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Elizabeth Kukura

Temple University, elizabeth.kukura@temple.edu

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BIRTH CONFLICTS: LEVERAGING STATE POWER TO COERCE HEALTH CARE DECISION-MAKING

Elizabeth Kukura*

I. INTRODUCTION

Pregnancy is a time filled with decision-making for the pregnant woman and her partner—ranging from major decisions about who will care for the infant and whether changes in housing or employment will be necessary to less consequential decisions about stroller choice, diapering method, and nursery design. Countless books and articles provide prospective parents with advice about their choices in baby names, feeding methods, and parenting philosophy.¹ For many women, however, the decisions they face about their medical care throughout pregnancy and childbirth are more difficult to navigate. Most women do not have the medical knowledge necessary to anticipate and understand complications as they arise, at least without independent research. Doctors help guide women through unfamiliar terrain, explaining childbirth and the risks and benefits of different approaches to managing it, but patients often lack critical information about factors that may influence a physician's clinical recommendation—including professional philosophy, prior experience with malpractice claims, potential financial incentives, or hospital protocols and policies that impact physician behavior.² Recognizing the complexities of pregnancy

* Visiting Assistant Professor of Law, Drexel University, Thomas R. Kline School of Law. LL.M., Temple Law School; J.D., NYU School of Law; M.Sc., London School of Economics; B.A., Yale University. Many thanks to participants at the University of Baltimore Center on Applied Feminism's Tenth Feminist Legal Theory Conference (March 2017) and at the Law and Society Association Annual Meeting (Mexico City 2017), especially Aziza Ahmed, for their comments and suggestions. Thanks also to Jacey Smith, Megan Micco, and the staff of the University of Baltimore Law Review for their dedicated editorial work and interest in the topic.

1. See, e.g., Jennifer Senior, *For Parents, Happiness Is a Very High Bar*, TEDTALKS (Mar. 2014), https://www.ted.com/talks/jennifer_senior_for_parents_happiness_is_a_very_high_bar (discussing the vast array of parenting books on bookstore shelves).
2. See, e.g., Tina Rosenberg, *Reducing Unnecessary C-Section Births*, N.Y. TIMES: OPINIONATOR (Jan. 19, 2016, 3:21 AM), <https://opinionator.blogs.nytimes.com/2016/0>

decision-making, some advocacy groups have organized to provide consumer education about women's rights during childbirth and the possible undisclosed risks and benefits of different courses of treatment.³ Two states have even taken legislative action to mandate hospital disclosure of certain maternal health outcomes in order to empower better decision-making among pregnant women as they choose where and how to give birth.⁴ Nevertheless, for some women, maternity care decision-making continues to be fraught with doubt, fear, and sometimes, conflict.

1/19/arsdarian-cutting-the-number-of-c-section-births/ (analyzing why choice of hospital influences likelihood of cesarean more than clinical indicators like fetal heart rate or labor progress).

3. See, e.g., CHOICES IN CHILDBIRTH, SER. NO. 4, NATIONAL GUIDE TO A HEALTHY BIRTH 4 (Milon Nagi ed., 2012), http://choicesinchildbirth.org/wp-content/uploads/2014/10/CIC_2013NationalGuide_WEB.pdf; *What to Ask . . . a Physician Who May Provide Your Maternity Care*, CHILDBIRTH CONNECTION, <http://www.nationalpartnership.org/research-library/maternal-health/what-to-ask-physician.pdf> (last visited Dec. 30, 2017).
4. MASS. GEN. LAWS ANN. ch. 111, § 70E (West 2018) ("Every maternity patient, at the time of pre-admission, shall receive complete information from an admitting hospital on its annual rate of primary caesarian sections, annual rate of repeat caesarian sections, annual rate of total caesarian sections, annual percentage of women who have had a caesarian section who have had a subsequent successful vaginal birth, annual percentage of deliveries in birthing rooms and labor-delivery-recovery or labor-delivery-recovery-postpartum rooms, annual percentage of deliveries by certified nurse-midwives, annual percentage which were continuously externally monitored only, annual percentage which were continuously internally monitored only, annual percentage which were monitored both internally and externally, annual percentages utilizing intravenous, inductions, augmentation, forceps, episiotomies, spinal, epidurals and general anesthesia, and its annual percentage of women breast-feeding upon discharge from said hospital."); N.Y. PUB. HEALTH LAW § 2803-j(2)(a)-(m) (McKinney 2018) ("[A hospital's informational] . . . leaflet shall also include statistics relating to the annual percentage of maternity related procedures performed at such hospital or birth center, as provided by the commissioner, including but not limited to the following: (a) the annual rate of cesarean sections, primary, repeat and total, performed at such facility; (b) the annual percentage of women with previous cesarean sections who have had a subsequent successful vaginal birth; (c) the annual percentage of deliveries by midwives; (d) the annual percentage of births utilizing electronic fetal monitoring listed on the basis of external and internal; (e) the annual percentage of births utilizing forceps, listed on the basis of low forceps delivery and mid forceps delivery; (f) the annual percentage of breech births delivered vaginally; (g) the annual percentage of births utilizing analgesia; (h) the annual percentage of births utilizing anesthesia including general, spinal, epidural, and paracervical listed on the basis of vaginal and cesarean births; (i) the annual percentage of births utilizing induction of labor; (j) the annual percentage of births utilizing augmentation of labor; (k) the annual percentage of vaginal births utilizing episiotomies; (l) whether birthing rooms are available for use in the facility; [and] (m) whether rooming-in is available in the facility, on the basis of twenty-four hours a day or daytime.").

One version of this occurs when a provider and patient disagree about the appropriate course of treatment during labor and delivery, with the patient declining to follow her care provider's recommendation.⁵ Although such conflict is most commonly associated with cesarean surgery, there are various other decision points during childbirth when a provider and patient may disagree regarding a clinical recommendation. These include the decision to induce labor artificially using drugs,⁶ the prophylactic administration of antibiotics after a positive Group B Strep (GBS) test,⁷ the use of continuous electronic fetal monitoring to measure fetal heart tones, which limits the woman's mobility during labor,⁸ and the use of a surgical incision to widen the birth canal—called an episiotomy.⁹ The reasons for a woman's resistance to her provider's preferred approach vary but may include religious objections, fear, negative experiences during a previous birth, preference for unmedicated delivery, or concern about the risks associated with the recommended course of treatment.¹⁰ In some cases, additional counseling and better communication between the provider and patient can help overcome the disagreement, leading either to a woman's consent to treatment or the identification of an alternative approach.¹¹ When the disagreement persists, however, women may find themselves in a

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5. Although most conflicts arise between a patient and a physician, other health care providers, such as nurses and midwives, may urge interventions or other types of clinical care that patients decline and which become the basis of conflict in the maternity care setting. In hospital-based maternity care, physicians usually occupy supervisory roles over nurses and midwives, and thus presumably have the ultimate authority in such circumstances, but this article will use the general term "provider" in order to include situations where patients experience coercion by non-physician maternity care providers. *See infra* Part II. However, because physicians play a dominant role in hospital-based maternity care, the legal analysis of providers' legal and ethical obligations in Part III will focus on physicians. *See infra* Part III.
 6. *See* HENCI GOER & AMY ROMANO, OPTIMAL CARE IN CHILDBIRTH: THE CASE FOR A PHYSIOLOGIC APPROACH 129–43 (2012) (discussing research that challenges the validity of assumptions underlying liberal use of elective induction of labor).
 7. *See id.* at 144–45 (comparing risks of GBS infection with risks of prophylactic administration of antibiotics during labor).
 8. *See id.* at 223–39 (discussing limitations of continuous electronic fetal monitoring as a tool to promote fetal well-being and its association with unnecessary surgeries).
 9. *See id.* at 353–63 (discussing research on the risks of prophylactic use of episiotomy).
 10. *See* Joel Jay Finer, *Toward Guidelines for Compelling Cesarean Surgery: Of Rights, Responsibility, and Decisional Authenticity*, 76 MINN. L. REV. 239, 285–90 (1991) (discussing reasons why a woman may disagree with her health care provider's approach, including voluntariness, authenticity, informed refusal, and religious objection).
 11. *See infra* note 218 and accompanying text.

standoff with their providers, leading to heightened conflict. Of particular concern are situations where providers threaten to use state power to compel a woman to consent to the recommended course of treatment—either by seeking a court order or by reporting the patient to the state child welfare authorities for neglect or abuse of the baby she will soon deliver.¹²

Although various legal scholars have examined the use of court orders to compel pregnant women to undergo medical treatment, examining constitutional questions related to religious liberty and reproductive freedom, the position of health care providers in such situations has garnered much less attention.¹³ This paper contributes to the existing scholarship by considering how the specter of state involvement acts coercively to impact maternity care decision-making. It examines the legal and ethical implications for health care providers as they navigate birth conflicts and make decisions about what kind of counseling they provide to their patients, how they approach the informed consent process, and how they exercise their judgment as medical experts. The paper uses the example of health care providers relying on health-based justifications to threaten or secure involvement of child welfare authorities in order to examine how coercing consent through threats of state involvement violates physicians' legal and ethical responsibilities and may also have broader negative public health implications.¹⁴ In doing so, the paper challenges the pregnancy exceptionalism that tolerates coercion in the provider-patient relationship and identifies types of changes required to ensure meaningful protection of a woman's right to control her medical treatment when giving birth.¹⁵

12. See *infra* Section II.A.

13. See, e.g., Finer, *supra* note 10, at 270–74; Janet Gallagher, *Prenatal Invasions & Interventions: What's Wrong with Fetal Rights*, 10 HARV. WOMEN'S L.J. 9, 14–31 (1987); Lisa C. Ikemoto, *The Code of Perfect Pregnancy: At the Intersection of the Ideology of Motherhood, the Practice of Defaulting to Science, and the Interventionist Mindset of Law*, 53 OHIO ST. L.J. 1205, 1240–46 (1992); Eric M. Levine, Comment, *The Constitutionality of Court-Ordered Cesarean Surgery: A Threshold Question*, 4 ALB. L.J. SCI. & TECH. 229, 272–90 (1994). Others have analyzed how pregnancy seems to create exceptions to established legal norms governing consent and the right to refuse unwanted medical treatment. See, e.g., Nancy K. Rhoden, *The Judge in the Delivery Room: The Emergence of Court-Ordered Cesareans*, 74 CALIF. L. REV. 1951, 1968–89 (1986).

14. See *infra* Sections II.A, II.B.2.

15. See *infra* Part IV. This Article refers to women as the actors against whom legal threats are made during childbirth, but the author acknowledges that some men also experience pregnancy and childbirth. See Robin Marantz Henig, *Transgender Men Who Become Pregnant Face Social, Health Challenges*, NPR (Nov. 7, 2014, 3:53 PM), <https://www.npr.org/sections/health-shots/2014/11/07/362269036/transgender->

Part II begins by exploring how coercion operates in maternity care decision-making, particularly in the form of child welfare threats, and highlights the ways in which bias influences and exacerbates coercion in health care settings. It then considers the potential consequences of such coercion during childbirth, including physical, emotional, and financial impacts, as well as possible implications for the medical system and public health more generally. Part II ends by describing the limited body of existing data on coercion during childbirth and identifying significant gaps in knowledge about women's childbearing experiences. Part III analyzes the legal and ethical norms that constrain provider behavior and should serve to prevent coercion from influencing women's reproductive decision-making. Finally, Part IV sets forth a multi-pronged approach to changing the conditions that allow coercion to creep into provider-patient relationships.

II. MAKING LEGAL THREATS DURING BIRTH

When a pregnant patient declines to follow medical advice, her health care provider may resort to coercive tactics to secure the woman's consent to treatment.¹⁶ Such tactics may include seeking judicial intervention to compel the recommended treatment,¹⁷ enforcing institution-wide policies that restrict access to particular types of health care,¹⁸ applying pressure by withholding treatment or using emotional scare tactics,¹⁹ or threatening involvement by child welfare authorities.²⁰ Cases involving maternity care provider coercion rarely make it to court, and even more rarely are they

men-who-become-pregnant-face-health-challenges. More research is needed on various aspects of coercion in maternity care, including the experiences of transgender individuals seeking maternity care in mainstream health care institutions.

16. See Michelle Oberman, *Mothers and Doctors' Orders: Unmasking the Doctor's Fiduciary Role in Maternal-Fetal Conflicts*, 94 NW. U. L. REV. 451, 469 (2000) ("It is only in the context of pregnancy that doctors assert the right to compel their patients to heed medical advice.").
17. Elizabeth Kukura, *Obstetric Violence*, 106 GEORGETOWN L.J. (forthcoming Mar. 2018) (manuscript at 14–15).
18. See Elizabeth Kukura, *Choice in Birth: Preserving Access to VBAC*, 114 PENN ST. L. REV. 955, 957, 971–73 (2010) (explaining the emergence of restrictions on vaginal birth after cesarean (VBAC) and their implications for pregnant women); see also Kukura, *supra* note 17 (manuscript at 18) (discussing restrictions on VBAC as a form of coercion in maternity care).
19. Kukura, *supra* note 17 (manuscript at 23–25).
20. See *id.* (manuscript at 20–22) (discussing coercion during childbirth as a form of obstetric violence).

reflected in written case law.²¹ Of those existing reported cases, most involve situations where a hospital and its physician initiate legal proceedings seeking permission to perform a cesarean over the woman's objection. After the birth, the woman appeals the court order or challenges it in federal court, resulting in a written opinion. The highest appellate court that has heard a challenge to a court-ordered cesarean vacated the order and held that the woman had the right to make treatment decisions for herself and her fetus, including refusing the cesarean.²² Nevertheless, the District of Columbia Court of Appeals left open the possibility that in "extremely rare and truly exceptional" cases, "a conflicting state interest may be so compelling that the patient's wishes must yield."²³ Some courts have subsequently enforced a pregnant woman's right to refuse treatment,²⁴ but others have rejected the *In re A.C.* court's reasoning and granted orders compelling cesareans.²⁵ In 1996, in what has become a notable case, Laura Pemberton left the hospital in active labor after she learned that administrators planned to seek a court

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21. See Theresa Morris & Joan H. Robinson, *Forced and Coerced Cesarean Sections in the United States*, 16 CONTEXTS 24, 25 (2017).
 22. *In re A.C.*, 573 A.2d 1235, 1237–38 (D.C. 1990) (en banc) (discussing how physicians obtained a court order to perform a cesarean against a cancer-stricken patient's wishes but the fetus was stillborn and the woman died two days later).
 23. *Id.* at 1252.
 24. See, e.g., *Burton v. State*, 49 So. 3d 263, 265–66 (Fla. Dist. Ct. App. 2010) (vacating order for forced bed rest on the basis of the woman's "fundamental constitutional right to refuse medical intervention"); *In re Brown*, 689 N.E.2d 397, 405 (Ill. App. Ct. 1997) (holding that "the State may not override a pregnant woman's competent treatment decision" in order to save the life of a viable fetus); *In re Baby Boy Doe*, 632 N.E.2d 326, 332 (Ill. App. Ct. 1994) ("[A] woman's right to refuse invasive medical treatment . . . is not diminished during pregnancy."). No appellate court has upheld a court order compelling a cesarean since 1981. Farah Diaz-Tello, *When the Invisible Hand Wields a Scalpel: Maternity Care in the Market Economy*, 18 CUNY L. REV. 197, 213 (2015).
 25. Lisa Collier Cool, *Could You Be Forced to Have a C-Section?*, BABY TALK (May 2005), http://advocatesforpregnantwomen.org/articles/forced_c-section.htm; *What Are Mothers' Rights During Childbirth?*, NBC NEWS (May 19, 2004), <http://www.nbcnews.com/id/5012918/> (discussing a Pennsylvania court order granting Wilkes-Barre General Hospital guardianship of Amber Marlowe's fetus in order to perform a cesarean against Marlowe's will). Doctors had informed Marlowe—who had previously delivered six children vaginally, all nearly 12 pounds each—that her baby was large and would require a cesarean delivery, which she did not believe was necessary. *What Are Mothers' Rights During Childbirth?*, *supra*. After the hospital obtained a court order, she went to another area hospital and vaginally delivered a healthy eleven-pound baby. *Id.*

order compelling a cesarean.²⁶ The sheriff and state's attorney subsequently removed her from her home for a judicial hearing at the hospital, during which the judge ordered a cesarean be performed, even though the woman reported she could feel the fetus progressing into the birth canal without complication.²⁷ A federal district court later rejected Pemberton's claims of negligence, false imprisonment, and violation of her constitutional rights.²⁸

The prospect of medical authorities using judicial power to force women to submit to major abdominal surgery against their will has, appropriately, drawn the attention of legal scholars.²⁹ Given the tendency of courts to locate the authority to compel a cesarean in the Supreme Court's recognition in *Roe v. Wade*³⁰ of a compelling state interest in protecting potential life, the pregnancy treatment cases have inspired analysis of a woman's liberty and privacy rights in childbirth and critique of the comparison between compelled treatment in pregnancy and abortion rights.³¹ Other situations where health care providers threaten to involve the state in order to secure a woman's consent have received much less attention, despite the potential for harm to women, babies, and families, and the serious constitutional and public health concerns such threats raise. In particular, threatening to report a woman to child welfare authorities

26. Pemberton v. Tallahassee Mem'l Reg'l Med. Ctr., Inc., 66 F. Supp. 2d 1247, 1249–50 (N.D. Fla. 1999).

27. *Id.*; Video Recording: Laura Pemberton's Talk at the 2007 National Summit to Ensure the Health and Humanity of Pregnant and Birthing Women (National Advocates for Pregnant Women 2007) [hereinafter Pemberton Video Recording], <https://vimeo.com/4895023>. Laura Pemberton had previously had a cesarean performed using a vertical incision, which increased the risk of uterine rupture associated with subsequent vaginal deliveries. *Pemberton*, 66 F. Supp. 2d at 1249. She had decided to deliver at home after being unable to find a physician who would support her decision to attempt a vaginal delivery, which she reasoned was safer than an elective repeat cesarean given her desire to have more children in the future. *See* Pemberton Video Recording, *supra*. Pemberton later moved to another state and subsequently delivered four more children vaginally, including twins. *Id.*

28. *Pemberton*, 66 F. Supp. 2d at 1257.

29. *See supra* note 13.

30. 410 U.S. 113 (1973).

31. *See, e.g.*, April L. Cherry, *Roe's Legacy: The Nonconsensual Medical Treatment of Pregnant Women and Implications for Female Citizenship*, 6 U. PA. J. CONST. L. 723, 723–39 (2004); Oberman, *supra* note 16, at 475–76; Lynn M. Paltrow & Jeanne Flavin, *Pregnant, and No Civil Rights*, N.Y. TIMES (Nov. 7, 2014), https://www.nytimes.com/2014/11/08/opinion/pregnant-and-no-civil-rights.html?_r=0; *see also* Kukura, *supra* note 17 (manuscript at 63–66) (providing recommendations for advocacy to protect women's rights in childbirth).

if she fails to consent to treatment represents an important, under-explored form of coercion in clinical settings.

This Part examines how child welfare threats constitute coercion in maternity care. In Section A, the paper sets forth several examples that illustrate how such threats arise, followed in Section B by an analysis of the potential implications of child welfare threats both for individual women and for the broader public health. Finally, Section C argues that, despite the current lack of data on this phenomenon, there is sufficient reason for concern about child welfare threats and the harms they pose.

A. *Coercing Consent with Child Welfare Threats*

Federal law requires that all states maintain procedures to investigate suspected cases of child maltreatment.³² Beginning in the 1970s, states established Child Protective Services (CPS) agencies to fulfill this mandate, with partial funding from the federal government.³³ State and federal law define child abuse and neglect, as well as set forth guidelines regarding the reporting of suspected abuse and neglect to the proper authorities.³⁴ Generally, an individual is required to report suspected maltreatment when he or she “knows or has reasonable cause to believe or suspect that a child has been subjected to abuse or neglect.”³⁵ Health care providers and other professionals are subject to heightened standards regarding

32. See Child Abuse Prevention and Treatment Act, Pub. L. No. 93-247, 88 Stat. 4 (1974) (requiring states to implement systems for reporting, investigation, and treatment of child abuse and neglect).

33. John E. B. Myers, *A Short History of Child Protection in America*, 42 FAM. L.Q. 449, 454, 456–57 (2008). States use different names and acronyms to refer to their CPS agencies, including Department of Children and Families (DCF), Department of Children and Family Services (DCFS), or the Department of Social Services (DSS). See *Related Organizations: State Child Welfare Agency Directors*, CHILD WELFARE INFO. GATEWAY, https://www.childwelfare.gov/organizations/?CWIGFunctionsaction=rols:main.dspList&rolType=Custom&RS_ID=158 (last visited Dec. 30, 2017).

34. See CHILD WELFARE INFO. GATEWAY, DEFINITIONS OF CHILD ABUSE AND NEGLECT 4 (2016), <https://www.childwelfare.gov/pubPDFs/define.pdf> (discussing standards for reporting child abuse and neglect). Federal law defines child abuse and neglect as “any recent act or failure to act on the part of a parent or caretaker, which results in death, serious physical or emotional harm, sexual abuse or exploitation, or an act or failure to act which presents an imminent risk of serious harm.” CAPTA Reauthorization Act of 2010, Pub. L. No. 111-320, sec. 142(a), § 3(2), 124 Stat. 3459, 3482 (codified as amended at 42 U.S.C. § 5101 (2012)).

35. CHILD WELFARE INFO. GATEWAY, *supra* note 34, at 4.

mandatory reporting of potential maltreatment that they encounter in their work with children and families.³⁶

A recent Florida case illustrates certain concerns and dynamics that are often present in situations of coerced decision-making in childbirth.³⁷ In 2014, doctors for Jennifer Goodall threatened possible intervention by child welfare authorities in their attempt to convince Goodall, a mother of three who was nearly thirty-nine weeks pregnant, to consent to an elective cesarean surgery for her impending birth.³⁸ After three previous cesarean surgeries, Goodall had considered the risks of both a vaginal birth after cesarean (VBAC) and repeat cesarean; she decided to pursue a vaginal delivery in order to avoid the potential complications of another surgery and minimize her recovery time.³⁹ After several conversations with her health care providers in which Goodall indicated her familiarity with the risks and benefits of each delivery method, she understood her doctors to be willing to attend her VBAC.⁴⁰

36. CHILD WELFARE INFO. GATEWAY, MANDATORY REPORTERS OF CHILD ABUSE AND NEGLECT 2 (2016), <https://www.childwelfare.gov/pubPDFs/manda.pdf>.

37. *See* Goodall v. Comprehensive Women's Health Ctr., No. 2:14-cv-399-FtM-38CM, 2014 WL 3587290, at *1–2 (M.D. Fla. July 18, 2014).

38. *Id.*

39. *See id.* Research suggests that a fourth cesarean surgery “carries a 1 in 8 chance of major complications.” Press Release, Nat'l Advocates for Pregnant Women, Florida Hospital Says It Will Force Pregnant Woman to Have Cesarean Surgery (July 25, 2014), http://advocatesforpregnantwomen.org/blog/2014/07/press_release_florida_hospital.php [hereinafter Goodall Press Release]. The American College of Obstetricians and Gynecologists says that 60–80% of women who attempt VBAC are successful. *Id.* Uterine rupture occurs in approximately 0.7% to 0.9% of VBAC attempts. Am. Coll. of Obstetricians & Gynecologists, *Practice Bulletin No. 115: Vaginal Birth After Previous Cesarean Delivery*, 116 *OBSTETRICS & GYNECOLOGY* 450, 451 tbl.1 (2010) [hereinafter ACOG Practice Bulletin]. The risk of infant death resulting from uterine rupture is even smaller—approximately one in 2,000. Mona Lydon-Rochelle et al., *Risk of Uterine Rupture During Labor Among Women with a Prior Cesarean Delivery*, 345 *NEW ENG. J. MED.* 3, 7 tbl.4 (2001). For more information about research on the safety of VBAC and the resulting impact on hospital policies restricting or encouraging VBAC for low-risk women, see Elizabeth Kukura, *Contested Care: The Limitations of Evidence-Based Maternity Care Reform*, 31 *BERKELEY J. GENDER L. & JUST.* 241, 260–61, 267–70 (2016).

40. *See* Declaration of Jennifer Goodall at 2–4, *Goodall*, No. 2:14-cv-399-FtM-36CM (M.D. Fla. July 18, 2014). Throughout her prenatal care and the later legal proceedings, Goodall expressed her “absolute[] . . . consent to such surgery if there is a complication that arises during . . . labor that requires this surgical intervention.” *Id.* at 3.

However, towards the end of her pregnancy, Goodall's case was referred to the hospital ethics committee.⁴¹ When she was one day short of thirty-nine weeks pregnant, she received a letter hand-delivered to her home from the Chief Financial Officer of Bayfront Health Port Charlotte (BHPC).⁴² The letter indicated that Goodall's maternity care providers intended to report her to the Department of Children and Family Services and petition for a court order to perform a cesarean.⁴³ In addition, the letter stated that if Goodall presented at the hospital in labor, "a Cesarean section . . . [would] be performed with or without . . . [her] consent."⁴⁴ The hospital also recommended that she seek care from another physician who would support her decision to deliver vaginally,⁴⁵ even though BHPC was the only hospital in the area that serves patients who want to pursue VBAC.⁴⁶

Goodall promptly sought a temporary restraining order (TRO) in federal court to prevent the hospital from following through on its threats.⁴⁷ In addition to claims based on her constitutional rights to privacy, bodily autonomy, medical decision-making, life, and due process—all stemming from her cesarean refusal⁴⁸—Goodall also argued that her right to privacy "encompass[e]d her right to family relationships and parental decision making undisturbed by the state," citing authority about "[t]he liberty interest . . . of parents in the care, custody, and control of their children"⁴⁹ She argued that "state

41. *Goodall*, 2014 WL 3587290, at *1.

42. Letter from Cheryl Tibbett, CFO, Bayfront Health Med. Grp., to Jennifer Goodall (July 10, 2014) [hereinafter Bayfront Letter] (attached as Exhibit 1 to Declaration of Jennifer Goodall, *supra* note 40); Complaint for Temp. Restraining Order, Preliminary Injunction, Declaratory Judgment, & Damages at 5, *Goodall*, No. 2:14-cv-399-FtM-38CM (M.D. Fla. July 18, 2014) [hereinafter Goodall Complaint].

43. Bayfront Letter, *supra* note 42, at 1–2.

44. *Id.* at 2. This statement begs the question of why it intended to "begin a process for an Expedited Judicial Intervention Concerning Medical Treatment Procedures," if the hospital intended to perform a cesarean with or without Goodall's consent should she seek further care there. *Id.*

45. *Id.*

46. Goodall Complaint, *supra* note 42, at 5.

47. *See id.* at 14.

48. *Id.* at 7–9.

49. Plaintiffs' Memorandum of Law in Support of the Motion for Temp. Restraining Order & Complaint for Preliminary Injunction, Declaratory Judgment, & Damages at 13–14, *Goodall v. Comprehensive Women's Health Ctr.*, No. 2:14-cv-399-FtM-38CM (M.D. Fla. July 18, 2014) [hereinafter Goodall Brief] (quoting *Troxel v. Granville*, 530 U.S. 57, 65 (2000)) ("The liberty interest . . . of parents in the care, custody, and control of their children . . . is perhaps the oldest of the fundamental liberty interests recognized by this Court."); *see also, e.g., Santosky v. Kramer*, 455 U.S. 745, 753

action must withstand strict scrutiny when it threatens to come between parents and their children.”⁵⁰ Intrusions upon family privacy in the interests of child welfare are limited to those circumstances recognized by state statute, which does not contemplate child welfare jurisdiction over the medical decisions of competent adults acting on their own behalf.⁵¹ Nor does mandatory reporting by health professionals extend to conflicts over medical treatment during childbirth.⁵² In addition to alleging various constitutional violations, Goodall also brought claims of intentional and negligent infliction of emotional distress on the basis “that she, a nearly full-term pregnant woman soon to deliver,” “experienced great fear and worry” upon receiving the hospital’s threats of forced surgery and child welfare involvement in her family’s life.⁵³

The federal court declined to issue a TRO, finding that Goodall had no “right to compel a physician or medical facility to perform a medical procedure in the manner she wishe[d] against their best medical judgment.”⁵⁴ This statement reflects a deep misunderstanding about the difference between a VBAC and a cesarean, seeming to equate the physiological process of labor resulting in vaginal delivery with a major abdominal surgery.⁵⁵ This

(1982) (noting a “historical recognition that freedom of personal choice in matters of family life is a fundamental liberty interest protected by the Fourteenth Amendment”); *Moore v. City of E. Cleveland*, 431 U.S. 494, 503 (1977) (“Our decisions establish that the Constitution protects the sanctity of the family precisely because the institution of the family is deeply rooted in this Nation’s history and tradition.”); *Meyer v. Nebraska*, 262 U.S. 390, 399 (1923) (recognizing the right “to marry, establish a home and bring up children”); *Moriarty v. Bradt*, 827 A.2d 203, 213 (N.J. 2003) (“The right to rear one’s children . . . has been identified as a fundamental liberty interest protected by the Due Process Clause of the Fourteenth Amendment . . .”).

50. Goodall Brief, *supra* note 49, at 14.

51. *Id.* (citing FLA. STAT. ANN. §§ 39.001–39.8298 (West 2018)).

52. *See generally* FLA. STAT. ANN. §§ 39.01, 39.201 (West 2018) (laying out requirements for mandatory reporting of child abuse, neglect, or abandonment without any mention of reporting pregnant women who disagree with their physicians’ recommendations). *See also* Goodall Brief, *supra* note 49, at 14 (noting absence of “indication that the Legislature has granted the DCFS jurisdiction over fetuses in addition to children”). Goodall also suggested that reporting her to DCFS “may even trigger an abrogation of reporter immunity,” resulting in civil and criminal liability. *Id.* (citing FLA. STAT. ANN. § 39.205(9) (West 2018)) (“A person who knowingly and willfully makes a false report of child abuse, abandonment, or neglect . . . is guilty of a felony of the third degree . . .”).

53. Goodall Complaint, *supra* note 42, at 2, 11.

54. *Goodall*, 2014 WL 3587290, at *3.

55. *See* Goodall Press Release, *supra* note 39 (“The process of labor and delivery isn’t a procedure; our client is the one trying to avoid a compelled medical procedure.”).

inaccurate comparison misrepresents the degree of intervention required in each birth, as well as the resulting hardship (or lack thereof) on the parties involved.⁵⁶ In doing so, the court suggests that a vaginal delivery saddles a physician with serious burden—one left unidentified and unquantified—elevating that supposed burden above the very real burden a woman suffers after undergoing an unwanted cesarean.⁵⁷ The court did not address Goodall’s arguments that the hospital’s threat to report her to the child welfare authorities was a wrongful attempt to “coerce Ms. Goodall into acquiescence” or constituted “a form of patient abandonment.”⁵⁸

Child welfare threats can be a powerful tool to secure a patient’s acquiescence to a course of treatment preferred by providers. In 2010, Michelle Mitchell went into labor and proceeded to Augusta Health in Augusta County, Virginia.⁵⁹ During her final weeks of pregnancy, her doctors had urged her to plan an induction or cesarean because they suspected she was carrying a large baby.⁶⁰ But Mitchell

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56. See Diaz-Tello, *supra* note 24, at 199. The misleading comparison between the burdens of vaginal and cesarean delivery reflects the high degree of medicalization of childbirth in modern maternity care, such that few hospital-based vaginal deliveries are free from medical intervention—even though many routine interventions offered to laboring women are not evidence-based. See *id.* (“[C]hildbirth has been medicalized to the point where vaginal delivery, the physiological process by which a fetus is expelled from the body, is now treated as a ‘procedure’ that facilities may decide to offer . . . or not. Medicalization transforms a fundamental right—the right to forego an invasive surgery—into a request that a medical facility can grant or deny.”); see also Kukura, *supra* note 39, at 250–53, 256–60 (discussing the trend towards medicalization of childbirth in the United States).
57. Hospitals and doctors who maintain VBAC-restrictive policies generally justify them by citing fear of medical malpractice liability and the increased cost of practicing obstetrics due to high malpractice awards for birth complications. See Goodall Brief, *supra* note 49, at 23–24. Even if liability exposure were a valid basis on which to force patients to accept unwanted medical treatment, Goodall argued that “her willingness to consent to surgery if she is advised that any condition indicating need for surgery arises during labor, as well as to memorialize in writing her understanding of the potential risks and benefits of . . . [trial of labor after cesarean] and repeat cesarean surgery . . . will serve to protect any interest the hospital has with respect to limiting exposure to medicolegal liability.” *Id.* at 25.
58. *Id.* at 14–51; see also Goodall, 2014 WL 3587290, at *3 (explaining why Goodall failed to meet the requirements for a temporary restraining order but failing to address her coercion argument).
59. Farah Diaz-Tello, *Invisible Wounds: Obstetric Violence in the United States*, 24 REPROD. HEALTH MATTERS, 56, 58 (2016).
60. *Id.*; see also Devin Turk, *UPDATE: Verdict Reached in Mother’s Lawsuit that Claimed C-Section Was Coerced*, WHSV (Nov. 7, 2015, 10:01 AM), <http://www.wHSV.com/content/news/Mothers-Lawsuit-Says-C-Section-Was-Coerced-341274302.html> (describing Mitchell’s lawsuit). Research does not support suspected fetal macrosomia—referring to a newborn who is significantly larger than average—

wanted to have an unmedicated vaginal delivery, having educated herself about childbirth and hired a doula for support.⁶¹ When the on-call physician at Augusta Health recommended that she proceed with a cesarean based on her medical records, Mitchell signed a form acknowledging that she declined to follow this medical recommendation and waiving liability.⁶² Nevertheless, “the physician became more and more insistent, shouting and swearing at Mitchell and her doula” about her decision to decline a cesarean in favor of vaginal delivery.⁶³ He ultimately threatened to seek a court order compelling a cesarean and to call the child welfare authorities to remove her baby after birth.⁶⁴ Confronted with such threats, Mitchell rescinded her informed refusal and acquiesced to the unwanted surgery.⁶⁵

Despite the fact that Mitchell relented and delivered by cesarean, the hospital still called the local child welfare agency, “accusing Mitchell of being unfit to care for her child because of the conflict that arose from her decision to deliver vaginally.”⁶⁶ The hospital prevented Mitchell from being with her newborn immediately after the birth and refused to release the child to her.⁶⁷ Three months of invasive interviews and home observations were necessary before the child welfare authorities deemed the investigation baseless and dismissed it.⁶⁸

No court has ruled on the question of whether a cesarean refusal can constitute a valid basis for a finding of child neglect or abuse. The closest a court has come to doing so arose out of a case before the Superior Court of New Jersey, Appellate Division.⁶⁹ In 2006, a pregnant woman, V.M., went to Saint Barnabas Hospital in New

as a valid indication for induction. CAROL SAKALA & MAUREEN P. CORRY, EVIDENCE-BASED MATERNITY CARE: WHAT IT IS AND WHAT IT CAN ACHIEVE 38 (2008), https://cdn2.sph.harvard.edu/wp-content/uploads/sites/32/2017/03/Sakala-Corry_Milbank_Evidence-based-MaternityCare.pdf.

61. Diaz-Tello, *supra* note 59, at 59.

62. *Id.* at 59.

63. *Id.*

64. *Update: Augusta Co. Jury Rules in Favor of Doctor in C-Section Case*, NBC29 (Nov. 20, 2015, 12:14 PM), <http://www.nbc29.com/story/30455784/update-augusta-co-jury-rules-in-favor-of-doctor-in-c-section-case>.

65. Diaz-Tello, *supra* note 59, at 59.

66. *Id.*

67. *Id.*

68. *Id.*

69. *See* N.J. Div. of Youth & Family Servs. v. V.M., 974 A.2d 448, 449 (N.J. Super. Ct. App. Div. 2009) (per curiam).

Jersey in labor and was presented with a variety of consent forms to sign upon her admission.⁷⁰ She “consented to the administration of intravenous fluids, antibiotics, oxygen, fetal heart rate monitoring, an episiotomy and an epidural anesthetic,” but she declined to consent at the outset to other invasive treatment, including a cesarean or fetal scalp stimulation.⁷¹ Her health care providers urged her to sign the cesarean consent form “in the event of an emergency,” despite the fact that there was no medical need for a cesarean, and the fact that declining to consent upon admission would not preclude her from choosing a cesarean should the medical circumstances later change.⁷² She experienced continued pressure from her health care providers, who also questioned her competence to refuse treatment and referred her to the hospital psychiatrist, who concluded that she was competent to determine her own course of treatment.⁷³ V.M. eventually delivered a healthy baby vaginally without complications.⁷⁴ Nevertheless, the hospital reported her to the Division of Youth and Family Services (DYFS) based on her refusal to provide advance consent to a cesarean.⁷⁵ DYFS removed the newborn from V.M.’s care and placed the infant in foster care—later securing termination of her parental rights, a decision that was upheld on appeal.⁷⁶

Although the appellate court ultimately affirmed the Family Court’s decision to terminate V.M.’s parental rights, the panel that heard her case disagreed about whether it was appropriate to consider a cesarean refusal as evidence of parental neglect.⁷⁷ The per curiam opinion recognized that the Family Court judge based his finding of

70. *Id.* at 449–50 (Carchman, P.J.A.D., concurring).

71. *Id.* at 450 (footnote omitted).

72. Brief of *Amici Curiae* Experts in Maternal & Neonatal Health, Birth, & Child Welfare at 4, *V.M.*, 974 A.2d 448 (N.J. Super. Ct. App. Div. 2009) (No. FN-07-572-06); *see also V.M.*, 974 A.2d at 449 (Carchman, P.J.A.D., concurring) (“Despite the medical opinion that the fetus demonstrated signs of distress and that the procedure was necessary to avoid imminent danger to the fetus, the child was born by vaginal delivery without incident.”).

73. Brief of *Amici Curiae* Experts in Maternal & Neonatal Health, Birth, & Child Welfare, *supra* note 72, at 4–5. The psychiatrist “concluded that V.M. was not psychotic and had the capacity for informed consent with regard to the c-section.” *V.M.*, 974 A.2d at 451 (Carchman, P.J.A.D., concurring).

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

75. *Id.* at 449–50, 452.

76. *Id.* at 450.

77. *Compare id.* at 448 (per curiam) (declining to decide whether cesarean refusal should be considered in assessing neglect), *with id.* at 450 (Carchman, P.J.A.D., concurring) (determining that consideration of cesarean refusal “is improper and beyond the legislative scope of the child-protective statutes”).

neglect in part on V.M.'s cesarean refusal but pointed to other grounds for an adverse finding based on the investigation conducted by DYFS after the baby's birth.⁷⁸ The concurring opinion cited hospital records that referred to V.M. as "combative," "uncooperative," "erratic," "noncompliant," "irrational," and "inappropriate," which the court may have found compelling in connection with evidence of her previous diagnosis of mental illness.⁷⁹ However, such adjectives could also describe many women in the midst of childbirth, especially under conditions where a woman perceives herself as being threatened by her health care providers. By relying on other grounds to affirm the termination of V.M.'s parental rights, the court dodged the need to address whether a cesarean refusal itself is a valid and sufficient basis for a neglect finding against a mother.⁸⁰ Although the appellate court technically avoided answering this question, it is clear that her cesarean refusal triggered the subsequent investigation by child welfare authorities that led to the permanent removal of her child from her custody.⁸¹

A pregnant woman choosing between a vaginal and cesarean delivery, or someone considering other possible medical interventions available to her during childbirth, must balance the risks and benefits of different courses of treatment. The experience of V.M. adds an additional factor to this risk-balancing exercise: possible intervention by child welfare authorities and the loss of one's child. This risk is not lost on women, particularly poor women, women of color, and young women, who are more likely to have experienced state—and sometimes public—scrutiny of their reproductive decision-making.⁸² Doctors or other hospital personnel

78. *Id.* at 449 (per curiam).

79. *Id.* at 450–51 (Carchman, P.J.A.D., concurring). The possibility that behavioral health issues could have been a factor in V.M.'s case—both the actual clinical encounter and the court's subsequent weighing of the facts in the record—highlight the complex role that mental illness can play in maternity care coercion. *See id.* at 451–52, 454–55. A current or prior diagnosis of mental illness may invite heightened scrutiny of a woman's decision making, especially a refusal of recommended treatment, and it may also negatively influence how a patient responds to perceived pressure from health care providers to pursue a particular course of treatment. In addition, maternity care coercion may also contribute to poor mental health outcomes for pregnant and postpartum women. *See infra* Section II.B.1.b. More attention to the relationship between behavioral and mental health and birth conflicts is needed on the part of researchers, advocates, and stakeholders within the health care system.

80. *V.M.*, 974 A.2d at 449 (per curiam).

81. *Id.* at 450–52 (Carchman, P.J.A.D., concurring).

82. *See generally* KHIARA M. BRIDGES, *THE POVERTY OF PRIVACY RIGHTS* (2017) (examining poor mothers' interactions with the state and arguing that poor mothers in

need not actually make a formal report to the child welfare agency in order to convince a patient to accept recommended treatment; in many instances, the mere threat is sufficient to accomplish the provider's goal of changing a patient's mind.

Consumer organizations dedicated to improving maternity care in the United States regularly receive reports from women across the country who have experienced mistreatment at the hands of their health care providers while pregnant or giving birth.⁸³ Included in their stories are accounts of being threatened with child welfare intervention if they did not consent to treatment. For example, a Texas woman who declined a labor induction reported that “[the doctor] said if . . . [she] didn't go through with the induction today that he would do everything in his power to make sure CPS would take . . . [her] children.”⁸⁴ When she told the physician assistant (PA) that she preferred to go into labor on her own without the aid of medication to start contractions, the doctor “was very upset . . . and [said] that . . . [she] wasn't to leave until . . . [she] saw him or they'd have to call CPS.”⁸⁵ The PA was “incredibly sympathetic” and agreed to send the woman home to wait for labor to start but warned the woman that the doctor “would definitely follow up on his threat.”⁸⁶ The pregnant woman's desire to forego induction “seemed to infuriate” the doctor, resulting in verbal abuse of the woman and

America have been denied the right to privacy); DOROTHY ROBERTS, *KILLING THE BLACK BODY: RACE, REPRODUCTION, AND THE MEANING OF LIBERTY* (1997) (discussing state intervention in the reproductive autonomy of African American women).

83. See Dawn Thompson, *Global Momentum Towards Respectful Care*, IMPROVING BIRTH (Sept. 25, 2014), <http://improvingbirth.org/2014/09/respectful-care/> (discussing Improving Birth's #BreakTheSilence campaign, which was designed to “giv[e] mothers around the country a forum to voice the abuse and trauma they have experienced in childbirth”). Improving Birth identifies itself as “the largest U.S. consumer advocacy organization for better maternity care.” Improving Birth, *Improving Birth/Consumers Welcome Recognition by Medical Community of Disrespect and Abuse in Childbirth*, KINDRED (Aug. 26, 2015), <http://kindredmedia.org/2015/08/improving-birthconsumers-welcome-recognition-by-medical-community-of-disrespect-and-abuse-in-childbirth/>.

84. Brief of Human Rights in Childbirth et al. as Amicus Curiae in Support of Plaintiff Rinat Dray at 27, *Dray v. Staten Island Univ. Hosp.*, No. 500510/14 (N.Y. Sup. Ct. filed Dec. 23, 2014) [hereinafter *Dray Amicus Brief*]. A selection of written testimonies by women who suffered mistreatment at the hands of their health care providers was included as an appendix to an amicus brief filed by the organization Human Rights in Childbirth in a compelled cesarean case litigated in New York. See *id.* app. A at A-2.

85. *Id.* at 27.

86. *Id.*

her husband, as the doctor “yell[ed] at the top of his lungs about what a horribly selfish and dangerous parent . . . [she] was.”⁸⁷ When she explained that she could not be induced immediately because she had to make arrangements for her children, the doctor “told . . . [her] if . . . [she] didn’t walk over to the hospital right now he’d call the police. He followed up the threat by picking up his phone.”⁸⁸

Another woman told *Improving Birth* how when she asked for clarification about the need for a cesarean, “[t]he nurse said in a very strict tone that . . . [she] needed to cooperate, otherwise . . . [she] could have . . . [her] baby taken away. [The nurse] . . . pointed out that . . . [she] was a young mother.”⁸⁹ Rinat Dray, an Orthodox Jewish mother of two who wanted a vaginal delivery after two prior cesareans, was told by her doctor “that she would be committing the equivalent of child abuse and that her baby would be taken away from her” if she did not consent to the cesarean.⁹⁰ Child welfare threats during birth—tacitly supported by the V.M. decision—have a potential chilling effect that reaches beyond individual cases of coercion, as women share their birth stories with other women, who then perceive the potential for state intervention as one more risk to fear during childbirth. Threats made in one delivery room are likely to influence other women to either submit to unwanted treatment or decline to ask relevant, appropriate questions of a care provider out of fear of similar consequences.⁹¹ For example, a New York woman recounted how the doctors wanted to give her newborn broad-spectrum antibiotics because the woman’s Group B Strep status was unknown; although they did not discuss benefits, risks, or possible alternatives with her, she “consented because . . . [she] was afraid if . . . [she] did not, they would call Child Protective Services.”⁹²

87. *Id.*

88. *Id.* app. A at A-18.

89. *Id.* at 27.

90. Anemona Hartocollis, *Mother Accuses Doctors of Forcing a C-Section and Files Suit*, N.Y. TIMES (May 16, 2014), <https://www.nytimes.com/2014/05/17/nyregion/mother-accuses-doctors-of-forcing-a-c-section-and-files-suit.html>. In her case, the threat did not have its desired effect of securing her consent to the cesarean, but the hospital lawyer ultimately advised the physician that a court order was unnecessary and the physician could simply override her competent consent refusal. See *Gorelik Affidavit* at 3, *Dray*, No. 500510/14 (N.Y. Sup. Ct. filed Nov. 26, 2014).

91. See *Diaz-Tello*, *supra* note 24, at 199 (“The use of the iron fist of the law is rare when health care providers find that the invisible hand works just as well.”).

92. *Dray Amicus Brief*, *supra* note 84, app. A at A-29.

CPS reporting triggers an investigation that subjects the entire family to state surveillance.⁹³ It may open other aspects of the family members' private lives to heightened scrutiny—including housing arrangements, family relationships, education, and nutrition—leading to the removal of children from their families and termination of parental rights, even if the circumstances prompting the original report are ultimately found to be baseless.⁹⁴ Intervention by child welfare authorities can have devastating consequences for parents and children. Once a child has been removed, the legal process to secure reunification is often long and arduous;⁹⁵ this poses particularly serious consequences for mothers and newborns whose opportunities for early bonding and breastfeeding are interrupted by the removal.⁹⁶ But even absent removal, threatening to report a pregnant woman to the child welfare authorities for disagreeing with her health care provider's treatment recommendation can cause harm by stripping the woman of her decision-making autonomy and increasing the risk of adverse health outcomes for both the woman and baby.

B. *Potential Consequences of Coerced Decision-Making During Birth*

When health care providers use coercive tactics to steer patients toward a particular course of treatment, a number of negative

93. See Josh Gupta-Kagan, *Toward a Public Health Legal Structure for Child Welfare*, 92 NEB. L. REV. 897, 899–900 (2014).

94. See *id.* at 900.

95. See, e.g., Larissa MacFarquhar, *When Should a Child Be Taken from His Parents?*, NEW YORKER (Aug. 7 & 14, 2017), <https://www.newyorker.com/magazine/2017/08/07/when-should-a-child-be-taken-from-his-parents> (discussing the delays and obstacles parents face when seeking to regain custody after removal of a child by child welfare authorities); *I-Team: Family Separated After Family Court Closes Early*, NBC N.Y. (Oct. 17, 2013), https://www.nbcnewyork.com/on-air/as-seen-on/I-TEAM_-Budget-Cuts-Delay-Family-Court-Hearings_-Unnecessarily-Traumatizing-Some-Children_New-York-228256391.html (discussing family court delays that prolong the separation of parents and children). The consequences of such separations include the interruption of breastfeeding and the ongoing traumatization of young children. *I-Team: Family Separated After Family Court Closes Early*, *supra* (discussing one child's fear of the doorbell after a baseless separation from her mother and four-day-long placement in foster care).

96. *I-Team: Family Separated After Family Court Closes Early*, *supra* note 95; see also *BDS Testifies Before Council Hearing on Abuse and Mistreatment of Women in City Jails: Testimony of Kelsey DeAvila*, BROOKLYN DEFENDER SERVICES (Dec. 15, 2015), <http://bds.org/category/testimony/> (describing, in the context of incarceration, how separation of a breastfeeding infant from her mother “can be damaging to the child's development and dangerous to a mother's mental health”).

consequences may result. Not only is the patient-provider relationship degraded, but the woman—and by extension, her family—may personally experience various harms. These include physical harm resulting from the increased risk associated with the unwanted medical treatment, emotional harm resulting from the experience of coercion and any adverse outcomes, and the financial burden of additional expenses incurred as a result of the unwanted intervention. In addition, when coercion creeps into clinical decision-making, it can erode trust in the medical profession as a whole, discouraging people from seeking medical care, especially critical prenatal care. It may deter pregnant women from seeking care at the hospital, inhibit women from communicating openly with their physicians, and contribute to the undermining of the principle of informed consent that lies at the heart of modern medical care.

The potential chilling effect of child welfare threats on women's decision-making in childbirth is troubling, as some women will submit to unwanted and unnecessary medical treatment out of fear of similar consequences. The consequences are particularly severe for poor women, women of color, and young women, as they are more likely to have their parental fitness, good judgment, and even the appropriateness of their pregnancies questioned and scrutinized by authority figures, and therefore may be more susceptible to interference in their medical decision-making. The remainder of this Section considers the potential consequences of coercion during childbirth for individual women and their families, as well as for the medical system and public health more generally.

1. Impact on Individual Women and Families

a. *Physical Harm*

Medically unnecessary interventions, especially those involving surgery, increase the risk of complications for women and babies.⁹⁷

97. See SAKALA & CORRY, *supra* note 60, at 4–5, 21. Research shows that the increase in cesareans in the United States has not improved birth outcomes. *Specifications Manual for Joint Commission National Quality Measures*, JOINT COMMISSION (2013), <https://manual.jointcommission.org/releases/TJC2013A/MIF0167.html> (last visited Dec. 30, 2017); see also SAKALA & CORRY, *supra* note 60, at 42 (“Recent analyses substantiate the World Health Organization’s recommendation that optimal national cesarean rates are in the range of 5 percent to 10 percent of all births and that rates above 15 percent are likely to do more harm than good.”). Evidence-based research has begun to document the extent to which cesareans are often unnecessary, performed in non-emergent situations without clinical indication. See SAKALA & CORRY, *supra* note 60, at 41–48.

Women who have cesareans are more likely to experience death, emergency hysterectomy, blood clots and stroke, surgical injury such as bladder and uterine lacerations, hemorrhage, infection, and intense and prolonged postpartum pain.⁹⁸ They are also more likely to suffer chronic pelvic pain and bowel obstruction than women who have vaginal births.⁹⁹ Cesareans require longer hospitalizations and more healing time; rehospitalization in the sixty days following a cesarean is almost twice as common as after a vaginal birth.¹⁰⁰ Research shows that cesareans also increase the risk of problems with future reproduction and are associated with involuntary infertility, cesarean scar ectopic pregnancy, placenta previa, placenta accreta, future deliveries with low birthweight babies, preterm babies, and stillbirths.¹⁰¹ A history of multiple cesareans is associated with cumulative abdominal adhesion formation and an increased risk of adverse reproductive effects.¹⁰² These outcomes disproportionately affect religious women whose desire for large families is rooted in their faith.¹⁰³

Babies may also suffer an increased risk of physical harm as a result of the coerced medical treatment provided to their mothers.

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98. CAROL SAKALA, *CHILDBIRTH CONNECTION, VAGINAL OR CESAREAN BIRTH?: A SYSTEMATIC REVIEW TO DETERMINE WHAT IS AT STAKE FOR MOTHERS AND BABIES* 3 (2006), <https://pqnc-documents.s3.amazonaws.com/sivbdoc/sivbeb/6ChildbirthConnectionEvidencereVaginalandCesareanBirth.pdf>; *see also, e.g.*, Anne Kjersti Daltveit et al., *Cesarean Delivery and Subsequent Pregnancies*, 111 *OBSTETRICS & GYNECOLOGY* 1327, 1329–33 (2008) (describing study that found higher rates of uterine rupture and placental complications after previous cesarean deliveries); Catherine Deneux-Tharoux et al., *Postpartum Maternal Mortality and Cesarean Delivery*, 108 *OBSTETRICS & GYNECOLOGY* 541, 544–47 (2006) (describing study that found a “three-fold increase in the risk of postpartum maternal death” after caesarean birth).
99. SAKALA, *supra* note 98, at 3.
100. F. GARY CUNNINGHAM ET AL., *WILLIAMS OBSTETRICS* 592 (Andrea Seils et al. eds., McGraw-Hill Cos. 22d ed. 2005).
101. SAKALA, *supra* note 98, at 4; *see also, e.g.*, Jeffrey L. Ecker & Fredric D. Frigoletto, Jr., *Cesarean Delivery and the Risk-Benefit Calculus*, 356 *NEW ENG. J. MED.* 885, 888 (2007) (“[S]pecific objections to cesarean delivery include concern regarding a mother’s future reproductive health, since later pregnancies are associated with increased risks of miscarriage, ectopic gestation, placenta previa, and placenta accreta.”); Robyn Kennare et al., *Risks of Adverse Outcomes in the Next Birth After a First Cesarean Delivery*, 109 *OBSTETRICS & GYNECOLOGY* 270, 272–74 (2007) (noting that cesarean birth significantly increases risk for placenta previa and placenta accreta when compared with vaginal birth and that cesarean birth infants also face risks, including low birth weight and “higher risk of unexplained stillbirth”).
102. *See* SAKALA, *supra* note 98, at 4.
103. *See* TINA CASSIDY, *BIRTH: THE SURPRISING HISTORY OF HOW WE ARE BORN* 108 (2006) (describing an increase in potentially life-threatening placental abnormalities in Mormon women who have previously given birth by cesarean).

Babies born by cesarean are more likely to experience respiratory problems, surgical injuries, and asthma during childhood and adulthood.¹⁰⁴ They also have higher rates of failure to establish breastfeeding.¹⁰⁵

Apart from cesareans, other unwanted interventions increase the risk of physical harm to women. Research has linked episiotomies with increased perineal injury, stitches, pain and tenderness, length of healing, a likelihood of leaking stool or gas, and pain with intercourse.¹⁰⁶ Interventions such as continuous electronic fetal monitoring, induction, and epidural can prompt the need for additional procedures, leading to injury.¹⁰⁷ Researchers use the term “cascade of secondary interventions” to capture the idea that the medical complexity of birth increases when additional interventions are required to monitor and treat the side effects of the original interventions.¹⁰⁸ For example, one study found that among first-time mothers who labored, 47% experienced an induction, and of those who were induced, 78% had an epidural; among women who had both an induction and an epidural, 31% ultimately had a cesarean.¹⁰⁹ By contrast, women who experienced either an induction or an epidural—but not both—had cesareans 19–20% of the time.¹¹⁰ Research shows that various interventions are routinely performed

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104. SAKALA, *supra* note 98, at 3; SAKALA & CORRY, *supra* note 60, at 44; *see also, e.g.*, James M. Alexander et al., *Fetal Injury Associated with Cesarean Delivery*, 108 *OBSTETRICS & GYNECOLOGY* 885, 886 (2006) (“The most common injury [in cesarean infants] was skin laceration . . .”); Anne Kirkeby Hansen et al., *Risk of Respiratory Morbidity in Term Infants Delivered by Elective Caesarean Section: Cohort Study*, *BMJ* 3–4 (2008), <http://www.bmj.com/content/bmj/336/7635/85.full.pdf> (describing study results which found that cesarean infants had increased risks for respiratory morbidity when compared with infants born through vaginal delivery); Astrid Sevelsted et al., *Cesarean Section and Chronic Immune Disorders*, *PEDIATRICS* 3–4 (2014), <http://pediatrics.aappublications.org/content/pediatrics/early/2014/11/25/peds.2014-0596.full.pdf> (describing study results in which cesarean delivery was found to significantly increase a child’s risk of asthma); *Analysis Shows Possible Link Between Rise in C-Sections and Increase in Late Preterm Birth*, *MARCH OF DIMES* (Dec. 16, 2008), http://208.74.202.51/24497_25161.asp (discussing the link between cesarean sections and increased preterm births).
105. SAKALA, *supra* note 98, at 3.
106. SAKALA & CORRY, *supra* note 60, at 49.
107. *Id.* at 39.
108. *Id.* at 28.
109. EUGENE R. DECLERCQ ET AL., *CHILDBIRTH CONNECTION, LISTENING TO MOTHERS III: PREGNANCY AND BIRTH* 24 (2013), http://transform.childbirthconnection.org/wp-content/uploads/2013/06/LTM-III_Pregnancy-and-Birth.pdf.
110. *Id.*

without evidence to support their safety and efficacy, or in situations lacking a clinical indication for the treatment, reflecting the degree to which childbirth in the United States has become a high-tech, procedure-intensive experience for a significant majority of women.¹¹¹ Medical intervention can be life-saving and injury-preventing in circumstances where complications arise, but intervention poses risk. When women are coerced into accepting medical treatment they do not want, their risk of physical harm—and in some instances, harm to their babies—increases, with the potential for serious, lasting consequences.

b. *Emotional Harm*

Coerced medical treatment can also cause emotional harm in the form of fear, trauma, depression, and impaired recovery and adjustment to parenthood. After she was informed that her hospital intended to seek a court-ordered cesarean and a child welfare investigation, Jennifer Goodall described her “feelings of deep distress, concern, and fear for . . . [herself] and . . . [her] pregnancy and . . . [her] family.”¹¹² As Goodall experienced, emotional harm may occur at the time of the coercive conduct or it may manifest later in the pregnancy or postpartum period.

Mental health professionals increasingly recognize birth trauma as a condition that interferes with postpartum well-being, often requiring counseling or other treatment.¹¹³ Trauma during childbirth can lead to Post Traumatic Stress Disorder (PTSD), postpartum depression, poor bonding and attachment, and difficulty with breastfeeding.¹¹⁴ A national study of women during the postpartum period found that up to 9% of respondents met the clinical criteria for

111. See Kukura, *supra* note 39, at 258–64.

112. Declaration of Jennifer Goodall, *supra* note 40, at 6, 11 (“I am now very near giving birth without an attending physician and am afraid to go to Bayfront Health Port Charlotte.”).

113. See Penny Simkin, *Birth Trauma: Definition and Statistics*, PATTCH: PREVENTION & TREATMENT TRAUMATIC CHILDBIRTH, <http://pattch.org/resource-guide/traumatic-births-and-ptsd-definition-and-statistics/> (last visited Dec. 30, 2017).

114. Cheryl Tatano Beck et al., *Posttraumatic Stress Disorder in New Mothers: Results from a Two-Stage U.S. National Survey*, 38 BIRTH: ISSUES IN PERINATAL CARE 216, 217 (2011) (“Birth trauma can also lead to distressing problems that hinder mothers’ breastfeeding attempts.”); Thompson, *supra* note 83 (describing the PTSD a woman suffered after her forced episiotomy, in addition to physical complications from the cutting itself); see also Dray Amicus Brief, *supra* note 84, at 34–35 (recounting specific birth stories of women who experienced trauma and suffered flashbacks and nightmares about giving birth).

PTSD.¹¹⁵ Research shows a strong association between coercion and postpartum PTSD.¹¹⁶ Researchers at the University of North Dakota found that 34% of women reported symptoms of PTSD related to their birth experience, concluding that “the strongest predictor of developing PTSD after labor was not a history of trauma, but rather *the level of coercion the women experienced during their labor and delivery.*”¹¹⁷ Longer-term emotional distress resulting from birth trauma may result in feelings of powerlessness and the desire to avoid anything associated with the birth.¹¹⁸

In general, women who give birth by cesarean are more likely to have poor overall mental health and functioning than women who deliver vaginally.¹¹⁹ Women who have cesareans are more likely to report a poor birth experience and have less early contact with their babies, which impedes postpartum hormonal adjustment and lactation.¹²⁰ Immediate skin-to-skin contact between mother and baby helps regulate newborn body temperature, reduces newborn crying, improves breastfeeding effectiveness, and results in more affectionate maternal behaviors.¹²¹ Although not all women and babies are able to breastfeed, women who breastfeed experience lower incidences of premenopausal breast cancer, ovarian cancer, retained gestational weight gain, type-2 diabetes, and myocardial

115. Beck et al., *supra* note 114, at 217.

116. *Id.* at 222 (identifying pressure to induce labor and pressure to have an epidural as two variables that differentiated women with high posttraumatic stress symptom levels).

117. *Caught on Video: Improving Birth Breaks the Silence on Abuse of Women in Maternity Care*, IMPROVING BIRTH (Aug. 28, 2014), <https://improvingbirth.org/2014/08/vid/> (describing a study that examined various risk factors, including history of physical and sexual abuse or domestic violence, low socioeconomic status, age, and education level).

118. See JENNIFER BLOCK, PUSHED: THE PAINFUL TRUTH ABOUT CHILDBIRTH AND MODERN MATERNITY CARE 146–47 (2007) (summarizing the experiences of women who chose not to celebrate their child’s first birthday due to painful associations with the violence they experienced during childbirth).

119. SAKALA & CORRY, *supra* note 60, at 44; see also Jennifer Fenwick et al., *Women’s Experiences of Cesarean Section and Vaginal Birth After Caesarian: A Birtherites Initiative*, 9 INT’L J. NURSING PRAC. 10, 12 (2003) (“Seventy-eight percent . . . of the women reported that their Cesarean section was both physically and emotionally traumatic.”).

120. See SAKALA & CORRY, *supra* note 60, at 37 (discussing the functioning of natural oxytocin production to produce postpartum hemorrhage and facilitate breastfeeding and bonding); see also Kukura, *supra* note 39, at 268 (discussing negative impact of cesarean on postpartum adjustment).

121. SAKALA & CORRY, *supra* note 60, at 55.

infarction.¹²² Babies who breastfeed have a lower rate of infectious morbidity and less risk of childhood obesity, diabetes, leukemia, and sudden infant death syndrome.¹²³ Early breastfeeding is associated with greater breastfeeding success and longer duration of breastfeeding.¹²⁴

In childbirth, hormonal changes associated with the physiology of labor and delivery mean that physical and emotional functioning are highly interdependent. Women whose healthcare providers pressure them to consent to treatment are at heightened risk of emotional injury due to the experience of coercion, as well as possible adverse emotional health and related physiological impacts suffered as a result of the treatment itself.

c. *Financial Burden*

Women who give birth by cesarean incur a greater financial burden as a result of the surgery, longer hospitalization, and in some instances, the costs associated with complications arising from the surgery.¹²⁵ Even when comparing uncomplicated deliveries, the cost of a cesarean is significantly higher than the cost of a vaginal delivery.¹²⁶ In 2011, the average hospital charge for an uncomplicated vaginal birth was \$10,657, while the average cost of an uncomplicated cesarean was \$17,859.¹²⁷ These amounts exclude the cost of anesthesia, newborn care, or compensation for the services of an obstetrician or midwife.¹²⁸ Considering all childbirth costs together, both commercial and Medicaid payers compensate maternity care providers approximately 50% more for cesareans than vaginal deliveries.¹²⁹

122. See Alison Steube, *The Risks of Not Breastfeeding for Mothers and Infants*, 2 REVIEWS OBSTETRICS & GYNECOLOGY 222, 222 (2009).

123. *Id.*

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

125. SAKALA & CORRY, *supra* note 60, at 47.

126. *Id.*

127. *Average Facility Labor and Birth Charge by Site and Method of Birth, United States, 2009-2011*, CHILD BIRTH CONNECTION 1 (2013), <http://transform.childbirthconnection.org/wp-content/uploads/2013/06/USCharges-chart-2009-2011.pdf> (showing that the average hospital charge for a complicated cesarean is \$23,923).

128. *Id.*

129. TRUVEN HEALTH ANALYTICS, *THE COST OF HAVING A BABY IN THE UNITED STATES: EXECUTIVE SUMMARY* (2013), <http://transform.childbirthconnection.org/wp-content/uploads/2013/01/Cost-of-Having-a-Baby-Executive-Summary.pdf>.

Higher provider reimbursement rates for cesareans, along with longer hospitalizations and more ancillary procedures, create financial incentives to recommend cesareans even in the absence of medical necessity.¹³⁰ Indeed, research suggests that such incentives do shape clinical decision-making whether or not providers are conscious of the role that financial considerations play.¹³¹ Women with private, fee-for-service insurance have cesareans at higher rates than those who are insured by HMOs, Medicaid, or who are uninsured.¹³² A California study revealed that for-profit hospitals were more likely to perform cesareans than not-for-profit hospitals, even for women experiencing low-risk pregnancies.¹³³ Researchers concluded that a woman who delivers at a for-profit hospital is 17% more likely to give birth by cesarean than a woman who obtains care at a not-for-profit institution.¹³⁴

Because cesareans require longer hospitalization and involve a more lengthy healing process—and indeed, are more likely to require rehospitalization—families experience an increased burden associated with caring for older children.¹³⁵ This may increase the financial strain on families facing higher-than-expected medical bills, along with the associated stress.

Other non-cesarean medical intervention may also increase the financial burden associated with childbirth. Under fee-for-service reimbursement structures, various obstetric procedures—such as artificial induction, administration of IV fluids, bladder catheterization, rupture of membranes to release amniotic fluid, fetal monitoring, episiotomy, shaving pubic hair, epidural anesthesia, and forceps- or vacuum-assisted delivery—may all generate additional

130. SAKALA & CORRY, *supra* note 60, at 59–60.

131. *See, e.g.*, Jonathan Gruber & Maria Owings, *Physician Financial Incentives and Cesarean Section Delivery*, 27 RAND J. ECON. 99, 100 (1996).

132. Emmett B. Keeler & Mollyann Brodie, *Economic Incentives in the Choice Between Vaginal Delivery and Cesarean Section*, 71 MILBANK Q. 365, 374, 374 tbl.1 (1993).

133. Nathanael Johnson, *For-Profit Hospitals Performing More C-Sections*, KAISER HEALTH NEWS (Sept. 13, 2010), <https://khn.org/news/californiawatch-profit-hospitals-performing-more-c-sections/>. Other studies have linked differences in cesarean rates with the profit orientation of the hospital where a woman gives birth. *See, e.g.*, Gruber & Owings, *supra* note 131, at 99 (analyzing the correlation between a fall in fertility over the 1970–1982 period and the rise of cesarean delivery as an offset to lost profit).

134. Johnson, *supra* note 133.

135. *See* SHEILA KITZINGER, *THE COMPLETE BOOK OF PREGNANCY & CHILDBIRTH* 355 (4th ed. 2005) (discussing postpartum care after cesarean and six-week restriction on heavy lifting).

fees.¹³⁶ When a woman feels pressure to accept a procedure that she does not otherwise want, she must also bear the increased costs associated with that procedure.

2. Impact on Medical System and Public Health

In addition to the negative impact on women and their families, coercion in the provider-patient relationship during childbirth poses a threat to the medical system and public health more broadly. The vast majority of women wish to give birth in a hospital, giving them access to any medical care necessary to ensure the health and safety of both mother and infant.¹³⁷ When women experience coercion by their maternity care providers—or hear other women recount threats wielded against them during pregnancy and childbirth—pregnant women lose trust in physicians, nurses, and hospitals.¹³⁸ Some will seek maternity care outside a hospital setting; in areas with midwifery access, women may be able to give birth in a freestanding birth center or at home with a trained attendant instead.¹³⁹ But in the many areas

136. See Keeler & Brodie, *supra* note 132, at 365.

137. See MARIAN F. MACDORMAN ET AL., CTRS. FOR DISEASE CONTROL & PREVENTION, U.S. DEP'T OF HEALTH & HUMAN SERVS., NCHS DATA BRIEF NO. 144: TRENDS IN OUT-OF-HOSPITAL BIRTHS IN THE UNITED STATES, 1990–2012, at 1 (2014), <https://www.cdc.gov/nchs/data/databriefs/db144.pdf> (reporting that 1.36% of births in 2012 occurred outside a hospital); see also Declaration of Jennifer Goodall, *supra* note 40, at 7 (expressing Jennifer Goodall's desire to give birth in a hospital attended by medical professionals who are trained to respond appropriately in the event of an emergency).

138. See, e.g., Jodi Jacobson, *Florida Hospital Demands Woman Undergo Forced C-Section*, REWIRE (July 25, 2014, 5:04 PM), <https://rewire.news/article/2014/07/25/florida-hospital-demands-woman-undergo-forced-c-section/>. After her hospital threatened legal action against her to force her to undergo a cesarean, Jennifer Goodall was “terrified to enter a hospital.” *Id.*

139. Thirty-three states provide formal legal recognition of Certified Professional Midwives (CPMs), who—unlike Certified Nurse Midwives (CNMs)—focus their practice on out-of-hospital births. See *CPMS Legal Status by State*, BIG PUSH FOR MIDWIVES, http://pushformidwives.nationbuilder.com/cpms_legal_status_by_state (last visited Dec. 30, 2017). There are fewer than 3,000 CPMs currently practicing in the United States. *Who Are CPMs*, NAT'L ASS'N CERTIFIED PROF. MIDWIVES, <http://nacpm.org/about-cpms/who-are-cpms/> (last visited Dec. 30, 2017). In addition, there are approximately eighty freestanding birth centers in the United States, where women can give birth in low-intervention settings attended by either CPMs or CNMs. See Susan Rutledge Stapleton et al., *Outcomes of Care in Birth Centers: Demonstration of a Durable Model*, 58 J. MIDWIFERY & WOMEN'S HEALTH 3, 5 (2013); see also, e.g., Kukura, *supra* note 39, at 256–57 (providing background on the options for out-of-hospital births, as well as the barriers women face when seeking midwife-attended out-of-hospital births); Stacey A. Tovino, *American Midwifery Litigation and State Legislative Preferences for Physician-Controlled Childbirth*, 11

of the country where women have no options for midwifery care, they may decide to give birth at home unassisted—with a higher risk of adverse outcomes—move their families to a different state or region,¹⁴⁰ or forego future pregnancies out of fear.¹⁴¹

The World Health Organization has recognized that “disrespectful, abusive or neglectful treatment . . . [c]onstitutes a violation of trust between women and their health-care providers and can also be a powerful disincentive for women to seek and use maternal health care services.”¹⁴² The violation of trust can also inhibit essential communication between a pregnant woman and her doctor, as women become less likely to disclose relevant sensitive information about their health and pregnancies, such as smoking, alcohol use, and drug use—both illicit drugs and legal medication.¹⁴³ When a woman feels safe to discuss issues that may impact fetal development and her own well-being, physicians can offer appropriate information, counseling, or treatment. Women who fail to disclose relevant information about their health miss opportunities to receive smoking cessation support, methadone treatment, or advice on how to safely continue taking

CARDOZO WOMEN’S L.J. 61, 68–69 (2004) (discussing legal regulation that restricts access to midwifery in certain areas).

140. Pemberton Video Recording, *supra* note 27 (discussing Pemberton’s decision to move out-of-state after forced cesarean in the absence of a midwife willing to attend Pemberton’s VBAC).
141. It is possible that some threats by hospitals and physicians are made with the purpose of reducing their liability risk by encouraging the patient to go elsewhere for care. *See* Diaz-Tello, *supra* note 24, at 216 (discussing threats of legal process as a liability-minimizing tool that “mak[es] the prospect of delivering at that facility so frightful that the pregnant person goes elsewhere”).
142. *The Prevention and Elimination of Disrespect and Abuse During Facility-Based Childbirth*, WORLD HEALTH ORG. (2015) [hereinafter WHO STATEMENT], http://apps.who.int/iris/bitstream/10665/134588/1/WHO_RHR_14.23_eng.pdf?ua=1&ua=1.
143. *See* Brief of Amici Curiae Nat’l Advocates for Pregnant Women & Experts in Maternal & Child Health & Drug Treatment in Support of Appellant Melissa McCann Arms at 10–14, *Arms v. State*, 471 S.W.3d 637 (Ark. 2015) (No. CR-15-124) (arguing that provider threats of state intervention deter women from seeking critical prenatal care); *see also, e.g.*, *Ferguson v. City of Charleston*, 532 U.S. 67, 78 n.14 (2001) (citing *Whalen v. Roe*, 429 U.S. 589, 599–600 (1977)) (recognizing that being reported to police by prenatal care providers “may have adverse consequences because it may deter patients from receiving needed medical care”); *Jaffee v. Redmond*, 518 U.S. 1, 9–10 (1996) (upholding confidentiality of mental health records because a “confidential relationship” is necessary for “successful [professional] treatment,” and “the mere possibility of disclosure may impede development of the confidential relationship necessary for successful treatment”).

medication for mental illness—increasing the risk of impaired fetal development, birth defects, and low birthweight.¹⁴⁴

Finally, threats to leverage state power in order to secure consent to medical treatment during pregnancy degrade the principle of informed consent. As discussed in Part III, informed consent protects patient autonomy and ensures respect for the right of patients to direct the course of their own care. It is central to modern medical care and respect for the value of patient dignity. Recognized in law and enshrined in ethical guidance to medical professionals, informed consent works when providers take their obligations seriously and ensure that patient consent is obtained after full disclosure of the risks and benefits of the proposed treatment, as well as the risks and benefits of any alternatives.¹⁴⁵ When a woman consents to treatment out of fear of losing her child to the state, informed consent is an empty promise.¹⁴⁶ The potential for erosion of the principle of informed consent threatens medical ethics and could have far-reaching consequences beyond the maternity care context.

C. *Data Gaps*

Analyzing the problem of child welfare threats—and coercion more generally—during childbirth is complicated by a lack of data on the occurrence of such threats. Identifying when, where, and how health care providers threaten state action against pregnant women is likely hindered by the shame some women feel resulting from birth trauma, but the bigger obstacle is how few people are asking the right questions.¹⁴⁷ This reflects the dearth of data on the broader

144. See, e.g., Patrick J. Sweeney et al., *The Effect of Integrating Substance Abuse Treatment with Prenatal Care on Birth Outcome*, 20 J. PERINATOLOGY 219, 219–23 (2000) (reporting better pregnancy outcomes when women received drug treatment and prenatal care).

145. See Kukura, *supra* note 17 (manuscript at 47–49, 51, 58, 61–63) (discussing the limitations on legal enforcement of the right to informed consent and the need for providers to uphold the principle even in the absence of possible legal sanction).

146. See Heather Joy Baker, Note, “*We Don’t Want to Scare the Ladies:*” *An Investigation of Maternal Rights and Informed Consent Throughout the Birth Process*, 31 WOMEN’S RTS. L. REP. 538, 540–41 (2010) (“If the repercussions for failure to consent to cesarean section are so severe that children can be taken from their mothers, what is the purpose of a consent form?”).

147. See Dray Amicus Brief, *supra* note 84, at 34–36 (describing types of emotional suffering that women may experience after traumatic births, including humiliation, degradation, and shame). Some women are reluctant to report mistreatment during the birth of their children out of fear that complaining will be perceived as ungratefulness about the birth of the baby, reflecting the oft-repeated sentiment that “a healthy baby is all that matters,” even in the face of birth-related injuries suffered by

phenomenon of obstetric violence, where a lack of research on the issue impedes efforts to assess the scope of the problem and develop effective interventions.¹⁴⁸ Nevertheless, existing research and data collection suggest that child welfare threats and other forms of coercion during birth are sufficiently prevalent to be taken seriously.

The few studies that have considered women's experiences of coercion during childbirth show that provider pressure to agree to medical treatment is not uncommon. A 2013 study found that 25% of women who had experienced labor induction or cesarean felt pressure by their health care provider to accept those interventions.¹⁴⁹ A 2014 study reported that women who experienced pressure to consent to a cesarean were more than 5 times more likely to have one, more than 6 times more likely to have one without a medical basis, and almost 7 times more likely to have an unplanned cesarean.¹⁵⁰ Reflecting the extent to which health care providers are able to assert their preferences upon their patients, 20% of women who were induced and 38% of women who had cesareans reported to researchers that their care provider made the "final decision" about their treatment.¹⁵¹ Together, this research suggests that provider coercion contributes to the high rates of medical intervention in maternity care in the United States. It also supports the conclusion that a significant number of women bear the increased risks of cesarean surgery without medical necessity and contrary to their wishes.

Other research suggests that provider preferences have a significant influence on women's decision-making during childbirth; specifically, the manner in which a health care provider presents risks and whether he or she is perceived to support a particular course of treatment shapes women's ultimate decisions. One study compared good candidates for VBAC who chose a repeat cesarean with those who chose a trial of labor, finding that maternity care providers strongly influence women's choice of delivery method, distinct from

the mother. See Kukura, *supra* note 17 (manuscript at 44–45) (discussing social expectations of self-sacrificing mothers and the disregard of maternal birth injuries in the presence of a healthy baby).

148. See Kukura, *supra* note 17 (manuscript at 29–33) (discussing the lack of research on obstetric violence in the United States).

149. DECLERCQ ET AL., *supra* note 109, at 35.

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

151. DECLERCQ ET AL., *supra* note 109, at 38 tbl.16.

the actual risk presented in the individual situations.¹⁵² Researchers suggested that the repeat cesarean rate among study subjects could have decreased from 70.4% to 25.5% if their health care providers had exhibited support for VBAC.¹⁵³ Another study concluded that women were extremely likely to choose repeat cesarean if they understood it to be their doctor's preferred approach, with only 4% of women who perceived a physician preference for surgery actually attempting a VBAC.¹⁵⁴

Not all women are impacted by provider coercion to the same degree. First, certain women are more likely to be threatened with state intervention in their medical decision-making. Young women, women of color, and poor women, who may already live with extensive surveillance by the state in order to receive public benefits, are more likely to receive child welfare threats and to encounter difficult decisions about whether to accept unwanted treatment—and the increased risk of complications—in order to avoid the risk of losing their children.¹⁵⁵

Second, certain women are more likely to succumb to provider pressure due to their vulnerability. Although research suggests that provider preferences may influence all women, regardless of background or status, it is likely that women with fewer resources, weaker support networks, and less perception of power in the treatment relationship will agree to unwanted treatment in the face of coercion.¹⁵⁶ This includes uninsured women and Medicaid recipients who do not have a preexisting relationship with the treating doctor, women without resources to hire a doula for emotional support throughout childbirth, young women, immigrant women, and women who have no or limited English language skills.¹⁵⁷ The disproportionate risk of coercion faced by such women is supported by global research on maternal health, which suggests that certain categories of women may be more vulnerable to mistreatment by

152. Torri D. Metz et al., *How Do Good Candidates for Trial of Labor After Cesarean (TOLAC) Who Undergo Elective Repeat Cesarean Differ from Those Who Chose TOLAC?*, 208 AM. J. OBSTETRICS & GYNECOLOGY 458.e1, 458.e4–e5 (2013).

153. *Id.* at 458.e5.

154. Sarah Bernstein et al., *Trial of Labor After Previous Cesarean Section Versus Repeat Cesarean Section: Are Patients Making an Informed Decision?*, 206 AM J. OBSTETRICS & GYNECOLOGY S21, S21 (Jan. 2012 Supp.).

155. *See generally, e.g.*, BRIDGES, *supra* note 82 (discussing the many ways poor women are deprived of reproductive privacy); DOROTHY ROBERTS, SHATTERED BONDS: THE COLOR OF CHILD WELFARE (2002) (arguing that African Americans are disproportionately represented in the child welfare system).

156. WHO STATEMENT, *supra* note 142.

157. *See id.*

their health care providers—especially young women, poor women, unmarried women, women with HIV, and women who belong to racial, ethnic, and religious minorities.¹⁵⁸

There are reasons to think that coercion in maternity care will continue to be a problem and may even increase in frequency. First, the high degree of medicalization in modern maternity care means that there are a variety of decision points during labor and delivery when intervention may be recommended by a health care provider without a strong evidence basis supporting its use.¹⁵⁹ Of all hospital procedures performed on individuals aged 18–44 in 2005, 49% were obstetric procedures.¹⁶⁰ Six of the fifteen most common hospital procedures for the entire population are associated with childbirth.¹⁶¹ Indeed, the most common operating room procedure is cesarean surgery; in 2013, 32.7% of all babies in the United States were born by cesarean.¹⁶²

Second, and relatedly, growing concern about record-high cesarean rates and the number of medically unnecessary inductions and surgeries performed each year have focused more public attention on maternal health and birthing rights.¹⁶³ Indeed, a growing consumer

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158. *Id.*; see also Jenna Murray de Lopez, “Birth is like a Battle of the Ancient Maya”: Obstetric Violence in South East Mexico 17 (undated) (unpublished manuscript) (on file with author) (reporting results of qualitative anthropological study of obstetric violence that suggested women’s experiences of violence, and the frequency of such violations, “are informed by their status and treatment in the wider society”).
159. See Kukura, *supra* note 39, at 258–60 (discussing the introduction of childbirth interventions without adequate study and regional variations in cesarean rates that suggest “a pattern of almost random decision making” for the use of cesarean surgery).
160. SAKALA & CORRY, *supra* note 60, at 11.
161. *Id.* at 11–12.
162. JOYCE A. MARTIN ET AL., CTRS. FOR DISEASE CONTROL & PREVENTION, U.S. DEP’T OF HEALTH & HUMAN SERVS., BIRTHS: FINAL DATA FOR 2013, at 7 (2015), https://www.cdc.gov/nchs/data/nvsr/nvsr64/nvsr64_01.pdf.
163. See, e.g., AM. COLL. OF OBSTETRICIANS & GYNECOLOGISTS & SOC’Y FOR MATERNAL FETAL MED., NO. 1, OBSTETRIC CARE CONSENSUS: SAFE PREVENTION OF THE PRIMARY CESAREAN DELIVERY (2014), <https://www.acog.org/-/media/Obstetric-Care-Consensus-Series/oc001.pdf?dmc=1&ts=20180120T2122047688> (“[T]he rapid increase in cesarean birth rates from 1996 to 2011 without clear evidence of concomitant decreases in maternal or neonatal morbidity or mortality raises significant concern that cesarean delivery is overused.”); Anna Almendrala, *U.S. C-Section Rate Is Double What WHO Recommends*, HUFFPOST (Apr. 16, 2015), https://www.huffingtonpost.com/2015/04/14/c-section-rate-recommendation_n_7058954.html; Rosenberg, *supra* note 2; Megan Thielking, *Sky-High C-Section Rates in the US Don’t Translate to Better Birth Outcomes*, STAT (Dec. 1, 2015), <https://www.statnews.com/2015/12/01/cesarean-section-childbirth/>.

advocacy movement is engaging the public in education and advocacy about the over-medicalization of childbirth in the United States and encouraging women to share their negative birth experiences.¹⁶⁴ Armed with more information about common childbirth interventions, more women are likely to question or challenge their doctors about the necessity of medical intervention, leading to more conflict between pregnant women and their health care providers.¹⁶⁵ As birth conflicts become even more common, it is likely that more providers will consider it necessary to resort to threats of judicial or child welfare intervention in order to convince patients to follow their treatment advice.

III. LEGAL AND ETHICAL RESPONSIBILITIES OF MATERNITY CARE PROVIDERS

Making child welfare threats and other coercive tactics used to secure a pregnant woman's agreement to treatment violate physicians' legal and ethical responsibilities. Although health care providers are generally under no legal obligation to begin treating an individual seeking care,¹⁶⁶ once they do undertake to provide health care services, the law requires them to provide care for patients in an existing treatment relationship.¹⁶⁷ As they treat patients, physicians

164. See Kukura, *supra* note 17 (manuscript at 31–32) (discussing the recent founding of three organizations to address obstetric violence in a four-year period, joining established groups advocating for maternity care reform). The groups are Improving Birth, Human Rights in Childbirth, and the Birth Rights Bar Association. *Id.* (manuscript at 31).

165. See, e.g., Diaz-Tello, *supra* note 59, at 57–59 (describing the experiences of Rinat Dray and Michelle Mitchell, who made educated decisions in declining medical intervention, despite their health care providers' adamant insistence to the contrary).

166. See, e.g., Childs v. Weis, 440 S.W.2d 104, 107 (Tex. Civ. App. 1969) (“Since it is unquestionably the law that the relationship of physician and patient is dependent upon contract, . . . a physician is not to be held liable for arbitrarily refusing to respond to a call of a person even urgently in need of medical or surgical assistance provided that the relation of physician and patient does not exist at the time . . .”). There are statutory exceptions to this common law rule, such as the federal Emergency Medical Treatment and Labor Act, which obligates providers to care for someone in certain emergency circumstances. EMTALA, 42 U.S.C. § 1395dd (2012).

167. See, e.g., Ricks v. Budge, 64 P.2d 208, 211 (Utah 1937) (“We believe the law is well settled that a physician or surgeon, upon undertaking an operation or other case, is under the duty, in the absence of an agreement limiting the service, of continuing his attention, after the first operation or first treatment, so long as the case requires attention.”). The law recognizes a small number of circumstances under which the treatment relationship may be ended without violating this legal duty. *Id.* at 211–12 (noting the obligation can be terminated when the need for medical care has ceased, when the patient has discharged the physician, or when the physician withdraws “after

are bound by certain legal and ethical obligations. These obligations shape the provider-patient relationship, as well as clinical decision-making about the patient's course of treatment. Before administering medical care, a physician must obtain the patient's informed consent to the treatment.¹⁶⁸ Failure to do so may result in a legal claim by the patient under tort law, although the legal requirements for proving a violation of informed consent are sufficiently onerous that routine violations are unlikely to result in successful claims.¹⁶⁹ Nevertheless, this legal duty applies to physicians across medical practice areas and establishes standards that are fundamental to patient counseling and treatment.¹⁷⁰ In addition to the legal requirement to obtain informed consent, physician conduct is also guided by ethical standards issued by the professional medical associations relevant to their area of practice.¹⁷¹ In some instances, such professional standard-setting results in enforceable rules; elsewhere, the policy statements and ethical guidance of professional organizations are merely advisory but, under certain circumstances, can be considered as evidence of the standard of care governing physician conduct in legal proceedings.¹⁷² This section will explore the legal doctrine of informed consent and the guidance of the two most important professional associations relevant to obstetric practice.

A. *Informed Consent*

Informed consent doctrine has shaped modern medical care, transforming the way physicians interact with their patients and view

giving the patient reasonable notice so as to enable the patient to secure other medical attention”).

168. See Bryan Murray, *Informed Consent: What Must a Physician Disclose to a Patient?*, 14 AM. MED. ASS'N J. ETHICS 563, 563 (2012).

169. See *id.*

170. See *id.*

171. See *infra* Section III.B (discussing professional ethical guidelines).

172. See, e.g., *Gallardo v. United States*, 752 F.3d 865, 880 (10th Cir. 2014) (discussing, approvingly, the district court's reliance on an ACOG bulletin in establishing standard of care in a malpractice action); *Bergman v. Kelsey*, 873 N.E.2d 486, 503 (Ill. App. Ct. 2007) (acknowledging ACOG guidelines established standard of care in medical malpractice suit). See generally Peter Moffett & Gregory Moore, *The Standard of Care: Legal History and Definitions: The Bad and Good News*, 12 W.J. EMERGENCY MED. (2011) (discussing clinical practice guidelines and the standard of care for emergency medicine readership).

their role in medical decision-making.¹⁷³ It evolved to protect patient autonomy and to ensure that patients can conduct their own medical decision-making.¹⁷⁴ In contrast to the historical approach to medical decision-making, which reflected paternalistic assumptions that the doctor knows best and should be the decision-maker on behalf of the patient, the requirement of informed consent recognizes that physicians' greater knowledge and expertise demand added protection for the patient as the less powerful player in the treatment relationship.¹⁷⁵

Justice Cardozo expressed the basic principle underlying informed consent in *Schloendorff v. Society of New York Hospital*, stating: "Every human being of adult years and sound mind has a right to determine what shall be done with his own body."¹⁷⁶ The requirement of informed consent imposes a duty on physicians "to volunteer . . . the information the patient needs for intelligent decision."¹⁷⁷ In other words, it is not simply enough to answer patients' questions; the physician must proactively provide information to inform patient decision-making. Some jurisdictions have developed a patient-based model of informed consent, which requires disclosure of the information relevant to the patient's decision about medical treatment,¹⁷⁸ in contrast to a physician-based model of informed consent, which requires disclosure of information "a reasonable medical practitioner of the same school, in the same or similar circumstances, would have disclosed."¹⁷⁹ A patient-based

173. See Julie Gantz, Note, *State Statutory Preclusion of Wrongful Birth Relief: A Troubling Re-Writing of a Woman's Right to Choose and the Doctor-Patient Relationship*, 4 VA. J. SOC. POL'Y & L. 795, 800-01 (1997).

174. *Id.* at 800 (discussing the evolution from physician control and autonomy to norm of information disclosure as "a fundamental ethical requirement").

175. See Sylvia A. Law, *Childbirth: An Opportunity for Choice That Should Be Supported*, 32 N.Y.U. REV. L. & SOC. CHANGE 345, 363-65 (2008) (discussing the tradition of paternalism and disrespect for women's choices in reproductive health care, especially childbirth).

176. 105 N.E. 92, 93 (N.Y. 1914).

177. *Canterbury v. Spence*, 464 F.2d 772, 783 n.36 (D.C. Cir. 1972) ("Physicians and hospitals have patients of widely divergent socio-economic backgrounds, and a rule which presumes a degree of sophistication which many members of society lack is likely to breed gross iniquities.").

178. See *id.* at 782 (shifting the emphasis of informed consent law to the individualized needs of the patient).

179. *Guebard v. Jabaay*, 452 N.E.2d 751, 755 (Ill. App. Ct. 1983); see also, e.g., Jaime Staples King & Benjamin W. Moulton, *Rethinking Informed Consent: The Case for Shared Medical Decision-Making*, 32 AM. J.L. & MED. 429, 480-83 (2006) (examining the physician-based and patient-based models of informed consent); Richard Weinmeyer, *Lack of Standardized Informed Consent Practices and Medical*

model of informed consent encourages physicians to consider the individual characteristics of the patient, including any personal, family, religious, or other considerations that might bear on what information that person needs in order to make an informed choice about medical care.¹⁸⁰

The United States Supreme Court has recognized that a competent person has a constitutionally protected liberty interest in refusing unwanted medical treatment.¹⁸¹ In its reasoning, the Court noted that courts had recognized the “right to refuse treatment either solely on the common-law right to informed consent or on both the common-law right and a constitutional privacy right.”¹⁸² Drawing on common law precedent to locate the constitutional right in the Fourteenth Amendment’s substantive due process protections, the Court held that “[n]o right is held more sacred, or is more carefully guarded, by the common law, than the right of every individual to the possession and control of his own person.”¹⁸³

The doctrine of informed consent applies across the medical profession with no exceptions for childbirth-related medical care.¹⁸⁴ The American Medical Association (AMA) states unequivocally that “[i]nformed consent is a basic policy in both ethics and law that physicians must honor, unless the patient is unconscious or otherwise incapable of consenting and harm from failure to treat is imminent.”¹⁸⁵ Informed consent requires the physician “to present the medical facts accurately to the patient or to the individual responsible for the patient’s care and to make recommendations for management in accordance with good medical practice.”¹⁸⁶ This means that patients have the right to be informed about a proposed treatment, including its purpose, risks, and benefits, as well as the potential risks and benefits of any alternative courses of treatment, including the decision to decline care.¹⁸⁷

Malpractice, 16 AM. MED. ASS’N J. ETHICS 120, 121 (2014) (noting that approximately half of states apply a reasonable medical practitioner standard).

180. See King & Moulton, *supra* note 179, at 482–83.

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

182. *Id.* at 271.

183. *Id.* at 269 (quoting *Union Pac. Ry. Co. v. Botsford*, 141 U.S. 250, 251 (1891)).

184. Am. Med. Ass’n, *Opinion 8.08 – Informed Consent*, as published in 14 AM. MED. ASS’N J. ETHICS 555, 555 (2012) [hereinafter *AMA Opinion 8.08*].

185. *Id.*

186. *Id.*

187. AM. MED. ASS’N, OPINION NO. 2.1.1, INFORMED CONSENT (2016) [hereinafter *AMA, OPINION NO. 2.1.1, INFORMED CONSENT*], <https://www.ama-assn.org/sites/default/files/media-browser/code-of-medical-ethics-chapter-2.pdf>.

In order for the right to informed consent to be meaningful, courts must recognize its necessary corollary—the right to informed refusal of medical treatment. When a physician properly discloses the risks, benefits, and alternatives to a proposed course of treatment but is unwilling to respect a patient’s refusal of treatment after such disclosure, any “consent” obtained from the patient cannot be considered true informed consent. Some courts recognize that health care providers should not be held liable in tort for good-faith compliance with a competent patient’s informed refusal of treatment, even if a preventable adverse outcome results.¹⁸⁸ But some courts have been unwilling to hold providers liable for violations of informed consent where the violation involves a physician overriding a pregnant woman’s informed refusal.¹⁸⁹ In such cases, courts often import reasoning from a separate area of the law—abortion jurisprudence—to assert the state’s interest in protecting potential life, as recognized in constitutional doctrine on abortion.¹⁹⁰ This unwillingness to recognize informed treatment refusals presents an ongoing obstacle to faithful adherence to the legal requirement of informed consent.¹⁹¹

Nevertheless, physicians are subject to the legal requirement to obtain informed consent before providing medical care. When doctors make child welfare threats or use other coercive means to secure a woman’s agreement to medical treatment during childbirth, they are violating their legal obligation to respect the patient’s right to provide or withhold her informed consent.

B. *Professional Ethical Guidelines*

In addition to their legal duties, health care providers are bound by medical ethics. Professional medical bodies have articulated the

188. See, e.g., *Stamford Hosp. v. Vega*, 674 A.2d 821, 832 (Conn. 1996) (“The hospital’s interests were sufficiently protected by Vega’s informed choice, and neither it nor the trial court was entitled to override that choice.”); *In re Dubreuil*, 629 So. 2d 819, 823–24 (Fla. 1993) (“When a health care provider, acting in good faith, follows the wishes of a competent and informed patient to refuse medical treatment, the health care provider is acting appropriately and cannot be subjected to civil or criminal liability.”).

189. See *Dray v. Staten Island Univ. Hosp.*, No. 500510/14, at 13 (N.Y. Sup. Ct. Dec. 15, 2015) (“This court thus rejects plaintiff’s assertion that she had an absolute right to reject medical care necessary to protect her viable fetus.”).

190. See *Kukura*, *supra* note 17 (manuscript at 58–61) (analyzing the flawed analogy between compelled treatment in pregnancy and abortion rights).

191. See *Dray Amicus Brief*, *supra* note 84, at 7–8, 21–25 (discussing the need for courts to consistently recognize an informed refusal of treatment as part of informed consent and enforce liability against providers who violate an informed refusal).

ethical obligations physicians have to their patients, providing guidance to inform how health care providers should deal with difficult cases. This professional ethical guidance affirms the centrality of informed consent and strongly cautions against resorting to judicial involvement in pregnancy decision-making. Statements by the leading organizations relevant to obstetrics, the AMA and the American College of Obstetricians and Gynecologists (ACOG), suggest that threats of intervention by child welfare authorities made in order to coerce a woman's consent to treatment also violate a physician's ethical obligations.

In 1987, the ACOG Ethics Committee published Opinion No. 55 on informed consent and the use of force against pregnant women.¹⁹² Responding to the prominent case of Angela Carder, whose court-ordered cesarean was subsequently vacated by the District of Columbia Court of Appeals,¹⁹³ the Ethics Committee clarified that "resort to the courts is almost never justified."¹⁹⁴ It expressed concern that judicial action interferes with the doctor-patient relationship and infringes women's rights, noting that "inappropriate reliance on judicial authority" to force treatment can result in "undesirable societal consequences, such as the criminalization of noncompliance with medical recommendations."¹⁹⁵ The Ethics Committee called on obstetricians to "refrain from performing procedures that are unwanted by a pregnant woman."¹⁹⁶ Although the statement does not expressly condemn the use of other coercive tactics to secure consent to treatment, it makes clear that ACOG opposes the use of judicial intervention to force medical treatment on pregnant women.¹⁹⁷

Several decades later, the ACOG Ethics Committee released Committee Opinion No. 321, "Maternal Decision Making, Ethics, and the Law," which stated that "[p]regnant women's autonomous decisions should be respected."¹⁹⁸ The Committee directed that

192. Am. Coll. of Obstetricians & Gynecologists Comm. on Ethics, *Patient Choice: Maternal-Fetal Conflict* (1987), published at 1 WOMEN'S HEALTH ISSUES 13-15 (1990) [hereinafter *Patient Choice*].

193. See *supra* Section II.A.

194. *Patient Choice*, *supra* note 192, at 14 (noting that court orders have a "destructive effect" on the physician-patient relationship).

195. *Id.* at 15.

196. *Id.*

197. See *id.*

198. Am. Coll. of Obstetricians & Gynecologists Comm. on Ethics, *Committee Opinion No. 321: Maternal Decision Making, Ethics, and the Law*, 106 OBSTETRICS & GYNECOLOGY 1127, 1135 (2005) [hereinafter *Committee Opinion No. 321*].

“[c]oncerns about the impact of maternal decisions on fetal well-being should be discussed in the context of medical evidence and understood within the context of each woman’s broad social network, cultural beliefs, and values.”¹⁹⁹ This guidance reinforces ACOG’s view that coercion in the form of judicial intervention is generally inappropriate in the treatment context, stating that “judicial authority should not be used to implement treatment regimens aimed at protecting the fetus, for such actions violate the pregnant woman’s autonomy.”²⁰⁰ Despite this strong warning, the Committee again leaves a narrow exception to the rule against compelled treatment, noting, however, that it “cannot currently imagine” what type of “extraordinary circumstances” would justify leveraging judicial power on behalf of the fetus.²⁰¹ Subsequently, in updated VBAC guidelines issued in 2010, ACOG affirmed that “patients should be allowed to accept increased levels of risk” out of respect for patient autonomy.²⁰² This means that it is for patients to decide whether or not to have a cesarean, even for women who are not considered optimal candidates for a trial of labor under ACOG guidelines.²⁰³

Although ACOG’s guidelines are not linked to an enforcement mechanism, they may constitute evidence of the applicable standard of ethical conduct in a proceeding to determine whether a physician has committed professional misconduct.²⁰⁴ They also “establish a profession’s collective vision of appropriate care and thus serve as a tacit indictment of practices that significantly diverge from these standards.”²⁰⁵

Shortly after the ACOG Ethics Committee released Opinion No. 55, the AMA Board of Trustees issued a policy statement that judicial involvement in medical decision-making during childbirth “is inappropriate when a woman has made an informed refusal of a medical treatment designed to benefit her fetus.”²⁰⁶ The Board stated that “[t]he physician’s duty is to provide appropriate information, . . . not to dictate the woman’s decision.”²⁰⁷ The AMA Board’s

199. *Id.*

200. *Id.*

201. *Id.*

202. ACOG Practice Bulletin, *supra* note 39, at 457.

203. *See id.*

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

205. Oberman, *supra* note 16, at 492.

206. Am. Med. Ass’n Bd. of Trs., *Legal Interventions During Pregnancy*, 264 J. AM. MED. ASS’N 2663, 2670 (1990).

207. *Id.*

statement left open the possibility of an “exceptional circumstance” when it might be appropriate for a maternity care provider to secure judicial intervention;²⁰⁸ however such an exception was limited to cases where the “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.”²⁰⁹ Though not enforceable on its own, the statement advocates a high bar for judicial intervention. The AMA Board statement does not discuss child welfare threats as a form of coercion against laboring women, but the same logic regarding judicial intervention would presumably apply to provider threats to leverage state power against a pregnant woman in the form of child welfare investigation and removal.

Outside of the pregnancy-specific context, the AMA’s Council on Ethical and Judicial Affairs (AMA Council) recognizes a patient’s right to refuse medical treatment, even if the result of such refusal is an avoidable death.²¹⁰ The AMA Council’s Code of Ethics takes the view that personal values and circumstances lead different patients to reach different decisions.²¹¹ In this regard, courts have cited the Code of Ethics when recognizing a patient’s right to refuse treatment.²¹² The Code of Ethics also includes provisions regarding the right of a patient to receive information and the patient’s right to make her own decisions regarding a treating physician’s recommendation.²¹³ In Opinion No. 1.1.3, which addresses the fundamental elements of the patient-physician relationship, the AMA also identifies the patient’s “right . . . [t]o courtesy, respect, dignity,

208. *Id.*

209. *Id.* (“[T]he fundamental principle against compelled medical procedures should control in all cases that do not present such exceptional circumstances.”).

210. COUNCIL ON ETHICAL & JUDICIAL AFFAIRS, AM. MED. ASS’N, CODE OF MEDICAL ETHICS: CURRENT OPINIONS WITH ANNOTATIONS, 8.08, at 134–35 (1998–1999 ed. 1998) (“The patient should make his or her own determination on treatment.”).

211. *Id.* at 135 (“Rational, informed patients should not be expected to act uniformly, even under similar circumstances, in agreeing to or refusing treatment.”).

212. *See, e.g., In re Lyle A.*, 830 N.Y.S.2d 486, 493 (N.Y. Fam. Ct. 2006) (citing AMA Code of Ethics section 8.08 to conclude that the mother had the right to withdraw consent to administration of a psychotropic drug to the minor patient).

213. AM. MED. ASS’N, OPINION NO. 1.1.3, PATIENT RIGHTS (2016) [hereinafter AMA, OPINION NO. 1.1.3, PATIENT RIGHTS], <https://www.ama-assn.org/sites/default/files/media-browser/code-of-medical-ethics-chapter-1.pdf>; *see also* AM. MED. ASS’N, OPINION NO. 1.1.1, PATIENT-PHYSICIAN RELATIONSHIPS (2016), <https://www.ama-assn.org/sites/default/files/media-browser/code-of-medical-ethics-chapter-1.pdf> (“The practice of medicine . . . is fundamentally a moral activity that arises from the imperative to care for patients and to alleviate suffering.”).

and timely, responsive attention to his or her needs.”²¹⁴ Violating the Code of Ethics may lead to “discipline by the AMA[] and by . . . county and state medical societies”; further, some states incorporate the AMA Code of Ethics into their medical practice acts, creating the possibility for official discipline for physicians who violate the Code.²¹⁵

Both ACOG and the AMA have published general guidance to their members on the meaning of informed consent. In its Opinion No. 108, entitled *Ethical Dimensions of Informed Consent*, ACOG confirms that informed consent “respects a patient’s moral right to bodily integrity, [and] to self-determination regarding sexuality and reproductive capacities.”²¹⁶ The AMA’s Code of Medical Ethics recognizes that “[t]he patient’s right of self-decision can be effectively exercised only if the patient possesses enough information to enable an informed choice.”²¹⁷ It identifies the physician’s “ethical obligation to help the patient make choices . . . consistent with good medical practice.”²¹⁸ The AMA advises physicians on the substantive aspects of informed consent, calling on physicians to discuss the risks and benefits of a proposed treatment, any alternatives regardless of cost or insurance coverage, the risks and benefits of any alternative treatments, and the risks and benefits of foregoing treatment.²¹⁹ In doing so, the AMA also reminds physicians that the process of securing informed consent is not only an ethical obligation but also a legal requirement in all fifty states.²²⁰

The public statements of leading professional medical organizations reinforce the importance of a physician’s legal duty to obtain informed consent and provide necessary ethical guidance to physicians caring for a patient who refuses medical treatment. The obligation to respect patient autonomy and abide by a patient’s informed refusal applies in maternity care just as in other aspects of medical practice.²²¹ Although pregnancy care is complicated by concern for fetal well-being, these expert bodies cannot identify a

214. AMA, OPINION NO. 1.1.3, PATIENT RIGHTS, *supra* note 213.

215. Orentlicher, *supra* note 204, at 592.

216. Am. Coll. of Obstetricians & Gynecologists, *Ethical Dimensions of Informed Consent: Committee Opinion No. 108*, 39 INT’L J. GYNECOLOGY & OBSTETRICS 346, 346 (1992).

217. *AMA Opinion 8.08*, *supra* note 184, at 555.

218. *Id.*

219. AMA, OPINION NO. 2.1.1, INFORMED CONSENT, *supra* note 187.

220. *Id.*

221. See Benjamin Grant Chojnacki, Note, *Pushing Back: Protecting Maternal Autonomy from the Living Room to the Delivery Room*, 23 CLEV.-MARSHALL C.L. J.L. & HEALTH 45, 69–70 (2010).

circumstance in which it would be appropriate to use judicial authority to override a woman's cesarean refusal—arguably the most invasive medical intervention into childbirth. The use of child welfare threats to secure consent to treatment should be considered akin to obtaining a court-ordered cesarean, as such threats attempt to leverage state power to force a woman's consent to medical care. In this way, child welfare threats to coerce consent violate health care providers' legal and ethical obligations.

IV. RECOMMENDATIONS

The experiences of women like Jennifer Goodall and V.M. suggest that there is a major disconnect between the legal and ethical obligations of physicians and the reality of what occurs in some clinical settings. Without a formal judicial determination on the validity of a cesarean refusal as a basis for a child neglect finding, some health care providers perceive that making child welfare threats is a permissible strategy for securing a pregnant woman's consent to medical treatment, or at least perceive that such threats will not prompt any form of sanction from legal or regulatory authorities. To alter this perception requires a multi-pronged approach that involves education, data collection, and the use of administrative mechanisms to lodge formal complaints, in addition to continued legal advocacy in the courts as appropriate cases arise.

A. *Education and Training*

Curbing the use of coercive tactics by maternity care providers requires targeted education, both within the field of medicine and among other stakeholders. Such education should include at least two different aspects of the problem. First, doctors and nurses working in maternity care settings, along with the hospital administrators who oversee their care, need to be familiar with the latest scientific research on VBAC, cesareans, and other forms of medical intervention during childbirth, such as medical induction, episiotomy, and the use of continuous electronic fetal monitoring. Research suggests that the incorporation of medical research results into practice is a slow process, sometimes taking up to two decades before clinical practice is adjusted to reflect the best available evidence.²²² All providers, whether still in training or several

222. *Translating Research into Practice (TRIP)-II*, U.S. DEP'T HEALTH & HUM. SERVICES (Mar. 2001), <http://archive.ahrq.gov/research/findings/factsheets/translating/tripfac/trip2fac.html>.

decades into their careers, should be familiar with evidence-based maternity care practices, especially those more recent research results that contradict conventional wisdom about the safety of certain practices and support fewer interventions into the labor and delivery process.²²³ Familiarity with evidence-based maternity care practices may help reduce conflict over treatment decisions in situations where a physician applies a traditional interventionist framework and a patient relies on more recent research about the risks associated with an interventionist approach. The need for ongoing education regarding evidence-based practices should include members of hospital legal and risk management departments, who may be accustomed to operating under the assumption that performing a cesarean—even over a woman’s objection—is safer than vaginal delivery, despite evidence to the contrary.²²⁴

Second, medical education should include training about the harms associated with coercion in maternity care. This includes the heightened risk of PTSD and other birth trauma that is associated with women feeling coerced by their health care providers during childbirth.²²⁵ It also includes the potential harm to provider-patient trust and physicians’ ability to provide care effectively.²²⁶ Such efforts to train health care providers and hospital administrators about issues related to maternity care decision-making would complement ongoing consumer education by non-profit advocacy groups dedicated to improving childbirth experiences and reducing adverse health outcomes in maternity care.

B. *Data Collection*

A significant obstacle to ending the use of coercive means to obtain consent during childbirth is the incomplete nature of data collection regarding maternity care practices and childbirth experiences. The United States lacks comprehensive data on obstetric practices and even on maternal health outcomes, which impedes efforts both inside

223. See Kukura, *supra* note 39, at 267–80 (discussing best available research on various childbirth interventions).

224. Should research reveal that *actual* reporting to child welfare authorities is occurring with some degree of frequency—as opposed to simply *threatening* to report a woman for refusing treatment—training for child welfare agencies about evidence-based maternity care and the ethical dimensions of maternity care decision making might also be necessary.

225. See *supra* Section II.B.1.b.

226. See *supra* notes 142–44 and accompanying text.

and outside the field of medicine to improve maternity care.²²⁷ Medical coding practices that fail to distinguish between scheduled cesareans, emergency cesareans, and post-induction cesareans, or between spontaneous and induced vaginal births, prevent researchers and maternity care consumers from reaching a robust understanding of the risks and benefits of interventions like medical induction and cesarean surgery.²²⁸

There is also a need for more qualitative research on women's birth experiences in order to understand how women feel coerced into accepting unwanted medical treatment and the frequency with which this occurs. In 2002, the non-profit organization Childbirth Connection conducted a survey of women's birth experiences, which for the first time documented the frequency of many practices that had not previously been recorded.²²⁹ Childbirth Connection has subsequently updated the survey twice, in 2006 and 2013, enabling them to track trends over that time period and also ask more nuanced questions informed by the results of previous surveys.²³⁰ The Listening to Mothers surveys capture a more complete account of various childbirth interventions than had previously been available and have provided several useful data points about pregnant women's

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227. See, e.g., AMNESTY INT'L, DEADLY DELIVERY: THE MATERNAL HEALTH CARE CRISIS IN THE USA 86–88 (2010), <https://www.amnestyusa.org/files/pdfs/deadlydelivery.pdf> (discussing the lack of consistent reporting on maternal mortality and other childbirth outcomes in the United States); SAKALA & CORRY, *supra* note 60, at 68–70 (calling for a standardized system of measuring maternity care performance and reporting mechanisms to identify “current patterns of overuse, underuse, and unjustified practice variation”); see also Elizabeth Kukura, *Giving Birth Under the ACA: Analyzing the Use of Law as a Tool to Improve Health Care*, 94 NEB. L. REV. 799, 850 & n.299 (2016) (discussing introduction of new diagnostic codes across various medical specialties).
228. See Peter B. Angood et al., *Blueprint for Action: Steps Toward a High-Quality, High-Value Maternity Care System*, 20 WOMEN'S HEALTH ISSUES S18, S26 (2010) (identifying the need for separate billing codes for cesareans and vaginal deliveries under different conditions).
229. EUGENE R. DECLERCQ ET AL., LISTENING TO MOTHERS: REPORT OF THE FIRST NATIONAL U.S. SURVEY OF WOMEN'S CHILDBEARING EXPERIENCES (2002), http://www.nationalpartnership.org/research-library/maternal-health/listening-to-mothers-i_2002.pdf.
230. *Listening to Mothers Reports and Surveys*, NAT'L PARTNERSHIP FOR WOMEN & FAMILIES, <http://www.nationalpartnership.org/issues/health/maternity/listening-to-mothers.html> (last visited Dec. 30, 2017) (discussing the “three initial surveys and two follow-up surveys directed to initial participants”). In 2014, Childbirth Connection became a program of the National Partnership for Women & Families. *History*, CHILD BIRTH CONNECTION, <http://www.childbirthconnection.org/about/history/> (last visited Dec. 30, 2017).

medical decision-making and their experience of coercion by their health care providers.²³¹ But this is just one study and as such, leaves much ground uncovered. The outpouring of testimonials collected by birth-oriented consumer advocacy groups suggests there are aspects of maternity care that remain woefully underexplored, including the use of coercive tactics to secure consent to treatment.²³² In particular, research is needed on the specific experiences of poor women, women of color, young women, immigrant women, women with mental illness, and other women who may be especially vulnerable to coercion by health care providers. The collection of more empirical and narrative data about women's birth experiences will bolster the work of advocates seeking to create cultural change within maternity care settings.

C. *Administrative Complaints*

A third approach to tackling inappropriate child welfare threats and other coercive means of securing a pregnant woman's consent to medical treatment focuses on the use of administrative mechanisms to lodge complaints about the improper conduct of health care providers. Depending on the circumstances, patients may have several different opportunities to make a formal complaint. First, each hospital has a review board that conducts oversight of staff and affiliates who work within the hospital, and receives complaints from patients treated at that hospital.²³³ Although some women have reported dismissive and disheartening responses from hospital administrators with whom they have shared their stories of mistreatment by maternity care providers, it is critically important that hospitals continue to hear about the quality of care provided within its walls.²³⁴ Advocates should work with hospitals and medical practices to improve the way patient complaints are investigated and addressed, with more transparency and

231. See *supra* notes 149, 151, 230 and accompanying text.

232. See, e.g., Dray Amicus Brief, *supra* note 84, at 7–8 (collecting testimonials for submission to *Dray* court); Letter from Dawn Thompson et al., President, Improving Birth, to Dr. Hal Lawrence, III et al., Exec. Vice President & CEO, Am. Coll. of Obstetricians & Gynecologists 1 (Sept. 4, 2015), <https://improvingbirth.org/wp-content/uploads/2015/09/9.04.15-Ltr-to-ACOG.pdf> (describing receipt of “an alarming--and alarmingly frequent--stream of consumer feedback to Improving Birth about instances of disrespect, misinformation, and abuse at the hands of maternity care providers”).

233. See Diaz-Tello, *supra* note 24, at 225.

234. See Dray Amicus Brief, *supra* note 84, at 29–30.

accountability for inappropriate provider behavior.²³⁵ In particular, hospitals should be encouraged to understand how taking action to reduce birth conflicts and improve provider-patient communication is likely to result in fewer malpractice lawsuits.²³⁶

Women should also consider filing complaints with oversight bodies outside the hospital. This might include a third-party administered complaint system through accrediting bodies like the Joint Commission, which is responsible for hospital oversight,²³⁷ or the Commission for the Accreditation of Birth Centers, which oversees freestanding birth centers.²³⁸ Affected patients should also consider filing a formal complaint with the appropriate state licensing agency alleging misconduct on the part of doctors and nurses who improperly use coercive tactics to secure consent to medical treatment. They can draw on the clinical and ethical guidelines of ACOG and the AMA, especially the AMA Code of Ethics, to encourage a more faithful adherence of medical practitioners to such professional standards.²³⁹ Even if such complaints fail to result in discipline or sanction by the oversight board, the process of receiving and reviewing such complaints will help educate members of the state licensing agency and create heightened awareness of coercion as a matter of integrity for the medical system. Consumer advocacy groups have a role to play in helping educate women about their options for filing administrative complaints and providing resources to assist them in doing so.²⁴⁰ To that end, education, data collection, and enhanced use of administrative mechanisms are interconnected strategies; more formal complaints will help educate stakeholders with power to influence clinical practice, such as hospital administrators, state regulators, and even physicians themselves.

235. See Diaz-Tello, *supra* note 24, at 225 (calling on consumer groups to advocate with health care facilities to develop accountability mechanisms for threatening and other inappropriate conduct by health care providers).

236. See Kukura, *supra* note 17 (manuscript at 41) (discussing research that links poor provider-patient communication and lack of trust with the decision to bring a malpractice claim).

237. See *About the Joint Commission*, JOINT COMMISSION, https://www.jointcommission.org/about_us/about_the_joint_commission_main.aspx (last visited Dec. 30, 2017).

238. *About the CABAC*, COMMISSION FOR ACCREDITATION BIRTH CENTERS, <https://www.birthcenteraccreditation.org/about-commission-accreditation-birth-centers/> (last visited Dec. 30, 2017).

239. See *supra* notes 210–20 and accompanying text.

240. See, e.g., *Accountability Toolkit: A Guide to Filing a Formal Grievance After a Difficult Childbirth*, IMPROVING BIRTH, <https://improvingbirth.org/resources/#accountability-toolkit> (last visited Dec. 30, 2017).

And better data collection about the nature and frequency of coercion in maternity care decision-making will help educate care providers about the problem and prepare those providing oversight to respond appropriately.

V. CONCLUSION

The legal and ethical requirements that bind physicians make clear that patients must give informed consent to medical treatment and that the use of state power to secure a pregnant woman's consent to treatment is virtually never acceptable. And yet, several recent cases, along with informal reports made to consumer advocacy organizations, suggest that coercion is present in some clinical settings, with a resulting increase in the risk of physical and emotional harm to women and babies, as well as increased financial burden for their families. Women who are poor, young, and members of religious, racial, and ethnic minorities may be particularly susceptible to coercive pressure during childbirth. Coercion in maternity care should raise concerns for all those invested in the medical profession, including those practitioners whose respect for patient autonomy is reflected in their clinical care, as the association with unethical practices might nevertheless impact relationships with their patients and have negative consequences for public health more generally.

There are some hopeful indications that the medical system can correct improper coercive conduct by health care providers, such as reforms instituted to deliver more patient-centered care, many of which were part of the Affordable Care Act.²⁴¹ In addition, growing concern about the United States' high cesarean rate among medical professionals themselves may be leading providers to adopt a more hands-off approach to labor and delivery for low-risk women, one which finds support in the medical research literature.²⁴² These

241. See Michael L. Millenson & Juliana Macri, *Will the Affordable Care Act Move Patient-Centeredness to Center Stage?: Timely Analysis of Immediate Health Policy Issues*, ROBERT WOOD JOHNSON FOUND. (Mar. 2012), <https://www.rwjf.org/content/dam/farm/reports/reports/2012/rwjf72412>.

242. See News Release, Am. Coll. of Obstetricians & Gynecologists, *Nation's Ob-Gyns Take Aim at Preventing Cesareans* (Feb. 19, 2014), http://www.acog.org/About_ACOG/News_Room/News_Releases/2014/Nations_Ob-Gyns_Take_Aim_at_Preventing_Cesareans (identifying guideline changes aimed at decreasing the number of cesareans, including recognizing cervical dilation of six (instead of four) centimeters as the start of active labor and extending the recommended time for the pushing phase); see also AM. COLL. OF OBSTETRICIANS & GYNECOLOGISTS & SOC'Y FOR MATERNAL FETAL MED., *supra* note 163 (noting the concern arising from the "rapid increase in cesarean birth rates").

reasons for cautious optimism should inform future research and advocacy to eliminate the improper use of child welfare threats and other coercive tactics employed to secure a woman's consent to treatment.

