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## Legislative Approaches to Reducing the Hegemony of the Priestly Model of Medicine

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LEGISLATIVE APPROACHES TO REDUCING THE  
HEGEMONY OF THE PRIESTLY  
MODEL OF MEDICINE

*Nancy K. Kubasek\**

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## INTRODUCTION

In the late 1970s, the American Medical Association, in a draft of its principles of ethics, flatly stated: "paternalism by the profession is no longer appropriate."<sup>1</sup> Despite this verbal sanction against doctors "treating individuals in the way a father treats his children,"<sup>2</sup> this practice maintains salience in the medical profession today.<sup>3</sup>

The paternalistic relationship between doctors and patients, although often assumed to be gender-neutral,<sup>4</sup> has specific implications for women. This Article concerns itself with how the physician's paternal role affects women as a heterogenous, as opposed to a homogenous, class of people.<sup>5</sup> The paternalistic relationship between doctors and their female patients<sup>6</sup> has different ramifications according to the race and socioeconomic class of the woman being treated.

The "priestly model" of medicine<sup>7</sup> captures well the dynamics of this gender-specific medical relationship. This Article argues that

1. Robert M. Veatch & Ernest Tai, *Talking About Death: Patterns of Lay and Professional Change*, ANNALS AM. ACAD. POL. SOC. SCI., Jan. 1980, at 38.
2. Tom L. Beauchamp, *Medical Paternalism, Voluntariness, and Comprehension*, in ETHICAL PRINCIPLES FOR SOCIAL POLICY 123, 124-25 (John Howie ed., 1983).
3. See Beauchamp, *supra* note 2, at 123 ("The patient/physician relationship is essentially paternalistic."); See also Allen E. Buchanan, *Medical Paternalism*, in PATERNALISM 61, 63-65 (Rolf Sartorius ed., 1983); JAY KATZ, THE SILENT WORLD OF DOCTOR AND PATIENT (1984). While not explicitly identifying it as paternalism, Katz says:

This book will offer contemporary and historical evidence that patients' participation in decision making is an idea alien to the ethos of medicine. The humane care that physicians have extended to patients throughout the ages rarely has been based on the humaneness of consensual understanding; rather it has been based on the humaneness of services silently rendered.

See KATZ, *supra* at xvi-xvii.

4. See Beauchamp, *supra* note 2, at 125; see also Buchanan, *supra* note 3, at 63-65; KATZ, *supra* note 3, at xvi-xvii.
5. Because gender is racialized and informed by class structure and history, it cannot be binary: "all women do not have the same gender." Elsa Barkley Brown, *Polyrhythms and Improvization: Lessons for Women's History*, HIST. WORKSHOP, Spring 1991, at 85, 88.
6. Unless otherwise stated, hereinafter the patient in this relationship will be assumed to be female.
7. "The main ethical principle which summarizes [the] priestly tradition is 'Benefit and do no harm to the patient.' . . . It takes the locus of decision-making away from the patient and places it in the hands of the professional." Robert M. Veatch, *Models for*

physicians' adherence to this model has a deleterious effect on women's reproductive health as well as gender justice. Recognizing, however, the deep historical roots of allegiance to this model,<sup>8</sup> this Article's primary intention is not to revolutionize doctors' attitudes and treatments of their patients.<sup>9</sup> Instead, the focus here is on the law.

This Article presents the case that the legal culture in many ways undergirds the priestly model's hegemony over the therapeutic relationship between a woman and her doctor. To the extent that law provides this fundamental support, it legitimizes the mistreatment of women, especially with respect to their reproductive health. The implications are that the movement toward a more just legal culture necessitates the extirpation of this support.

Part I describes the priestly model, explains why it aptly characterizes the doctor-patient relationship, and argues that as a

*Ethical Medicine in a Revolutionary Age*, in BIOMEDICAL ETHICS 55, 56 (Thomas A. Mappes & Jane S. Zimbaty eds., 1991).

8. The Hippocratic Oath reads as follows:

I swear by Apollo Physician, Asclepis, by Health, by Panacea and by all the gods and goddesses, making them my witnesses, that I will carry out according to my ability and judgment, this oath and this indenture.

... I will use treatment to help the sick according to my ability and judgment, but never with a view to injury and wrongdoing.

Neither will I administer a poison to anybody when asked to do so, nor will I suggest such a course. Similarly I will not give to a woman a pessary to cause abortion. I will keep pure and holy both my life and my art.

... In whatsoever houses I enter, I will enter to help the sick, and I will abstain from all intentional wrongdoings and harm, especially from abusing the bodies of man or woman, bond or free.

And whatsoever I may see or hear in the course of my profession in my intercourse with men, if it be what should not be published abroad, I will never divulge, holding such things to be holy secrets.

Now if I carry this oath, and break it not, may I gain forever reputation among all men for my life and for my art.

Hippocrates, *The Physician's Oath*, in FAMILIAR QUOTATIONS 71 (Justin Kaplan ed., 16th ed. 1992).

9. This is not to say that such revolutionizing should not be undertaken. The achievement of dramatic changes in physicians' attitudes is not hopeless; however, in many cases, including this one, changing the law is necessary for changing behavior. For example, before the abolition of slavery, *some* slaveholders freed those whom they enslaved. However, the *wholesale rejection* of slavery did not come until *after* the law abolishing it was passed. See generally Lea Vandervelde & Sandhya Subramanian, *Mrs. Dred Scott*, 106 YALE L.J. 1033 (1997).

consequence of the priestly model's hegemony, it reinforces negative stereotypes of women. Part II continues to highlight the negative implications of the priestly model for women, but the discussion takes a decidedly legal turn. Specifically, it examines how laws pertaining to sterilization, implied consent, cesarean sections, and midwifery reinforce the unequal power relationship between doctor and patient to the detriment of all women and especially women of color and of low socioeconomic class. Finally, Part III will suggest legal changes that might promote the medical community's movement away from both the priestly model and the harmful consequences attendant to it.

## I. THE HEGEMONY OF THE PRIESTLY MODEL

### *A. Explication of the Model*

Broadly construed, the priestly model of medicine<sup>10</sup> is based on a parental relationship between the physician and the lay person. The guiding principle of this model is that the physician should benefit the patient without doing harm. The priestly model rests on two assumptions. First, that a significant power and knowledge differential exists between physician and patient. Consequently, the health care provider is expected to make decisions for the patient,<sup>11</sup> whose autonomy with respect to decision-making is presumed to run counter to her own personal well-being.<sup>12</sup> In essence, the doctor fills a parental role for the patient.

This parental role is not gender neutral. The vast majority of higher paid, higher status positions in the medical profession are occupied by

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10. Robert M. Veatch, Director of the Kennedy Institute of Ethics at Georgetown University and Adjunct Professor at Georgetown Medical School, discusses the priestly model of medicine in his piece *Models for Ethical Medicine in a Revolutionary Age*. See Veatch, *supra* note 7, at 56.

11. See, e.g., *supra* note 8.

12. The historical roots of societal norms against patient autonomy are deeply entrenched. The American Medical Association's (AMA) third edition of its Code of Ethics, published in 1879, stipulated that patients should be submissive to their doctors: "obedience . . . to the prescriptions of [their] physician should be prompt and implicit. . . . [They] should never permit [their] own crude opinions to . . . influence [their] attention to [their physicians]." AMERICAN MEDICAL ASSOCIATION CODE OF MEDICAL ETHICS, 11-12 (3d ed. 1879).

men. As of 1973, just 8.3 percent of all physicians were women,<sup>13</sup> and by 1993 the number had increased to only nineteen percent.<sup>14</sup> While there has been an increase in medical school admissions for women in recent years, women's numbers in the medical profession are still sparse vis-à-vis their proportion of the entire population. Thus, the priestly model is not only parental, but paternal. Frequently, control of the patient's health is in the hands of the health care provider, who is usually an upper-middle class man of European descent, and who probably possesses the values and priorities of his gender and class.<sup>15</sup>

As recent research suggests, the physician's paternalistic role under the priestly model is one that the patient accepts, but not simply because she has no other choice.<sup>16</sup> Instead, the patient herself responds to societal expectations by endorsing the relationship with her physician.<sup>17</sup> In most cases, the woman recognizes the skill and knowledge differential between herself and the physician vis-à-vis medical considerations and interprets this differential as necessitating a paternalistic role for the physician.<sup>18</sup> The patient believes that because the doctor knows more, he should make *all* the decisions. Thus, the woman fulfills the model described by the AMA's Code of Ethics.<sup>19</sup>

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13. See MARYLAND PENNELL & SHIRLENE SHOWELL, *WOMEN IN HEALTH CAREERS: STATUS OF WOMEN IN HEALTH CAREERS IN THE UNITED STATES AND OTHER SELECTED COUNTRIES* 26 (1975).
  14. See AMERICAN MEDICAL ASSOCIATION, *PHYSICIAN CHARACTERISTICS AND DISTRIBUTION IN THE U.S.* 50, 52 (1994) (reporting that 125,899 of 670,336 physicians in 1993 were women). Because males predominate not only in practice but also in the teaching institutions, there is a high likelihood of the overall profession's being paternalistic as opposed to maternalistic.
  15. See Ben Gose, *Women's Place in Medicine*, *CHRON. HIGHER EDUC.*, Nov. 3, 1995, at 49-50.
  16. See SUE FISHER, *IN THE PATIENT'S BEST INTEREST* 6 (1986). Patients "were not too emotional to understand complex medical explanations, nor were they too passive to ask for needed information. . . . Patients believed that the doctors had information and skills that they lacked; they believed, therefore, that the doctors should be the ones making the medical decisions." FISHER, *supra* at 6.
  17. See FISHER, *supra* note 16, at 6.
  18. See FISHER, *supra* note 16, at 6. After spending six years in two large teaching hospitals examining the manner in which doctors and patients communicate to reach decisions, Fisher concluded that patients "believed that the doctor knew best and would act in their best interests." FISHER, *supra* note 16, at 6.
  19. See *supra* note 12 and accompanying text.

### B. *The Priestly Model's Dominance*

Evidence of the priestly model's applicability to physicians' attitudes and actions in women's health care is abundant. The extent to which the childbirth process is controlled by male obstetricians is one illustration. As one resident in obstetrics and gynecology wrote "[in the hospital] . . . the doctor's word is law, and the patient's proper attitude is submission."<sup>20</sup> The doctor, regardless of his experience, is considered a "fount of knowledge," and the woman is characterized as "anxious" and "messy," and perhaps even "ashamed" and "guilty."<sup>21</sup> Moreover, the use of the verb "deliver" as an active transitive verb, as in "he delivered her child," places the male practitioner in the locus of control.<sup>22</sup> The man "delivering" assumes an active role in the birthing process while the woman is linguistically conceptualized as a passive participant—a seeming contradiction to her physical labor.

Residents' preferred patient types provide another example of the priestly model's hegemony. Diana Scully surveyed obstetrics and gynecology residents in several large hospitals and found that the residents preferred "happy, obedient, respectful, and thankful patients."<sup>23</sup> In addition, these residents indicated to Scully that they preferred middle-class women with middle-class values, including a respect for authority.<sup>24</sup> She reported no examples of residents expressing a preference for inquisitive patients who want to secure active roles in their care.<sup>25</sup>

The nature of doctor-patient communication provides great insight into the power differential present in this relationship and further demonstrates the dominance of the priestly model. In a 1993 Commonwealth Fund survey of 2,500 women, one in four said that they had been "talked down to" by their physician,<sup>26</sup> while one in

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20. MICHELLE HARRISON, *A WOMAN IN RESIDENCE* 93-94 (1982).

21. See generally, MOSBY'S GUIDE TO PHYSICAL EXAMINATION (Henry Seidel et al. eds., 3d ed. 1995).

22. See generally, THE WOMEN AND LANGUAGE DEBATE: A SOURCEBOOK (Camille Roman et al. eds., 1994).

23. DIANA SCULLY, *MEN WHO CONTROL WOMEN'S HEALTH* 92 (1980).

24. See SCULLY, *supra* note 23, at 91-93.

25. See SCULLY, *supra* note 23, at 91-93.

26. See LESLIE LAURENCE & BETH WEINHOUSE, *OUTRAGEOUS PRACTICES: THE ALARMING TRUTH ABOUT HOW MEDICINE MISTREATS WOMEN* 331 (1994).

five claimed that they had been told that a condition was "all in your head."<sup>27</sup>

A physician expects patients to provide requested information.<sup>28</sup> While it is appropriate for patients to express uncertainty, request clarification, and even occasionally to interrupt, physicians believe their patients should neither disagree with their physician nor expand or amend the topic under discussion.<sup>29</sup>

A final illustration of the appropriateness of the priestly model for characterizing these doctor-patient relationships is the gynecological examination. From the time she enters the examination room, the patient is put in a position that heightens her childlike status with respect to the doctor. Upon entering the examining room, she is usually told to undress and is given a paper gown to put on. At the request of a nurse, the woman patient usually lies on her back "looking at a blank ceiling while waiting . . . for him (i.e., the doctor) to enter . . . [with] no one thinking that 'meeting' a doctor for the first time in this position is slightly odd."<sup>30</sup>

The physician's position of strength affords him the luxury of stipulating the conditions under which the meeting will occur, often with little regard for the patient's wishes or needs. While patients enter medical interactions from a position of relative weakness, physicians often take few or no steps in the structuring of gynecological examinations to alleviate the discomfort of this position and, in fact, they often exacerbate it.<sup>31</sup>

The general dominance of the priestly model of medicine reinforces negative social stereotypes of women. Physicians' belief that women are like children is encouraged and reinforced,<sup>32</sup> thereby

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27. See LAURENCE & WEINHOUSE, *supra* note 26, at 331.

28. See FISHER, *supra* note 16, at 80.

29. See FISHER, *supra* note 16, at 80.

30. Ellen Frankfort, *Vaginal Politics*, in SEIZING OUR BODIES 263, 266 (Claudia Dreifus ed., 1977).

31. The most recent textbooks however, have begun to recognize the need for doctors to modify their behavior to make women feel more comfortable. One text, for example, tells physicians that the patient will be anxious and that the doctor should try to make eye contact with the patient during the exam because such contact is "a humanizing gesture that will not be unappreciated by the patient." The doctor is also advised to tell the patient when he is about to start to perform the examination. See MOSBY'S GUIDE TO PHYSICAL EXAMINATION, *supra* note 21, at 542.

32. See HARRISON, *supra* note 20, at 88. Recounting an incident which occurred during her residency, the author describes a male obstetrician's angry reaction to her suggestion that one would not simply provide drugs to a woman experiencing pain in labor.



belittling women's advances and achievements. Women continue to be associated with characteristics devalued in our culture and even though stereotyping has declined, "women continue to be typecast as more emotional, more passive, more excitable, and less aggressive."<sup>33</sup> Historically, this characterization of women has been especially prevalent in medical texts. A systematic review of the twenty-seven most widely used medical texts published between 1943 and 1973 found a continued reinforcement of the stereotyped roles for women.<sup>34</sup>

While reinforcement of negative conceptions of women is deleterious to the struggle for equality, a related and perhaps more important difficulty with the priestly model is that it greatly restricts women's control over their own health. The harmful consequences of this stricture on women's autonomy and self-expression with respect to care for their health will be developed in subsequent sections. As this Article will argue, a primary force in the structure is the law's reinforcement of the priestly model of medicine.

## II. LEGAL SUPPORT FOR THE PRIESTLY MODEL

### *A. Sterilization*

Although both men and women can and, in fact, do undergo sterilization, statistics show this method of contraception is strongly associated with women. About one million people are sterilized every year, and of those, two-thirds are women.<sup>35</sup> The gender disparity in sterilization rates, however, is not necessarily a sign that women's mates and doctors treat them unfairly. Arguably, the choice to undergo sterilization is a manifestation of a woman's more general

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33. FISHER, *supra* note 16, at 157.

34. See Diana Scully & Pauline Best, *A Funny Thing Happened on the Way to the Orifice: Women in Gynecology Textbooks*, 78 AM. J. SOC. 1045, 1045 (1973). There have been no recent systematic studies since this one. The medical profession is still dominated, however, by physicians trained with the same texts referred to in this study. See HARRISON, *supra* note 20, at 250 (critiquing the current system, Dr. Michelle Harrison wrote, "Physicians are trained and conditioned to see their patients as objects to be assembled and reassembled once they enter the system. If you are sick, or even if you are having a baby, you are presumed to be incapable of intelligent judgment, and therefore under the control of experts.").

35. See Lynn Smith, *For Millions, Sterilization is the Answer—But Regrets Are Not Uncommon*, L.A. TIMES, Jan. 6, 1993, at A12.

decision to seize control of her body and her reproductive future, an effective counter to portrayals of her gender as "passive."<sup>36</sup>

This interpretation becomes somewhat problematic when extended beyond theory. Figures reported in a 1993 Senate hearing on hysterectomies indicate that between twenty-four and thirty percent of all hysterectomies are "unnecessary."<sup>37</sup> While forty percent of women in the United States undergo hysterectomies by the age of sixty, the Swedish rate is just ten percent.<sup>38</sup> The Swedish statistic supports the U.S. Senate conclusion that many hysterectomies are unnecessary.

The high rate at which women undergo unnecessary operations on the advice of their doctors is troublesome for several reasons. First, hysterectomies are not operations performed without risk. In addition to the incidence of death subsequent to this surgical procedure, estimates suggest that nonfatal complications occur in somewhere between twenty-five to fifty percent of the cases; long term effects of hysterectomies may include premature ovarian failure, persistent pelvic pain, and depression.<sup>39</sup> Second, arguably, hysterectomies are objectionable because they make a mockery of women's autonomy. One might assume few women would undergo major surgery such as a hysterectomy unless they think it necessary. Thus, to the extent that physicians may deceive or misinform women with respect to this

36. See *supra* notes 32–34 and accompanying text for a discussion of women's character as passive.

37. *Unnecessary Hysterectomies, The Second Most Common Major Surgery in the United States: Hearing Before the Subcomm. on Aging of the Senate Comm. on Labor and Human Resources*, 103d Cong. (1993) [hereinafter, *Hysterectomy Hearings*]. Although "unnecessary" was not explicitly defined by Congress, the hearing referred to inappropriate reasons for hysterectomies:

Hysterectomy is rarely appropriate for chronic pelvic pain or pelvic congestion syndrome. Hysterectomy should not be performed as prophylaxis against cancer, for contraception in a gynecologically normal patient, for management of the menopause, for chronic cervicitis, for primary dysmenorrhea, for premenstrual tension, for mild urinary incontinence, for a single episode of postmenopausal bleeding, for an abnormal Pap smear report, or for mild or moderate cervical dysplasia. Practitioners sometimes attempt to justify hysterectomy by combining several inappropriate indications, any one of which would not justify the hysterectomy alone. Combining inappropriate indications to justify hysterectomy does not constitute appropriate practice. Instead, each indication should be treated individually.

Hysterectomy Hearings, *supra* at 109.

38. See *Hysterectomy Hearings, supra* note 37, at 83.

39. See *Hysterectomy Hearings, supra* note 37, at 26.

decision, a woman's choice in a practical sense is a quasi-choice at best and a non-choice at worst.

The rate of unnecessary hysterectomies is also troublesome because of the manner in which racial considerations appear to influence doctors' paternalistic decisions. Areas in the South with large populations of African-American women have the highest rates of hysterectomies in the nation.<sup>40</sup> Data analysis of hospital discharge records affirms the correlation between race and hysterectomy rates suggested by the regional disparities.<sup>41</sup> Even more disturbingly, recent research links hysterectomies for African-American women with higher postsurgery complication rates, including death.<sup>42</sup>

The history of sterilization in the United States prompts us to consider the role played by racial and class biases in not only physicians' paternalistic medical decisions but in their legal judgments as

40. See ROBERT POKRAS, U.S. DEP'T OF HEALTH & HUMAN SERV., PUB. NO. 85-1753, *HYSTERECTOMIES IN THE UNITED STATES, 1965-84*, 19 (1987) (reporting data from the National Health Survey indicating that among women age 15-44, the hysterectomy rate was 10.0 per 1000 women in the South in 1984, while it was 3.8, 6.7, and 7.9 in the Northeast, North Central, and West regions respectively); see also Charlotte Rutherford, *Reproductive Freedoms and African American Women*, 4 *YALE J.L. & FEMINISM* 255, 274 (1992).

41. See Lynne S. Wilcox et al., *Hysterectomy in the United States, 1988-1990*, 83 *OBSTETRICS & GYNECOLOGY* 549, 551 (1994) (using 1988 to 1990 data from National Hospital Discharge Survey and concluding that hysterectomy rates were 61.7 per 10,000 for African-American women compared to 56.5 for white women); see also Kristen H. Kjerulff et al., *Hysterectomy and Race*, 82 *OBSTETRICS & GYNECOLOGY* 757, 762-64 (1993) (analyzing discharge summary data for 53,159 hysterectomies that occurred in Maryland between 1986 and 1991 and concluding that the hysterectomy rate for African-American women was 49.5 per 10,000 while that for white women was 41.2 per 10,000).

42. See Kjerulff et al., *supra* note 41, at 761-62 (reporting that African-American women were at a higher risk of one or more postsurgical complications relative to white women and that African-American women had more than three times the in-hospital mortality rate of white women); see also Theresa Wiltz, *Hysterectomy Hysteria*, *ESSENCE*, Oct. 1992, at 24 (citing a University of Maryland at Baltimore Medical School study concluding that African-American women, compared to white women, are more than two times as likely to die from hysterectomy procedures).

It should be noted that higher rates of some diseases among African-American women might account for the ethnic disparities in both hysterectomy operation and complication rates. See Wilcox, *supra* note 41, at 532 (reporting that the primary diagnosis for 61% of African-American women, receiving hysterectomies in the data sample was uterine leiomyoma, or "fibroid tumor," while the same figure was just 29% for white women). See also Kjerulff et al., *supra* note 41, at 760 (reporting that the primary diagnosis was uterine fibroids for 65.4% of African-American women and 28.5% for white women).

well. Contrary to the celebratory hypothesis that sterilization is strictly a manifestation of a woman's exercising her autonomy, Robert Blank argues that at the turn of the century social control was the basis for interest in sterilization in the United States.<sup>43</sup> Law and medicine intersected, as "medical theories postulating that mental illness was inherited and by social elitist theories stemming from Darwinism" led to legislation.<sup>44</sup>

Indiana adopted the nation's first sterilization statute in 1907.<sup>45</sup> Between 1907 and 1964, at least 63,000 people were sterilized in the United States under similar laws legalizing sterilization.<sup>46</sup> One estimate reports that over half of these sterilizations were done to persons classified as mentally retarded.<sup>47</sup> As of 1961, state law in twenty-six states made involuntary eugenic sterilization legally possible.<sup>48</sup> Having passed through a good part of the Civil Rights Era, sixteen states still had such laws on the books in 1972,<sup>49</sup> and many retained them throughout the 1970s.<sup>50</sup>

Oftentimes, it was poor women and women of color, two groups that often overlap, who suffered most, usually at the hands of public assistance officials.<sup>51</sup> These officials reportedly "tricked . . . [African-American] welfare recipients into consenting to sterilization of their teenage daughters."<sup>52</sup> In North Carolina alone, more than 7,500 women were sterilized for what was alleged to be mental retardation from 1933 through 1974, and 5,000 of them were African-Americans.<sup>53</sup> As of 1973, more than forty percent of women sterilized

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43. See ROBERT H. BLANK, *FERTILITY CONTROL: NEW TECHNIQUES, NEW POLICY ISSUES* 57 (1991).

44. BLANK, *supra* note 43, at 57.

45. See Dan L. Burk, *Patenting Transgenic Human Embryos: A Nonuse Cost Perspective*, 30 Hous. L. Rev. 1597, 1645 n.367 (1993) (citing J.H. Landman, *The Human Sterilization Movement*, 24 J. CRIM. L. & CRIMINOLOGY 400, 403 (1933)).

46. See JONAS ROBITSCHER, *EUGENIC STERILIZATION* apps. at 118-19, 123 (1973); see also Helen Rodrigues-Triaz, *Sterilization Abuse*, in *BIOLOGICAL WOMAN: THE CONVENIENT MYTH* 147, 148 (Ruth Hubbard et al. eds., 1982).

47. See ROBITSCHER, *supra* note 46, app. at 123 (illustrating that 33,374, or 52.4%, of forced sterilization patients were labeled mentally retarded).

48. See PHILLIP R. REILLY, *THE SURGICAL SOLUTION: A HISTORY OF INVOLUNTARY STERILIZATION IN THE UNITED STATES* 148 (1991).

49. See GENA COREA, *THE HIDDEN MALPRACTICES: HOW AMERICAN MEDICINE TREATS WOMEN AS PATIENTS AND PROFESSIONALS* 128 (1977).

50. See COREA, *supra* note 49, at 128.

51. See Nancy Ehrenreich, *The Colonization of the Womb*, 43 DUKE L.J. 492 (1993).

52. Rutherford, *supra* note 40, at 273.

53. See ANGELA Y. DAVIS, *WOMEN, RACE, AND CLASS* 217 (1981).

in federally financed "family programs" were African-American.<sup>54</sup> Additionally, many "Native American women, under twenty-one years of age, were subjected to radical hysterectomies and informed consent procedures were ignored."<sup>55</sup> In 1976, twenty-four percent of Native American women of childbearing age had been sterilized.<sup>56</sup> A law journal article at the time reported that "[t]he overall increase in surgical sterilizations has taken place disproportionately by sex, race, class, and age."<sup>57</sup>

Statistics from the 1980s suggest that this has continued. In 1982, while just fifteen percent of European-American women had undergone sterilization, the same was true for twenty-four percent of African-Americans, thirty-five percent of Puerto Ricans, and forty-two percent of Native Americans.<sup>58</sup> In 1985, the Committee to Defend Reproductive Rights reported that sterilization rates were forty-nine percent higher for women on welfare.<sup>59</sup>

Throughout this legacy of legislatively permitted sterilization, the judiciary has played an integral role. Twenty years after Indiana adopted the nation's first sterilization statute in 1907,<sup>60</sup> the Supreme Court first addressed the issue. In *Buck v. Bell*,<sup>61</sup> the Court upheld the constitutionality of Virginia's statute permitting involuntary sterilization.<sup>62</sup> Fifteen

54. See Rodrigues-Triaz, *supra* note 46, at 149 (citing survey research on women in federally funded family planning programs in 1972); Denton Vaughan & Gerald Sparer, *Ethnic Group and Welfare Status of Women Sterilized in Federally Funded Family Planning Programs—1972*, 6 FAM. PLAN. PERSP. 224 (1974).

55. Rutherford, *supra* note 40, at 273; see also Rodrigues-Triaz, *supra* note 46, at 147.

56. See DAVIS, *supra* note 53, at 218 (citing testimony by Dr. Connie Uri at a Senate committee hearing).

57. Dick Grosboll, *Sterilization Abuse: Current State of Law and Remedies for Abuse*, 10 GOLDEN GATE U. L. REV. 1147, 1153 (1980); see also Activities of the Indian Health Service, General Accounting Office, HRD-77-3 (1976) (finding that there had been 3,000 female sterilizations performed over a four-year period in federally funded Indian Health Service facilities using consent forms not in compliance with the federal regulations).

58. See Rutherford, *supra* note 40, at 273-74 (citing Vicki Alexander, *Black Women and Health*, 6 CHOICES 6, 16 (1986)).

59. See BLANK, *supra* note 43, at 65.

60. See *supra* note 45 and accompanying text.

61. *Buck v. Bell*, 274 U.S. 200 (1927).

62. See *Buck*, 274 U.S. at 208. In denying that a compulsory sterilization of Carrie Buck, "a feeble minded white woman," violated the Fourteenth Amendment's Equal Protection Clause, Justice Holmes offered a seemingly utilitarian perspective in his derogation of the mentally handicapped:

We have seen more than once that the public welfare may call upon the best citizens for their lives. It would be strange if it could not call upon

years later, in 1942, the Court placed the first limitations on sterilization in *Skinner v. Oklahoma*.<sup>63</sup>

More recently, the courts have played a more indirect role in supporting the sterilization of women against their will. Currently, five states have legislation permitting involuntary sterilization.<sup>64</sup> Until 1980, such statutes were generally a necessary condition for court-ordered sterilizations.<sup>65</sup> However, such statutes are not always essential. Because of a series of state supreme court decisions in the 1980s,<sup>66</sup> the lower courts of general jurisdiction in eight additional states can now decide sterilization petitions even in the absence of an express grant of power to do so by the legislature.<sup>67</sup> Thus, court ordered sterilizations that supplement physician paternalism and further weaken

*those who already sap the strength of the State for these lesser sacrifices . . . in order to prevent our being swamped with incompetence.*

*Buck*, 274 U.S. at 207 (emphasis added).

63. *Skinner v. Oklahoma*, 316 U.S. 535, 541 (1942) (arguing that the Oklahoma statute's unequal treatment of similar crimes such as theft and embezzlement, where the former could be punished with sterilization and the latter could not, was unacceptable because of the gravity of sterilization as a punishment). In delivering the opinion of the Court, however, Justice Douglas distinguished the judgment in *Buck v. Bell*, and left the door open for compulsory sterilization. See *Skinner*, 316 U.S. at 538.
64. See DEL. CODE ANN. tit. 16, §§ 5701-5716 (1995) (permitting involuntary sterilization); IDAHO CODE §§ 39-3901 to 39-3910 (1993) (permitting involuntary sterilization); MISS. CODE ANN. §§ 41-45-3 to 41-45-19 (1996) (permitting sterilization of patients and inmates at state mental hospitals when it is in the best interests of the patient and society); N.C. GEN. STAT. §§ 35-36 to 35-50 (1990) (permitting sterilization of mentally ill or mentally retarded persons); W. VA. CODE §§ 27-16-1 to 27-16-5 (1992) (allowing sterilization of the mentally incompetent upon consent and court approval).
65. See BLANK, *supra* note 43, at 69 ("Until 1980, with very few exceptions . . . the vast majority of courts ruled that they had no authorization to order permanent sterilization of incompetents without an express legislative grant of such power . . .").
66. See BLANK, *supra* note 43, at 68. Blank states that a 1978 Supreme Court decision holding that "a judge who exceeds his authority and orders a sterilization without a proper legal basis for doing so enjoys judicial immunity from any future suits for damages" paved the way for these state supreme court decisions. BLANK, *supra* note 43, at 71 (citing *Stump v. Sparkman*, 435 U.S. 349 (1978)). Blank notes that while there is no uniform response from the courts on the issue of whether in the absence of express statutory authority the courts have equitable jurisdiction to approve sterilization petitions for incompetent persons, a move toward allowing such orders, within strict parameters, is growing. See BLANK, *supra* note 43, at 68.
67. See *In re C.D.M.*, 627 P.2d 607 (Alaska 1981); *In re A.W.*, 637 P.2d 366 (Colo. 1981); *In re Guardianship of Matejski*, 419 N.W.2d 576 (Iowa 1988); *In re Moe*, 432 N.E.2d 712 (Mass. 1982); *In re Penny N.*, 414 A.2d 541 (N.H. 1980); *In re Grady*, 426 A.2d 467 (N.J. 1981); *In re Guardianship of Hayes*, 608 P.2d 635 (Wash. 1980).

women's autonomy with respect to reproductive control are permitted in twelve, or nearly one-quarter, of the nation's states.<sup>68</sup>

Court-ordered sterilizations in most of these states are legal only in cases where the woman is mentally incompetent.<sup>69</sup> This restriction, however, does not make this legal endorsement of medical paternalism any more acceptable. First, there are many reasons that extend beyond the scope of this Article why sterilization of the mentally incompetent is problematic.<sup>70</sup> Second, a concern encompassing all women emerges when we assume that there is a *clear demarcation* as opposed to a *continuum* between the mentally competent and the mentally incompetent. According to Blank, only five percent of all mentally retarded persons lack the capacity to comprehend reproduction, and only six percent are "moderately retarded."<sup>71</sup> At the same time, a vast majority of all retarded persons are classified as "mildly retarded," which is "often only a fractional deviation from the norm."<sup>72</sup> Given the arbitrary nature of "the norm," even those who endorse the forced sterilization of the mentally incompetent might need to reconsider their endorsement of any particular sterilization. Regardless of whether or not the forced sterilization of women who are judged mentally incompetent is ethical, the indistinct lines separating competence and incompetence means that a great proportion of women live under the shadow of the possibility of forced sterilization. To paraphrase Martin Luther King in a slightly modified form: in the case of the forced sterilization of women, injustice anywhere is *potential* injustice everywhere.<sup>73</sup>

68. I arrived at this figure simply by adding together the number of states permitting compulsory sterilization statutorily (five) and those who permit sterilization through state supreme court decisions (seven). It should be noted that the furthest extensions of the federal government into these laws was legislation enacted in 1979 that prohibited federal funding for sterilization of persons under 21, as well as those institutionalized and/or adjudicated incompetent. See BLANK, *supra* note 43, at 64.

69. See *supra* note 64. Only in Idaho and Delaware can compulsory sterilization extend beyond the mentally incompetent.

70. See e.g., Roberta Cepko, *Involuntary Sterilization of Mentally Disabled Women*, 8 BERKELEY WOMEN'S L.J. 122, 163 (1993) (arguing that the court ordered sterilization of a mentally incompetent woman "overemphasizes the interests of others and trivializes or ignores the individual's interest in non-intrusion").

71. BLANK, *supra* note 43, at 79.

72. BLANK, *supra* note 43, at 74. 89% of all persons who are mentally retarded are classified in this manner. See BLANK, *supra* note 43, at 79.

73. JOAN MORRISON & CHARLOTTE FOX, *AMERICAN MOSAIC* 439 (1980) ("Injustice anywhere is a threat to justice everywhere.").

As the earlier discussion of unnecessary hysterectomies might suggest,<sup>74</sup> just as the lines between competent and incompetent are blurred if not indistinguishable, so too are those between voluntary and involuntary sterilization. Literature from and about the 1970s demonstrates this point most strongly. Some physicians conditioned the delivery of babies and the performance of abortion on obtaining consent to sterilization.<sup>75</sup> State Medicaid programs helped these physicians accomplish their agendas by providing funding for sterilization, while doing nothing to provide information about other forms of birth control.<sup>76</sup>

At least one federal court also gave these physicians the necessary support. In *Walker v. Pierce*,<sup>77</sup> the plaintiff filed suit against her physician for his refusal to assist in giving birth to her child except on the condition that she be sterilized.<sup>78</sup> During the court proceedings, Dr. Pierce made no attempt to deny Walker's allegations and, in fact, stated that subjecting the delivery of children to such conditions in the case of poor women was his normal policy.<sup>79</sup> After hearing the opposing parties' arguments, the Court of Appeals for the Fourth Circuit reversed the lower court's judgment against Dr. Pierce.<sup>80</sup>

74. See *supra* notes 37–42 and accompanying text.

75. See Laurie Nsiah-Jefferson, *Reproductive Laws, Women of Color, and Low-Income Women*, in *REPRODUCTIVE LAWS FOR THE 1990's* 23, 46 (Nadine Taub & Sherrill Cohen eds., 1989).

76. See Nsiah-Jefferson, *supra* note 75, at 47.

77. *Walker v. Pierce*, 560 F.2d 609 (4th Cir. 1977).

78. As explained in the case, Virgil Walker sought Dr. Pierce's assistance upon learning that she would give birth to her fourth child. Dr. Pierce told Ms. Walker that he would assist her only if she agreed to be sterilized subsequent to giving birth. After much resistance, Ms. Walker consented. See *Walker*, 560 F.2d at 611.

79. See *Walker*, 560 F.2d at 611. Dr. Pierce flatly stated:

My policy was with people who were unable to financially support themselves, whether they be on Medicaid or just unable to pay their own bills, if they were having a third child, to request they voluntarily submit to sterilization following the delivery of the third child. If they did not wish this as a condition for my care, then I requested that they seek another physician other than myself.

*Walker*, 560 F.2d at 611.

80. See *Walker*, 560 F.2d at 613. The court stated, "We perceive no reason why Dr. Pierce could not establish and pursue the policy he has publicly and freely announced. Nor are we cited to judicial precedent or statute inhibiting this personal economic philosophy." *Walker*, 560 F.2d at 613. The court's reversal here was not monumental; the jury fined him a mere five dollars and the district court denied declaratory and injunctive relief. See *Walker*, 560 F.2d at 610–11.



Seeking a woman's consent to sterilization extended into the labor room as well. One researcher has described how young women in Los Angeles County, often African-American or Latina, were convinced to sign consent forms for tubal ligations while in labor.<sup>81</sup> These patients were frightened, in pain, and often under the influence of medication.<sup>82</sup> An intern at Wayne State Medical School in Detroit corroborates the stories from Los Angeles:

Most of our patient population was black, inner-city. . . . We had a lot of young girls come in . . . thirteen and sixteen and they'd have two or three children. In those cases, we'd ask them, often when they were in labor, if they wanted tubal ligations. There were *so many* young girls and most of them had a real low mentality. We'd tell them about birth control and they wouldn't take it. It would get some of the residents really mad.<sup>83</sup>

This practice of securing consent from a woman who is in labor is analogous to a policeman obtaining a confession from a suspected criminal under duress. In both cases, a person in authority, whether he be an investigator or a physician, takes advantage of an individual in a position of relative weakness, rendering the "voluntariness" of that individual's utterings suspect.<sup>84</sup> For a woman's consent to sterilization

81. See BARBARA SEAMAN & GIDEON SEAMAN, *WOMEN AND THE CRISIS IN SEX HORMONES* 229–30 (1977); Claudia Dreifus, *Sterilizing the Poor*, in *SEIZING OUR BODIES* 105, 113 (Claudia Dreifus ed., 1977).

82. See Dreifus, *supra* note 81, at 110–11.

83. Dreifus, *supra* note 81, at 113.

84. One might also construe physicians' actions in these cases as taking advantage of the Odysseus problem seemingly common to all human beings, in order to promote their own economic and reproductive agenda. In Greek mythology, Odysseus wanted to sail around the Island of the Sirens; however, he knew the fate of sailors before him—upon hearing the mellifluous singing of the Island's nymphs, they crashed their ships headlong into the rocks in an effort to reach its source. The sailors' immediate circumstances precluded their acting in their long-term interests. To circumvent this problem, Odysseus had his men tie him to the mast of the ship so that he might both hear the singing and survive. Upon hearing the Sirens, Odysseus pleaded with his men to untie him, but, consistent with his earlier orders, they did not.

Unfortunately, in the case of poor women and women of color in labor, doctors are not so loyal as Odysseus' sailors. While undergoing childbirth, a woman experiences a great deal of pain. The woman might be pained to such an extent that she believes she never wants to have a similar experience, even though this immediate belief may be contrary to her wishes outside of the childbirth experience. Instead of looking out for the woman's long term interests, the doctor takes the opportunity to advance his own racist and classist agenda and "unties the woman from the mast" by performing a tubal ligation.

to be considered voluntary (and thus acceptable) it must be *informed*. To meet the criteria for autonomous decision-making, she must be given all relevant information about her options and adequate time to contemplate the alternatives, while in a state of mind capable of understanding and evaluating the complexities of her situation.<sup>85</sup> The next section argues that most informed consent laws do not promote the existence of these conditions.

### *B. Informed Consent*

#### 1. Often Uninformed "Informed Consent"

One does not need to go into labor rooms and witness doctors obtaining permission to do a sterilization from a woman under extreme physical and emotional strain to find the efficacy of informed consent laws lacking. One incident involved women who were part of an experiment which necessitated multiple amniocentesis procedures.<sup>86</sup> Even though these women spoke and read very little English, their "consent" was obtained by having them sign a three page consent form written in college-level English.<sup>87</sup>

The case of Puerto Rican women in the New York City area provides another more substantial, if somewhat ambiguous example. In conducting an ethnographic study of a predominantly Puerto Rican neighborhood in Brooklyn, New York, Iris Lopez found that of those households in which one or more Puerto Rican women over the age of twenty lived, forty-seven percent sheltered one or more sterilized women, ninety-three percent of whom were born in Puerto Rico but sterilized in the United States while between the ages of seventeen and twenty-one.<sup>88</sup>

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85. See Howard Brody, *Transparency: Informed Consent in Primary Care*, HASTINGS CENTER REP., Sept.-Oct. 1989, at 5, 5-9.

86. See Karen Marie Perrin, *Informed Consent: A Challenge for Patient Advocacy*, in ETHICAL DILEMMAS IN CONTEMPORARY NURSING PRACTICE 105-106 (Gladys B. White ed., 1992).

87. See Perrin, *supra* note 86, at 106.

88. See Iris Lopez, *Agency and Constraint: Sterilization and Reproductive Freedom Among Puerto Rican Women in New York City*, 22 URB. ANTHROPOLOGY & STUD. CULTURAL SYS. & WORLD ECON. DEV. 299, 303 (1993). Notably, these women were not affluent. Seventy percent of them received some form of Aid to Dependent Children. See Lopez, *supra* at 310.

This Brooklyn neighborhood is not an anomaly in New York City. The overall sterilization rate for Puerto Rican women in this city stands at 31.4 percent, more than seventeen points higher than the national rate.<sup>89</sup> Considering the earlier discussion of doctors' obtaining sterilization consent from women who are in labor,<sup>90</sup> figures like these can be very disturbing. There are alternative explanations for these statistics, however. As Lopez points out, a woman's decision to be sterilized is often influenced by socioeconomic pressures and realities.<sup>91</sup> Indeed, four out of five women in the Lopez study cited economic circumstances as having either directly or indirectly influenced their decision to be sterilized.<sup>92</sup>

Putting aside the argument that economic conditions give Puerto Rican women no "real" choice in the matter, sterilization decisions by Puerto Rican women may be a manifestation of an exercise of agency on their part. Such an interpretation exonerates both the medical community and the legal system of any fault.

At the same time, other evidence strongly suggests that a personal choice model is an incomplete, if not altogether wrong, tool for interpreting these sterilization decisions. In support of this argument Lopez points to the Hyde Amendment of 1977,<sup>93</sup> which prohibits funding for abortions for women on Medicaid while making sterilizations "readily available."<sup>94</sup> This policy could have given women in the Lopez study the impression that sterilization was their only feasible option in controlling reproduction. Indeed, a large number of these women did not know about alternative birth control methods such as the diaphragm.<sup>95</sup> Moreover, not only did the women lack information about birth control, there was also important *misinformation* about the sterilization imparted to them by the medical community. Such deceptive phrases as "band-aid sterilization" and "bikini cut" are common references made to the procedure in hospitals;<sup>96</sup> these mislabellings are of no small

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89. See Joseph J. Salvo et al., *Contraceptive Use and Sterilization Among Puerto Rican Women*, 24 *FAM. PLANNING PERSP.* 219, 220 (1992). The authors based these figures on a survey of Puerto Rican women living in the New York area.

90. See *supra* notes 81-85 and accompanying text.

91. See Lopez, *supra* note 88, at 311.

92. See Lopez, *supra* note 88, at 311.

93. Hyde Amendment, Pub. L. No. 95-205, 91 Stat. 1460 (1977).

94. See Lopez, *supra* note 88, at 307.

95. See Lopez, *supra* note 88, at 305.

96. Lopez, *supra* note 88, at 316.

consequence. Among the women, there was a salient distinction between "tying" and "cutting" the fallopian tubes, the former being temporary and the latter permanent.<sup>97</sup> One woman explained, "I feel that if a woman is not sure if she wants anymore kids, then she should have her tubes tied. If a woman has decided she absolutely does not want to have more children, then she should have her tubes 'cut.'"<sup>98</sup>

Of the sterilized women in the Brooklyn neighborhood surveyed, thirty-three percent regretted their decision, and while another forty-six percent did not regret their decision, they were not happy with it either.<sup>99</sup> These high rates of dissatisfaction, along with the earlier described experimentation performed on foreign-born women,<sup>100</sup> attest to the importance of fully informing women about the procedure that doctors wish to perform on them. Legal safeguards do not appear to be affecting this outcome. We will now turn to why this inefficacy might be the case.

## 2. Remedy? A History and Criticism of the Reasonable Physician Standard

Unlike the case of forced sterilizations, there are no laws that sanction the medical community's gaining "coerced" consent to sterilization from low-income women or women of color. Nor are there enabling statutes that permit doctors to misinform or fail to inform women about medical procedures in order to gain their consent. However, the legal guidelines for obtaining informed consent in several states, which favor the reasonable physician standard,<sup>101</sup> not only

97. Lopez, *supra* note 88, at 316.

98. Lopez, *supra* note 88, at 316. Lopez found that although there was not in reality a distinction, the women believed there to be one. Those women who did not want to be permanently sterilized therefore chose to have their tubes "tied" since they incorrectly believed that to "tie" was a less permanent solution than to "cut." The women believed that the doctor could simply untie tubes that were tied, but could not restore fertility once the tubes had been cut. See Lopez, *supra* note 86, at 316.

99. See Lopez, *supra* note 88, at 316.

100. See *supra* notes 86-87 and accompanying text.

101. See ARIZ. REV. STAT. § 12-563 (1992 & Supp. 1996) (stating the "necessary elements of proof" for medical malpractice claims generally and confirming the reasonable physician standard); IDAHO CODE § 39-4304 (1993) (establishing an objective medical community standard for informed consent cases); NEB. REV. STAT. § 44-2816 (1993) (defining informed consent in terms of the "reasonably prudent health care provider"); N.D. CENT. CODE § 26.1-14 (1992) (dealing with medical malpractice insurance generally); UTAH CODE ANN. § 78-14-5(2)(d) (1996) (stating that a physi-

perpetuate medical paternalism in women's health care, but also make a doctor's failure to gain consent difficult to prove in a court of law. The reasonable physician standard thereby reinforces the priestly model of medicine to the detriment of both women's health and autonomy.

Taken together, *Salgo v. Leland*<sup>102</sup> in 1957 and *Natanson v. Kline*<sup>103</sup> in 1960 formulated the informed consent law and the reasonable physician standard respectively. In *Salgo v. Leland*, the plaintiff Salgo filed a malpractice suit alleging that his physician was negligent in performing an aortography, resulting in his paraplegia.<sup>104</sup> During the trial, Salgo testified that he was not informed that an aortography would be performed while he was anesthetized.<sup>105</sup> Addressing this alleged failure to disclose on the part of the physician, the court stipulated two instances in which a physician violates his duty to a patient: 1) "if he withholds any facts which are necessary to form the basis of an intelligent consent by the patient to the proposed

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cian's use of "reasonable discretion," after "considering all the attendant facts and circumstances," is a defense to a malpractice suit based on a lack of informed consent); *Rush v. Miller*, 648 F.2d 1075 (6th Cir. 1981); *Dessi v. United States*, 489 F. Supp. 722, 727-28 (E.D. Va. 1980); *Dewes v. Indian Health Serv.*, 504 F. Supp. 203, 206-07 (D.S.D. 1980); *Fuller v. Starnes*, 597 S.W.2d 88, 89-90 (Ark. 1980); *Robinson v. Mroz*, 433 A.2d 1051, 1055-56 (Del. Super. Ct. 1981); *Buckner v. Allergan Pharms., Inc.*, 400 So. 2d 820, 823-24 (Fla. Dist. Ct. App. 1981); *LePelley v. Grefenson*, 614 P.2d 962, 969 (Idaho 1980); *Searcy v. Manganhas*, 415 N.E.2d 142, 144-45 (Ind. Ct. App. 1981); *Natanson v. Kline*, 350 P.2d 1093, 1106 (Kan. 1960); *Rice v. Jaskolski*, 313 N.W.2d 893 (Mich. 1981); *Cress v. Mayer*, 626 S.W.2d 430, 436 (Mo. Ct. App. 1981); *Collin v. Itoh*, 503 P.2d 36, 40-41 (Mont. 1972); *Folger v. Corbett*, 394 A.2d 63 (N.H. 1978); *Davis v. Caldwell*, 429 N.E.2d 741, 744-45 (N.Y. 1981); *McPherson v. Ellis*, 287 S.E.2d 892, 895 (N.C. 1982); *Cunningham v. Yankton Clinic*, 262 N.W.2d 508, 511-12 (S.D. 1978); *Roark v. Allen*, 633 S.W.2d 804, 808-09 (Tex. 1982). In Utah, there have been conflicting decisions. *Compare Ficklin v. MacFarlane*, 550 P.2d 1295, 1297 (Utah 1976) (holding in favor of a reasonable physician standard), *with Nixdorf v. Hicken* 612 P.2d 348, 354 (Utah 1980) (holding in favor of a reasonable patient standard). *See also Susan Oliver Renfer et al., The Woman's Right to Know: A Model Approach to the Informed Consent of Abortion*, 22 LOY. U. CHI. L.J. 409 (1991) (naming and explaining the "reasonable physician's" standard).

102. *Salgo v. Leland* Stanford Jr. Univ. Bd. of Trustees, 317 P.2d 170 (Cal. Ct. App. 1957).

103. *Natanson v. Kline*, 350 P.2d 1093 (Kan. 1960).

104. *See Salgo*, 317 P.2d at 174-75.

105. *See Salgo*, 317 P.2d at 181.

treatment”<sup>106</sup> and 2) if he “minimize[s] the known dangers of a procedure or operation in order to induce his patient’s consent.”<sup>107</sup>

Although this judgment seems *prima facie* to be a boon to patients’ autonomy, that was not the effect for at least two reasons. First, after giving the guiding stipulations, the court made a qualification that seems tantamount to an about-face. Concerned that complete disclosure might actually end up harming the patient,<sup>108</sup> *Salgo* holds that part of a doctor’s proper duty was as follows:

[t]o recognize that each patient presents a separate problem, that the patient’s mental and emotional condition is important and in certain cases may be crucial, and that in discussing the element of risk a certain amount of discretion must be employed consistent with the full disclosure of facts necessary to an informed consent.<sup>109</sup>

Not only is this qualification ambiguous—the court says the physician should use “discretion” in providing “full disclosure”—<sup>110</sup> it also illustrates the extent to which the legal system defers to physicians. The court assumes that the physician, who is not trained in psychology or psychiatry but in maintaining the physical well-being of patients, has the ability to judge properly the “mental and emotional condition” of his patients. Thus, he may use “a certain amount of discretion” in informing the patient about the procedure.<sup>111</sup> Not only is this assumption deferential, it endorses the doctor’s paternalism as well. *He* can decide what is okay for *her* to hear.

Three years after *Salgo v. Leland* was decided, a Kansas court seemed none too concerned with this rather gratuitous granting of psychological wisdom to physicians.<sup>112</sup> Notwithstanding that the informed consent doctrine outlined in *Salgo v. Leland* simply comprised

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106. *Salgo*, 317 P.2d at 181.

107. *Salgo*, 317 P.2d at 181.

108. *See Salgo*, 317 P.2d at 181 (stating that informing the patient of all risks associated with a procedure “may well result in alarming a patient who is already unduly apprehensive and who may as a result refuse to undertake surgery in which there is in fact minimal risk; it may also result in actually increasing the risks by reason of the physiological results of the apprehension itself”).

109. *Salgo*, 317 P.2d at 181.

110. *Salgo*, 317 P.2d at 181.

111. *Salgo* 317 P.2d at 181.

112. *See Natanson*, 350 P.2d at 1093.

the jury instructions,<sup>113</sup> it was nonetheless followed in *Natanson v. Kline*.<sup>114</sup> The court in *Natanson*, finding in favor of a woman who alleged that she was not informed of the risks attendant to cobalt treatment, quoted the earlier case extensively.<sup>115</sup> However, the latter court made one additional stipulation regarding the manner in which the appropriateness of disclosure should be judged: "The duty of the physician to disclose, however, is limited to those disclosures which a reasonable medical practitioner would make under the same or similar circumstances."<sup>116</sup>

This stipulation is a second reason<sup>117</sup> why informed consent in many states has not been a boon to a patient's autonomy. Under the reasonable physician's standard, should a patient take her doctor to court, an expert medical witness or expert medical witnesses determine and testify as to what constitutes reasonable disclosure.<sup>118</sup> As a consequence, for a patient to win a civil suit under this standard, she must persuade another doctor from the community ("community" meaning the doctor's field) to testify as an expert witness against the alleged malpracticing peer.<sup>119</sup>

This requirement immediately puts the woman at a disadvantage. Given all the deference paid to doctors by the courts, a woman who is the alleged victim of a wrongful medical practice is already in a position of weakness in a suit vis-à-vis her doctor. Her position is weaker still if she is a poor woman, especially of color. One can safely assume that more often than not, judges and physicians occupy the same socioeconomic standing, race, and gender. A judge can look at the woman and her physician and see that the latter is "one of us." These differences are a tremendous burden for a woman to overcome.

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113. See *Natanson*, 350 P.2d at 1104 (quoting *Salgo*, 317 P.2d at 181). The court said with respect to its qualifications: "The instruction given should be modified to inform the jury that the physician has such discretion . . ."

114. See *Natanson*, 350 P.2d at 1104.

115. See *Natanson*, 350 P.2d at 1104.

116. *Natanson*, 350 P.2d at 1106.

117. Recall that the first reason is the *Salgo* court's granting of undue discretion to physicians in determining what information should be disclosed. See *supra* notes 108-110 and accompanying text.

118. See Renfer et al., *supra* note 101, at 412.

119. See Renfer et al., *supra* note 101, at 412. I use "community" here in the sense of having the same specialization. The term does not imply geographic limitations, although certainly the more similar the conditions under which the expert worked are to those under which the defendant doctor worked, the more credible that doctor's testimony would be.

Requiring her to secure the testimony of a physician *against* her physician, both of whom are from the same "community," only exacerbates the difficulty of her situation.

Moreover, as Brody points out, instructing physicians to behave as their colleagues would in a similar situation says nothing about ethical procedures in medicine.<sup>120</sup> It may be easy for physicians to behave in a manner comparable to that of other physicians, but the question remains: How well do those other physicians behave?<sup>121</sup> A woman is no better off in the Midwestern hospital where doctors were coercing consent to sterilizations from mostly poor, African-American women<sup>122</sup> if her doctor treats her in accordance with the community standard.

Furthermore, the reasonable physician standard strengthens control in the hands of the medical community, thereby reinforcing its paternalistic behavior. When, for example, a doctor fails to tell a young Puerto Rican woman about alternatives to sterilization,<sup>123</sup> he knows that, ultimately, it will not be a judge, a jury, or a patient who determines his ethical and legal standing, but his own peers. In essence, the same medical community whose members have taken advantage of their positions of power vis-à-vis their patients decides what is right and wrong in physician-patient interactions.

Other criticisms made regarding the efficacy of the reasonable physician standard relate directly to why informed consent often fails women. Katz conceptualizes informed consent as a hybrid: it speaks both to physician's disclosure obligations as well as patients' willingness to undergo treatment.<sup>124</sup> However, according to Katz, the law concerning this dual requirement places too much emphasis on consent at the expense of disclosure.<sup>125</sup> As a consequence, the law leaves the patient's body up in the air, exacerbating the harmfulness of the common notion in medicine that ownership of the body is temporarily transferred to the doctor's discretion.<sup>126</sup>

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120. See Brody, *supra* note 85, at 6.

121. See KATZ, *supra* note 3, at 69-70.

122. See *supra* notes 81-83 and accompanying text.

123. See *supra* notes 88-99 and accompanying text.

124. See KATZ, *supra* note 3, at 70-71.

125. See KATZ, *supra* note 3, at 69-71.

126. See KATZ, *supra* note 3, at 59-84.



Ruth Faben and Tom Beauchamp have also been critical of where the "ownership of the body" lies.<sup>127</sup> They describe the primacy of patient autonomy in the doctor-patient relationship as still being a "novel, provocative, and even radical idea" for most physicians.<sup>128</sup> After reviewing the history of informed consent, including the time prior to 1957 when the required consent did not have to be "informed," Faben and Beauchamp posit that the paternalistic line of authority between doctor and patient continues to reign, with little change, if at all.<sup>129</sup> Wendy Margolis concurs with them, implicating the legal system. She argues that "[d]espite [the court's] frequent proclamations of the patient's right to self-determination, the courts have demonstrated a willingness to defer to the physician's judgment of what is best for the patient."<sup>130</sup>

Stephen Wear is less critical of medical paternalism but no kinder to informed consent law. He asserts that the legal requirements for informed consent give too little attention to the patient, minimizing the importance of how she evaluates the information disclosed.<sup>131</sup> This criticism is particularly significant given that many in the medical profession believe that a patient on average remembers just thirty-seven to fifty percent of the information the physician imparts to her in a typical consultation.<sup>132</sup> Wear goes on to say that informed consent law gives insufficient ethical guidance concerning what can satisfactorily be deemed informed consent and instead highlights only obvious and blatant assaults.<sup>133</sup>

The above criticisms of informed consent law under the reasonable physician standard—that it reinforces medical paternalism, that it gives deference to the medical community, that it provides no ethical guidelines for the doctor-patient relationship—are important to all

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127. See RUTH R. FABEN & TOM L. BEAUCHAMP, *A HISTORY AND THEORY OF INFORMED CONSENT* (1986).

128. FABEN & BEAUCHAMP, *supra* note 127, at 75.

129. See FABEN & BEAUCHAMP, *supra* note 127, at 100.

130. Wendy M. Margolis, Comment, *The Doctor Knows Best: Patient Capacity for Health Care Decisionmaking*, 71 OR. L. REV. 909, 917 (1992) (internal citation omitted).

131. See STEPHEN WEAR, *INFORMED CONSENT: PATIENT AUTONOMY AND PHYSICIAN BENEVOLENCE WITHIN CLINICAL MEDICINE* 14 (1993).

132. See Heather Draper, *Sterilization Abuse: Women and Consent to Treatment*, in *PROTECTING THE VULNERABLE: AUTONOMY AND CONSENT IN HEALTH CARE* 77, 81 (Margaret Brazier & Mary Lobjoit eds., 1991) (citing P. Ley, *Toward Better Doctor-Patient Communication*, in *COMMUNICATION BETWEEN DOCTORS AND PATIENTS* 85 (A.E. Bennett ed., 1976)).

133. See WEAR, *supra* note 131, at 14.

patients, especially given the long history of individual rights in Western tradition.<sup>134</sup> Women often confront a far greater harm than weakened individual autonomy, however, when they enter a hospital or doctor's office.<sup>135</sup> For these women, interactions with doctors can be a threat to their reproductive health. By deferring to the judgment of the medical community in informed consent with the reasonable physician standard, the laws in most states not only reinforce the paternalism of the priestly model of medicine but also increase the likelihood that in this unequal situation a patient will be taken advantage of to her detriment.

### C. Cesarean Sections

An examination of the rate of cesarean sections performed unnecessarily in the United States suggests that the negative effects on women of informed consent laws extend beyond sterilizations. Additionally, the legal sanctioning of physician's virtual disregard for informed consent through court-ordered cesarean sections provides another instance in which the law undergirds the priestly model of medicine. This section addresses both of these assertions.

#### 1. Unnecessary Surgeries

The incidence of cesarean sections in the United States offers strong support to those who claim the birthing process has undergone a "medicalization."<sup>136</sup> The rate of babies delivered by cesarean was four times higher in 1983 than it was in 1965, climbing from approximately five to twenty percent.<sup>137</sup> More recent figures suggest that this

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134. For a broad discussion of the evolution of individual freedom in the West, see Gerald Sirkin, *The Future of Government Regulation and Freedom*, in *THE FUTURE OF OUR LIBERTIES: PERSPECTIVES ON THE BILL OF RIGHTS 77* (Stephen C. Halpern ed., 1982).

135. See *supra* Part II.A. for a discussion of the health risks associated with sterilization.

136. See generally HARRISON, *supra* note 20.

137. See Selma M. Taffel et al., *One Fifth of 1983 U.S. Births by Cesarean Section*, 75 AM. J. PUB. HEALTH 190 (1985) (citing data from National Center for Health Statistics); see also Rose Weitz & Deborah A. Sullivan, *The Politics of Childbirth: The Re-emergence of Midwifery in Arizona*, 33 SOC. PROBS. 163, 165 (1986).

proportion has continued its ascendancy, reaching almost twenty-four percent of all births in 1990.<sup>138</sup>

A high incidence of cesarean sections is not in itself cause for concern. If the more frequent performance of this surgery leads to better medical outcomes, then increases in cesarean sections should be a welcome improvement to women's health.<sup>139</sup> However, substantial evidence questions the causal relationship between more cesarean births and better health. Some argue that many cesareans may be performed for reasons not related to whether either the mother or the newborn benefit.<sup>140</sup> Other estimates suggest that between thirty and seventy-seven percent of all cesarean sections performed are unnecessary.<sup>141</sup> Even if we accept the most conservative figure of thirty percent, that would mean that nearly 300,000 cesarean sections are unnecessarily performed in the United States in a given year.<sup>142</sup> These are performed due to factors involving characteristics of delivery systems, physicians, and childbearing women.

Related studies support the verity of this claim. Consider that among hospitals and physicians there are a broad range of documented cesarean birth rates, ranging from zero to more than fifty percent.<sup>143</sup> In the absence of unnecessary operations, one would assume that these differences might be due to varying risks existing among the women and children receiving services: the more women and children at risk, the greater the probability that physicians would perform cesarean sections. Multiple studies demonstrate that in fact,

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138. See Carol Sakala, *Midwifery Care and Out-of-Hospital Birth Settings: Do They Reduce Unnecessary Cesarean Section Births*, 37 Soc. Sci. MED. 1233, 1233 (1993) (citing E.J. Graves, *Summary: National Hospital Discharge Survey*, 210 ADV. DATA VITAL HEALTH STAT. 1-12 (1992)).

139. Results of one study seemed to indicate that the woman's condition was of less importance in determining whether she would have a cesarean section than was her physician's practice pattern. The variability in cesarean section rates ranged from 19.1% to 42.3%. See G.L. Goyert et al., *The Physician Factor in Cesarean Birth Rates*, 320 NEW ENG. J. MED. 706 (1989).

140. See generally Goyert, *supra* note 139.

141. See Sakala, *supra* note 138, at 1233. This percentage comes from Sakala's numeric estimate of unnecessary cesarean sections per year (290,000 to 731,000) which she bases on studies by the U.S. Department of Health's estimation that the attainable rate of cesarean section is 6% to 16.5%.

142. See Sakala, *supra* note 138, at 1233.

143. See Sakala, *supra* note 138, at 1235 (citing L. SILVER & S.M. WOLFE, PUBLIC CITIZEN HEALTH RESEARCH GROUP, UNNECESSARY CESAREAN SECTIONS: A RAPIDLY GROWING NATIONAL EPIDEMIC (1989)).

however, this variation very often is not positively correlated with the risk status of the women and newborns involved in the procedure.<sup>144</sup>

International comparisons also bring cesarean rates in the United States under suspicion. Vis-à-vis other nations, the United States sometimes has higher rates of cesarean births without a correspondingly lower perinatal mortality rate.<sup>145</sup> In Great Britain, the cesarean sections are performed at a rate of roughly twelve percent,<sup>146</sup> about half that of the United States,<sup>147</sup> while its perinatal mortality rate of eight per 1,000 live births<sup>148</sup> is 1.6 percentage points less than that of the United States.<sup>149</sup> Similarly, the Netherlands has a cesarean section rate hovering around five percent<sup>150</sup> with a corresponding perinatal mortality rate of just 6.5 percent.<sup>151</sup>

There appears to be an unusually high rate at which physicians in the United States perform cesarean sections. While “known” and agreed obstetric indications suggest that a rate of six to eight percent would be adequate,<sup>152</sup> “the current rate of cesarean sections—just about 24 [percent] of all births—is too high.”<sup>153</sup> This gap between normative and positive rates, as with hysterectomies, suggests that physicians too often take advantage of the paternalistic power afforded to them to the detriment of women’s autonomy.<sup>154</sup>

144. See, e.g., Mary C. Brucker & Maggie Muellener, *Nurse-Midwifery Care of Adolescents*, 30 J. NURSE-MIDWIFERY 277, 279 (1985); Elizabeth Feldman & Marsha Hurst, *Outcomes and Procedures in Low Risk Birth: A Comparison of Hospital and Birth Center Settings*, 14 BIRTH 18–24 (1987); Wenda R. Trevathan, *Childbirth in a Bicultural Community: Attitudinal and Behavior Variation*, in *CHILDBIRTH IN AMERICA: ANTHROPOLOGICAL PERSPECTIVES* 216, 217 (Karen L. Michaelson ed., 1988).

145. See Colin Francome & Wendy Savage, *Cesarean Section in Britain and the United States 12% or 24%: Is Either the Right Rate?*, 37 SOC. SCI. & MED. 1199, 1199 (1993).

146. See Francome & Savage, *supra* note 145, at 1199.

147. See Alice K. LoCiero, *Explaining Excessive Rates of Cesareans and Other Childbirth Interventions: Contributions From Contemporary Theories of Gender and Psychosocial Development*, 37 SOC. SCI. & MED. 1261 (1993).

148. All perinatal mortality rates given are from 1989. See Francome & Savage, *supra* note 145, at 1199.

149. See Francome & Savage, *supra* note 145, at 1200–01.

150. See Francome & Savage, *supra* note 145, at 1200.

151. See Francome & Savage, *supra* note 145, tbl.9 at 1212.

152. Francome & Savage, *supra* note 145, at 1199.

153. LoCiero, *supra* note 147, at 1261.

154. Performing a cesarean may be easier for the physician and may be used by physicians to make the birthing process easier for themselves. See generally HARRISON, *supra* note 20.

At issue is not just women's *control* over their health, but also their health itself. The risk of death to the mother is four times greater for cesarean sections than for vaginal births.<sup>155</sup> Also, one-third of women develop infections subsequent to cesarean birth.<sup>156</sup> Moreover, incurring these risks usually means incurring them multiple times because cesarean sections increase the likelihood that later births will require a cesarean section.<sup>157</sup>

## 2. Forced Cesarean Sections, Race, and Class

Despite the considerable rate at which cesarean sections are performed in the United States,<sup>158</sup> not all women agree with the use of this birthing method.<sup>159</sup> However, failure to gain the consent of those women opposed to cesarean births has not deterred the medical community from attempting to make use of this surgical procedure, especially in "treating" low income women and women of color.<sup>160</sup> Increasingly, physicians and hospitals are challenging a woman patient's refusal to consent by seeking court orders to carry out the surgery.<sup>161</sup>

A number of state statutes are relevant to the issue of court ordered cesareans<sup>162</sup> and lend to it conflicting resolutions. The Supreme

155. See Nancy K. Rhoden, *The Judge in the Delivery Room: The Emergency of Court-Ordered Cesareans*, 74 CAL. L. REV. 1951, 1958 (1986). See also Sakala, *supra* note 138, at 1234 (stating that cesarean sections are associated with increased mortality rates for the mother as well as a greater probability of many morbid conditions in both mother and infant). Of course, these rates may be influenced by the fact that more high risk pregnancies are delivered by cesarean sections.

156. See Helen J. Marieskind, *Cesarean Section*, 7 WOMEN & HEALTH 179, 186 (1982) (citing R.S. Gibbs et al., *The Effect of Internal Fetal Monitoring on Maternal Infection Following Cesarean Section*, 48 OBSTETRICS & GYNECOLOGY 653-58 (1976)).

157. See Marieskind, *supra* note 156, at 186.

158. See *supra* notes 145-153 and accompanying text.

159. Some women refuse to undergo cesarean sections because this procedure violates their religious principles. See, e.g., *In re Madyun Fetus*, 114 DAILY WASH. L. REP. 2233, 2239 (D.C. Sup. Ct. 1986).

160. See Deborah J. Krauss, Note, *Regulating Women's Bodies: The Adverse Effect of Fetal Rights Theory on Childbirth Decisions and Women of Color*, 26 HARV. C.R.-C.L. L. REV. 523 (1991).

161. See Krauss, *supra* note 160, at 529.

162. For a thorough discussion of these laws, see Charity Scott, *Resisting the Temptation to Turn Medical Recommendations into Judicial Orders: A Reconsideration of Court-Ordered Surgery for Pregnant Women*, 10 GA. ST. U. L. REV. 615 (1994).

Court,<sup>163</sup> like most state courts,<sup>164</sup> has recognized a patient's right to refuse treatment. This right is conditioned, however, on the absence of conflicting state interests.<sup>165</sup> These interests include the preservation of life, the protection of third parties, the prevention of suicide, and the preservation of the medical profession's ethical integrity.<sup>166</sup> Of these, all but the prevention of suicide is used to justify court ordered cesarean sections.<sup>167</sup> The Supreme Court has held that a state can assert a "compelling interest" in the viable fetus's potential life.<sup>168</sup> However, this interest is subordinate to the woman's health and life.<sup>169</sup>

In addition to the concern about a woman's health and life, there are other reasons why we should pause before condoning court-ordered cesarean sections. First and perhaps most obviously, court-ordered surgeries violate women's autonomy.<sup>170</sup> The American Medical Association has said that judicial interventions are appropriate only if the procedure does not violate the "bodily integrity" of the woman.<sup>171</sup> Another reason to oppose court-ordered cesarean sections,

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163. See *Cruzan v. Director, Mo. Dep't of Health*, 497 U.S. 261, 279 (1990).

164. See Scott, *supra* note 162, at 621-22.

165. See Scott, *supra* note 162, at 621-22.

166. See *Superintendent of Belchertown State Sch. v. Saikewicz*, 370 N.E.2d 417, 425 (Mass. 1977). See generally Rhoden, *supra* note 155, at 1971 (discussing the weight given to these state interests).

167. See Scott, *supra* note 162, at 631-40.

168. See *Planned Parenthood of Southeastern Pa. v. Casey*, 505 U.S. 833 (1992); see also *Thornburgh v. American College of Obstetricians & Gynecologists*, 476 U.S. 747 (1986); *Roe v. Wade*, 410 U.S. 113, 159 (1973).

169. See *Planned Parenthood of Southeastern Pa.*, 505 U.S. 833.

170. See Scott, *supra* note 162, at 641 (citing American College of Obstetricians & Gynecologists (ACOG) Comm. on Ethics Op. No. 55, PATIENT CHOICE: MATERNAL-FETAL CONFLICT (Oct. 1987)).

171. Scott, *supra* note 162, at 641. Scott provides the American Medical Association's statement:

Judicial intervention is inappropriate when a woman has made an informed refusal of a medical treatment designed to benefit her fetus. If an exceptional circumstance could be found in which a medical treatment poses an insignificant or no health risk to the woman, entails a minimal invasion of her bodily integrity, and would clearly prevent substantial and irreversible harm to her fetus, it might be appropriate for a physician to seek judicial intervention. However, the fundamental principle against compelled medical procedures should control in all cases that do not present such exceptional circumstances.

Scott, *supra* note 162, at 641 (citing Board of Trustees Report, AMA, *Legal Interventions During Pregnancy*, 264 JAMA 2663, 2670 (1990)).

and the physical violence that they sometimes entail,<sup>172</sup> is the idea that a woman's bodily integrity can almost never be protected under such circumstances. In one example quoted in the medical literature, a Nigerian woman in Chicago did not want a cesarean birth for religious reasons.<sup>173</sup> After obtaining a court order without the knowledge of either the patient or her husband, "hospital staff violently fastened her to the hospital bed and forcibly removed her husband from the delivery room so that the surgery could be performed."<sup>174</sup>

After a more thorough review of the arguments for and against judicial intervention into cesarean sections, the debate may be judged a legal stalemate. Scott says, "[b]oth sides can confidently point to tort law, criminal law, family law, and constitutional law to support—as well as to refute—the presence or absence of judicial authority to compel unwanted surgery."<sup>175</sup> One might suppose that the ambivalent nature of the legal guidelines to court-ordered surgeries would cause judges to pause in sanctioning these surgeries. In addition, the high rate of unnecessary cesarean sections<sup>176</sup>—which suggests that doctors often are wrong about the dangers of vaginal delivery—implies that judges might actually be averse to granting these court orders.<sup>177</sup> The evidence runs counter to both of these suppositions, however. Judges do not merely *sometimes* permit doctors to perform cesarean sections against a woman's consent; they *almost always* do.<sup>178</sup> Relying solely on

Scott adds that the only "exceptional circumstance" cited by the report was a hypothetical case in which a woman would refuse to orally take a drug innocuous to her and beneficial to the fetus. Scott, *supra* note 162, at 641 n.117.

172. See Krauss, *supra* note 160, at 539. "Enforcement of court-ordered treatment can be accomplished only through physical force, such as bodily restraint and involuntary anesthesia, actions that 'surely give one pause in a civilized society.'" (quoting *In re A.C.*, 573 A.2d 1235, 1244 n.8 (D.C. 1990)).

173. See Krauss, *supra* note 160, at 532.

174. Krauss, *supra* note 160, at 532.

175. Scott, *supra* note 162, at 650.

176. See *supra* Part II.C.1.

177. See *supra* Part II.C.1.

178. See Eric M. Levin, *The Constitutionality of Court-Ordered Cesarean Surgery: A Threshold Question*, 4 ALB. L.J. SCI. & TECH. 229, 240 (1994) (averring that "[i]n most instances" the lower courts consent to a physician's wishes for a court ordered cesarean section); see also Krauss, *supra* note 160, at 538 (noting that judges "almost always" grant the court ordered cesarean section); Scott, *supra* note 162, at 618 ("In most cases where a court order has been sought, a court order has been granted").

the physician's recommendation,<sup>179</sup> courts often force a woman "to go under the knife" at her physician's request, transferring control of her body to her doctor. This type of judicial intervention further legitimizes the priestly model of medicine.

Reinforcing the paternalistic role of the doctor with respect to determining both the need and the desirability of cesarean births is especially significant because of the manner in which race and class influence this issue. Overall cesarean rates do not differ significantly by race.<sup>180</sup> Additionally, the cesarean birth rate actually rises with increases in educational attainment<sup>181</sup> and social class.<sup>182</sup> However, as with coerced sterilizations, low income women of color are the ones most often involved in court-ordered cesarean sections.<sup>183</sup> In fact, Nancy Ehrenreich argues that forced cesarean sections are replacing coerced sterilizations as a principal means by which the legal and medical communities assert coercive control over the reproductive and sexual behavior of women of color.<sup>184</sup>

A study reported in the *New England Journal of Medicine*<sup>185</sup> lends strong statistical evidence to this claim. Veronica Kolder et al. surveyed medical institutions in forty-five states and the District of Columbia and obtained detailed descriptions of the court orders for obstetrical intervention that had been sought by these institutions over a five-year period.<sup>186</sup> Of those court orders obtained, more than eighty percent involved African-American, Asian, or Latina women.<sup>187</sup>

179. See Scott, *supra* note 162, at 618–19 (explaining that for most of the cases, there is no official report in the state case digests and stating "that in most cases where a court order has been sought, a court order has been granted").

180. See Selma Taffel, *Cesarean Delivery in the United States, 1990*, in VITAL AND HEALTH STATISTICS, at 2 (U.S. Dep't of Health & Human Serv., Series 21, No. 51, 1994). (Cesarean rates among African-American and white women are 22.1% and 23.0% respectively. Most other ethnicities and races have rates no higher than 23%.)

181. See Taffel, *supra* note 180, at 5 (asserting women with 12 years of education or more are 30% to 40% more likely to have a cesarean section as are those with educational attainments of nine years or less).

182. See Sakala, *supra* note 138, at 1235.

183. See Ehrenreich, *supra* note 51, at 517 ("the majority of those subjected to court-ordered surgery are non-white women, many of them immigrants and refugees"); see also Krauss, *supra* note 160, at 523 (noting that court-ordered cesarean sections "occur disproportionately in cases involving low-income women of color").

184. See Ehrenreich, *supra* note 51, at 516–17.

185. Veronika E.B. Kolder et al., *Court-Ordered Obstetrical Interventions*, 316 NEW ENG. J. MED. 1192 (1987).

186. See Kolder et al., *supra* note 185, at 1192.

187. See Kolder et al., *supra* note 185, at 1192.



This disproportionate impact of court-ordered cesarean sections by race and class is especially significant for two reasons. First, by threatening low-income women's birthing process with legal action, court-ordered surgeries may deter those most in need of prenatal care from seeking it.<sup>188</sup> Two examples illustrate this; Barbara Jean Jeffries, a low-income African-American woman who objected to cesarean births on religious grounds, went into hiding and gave birth naturally after learning she would have to undergo this surgical procedure.<sup>189</sup> Another woman of the same race and class, upon learning that a cesarean section would be likely, never returned to the hospital and gave birth at home.<sup>190</sup>

Second, any cesarean birth, whether court-ordered or not, will not affect all women in the same manner. Because the children of low-income women and women of color are more likely to be born with low birth weight and/or prematurely, the complications of cesarean birth are exacerbated for him or her.<sup>191</sup>

The legal and medical issues surrounding cesarean sections illustrate well the diverse impact of the priestly model of medicine among women. It is clear that unnecessary cesarean sections—a detriment to women's health, autonomy, and even pocketbooks—affect all women. The negative impact of court-ordered cesarean section procedures is, however, disproportionately concentrated on low-income women and women of color.

Ehrenreich attempts to capture the dynamics of this differential treatment by suggesting divergent metaphorical constructs for different women.<sup>192</sup> Affluent European-American women are characterized as the "good girls" who obey their doctors' orders in taking seriously their "role as selfless nurturers."<sup>193</sup> For them, disobedience might be a sign of a "bad" mother.<sup>194</sup> On the other hand, there are the "outsider" women—those women that are low-income, of color, or both.<sup>195</sup> Many doctors consider these women stubborn, recalcitrant, and in need of reform.<sup>196</sup>

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188. See Krauss, *supra* note 160, at 523.

189. See Krauss, *supra* note 160, at 538.

190. See Krauss, *supra* note 160, at 538.

191. See Krauss, *supra* note 160, at 530.

192. See Ehrenreich, *supra* note 51, at 531.

193. Ehrenreich, *supra* note 51, at 531.

194. See Ehrenreich, *supra* note 51, at 531.

195. See Ehrenreich, *supra* note 51, at 495.

196. See Ehrenreich, *supra* note 51, at 513, 521.

Altering these metaphorical constructs can be enlightening with respect to cesarean sections under the priestly model of medicine. In his paternalistic role, the doctor presumably has his favorite "children," which are likely to be from a similar racial and socioeconomic background—i.e., middle- to upper-income European-American women. His orders to these women are most often dutifully followed. At the same time, the paternalistic doctor has "children" not so highly prized—low-income women of color—who he believes are in need of discipline. Indeed, when a low-income woman of color refuses to undergo a cesarean section, these roles manifest themselves. "Father," or doctor, goes to a judge to obtain the means for the necessary corrections. In granting court-ordered obstetrical interventions, the law legitimizes these roles and sides with the "father." Additionally, as we shall see in the next section, the law also hinders women's attempts to avoid these detrimental situations altogether.

#### *D. Midwifery*

In turn of the century Massachusetts, Hannah Porn was a midwife who served an immigrant clientele mainly from Finland and Sweden.<sup>197</sup> Ms. Porn performed her services more than adequately; the neonatal rates of births attended by her were less than half those of births attended by local physicians.<sup>198</sup> Nonetheless, after a suit brought in 1907 Ms. Porn and other midwives in Massachusetts were no longer permitted to practice midwifery.<sup>199</sup>

Hannah Porn's story is an all too familiar one in the history of midwifery in the United States. Despite its providing numerous benefits to women, including the opportunity to circumvent the above-mentioned problems associated with cesarean sections under the priestly model of medicine, midwifery has been severely limited by the medical and legal communities in its scope, and consequently in its effectiveness. This stifling of midwifery's practice reinforces medical paternalism, or at least leaves it unchecked.

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197. See Eugene R. Declercq, *The Trials of Hanna Porn: The Campaign to Abolish Midwifery in Massachusetts*, 84 AM. J. PUB. HEALTH 1022, 1023 (1994) [hereinafter Declercq, *Hanna Porn*].

198. See Declercq, *Hanna Porn*, *supra* note 197, at 1025.

199. See Declercq, *Hanna Porn*, *supra* note 197, at 1022–23.

## 1. Potential Positive Benefits of Midwifery

In its various manifestations,<sup>200</sup> midwifery appears to provide care superior to that provided by doctors in many respects, the most notable of which is the lesser use of cesarean sections. In a nation in which some would assert this surgical procedure is generally used superfluously, births attended by midwives depart dramatically from the norm as evidenced by a series of carefully matched or adjusted cohort studies of women's birthing experiences.<sup>201</sup> Those women who began labor with a midwife or in an out-of-hospital setting or both had cesarean rates at least forty-three percent and as much as ninety-one percent lower than women who used doctors and hospitals.<sup>202</sup>

The practice of midwifery provides other benefits as well. When midwives are used to assist births, low birth weight babies<sup>203</sup> are born with a periodicity less than half that of the general rate.<sup>204</sup> Also, midwife-attended births are associated with low neonatal mortality rates.<sup>205</sup> In the five European countries with the lowest infant mortality rates,

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200. Midwives are commonly classified as either "nurse midwives" or "lay midwives." See *infra* notes 244-254 and accompanying text (describing key differences between these two types).

201. See Gigliola Baruffi et al., *Patterns of Obstetric Procedures Use in Maternity Care*, 64 *OBSTETRICS & GYNECOLOGY* 493 (1984); Gigliola Baruffi et al., *A Study of Pregnancy Outcomes in a Maternity Center and a Tertiary Care Hospital*, 74 *AM. J. PUB. HEALTH* 973 (1984); A. Mark Durand, *The Safety of Home Birth: The Farm Study*, 82 *AM. J. PUB. HEALTH* 450 (1992); Elizabeth Feldman & Marsha Hurst, *Outcomes and Procedures in Low Risk Birth: A Comparison of Hospital and Birth Center Settings*, 14 *BIRTH* 18 (1987); Lewis Mehl & Gail Peterson, *Home Birth Versus Hospital Birth: Comparisons of Outcomes of Matched Populations*, in *PREGNANCY, CHILDBIRTH, AND PARENTHOOD* 315 (Paul Ahmed ed., 1981); Anne Scupholme et al., *A Birth Center Affiliated with the Tertiary Care Center: Comparison of Outcome*, 67 *OBSTETRICS & GYNECOLOGY* 598 (1986).

202. See Archie Brodsky, *Home Delivery: Midwifery Works. So Should Midwives*, 23 *REASON* 28, 31 (Mar. 1992). A 1991 study by the National Birth Center Study supports these findings. Nearly 12,000 women were admitted into "freestanding" birth centers in the United States, three-fourths of which are operated by midwives. The subsequent cesarean section rate was just 4.4%.

203. Low birthweight babies are those weighing less than 2,500 grams at birth. See Eugene R. Declercq, *The Transformation of American Midwifery: 1975 to 1988*, 82 *AM. J. PUB. HEALTH* 680, 681 (1992)[hereinafter Declercq, *Transformation*]. Declercq bases this figure on his analysis of birth certificate data from the Natality, Marriage and Divorce Statistics Branch of the National Center for Health Statistics, Centers for Disease Control. See Declercq, *Transformation*, *supra* at 681.

204. See Declercq, *Transformation*, *supra* note 203, at 681.

205. See Declercq, *Transformation*, *supra* note 203, at 680.

seventy percent of all births are assisted by midwives.<sup>206</sup> Moreover, midwifery has had overall good effects for the urban poor. One-third of the clientele at North Central Bronx Hospital midwifery service is classified as high risk.<sup>207</sup> Yet, the hospital has not only the lowest cesarean rate in New York City but lower-than-average rates of low birth weight and perinatal and neonatal mortality rates as well.<sup>208</sup>

The positive contributions that midwifery can make to the birthing experience have not gone unnoticed. As early as 1925, a White House conference on child health acclaimed the merits of midwifery, citing not only this practice's better record vis-à-vis physicians, but also the superior care that it provides the child-bearing woman.<sup>209</sup> More recently, a number of prestigious institutions including the World Health Organization<sup>210</sup> and the American Public Health Association<sup>211</sup> have called for widespread implementation of midwifery care practices.<sup>212</sup> Even some obstetricians have given midwifery ringing endorsements, including a Dutch obstetrician who

206. See Caroline Hall Otis, *Midwives Still Hassled By Medical Establishment*, UTNE READER, Nov.-Dec. 1990, at 32, 34. A "real-life experiment" in Modera County, California provides further support. In 1960, nurse-midwives were introduced into a poor agricultural area in which the mortality rate was 24 per 1,000, and the rate subsequently dropped to 10 per 1,000. After pressure from the state medical association ended the program in 1963 and obstetricians returned, the rate ascended to 32 per 1,000. See Brodsky, *supra* note 202, at 31.

207. See Brodsky, *supra* note 202, at 31.

208. See Brodsky, *supra* note 202, at 31. New Mexico Department of Health statistics compiled from 1981 to 1990 illustrate the difference that midwives can make. During the years midwives attended births, women had lower episiotomy (5.1 per 1000 compared to "nearly routine"), cesarean (2.2-8.17 per 1000 compared to 15-25 per 1000), and perinatal mortality (5.2 per 1000 compared to 11.3 per 1000) rates than obstetricians and physicians. Reported in Sharon Bloyd-Peshkin, *Midwifery: Off to A Good Start*, 184 VEGETARIAN TIMES 69 (1992).

209. See Judith P. Rooks, *Nurse-Midwifery: The Window is Wide Open*, 90 AM. J. NURSING 30, 31 (1990) (stating that for normal delivery the record of trained midwives surpasses that of physicians); see also Julius Levy, *Maternal Mortality in the First Month of Life in Relation to Attendant at Birth*, 13 AM. J. PUB. HEALTH 88, 90-91 (1923) (claiming that the lowest maternal mortality rates were in the localities with the highest percentage of midwife-attended births).

210. See Brodsky, *supra* note 202, at 33.

211. See Brodsky, *supra* note 202, at 33.

212. See Brodsky, *supra* note 202, at 33. Institutions which suggest the same practice are the European Economic Community, the Institute of Medicine, the Office of Technology Assessment, the General Accounting Office, the National Commission to Prevent Infant Mortality, the Women's Institute for Childbearing Policy, the National Women's Health Network, the National Black Women's Health Project, and the Boston Women's Health Book Collective. See Brodsky, *supra* note 202, at 33.

praised midwives for promoting women's self-confidence and self-respect.<sup>213</sup>

The sources of this positive recognition include mothers as well. Increases in quantity of midwife-attended births express at least some women's approval of midwifery. Of all births, the rate of those in which a midwife was the primary caregiver nearly quadrupled from 1975<sup>214</sup> to 1988.<sup>215</sup> Additionally, statistics show that in 1989 midwives assisted in two and one-half times the number of births attended by them in 1975.<sup>216</sup>

The cause of this development renders it especially significant. Increasingly women have come to mistrust the medical profession,<sup>217</sup> and along with that mistrust have come to question the medical domination of the childbirth process.<sup>218</sup> No longer relying on the ostensible wisdom of physicians, many women demand the right to choose the place of birth as well as the birth practitioner.<sup>219</sup> Desiring a more natural and women-centered birthing experience,<sup>220</sup> these

213. Obstetrician G.J. Kloosterman comments on a home birth setting, generally the domain of a midwife:

The advantages of home confinements are that in her own home the expectant mother is not considered a patient, but a woman, fulfilling a natural and highly personal task. She is the real center around which everything (and everybody) revolves. The midwife or doctor and the maternity aide nurse are all her guests, there to assist her. This setting reinforces her self-respect and self-confidence.

Brodsky, *supra* note 202, at 30.

214. See Declercq, *Transformation*, *supra* note 203, at 680. Midwives attended 0.9% of all births in 1975. See Declercq, *Transformation*, *supra* note 203, at 680 (citing U.S. Dep't of Health & Human Serv., *Advance Report of Final Natality Statistics, 1988*, 40 MONTHLY VITAL STAT. REP. 39 (Suppl. 1990)).

215. See Jennifer D. Parker, *Ethnic Differences in Midwife-Attended U.S. Births*, 84 AM. J. PUB. HEALTH 1139, 1140 (1994) (stating midwives attended 3.99% of all births in 1988). Parker's figure derives from her examination of a sample population of natality files compiled by the National Center for Health Statistics. Parker, *supra* at 1139.

216. See Parker, *supra* note 215, at 1139. Midwives attended 150,000 births in 1989 compared to 60,000 a decade earlier. See Parker, *supra* note 215, at 1139 (citing U.S. Dep't of Health & Human Serv., *Advance Report of Final Natality Statistics, 1989*, 40 MONTHLY VITAL STAT. REP. 1 (1991) and U.S. Dep't of Health & Human Serv., *Midwife and Out-of-Hospital Deliveries: United States*, 21 VITAL HEALTH STAT. 21 (1984)).

217. See Rooks, *supra* note 209, at 33-34.

218. See Irene H. Butter & Bonnie J. Kay, *State Laws and the Practice of Lay Midwifery*, 78 AM. J. PUB. HEALTH 1161, 1161 (1988).

219. See Butter & Kay, *supra* note 218, at 1161.

220. See Butter & Kay, *supra* note 218, at 1161.

women turn to midwives in asserting these rights. This turn appears to reflect women's interest in moving away from the medical domination of "normal" childbirth and towards an experience in which they have more substantive control as childbearers.

## 2. The Marriage of Law and Medicine in the Suppression of Midwifery

Notwithstanding the positive effect it can have on women's health care as well as its substantive support from both important health organizations and a good portion of women, midwifery has been the object of scathing attacks and suppression for nearly a century. The suit brought against Hannah Porn<sup>221</sup> was part of a larger turn of the century campaign to abolish midwifery.<sup>222</sup> In the move to end its practice, midwifery's critics were not only unusually vituperative but racist as well. Critics described midwifery as "filthy and ignorant and not far removed from the jungles of Africa"<sup>223</sup> and as "a relic of barbarism."<sup>224</sup> This biting rhetoric apparently did not fall on deaf ears: midwifery's share of births fell from almost half in 1900 to one-eighth in 1935.<sup>225</sup>

Judy Litoff argues that the virtual demise of midwifery in the early 1900s was due in large part to the campaign successfully led by obstetric specialists to redefine birth as dangerous, birth attendance as a scientific process, and midwives as dangerously unskilled.<sup>226</sup> The *motivation* for this campaign might explain more about why the suppression of midwifery continues.<sup>227</sup> Litoff suggests that the obstetricians recognized that women's continued success as midwives (because they were untrained in the medical sciences) would prevent those with specialized skill and knowledge such as themselves from enjoying "due recognition."<sup>228</sup>

221. *Commonwealth v. Porn*, 82 N.E. 31 (Mass. 1907).

222. See Declercq, *Hanna Porn*, *supra* note 197, at 1022.

223. Neal Devitt, *The Statistical Case for the Elimination of the Midwife: Fact versus Prejudice, 1890-1935 (Part I)*, 4 *WOMEN & HEALTH* 81, 89 (1979).

224. Devitt, *supra* note 223, at 89.

225. See Devitt, *supra* note 223, at 81-82.

226. See JUDY B. LITOFF, *AMERICAN MIDWIVES, 1860 TO THE PRESENT* 64-83 (1978).

227. See *infra* notes 233-235 and accompanying text (discussing tactics employed by the medical community to suppress lay midwifery).

228. LITOFF, *supra* note 226, at 64.

Cynthia Watchorn follows Litoff in a broader sense, tying the motivation for ending midwifery to issues of class and gender.<sup>229</sup> She argues that as the all-male medical field made significant gains in power, prestige, and money, doctors wanted to eliminate or at least marginalize those practicing medicine who did not hold a class position comparable to that of most in the medical field.<sup>230</sup> Such an exclusion included midwives.<sup>231</sup>

As the continuum of history melts into the present, the still largely male obstetrics field<sup>232</sup> continues not just to slight the merits of midwifery but to demonize it as well. For example, the growth of midwife-assisted home births in Arizona has met substantial opposition from physicians and hospitals. One physician refused to provide any care to a woman considering home delivery.<sup>233</sup> Additionally, some hospital personnel reportedly tell mothers that "home birth is akin to walking across the street blindfolded."<sup>234</sup> Going beyond these hospital personnel's condemnation, the president of the American College of Obstetrics has likened home birth to child abuse.<sup>235</sup>

Important to the viability of midwifery is the fact that these scathing attacks are little more than rhetorical. In a study of contemporary court cases against midwives, the plaintiff typically was not a patient, as one might expect, but rather a physician.<sup>236</sup> Interestingly, it was *not* patients who were dissatisfied with midwives' services. Besides demonstrating that obstetricians are men of action as well as words, some researchers suggest that the medical community's attempt to stifle midwifery, in its turn of the century campaign, is motivated

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229. See Cynthia Watchorn, *Midwifery: A History of Statutory Suppression*, 9 GOLDEN GATE U. L. REV. 631, 632-33 (1978-1979).

230. See Watchorn, *supra* note 229, at 633-36.

231. See Watchorn, *supra* note 229, at 633-36.

232. See AMERICAN MEDICAL ASSOCIATION, *supra* note 14, at 50, 52. While no data are available for obstetricians alone, the American Medical Association reports that just 9,240 of the 35,619 obstetricians and gynecologists in the United States are female. See AMERICAN MEDICAL ASSOCIATION, *supra* note 14, at 50, 52.

233. See Weitz & Sullivan, *supra* note 137, at 170.

234. Weitz & Sullivan, *supra* note 137, at 171.

235. "[T]he head of the American College of Obstetrics and Gynecology said, 'Home birth is child abuse.'" Otis, *supra* note 206, at 32.

236. See Declercq, *Hanna Porn*, *supra* note 197, at 1023 (citing D. SULLIVAN & R. WEITZ, LABOR PAINS 18 (1988)).

more by concern for its own power than by an interest in an expectant mother's well-being.<sup>237</sup>

Thus, throughout the twentieth century, the mainstream medical community has painted an extremely negative portrait of midwifery.<sup>238</sup> Significantly, this Mephistopholean portrait's effect extends well into the legal sphere. Legislators and courts now lend the hand necessary to transform the bias against midwifery into legal suppression, just as they did in the incipient stages of the turn of the century campaign against midwifery.<sup>239</sup>

An international comparison begins to support this assertion. In most industrialized nations, a woman has the right to choose not only who will be her birthing attendant but where she will give birth as well.<sup>240</sup> In the United States, Canada, and South Africa, however, women possess neither of these rights.<sup>241</sup> Possibly as a consequence, midwives in the United States have yet to achieve a status comparable to that enjoyed by midwives in other countries.<sup>242</sup> Additionally, midwifery as an *independent* profession has largely been abolished.<sup>243</sup>

The word "independent" is stressed because midwifery as practiced in the United States is not isomorphic. There are two basic types of midwives, nurse<sup>244</sup> and lay,<sup>245</sup> and their differences are very important. These midwives each work in different settings. While the lay midwife almost never has hospital privileges,<sup>246</sup> nurse-midwives work more often in medical institutions.<sup>247</sup> In this setting,

237. See Declercq, *Hanna Porn*, *supra* note 197, at 1022–23 (citing LITOFF, *supra* note 226, at 64).

238. For a thorough review of the mainstream opposition to midwifery during the early twentieth century, see LITOFF, *supra* note 226, at 64–90.

239. See *supra* notes 220–230 and accompanying text.

240. See Otis, *supra* note 206, at 32.

241. See Otis, *supra* note 206, at 32.

242. See generally, Declercq, *Hanna Porn*, *supra* note 197, at 1022–23.

243. See Declercq, *Hanna Porn*, *supra* note 197, at 1022 (citing SULLIVAN & WEITZ, *supra* note 233, at 18).

244. See Butter & Kay, *supra* note 218, at 1161. Certified nurse-midwives are "RNs with additional training and certification in midwifery . . . who usually practice in hospital settings." Butter & Kay, *supra* note 218, at 1161.

245. See Butter & Kay, *supra* note 218, at 1161. A lay midwife is "someone who practices in a home setting and who has been trained in a variety of ways, often not linked to formal programs in educational institutions but including substantial clinical training in apprenticeships." Butter & Kay, *supra* note 218, at 1161.

246. See Declercq, *Transformation*, *supra* note 203, at 680 (citing Butter & Kay, *supra* note 218).

247. See Sakala, *supra* note 138, at 1236.



nurse-midwives operate under the control of physicians<sup>248</sup> and their frameworks.<sup>249</sup> In contrast, for lay midwives, the obstetrician is merely a "back-up."<sup>250</sup> To a great extent it appears that nurse-midwives accept their subordination to the work of physicians, while lay midwives seek an independent source of legitimacy.<sup>251</sup> Carol Sakala highlights the importance of this distinction in citing the principle advantage of lay midwifery.<sup>252</sup> She writes, this advantage is "the ability to construct the meaning of birth and to practice maternity care in a manner that is largely unconstrained by prevailing medical approaches."<sup>253</sup> Indeed, Sakala identifies this form of midwifery as the autonomous manifestation of the profession (as opposed to nurse-midwifery), calling it not "lay" but "independent" midwifery.<sup>254</sup>

While the physician-controlled type of midwifery enjoys general acceptance,<sup>255</sup> lay midwifery—removed from the hegemony of the medical profession and thus the priestly model of medicine—does not.<sup>256</sup> In an interstate comparison of the legal status of lay midwifery, researchers found that independent midwifery is clearly legal in just ten states.<sup>257</sup> At the same time, it is clearly illegal in ten states and legally ambiguous in thirty others.<sup>258</sup> Moreover, in eight of the ten states in which lay midwifery is legal, it is regulated and monitored by the department of public health or its equivalent.<sup>259</sup> This requirement does not afford lay midwifery the autonomy possessed by other health occupations, which have their own regulatory board consisting of their own members.<sup>260</sup> Thus, even where lay midwifery is legal, most states

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248. See Weitz & Sullivan, *supra* note 137, at 164.

249. See Sakala, *supra* note 138, at 1236.

250. See Weitz & Sullivan, *supra* note 137, at 164.

251. See Beth Rushing, *Ideology in the Reemergence of North American Midwifery*, 20 *WORK & OCCUPATIONS* 46, 49–51 (1993).

252. See Sakala, *supra* note 138, at 1237.

253. Sakala, *supra*, note 138, at 1237. Sakala adds, "These midwives have the opportunity to develop a women-derived and centered body of knowledge and practice regarding childbearing that reflects women's subjective experiences, in contrast to externally imposed obstetrical models." Sakala, *supra* note 138, at 1237.

254. Sakala, *supra* note 138, at 1237.

255. See Rooks, *supra* note 209, at 34 (explaining that in the 1980s, nurse-midwives gained unprecedented acceptance).

256. Only 2% of United States births each year are attended by lay midwives. See Sakala, *supra* note 138, at 1237.

257. See Butter & Kay, *supra* note 218, at 1162.

258. See Butter & Kay, *supra* note 218, at 1162.

259. See Butter & Kay, *supra* note 218, at 1165.

260. See Butter & Kay, *supra* note 218, at 1165.

keep its practice subject to the control of the male-dominated physician community at least to some extent.

Bombarded with physicians' lobbyists at the turn of the century, legislators molded the laws to give male physicians control over the health field.<sup>261</sup> Almost a century later, that imperative has changed little as legal regulations of maternity care continue to stifle midwifery practice almost completely.<sup>262</sup> Significantly, the marginalization of midwifery does not appear to be changing. Major policy reports addressing the rising rate of cesarean births do not give attention to midwifery's potential to alleviate this problem.<sup>263</sup>

The legal suppression of midwifery is especially significant with respect to race and class. Midwifery could help alleviate the medical crisis of providing maternity care to poor women and women of color living in rural areas.<sup>264</sup> Between 1982 and 1989, African-American, Latina, and Native American women were roughly 1.5, 2.5, and 5.5 times, respectively, more likely to have a midwife attend their births than was a white woman.<sup>265</sup> Thus, the legal suppression of midwifery, to the extent that it hinders the fulfillment of the needs and desires of poor women, and women of color, also provides another example of how the legal support of the priestly model of medicine has an especially deleterious effect upon these groups.

### III. PROPOSED LEGAL REFORMS

This Article has argued that the priestly model of medicine dominates physician-patient relationships in a manner detrimental to women because it violates their autonomy and reinforces societal stereotypes of them. Also where the negative effects of the medical community's paternalistic power manifest themselves most conspicuously, in unnecessary and forced operations, the law provides support

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261. See Watchorn, *supra* note 229, at 632-33.

262. See Kerry E. Reilly, Note, *Midwifery in America: The Need for Uniform and Modernized State Law*, 20 SUFFOLK U. L. REV. 1117 (1986) (discussing status of midwife statutes in all fifty states).

263. See Sakala, *supra* note 138, at 1235 (pointing out that the low cesarean rate "of U.S. women using midwifery care and/or out-of-hospital birth settings is often dismissed as an artifact of self-selection, attributable to the presumed low-risk status of women using these care arrangements").

264. See Rooks, *supra* note 209, at 31-32.

265. See Parker, *supra* note 215, at 1140.

in a variety of ways, most often to the detriment of low income women and women of color. In effect, law and medicine are wed in a matrimony harmful to women's health care as well as their general autonomy. This final section suggests ways by which the law can divorce itself from this unholy marriage.

### A. *The Reasonable Patient Standard*

The dominance of the reasonable physician standard in guiding informed consent requirements provides a clear example of how the law reinforces the priestly model of medicine. This standard not only gives physicians undue discretion in deciding what they will tell their patients,<sup>266</sup> it also affords the medical community considerable control over what can be considered a violation of informed consent law.<sup>267</sup> These attributes of the reasonable physician standard help to create an environment in which unnecessary and coerced operations not only can be, but are performed with impunity.<sup>268</sup>

There is, however, an alternative. The reasonable patient standard is more supportive of a patient's control over health care decisions.<sup>269</sup> This standard was first articulated in *Canterbury v. Spence*.<sup>270</sup> In this case, the plaintiff claimed that he was entitled to damages for injuries allegedly caused by the performance of a procedure used to remedy his ruptured disk.<sup>271</sup> The plaintiff charged inter alia that his physician failed to meet disclosure obligations.<sup>272</sup> While admitting that there was approximately a one percent risk of paralysis attendant to the surgical procedure, the physician claimed that the negligible nature of this risk did not necessitate his telling the patient, especially since disclosure

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266. See *supra* notes 108–117 and accompanying text.

267. See *supra* Part II.B.2.

268. For a discussion of informed consent and the reasonable physician standard, see Thomas R. Eller, *Informed Consent Civil Actions for Post-Abortion Psychological Trauma*, 71 NOTRE DAME L. REV. 639, 642–48 (1996).

269. Under the reasonable patient standard, the physician must disclose what the reasonable patient would deem significant in deciding whether to undergo the proposed treatment. For an elaboration of what information the reasonable patient might require doctors to disclose, see *Hondroulis v. Schuhmacher*, 553 So. 2d 398, 411 (La. 1988).

270. *Canterbury v. Spence*, 464 F.2d 772, 787 (D.C. Cir. 1972).

271. See *Canterbury*, 464 F.2d at 776–77.

272. See *Canterbury*, 464 F.2d at 776.

might have unduly alarmed the patient and prompted him not to consent to what the physician deemed to be necessary surgery.<sup>273</sup>

This justification for nondisclosure enjoys rough support from *Salgo v. Leland*.<sup>274</sup> However, the court in *Canterbury* rejected the nondisclosure argument's cogency and more generally articulated an outright repudiation of the reasonable physician standard for disclosure.<sup>275</sup> Instead of being guided by the standard generally accepted by the medical community, the court stated the extent of disclosure should be that which enables the patient to make an "intelligent choice."<sup>276</sup> Specifically, potential harms must be divulged to the extent that they possess "materiality to the patient's decision."<sup>277</sup> This means that all risks that might affect a patient's decision must be disclosed.<sup>278</sup>

The court altered informed consent law in another significant way. While expert testimony of physicians is necessary to make a claim actionable under the reasonable physician standard, this requirement is no longer the case in the new patient-centered standard.<sup>279</sup> This change alleviates the burden of a patient who believes she has been harmed by her doctor in seeking a remedy.

273. See *Canterbury*, 464 F.2d at 778.

274. *Salgo v. Leland Stanford Jr. Univ. Bd. of Trustees*, 317 P.2d 170 (Cal. Ct. App. 1957); see *supra* notes 102–110 and accompanying text.

275. See *Canterbury*, 464 F.2d at 786. The court stated:

The duty to disclose, we have reasoned, arises from phenomena apart from medical custom and practice. The latter, we think, should no more establish the scope of the duty than its existence. Any definition of scope in terms purely of a professional standard is at odds with the patient's prerogative to decide on projected therapy himself. That prerogative, we have said, is at the very foundation of the duty to disclose, and both the patient's right to know and the physician's correlative obligation to tell him are diluted to the extent that its compass is dictated by the medical profession.

*Canterbury*, 464 F.2d at 786 (citations omitted). The court, based on a concern for patient autonomy, also stated, "Respect for the patient's right of self-determination on particular therapy demands a standard set by law for physicians rather than one which physicians may or may not impose upon themselves." *Canterbury*, 464 F.2d at 784 (citations omitted) (emphasis added).

276. *Canterbury*, 464 F.2d at 786.

277. *Canterbury*, 464 F.2d at 787.

278. See *Canterbury*, 464 F.2d at 787.

279. See *Canterbury*, 464 F.2d at 792. The court stated:

Lay witness testimony can competently establish a physician's failure to disclose particular risk information, the patient's lack of knowledge of the risk, and the adverse consequences following the treatment. Experts are

Also known as the "patient autonomy" standard,<sup>280</sup> the reasonable patient standard is now the guideline for disclosure in seventeen states and the District of Columbia,<sup>281</sup> and should be established in all fifty. This standard runs counter to physician paternalism under the priestly model of medicine by making the test of what constitutes proper disclosure that which affords a patient the opportunity to make an intelligent decision, rather than what the medical community thinks she needs to know. Such a standard permits the patient more substantial control over medical decision-making.

Besides increasing patient autonomy, the reasonable patient standard will also help alleviate problems discussed above, such as the performance of unnecessary cesarean sections and sterilizations in which consent is gained by physician coercion. If women were more fully informed of the risks associated with these surgeries, then they might be more likely to forego them. Furthermore, the fact that plaintiffs do not need expert testimony to win their case under the patient-centered standard might deter doctors from violating these stronger disclosure requirements. The state of Washington's codification of the reasonable patient standard provides a model for other states that have not yet moved to this standard. The Washington Code provides:

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unnecessary to a showing of the materiality of a risk to a patient's decision on treatment, or to the reasonably, [sic] expectable effect of risk disclosure on the decision.

*Canterbury*, 464 F.2d at 792 (citations omitted).

280. See Renfer et al., *supra* note 101, at 412.

281. See *Canterbury*, 464 F.2d at 784-87 (recognizing that the patient's right of self-determination requires the standard of physician disclosure to be set by law and measured by the patient's need); TEX. REV. CIV. STAT. ANN. art. 4590i, § 6.02 (West Supp. 1977); WASH. REV. CODE § 7.70.050(1)-(2) (1996); *Korman v. Mallin*, 858 P.2d 1145, 1148-49 (Alaska, 1993); *Cobbs v. Grant*, 502 P.2d 1, 11 (Cal. 1972); *Revord v. Russell*, 401 N.E.2d 763, 766 (Ind. Ct. App. 1980); *Percle v. Sr. Paul Fire & Marine Ins. Co.*, 349 So. 2d 1289, 1299 (La. Ct. App. 1977); *Sard v. Hardy*, 379 A.2d 1014, 1022 (Md. 1977); *Harnish v. Children's Hosp. Med. Ctr.*, 439 N.E.2d 240, 242-44 (Mass. 1982); *Cornfeldt v. Tongen*, 295 N.W.2d 638, 640 (Minn. 1980); *Phillips v. Hull*, 516 So. 2d 488, 493 (Miss. 1987); *Largey v. Rothman*, 540 A.2d 504, 508-10 (N.J. 1988); *Gerety v. Demers*, 589 P.2d 180, 193-95 (N.M. 1978); *Congrove v. Holmes*, 308 N.E.2d 765, 771 (Ohio Ct. C.P. 1973); *Scott v. Bradford*, 606 P.2d 554, 557-58 (Okla. 1979); *Getchell v. Mansfield*, 489 P.2d 953, 957 (Or. 1971); *Cooper v. Roberts*, 286 A.2d 647, 650-51 (Pa. Super. Ct. 1971); *Wilkinson v. Vesey*, 295 A.2d 676, 685-89 (R.I. 1972).

- (1) The following shall be necessary elements of proof that injury resulted from health care in a civil negligence case or arbitration involving the issue of the alleged breach of the duty to secure an informed consent by a patient or his representatives against a health care provider:
  - (a) That the health care provider failed to inform the patient of a material fact or facts relating to the treatment;
  - (b) That the patient consented to the treatment without being aware of or fully informed of such material fact or facts.
  - (c) That a reasonable prudent patient under similar circumstances would not have consented to the treatment if informed of such material fact or facts;
  - (d) That the treatment in question proximately caused injury to the patient.
- (2) Under the provisions of this section a fact is defined as or considered to be a material fact, if a reasonably prudent person in the position of the patient or his representative would attach significance to it deciding whether or not to submit to the proposed treatment.<sup>282</sup>

### *B. Forced Surgeries: A Moratorium*

While the rate of unnecessary surgeries may decline with improvements in informed consent laws, this change does nothing for court-ordered surgical procedures. Such procedures are approved by courts and enacted by the medical community with no pretense of attention to the patient's wishes. That the procedure is court-ordered indicates that it is done without the consent of the patient and with the sanction of the law. In the two areas discussed above, forced sterilizations and court-ordered cesarean sections, this Article proposes that the law's legitimization of the medical community's dominance of women's bodies should cease. Except in cases where the woman is physically unable to provide consent, there should be no forced cesarean sections or sterilizations.

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282. WASH. REV. CODE § 7,70.050(1)-(2) (1996).

## 1. Court-ordered Cesarean Sections

The strongest case can be made against court-ordered cesarean sections. The high rates of unnecessary cesarean sections suggests strongly that doctors are not altogether successful at determining when childbirth intervention is necessary.<sup>283</sup> As a consequence, judges should not be so quick to defer to doctors' medical expertise regarding the necessity of a cesarean section. To do so very often constitutes legitimizing frequently misguided medical testimony at the expense of due respect for a woman's health and autonomy.

*In re A.C.*<sup>284</sup> provides courts with a precedent to follow in rejecting physician requests to perform court-ordered obstetrical interventions. In vacating the Superior Court's motion for a stay by a woman ordered by the court to undergo a cesarean section, the District of Columbia Court of Appeals stated that the woman has the right to decide what will be done on behalf of herself and her fetus in "virtually all cases."<sup>285</sup> Moreover, in the event that the patient is "incompetent or otherwise unable to give an informed consent," the court ruled that her decision is properly ascertained through "substituted judgement."<sup>286</sup> Even substituted judgement, as construed by the court in this case, respects a woman's right to determine what will be done with her body. The court stressed the need to probe the female patient's value system to help determine what she would choose if she were capable.<sup>287</sup> Moreover, the court cited the patient's family, not the doctor, as the "best source" regarding information about the patient's decision.<sup>288</sup>

## 2. Court-Ordered Sterilizations

The proper course to take in regard to court-ordered sterilization is far more difficult to chart. Certainly, those statutes that permit state-ordered involuntary sterilizations of clearly competent persons should be repealed.<sup>289</sup> However, when the sterilization involves one

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283. See *supra* Part II.C.1.

284. *In re A.C.*, 573 A.2d 1235 (D.C. 1990).

285. *A.C.*, 573 A.2d at 1237.

286. *A.C.*, 573 A.2d at 1237.

287. See *A.C.*, 573 A.2d at 1250.

288. *A.C.*, 573 A.2d at 1250.

289. Specifically, such statutes are in place in Idaho and Delaware. See *supra* note 64.

who is deemed by the court to be incompetent, the issue becomes far more complicated as questions are raised concerning the ability of the parent to raise the child, as well as who will bear this burden in the event that the parents cannot do so. Given the difficulty in distinguishing between those who are competent and those who are not with respect to mental faculties,<sup>290</sup> and given the apparent race and class biases that this paper argues are evident in both the medical and the legal systems, this Article recommends placing a moratorium on all forced sterilizations until we not only have studied the abilities of parents of different perceived competence levels to raise children, but also have eliminated, or at least weakened, racial and class biases.

### *C. Mandatory Patient Advocates*

Many of the problems associated with the priestly model of medicine both stem from and lead to a lack of information on the part of the female patient. It is often difficult for a patient to make a truly informed decision, because she lacks the information to do so. Female patients may have been taught that asking questions implies a lack of confidence in their doctor, and therefore they simply wait for the doctor to give them the necessary information.<sup>291</sup> The doctor then makes a decision that he feels is best for the patient, often without giving the patient any real choice.<sup>292</sup>

One more radical approach to this problem may be to require hospitals to provide advocates for women who are scheduled to give birth. The advocate would accompany the patient during labor and delivery and could also accompany the woman to her doctor's appointments during her last month of pregnancy. The role of the advocate would vary from case to case, depending on the needs of the patient, but in general, an advocate "interprets, rephrases, . . . records . . . demands, defends, explains, and acts as a witness."<sup>293</sup> The advocate is thus a person who is looking out for the patient's interests. The advocate ensures that the patient understands what is happening to her,

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290. See *supra* notes 70–72 and accompanying text.

291. See MARION CROOK, *MY BODY: WOMEN SPEAK OUT ABOUT THEIR HEALTH CARE* 87 (1995). Crook writes, "When a woman does not get the information she needs from her doctor, she often does without the information." CROOK, *supra* at 88.

292. See CROOK, *supra* note 291, at 83–86.

293. CROOK, *supra* note 291, at 87.



which should allow the patient to make more informed health care decisions.

Advocates could be drawn from the public health profession. Because of their health care training, these professionals would be adequately skilled to understand what the doctor is saying, and they would be able to communicate this information to the patient. Careful training of advocates would be important so that the advocate would not fall into a parental or paternal role. Obviously, a patient would not be required to use the advocate. But making these advocates available, especially for women who are not well-educated, would go a long way toward ensuring that women's decisions with regard to matters such as hysterectomies and cesareans are made under conditions that are more likely to result in a truly informed choice.

#### *D. Midwifery*

The promotion of midwifery care seems to offer another method of reducing not only unnecessary and forced surgeries, but also the extent to which male doctors possess hegemonic control over women's health care. Besides yielding substantially lower rates of unnecessary medical interventions,<sup>294</sup> midwifery care in many instances effects a more woman-centered birthing experience.<sup>295</sup> This is especially true of lay midwifery, the type of midwifery care stifled most by the law.<sup>296</sup> To both reduce the rate of unnecessarily performed and forced surgeries, as well as more generally to afford women greater autonomy and respect in the childbirthing process, we should enact legal reform that makes lay midwifery legal in all fifty states. Such reform could come in the form of national protective legislation for this practice.

#### CONCLUSION

This Article proposes a number of reforms: mandated use of a reasonable patient standard for informed consent; a moratorium on forced sterilizations; the mandatory provision of patient advocates by hospitals; and enactment of national protective legislation for lay

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294. See *supra* notes 201–202 and accompanying text.

295. See *supra* notes 218–220 and accompanying text.

296. See *supra* Part II.D.2.

midwifery. These reforms would go a long way toward reducing the hegemony of the priestly model of medicine. Such a reduction of the dominance of this model would in turn increase the autonomy of women in our society and decrease the medical risks to which they are subjected. ♪

