

## Notes

# **A VIOLENT BIRTH: REFRAMING COERCED PROCEDURES DURING CHILDBIRTH AS OBSTETRIC VIOLENCE**

MARIA T.R. BORGES<sup>†</sup>

### ABSTRACT

*In the United States, women are routinely forced to undergo cesarean sections, episiotomies, and the use of forceps, despite their desire to attempt natural vaginal delivery. Yet, the current American legal system does little to provide redress for women coerced to undergo certain medical procedures during childbirth. Courts and physicians alike are prepared to override a woman's choice of childbirth procedure if they believe this choice poses risks to the fetus, and both give little value to the woman's right to bodily autonomy. This Note proposes a solution for addressing the problem of coerced medical procedures during childbirth by importing a framework created in Venezuela and Argentina that characterizes this issue as "obstetric violence." First, this Note contains an overview of the shortcomings of the existing American legal framework to address the problem. Second, it explains the advantages of the obstetric violence framework and argues that its adoption in the United States would address many of the failures of the existing system. And third, this Note introduces a few legislative and litigation strategies that can be used to implement this framework in the United States and briefly addresses some of the challenges these strategies may pose.*

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<sup>†</sup> Duke University School of Law, J.D. expected 2018, LL.M. in International & Comparative Law expected 2018; Universidade Federal de Minas Gerais, LL.B., 2015.

*Patient:* What do I do?

*Dr. Spenser:* Nothing, dear! You're not qualified!<sup>1</sup>

## INTRODUCTION

In 2014, the nongovernmental organization (NGO) Improving Birth started a social media campaign calling on women to break the silence on their experiences of coercion and abuse during childbirth.<sup>2</sup> The #BreaktheSilence campaign collected over 150 accounts from American women who were victimized by doctors, midwives, or nurses during labor.<sup>3</sup> Reports included accounts of emotional abuse,<sup>4</sup> disregard of the laboring woman's pain,<sup>5</sup> coerced procedures,<sup>6</sup> and even physical violence.<sup>7</sup> This is not a uniquely American problem. The list of abuses and disrespect that women all across the globe face during childbirth is even longer, and includes "the denial of treatment, . . . invasive practices, . . . detention in facilities for failure to pay, dehumanizing or rude treatment and discrimination or humiliation based on race, ethnic or economic background, age, HIV status, [and] gender non-conformity, among others."<sup>8</sup>

In the past three decades, mobilization to address abuse during childbirth has increased among NGOs and international human rights bodies. This mobilization grew from the findings of medical studies in the 1980s and 1990s that investigated the conditions of obstetric care

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1. MONTY PYTHON'S THE MEANING OF LIFE (Universal Pictures 1983). The relevant excerpt can be found online and is highly recommended. See Monty Python, *Birth - Monty Python's The Meaning of Life*, YOUTUBE (Nov. 13, 2008), <https://www.youtube.com/watch?v=NcHdF1eHhg>.

2. Improving Birth, #BreaktheSilence, FACEBOOK, <http://on.fb.me/1T0Wbo8> [<https://perma.cc/3PFH-2TAV>]; see also Farah Diaz-Tello, *Invisible Wounds: Obstetric Violence in the United States*, 47 REPROD. HEALTH MATTERS 56, 57 (2016) (discussing accounts in #BreaktheSilence and other statistics).

3. Improving Birth, *supra* note 2.

4. *Id.* ("I still can't trust that my cesarean was 'necessary' after 18 hours of abusive language, bullying & starvation.")

5. *Id.* ("My client had a fast, drug-free birth, caught by a nurse. The [doctor] arrived late, and began repairing her perineum without local anesthesia. He said, 'You want a birth with no pain meds, this is what you get.'")

6. *Id.* ("My vagina was cut without my consent!")

7. *Id.* ("My client had a cervical exam that was so violent, she cried in pain while begging the ObGyn to stop. He wouldn't.")

8. Women's Glob. Network for Reprod. Rights, *Obstetric Violence*, MAY28.ORG, <https://www.may28.org/obstetric-violence> [<https://perma.cc/3999-B5KS>].

around the world.<sup>9</sup> In Latin America, this increased awareness of the pervasiveness of abusive practices in obstetric and gynecological care gave rise to strong grassroots childbirth rights advocacy movements. One of their first victories was the adoption of a legal framework in Argentina, which granted women the right to a humanized childbirth experience in 2004.<sup>10</sup> This framework introduced a human rights-based approach to childbirth<sup>11</sup> that was meant to ensure to women a more dignified and respectful experience in facility-based childbirth.<sup>12</sup> A bigger victory came a few years later, in 2007, when Venezuela passed a law to create a comprehensive framework to protect the “right of women to a life free of violence,” which included specific provisions to address the abuse and disrespect of medical professionals against pregnant women.<sup>13</sup> This law starts with a set of definitions of types of gender-based violence that women experience and includes “obstetric violence” in this roll, defined as

the appropriation of the body and reproductive processes of women by health personnel, which is expressed as dehumanized treatment, an abuse of medication, and to convert the natural processes into

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9. Silvia Bellón Sánchez, *Obstetric Violence: Medicalization, Authority Abuse and Sexism within Spanish Obstetric Assistance. A New Name for Old Issues?* 41 (Aug. 2014) (unpublished Master’s thesis, Utrecht University) (on file with the *Duke Law Journal*) (“Since the 1990s several authors in Latin-America began to study the problems that women face in the obstetric units of hospitals from a gender perspective and as violations of reproductive rights.”).

10. Law No. 25929, Aug. 25, 2004, [CXII-30489] B.O. 1 (Arg.) [hereinafter Law No. 25929].

11. See Siri Gloppen, Malcolm Langford, Alicia Yamin, Roberto Iunes, Leonardo Cubillio & Maria-Luisa Escobar, *Operationalizing a Rights-Based Approach to Health Service Delivery*, CHRISTIAN MICHELSEN INST., <https://www.cmi.no/projects/1791-operationalizing-a-rights-based-approach-to-health> [<https://perma.cc/E5XR-HPX3>] (“A rights-based approach means integrating human rights norms and principles in the design, implementation, monitoring, and evaluation of health-related policies and programs.”).

12. See Law No. 25929, *supra* note 10, art. 2(b) (guaranteeing to women the right to be treated respectfully throughout pregnancy and childbirth).

13. See generally *Ley Orgánica sobre el Derecho de las Mujeres a una Vida Libre de Violencia* arts. 15(13), 51, Mar. 19, 2007, 38678 *Boletín Oficial* 353348 (Venez.) [hereinafter *Law on the Right of Women to a Life Free of Violence*] (defining obstetric violence as a subset of violence against women). A similar law was adopted in Argentina in 2009, although it does not criminalize the practice, but instead establishes a number of administrative proceedings to give recourse to women. Law No. 26485, Mar. 11, 2009, [CXVII-31632] B.O. 1 (Arg.) [hereinafter Law No. 26485]. But “despite the passage of [the] 2004 statute guaranteeing the rights of birthing women and [the] 2009 statute prohibiting obstetric violence, courts adjudicating tort suits continue to rely on a malpractice analysis rather than the norms of humanized childbirth and freedom from violence.” Diaz-Tello, *supra* note 2, at 62.

pathological ones, bringing with it loss of autonomy and the ability to decide freely about their bodies and sexuality, negatively impacting the quality of life of women.<sup>14</sup>

On its face, “obstetric violence” seems to be just a new term for the old problem of disrespect and abuse in obstetric and gynecological care.<sup>15</sup> But the innovation introduced by this definition is an express recognition of how individual instances of obstetric abuse are part of the broader problem of gender-based violence because they “bring[] with [them] loss of autonomy and the ability to decide freely about their bodies and sexuality.”<sup>16</sup> This innovation is important because abuse in obstetric and gynecological care is a type of violence often left out of the conversation about violence against women.<sup>17</sup> Moreover, the definition of obstetric violence as a subset of gendered violence highlights that it is also a type of structural violence and, therefore, needs to be addressed systemically.<sup>18</sup>

The Venezuelan law criminalizes several types of obstetric violence. One is the performance of cesarean sections without the informed and voluntary consent of the patient.<sup>19</sup> Another is the practice of artificially accelerating labor without informed and voluntary consent.<sup>20</sup> Globally, these are two of the most common types of procedures that women are coerced to undertake<sup>21</sup> and that

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14. Law on the Right of Women to a Life Free of Violence, *supra* note 13, art. 15(13), translated in Rogelio Pérez D’Gregorio, *Obstetric Violence: A New Legal Term Introduced in Venezuela*, 111 INT’L J. GYNECOLOGY & OBSTETRICS 201, 201 (2010).

15. As one author noted,

Since the 1990s several authors in Latin-America began to study the problems that women face in the obstetric units of hospitals from a gender perspective and as violations of reproductive rights. For the most part of these works do not employ the term “obstetric violence”, but the range of practices studied mirror practices covered by the recent usage of the concept.

Sánchez, *supra* note 9, at 41 (citations omitted).

16. Law on the Right of Women to a Life Free of Violence, *supra* note 13, art. 15(13).

17. Women’s Glob. Network for Reprod. Rights, *supra* note 8.

18. Diaz-Tello, *supra* note 2 at 62 (“Individual tort litigation is necessary, but not sufficient, to the task of ending obstetric violence. True transformation will also require provider education and greater connection between health infrastructure and civil society advocacy to address harmful gender norms.”).

19. Law on the Right of Women to a Life Free of Violence, *supra* note 13, art. 51(5).

20. *Id.* art. 51(4).

21. Although there seems to be no statistical research yet at this point, the conclusion is supported by anecdotal evidence. See *Improving Birth*, *supra* note 2. The World Health

contribute to the excessive medicalization of childbirth.<sup>22</sup> The medicalization of childbirth is linked to an increasing pathologization of pregnancy and birth, transforming a natural process experienced by women into a clinical problem.<sup>23</sup>

In the American context, the use of coercive medical procedures during childbirth has a long history and examples are quite severe. In the 1950s, a report published in the *Ladies' Home Journal* shocked the nation<sup>24</sup> by exposing the inhumane treatment suffered by women in maternity wards around the country.<sup>25</sup> Among the testimonies, women reported coerced use of medication during labor and unconsented resort to forceps to accelerate birth.<sup>26</sup> Fast-forward over fifty years and the situation remains largely similar, despite the modernization of childbirth practices.<sup>27</sup> In 2014, for example, a physician was caught on camera performing an episiotomy<sup>28</sup> despite the patient's shouts ordering him to stop and denying consent to the procedure.<sup>29</sup> Because the video went viral, media attention to the case was hyped, and the physician was ultimately forced to hand over his medical license in

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Organization (WHO) has been fighting the excessive medicalization of the childbirth process since 1985. See generally World Health Org., *Appropriate Technology for Birth*, 326 LANCET 436 (1985).

22. "Medicalization describes the expansion of medical jurisdiction into the realms of other previously nonmedically defined problems . . ." Heather A. Cahill, *Male Appropriation and Medicalization of Childbirth: An Historical Analysis*, 33 J. ADVANCED NURSING 334, 338 (2001).

23. See *id.* at 339 (examining studies of how medicalization leads to a pathologization of childbirth).

24. Henci Goer, *Cruelty in Maternity Wards: Fifty Years Later*, 19 J. PERINATAL EDUC. 33, 33 (2010).

25. See generally Gladys Denny Shultz, *Journal Mothers Report on Cruelty in Maternity Wards*, 75 LADIES' HOME J. 44 (1958) (detailing individual cases of maternity ward abuse and mistreatment of patients).

26. *Id.* at 44 ("They give you drugs, whether you want them or not, strap you down like an animal. Many times the doctor feels too much time is being taken up and he either forces the baby with forceps or slows things up.").

27. Goer, *supra* note 24, at 33.

28. "An episiotomy is a surgical cut in the perineum, the musculature between the vagina and the anus, for the purpose of widening the vaginal opening." 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, 576 (2010).

29. *Kimberly Turbin's Forced Episiotomy Case: The Resolution*, IMPROVING BIRTH (Mar. 16, 2017), <http://improvingbirth.org/kimberlys-case-the-resolution> [https://perma.cc/92LG-GQYT]. The original video can still be found online. Rios jahir, *Birth Video Epidural and Episiotomy*, YOUTUBE (Aug. 27, 2014), <https://youtu.be/ICfXxtoAN-I>.

order to reach a settlement with the victim.<sup>30</sup> But many of these cases do not reach the legal system. Some examples include a seventeen-year-old who had a fourth degree episiotomy<sup>31</sup> despite her express pleas that she did not want one;<sup>32</sup> a mother of six children who was forced to induce labor despite the increased risks for both her and the fetus;<sup>33</sup> and a mother of twins who was forced into a vacuum-assisted delivery despite her uncomplicated vaginal labor because she was taking up the operating room.<sup>34</sup> These represent a handful of horror stories collected by Human Rights in Childbirth, an NGO dedicated to realizing women's rights in childbirth, and its partner organizations.<sup>35</sup> And the anecdotal cases show only the tip of the iceberg, because abuse during pregnancy and childbirth is underreported<sup>36</sup> and largely unexplored by medical researchers. The few existing reports have also found increasing evidence of coerced procedures during labor in the United States.<sup>37</sup>

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30. *Kimberly Turbin's Forced Episiotomy Case: The Resolution*, *supra* note 29.

31. A fourth degree episiotomy “extends through the rectum and cuts through skin, muscle, the rectal sphincter, and anal wall.” *Episiotomy*, ENCYCLOPEDIA SURGERY, <http://www.surgeryencyclopedia.com/Ce-Fi/Episiotomy.html> [<https://perma.cc/YAE7-MKTL>].

32. Brief of Human Rights in Childbirth et al. as Amicus Curiae in Support of Plaintiff at A-11–A-13, *Dray v. Staten Island Univ. Hosp.*, No. 500510/2014 (N.Y. Sup. Ct. filed Jan. 22, 2014) [hereinafter HRC Amicus Curiae] (relying on collected testimony to discuss emotional implications of obstetric violence). Human Rights in Childbirth is an NGO whose purpose is to promote women's rights in childbirth across the globe. HUMAN RIGHTS IN CHILDBIRTH, <http://www.humanrightsinchildbirth.org> [<https://perma.cc/9CAW-T2VS>].

33. HRC Amicus Curiae, *supra* note 32, at A-16 to A-19.

34. *Id.* at A-26 to A-27.

35. *See generally id.* (detailing various accounts of victims abused during maternity procedures).

36. 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, 304 (2013) (“Most cases involving hospital detentions and compelled treatment do not result in reported opinions or media coverage, making it unlikely that such cases would be identifiable . . .”).

37. *See* DIANA BOWSER & KATHLEEN HILL, U.S. AGENCY FOR INT'L DEV., EXPLORING EVIDENCE FOR DISRESPECT AND ABUSE IN FACILITY-BASED CHILDBIRTH 10 (2010) (“Reports from Kenya, the United States, Dominican Republic, and Peru document women's stories of feeling coerced into a cesarean section.” (internal citations omitted)); Diaz-Tello, *supra* note 2, at 57 (“[M]ore than half [of surveyed doulas, childbirth educators, and labor and delivery nurses] had witnessed a physician engage in a procedure explicitly against a woman's will, and nearly two-thirds had witnessed providers ‘occasionally’ or ‘often’ engage in procedures without giving a woman a choice or time to consider the procedure.”).

Despite the gravity of the problem, the American legal system does not treat the issue adequately. Courts have been somewhat reluctant to recognize the extent of the harm generated by coerced childbirth procedures.<sup>38</sup> Civil liability claims of medical battery and lack of informed consent in this context are not common when only the mother has suffered harm, primarily because recovery in such cases is difficult at best.<sup>39</sup> Criminal prosecutions of physicians in the context of forced obstetric care are basically nonexistent. Not only that, courts have in some instances overridden the woman's decision and allowed doctors to perform cesarean sections and other invasive procedures on the grounds that the woman's right to decide her course of treatment needs to be weighed against the state's interest in protecting fetal potential for life.<sup>40</sup> Courts have done all this without recognizing that coerced procedures in childbirth are linked to a broader context of violence against women.

This Note proposes a strategy to address these shortcomings in the existing American legal system by importing to the United States the obstetric violence framework<sup>41</sup> adopted in Venezuela and Argentina. This proposal is not to transplant the actual legal text adopted in Venezuela and Argentina to the United States. Rather, the proposal is to import the concept of "obstetric violence" to the American legal system and, from there, to develop a civil and criminal liability regime to address the problem, taking into account the specificities of the American legal system. The details of this new legal framework, however, are beyond the scope of this Note. Here, the proposal is to adopt the concept of obstetric violence in an effort to recognize first,

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38. For a discussion of how courts have failed to recognize that women are hurt by coerced procedures during childbirth, see *infra* Part I.A.

39. For a discussion of why courts rarely allow recovery for psychological trauma and recovery in cases of actual harm because the injury resulted from a natural bodily process, see *infra* Part I.B.

40. For a discussion of how courts have used the state's interest in protecting the fetus potential for life to coerce women into undergoing surgery, see *infra* Part I.A.

41. Here, the expression "obstetric violence framework" is used to refer to introducing a legal concept that can give rise to criminal and civil liability independent of traditional frameworks that address medical battery and malpractice. As such, this Note does not propose the elements for a crime of obstetric violence or for a claim for an independent tort of obstetric violence. Rather, the proposal here is for the adoption of a framework based on the concept of obstetric violence that would be compatible with existing particularities of the American legal system, while disentangling the issue of obstetric violence from medical battery and malpractice.

that coerced procedures harm women by taking away their right to refuse treatment and subjugating their well-being to the potential life of the fetus; second, that the problem is part of a broader context of violence against women; and third, that it should not be entangled with abortion jurisprudence.

Although the obstetric violence framework can and should eventually be used to address other practices of abuse during pregnancy and childbirth, this Note's proposal is limited to using the concept to define the legal treatment of coerced procedures during childbirth. The reason for this limitation<sup>42</sup> is twofold. First, although the phenomenon of "obstetric violence" is widely recognized as a problem impacting women's health, there is no consensus on what practices actually constitute incidences of obstetric violence.<sup>43</sup> Coerced medical procedures are among the few practices that are widely regarded as instances of abuse.<sup>44</sup> Second, addressing coerced procedures in childbirth poses a particular challenge to courts and legislators because the legal implications of recognizing a right for women in childbirth to be free from forced medical procedures implicates the state's interest in protecting fetal potential for life. This

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42. This is not to say that the obstetric violence framework is not appropriate to deal with other types of abuse and disrespect during childbirth. For example, there are similar situations during pregnancy in which courts and physicians have forced women to undergo invasive procedures to allow treatment of the fetus. This type of coerced fetus treatment can (and should) be addressed by the obstetric violence framework and essentially the same arguments developed here for coerced childbirth procedures would apply.

43. *The Prevention and Elimination of Disrespect and Abuse During Facility-Based Childbirth*, WORLD HEALTH ORG. (2015) [hereinafter WHO Statement], [http://apps.who.int/iris/bitstream/10665/134588/1/WHO\\_RHR\\_14.23\\_eng.pdf?ua=1&ua=1](http://apps.who.int/iris/bitstream/10665/134588/1/WHO_RHR_14.23_eng.pdf?ua=1&ua=1) [<https://perma.cc/BW3L-7772>] (recognizing that there needs to be a better understanding of the instances of abuse during pregnancy and labor and making a call to action for research "to better define, measure and understand disrespectful and abusive treatment of women during childbirth, and how it can be prevented and eliminated"). For attempts to define disrespect and abuse in childbirth, see Lynn P. Freedman et al., *Defining Disrespect and Abuse of Women in Childbirth: A Research, Policy and Rights Agenda*, 92 BULL. WORLD HEALTH ORG. 915, 915 (2014), <http://dx.doi.org/10.2471/BLT.14.137869> [<https://perma.cc/HM23-4UUY>] (proposing a definition of disrespect and abuse in childcare that "would capture both individual disrespect and abuse (i.e. specific provider behaviours experienced or intended as disrespectful or humiliating, such as slapping or scolding of women) and structural disrespect and abuse").

44. See, e.g., WHO Statement, *supra* note 43 ("Reports of disrespectful and abusive treatment during childbirth in facilities have included . . . coercive or unconsented medical procedures . . . , [and] failure to get fully informed consent . . .").



interplay is absent regarding incidences of sexual, physical, and verbal abuses during birth.

Part I contains an overview of the shortcomings of the existing American legal framework to address the issue. Part II expands on the innovations introduced by the obstetric violence framework and makes the argument for its adoption to deal with issues of coerced medical treatment in the United States. Part III briefly introduces an agenda for implementing this framework in the United States.

#### I. THE SHORTCOMINGS OF THE LEGAL TREATMENT OF COERCED PROCEDURES IN CHILDBIRTH IN THE UNITED STATES

The existing legal framework in the United States inadequately redresses obstetric violence. For one, it treats the problem as just another subset of medical torts,<sup>45</sup> even though the problem has structural, gender-based origins that cannot be resolved merely through tort litigation.<sup>46</sup> This means that there is little recognition of the need to address systemically the problem of abuse during childbirth and its implications for women's equality in society. Moreover, the tort system itself is inadequate because it places little to no value on women's suffering from coerced procedures or an invasion of their rights to refuse a procedure. The system is also flawed in that it perpetuates retrograde ideals of motherhood and a medicalized view of childbirth. Worse, it treats pregnancy and motherhood as excuses to limit women's right to refuse treatment, entangling the discussion with the abortion debate and failing to recognize how courts contribute to diminishing the agency of women.<sup>47</sup>

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45. Although, in theory, more egregious cases could constitute assault or battery under existing criminal laws, there are no accounts of prosecution in relevant legal scholarship brought against physicians who performed unconsented medical interventions on their laboring patients. It is impossible to know if the absence of such accounts is due to a lack of reporting, prosecutors' resistance in bringing cases against physicians, *nolo contendere* plea deals, or court dismissals.

46. Diaz-Tello, *supra* note 2, at 62 ("Individual tort litigation is necessary, but not sufficient, to the task of ending obstetric violence. True transformation will also require provider education and greater connection between health infrastructure and civil society advocacy to address harmful gender norms."). For a more detailed argument of the link between obstetric violence and gender, see *infra* Part II.B.

47. For further discussion, see *infra* Part I.C.

A. *The Shortcomings of Medical Malpractice and Battery Cases Involving Coerced Procedures*

In theory, women coerced to undergo certain procedures during childbirth should be allowed to recover under medical malpractice or battery claims. However, trial courts are rather reluctant to allow recovery. For example, in *Curtis v. Jaskey*,<sup>48</sup> a trial court originally granted summary judgment for the physician-defendant on a claim involving medical battery and found that the emergency exception allowed him to bypass patient Rachel Curtis's express refusal of an episiotomy.<sup>49</sup> The Appellate Court of Illinois reversed the ruling, however, clarifying that "in the face of a clear refusal to submit to a medical procedure, the emergency exception is inapplicable."<sup>50</sup>

Similarly, in *Dray v. Staten Island University Hospital*,<sup>51</sup> plaintiff Rinat Dray sued her doctor for performing a cesarean section despite her express refusal of the surgery.<sup>52</sup> Although an applicable New York statute gave patients the unrestrained right to refuse treatment, the trial court judge refused Dray's motion for summary judgment, holding that the right of pregnant women to refuse medical treatment was not absolute because of the state's interest in protecting the viable fetus.<sup>53</sup>

When cases do actually reach a jury, the results can be rather disappointing there too. In *Mitchell v. Brooks*,<sup>54</sup> a woman alleged that she was coerced into consenting to a cesarean section under threat that the hospital would take her child away from her. She lost a case for medical battery against the hospital and her attending physician after jury deliberations that took just 20 minutes.<sup>55</sup>

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48. *Curtis v. Jaskey*, 759 N.E.2d 962 (Ill. App. Ct. 2001).

49. *Id.* at 964. In the case, there was no dispute that the episiotomy was performed in an emergency situation. *Id.*

50. *Id.* at 968.

51. *Dray v. Staten Island Univ. Hosp.*, No. 500510/2014 (N.Y. Sup. Ct. filed Jan. 22, 2014).

52. HRC Amicus Curiae, *supra* note 32, at 1.

53. Order dated May 15, 2015 at 12, *Dray*, No. 500510/2014 (No. 58) ("[T]he state interest in the well being of a viable fetus is sufficient to override a mother's objection to medical treatment, at least where there is a viable full term fetus and the intervention itself presents no serious risk to the mother's well being."). Plaintiff has appealed this decision. For an analysis of why this balancing is problematic, see *infra* Part I.C.

54. *Mitchell v. Brooks*, No. CL13001773-00 (Va. Cir. Ct. filed Aug. 29, 2013).

55. *Diaz-Tello*, *supra* note 2, at 58–59.

Even the decisions that grant recovery to women generally only allow recovery of the difference between the fees for the procedure and extended recovery.<sup>56</sup> The first problem with this standard is that “the ultimate dollar value of these claims is relatively small, which in turn disincentivizes plaintiffs’ lawyers to pursue these causes of action.”<sup>57</sup> This constitutes a barrier to access that prevents a legal remedy even before courts have a chance to examine the claim.<sup>58</sup> The second problem is that this standard may bar recovery altogether. For example, if a woman is not given the choice of a cesarean,<sup>59</sup> she likely will not get any damages because vaginal delivery is cheaper than a cesarean<sup>60</sup> and any tear or complication from vaginal delivery is likely unrecoverable.<sup>61</sup> The third, and more pressing, problem with this recovery standard is that it fails to recognize the gravity of a coerced medical procedure because it ignores the *actual* injury.<sup>62</sup> A birthing

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56. Jamie R. Abrams, *Distorted and Diminished Tort Claims for Women*, 34 CARDOZO L. REV. 1955, 1980 n.161 (2013) (“[T]he injuries in an unnecessary cesarean-section case . . . include the increased cost of the procedure itself, as well as longer maternal recovery time.”).

57. *Id.* at 1979–80; Diaz-Tello, *supra* note 2, at 59 (“[A]bsent an injury to the baby or an extraordinary injury to the mother (beyond an unwanted or even unconsented medical invasion), the monetary value ascribed to harm to women during birth is low . . . providing little incentive for attorneys from taking cases on a contingent fee basis.”).

58. Abrams, *supra* note 56, at 1979.

59. Even without medical recommendation, the practice of cesareans at the mother’s request is recognized as legitimate (albeit with certain limitations). See COMM. ON OBSTETRIC PRACTICE, AM. COLL. OF OBSTETRICIANS & GYNECOLOGISTS, COMMITTEE OPINION NO. 559: CESAREAN DELIVERY ON MATERNAL REQUEST 2, 3 (2013), <https://www.acog.org/-/media/Committee-Opinions/Committee-on-Obstetric-Practice/co559.pdf?dmc=1&ts=20171105T1638498170> [<https://perma.cc/42JG-NQU8>].

60. *Average Charges For Giving Birth: State Charts*, TRANSFORMING MATERNITY CARE, <http://transform.childbirthconnection.org/resources/datacenter/chargeschart/statecharges> [<https://perma.cc/3L6C-Q2S4>] (compiling data from the U.S. Agency for Healthcare Research and Quality to find that “[c]harges for uncomplicated cesarean births were \$5,845 (68%) higher than charges for uncomplicated vaginal births [and c]harges for complicated cesarean births were \$8430 (73%) higher than charges for complicated vaginal births”).

61. Natural injuries from a bodily process are not recoverable in civil suits. See Abrams, *supra* note 56, at 1982 (“Courts also wrestle with the complexity of excluding ‘natural harms’ in childbirth from the scope of liability.”).

62. As Baker notes:

[A] woman making a lack of informed consent claim must establish a prima facie case including a breach of the physician’s duty that caused some identifiable harm to the childbearing woman. Because our society has so drastically medicalized delivery and prenatal care, we have completely devalued a mother’s right to a healthy birth experience. . . . Society fails to recognize that a failed birth

experience that does not follow the woman's choices can provoke lasting emotional injuries.<sup>63</sup> Indeed, forced procedures are often described as birth rape or with equally strong language.<sup>64</sup> Even without physical or economic consequences, when a woman is denied her choice of childbirth procedure—either because the physician did not properly inform her, did not give her any choice, or had a court bypass her refusal—she is denied agency to make a decision<sup>65</sup> that affects what is probably one of the most significant moments of her life. The trauma of being denied this choice generates psychological trauma, and even posttraumatic stress disorder (PTSD).<sup>66</sup> But the denial of choice itself should be viewed as an injury; otherwise, this choice becomes a right without a remedy—which is no right at all.

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experience is not just a description of a few dark hours in a labor unit, but rather has lasting implications for a woman and her family.

Baker, *supra* note 28, at 553–54 (footnotes omitted) (first citing Laura Hunter Dietz et al., Annotation, *Physicians, Surgeons, and Other Healers*, 61 AM. JUR. 2D § 183 (2008); Jay M. Zitter, Annotation, *Malpractice: Physician's Duty Under Informed Consent Doctrine, To Obtain Patient's Consent to Treatment in Pregnancy or Childbirth Cases*, 89 A.L.R.4th 799, § 2[b] (1991); Laurent B. Frantz, Annotation, *Malpractice: Questions of Consent in Connection with Treatment of Genital or Urinary Organs*, 89 A.L.R.3d 32, § 16[a]–[b] (1979); then citing JENNIFER BLOCK, PUSHED: THE PAINFUL TRUTH ABOUT CHILDBIRTH AND MODERN MATERNITY CARE, at xiv (2007)).

63. *Id.*

64. Sara Cohen Shabot, *Making Loud Bodies "Feminine": A Feminist-Phenomenological Analysis of Obstetric Violence*, 39 HUM. STUD. 231, 238 (2016) ("Several studies show parturient women using metaphors of rape to describe their experiences of obstetric violence." (citations omitted) (citing Rakime Elmir, Virginia Schmied, Lesley Wilkes & Debra Jackson, *Women's Perceptions and Experiences of a Traumatic Birth: A Meta-Ethnography*, 66 J. ADVANCED NURSING 2142 (2010); Ibone Olza Fernandez, *PTSD and Obstetric Violence*, 105 MIDWIFERY TODAY 48 (2013); Sheila Kitzinger, *Birth as Rape: There Must Be an End To "Just in Case" Obstetrics*, 14 BRITISH J. OF MIDWIFERY 544 (2006)).

65. See Baker, *supra* note 28, at 548 ("Our paternalistic medical system either assumes that women are not capable of making the 'right' decision for their unborn children or fears that women will prioritize other interests above the desires of the practitioner.").

66. See, e.g., Jo Czarnocka & Pauline Slade, *Prevalence and Predictors of Post-Traumatic Stress Symptoms Following Childbirth*, 39 BRITISH J. CLINIC. PSYCHOL. 35, 35, 43, 48 (2000) (finding increased incidence of PTSD in women who underwent emergency cesarean sections in which "low perceived control in labour [was] found to be particularly related to experience of post-traumatic stress symptoms"); Susan Garthus-Niegel et al., *The Influence of Women's Preferences and Actual Mode of Delivery on Post-Traumatic Stress Symptoms Following Childbirth: A Population-Based, Longitudinal Study*, 14 BMC PREGNANCY & CHILDBIRTH 191, 191 (2014) ("[R]esults suggest increased post-traumatic stress symptoms in women who preferred delivery by cesarean section but delivered vaginally . . .").

*B. The Problems of Applying the Informed Consent Standards in the Childbirth Context*

Cases brought under the lack of informed consent rubric also do not provide significant redress for women in cases involving coerced procedures during childbirth.<sup>67</sup> Traditionally, informed consent requires a woman to allege and prove that a reasonable decisionmaker would have taken a different course with all the necessary information.<sup>68</sup> The problem with this standard is that courts, often unconsciously, subscribe to the idea of the woman as a sacrificial lamb and a vessel to bring a new child into the world.<sup>69</sup> As Abrams explains,

Problematic maternal essentializing occurs [in litigation of childbirth tort cases] whereby mothers are universally assumed to make decisions exclusively to reduce harms to the fetus, without a more robust consideration of maternal decision-making and risk assessment. This romanticized, idealized, and grossly simplified view of maternal decision-making creates a fictitious “reasonable mother” standard that is not grounded in the facts or the historical roots of childbirth and is used to supplant a meaningful duality of childbirth decision-making.<sup>70</sup>

Because of this view, courts are fairly willing to protect a mother’s decision to undergo a procedure that would pose more risk to herself, but improve the fetus’s life expectancy,<sup>71</sup> but not the other way

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67. Baker, *supra* note 28, at 550 (“A common doctrine used to undermine the rights of childbearing women is the tort law doctrine of implied consent.”).

68. See, e.g., *Saguid v. Kingston Hosp.*, 623 N.Y.S.2d 341, 344 (1995) (“The complaint does not state a valid cause of action based on lack of informed consent . . . [T]he record does not reflect that a reasonably prudent person in [the plaintiff’s] position would not have undergone the procedures to which she was subjected.”).

69. See Abrams, *supra* note 56, at 1990 (“[C]ourts essentialize maternal decision-making, concluding that maternal decision-making should always result in the minimization of fetal harms.”); Baker, *supra* note 28, at 553 (“American caregivers are virtually insulated from liability for lack of informed consent claims because women struggle to establish damage or harm, despite their individual suffering, in a court of law.”).

70. Abrams, *supra* note 56, at 1996.

71. The United States District Court for the District of Massachusetts found:

[Plaintiff’s] choice [of cesarean over vaginal birth]—essentially a subordination of her risks to those of her child—would have been reasonable. Indeed, the *Harrison* court stressed the importance of allowing a mother to balance the risks to herself against the risks to her child. It noted that “the mother may consider her baby’s health as the paramount concern,” and cited the American Medical Association’s

around.<sup>72</sup> This creates a distorted incentive for physicians to avoid liability by prioritizing the health of the fetus over the women's choice—a typical example of defensive medicine.<sup>73</sup>

How courts decide what information must be disclosed to the patient, in order to find that informed consent was missing, is also problematic. For example, in *Sinclair v. Block*,<sup>74</sup> the court ruled that the physician was not required to inform his patient about the risks of forceps use<sup>75</sup> during vaginal birth, because “the natural delivery process does not require that the patient give specific informed consent for the procedure [of forceps use to assist delivery]; rather, general consent is appropriate.”<sup>76</sup> The fact that courts were willing to equate natural birth to delivery assisted by forceps is evidence of the pathologization of childbirth because courts are unable to conceive of birth as a natural, nonpathological bodily function given the

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statement that “pregnant women routinely choose,” and *should* choose, a C-section “for the benefit of their fetuses.”

Harrison v. United States, 233 F. Supp. 2d 128, 134 (D. Mass. 2002) (emphasis in original) (quoting Harrison v. United States, 284 F.3d 292, 301 n.7 (1st Cir. 2002)).

72. See, e.g., *Pemberton v. Tallahassee Mem'l Reg'l Med. Ctr.*, 66 F. Supp. 2d 1247, 1252 n.11 (N.D. Fla. 1999) (noting, in the context of a forced cesarean, that “it is only rarely that a mother refuses to consent to a medical procedure necessary to the survival of her viable fetus”); *Saguid*, 623 N.Y.S.2d at 344 (finding, in a case when a plaintiff attempted a vaginal birth that had to be converted into a cesarean and had not received full information about her options for the childbirth procedure, that the “record [did] not reflect that a reasonably prudent person in [plaintiff's] position would not have undergone the procedures to which she was subjected”).

73. See *Baker*, *supra* note 28, at 550 (“Defensive medicine is rampant in the delivery room because obstetricians and gynecologists are sued more frequently than other physicians, and thus they routinely feel the pressure of bringing new life into this world.”); *Diaz-Tello*, *supra* note 2, at 60 (“[The] perception of [liability] risk [for harm to the fetus], while usually significantly overestimated, leads practitioners to pressure or coerce women out of fear of malpractice liability . . . . This, when combined with the low value ascribed to injury or failure of informed consent for the pregnant woman, results in perverse incentives.”). *But see* Beomsoo Kim, *The Impact of Malpractice Risk on the Use of Obstetrics Procedures*, 36 J. LEGAL STUD. S79, S79 (2007) (finding that “cesarean section rates and most other measures of physician behavior are not sensitive to medical malpractice risk” and that obstetricians do not seem to engage in defensive medicine).

74. *Sinclair v. Block*, 633 A.2d 1137, 1140 (Pa. 1993).

75. A forceps is a metal tool shaped like two spoons that is used in assisted vaginal births to pull the baby through the birth canal. *Forceps Delivery: Definition*, MAYO CLINIC, <http://www.mayoclinic.org/tests-procedures/forceps-delivery/basics/definition/prc-20014741> [<https://perma.cc/L4TW-R8CE>].

76. *Sinclair*, 633 A.2d at 1141.

widespread use of delivery-assisting devices.<sup>77</sup> Similarly, courts have also held that a woman's choice of hospital serves as her implied consent to the common practices of that facility, in effect dispensing with the informed consent requirement.<sup>78</sup> This argument ignores the reality that facility-based childbirth is prevalent in the United States<sup>79</sup> and that hospitals are often under no duty to disclose their standard childbirth practices.<sup>80</sup> Moreover, the argument ignores the power dynamics between women and their care providers, an imbalance that is augmented by the fact that a woman can go into labor unexpectedly and be unable to get to her facility of choice.

C. *Courts' Failure To Recognize the Woman's Absolute Right To Refuse Treatment During Childbirth*

Physicians are not the only ones ready to override women's choices in relation to childbirth procedures.<sup>81</sup> Courts have on more than one occasion allowed physicians to perform procedures to induce labor or cesarean sections without the consent of the pregnant woman.<sup>82</sup> It is hard to estimate the number of cases in which courts were asked to override a woman's decision on childbirth procedures, although reports have found more than thirty cases involving some type of court-sanctioned coercive medical procedure between 1973 and

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77. Forceps were one of the first tools used to medicalize childbirth; midwives were prohibited from owning them, so only male physicians could resort to the technique. Richard Johanson, Mary Newburn & Alison Macfarlane, *Has the Medicalisation of Childbirth Gone Too Far?*, 324 BRITISH MED. J. 892, 892 (2002) ("Before the invention of forceps, men had been involved only in difficult deliveries . . . . Instrumental delivery with forceps became the hallmark of the obstetric era."); Martelia L. Henson, *Medicalized Childbirth in the United States: Origins, Outcomes, and Opposition* 5–6 (Jan. 1, 2002) (unpublished M.A. thesis, Marshall University) (on file with the *Duke Law Journal*) (recounting the early use of forceps in medicalized birth).

78. Baker, *supra* note 28, at 552 ("A number of courts have held that by choosing to give birth in a hospital, the patient has implied consent to the customary practices of that facility.")

79. Marian F. MacDorman, T.J. Mathews & Eugene Declercq, Nat'l Ctr. for Health Statistics, *Trends in Out-of-Hospital Births in the United States, 1990–2012*, CTRS. DISEASE CONTROL & PREVENTION 1 (2014), <https://www.cdc.gov/nchs/data/databriefs/db144.pdf> [<https://perma.cc/A7M9-7SVS>] (finding that in 2012, only 1.36% of babies were born outside hospitals).

80. See Goer, *supra* note 24, at 40 (recounting anecdotal evidence of a "conspiracy of silence" to keep confidential the cesarean rates of local hospitals).

81. For a disheartening account of the number of arrests and forced medical interventions in the context of pregnancies, see Paltrow & Flavin, *supra* note 36, at 299.

82. See, e.g., *id.* at 325 (reporting instances in which courts have granted court orders to coerce women into undergoing coerced procedures during childbirth).

2005.<sup>83</sup> Nonetheless, this number is thought to be a gross understatement of actual cases,<sup>84</sup> especially considering that many remain unpublished.<sup>85</sup> A national survey conducted in 1989 reported that health care institutions in eighteen states had filed for court orders to coerce women into accepting some type of medical intervention on thirty-six occasions in the previous five years.<sup>86</sup>

Approximately 58 percent of cases that result in arrest or forced intervention for pregnant women are submitted to courts and authorities by health care providers and hospitals.<sup>87</sup> Around 46 percent of the heads of fellowship programs in obstetrics believe that nonconsenting women should be coerced to accept medically prescribed treatment to prevent increased risk for the fetus.<sup>88</sup> These opinions are by no means representative of the whole profession. In fact, the American College of Obstetricians and Gynecologists Committee on Ethics has expressly chastised the practice, because “[c]ourt-ordered interventions . . . exploit power differentials; involve incursions against individual rights and autonomy; and manifest as violations of bodily integrity and, often, gender and socioeconomic equality.”<sup>89</sup> Regardless, these cases continue to be brought by hospitals and health care providers.

That courts regularly bypass the woman’s choice of childbirth procedure shows a deficient legal standard in and of itself because such decisions subjugate women’s interests to those of the fetus. The most common argument for this action is to preserve the state’s interest in protecting the fetus after viability. They may hold, for example, that states should be allowed to take measures to preserve the fetus’s

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83. *Id.* at 317.

84. *Id.* at 303.

85. Nancy K. Rhoden, *The Judge in the Delivery Room: The Emergence of Court-Ordered Cesareans*, 74 CALIF. L. REV. 1951, 1951 n.3–4 (1986) (listing unpublished cases that resulted in court-ordered cesarean sections).

86. Veronika E.B. Kolder, Janet Gallagher & Michael T. Parsons, *Court-Ordered Obstetrical Interventions*, 316 NEW ENG. J. MED. 1192, 1192 (1987).

87. Paltrow & Flavin, *supra* note 36, at 311. This number does not include cases reported by social workers employed by hospitals.

88. Kolder et al., *supra* note 86, at 1193.

89. COMM. ON ETHICS, AM. COLL. OF OBSTETRICIANS & GYNECOLOGISTS, COMMITTEE OPINION NO. 664: REFUSAL OF MEDICALLY RECOMMENDED TREATMENT DURING PREGNANCY 4 (2016), <https://www.acog.org/-/media/Committee-Opinions/Committee-on-Ethics/co664.pdf?dmc=1&ts=20170814T0001015083> [<https://perma.cc/GDM2-CGLU>].



potential for life after it reaches viability, including regulating what the pregnant woman does to her body.<sup>90</sup> The courts thus hold that a woman's right to refuse treatment<sup>91</sup> is not absolute; rather it has to be balanced against the state's interest in protecting the fetus's potential for life.<sup>92</sup> For example, in *Pemberton v. Tallahassee Memorial Regional Medical Center*,<sup>93</sup> a Florida hospital sought a court order from the federal district court to compel Ms. Pemberton to undergo a cesarean section.<sup>94</sup> Ms. Pemberton had made arrangements for a home delivery and, when she was close to labor, she went to the hospital to get an IV because she was dehydrated.<sup>95</sup> The physicians deemed that Ms. Pemberton needed a cesarean primarily because she had undergone a cesarean on a previous occasion and the doctor on call deemed the risk of uterine rupture in a vaginal birth after cesarean too high to be acceptable.<sup>96</sup> Ms. Pemberton had religious reasons to refuse to deliver her child through any procedure other than vaginal delivery.<sup>97</sup> The court reasoned that “[w]hatever the scope of Ms. Pemberton's personal constitutional rights in this situation, they clearly did not outweigh the interests of the State of Florida in preserving the life of the unborn

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90. Most cases cite to *Roe* for the proposition that the state may regulate based on its interest in protecting fetal viability. *Roe v. Wade*, 410 U.S. 113, 163 (1973) (“With respect to the State’s important and legitimate interest in potential life, the ‘compelling’ point is at viability . . . because the fetus then presumably has the capability of meaningful life outside the mother’s womb.”); see also *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 872 (1992) (reaffirming *Roe*’s recognition of the state’s compelling interest in protecting the potential life of the fetus).

91. Although the Supreme Court has never positively affirmed that such a right to refuse medical treatment exists, it is arguably one of the rights rooted in the traditions of the nation that would justify its protection under the due process clause of the 5th and 14th Amendments. See *Cruzan v. Dir., Mo. Dep’t of Health*, 497 U.S. 261, 289 (1990) (O’Connor, J., concurring) (“Accordingly, the liberty guaranteed by the Due Process Clause must protect, if it protects anything, an individual’s deeply personal decision to reject medical treatment, including the artificial delivery of food and water.”).

92. See, e.g., *Pemberton v. Tallahassee Mem’l Reg’l Med. Ctr., Inc.*, 66 F. Supp. 2d 1247, 1252 n.12 (N.D. Fla. 1999) (finding that the interest of the fetus can be considered in determining if the woman should be forced to have a cesarean).

93. *Pemberton v. Tallahassee Mem’l Reg’l Med. Ctr., Inc.*, 66 F. Supp. 2d 1247 (N.D. Fla. 1999).

94. *Id.* at 1249–50.

95. *Id.* at 1249.

96. *Id.* at 1252–53. Note that the hospital presented five experts in support of its case and Ms. Pemberton only presented one. *Id.* Note also that the court did not discuss in any detail the types of risks associated in elective cesareans performed to avoid vaginal birth after cesarean. *Id.*

97. *Id.* at 1251 n.5.

child.”<sup>98</sup> The court justified its reasoning primarily with *Roe v. Wade*,<sup>99</sup> arguing that if the state’s interest in protecting the potential life of the fetus was enough to prevent women from aborting in the third trimester—an arguably more invasive intervention—then it was also enough to outweigh the mother’s constitutional interests—whatever they may be—in choosing her birthing method.<sup>100</sup>

Previous cases had adopted a similar approach. In *Jefferson v. Griffin Spalding County Hospital Authority*,<sup>101</sup> the Supreme Court of Georgia refused to stay an order compelling a pregnant woman to undergo a cesarean surgery.<sup>102</sup> There, the court justified its decision on the grounds that “[b]ecause the life of defendant and of the unborn child are, at the moment, inseparable . . . it [is] appropriate to infringe upon the wishes of the mother to the extent it is necessary to give the child an opportunity to live.”<sup>103</sup> The court went as far as to argue that the fetus was a “a living, unborn human” thereby recognizing in the fetus a right to live.<sup>104</sup>

The balancing adopted in these decisions is inherently problematic because it implies that the woman’s interests are subordinated to those of the fetus.<sup>105</sup> Conspicuously absent from all these balancing cases involving coerced medical procedures is the mention of the state’s interest in protecting the woman’s life. This interest has been emphasized in cases seeking recognition of the right to die, in which courts have accepted a state’s “unqualified interest in the preservation

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98. *Id.* at 1251.

99. *Roe v. Wade*, 410 U.S. 113 (1973).

100. *Pemberton*, 66 F. Supp. 2d at 1251–52.

101. *Jefferson v. Griffin Spalding Cty. Hosp. Auth.*, 274 S.E.2d 457 (Ga. 1981).

102. *Id.* at 460.

103. *Id.* at 458 (quoting the trial court order from emergency hearing below).

104. *See id.* at 560 (“The Court finds that the intrusion involved into the life of [the plaintiff] is outweighed by the duty of the State to protect a living, unborn human being from meeting his or her death before being given the opportunity to live.” (quoting from the lower trial court’s order)). However, Georgia’s courts have not followed this case, so its precedential value is questionable. Paltrow & Flavin, *supra* note 36, at 321 n.59 (noting that the decision does not have precedential value even in Georgia).

105. Lisa C. Ikemoto, *The Code of Perfect Pregnancy: At the Intersection of the Ideology of Motherhood, the Practice of Defaulting to Science, and the Interventionist Mindset of Law*, 53 OHIO ST. L.J. 1205, 1259 (1992) (“Balancing tests all imply that one set of interests can be subordinated to the other. . . . The balancing test says that preventing harm to the fetus justifies restrictions on the woman’s decisional autonomy and invasions of her bodily integrity.”).

of human life.”<sup>106</sup> Yet, in the context of coerced procedures in childbirth, no state has ever used its “unqualified interest in the preservation of human life” to force a woman to undergo a procedure that was *less* risky for her but *riskier* for the fetus. For example, courts seem to have no problem with allowing women to undergo voluntary cesareans, despite the significant risks that the procedure poses when compared to vaginal birth.<sup>107</sup> In a way, the court-ordered interventions allow the state both to choose which risks the woman has to accept in childbirth and to subjugate the mother’s life to the fetus’s potential for life.<sup>108</sup>

The legal standard for court-ordered interventions has also conflated the treatment of two very different situations: abortion and childbirth. To justify the need for a balancing test, courts have argued that, if the state’s interest is sufficiently compelling to force a woman to carry to term an unwanted pregnancy, it certainly is enough to override her choice of childbirth procedure.<sup>109</sup> First, this is a false equivalency. In the context of abortion, the woman is seeking a medical

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106. *Washington v. Glucksberg*, 521 U.S. 702, 728 (1997) (quoting *Cruzan v. Dir., Mo. Dep’t of Health*, 497 U.S. 261, 282 (1990)).

107. According to a report by the National Vital Statistics System,

[r]ates of maternal morbidity were higher for cesarean than vaginal deliveries—rates of transfusion (525.1 per 100,000) and ICU admission (383.1) were highest for primary cesarean deliveries, while rates of ruptured uterus (88.9) and unplanned hysterectomy (143.1) were highest for repeat cesarean deliveries. Higher rates of maternal morbidity for cesarean compared with vaginal deliveries were found for nearly all maternal age groups and for women of all races and ethnicities. Women with no previous cesarean delivery who had vaginal deliveries had lower rates for all maternal morbidities compared with those who had cesarean deliveries. Women with a previous cesarean delivery who labored and had vaginal birth generally had lower rates for most of the morbidities, but failed trials of labor were generally associated with higher morbidity than scheduled repeat cesarean deliveries, especially for ruptured uterus, which was seven times higher (495.4 per 100,000 compared with 65.6).

Sally C. Curtin, Kimberly D. Gregory, Lisa M. Korst & Sayeedha F.G. Uddin, Nat’l Ctr. for Health Statistics, *Maternal Morbidity for Vaginal and Cesarean Deliveries, According to Previous Cesarean History: New Data From the Birth Certificate, 2013*, 64(4) NAT’L VITAL STAT. REP., May 20, 2015, at 1, 2 (2015), [https://www.cdc.gov/nchs/data/nvsr/nvsr64/nvsr64\\_04.pdf](https://www.cdc.gov/nchs/data/nvsr/nvsr64/nvsr64_04.pdf) [<https://perma.cc/6GAK-ZDMB>].

108. None of these courts has ever held that the fetus has a right to life, having refrained from deviating from the “state’s interest” language found in abortion cases.

109. *Pemberton v. Tallahassee Mem’l Reg’l Med. Ctr., Inc.*, 66 F. Supp. 2d 1247, 1251–52 (N.D. Fla. 1999) (“Bearing an unwanted child is surely a greater intrusion on the mother’s constitutional interests than undergoing a caesarean section . . . . Thus the state’s interest here was greater, and the mother’s interest less, than during the third trimester situation addressed in *Roe*.”).

procedure to end pregnancy and the state is *preventing* her from getting the procedure, whereas in the context of coerced childbirth procedure, the state is *forcing* the woman to undergo a medical procedure. In the context of compelling organ donations, a situation significantly more similar to that of coercing a woman to accept a particular childbirth procedure, courts have strongly repudiated the argument that a parent has a duty to donate organs to his or her child.<sup>110</sup>

In addition, this argument misses the fact that when women choose how to give birth, there is no intention of stopping fetal development.<sup>111</sup> Just because a woman has chosen a procedure that poses relatively higher risks to the fetus does not mean she wishes that the fetus will perish. More likely than not, her choice of childbirth procedure is being informed by a number of cultural, religious and social beliefs,<sup>112</sup> as well as by an individualized assessment of which risks she is willing to undertake for herself and for the fetus.<sup>113</sup> As such, the court-ordered interventions deny a choice to women by presuming that any choice prioritizing their own health over the health of their fetus is irrational, and requires medical intervention.<sup>114</sup> The courts treat medical estimates of fetal outcome chances as certain, and deny women the right to consider factors aside from mathematical probability. This equates the right choice with the physician's choice, thereby completely rejecting the woman's agency to make an assessment of risk independent from her doctor.

Granted, not all courts accept that a state's interest in the protection of the fetal potential for life, as recognized in *Roe*, is always

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110. See Erin P. Davenport, *Court Ordered Cesarean Sections: Why Courts Should Not Be Allowed To Use a Balancing Test*, 18 DUKE J. GENDER L. & POL'Y 79, 98 (2010) (recounting attempts to compel donation of organs and bone marrow in the familial context and how courts have uniformly rejected these requests).

111. It is conceivable that this may eventually happen; and in such case, the woman would arguably be making an 'abortion' choice. But all reported incidences involved women that had preferences on childbirth procedure rooted in religious or personal beliefs.

112. Some women, for example, cannot undergo surgery for religious reasons. Others believe that birthing is a natural experience and that they should be given the opportunity to attempt natural birth before opting for a medicalized birth experience.

113. Abrams, *supra* note 56, at 1994 ("[B]irthing is often contemplated in a much broader context of a particular woman's life, depending on her age, her fertility, her risk factors, her prior children, her prior birth experiences, etc.").

114. See *id.* at 1994-95 (discussing how the "judicial narrative" has portrayed mothers as emotional and irrational while ignoring the broader concerns they face).

enough to overcome a woman's decision regarding her childbirth experience. In *In re A.C.*,<sup>115</sup> the George Washington University Hospital secured a court order to allow the physicians of Angela Carder, a terminally ill cancer patient, to proceed with a cesarean section over her family's objection.<sup>116</sup> The patient was unconscious when the decision was made and had not consented to a cesarean section before her fetus reached twenty-eight weeks.<sup>117</sup> The lower court granted the order to the hospital and the D.C. Court of Appeals originally refused to stay the order.<sup>118</sup> Carder had consented to the surgery when first told of the court order but subsequently withdrew that consent.<sup>119</sup> The court granted the order regardless, based on the state's interest in preserving the life of the fetus, and despite evidence that the operation would likely hasten Carder's death.<sup>120</sup> Both mother and child perished two days after the surgery.<sup>121</sup> Later, the D.C. Court of Appeals reversed itself in an en banc decision that recognized that "if a patient is competent and has made an informed decision regarding the course of her medical treatment that decision will control in virtually all cases."<sup>122</sup> The Court of Appeals found that the lower court had to evaluate if Carder was competent to make the decision and, if it had to substitute for her judgment, it needed to look for evidence of what her decision would be.<sup>123</sup> Yet, the harm was done,<sup>124</sup> so the decision was little consolation to her family, who were deprived of her last few days before her passing from cancer. Also, the D.C. Court of Appeals could have but did not use *In re A.C.* to revisit a previously

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115. *In re A.C.*, 573 A.2d 1235 (D.C. 1990) (en banc).

116. *Id.* at 1238.

117. *Id.* at 1239–41.

118. *Id.* at 1238.

119. *Id.* at 1240–41.

120. *Id.* at 1240.

121. *Id.* at 1241.

122. *Id.* at 1249; *see also* *Illinois v. Mother Doe*, 632 N.E.2d 326, 332 (Ill. App. Ct. 1994) ("[A] woman's right to refuse invasive medical treatment, derived from her rights to privacy, bodily integrity, and religious liberty, is not diminished during pregnancy. The woman retains the same right to refuse invasive treatment, even of lifesaving or other beneficial nature, that she can exercise when she is not pregnant.").

123. *In re A.C.*, 573 A.2d. at 1251–52.

124. *See id.* at 1241 ("[T]he surgery which was ordered in this case has been performed, and no decision of ours can put the parties in the same position in which they found themselves before the trial court's order was issued.").

unreported opinion<sup>125</sup> ordering a cesarean in circumstances where it found the interest of the mother was the same as that of the fetus.<sup>126</sup> As such, the court fell short of recognizing an absolute right for pregnant women to determine the course of treatment for themselves and their fetuses.<sup>127</sup> And because the court did not go so far, it kept the door open to reasoning that subjugates the woman's interest to the fetus and that denies her agency to assess which medical risks she wishes to take.

## II. WHY ADOPT THE OBSTETRIC VIOLENCE FRAMEWORK TO ADDRESS COERCED PROCEDURES IN CHILDBIRTH

As explained above, Venezuela and Argentina have recently introduced a new legal concept to address abuse and disrespect during pregnancy and childbirth: obstetric violence. This legal framework is premised on a definition of obstetric violence as

the appropriation of the body and reproductive processes of women by health personnel, which is expressed as dehumanized treatment, an abuse of medication, and to convert the natural processes into pathological ones, bringing with it loss of autonomy and the ability to decide freely about their bodies and sexuality, negatively impacting the quality of life of women.<sup>128</sup>

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125. *In re Madyun*, 114 Daily Wash. L. Rptr. 2233 (D.C. Super. Ct. 1986), *reprinted in* Appendix, *In re A.C.*, 573 A.2d 1235.

126. *In re A.C.*, 573 A.2d at 1252 n.23 (stressing that nothing in the opinion should be read as approval or disapproval of the case *In re Madyun*, and differentiating A.C.'s case from *In re Madyun* because, in the latter, "there was strong evidence that the proposed cesarean would be beneficial to both [the fetus and the mother]").

127. *See id.* at 1252 ("We need not decide whether, or in what circumstances, the state's interests can ever prevail over the interests of a pregnant patient. We emphasize, nevertheless, that it would be an extraordinary case indeed in which a court might ever be justified in overriding the patient's wishes . . .").

128. Law on the Right of Women to a Life Free of Violence, *supra* note 13, art. 15(13), *translated in* D'Gregorio, *supra* note 14, at 201. Similar definitions were introduced in Argentina and certain Mexican states that later followed the Venezuelan model of criminalization of the practice. The Argentinean law that addresses obstetric violence defines it as "violence perpetrated by medical professionals on the body and reproductive processes of women, manifested as dehumanized treatment, abuse of medicalization and pathologization of the natural [birth] processes . . ." Law No. 26485, *supra* note 13, art. 6 (translation by author). Although Brazil has not adopted a specific statutory framework to address the issue, the Public Defender's Office of the State of São Paulo also adopted the Venezuelan definition in its 'know your rights' material directed to pregnant women. DEFENSORIA PÚBLICA DO ESTADO DE SÃO PAULO,

Venezuela has used this concept to criminalize particular circumstances of obstetric violence, as well as to regulate public policies directed at reducing gendered violence in the country.<sup>129</sup> Argentina and some Mexican states that also adopted this framework have not criminalized the conduct<sup>130</sup> but “provide a range of remedies [against the conduct], including administrative complaints, specialized medical arbitration, and complaints before federal and state human rights commissions.”<sup>131</sup>

Across the globe, advocacy groups for improving childbirth experiences have imported the term “obstetric violence” into their discourse with essentially the same meaning used in the Venezuelan legislation. In Spain, for example, the advocacy group *La Revolución de las Rosas* defines obstetric violence as

the act of disregarding the authority and autonomy women have over their own sexualities, their bodies, their babies and their birth experiences. It is also the act of disregarding the spontaneity, the positions, the rhythms and the time labor requires in order to progress normally when there is no need for intervention. It is also the act of disregarding the [emotional needs] of the mother and baby throughout the whole labor process.<sup>132</sup>

Similarly, the Women’s Global Network for Reproductive Rights defines obstetric violence as a type of institutional, gender-based violence directed at women during pregnancy, childbirth, and

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VIOLÊNCIA OBSTÉTRICA: VOCÊ SABE O QUE É? (2013), <https://www.defensoria.sp.def.br/dpesp/repositorio/41/violencia%20obstetrica.pdf> [<https://perma.cc/64ES-72WC>].

129. See Law on the Right of Women to a Life Free of Violence, *supra* note 13, art. 51 (relying on the definition of obstetric violence in art. 15(13) to criminalize certain particular types of obstetric violence).

130. Three Mexican states also criminalize the conduct. Diaz-Tello, *supra* note 2, at 62 (“[T]he states of Chiapas, Guerrero, and Veracruz even impose criminal penalties on offenders.”).

131. *Id.*

132. Sánchez, *supra* note 9, at 94 (citing *Violencia obstétrica, de género e institucional*, JESUSA RICOY OLARIAGA (Apr. 21, 2014), <http://jesusaricoy.blogspot.co.uk/2014/04/violencia-obstetrica-de-genero-e.html> [<https://perma.cc/6MHB-TY3J>]).

postpartum recovery.<sup>133</sup> These advocacy groups generally believe that the term increases social awareness of the problem.<sup>134</sup>

The medical discussion on childbirth practices seems to be slowly embracing the concept of obstetric violence as defined in the Venezuelan law. A recent lecture during the 2014 World Congress of the Royal College of Obstetrics and Gynecologists addressed the interplay between obstetric violence and human rights, and expressly defined obstetric violence with reference to the Venezuelan legislation.<sup>135</sup> Recent medical studies developed in Latin America also used the term to discuss disrespect and abuse of women during facility-based childbirth.<sup>136</sup>

But why adopt the concept of “obstetric violence” in the American context instead of talking about abuse and disrespect<sup>137</sup> more generally? Is there a particular advantage to using it in the context of coerced procedures in childbirth? First, the concept highlights the gravity of the harm resulting from coercion during childbirth even when no physical damage occurs. Second, the concept recognizes the link between coerced procedures and gender by defining obstetric violence as a subtype of gender-based violence. Finally, in the American context, moving away from traditional medical torts could help detach maternal rights from the polarized debate over abortion rights.

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133. Women’s Glob. Network for Reprod. Rights, *supra* note 8 (“Obstetric violence is a specific type of violation of women’s rights, including the rights to equality, freedom from discrimination, information, integrity, health, and reproductive autonomy. It occurs . . . during health care related to pregnancy, childbirth, and post-partum and is a multi-factorial context of institutional and gender violence.”).

134. *See* Sánchez, *supra* note 9, at 95–96 (discussing how Spanish activists have embraced the term because it is thought to help raise social awareness and increase recognition of the underlying problem).

135. Amali Lokugamage, *Obstetric Violence and Human Rights Lecture, ROCG Congress 2014*, YOUTUBE (Apr. 10, 2014), <https://youtu.be/Ziy5kSFm7U8>.

136. *See, e.g.*, Michelle Gonçalves da Silva et al., *Violência Obstétrica na Visão de Enfermeiras Obstetras*, 15 REV. RENE 820, 820 (2014) (inquiring into the “experience of obstetric nurses on the obstetric violence experienced, witnessed and observed during their professional careers”).

137. This disrespect and abuse language has been used by the White Ribbon Alliance in previous projects to strengthen maternal rights around the world. *See, e.g.*, Mary Beth Hastings, *Policy Brief: Pulling Back the Curtain on D&A*, WHITE RIBBON ALLIANCE 4 (2015), <http://whiteribbonalliance.org/wp-content/uploads/2016/03/Policy-Brief-Pulling-Back-the-Curtain-on-DR.pdf> [<https://perma.cc/RQ32-KEDJ>] (advancing the need to promote respectful maternal care to prevent disrespect and abuse during pregnancy and childbirth).



A. *Recognizing the Woman as the Final Decisionmaker and the Harm of Coerced Procedures*

The obstetric violence framework has the benefit of explicitly acknowledging the damage caused by coerced procedures. As explained above, the current American legal system places little value on a woman's birthing experience or on her ability to consent to treatment in the absence of physical harm.<sup>138</sup> But for many women, the experience of childbirth is a central moment in their lives, which means that a negative birth experience often has severe and lasting consequences.<sup>139</sup> Research strongly suggests that women's perception of control over their birthing process impacts how they experience childbirth overall and that, when original choices are overridden by medical or court decisions, the experience is overwhelmingly described as violent and negative.<sup>140</sup> Indeed, women who were coerced into medical procedures in childbirth often make comparisons to rape.<sup>141</sup> By recognizing that coerced procedures are a form of violence, the legal system validates these women's traumas<sup>142</sup> to a skeptical community.<sup>143</sup>

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138. For further discussion of the shortcomings of the current American legal system in protecting women's choice during childbirth, see *supra* Part I.

139. Katie Cook & Colleen Loomis, *The Impact of Choice and Control on Women's Childbirth Experiences*, 21 J. PERINATAL EDUC. 158, 158 ("The outcome of childbirth, however, is not the only factor of importance in a mother's well-being. Some research suggests that the way in which a woman experiences pregnancy and childbirth is also vitally important for a mother's relationship with her child and her future childbearing experiences . . .").

140. *Id.* at 165 (listing that "[t]he most drastic changes to women's birth plans include transfers of care from home to hospital and/or from midwife to obstetrician, the use of medical pain control techniques and other medical interventions, and unexpected stays in the hospital after the birth of the child" and noting that women who experience these drastic changes without being given a say in the process tend to describe their childbirth as a traumatizing experience). This is further evidenced by the testimonials collected in the #BreaktheSilence campaign. See *Improving Birth*, *supra* note 2.

141. Rakime Elmir, Virginia Schmied, Lesley Wilkes & Debra Jackson, *Women's Perceptions and Experiences of a Traumatic Birth: A Meta-Ethnography*, 66 J. ADVANCED NURSING 2142, 2150–51 ("The term 'birth rape' has been used by women who feel that their bodies have been violated, and that they have been coerced into consenting to procedures without being informed of their details and accompanying risks.").

142. See Sánchez, *supra* note 9, at 95 (recognizing that the use of the term obstetric violence "can help to put a name to the malaise that many women feel after childbirth, even though society tells them that everything is alright and all that is important is that the baby is alive").

143. Some authors have noted:

It is sometimes difficult for healthcare professionals to understand how a 'natural' event such as of childbirth can be traumatic for women. . . . The literature suggests that many healthcare professionals ignore or do not recognize the signs of

This helps women overcome their negative experiences because “having words to describe these unfair situations and to realize that it is part of an unfair violence can become a tool for transforming a traumatic experience into a chance to question and change reality.”<sup>144</sup>

The legal recognition of coerced procedures as abuse, as opposed to caregiving, will make it harder for courts to protect medical providers in childbirth tort litigation. Indeed, because the concept of obstetric violence is partially defined in terms of the emotional impact of being victimized by professionals who are supposed to be caretakers,<sup>145</sup> it is harder for courts to condition recovery on proof of physical harm or to confine remedy to the difference in the price of the procedures. Similarly, it would shift the perverse incentives for doctors to practice defensive medicine in favor of the fetus instead of the mother, because it reprioritizes the harm to the woman in their cost-benefit analysis.<sup>146</sup> This is because, as explained above, if the woman has an absolute right to refuse a particular procedure, the physician will have no duty under tort law to go ahead with that procedure, and therefore, will not be liable for problems caused to the fetus because he did not perform the procedure.<sup>147</sup>

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psychological and emotional trauma, due to their perception that birth trauma is a physical injury.

Elmir et al., *supra* note 141, at 2151.

144. Sánchez, *supra* note 9, at 95.

145. The concept of obstetric violence adopted in Venezuela does this by defining the practice as an “appropriation of the body and reproductive processes of women by health personnel.” Law on the Right of Women to a Life Free of Violence, *supra* note 13, art. 15(13).

146. An example of how doctor’s decisionmaking is influenced by the liability potential is the de facto ban on Vaginal Birth After Cesarean (VBAC). As Baker explains,

“You don’t get sued for doing a C-section. You get sued for not doing a C-Section.” [This] vocalizes a common sentiment among practitioners that because cesarean sections are widely performed, they have become the standard, and deviation from that standard, even when medically sound, is a potential liability for the physician. Physicians have come to perceive VBACs as “indefensible” in medical malpractice suits, thus encouraging doctors to avoid them entirely despite indications that repeat cesareans carry significant risks to the mother.

Baker, *supra* note 28, at 588. By analogy, if overriding women’s decision in childbirth carries an indefensible risk of liability (whether criminal or civil), then it is unlikely that they would risk engaging in this practice, no matter what their views are about their duty to the fetus.

147. See *Curtis v. Jaskey*, 759 N.E.2d 962, 968 (Ill. App. Ct. 2001) (“Where a patient refuses to consent to a medical procedure, no duty arises on behalf of a physician to perform that procedure such that the physician can be held liable for failing to perform it.”).

*B. Recognizing the Gendered Undertones of Obstetric Violence*

What makes coerced medical procedures in childbirth, and other types of obstetric violence, different from other medical battery is that they are a type of gender-based violence. This is a type of gendered violence because its victims are primarily women and its origins are traceable to “how women (and their (dis)abilities) are perceived and perceive themselves in Western patriarchal societies.”<sup>148</sup> Therefore,

[although] it has much in common with the more general experience of alienation and objectification within medicalization . . . , obstetric violence appears to be unique in being directed almost exclusively at women and being experienced and interpreted by women mostly as gender violence, an affront to and banishment of their otherwise healthy, powerful, sexual, and creative embodied subjectivities.<sup>149</sup>

That women are the primary victims of obstetric violence follows from the fact that pregnancy is—by and large—a uniquely female experience. But uncovering its roots requires an analysis of the view of motherhood and pregnancy in Western societies and of the power dynamics present in obstetric and gynecological care.

Modern motherhood is constructed on the myth of the perfect mother, who gladly sacrifices herself for her child.<sup>150</sup> As a result, courts are unprepared to accept a mother’s decision to prioritize her own health and beliefs over the fetus’s potential for life.<sup>151</sup> This also makes courts willing to later penalize women who are perceived to have acted selfishly during pregnancy and labor, and on more than one occasion, courts have put firstborn children under the guardianship of a hospital based exclusively on a mother’s refusal of a particular course of treatment.<sup>152</sup> This dualism of the “good” mom versus the “bad” mom

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148. Shabot, *supra* note 64, at 233.

149. *Id.* at 241.

150. *See generally* Ikemoto, *supra* note 105 (describing how ideals of motherhood based on the good mother archetype shape the courts’ intervention in the decisionmaking of pregnant women).

151. *Accord, e.g.*, *Pemberton v. Tallahassee Mem’l Reg’l Med. Ctr.*, 66 F. Supp. 2d 1247, 1254 (N.D. Fla. 1999) (refusing to allow a woman to attempt natural birth for fear of increased risk for fetus); *see also* Ikemoto, *supra* note 105, at 1251 (“[D]irect pregnancy regulations [like court-ordered childbirth procedures] are a way of labeling certain women ‘bad mothers.’ These are women who have failed to act selflessly for the sake of others, as a good mother should.”).

152. *See, e.g.*, *Baker*, *supra* note 28, at 539–40 (describing a case in which family services obtained custody of a child after the hospital reported the new parents because the mother

model is also present when courts describe women who insist on a particular birthing method as stubborn, difficult patients.<sup>153</sup> Ultimately, this translates to an overall distrust of the woman's agency to control her own body and to make decisions for herself and the fetus that she is carrying. As such, "[w]omen are treated as infants when they are not recognized as subjects capable of making decisions about their health nor understanding what is happening in their bodies."<sup>154</sup>

These traditional views of motherhood as an opportunity for martyrdom also manifest as the view that a woman's sexual pleasure is a reasonable sacrifice toward fulfilment of her maternal role.<sup>155</sup> This view engenders obstetric violence because it leads physicians to disregard the woman's needs and requests for pain management based on views that women should passively take on the pain of labor.<sup>156</sup> Another way in which this view becomes obstetric violence is by the practice of unnecessary episiotomies—a cut between the vagina and anus made to enlarge the opening during birth—often without informed consent of the woman.<sup>157</sup> Such practice increases the risk of

refused to undergo a recommended cesarean, even though she gave birth vaginally to a healthy baby girl).

153. See Abrams, *supra* note 56, at 1994 (“[M]others are characterized as stubborn, perhaps reckless, and their medical preferences are framed as emotional wants or desires, rather than medical preferences. In each of these cases, the birthing woman is denied recovery.”).

154. Sánchez, *supra* note 9, at 60.

155. As one author notes,

Traditional views of women as destined to be sacrificed to motherhood combined with the idea that women sexual pleasure has to pay a tribute—as for instance a painful childbirth—maintains harmful practices and behaviors that negatively impacts the health of women, fetuses and children during the process of pregnancy and delivery.

*Id.* at 28–29.

156. See *id.* (discussing how traditional views of motherhood shape the way physicians treat women during birth).

157. It has been noted that:

70–80% of first time mothers in the United States undergo episiotomy, representing 35% of all vaginal births in the nation. . . . The evidence collected by obstetricians and perinatal scientists indicates that episiotomy ‘should be limited to specific maternal and fetal indications,’ which will arise in 5–10% of all vaginal births.

Baker, *supra* note 28, at 575 (citations omitted) (citing MARSDEN WAGNER, BORN IN THE USA: HOW A BROKEN MATERNITY SYSTEM MUST BE FIXED TO PUT WOMEN AND CHILDREN FIRST 57 (2006); then citing Michael C. Klein et al., *Relationship of Episiotomy To Perineal Trauma and Morbidity, Sexual Dysfunction, and Pelvic Floor Relaxation*, 171 AM. J. OBSTETRICS & GYNECOLOGY 591, 591–98 (1994); then citing WAGNER at 58).

future “pain during intercourse, which may afflict a woman for the remainder of her life” as well as of “pelvic floor damage, which results in urinary and fecal incontinence.”<sup>158</sup> There is little to no evidence to justify the use of routine episiotomy, as some American hospitals do.<sup>159</sup> Yet, practitioners continue to employ the practice indiscriminately.<sup>160</sup>

A sexist view of the female pregnant body is also at the root of many manifestations of obstetric violence during childbirth. Since the nineteenth century, the discourse has been about the frailty of the pregnant body, thus creating a need for protection and oversight by *male* physicians.<sup>161</sup> The construal of this sickly pregnant body coincided with a decrease in unassisted birth and a formal subjugation of doulas and midwives to obstetricians.<sup>162</sup> This view is at the heart of the excessive medicalization and pathologization of pregnancy and childbirth. And in modern times it also translates to a distrust of women’s natural labor timing. This perception engenders obstetric violence to the extent that it may affect physicians’ perception of risk and thus make physicians defensively prefer to artificially accelerate labor—even without consent—over allowing extended gestational periods.<sup>163</sup> The distrust of natural birth processes may also translate

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158. *Id.* at 577.

159. *Id.* at 575–82 (reviewing the medical literature that shows no support for the use of episiotomies in most birthing procedures and explaining the ritualistic nature of the procedure in modern medicine).

160. *Id.* at 581–82 (“Criticism of this sacrosanct practice has been written for generations, but . . . [has] been summarily dismissed or ignored by practitioners. Physicians opposing the practice have boldly identified episiotomy as the ‘deliberate mutilation of the maternal perineum.’” (internal citations omitted) (citing JENNIFER BLOCK, *PUSHED: THE PAINFUL TRUTH ABOUT CHILDBIRTH AND MODERN MATERNITY CARE*, at xxx (2007); then quoting *id.*). Further evidence in support of the link between the practice of routine episiotomies and the view that women’s sexual pleasure was a fair “tribute” given to motherhood is that, in the old days, it was followed by a practice called the “husband’s knot,” which consisted in surgically tightening “a woman’s vaginal canal and perineum after delivery in an effort to stave off male sexual dissatisfaction after his wife endured a vaginal delivery,” regardless of the pain this caused to women. *Id.* at 579.

161. See Sánchez, *supra* note 9, at 35 (“Since mid-19th century ‘gender ideals of women as frail and dependent—and thus incapable of either giving or attending births unaided by male experts—flourished during this time as well, especially among middle and upper classes.’”).

162. *Id.* at 32–34 (describing the power struggle between physicians and midwives and doulas for control over the childbirth process and how to this date this power dynamic influences medical debate over legitimate best practices in obstetric care).

163. See Baker, *supra* note 28, at 559 (“Artificial labor induction has become a part of our maternal care system that women expect . . . This misconception that induction is a ‘natural’ part

into obstetric violence to the extent that it leads physicians to overestimate the risk of Vaginal Birth After Cesarean (VBAC)<sup>164</sup> and thus to prefer to perform unconsented cesareans over allowing the trials of labor.<sup>165</sup>

These are only examples of how most instances of obstetric violence can be traced to sexist conceptions of motherhood and pregnancy. But this is not to say that physicians and courts are motivated by intent to cause harm to women by allowing coerced medical procedures during labor. The point is that, despite their best intentions, the beliefs and values shown through medical and judicial discourse addressing the problem are part of a value system that subjugates women and diminishes their status in society.<sup>166</sup> What this means is that, although offenses are perpetrated by specific individuals, the phenomenon of obstetric violence has an aspect of structural violence and therefore, “the medical staff is not necessarily aware of performing this kind of violence, often functioning as an unconscious perpetrator of an existing violent structure (and even in some cases attempting to resist that structure).”<sup>167</sup>

Nonetheless, recognizing obstetric violence as a subset of gender-based violence is important even if the perpetrators are not aware of it, or maybe precisely *because* they are unaware of it. The framework of obstetric violence developed in Venezuela and Argentina is

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of childbirth undermines women’s rights to informed consent because women do not question their caregivers motivation or resist the ‘foregone conclusion’ of labor induction.”).

164. F. GARY CUNNINGHAM ET AL., NIH CONSENSUS DEVELOPMENT CONFERENCE STATEMENT ON VAGINAL BIRTH AFTER CESAREAN: NEW INSIGHTS, 1, 27 (2010), [https://consensus.nih.gov/2010/images/vbac/vbac\\_statement.pdf](https://consensus.nih.gov/2010/images/vbac/vbac_statement.pdf) [<https://perma.cc/3RRF-KQ3K>] (finding physicians significantly less willing to allow the trial of labor after cesareans because of their fear of liability risks “derive[d] from the perception that catastrophic events associated with trial of labor could lead to compensable claims with large verdicts or settlements for fetal/maternal injury” and despite evidence that VBAC reduces risks for women and the fetus in some cases).

165. Many of the cases involving coerced cesareans begin as planned VBACs. *See, e.g.,* Pemberton v. Tallahassee Mem’l Reg’l Med. Ctr., Inc., 66 F. Supp. 2d 1247, 1252–53 (N.D. Fla. 1999) (upholding court order to compel a woman that was planning a VBAC to undergo a cesarean surgery); Complaint at 2–4, Dray v. Staten Island Univ. Hosp., No. 500510/2014 (N.Y. Sup. Ct. filed Jan. 22, 2014) (describing how a physician ignored the patient’s preference for VBAC and performed a cesarean over her express refusal).

166. Shabot, *supra* note 64, at 241–45 (2016) (using feminist phenomenology to explain how obstetric violence is experienced alongside other subjugation mechanisms).

167. *Id.* at 236 n.7.

particularly well suited to highlight this aspect of the problem. For one, the legal treatment of obstetric violence was included in a larger statutory framework directed at protecting women against gender-based violence.<sup>168</sup> Not only that, the legal definition of the term explicitly articulates that obstetric violence often reflects a denial of agency to the birthing woman; it is described as “an appropriation of the body . . . by health personnel.”<sup>169</sup> The Venezuelan framework goes further by recognizing that obstetric violence *causes* a loss of agency, explicitly noting the “loss of autonomy and the ability to decide freely about their bodies and sexuality.”<sup>170</sup> Moreover, the term violence prioritizes the woman’s experience of violence over the physician’s view, thereby refusing to further subjugate her to the medically imposed characterization of childbirth. Argentina’s framework adopts a similar experience-oriented approach by recognizing obstetric violence as a modality of gender-based violence, which manifests as certain types of violence, defined as physical, psychological, sexual, economic and symbolic.<sup>171</sup> This distinction is particularly helpful in framing childbirth practices that women also experience as sexual violence,<sup>172</sup> in particular the performance of episiotomies without consent.

Moreover, because this framework is not centered around the “reasonable patient” and what she would do had she received information withheld by her attending obstetrician, the obstetric violence framework does not give courts a mirror to reflect idealized archetypes of the “good” mom and the “bad” mom. Indeed, the concept of obstetric violence as articulated in these legal statutes recognizes the centrality and control of women over the process, rejecting the hedges that American courts have often erected to

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168. See generally Law No. 26485, *supra* note 13 (including the regulation of obstetric violence in a statute created to provide for the full protection of women and eradicate gender-based violence); Law on the Right of Women to a Life Free of Violence, *supra* note 13 (criminalizing obstetric violence in a comprehensive statute that tackles an array of gender-based violence, including psychological, physical and sexual violence).

169. Law on the Right of Women to a Life Free of Violence, *supra* note 13, art. 15(13).

170. *Id.*

171. Law No. 26485, *supra* note 13, art. 5(3).

172. The law defines sexual violence broadly as “[a]ny action that implies a violation in all forms it may take, with or without genital touch, of the woman’s right to voluntarily decide matters relating to her sexual and reproductive life . . .” *Id.*

disguise the undermining of women's choices. Also, as the concept of obstetric violence is articulated in conjunction with the patient's right to a natural birth process, the obstetric violence framework denormalizes medical intervention and forces physicians and courts to articulate justifiable reasons for their choices, rather than ritualistic ones.

Finally, the legal frameworks established in Venezuela and Argentina to address obstetric violence were part of overall programs designed to address gender-based violence systemically, in all forms and types. This concept was conceived to work not only as a tool for prosecution and reparation, but also as a public policy guide for future actions by the government. For example, the Venezuelan law addresses obstetric violence in a statute created to address women's right to a life free of violence, establishing guiding principles for how education and prevention campaigns should be pursued to reduce incidences of gendered violence in the country, and creating monitoring systems to improve detection of the problem.<sup>173</sup> Similarly, the Argentinean framework inserted obstetric violence into a broader statute addressing violence against women that established principles that will guide how the state develops related public policies, such as education and prevention campaigns and systems for providing economic assistance to victims.<sup>174</sup> Given the absence of a public policy in the United States to address the systemic roots behind physician and court decisions overriding women's agency over childbirth, it may be useful to draw inspiration from a legal tool conceived for this purpose when implementing solutions.

### C. *Disentangling the Fight for Maternal Rights from Abortion Rights*

As explained above, courts and physicians have often conflated the decision that goes into choosing a childbirth procedure with the decision that a woman faces when choosing to have an abortion.<sup>175</sup> The obstetric violence framework can help childbirth rights advocates to weaken the abortion analogy by highlighting the violent nature of coerced medical procedures that differentiates this scenario from

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173. Law on the Right of Women to a Life Free of Violence, *supra* note 13, arts. 16–32.

174. Law no. 26485, *supra* note 13, arts. 7–15.

175. For further discussion of how courts and physicians blur the lines between abortion and legitimate childbirth choices, see *supra* Part I.B.



abortion restrictions. The obstetric violence framework problematizes coerced procedures not only in terms of a woman's right to choose her preferred delivery method; it inserts this right within the context of a women's right to a life free of violence.<sup>176</sup> Because it is hard for courts and physicians to argue that women are not entitled to a life free of violence, the potential for backlash is reduced. It also makes it harder to justify an interest in protecting the fetal potential for life that would somehow allow the state to sign off on violence against the mother-to-be, unless it argues against the characterization of the coercive procedure as "violence."

This is not to say that abortion rights are not fundamental to the autonomy of women over their body and reproductive process or necessary to ensure women's equality.<sup>177</sup> Maternal rights and abortion rights are simply different facets of the same quest for sexual and reproductive autonomy. But, given the amount of contention around abortion rights in the United States, it may not be the best strategy to address them simultaneously.

### III. A CALL FOR ACTION: AN AGENDA FOR IMPLEMENTING THE OBSTETRIC VIOLENCE FRAMEWORK IN THE UNITED STATES

The best way to introduce a prevention framework for obstetric violence in the United States would be to lobby Congress for a specific statute to introduce the concept into broader initiatives that address violence against women. As such, advocates may try to introduce the term in public policy statutes addressing gendered violence, in particular, in the Violence Against Women Act of 1994<sup>178</sup> or of 2000.<sup>179</sup>

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176. See Law No. 26485, *supra* note 13, art. 6 (translation by author) ("This law has as a purpose promoting and guaranteeing . . . the adequate conditions to sensitize and prevent, sanction and eradicate discrimination and violence against women in all its manifestations and scope . . ."); Law on the Right of Women to a Life Free of Violence, *supra* note 13, art. 1 (translation by author) ("This law has the purpose of guaranteeing and promoting the right of women to a life free of violence . . .").

177. See generally, e.g., Neil S. Siegel & Reva B. Siegel, *Equality Arguments for Abortion Rights*, 60 UCLA L. REV. DISCOURSE 160 (2013) (making the argument of why abortion rights are necessary if women are to enjoy full equality).

178. Violence Against Women Act of 1994 (VAWA), Pub. L. No. 103-322, tit. IV, 108 Stat. 1902 (codified as amended in scattered sections of 16, 18 and 42 U.S.C.), *invalidated in part by* United States v. Morrison, 529 U.S. 598 (2000).

179. Violence Against Women Act of 2000, Pub. L. No. 106-386, div. B, 114 Stat. 1491 (codified as amended in scattered sections of 42 U.S.C.).

“Incorporation of obstetric violence into these existing frameworks would provide opportunities for funding of research and investigatory bodies, victim restitution mechanisms, and rights-based education on respectful maternity care and prevention of mistreatment during childbirth for both patients and providers.”<sup>180</sup> This may be a better approach than seeking comprehensive regulation of the issue on a federal level, given the strength of the medical and insurance lobby in Congress.<sup>181</sup>

Because of restrictions on Congress’s power to legislate on civil liability for gender-based violence,<sup>182</sup> a legislative solution to address the civil liability side of coerced medical procedures in childbirth will have to be pursued at the state level. By creating an independent tort of obstetric violence, states would be free to establish requirements of proof that address the shortcomings of the existing system. This would mean, to start, legally recognizing women’s absolute right to make decisions over childbirth procedures, in spite of a state’s interest in preserving the fetus’s potential for life. Moreover, the creation of an independent tort would allow legislatures to properly consider noneconomic injuries without fear of increasing medical liability in other contexts. Because this change would increase recovery potential for women, it would help victims to overcome the problem of finding a lawyer to take their case.<sup>183</sup>

However, the experiences in Argentina and Venezuela suggest that the adoption of legal text is not enough. In Argentina, for example, “despite the passage of [the] 2004 statute guaranteeing the rights of birthing women and [the] 2009 statute prohibiting obstetric violence, courts adjudicating tort suits continue to rely on a malpractice analysis rather than the norms of humanized childbirth and freedom from

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180. Diaz-Tello, *supra* note 2, at 62.

181. Evidence of the strength of the medical liability lobby is readily available. One example is that a “House committee [has recently] advanced a tort reform bill that would put a nationwide cap on noneconomic damages in medical malpractice cases arising out of federally funded healthcare.” Y. Peter Kang, *House Bill To Cap Med Mal Damages Clears Committee*, LAW360 (Mar. 1, 2017), <https://www.law360.com/articles/897075/house-bill-to-cap-med-mal-damages-clears-committee> [<https://perma.cc/XXW2-5AEH>].

182. *Morrison*, 529 U.S. at 627 (finding that Congress did not have the power to regulate civil liability for gender-based violence).

183. For further discussion of how women have trouble finding lawyers willing to litigate their medical malpractice claims in cases that do not result in an injury to the fetus, see *supra* Part I.A.

violence.”<sup>184</sup> This means that aside from articulating the legal concept and succeeding in its adoption, childbirth advocacy groups will need to focus their efforts in promoting education among the population, legal practitioners, and the medical community. It may also be helpful to investigate possible administrative schemes to monitor reported occasions of coerced procedures.<sup>185</sup>

In terms of litigation strategies under the current torts of medical battery, malpractice, and lack of informed consent, it is unclear whether a change in the language used to describe coerced procedures would impact the courts’ reasoning. In Dray’s case, the amicus brief filed by the National Advocates for Pregnant Women and Human Rights in Childbirth used the term “obstetric violence” to describe the experiences of women coerced into treatment by physicians, but whether this will help sway the jury is still unclear.<sup>186</sup> The judge seemed unconvinced by their arguments when assessing Dray’s motion for summary judgment.<sup>187</sup> But the fact that childbirth rights advocacy groups in the United States have already embraced the obstetric violence concept in their legal arguments may be helpful in changing how legal decisionmakers address the phenomenon.<sup>188</sup> Similarly, as for preventing doctors from obtaining court orders compelling women to undergo certain procedures, it may be that describing the procedure in terms of obstetric violence will help courts to see the nature of the problem. Because this concept focuses on how women perceive the coerced procedure, it makes it less about choice and more about the right to be free from violence. This is likely to give the courts a reason

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184. Diaz-Tello, *supra* note 2, at 62.

185. A bipartisan group is currently trying to set up such a scheme for addressing maternal morbidity. Preventing Maternal Deaths Act of 2017, H.R. 1318, 115th Cong. (1st Sess. 2017). Monitoring for coercion during childbirth could easily be conducted in a similar fashion, or even as part of the same initiative, given that obstetric violence is thought to negatively impact maternal health.

186. *See generally* HRC Amicus Curiae, *supra* note 32 (using the term obstetric violence to describe the experience of women that suffered abuse during childbirth); National Advocates for Pregnant Women et al. as Amicus Curiae in Support of Plaintiff Rinat Dray, *Dray v. Staten Island Univ. Hosp.*, No. 500510/2014 (N.Y. Sup. Ct. filed Jan. 22, 2014) (using the term obstetric violence throughout the brief to describe the experience of women that suffered abuse during childbirth).

187. Order dated May 15, 2015 at 12, *Dray*, No. 500510/2014.

188. Sánchez, *supra* note 9, at 93–96 (recognizing that the concept of obstetric violence is perceived by advocacy groups as a powerful tool to raise social awareness to the issue).

to pause and think about how to phrase their decisions, because the case will not be “simply” about choosing among procedures.

As for criminalization of the practice, it is not essential to implementing an obstetric violence framework. In fact, in Mexican states that have criminalized the practice, “authorities are reticent to criminally charge physicians.”<sup>189</sup> However, even in absence of prosecutorial interest in charging physicians, criminalization might be helpful in shifting the public perception of coerced procedures.<sup>190</sup>

#### CONCLUSION

The obstetric violence framework used in Latin America may be a powerful tool to address the shortcomings of the American legal system regarding coerced procedures during childbirth. This framework could reshape how courts have historically addressed cases of coerced medical procedures during childbirth because it exposes the gendered aspect of the phenomenon, recognizes the gravity of the harm that results from these violations of women’s bodily autonomy, and prevents the debate over maternal rights from being bundled together with abortion rights. Whether such framework would be successful depends not only on its use in legal texts. There must also be education initiatives directed at communities, medical personnel, and legal practitioners to promote it as a viable and ethical way of addressing the issue of maternal rights during childbirth. Regardless, by articulating the problem from the perspective of women forced into traumatic labor experiences and by acknowledging their suffering and their status as victims of violence, the obstetric violence framework would do a lot more than the current American legal system.

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189. Diaz-Tello, *supra* note 2, at 62.

190. To this author’s knowledge, there is no empirical study so far that would support this hypothesis.