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Invisible wounds: obstetric violence in the United States

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Abstract: *In recent years, there has been growing public attention to a problem many US health institutions and providers disclaim: bullying and coercion of pregnant women during birth by health care personnel, known as obstetric violence. Through a series of real case studies, this article provides a legal practitioner's perspective on a systemic problem of institutionalized gender-based violence with only individual tort litigation as an avenue for redress, and even that largely out of reach for women. It provides an overview of the limitations of the civil justice system in addressing obstetric violence, and compares alternatives from Latin American jurisdictions. Finally, the article posits policy solutions for the legal system and health care systems. © 2016 Reproductive Health Matters. Published by Elsevier B.V. This is an open access article under the CC BY-NC-ND license (<http://creativecommons.org/licenses/by-nc-nd/4.0/>).*

Keywords: obstetric violence, disrespect and abuse in childbirth, mistreatment in childbirth, respectful maternity care, United States

Introduction

In June 2014, a Florida obstetrician, Dr. Sarah Digiorgi, declared to a television news interviewer that there is no such thing as a forced caesarean surgery.¹ Asked to comment on an incident unfolding at a nearby hospital, she told media, "If that woman says, 'No way, I refuse to have a C-section,' then you cannot take that person to the operating room."

Despite Digiorgi's insistence that no such thing was possible, this was the exact threat being levelled against Jennifer Goodall, a mother of three who hoped to deliver her fourth child vaginally after three caesareans. In her thirty-seventh week of pregnancy, Goodall had received a letter from her obstetrician's office. The letter, signed by the hospital's chief financial officer, advised her that the hospital planned to take the following actions:

- "1. We will contact the Department of Children and Family Services about your refusal to undergo a Cesarean section and other care and treatment recommended by your physicians and the high risks your refusals have on your life and health, as well as the life and health of your unborn child.*
- 2. We will begin a process for an Expedited Judicial Intervention Concerning Medical Treatment Procedures. This is a proceeding for expedited judicial intervention concerning medical treatment procedures relating to the delivery of your child.*
- 3. If you present to our hospital in labor, and your physician deems it clinically necessary, a Cesarean*

section will be performed with or without your consent."

The letter claimed that the hospital's ethics committee had authorized these threats and included a curious assessment of Goodall's rights:

"While we recognize that you have the right to consent to a Cesarean section, you have elected to refuse this procedure despite the advice of your treating physicians. This decision places both you and your unborn child at risk for death or serious injury. We will act in the best interests of you, your family, and your unborn child."

Seemingly, Goodall had a right to consent to the surgery, but not a right to refuse it. And for its part, the institution asserted a right to act in Goodall's best interest (as defined by the hospital) as well as that of her foetus and her family, even over her objection. Finally, having threatened her custody of her children by invoking child protective authorities, her right to due process of law, and her bodily integrity, the hospital urged her to "trust your physicians and our staff to do the right thing for you, your unborn child, and family."

What, then, of Digiorgi's assurance that there is no such thing as a forced caesarean? How is it reconciled with the hospital's claim – that it was justified in performing surgery "with or without" Goodall's consent? In fact, each is only half-right, and the truth is multi-layered: there is such a thing

as a forced caesarean, it is illegal, and it is seldom redressed by courts. Most importantly, forced surgery is only the most egregious indicator in a larger underlying pattern of disrespect and abuse toward pregnant and birthing women by health care providers and medical institutions.

Any forced surgery is a violent act. But forced *caesarean* surgery, that takes place in a setting where women hold less power than doctors, in a society where women's capacity for pregnancy has been historically used to sanction their exclusion from full citizenship, is more than a simple battery. It is a form of gender-based violence, increasingly recognized around the world as *obstetric violence*. Most importantly, as the case studies in this article bear out, this obstetric violence is an infringement of women's human rights to non-discrimination, liberty and security of the person, reproductive health and autonomy, and freedom from cruel, inhuman, and degrading treatment. Such an attack on women's human dignity requires a more robust state response than access to civil courts – a remedy that itself remains elusive.

This article takes the important step of acknowledging that the problem of obstetric violence exists in the United States – a proposition that, as Digiori's statement demonstrates, is not yet fully recognized. It begins with a discussion of several case studies from recent years (which are a key form of data to a precedent-based, or "common law", legal system such as that of the United States), which illustrate the nature of the problem. It then provides an overview of legal recognition in US courts, exposing the limitations of tort litigation as an avenue for addressing a systemic problem and providing a comparison to avenues of legal redress from other jurisdictions. Finally, it recommends some potential solutions to more fully address the root causes of obstetric violence.

Recent case studies

What follows is only a small sample of the numerous cases of obstetric violence, representing various levels of threat and actual violence, that have been documented or pursued by National Advocates for Pregnant Women and other maternity care advocacy organizations within the past several years.* It is difficult to get a sense of how prevalent the problem is from case reports alone; however, the

existing US research suggests that women experience significant pressure and loss of autonomy in maternity care. Roth et al² surveyed birth workers (including doulas, childbirth educators, and labour and delivery nurses) and found that more than half 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. The *Listening to Mothers III* survey by Declercq et al³ found that as many as a quarter of new mothers who had induced labours or caesarean deliveries felt pressure to do so, and 63% of women who had a primary caesarean identified their doctor as the "decision maker".[†] During the #BreaktheSilence social media campaign led by consumer advocate group *Improving Birth*, hundreds of women shared their experiences of bullying, coercion, and even unconsented procedures such as episiotomies and vaginal examinations during birth.⁴

While the incidents captured in legal and media reports are few in number compared to the approximately 4,000,000 births that take place in the US each year, their significance to the individuals who experienced the violation, and to the health systems in which they occur, is profound. And in a common law jurisdiction like the US, even a single story has the power to shape the law.

Unconsented surgery

Rinat Dray is an Orthodox Jewish woman from the Crown Heights area of Brooklyn, New York.^{5,6} In her religion, children are a blessing, and families welcome as many as possible. She delivered her first two children by caesarean surgery. The surgeries had been emotionally difficult for her and she had postoperative pain for many months; she also knew that having more surgeries would lead to greater risk to her health and fertility.⁷ Dray was therefore highly motivated to have a vaginal birth after caesarean (VBAC) for her third delivery.

When she became pregnant in 2010, she researched medical recommendations, including the American College of Obstetricians and Gynecologists' (ACOG) 2010 Practice Bulletin on VBAC,⁸ which says that VBAC after two surgeries can be a safe option for some women. Dray made use of

[†]That said, 83% of women in the same survey reported positive regard (either "good" or "excellent") for the US maternity care system.

*Individual cases have been shared with permission.

the resources available in New York City (including consumer advocacy and support groups, doula care, and a state-wide Maternity Information Act⁹ that requires all hospitals to disclose their caesarean and VBAC rates) to find a practice where she was most likely to achieve a VBAC.[‡] She settled on a hospital in Staten Island, which would require her to travel a significant distance over a notoriously high-traffic bridge while in labour, because it boasts one of the lowest caesarean rates and highest rate of VBAC success in the city's dozens of hospitals with maternity services.

When she arrived at the hospital in labour, the doctor present was not the one who had supported her planned VBAC throughout her pregnancy.⁶ This doctor urged her toward a caesarean, telling her “You had two before, why not have another one?” As the hours passed and her labour progressed slowly, the doctor became increasingly insistent that she have surgery, but offered no clinical justification for the urgency. She considered going back home to labour, but was told that if she left she should not come back, and that she could not transfer care to another facility because “nobody would take you”. When she asked for more time to labour, the doctor told her that he would get a court order against her to force surgery, and that the state would take her baby because she would not agree to surgery. According to legal documents filed by Dray, the doctor told her, “My license is more important than you.”

The obstetrician brought in a maternal-foetal medicine specialist who also urged Dray to have surgery, but neither physician cited an emergency to warrant it. Unknown to Dray, the physicians had consulted several times about getting a court order to force her into surgery. And although these events transpired over the course of a Monday morning and afternoon when courts were open, no court order was sought. Instead, the surgery was approved by hospital counsel, with the record by the specialist noting “the patient has capacity [to make her own medical decisions]. I have decided to override her refusal to have a c-section.”

As she was wheeled to surgery, Dray begged not to be operated on. The doctor just told her, “Don't speak”. Dray was seriously injured during the surgery, suffering a bladder transection that causes her pain

[‡]These resources are, of course, predicated on language and health literacy, access to information, and in the case of doula care, significant financial means.

and urinary issues to this day. She filed suit against the physicians and hospital, and her case is currently pending appeal, the trial court having rejected her argument and that of *amici curiae* (friend of the court) interveners that pregnant patients have a right to refuse any unwanted medical care on equal footing with other patients.⁶

Threats of arrest

At one week past her due date with her fifth child, Lisa Epsteen went to her ob/gyn clinic for an ultrasound.¹⁰ Having undergone four previous caesareans, the Tampa Bay, Florida mother was excited to have found a physician who would support her in attempting a trial of labour for the fifth birth. As her due date passed, however, Epsteen readied herself for the possibility of a repeat surgery, even agreeing to schedule the surgery because of health factors including gestational diabetes and the foetus's unfavourable position.

The physicians who saw her on the day of her ultrasound found the results concerning and advised that she report to the hospital for surgery. Epsteen did not have anyone to take care of her two-year-old and had the family's single vehicle with her, so she opted to wait to have the surgery a few days later as planned. The following morning, she woke to find an email from her obstetrician instructing her to report for immediate surgery, adding

“I would hate to move to the most extreme option, which is having law enforcement pick you up at your home and bring you in, but you are leaving the providers of [the hospital] no choice.”

Fearful that she was going to be arrested, separated from her children, and forced into unwanted surgery, Epsteen went into hiding. She contacted National Advocates for Pregnant Women, which consulted with the hospital's attorneys. Hospital counsel eventually agreed that the threats were legally unjustifiable, and Epsteen gave birth to a healthy baby on the previously agreed-upon date with no legal action taken.¹¹

Threats of child apprehension

In June 2010, Michelle Mitchell presented in active labour to a hospital in Augusta County, Virginia.¹² Mitchell had recently left the obstetrical practice where she had been a patient because of pressure to have an induction of labour due to a suspected large baby. Although an induction or caesarean had been recommended, she was never told that

a vaginal birth was not an option. Wishing to have an unmedicated vaginal delivery, Mitchell took childbirth classes, joined groups advocating natural birth, and hired a doula who is a certified professional midwife.

When Mitchell arrived at the hospital, the physician on call recommended that she deliver via caesarean surgery, based on her medical records. Mitchell declined, signing a form acknowledging that she was acting against medical advice and waiving liability. However, according to legal documents, the physician became more and more insistent, shouting and swearing at Mitchell and her doula and eventually threatening that he would get a magistrate to issue a court order to force her into surgery and call child protective authorities to have her baby taken away.¹³ Faced with the threat of forced surgery and loss of her infant, Mitchell rescinded her informed refusal and underwent surgery against her will. Despite her eventual acquiescence to the surgery, the hospital called child protective authorities, accusing Mitchell of being unfit to care for her child because of the conflict that arose from her decision to deliver vaginally. As a result, the hospital denied Mitchell immediate access to her newborn and refused to release the infant to her care, and she had to undergo three months of intrusive interviews and home observations by child welfare authorities before the investigation was dismissed as baseless.

Mitchell later filed suit for battery, alleging the consent for the surgery was obtained under duress and was therefore invalid. Her case survived numerous motions over more than four years of litigation. But when it finally went to trial, it took the jury less than 20 minutes to return a verdict in favour of the physician.¹⁴ One witness to the proceedings, a nurse who had worked with the defendant, told media that she felt the defendant “made the best choice for [Mitchell] and her baby.” Mitchell has since filed an appeal, which will – in the best case – lead to a retrial in the same jurisdiction.

The nurse’s comment illuminates the jury’s likely reasoning, and one of the major shortcomings of tort litigation as a tool for ending obstetric violence. Namely, juries are susceptible to the very biases that lead to obstetric violence in the first place. Despite the best efforts of attorneys and advocates in these cases, there is a persistent belief that physicians, instead of pregnant women,

are the ones vested with the decision-making authority, thereby justifying threat and coercion.

Profound injuries and piecemeal justice

All of the women described above suffered extreme incursions into their personal and reproductive autonomy and sense of security. They left the experience of birth feeling betrayed and frightened in addition to the physical challenge of giving birth (whether vaginally or surgically). Many of them experienced trauma that required therapy or changed the course of their reproductive lives. This is consistent with research by Ballard and others¹⁵ suggesting that even in high-resource settings, childbirth can be “an excruciating and terrifying experience.” Beck et al¹⁶ have found that degrading treatment and loss of dignity and control during birth can contribute to birth trauma and even postpartum post-traumatic stress disorder.

But despite the gravity of the injuries suffered, justice is elusive for many American women who experience obstetric violence. According to the common law of tort in most jurisdictions, anyone subjected to unconsented touching may sue for battery, even if that touching is for medical purposes.¹⁷ No law abridges this right for pregnant women. Even so, having a theoretical cause of action is not justice, and many women who have endured serious mistreatment find themselves barred from the courthouse door.

The first hurdle is even finding an attorney who will take their case. Funding a legal defence is extraordinarily expensive and beyond the means of most women. And as Abrams¹⁸ explains, absent 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 – or non-existent in the case of psychic injury – providing little incentive for attorneys from taking cases on a contingent fee basis. This may be so even when the violation is clear, as was the case for Kimberly Turbin, a California mother who captured an unconsented episiotomy on video and still had to consult nearly 80 attorneys and crowdsource a *pro se* legal defence fund to file on her own before finding an attorney who would pursue the case.¹⁹

Even women who manage to find an attorney may find that their case is time-barred or subject to unpredictable statutes of limitations. For instance, Rinat Dray struggled to find an attorney who would pursue her extraordinarily well-documented case of

unconsented surgery and only managed to find an attorney after the one-year statute of limitations for battery had expired. She was therefore left litigating the case as a malpractice and negligence suit, and the court has dismissed some of her claims on the basis that they amount to battery rather than malpractice. Other women have been told the opposite – that their allegations of abusive and unconsented interventions are malpractice instead of battery. The one predictable factor is that the correct cause of action usually seems to be the one that is time-barred, foreclosing litigation as an option.

Systemic failures with politicized roots

The most troubling aspect of leaving the adjudication of obstetric violence to the civil justice system is that it treats the matter as either a medical error or an interpersonal conflict similar to a fistfight on a street corner.⁵ The problem is significantly more complicated. One aspect is the perceived liability risk for harm to a foetus. This perception of risk, while usually significantly overestimated, leads practitioners to pressure or coerce women out of fear of malpractice liability,¹⁸ and institutions to implement policies that restrict women's choices about delivery.²¹ This, when combined with the low value ascribed to injury or failure of informed consent for the pregnant woman, results in perverse incentives. These are evident in the fact that the threats against Goodall were authored by the hospital's chief financial officer, and Dray's forced surgery was approved by the hospital's risk management counsel. But the perverse incentives are not the entire picture – obstetric violence is more than the aggregation of individual cost-benefit analyses. Rather, the lack of monetary value ascribed to birthing women's dignity is a symptom of pernicious beliefs about women's autonomy that have an independent, direct effect on interactions between providers and patients.

⁵There is one known exception – Catherine Skol filed suit for gross negligence and negligent emotional distress after being abused by a physician who refused her an epidural, made her lay in an excruciating position for hours, told her to “shut up and push”, when she protested, sewed an episiotomy with an inappropriately large needle, and told her that “pain was the best teacher” for her failure to notify the physician that she was coming to the hospital. She was awarded \$1.4 million by a jury, the highest Illinois verdict for negligent/intentional infliction of emotional distress in a medical malpractice case.²⁰

Oberman²² theorizes that the overmastering of a birthing woman's will is a breach of a fiduciary duty, (given the imbalance of information and power between the physician and the patient) driven by “divided loyalties” when physicians rationalize the foetus as a “second patient”. This is certainly so, but a survey conducted by Samuels et al²³ also points to underlying beliefs about women's reproductive autonomy as a significant factor in perpetration of obstetric violence. Samuels et al surveyed physicians and health attorneys and found that the personal value they ascribe to the foetus (i.e. anti-abortion or conservative attitudes) correlated strongly with their willingness to seek a court-ordered caesarean surgery over the protest of an unwilling patient. The authors concluded that this tension leaves women caught “in proxy wars between those who place a premium on maternal autonomy rights and those who believe that foetal interests are more compelling.” In this light, use of legal process to compel compliance is revealed as a violent policing of gender norms.

Physicians who attempt to justify obstetric violence with foetal protection usurp the role of carrying out the state's interest in the protection of potential life to a degree that has never been supported by US jurisprudence. The defendants in Rinat Dray's case argued as much, saying that it was “naïve and foolish” to suggest that pregnant patients have the same rights as others “given the considerations the pregnant status invokes”.⁶ The defendants went so far as to suggest that Dray should seek a legislative remedy rather than a litigated one; that is, they asserted that pregnancy creates *ipso facto* immunity for any act deemed by the medical provider to be in the best interest of a foetus. Calling her case “thought provoking” and “controversial”, the defendants claimed a duty on the part of physicians to vindicate the state's interest in protection of potential life, even over the objection of a competent and unwilling patient. To do so, they cited decisions that *favour* pregnant women, including New York's seminal cases establishing abortion rights²⁴ and establishing a duty to provide competent medical care to a foetus later born alive.²⁵ The defendants' assertions reveal the gender discrimination underpinning obstetric violence: women are guaranteed equal protection under existing law, but health care providers, institutions, and even courts are willing to “read in” exceptions that do not exist, perpetuating a second-class status for women under the law.

As Charles²⁶ argued in a controversial article, by enforcing coercive gender norms, bullying and court-mandated interventions share significant

features in common with domestic violence. Responses to the article were deeply divided,²⁷ but one recurring theme was the idea that the behaviours described cannot be gender-based violence because so many obstetricians are women. This misses an important understanding: an act of gender-based violence is not considered such because the *perpetrator* is a man, but rather because the *victim* is a woman. This explains research from around the world in which women were found to be abused by men *and* women in the birth setting.²⁸

Some of this unethical behaviour is likely related to the fact that the law has failed to directly rectify the lingering controversy among practitioners as to the appropriateness of overriding the decisions of pregnant patients in all jurisdictions. The ACOG Committee on Ethics is clear and directive in its opinion that forced surgeries and litigation over medical interventions are virtually never ethically justifiable.²⁹ And in spite of some aberrations in trial courts, modern case law rejects the notion that pregnant women have any lesser entitlement to the fundamental rights to bodily autonomy than any other person under the Constitution.^{30–32} But these rights do not always translate into remedies: extreme outliers exist both in practice and in academia.³³

The extent to which these outliers are held to account for their violation of women's common law and human rights beyond the civil justice system is unknown, but is likely quite limited. The ACOG Ethics Committee opinion is not legally binding – and was in fact excluded from evidence in Michelle Mitchell's case. One physician, who was sued for threatening a New Jersey mother with child apprehension and a court-mandated caesarean until she capitulated to surgery, openly admitted in a deposition that she disagreed with the notions that informed consent is necessary and that a pregnant woman is the ultimate decision maker about her healthcare. As she explained:

*“She certainly can refuse the C-section, that is not the problem. I respect patient's opinion. ...[But] I have two patients. I don't have just one patient ... that is why I disagree with the statement of your, of the American, whatever, ACOG, that the desire of the mother has to supersede the desire of the fetus. I disagree with that. ... I have an obligation now toward the baby. I've gotta speak for the baby because that is my second patient.”*³⁴

The gender bias underpinning the use of threats and coercion to enforce medical advice is not subtle.

It is axiomatic that a person of sound mind cannot be forced to undergo a medical procedure (such as a kidney transplant). This principle applies even if the procedure would save the life of another person and even if that other person were their child. Pregnant women, however, are expected to sacrifice their health and dignity, and even potentially their lives, in the name of having a healthy baby.

Alternatives in foreign law

The problems described throughout this article are not unique to the United States. Just last year, the World Health Organization (WHO)³⁵ issued a statement on the prevention and elimination of disrespect and abuse during facility-based childbirth. Calling the phenomenon “an important public health and human rights issue”, the WHO urged governments and development partners to research, recognize, and redress disrespectful and abusive maternity care. Moreover, the United Nations Special Rapporteur on health³⁶ and the Special Rapporteur on cruel, inhuman, and degrading treatment³⁷ have expressed concerns about mistreatment of pregnant women seeking reproductive health care as causing unnecessary suffering on the basis of gender. As Erdman notes,³⁸ the growing attention to childbirth in maternal rights advocacy has created opportunities to highlight institutional injustices and social inequities, and call for broader reform.

Latin America, where many countries have relatively newer, human rights-based constitutions and bodies of law, has taken the lead in creating legal structures addressing this issue. Venezuela was one of the first jurisdictions to create a statutory right of action recognizing obstetric violence.³⁹ Specifically, it is recognized as a form of gender-based violence as a part of the Organic Law on the Right of Women to a Life Free of Violence. The law defines 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.”

A number of examples are provided, including inattention to obstetric emergencies, birth in the lithotomy position, needless separation of mother

and child, and augmentation of labour or caesarean delivery without consent. The penalty for commission of obstetric violence is a fine of 250 to 500 tax units – the equivalent of \$5,000 to \$10,000 – and professional disciplinary proceedings. Argentina and ten Mexican states also recognize obstetric violence as a form of violence against women; the states of Chiapas, Guerrero, and Veracruz even impose criminal penalties on offenders. These laws provide a range of remedies, including administrative complaints, specialized medical arbitration, and complaints before federal and state human rights commissions.

It is critical to recognize that implementation of these laws has been beset by challenges, and women face significant barriers to justice because of lax enforcement, lack of rights-based training among health care providers, and failure to address infrastructural weaknesses.^{40–41} For instance, Herrera⁴² demonstrates that, in Argentina, despite the passage of a 2004 statute guaranteeing the rights of birthing women and a 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. In Mexico, *Grupo de Información en Reproducción Elegida* (GIRE)⁴³ has observed that authorities are reticent to criminally charge physicians, so there has never been a successful prosecution for obstetric violence. Moreover, the group points out that administrative complaints and medical arbitration focus on the acts of individual medical personnel, but not institutions as a whole.

Even so, the articulation of obstetric violence in law – specifically within the ambit of women’s human rights to health, equality, and freedom from violence – shows an understanding of the causes and consequences of abuses in childbirth that far exceeds that in US jurisprudence. Notably, complaints to Mexican state-based human rights commissions have recently yielded positive results, including restitution for women and agreements by the state to improve infrastructure and disseminate maternity care standards.⁴³ The work of eliminating gender-based violence in childbirth is far from complete, but legal frameworks that invoke state and institutional responsibility for ensuring respectful care in birth are promising.

Recommendations

The primary tool at the disposal of the US patient for creating change in the health care setting is tort

litigation. With respect to obstetric violence, this tool can be sharpened through legislative changes, including lengthening of statutes of limitations, delineating causes of action, and assigning punitive damages.

But even if all this came to pass, given the barriers to justice women face in a system that does not yet acknowledge obstetric violence, it is unlikely that abusive and disrespectful treatment in labour will be significantly changed by individual civil litigation in the near term. Obstetric violence is a systemic problem and therefore calls for systemic solutions. The Latin American model of inclusion of obstetric violence in bodies of law addressing gender-based violence is instructive. As research from these jurisdictions shows, imposition of penalties creates only limited change without preventative interventions to address attitudes that give rise to obstetric violence in the first place, promulgation of protocols for respectful care, and state accountability for prevention and redress for obstetric violence.

In spite of the general lack of redress for human rights violations by non-state actors in the US, federal policy regarding gender-based violence (specifically the Violence Against Women Act) provides a model for addressing the root causes of obstetric violence. Incorporation of obstetric violence into these existing frameworks would provide opportunities for funding of research and investigatory bodies, victim restitution mechanisms, and funding rights-based education on respectful maternity care and prevention of mistreatment during childbirth for both patients and providers. One such model for local, facility-based intervention is that undertaken by the White Ribbon Alliance and others worldwide.^{44,45} Additionally, some measure of state accountability could be instituted through development of concrete standards and benchmarks for respectful maternity care standards that can be attached to federal funding (e.g. the Maternal and Child Health Services Block Grant).

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. But the first step is to surface and name a problem toward which US law has largely turned a blind eye.

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Résumé

Ces dernières années, un problème que beaucoup d’institutions et prestataires de santé des États-Unis réfutent a attiré une attention publique croissante: les actes de maltraitance et coercition des femmes enceintes pendant l’accouchement de la part du personnel sanitaire, connus sous le nom de violence obstétricale. Par une série d’études de cas réels, cet article fournit la perspective d’un juriste sur un problème systémique de violence sexiste institutionnalisée avec pour l’heure uniquement des voies individuelles pour obtenir réparation. Il donne un aperçu des limitations du système de droit civil pour traiter la violence obstétricale et compare les options dans les juridictions latino-américaines. Enfin, l’article propose des solutions pour le système juridique et les systèmes de soins de santé.

Resumen

En los últimos años, el público ha prestado cada vez más atención a un problema negado por muchas instituciones y profesionales de salud en Estados Unidos: el acoso y la coacción de mujeres embarazadas durante el parto por personal de salud, conocido como violencia obstétrica. Por medio de una serie de casos reales, este artículo expone la perspectiva de un abogado respecto al problema sistémico de la violencia de género institucionalizada, con solo vías individuales para rectificación en la actualidad. Ofrece una visión general de las limitaciones del sistema de justicia civil para abordar la violencia obstétrica y compara las alternativas de jurisdicciones latinoamericanas. Por último, el artículo sugiere soluciones para el sistema jurídico y los sistemas de salud.