and paints a broad picture of how childbirth can be a damaging experience for some women, even when they leave the hospital with a healthy baby. Having developed a nuanced view of provider mistreatment and its implications, this Article then examines the current failure of law and regulation to provide meaningful prevention or recourse. It concludes by suggesting forms of advocacy within the legal and health care systems that offer promising approaches to shifting maternity care culture and, ultimately, to securing necessary changes in the tort system for women harmed by provider mistreatment during childbirth.

TABLE OF CONTENTS

INTRODUCTION	723
I. UNDERSTANDING OBSTETRIC VIOLENCE	726
A. CLASSIFYING MISTREATMENT DURING CHILDBIRTH	728
1. Abuse	730

* Visiting Assistant Professor of Law, Drexel University Kline School of Law. © 2018, Elizabeth Kukura. LL.M., Temple Law School; J.D., NYU School of Law; M.Sc., London School of Economics; B.A. Yale University. Many thanks to participants at the Vulnerability and the Human Condition Initiative Workshop on Reproductive and Sexual Justice, the Law & Society Association Annual Meeting (New Orleans, Louisiana), and the ASLME Health Law Professors Conference (Atlanta, Georgia) for their feedback on this project. I am particularly grateful to Rachel Rebouché, Barry Furrow, Pam Bookman, Farah Diaz-Tello, David Cohen, Sylvia Law, Jamie Abrams, and Caitlin Coslett for their comments and suggestions, and to George Manley and his colleagues on *The Georgetown Law Journal* for their excellent editorial work.

a.	<i>Forced Surgery</i>	730
i.	<i>Forced Cesareans</i>	731
ii.	<i>Forced Episiotomies</i>	732
b.	<i>Unconsented Medical Procedures</i>	734
c.	<i>Sexual Violation</i>	735
d.	<i>Physical Restraint</i>	737
e.	<i>Other Abusive Conduct</i>	737
2.	Coercion	738
a.	<i>Coercion by Judicial Intervention</i>	738
b.	<i>Coercion by VBAC Restrictions</i>	743
c.	<i>Coercion by Child Welfare Intervention</i>	747
d.	<i>Coercion by Withholding Treatment, Manipulating Information, or Applying Emotional Pressure</i>	750
3.	Disrespect	753
B.	OBSTETRIC VIOLENCE AS HARM	754
C.	QUANTIFYING THE PROBLEM	757
1.	Existing Research: An Incomplete Picture	758
a.	<i>Research on American Childbearing Experiences</i>	759
b.	<i>Consumer Groups Focused on Childbirth</i>	760
c.	<i>International Studies</i>	761
2.	Language Choices: Definitional Challenges	762
D.	FACTORS CONTRIBUTING TO OBSTETRIC VIOLENCE	765
1.	Structural Factors in Health Care Finance and Delivery	765
a.	<i>Economic Pressures</i>	766
b.	<i>Medicalization of Childbirth</i>	769
c.	<i>Liability and Defensive Medicine</i>	771
2.	Social Norms	775
II.	LEGAL AND REGULATORY RESPONSES TO OBSTETRIC VIOLENCE	778
A.	TORT LAW	779
1.	Inadequate Access to Representation	781

2.	Establishing a Cognizable Claim	783
3.	Proving Harm	786
a.	<i>Unreliability of Juries</i>	787
b.	<i>Causation Difficulties</i>	788
c.	<i>Failure to Recognize Injuries Resulting from Mistreatment</i>	788
B.	OTHER SOURCES OF PROTECTION	790
1.	Fiduciary Law	790
2.	Constitutional Law	792
3.	Professional Standard Setting	795
	CONCLUSION & RECOMMENDATIONS	798

INTRODUCTION

Maternity care in the United States is in a state of crisis, characterized by high cesarean rates,¹ poor performance on various mortality and morbidity measures,² and a steep price tag.³ There are many factors that impede access to

1. See JOYCE A. MARTIN ET AL., NAT'L VITAL STATISTICS SYS., U.S. DEP'T OF HEALTH AND HUMAN SERVS., BIRTHS: FINAL DATA FOR 2015, at 9 (2017), https://www.cdc.gov/nchs/data/nvsr/nvsr66/nvsr66_01.pdf [<https://perma.cc/3JDJ-LGPF>] (reporting that 32% of babies born in the United States in 2015 were by cesarean). The cesarean rate peaked in 2009 at 32.9%, having increased every year since 1996 when it was 20.7%. See *id.*

2. See Alice Chen et al., *Why is Infant Mortality Higher in the United States than in Europe?*, 8 AM. ECON. J. ECON. POL'Y 89, 89, 91 (2016) (noting American infant mortality rate ranks 51st internationally and discussing variables involved in comparing global data sets); Maggie Fox, *Infant Mortality Rates Fall 15 Percent in U.S.*, NBC NEWS (Mar. 21, 2017), <https://www.nbcnews.com/health/health-news/infant-mortality-rates-fall-15-percent-u-s-n736366> [<https://perma.cc/AZ4K-TR88>] (reporting American infant mortality rate of 5.8 deaths per 1,000 live births “puts it on a par with the Slovak Republic, which ranks about 30th out of 40 countries the [Organization for Economic Cooperation and Development] ranks”); Sabrina Tavernise, *Maternal Mortality Rate in U.S. Rises, Defying Global Trend, Study Finds*, N.Y. TIMES (Sept. 21, 2016), <https://www.nytimes.com/2016/09/22/health/maternal-mortality.html> [<https://nyti.ms/2k4B6h5>] (reporting that data showing rise in maternal mortality rates make the United States an outlier among wealthy nations); see also Andis Robeznieks, *U.S. Has Highest Maternal Death Rate Among Developed Countries*, MOD. HEALTHCARE (May 6, 2015), <http://www.modernhealthcare.com/article/20150506/NEWS/150509941> [<https://perma.cc/GDB9-JDKB>] (reporting that the United States ranks 61st among all nations in maternal health, based on data from the World Health Organization). Research suggests that current maternal mortality statistics undercount the actual number of deaths directly related to pregnancy or birth due to inconsistent and unreliable reporting practices. See Ina May Gaskin, *Maternal Death in the United States: A Problem Solved or a Problem Ignored?*, 17 J. PERINATAL EDUC. 9, 10–11 (2008) (discussing a study that documented a 93% underreporting rate of maternal death in Massachusetts).

3. Hospital charges for childbirth often exceed expenditures for any other condition, totaling \$111 billion in 2010. See CHILDBIRTH CONNECTION, UNITED STATES MATERNITY CARE FACTS AND FIGURES (2012), http://transform.childbirthconnection.org/wp-content/uploads/2012/12/maternity_care_in_US_health_care_system.pdf [<https://perma.cc/M5PK-64EB>] (footnote omitted). Significantly, the United States

high-quality, evidence-based maternity care for certain women. Fragmentation in health care financing and high malpractice insurance rates lead to economic pressures on providers that can compromise quality of care. Long-standing professional turf battles between physicians and midwives have limited access to low-cost, low-intervention midwifery care for many women.⁴ Cultural attitudes about women's bodies shape the delivery of maternity care and, over time, patriarchal views have devalued reproductive labor, pathologized the process of giving birth, and transformed childbirth into a private and isolating endeavor.⁵ In recent years, grassroots organizing and advocacy campaigns have raised awareness about the extent to which giving birth in the United States has become overly medicalized and the negative implications of this approach.⁶ Perhaps less widely known, however, is the extent to which women experience abuse, coercion, and disrespect while giving birth.⁷

The mistreatment of women during childbirth is a poorly understood phenomenon. Women's accounts of trauma or mistreatment are shared privately with friends and family but rarely emerge in public discussion of the childbirth experience. Regardless of whether this is due to shame, perceptions of stigma, or a lack of awareness about what to expect during labor and delivery, women often doubt whether their injuries are worthy of complaint.⁸ In the absence of a centralized body to receive reports of mistreatment, this dimension of American maternity care has been obscured from public view and lacks attention and research funding. Because there has been minimal research conducted in the United States on the subject, huge gaps persist in knowledge about women's

spends more per capita on health care (\$9,237) than any other nation. *See* Susan Brink, *What Country Spends the Most (and Least) on Health Care Per Person?*, NAT'L PUB. RADIO (Apr. 20, 2017), <https://www.npr.org/sections/goatsandsoda/2017/04/20/524774195/what-country-spends-the-most-and-least-on-health-care-per-person> [<https://perma.cc/L9MW-FJRJ>]; *see also* *U.S. Spends More on Health Care Than Other High-Income Nations But Has Lower Life Expectancy, Worse Health*, COMMONWEALTH FUND (Oct. 8, 2015), <http://www.commonwealthfund.org/publications/press-releases/2015/oct/us-spends-more-on-health-care-than-other-nations> [<https://perma.cc/3C5K-9W9K>] (finding the United States to be "a substantial outlier when it comes to health spending").

4. *See* Elizabeth Kukura, *Contested Care: The Limitations of Evidence-Based Maternity Care Reform*, 31 BERKELEY J. GENDER L. & JUST. 241, 250–55 (2016) (discussing history and decline of midwifery in United States).

5. *See generally* JENNIFER BLOCK, *PUSHED: THE PAINFUL TRUTH ABOUT CHILDBIRTH AND MODERN MATERNITY CARE* (2007) (describing cultural and political forces that shape modern maternity care).

6. *See* Kukura, *supra* note 4, at 283–85.

7. This Article refers to the people who experience mistreatment during childbirth as women but acknowledges that some men also experience pregnancy and childbirth. *See* Robin Marantz Henig, *Transgender Men Who Become Pregnant Face Social, Health Challenges*, NPR (Nov. 7, 2014, 3:53 PM), <https://www.npr.org/sections/health-shots/2014/11/07/362269036/transgender-men-who-become-pregnant-face-health-challenges> [<https://perma.cc/UV9F-T8J5>]. More research is needed on various aspects of abuse, coercion, and disrespect in maternity care, including the experiences of transgender individuals seeking maternity care in mainstream health care institutions.

8. *See id.* at 256–58 (discussing how the twentieth-century shift to hospital birth from childbirth at home—where a woman was surrounded by female relatives and neighbors—diminished the social dimensions of childbirth, increased childbearing women's isolation, and disrupted their experience with the birthing process).

negative experiences with their maternity care providers and about any harms flowing from the care provided.

This gap in knowledge is perpetuated by privacy norms governing health care, operating together with a sense of shame on the part of women who experience mistreatment, and by other providers who witness but choose to deny the reality of such conduct rather than address abuses that occur within the health care system. For institutional stakeholders, it is easier to blame individual bad actors for misconduct than to acknowledge structural factors that create conditions where mistreatment is tolerated and enabled. For women and families, the demands of newborn care, emotional adjustment, and physical healing can leave little time or energy to protest mistreatment perpetrated by those entrusted to care for them. Lack of awareness regarding the mistreatment of childbearing women has profound consequences for how the law addresses rights violations and provides recourse for injuries inflicted by health care providers.

Inspired by advocates in Latin America who have tackled the issue of mistreatment in childbirth directly and, in some jurisdictions, secured legal prohibitions against such conduct, advocates in the United States have begun to adopt the language of “obstetric violence” to describe and condemn these abuses.⁹ Though not without complication, using the concept of obstetric violence to shed light on previously unacknowledged harm holds great potential as a strategic approach. However, the existing research on obstetric violence is

9. Although discussion of obstetric violence in the United States has increased among advocates and has appeared in commentary on blogs and websites discussing women’s childbirth experiences, references to obstetric violence in the American law review literature are limited to scholarship addressing developments outside the United States. *See generally, e.g.*, Susana Chiarotti Boero, Keynote Address at the University of Miami School of Law Conference on Gender Justice and Human Rights in the America’s Convening: Women’s Citizen Security (Feb. 23–25, 2011), in 65 U. MIAMI L. REV. 797 (2011) (discussing developments in several Latin American countries); Caitlin McCartney, “Childbirth Rights”?: *Legal Uncertainties Under the European Convention after Ternovszky v. Hungary*, 40 N.C.J. INT’L L. & COM. REG. 543 (2015) (discussing developments in Venezuela); Kelsey M. Jost-Creegan, *Debts of Democracy: Framing Issues and Reimagining Democracy in Twenty-First Century Argentine Social Movements*, 30 HARV. HUM. RTS. J. 165, 201 (2017) (mentioning obstetric violence in context of Argentine dictatorship’s impact on women’s reproductive health); Liiri Oja & Alicia Ely Yamin, “Woman” in the European Human Rights System: *How is the Reproductive Rights Jurisprudence of the European Court of Human Rights Constructing Narratives of Women’s Citizenship?*, 32 COLUM. J. GENDER & L. 62, 79 (2016) (noting use of term “obstetric violence” throughout Latin America).

Other American scholarly journals contain some limited discussion of obstetric violence. Joanna Erdman discusses a Mexican midwifery campaign on obstetric violence in an article on bioethics and human rights in childbirth. *See* Joanna N. Erdman, *Bioethics, Human Rights, and Childbirth*, 17 HEALTH & HUM. RTS. 43, 48 (2015). Further, attorney Farah Diaz-Tello has written about obstetric violence as a “systemic problem of institutionalized gender-based violence” in an issue of *Reproductive Health Matters* containing several articles on abuse and mistreatment in health care settings. *See generally* Farah Diaz-Tello, *Invisible Wounds: Obstetric Violence in the United States*, 24 REPROD. HEALTH MATTERS 56 (2016) [hereinafter Diaz-Tello, *Invisible Wounds*]. She also discusses forced surgeries as a form of violence. *See* Farah Diaz-Tello, *When the Invisible Hand Wields a Scalpel: Maternity Care in the Market Economy*, 18 CUNY L. REV. 197, 228 (2015) [hereinafter Diaz-Tello, *Invisible Hand*].

minimal, which complicates the task of defining the problem and identifying solutions.

To that end, this Article explores the profound mistreatment that some women experience during childbirth at the hands of their health care providers. It identifies various types of provider behavior that qualify as obstetric violence, painting a broad picture of how childbirth can be a damaging experience for some women even when they leave the hospital with a healthy baby. After developing a nuanced view of provider mistreatment and its implications, the Article then examines the failure of law and regulation to provide meaningful prevention or recourse.

Part I establishes the meaning of obstetric violence, beginning in section I.A with a detailed examination of mistreatment perpetrated by health care providers. This section draws on individual narratives to illustrate the serious consequences of provider mistreatment. Section I.B identifies specific harms that result from obstetric violence, including physical and emotional harms to women and babies. Next, section I.C attempts to quantify the phenomenon based on the patchwork of existing research about mistreatment in childbirth and examines how language complicates the effort to identify and study obstetric violence. Finally, section I.D identifies several factors that create conditions that allow the mistreatment of women during childbirth to occur, including structural factors related to economic and legal pressures on health care providers and social norms related to gender and maternity that shape how health care is delivered.

In Part II, the Article examines how existing law fails to prevent obstetric violence or provide meaningful recourse to women who experience mistreatment at the hands of their health care providers. It explores several significant barriers to bringing a successful tort claim before examining how other areas of law and policy—including fiduciary law, constitutional law, and professional standard-setting—are currently inadequate to deal with the problem.

The Article concludes by suggesting forms of advocacy within the legal and health care systems that offer promising approaches to shifting maternity care culture and, ultimately, to securing necessary changes in the tort system for women harmed by provider mistreatment during childbirth.

I. UNDERSTANDING OBSTETRIC VIOLENCE

The World Health Organization (WHO) has acknowledged that “[m]any women across the globe experience disrespectful, abusive or neglectful treatment during childbirth in facilities.”¹⁰ Such conduct is not restricted to under-

10. WORLD HEALTH ORGANIZATION, THE PREVENTION AND ELIMINATION OF DISRESPECT AND ABUSE DURING FACILITY-BASED CHILDBIRTH (2015), http://www.who.int/reproductivehealth/topics/maternal_perinatal/statement-childbirth/en/ [<https://perma.cc/E2UH-L7WP>] [hereinafter WHO STATEMENT] (advocating a plan to prevent “disrespectful, abusive, or neglectful treatment” that received endorsements by over 90 organizations).

resourced health care systems or facilities located in countries with high rates of gender-based violence and discrimination. Women in the United States experience mistreatment during childbirth, including, but not limited to, violations of the rights to informed consent and bodily autonomy, which lead to both physical and emotional harms.¹¹ Mistreatment during childbirth may be perpetrated by physicians or nurses, as well as other professional staff present during labor and delivery.¹² The phenomenon is often obscured by privacy norms that govern health care—particularly reproductive health care—or by the complicated power dynamics present in many provider–patient relationships.¹³

Part of what makes obstetric violence so troubling is that it challenges the trust that most people have in their physicians and other health care providers. Doctors care for patients in their weak and vulnerable moments, and patients trust their doctors to look out for their best interests and help them heal. This deep level of trust in health care providers makes mistreatment during childbirth feel like a betrayal and may make it harder for family, friends, and the broader public to acknowledge and grapple with this problem.¹⁴

Section I.A describes various types of mistreatment during childbirth that contribute to obstetric violence. This section identifies a wide range of experiences and classifies them as abuse, coercion, or disrespect, based on how the mistreatment is inflicted and its impact. These categories are somewhat fluid, however, and one instance of obstetric violence may involve abusive, coercive, *and* disrespectful conduct. Section I.B identifies how such mistreatment causes harm to women and babies. Section I.C examines existing research on obstetric violence, attempting to quantify the extent of the problem while identifying gaps in knowledge about how women experience childbirth in the United States. This section also explores the complicated language choices involved in research and advocacy on mistreatment during childbirth. Finally, section I.D identifies structural factors in the delivery of maternity care services that contribute to the phenomenon of obstetric violence and that may help explain why such mistreatment persists.

11. See Brief of Human Rights in Childbirth et al. as Amicus Curiae in Support of Plaintiff Rinat Dray at 1, *Dray v. Staten Island Univ. Hosp.*, No. 500510/14 (N.Y. Sup. Ct., complaint filed Apr. 11, 2014) [hereinafter *Dray Amicus Brief*].

12. See Rogelio Pérez D’Gregorio, *Obstetric Violence: A New Legal Term Introduced in Venezuela*, 111 INT’L J. GYNECOLOGY & OBSTETRICS 201, 201 (2010).

13. See Michelle Oberman, *Mothers and Doctors’ Orders: Unmasking the Doctor’s Fiduciary Role in Maternal-Fetal Conflicts*, 94 NW. U. L. REV. 451, 496–97 (2000) (discussing the role of physician–patient power dynamics in keeping conflicts over treatment decisions private and shielded from public, professional, or legal scrutiny).

14. However, this proposition is not true in all communities. For instance, skepticism or fear of medical institutions and medical professionals among some communities of color reflect a legacy of bias and mistreatment by “trusted” doctors. See generally HARRIET A. WASHINGTON, *MEDICAL APARTHEID: THE DARK HISTORY OF MEDICAL EXPERIMENTATION ON BLACK AMERICANS FROM COLONIAL TIMES TO THE PRESENT* (2006) (discussing legacy of dehumanizing treatment of black people by medical professionals that suggests some black women may experience obstetric violence as reinforcing historical traumas rather than betraying their trust in doctors).

A. CLASSIFYING MISTREATMENT DURING CHILDBIRTH

Researchers who have studied the phenomenon of mistreatment during childbirth identify various practices that occur along a continuum of severity, ranging from less dramatic forms of subtle humiliation to coercion, unconsented clinical care, and more extreme instances of verbal and physical abuse.¹⁵ The nature and degree of harm will depend on the particular circumstances of the case and individual characteristics of the woman. The language of obstetric violence is used to refer to various kinds of conduct by health care providers. There is no definition of obstetric violence that is universally adopted in global public health discourse or used consistently in the United States. Indeed, the subjectivity inherent in how obstetric violence is experienced complicates the work of defining and categorizing such mistreatment with precision.¹⁶

Because no official definition of obstetric violence exists, the issue is best explained by illustrating types of relevant conduct. This section organizes types of mistreatment into three categories: abuse, coercion, and disrespect. It illustrates types of conduct that women's health advocates and individual patients find objectionable, traumatic, or harmful. The categorization offered here is fluid and non-exhaustive. Although the examples range from more severe to less severe, there is obvious overlap between abusive, coercive, and disrespectful treatment, and the concepts should not be considered entirely distinct types of conduct. In some instances, it may seem overstated to refer to individual episodes of disrespect as violence. Therefore, the categorization offered here implicitly acknowledges that many incidents women report involve multiple forms of conduct that cumulatively rise to the level of violence. It is also important to identify less severe forms of conduct, which, when left unaddressed, may create conditions that tolerate more severe forms of mistreatment. Given the lack of comprehensive data about mistreatment during childbirth (explored further in section I.C.1), this section draws on examples from specific cases to describe the conduct and illustrate its impact on women.

To understand how the mistreatment women identify as obstetric violence disrupts the childbirth experience and may cause physical and emotional harm beyond what might be expected from the process of delivering a baby, it is necessary to understand how the physiologic birthing process generally un-

15. See, e.g., WHO STATEMENT, *supra* note 10; Ana Flávia Pires Lucas d'Oliveira et al., *Violence Against Women in Health-Care Institutions: An Emerging Problem*, 359 LANCET 1681, 1681 (2002).

16. For example, while certain conduct is likely to be perceived by any woman as problematic, other conduct may impact different women quite differently. Whereas one woman may find a vaginal exam performed to check cervical dilation without warning or consent to be an aggravating annoyance, another woman—particularly one with a history of sexual assault—may find the same vaginal penetration to be deeply traumatic. The fact that some women may not suffer severe consequences from this type of exam does not relieve the health care provider of the obligation to obtain consent before any exam or procedure. Rather, this example serves to highlight the personal, subjective nature of women's childbirth experiences that must be accounted for in the application of medical ethics and legal standards.

folds.¹⁷ During the first of three stages of labor, the uterus contracts to help prepare the cervix to open fully and to allow passage of the baby through the vaginal canal.¹⁸ In the vast majority of births where a woman intends to deliver at a hospital, she is expected to experience early labor at home.¹⁹ This is because hospitals do not want to dedicate staff and resources to attend a woman during the latent phase of labor as her cervix begins to dilate and efface (or thin), which can take hours or even days.²⁰ By the time contractions are less than five minutes apart, she is usually advised to go to the hospital, where she will go through the admitting process—often signing paperwork and passing through a triage floor where vital signs are measured—before proceeding to a delivery room.²¹ The second stage of labor begins when the cervix is fully opened and the force of the woman pushing, along with uterine contractions, moves the baby through the pelvis and down the birth canal.²² After the baby has emerged, the final stage of labor is completed when the woman delivers the placenta, which is the organ that nourished the fetus throughout the pregnancy.²³

There are certain complications related to maternal or fetal health that, when they arise during labor, make cesarean delivery necessary.²⁴ A woman's obstetrician may recommend a cesarean due to conditions present towards the end of pregnancy (before labor begins), for complications that arise during labor, or because the doctor diagnoses a "failure to progress."²⁵ Currently, approximately one-third of all births in the United States are by cesarean—significantly higher than the WHO's estimation that medically necessary cesareans should represent 10–15% of births in an industrialized nation²⁶—a difference which researchers have concluded means that a significant number of women have medically unnecessary cesareans.²⁷

17. Childbirth is a varied experience influenced by many factors beyond a woman's control, including her physiology, genetics, existing health conditions, the practices of the hospital where she plans to give birth, and the philosophy and preferences of her care providers, as well as factors like stress and even weather.

18. See SHEILA KITZINGER, *THE COMPLETE BOOK OF PREGNANCY & CHILDBIRTH* 249, 254 (4th ed. 2008).

19. See *id.* at 255–56.

20. See *id.* at 256–57.

21. See *id.* at 256.

22. See *id.* at 260–62.

23. See *id.* at 263.

24. See *id.* at 348 (discussing possible reasons a cesarean might be medically necessary, including active herpes outbreak in the laboring woman, kidney disease, severe hypertension, or fetal distress diagnosed during labor).

25. For a description of absolute indications for cesarean surgery, see *infra* Section I.A.1.a.

26. World Health Organisation, *Appropriate Technology for Birth*, 326 *LANCET* 403, 437 (1985) ("There is no justification for any region to have a rate higher than 10–15%."); see also Fernando Althabe & José M. Belizán, *Cesarean Section: The Paradox*, 368 *LANCET* 1467, 1472–73 (2006).

27. See CAROL SAKALA & MAUREEN P. CORRY, *EVIDENCE-BASED MATERNITY CARE: WHAT IT IS AND WHAT IT CAN ACHIEVE* 41–42 (2008), www.childbirthconnection.org/pdfs/evidence-based-maternity-care.pdf [<https://perma.cc/WG2C-9AAG>] (discussing research relating to rise of cesarean rate since 1996).

Maternity care providers expect labor to progress from first to second stage labor and through the pushing phase within certain periods of time.²⁸ When onset of labor or the length and frequency of contractions seem delayed, artificial induction or augmentation is available through the use of drugs to make the uterus contract.²⁹ Although use of drugs like Pitocin to increase the pace of labor is now commonplace in mainstream maternity care, their use is associated with negative side effects and also increases the risk that labor will end in a cesarean.³⁰ Existing guidelines are based on averages—meaning some women with healthy deliveries take more or less time than the average—and these expectations have changed over time, shortening in response to hospital and provider desires to make birth more efficient.³¹ More recently, the American College of Obstetricians and Gynecologists (ACOG) issued liberalized guidelines for active labor, extending the amount of time a woman might be expected to labor actively before additional intervention should be considered.³² Nevertheless, many women who report mistreatment by their maternity care providers identify patient-provider disagreement over the need for labor induction or augmentation—or the wisdom of pursuing another intervention into the birth process, such as cesarean surgery or an episiotomy—as a source of tension in the clinical relationship. The following sections will explore specific examples of such situations.

1. Abuse

The most extreme forms of mistreatment women experience while giving birth rise to the level of abuse by medical staff. Abuse in this context includes: (a) forced surgery; (b) unconsented medical procedures; (c) sexual violation; (d) physical restraint; and (e) other forms of abuse.

a. Forced Surgery. The concept of forced surgery during childbirth usually refers to a cesarean or an episiotomy—two surgical procedures that are prevalent in American maternity care, though not without controversy. A cesarean involves a surgical incision in the woman's abdomen and uterus to remove the fetus and placenta manually. Under the principles of evidence-based medicine, cesareans should be performed for absolute indications such as prolapsed

28. Am. C. Obstetrics & Gynecologists (ACOG) & Soc'y Maternal-Fetal Med., *Safe Prevention of the Primary Cesarean Delivery*, 1 OBSTETRIC CARE CONSENSUS, Mar. 2014 [hereinafter OBSTETRIC CARE CONSENSUS No. 1], at 1, 4.

29. See KITZINGER, *supra* note 18, at 334–39 (discussing induction and augmentation of labor).

30. See SAKALA & CORRY, *supra* note 27, at 28–29.

31. See *id.* at 60 (discussing the impact of efficiency and financial incentives on clinical maternity care practices); Kukura, *supra* note 4, at 258–59 (discussing how the average length of second stage labor decreased from eighty to fifty minutes between 1971 and 1985).

32. OBSTETRIC CARE CONSENSUS No. 1, *supra* note 28, at 4–5 (identifying the necessity “to revisit the definition of labor dystocia [abnormally slow progress of labor] because recent data show that contemporary labor progresses at a rate substantially slower than what has been historically taught” and adopting six centimeters of dilation (instead of four, as previously thought) as the beginning of active labor).

umbilical cord, placenta previa, placental abruption, or persistent transverse lie, as well as when complications diagnosed before or during labor make the risk of vaginal delivery greater than the risk of cesarean delivery.³³ An episiotomy is a surgical incision to widen the vaginal opening, intended to create more room for the baby's head. The procedure was developed in the 1920s—without research on its efficacy or risks—by Dr. Joseph DeLee, who advocated for greater use of intervention in childbirth to save women from “‘the evils’ that are ‘natural to labor. . . .’”³⁴ Until recently, routine episiotomy was common, even where not medically necessary.³⁵ Research now shows that routine episiotomy is associated with increases in perineal injury, stitches, pain and tenderness, length of healing, the likelihood of leaking stool or gas, and pain with intercourse.³⁶

Both cesareans and episiotomies involve surgical incisions made ostensibly to ease the delivery, although research suggests both are overused and bear risks to maternal or infant health.³⁷ If performed in the absence of medical necessity—whether for provider convenience, fear of malpractice liability, or some other non-medical reason—women and babies have an unnecessarily increased risk of experiencing complications.³⁸ When performed without a woman's consent, both cesarean surgery and episiotomy constitute direct violations of the body—compounding the potential for severe physical and emotional injury. Although there are different kinds of unwanted cesareans, this section focuses on forced cesareans imposed on a woman without her consent and in the absence of a court order. Section I.A.2 considers cesareans where coercive means are used to obtain a woman's consent (or acquiescence) to the surgery. Other unwanted cesareans, such as a medically unnecessary cesarean that a woman consents to, would not be considered obstetric violence in the absence of coercive means used to secure her consent, and are thus not discussed here, although they raise other concerns about why providers depart from evidence-based research about the risks and benefits associated with surgical interventions during birth.

i. Forced Cesareans. A prominent, recent example of a forced cesarean is the case of Rinat Dray, who delivered her third child at Staten Island University

33. See SAKALA & CORRY, *supra* note 27, at 41.

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

35. See, e.g., MARSDEN WAGNER, *BORN IN THE USA: HOW A BROKEN MATERNITY SYSTEM MUST BE FIXED TO PUT MOTHERS AND INFANTS FIRST* 57 (2006) (illustrating the routine nature of episiotomy with story about intern who performed one after the woman had finished delivering because he “had been told that the procedure was to be done on all births” and there had been insufficient time to perform the incision *before* the baby arrived).

36. See SAKALA & CORRY, *supra* note 27, at 49.

37. See *infra* Section I.B for a detailed discussion of the risks to maternal and infant health associated with cesareans and episiotomies.

38. See *infra* Section I.B.

Hospital in New York in 2011.³⁹ Having had two previous cesareans, she specifically sought out a hospital with a reputation for supporting vaginal birth after cesarean (VBAC), so she could attempt a vaginal delivery with her third.⁴⁰ As a Hasidic Jew who wished to have a large family, Dray knew the risk of complications in future pregnancies increases significantly with each additional cesarean, and she determined that this risk outweighed the risk of complications from a VBAC.⁴¹

Upon arriving at the hospital, the on-call obstetrician immediately advised her to have another cesarean, which she declined in favor of continuing with labor.⁴² The doctor “told her that she would be committing the equivalent of child abuse and that her baby would be taken away from her” if she did not consent to the cesarean.⁴³ Dray and the doctor continued to argue about the need for a cesarean, at which point the attending physician sought the support of the hospital’s Director of Obstetrics, who also pressured her to consent.⁴⁴ The Director then consulted with the hospital attorney, who advised the Director that no court order was necessary to proceed with a cesarean.⁴⁵ The Director noted in Dray’s chart that she was competent to make medical decisions, but he was nevertheless overriding her refusal to consent and, over her continued objections, she was taken to the operating room and prepared for surgery.⁴⁶ She recalls lying on the operating table and begging for more time, to which the doctor responded, “Don’t speak.”⁴⁷ In the course of delivering her baby—who was healthy and showed no signs of distress—the physicians cut her bladder, which required further surgery to repair.⁴⁸

ii. Forced Episiotomies. Unlike a forced cesarean, where the woman knows that the surgery is underway unless she has been sedated, a woman may not be immediately aware that an episiotomy is being performed on her without her

39. See Anemona Hartocollis, *Mother Accuses Doctors of Forcing a C-Section and Files Suit*, N.Y. TIMES (May 16, 2014), <http://www.nytimes.com/2014/05/17/nyregion/mother-accuses-doctors-of-forcing-a-c-section-and-files-suit.html> [https://nyti.ms/2oOwpLJ].

40. See *id.* (noting the hospital’s 22% cesarean rate, as compared to the New York state average rate of 34%, and the hospital’s VBAC rate of 29%, compared to the state average of 11%).

41. See *id.*; Kukura, *supra* note 4, at 269–70 (discussing the risks associated with multiple cesareans and VBAC).

42. Affidavit of Leonid Gorelik at ¶ 8, *Dray v. Staten Island Univ. Hosp.*, No. 500510/14 (N.Y. Sup. Ct., complaint filed Apr. 11, 2014) [hereinafter *Gorelik Affidavit*].

43. Hartocollis, *supra* note 39.

44. *Gorelik Affidavit*, *supra* note 42, at ¶¶ 9, 11.

45. *Id.* at ¶¶ 11, 12, 16.

46. See *id.* at ¶¶ 12, 13 (reporting refusal was overridden and that she was brought to the operating room for surgery); Hartocollis, *supra* note 39 (noting the doctor’s handwritten comment in her medical records: “I have decided to override her refusal to have a C-section”).

47. See Hartocollis, *supra* note 39; see also Birthbeyondbias, *Obstetrical Violence? What’s That?!*, FEMINISTING (July 21, 2016), <http://feministing.com/2016/07/21/obstetrical-violence-whats-that/> [https://perma.cc/G7DA-Y99R] (Dray recalls the surgeon was “rough during the surgery, almost as if to punish me.”).

48. See *Gorelik Affidavit*, *supra* note 42, at ¶ 14; Hartocollis, *supra* note 39.

consent. This may be due to the use of pain medication, supine labor positioning, other painful sensations while pushing, or a combination of these factors. There are many accounts of women being subjected to unwanted episiotomies without their consent or knowledge. For instance, a Northern California woman who had clearly stated her desire to avoid an episiotomy during childbirth, had received an epidural, anesthetizing her body below the waist.⁴⁹ When she reminded the physician about her non-consent to an episiotomy, he responded “too late,” having performed the procedure without medical indication or informed consent.⁵⁰ In another typical experience of disregard for informed consent and bodily integrity, a Mississippi woman was told by her physician that he was “sewing [her] up” after her vaginal delivery, and when she asked if she had torn, the doctor responded, “No, I cut you.”⁵¹

In a particularly egregious case, Kimberly Turbin was subjected to an unconsented episiotomy during the birth of her first child at Providence Tarzana Medical Center in Tarzana, California, in 2013.⁵² When Turbin reached the final pushing phase of labor, her doctor sat on a stool between Turbin’s legs and “took out a long pair of scissors and stated that he would be performing an episiotomy. . . .”⁵³ Turbin objected and asked for more information about the need for an episiotomy.⁵⁴ When she was given no medical reason for the procedure, she pleaded with the doctor to wait, saying “[b]ut why can’t we just try?”⁵⁵ The doctor held the scissors while standing between her legs and “threatened [her] with a downward slashing motion that her ‘butthole’ might ‘rip.’”⁵⁶ When she objected again, the doctor “raised his voice” and said “[w]hat do you mean ‘[w]hy’? I am the expert here!”⁵⁷ During the next contraction, as she was unable to argue, the doctor cut her perineal flesh twelve times, reached into her vagina, and pulled out the baby.⁵⁸ He “noted in her

49. See WAGNER, *supra* note 35, at 3–4.

50. *Id.* at 4.

51. BLOCK, *supra* note 5, at 31 (internal quotations omitted); see also Dray Amicus Brief, *supra* note 11, at 7 (recounting experiences of other women who were given medically unnecessary episiotomies after explicitly refusing to consent).

52. See Complaint for Assault and Battery at ¶ 5, *Turbin v. Abassi*, BC580006 (Cal. Super. Ct., filed Apr. 27, 2015) [hereinafter *Turbin Complaint*].

53. *Id.* at ¶ 6.

54. *Id.* at ¶ 7.

55. *Id.* (internal quotation omitted).

56. *Id.*

57. *Id.* (internal quotations omitted). The doctor then added, “[y]ou can go home and do it! You go to Kentucky!” *Id.* This was perhaps a reference to The Farm in Tennessee, a spiritual community founded in the 1970s where midwife Ina May Gaskin led a group of midwives in creating a system of maternal-child health care for the community, promoting a low-intervention approach to childbirth. See Katherine Beckett & Bruce Hoffman, *Challenging Medicine: Law, Resistance, and the Cultural Politics of Childbirth*, 39 *LAW & SOC’Y REV.* 125, 131–32 (2005).

58. See *Turbin Complaint*, *supra* note 52, at ¶ 7; see also Hermine Hayes-Klien, *The Birth*, in Cristen Pascucci, *Caught on Video: Improving Birth Breaks Silence on Abuse of Women in Maternity Care*, *Improving Birth* (Aug. 28, 2014), <http://improvingbirth.org/2014/08/vid/> [<https://perma.cc/G6M3-U9QN>] (describing Turbin’s birth video in a narrative).

medical records that ‘patient refused any surgical intervention’ but that he nonetheless performed the episiotomy under local anesthesia.”⁵⁹ Turbin—a sexual assault survivor, who had previously informed the medical staff about her history of trauma and requested that permission be sought before she was touched by hospital personnel⁶⁰—suffered both physical and emotional injuries as a result of the excessive cutting.⁶¹ The entire episode, including Turbin’s dialogue with the doctor and the forced episiotomy itself, is captured on video footage recorded by Turbin’s mother, who was present to film the birth.⁶²

b. Unconsented Medical Procedures. In addition to forced surgery, medical abuse during childbirth may take the form of other unconsented medical procedures, including labor induction, membrane stripping or breaking, vacuum-assisted or forceps-assisted delivery, or manual removal of the placenta.⁶³ Some women are told they will automatically have labor artificially induced on a certain date without being informed about the risks of induction or alternative approaches.⁶⁴ Some report not knowing that Pitocin—the drug used to induce or accelerate contractions, which can significantly increase the pain of contractions and lead to other medical interventions⁶⁵—had been administered until they or a family member inspected the labels on bags hanging from the IV pole.⁶⁶ Some providers recommend the artificial rupture of membranes—the sac containing amniotic fluid that supports the fetus—as a way to induce or accelerate labor.⁶⁷ However, this can increase the risk of infection with frequent cervical checks because the membranes no longer provide a protective barrier.⁶⁸ Some women report consenting to a vaginal exam to determine the degree of cervical dilation, but during the exam the care provider sweeps (separates the membranes from

59. Turbin Complaint, *supra* note 52, at ¶ 8.

60. *See id.* at ¶ 5.

61. *See id.* at ¶ 11.

62. *See id.* at ¶ 5; Pascucci, *supra* note 58 (noting that the doctor was aware that the entire birth was being recorded on video).

63. Although not performed until after the delivery, sterilization is another medical procedure that some women are subjected to without informed consent. There is a long history of forced sterilization of women of color, poor women, and indigenous women in the United States, and some women continue to be subjected to sterilization without their knowledge or consent. *See generally* HARRY BRUINIUS, *BETTER FOR ALL THE WORLD: THE SECRET HISTORY OF FORCED STERILIZATION AND AMERICA’S QUEST FOR RACIAL PURITY* (2007); Sarah Netter, *Mother of Nine Sues Massachusetts Hospital After Unauthorized Sterilization*, ABC NEWS (Jan. 5, 2010), <http://abcnews.go.com/Health/mother-sterilized-lawsuit-claims/story?id=9474471> [<https://perma.cc/V5NR-QL6K>].

64. *See, e.g.*, Dray Amicus Brief, *supra* note 11, at 7; Kukura, *supra* note 4, at 271 (discussing the risks associated with elective induction using Pitocin).

65. *See* Kukura, *supra* note 4, at 271–72.

66. Dray Amicus Brief, *supra* note 11, at 8 (citing testimonial evidence of this phenomenon from two separate women).

67. *See* SAKALA & CORRY, *supra* note 27, at 49.

68. *See* Amita Ray & Sujoy Ray, *Antibiotics Prior to Amniotomy for Reducing Infectious Morbidity in Mother and Infant*, 10 COCHRANE DATABASE OF SYSTEMATIC REVIEWS, Oct. 2014, at 1, 2 (“This invasive procedure allows vaginal micro-organisms access into the uterine cavity, which can in turn lead to infections in both the mother and the infant.”).

the cervix) or breaks the membranes without having obtained consent.⁶⁹ Although the membranes can rupture spontaneously at any point during labor—and, in fact, must rupture prior to birth—this is distinct from having a provider break them intentionally, prematurely, and without consent.

Although use of forceps or a vacuum extractor is medically indicated in a small number of cases to assist with vaginal delivery or to avoid a cesarean, some physicians unnecessarily resort to these tools to expedite childbirth, whether out of concern for the physician's own convenience or to enable the hospital to serve a higher volume of maternity patients and increase revenue.⁷⁰ An Ohio woman, who declined use of vacuum extraction to assist with her uncomplicated vaginal delivery, recalls that her physician “had four to five nurses hold me down while he forcibly used the vacuum . . . very brutally, lacerating [my] vaginal wall in the process.”⁷¹ A Louisiana woman recounted her birth story to a maternity care consumer advocacy organization, describing how the obstetrician “manually removed her placenta and performed a uterine sweep” after the delivery: “I have never had someone put their arm up inside of me in my three previous births, let alone without telling me what they were doing first, and without asking permission.”⁷²

c. Sexual Violation. Some women experience unwanted touching during childbirth that amounts to sexual violation. Although regular vaginal exams are not necessary during childbirth, women may be subjected to frequent vaginal penetration during labor, sometimes without their consent or knowledge, by nurses or doctors when checking the dilation, effacement, and position of the cervix.⁷³ Some women describe their birth experiences and the emotional aftermath as rape.⁷⁴

69. See Dray Amicus Brief, *supra* note 11, at A-56–A-57. Though artificial rupture of membranes (AROM) is widely believed to accelerate labor, a 2007 systematic review found no evidence of shorter labor or improved newborn outcomes when this procedure is performed after spontaneous labor is underway. See Rebecca M.D. Smyth et al., *Amniotomy for Shortening Spontaneous Labour*, 6 COCHRANE DATABASE OF SYSTEMATIC REVIEWS, June 2013, at 1. AROM is, however, associated with possible adverse effects on fetal heart rate, risk of umbilical cord prolapse or compression, and an increase in cesareans. See *id.* at 2, 3–4.

70. See SAKALA & CORRY, *supra* note 27, at 59–61 (discussing incentives for hospitals and individual providers to control timing of birth through interventions, including concern for convenience or finances).

71. Dray Amicus Brief, *supra* note 11, at 7.

72. Pascucci, *supra* note 58 (noting that the doctor “ignor[ed] her distress and actually refus[ed] to speak to her”) (internal quotations omitted).

73. See Dray Amicus Brief, *supra* note 11, at 32–33 (recounting birth experiences of women who felt violated and traumatized by how they were touched during childbirth).

74. See BLOCK, *supra* note 5, at 146 (“I felt raped. Lying naked on a cold table, strangers sticking tubes up my body, pulling my innermost organs out to fondle. I could not even pull myself out of bed for the first 3 weeks. My life was hell for months.” (internal quotations omitted)). Advocates have used the analogy to sexual assault to explain the role of consent in maternity care—a cesarean performed with consent is health care, but a cesarean lacking consent is an injury, just as vaginal penetration with consent is sex, and vaginal penetration lacking consent is rape. See Dray Amicus Brief, *supra* note 11, at 32–33.

In other contexts, the medical care administered may become sexualized by the maternity care provider performing the services. For example, when they repair a vaginal tear (spontaneous or cut during an episiotomy), some doctors perform an unnecessary extra stitch—referred to as a “husband stitch”—on the assumption that doing so will tighten the woman’s vagina and create more sexual pleasure for her male partner.⁷⁵ Providers who engage in this practice sexually objectify women’s bodies at a moment of vulnerability and heightened emotions—including exhilaration, exhaustion, gratitude to one’s birth attendant, and fear, among others—and transform a woman who has just delivered a baby into a source of male sexual pleasure.⁷⁶ This practice not only increases the likelihood that a woman will subsequently experience pain during sex, but also instills a feeling of betrayal and violation in women who discover they were subjected to the practice.⁷⁷

In 2015, the *Annals of Internal Medicine* published an anonymous essay called “Our Family Secrets,” in which a physician recounted an episode of sexual assault during childbirth he had observed as a medical student.⁷⁸ After delivering her baby, the woman (Mrs. Lopez) started hemorrhaging due to uterine atony, causing the resident to perform an internal bimanual uterine massage, as called for in such circumstances.⁷⁹ The procedure involved inserting his left hand in her vagina and forming a fist to press it against the uterus while he massaged her abdomen with his right hand, causing the uterus to contract.⁸⁰ Upon cessation of the bleeding, the author recalled how the resident “raises his right hand into the air. . . . [He] starts to sing ‘La Cucaracha’ It looks like he is dancing with her. He stomps his feet, twists his body, and waves his right arm above his head. All the while, he holds her, his whole hand still inside her vagina.”⁸¹ While there are no data on sexual assault during childbirth, an editorial accompanying this essay acknowledged that most doctors witness inappropriate conduct by a colleague toward a patient at some point during their careers, implicitly

75. See Carrie Murphy, *The Husband Stitch Isn’t Just a Horrifying Childbirth Myth*, HEALTHLINE (Jan. 24, 2018), <https://www.healthline.com/health-news/husband-stitch-is-not-just-myth> [<https://perma.cc/2UQC-9GHX>] (discussing anecdotal evidence of the “husband stitch” as a post-delivery practice that continues today, despite lack of research quantifying its prevalence); see also Chelsea Ritschel, *The “Husband Stitch” During Episiotomy Repair is a Disturbing Reality for Many New Mothers*, INDEPENDENT (Jan. 29, 2018), <http://www.independent.co.uk/life-style/husband-stitch-episiotomy-misogyny-motherhood-pregnancy-surgery-stitch-sexism-childbirth-a8184346.html> [<https://perma.cc/E5DW-W6TT>].

76. Murphy, *supra* note 75 (“As much as we try to remove the sexualization of women from appropriate obstetric care, of course the patriarchy is going to find its way in there.”).

77. *Id.* (quoting women who describe feeling “horrified,” “betrayed,” and “violated” to discover their providers had performed a husband stitch after they gave birth).

78. See Anonymous, *On Being a Doctor: Our Family Secrets*, 163 *ANNALS INTERNAL MED.* 321, 321 (2015).

79. See *id.*

80. See *id.*

81. *Id.*

suggesting that the published story is not unique.⁸²

d. Physical Restraint. When permitted to move around freely, women may deliver their babies in a number of different positions, including squatting or lying on their sides, which often feels more comfortable based on their pelvis and the baby's position.⁸³ However, some women report being forced onto their backs in the final stages of pushing and being forcibly restrained in a supine position.⁸⁴ One woman recalls laboring on her hands and knees, when suddenly she was screamed at to "GET ON YOUR BACK NOW" and "two nurses grabbed [her] arms and legs, violently flipping [her] onto [her] back."⁸⁵ A New York woman who was forcibly restrained on her back during delivery pursued a complaint with the hospital and was told "that all women deliver on their backs in that hospital, and if a woman is not on her back when the doctor wants her to be, she will be forcibly moved into that position."⁸⁶ Such restrictions are imposed for provider convenience or due to clinical inertia, despite extensive research showing that non-supine positions are associated with less severe pain, fewer episiotomies, less resort to vacuum extraction and forceps use, fewer heart rate abnormalities in babies, and shorter pushing phases.⁸⁷

e. Other Abusive Conduct. Several other types of conduct by health care providers may constitute abuse of a woman in childbirth, including the denial of pain relief and verbal attacks. Some women find themselves punished by a hostile care provider who delays the administration of pain medication or foregoes pain relief altogether. This may occur during a forceps-assisted birth⁸⁸ or during the repair of an episiotomy or natural perineal tearing.⁸⁹ Other women

82. The editorial board noted that "most physicians at some point find themselves in the midst of situations where a colleague acts in a manner that is disrespectful to a patient" and that "[b]y shining a light on this dark side of the profession, we emphasize to physicians young and old that this behavior is unacceptable." Christine Lane et al., *On Being a Doctor: Shining a Light on the Dark Side*, 163 ANNALS. INTERNAL MED. 320, 320 (2015).

83. See SAKALA & CORRY, *supra* note 27, at 55 (reporting research on benefits of non-supine positions for delivery, including less severe pain and shorter pushing phase of labor).

84. See, e.g., Dray Amicus Brief, *supra* note 11, at 14–15.

85. *Inappropriate Use of Restraints*, INVESTIGATING BIRTH (Oct. 19, 2014), <https://investigatingbirth.wordpress.com/2014/10/19/inappropriate-use-of-restraints/> [<https://perma.cc/6XPC-DUZC>]. She suffered a "minor, but permanent, injury" from the delivery as well as symptoms of PTSD. *Id.*

86. Dray Amicus Brief, *supra* note 11, at 15.

87. See SAKALA & CORRY, *supra* note 27, at 55 (citing Janesh K. Gupta, *Position in the Second Stage of Labour for Women without Epidural Anaesthesia*, 1 COCHRANE DATABASE OF SYSTEMATIC REVIEWS, Jan. 26, 2004, at 1); see also Christine L. Roberts et al., *A Meta-Analysis of Upright Positions in the Second Stage to Reduce Instrumental Deliveries in Women with Epidural Analgesia*, 84 ACTA OBSTETRICIA ET GYNECOLOGICA SCANDINAVICA 794, 795–98 (2005) (calling for further study of upright positioning among women choosing epidural analgesia based on research findings that upright positioning is associated with decreased instrumental delivery rate).

88. See Dray Amicus Brief, *supra* note 11, at 32. A Louisiana woman whose doctor used forceps without anesthesia "suffered third degree tears as well as severe emotional trauma, knowing my screams didn't mean anything to any of them." *Id.*

89. See *id.* at 7.

are subjected to verbal abuse by their physicians or nurses if they decline an induction or cesarean, or question why a particular intervention is necessary. For example, a Texas woman who declined induction in favor of spontaneous onset of labor found her doctor began “yelling at the top of his lungs about what a horribly selfish and dangerous parent [she] was.”⁹⁰ Women are subjected to degrading put-downs about their qualities as mothers or their ability to withstand pain, and are made to feel like animals, like failures, or like they are worthless.⁹¹

The abusive conduct described in this section constitutes the most extreme forms of mistreatment some childbearing women suffer at the hands of their health care providers. In such forms of abuse, the assertion of power over a patient is generally explicit, whether through action or word. The directness of such obstetric violence contrasts with forms of obstetric violence rooted in coercion, explored in the next section.

2. Coercion

When doctors encounter a pregnant patient who declines to follow medical advice, they may resort to a variety of coercive tactics to secure consent.⁹² Such measures include: (a) seeking judicial intervention; (b) instituting blanket policies restricting access to particular forms of care; (c) threatening involvement of child welfare authorities; or (d) withholding treatment, manipulating information, or applying emotional pressure. Commentators have noted sympathetically that physicians may experience “conflicting ethical impulses” when a patient refuses treatment because although they have a duty to respect patient autonomy, their professional training has prepared them to heal and cure.⁹³ However, when women experience coercion by their health care providers, it is a betrayal of provider–patient trust and emotional and physical injury may result.

a. Coercion by Judicial Intervention. The most prevalent forced cesarean experience is one where the doctors and hospital administration seek judicial intervention to compel the woman to submit to surgery.⁹⁴ Such actions disregard the right to informed consent—along with its corollary, the right to

90. *Id.* at 27.

91. *See generally* Dray Amicus Brief, *supra* note 11 (describing yelling, insults, and other verbal abuse directed at laboring women).

92. *See* Oberman, *supra* note 13, at 469 (“It is only in the context of pregnancy that doctors assert the right to compel their patients to heed medical advice.”).

93. *Id.* at 468–69 (citing Jeffrey P. Phelan, *Symposium on Biomedical Technology and Health Care: Social and Conceptual Transformations: Technical Article: The Maternal Abdominal Wall: A Fortress Against Fetal Health Care?*, 65 S. CAL. L. REV. 461, 472 (1991)).

94. *See* Oberman, *supra* note 13, at 478–82 (describing a typical scenario in which a doctor seeks to compel a woman who has refused a cesarean to consent to the surgery).

informed refusal of treatment—and the right to bodily integrity.⁹⁵ These actions also suffer from procedural defects and a high degree of arbitrariness, as the decision to pursue a court-ordered cesarean may be based on subjective judgments about a patient's age, race, socioeconomic status, religious faith, or perceived compliance, rather than medical necessity and the impaired competence of the woman to determine her own treatment.⁹⁶ While the majority of this discussion focuses on court-ordered cesareans, physicians and hospitals have also sought judicial intervention to impose other forms of medical treatment on pregnant women, including bed rest, labor induction, and blood transfusions.⁹⁷

The right to refuse medical treatment for one's own benefit is firmly settled.⁹⁸ However, courts have been willing to compel medical treatment of pregnant women justified on the basis of fetal health and well-being.⁹⁹ After an increase in the number of court-ordered cesareans, courts in the 1990s began to reject judicial intervention as incompatible with the right to refuse medical treatment.¹⁰⁰ In 1993, Talitha Bricci was told she needed a cesarean to avoid cognitive disabilities that were likely to result from a vaginal delivery.¹⁰¹ When she refused, citing her religious beliefs, her doctors and the hospital officials sought custody of the fetus to secure a court order compelling the cesarean.¹⁰²

95. See *infra* Sections II.A (discussing the right to informed consent and the right to refusal of treatment) & II.B.2 (discussing the right to bodily integrity).

96. See, e.g., Nancy Ehrenreich, *Colonization of the Womb*, 43 DUKE L.J. 492, 501, 520–21 (1993) (discussing how race and class privilege facilitate court-ordered cesareans and noting study finding 80% of women subjected to court-ordered cesareans were women of color) (footnotes omitted).

97. Cf. April L. Cherry, *The Detention, Confinement, and Incarceration of Pregnant Women for the Benefit of Fetal Health*, 16 COLUM. J. GENDER & L. 147, 148 (2007) (discussing how courts have used “incarceration, detention, orders of hospital confinement, and threats thereof, to compel pregnant women . . . to submit to their physicians’ directions regarding medical treatment for the benefit of fetal health”) (footnote omitted).

98. See Oberman, *supra* note 13, at 467 (discussing the absence of any cases decided after 1972 “in which a competent patient was forced to undergo medical treatment intended strictly for her own benefit”).

99. See, e.g., *Jefferson v. Griffin Spalding Cty. Hosp. Auth.*, 274 S.E.2d 457, 458 (Ga. 1981) (upholding an order allowing physician to “infringe upon the wishes of the mother . . . to give the child the opportunity to live”) (internal quotations omitted); see also John Alan Cohan, *Judicial Enforcement of Lifesaving Treatment for Unwilling Patients*, 39 CREIGHTON L. REV. 849, 896–911 (2006) (documenting cases involving pregnant women who refuse medical treatment).

100. See, e.g., *In re A.C.*, 573 A.2d 1235, 1237 (D.C. 1990) (holding that “in virtually all cases,” the pregnant woman has the right to make treatment decisions for herself and the fetus). In this case, the D.C. appellate court found that an order compelling a cesarean on a terminally-ill cancer patient had been improperly issued, and that in the event a patient is incompetent or unable to provide informed consent, the court should use “substituted judgment” to ascertain the patient’s wishes. See *id.* No appellate court has upheld a court-ordered cesarean after consideration of a full record since 1981. See Diaz-Tello, *Invisible Hand*, *supra* note 9, at 213 (footnote omitted).

101. See *In re Baby Boy Doe, a Fetus*, 632 N.E.2d 326, 327 (Ill. App. Ct. 1994).

102. See *id.* at 327. At the time the Chicago-based Bricci case was decided, doctors at Rush-Presbyterian Medical Center in Chicago were interviewed about judicial intervention to compel medical treatment during childbirth. See Oberman, *supra* note 13, at 481 n.120. They discussed five or six similar cases of the hospital wishing to override a woman’s refusal to consent to a cesarean, “but

The court denied the petition, finding no authority “to support justifying the intrusive procedure . . . against a competent person,” and Bricci gave birth to a healthy baby two weeks later.¹⁰³ On appeal, the court affirmed that a “woman’s right to refuse invasive medical treatment . . . is not diminished during pregnancy.”¹⁰⁴

While some courts have recognized a pregnant woman’s right to refuse treatment, others have continued to issue orders compelling cesareans. In 1996, Laura Pemberton decided to deliver at home after she was unable to find a local obstetrician who would attend her VBAC.¹⁰⁵ After laboring for a day—with no signs of complications—she was worried about dehydration and decided to visit the hospital to receive IV fluids before returning home.¹⁰⁶ Medical staff refused to provide fluids unless she consented to a cesarean.¹⁰⁷ When Pemberton learned that the hospital intended to seek a court order, she snuck down the back stairs of the hospital in her bare feet and went home to continue laboring.¹⁰⁸ Subsequently, the sheriff and State Attorney removed her from her home—strapping her legs together on a stretcher—to attend a hearing at the hospital.¹⁰⁹ The judge ordered the cesarean, even though Pemberton could feel the fetus progressing into her birth canal without complication.¹¹⁰ A federal district court later rejected Pemberton’s claims of negligence, false imprisonment, and violation of her constitutional rights.¹¹¹

In 2004, Amber Marlowe was informed that her baby was approximately 13 pounds and thus would require a cesarean delivery.¹¹² Having previously delivered six children vaginally, all nearly 12 pounds each, she refused to provide

[noted] that the women had backed down when legal action was threatened.” *Id.* at 482 (footnote omitted).

103. *In re Baby Boy Doe, a Fetus*, 632 N.E.2d at 329 (quoting the holding from the decision below) (citation omitted).

104. *Id.* at 332; *see also In re Fetus Brown*, 689 N.E.2d 397, 405 (Ill. App. Ct. 1997) (holding that the State may not override a pregnant woman’s competent treatment decision to save the life of a viable fetus).

105. *Pemberton v. Tallahassee Mem’l Reg’l Med. Ctr.*, 66 F. Supp. 2d 1247, 1249 (N.D. Fla. 1999). She had previously had a cesarean performed using a vertical incision, which increased the risk of uterine rupture associated with subsequent vaginal deliveries. *See id.*

106. *See id.*

107. *See id.*

108. *See id.*; Audio Tape: Address by Laura Pemberton at National Advocates for Pregnant Women’s National Summit to Ensure the Health and Humanity of Pregnant and Birthing Women (Jan. 18–21, 2007) [hereinafter Pemberton Address], at 7:46–8:20 (audio recording on file with NAPW).

109. *See Pemberton Address*, *supra* note 108, at 9:25–13:20.

110. *See Pemberton*, 66 F. Supp. 2d at 1250; Pemberton Address, *supra* note 108, at 14:12–17:05. Pemberton later moved to another state and subsequently delivered four more children vaginally, including twins.

111. *See Pemberton*, 66 F. Supp. 2d at 1249.

112. *See Lisa Collier Cool, Could You Be Forced to Have a C-Section?*, BABYTALK (May 2005), http://advocatesforpregnantwomen.org/articles/forced_c-section.htm [<https://perma.cc/47DL-UXYX>].

consent to the surgery.¹¹³ The hospital obtained a court order naming it the legal guardian of Marlowe's fetus, meaning that she could be subjected to a cesarean against her will if she returned to that hospital.¹¹⁴ Instead, she went to another area hospital and vaginally delivered a healthy eleven-pound baby.¹¹⁵

Threats to seek a court-ordered cesarean may be sufficient to compel consent from a woman in or approaching labor. In 2014, Jennifer Goodall was almost thirty-nine weeks pregnant, hoping to deliver vaginally after three previous cesareans, when she received a letter from the hospital where she planned to give birth.¹¹⁶ Signed by the hospital's Chief Financial Officer, the letter expressed concern about Goodall's decision to decline an elective cesarean and indicated that the hospital intended to seek "expedited judicial intervention" to compel her to undergo a cesarean.¹¹⁷ Despite the fact that Goodall had told her care providers that she "absolutely will consent to such surgery, if there is a complication that arises during . . . labor" necessitating a cesarean,¹¹⁸ the hospital's letter clearly indicated that if Goodall came to the hospital in labor and a physician "deems it clinically necessary, a Cesarean section will be performed with or without your consent."¹¹⁹ A federal court denied her petition for a temporary restraining order (TRO) to prevent the hospital from pursuing the threatened action.¹²⁰ On the eve of labor, Goodall scrambled to find another care provider and ultimately delivered by cesarean at another hospital, consenting to the procedure when it appeared medically necessary.¹²¹

113. *See id.*; *What Are Mothers' Rights During Childbirth?*, WOMEN'S HEALTH ON NBC NEWS (May 19, 2004) [hereinafter *Mother's Rights*], <http://www.msnbc.msn.com/id/5012918/> [<https://perma.cc/BZ35-JZL4>].

114. *See Cool*, *supra* note 112.

115. *See Mothers' Rights*, *supra* note 113 (describing the delivery as "a piece of cake") (internal quotation omitted).

116. *See Florida Hospital Says It Will Force Pregnant Woman to Have Cesarean Surgery*, Press Release (NAT'L ADVOC. FOR PREGNANT WOMEN) (July 25, 2014) [hereinafter *Goodall Press Release*] http://advocatesforpregnantwomen.org/blog/2014/07/press_release_florida_hospital.php [<https://perma.cc/455V-VKPU>]. Research indicates that a fourth cesarean puts women at a one in eight chance of major complications. *See id.*

117. Declaration of Jennifer Goodall at Exhibit 1 (Letter from Cheryl Tibbett, as CFO of Bayfront Health Medical Group to Jennifer Goodall (July 10, 2014)) [Exhibit 1 hereinafter *Bayfront Letter*], *Goodall v. Comprehensive Women's Health Ctr.*, 2014 WL 3587290 (M.D. Fla. Jul. 18, 2014) [hereinafter *Goodall Declaration*].

118. *Id.* at ¶ 5.

119. *Bayfront Letter*, *supra* note 117. This threat begs the question of why the hospital intended to "begin a process for an Expedited Judicial Intervention Concerning Medical Treatment Procedures" if it was prepared to perform a cesarean with or without the patient's consent should she return there for further care. *Id.*

120. *See Goodall*, 2014 WL 3587290, at *3.

121. *See Frank Gluck*, *Woman in Legal Fight Over C-Section Delivers Baby*, USA TODAY (July 29, 2014), <https://www.usatoday.com/story/news/nation/2014/07/29/fla-baby-c-section/13318391/> [<https://perma.cc/AV3H-3C9A>] ("I welcomed my son into the world after laboring, consenting to surgery when it became apparent that it was necessary because labor was not progressing. This was all I wanted to begin with." (internal quotation omitted)).

In 2010, when Michelle Mitchell arrived in labor at Augusta Health in Augusta County, Virginia, the on-call physician recommended that she have a cesarean based on medical records that indicated her doctors suspected she was carrying a large baby.¹²² Hoping to avoid a cesarean, Mitchell signed an acknowledgement declining to follow the doctor's recommendation and waiving liability.¹²³ Nevertheless, the provider threatened to pursue a court order compelling the surgery (as well as to report her to the child welfare authorities).¹²⁴ Upon hearing these threats, Mitchell rescinded her informed refusal and acquiesced to the cesarean.¹²⁵

Judicial intervention to compel the medical treatment of pregnant women raises several procedural concerns.¹²⁶ Hearings on the eve or in the midst of labor are typically held quickly, either by telephone or with a judge appearing in the hospital room.¹²⁷ Women are unlikely to have immediate access to counsel, nor are they likely to be prepared with references to medical research or case law that support their decision.¹²⁸ Non-native English speakers may find it particularly difficult to advocate for themselves regarding medical treatment.¹²⁹ In many instances, a woman will already have heard from a variety of hospital staff—including doctors, nurses, social workers, pastoral care workers, and attorneys—who have tried to convince her to consent.¹³⁰ Judges tend to be unfamiliar with the medical facts necessary to understand and balance risks during childbirth and are therefore likely to find the arguments of hospital legal and medical staff more compelling than those of a non-legally trained and

122. See Diaz-Tello, *Invisible Wounds*, *supra* note 9, at 58–59; see also *Verdict Reached in Mother's Lawsuit that Claimed C-Section Was Coerced*, WHSV (Nov. 7, 2015), <http://www.wHSV.com/content/news/Mothers-Lawsuit-Says-C-Section-Was-Coerced-341274302.html> [<https://perma.cc/PZ6C-B88W>].

123. See Diaz-Tello, *Invisible Wounds*, *supra* note 9, at 58–59.

124. See *Augusta Co. Jury Rules in Favor of Doctor in C-Section Case*, NBC (Nov. 20, 2015), <http://www.nbc29.com/story/30455784/update-augusta-co-jury-rules-in-favor-of-doctor-in-c-section-case> [<https://perma.cc/EE73-3XHK>] [hereinafter *Jury Rules*].

125. See Diaz-Tello, *Invisible Wounds*, *supra* note 9, at 59.

126. See Janet Gallagher, *Prenatal Invasions & Interventions: What's Wrong with Fetal Rights*, 10 HARV. WOMEN'S L.J. 9, 49 (1987) (“The procedural shortcomings rampant in these cases are not mere technical deficiencies. They undermine the authority of the decisions themselves, posing serious questions as to whether judges can, in the absence of genuine notice, adequate representation, explicit standards of proof, and right of appeal, realistically frame principled and useful legal responses to the dilemmas with which they are being confronted.”).

127. See Veronika E.B. Kolder et al., *Court-Ordered Obstetrical Interventions*, 316 NEW ENG. J. MED. 1192, 1193 (1987) (reporting on survey of judicial interventions during childbirth that found in 88% of cases, orders were issued in less than six hours, and in 19%, in less than one hour, once by telephone); see also Oberman, *supra* note 13, at 481 n.120 (discussing the practice of judges ordering treatment after a telephonic hearing).

128. See Oberman, *supra* note 13, at 481–82.

129. See *Non-Native English Speakers Face Numerous Linguistic, Cultural Barriers to Medical Care*, CAL. HEALTHLINE (Oct. 30, 2009), <https://californiahealthline.org/news/nonnative-english-speakers-face-numerous-linguistic-cultural-barriers-to-medical-care/> [<https://perma.cc/Q8AG-CVKY>] (reporting on study findings that non-native English speakers experience difficulty communicating with health care providers).

130. See Oberman, *supra* note 13, at 480.

unprepared laboring woman.¹³¹ Significantly, pursuing judicial intervention and holding such a hearing transforms the woman's physician into her adversary, disrupting the treatment relationship, interfering with physician-patient trust, and exacerbating the woman's vulnerability.¹³²

Not all jurisdictions have considered cases involving forced medical treatment of pregnant women, meaning that the law is in different stages of development across the country. The D.C. Superior Court's 1990 decision in *In re A.C.* is widely cited in support of pregnant women's right to refuse treatment, but even that opinion leaves room for an exception in particular, undefined circumstances.¹³³ Given this uncertainty, women continue to face the risk of judicial intervention to compel unwanted medical treatment during childbirth.¹³⁴

b. Coercion by VBAC Restrictions. Restrictions on access to VBAC are perhaps the most widespread form of coercion in the American maternity care system. A large survey revealed that in 2009, more than 800 hospitals country-wide had instituted official policies against supporting VBAC.¹³⁵ More than 600 hospitals had de facto bans due to the unavailability of providers willing to attend VBACs or prohibitively strict rules about the conditions required for a VBAC.¹³⁶ Among the reasons hospitals and providers choose to restrict VBAC access are concerns about malpractice exposure, high insurance premiums for obstetricians, distortion of the risks associated with VBAC, and the desire to maximize revenue by performing more cesareans, which have higher reimbursement rates than vaginal deliveries and which enable a greater patient volume by reducing the average time from admission to delivery.¹³⁷ Women facing VBAC restrictions who live in areas with multiple hospitals may be able to find another place to give birth, and some women may choose to relocate at the end of

131. See Nancy K. Rhoden, *The Judge in the Delivery Room: The Emergence of Court-Ordered Cesareans*, 74 CAL. L. REV. 1951, 2029 (1986) (highlighting the one-sidedness of compelled cesarean hearings because judges are not "likely to hear lucid constitutional arguments from [a woman] in the hospital, in the sweaty agonies of labor").

132. See Alicia Ouellette, *New Medical Technology: A Chance to Reexamine Court-Ordered Medical Procedures During Pregnancy*, 57 ALB. L. REV. 927, 936-37 (1994) (discussing patients' vulnerability in the context of medical disputes during childbirth) (citations omitted).

133. See 573 A.2d 1235, 1237 (D.C. 1990); see also Oberman, *supra* note 13, at 480-82 (discussing factors contributing to continued judicial intervention despite favorable rulings in cases like *In re A.C.*) (citations omitted).

134. Other forms of state power may be wielded to coerce a pregnant woman's consent to treatment. For example, a Florida woman named Lisa Epsteen received an email from her obstetrician threatening to have her arrested for delaying a scheduled cesarean for a few days. See Diaz-Tello, *Invisible Wounds*, *supra* note 9, at 58 (quoting the physician's email, which said "I would hate to move to the most extreme option, which is having law enforcement pick you up at your home and bring you in, but you are leaving the providers of [the hospital] no choice.") (emphasis removed).

135. See *Access to VBAC Shrinking: New Survey Shows Shrinking Options for Women with Prior Cesarean*, INT'L CESAREAN AWARENESS NETWORK (Feb. 19, 2009), <http://icanofjacksonms.blogspot.com/2009/02/access-to-vbac-is-shrinking.html> [<https://perma.cc/AH2T-BF6M>] (citation omitted).

136. See *id.* (citation omitted).

137. See Elizabeth Kukura, *Choice in Birth: Preserving Access to VBAC*, 114 PENN ST. L. REV. 955, 967-70 (2010) (discussing the roles of profit and liability in the introduction of VBAC restrictions).

pregnancy in search of VBAC-friendly care providers, incurring significant expense and disruption to avoid such restrictions.¹³⁸ Otherwise, women who rely on VBAC-restrictive hospitals for maternity care have no choice other than to consent to an elective repeat cesarean, unless they deliver at home (unassisted or with a midwife, where available). Such policies, whether formal or informal, compel women to undergo unwanted surgery.

Formal and informal restrictions on supporting VBAC are not consistent with evidence-based maternity care. Historically, women who gave birth by cesarean would automatically have a cesarean for any subsequent deliveries.¹³⁹ After the cesarean rate rose from 5% of births in 1970 to almost 25% in 1988, medical authorities began to promote VBAC as a method to reduce the number of cesareans and their associated risks.¹⁴⁰ By 1996, the cesarean rate had declined to 20.7%; at the same time, the VBAC rate reached an all-time high of 28.3%, up from less than 18.9% in 1989.¹⁴¹ However, in 1999, ACOG issued stricter recommendations for health care providers, requiring that facilities and personnel for an emergency cesarean be “immediately available,” which effectively meant VBAC would only be possible for women delivering at university and tertiary-level medical centers.¹⁴² By 2005, VBAC rates had declined to 8%, reflecting the impact of the 1999 ACOG guidelines.¹⁴³ Cesarean rates continued

138. See, e.g., Elizabeth Cohen, *Mom Won't Be Forced to Have C-Section*, CNN (Oct. 15, 2009), <http://www.cnn.com/2009/HEALTH/10/15/hospitals.ban.vbacs/> [<https://perma.cc/59M9-Mp6Z>] (discussing woman's plan to move 350 miles away to deliver at VBAC-supportive hospital without her family).

139. See generally Bruce L. Flamm, *Once a Cesarean, Always a Controversy*, 90 OBSTETRICS & GYNECOLOGY 312 (1997) (discussing reasons why elective repeat cesarean is no longer the unquestioned default for women who previously delivered by cesarean).

140. See ACOG Committee on Practice Bulletins—Obstetrics, *ACOG Practice Bulletin No. 54: Vaginal Birth After Previous Cesarean Delivery*, in 104 OBSTETRICS & GYNECOLOGY 203, 203–04 (2004) [hereinafter Practice Bulletin No. 54] (replacing Practice Bulletin No. 5, *infra* note 142). By the mid-1980s, adoption of a low transverse incision as standard practice in most procedures lowered the risk of VBAC for women in subsequent low-risk pregnancies. See Sheryl Gay Stolberg, *A Risk is Found in Natural Birth After Cesarean*, N.Y. TIMES (July 5, 2001), <http://www.nytimes.com/2001/07/05/us/a-risk-is-found-in-natural-birth-after-caesarean.html> [<https://nyti.ms/2eROIvO>]. Despite this lowered risk, during VBAC there is still a chance of uterine rupture, meaning that the existing scar gives way during labor, causing complications. See HENCI GOER & AMY ROMANO, OPTIMAL CARE IN CHILDBIRTH: THE CASE FOR A PHYSIOLOGIC APPROACH 95–105 (2012) (discussing research on risks and benefits of VBAC relative to elective repeat cesarean).

141. See Practice Bulletin No. 54, *supra* note 140, at 204.

142. See ACOG Committee on Practice Bulletins—Obstetrics, *ACOG Practice Bulletin No. 5: Vaginal Birth After Cesarean Delivery*, in 66 INT'L J. OBSTETRICS & GYNECOLOGY 197, 201 (1999). The previous guidelines had called for medical personnel to be “readily available,” as they would be for an emergency cesarean. For a discussion of the methodological flaws in research that heightened fears surrounding VBAC and led to the stricter guidelines, see HENCI GOER, THE THINKING WOMAN'S GUIDE TO A BETTER BIRTH 164 (1999). For a discussion of the negative impact of the ACOG guidelines on access to VBAC at rural hospitals, see John Zweifler et al., *Vaginal Birth After Cesarean in California: Before and After a Change in Guidelines*, 4 ANNALS FAM. MED. 228, 230 (2006).

143. See SAKALA & CORRY, *supra* note 27, at 41 (noting the decline).

to rise, reaching a record high of 32.9% of all births in 2009.¹⁴⁴

In 2010, ACOG replaced the 2004 Practice Bulletin with revised guidelines, which stated that a VBAC-restrictive “policy cannot be used to force women to have cesarean delivery or to deny care to women in labor who decline to have a repeat cesarean delivery.”¹⁴⁵ However, the 2010 Practice Bulletin still retained the restrictive “immediately available” language, which continued to limit access to VBAC.¹⁴⁶ ACOG recommended that when a conflict arises between a woman and the physician or hospital, and consensus cannot be reached, the provider should not use coercive means to promote elective cesarean but should instead transfer the woman to a facility that will support her attempt to deliver vaginally, which is referred to as a trial of labor.¹⁴⁷ But this failed to address the needs of women who are already laboring or who do not live near a tertiary-level hospital where VBAC is available. A 2013 study found that 48% of pregnant women wanted the option of VBAC, but 39% of those women were either unable to locate a provider (15%) or hospital (24%) where they could avoid a compelled repeat cesarean.¹⁴⁸

In October 2017, ACOG once again issued new VBAC guidelines,¹⁴⁹ noting that the continued upward trend in the cesarean rate “is the opposite of what we want to see happening” and citing “misunderstanding regarding the safety of . . . VBAC and a reticence to consider this a viable option due to medical liability concerns.”¹⁵⁰ The 2017 Practice Bulletin reiterates certain findings of the 2010 guidelines, but most notably states that VBAC should be attempted in “facilities capable of performing emergency deliveries,”¹⁵¹ which includes mater-

144. See JOYCE A. MARTIN ET AL., NAT'L VITAL STATISTICS SYS., U.S. DEP'T. OF HEALTH AND HUMAN SERVS., BIRTHS: FINAL DATA FOR 2013, at 1 (2015) [hereinafter NVS Birth Reports 2013] http://www.cdc.gov/nchs/data/nvsr/nvsr64/nvsr64_01.pdf [<https://perma.cc/AFM6-XE3B>].

145. ACOG Committee on Practice Bulletins—Obstetrics, *Practice Bulletin No. 115: Vaginal Birth After Previous Cesarean Delivery*, in 116 *OBSTETRICS & GYNECOLOGY* 450, 457 (2010) [hereinafter Practice Bulletin No. 115] (replacing Practice Bulletin No. 54, *supra* note 140).

146. *Id.* (internal quotations omitted).

147. *See id.*

148. See EUGENE R. DECLERQ ET AL., LISTENING TO MOTHERS III: REPORT OF THE THIRD NATIONAL U.S. SURVEY OF WOMEN'S CHILDBEARING EXPERIENCES 21 (2013) [hereinafter LrM III], http://transform.childbirthconnection.org/wp-content/uploads/2013/06/LTM-III_Pregnancy-and-Birth.pdf [<https://perma.cc/R5BZ-U9V9>]. Some women have tried to force a VBAC by timing their arrival at the hospital to leave insufficient time to be prepared for surgery—sometimes even laboring in a car in the parking lot until delivery is imminent. See Paul Christopher Estaris Torio, *Nature Versus Suture: Why VBAC Should Still Be in Vogue*, 31 *WOMEN'S RTS. L. REP.* 487, 503 (2010) (citations omitted). As physicians have recognized this tactic, some have continued to “force surgery through deceptive practices such as anesthetizing under the pretense of administering oxygen or police and judicial strong-arming.” *Id.* (footnote omitted).

149. See ACOG Committee on Practice Bulletins—Obstetrics, *Practice Bulletin No. 184: Vaginal Birth After Cesarean Delivery*, in 130 *OBSTETRICS & GYNECOLOGY* 217 (2017) [hereinafter Practice Bulletin No. 184] (replacing Practice Bulletin No. 115, *supra* note 145).

150. Press Release, ACOG, ACOG Releases New Guidance Aimed at Making VBAC Available to More Women (Oct. 24, 2017), <https://www.acog.org/About-ACOG/News-Room/News-Releases/2017/ACOG-Releases-New-Guidance-Aimed-at-Making-VBAC-Available-to-More-Women> [<https://perma.cc/9H9N-7FX4>].

151. Practice Bulletin No. 184, *supra* note 149, at 224.

nal care facilities that “typically manage uncomplicated births”¹⁵²—a departure from the “immediately available” language in prior bulletins. Advocates have welcomed the new guidelines with cautious optimism, noting the importance of provider education to ensure adoption of the new guidelines and increased access to VBAC.¹⁵³

ACOG’s approach over the years would seem to suggest that VBAC is clearly the more dangerous choice. However, research favors vaginal delivery for low-risk women over elective repeat cesarean because VBAC entails a lower risk of complications for both women and babies.¹⁵⁴ The risk of rupture during a VBAC attempt is less than 1% even with multiple cesarean scars,¹⁵⁵ and this number decreases when a woman is able to labor without the use of drugs to induce or augment contractions.¹⁵⁶ The risk of infant death resulting from uterine rupture is even lower—approximately 1 in 2,000.¹⁵⁷ The likelihood that a woman would require an emergency hysterectomy or die does not differ significantly between VBAC and repeat cesarean.¹⁵⁸ However, when a VBAC ban imposes an unwanted cesarean on a woman, she suffers an increased risk of various complications associated with cesareans, including maternal death, blood clots and stroke, surgical injury, longer hospitalization, rehospitalization, infection, poor birth experience, less early contact with babies, intense and prolonged postpartum pain, poor overall mental health and self-esteem, and

152. Press Release, *supra* note 150; *see also* Practice Bulletin No. 184, *supra* note 149, at 226 (discussing development of uniform designations of levels of maternal care and recommending that women attempting VBAC receive care at a Level 1 center or higher). By defining Level 1 facilities as those that “must have the ability to begin emergency cesarean delivery within a time interval that best considers maternal and fetal risks and benefits with the provision of emergency care,” ACOG clarifies that it no longer applies the “immediately available” standard. *Id.* at 225.

153. *See, e.g.*, Jen Kamel, “Eleven Things I Love About ACOG’s 2017 VBAC Guidelines,” VBAC FACTS (Oct. 25, 2017), <https://vbacfacts.com/2017/10/25/acog-2017-vbac-guidelines/> [<https://perma.cc/X2X5-4JWB>] (praising ACOG’s strong opposition to coercion caused by VBAC restrictions but noting that prior ACOG guideline revisions have “ma[de] very little difference in terms of hospital policies and individual provider preferences” in the absence of “[i]nformed parents teaming up with advocates and professionals in their area to create change”).

154. *See* Kukura, *supra* note 4, at 269–70 (citations omitted) (discussing research comparing risks of VBAC with risks of repeat cesareans); *see also* Zweifler et al., *supra* note 142, at 228 (reporting results of 2006 study that found no improvement in neonatal and maternal mortality rates after the imposition of ACOG’s restrictive guidelines, despite a vast decrease in the VBAC rate).

155. *See* Mark B. Landon et al., *Risk of Uterine Rupture with a Trial of Labor in Women with Multiple and Single Prior Cesarean Delivery*, 108 *OBSTETRICS & GYNECOLOGY* 12, 12 (2006); Mona Lydon-Rochelle et al., *Risk of Uterine Rupture During Labor Among Women with a Prior Cesarean Delivery*, 345 *NEW ENG. J. MED.* 3, 3 (2001). Women who have an elective repeat cesarean also have a slight risk of uterine rupture during the surgery—approximately 0.2%. BLOCK, *supra* note 5, at 90 (citation omitted).

156. *Cf.* Ron Gonen et al., *Results of a Well-Defined Protocol for a Trial of Labor After Prior Cesarean Delivery*, 107 *OBSTETRICS & GYNECOLOGY* 240, 243 (2006) (suggesting risk of rupture increases when drugs are used to induce labor).

157. *See* Lydon-Rochelle et al., *supra* note 155, at 7.

158. *See* Jeanne-Marie Guise et al., *Systematic Review of the Incidence and Consequences of Uterine Rupture in Women with Previous Cesarean Section*, 329 *BMJ*, 2004, at 1, 4–6, <http://www.bmj.com/content/bmj/329/7456/19.full.pdf> [<https://perma.cc/9ZQE-EWQZ>].

poor overall functioning.¹⁵⁹ Being forced to submit to unwanted surgery may also inflict intense emotional and psychological injuries.¹⁶⁰

c. Coercion by Child Welfare Intervention. Another way that health care providers obtain a woman's consent to treatment is to threaten legal intervention by child welfare authorities. An investigation into whether a parent has abused or neglected a child subjects the entire family to state surveillance and may trigger scrutiny of other aspects of their private lives, including housing, family relationships, and nutrition.¹⁶¹ Such scrutiny may lead to the removal of children from their families and termination of parental rights.¹⁶² Involving child welfare authorities can have devastating consequences for parents and children, especially when the child in question is a newborn and state intervention disrupts early bonding and breastfeeding.¹⁶³ Where health care providers threaten to report a patient to the child welfare authorities in order to secure consent to treatment, they wield their obligation to report suspected child maltreatment as a weapon, misusing the mandatory reporting mechanism in punitive ways.¹⁶⁴

In 2006, when V.M. went to Saint Barnabas Hospital in New Jersey, she consented to administration of IV fluids, antibiotics, oxygen, fetal heart rate monitoring, an episiotomy, and an epidural, but she declined to consent to other invasive treatment, including a cesarean or fetal scalp stimulation.¹⁶⁵ The hospital staff urged her to sign the consent form “in the event of an emer-

159. See CAROL SAKALA, CHILDBIRTH CONNECTION, VAGINAL OR CESAREAN BIRTH?: A SYSTEMATIC REVIEW TO DETERMINE WHAT IS AT STAKE FOR MOTHERS AND BABIES 3–4 (2006), <http://www.pqcnc.org/> [<https://perma.cc/B9F2-PRG7>]; see also Kukura, *supra* note 4, at 268–70 (discussing negative impact of cesarean on future fertility and subsequent deliveries).

160. See *infra* Section I.B.

161. See Josh Gupta-Kagan, *Toward a Public Health Legal Structure for Child Welfare*, 92 NEB. L. REV. 897, 937 (2014).

162. See *id.* at 916.

163. See *Oversight Hearing—Examining the Unique Issues Facing Women in City Jails & Intro 0899-2015* (Dec. 15, 2015) (statement of Kelsey De Avila, Social Worker, Jail Services), <http://bds.org/category/testimony/> [<https://perma.cc/L7LY-X2JK>] (describing, in the context of incarceration, how separation of a breastfeeding infant from her mother “can be damaging to the child’s development and dangerous to a mother’s mental health”); Larissa MacFarquhar, *When Should a Child Be Taken From His Parents?*, NEW YORKER (Aug. 7 & 14, 2017), <https://www.newyorker.com/magazine/2017/08/07/when-should-a-child-be-taken-from-his-parents> [<https://perma.cc/SXZ5-F7GU>] (discussing the emotional and psychological impact of removing children from their parents, even temporarily).

164. See CHILD WELFARE INFO. GATEWAY, U.S. DEP’T OF HEALTH AND HUMAN SERVS., MANDATORY REPORTERS OF CHILD ABUSE AND NEGLECT 2 (2015), <https://www.childwelfare.gov/pubPDFs/manda.pdf/> [<https://perma.cc/J9JA-NJ8T>] (discussing physician and nurse obligation to report suspected child abuse). For more discussion of maternity care coercion in the form of child welfare threats and the legal and ethical obligations of health care providers, see Elizabeth Kukura, *Birth Conflicts: Leveraging State Power to Coerce Health Care Decision-Making*, 47 U. BALT. L. REV. 247 (2018).

165. See *New Jersey Div. of Youth & Family Servs. v. V.M.*, 974 A.2d 448, 449 (N.J. Super. Ct. App. Div. 2009) (per curiam) (adopting the facts as described in the concurring opinion of Judge Carchman, see *id.* at 450–55), *cert. to N.J. denied*, 983 A.2d 1113 (table) (N.J. 2009), *cert. to U.S. denied*, 561 U.S. 1028 (2010).

gency,”¹⁶⁶ but there was no medical indication that a cesarean was necessary.¹⁶⁷ She reported being subjected to a high degree of pressure and having her mental state questioned to determine whether she was competent to refuse treatment, which the hospital psychiatrist concluded she was.¹⁶⁸ She eventually had a healthy baby by vaginal delivery without complication.¹⁶⁹ Nevertheless, the hospital reported her to the Division of Youth and Family Services (DYFS) on the theory that her refusal to consent to a cesarean constituted child neglect or abuse.¹⁷⁰ DYFS put the newborn into foster care and ultimately secured termination of the woman’s parental rights.¹⁷¹

An appellate court affirmed the termination of parental rights, though the panel disagreed about whether refusal to consent to a cesarean can be considered in determining neglect.¹⁷² The *per curiam* decision acknowledges that the Family Court judge relied in part on the cesarean refusal in his findings but states that it need not consider the refusal because there were sufficient grounds for a finding of neglect based on other facts revealed in the investigation.¹⁷³ Commentators have noted that but for the cesarean refusal and subsequent conflict over V.M.’s lack of consent, there would have been no investigation in the first place, rendering the court’s disavowal of the woman’s refusal as a factor supporting termination of parental rights disingenuous.¹⁷⁴

When Jennifer Goodall’s hospital notified her by letter that it intended to seek a court-ordered cesarean, it also threatened to report her to the Department of

166. See Brief of Amici Curiae Experts in Maternal and Neonatal Health, Birth and Child Welfare at 4, *New Jersey Div. of Youth & Fam. Servs. v. V.M.*, 974 A.2d 448 (N.J. Super. Ct. App. Div. 2009) [hereinafter *Expert Amicus Brief*] (Docket No. A-04627-06T4) (internal quotations omitted).

167. See *V.M.*, 974 A.2d at 449–50 (Carchman, P.J.A.D., concurring) (“Despite the medical opinion that the fetus demonstrated signs of distress and that the procedure was necessary to avoid imminent danger to the fetus, the child was born by vaginal delivery without incident.”). Given that her refusal pertained to a blanket consent sought at the outset of treatment, she certainly could have changed her mind and proceeded with a cesarean if medical complications arose. As one commentator notes, “[i]f the repercussions for failure to consent to cesarean section are so severe that children can be taken from their mothers, what is the purpose of a consent form?” Heather Joy Baker, “*We Don’t Want to Scare the Ladies:*” *An Investigation of Maternal Rights and Informed Consent Throughout the Birth Process*, 31 *WOMEN’S RTS L. REP.* 538, 540–41 (2010).

168. See *Expert Amicus Brief*, *supra* note 166, at 4–5.

169. See *V.M.*, 974 A.2d at 449 (Carchman, P.J.A.D., concurring).

170. See *id.* at 452 (Carchman, P.J.A.D., concurring).

171. See *id.* at 450 (Carchman, P.J.A.D., concurring).

172. Compare *V.M.*, 974 A.2d 448 (per curiam) (declining to review whether cesarean refusal should be considered in assessing neglect), with *V.M.*, 974 A.2d at 450 (Carchman, P.J.A.D., concurring) (determining that consideration of cesarean refusal is improper as “beyond the legislative scope of the child-protective statutes”).

173. *V.M.*, 974 A.2d at 449. The court cites hospital records that describe V.M. as “combative, uncooperative, erratic, noncompliant, irrational, and inappropriate,” which may have been compelling in light of evidence about V.M.’s previous mental health diagnosis, see *id.* at 450–51 (internal quotations omitted), but could also easily describe many women in the midst of giving birth. See Louise Marie Roth, *Is a Woman in Labor a “Person”?* *New Assaults on Pregnant Women’s Civil Rights in a NJ Case*, *HUFFINGTON POST* (May 25, 2011), http://www.huffingtonpost.com/louise-marie-roth/is-a-woman-in-labor-a-per_b_242307.html [https://perma.cc/5A92-437Z].

174. See Roth, *supra* note 173.

Children and Family Services (DCFS) for pursuing a VBAC.¹⁷⁵ In Goodall's petition for a TRO, she argued that her right to privacy "encompass[ed] her right to family relationships and parental decision making undisturbed by the state," citing authority about parental interests in the "care, custody, and control of their children" as being "perhaps the oldest of the fundamental liberty interests recognized by [the] Court."¹⁷⁶ She also argued that state intrusion into family privacy for the sake of child welfare is restricted to circumstances recognized by state statute, and the relevant Florida statute did not recognize the medical decision making of competent adults acting on their own behalf as a permissible intrusion.¹⁷⁷ Goodall also pointed out that mandatory reporting by health professionals does not extend to conflicts over maternity care decision making.¹⁷⁸ In addition to the constitutional violations she argued, she also claimed intentional and negligent infliction of emotional distress caused by the hospital's threats.¹⁷⁹ In declining to issue the TRO, the court responded with silence to Goodall's arguments that the child welfare threat was a wrongful act to "coerce Ms. Goodall into acquiescence. . . ."¹⁸⁰

Michelle Mitchell, the Virginia woman discussed in section I.A.2.a, *supra*, had also been threatened with both judicial intervention and child welfare reporting, prompting her to acquiesce to the cesarean she did not want. However, despite the fact that Mitchell rescinded her cesarean refusal, the hospital still contacted the child welfare authorities, "accusing [her] of being unfit to care for her child because of the conflict that arose from her decision to deliver vaginally."¹⁸¹ The hospital separated Mitchell from her newborn immediately after the birth and refused to release the infant to her.¹⁸² She was subjected to three months of "invasive interviews and home observations" before the agency decided the investigation was baseless and closed it.¹⁸³

The experiences of women like V.M., Goodall, and Mitchell add an additional factor to the balancing of risks involved in deciding whether to choose a cesarean delivery: possible intervention by child welfare authorities. Refusing

175. See Bayfront Letter, *supra* note 117.

176. Plaintiff's Memorandum of Law in Support of the Motion for Temporary Restraining Order and Complaint for Preliminary Injunction, Declaratory Judgment and Damages at 14, Goodall v. Comprehensive Women's Health Ctr., 2014 WL 3587290 (M.D. Fla. Jul. 18, 2014) [hereinafter Goodall Brief] (citing Troxel v. Granville, 530 U.S. 57, 65 (2000)) (internal quotations omitted).

177. See *id.* (citing Fla. Stat. §§ 39.001–39.908 (2014)).

178. See Goodall Brief, *supra* note 176, at 14 (noting absence of "indication that the Legislature has granted the DCFS jurisdiction over fetuses in addition to children") (citation omitted); see also Fla. Stat. §§ 39.001, 39.201 (laying out purpose of and requirements for mandatory reporting of child abuse, neglect, or abandonment without any mention of reporting pregnant women who disagree with their physicians' recommendations).

179. See Goodall Declaration, *supra* note 117, at ¶ 11.

180. Goodall Brief, *supra* note 176, at 15; see generally Goodall v. Comprehensive Women's Health Ctr., 2014 WL 3587290 (M.D. Fla. Jul. 18, 2014) (failing to address these arguments).

181. Diaz-Tello, *Invisible Wounds*, *supra* note 9, at 59.

182. See *id.*

183. *Id.*

to consent to unwanted medical treatment may invite mental health examinations, scrutiny of home and family life, and the removal of one's children. The potential chilling effect of a decision like *V.M.*¹⁸⁴ on women's decision making in childbirth is troubling, as some women are likely to submit to unwanted treatment out of fear of similar consequences.¹⁸⁵ A Texas woman who declined a labor induction reported that "[the doctor] said if I didn't go through with the induction today that he would do everything in his power to make sure CPS would take my children."¹⁸⁶ Young women and poor women, who may already live with a high degree of state surveillance in order to receive public benefits, are more likely to be threatened with child welfare intervention, and to face difficult decisions about whether to accept unwanted treatment—and increased risk of complications—to avoid the risk of losing their children.¹⁸⁷

d. Coercion by Withholding Treatment, Manipulating Information, or Applying Emotional Pressure. A final category of coercive conduct used to secure a woman's consent involves controlling the situation by withholding treatment, manipulating information, or applying emotional pressure. Some women report consenting to treatment under duress, such as being threatened with lack of treatment,¹⁸⁸ abandonment by the doctor,¹⁸⁹ or the choice between two unwanted treatments.¹⁹⁰

For example, one woman was five centimeters dilated and experiencing regular contractions when her doctor threatened to drop her as a patient if she did not consent to labor augmentation with Pitocin.¹⁹¹ That her labor was

184. 974 A.2d 448 (N.J. Super. Ct. App. Div. 2009).

185. Benjamin Grant Chojnacki, *Pushing Back: Protecting Maternal Autonomy from the Living Room to the Delivery Room*, 23 J. L. & HEALTH 45, 66 n.176 (2010); see also INVESTIGATING BIRTH, *supra* note 85 (describing story of mother who agreed to unwanted administration of medication for infant, despite lack of proper informed consent, out of fear that hospital staff would report her to Child Protective Services).

186. Dray Amicus Brief, *supra* note 11, at 27.

187. See, e.g., *id.* ("The nurse said in a very strict tone that I needed to cooperate, otherwise I could have my baby taken away. She pointed out that I was a young mother."); see generally KHIARA M. BRIDGES, *THE POVERTY OF PRIVACY RIGHTS* (2017) (examining poor mothers' interactions with the state and arguing that poor mothers in America have been denied the right to privacy); DOROTHY ROBERTS, *SHATTERED BONDS: THE COLOR OF CHILD WELFARE* (2002) (arguing that child welfare policy reflects a political choice to punish poor black parents with removal of their children instead of addressing the root causes of poverty).

188. See Pascucci, *supra* note 58 ("The doctor won't come in until you let me give you another vaginal exam.").

189. See Dray Amicus Brief, *supra* note 11, at A-59 ("[I]f I wouldn't consent to a C-section . . . he would leave me and let me labor with another doctor (who by the way I had been seen by before and HATED).").

190. See *id.* at 7 (recounting how, despite no fetal distress, the doctor "said that he was 'either going to take me in the next room and cut me open or he was going to use the vacuum extractor. Which is it?").

191. See *Because We Can: A Year of Inspiration*, IMPROVING BIRTH (Jan. 2, 2014) [<https://perma.cc/ZH T4-QJ94>] [hereinafter *Because We Can*] ("[D]octor refused to discuss the risks [of Pitocin], citing her credentials and: 'When I take my car to the mechanic, I don't question him.'" (emphasis removed)).

progressing without complication suggests augmentation was medically unnecessary, yet the fact that she was actively laboring left her without a viable alternative for receiving care should the doctor refuse to treat her. Similarly, an Ohio woman reported that her doctor threatened to force her to have a cesarean if she refused vacuum extraction during a vaginal delivery that was proceeding without complications.¹⁹² Some women are told they are not allowed to object to a particular form of treatment due to hospital policy or “doctor’s orders.”¹⁹³ In such situations, women—especially if already in labor—have little power to challenge the basis for these unidentified policies or orders and often perceive no other option but to “consent.”

Because health care providers have specialized training in maternity care and are almost always more knowledgeable than their patients about obstetrics, it is possible for providers to control what information patients have and how they receive new information about treatment options and their relative risks. In some situations, the presentation of information can be manipulated to serve goals other than the health of the woman and her baby.¹⁹⁴ For example, an Illinois woman whose baby was breech at the end of pregnancy recounted how her doctor steered her away from a vaginal breech delivery due to the risks involved but never advised her of any risks associated with cesarean surgery.¹⁹⁵ She later learned that the obstetrician “was trying to clear litigation records due to past complications with a breech birth.”¹⁹⁶

Certain medical justifications that are commonly relied on to recommend a cesarean are subjective diagnoses—such as “nonreassuring fetal status” and “failure to progress”—that can be used selectively to pressure women to consent.¹⁹⁷ Research suggests that primary cesareans performed for subjective indications have contributed more to the overall cesarean rate increase than surgeries performed for objective indications.¹⁹⁸ The ambiguity involved in these subjective diagnoses allows physicians to use them to manipulate women

192. See Dray Amicus Brief, *supra* note 11, at 7.

193. See *id.* at 7.

194. See *id.* at 28–31 (discussing susceptibility of informed consent process to manipulation in order to serve provider’s treatment goals); see also *infra* Section I.D.1 (exploring the role of economic incentives in shaping clinical practice).

195. See Dray Amicus Brief, *supra* note 11, at 29.

196. *Id.*

197. Emma L. Barber et al., *Indications Contributing to the Increasing Cesarean Delivery Rate*, 118 OBSTETRICS & GYNECOLOGY 29, 34 (2011) (discussing increase of these subjective factors as indicators for cesarean delivery). That guidelines regarding the stages of labor continue to evolve highlights the subjective aspect of “failure to progress” as a diagnosis; an amount of time elapsed in labor that would have previously caused a doctor to call for a cesarean is now considered “normal.” See ACOG & Soc’y Maternal-Fetal Med., *Nation’s Ob-Gyns Take Aim at Preventing Cesareans* (Feb. 19, 2014), <https://www.acog.org/About-ACOG/News-Room/News-Releases/2014/Nations-Ob-Gyns-Take-Aim-at-Preventing-Cesareans> [<https://perma.cc/R63R-78PT>] [hereinafter *Nation’s Ob-Gyn’s*] (announcing new guidelines that allow prolonged early labor, consider cervical dilation of six (instead of four) centimeters the beginning of active labor, and extend the length of the pushing phase, all of which better reflect evidence from scientific research about labor progress).

198. See Barber, *supra* note 197, at 34.

into consenting to medically unnecessary intervention.¹⁹⁹ Provider control of access to information about fetal status can limit women's ability to make informed treatment decisions in other ways. For example, it is not uncommon for a woman to agree to a cesarean after the electronic fetal monitor (EFM) indicates a drop in fetal heart rate; however, if the heart rate stabilizes before surgery is performed, women may not be given an opportunity to revisit the decision and forego the cesarean.²⁰⁰

Physicians and hospitals may also apply pressure in the form of economic threats. A Marquette, Michigan woman, whose local care providers refused to attend her VBAC, found a provider 440 miles away in Ann Arbor and made plans to relocate there for the final weeks of her pregnancy.²⁰¹ She also contacted Marquette General Hospital (MGH) to make arrangements in the event she went into labor early or needed care before she moved to Ann Arbor.²⁰² MGH indicated that if she came to the hospital in labor, she would be transferred by airplane to the hospital in Ann Arbor, regardless of how far she had progressed, and demanded a credit card number to bill the patient in advance for plane fuel.²⁰³ While the impact on this patient and her family was simply to convince them to move to Ann Arbor sooner than planned,²⁰⁴ the prospect of economic coercion has the potential to interfere improperly with patient decision making.

Finally, some women experience coercion during childbirth in the form of intense emotional pressure from their health care providers. Doctors and nurses present stories of disfigurement, brain damage, and fetal death to scare women into consenting to unwanted medical intervention.²⁰⁵ Journalist Jennifer Block, who has written about American maternity care, refers to the “exploding uterus card”—raised to coerce women into choosing a cesarean instead of vaginal delivery—which “is usually followed by the ‘dead baby card.’”²⁰⁶ Providers who deliver warnings about possible uterine rupture and infant mortality in this way choose language intended to shock and frighten, rather than to inform and assist in effective decision making. Frank discussion of risks involved in different treatment choices is an important part of informed consent, but such emotionally-charged statements serve coercive, rather than informative, purposes and are therefore improper tools for influencing medical decision making.

199. See, e.g., GOER & ROMANO, *supra* note 140, at 225 (describing obstetrician's characterization of one way that doctors manipulate ambiguity regarding fetal heart rate monitoring: “The minute you see a deceleration on the heart monitor, you say maybe it's fetal distress, better to do a cesarean. . . . A lot of that is driven by fear of liability.”).

200. See Dray Amicus Brief, *supra* note 11, at 25.

201. See Diaz-Tello, *Invisible Hand*, *supra* note 9, at 218.

202. See *id.* at 218–19.

203. See *id.* at 219.

204. See *id.*

205. See, e.g., Dray Amicus Brief, *supra* note 11, at A-34, A-50 (recounting scare tactics involving talk of death).

206. BLOCK, *supra* note 5, at 91–92.

3. Disrespect

Other forms of childbirth-related mistreatment are characterized by disrespectful comments directed at women in labor. Women are accused of either being too sensitive to pain or naïve about their ability to handle labor pains without an epidural.²⁰⁷ They are yelled at for feeling scared or vocalizing too loudly during contractions, or told that their behavior during labor and delivery reflects poorly on their qualities as a mother.²⁰⁸ They may be ignored when they ask questions about their treatment or are made to feel guilty about their decisions when complications subsequently arise.²⁰⁹ Women who desire a VBAC or decline a cesarean in favor of continued labor may find themselves accused of selfishness—caring more about the birth experience than the health of their babies—or bad mothering, despite the fact that such decisions are made with the well-being of their babies in mind.²¹⁰ Other forms of subtle humiliation may occur in the form of privacy violations about preexisting health conditions, sexually transmitted infections, and marital or family status.²¹¹

Heightened emotions and hormonal changes surrounding the childbirth process may make insulting and condescending comments by a health care provider particularly injurious to a laboring woman.²¹² For example, one woman recounted how every time she tried to draft a formal complaint to the state medical board about the abuse she suffered during childbirth, she “hear[d] [the doctor’s] voice jeering at me telling me I’m just a baby crying for not getting my way.”²¹³ Birgit Amadori, who has blogged about her traumatic birth experience, was told after her cesarean that she would have to “earn [her] baby.”²¹⁴ This meant that she would not be allowed to bond with the baby until the anesthesia wore off and she was able to move her legs—5 hours and 33 minutes

207. See Dray Amicus Brief, *supra* note 11, at A-6, A-25 (recounting critical comments by nurses regarding tolerance for pain).

208. See *id.* at A-32 (describing experience of being “belittled, laughed at . . . and told I had ‘issues’ by L&D nurses”); A-44 (recalling nurse who instructed laboring woman to quiet down said, “you’re kind of high-strung, aren’t you?”) (internal quotations omitted).

209. See *id.* at A-13, A-52 (describing ignored questions and criticism for patient decision making).

210. See *id.* at A-15 (recalling being accused of selfishness); A-17 (recounting that doctor was “yelling at the top of his lungs about what a horribly selfish and dangerous parent I was” for wanting to wait for spontaneous onset of labor in absence of any medical concerns).

211. See WHO STATEMENT, *supra* note 10 (identifying lack of confidentiality as contributing to abuse and disrespect in maternity care).

212. See Lesley Dixon et al., *The Emotional and Hormonal Pathways of Labor and Birth: Integrating Mind, Body and Behaviour*, 48 NEW ZEALAND C. MIDWIVES J. 15, 19–20 (2013) (describing how hormonal changes facilitate labor and delivery and identifying relationships between hormonal shifts and how women feel or act during different labor stages). Provider comments that disrupt natural hormonal changes by introducing additional stress or fear may interrupt labor progress. See *id.* at 20 (discussing reduced functioning of the neocortex as beta-endorphin and oxytocin levels rise). Women’s changes in perception during these hormonal shifts may also make someone more vulnerable to emotional harm. See *id.* (describing the “feeling that their world is ‘shrinking’ and that they are ‘on a different planet’” as hormones increase).

213. Dray Amicus Brief, *supra* note 11, at 14 (internal quotations omitted).

214. BLOCK, *supra* note 5, at 143.

later—a requirement that she perceived as punishment, having no medical justification and running contrary to evidence about the importance of early bonding.²¹⁵

Women who have experienced such types of patronizing and disrespectful conduct during childbirth talk about the violation of their dignity that comes from being treated as an object rather than a person.²¹⁶ Research shows that the quality of women's personal interactions with their caregivers significantly informs whether the treatment experience is positive or negative—regardless of the type of delivery or birth outcome.²¹⁷ Dehumanizing behavior on the part of maternity care providers is inappropriate, unprofessional, and can cause lasting harm to women.

B. OBSTETRIC VIOLENCE AS HARM

Obstetric violence can result in physical harm to women and babies, as well as emotional and psychological harm to women. It may interfere with bonding and newborn adjustment, negatively impacting longer-term development. All intervention into the physiological birthing process entails some degree of risk. When a woman decides on a course of treatment, she weighs those risks against the expected benefits of the treatment. However, when that decision is taken away from the woman through coercion or otherwise, resulting in treatment that is unwanted and often medically unnecessary, the resulting negative physical and emotional impacts of the treatment constitute injuries to the woman.

Medically unnecessary interventions, especially surgeries like cesareans and episiotomies, increase the risk of childbirth complications for women.²¹⁸ Short-term physical harms more likely to result from a cesarean include maternal death, emergency hysterectomy, blood clots and stroke, surgical injury, infection, and intense and prolonged postpartum pain.²¹⁹ Women are also more likely

215. *Id.* at 142–43; see also GOER & ROMANO, *supra* note 140, at 397–98 (describing the newborn adaptation and maternal-child bonding behaviors that occur in the first hour after birth, the success of which “can have far-reaching and long-term effects”).

216. See Dray Amicus Brief, *supra* note 11, at 35 (“I felt like an animal they were working on.”).

217. See SAKALA & CORRY, *supra* note 27, at 53 (citing research showing “support from caregivers, involvement in decision making, quality of mother-caregiver relationship, and having high expectations for the child-birth experience” as the four most important factors contributing to women’s satisfaction with childbirth); see also Jennifer Fenwick et al., *Women’s Experiences of Cesarean Section and Vaginal Birth After Caesarian: A Birthrites Initiative*, 9 INT’L J. NURSING PRAC. 10, 12–16 (2003) (“Poor staff-client relationships in which women’s experiences were seemingly dismissed only heightened feelings of grief and failure.”).

218. Public health data show that the increase in cesarean surgeries in the United States has not improved birth outcomes. See JOINT COMM’N, SPECIFICATIONS MANUAL FOR JOINT COMMISSION NATIONAL QUALITY MEASURES: PERINATAL CARE 1 (2012), <https://manual.jointcommission.org/releases/TJC2013A/MIF0167.html> [<https://perma.cc/2GGY-73S8>]. In fact, major health organizations, such as the Center for Disease Control and Prevention, have called for a reduction in the cesarean rate. See, e.g., Wanda D. Barfield, *Reducing the C-Section Rate*, MEDSCAPE, (Aug. 25, 2014), <http://www.medscape.com/viewarticle/830154>.

219. See SAKALA, *supra* note 159, at 3–4; see also Anne Kjersti Daltveit et al., *Cesarean Delivery and Subsequent Pregnancies*, 111 OBSTETRICS & GYNECOLOGY 1327, 1331–33 (2008); Catherine Deneux-

to experience longer-term chronic pelvic pain and bowel obstruction after a cesarean than women who deliver vaginally.²²⁰ Cesareans require longer hospitalization and healing time, and are more likely to lead to rehospitalization.²²¹ Research shows that cesareans pose risk to a woman's future reproduction—after a cesarean birth, women are more likely to experience involuntary infertility, cesarean scar ectopic pregnancy, placenta previa, placenta accreta, placental abruption, uterine rupture, hemorrhage, low birthweight babies, preterm birth, stillbirth, and maternal death.²²² Multiple cesareans are associated with cumulative abdominal adhesion formation and adverse reproductive effects.²²³ The physical harm of unwanted treatment may also accrue to newborns. Babies born by cesarean are more likely to experience respiratory problems, surgical injuries, failure to establish breastfeeding, and asthma in childhood and adulthood.²²⁴

Beyond cesareans, other unwanted interventions can also cause physical harm. Episiotomy is associated with increases in perineal injury, stitches, pain and tenderness, length of healing, the likelihood of leaking stool or gas, and pain with intercourse.²²⁵ Women who experience forcible restraint in certain positions suffer back, hip, and pelvic injuries due to the force of pushing in an unnatural position.²²⁶ Research shows that various other interventions—including continuous EFM, induction, and epidural—can generate the need for additional procedures, which can lead to further injury. Researchers refer to the “cascade of secondary interventions” that are used to monitor and treat the side effects of the original interventions.²²⁷

Tharaux et al., *Postpartum Maternal Mortality and Cesarean Delivery*, 108 *OBSTETRICS & GYNECOLOGY* 541, 545–47 (2006).

220. See SAKALA, *supra* note 159, at 3–4.

221. See *id.*

222. See *id.*; see also Jeffrey L. Ecker & Fredric D. Frigoletto, Jr., *Cesarean Delivery and the Risk-Benefit Calculus*, 356 *NEW ENG. J. MED.* 885, 888 (2007); Robyn Kennare et al., *Risks of Adverse Outcomes in the Next Birth After a First Cesarean Delivery*, 109 *OBSTETRICS & GYNECOLOGY* 270, 274–76 (2007).

223. See SAKALA, *supra* note 159, at 4.

224. See *id.* at 3; see also James M. Alexander et al., *Fetal Injury Associated with Cesarean Delivery*, 108 *OBSTETRICS & GYNECOLOGY* 885, 888–90 (2006) (discussing different types of fetal injury resulting from cesarean delivery and their relative frequency); Anne Kirkeby Hansen et al., *Risk of Respiratory Morbidity in Term Infants Delivered by Elective Caesarean Section: Cohort Study*, 336 *BMJ Jan. 10, 2008*, at 1, 4–6; Astrid Sevelsted et al., *Cesarean Section and Chronic Immune Disorders*, 135 *PEDIATRICS* e92, e94–e96 (2015); *Analysis Shows Possible Link Between Rise in C-Sections and Increase in Late Preterm Birth*, *MARCH OF DIMES*, (Dec. 16, 2008), http://208.74.202.108/24497_25161.asp [<https://perma.cc/PG25-T3C2>].

225. See SAKALA & CORRY, *supra* note 27, at 49.

226. See, e.g., *Nelson v. Corr. Med. Servs.*, 583 F.3d 522, 526 (8th Cir. 2009) (summarizing orthopedist's testimony regarding permanent damage to woman's hips after shackling during labor prevented her from shifting position).

227. SAKALA & CORRY, *supra* note 27, at 28. The Listening to Mothers III survey reported that of first-time mothers who labored, 47% experienced an induction and, of those having an induction, 78% had an epidural. See LTM III, *supra* note 148, at 24. Of women who had both an attempted induction and an epidural, 31% ultimately had a cesarean. See *id.* Women who experienced either induction or an

In addition to physical harm, the emotional impact of mistreatment during childbirth may create lasting injuries. A common injury women suffer after forced medical treatment is emotional trauma. Mental health professionals have increasingly come to recognize birth trauma as a factor that impairs postpartum well-being and that may require counseling or other treatment.²²⁸ Many women report experiencing post-traumatic stress disorder (PTSD) from traumatic birth experiences, including being coerced to have a cesarean due to VBAC restrictions.²²⁹ Experts have concluded that up to 9% of new mothers satisfy the clinical criteria for PTSD.²³⁰ Research also suggests that women who have cesareans are more likely to have poor overall mental health and self-esteem and poor overall functioning than women who deliver vaginally.²³¹ Some women experience shame associated with trauma, making them less willing or able to complain about their treatment during labor and seek counseling, and some women fear that complaining about their mistreatment suggests ungratefulness about the birth of the baby.²³² Longer-term emotional distress resulting from birth trauma may manifest in feelings of powerlessness and the need to avoid all associations with the birth.²³³

The mistreatment of women during childbirth, leading to unwanted and unnecessary intervention, may also interfere with the transition to motherhood and healthy adjustment for both the woman and baby. Evidence shows that skin-to-skin contact between women and their babies immediately after birth—and for the first twenty-four hours of life—is associated with more effective breastfeeding, improved newborn temperature regulation, reduced newborn crying, and more affectionate maternal behaviors.²³⁴ Women who have cesareans have less early contact with their babies than women who have vaginal

epidural—but not both—had cesarean rates of 19% (induction but no epidural) or 20% (no induction but epidural). *See id.*

228. *See* Penny Simkin, *Birth Trauma: Definition and Statistics*, PREVENTION AND TREATMENT OF TRAUMATIC CHILDBIRTH, <http://pattch.org/resource-guide/traumatic-births-and-ptsd-definition-and-statistics/> [<https://perma.cc/3J3T-XCLF>].

229. *See* Dawn Thompson et al., *Global Momentum Towards Respectful Care*, IMPROVING BIRTH (Sept. 25, 2014) [hereinafter *Global Momentum*], <http://improvingbirth.org/2014/09/respectful-care/> [<https://perma.cc/JK79-U792>] (describing the PTSD Kimberly Turbin suffered after her forced episiotomy, in addition to physical complications from the cutting itself); *see also* Dray Amicus Brief, *supra* note 11, at 34–35 (recounting birth stories of women who experienced trauma, suffering flashbacks and nightmares about giving birth).

230. *See* Cheryl Tatano Beck et al., *Posttraumatic Stress Disorder in New Mothers: Results from a Two-Stage U.S. National Survey*, 38 BIRTH: ISSUES IN PERINATAL CARE 216, 217 (2011) (reporting between 1.7–9% of mothers suffer from PTSD); Cheryl Tatano Beck, *Post-Traumatic Stress Disorder Due to Childbirth: the Aftermath*, 53 NURSING RES. 216, 216 (2004) (reporting between 1.5% and 6% of mothers in the United Kingdom suffer from PTSD).

231. *See* SAKALA, *supra* note 159, at 3; *see also* Fenwick, *supra* note 217, at 12 (78% of women surveyed reported that their cesarean was both physically and emotionally traumatic).

232. *See* Dray Amicus Brief, *supra* note 11, at 34–36 (describing types of emotional suffering that women may experience after traumatic births, including humiliation, degradation, and shame).

233. *See* BLOCK, *supra* note 5, at 146 (recounting story of woman who chose not to celebrate her child's first birthday due to painful associations with the violence inflicted on them during the birth).

234. *See* SAKALA & CORRY, *supra* note 27, at 55.

deliveries.²³⁵ The use of synthetic oxytocin to induce or augment contractions during labor interferes with the functioning of the woman's oxytocin receptors and her own oxytocin production, which helps to reduce postpartum hemorrhage, and facilitates breastfeeding and bonding with the baby.²³⁶ Thus, when a woman is forced or coerced into using drugs to accelerate labor, she is more likely to experience interference with early bonding and breastfeeding.²³⁷ Experts recommend breastfeeding as the best nutrition for infants.²³⁸ Although not all women and babies are able to breastfeed, those babies who do breastfeed experience a lower incidence of infectious morbidity and less risk of childhood obesity, diabetes, leukemia, and sudden infant death syndrome.²³⁹ Women who breastfeed experience a lower incidence of premenopausal breast cancer, ovarian cancer, retained gestational weight gain, type 2 diabetes, and myocardial infarction.²⁴⁰ Breastfeeding early in the postpartum period is associated with greater breastfeeding success and longer duration of breastfeeding.²⁴¹ Finally, the physical and emotional harm of mistreatment during childbirth leads to poorer overall health for women, making it more difficult to care for their babies. Whether due to longer recovery periods for unnecessary surgery or diminished emotional health, including post-partum depression and anxiety, mistreatment during childbirth can have lasting effects on adjustment for both women and babies.

C. QUANTIFYING THE PROBLEM

Knowledge about mistreatment in childbirth is uneven and incomplete, complicating efforts to quantify the prevalence of the problem. To the extent research on the subject is planned or underway, it is modest in scope and remains in the early stages of development. This section (1) examines existing sources of information about obstetric violence and (2) explores how definitional challenges obscure the phenomenon of mistreatment in childbirth.

235. See SAKALA, *supra* note 159, at 3.

236. See SAKALA & CORRY, *supra* note 27, at 37.

237. See Megan Lewis, *An Investigation of the Effects of Pitocin for Labor Induction and Augmentation on Breastfeeding Success* (Apr. 23, 2012) (unpublished B.A. thesis, Claremont McKenna, Pitzer, and Scripps Colleges) (comparing data on postpartum breastfeeding with and without administration of Pitocin during labor and concluding effects of artificial induction or augmentation “can interfere with breastfeeding in the early postpartum period”), http://scholarship.claremont.edu/cgi/viewcontent.cgi?article=1112&context=scripps_theses [<https://perma.cc/KP4Z-BSPQ>]; see also BLOCK, *supra* note 5, at 144 (“I remember thinking, who is this kid? Is he mine? . . . when you’re lying there gutted like a fish, you can’t really relate.”).

238. See American Academy of Pediatrics, *Breastfeeding and the Use of Human Milk*, 129 *PEDIATRICS* e827, e827 (2012).

239. See Alison Steube, *The Risks of Not Breastfeeding for Mothers and Infants*, 2 *REV. OBSTETRICS & GYNECOLOGY* 222, 223–26 (2009).

240. See *id.* at 226–27.

241. See Jeannette T. Crenshaw, *Health Birth Practice #6: Keep Mother and Baby Together—It’s Best for Mother, Baby, and Breastfeeding*, 23 *J. PERINATAL EDUC.* 211, 213 (2014).

1. Existing Research: An Incomplete Picture

There has been no comprehensive study of obstetric violence in the United States, and no estimate of its prevalence exists in the research literature. As the WHO notes, there is “no international consensus on how disrespect and abuse should be scientifically defined and measured,” which are initial steps before comprehensive study of the phenomenon can be undertaken.²⁴² The WHO’s work on the subject has helped generate a “considerable research agenda . . . to better define, measure and understand disrespectful and abusive treatment of women during childbirth,” including its prevention and elimination.²⁴³

There are relatively few reported cases involving obstetric violence in American case law. The legal advocacy organization National Advocates for Pregnant Women (NAPW) has documented thirty cases of women who have been forced by court order to undergo a cesarean or other medical procedure to which they did not consent.²⁴⁴ NAPW concluded that its study represents a “substantial undercount” of the phenomenon because most compelled treatment cases do not generate reported opinions or media coverage, making them harder to identify.²⁴⁵ Although there is an extensive body of case law involving medical malpractice related to maternity care, the fact that many forms of mistreatment in childbirth have not been recognized as compensable injuries means that relevant facts showing mistreatment may be omitted from reported opinions.

The lack of research on mistreatment in childbirth does not mean the problem is nonexistent or can simply be attributed to isolated rogue health care providers. Instead, it reflects the extent to which it has been obscured from public awareness. This lack of public awareness is likely due to the fact that women often keep their experiences of trauma and mistreatment private, out of a sense of shame or internalization of the social norms discussed in section I.D.2, *infra*. These norms suggest that women should sacrifice their own needs in favor of their babies’ needs in order to be considered good mothers. Shrouded in privacy, women’s experiences of obstetric violence have failed to garner the research interest and funding that a phenomenon with such a profound impact on maternal and infant health deserves.²⁴⁶ It is possible to construct a limited picture of the nature and frequency of obstetric violence using three types of sources, each of which sheds some light on how women experience mistreatment during childbirth: (a) studies of women’s childbirth and postpartum experi-

242. WHO STATEMENT, *supra* note 10.

243. *Id.*

244. See Lynn M. Paltrow & Jeanne Flavin, *Arrests of and Forced Interventions on Pregnant Women in the United States, 1973–2005: Implications for Women’s Legal Status and Public Health*, 38 J. HEALTH POL., POL’Y & L. 299, 317 (2013).

245. *Id.* at 304.

246. Other aspects of women’s health have likewise been neglected by researchers and their funding bodies due to patriarchal views about medical priorities and misguided assumptions that research on men’s health will be generalizable to women. See, e.g., Anita Holdcroft, Editorial, *Gender Bias in Research: How Does it Affect Evidence Based Medicine?*, 100 J. ROYAL SOC’Y MED. 2, 2–3 (2007). Some of the same dynamics may influence the lack of research on obstetric violence.

ences within the American maternity care system; (b) advocacy efforts of consumer groups focused on childbirth; and (c) international studies about global maternal health.

a. Research on American Childbearing Experiences. Several large nationwide surveys have collected information about women's childbearing experiences, including everything from prenatal care and provider type to pain management, medical interventions, birth outcomes, and postpartum support.²⁴⁷ When the first *Listening to Mothers* survey was conducted in 2002, it captured aspects of maternity care that had not previously been measured on a national scale.²⁴⁸ In subsequent years, health plans, hospitals, professional organizations, and advocacy groups have used the information generated by the surveys to advocate for maternity care reform.²⁴⁹ These surveys reveal that significant numbers of women receive treatment—including surgery—to which they did not consent or experience coercion regarding treatment decisions. In 2013, researchers found that 59% of women who had an episiotomy did not consent to the procedure.²⁵⁰ The study also found that 25% of women who experienced induction of labor or a cesarean felt pressure from their care provider to consent to such treatment.²⁵¹ 20% of women who were induced and 38% of women who had a cesarean reported that their provider made the “final decision” regarding this course of treatment.²⁵²

Social science and public health researchers have also contributed to the existing knowledge base about mistreatment in childbirth. A 2014 study of birth workers—including doulas, childbirth educators, and labor and delivery nurses—found that more than half of respondents had witnessed a physician conduct a procedure over a woman's explicit objections, and almost two-thirds had witnessed providers “occasionally” or “often” perform procedures without allowing a woman a choice or sufficient time to consider the procedure.²⁵³ A 2015 study found that women who perceived pressure to have a cesarean were more than five times more likely to have one, more than six times more likely to have one without a clear medical basis for the surgery, and almost seven times more

247. See generally LTM III, *supra* note 148 (discussing results of nation-wide poll of mothers regarding childbearing experiences).

248. See *id.* at v.

249. See *id.*

250. Cf. *id.* at 36 (reporting that 41% of women receiving an episiotomy “said they had a choice about having the procedure”)

251. See *id.* at xv.

252. *Id.* at 38.

253. See LOUISE MARIE ROTH ET AL., MATERNITY SUPPORT SURVEY: A REPORT ON THE CROSS-NATIONAL SURVEY OF DOULAS, CHILDBIRTH EDUCATORS AND LABOR AND DELIVERY NURSES IN THE UNITED STATES AND CANADA 37 (2014), <https://maternitysurvey.files.wordpress.com/2014/07/mss-report-5-1-14-final.pdf> [<https://perma.cc/YT7V-SYJJ>].

likely to have their birth result in an unplanned cesarean.²⁵⁴ This suggests that provider coercion does play a role in producing high rates of medical intervention and adds to the evidence that there is a significant category of women who suffer the increased risks of cesarean surgery without medical necessity.

Other research has found a strong association between coercion and postpartum PTSD. A study by University of North Dakota researchers found that 34% of mothers reported symptoms of PTSD related to their birth experience and concluded that the “strongest predictor of developing PTSD after labor was not a history of trauma, but rather the level of coercion the woman experienced during their labor and delivery.”²⁵⁵

b. Consumer Groups Focused on Childbirth. Several consumer advocacy organizations have formed to respond to mistreatment during childbirth. Reflecting the growing visibility of the issue, three American-based organizations were established in a span of four years to address issues of obstetric violence: Improving Birth, Human Rights in Childbirth, and the Birth Rights Bar Association.²⁵⁶ They report receiving complaints from women across the country who have experienced abuse, coercion, and disrespect by their health care providers during childbirth.²⁵⁷ Among other advocacy activities, these organizations collect stories from women who suffered mistreatment during childbirth. For example, the amicus brief filed in litigation regarding Rinat Dray’s forced cesarean presents direct narratives to bolster its argument that the court should recognize informed treatment refusal during childbirth.²⁵⁸

After hearing from women nationwide about mistreatment during birth, Improving Birth ran a campaign called “#BreakTheSilence,” which was designed to “giv[e] mothers around the country a forum to voice the abuse and

254. See Judy Jou et al., *Patient-Perceived Pressure from Clinicians for Labor Induction and Cesarean Delivery: A Population-Based Survey of U.S. Women*, 50 HEALTH SERVS. RES. 961, 969–71 (2015).

255. Pascucci, *supra* note 58 (interviewing researcher Sarah Edwards about an unpublished study which examined various risk factors for PTSD, including history of physical and sexual abuse or domestic violence, low socioeconomic status, age, and education level); see also Jennifer Jamison Griebenow, *Healing the Trauma: Entering Motherhood with Posttraumatic Stress Disorder (PTSD)*, MIDWIFERY TODAY (Winter 2006), <https://midwiferytoday.com/mt-articles/healing-the-trauma/> [<https://perma.cc/RJ3Q-A69R>] (discussing examples of coercive and dehumanizing behavior experienced during childbirth by women who developed PTSD symptoms after giving birth).

256. See Letter from Dawn Thompson to Hal Lawrence, III, Executive Vice President & Chief Executive Officer of ACOG (Sept. 4, 2015) [hereinafter *Improving Birth Letter*], at 1, <https://improvingbirth.org/wp-content/uploads/2015/09/9.04.15-Ltr-to-ACOG.pdf> [<https://perma.cc/7EKL-LA6X>].

257. See Dray Amicus Brief, *supra* note 11, at 2; see also *Improving Birth Letter*, *supra* note 256, at 1 (describing receipt of “an alarming—and alarmingly frequent—stream of consumer feedback to Improving Birth about instances of disrespect, misinformation, and abuse at the hands of maternity care providers”).

258. See Dray Amicus Brief, *supra* note 11, at 5–17, 25–31 & A-2–A-95. The International Cesarean Network, Inc. (ICAN) is also an amicus curiae in the Dray case. See *id.* at 1.

trauma they have experienced in childbirth.”²⁵⁹ The organization received hundreds of responses “describing bullying, coercion, forced interventions, refusal to provide pain medication, and refusal to provide care in childbirth.”²⁶⁰ New organizations, like Improving Birth, join groups that have been collecting and disseminating information about coerced cesareans and VBAC restrictions for years. For example, the International Cesarean Awareness Network (ICAN) formed in 1981 to support women who had experienced unwanted cesareans, educate women about VBAC, and conduct advocacy to prevent unwanted and unconsented cesareans.²⁶¹ Other groups have collected information about VBAC restrictions and engaged in public education about VBAC.²⁶² That grassroots groups from ICAN to Improving Birth have attracted such a high volume of testimonials and other support underscores the depth and breadth of the problem of obstetric violence.

c. International Studies. In addition to the American-based surveys of child-bearing experiences and the work of childbirth-oriented advocacy groups, a growing body of research on maternity care worldwide provides information about the dynamics of obstetric violence and institutional factors that enable or contribute to the mistreatment of women in childbirth.²⁶³ Of particular note,

259. *Global Momentum*, *supra* note 229. Improving Birth identifies itself as the “largest U.S. consumer advocacy organization for better maternity care.” Christen Pascucci, *Improving Birth/Consumers Welcome Recognition by Medical Community of Disrespect and Abuse in Childbirth*, IMPROVING BIRTH (Aug. 19, 2015), <http://kindredmedia.org/2015/08/improving-birthconsumers-welcome-recognition-by-medical-community-of-disrespect-and-abuse-in-childbirth/> [<https://perma.cc/8ZAD-SFXA>] [hereinafter *Consumers Welcome*].

260. *Global Momentum*, *supra* note 229.

261. See *History of ICAN*, ICAN, <http://www.ican-online.org/history/> [<https://perma.cc/6YW2-F5BD>].

262. For example, Evidence Based Birth is an organization that provides non-biased evidence about available birthing options and common medical interventions. See Rebecca Dekker, *About Evidence Based Birth*, EVIDENCE BASED BIRTH, <https://evidencebasedbirth.com/> [<https://perma.cc/65N9-UCJ9>]. VBAC Facts is an organization that seeks to “amplify the evidence in order to change the conventional wisdom as well as legislation and hospital policies that limit access to VBAC.” See Jan Kamel, *About Me*, VBAC FACTS, <http://vbacfacts.com/> [<https://perma.cc/9A2K-THES>].

263. See, e.g., DIANE BOWSER & KATHLEEN HILL, USAID-TRACTION PROJECT, EXPLORING EVIDENCE FOR DISRESPECT AND ABUSE IN FACILITY-BASED CHILDBIRTH: REPORT OF A LANDSCAPE ANALYSIS (2010) (reviewing patterns of disrespect and abuse in facility based childbirth in a range of countries); Meghan A. Bohren et al., *The Mistreatment of Women During Childbirth in Health Facilities Globally: A Mixed-Methods Systematic Review*, 12 PLoS MED., June 30, 2015, at 1 (2015) (synthesizing 65 qualitative and quantitative studies on mistreatment of women during childbirth in order to develop evidence-based typology); Meghan A. Bohren et al., *Facilitators and Barriers to Facility-Based Delivery in Low- and Middle-Income Countries: A Qualitative Evidence Synthesis*, 11 REPROD. HEALTH, at 1 (2014) (describing study conducted to understand how facilitators and barriers influence delivery location in low-and-middle income countries); Virgínia Junqueira Oliveria & Claudia Maria de Mattos Penna, *Discussing Obstetric Violence Through the Voices of Women and Health Professionals*, 26 TEXT & CONTEXT NURSING, Sept. 19, 2016, at 1 (interviewing laboring women, midwives, and obstetricians in Minas Gerais, Brazil and concluding hostile treatment presents continued obstacle to humanization of childbirth); Charlotte Warren et al., *Study Protocol for Promoting Respectful Maternity Care Initiative to Assess, Measure and Design Interventions to Reduce Disrespect and Abuse During Childbirth in Kenya*, 13 BMC PREGNANCY & CHILDBIRTH, Jan. 24, 2013, at 1.

research on global maternal health care suggests that certain categories of women may be more susceptible to mistreatment by care providers—especially young women, poor women, unmarried women, women with HIV, and women who belong to racial, ethnic, and religious minorities.²⁶⁴

2. Language Choices: Definitional Challenges

As discussed in section I.A, there is a wide range of provider conduct that violates the rights of childbearing women and causes physical and emotional harm. This Article has used the categories of abuse, coercion, and disrespect to examine different types of conduct along a continuum of severity, using “mistreatment” as a general term to refer to such conduct together. In addition to these terms, researchers who study this phenomenon may also refer to bullying or neglect as other methods of categorizing problem behavior.²⁶⁵ Confronted with low awareness of the problem, advocates have sought compelling ways to explain women’s experiences and articulate claims for legal recourse or systemic reform.

For example, global maternal health advocates rely on the human rights framework to articulate a robust set of rights that should protect women in childbirth—including the right to the highest attainable standard of health, the right to equality and non-discrimination, the right to information, the right to redress, the right to privacy, and the right to be free from torture and cruel, inhuman, or degrading treatment.²⁶⁶ Reproductive justice (RJ) advocates apply a conceptual framework which recognizes that deciding how one gives birth is an essential part of human dignity.²⁶⁷ The RJ movement uses the language of birth justice to refer not only to choice in care provider and location but also the pursuit of birth as an empowering experience free from coercion for all people, regardless of identity or circumstances.²⁶⁸

264. See WHO STATEMENT, *supra* note 10; see also Jenna Murray de López, “Birth is Like a Battle of the Ancient Maya”: Obstetric Violence in South East Mexico, at 17 (undated manuscript, on file with author) (reporting results of qualitative anthropological study of obstetric violence that suggested women’s experiences of violence “are informed by their status and treatment in the wider society”).

265. See WHO STATEMENT, *supra* note 10 (describing neglectful treatment during childbirth in facilities); Diaz-Tello, *Invisible Wounds*, *supra* note 9, at 1 (identifying bullying and coercion of pregnant women during birth by health care personnel).

266. WHO STATEMENT, *supra* note 10; see also Diaz-Tello, *Invisible Wounds*, *supra* note 9, at 57 (“This obstetric violence is an infringement of women’s human rights to non-discrimination, liberty and security of the person, reproductive health and autonomy, and freedom from cruel, inhuman, and degrading treatment.”). Advocates also refer to obstetric violence as a form of gender-based violence. See *id.*; see also Erdman, *supra* note 9, at 43.

267. See FARAH DIAZ-TELLO & LYNN M. PALTRON, NAPW WORKING PAPER: BIRTH JUSTICE AS REPRODUCTIVE JUSTICE 3 (2010), <http://www.advocatesforpregnantwomen.org/BirthJusticeasReproRights.pdf> [<https://perma.cc/3JNU-BQ3B>]; MZP, *Birth(ing) Justice*, RADICAL DOULA (Aug. 11, 2011), <https://radicaldoula.com/2011/08/11/birthing-justice/> [<https://perma.cc/DBZ2-UWU7>]. For an introduction to the reproductive justice framework, see generally REPRODUCTIVE JUSTICE BRIEFING BOOK: A PRIMER ON REPRODUCTIVE JUSTICE AND SOCIAL CHANGE, <https://www.law.berkeley.edu/php-programs/courses/fileDL.php?fid=4051> [<https://perma.cc/4BVD-NMVW>].

268. See Diaz-Tello, *Invisible Hand*, *supra* note 9, at 198 n.4.

In addition to the language of birth justice, advocates have increasingly used the term “obstetric violence” to identify and condemn various forms of mistreatment during childbirth.²⁶⁹ Advocates have adopted this language to convey the profound harm some women experience while receiving maternity care. Obstetric violence emerged as a legal concept in Latin America, and “violencia obstetrica” is a “widely used and accepted term” there in discussions about the problems with maternity care.²⁷⁰ A small number of jurisdictions in Latin America have codified the concept of obstetric violence in the form of a legal prohibition on such conduct.²⁷¹ For example, Venezuela codified “obstetric violence” in 2007.²⁷² Recognizing it as a form of gender-based violence, Venezuelan legislators defined “obstetric violence” to mean “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 . . . negatively impacting the quality of life of women.”²⁷³ The Venezuelan law characterizes the following actions as obstetric violence: the delay or denial of care during obstetric emergencies, forcing a woman to deliver in a supine position “when the necessary means to perform a vertical delivery are available,” interfering with early attachment and breastfeeding immediately after the birth without medical necessity, accelerating labor in low-risk deliveries without the woman’s voluntary and informed consent, and performing cesareans, when natural childbirth is possible, without voluntary and informed consent.²⁷⁴ Nevertheless, despite a nuanced identification of obstetric violence in certain jurisdictions, there is still no consistent definition in the academic literature.²⁷⁵

269. See, e.g., *Obstetric Violence*, INT’L DAY OF ACTION FOR WOMEN’S HEALTH, <http://www.may28.org/obstetric-violence/> [<https://perma.cc/N2BB-XV6H>]; Lori Adelman, “*Obstetric Violence*” and the Ongoing Movement to Redefine Consent, FEMINISTING, <http://feministing.com/2010/11/10/obstetric-violence-and-the-ongoing-movement-to-redefine-consent/> [<https://perma.cc/HVQ5-NWJQ>]; Charlene Hamilton, *The Reality of Obstetric Violence*, HEART OF BIRTH (May 29, 2015), <http://heartofbirth.net/the-reality-of-obstetric-violence/> [<https://perma.cc/NE3L-27JG>].

270. Jenna Murray de López, *Conflict and Reproductive Health in Urban Chiapas: Disappearing the Partera Empírica*, 16 ANTHROPOLOGY MATTERS J., 2015, at 1, 8–9.

271. See WHO STATEMENT, *supra* note 10 (providing links to laws on obstetric violence from Argentina, Puerto Rico, and Venezuela); Murray de López, *supra* note 264, at 8 (discussing obstetric violence legislation passed by the State of Chiapas in Mexico that refers to “unnecessary obstetric interventions at birth”) (citing Ley de Acceso a una Vida Libre de Violencia para las Mujeres en el Estado de Chiapas, 23 March 2009, Gobierno Estatal de Chiapas); “*Obstetric Violence*” Introduced as a New Legal Term in Venezuela, UNNECESSAREAN (Nov. 7, 2010) [<https://perma.cc/LZ52-2MPX>].

272. Organic Law on the Right of Women to a Life Free of Violence, art. 15 (2007).

273. D’Gregorio, *supra* note 12, at 201.

274. See *id.* at 201–02. Violation of the law may result in a monetary fine and submission of the court order to the appropriate professional regulatory body. See *id.* at 202.

275. Murray de López, *supra* note 270, at 3.

As domestic advocacy groups have increasingly adopted the language of obstetric violence, it is clear the concept holds rhetorical power to help identify, condemn, and organize around the mistreatment of women in childbirth. It effectively conveys the seriousness of the harms experienced by women and connects such violations to other forms of violence.²⁷⁶ However, there may be reasons to be cautious about application of a “violence” frame to problems within maternity care. First, the infliction of violence begs for a response from the criminal law, but relying on criminalization to eliminate socially undesirable conduct can have devastating consequences, especially for people who belong to racial, ethnic, and religious minorities.²⁷⁷ Although not all violence is physical violence—for example, structural violence is a concept that helps explain “systematic ways in which social structures harm or otherwise disadvantage individuals”²⁷⁸—and not all violence is addressed by criminal prohibition,²⁷⁹ advocates should consider how their reliance on obstetric violence to explain and condemn mistreatment during childbirth might prompt calls for a criminal law response.

Relatedly, advocates should be wary of strategic choices that might introduce conflict into the patient–provider relationship or increase the degree of conflict between a patient and provider who disagree about the best course of treatment. Describing maternity care as violence has the potential to increase suspicion and distrust in both patients and their doctors.²⁸⁰ Although “violent” may accurately characterize the birthing experiences of many women, there may also be other factors responsible for disagreement over treatment decisions, making such discordance better addressed by interventions designed to clarify ethical obligations regarding pregnancy-related health care, improve doctor–patient communi-

276. See Erdman, *supra* note 9, at 48.

277. See generally MICHELLE ALEXANDER, *THE NEW JIM CROW: MASS INCARCERATION IN THE AGE OF COLOR BLINDNESS* (2010) (arguing that punitive drug laws targeting African-Americans have transformed the criminal justice system into a system of racial control).

278. Adam Burtle, *Structural Violence*, STRUCTURAL VIOLENCE, <http://www.structuralviolence.org/structural-violence/> [https://perma.cc/V9H9-WSXX]; see Johan Galtung, *Violence, Peace, and Peace Research*, 6 J. OF PEACE RES. 167, 171 (1969); see also Johan Galtung, *Cultural Violence*, 27 J. OF PEACE RES. 291, 291 (1990) (defining “cultural violence” as “any aspect of culture that can be used to legitimize violence in its direct or structural form”).

279. This includes the “multifaceted structural violence that has plagued Haiti for decades,” only to be revealed to the world after the 2010 earthquake that caused thousands of deaths due to lack of clean water, inadequate shelter and food, and poor access to medical care. See BARBARA RYLKO-BAUER AND PAUL FARMER, *STRUCTURAL VIOLENCE, POVERTY, AND SOCIAL SUFFERING* 5 (2016 ed. David Brady and Linda M. Burton). Another type of non-criminalized violence—in a very different form—is the violence encouraged in organized sports such as football, ice hockey, lacrosse, boxing, and rugby. See Leonard L. Glass, *The Psychology of Violence in Sports—On the Field and In the Stands*, WBUR (Mar. 14, 2014), <http://www.wbur.org/cognoscenti/2014/03/18/sports-violence-psychology-leonard-l-glass> [https://perma.cc/3KHQ-VGBZ] (discussing research that shows violence in a game increases the likelihood of violent acts by spectators).

280. See Chojnacki, *supra* note 185, at 64–65 (discussing the potential ratcheting-up of hostility in hospital birth settings due to more women refusing cesareans, and the subsequent resort to judicial intervention).

cation, enhance patient education, and strengthen informed consent protocols and practices. Broad use of the language of obstetric violence to describe problems in maternity care may introduce unnecessary hostility in the patient-provider relationship, and more conflict or mistrust in clinical settings will not result in better quality care or better health outcomes.

Finally, using the language of violence to describe a wide array of mistreatment runs the risk of collapsing types of conduct of varying degrees of severity and losing certain nuances regarding how, when, and why mistreatment occurs. For example, applying the language of violence to low-level forms of insulting and disrespectful treatment may detract from the outrage properly directed at more extreme violations. At the same time, using obstetric violence as an umbrella concept for mistreatment in childbirth may undermine attempts to address subtler forms of coercion and disrespect by obscuring the structural conditions that enable such conduct to occur unchecked in the provision of health care services.²⁸¹ Because it does not distinguish between egregious cases of bodily violation and less extreme—though still harmful—ways that coercion and disrespect creep into clinical relationships, the language of obstetric violence may cast damaging aspersions on well-intentioned care providers working within flawed institutions.

The concerns raised in this section should not be interpreted as a call for advocates to abandon the language of obstetric violence. This is a powerful conceptual frame, and the language used to identify and describe a problem creates the conditions for finding and implementing solutions. Because this language is so powerful, it should be used precisely and with consideration for possible unintended consequences.

D. FACTORS CONTRIBUTING TO OBSTETRIC VIOLENCE

An examination of obstetric violence would be incomplete without considering possible explanations for why it occurs. This section explores structural issues in health care finance and delivery that may create conditions that contribute to the mistreatment of women during childbirth. Then it identifies powerful social norms related to gender and maternity that influence how maternity care is provided and that explain why obstetric violence is tolerated in some health care settings.

1. Structural Factors in Health Care Finance and Delivery

Ending mistreatment in childbirth cannot be accomplished by simply identifying individual bad actors and removing them from clinical practice. The problem has roots in the history and structure of maternity care. Addressing obstetric violence requires reshaping institutional conditions that contribute to a professional culture in some health care settings that tolerates, enables, or even

281. See *infra* Section I.D.1 (discussing structural factors contributing to and enabling obstetric violence).

encourages such conduct. This section examines three general concerns that help create the conditions for mistreatment of women in childbirth: (a) economic pressures on hospitals and physicians; (b) the trend towards medicalization of childbirth; and (c) the role that fear of liability and defensive medicine play in contributing to obstetric violence. While not exclusive to maternity care, these concerns are particularly important for explaining how and why the mistreatment of women during childbirth persists in modern medical practice.

a. Economic Pressures. Identifying the economic arrangements governing maternity care services is important for understanding how childbearing women access health care and what conditions shape their health care experiences.²⁸² Economic pressures have changed the landscape of where and how maternity care is available, due to hospital consolidation,²⁸³ the shuttering of labor and delivery wards,²⁸⁴ and the shift away from solo and small-practice obstetricians to larger medical practices and reliance on hospital-based laborists.²⁸⁵ The closing of entire maternity care sites has reduced access to evidence-based maternity care by eliminating maternity wards with good reputations for woman-centered and family-centered care.²⁸⁶ For some women, these changes have dramatically limited the options available for birth location and provider.²⁸⁷

282. See generally Diaz-Tello, *supra* note 9 (arguing that economic and political considerations prevent women from exercising their right to refuse unwanted surgery).

283. See, e.g., Katy Kozhimannil, *Rural-Urban Differences in Childbirth Care, 2002–2010, and Implications for the Future*, 52 MED. CARE 4, 5 (2014) (identifying reduced availability of obstetric services in rural areas as consequence of perinatal regionalization, raising concerns about additional access restrictions caused by future hospital consolidations); Gregg Lagan, *Mercy to Consolidate Maternity Services This Summer*, NEWS ARCHIVE (June 9, 2016), <https://www.mercydesmoines.org/about-mercy/news-archive/maternity-consolidate-16554> [<https://perma.cc/J7WM-FVVE>].

284. See, e.g., Susan FitzGerald, *Methodist Hospital to Close Maternity Ward; Officials Cited Rising Insurance Costs. Pregnant Women in S. Phila. Will Be Referred to Jefferson Hospital, 2 Miles North*, PHILADELPHIA INQUIRER (Apr. 25, 2002), http://articles.philly.com/2002-04-25/news/25338252_1_maternity-ward-obstetrical-services-costs-of-malpractice-insurance (noting that the shuttered hospital represented approximately five percent of all births citywide and would eliminate 91 full-time and part-time positions).

285. See ACOG COMM. ON PATIENT SAFETY AND QUALITY IMPROVEMENT & ACOG COMM. ON OBSTETRIC PRACTICE, COMMITTEE OPINION No. 657: THE OBSTETRIC AND GYNECOLOGIC HOSPITALIST 1–2 (2016) (replacing COMMITTEE OPINION No. 459), <http://www.acog.org/Resources-And-Publications/Committee-Opinions/Committee-on-Patient-Safety-and-Quality-Improvement/The-Obstetric-and-Gynecologic-Hospitalist> [<https://perma.cc/BRL8-K4L7>] (explaining the emergence of the OB-GYN hospitalist); Phil Galewitz, *Hospitals Look to Laborists to Fill Gaps Left By On-Call Obstetricians*, KAISER HEALTH NEWS (July 29, 2015), <http://www.acog.org/Resources-And-Publications/Committee-Opinions/Committee-on-Patient-Safety-and-Quality-Improvement/The-Obstetric-and-Gynecologic-Hospitalist> [<https://perma.cc/QWG6-K5ZE>].

286. See, e.g., FitzGerald, *supra* note 284 (noting that the shuttered Methodist Hospital in South Philadelphia had been a leader in “having a nurse midwifery program and family-centered care early on” (internal quotations omitted)).

287. For a discussion of legal and practical restrictions on women’s ability to access midwifery care, as well as concerns about economic competition that have prompted some physicians to oppose midwifery licensure, see Amy F. Cohen, *The Midwifery Stalemate and Childbirth Choice: Recognizing Mothers-to-Be as the Best Late Pregnancy Decisionmakers*, 80 IND. L. J. 849, 854–68 (2005).

Research suggests that the cost of treatment influences clinical decision making in maternity care and results in the provision of medically unnecessary care. Significantly, the cost of a cesarean is higher than a vaginal delivery: in 2011, the average hospital charge nationwide for an uncomplicated vaginal birth was \$10,657, while an uncomplicated cesarean cost an average of \$17,859.²⁸⁸ These figures exclude the cost of newborn care, anesthesia, or compensation for the care provided by an obstetrician or midwife.²⁸⁹ When all childbirth costs are considered, both commercial and Medicaid payers compensated providers approximately 50% more for cesareans than vaginal deliveries.²⁹⁰

Higher reimbursement rates for cesareans, along with longer hospitalizations and more related ancillary procedures, provide incentives to recommend cesareans even when medical necessity is lacking.²⁹¹ In some jurisdictions, women with private, fee-for-service insurance have higher cesarean rates than those covered by HMOs, Medicaid, or those who are uninsured.²⁹² A number of studies have identified differences in cesarean rates associated with the profit orientation of the hospital or the availability of increased reimbursement for cesarean births.²⁹³ A California study showed that for-profit hospitals were more likely to perform cesareans than not-for-profit hospitals, even for women with low-risk pregnancies.²⁹⁴ Researchers concluded that when a woman delivers at a for-profit hospital, she is 17% more likely to end up with a cesarean.²⁹⁵ Other research has found that risk-adjusted capitation for Medicaid patients was associated with lower cesarean rates when compared to privately insured pa-

288. See CHILD BIRTH CONNECTION, AVERAGE FACILITY LABOR AND BIRTH CHARGE BY SITE AND METHOD OF BIRTH, UNITED STATES, 2009–2011, at 1 (2013), <http://transform.childbirthconnection.org/wp-content/uploads/2013/06/USCharges-chart-2009-2011.pdf> [<https://perma.cc/V5XL-YQYB>] (average hospital charge for complicated vaginal birth is \$13,749 and for complicated cesarean birth is \$23,923).

289. See *id.*

290. See TRUVEN HEALTH ANALYTICS, THE COST OF HAVING A BABY IN THE UNITED STATES: EXECUTIVE SUMMARY (2013), <http://transform.childbirthconnection.org/wp-content/uploads/2013/01/Cost-of-Having-a-Baby-Executive-Summary.pdf> [<https://perma.cc/4V4L-EZBM>].

291. See SAKALA & CORRY, *supra* note 27, at 59–60 (discussing perverse incentives in payment systems).

292. See Emmett B. Keeler & Mollyann Brodie, *Economic Incentives in the Choice between Vaginal Delivery and Cesarean Section*, 71 MILBANK Q. 365, 374 (1993) (describing this phenomenon in California).

293. See, e.g., Jonathan Gruber & Maria Owings, *Physician Financial Incentives and Cesarean Section Delivery*, 27 RAND J. ECON. 99, 99 (1996) (analyzing declining fertility from 1970–1982 and the rise of cesareans as a way to offset lost profit). Research on maternity care systems outside the United States supports the conclusion that economic forces often lead to higher rates of cesarean deliveries and other medical interventions. See Dray Amicus Brief, *supra* note 11, at 19 n.37 (citing studies in Greece, Australia, Thailand, and Brazil concluding that economic incentives play a role in driving up cesarean rates) (citations omitted).

294. See Nathanael Johnson, *For-profit Hospitals Performing More C-sections*, CALIFORNIA WATCH (Sept. 13, 2010), <http://californiawatch.org/health-and-welfare/profit-hospitals-performing-more-c-sections-4069> [<https://perma.cc/CVY9-9LV6>].

295. See *id.*

tients.²⁹⁶ Because per-patient reimbursement was limited, physicians were incentivized to provide cost-efficient care and thus prioritized vaginal delivery, avoiding medically unnecessary cesareans and the higher risk of complications associated with them.²⁹⁷

Economic incentives may also influence the provision of non-cesarean maternity care. Medical procedures generate fees for hospitals and physicians, and the ability to collect additional reimbursement for certain procedures reinforces existing trends that normalize medical intervention in the childbirth process.²⁹⁸ Obstetric procedures besides induction and cesarean—such as administration of IV fluids, bladder catheterization, rupture of membranes to release amniotic fluid, fetal monitoring, episiotomy, shaving pubic hair, epidural anesthesia, and forceps-assisted or vacuum-assisted delivery—may all accrue additional fees, which incentivizes the overuse of unnecessary procedures.²⁹⁹ That physicians and hospitals respond to economic incentives with changes in clinical practices does not prove that they have acted intentionally in immoral ways—indeed, considerations of financial benefit and convenience may occur subconsciously, shifting behavior without health care providers being aware of the impact of economic concerns on their decision making.³⁰⁰

In addition to maximizing reimbursement, there are indications that hospitals are incentivized to perform cesareans and other interventions out of concern for the convenience of physicians and hospital staff.³⁰¹ Despite the fact that scheduled elective cesareans are lower quality care,³⁰² they make it easier for

296. Arpit Misra, *Impact of the HealthChoice Program on Cesarean Section and Vaginal Birth After C-Section Deliveries: A Retrospective Analysis*, 12 *MATERNAL & CHILD HEALTH J.* 266, 270 (2007).

297. See *id.* at 270–72. The Washington State Department of Social and Health Services has responded to concerns about financial incentives driving clinical decisions by lowering the Medicaid reimbursement rate for nonemergent cesareans, which is now equal to the rate for vaginal deliveries. See WASH. ST. DEP'T SOC. & HEALTH SERV., 2009 FACT SHEET: CONTROLLING C-SECTION GROWTH (2009), [<https://perma.cc/4Y8N-ZWYZ>].

298. See *infra* Section I.D.1.b (discussing medicalization of childbirth) & Section I.D.2 (discussing social norms that enable obstetric violence).

299. See AM. PUB. HEALTH ASS'N, MAJOR AFFORDABLE CARE ACT DELIVERY AND PAYMENT REFORMS: SUMMARY TABLE 1 (2013) (noting that fee-for-service payment arrangements—which involve reimbursement for each service provided with no limit—are widely believed to incentivize overtreatment and overbilling); see also Elizabeth Kukura, *Giving Birth Under the ACA: Analyzing the Use of Law as a Tool to Improve Health Care*, 94 *NEB. L. REV.* 799, 843 n.252 (discussing typical payment structures for vaginal and cesarean births, including breakdown of how the reimbursement is divided among hospitals, providers, and specialists).

300. See Kukura, *supra* note 4, at 294–95 (discussing the impact of health care financing on shaping clinical practice); see also Dray Amicus Brief, *supra* note 11, at 17–21 (“The fact that doctors perform unnecessary surgery for financial gain or time convenience does not prove their collective or individual moral turpitude, only their very human response to economic incentives.” (internal quotations omitted)).

301. See, e.g., H. Shelton Brown, III, *Physician Demand for Leisure: Implications for Cesarean Section Rates*, 15 *J. HEALTH ECON.* 233, 234 (1996); Joanne Spetz et. al, *Physician Incentives and the Timing of Cesarean Sections: Evidence from California*, 39 *MED. CARE* 536, 536 (2001).

302. See SAKALA & CORRY, *supra* note 27, at 42–43 (discussing risks associated with elective cesarean).

hospitals to plan.³⁰³ Gene Declercq, an expert on maternity care at the Boston University School of Public Health, refers to “subtle incentives to increase efficiency,” which “could have the same effect” as if hospitals were “explicitly push[ing] C-sections for profit.”³⁰⁴ He notes that the unpredictability of vaginal births “creat[es] inefficiencies that can hurt the bottom line.”³⁰⁵ Researchers who studied cesareans performed for “failure to progress”³⁰⁶ found that the percentage of such cesareans conducted less than thirty minutes after the decision to proceed with a cesarean increased from 33% in 2004 to 54% in 2006.³⁰⁷ Such evidence of efficiency concerns on the part of the hospital and individual physicians reflects a rational desire to maximize resources and maintain profitability. However, the desire for efficiency in childbirth can easily transform into an urgency to expedite the labor and delivery process, leading to coercion and other pressure on women to accept unwanted treatment.

b. Medicalization of Childbirth. The economic incentives discussed above have contributed to the medicalization of childbirth—characterized by use of more technology and more interventions into labor and delivery—as hospital administrators, seeking to maximize revenue and efficiency, further entrench the incorrect view that more intervention in the birth process is preferable because it increases safety without additional risk. Since physicians began to professionalize in the nineteenth century, displacing midwives and asserting control over childbirth-related health care, birth has become an increasingly technological matter.³⁰⁸ A medical model of childbirth has come to dominate maternity care, reflecting an understanding of childbirth as a pathological process in need of medical care for monitoring and treatment rather than childbirth as a normal, physiologic process.³⁰⁹

This medicalized norm is reflected in high rates of intervention reported in American maternity care. Nearly one-third of all births are cesareans, making cesarean surgery the most common operating room procedure in the United States.³¹⁰ In 2005, 49% of all hospital procedures performed on individuals aged 18–44 were obstetric procedures, and six of the ten most common proce-

303. See CATALYST FOR PAYMENT REFORM, ACTION BRIEF: MATERNITY CARE PAYMENT 2 (2012) (noting that “decreased opportunity costs help drive the increase in cesarean deliveries”).

304. Johnson, *supra* note 294 (internal quotations omitted).

305. *Id.* (“It’s a lot easier if you can do all your births between seven and 10 in the morning and know exactly how many operating rooms and beds you need.” (internal quotations omitted)).

306. See *supra* Section I.A.2.c (discussing “failure to progress” as a diagnosis).

307. See Roberta Haynes de Regt et al., *Time from Decision to Incision for Cesarean Deliveries at a Community Hospital*, 113 *OBSTETRICS & GYNECOLOGY* 625, 625 (2009).

308. See Kukura, *supra* note 4, at 250–53, 256–64 (discussing the early history of birth politics in the United States and the trend towards medicalization).

309. See *id.* at 258; see generally GOER & ROMANO, *supra* note 199 (analyzing childbirth research literature to explain gaps between current clinical practices and under-utilized evidence-based approaches).

310. See NVS Birth Reports 2013, *supra* note 144, at 7 (32.7% of births in the United States were cesareans); SAKALA & CORRY, *supra* note 27, at 2 (reporting cesareans as most common operating room procedure).

dures billed to Medicaid and to private insurers were related to maternity care.³¹¹ The fact that cesarean rates range from 7–69%, depending on the hospital, indicates that something more than medical necessity is responsible for increases in the cesarean rate.³¹² High rates of cesareans and other interventions deviate from evidence-based medicine, thereby reducing the quality of care provided.³¹³

The medicalization of childbirth has the potential to impact patient–physician relationships negatively in several ways. First, reliance on technology such as electronic fetal monitoring (EFM) has “resulted in a more depersonalized approach to obstetrics” because nurses can remotely monitor many patients at the same time.³¹⁴ Second, the medical model may alter power dynamics between a patient and physician, as medical intervention removes the woman as an agent in her own childbirth experience and makes the physician the gatekeeper to medical technology and knowledge about whether an intervention is achieving its desired effect.³¹⁵ The medical model both draws on and perpetuates hierarchical and paternalistic power dynamics between physicians and patients.³¹⁶ Third, when intervention becomes the norm, a woman who questions a provider’s bias towards intervention—or merely asks for additional information—may be viewed as difficult or irresponsible and treated accordingly.³¹⁷

The maternity care culture in which new physicians are trained impacts their clinical orientation and expectations of the profession. Most medical care is based on custom—the way physicians were taught as medical students—rather than scientific evidence,³¹⁸ and new research results can take up to two decades

311. See SAKALA & CORRY, *supra* note 27, at 11–12.

312. See Katy Backes Kozhimannil et al., *Cesarean Delivery Rates Vary Tenfold Among US Hospitals: Reducing Variation May Address Quality and Cost Issues*, 32 HEALTH AFF. 527, 530–33 (2013). These variations are not explained by differences in individual women’s health conditions or the complexity of their pregnancies. See Katy B. Kozhimannil et al., *Maternal Clinical Diagnoses and Hospital Variation in the Risk of Cesarean Delivery: Analyses of a National US Hospital Discharge Database*, 11 PLoS MED., 2014, at 1, 2.

313. See GOER & ROMANO, *supra* note 199, at 53–62 (documenting the harms of cesarean surgery and refuting claims for its benefits compared with vaginal birth).

314. James Gibson, *Doctrinal Feedback and (Un)Reasonable Care*, 94 VA. L. REV. 1641, 1681 (2008) (footnote omitted).

315. See ROBBIE E. DAVIS-FLOYD, *BIRTH AS AN AMERICAN RITE OF PASSAGE* 130 (2003) (discussing the power rush physicians receive from medical intervention into childbirth: “Performing a cesarean is the one time that truly gives you the feeling of delivering the baby. I remember having my hand in the uterus . . . [M]y hand grasped the head of the baby and assisted it out through the incision. I felt a sense of excitement and of power and of personal accomplishment that is not present in a vaginal birth. This is the time the *obstetrician* truly delivers the baby; in a vaginal birth, it is the mother.” (internal citation omitted)).

316. *Id.*

317. See *supra* Section I.A.3.

318. See Gibson, *supra* note 314, at 1663 (“[P]hysicians do what they see other physicians do, or what they were taught in medical school.”) (footnote omitted); Lucian L. Leape et al., *What Practices Will Most Improve Safety? Evidence-Based Medicine Meets Patient Safety*, 288 JAMA 501, 506 (2002).

to be incorporated into clinical practice.³¹⁹ Most obstetric residents have limited exposure to physiologic birth unmediated by intervention, as IV drips, continuous EFM, artificial induction or augmentation, and other obstetric procedures have become the norm.³²⁰ They are trained to favor intervention as a way to manage labor, decrease risk, and limit liability.

c. Liability and Defensive Medicine. Fear of malpractice liability leads some physicians to practice defensive medicine, including the use of unwanted, unconsented, and non-evidence-based interventions. When compared with colleagues in other medical specialties, obstetricians are sued more often and thus face higher malpractice insurance premiums.³²¹ More than three-quarters of OB/GYNs have been sued at least one time, while half have faced malpractice claims three times or more.³²² Obstetrics cases account for three-quarters of all malpractice insurance losses, with an average payment to plaintiffs of over \$1.1 million.³²³ In the 2000s, a growing number of physicians cited malpractice risk as their reason for ceasing to practice obstetrics or restricting what services they provided.³²⁴ During the same period, residency programs saw interest in obstetrics decline significantly.³²⁵ In response, ACOG issued alarmist reports warning that the malpractice liability “crisis” posed a threat to access to obstetrical services.³²⁶

Research on obstetrics malpractice claims suggests there are certain factors that make it more likely a physician will be sued. Many of them relate to

319. See U.S. DEP’T OF HEALTH & HUMAN SERVS., AGENCY FOR HEALTHCARE RESEARCH & QUALITY, TRANSLATING RESEARCH INTO PRACTICE (TRIP)-II, at 1 (2001), <http://archive.ahrq.gov/research/findings/factsheets/translating/tripfac/trip2fac.html> [<https://perma.cc/8MK2-BWWA>].

320. See Kukura, *supra* note 4, at 287.

321. See Gibson, *supra* note 314, at 1674 (noting that obstetricians are also more likely to lose a malpractice trial than other physicians).

322. See VICTORIA L. GREEN, *Liability in Obstetrics and Gynecology*, in L. MED. 441, 441 (7th ed. 2007).

323. See Gibson, *supra* note 314, at 1674–75. The most common obstetrical injury is neurological damage to newborns. See *id.* Contrary to the view that the legal system is overrun with malpractice claims, research suggests a very small percentage of injuries caused by medical negligence result in the filing of legal claims. See Melissa Patterson, *The Medical Malpractice Crisis: The Product of Insurance Companies and a Threat to Women’s Health*, 8 QUINNIPIAC HEALTH L. J. 109, 128 (“[O]nly 1.53% of patients injured by medical negligence filed malpractice claims.”) (footnote omitted).

324. See *Medical Liability Survey Reflects More OB-GYNs are Quitting Obstetrics*, ACOG NEWS RELEASE (ACOG OFFICE OF COMMUNICATIONS), July 16, 2004, [hereinafter *Quitting Obstetrics*], www.acog.org/from_home/publications/press_releases/nr07-16-04.cfm [<https://perma.cc/J928-N959>] (reporting in 2004 that one in seven ACOG fellows had stopped practicing obstetrics due to malpractice risk).

325. See Jennifer Silverman, *Malpractice Crisis Blamed; Fewer U.S. Seniors Match to OB/Gyn Residency Slots: The Fill Rate for This Group Falls to 65.1%*, OBGYN NEWS (Apr. 1, 2004), <https://www.highbeam.com/doc/1G1-101495931.html> [<https://perma.cc/B3KR-FMD4>].

326. See *Quitting Obstetrics*, *supra* note 324; “Who Will Deliver My Baby?” *Ob-gyns, Patients Push US Senate for Tort Reform, ACOG Names Latest “Red Alert” States Facing Liability Insurance Crisis*, ACOG NEWS RELEASE (ACOG OFFICE OF COMMUNICATIONS) [<https://perma.cc/VE4Z-CRZW>].

physician behavior.³²⁷ Patients frequently cite poor communication and lack of trust as reasons they choose to sue.³²⁸ Patients who are frustrated with brief, rushed appointments and who believe their physicians show insufficient attention are also more likely to sue, as are patients who perceive their physicians to be patronizing them by providing insufficient detail or glossing over medical explanations.³²⁹ A study of deposition transcripts from obstetrics malpractice cases identified four types of communication problems that occurred in more than 70% of the depositions: deserting the patient, devaluing patients' views, delivering information poorly, and failing to understand patients' perspectives.³³⁰ This research underscores how important physician-patient trust and satisfaction with the clinical experience are to avoiding litigation arising out of maternity care.³³¹

Given the high malpractice premiums obstetricians face and concern about malpractice exposure, it is perhaps no surprise that fear of liability causes some physicians to practice defensive medicine.³³² Defensive medicine refers to a clinical orientation that seeks to reduce legal liability by ordering excessive testing, prescribing unneeded medication, or recommending unnecessary surgeries.³³³ Although experts initially believed that defensive medicine would lower

327. See Gerald B. Hickson et al., *Obstetricians' Prior Malpractice Experience and Patients' Satisfaction With Care*, 272 JAMA 1583, 1588 (1994) (concluding that patient dissatisfaction results largely from poor physician communication skills, frequently resulting in malpractice claims). The study found that the physicians with the highest number of malpractice claims also had the largest number of complaints about care they provided (even by patients who did not sue), including poor interpersonal skills, yelling at patients, or the perception of physician disinterest in patient well-being. See *id.* at 1585–86. These frequently-sued physicians were not those with the greatest number of cases of perinatal and neonatal deaths, suggesting that factors beyond an adverse outcome lead people to sue for malpractice. See *id.* at 1586–87.

328. Robyn S. Shapiro et al., *A Survey of Sued and Nonsued Physicians and Suing Patients*, 149 ARCHIVES INTERNAL MED. 2190, 2192–93 (1989) (reporting only one-third of surveyed patients who sued believed their physicians had been open, with one-fifth stating that their physicians had been dishonest).

329. See Wendy Levinson, *Physician-Patient Communication: A Key to Malpractice Prevention*, 272 JAMA 1619, 1619–20 (1994) (discussing common factors that lead patients to sue).

330. See *id.* at 1619.

331. See Elizabeth Swire Falker, *The Medical Malpractice Crisis in Obstetrics: A Gestalt Approach to Reform*, 4 CARDOZO WOMEN'S L. J. 1, 27 (1997) (discussing correlation of satisfaction with less use of technology and a "less aggressive birth environment" (footnote omitted)).

332. Doctors themselves recognize the impact of liability concerns on obstetrical practice. See Sandra S. Friedland, *Rise in Caesarean Births Stirs Dispute*, N.Y. TIMES (Dec. 13, 1981), <http://www.nytimes.com/1981/12/13/nyregion/rise-in-caesarean-births-stirs-dispute.html> [<https://nyti.ms/2tzQ8VR>] (quoting Dr. Daniel Colombi, then-President of the New Jersey Obstetrical and Gynecological Society: "You won't see it written on the chart that a Cesarean was done because a doctor was afraid of malpractice. But faced with a difficult vaginal birth and the potential for litigation 18 years after the fact, it would take a doctor of iron will not to have malpractice in the back of his mind.") (internal quotations omitted).

333. See, e.g., Laura D. Hermer & Howard Brody, *Defensive Medicine, Cost Containment, and Reform*, 25 J. GEN. INT. MED. 470, 470 n.13 (2010) (Massachusetts study found that approximately 33% of CT scans and 40% of specialist referrals ordered by OB/GYNs were medically unnecessary, and 35% of OB/GYNs reported that liability concerns affected the care they provide "a lot"); see also Gibson, *supra* note 314, at 1683 (defensive medicine "refers to the knowing provision of inefficient care").

rates of malpractice because physicians were being more cautious, the increase in unnecessary interventions has led to other injuries and “serves to weaken the doctor–patient relationship, thus increasing the adversarial nature of the relationship.”³³⁴ Estimates of the annual cost of defensive medicine vary widely—often reaching tens of billions³³⁵—but in obstetrics, the impact reaches far beyond the pocketbook, as women suffer physical injury, emotional trauma, and rights violations.³³⁶

Research confirms that obstetricians’ fear of liability results in the practice of defensive medicine.³³⁷ Concern about malpractice liability leads physicians to overuse medical intervention during labor and delivery, resulting in a rising cesarean rate and a decreasing VBAC rate.³³⁸ Obstetricians are more likely to face liability for actions they did not perform than for actions they did take.³³⁹ A

334. Falker, *supra* note 331, at 15 n.86 (citation omitted).

335. See George F. Will, *Tort Reform Now*, WASH. POST (Sept. 29, 2002), <https://www.washingtonpost.com/archive/opinions/2002/09/29/tort-reform-now/8ca6b156-0c13-42d4-bc2e-8675e73f081a/> [<https://perma.cc/J3VK-TGAV>] (U.S. Chamber of Commerce estimates defensive medicine costs American consumers between \$60–100 billion annually). *But see* OFFICE OF TECH. ASSESSMENT, U.S. CONG., DEFENSIVE MEDICINE & MEDICAL MALPRACTICE 154–59 (1994) (critiquing studies that identify billions of dollars in defensive medicine costs annually).

336. See Baker, *supra* note 167, at 550.

337. See Y. Tony Yang et al., *Does Tort Law Improve the Health of Newborns, or Miscarry? A Longitudinal Analysis of the Effect of Liability Pressure on Birth Outcomes*, 9 J. EMPIRICAL LEGAL STUD. 217, 239 (2012) [hereinafter Yang, *Longitudinal Analysis*]; Y. Tony Yang et al., *Relationship Between Malpractice Litigation Pressure and Rates of Cesarean Section and Vaginal Birth After Cesarean Section*, 47 MED. CARE 234, 234 (2009) [hereinafter Yang, *Malpractice Litigation Pressure*]. *But see* David Dranove & Yasutora Watanabe, *Influence and Deterrence: How Obstetricians Respond to Litigation Against Themselves and their Colleagues*, 12 AM. L. & ECON. REV. 69, 69 (2010) (concluding data do not support theory that fear of litigation has driven the increase in cesarean rates nationwide, despite finding a small temporary increase in cesarean rates after physician notification of lawsuit).

338. See Yang, *Longitudinal Analysis*, *supra* note 337, at 218 (concluding results “strongly suggest that liability pressures influence obstetrical practice” and noting that a decrease in insurance premiums for OB/GYNs would be associated with fewer cesareans and more VBACs); *see also* Yang, *Malpractice Litigation Pressure*, *supra* note 337, at 242 (concluding that reducing the threat of litigation would lead to decreases in the number of cesarean deliveries performed and total delivery costs); *see also* Lisa Dubay et al., *The Impact of Malpractice Fears on Cesarean Section Rates*, 18 J. HEALTH ECON. 491 (1999); A. Russell Localio et al., *Relationship Between Malpractice Claims and Cesarean Delivery*, 269 JAMA 366, 371–72 (1993) (reporting study results that reveal existence of a positive relationship between medical malpractice claims and the cesarean rate). Having identified a link between liability pressure and changes in obstetrical practice, the Yang research team examined whether those clinical changes impact health outcomes and found that “birth outcomes are no better in states where obstetricians face high liability pressure than in states where liability pressures are lower.” Yang, *Longitudinal Analysis*, *supra* note 337, at 237.

339. James M. Shwayder, *Liability in High-Risk Obstetrics*, 34 OBSTETRICS & GYNECOLOGY CLINICS OF N. AM. 617, 619 (2007) (reporting that six of the nine most common reasons for obstetric malpractice suits allege failure to perform a cesarean delivery or failure to perform a timely cesarean delivery); *see also* Pamela Paul, *The Trouble with Repeat Cesareans*, TIME, Feb. 19, 2009, at 1, 37 (quoting Colorado Springs obstetrician who stopped attending VBACs in 2003: “You don’t get sued for doing a C-section. You get sued for not doing a C-Section.” (internal quotations omitted)). This begs the question of whether, if the tort system were less hostile to claims of injury based on medically unnecessary cesareans, such a large proportion of suits would be failure-to-act claims. *See infra* Section II.A.

2006 survey ACOG conducted among its membership reported that 64.6% of obstetricians and gynecologists admitted making changes to their practice out of fear of malpractice.³⁴⁰ One study found that the likelihood of labor ending in a cesarean was 15% higher when the hospital's obstetrics practice had been sued a certain number of times in the previous four years.³⁴¹ But even more than the impact of liability pressure, research shows that physicians report a strong belief in liability pressure as a factor in shaping clinical practice.³⁴² This matters because physicians overestimate their risk of being sued,³⁴³ as well as the likelihood that a malpractice plaintiff will prevail.³⁴⁴ Physician misperceptions of liability have important consequences for women receiving unwanted and unnecessary medical treatment.³⁴⁵ Finally, in addition to shaping clinical practices, concern about liability may prompt physicians to ignore an informed refusal of treatment due to the perception that they could still be held liable for any resulting harm, even though the decision ultimately rested with the woman.³⁴⁶

Several structural factors influence the maternity care landscape and create conditions which enable the mistreatment of women in childbirth to occur. Economic pressures on individuals and institutions, which have resulted in structural changes to the delivery of maternity care and the medicalization of birth, along with the perception and the misperception of risk, all help to explain why coercion and other forms of mistreatment have become part of the childbirth landscape.

340. See Nonda Wilson & Albert L. Strunk, *Editorial, Overview of the 2006 ACOG Survey on Professional Liability*, ACOG CLINICAL REV., Mar.–Apr. 2007, at 1, 15.

341. See *Frequency of C-Sections Linked to Legal Claims*, SACRAMENTO BEE, Jan. 20, 1993, at A1, 1993 WL 7420737; see also Dranove & Watanabe, *supra* note 337 (finding short-term increase in cesareans following the initiation of a lawsuit against a colleague).

342. See JEFFREY KLAGHOLZ & ALBERT L. STRUNK, OVERVIEW OF THE 2009 ACOG SURVEY ON PROFESSIONAL LIABILITY (2009) (reporting 62.9% of OB-GYNs changed clinical practices in response to liability pressures); Richard Hyer, *ACOG 2009: Liability Fears May be Linked to Rise in Cesarean Rates*, MEDSCAPE MED. NEWS, (May 12, 2009), <http://www.medscape.com/viewarticle/702712>; see also generally Carol Sakala et al., *Maternity Care and Liability: Least Promising Policy Strategies for Improvement*, 23 WOMEN'S HEALTH ISSUES e15 (2013) (discussing how the perception of liability risk impacts obstetricians).

343. See Ann G. Lawthers et al., *Physicians' Perceptions of the Risk of Being Sued*, 17 J. HEALTH POL. POL'Y & L. 463, 469 (1992) (finding that physicians practicing high-risk obstetrics overestimate their chances of being sued by a factor of 1.6). Physicians also believe a negligently injured patient is thirty times more likely to sue than they are. See *id.* at 468, 475.

344. See Bryan A. Liang, *Layperson and Physician Perceptions of the Malpractice System: Implications for Patient Safety*, 57 SOC. SCI. & MED. 147, 149 (2003).

345. See *Clark v. Gibbons*, 426 P.2d 525, 538 n.9 (Cal. 1967) (Tobriner, J., concurring) (“When every patient is viewed largely as a potential plaintiff, the method of treatment chosen by the physician may well be that which appears easiest to justify in court rather than that which seems best from a purely medical standpoint.” (citation omitted)).

346. See Dray Amicus Brief, *supra* note 11, at 21–25 (discussing liability pressures in maternity care and arguing that courts should enforce informed treatment refusals because “[p]roviders deserve assurance that their responsibility ends where their patients’ rights begin”).

2. Social Norms

In addition to the structural factors discussed above, certain social norms relating to gender and maternity play a role in the enabling and toleration of obstetric violence. Researchers have long explored how gender bias in health care undermines women's health and well-being.³⁴⁷ Scholars, ethicists, practitioners, and patients widely acknowledge that the health care system developed on a paternalistic model "in which the physician maintained complete and unquestionable authority over all health-related decisions and information."³⁴⁸ Although modern medicine has departed from once-routine practices in which doctors withheld fatal diagnoses from their patients in the belief that it served the patients' best interests to be ignorant of their prognosis,³⁴⁹ the medical profession has not shed the influence of the paternalistic model.³⁵⁰ In particular, modern maternity care rests on the paternalistic views of male physicians in the nineteenth and early twentieth centuries who declared themselves experts in childbirth and introduced a variety of interventions on the assumption that female weakness required pain medication and other interference with the body's natural labor process.³⁵¹ Although the "normative modern doctor–patient relationship is based on an interactive model of shared decision making"³⁵² and has "replac[ed] the formerly entrenched paradigm of the all-knowing, all-powerful, father-figure doctor and the uninformed, blindly trusting, child-like patient,"³⁵³ elements of paternalism still creep into the clinical relationship, influencing treatment recommendations and generating bias towards medical intervention. The mistreatment of women during childbirth is enabled by a

347. See, e.g., Cecile M.T. Gusbers Van Wijk et al., *Gender Perspectives and Quality of Care: Towards Appropriate and Adequate Health Care for Women*, 43 *SOC. SCI. & MED.* 707, 711–15 (1996) (critiquing assumption that more health care is better); Michelle Oberman & Margie Schaps, *Women's Health and Managed Care*, 65 *TENN. L. REV.* 555, 564–69 (1998) (discussing gender bias in diagnosis and mistreatment); Karen H. Rothenberg, *Gender Matters: Implications for Clinical Research and Women's Health Care*, 32 *HOUS. L. REV.* 1201, 1211–18 (1996).

348. Holly Goldberg, *Informed Decision Making in Maternity Care*, 18 *J. PERINATAL EDUC.* 32, 34 (2009) (citation omitted).

349. See Kathryn M. Taylor, 'Telling Bad News': *Physicians and the Disclosure of Undesirable Information*, 10 *SOC. HEALTH & ILLNESS* 109, 109 (1988).

350. See Goldberg, *supra* note 348, at 34 (discussing scholarship that concludes the "paternalistic model not only still exists, but thrives in today's health-care systems") (citations omitted). The ACOG Committee on Ethics recognizes that paternalism in obstetric care reflects the "historical imbalance of power in gender relations, the constraints on individual choice posed by complex medical technology, and the intersection of gender bias with race and class bias in the attitudes and actions of individuals and institutions." ACOG, *Informed Consent*, in *ETHICS IN OBSTETRICS AND GYNECOLOGY* 13 (2d ed. 2004).

351. See Kukura, *supra* note 4, at 258 n.20 (discussing pioneering obstetrician who introduced various interventions designed to save women from the "evils that are natural to labor") (internal quotations omitted) (citations omitted).

352. Julie Gantz, *State Statutory Preclusion of Wrongful Birth Relief: A Troubling Re-Writing of a Woman's Right to Choose and the Doctor–Patient Relationship*, 4 *VA. J. SOC. POL'Y & L.* 795, 797 (1997).

353. *Id.* at 798.

societal understanding of female bodies as objects to be acted upon—with childbirth in particular inviting the violation of bodily integrity.³⁵⁴

Certain gendered norms regarding women as mothers further complicate the identification and acknowledgment of obstetric violence. Society's widespread expectation of maternal self-sacrifice makes it difficult for courts to recognize the injury associated with forcing medical treatment on an unwilling woman in labor.³⁵⁵ Women face an uphill battle against these entrenched maternal values, which suggest that good mothers are those who subordinate their own needs (and bodies) in service of their children and families.³⁵⁶ Women with healthy babies who nevertheless bring suit over injuries they suffered violate this norm. They are often perceived to be acting selfishly and may find a less sympathetic audience in court.³⁵⁷ Women themselves may internalize these social expectations, downplaying the extent of their physical and emotional injuries and choosing not to voice concerns about mistreatment for fear of appearing ungrateful.³⁵⁸

The powerful idea of the self-sacrificing mother is particularly relevant in the context of confusion over so-called maternal-fetal conflict, a concept that forms the basis for disagreement between patients and physicians over treatment decisions and sometimes leads to abusive and coercive interventions by health care providers. The idea of a two-patient model of pregnancy emerged in the middle of the twentieth century in tandem with the development of new technologies, such as the ultrasound, that changed how physicians could ob-

354. See Pascucci, *supra* note 58 (recounting story of woman who reported doctor to local law enforcement for “manually penetrat[ing] her with both hands while she was pushing, ignor[ing] her shouts of ‘No!’, [and] intentionally [tearing] her vagina with his fingers” was told by the district attorney’s office that the “doctor’s ‘duties’ included ‘invas[ing] certain areas.’”).

355. See Diaz-Tello, *Invisible Wounds*, *supra* note 9, at 61 (discussing barriers to tort recovery in the context of expectation that women “sacrifice their health and dignity, and even potentially their lives, in the name of having a healthy baby”).

356. See Howard M. Bahr & Kathleen S. Bahr, *Families and Self-Sacrifice: Alternative Models and Meanings for Family Theory*, 79 SOC. FORCES 1231, 1234–37 (2001); Jennifer L. Barkin & Katherine L. Wisner, *The Role of Maternal Self-Care in New Motherhood*, 29 MIDWIFERY 1050, 1054 (2013); see also April L. Cherry, *Roe’s Legacy: The Nonconsensual Treatment of Pregnant Women and Implications for Female Citizenship*, 6 U. PA. J. CONST. L. 723, 740–41 (2004) (discussing cultural norms that expect women to be altruistic and “sacrifice their own lives for their children or fetuses”) (footnote omitted); Oberman, *supra* note 13, at 454 n.13 (“[B]ecause ‘mother’ carries with it connotations of loving altruism, the notion of a conflict between mother and fetus implies that, by refusing to follow medical advice, the mother has cruelly betrayed the sacred trust between mother and child.”).

357. See Jamie R. Abrams, *Distorted and Diminished Tort Claims for Women*, 34 CARDOZO L. REV. 1955, 1960 (2013) (concluding “the normative dualities of childbirth are distorted and diminished in tort by the modern dominance of fetal harms and the subordination of maternal harms”); *Consumers Welcome*, *supra* note 259 (“[W]omen are admonished to just be grateful they have a healthy baby, regardless of the humiliation, bullying, or trauma they endured.”).

358. See, e.g., Dray Amicus Brief, *supra* note 11, at 13 (recounting birth story of woman who said she declined to seek legal action “because I don’t have serious medical complications from the birth, unless you count a scarred, torn urethra”).

serve the fetus and what information was available to clinicians directly.³⁵⁹ Physicians now understand themselves to be responsible for two patients, and if the woman questions or disagrees with a recommendation, she may be accused of putting her own interests ahead of the fetus, rather than acting to maximize the well-being of both.³⁶⁰ Abortion rights jurisprudence that weighed a woman's liberty interest against the state's interest in potential life has contributed to the idea that a conflict exists between the legal rights of a mother and those of her future baby. When courts apply abortion doctrine to grant court orders compelling cesareans, "doctors receive a message through these legal decisions . . . that paternalism towards expecting mothers is not only acceptable, but necessary."³⁶¹

In her analysis of so-called maternal-fetal conflicts, Michelle Oberman argues that it is more appropriate to think of this phenomenon as "maternal-doctor conflicts" as they involve "doctors' seemingly well-motivated efforts to promote maternal or fetal well-being by imposing their perception of appropriate medical care on their pregnant patients."³⁶² She describes how a woman's disagreement with or resistance to a recommended treatment leads the physician to "invest[] the fetus with interests and rights that directly coincide with his own personal treatment preferences."³⁶³ Discussion of such cases tends to omit the

359. See JACK A. PRITCHARD & PAUL C. MACDONALD, *WILLIAMS OBSTETRICS* vii (16th ed. 1980) ("Happily, we have entered an era in which the fetus can be rightfully considered and treated as our second patient."); F.A. Manning, *Reflections on Future Directions of Perinatal Medicine*, 13 *SEMINARS IN PERINATOLOGY* 342, 343 (1989) (heralding the adoption of technology enabling doctors "to see, examine and invade the fetus and its environment" as significant change in perinatal care). For a critique of the two-patient model, see Susan S. Mattingly, *The Maternal-Fetal Dyad: Exploring the Two-Patient Obstetric Model*, 22 *HASTINGS CENTER REP.* 13, 15 (1992). Michelle Oberman highlights an ethical problem with the notion of a two-patient model of pregnancy in a medical system where the doctor-patient relationship is understood to begin when a patient seeks treatment. See Oberman, *supra* note 13, at 472 ("Absent a patient or guardian's consent, a doctor has no power to adopt an individual as a patient.").

360. See Dray Amicus Brief, *supra* note 11, at 28 ("The assertion of maternal-fetal conflict in cases of forced care rests upon the assumption that a woman is aligned with her baby's needs only so long as she complies with her provider's recommendations."); see also Howard Minkoff & Lynn M. Paltrow, *The Rights of "Unborn Children" and the Value of Pregnant Women*, 36 *HASTINGS CENTER REP.* 26, 27-28 (2006) (discussing the misleading notion of "maternal-fetal conflict" and noting that "[u]nless stripped of their rights, pregnant women will continue to be the most powerful advocates for the wellbeing of unborn children").

361. Margaret M. Donohoe, *Our Epidemic of Unnecessary Cesarean Sections: The Role of the Law in Creating it, the Role of the Law in Stopping It*, 11 *WIS. WOMEN'S L. J.* 197, 236 (1996); see also Terri-Ann Samuels et al., *Obstetricians, Health Attorneys, and Court-Ordered Cesarean Sections*, 17 *WOMEN'S HEALTH ISSUES* 107, 111-13 (2007) (concluding that anti-abortion or conservative values correlated strongly with physicians' and health attorneys' willingness to pursue court-ordered cesareans over patient objections). For more discussion of the application of abortion right doctrine to cases compelling treatment of pregnant women, see *infra* Section II.B.2 (discussing constitutional law frameworks).

362. Oberman, *supra* note 13, at 454 (identifying the paradigm of maternal-fetal conflict as "fundamentally flawed and incomplete"). Various commentators have objected to the "conflict characterization" as misleading and unnecessarily adversarial. See, e.g., Bonnie Steinbock, *Mother-Fetus Conflict*, in *A COMPANION TO BIOETHICS: SECOND EDITION* 152-53 (Kuhse & Singer eds., 2009).

363. Oberman, *supra* note 13, at 454 (describing doctor as "seemingly neutral arbitrator" settling the "conflict") (internal quotations omitted).

role of the physician in generating the conflict in the first place.³⁶⁴ Instead, the woman is vilified for making an irresponsible choice, or simply overruled as incapable of making the “right” decision to maximize her own well-being and that of her baby.³⁶⁵ Rather than having the opportunity to weigh the risks and benefits of different approaches, and make the decision they consider best, women find themselves bullied, coerced, or forced to accept unwanted medical intervention.³⁶⁶

* * *

Obstetric violence takes many forms, including direct violation of the body through forced surgeries or physical restraint, coercive mechanisms employing state power or emotional manipulation to secure a woman’s consent to treatment, and disrespectful or insulting language that diminishes rather than supports a laboring woman. There are huge gaps in research on where and how women experience mistreatment during childbirth, but sufficient evidence supports the conclusion that some childbearing women experience serious physical and emotional harms due to obstetric violence. It is important to understand the structural constraints care providers face—including economic pressures, the pervasive medicalization of birth, and fear of malpractice liability—as well as the gendered social norms shaping maternity care culture, in order to appreciate why the legal system often fails women subjected to obstetric violence. The next Part turns to the law and its role in preventing and redressing mistreatment during childbirth.

II. LEGAL AND REGULATORY RESPONSES TO OBSTETRIC VIOLENCE

Current legal and regulatory frameworks are inadequate for addressing the abuse, coercion, and disrespect of women in childbirth.³⁶⁷ Rights to informed consent and bodily integrity are rendered meaningless by courts’ inability to see coercive and dehumanizing treatment by health care providers as a source of lasting harm. Women who sue in tort over mistreatment they suffered during childbirth struggle—and usually fail—to convince courts of the seriousness of their injury, especially if their child suffered no harm. This Part examines the

364. *See id.* at 454–55. Oberman suggests that commentators fail to recognize that “it is the doctor who identifies the conflict, [and] the doctor who transforms a patient’s assertion of her right to bodily integrity and autonomy into an adversarial confrontation. . . .” *Id.* at 482.

365. *See* Abrams, *supra* note 357, at 1960 (describing how fetal-focused decision making in medicine and law “villainizes maternal responses that do not conform to an essentialized, self-sacrificial, and historically myopic view of childbirth”).

366. *See* Sylvia A. Law, *Childbirth: An Opportunity for Choice That Should Be Supported*, 32 N.Y.U. REV. L. & SOC. CHANGE 345, 366 (2008) (arguing that women’s preferences should be prioritized, particularly where medical professionals disagree).

367. *See* *Because We Can*, *supra* note 191 (concluding “there is no meaningful process for recourse or enforcement when violations occur” from hundreds of reports from women); Improving Birth Letter, *supra* note 256, at 2 (detailing reports of ignored hospital complaints and the inadequacy of state licensing boards as a source of potential recourse, given the slow pace and lack of transparency that characterize their work).

limitations of tort law in remedying obstetric violence, including access to representation, what constitutes a cognizable claim, and how legal decision-makers interpret childbirth-related harms. This Part then proceeds to examine other areas of law and policy that should address the mistreatment of women in childbirth but, as currently interpreted, fail to offer meaningful relief. This Part concludes by offering several recommendations for scholars and advocates, laying the groundwork for future efforts to understand and address obstetric violence.

A. TORT LAW

The tort system is intended to address civil wrongs “by creating incentives to engage in optimal levels of precaution taking.”³⁶⁸ Failure to take necessary precaution may result in liability for negligence, or “conduct which falls below the standard established by law for the protection of others against unreasonable risk of harm.”³⁶⁹ A plaintiff who has suffered medical injury due to provider negligence may choose to bring a claim for medical malpractice.³⁷⁰ To do so, she must establish: (1) the existence of a physician–patient relationship giving rise to a duty; (2) the violation of the relevant standard of care; (3) an injury suffered; and (4) a causal connection between the violation of the standard of care and the injury suffered.³⁷¹ Conflicts between women and their physicians over childbirth-related care could theoretically result in legally cognizable claims for battery, failure to obtain informed consent, or breach of confidentiality, but for reasons discussed below, these are difficult claims to bring and to win. Such a claim might accompany a malpractice claim, if the patient can establish that the physician violated the relevant standard of care, but many maternal–doctor conflicts do not legally constitute malpractice because coercing a patient to accept treatment out of concern for the fetus “may be standard operating procedure, or at the very least, sufficiently commonplace that a court could not classify [it] as a violation of the standard of care.”³⁷² Other maternal–doctor conflicts do not constitute a tort because doctors successfully convince patients to consent using legal threats and emotional manipulation.³⁷³

The doctrine of informed consent has evolved to protect patients’ rights to control medical decision making, recognizing that physicians have more knowledge and expertise, and therefore more power in the treatment relationship.³⁷⁴

368. Yang, *Longitudinal Analysis*, *supra* note 337, at 240 (citation omitted).

369. RESTATEMENT (SECOND) OF TORTS § 282 (1965); *see also* W. PAGE KEETON ET AL., PROSSER AND KEETON ON THE LAW OF TORTS 31, 170 (5th ed. 1984).

370. *See* KEETON ET AL., *supra* note 360, at 170.

371. *See* J.D. LEE & BARRY A. LINDAHL, MODERN TORT LAW § 25:1 (2d ed. 2017).

372. Oberman, *supra* note 13, at 489.

373. *See supra* Section I.A.2 (describing coercive tactics) and I.A.3 (describing disrespect).

374. *See* Gantz, *supra* note 352, at 799–800 (discussing the evolution from physician control and autonomy to norm of information disclosure as “a fundamental ethical requirement”) (internal quotations omitted) (footnote omitted); *see also* Law, *supra* note 366, at 362–71 (discussing strong tradition of paternalism and disrespect for women’s choices in reproductive health care, particularly childbirth).

The requirement that a physician disclose the risks, benefits, and alternatives before any treatment is commenced is “grounded in patient autonomy and the notion that unconsented treatment constitutes an intentional tort or negligence.”³⁷⁵ In *Schloendorff v. Society of New York Hospital*, Justice Cardozo famously articulated the principle that underlies modern notions of informed consent: “Every human being of adult years and sound mind has a right to determine what shall be done with his own body.”³⁷⁶ Subsequent courts have made clear that informed consent means more than answering patients’ questions but also imposes a duty on physicians “to volunteer . . . the information the patient needs for intelligent decision.”³⁷⁷ This focus on patient needs has shifted some jurisdictions to adopt a patient-based model of informed consent, which requires the disclosure of information relevant to the patient’s treatment decision,³⁷⁸ rather than a physician-based model of informed consent, which obligates physicians to disclose whatever information “a reasonable medical practitioner of the same school, in the same or similar circumstances, would have disclosed.”³⁷⁹ The physician-based model obscures the individuality of each patient and fails to require consideration of any personal, family, religious, or other considerations that might necessitate disclosure of certain information.³⁸⁰ The lack of a uniform standard for determining what constitutes a breach of informed consent makes it harder for women to use the doctrine to redress mistreatment during childbirth.

Ultimately, the tort system is inadequate for deterring behavior that leaves women uninformed about the risks of a particular treatment or subjects them to poorly performed medical care. Because negligent behavior is not closely

375. Marc D. Ginsberg, *Informed Consent: No Longer Just What the Doctor Ordered? The “Contributions” of Medical Associations and Courts to a More Patient Friendly Doctrine*, 15 MICH. ST. J. MED. & LAW 17, 19 (2011) (footnotes omitted). See *Canterbury v. Spence*, 464 F.2d 772, 780 (D.C. Cir. 1972) (“True consent to what happens to one’s self is the informed exercise of a choice, and that entails an opportunity to evaluate knowledgeably the options available and the risks attendant upon each.”) (footnote omitted).

376. 105 N.E. 92, 93 (N.Y. 1914).

377. *Canterbury*, 464 F.2d at 783 n.36 (“Physicians and hospitals have patients of widely divergent socio-economic backgrounds, and a rule which presumes a high degree of sophistication which many members of society lack is likely to breed gross inequities.” (citation omitted)).

378. See *id.* at 786 (shifting the emphasis of informed consent law to the individualized needs of the patient). The court found that “the patient’s prerogative to decide . . . [i]s at the very foundation of the duty to disclose, and both the patient’s right to know and the physician’s correlative obligation to tell him are diluted to the extent that its compass is dictated by the medical profession.” *Id.* (footnotes omitted).

379. *Guebard v. Jabaay*, 452 N.E.2d 751, 755 (Ill. App. Ct. 1983) (citations omitted). For more discussion of the physician-based and patient-based models of informed consent, see Jaime Staples King & Benjamin N. Moulton, *Rethinking Informed Consent: The Case For Shared Medical Decision-Making*, 32 AM. J. L. & MED. 429, 480–83 (2006). Slightly more than half of all states still apply a reasonable medical practitioner standard. See Richard Weinmeyer, *Lack of Standardized Informed Consent Practices and Medical Malpractice*, 16 AM. MED. ASSN. J. OF ETHICS 120, 121 (2014).

380. See King & Moulton, *supra* note 379, at 430 (emphasizing that where individual patient values and needs are relevant to patient care, “physicians are not in the best position to make treatment decisions and should not limit disclosure of alternatives”).

related to the likelihood of an injured patient receiving a damages award, the law fails to send clear signals to physicians about proper conduct.³⁸¹ The requirement that a patient suffer an injury that leads to a cognizable claim means tort law can only deter certain types of behavior without “identify[ing] and correct[ing] [other] substandard medical practices.”³⁸² The specter of liability can also degrade the integrity of the provider–patient relationship, replacing a relationship of trust with an adversarial relationship and interfering with treatment.³⁸³ In short, litigation is “a last resort . . . a blunt and slow-moving tool, inaccessible for most women. . . .”³⁸⁴

The remainder of this section considers the following specific obstacles women face in bringing a successful tort claim for injuries arising out of mistreatment in childbirth: (1) inadequate access to representation; (2) difficulty in establishing a cognizable claim; and (3) difficulty in proving harm.

1. Inadequate Access to Representation

For most women who have experienced mistreatment during childbirth, seeking legal recourse requires representation by legal counsel. Attorneys act as the gatekeepers to justice for patients harmed by medical treatment performed negligently or without informed consent. In the absence of financial resources to hire private counsel on a retainer,³⁸⁵ most women depend on counsel who are willing to provide legal services on a contingency fee basis.³⁸⁶ Because contingency fee structures require counsel to share the risk that the case will be unsuccessful, attorneys are likely to decline to take on legal matters where they perceive insufficient damages will be available to cover costs and fees, or where they do not find the prospective client’s claims compelling.³⁸⁷ Even relatively

381. See Kirk B. Johnson et al., *A Fault-Based Administrative Alternative for Resolving Medical Malpractice Claims*, 42 VAND. L. REV. 1365, 1371 (1989). In fact, research suggests that only about “2% of the overall population that experiences negligent injury appears to make a claim, [and] about half of those receive any compensation for damages” CAROL SAKALA ET AL., *MATERNITY CARE AND LIABILITY: PRESSING PROBLEMS, SUBSTANTIVE SOLUTIONS* 6 (2013), <http://transform.childbirthconnection.org/wp-content/uploads/2013/02/Maternity-Care-and-Liability.pdf> [<https://perma.cc/D8BY-NYVF>].

382. Johnson et al., *supra* note 381, at 1373 (footnote omitted).

383. See U.S. DEPT. OF HEALTH & HUMAN SERVS., *REPORT OF THE TASK FORCE ON MEDICAL LIABILITY AND MALPRACTICE* 17 (1987) (finding “a compensation system that creates distrust, or encourages precautionary actions in anticipation of legal conflict, places stress on [the physician–patient] relationship”).

384. Improving Birth Letter, *supra* note 256, at 2.

385. See REBECCA L. SANDEFUR & AARON C. SMYTH, *ACCESS ACROSS AMERICA: FIRST REPORT OF THE CIVIL JUSTICE MAPPING PROJECT v* (2011), http://www.americanbarfoundation.org/uploads/cms/documents/access_across_america_first_report_of_the_civil_justice_infrastructure_mapping_project.pdf [<https://perma.cc/37GE-NX82>] (concluding that various programs and models exist for providing access to civil justice, but availability of counsel is inconsistent and uncoordinated).

386. The possibility of high damages awards in obstetrical malpractice cases increases the appeal of contingency fee arrangements for plaintiffs’ attorneys, who may profit significantly from a single case. See, e.g., *Ayes v. Shah*, 997 F.2d 762, 764 (10th Cir. 1993) (affirming jury verdict of over \$21 million for birth-related injuries).

387. See Dray Amicus Brief, *supra* note 11, at 11–12 (estimating average cost for tort cases to be \$30,000–50,000, not including the cost of the attorney’s services).

small injuries may require extensive time and resources to investigate.³⁸⁸ Tort reform in certain jurisdictions has capped the amount of damages available to plaintiffs, further complicating the task of finding a lawyer to take a malpractice case on a contingency fee basis.³⁸⁹

Despite the prevalent view that Americans are overly litigious and rush to litigation after poor medical outcomes, research shows that only a small percentage of incidents of medical negligence result in a lawsuit.³⁹⁰ In obstetrics, the widespread attitude that a healthy baby trumps all other suffering virtually precludes the assignment of monetary damages to “invisible” physical and emotional injuries, making it difficult to find a lawyer willing to take a birth injury case unless there was lasting harm to the baby.³⁹¹ For reasons discussed below, judges and juries often do not understand the physical and emotional injuries that women suffer as a result of mistreatment in childbirth and are unwilling to award damages in the absence of death or severe disfigurement.³⁹² Indeed, Rinat Dray had difficulty finding a lawyer to represent her after her forced cesarean.³⁹³ Kimberly Turbin experienced similar difficulties after her forced episiotomy and was turned down by dozens of lawyers over a year-and-a-half; she ultimately crowdsourced funds and initially filed the suit representing herself.³⁹⁴ Even where a plaintiff is able to secure counsel after a lengthy search, the delay may result in certain claims expiring under the statute of

388. See Andrew Tobias, *Background Paper to TREATING MALPRACTICE: REPORT OF THE TWENTIETH CENTURY FUND TASK FORCE ON MEDICAL MALPRACTICE INSURANCE* 5 (1986).

389. See Sakala et al., *supra* note 342, at e17–e18 (2013) (noting that “caps may . . . reduce incentives for deterring harm”).

390. See PATRICIA M. DANZON, *MEDICAL MALPRACTICE: THEORY, EVIDENCE, AND PUBLIC POLICY* 19 (1985) (concluding that at the height of the malpractice crisis, “at most 1 in 10 [patients experiencing negligent injuries] filed a claim, and only 40% of these claims resulted in payment to the plaintiff”); Kenneth C. Chessick & Matthew D. Robinson, *Medical Negligence Litigation is Not the Problem*, 26 N. ILL. U. L. REV. 563, 566 (2006) (discussing research that concluded fewer than 2% of those injured by medical negligence sued) (footnotes omitted); David Pratt, *Health Care Reform: Will it Succeed?*, 21 ALB. L.J. SCI. & TECH. 493, 570 (“Only about 2% of malpractice incidents result in a lawsuit: physicians think the rate is 30% to 60%.”) (footnote omitted).

391. See Abrams, *supra* note 357, at 1960 (analyzing how “birthing women’s rights to tort remedies are subsumed within the positive birthing outcome”). Abrams’ thorough explication of how “[h]ealthy babies negate maternal harms,” *id.*, helps to explain why lawyers perceive maternal harm cases as losers and are unwilling to accept such representations. See *id.* at 1979–80 (discussing financial disincentives for plaintiffs’ lawyers to pursue maternal harm causes of action).

392. See, e.g., Abrams, *supra* note 357, at 1989 (explaining the fetal consequentialist thinking that limits ability of courts to understand maternal harms: “the only real harm that a woman can suffer is a harmed child”). The unwillingness of lawyers to represent women claiming birth injuries undoubtedly reflects the lawyers’ understanding that such judicial reasoning means there is little chance of recovery. See Pascucci, *supra* note 58 (lawyers consulted regarding forced episiotomy were “unable to see the value in a case where there were no permanent damages or deaths”).

393. See, e.g., Plaintiff’s Affidavit, *Dray v. Staten Island Univ. Hosp.*, No. 500510/14 (N.Y. Sup. Ct., complaint filed Apr. 11, 2014).

394. See *California Woman Charges Doctor with Assault & Battery for Forced Episiotomy*, IMPROVINGBIRTH PRESS RELEASE (Dawn Thompson, June 4, 2015), <https://www.crowdrise.com/kellygoestocourt/fundraiser/improvingbirth> [<https://perma.cc/2N7S-2BUF>] (discussing Turbin’s difficulty finding an attorney: “dozens of whom turned down Ms. Turbin’s case on the assumption that courts would not

limitations or may make it harder to develop an evidentiary record so long after the incident occurred.³⁹⁵

2. Establishing a Cognizable Claim

A woman seeking to recover for harm caused by obstetric violence is constrained by how the law understands claims of wrongdoing within the tort system. A plaintiff must establish the breach of a duty owed by the physician and that the breach was the cause of her injuries.³⁹⁶ To determine whether the physician breached a duty in a malpractice case, the court compares the physician's conduct to the applicable standard of care, which refers to "that degree of skill and learning ordinarily possessed and exercised, under similar circumstances, by the members of his profession in good standing. . . ."³⁹⁷ The standard of care is based on what is "customary and usual in the profession," requiring extensive evidence from experts.³⁹⁸ ACOG guidelines serve as evidence of the standard of care in malpractice suits, but many of them do not reflect the best available evidence about maternity care practices, favoring a more procedure-intensive approach to labor management than the scientific literature supports.³⁹⁹ This makes it difficult for women to establish that being pressured into unwanted medical intervention violates the standard of care and thus constitutes a breach of the physician's duty. In general, the traditional standard of care may act as a deterrent to—or at least slow down—the adoption of evidence-based clinical practices by well-informed practitioners until their colleagues in the medical community have also updated their clinical practices.⁴⁰⁰

assign meaningful monetary value to the injuries she suffered"). Her case was subsequently taken on by a civil rights lawyer in Sacramento. *See id.*

395. For example, because the one-year statute of limitations for battery expired before Rinat Dray secured representation for her claims against the physician and hospital that performed a cesarean on her against her will, she was required to litigate the case as a malpractice and negligence action. *See* Diaz-Tello, *Invisible Wounds*, *supra* note 9, at 59–60. The court dismissed some of Dray's claims on the grounds that they amount to battery instead of malpractice. *See id.*

396. *See* LINDAHL, *supra* note 371, at § 25:1.

397. Herbert Dicker & Jeffrey D. Robertson, *The Defense of a Malpractice Case*, in *LEGAL ASPECTS OF MEDICINE INVOLVING CARDIOLOGY, PULMONARY MEDICINE, AND CRITICAL CARE MEDICINE* 17 (J.R. Vevaina et al. eds., 1989).

398. KEETON ET AL., *supra* note 369, at 189; *see also* Mark R. Chassin et al., *Standards of Care in Medicine*, 25 *INQUIRY* 437, 448 (1988) (noting that the law "faces far more difficulty in uncovering what the standard of care is in a particular domain of medicine than it does in adjudicating matters of fact regarding what actually took place"); Richard E. Leahy, *Rational Health Policy and the Legal Standard of Care: A Call for Judicial Deference to Medical Practice Guidelines*, 77 *CAL. L. REV.* 1483, 1496 (1989) (discussing the centrality of expert witness testimony in judicial determination of applicable standard of care).

399. *See* Kukura, *supra* note 4, at 266–67 (discussing analysis of ACOG obstetrical practice bulletins that found only 23% were "based on good and consistent scientific evidence").

400. *See id.* at 296–97 (discussing tort law as an impediment to evidence-based maternity care); Carter L. Williams, *Evidence-Based Medicine in the Law Beyond Clinical Practice Guidelines: What Effect Will EBM Have on the Standard of Care?*, 61 *WASH. & LEE L. REV.* 479, 498–512 (2004) (discussing potential incompatibility of evidence-based medicine and current standard of care analysis).

Informed consent doctrine also makes it difficult to bring a viable claim against a physician for failing to satisfy his duty to discuss the risks, benefits, and alternatives to a particular course of treatment. A plaintiff must show that the undisclosed risk materialized and must prove that she would have refused treatment had she been aware of the risk.⁴⁰¹ In maternity care, where one procedure can set off a chain reaction of additional interventions, eventually leading to injury, this can be an impossible standard to satisfy. In addition, the susceptibility of physician disclosure to manipulation and distortion to serve goals other than patient well-being means that a physician may appear to have satisfied the technical requirements of informed consent while straying far from the values of self-determination and patient empowerment.⁴⁰² Cases involving biased or manipulated disclosure processes will not be redressed by existing informed consent doctrine.

Claims arising out of mistreatment during childbirth are also limited by what constitutes harm under tort law. For example, the law does not enable a woman who received a medically unnecessary, but non-negligently performed, cesarean to claim injury and recover through the civil justice system because a cesarean is a common medical procedure, and a medical procedure alone does not constitute injury in the absence of negligence.⁴⁰³ While not all cesareans constitute injuries in and of themselves, this treatment of cesarean-related claims precludes recovery for injury from a non-negligently performed cesarean, even where the woman did not give her informed consent or where coercive methods were used to obtain her consent.⁴⁰⁴ It also makes recovery difficult for other harms flowing from non-negligently performed, medically unnecessary cesareans, including injuries that impact subsequent fertility.⁴⁰⁵

Courts tend to privilege claims for injury to fetuses or babies over those to women. As Jamie Abrams has observed, in those rare instances where women have prevailed on claims brought for injuries suffered during childbirth, it is

401. See JAY KATZ, *THE SILENT WORLD OF DOCTOR AND PATIENT* 71–80 (1984) (discussing the difficulty of meeting informed consent standard through a critique of *Canterbury v. Spence*, 464 F.2d 772 (D.C. Cir. 1972)).

402. See *supra* Section I.A.2.d (discussing coercion by withholding treatment, manipulating information, or applying emotional pressure).

403. See Dray Amicus Brief, *supra* note 11, at 15 (discussing reluctance within both medicine and law to acknowledge that an unwanted and unconsented cesarean surgery constitutes an injury, “even when perfectly and expertly performed”).

404. See Lisa Zolotusky, *Analysis of the Primary Cesarean Delivery Rate: A Legal and Policy Approach*, 24 *HASTINGS WOMEN’S L. J.* 225, 229 (2013).

405. See *id.* (discussing difficulty of establishing required causal link between cesarean and injuries resulting from cesarean); see also *Albala v. City of New York*, 429 N.E.2d 786, 788–89 (N.Y. 1981) (noting the “cost of our placing physicians in a direct conflict between their moral duty to patients and the proposed legal duty to those hypothetical future generations outside the immediate zone of danger”). In *Albala*, five years after an abortion where the woman’s uterus had been perforated during the procedure, she gave birth to a baby with brain damage that allegedly resulted from the prior damage to her uterus. See *id.* at 787. The court denied a cause of action, expressing concern that doctors would refuse to treat women if they could be held liable for care that impacted subsequent fertility. See *id.* at 789.

typically through a fetal injury derivative claim.⁴⁰⁶ This focus on neonatal outcomes to the exclusion of maternal health outcomes means that when women “seek a legal declaration that their treatment was unacceptable, they are often told that they ‘have no damages’ and reminded that their babies are healthy.”⁴⁰⁷

The existence of a healthy baby is often used to deflect women’s claims of emotional harms suffered as a result of obstetric violence and birth trauma.⁴⁰⁸ Although the availability of tort remedies for the intentional or negligent infliction of emotional distress has gradually expanded, the law’s recognition of emotional suffering as compensable is still largely a “patchwork.”⁴⁰⁹ New York’s treatment of emotional distress claims arising from childbirth provides a helpful illustration of the limitations women confront when seeking recourse for emotional harms. In 2004, the New York Court of Appeals held in *Broadnax v. Gonzalez* that a woman could bring a medical malpractice claim after the stillbirth of her fetus, despite the absence of an independent physical injury to the woman.⁴¹⁰ The court reasoned that the old rule requiring a separate physical injury to the woman in order for her to recover for negligent infliction of emotional distress created a “logical gap,” depriving a certain class of injured parties any remedy.⁴¹¹

However, the following year, the court declined to extend *Broadnax*’s relaxation of the physical injury requirement in cases where the fetus survives birth. In *Sheppard-Mobley v. King*, a woman experienced an unsuccessful chemical abortion using methotrexate, and when the child was born suffering from fetal methotrexate syndrome, she alleged both physical and emotional injuries in a suit brought on behalf of herself and the infant.⁴¹² The court granted summary judgment for the defendants on the woman’s claim for emotional distress, observing that the *Broadnax* holding was narrow and did not allow her to recover for emotional injuries in the absence of her own physical harm.⁴¹³ Because the child could bring suit in *Sheppard-Mobley*, the logic that had supported easing the physical injury requirement in *Broadnax* did not apply.⁴¹⁴ In a subsequent case, the trial court interpreted *Broadnax* merely to “fill[] the

406. See Abrams, *supra* note 357, at 1980 (noting that even where a fetal injury derivative claim is available, counsel must “press heavily to maintain the viability of a stand-alone maternal harms claim”).

407. Dray Amicus Brief, *supra* note 11, at 2.

408. See *id.* at 33–34 (describing the way women’s emotional and physical health after a traumatic birth can be minimized by this refrain).

409. See Nancy Levit, *Ethereal Torts*, 61 GEO. WASH. L. REV. 136, 140–46 (1992) (tracing the evolution of infliction of emotional distress claims); see also Daniel Givelber, *The Right to Minimum Social Decency and the Limits of Evenhandedness: Intentional Infliction of Emotional Distress by Outrageous Conduct*, 82 COLUM. L. REV. 42, 43–62 (1982) (discussing the “evolving” nature of tort remedies for infliction of emotional distress).

410. See 809 N.E.2d 645, 649 (N.Y. 2004).

411. See *id.* at 648.

412. See 830 N.E.2d 301, 303 (N.Y. 2005).

413. *Id.* at 304.

414. *Id.* at 304–05.

gap,” permitting a cause of action where there would otherwise be none due to stillbirth or miscarriage.⁴¹⁵ However, the law still precludes recovery for a woman’s emotional distress resulting from mistreatment during childbirth in the absence of physical injury.⁴¹⁶ This means that the legal system provides no recourse for the emotional suffering of women who experience PTSD or other psychological trauma due to obstetric violence without physical injury.

In an unusual case from New Jersey, the court recognized emotional harms flowing from a case of medical neglect that ended in the baby’s death, requiring the mother to “prove that she suffered emotional distress so severe that it resulted in physical manifestations or that it destroyed her basic emotional security.”⁴¹⁷ In this case, a pregnant diabetic woman in her sixth month of pregnancy was unable to control her blood sugar level and, after a day-and-a-half of ignoring her calls, her obstetrician told her to go the hospital, where staff was unable to detect a fetal heartbeat.⁴¹⁸ Although she insisted the fetus was alive and moving inside her, the staff ignored her insistence, induced her labor with drugs, and left her alone to labor.⁴¹⁹ She vaginally delivered a breech baby, who fell on the bed and was announced dead, although was shortly thereafter determined to be alive.⁴²⁰ The baby’s condition subsequently deteriorated and she died several days later.⁴²¹ In considering whether the woman could recover for emotional distress without proving an independent physical injury, the court determined that “a mother and her fetus are so interconnected that they may be considered as one” and “an injury to the fetus could be viewed as supporting a direct parental claim for emotional distress,” obviating the need for proof of an independent physical injury.⁴²² While this decision seems to allow more leeway for women to bring claims for standalone emotional injuries, the court’s discussion of the maternal–fetal relationship suggests that it is imputing the fetus’ pain to the mother rather than recognizing her emotional injuries independently.⁴²³

3. Proving Harm

Even if a woman is able to allege a cognizable claim arising out of childbirth-related mistreatment, she may nevertheless face an uphill battle when trying to prove the existence of a compensable injury. The challenge of proving her injuries relates to: (a) the unreliability of juries in cases involving scientific and

415. See *Mendez v. Bhattacharya*, 838 N.Y.S.2d 378, 384–85 (N.Y. Sup. Ct. 2007) (providing cause of action for emotional distress where the infant died within minutes of birth as a result of malpractice prior to or during delivery, applying the logic of *Broadnax* despite the fact that the infant was born alive and lived for a few moments).

416. See, e.g., *Sheppard-Mobley*, 830 N.E.2d at 304.

417. *Carey v. Lovett*, 622 A.2d 1279, 1288 (N.J. 1993).

418. See *id.* at 1282–83.

419. See *id.* at 1283.

420. See *id.*

421. See *id.* at 1284.

422. *Id.* at 1286.

423. See *id.* at 1286–87; see also Donohoe, *supra* note 361, at 217.

medical knowledge; (b) difficulties related to causation in medical care; and (c) the inability of third parties to recognize the difference between the normal physical impact of childbirth and injuries related to unwanted and unconsented treatment.

a. Unreliability of Juries. When a plaintiff brings suit for childbirth-related harm, whether she prevails may depend on the ability of the jury to process complex medical information. Jurors are generally ill-equipped to evaluate expert testimony that pertains to whether the physician met the relevant standard of care or to whether a particular treatment caused harm.⁴²⁴ In jurisdictions where the traditional standard of care applies, juries may have difficulty parsing evidence from the scientific literature about what constitutes evidence-based maternity care.⁴²⁵ Especially on issues where highly-trained professionals disagree about a preferred course of treatment, lay juries are not in a position to determine medical responsibility reliably and accurately.⁴²⁶ As maternity care involves decision making that affects the health of both woman and fetus—sometimes requiring the balancing of risks and benefits to one or the other—how a physician makes such value-based decisions and counsels the patient may “render[] medical judgements subject to retrospective criticism by other practitioners who may weigh these values differently.”⁴²⁷ The influence of subjective values makes it even more difficult for juries to weigh expert testimony appropriately.⁴²⁸ Clouding the picture further, a general sense of sympathy regarding the physician’s concern for the fetus may interfere with the jury’s ability to appreciate the harms to the woman resulting from compelled treatment.⁴²⁹

424. See Johnson et al., *supra* note 381, at 1370–71 (noting that “jurors are exposed to the medical issues only once,” which “increases costs and the likelihood of inconsistency across different cases”).

425. See Leahy, *supra* note 398, at 1496 (explaining that use of expert testimony to inform jurors about appropriate medical practice is problematic because it is often “too complex and arcane” and “can result in a distorted picture of what constitutes proper medical care”).

426. See U.S. DEPT. OF JUSTICE, REPORT OF THE TORT POLICY WORKING GROUP ON THE CAUSES, EXTENT AND POLICY IMPLICATIONS OF THE CURRENT CRISIS IN INSURANCE AVAILABILITY AND AFFORDABILITY 63 (1986) (concluding that “[l]ay juries are a very poor mechanism for second-guessing the judgment of established mainstream scientific and medical views”); Johnson, *supra* note 381, at 1370 (noting the difficulty of evaluating technical evidence where “the appropriate treatment for a particular case is often debated within the medical field because medical science remains an art”).

427. Michael A. Haskel, *A Proposal for Addressing the Effects of Hindsight and Positive Outcome Biases in Medical Malpractice Cases*, 42 TORT TRIAL & INS. PRAC. L. J. 895, 932–33 n.188 (2007).

428. See Renee A. Forinash, *Analyzing Scientific Evidence: From Validity to Reliability with a Two-Step Approach*, 24 ST. MARY’S L.J. 223, 270 (1992) (discussing the risk that professional witnesses can present subjective opinions as scientific evidence). Juror values may also influence the impact of expert testimony in a birth injury case, especially to the extent that jurors are unable to comprehend certain scientific information and may substitute their own evaluation of the situation.

429. See Oberman, *supra* note 13, at 490–91 (discussing jury unwillingness to second-guess coercive physician behavior that ultimately results in healthy baby); *Jury Rules*, *supra* note 124 (noting the jury returned a verdict in favor of the physician in less than 20 minutes). A nurse who observed the proceedings was quoted as saying she believed the defendant “made the best choice for [the patient] and her baby.” *Id.*

b. Causation Difficulties. The requirement that plaintiffs prove the physician's breach of duty was the cause of the injury also hinders the effectiveness of tort claims for women harmed by obstetric violence. It can be difficult to prove that a medical procedure performed negligently or without informed consent was the proximate cause of a bad outcome leading to injury.⁴³⁰ For example, a woman who is coerced into a medical induction of labor without proper informed consent may develop high blood pressure from the procedure, which can lead to preeclampsia and emergency surgery. However, the woman could also have developed high blood pressure after the onset of spontaneous labor, making the causation element of a subsequent legal claim difficult to prove for women whose harm was caused by coerced treatment. In other situations, symptoms will not be apparent immediately and may not be identified until months or years after the birth, at which point a defendant might be able to point to intervening factors related to the physical work of childcare or other health conditions as possible causes of the woman's injury.

c. Failure to Recognize Injuries Resulting from Mistreatment. Many of the obstacles women face in bringing successful tort claims arising from mistreatment in childbirth stem from the inability of judges and juries to understand the difference between the normal physical impact of childbirth and injuries caused by unwanted, unconsented, and coerced treatment. Legal decision-makers tend to operate under a narrow conception of harm when considering obstetric violence-related claims. As discussed above, the fact that some injuries are emotional or psychological—and thus invisible to third parties—can obscure the reality and extent of the harm, especially when the jury views the existence of a healthy baby as an indication that the birth was successful.⁴³¹ It is certainly possible for birth injuries to result from uncomplicated vaginal deliveries without any mistreatment—unfortunate and sometimes unpreventable results of giving birth.⁴³² To the extent that judges and jurors have a general awareness that injury during childbirth is possible—and consider it even inevitable—it may be hard to grasp the difference between normal injuries and preventable

430. See Abrams, *supra* note 357, at 1982–83 (discussing the challenges of proving causation in maternal harms tort litigation).

431. See Friedland, *supra* note 332 (quoting former president of ACOG, James Breeden: “the end product is what you look for”) (internal quotations omitted); see also Baker, *supra* note 167, at 555 (“Barring some unspeakable maternal deformation, jurors look at the healthy child and ask the mother, quite cynically, ‘What are you complaining about?’”).

432. For example, some women experience serious vaginal tearing that requires postpartum surgery to repair. See Ashley Nelson, *An Unspoken Risk of Vaginal Birth*, N.Y. TIMES: MOTHERLODE (Oct. 24, 2012), <https://parenting.blogs.nytimes.com/2012/10/24/an-unspeken-risk-of-vaginal-birth/> [<https://perma.cc/B42L-Y3G2>] (discussing the diagnosis and symptoms of third-degree and fourth-degree vaginal tears). Other women endure tailbone injuries during vaginal delivery. See *Tailbone (Coccyx) Injury*, WEBMD, <https://www.webmd.com/fitness-exercise/tailbone-coccyx-injury#1-2> [<https://perma.cc/PYR8-FJWP>].

injuries that arise from abuse or coercion to accept unwanted treatment.⁴³³

Surgical procedures and other forms of medical intervention during childbirth are so common that preventable injuries flowing from them may be obscured by a sense that cesareans are mundane and without significant risk. The fact that nearly one-third of all babies are born by cesarean makes surgical birth seem normal and routine, and presumably “no more taxing on the mother than a vaginal birth.”⁴³⁴ In *Sceusa v. Mastor*, an appellate court in New York ruled that a woman could not establish an independent physical injury based on a cesarean surgery after one twin was stillborn and the other died shortly after birth.⁴³⁵ Having heard testimony that “a cesarean section is potentially a part of every childbirth process,”⁴³⁶ the court concluded that “a cesarean section does not constitute a physical injury but is a surgical procedure which is an acceptable method of delivery.”⁴³⁷

In *Miller v. Chalom*, an appellate court in New York was unwilling to recognize an episiotomy as an injury, even though the cut was performed crudely enough to cut off part of the baby’s left index finger.⁴³⁸ The fact that procedures like episiotomies and cesareans are routinely performed during labor—regardless of medical necessity or support in the scientific literature for their frequent use—precludes courts from understanding them as injuries in situations where they are unconsented or coerced.

Women who are harmed by provider mistreatment during childbirth are likely to encounter a variety of obstacles if they decide to bring a tort claim to recover for their injuries. Some find it difficult or impossible to secure legal representation because the lawyers they consult do not perceive their injuries to be compensable, or they are unwilling to take the risk of assuming the matter on a contingency fee basis. Women may also have trouble establishing a cognizable claim due to constrained notions of what constitutes harm under existing tort theories and the operation of the applicable standard of care. Furthermore, plaintiffs bringing maternal harm lawsuits must contend with the unreliability of juries in assessing complex expert testimony, the difficulty of establishing causation, and challenges associated with distinguishing the normal physical

433. See Dray Amicus Brief, *supra* note 11, at 15 (identifying the reluctance of attorneys’ to bring obstetric violence cases as “reflecting a cultural assumption that injury during childbirth is inevitable, and that a mother should be grateful to have a healthy baby”); *Global Momentum*, *supra* note 229 (“Trauma from being mistreated in maternity care is often blamed on trauma from the process of childbirth itself . . .”).

434. Donohoe, *supra* note 361, at 212.

435. See 525 N.Y.S.2d 101, 102 (N.Y. App. Div. 1998). The lack of independent physical injury meant that she could not recover for the negligent infliction of emotional distress. See *id.*

436. *Id.*

437. *Id.* at 103.

438. See 710 N.Y.S.2d 154, 156 (N.Y. App. Div. 2000). The opinion is silent about whether the requirement of informed consent was satisfied before the episiotomy was performed. Even if Stacey Murphy were one of the 59% of women who did not consent to their episiotomies, see Holdcroft, *supra* note 246, at 36, the court’s opinion suggests she would be precluded from recovery for trauma related to the episiotomy.

impact of childbirth from obstetric violence-related injuries. These barriers to tort recovery have prompted some women and their lawyers to look for other legal theories to support their claims. The next Section considers several alternative potential sources of protection for women harmed by mistreatment during childbirth.

B. OTHER SOURCES OF PROTECTION

Tort law in its current form is an inadequate tool for addressing the problem of obstetric violence, often leaving women who suffer mistreatment during childbirth excluded from the very system designed to remedy civil wrongs in the form of medical injuries. This section addresses the following areas of law and regulation that could supplant or supplement tort law in preventing and providing recourse for obstetric violence: (1) fiduciary law; (2) constitutional law; and (3) professional standard setting. Ultimately, like tort law, these alternatives have inherent weaknesses that render them insufficient for dealing with obstetric violence.

1. Fiduciary Law

The concept of a fiduciary relationship—and its attendant duties—could offer women some protection from mistreatment during childbirth. But although courts have recognized the physician–patient relationship as a fiduciary one, they have failed to enforce fiduciary principles in the form of legal regulation or enhanced supervision of physician conduct, undermining the potential of this legal principle to protect the rights of women in childbirth.

Broadly defined, a fiduciary is someone who is “entrusted with power or property to be used for the benefit of another and legally held to the highest standard of conduct.”⁴³⁹ The law regulates or supervises fiduciaries and imposes penalties for the breach of trust by a fiduciary.⁴⁴⁰ Emerging from the law of trust and agency, the concept of a fiduciary relationship has expanded significantly over the last century to include a variety of other actors, including doctors in relation to their patients.⁴⁴¹ In many ways, physician–patient relationships resemble traditional fiduciary relationships, including the fact that physicians have specialized knowledge and expertise, and control patient access to resources and information, as well as that physician–patient relationships are characterized by dependence that may grow even deeper as the relationships

439. Marc A. Rodwin, *Strains in the Fiduciary Metaphor: Divided Physician Loyalties and Obligations in a Changing Health Care System*, 21 AM. J. L. & MED. 241, 243 (1995); see also Oberman, *supra* note 13, at 457–58.

440. See Rodwin, *supra* note 439, at 247.

441. See Tamar Frankel, *Fiduciary Law*, 71 CAL. L. REV. 795, 795–96 (1983); Rodwin, *supra* note 439, at 242 (referring to the concept of physicians as fiduciaries for their patients as “a dominant metaphor in medical ethics and law today”).

continue.⁴⁴² Both federal and state courts recognize the fiduciary nature of the physician–patient relationship and have used the concept when analyzing doctors’ obligations to their patients.⁴⁴³

Fiduciary principles appear particularly well-suited to deal with physician–patient dynamics in maternity care that lead to mistreatment. When a woman refuses a cesarean or other intervention, subsequent forms of pressure applied to secure her consent should constitute a breach of fiduciary duty, as the physician elevates other interests above the patient’s stated interests.⁴⁴⁴ When doctors use the language of “maternal–fetal conflict” to discuss disagreement over treatment decisions, it should also be considered a breach of fiduciary duty, as the physician’s promotion of his treatment preference in the name of fetal health and safety means he has subordinated his duty to the woman in favor of the fetus.⁴⁴⁵ Similarly, a physician’s failure to disclose to his patient his belief that he has an independent obligation to the fetus as a second patient—and that he may use his authority to force her to receive treatment against her will based on that perceived obligation—could be considered a violation of fiduciary duty, as he has prioritized other interests above the interests of the patient for whom he has been entrusted to care. Further, the harm caused by a breach of fiduciary duty is similar to that caused by obstetric violence in that it “is less tangible and more dignitary in nature.”⁴⁴⁶ Indeed, like the expectations that attach to a fiduciary relationship, these harms impact essential human dignity.

Although the physician–patient relationship seems to fit the fiduciary model and has been recognized as such by courts, doctors have been “virtually exempt” from the regulation and oversight that usually applies to fiduciary relationships.⁴⁴⁷ In the medical context, courts apply fiduciary law principles in limited circumstances, such as the requirement that doctors not abandon their patients, keep information confidential, disclose financial interests in research, and obtain informed consent; in the informed consent context, application of fiduciary law principles is further limited, used only as a “vehicle for evaluating the physician’s technical clinical competence.”⁴⁴⁸ Additionally, in nonmedical

442. See Rodwin, *supra* note 439, at 245–46 (“The patient-physician relationship presupposes patients entrusting physicians to act on their behalf and physicians remaining loyal to their patients.”).

443. See, e.g., *Emmett v. E. Dispensary & Cas. Hosp.*, 396 F.2d 931, 935 (D.C. Cir. 1967) (“We find in the fiducial qualities of [the physician–patient] relationship the physician’s duty to reveal to the patient that which in his best interests it is important that he should know.”); *Hammonds v. Aetna Cas. & Sur. Co.*, 243 F. Supp. 793, 799 (N.D. Ohio 1965) (holding physicians owe patients “the duty of secrecy” and “the duty of undivided loyalty”); *Neade v. Portes*, 710 N.E.2d (Ill. App. Ct. 1999) (recognizing existence of fiduciary relationship between physician and patient); *Shadrick v. Coker*, 963 S.W. 2d 726, 736 (Tenn. 1998) (same); *Branom v. State*, 974 P.2d 335, 342 (Wash. Ct. App. 1999) (same).

444. See *Oberman*, *supra* note 13, at 477.

445. See *id.*

446. *Id.* at 490.

447. See *id.* at 458.

448. *Id.* at 459 (noting the absence of a “rich body of case law articulating broad fiduciary standards for physicians, the violation of which would constitute a distinct form of malpractice”); Rodwin, *supra*

contexts, a plaintiff alleging violation of fiduciary duty is not required to show injury resulting from the breach, but the equivalent rule does not exist in the medical context.⁴⁴⁹ This difference likely exists because licensing boards and medical associations have not defined the duties of a physician as a fiduciary and the legal consequences for violating such duties.⁴⁵⁰

The underdevelopment of fiduciary law as applied to physicians means that they are liable for breaches of fiduciary duty only when a breach also constitutes medical malpractice—leaving women with only the traditional tort framework to vindicate their rights.⁴⁵¹ Although doctors “pose as fiduciaries to their pregnant patients,” women are not able to hold them accountable under fiduciary law.⁴⁵² As such, harm related to the maternal-doctor conflict, the two-patient model of pregnancy, and various forms of coerced treatment are not understood as the breaches of fiduciary duty they represent.⁴⁵³

2. Constitutional Law

Although important constitutional values regarding autonomy and reproductive liberty are central to women’s freedom from coercive treatment during childbirth, the Constitution provides little direct protection to women harmed by obstetric violence. The U.S. Supreme Court has recognized that the right to be free from unwanted medical treatment is a protected constitutional liberty interest.⁴⁵⁴ In *Cruzan*, the Court based this liberty interest in the Fourteenth Amendment’s substantive due process protections, drawing on strong common law precedent in its analysis.⁴⁵⁵

Before *Cruzan*, the leading case on avoiding unwanted medical treatment had been *In re Quinlan*, in which the New Jersey Supreme Court recognized that competent patients enjoy a constitutional privacy right that protects their ability

note 439, at 247–48 (noting limited circumstances in which fiduciary law principles apply in the medical context); *see also* *Cobbs v. Grant*, 502 P.2d 1, 7–8 (Cal. 1972) (categorizing failure to obtain informed consent as a tort and not a breach of fiduciary duty); *Lockett v. Goodill*, 430 P.2d 589, 591 (Wash. 1967) (*per curiam*); *Miller v. Kennedy*, 522 P.2d 852, 860 (Wash. Ct. App. 1974), *aff’d* 530 P.2d 334 (mem) (1975) (*en banc*) (*per curiam*) (stating standard for breach of fiduciary duty by failing to receive informed consent as “would the patient as a human being consider this item in choosing treatment”).

449. *See* Oberman, *supra* note 13, at 490.

450. *See* Rodwin, *supra* note 439, at 249–51.

451. *See* Oberman, *supra* note 13, at 459. Michelle Oberman notes that the majority of maternal-doctor conflicts—involving divided loyalties and coercion, but not necessarily battery, negligence, or a violation of informed consent—“will be unattractive to most plaintiffs’ lawyers.” *Id.* at 491.

452. *Id.* at 482.

453. *Id.* at 459.

454. *Cruzan v. Director, Mo. Dep’t of Health*, 497 U.S. 261, 278 (1990).

455. *Id.* at 278 (“The principle that a competent person has a constitutionally protected liberty interest in refusing unwanted medical treatment may be inferred from our prior decisions.”). The Court noted that most courts had based a right to refuse medical treatment either “solely on the common law right to informed consent or on both the common law right and a constitutional privacy right.” *Id.* at 271.

to refuse unwanted treatment.⁴⁵⁶ Most reported unwanted treatment cases involve the termination of treatment that is sustaining the life of someone who is incapacitated or suffering from a terminal illness.⁴⁵⁷ However, in a more recent case, a federal district court applied *Cruzan* to the case of an elderly woman who, in the course of being transported to the hospital by paramedics, refused the administration of IV fluids.⁴⁵⁸ The paramedic nevertheless inserted the needle in her arm but missed the vein, causing injury.⁴⁵⁹ The court applied *Cruzan* to establish that the woman had a constitutional right to refuse treatment and that the paramedic's failure to honor her wishes "violated that clearly established right."⁴⁶⁰

Justice Brandeis famously articulated the constitutional principle underlying this jurisprudence when he referred to "the right to be let alone—the most comprehensive of rights and the right most valued by civilized men."⁴⁶¹ This concept lies at the heart of court-ordered cesareans and other physician–patient conflicts over unwanted medical treatment.⁴⁶² When invoked in situations of maternal–doctor treatment conflict, however, it becomes clear that the right is limited, at least for pregnant women. In fact, the reproductive liberty jurisprudence that has expanded women's ability to control when they become pregnant

456. See 355 A.2d 647, 662–65 (N.J. 1976), *cert. denied sub nom.* Garger v. New Jersey, 429 U.S. 922 (1976).

457. See, e.g., *Blouin v. Spitzer*, 356 F.3d 348 (2d Cir. 2004) (rejecting decedent's sister's claim that state attorney general unconstitutionally intervened in medical treatment decision concerning sister's terminal illness); *In re Christopher I*, 131 Cal.Rptr.2d 122 (Cal. Ct. App. 2003) (affirming order removing life support of child in persistent vegetative state); *In re Jane Doe, an Incapacitated Person*, 37 N.Y.S.3d 401 (N.Y. Sup. Ct. 2016) (denying injunction of withdrawal of life-sustaining treatment of incapacitated person).

458. See *Granato v. City & County of Denver*, No. 11-cv-00304-MSK-BNB, 2011 U.S. Dist. LEXIS 97007, *23 (D. Colo. Aug. 30, 2011).

459. See *id.* at *3–4.

460. *Id.* at *23.

461. *Olmstead v. United States*, 277 U.S. 438, 478 (1928) (Brandeis, J., dissenting) (cited with approval in *Whalen v. Roe*, 429 U.S. 589, 599–600 n.25 (1976)). The right includes "independence in making certain kinds of important decisions." *Whalen*, 429 U.S. at 599–600.

462. While the principle of being free from unwanted medical treatment pertains to a significant number of the situations constituting abuse and coercion described in Part I above, as the Fourteenth Amendment only applies to state actors, any application of this liberty interest would be limited to those situations involving state action, such as court-ordered cesareans or mistreatment perpetrated in a public hospital. See *Shelley v. Kraemer*, 334 U.S. 1, 13 (1948) ("[T]he principle has become firmly embedded in our constitutional law that the action inhibited by the first section of the Fourteenth Amendment is only such action as may fairly be said to be that of the States. That Amendment erects no shield against merely private conduct, however discriminatory or wrongful."). Courts are divided on whether the state action doctrine applies to private hospitals that engage in certain forms of federal involvement, such as receiving federal money for facility construction and modernization under the Hill-Burton Act, being regulated or inspected by a government entity, or leasing land from a government body. See generally *Action of Private Hospital as State Action Under 42 U.S.C.A. § 1983 or Fourteenth Amendment*, 42 A.L.R. Fed. 463 (1979) (summarizing cases where courts considered private hospitals to have engaged in state action by virtue of government involvement, as well as cases where no state action was found).

is often invoked to limit pregnant women's rights to make their own treatment decisions.

When confronted with a conflict over forced medical treatment, courts often turn to the Supreme Court's abortion rights doctrine. Although the cases beginning with *Roe v. Wade* clearly recognize a personal privacy right that protects women's decisions regarding pregnancy, this right is not absolute and is considered in relation to various state interests—including the state's interest in protecting potential life.⁴⁶³ Under *Roe* and its progeny, the state's interest in the fetus will outweigh the mother's liberty interest after viability, allowing states to restrict access to abortion after a certain point in pregnancy.⁴⁶⁴ Courts considering compelled cesareans have used this limitation on a woman's reproductive liberty interest to justify overriding a cesarean refusal, reasoning that after viability, the state's interest in protecting fetal life trumps a woman's constitutional rights.⁴⁶⁵ In *Pemberton*, one of the most prominent court-ordered cesarean cases, the court concluded that the "balance tips far more strongly in favor of the state" and its interest in protecting fetal life because the woman sought "only to avoid a particular procedure for giving birth, not to avoid giving birth altogether."⁴⁶⁶ It reasoned that bearing an unwanted child is a greater intrusion on a woman's constitutional interests than having a cesarean to deliver a wanted child, so the state's interest was even stronger relative to the woman's interest than it had been in *Roe*.⁴⁶⁷

Compelling someone to have an unwanted, major abdominal surgery implicates important constitutional interests, but when a court (or hospital) characterizes the woman as simply desiring to "avoid a particular procedure,"⁴⁶⁸ it minimizes the seriousness of the intervention and its constitutional dimensions. By focusing on the difference between whether a woman is carrying a wanted or unwanted pregnancy, the court downplays the extent of the intrusion the state seeks to compel.

Furthermore, the overall comparison between compelled treatment in pregnancy and abortion rights is a flawed one. In the abortion context, a woman seeks to terminate an unwanted pregnancy, meaning that her interests diverge from any interests of the fetus.⁴⁶⁹ By contrast, in the compelled treatment context, a woman who has decided to carry a pregnancy to term is making decisions with the fetus in mind—and arguably is the most motivated party to

463. See 410 U.S. 113, 154 (1973).

464. See *id.* at 163–64; *Planned Parenthood of Southeastern Pennsylvania v. Casey*, 505 U.S. 833, 846 (1992).

465. See, e.g., *Pemberton v. Tallahassee Mem'l Reg'l Med. Ctr., Inc.*, 66 F. Supp. 2d 1247, 1251–52 (N.D. Fla. 1999).

466. *Id.* at 1251.

467. See *id.* at 1251–52.

468. *Pemberton*, 66 F. Supp. 2d at 1251.

469. Scholars, ethicists, and advocates have engaged in lengthy debate about whether a pre-viability fetus has any interests at all and what the nature of those interests would be if they exist. See, e.g., Steinbock, *supra* note 362, at 149–50.

make the best possible decision to protect the fetus' health and well-being.⁴⁷⁰ Suggestions to the contrary, which characterize pregnant women as selfish for declining to follow the recommendations of their physicians, ignore the often complicated decision making process women undertake when balancing the risks and benefits of treatment. Application of abortion rights doctrine to the compelled treatment of pregnant women produces judicial reasoning that suggests women waive certain constitutional rights by choosing to carry to term.⁴⁷¹ The misplaced analogy to abortion both draws on and helps to perpetuate the concept of so-called maternal-fetal conflict, discussed above in section I.C.

Because this idea is so entrenched in clinical practice, as well as in legal and popular commentary about pregnancy decision making, it is unlikely that constitutional law will provide meaningful protection or recourse for women who experience obstetric violence.

3. Professional Standard Setting

Professional medical associations play an important role in establishing guidelines for clinical practice and ethical concerns faced by medical professionals. Organizations such as the American Medical Association (AMA) and ACOG have issued a number of practice bulletins and policy statements related to the compelled treatment of pregnant women and informed consent. Some professional standards are binding, while others may serve as evidence of the standard of care in lawsuits,⁴⁷² even though the entities issuing them are professional membership organizations, and not research or scientific entities.⁴⁷³ In general, these professional medical organizations have affirmed the autonomy of pregnant women and clarified the principle that compelled treatment is inappropriate in all but the most extreme circumstances.

470. This glosses over the fact that restrictive abortion laws have resulted in an increasing number of women forced to carry unwanted pregnancies to term. *See, e.g.*, Heather D. Boonstra, *Abortion in the Lives of Women Struggling Financially: Why Insurance Coverage Matters*, 19 GUTTMACHER POL'Y. REV. 46, 50 (2016) (noting that among women who seek an abortion and are subject to the Hyde Amendment because they obtain health insurance through Medicaid, one in four are unable to obtain the procedure due to lack of insurance coverage for abortion care); *An Overview of Abortion Laws*, GUTTMACHER INSTITUTE (Jan. 1, 2018), <https://www.guttmacher.org/print/state-policy/explore/overview-abortion-laws> [<https://perma.cc/QDT8-FHVV>] (summarizing various state laws that limit women's access to abortion care). But even women who would have preferred to terminate or who intend to place their baby with another family through adoption are highly motivated to maximize fetal well-being by making treatment decisions they consider to be in their best judgment.

471. *See* Oberman, *supra* note 13, at 475–76; Lynn M. Paltrow & Jeanne Flavin, Opinion, *Pregnant, and No Civil Rights*, N.Y. TIMES, (Nov. 7, 2014), <http://www.nytimes.com/2014/11/08/opinion/pregnant-and-no-civil-rights.html> [<https://nyti.ms/2jDuVnl>].

472. *See, e.g.*, Gallardo v. U.S., 752 F.3d 865, 880 (10th Cir. 2014) (discussing, approvingly, district court's reliance on ACOG bulletin in establishing standard of care in malpractice action); Bergman v. Kelsey, 873 N.E.2d 486, 503 (Ill. App. Ct. 2007) (acknowledging ACOG guidelines established standard of care in medical malpractice suit).

473. *See* ACOG: ABOUT US, <http://www.acog.org/About-ACOG/About-US> [<https://perma.cc/E9CY-2LFZ>] (noting that ACOG is a private “professional membership organization” with over 58,000 members).

The most prominent professional standard-setting body for the medical profession is the AMA's Council on Ethical and Judicial Affairs ("AMA Council"). A violation of the AMA Code of Ethics may result in discipline by the AMA and by county and state medical societies—in fact, some states expressly incorporate the AMA Code of Ethics into their medical practice acts.⁴⁷⁴ The AMA Council has not issued specific provisions regarding the compulsory treatment of pregnant women. It has, however, recognized the right of a patient to refuse medical treatment, even when it will result in a patient's easily avoidable death.⁴⁷⁵ The AMA Code of Ethics contemplates that different patients will reach different decisions based on their own personal values and circumstances.⁴⁷⁶ Courts have relied on this section of the AMA Code of Ethics in recognizing a patient's right to refuse treatment.⁴⁷⁷

In 1990, the AMA Board of Trustees ("Board") issued a policy statement opposing court-ordered treatment for pregnant women.⁴⁷⁸ According to the Board, the physician's duty is to provide the relevant information, "not to dictate the woman's decision."⁴⁷⁹ However, this statement was not issued as part of the Code of Ethics, so there is no mechanism to enforce physician compliance. Furthermore, the statement leaves room for intervention in the "exceptional circumstance" and seems to consider acceptable those interventions "in which a medical treatment poses an insignificant or no health risk for the woman, entails a minimal invasion of her bodily integrity, and would clearly prevent substantial and irreversible harm to her fetus."⁴⁸⁰

Shortly after Angela Carder's court-ordered cesarean made headlines in 1987, the ACOG Ethics Committee ("Committee") issued an opinion on informed consent and the use of force against women in maternity care.⁴⁸¹ Noting that court orders have a "destructive effect" on the physician-patient relationship, the Committee concluded that "resort to the courts is almost never justified."⁴⁸² Several decades later, the Committee issued an opinion entitled "Maternal Decision Making, Ethics, and the Law, which also left some room for an

474. See David Orentlicher, *The Influence of a Professional Organization on Physician Behavior*, 57 ALB. L. REV. 583, 592 (1994).

475. See AMA Council, AMA CODE OF MEDICAL ETHICS, OPINION NO. 8.08, in 14 AM. MED. ASS'N J. ETHICS 555, 555 (2012) ("The patient should make his or her own determination on treatment.").

476. See *id.* ("Rational, informed patients should not be expected to act uniformly, even under similar circumstances, in agreeing to or refusing treatment.").

477. See *In re Lyle A.*, 830 N.Y.S.2d 486, 493 (N.Y. Fam. Ct. 2006) (citing § 8.08 to conclude mother had right to withdraw consent to administration of psychotropic drug to minor patient).

478. Board, *Legal Intervention During Pregnancy, Court-ordered Medical Treatments and Legal Penalties for Potentially Harmful Behavior by Pregnant Women*, 264 JAMA 2663, 2670 (1990) ("Judicial intervention is inappropriate when a woman has made an informed refusal of a medical treatment designed to benefit her fetus.").

479. *Id.*

480. *Id.*

481. ACOG COMM. ON ETHICS, OPINION NO. 55, PATIENT CHOICE: MATERNAL-FETAL CONFLICT (1987), reprinted in 1 WOMEN'S HEALTH ISSUES 13 (1990).

482. *Id.*

exception.”⁴⁸³ As in Opinion 55, the Committee again articulated an exception to the general rule against compelled treatment, but indicated that it “cannot currently imagine” what type of “extraordinary circumstances” would justify resort to judicial authority to force treatment on behalf of the fetus.⁴⁸⁴ This begs the question of why the Committee felt it was necessary to recognize an exception that does not seem to exist in actual clinical practice, rather than announce its clear and unambiguous support for women’s autonomy. These ACOG guidelines lack an enforcement mechanism but may constitute evidence of the standard of ethical conduct in professional misconduct proceedings.⁴⁸⁵ Further, these guidelines “establish a profession’s collective vision of appropriate care and thus serve as a tacit indictment of practices that significantly diverge from these standards.”⁴⁸⁶

In addition to the professional guidelines on compelled treatment, several documents articulate physicians’ obligations regarding informed consent. The AMA Code of Ethics Opinion 8.08 acknowledges that “[t]he patient’s right of self-decision can be effectively exercised only if the patient possesses enough information to enable an informed choice.”⁴⁸⁷ It calls on physicians to discuss the risks and benefits of a proposed treatment, any alternatives regardless of cost or insurance coverage, the risks and benefits of any alternative treatments, and the risks and benefits of foregoing treatment.⁴⁸⁸ The Committee has also addressed informed consent in its Opinion No. 108 on the ethical dimensions of informed consent.⁴⁸⁹ Specifically, Opinion No. 108 states that informed consent “respects a patient’s moral right to bodily integrity [and] to self-determination regarding sexuality and reproductive capacities.”⁴⁹⁰

The professional standards issued by the AMA and ACOG regarding the right to refuse treatment and the ethical and legal demands of informed consent are directly relevant to obstetric violence. They strongly oppose most forms of compelled treatment, including those involving judicial intervention to overcome a woman’s refusal. They prioritize a patient’s right to direct the course of her medical treatment and set forth expectations regarding the scope of information disclosure necessary for a physician to obtain the informed consent of a patient. Nevertheless, women continue to report mistreatment during childbirth. This is likely because professional standards are only effective to the extent

483. ACOG COMM. ON ETHICS, COMMITTEE OPINION NO. 321: MATERNAL DECISION MAKING, ETHICS, AND THE LAW (2005).

484. *Id.* at 9.

485. *See* Orentlicher, *supra* note 474, at 592.

486. Oberman, *supra* note 13, at 492.

487. AMA CODE OF ETHICS, *Opinion No. 8.08*, *supra* note 475.

488. *See* AMA, INFORMED CONSENT, PATIENT PHYSICIAN RELATIONSHIP (2009), <http://www.ama-assn.org/ama/pub/physician-resources/legal-topics/patient-physician-relationship-topics/informed-consent.shtml> [<https://perma.cc/BMX2-FWNY>].

489. AMA COMM. ON ETHICS, OPINION NO. 108: ETHICAL DIMENSIONS OF INFORMED CONSENT 1 (1992).

490. *Id.*

they become a routine part of medical practice.⁴⁹¹ Physicians are more likely to adapt their practices to reflect clinical and ethical guidelines when those guidelines provide clear rules with a “credible threat of enforcement” from outside of the profession.⁴⁹² Finally, for professional standards to be effective tools to address misconduct, people must be willing to police their colleagues’ behavior, including allocating sufficient resources for professional licensing boards to investigate properly.⁴⁹³ Without these conditions, professional standard-setting cannot provide meaningful recourse for the mistreatment of women during childbirth.

CONCLUSION & RECOMMENDATIONS

The mistreatment and trauma that some childbearing women experience conflicts with dominant narratives about the birth of a new baby as a time filled with love and joy. Such mistreatment takes a variety of forms, ranging in nature, severity, and impact. At one extreme, there are cases of forced surgeries, unconsented medical procedures, and other physical, sexual, and verbal abuse. Women also face coercion by judicial intervention, by policies prohibiting VBAC, through the looming threat of child welfare intervention, or with the manipulation of information or application of emotional pressure. Finally, women are insulted, belittled, and dehumanized by health care providers they have trusted with their health and the well-being of their babies. The physical and emotional harms to women and their babies as a result of such conduct are profound and lasting.

The research on obstetric violence is thin; researchers and advocates must piece together a patchwork understanding of the phenomenon from existing sources of information about maternity care and the childbearing experience. It is clear, however, that existing law fails to prevent and redress harm resulting from the mistreatment of women in childbirth. Injured patients turn to the tort system to recover for harms resulting from negligence or the lack of informed consent, but several factors limit women’s ability to secure meaningful relief through tort.

First, women have difficulty securing counsel willing to represent them in lawsuits arising from mistreatment they suffered during childbirth. Second, recognized causes of action do not fit many types of childbirth-related mistreatment, and it is difficult to establish a cognizable claim alleging maternal injuries in the absence of death or severe injury to the baby. Third, women face an uphill battle getting juries to understand how the harms they have suffered differ from birth injuries that may occur in normal births, and the success of their claims depends on jurors’ ability to understand complicated medical information correctly. Beyond tort law, other legal and regulatory frameworks—including

491. See Oberman, *supra* note 13, at 496.

492. Orentlicher, *supra* note 474, at 596.

493. See *id.* at 604.

fiduciary law, constitutional law, and professional standard-setting—similarly fail to provide meaningful relief to women harmed by mistreatment in childbirth.

There are occasional successes where women who suffer harm by their health care providers during childbirth obtain meaningful relief through the court system. In August 2016, an Alabama woman named Caroline Malatesta received a \$16 million jury verdict for medical negligence and reckless fraud claims after suffering a pudendal neuralgia nerve injury from maternity care provided by a hospital that falsely marketed itself as a proponent of natural child birth.⁴⁹⁴ In 2012, an Illinois woman named Catherine Skol received a \$1.4 million jury award in her suit for gross negligence and negligent emotional distress, filed after her physician denied her an epidural, made her lie in an excruciating position for hours, told her to “shut up and push,” and sewed an episiotomy with an inappropriately large needle, telling her that “pain was the best teacher” for failing to notify the doctor that she was heading to the hospital.⁴⁹⁵

Both Rinat Dray and Kimberly Turbin filed lawsuits in state court after the surgeries they were forced to endure without their consent. Although the trial court dismissed Dray’s claims, her case is currently pending on appeal, including a cause of action under New York’s public health law—a version of a Patient’s Bill of Rights—which provides that patients have a right to refuse treatment.⁴⁹⁶ This is understood to be the first time an affirmative claim of this nature has been brought under the New York law, which will test whether it provides meaningful recourse for patients who suffer at the hands of their health care providers.⁴⁹⁷ It took Turbin so long to find an attorney, she initially filed *pro se* to preserve her claims before the statute of limitations expired.⁴⁹⁸ Although the Judge allowed her battery claim to proceed, Turbin ultimately decided to settle the case during mediation in order to avoid an additional three years of litigation.⁴⁹⁹ Supporters have expressed their outrage at what Dray and Turbin experienced, but what makes these cases truly exceptional is that they

494. See Kent Faulk, *Jury Awards Mountain Brook Couple \$16 Million in Case Against Brookwood Medical Center*, BIRMINGHAM REAL TIME NEWS (Aug. 6, 2016), http://www.al.com/news/birmingham/index.ssf/2016/08/jury_awards_mountain_brook_cou.html [<https://perma.cc/9AyA-WYTA>]. Malatesta was forcibly flipped from her hands and knees onto her back and restrained by nurses in a supine position; the nurses also held the baby inside the birth canal for six minutes until the doctor arrived, causing a serious nerve injury. *Id.*

495. *Out of the Jury Box: Illinois Jury Verdicts 2012/2013*, CHICAGO LAWYER, 2012, at 28, <http://cdn.coverstand.com/3287/141683/141683.1.pdf> [<https://perma.cc/M64Q-RUF7>]; see also Diaz-Tello, *Invisible Wounds*, *supra* note 9, at 60 n.5.

496. See Amended Verified Complaint at ¶¶ 22–28, *Dray v. Staten Island Univ. Hosp.*, No. 500510/14 (N.Y. Sup. Ct., complaint filed Apr. 11, 2014) (alleging violation of N.Y. Public Health Law 2803-c(3)(e)).

497. See Jessica Mason Pieklo, *Lawsuit: Staten Island Hospital Forced Patient Into C-Section Against Her Will*, REWIRE (May 13, 2014), <https://rewire.news/article/2014/05/13/lawsuit-staten-island-hospital-forced-patient-c-section-will/> [<https://perma.cc/AMJ8-YBJQ>].

498. See *supra* Section II.A.1.

499. See *Kimberly Turbin’s Forced Episiotomy Case: The Resolution*, IMPROVING BIRTH (Mar. 16, 2017), <http://improvingbirth.org/2017/03/kimberlys-case-the-resolution/> [<https://perma.cc/J8P4-FWFP>].

made it to court—with the help of willing legal counsel and community support—giving these women a chance to see their injuries redressed through the legal system. In this way, they do not represent the typical experience of women who have experienced of abuse, coercion, and disrespect during childbirth.

Advocacy is needed to make the tort system more responsive to women's claims of mistreatment during childbirth, so that women who do manage to get a fair hearing of their claims are not such rare exceptions. The following suggestions emerge from this Article's analysis of obstacles to recognition within the legal system of obstetric violence and its harms. They also provide a roadmap for future scholarship on the legal dimensions of obstetric violence.

First and foremost, obstetric violence will continue as long as doctors perceive that they risk liability by not intervening and thus force treatment on unwilling women out of fear of malpractice exposure. Courts must recognize and enforce informed treatment refusals as a necessary part of robust and meaningful informed consent. Amici in the *Dray* litigation made this point forcefully,⁵⁰⁰ but more voices are needed to explain this critical concept to courts and push for judicial enforcement of informed refusals. Until this liability pressure—or perception of liability pressure—is lessened, some maternity care providers will be uncomfortable or unwilling to accept and respect a patient's decision that departs from their own preferred approach.

Second, the project of professional standard-setting creates openings for advocacy to shape and refine the guidelines that provide the standard of care in tort cases. Existing AMA and ACOG opinions that reject judicially-compelled medical treatment for pregnant women and guide the clinical practice of obtaining informed consent should be held up as the profession's own reasoned wisdom about the dangers of forcing maternity care decision making through abusive and coercive means. These statements should be made relevant to courts, hospitals, and individual providers as important sources of protection for women, as well as for the integrity of the medical profession itself. There is also reason to think that targeted advocacy aimed at professional standard-setting bodies may result in new and revised clinical guidance that incorporates the best available evidence on common childbirth interventions. For example, in 2014, ACOG and the Society for Maternal-Fetal Medicine released a new first-stage labor guideline, which recognized that “allowing most women with low-risk pregnancies to spend more time in the first stage of labor may avoid medically unnecessary cesareans.”⁵⁰¹ It recommends specific changes in clinical practice, such as allowing prolonged early labor and longer active labor, making cervical dilation of six—instead of four—centimeters the start of active labor, and extending the time for the pushing phase.⁵⁰² The revised guideline better reflects

500. See *Dray* Amicus Brief, *supra* note 11, at 5–8.

501. *Nation's Ob-Gyn's*, *supra* note 197.

502. See *id.*

evidence regarding how labor unfolds and represents a victory for advocates seeking less restrictive clinical practices to enable labor to unfold with fewer interventions and less pressure for medically unnecessary cesareans due to “failure-to-progress.” Much work remains to be done before the professional standards setting forth clinical and ethical guidelines for obstetricians fully reflect evidence-based maternity care practices. A growing feminist bioethics literature is available to inform arguments on behalf of less interventionist, more patient-centered guidelines.⁵⁰³ Applying pressure on the professional organizations and their members to generate such guidelines is worthwhile, as those guidelines directly inform the standard of care applied to tort claims women bring for injuries resulting from mistreatment during childbirth.

Finally, the success of all efforts to prevent and remedy obstetric violence rely on the collection of more data about women’s experiences of abuse, coercion, and disrespect in childbirth. Advocates need more data about the frequency of mistreatment in maternity care clinical settings and long-term study of the extent to which mistreatment leads to physical and emotional injuries. Academic researchers should help satisfy this need by taking the existing patchwork of information about mistreatment in childbirth and designing studies to examine the impact of obstetric violence on women, babies, families, and the medical profession. Consumer organizations dedicated to maternity care reform should continue their efforts to collect powerful qualitative data about women’s experiences and the profound consequences that mistreatment has on their lives. Together, these forms of advocacy will lay the groundwork for shifting maternity care culture and fulfilling the promise of tort law for women harmed by provider mistreatment during childbirth.

503. See, e.g., Jan Crosthwaite, *Gender and Bioethics*, in *A COMPANION TO BIOETHICS: SECOND EDITION* 47–48 (Kuhse & Singer eds., 2009); Mary. C. Rawlinson, *The Concept of a Feminist Bioethics*, 26 *J. MED. & PHIL.* 405, 413–14 (2001).