

ERIN K. DUNCAN*

The United States' Maternal Care Crisis: A Human Rights Solution

Abstract	404
Introduction	404
I. Identifying the United States' Obligations Under International Law	411
II. Identifying Pregnant Women's Human Rights	413
A. The Right to Health	415
1. The Right to Health Includes Reproductive Rights..	416
2. Evidence-Based Care Promotes the Highest Attainable Standard of Health	418
3. Maternal Mortality Is the Ultimate Violation of the Right to Health	423
B. The Right to Autonomy	425
1. Women's Human Rights Should Preclude Recognition of Fetal Rights.....	426
2. Interventions in Pregnancy Require Informed Consent.....	429
3. Respect for Autonomy Does Not Negate Duties to Minimize Risks to Health.....	436
C. The Right to Freedom from Discrimination.....	439
III. Respecting, Protecting, and Fulfilling Pregnant Women's Human Rights.....	441
A. Addressing Past Grievances: Redress and Reparations for Violations	444

* J.D., Lewis & Clark Law School. Thank you to the facilitators and participants of the May 2011 CEDAW for Change Institute hosted by the Women's Human Rights Education Institute in Toronto, who sparked my interest in the concept of substantive equality and inspired me with their local efforts to put human rights into practice.

B. Preventing Future Violations: Correcting Systemic Failures.....	446
C. Eliminating Discrimination: Removing Barriers to an Effective Human Rights-Based Approach	448
D. Developing Accountability: Improving Monitoring and Evaluation of State Obligations.....	449
Conclusion.....	450

ABSTRACT

In the United States, unnecessarily high rates of cesarean sections, artificial labor inductions performed without medical indication, and other medical interventions that can cause preventable injury during childbirth are just some of the indicators of a system that is failing to protect the rights of pregnant women. Other deficiencies in maternal care in the United States include healthcare providers' failure to obtain informed consent reflecting the risks and benefits of medical interventions, enactment of fetal rights laws that infringe on the rights of pregnant women, the lack of a comprehensive reporting system for maternal mortality, and racial and socioeconomic disparities in maternal mortality and morbidity (serious injury).

International human rights—including the rights of autonomy, freedom from discrimination, and the highest attainable standard of health—should inform the United States' approach to solving this maternal care crisis. These rights, which are extensively defined and described in international human rights instruments, create normative and legal standards entitling women to maternal care that is self-determinative, nondiscriminatory, and evidence-based. The principle that pregnant women have definable, innate human rights and that states have obligations under international law to respect, protect, and fulfill those rights is a compelling starting point for achieving substantive equality for women in the context of childbirth.

INTRODUCTION

A woman in Northern California, “Ms. C,” had a normal, “low-risk” pregnancy and wished for a normal birth. A week before her due date, her doctor suggested labor induction with Pitocin, an artificial oxytocin drug, despite no medical need for induction. Ms. C refused and went into labor naturally a week later. At the hospital, without Ms. C's consultation or consent, a nurse followed the doctor's phone order to start a Pitocin drip. Her artificial induction caused a

hard, painful labor that might have been less painful if the labor had taken a natural, albeit longer, course. Ms. C was given a catheter injection through the epidural space of her spinal cord to block the pain. Without feeling in her lower body, Ms. C did not know that she was fully dilated and ready to push. Her nurses again consulted the doctor over the phone and were advised to take measures to forestall the birth until the doctor arrived. They pushed on the fetus's head and gave Ms. C oxygen through a facemask, presumably because the fetus was at risk. The doctor finally arrived and, without asking or informing Ms. C, gave her an episiotomy—a surgical cut to the vagina—without clear reason. Ms. C could not feel the episiotomy because of the epidural, but she had stated earlier that she did not want the procedure. The baby was finally born with the use of a vacuum extractor, again without any indication of medical need.¹

Dr. Marsden Wagner describes the story above in *Born in the USA: How a Broken Maternity System Must Be Fixed to Put Women and Children First*. It is one of many such stories reported by journalists, doctors, midwives, and human rights advocates who are working to change common practices of over-intervention and iatrogenic (doctor-caused)² harm in maternal care in the United States. The experience of Marsden's Ms. C reflects hospital practices that have changed little since medicalized birth became the norm in the United States.³ In 2014, cesarean section (“C-section”), labor induction at term or pre-term, epidural pain management, and episiotomy⁴ are common

¹ MARSDEN WAGNER, *BORN IN THE USA: HOW A BROKEN MATERNITY SYSTEM MUST BE FIXED TO PUT WOMEN AND CHILDREN FIRST* 3–4 (2006). Wagner passed away April 27, 2014. He was a perinatologist and perinatal epidemiologist and served as head of Maternal and Child Health for the Regional Office for Europe of the World Health Organization (WHO) for fifteen years.

² *Id.* at 2.

³ See generally CHERYL KRASNICK WARSH, *Modern Childbirth: Mothers and Doctors*, in *PRESCRIBED NORMS: WOMEN AND HEALTH IN CANADA AND THE UNITED STATES SINCE 1800* (2010) (describing the progression of medicalized childbirth in North America in the twentieth century, including: (1) the development of pain management from ether and chloroform in the early 1900s, to nitrous oxide and the “Twilight Sleep” cocktail of morphine and scopolamine in 1914 and 1915, to local anesthetics in the 1950s, and the common use of epidural anesthesia by the 1990s; (2) the advent and subsequent routine use of forceps in the 1920s and the development of vacuum extraction to replace forceps; (3) the development of episiotomy as an intervention accompanying the use of forceps, and its subsequent use as a standard procedure for non-cesarean births; and (4) the increased use of electronic fetal monitoring and cesarean section in the last half of the twentieth century).

⁴ Rates of episiotomy have decreased, but according to a recent national survey, when this intervention is performed, it is often done without the mother taking part in the decision. The survey reports a seventeen percent rate of episiotomy among new mothers

medical interventions used for labor management and delivery in hospitals, where ninety-nine percent of U.S. women give birth.⁵ Some doctors would see Ms. C's childbirth, in which several of these interventions were used, as having a good outcome: a mother and her baby left the hospital relatively healthy. But such interventions are not without risks.

The World Health Organization (WHO) does not recommend labor induction for low-risk women before forty-one weeks gestation.⁶ However, in the United States, at least twenty-three percent of births include the administration of drugs to start or stimulate labor.⁷ Inducing labor with Pitocin⁸ creates a risk of overly rapid uterine contractions and uterine rupture, which can be fatal for both mother and child. Nonmedically indicated induction has been shown to increase the likelihood of C-section for first-time mothers⁹ and has raised rates of preterm births and related complications.¹⁰ Induction

who gave birth vaginally in hospitals. EUGENE R. DECLERCQ ET AL., *CHILDBIRTH CONNECTION, LISTENING TO MOTHERS III: PREGNANCY AND BIRTH, REPORT OF THE THIRD NATIONAL U.S. SURVEY OF WOMEN'S CHILDBEARING EXPERIENCES 19* (2013) [hereinafter *LISTENING TO MOTHERS III*]. Of those mothers, only forty-one percent said they had a choice. *Id.* at 36.

⁵ AMNESTY INT'L, *DEADLY DELIVERY: THE MATERNAL HEALTH CARE CRISIS IN THE USA: ONE YEAR UPDATE 4* (2011), AI Index AMR 51/108/2011 [hereinafter *DEADLY DELIVERY ONE YEAR UPDATE*].

⁶ WHO, *WHO RECOMMENDATIONS FOR INDUCTION OF LABOUR 5*, 13 (2011) [hereinafter *INDUCTION OF LABOUR*], available at http://whqlibdoc.who.int/publications/2011/9789241501156_eng.pdf; see generally WHO, *WHO RECOMMENDATIONS FOR AUGMENTATION OF LABOUR* (2014) [hereinafter *AUGMENTATION OF LABOUR*], available at http://apps.who.int/iris/bitstream/10665/112825/1/9789241507363_eng.pdf.

⁷ AMNESTY INT'L, *DEADLY DELIVERY: THE MATERNAL HEALTH CARE CRISIS IN THE USA 78* (2010), AI Index AMR 51/007/2010 [hereinafter *DEADLY DELIVERY*].

⁸ Other methods of artificial induction include the administration of prostaglandins or manual rupturing of the amniotic membranes. See *INDUCTION OF LABOUR*, *supra* note 6, at 6.

⁹ CAROL SAKALA & MAUREEN P. CORRY, *EVIDENCE-BASED MATERNITY CARE: WHAT IT IS AND WHAT IT CAN ACHIEVE 38* (2008); see also Rosalie M. Grivell et al., *Maternal and Neonatal Outcomes Following Induction of Labor: A Cohort Study*, 91 *ACTA OBSTETRICIA ET GYNECOLOGICA SCANDINAVICA* 198 (2012) (describing similar increases in South Australia in the risk of cesarean section, postpartum complications, and neonatal complications when labor induction is used in the absence of maternal or fetal indications).

¹⁰ See *MARCH OF DIMES ET AL., BORN TOO SOON: THE GLOBAL ACTION REPORT ON PRETERM BIRTH 5* (Christopher Howson et al. eds., 2012) (recommending reduction of nonmedically indicated labor inductions and cesarean births especially before thirty-nine weeks of gestation in order to reduce preterm births); JOYCE A. MARTIN ET AL., *NAT'L CTR. FOR HEALTH STATISTICS, BORN A BIT TOO EARLY: RECENT TRENDS IN LATE PRETERM BIRTHS 1* (2009) (showing that the percentage of late preterm, thirty-four to

also restricts mobility and can cause intense labor pains, so a pain-blocking epidural often follows.¹¹ Epidurals inhibit the natural production of helpful birth hormones, increase the likelihood of episiotomy or vaginal tearing, and can lengthen labor and disrupt breastfeeding.¹² Twenty to thirty percent of epidural patients experience a drop in blood pressure requiring additional drug treatment, and fifteen to twenty percent develop fevers that may necessitate immediate separation of mother and child after birth.¹³ In rare cases, epidural anesthesia can result in paralysis or death.¹⁴ Research shows that episiotomy increases risks of future painful sexual intercourse, fecal incontinence, and extended tears requiring suturing,¹⁵ whereas some proponents' claims of the procedure's benefits are unsupported by evidence.¹⁶ Vacuum extraction also puts the mother at risk of permanent urinary and fecal incontinence and creates a risk of brain hemorrhage for the child being born.¹⁷ The interventions performed during Ms. C's labor without medical indication and without her informed consent (or despite her express lack of consent) subjected her to each of these preventable risks.

Medical interventions are at times necessary in birth. Access to emergency obstetric care is one of the most significant factors distinguishing the quality of maternal care in the United States from that of many lower income countries with higher rates of maternal morbidity and mortality.¹⁸ However, when such interventions are used without clear evidence-based indications that the expected benefits will outweigh the potential harms, they can negatively impact women's health. And when they are employed without free and

thirty-six weeks gestation, singleton births resulting from labor induction increased by twenty percent between 1990 and 2006).

¹¹ WAGNER, *supra* note 1, at 39.

¹² *See id.* at 63–65.

¹³ JENNIFER BLOCK, PUSHED: THE PAINFUL TRUTH ABOUT CHILDBIRTH AND MODERN MATERNITY CARE 172 (2007).

¹⁴ WAGNER, *supra* note 1, at 7.

¹⁵ *Id.* at 57–58 (citing Katherine Hartmann et al., *Outcomes of Routine Episiotomy: A Systematic Review*, 293 J. AM. MED. ASS'N. 2141–48 (2005)).

¹⁶ WAGNER, *supra* note 1, at 58 (unsupported claimed benefits include the prevention of third-degree tears and pelvic floor damage); accord WHO DEP'T OF REPRODUCTIVE HEALTH AND RESEARCH, CARE IN NORMAL BIRTH: A PRACTICAL GUIDE 29, WHO Doc. WHO/FRH/MSM/96.24 (1996) [hereinafter CARE IN NORMAL BIRTH], available at http://whqlibdoc.who.int/hq/1996/WHO_FRH_MSM_96.24.pdf?ua=1.

¹⁷ WAGNER, *supra* note 1, at 7–8.

¹⁸ *See generally* Rebecca J. Cook et al., *Advancing Safe Motherhood Through Human Rights* (WHO, Occasional Paper No. 5, 2001), WHO Doc. WHO/RHR/01.5.

informed consent, which requires that the patients understand the risks of and alternatives to treatment, they violate women's right to make informed choices about their health and bodily integrity. The Department of Reproductive Health and Research at the WHO recommends that care in birth be achieved with "the least possible level of intervention that is compatible with safety."¹⁹ Over-intervention can range from seemingly minor practices, such as requiring routine intravenous infusion instead of oral nutrition during labor,²⁰ to major abdominal surgery when a woman undergoes an unnecessary C-section. These practices disempower and discriminate against women. Over-intervention in U.S. maternity wards has contributed to a rate of C-section that is more than twice as high as that recommended by the WHO,²¹ unnecessary maternal morbidity, and gross infringement on pregnant women's rights.²²

These documented deficiencies in maternal care²³ are evidence that the United States is experiencing a maternal care crisis. But a solution to this crisis, or at least the seeds of a solution, exists in international

¹⁹ CARE IN NORMAL BIRTH, *supra* note 16, at 4.

²⁰ This practice unnecessarily restricts movement during labor. *Id.* at 9–10.

²¹ DEADLY DELIVERY ONE YEAR UPDATE, *supra* note 5, at 8.

²² Over-intervention also contributes to under-intervention. A 2010 WHO report examines the implications of "needed" and "excess" C-sections, tying together the lack of access to such interventions in the developing world and their overuse in the developed world. The report shows that cesareans that may be medically unnecessary are commanding "a disproportionate share of global economic resources." LUZ GIBBONS ET AL., THE GLOBAL NUMBERS AND COSTS OF ADDITIONALLY NEEDED AND UNNECESSARY CAESAREAN SECTIONS PERFORMED PER YEAR: OVERUSE AS A BARRIER TO UNIVERSAL COVERAGE 3, 10, 15 (WHO, Background Paper No. 30, 2010). The WHO determined that more countries were overusing cesarean sections (rates above fifteen percent) than those countries underusing them (rates below ten percent). *Id.* at 3. Only fourteen countries had rates in the optimal range between ten and fifteen percent to avoid death and severe morbidity (a standard set by the WHO in 1985). *Id.*; see also Luz Gibbons et al., *Inequities in the Use of Cesarean Section Deliveries in the World*, 206 AM. J. OBSTETRICS & GYNECOLOGY 331.e1 (2012) (confirming the overuse of medically unjustified cesarean sections and advocating a ten percent cesarean rate, which would result in global savings of \$432 million).

²³ "Maternal care" can encompass abortion, care during the postpartum period, prenatal care, and arguably any fertile woman's primary care prior to pregnancy. This Article focuses specifically on care of women during labor and birth, including low-risk women who experience unnecessary interventions that increase risks to their health, and higher-risk women whose right of autonomy is violated when medical treatment is compelled without consent. The assessment of risk level going into labor is based on a variety of factors, including maternal age, height and parity, past obstetric history, and present abnormalities in pregnancy, including preeclampsia, multiple pregnancy, antepartum hemorrhage, and severe anemia. CARE IN NORMAL BIRTH, *supra* note 16, at 2–3. A generally healthy woman without pregnancy abnormalities going into labor is usually "low-risk" at that time. *Id.* at 3.

human rights norms. International human rights instruments such as treaties and declarations, along with resolutions and protocols generated by human rights monitoring bodies, define and describe a number of rights that are particularly vulnerable to infringement during pregnancy, labor, and birth. The rights to health, autonomy, and freedom from discrimination form the core of a bundle of rights that underpin the best possible maternal care. More specific rights, such as the right to reproductive health, further amplify these core rights.²⁴ This Article argues that these explicit, named human rights, which overlap and inform each other in normative content, create an implied, encompassing human right to evidence-based, self-determinative, and nondiscriminatory maternal care. In addition, the human rights framework creates state²⁵ obligations to respect, protect, and fulfill identified human rights, including taking all necessary steps to safeguard rights from infringement by third parties.²⁶ Recognizing maternal care problems in the United States as violations of human rights invokes a state duty to compel legal action and systemic change. As the Office of the United Nations High Commissioner for Human Rights (OHCHR) stresses, a human rights-based approach “identifies rights-holders and their entitlements and corresponding duty-bearers and their obligations, and promotes strengthening the capacities of both rights-holders to make their claims and duty-bearers to meet their obligations.”²⁷

²⁴ Other rights relevant to maternity are numerous. The Commission on the Status of Women points to the right to life, the right to education, the right to freedom from discrimination, the right to the highest attainable standard of health, the right to privacy, and the right to an effective remedy. Comm’n on the Status of Women, *Elimination of Preventable Maternal Mortality and Morbidity and the Empowerment of Women*, ¶ 8, Feb. 22–Mar. 4, 2011, U.N. Doc. E/CN.6/2011/CRP.8 (Mar. 18, 2011) [hereinafter *Preventable Maternal Mortality*]. Other relevant rights include the right to not be subjected to torture or to cruel, inhuman, or degrading treatment or punishment, the right to private and family life, and the right to enjoy the benefits of scientific progress. Cook et al., *supra* note 18, at 26–48.

²⁵ This Article uses the term “state” to refer to federal states having the following characteristics: (a) a permanent population, (b) a defined territory, (c) government, and (d) capacity to enter into relations with the other states. See Montevideo Convention on the Rights and Duties of States, art. 1, Dec. 26, 1933, 49 Stat. 3097, 165 L.N.T.S. 19, available at http://avalon.law.yale.edu/20th_century/intam03.asp. “U.S. state” is used to denote federated states of the United States of America.

²⁶ U.N. Econ. and Soc. Council, *General Comment No. 14: Substantive Issues Arising in the Implementation of the International Covenant on Economic, Social and Cultural Rights*, 22nd Sess., ¶¶ 33–37, Apr. 25–May 12, 2000, U.N. Doc. E/C.12/2000/4 (Aug. 11, 2000) [hereinafter *General Comment No. 14*].

²⁷ Office of the U.N. High Comm’r for Human Rights [OHCHR], *Rep. of the OHCHR: Technical Guidance on the Application of a Human Rights-Based Approach to the*

A rights-based approach to maternal care has been advocated by the Commission on the Status of Women (a commission of the U.N. Economic and Social Council), which has stated that “[g]ood maternal health is not only a question of medical care, but fundamentally a question of social justice and enjoyment of human rights.”²⁸ The human rights perspective “places the individual at the cent[er]” of development of health systems and initiatives and provides a framework of international accountability for states in fulfilling their obligations to improve maternal health.²⁹ By recognizing a right to maternal care under international law, the United States can better devise health care protocols to meet international standards for the appropriate treatment of pregnant women, and pregnant women can appeal to these norms to demand appropriate treatment from their health care providers. If states better tether rights to effective monitoring, resource allocation, and policy implementation, the full realization of women’s human rights in pregnancy and childbirth can begin to look like a real possibility.

International nongovernmental coalitions have begun to lay the foundation for this human rights approach to childbirth. For example, the White Ribbon Alliance for Safe Motherhood has developed a “Respectful Maternity Care Rights Charter.” The charter identifies categories of disrespect and abuse in maternal care and associates the categories with corresponding rights in order to address those abuses.³⁰ All of the charter rights—such as the right to informed consent and refusal, the right to equitable care, and the right to freedom from harm and ill treatment—are grounded in international or multinational human rights instruments.³¹ The International Federation of Gynecology and Obstetrics (FIGO) has also adopted a “rights-based code of ethics for women’s health,” acknowledging that “women’s health is often compromised, not by lack of medical

Implementation of Policies and Programmes to Reduce Preventable Maternal Morbidity and Mortality, ¶ 10, U.N. Doc A/HRC/21/22 (July 2, 2012) [hereinafter *Rep. of the OHCHR: Technical Guidance*].

²⁸ *Preventable Maternal Mortality*, *supra* note 24, ¶ 8.

²⁹ *Id.*

³⁰ WHITE RIBBON ALLIANCE FOR SAFE MOTHERHOOD, RESPECTFUL MATERNITY CARE: THE UNIVERSAL RIGHTS OF CHILDBEARING WOMEN 2 (2011), available at http://whiteribbonalliance.org/wp-content/uploads/2013/10/Final_RMC_Charter.pdf.

³¹ *Id.*; see generally DIANA BOWSER & KATHLEEN HILL, USAID, EXPLORING EVIDENCE FOR DISRESPECT AND ABUSE IN FACILITY-BASED CHILDBIRTH: REPORT OF A LANDSCAPE ANALYSIS (2010).

knowledge, but by infringements on women's human rights."³² FIGO calls upon members of the profession to "respect and protect women's rights in their daily practice" in accordance with international law.³³ Such charters and codes of conduct help identify which human rights are implicated by the childbearing process and establish that international norms for maternal care should stem from these rights.³⁴

When ideal maternal care is framed in the language of rights, both positive and negative (e.g., the right to *not* have a medical procedure performed on one's body), the disparity between the treatment of pregnant women in the United States and the standard of care for other adults becomes starkly clear. If the United States is going to take maternal health seriously and develop a health care delivery system that will better protect the rights of pregnant women, the state as a guarantor and potential violator of human rights must embrace a rights-based approach that identifies problems in terms of rights violations and links those problems with the state's international legal duty to develop solutions.

I IDENTIFYING THE UNITED STATES' OBLIGATIONS UNDER INTERNATIONAL LAW

International human rights law defines not only globally recognized human rights norms, but also state obligations related to those rights. The United States is bound to uphold human rights by

³² *Resolution on Professional and Ethical Responsibilities Concerning Sexual and Reproductive Rights (Santiago, 2003)*, INT'L FED'N OF GYNECOLOGY & OBSTETRICS, <http://www.figo.org/sites/default/files/uploads/OurWork/2003%20Res%20on%20Prof%20and%20Eth%20Responsibilities%20Concerning%20Sexual%20and%20Reproductive%20Rights.pdf> (last visited July 27, 2014).

³³ *Id.*

³⁴ Once human rights are identified, dissemination of knowledge about those rights is the next important step in order for individuals to be empowered by human rights law. Human Rights in Childbirth, based in The Hague, Netherlands, and Portland, Oregon, is working with regional coordinators to develop and distribute "know your rights" materials based both on universal norms and the problems faced by women in particular maternity care systems worldwide. Press Release, Human Rights in Childbirth, HRiC Launches Campaign to Address Human Rights Violations in Maternity Care (June 16, 2014), *available at* <http://humanrightsinchildbirth.com/press-release>. Childbirth Connection, based in New York, New York, has developed "The Rights of Childbearing Women," a pamphlet with a statement of rights drawing largely from human rights law which denotes those legal rights to which women in the United States are entitled and those rights that the United States legal system would "probably uphold." CHILDBIRTH CONNECTION, THE RIGHTS OF CHILDBEARING WOMEN (2004), *available at* <http://childbirthconnection.org/rights>.

treaties and by customary law. The United States has ratified the International Covenant on Civil and Political Rights (ICCPR) and the International Convention on the Elimination of All Forms of Racial Discrimination (ICERD), which create obligations to protect women from discrimination and to actively eliminate discrimination in all its forms and manifestations.³⁵ The United States has also signed the International Covenant on Economic, Social and Cultural Rights (ISECSR), the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), and the Vienna Convention on the Law of Treaties.³⁶ Signatories of the Vienna Convention have an obligation to refrain from acts that defeat the object and purpose of treaties signed by that state, even when the state has not ratified those treaties.³⁷ Thus, while the United States has failed to ratify the ISECSR and the CEDAW, the government must not act to defeat those treaties' purposes, for example, by legislating in ways that discriminate against women or harm their health and autonomy.³⁸

The United States should also be held accountable to international standards under customary international law. Human rights treaty language typically creates enumerated individual rights by codifying preexisting international standards that are generally applicable. The principles of the Universal Declaration of Human Rights, which is considered to be customary international law and does not require a state's signature or ratification to have legal effect,³⁹ are reflected and fleshed out by numerous other human rights documents which the United States should look to in fulfilling its human rights obligations. Further, as a member of the U.N., the United States should comply

³⁵ See International Covenant on Civil and Political Rights, Dec. 16, 1966, 999 U.N.T.S. 171 [hereinafter International Covenant on Civil and Political Rights]; International Convention on the Elimination of All Forms of Racial Discrimination, Mar. 7, 1966, 660 U.N.T.S. 195.

³⁶ See International Covenant on Economic, Social and Cultural Rights, Dec. 16, 1966, 993 U.N.T.S. 3 [hereinafter International Covenant on Economic, Social and Cultural Rights]; Convention on the Elimination of All Forms of Discrimination Against Women, Dec. 18, 1979, 1249 U.N.T.S. 13 [hereinafter Convention on the Elimination of All Forms of Discrimination Against Women]; Vienna Convention on the Law of Treaties, May 23, 1969, 1155 U.N.T.S. 331 [hereinafter Vienna Convention].

³⁷ DEADLY DELIVERY, *supra* note 7, at 13; Vienna Convention, *supra* note 36.

³⁸ The current ratification statuses are available at <http://www.treaties.un.org> (last visited Oct. 19, 2014).

³⁹ *About Us*, U.N. GLOBAL COMPACT, <http://www.unglobalcompact.org/aboutthegc/theprinciples/humanrights.html> (last visited Oct. 28, 2014); see also Universal Declaration of Human Rights, G.A. Res. 217 (III) A, U.N. Doc. A/RES/217(III) (Dec. 10, 1948) [hereinafter Universal Declaration of Human Rights].

with U.N. petitions on human rights. For instance, the U.N. Human Rights Council (HRC) has urged states to integrate a human rights perspective into initiatives to reduce preventable maternal mortality.⁴⁰ As a member of the HRC,⁴¹ the United States cannot turn a blind eye to such international directives. A state's accountability to its citizens and to the global community through these international law mechanisms is a foundational principle of a rights-based approach to maternal care.

II

IDENTIFYING PREGNANT WOMEN'S HUMAN RIGHTS

A complex web of factors informs the United States' current state of maternal care, including the presence of a fetus; the intense physicality of childbirth and risk of harm to both woman and fetus during labor and birth; and the historical, social, and political responses to those physiological facts. These factors make women's rights to health, autonomy, and freedom from discrimination particularly susceptible to violation by government and private actors during pregnancy and birth. Although there is no distinctive right to maternal care in the text of international human rights treaties, that right is implied by the convergence of underlying rights in the international human rights context.

The right to health, one of the most fundamental international human rights, necessitates the use of evidence-based care to prevent iatrogenic harm in childbirth. Childbirth is the most common reason for hospitalization in the United States,⁴² and pathology- and surgery-oriented obstetric specialists attend seventy-nine percent of U.S. births.⁴³ In that environment, medical intervention has the potential to both prevent and create harm. As delineated in international human rights documents, the "highest attainable" standard includes the right

⁴⁰ See H.R.C. Res. 11/8, Rep. of the Human Rights Council [HRC], 11th Sess., June 2–18, 2009, U.N. GAOR, 64th Sess., Supp. No. 63, A/64/53, at 134–36 (June 17, 2009) [hereinafter H.R.C. Res. 11/8]; H.R.C. Res. 15/17, Rep. of the HRC, 15th Sess., Sept. 13–Oct. 1, 2010, U.N. GAOR, 65th Sess., Supp. No. 53 A, A/65/53/Add.1, at 46–48 (Oct. 1, 2010).

⁴¹ *Current Membership of the Human Rights Council, 1 January–31 December 2014*, OHCHR, <http://www.ohchr.org/EN/HRBodies/HRC/Pages/CurrentMembers.aspx> (last visited June 29, 2014).

⁴² Jennifer Podulka et al., *Hospitalizations Related to Childbirth, 2008*, HEALTHCARE COST AND UTILIZATION PROJECT (Apr. 2011), <http://www.hcup-us.ahrq.gov/reports/statbriefs/sb110.jsp>.

⁴³ SAKALA & CORRY, *supra* note 9, at 62.

to receive the benefits of medical intervention when necessary and an equally important right to be assisted with natural birth, without invasive procedures, if those procedures have unknown effectiveness or the potential to cause more harm than good to women's health.⁴⁴

The right to autonomy, which is the right to make choices about one's personal dignity and bodily integrity, supports the right to health. The right to autonomy affirms that women, as rights-holders, have the power to decide how to claim and seek enforcement of their other human rights. The right to autonomy encompasses the principle of informed consent and is in tension with fetal rights laws that infringe on the human rights of pregnant women.

The right to freedom from discrimination underlies effective enforcement of the rights to health and autonomy. Discrimination against women, and especially compound discrimination against minority women, may limit access to maternal health care, prevent women from knowing their rights and being educated about their childbirth options, and lead to higher rates of rights violations. Where discrimination is present, states must work harder to protect and enforce the rights of those women who are most vulnerable to rights infringement.

These three rights of health, autonomy, and freedom from discrimination are explicitly included in multiple conventions and discussed in the context of maternal care in international human rights documents. These rights also contain overlapping principles and normative content. For instance, the right to health imposes an immediately effective "duty on the State to respect an individual's freedom to control his or her health and body."⁴⁵ By the same token, respect for bodily integrity and control over health care choices is a core aspect of the right to autonomy. In fact, documents that seek to

⁴⁴ The WHO's recent clinical guide on recommendations for the augmentation of labor using evidence-based principles exemplifies this approach. One of the "guiding principles" is that augmentation of labor (through the administration of oxytocin or other means) should be performed "only when there is a clear medical indication and the expected benefits outweigh the potential harms." AUGMENTATION OF LABOUR, *supra* note 6, at 4. The authors also tie evidence-based care to the right of autonomy, noting, "unnecessary clinical intervention in the natural birth process undermines women's autonomy and dignity as recipients of care and may negatively impact their childbirth experience." *Id.* at 3.

⁴⁵ Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health, *The Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health: Rep. of the Special Rapporteur, Paul Hunt, Comm'n on Human Rights, ¶ 27, U.N. Doc. E/CN.4/2004/49* (Feb. 16, 2004) [hereinafter *Report of the Special Rapporteur*].

illuminate state obligations regarding human rights often comment on the connections between these rights. The Inter-American Commission on Human Rights has identified health as a “basic need” and stated that the “‘right to survival’ [*sic*] and ‘basic needs’ is a natural consequence of the right to personal security,”⁴⁶ and CEDAW compels states to “take all appropriate measures to eliminate discrimination against women in the field of health care.”⁴⁷ Due to their interwoven nature and their significance in the context of labor and birth, these rights should be read together as the core of a bundle of rights defining a comprehensive right to evidence-based, self-determinative, and nondiscriminatory maternal care for pregnant women.

A. *The Right to Health*

The WHO first articulated the “fundamental right” to health in its 1946 Constitution, which declared “[t]he right to the enjoyment of the highest attainable standard of physical and mental health” for all, meaning the right to “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.”⁴⁸ This right was affirmed in the 1948 Universal Declaration of Human Rights (“Everyone has the right to a standard of living adequate for the health and well-being of [her]self and of [her] family”),⁴⁹ and the “highest attainable” standard was echoed in the International Covenant on Economic, Social and Cultural Rights in 1966.⁵⁰ Many formal international legal instruments have asserted the right to health, including the Convention on the Rights of Persons with Disabilities (CRPD), CEDAW, and ICERD.⁵¹ The right to health is a

⁴⁶ Cook et al., *supra* note 18, at 30 (quoting Annual Rep. of the Inter-Am. Comm’n on Human Rights, 1980–1981, OEA/Serv.L/V/II.54 (Oct. 16, 1981), available at <https://www.cidh.oas.org/annualrep/80.81eng/TOC.htm>).

⁴⁷ Convention on the Elimination of All Forms of Discrimination Against Women, *supra* note 36, at art. 12(1).

⁴⁸ OHCHR & WHO, THE RIGHT TO HEALTH: FACT SHEET NO. 31, 1 (2008) [hereinafter FACT SHEET NO. 31] (emphasis omitted) (internal quotation marks omitted); see also WHO, *Constitution of the World Health Organization*, in BASIC DOCUMENTS (45th ed., Supp. Oct. 2006) (1946) [hereinafter *WHO Constitution*].

⁴⁹ Universal Declaration of Human Rights, *supra* note 39, at art. 25.

⁵⁰ International Covenant on Economic, Social and Cultural Rights, *supra* note 36, at art. 12.

⁵¹ Further, the International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families, the African Charter on Human and Peoples’ Rights, the Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights (Protocol of San Salvador), and the American

truly universal norm: every state has ratified at least one international human rights treaty recognizing this human right.⁵²

1. The Right to Health Includes Reproductive Rights

Reproductive rights as health rights were specifically enshrined in international law by declarations following the 1994 International Conference on Population and Development in Cairo and the 1995 Fourth World Conference on Women in Beijing. The Cairo Programme expanded the scope and definition of reproductive and sexual rights as international human rights by defining reproductive health as “a state of complete physical, mental and social well-being . . . in all matters relating to the reproductive system and to its functions and processes,”⁵³ including pregnancy. The Beijing Platform then incorporated the concepts of autonomy and freedom from discrimination into reproductive rights (women have the right “to make decisions concerning reproduction free of discrimination, coercion and violence, as expressed in human rights documents”).⁵⁴ In 2003, the Commission on Human Rights confirmed that sexual and reproductive health are “integral elements” of the right to health.⁵⁵

After Cairo and Beijing, reproductive rights were further developed as human rights by CEDAW, the premier human rights instrument delineating the rights of women. Article 12 of the convention demands that states ensure appropriate health services in connection with pregnancy and eliminate discrimination against women in the field of health care, including reproductive health care.⁵⁶ The “highest attainable” standard of health is further elucidated by the Committee on the Elimination of Discrimination Against Women’s (CEDAW

Declaration of the Rights and Duties of Man all reaffirm and strengthen the right to health. *See generally* International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families, Dec. 18, 1990, 2220 U.N.T.S. 93; African Charter on Human and Peoples’ Rights, June 27, 1981, 1520 U.N.T.S. 217; Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights, Nov. 16, 1999, 28 I.L.M 156; American Declaration of the Rights and Duties of Man, 43 AM. J. INT’L L. Supp. 133 (1948).

⁵² FACT SHEET NO. 31, *supra* note 48, at 1.

⁵³ Rep. of the Int’l Conference on Population and Dev., Sept. 5–13, 1994, ¶ 7.2, U.N. Doc. A/CONF.171/13 (Oct. 18, 1994).

⁵⁴ Rep. of the Fourth World Conference on Women, Sept. 4–15, 1995, ¶ 95, U.N. Doc. A/CONF.177/20/Rev.1 (Sept. 15, 1995).

⁵⁵ *Report of the Special Rapporteur*, *supra* note 45, ¶ 9 (citation omitted) (internal quotation marks omitted).

⁵⁶ Convention on the Elimination of All Forms of Discrimination against Women, *supra* note 36, at art. 12.

Committee) general recommendation regarding Article 12. The recommendation, developed in 1999, affirmed reproductive health as a basic right under Article 12 and declared that it is the duty of states to “ensure women’s right to safe motherhood”⁵⁷ and to “[r]equire all health services to be consistent with the [other] human rights of women, including the rights to autonomy, privacy, confidentiality, informed consent and choice.”⁵⁸

International dialogue and documents continue to expound pregnant women’s right to reproductive health. Following the U.N. Millennium Summit in 2000, all U.N. member states adopted eight “Millennium Development Goals” (MDGs) to be substantially achieved by 2015, including the goal of improving maternal health.⁵⁹ While the MDGs focused on developing countries, their aims are universal, and the U.N. has since agreed that post-2015 development goals should be applicable to all countries.⁶⁰ In 2009, numerous NGO⁶¹ and IGO⁶² advocates for women’s human rights, in consultative status with the Economic and Social Council, submitted a joint statement to the Council’s Commission on Population and Development urging U.N. member states to reaffirm the MDG targets, and explicitly stated that the MDG goal of universal access to reproductive health “includes, based on the concept of informed choice . . . adequate delivery assistance that avoids excessive recourse to [c]esarean sections, episiotomy, administration of oxytocin, and other medical procedures[.]”⁶³ International reminders of state

⁵⁷ Rep. of the Comm. on the Elimination of Discrimination Against Women (CEDAW), 20th Sess., Jan. 19–Feb. 5, 1999, U.N. GAOR, 54th Sess., Supp. No. 38, A/54/38/Rev.1, at 6 (June 25, 1999) [hereinafter CEDAW Report].

⁵⁸ *Id.* at 7.

⁵⁹ The goals established by the MDGs will continue to be pursued at the international level through the “Post-2015 Development Agenda” led by a UN System Task Team. For more information, see *Millennium Development Goals and Post-2015 Development Agenda*, U.N. ECON. AND SOC. COUNCIL, www.un.org/en/ecosoc/about/mdg.shtml (last visited July 29, 2014).

⁶⁰ U.N. Pres. of the General Assembly, *Outcome Document of the Special Event to Follow Up Efforts Made Towards Achieving the Millennium Development Goals*, ¶ 19, U.N. Doc. A/68/L.4* (Oct. 1, 2013). For an overview of the Post-2015 Agenda as it relates to reproductive rights, see CTR. FOR REPRODUCTIVE RIGHTS, SUBSTANTIVE EQUALITY AND REPRODUCTIVE RIGHTS: A BRIEFING PAPER ON ALIGNING DEVELOPMENT GOALS WITH HUMAN RIGHTS OBLIGATIONS (2014), available at http://reproductiverights.org/sites/crr.civicaactions.net/files/documents/Equality_Guide__5.28.14_Web.pdf.

⁶¹ Nongovernmental organization.

⁶² Intergovernmental organization.

⁶³ Comm’n on Population Dev., Follow up actions on 42nd Sess., Mar. 30–Apr. 3, 2009, ¶ 5, U.N. Doc. E/CN.9/2009/NGO/10 (Jan. 20, 2009). The group also urged the

obligations regarding reproductive health have accompanied this expanded definition of pregnancy-related rights. In a July 2011 report to the HRC, the OHCHR wrote, “States have the immediate obligation to take deliberate, concrete and targeted steps towards fulfilling the right to health in the context of pregnancy and childbirth.”⁶⁴ To fulfill this obligation, states should follow the advice of women’s human rights advocates like those cited above and should effectuate the highest attainable standard of health by promoting a model of evidence-based care that avoids excessive recourse to interventions.

2. Evidence-Based Care Promotes the Highest Attainable Standard of Health

The Committee on Economic, Social, and Cultural Rights (CESCR) has explained that the right to health entails freedoms and entitlements, rather than the right to “be healthy.” The right includes the freedom “to control one’s health and body, including sexual and reproductive freedom, and the right to be free from interference, such as the right to be free from . . . non-consensual medical treatment.”⁶⁵ As holders of the right to health, all humans are entitled “to a system of health protection which provides equality of opportunity for people to enjoy the highest attainable level of health.”⁶⁶ According to the CESCR, the “highest attainable standard” is subjective because it takes account of individuals’ “biological and socio-economic preconditions” and a state’s resources.⁶⁷ The Committee recognizes that states cannot ensure “good health” for all, nor provide protection against “every possible cause of human ill health.”⁶⁸ However, the right to health still places affirmative obligations on states to ensure that health services are provided in a way that is respectful of medical ethics, sensitive to “gender and life-cycle requirements,” and

member states to renew their focus on nondiscrimination and autonomy as human rights when considering conception and implementation of population and development policies. *Id.* ¶ 2.

⁶⁴ OHCHR, *Rep. of the OHCHR: Practices in Adopting a Human Rights-Based Approach to Eliminate Preventable Maternal Mortality and Human Rights*, ¶ 4, U.N. Doc. A/HRC/18/27 (July 8, 2011) [hereinafter *Rep. of the OHCHR: Practices*].

⁶⁵ *General Comment No. 14*, *supra* note 26, ¶ 8.

⁶⁶ *Id.*

⁶⁷ *Id.* ¶ 9.

⁶⁸ *Id.*

culturally, scientifically, and medically appropriate⁶⁹—in other words, evidence-based care.

Evidence-based health care means using the best, most current evidence to make health care decisions. Providers should use relevant, valid scientific research⁷⁰ on the effects of particular kinds of care, including the potential for harm, and should refrain from use of procedures that are not clearly beneficial.⁷¹ Individual situations require unique balancing tests of benefit and harm, but as a rule, “[e]vidence-based maternity care gives priority to care paths and practices that are effective and least invasive, with limited or no known harms whenever possible.”⁷² This model reflects the CESCR’s explication of the normative content of the right to health as including scientifically and medically appropriate care. It is also supported by U.N. Secretary-General Ban Ki-moon’s “Every Woman Every Child” campaign, also known as the “Global Strategy for Women’s and Children’s Health.”⁷³ The strategy implores the healthcare profession to provide “the highest-quality care, grounded in evidence-based medicine.”⁷⁴

Epidemiologist Archie Cochrane advocated for evidence-based care, and the highest standard for systemic reviews of primary health care research bears his name.⁷⁵ Cochrane’s student, obstetrician Iain Chalmers, is credited with developing evidence-based care in the maternal care context.⁷⁶ Chalmers’s *Effective Care in Pregnancy and Childbirth*, published in 1989, included a systematic review of the field of obstetrics and classification of common obstetric practices along a scale of “beneficial” to “ineffective or harmful.”⁷⁷ The results

⁶⁹ *Id.* ¶ 12(c).

⁷⁰ The Cochrane Collaboration defines “best evidence” as “the best available external clinical evidence from systematic research,” and “systematic review” as “a high-level overview of primary research on a particular research question that tries to identify, select, synthesize and appraise all high quality research evidence relevant to that question in order to answer it.” *About Us: Evidence-Based Health Care*, COCHRANE COLLABORATION, <http://www.cochrane.org/about-us/evidence-based-health-care> (last updated May 26, 2014).

⁷¹ *Id.*

⁷² SAKALA & CORRY, *supra* note 9, at 21 (emphasis omitted).

⁷³ U.N. SEC’Y-GEN. BAN KI-MOON, GLOBAL STRATEGY FOR WOMEN’S AND CHILDREN’S HEALTH 17 (2010).

⁷⁴ *Id.*

⁷⁵ Archie Cochrane: *The Name Behind Cochrane*, COCHRANE COLLABORATION, <http://www.cochrane.org/about-us/history/archie-cochrane> (last updated Dec. 5, 2013).

⁷⁶ BLOCK, *supra* note 13, at 36–37.

⁷⁷ *Id.* at 36.

of Chalmers's study showed that many routine obstetric practices at the time were being used without valid evidence of benefit.⁷⁸ Nearly a quarter of common hospital practices surrounding childbirth were being used with "unknown effectiveness," meaning no clear evidence of benefit or harm, and a third of common practices at the time were unlikely to have any benefit or were actually likely to cause harm.⁷⁹ "First, do no harm" is a traditional maxim of medicine.⁸⁰ The development of evidence-based care gave that maxim more substantive meaning by discouraging intervention that could result in known harms or in potential harms where the available evidence does not establish that a procedure is safe, let alone beneficial.⁸¹ Because harmful effects measured in randomized trials are limited to those effects predicted to occur, "[m]any unanticipated harmful effects probably never come to light."⁸² For this reason, special scrutiny is warranted before interventions in pregnancy and childbirth are performed.⁸³

The twentieth century's legacy of harm from medical interventions in pregnancy without clear evidence of benefit is troubling. The clearest examples are bad outcomes from the overuse of pharmaceutical drugs. Such outcomes include cervical cancer affecting generations of women whose mothers and grandmothers were given diethylstilbestrol to stop vaginal bleeding (which the drug was not effective at stopping), birth deformities from the use of thalidomide for the same purpose, and severe contractions and uterine rupture from the common and continuing off-label use of the drug Cytotec to induce labor.⁸⁴ These examples may overshadow, but should not diminish, the seriousness of less obvious violations of evidence-based care, like today's routine overuse of labor interventions for purportedly "precautionary," but not evidence-based, reasons. For example, many mothers who receive labor inductions or

⁷⁸ *Id.*

⁷⁹ *Id.* at 36–37.

⁸⁰ SAKALA & CORRY, *supra* note 9, at 21; *see also* WAGNER, *supra* note 1, at 87.

⁸¹ *See* BLOCK, *supra* note 13, at 37.

⁸² G. JUSTUS HOFMEYR ET AL., A COCHRANE POCKETBOOK: PREGNANCY AND CHILDBIRTH xiii (2008).

⁸³ *Id.*

⁸⁴ *See* WAGNER, *supra* note 1, and BLOCK, *supra* note 13, for descriptions of the use of Cytotec in the 1990s, and Mildred M. Ramirez, *Labor Induction: A Review of Current Methods*, 38 OBSTETRICS GYNECOLOGY CLINICS N. AM. 215, 215–25 (2011), for a discussion on the ongoing use and adverse effects of Cytotec as an induction agent in the twenty-first century.

C-sections report that the caregiver justified the intervention on the basis that the fetus was too large for natural vaginal birth.⁸⁵ This is not a valid medical indication for either intervention according to multiple rigorous reviews of the best available research.⁸⁶ Thus, the intervention and its risks were imposed upon those women without an appropriate countervailing benefit.

Another example of a widespread breach of evidence-based care in low-risk birth is the use of electronic fetal monitoring (EFM). EFM severely limits women's ability to move and try different laboring positions, increases women's discomfort, and encourages providers to "focus on the machine rather than the woman."⁸⁷ It also dramatically increases rates of C-section (and all the attendant risks of surgery)⁸⁸ and vacuum- or forceps-assisted vaginal delivery because of perceived fetal distress and providers' fear of liability.⁸⁹ Current evidence now shows that there is no clear benefit to using EFM in low-risk birth, no clear support for improved fetal outcomes, and no evidence that EFM can better detect fetal distress than manual monitoring methods.⁹⁰ The WHO, the U.S. Preventative Services Task Force (part of the U.S. Department of Health and Human Services), and the professional obstetric organizations of the United Kingdom, New Zealand, and Australia all recommend against routine use of EFM.⁹¹ Yet, a survey of new mothers who experienced labor in U.S. hospitals from July 2011 to June 2012 reported an eighty-nine percent rate of use of EFM to record the fetus's heartbeat.⁹²

In addition to minimizing risks of unnecessary harm, an evidence-based approach to health care also takes into account evidence of the physiological foundations of childbearing to guide the provision of care in a way that will not diminish the benefits of the natural birth process. For instance, a provider who seeks to use a medical

⁸⁵ LISTENING TO MOTHERS III, *supra* note 4, at 36–39; SAKALA & CORRY, *supra* note 9, at 21.

⁸⁶ *Id.*

⁸⁷ SAKALA & CORRY, *supra* note 9, at 48.

⁸⁸ See *infra* Part II.B.2.

⁸⁹ C-sections increased three-fold between 1968 and 1976, the first nine years of EFM use. BLOCK, *supra* note 13, at 34; see also SAKALA & CORRY, *supra* note 9, at 48.

⁹⁰ BLOCK, *supra* note 13, at 33–35; see also CARE IN NORMAL BIRTH, *supra* note 16, at 17.

⁹¹ See BLOCK, *supra* note 13, at 34–35.

⁹² EUGENE R. DECLERCQ ET AL., CHILDBIRTH CONNECTION, LISTENING TO MOTHERS III: NEW MOTHERS SPEAK OUT, REPORT OF NATIONAL SURVEYS OF WOMEN'S CHILDBEARING EXPERIENCES, CONDUCTED OCTOBER–DECEMBER 2012 AND JANUARY–APRIL 2013 85 (2013) (a follow-up report to LISTENING TO MOTHERS III, *supra* note 4).

intervention should include in her calculation of risks and benefits the risk of disrupting the mother's natural production of oxytocin, beta-endorphins, and other hormones that facilitate the onset of labor, create expulsion reflexes shortly before birth, and lead to the development of mother and baby attachment.⁹³ Certified nurse-midwives (CNMs), certified midwives (CMs), and certified professional midwives (CPMs) support these physiological processes by avoiding unnecessary interventions and providing care that is flexible and responsive to women's needs.⁹⁴ These professionals are underutilized by pregnant women in the United States, sometimes because of restrictive state laws on licensing and regulation of midwives.⁹⁵ There is moderate to high evidence that CNMs in the United States achieve similar or better outcomes than physicians when attending low-risk births, partly because of their tendency to rely less on interventional technologies.⁹⁶

The connection between human rights and evidence-based care has been explicated by experts such as Paul Hunt, the former U.N. Special Rapporteur on the right to health. In the Supplementary Note to his April 2010 report on maternal mortality in India, Hunt discussed the meaning of states' international obligations to take "all appropriate measures" to reduce maternal mortality.⁹⁷ He emphasized that "appropriate" health interventions "must be consistent with the best evidence in clinical medicine and public health," and that a state and its health care providers are not free "to choose whatever maternal health interventions [they] wish[] so long as they are broadly going in the right direction."⁹⁸ Hunt included "emergency obstetric care" as a "cornerstone intervention[]" for maternal health. However, non-emergent obstetric care that is not "consistent with the best evidence"

⁹³ SAKALA & CORRY, *supra* note 9, at 25.

⁹⁴ *Id.* at 62.

⁹⁵ See, for example, Requirements for Collaborative Practice by Physicians and Certified Nurse Midwives, ALA. ADMIN. CODE r. 540-x-8-.22 (2012), which prohibits CNMs from practicing without "professional medical oversight and direction" from a physician.

⁹⁶ See Meg Johantgen et al., *Comparison of Labor and Delivery Care Provided by Certified Nurse-Midwives and Physicians: A Systematic Review, 1990 to 2008*, 22 WOMEN'S HEALTH ISSUES e73, e78 (2012).

⁹⁷ Paul Hunt, *Supplementary Note on the UN Special Rapporteur's Report on Maternal Mortality in India*, UNIV. OF ESSEX 13 (Apr. 21, 2010), <http://repository.essex.ac.uk/9818/1/supplementary-note-on-unsp-report-on-maternal-mortality-in-india-21-April-2010.pdf> (internal quotation marks omitted).

⁹⁸ *Id.*

is not compatible with his interpretation of human rights obligations.⁹⁹

At least one international organization has unequivocally tied women's human rights to evidence-based maternal care. The International MotherBaby Childbirth Initiative (IMBCI) is an international model of maternal care promulgated by the International MotherBaby Childbirth Organization (IMBCO).¹⁰⁰ The initiative is primarily based on "mother friendly" principles first set out by the Coalition for Improving Maternity Services' Mother-Friendly Childbirth Initiative in 1996.¹⁰¹ The IMBCO then took these principles, which were initially developed for use in the United States, and sought input from experts and international organizations to create a more global initiative for maternal care that incorporates international principles such as human rights.¹⁰² This rights-centric model has also been called the "midwifery model of care."¹⁰³ Three of the "Basic Principles" of the IMBCI are: (1) "[w]omen's and children's rights are human rights," (2) "[a]ccess to humane and effective healthcare is a basic human right," and (3) "[w]omen should receive full, accurate, and unbiased information based on the best available evidence about the harms, benefits, and alternatives so that they can make an informed decision about their care and their babies' care."¹⁰⁴ Promoting evidence-based care is necessary to prevent iatrogenic harm, protect pregnant women's freedoms, and ensure pregnant women's entitlements flowing from the right to health.

3. Maternal Mortality Is the Ultimate Violation of the Right to Health

The right to life, which itself is guaranteed by human rights law,¹⁰⁵ could be thought of as the ultimate fulfillment of the right to health. It

⁹⁹ *Id.*

¹⁰⁰ *History*, IMBCO, <http://www.imbci.org> (last visited Oct. 19, 2014) (click "The Initiative"; then click "IMBCI – The 10 Steps"; then click "History and Purpose").

¹⁰¹ *Id.*

¹⁰² *Id.*

¹⁰³ Robbie Davis-Floyd et al., *The International MotherBaby Childbirth Initiative: A Human Rights Approach to Optimal Maternity Care*, 94 *MIDWIFERY TODAY* (2010), available at <http://midwiferytoday.com/articles/IMBCI.asp>.

¹⁰⁴ *Basic Principles of the International MotherBaby Childbirth Initiative*, IMBCO, <http://www.imbci.org/> (last visited July 27, 2014) (click "The Initiative"; then click "Basic Principles of the IMBCI").

¹⁰⁵ The ICCPR guarantees humans the inherent right to life, protected by law, and the right to not be arbitrarily deprived of life. International Covenant on Civil and Political Rights art. 6, Dec. 19, 1966, 999 U.N.T.S. 171.

follows that maternal mortality—death resulting from complications related to pregnancy—is the ultimate deprivation of childbearing women’s right to health. The reported U.S. maternal mortality rate of 18.5 deaths per 100,000 live births is higher than fifty-nine other countries¹⁰⁶ and more than four times as high as the goal set by the United States government for 2010.¹⁰⁷ It is also likely significantly underreported due to the lack of a comprehensive reporting and review protocol for maternal death.¹⁰⁸ Further, more than one million women in the United States each year experience maternal morbidity, a pregnancy-related complication that negatively affects their health.¹⁰⁹

The U.N. Human Rights Council passed a resolution in June 2009 recognizing maternal mortality and morbidity as a “human rights challenge.”¹¹⁰ The Council also recognized the need for integrating “a human rights perspective in international and national responses to maternal mortality and morbidity.”¹¹¹ As a result, the Council requested that all states “renew their political commitment to eliminating preventable maternal mortality and morbidity” and “redouble their efforts to ensure the full and effective implementation of their human rights obligations,” including commitments to fulfill health and reproductive rights under the Beijing Platform, the Cairo Programme, and the MDGs.¹¹² The Council’s appeal connects states’ internal governmental commitments to improving citizens’ health to

¹⁰⁶ Nicholas J. Kassebaum et al., *Global, Regional, and National Levels and Causes of Maternal Mortality During 1990–2013: A Systematic Analysis for the Global Burden of Disease Study 2013*, 384 LANCET 980, 990 (2014), available at <http://www.sciencedirect.com/science/article/pii/S0140673614606966>. The United States is one of eight countries whose rate of maternal death has risen over the past decade; the 2013 rate of 18.5 maternal deaths for every 100,000 births is up from 12.4 in 1990 and 17.6 in 2003. *Id.* at 990, 998. In 2013, the country ranked sixtieth out of 180 countries studied, down from twenty-second in 1990. *Id.*

¹⁰⁷ DEADLY DELIVERY ONE YEAR UPDATE, *supra* note 5, at 5. The Healthy People 2010 goal of 4.3 per 100,000 maternal deaths has since been revised for Healthy People 2020 to 11.4 maternal deaths per 100,000 (using the lower baseline figure of 12.7 maternal deaths per 100,000 live births based on 2007 National Vital Statistics reports, rather than the 18.5 figure reported for 2013 in Kassebaum et al., *supra* note 106, at 990). *Maternal, Infant, and Child Health: Objectives*, HEALTHY PEOPLE, <http://healthypeople.gov/2020/topicsobjectives2020/objectiveslist.aspx?topicId=26> (last visited Aug. 1, 2014) [hereinafter *Maternal, Infant, and Child Health: Objectives*].

¹⁰⁸ DEADLY DELIVERY, *supra* note 7, at 86–91; see also INA MAY GASKIN, BIRTH MATTERS: A MIDWIFE’S MANIFESTA 129–32 (2011).

¹⁰⁹ DEADLY DELIVERY ONE YEAR UPDATE, *supra* note 5, at 6.

¹¹⁰ H.R.C. Res. 11/8, *supra* note 40, at 134.

¹¹¹ *Id.*

¹¹² *Id.* at 135.

state obligations based in human rights law. This connection is important because it puts the pressure of international monitoring on states' domestic health policies.

Death from pregnancy-related causes in the United States is especially egregious when it results from iatrogenic complications such as doctor-imposed medically unnecessary interventions. Reducing these complications by improving accountability mechanisms and promoting evidence-based maternal health care would go a long way toward lowering rates of morbidity and mortality and achieving U.S. compliance with international appeals to ensure women's human rights to life and health.

B. The Right to Autonomy

The human right to autonomy derives from the concepts of human dignity and liberty, which encompass and inform other rights. The ICESCR states that the rights incorporated in that treaty “derive from the inherent dignity of the human person,”¹¹³ and the CESCR's general comment on the right to health begins with the declaration that humans are entitled to “the highest attainable standard of health conducive to living a life in dignity.”¹¹⁴ The ICCPR guarantees individuals' right to liberty and security.¹¹⁵ In the same vein, the right of “self-determination” in the ICESCR, often applied to groups of people and the concept of self-governance, can also be applied to individuals.¹¹⁶ In the United States, the Fifth and Fourteenth Amendments also protect the right to liberty, and the Supreme Court has explicitly affirmed this liberty right in the context of reproductive choice.¹¹⁷ CEDAW General Recommendation No. 24 attaches the concepts of dignity and liberty to the right of women to make autonomous decisions about their health. The recommendation identifies autonomy as one of the “human rights of women” with which the provision of health services must be consistent.¹¹⁸

¹¹³ International Covenant on Economic, Social and Cultural Rights, *supra* note 36, at pmb.

¹¹⁴ *General Comment No. 14*, *supra* note 26, ¶ 1.

¹¹⁵ International Covenant on Civil and Political Rights, *supra* note 35, at art. 9.

¹¹⁶ *Id.*

¹¹⁷ See *Planned Parenthood of Southeastern Pennsylvania v. Casey*, 505 U.S. 833, 851 (1992) (“[M]atters . . . involving the most intimate and personal choices a person may make in a lifetime, choices central to personal dignity and autonomy, are central to the liberty protected by the Fourteenth Amendment.”).

¹¹⁸ CEDAW Report, *supra* note 57, at 7.

Accordingly, “[t]he obligation to respect rights requires [s]tates parties to refrain from obstructing action taken by women in pursuit of their health goals.”¹¹⁹

There are two examples of rights violations that best demonstrate the significance of the human rights principle of autonomous reproductive choice in the context of pregnancy and birth: (1) the imposition of medical interventions based on “fetal rights” rather than women’s rights during childbirth, and (2) providers’ failures to obtain women’s informed consent to medical interventions during childbirth. These actions also violate the right to health when they increase health risks to the pregnant woman, and by extension violate the right to not be discriminated against when receiving maternal health care.

1. Women’s Human Rights Should Preclude Recognition of Fetal Rights

The question of autonomy is uniquely implicated in the choices a pregnant woman makes about her body because of the presence of the fetus. Whether or not a fetus is a legal entity distinct from the mother is a complicated question that is at the heart of the abortion debate, but it also has significant bearing on the treatment of pregnant women who choose to carry to term. When the medical field views the fetus as a separate right-holding entity, there is an inevitable conflict between the mother’s rights and the fetus’s rights. The conflict is not present under English law, where a fetus has no rights until born alive.¹²⁰ This theory carried over to American inheritance law, where a fetus has contingent interests that do not crystallize until it is born alive.¹²¹ The common law background has also persisted in the criminal context in many U.S. states, where a murder conviction can be prevented with respect to the fetus when a pregnant woman is killed.¹²² Yet, in some U.S. states, the courts have made exceptions once a fetus is at full term and capable of survival apart from the mother, allowing a homicide conviction for the death of a “viable fetus.”¹²³ U.S. states have amended their criminal statutes or medical

¹¹⁹ *Id.* at 4.

¹²⁰ ELIZABETH WICKS, HUMAN RIGHTS AND HEALTHCARE 187–203 (2007).

¹²¹ JOHN SEYMOUR, CHILDBIRTH AND THE LAW 136–37 (2000).

¹²² *Id.* at 137.

¹²³ *Id.* at 140 (citing *Commonwealth v. Lawrence*, 536 N.E.2d 571 (Mass. 1989); *State v. Home*, 319 S.E.2d 703 (S.C. 1984); *Hughes v. State*, 868 P.2d 730 (Okla. Crim. App. 1994)).

liability acts to include offenses against fetuses,¹²⁴ and some have gone so far as to propose definitional statutes including fetuses, fertilized eggs, and embryos within the definition of a person or human being, which would expand the scope of all other statutes that are applicable to persons or human beings, with harmful consequences for pregnant women.¹²⁵

Under *Roe v. Wade*, a fetus does not fall within the definition of a “person” under the Fourteenth Amendment.¹²⁶ However, *Roe* also identifies a state interest in protecting potential life.¹²⁷ Crucially, this state interest cannot overcome a woman’s right to health and life.¹²⁸ Yet, legislation allowing fetal rights, using “state interest” language for support, undermines *Roe*’s ruling, which excludes fetuses from personhood. Such statutes and decisions have led to the criminalization of pregnant women who use illicit drugs or attempt suicide during pregnancy, and could lead to criminal investigations of women anytime they suffer a miscarriage.¹²⁹

¹²⁴ SEYMOUR, *supra* note 121, at 142.

¹²⁵ See, for example, H. Con. Res. 44, 2011 Leg. Reg. Sess. (Miss. 2011), or Mississippi Initiative Measure No. 26, providing for the creation of a new section of the Mississippi Constitution of 1890: “Section 33. Person defined. As used in this Article III of the state Constitution, ‘The term ‘person’ or ‘persons’ shall include every human being from the moment of fertilization, cloning, or the functional equivalent thereof.’” The resolution was defeated in 2011. Such proposed statutes have also been bolstered by federal regulations such as the United States Department of Health and Human Services’ 2002 redefinition of “child” as including “unborn children” for the purposes of the State Children’s Health Insurance Program. SHEENA MEREDITH, *POLICING PREGNANCY: THE LAW AND ETHICS OF OBSTETRIC CONFLICT* 13 (2005).

¹²⁶ 410 U.S. 113, 158 (1973).

¹²⁷ *Id.* at 162–63.

¹²⁸ See *Stenberg v. Carhart*, 530 U.S. 914, 931 (2000) (“[A] State may promote but not endanger a woman’s health when it regulates the methods of abortion.”).

¹²⁹ See generally MEREDITH, *supra* note 125. Several recent noteworthy cases include the prosecution of Bei Bei Shuai in Indiana for murder and Class B felony attempted feticide after Shuai ingested rat poison in a suicide attempt while pregnant, *Shuai v. State*, 966 N.E.2d 619, 622–23 (Ind. Ct. App. 2012), and the prosecution of Astasia Clemons for “corrupting another with drugs” after giving “birth to a child who, upon birth, tested positive for marijuana, morphine [and] oxycodone,” but suffered no injury from drug exposure, *State v. Clemons*, 996 N.E.2d 507, 508 (Ohio Ct. App. 2013). Shuai ultimately accepted a plea agreement and pled guilty to criminal recklessness. Laura Huss, *Thank You! Bei Bei Shuai is Free and More!*, NAT’L ADVOCATES FOR PREGNANT WOMEN (Aug. 6, 2013 12:21 PM), http://advocatesforpregnantwomen.org/blog/2013/08/thank_you_bei_bei_shuai_is_fre.php. Clemons pled no contest after her motion to dismiss was denied. *Clemons*, 996 N.E.2d at 508–09. She was sentenced to two years in prison, but the Ohio Court of Appeals vacated that sentence, finding that although the viable unborn fetus was a “person” and thus “another” under the Ohio statute, the statute excepted pregnant women from prosecution based on conduct during pregnancy affecting an unborn child. *Id.* at 509, 511, 513. For further reading on the impact of fetal personhood measures on pregnant

During the final stages of pregnancy and birth, fetal rights laws can greatly impact a pregnant woman's right to choose what interventions are used on her body. A grievous example of a violation of a pregnant woman's right to autonomy (and the attendant rights of health, life, and freedom from discrimination) is the story of Angela Carder. In 1987, Carder, then twenty-seven years old, had been in remission from cancer, but at twenty-five weeks pregnant she learned she had a cancerous lung tumor.¹³⁰ She was first denied chemotherapy and radiation because of risks to the fetus.¹³¹ At twenty-six weeks pregnant and "high risk," she was told she must undergo a C-section to save her fetus and avoid the risk of fetal death in the event of her own death from the cancer.¹³² Carder's doctors were convinced the surgery would hasten Carder's death, and she and her family opposed the C-section.¹³³ George Washington University Hospital in Washington, D.C. appointed an attorney for Carder's fetus and requested a court hearing before a judge who mandated the C-section against Carder's will.¹³⁴ Carder's baby died shortly after surgery, and she died two days later.¹³⁵

In Carder's case, the court-ordered intervention was based on the premise that her fetus would be more likely to survive if born prematurely by planned C-section than by emergency C-section after Carder's death, and that the fetus had a right to life that could override Carder's consent.¹³⁶ That reasoning is in direct opposition to *Roe's* guarantee that women's right to health and life must supersede any state interest in protecting the life of non-person fetuses. In an appeal after Carder's death, led by American Civil Liberties Union attorneys, the District of Columbia Court of Appeals held that when a pregnant patient is near death, unless she is incompetent, "what is to be done" in regards to the course of medical treatment "is to be decided by the

women, see Lynn M. Paltrow and Jeanne Flavin's article "The Policy and Politics of Reproductive Health, Arrests of and Forced Interventions on Pregnant Women in the United States, 1973–2005: Implications for Women's Legal Status and Public Health," wherein the authors review 413 cases from 1973 to 2005 "in which a woman's pregnancy was a necessary factor leading to attempted and actual deprivations of a woman's physical liberty." 38:2 J. HEALTH POL., POL'Y & L. 299, 299–343 (2013).

¹³⁰ BLOCK, *supra* note 13, at 254–55; *see also In re A.C.*, 573 A.2d 1235 (D.C. 1990).

¹³¹ BLOCK, *supra* note 13, at 254.

¹³² *Id.*

¹³³ *Id.*; *see also In re A.C.*, 573 A.2d at 1239–40.

¹³⁴ *In re A.C.*, 573 A.2d at 1239–41.

¹³⁵ *Id.* at 1241.

¹³⁶ *Id.*

patient—the pregnant woman—on behalf of herself and the fetus.”¹³⁷ This rule of autonomy is echoed in The American College of Obstetricians and Gynecologists’ (ACOG) ethics opinion on maternal decision making: “judicial authority should not be used to implement treatment regimens aimed at protecting the fetus, for such actions violate the pregnant woman’s autonomy.”¹³⁸

Despite precedent such as *In re A.C.* and policy statements like ACOG’s, other U.S. state laws and judicial opinions focusing on the compelling state interest in the potentiality of life of an unborn fetus have chipped away at women’s autonomy to make decisions about interventions when they are pregnant with a viable fetus.¹³⁹ A 2010 case out of Florida, citing *Roe*, notes that in that state, “[t]he test to overcome a woman’s right to refuse medical intervention in her pregnancy is whether the state’s compelling state interest is sufficient to override the pregnant woman’s constitutional right to the control of her person, including her right to refuse medical treatment.”¹⁴⁰ Under a human rights-based framework that considers but is not limited by U.S. constitutional law, the state’s interest in potential life is never sufficient to override a pregnant woman’s inherent human rights to autonomy and health.

2. Interventions in Pregnancy Require Informed Consent

A review of the benefits and risks of cesarean surgery in the United States gives context to the human rights principles of informed consent and refusal. While court-ordered C-sections may be relatively rare, birth by C-section is quite common in the United States—too

¹³⁷ *Id.* at 1237.

¹³⁸ *Committee Opinion No. 321: Maternal Decision Making, Ethics, and the Law*, ACOG (2005), <http://www.acog.org/Resources-And-Publications/Committee-Opinions/Committee-on-Ethics/Maternal-Decision-Making-Ethics-and-the-Law>, *quoted in* BLOCK, *supra* note 13, at 255.

¹³⁹ See *Raleigh Fitkin-Paul Morgan Memorial Hospital v. Anderson*, 201 A.2d 537, 538 (N.J. 1964), and *Matter of Jamaica Hospital*, 491 N.Y.S.2d 898, 899–900 (N.Y. Sup. Ct. 1985), for examples of cases involving pregnant women’s refusals to undergo blood transfusions; the courts held that unborn children are entitled to the law’s protection. See also *Jefferson v. Griffin Spalding County Hospital Authority*, 274 S.E.2d 457, 460 (Ga. 1981), and *Pemberton v. Tallahassee Memorial Regional Medical Center, Inc.*, 66 F. Supp. 2d 1247, 1251 (N.D. Fla. 1999), for examples of courts that, in ordering cesareans or upholding other court-ordered cesareans, invoked *Roe*’s determination that the state has an important and legitimate interest in protecting the potentiality of human life.

¹⁴⁰ *Burton v. State*, 49 So. 3d 263, 266 (Fla. Dist. Ct. App. 2010).

common, according to the WHO and ACOG.¹⁴¹ Some C-sections are needed when emergency surgery can benefit mother and child and lead to fewer deaths from birth obstructions or other complications.¹⁴² Indeed, the lack of access to such surgery is a leading cause of maternal death in low-income countries.¹⁴³ The benefits of C-sections are reflected in the WHO's recommendation of a five to fifteen percent C-section rate, which accounts for a cost-benefit analysis where benefits outweigh or neutralize the risks of surgery.¹⁴⁴ Yet, the United States has a C-section rate of 32.8 percent, more than twice the recommended rate.¹⁴⁵ When the five to fifteen percent rate is passed, the risks of C-section begin to outweigh the benefits, including higher rates of maternal re-hospitalization¹⁴⁶ and a risk of maternal death from complications that is three to four times higher than the risk to women who give birth vaginally.¹⁴⁷ Other risks of C-section include infection; improper healing of scars; and serious complications in future surgeries, such as abdominal adhesions (creating pelvic pain, infertility, and abnormal bowel function), uterine rupture, and placental complications such as accreta, increta, and percreta (implantation of the placenta along or through the cesarean scar, which can lead to severe hemorrhage).¹⁴⁸ The bottom line is that a C-

¹⁴¹ New ACOG guidelines note the concerning overuse of cesarean surgery in the United States and suggest labor management practices to reduce its incidence. See ACOG/SMFM Consensus, *Safe Prevention of the Primary Cesarean Delivery*, 210 AM. J. OBSTETRICS & GYNECOLOGY 179 (2014).

¹⁴² Emergency C-sections are an evidence-based obstetric practice where the alternate risks involving vaginal delivery under those facts outweigh the risks of the surgery. For instance, "absolute indications" for cesarean, which apply to only a small proportion of births, include prolapsed umbilical cord, placenta previa (placenta blocking the cervix), placental abruption, and "persistent transverse lie," where the fetus is fixed in a horizontal position. SAKALA & CORRY, *supra* note 9, at 41.

¹⁴³ However, over-intervention can also be a problem in countries with significant wealth disparities, in which large parts of the population lack access to medically indicated surgery. Health advocates in India have noted that the high rate of unnecessary cesarean section surgeries in wealthy areas is leading to additional iatrogenic maternal morbidity (for example, forty-five percent of deliveries are done by cesarean in private hospitals in Chennai). See JAN SWASTHYA ABHIYAN, ASIAN SOC. FORUM, RIGHT TO HEALTH CARE: MOVING FROM IDEA TO REALITY 10 (2003), available at <http://www.cehat.org>.

¹⁴⁴ WHO, *Appropriate Technology for Birth*, 326 LANCET 436, 436-37 (1985).

¹⁴⁵ BRADY E. HAMILTON ET AL., BIRTHS: PRELIMINARY DATA FOR 2013, 63 NAT'L VITAL STATISTICS REPORTS 2 (2014), available at <http://www.cdc.gov/nchs/products/nvsr.htm#vol62>.

¹⁴⁶ Podulka, *supra* note 42.

¹⁴⁷ BLOCK, *supra* note 13, at 118 (citing MURRAY ENKIN ET AL., A GUIDE TO EFFECTIVE CARE IN PREGNANCY AND CHILDBIRTH 362 (1989)); DEADLY DELIVERY, *supra* note 7, at 7-8.

¹⁴⁸ BLOCK, *supra* note 13, at 116-17.

section is major surgery that, like any surgery, a person has an absolute right to refuse.

The United States' high C-section rate evidences the unnecessary use of cesarean surgery in low-risk circumstances in which the surgery puts women at a greater risk of harm. Between 1998 and 2007, the rate of cesarean births for low-risk women without a previous C-section increased by forty-four percent—up to twenty-six percent of those with low-risk births—compared to the country's 2010 Healthy People goal of a fifteen percent rate among women who had not had a prior C-section.¹⁴⁹ In 2014, a *Consumer Reports* investigation examined hospitals' public billing records for women who anticipated a low-risk delivery (“women who haven't had a C-section before, don't deliver prematurely, and are pregnant with a single baby who is properly positioned”), revealing unexplained geographic variations in C-section rates for low-risk women ranging from fifteen to fifty-five percent at hospitals in Los Angeles, fifteen to thirty-seven percent in El Paso, and eight to twenty percent in Denver.¹⁵⁰ These unexplained variations and high rates of C-section for low-risk women indicate serious systemic breaches of evidence-based medical practice through imposition of increased risks outweighing the intervention's benefits. A provider violates a woman's right to make autonomous decisions about her health when the provider performs a C-section without informing the woman of the risks of the surgery, regardless of whether the C-section is medically indicated or unnecessary.¹⁵¹ The high rate at which providers are unnecessarily performing C-sections in the United States highlights the probability that women are not being fully informed of the risks and are experiencing provider pressure to

¹⁴⁹ CTRS. FOR DISEASE CONTROL AND PREVENTION, MATERNAL, INFANT, AND CHILD HEALTH 16-5 (2010). New Healthy People 2020 goals are less optimistic and more realistic; the new target for 2020 is 23.9%. See *Maternal, Infant, and Child Health: Objectives*, *supra* note 107.

¹⁵⁰ *What Hospitals Don't Want You to Know About C-Sections*, CONSUMER REP. (May 2014), <http://consumerreports.org/cro/2014/05/what-hospitals-do-not-want-you-to-know-about-c-sections/index.htm>; see also *Hospital Ratings: Avoiding C-Sections*, CONSUMER REP. (May 2014), <http://www.consumerreports.org/cro/resources/streaming/PDFs/Consumer-Reports-Hospital-Ratings-Avoiding-C-sections-FULL.pdf>.

¹⁵¹ Those risks include not only health risks but risks to future autonomy such as the good chance that her provider may not allow her to attempt a vaginal birth after cesarean with future children. See BLOCK, *supra* note 13, at 142–48.

consent, leading to widespread violations of the rights to informed consent and refusal that are inherent in the right to autonomy.¹⁵²

Violations of the right to autonomy are also clear when a provider performs a C-section or other intervention despite a woman's express lack of consent. Several recent lawsuits show that provider-coerced interventions denying women's right of refusal are an ongoing problem in the United States.¹⁵³ A health provider may determine that a particular medical procedure is essential to secure the health of the pregnant mother, the fetus, or both, and that provider has a duty to ensure health and to educate the patient about the relative risks and benefits of intervention to both herself and the fetus. Yet, once this duty is effectuated, the provider also has a duty to refrain from intervening if the woman asserts her rights and competently refuses treatment. Again, the woman's rights in this context must override any state interest in fetal rights; the right of bodily integrity includes a pregnant woman's refusal of medical treatment even where refusal could potentially harm her fetus.¹⁵⁴ However, a woman may accept a medical intervention to benefit her child at the cost of a higher risk to her own health. She is entitled to this choice, provided it is a well-informed choice in accordance with human rights standards.

¹⁵² The authors of *Evidence-Based Maternity Care: What It Is and What It Can Achieve* conclude that "[t]he increase [in the United States' cesarean rate] reflects changing professional standards, with growing casual acceptance of cesarean surgery, lowered thresholds for applying traditional indications, and the appearance of new and unsupported justifications such as 'baby seems large.'" SAKALA & CORRY, *supra* note 9, at 43. Twenty-eight percent of women in the *Listening to Mothers III* survey who received a primary C-section reported experiencing pressure from a health professional to have the surgery. LISTENING TO MOTHERS III, *supra* note 4, at 35–36.

¹⁵³ In one case, for example, the hospital record contains a note handwritten by the woman's doctor stating, "I have decided to override her refusal to have a C-section." Anemona Hartocollis, *Mother Accuses Doctor of Forcing a C-Section and Files Suit*, N.Y. TIMES (May 16, 2014), http://www.nytimes.com/2014/05/17/nyregion/mother-accuses-doctors-of-forcing-a-c-section-and-files-suit.html?_r=0; see also Amended Verified Complaint, *Dray v. Staten Island University Hospital*, Supreme Court of the State of New York, County of Kings, Index No. 500510 (Apr. 11, 2014) (detailing Rinat Dray's lawsuit alleging negligence, medical malpractice, lack of informed consent, violation of the New York Patient's Bill of Rights statute, and punitive damages after her doctor conducted a C-section against her will instead of allowing a trial of labor after cesarean (TOLAC)). For another example, see *Goodall v. Comprehensive Women's Health Center*, No. 2:14-cv-399-FtM-38CM, 2014 WL 3587290 (M.D. Fla. July 18, 2014) (the federal court refused to grant Jennifer Goodall's request for a temporary restraining order when the hospital where she sought prenatal care threatened to begin a process for Expedited Judicial Intervention Concerning Medical Treatment Procedures, to contact the Department of Children and Family Services, and to perform a cesarean surgery without her consent and over her objection after Ms. Goodall described her desire to attempt TOLAC).

¹⁵⁴ *Commonwealth v. Pugh*, 969 N.E.2d 672, 690 (Mass. 2012).

Cesarean surgery is merely a contextualizing example. The rights to informed consent and refusal apply to any medical intervention used in obstetric practice, from induction and episiotomy to routine vaginal examination during labor.¹⁵⁵ Common law has well established that providers need to obtain consent before performing medical procedures on patients.¹⁵⁶ If a person with the mental capacity¹⁵⁷ to choose does not consent to a surgery, and the surgeon performs it anyway, the surgeon commits a battery¹⁵⁸ and a constitutional violation.¹⁵⁹ Common law has also qualified how consent must be achieved: it must be “informed.”¹⁶⁰ That is, it must be accompanied by appropriate knowledge and comprehension of risks and benefits.¹⁶¹ The concept of informed consent is not only

¹⁵⁵ On July 1, 2014, new provisions of the Arizona Administrative Code took effect requiring midwives to perform vaginal examinations during labor. ARIZ. ADMIN. CODE § R9-16-108 (2014), available at http://www.azsos.gov/public_services/Title_09/9-16.htm#pgfid. Such laws tie the hands of health providers seeking to avoid liability for regulatory non-compliance and minimize women’s right to informed refusal of unwanted treatment when they otherwise wish to seek a midwife’s services for assistance with birth.

¹⁵⁶ See, e.g., *Schloendorff v. Soc’y of New York Hosp.*, 105 N.E. 92, 93 (N.Y. 1914) (“Every human being of adult years and sound mind has a right to determine what shall be done with his own body”); see also *Cruzan v. Dir., Mo. Dep’t of Health*, 497 U.S. 261, 269 (1990) (“The informed consent doctrine has become firmly entrenched in American tort law.”).

¹⁵⁷ When a pregnant woman is genuinely incapable of choosing whether or not to consent, policy considerations dictate that she be assured an independent assessment of her best interests or substituted judgment of her preferences. MEREDITH, *supra* note 125, at 216. Providers’ failure to follow family member directives may violate the rights of pregnant women who are unable to make their own health care decisions. See, e.g., *Manny Fernandez, Judge Orders Hospital to Remove Pregnant Woman from Life Support*, N.Y. TIMES (Jan. 24, 2014), <http://www.nytimes.com/2014/01/25/us/judge-orders-hospital-to-remove-life-support-from-pregnant-woman.html> (a case highlighting tension between fetal rights and the rights of a brain-dead woman who was kept on life support based on a provision regarding pregnant women in the Texas Advance Directives Act, TEX. HEALTH & SAFETY CODE ANN. § 166.049 (West 1999)). But see *Cruzan*, 497 U.S. at 286 (a Missouri statute can require clear and convincing evidence of a patient’s wishes and allow providers to reject family members’ “substituted judgment” in the absence of substantial proof that their views reflect the patient’s).

¹⁵⁸ See, e.g., *Montgomery v. Bazaz-Sehgal*, 798 A.2d 742, 748 (Pa. 2002); *Vitale v. Henchey*, 24 S.W.3d 651, 656 (Ky. 2000); *Perna v. Pirozzi*, 457 A.2d 431, 439 (N.J. 1983).

¹⁵⁹ In *Cruzan v. Director, Missouri Department of Health*, the Supreme Court made an explicit connection between constitutional liberty and the right to physical freedom and self-determination in refusing unwanted medical treatment. 497 U.S. at 278, 287; SEYMOUR, *supra* note 121, at 204.

¹⁶⁰ See, e.g., *Cobbs v. Grant*, 502 P.2d 1, 9 (Cal. 1972) (“[T]he patient’s consent to treatment, to be effective, must be an informed consent.”).

¹⁶¹ See, e.g., *Canterbury v. Spence*, 464 F.2d 772, 780 (D.C. Cir. 1972) (discussed *infra*); *Sard v. Hardy*, 379 A.2d 1014, 1020 (Md. 1977) (“This duty to disclose is said to

present in U.S. jurisprudence, but is incorporated by human rights instruments as a part of the rights to health and autonomy. For instance, CEDAW General Recommendation No. 24 reads, “Women have the right to be fully informed, by properly trained personnel, of their options in agreeing to treatment or research, including likely benefits and potential adverse effects of proposed procedures and available alternatives.”¹⁶² Likewise, the European Convention on Human Rights and Biomedicine allows “intervention in the health field” only when the patient “has given free and informed consent” based on “appropriate information as to the purpose and nature of the intervention as well as . . . its consequences and risks.”¹⁶³ Some commentators have also argued that the right to receive information enumerated in Article 19 of the ICCPR includes an affirmative duty of states to ensure the provision of information related to reproductive health and choice.¹⁶⁴ If women have an established human right to reproductive health information generally, women clearly have a right to information about risks and benefits when reproductive health decisions are immediately at stake.

The legal rules governing informed consent in the United States are inconsistent across the states. Different states apply different standards, some recognizing a healthcare professional’s obligation to provide a patient with information that a reasonable person in the patient’s position would consider “material” to the question of consent,¹⁶⁵ and some recognizing a duty to provide the “normal” information given by a responsible practitioner related to that procedure.¹⁶⁶ Regardless of how much information is given,

require a physician to reveal to his patient the nature of the ailment, the nature of the proposed treatment, the probability of success of the contemplated therapy and its alternatives, and the risk of unfortunate consequences associated with such treatment. . . . The law does not allow a physician to substitute his judgment for that of the patient in the matter of consent to treatment”). See also ACOG, *Committee Opinion No. 439: Informed Consent*, 114 AM. J. OBSTETRICS & GYNECOLOGY 401–08 (2009; reaffirmed 2012) [hereinafter *Informed Consent*].

¹⁶² CEDAW Report, *supra* note 57, ¶ 20.

¹⁶³ WICKS, *supra* note 120, at 63 (citing Convention for the Protection of Human Rights and Dignity of the Human Being with Regard to the Application of Biology and Medicine: Convention on Human Rights and Biomedicine, Apr. 4, 1997, C.E.T.S. 164).

¹⁶⁴ Cook et al., *supra* note 18, at 58 (citing Sandra Coliver, *The Right to Information Necessary for Reproductive Health and Choice Under International Law*, 44 AM. U. L. REV. 1279 (1995)).

¹⁶⁵ This is sometimes called the “prudent patient” approach. WICKS, *supra* note 120, at 82.

¹⁶⁶ *Id.* at 85.

providing information alone is not enough; informed consent requires that the patient understands the given information.¹⁶⁷ The “reasonable person” standard is a patient-centered approach, while the focus on “normal information” approaches consent from the provider’s point of view. The second approach, known as the “professional rule,” was first firmly rejected in *Canterbury v. Spence*; the United States Court of Appeals, District of Columbia Circuit, recognizing the fundamental concept that every human “of adult years and sound mind” has a right to bodily integrity and choice about what shall be done with her body,¹⁶⁸ also accepted that “[t]rue consent to what happens to one’s self is the informed exercise of a choice” that “entails an opportunity to evaluate knowledgeably the options available and the risks attendant upon each.”¹⁶⁹ In *Wheeldon v. Madison*, the Supreme Court of South Dakota adopted the *Canterbury* rule and further focused on patient rights rather than provider discretion.¹⁷⁰ In *Wheeldon*, a plaintiff alleged that her provider had failed to inform her of the risks associated with amniocentesis (a sampling of amniotic fluid used to test for fetal genetic abnormalities).¹⁷¹ The court held that the right “to know—to be informed—is a fundamental right personal to the patient and should not be subject to restriction by medical practices that may be at odds with the patient’s informational needs.”¹⁷² Providers must use discretion under quickly changing circumstances during labor and delivery, but the need to make quick calls about medical interventions does not relieve a provider of the duty to inform a pregnant patient about the risks involved in each medical act and available alternatives.¹⁷³

For a patient to take legal action for a provider’s failure to obtain informed consent, she must demonstrate that she was not adequately

¹⁶⁷ *Informed Consent*, *supra* note 161, at 2–3.

¹⁶⁸ 464 F.2d 772, 780 (D.C. Cir. 1972) (quoting *Schloendorff v. Soc’y of N.Y. Hosp.*, 105 N.E. 92, 93 (N.Y. 1914)).

¹⁶⁹ *Canterbury*, 464 F.2d at 780.

¹⁷⁰ 374 N.W.2d 367, 374 (S.D. 1985).

¹⁷¹ *Id.* at 370–71.

¹⁷² *Id.* at 374; *see also* MEREDITH, *supra* note 125, at 7 (citing *Matter of Conroy*, 486 A.2d 1209, 1225 (N.J. 1985) (“[I]f the patient’s right to informed consent is to have any meaning at all, it must be accorded respect even when it conflicts with the advice of the doctor or the values of the medical profession as a whole.”)).

¹⁷³ ACOG states in guidance to providers that, “[t]he ethical requirement to seek informed consent need not conflict with physicians’ overall ethical obligation of beneficence; that is, physicians should make every effort to incorporate a commitment to informed consent within a commitment to provide medical benefit to patients and, thus, to respect them as whole and embodied persons.” *Informed Consent*, *supra* note 161, at 1.

informed and that she would have made a different choice and avoided the harm of the action or procedure if she had been provided the information to which she was entitled.¹⁷⁴ Numerous jurisdictions require that the proposed treatment actually caused physical injury to the plaintiff.¹⁷⁵ But under a rights-based rubric of accountability, physical harm following a provider's failure to give appropriate information about risks is not a necessary element—the violation of one's right to make an autonomous decision is itself harmful. Whether or not a woman currently has a legally actionable claim, she is entitled to informed consent as a core tenet of her human right to autonomy. Shifting the focus on informed consent in the delivery room away from the provider's fear of liability to the affirmative acknowledgement of women's rights can empower women to assert their right to consent or not consent before a violation occurs. Some countries have identified pregnant women's specific right to informed consent during childbirth in their domestic legislation; this state acknowledgement of rights reminds providers of their duties to inform patients and to respect patient choices at the outset of treatment.¹⁷⁶

3. Respect for Autonomy Does Not Negate Duties to Minimize Risks to Health

The interplay between autonomy and the highest attainable standard of health raises the issue of a woman's right to choose a

¹⁷⁴ See *Sard v. Hardy*, 379 A.2d 1014, 1024 (Md. 1977) (“All courts recognizing the doctrine of informed consent require proof of proximate causation. The rule is that a plaintiff cannot recover under the doctrine unless he can prove by a preponderance of the evidence that he would not have given his consent to the proposed procedure had full and adequate disclosure been made at the time consent was originally given”) (citing *Karp v. Cooley*, 493 F.2d 408, 422 (5th Cir. 1974)). Courts have found that for an injury to be actionable, (1) “an unrevealed risk that should have been made known must materialize,” (2) “the unrevealed risk must be harmful to the patient,” and (3) “causality exists only when disclosure of significant risks incidental to treatment would have resulted in the patient’s decision against it.” *Karp*, 493 F.2d at 422.

¹⁷⁵ See, e.g., *Brandt v. Engle*, 791 So. 2d 614, 620 n.2 (La. 2001); *Bankert v. United States*, 937 F. Supp. 1169 (D. Md. 1996); *Roberts v. Patel*, 620 F. Supp. 323 (N.D. Ill. 1985); *Wale v. Barnes*, 278 So. 2d 601 (Fla. 1973).

¹⁷⁶ See, e.g., Law of Georgia of 5 May 2000 (Text No. 283-II) on the Rights of Patients; Chapter VII: Rights of pregnant women and nursing mothers (arts. 35–38), available at https://matsne.gov.ge/index.php?option=com_idmssearch&view=docView&id=16978&lang=e# (stating that women have a right to receive information on the direct or indirect effects of planned interventions during pregnancy, childbirth, and lactation (art. 35) and to make decisions concerning proposed interventions (art. 36)); Rights of Pregnant Women, P.R. LAWS ANN. tit. 24, § 3692 (2006).

method of birth—for example, a vaginal birth after a previous C-section, early elective induction, or elective C-section.

While women's rights to autonomy should allow them to make choices about their health and bodies, the state has an obligation to protect the right to health through an evidence-based system of care, including respect for the physiological processes of childbirth, as discussed in Part II.A.2. Currently, many women lack the necessary information about the relevant risks to make an informed choice about "early elective delivery."¹⁷⁷ Yet, these deliveries may account for ten to fifteen percent of births in the United States¹⁷⁸ Elective deliveries of low-risk women between thirty-seven and thirty-eight weeks carry a greater risk of C-section, anemia, infection, and sepsis, which can harm both the mother and the baby.¹⁷⁹ Early delivery without medical indicators, whether by C-section or induction, is not based in evidence. Medical providers who ignore this science and encourage or allow elective C-sections or early inductions, and states that fail to regulate these practices, do not promote "the highest attainable standard of health conducive to living a life in dignity."¹⁸⁰ Although women have a right to refuse treatment that may be medically indicated, they do not have an absolute right to demand treatments that are not medically indicated, which would place providers in the untenable position of actively providing inferior care on patient demand.

On the other hand, providers should support women's choices to try birth methods that have met with historical professional resistance where evidence now shows that those methods are reasonable and beneficial. "Trial of labor after cesarean" (TOLAC) (often referred to as VBAC—denoting the outcome of a vaginal birth after cesarean) was fairly common in the 1980s and mid-1990s, but rates of VBAC greatly decreased in the past several decades due to professional liability pressures and restrictions on access resulting from reports of

¹⁷⁷ DEADLY DELIVERY ONE YEAR UPDATE, *supra* note 5, at 10–11 (explaining that "early elective delivery" is the induction or C-section planned before thirty-nine weeks of pregnancy without medical indication).

¹⁷⁸ *Id.* at 11.

¹⁷⁹ *Id.* at 10–11; *see also* Comm. on Obstetric Practice, *Committee Opinion No. 559: Cesarean Delivery on Maternal Request*, 121 AM. J. OBSTETRICS & GYNECOLOGY 904–07 (2013) (advising that elective cesareans should not be performed before thirty-nine weeks, should not be motivated by the unavailability of effective pain management, and are not recommended for women desiring several children, given the increased risks related to each cesarean delivery).

¹⁸⁰ *General Comment No. 14, supra* note 26, ¶ 1.

complications.¹⁸¹ After finding that the actual data on maternal and neonatal outcomes did not warrant such severe limitations on this approach to delivery, ACOG issued revised guidelines in 2010 acknowledging the benefits of VBAC, including, on an individual level, fulfilling patient preferences, decreasing maternal mortality, and decreasing risks of complications in future pregnancies.¹⁸² However, ACOG did not change its guidelines requirement that surgical and anesthesia personnel be “immediately available” during TOLAC, despite a National Institutes of Health recommendation that ACOG reevaluate its guidelines, given the little evidence supporting that requirement and the resulting shortage of clinicians and facilities willing and able to offer TOLAC.¹⁸³ To uphold the right to autonomy, professional organizations, government regulatory entities, and individual providers must continually reevaluate past practices to make access to safe birth methods available for women, including safe trials of labor.

In exercising their right to autonomy, women also make choices about where to give birth and from whom to seek care. Those choices are often limited by U.S. state regulations. When regulating care providers and settings, U.S. states should support women’s choices when evidence shows that their choices are as safe or safer than alternatives. For example, studies show that low-risk pregnant women who plan midwife-led home births experience high rates of physiological birth and low rates of intervention without an increase in adverse outcomes.¹⁸⁴ The European Court of Human Rights has held that the choice to give birth at home flows from the right to personal autonomy and respect for private and family life guaranteed by human rights instruments.¹⁸⁵ Yet, homebirth presents its own

¹⁸¹ *Nat’l Inst. of Health Consensus Dev. Conference Statement, Vaginal Birth After Cesarean: New Insights, March 8–10, 2010*, 115 *OBSTETRICS & GYNECOLOGY* 1279 [hereinafter *NIH Development Conference Statement*].

¹⁸² *Practice Bulletin No. 115: Vaginal Birth After Cesarean*, 115 *AM. J. OBSTETRICS & GYNECOLOGY* 450–63 (2010).

¹⁸³ *NIH Development Conference Statement, supra* note 181, at 1287.

¹⁸⁴ Melissa Cheyney et al., *Outcomes of Care for 16,924 Planned Home Births in the United States: The Midwives Alliance of North America Statistics Project, 2004 to 2009*, 59:1 *J. MIDWIFERY & WOMEN’S HEALTH* 17 (2014), available at <http://ir.library.oregonstate.edu/xmlui/bitstream/handle/1957/45499/BovbjergMaritPublicHealthHumanSciencesOutcomesOfCare.pdf?sequence=1>.

¹⁸⁵ The court based its decision on Article 8 of the European Convention on Human Rights, holding that “the right concerning the decision to become a parent includes the right of choosing the circumstances of becoming a parent.” *Ternovszky v. Hungary*, App.

unique health risks. As the Supreme Judicial Court of Massachusetts, Worcester stated in the 2012 unassisted home delivery case *Commonwealth v. Pugh*, “All births, regardless of venue, carry inherent risks.”¹⁸⁶ States thus should act to minimize health risks in the variety of possible venues in which women may choose to give birth, and states should not criminalize women or their providers for those choices.¹⁸⁷ Government and private parties must remember that the rights to health and autonomy are entwined; actions taken to effectuate one right must not violate the other.

C. The Right to Freedom from Discrimination

Freedom from discrimination is a fundamental human right guaranteed by numerous human rights treaties, including the ICESCR, ICCPR, and CEDAW. States have an obligation to prohibit and eliminate discrimination on all grounds and to ensure that other rights are enjoyed without discrimination.¹⁸⁸ The right to not be discriminated against during labor and birth is closely tied to women’s rights to health and autonomy. The CESCR notes that the right of freedom from discrimination addresses an “integral component[] of the right to health,” and that a comprehensive national strategy for promoting women’s health is necessary to eliminate discrimination against women.¹⁸⁹ Discrimination against women as defined by CEDAW means “any distinction, exclusion or restriction made on the basis of sex which has the effect or purpose of impairing or nullifying the recognition, enjoyment or exercise by women . . . of human rights and fundamental freedoms.”¹⁹⁰ Because pregnancy is unique to the female sex, actions taken by health care providers that have the effect of impairing women’s rights to health and autonomy

No. 67545/09, Eur. Ct. H.R., Judgment (2010), available at <http://hudoc.echr.coe.int/sites/eng/pages/search.aspx?i=001-102254>.

¹⁸⁶ 969 N.E.2d 672, 692 (Mass. 2012).

¹⁸⁷ In *Pugh*, the court failed to impose criminal liability on a woman charged with unintentional death of a viable fetus. *Id.* at 694–95. The court noted, “We are not free to ignore that the imposition of criminal liability on a woman in labor for breach of the duty at issue here is likely to have the greatest impact on the most vulnerable groups of pregnant women—young teens, victims of rape and incest, the undocumented, residents of remote areas—who may have no realistic alternatives than to give birth unassisted.” *Id.* at 694. The state should take note of the unique circumstances of those vulnerable populations in considering new avenues for access to maternal health services.

¹⁸⁸ FACT SHEET NO. 31, *supra* note 48, at 7.

¹⁸⁹ *General Comment No. 14*, *supra* note 26, ¶ 3.

¹⁹⁰ Convention on the Elimination of All Forms of Discrimination Against Women, *supra* note 36, at art. 1.

in childbirth are necessarily actions that are “made on the basis of sex.” Thus, health care providers discriminate against women when they disallow full enjoyment of the rights to autonomy and health by overriding a woman’s wishes about how her labor will proceed, or by failing to give her the information necessary to make an informed choice about a particular medical intervention. Discrimination by a state occurs when the state limits women’s personal autonomy as it relates to their reproductive health. Discrimination also occurs when the government fails to appropriately allocate health resources or denies health services that only women need.¹⁹¹

The OHCHR describes state obligations to achieve gender equality and freedom from discrimination as obligations to ensure that state laws, policies, and practices “meaningfully address the specific needs of women,”¹⁹² which in the context of pregnancy are clearly distinct from the needs of men. Meaningfully addressing specific needs is necessary to achieve “substantive equality” for women, which takes into account differences (such as the biological ability to become pregnant), as opposed to “formal equality,” which purports to be gender-blind and maintains structural discrimination embedded in institutions through a history of past discrimination.¹⁹³ The concept of “substantive equality” also applies to the different and specific needs of groups facing particular health challenges such as vulnerability to specific diseases or higher mortality rates. States must recognize and provide for those differences in developing health care policies.¹⁹⁴

Individuals who are part of traditionally discriminated groups often experience a disproportionate share of rights violations,¹⁹⁵ including the rights to health and autonomy. Women who experience discrimination on the basis of both sex and race are likely to suffer from a compounded impact of this “double” discrimination.¹⁹⁶ According to Amnesty International, women of color in the United States are more likely to die from pregnancy-related complications than white women, which reflects disparities in access to care and information, inappropriate treatment and discrimination by service

¹⁹¹ *Rep. of the OHCHR: Practices*, *supra* note 64, ¶ 4.

¹⁹² *Id.* ¶ 18.

¹⁹³ See generally Alda Facio & Martha I. Morgan, *Equity or Equality for Women? Understanding CEDAW’s Equality Principles* (Int’l Women’s Rights Action Watch Asia Pac. Occasional Paper Series No. 14, 2009).

¹⁹⁴ FACT SHEET NO. 31, *supra* note 48, at 7–8.

¹⁹⁵ *Id.* at 7.

¹⁹⁶ *Id.*

providers, and socioeconomic disparities generally impacting these women's right to health.¹⁹⁷ Language barriers also impact women's abilities to assert their rights. A woman who does not speak English may not understand an explanation of the risks of a certain intervention, or may want to refuse treatment but may not be provided an interpreter who can fully express her wishes, preventing her from claiming her right to informed consent or refusal.¹⁹⁸ Further, a recent case report shows that low-income women and women of color are overrepresented in cases of women suffering deprivations of liberty (including arrest, imprisonment, and judicially-ordered interventions during birth) where, but for her pregnancy, the action taken against the woman would not have occurred.¹⁹⁹ When women encounter these overlapping structural inequalities, the state's obligations with respect to nondiscrimination are enhanced.²⁰⁰

States are obligated under the human rights framework to ensure that historically marginalized groups are especially protected from abuses of power from both public and private parties, to provide culturally appropriate health services,²⁰¹ and to recognize and provide for the specific needs of groups that experience these higher rates of rights violations.²⁰² In developing measures for better maternal care, the state should address policies and practices that discriminate against women generally, as well as those that have a disparate impact on certain groups, and act to eliminate those disparities to promote effective and appropriate maternal care for all women. The principles of freedom from discrimination and substantive equality to address women's specific needs should be touchstones for the United States as it seeks to meet its duties to ensure women's human rights.

III RESPECTING, PROTECTING, AND FULFILLING PREGNANT WOMEN'S HUMAN RIGHTS

Once individual human rights are identified, the international law doctrine of "respecting, protecting, and fulfilling" human rights

¹⁹⁷ DEADLY DELIVERY ONE YEAR UPDATE, *supra* note 5, at 6.

¹⁹⁸ *See generally* DEADLY DELIVERY, *supra* note 7.

¹⁹⁹ Paltrow & Flavin, *supra* note 129, at 300–01, 311–12.

²⁰⁰ FACT SHEET NO. 31, *supra* note 48, at 7–8.

²⁰¹ *General Comment No. 14*, *supra* note 26, ¶ 12(c).

²⁰² FACT SHEET NO. 31, *supra* note 48, at 7.

should be applied.²⁰³ Respect for rights means nations must refrain from interfering with people's enjoyment of their rights; for example, states should not limit equal access to effective maternal care for specific populations such as prisoners or undocumented immigrants.²⁰⁴ Protection of rights obligates states to act to prevent the interference of third parties with those rights, so that even when health care is privatized, the state must ensure the maternal care available to pregnant women is adequate.²⁰⁵ States can be charged with violations of human rights when they are ineffective in regulating other entities that violate rights.²⁰⁶ Fulfillment of rights obligates states to take positive action to promote the realization of rights through legislative, budgetary, judicial, administrative, and other types of measures.²⁰⁷

"Progressive realization"²⁰⁸ is a human rights principle applied to economic, social, and cultural rights that accounts for states' resource limitations in defining the scope of state obligations.²⁰⁹ The right to health is one example of a resource-dependent right subject to progressive realization.²¹⁰ However, other rights and obligations are "of immediate effect," such as the right to nondiscrimination and the state's obligation to guarantee that all other rights are exercised on the basis of nondiscrimination.²¹¹ Further, even when rights are subject to progressive realization, some state obligations pertaining to those rights are so central to the right's realization that they are considered non-derogable "core obligations" that are also "of immediate effect."²¹² According to the CEDAW Committee and the CESCR, the provision of maternal health services and the prevention of maternal mortality and morbidity are "core obligations" of the right to health, meaning that "[s]tates have the immediate obligation to take deliberate, concrete and targeted steps towards fulfilling the right to health in the context of pregnancy and childbirth" regardless of

²⁰³ See *id.* at 25–28; Cook et al., *supra* note 18, at 24–26; *General Comment No. 14*, *supra* note 26, ¶ 33.

²⁰⁴ *General Comment No. 14*, *supra* note 26, ¶ 34.

²⁰⁵ *Id.* ¶ 35.

²⁰⁶ *Id.* ¶ 47.

²⁰⁷ Cook et al., *supra* note 18, at 25; *General Comment No. 14*, *supra* note 26, ¶ 33.

²⁰⁸ *General Comment No. 14*, *supra* note 26, ¶ 31.

²⁰⁹ FACT SHEET NO. 31, *supra* note 48, at 23.

²¹⁰ *Id.*

²¹¹ *Id.* at 24.

²¹² *Rep. of the OHCHR: Practices*, *supra* note 64, ¶ 4.

resource availability.²¹³ Human rights are often mistakenly considered “aspirational.” In fact, the language of human rights asserts that the rights themselves are innate and that states have real, extant obligations to take steps to respect, protect, and fulfill those rights while working toward their full realization.²¹⁴

Before launching new rights-based maternal care measures, the state should identify and acknowledge the human right at issue by naming maternal care as a distinctive human right, and the state should better define the subsidiary rights that circumscribe that comprehensive right. In the Commonwealth of Puerto Rico, pregnant women may cite the Rights of Pregnant Women statute, 24 L.P.R.A. § 3692, as a domestic legal guarantee of their human rights. This law affirms pregnant women’s rights during labor, childbirth, and postpartum. A pregnant woman in Puerto Rico has the following rights: (1) the right “to be informed . . . about the different medical interventions that may be performed”; (2) the right “to be treated with respect and in an individual, personalized manner”; (3) the right “to natural childbirth as a first alternative, respecting her physiological, biological and psychological aspects, avoiding invasive practices and the administration of medication that is not justified by the health condition of the woman in labor or the child to be born”; (4) the right “to be informed about the development of her labor . . . and to be made a participant in the various actions undertaken by the assisting professionals”; (5) the right to “be informed of the various medical interventions that could be performed” where complications are foreseen; and (6) the right “not to be intimidated about the process of childbirth if there [are] no risks involved” at the outset.²¹⁵ Puerto Rico’s law does not provide practical guidelines for health providers or legislators to follow, but it serves the purpose of educating women about their rights and affirming that the state and private parties have duties to pregnant women that derive from human rights. Laws such as this one, which demonstrate the government’s unambiguous intent to vest individuals with rights, can bring human rights out of the ether and into the more concrete sphere of the state’s domestic legal duties to respect, protect, and fulfill.

The immediate, core obligation of states to take “deliberate, concrete and targeted steps” to fulfill pregnant women’s right to

²¹³ *Id.*

²¹⁴ *General Comment No. 14*, *supra* note 26, ¶ 30; *Rep. of the OHCHR: Practices*, *supra* note 64, ¶ 4.

²¹⁵ Rights of Pregnant Women, P.R. LAWS ANN. tit. 24, § 3692 (2006).

health was reaffirmed in the OHCHR's July 2011 report to the HRC on maternal mortality.²¹⁶ The report identified key criterion of good and effective practices in adopting a human rights-based approach to maternal care. To fulfill their duties to respect, protect, and fulfill the right to maternal care, states should (a) address past grievances, (b) prevent future violations, (c) eliminate discriminatory barriers to the enjoyment of rights, and (d) improve monitoring and evaluation mechanisms.²¹⁷ These components of the state's duties all contribute to accountability, which is "not an afterthought in a rights-based approach, but fundamental to each stage of the process,"²¹⁸ and is "at the core of the enjoyment of all human rights."²¹⁹ In developing state actions to give effect to the right to maternal care based on these criterion, the United States should utilize existing expert reports and human rights authority to formulate effective rights-based legislation and identify the agencies that are best equipped to execute its duties. Measures developed in the four areas of accountability identified by OHCHR should be consistent with international human rights treaties²²⁰ and should be participatory by involving women in planning and implementation processes and placing a gender perspective at the center of policies affecting women's health.²²¹ A few examples of potential actions follow.

A. Addressing Past Grievances: Redress and Reparations for Violations

Human rights law calls for progressive change but does not ignore past conduct. To fulfill its human rights obligations, the United States must develop specialized remedies for past violations of the right to quality maternal care. This includes ensuring that existing remedies can address all violations of the right at issue. For example, U.S. states should provide a remedy for a violation of autonomy due to a lack of informed consent to procedures during labor, even when the fact finder determines that there is no demonstrable physical injury. Because the right to maternal care incorporates an evidence-based approach, states also have an obligation to reform their liability

²¹⁶ *Rep. of the OHCHR: Practices*, *supra* note 64, ¶ 4.

²¹⁷ *Id.* ¶¶ 5–30.

²¹⁸ *Rep. of the OHCHR: Technical Guidance*, *supra* note 27, ¶ 18.

²¹⁹ *Rep. of the OHCHR: Practices*, *supra* note 64, ¶ 31.

²²⁰ *Id.* ¶ 34.

²²¹ CEDAW Report, *supra* note 57, at 7.

systems to align with evidence-based care, as liability currently often turns on non-scientific opinion-based standards of care.²²²

For women who have suffered the ultimate deprivation of the right to health and died from pregnancy-related complications, the United States should acknowledge the violation through a better system of recording maternal deaths. The U.N. Special Rapporteur on the right to health has implored states to establish a comprehensive and effective federal registration system to record and analyze the causes of maternal deaths, including nonmedical factors such as social, economic, and cultural reasons that contributed to the death.²²³ This system would address past violations by acknowledging that the violations occurred, and it would prevent future morbidity and mortality by providing better data on the kinds of natural occurrences and obstetric practices contributing to maternal injury and death.

The HRC has reaffirmed states' obligation to address past violations of human rights in childbirth. In a 2014 report on human rights in Ireland, the HRC examined the practice of symphysiotomy, a childbirth operation which "severs one of the main pelvic joints and unhinges the pelvis," used in public and private Irish hospitals on 1500 women and girls in the twentieth century without their free and informed consent.²²⁴ The report calls for Ireland to initiate a "prompt, independent and thorough investigation into cases of symphysiotomy, prosecute and punish the perpetrators, including medical personnel, . . . provide the survivors of symphysiotomy an effective remedy for the damage sustained, including fair and adequate compensation and rehabilitation, on an individualized basis" and "facilitate access to judicial remedies by victims . . . including allowing them to challenge the sums offered to them under the [*ex-gratia*] scheme."²²⁵ This report is a call for states to take it upon themselves to devise remedial schemes for specific rights violations in order to fulfill women's human rights in childbirth, in addition to improving more general remedial routes.

²²² SAKALA & CORRY, *supra* note 9, at 63–64.

²²³ *Rep. of the OHCHR: Practices*, *supra* note 64, ¶ 33.

²²⁴ United Nations Human Rights Committee [UNHRC], *Concluding Observations on the Fourth Periodic Report of Ireland*, ¶ 11, U.N. Doc. CCPR/C/IRL/CO/4 (Aug. 19, 2014).

²²⁵ *Id.*

B. Preventing Future Violations: Correcting Systemic Failures

The correction of systemic failures in health care delivery requires a comprehensive and targeted approach, with many measures targeting specific problems that can cumulatively achieve change. The CESCR suggests that human rights may be realized through “numerous, complementary approaches,” including “the formation of health policies,” “the implementation of health program[s] developed” by the WHO or other intergovernmental organizations, and “the adoption of specific legal instruments.”²²⁶

In formulating human rights-based maternal health programs, the United States should take note of the WHO’s course in modern evidence-based obstetric care, which has contributed to positive health care changes in other countries. Georgia served as a pilot country for this program, and the success of Georgia’s efforts has been reflected in the country’s statistical outcomes. C-sections now make up just ten percent of all deliveries, and episiotomy rates plummeted from sixty-nine percent to just nine percent of births in 2010. Holistic measures such as partner attendance have also changed: ninety-nine percent of deliveries are now partner-attended, where none were prior to the WHO implementation.²²⁷ Using internationally developed health recommendations like this one put forth by the WHO can help the United States achieve the “highest attainable” standard of maternal health.

The United States should also take policy recommendations from U.N. committee documents. In its General Recommendation No. 24 on the Right to Health, the CEDAW Committee advises states on how to fulfill their duties to protect the right to health.²²⁸ The Committee recommends that states “[e]nsure that the training curricula of health workers includes comprehensive, mandatory, gender-sensitive courses on women’s health and human rights.”²²⁹ The WHO has stated that passive dissemination of guidelines is not enough to change providers’ practices.²³⁰ For the United States to fulfill its

²²⁶ *General Comment No. 14*, *supra* note 26, ¶ 1.

²²⁷ Testimony of His Excellency Mr. Mikheil Saakashvili, President of Georgia included in the official records of the High-Level Plenary Meeting on the Millennium Development Goals, U.N. Doc. A/65/PV.4 (Sept. 20, 2010).

²²⁸ See generally CEDAW Report, *supra* note 57.

²²⁹ *Id.* ¶ 31.

²³⁰ See WHO, *Introducing WHO’s Sexual and Reproductive Health Guidelines and Tools Into National Programmes: Principles and Processes of Adaptation and Implementation*, at 4, WHO Doc. WHO/RHR/07.9 (2007).

duties related to pregnant women's rights, it must promote changes in the behavior and attitudes of health professionals.²³¹ These two recommendations taken together provide guidance for states seeking to develop domestic human rights-based training materials for providers of maternal care. In tandem with such training measures, states should evaluate how their health care systems support or discourage evidence-based provider behavior. For example, in the United States, individual states should reevaluate scope of practice laws and licensing procedures to better promote the midwifery model of care, since scientific evidence demonstrates the many benefits of midwife care for low-risk women, including fewer unnecessary interventions.²³²

Education measures should also extend beyond providers to the patients whose rights are at issue. U.S. women are expressing a desire to know more about the complications involved in pregnancy-related medical procedures, but their demonstrated knowledge about the risks of procedures is poor.²³³ Education about rights and childbirth are necessary to ensure state measures effectively protect those rights. The WHO's Constitution affirms that "[i]nformed opinion and active co-operation on the part of the public are of the utmost importance in the improvement of the health of the people."²³⁴ By improving education and comprehensive data collection and analysis, the state can widen the range of care options for pregnant women and ensure that they can make informed choices about their health and the health of their families.²³⁵

The evidence-based approach to maternal care already has a strong foundation developed by women's rights advocates. The authors of the 2008 report *Evidence-Based Maternity Care: What It Is and What It Can Achieve* make several policy suggestions that could be implemented through federal government measures, including: educating U.S. state and federal policymakers and health professionals about evidence-based care; supporting research to further evidence-based care; reforming reimbursement processes to

²³¹ *Id.*

²³² See, e.g., Mayri Sagady Leslie & Amy Romano, Coal. for Improving Maternity Servs., *Appendix: Birth Can Safely Take Place at Home and in Birthing Centers*, 16 J. PERINAT. EDUC. 1, 81S (2007).

²³³ SAKALA & CORRY, *supra* note 9, at 38 (citing EUGENE R. DECLERCQ ET AL., CHILD BIRTH CONNECTION, LISTENING TO MOTHERS II: REPORT OF THE SECOND NATIONAL U.S. SURVEY OF WOMEN'S CHILDBEARING EXPERIENCES (2006)).

²³⁴ WHO Constitution, *supra* note 48.

²³⁵ See DEADLY DELIVERY, *supra* note 7, at 17.

promote effective care with the least harm (including incentivizing medical schools to teach evidence-based care through modification of Medicaid graduate medical education fund distributions and setting adequate Medicaid and Medicare reimbursement rates for CNMs, CMs, and CPMs); and developing national standardized maternity performance measurement and reporting mechanisms to identify and address “current patterns of overuse, underuse, and unjustified practice variation.”²³⁶

Systemic failures are often interconnected. In addition to addressing failures of the health care system by enacting new substantive policies and programs to promote maternal health, U.S. states must reconsider or reform other individual state laws that are inconsistent with pregnant women’s human rights. For instance, in order to fully realize health policy reforms for all childbearing women, U.S. states must reaffirm women’s rights by rejecting fetal rights laws and eliminating distinctions based on pregnancy that engrain sex discrimination in the criminal justice system.

C. Eliminating Discrimination: Removing Barriers to an Effective Human Rights-Based Approach

Many of the above recommendations will combat discrimination against women by helping pregnant women realize their right to quality maternal care. Yet, gender, race, and other stereotypes perpetuated both by formal laws and social norms can greatly impede the progress of forward-looking measures.²³⁷ To combat the effects of “double” discrimination in maternal care, Amnesty International recommends comprehensive planning at every level of government to address fundamental inequalities in nutrition, education, and housing, which are “at the root of general health and maternal mortality disparities.”²³⁸ The IGO also suggests: (1) increasing funding for the Office of Civil Rights in the U.S. Department of Health and Human Services and encouraging investigations into the quality of maternal health care; (2) creating a Health Section in the Civil Rights Division of the U.S. Department of Justice to address discrimination in maternal health care; (3) incorporating culturally appropriate training

²³⁶ SAKALA & CORRY, *supra* note 9, at 68–70; *see also* Martha Cook Carter et al., *2020 Vision for a High-Quality, High-Value Maternity Care System*, 20 WOMEN’S HEALTH ISSUES S7 (2010); Peter B. Angood et al., *Blueprint for Action: Steps Toward a High-Quality, High-Value Maternity Care System*, 20 WOMEN’S HEALTH ISSUES S18 (2010).

²³⁷ *Rep. of the OHCHR: Practices*, *supra* note 64, ¶¶ 6–9.

²³⁸ DEADLY DELIVERY, *supra* note 7, at 94.

into the education of all health care professionals; and (4) changing Medicaid rules and other public funding services to benefit disadvantaged populations such as immigrant women and Native American women.²³⁹

Advocates are already seeing some changes in political will around discrimination in maternal health in the United States through the development of bills such as the Health Equity and Accountability Act (HEAA), versions of which were introduced in the House and Senate in recent years but not enacted.²⁴⁰ The HEAA seeks to eliminate disparities in access to health care and in health care outcomes by ensuring the availability and accessibility of culturally appropriate and language-appropriate public health services.²⁴¹ The Patient Protection and Affordable Care Act, passed on March 23, 2010, is also effecting important changes by expanding health care data collection and reporting to include race, ethnicity, sex, primary language, disability, and rural residence in order to monitor trends in health disparities.²⁴² Yet, health care reform continues to meet legal challenges that may result in backsliding. Such new and proposed legislation to improve maternal care is heartening, but these acts should be the beginning and not the end of measures to ensure the right to freedom from discrimination in pregnant women's enjoyment of the right to health.

D. Developing Accountability: Improving Monitoring and Evaluation of State Obligations

A human rights-based public health strategy for pregnant women should include “accessible, effective, independent and transparent accountability mechanisms at the national level, operating in public and private sectors” which lead to “constant[] improv[ement]” of existing programs and policies and assure “redress and reparations when pregnancy-related violations occur.”²⁴³ International human rights accountability mechanisms can provide guidance for such national mechanisms. States that are parties to CEDAW must report on their own compliance and must ensure that health care providers

²³⁹ *Id.*

²⁴⁰ See H.R. 2954, 112th Cong. (2011); S. 2474, 112th Cong. (2012). Representative Lucille Roybal-Allard introduced a 2014 version of the bill on July 30, 2014. H.R. 5294, 113th Cong. (2014) (still in committee as of December 1, 2014).

²⁴¹ H.R. 5294, 113th Cong. (2014).

²⁴² DEADLY DELIVERY ONE YEAR UPDATE, *supra* note 5, at 17.

²⁴³ *Rep. of the OHCHR: Practices*, *supra* note 64, ¶ 32.

and others in the private sector meet their duties to respect women's rights.²⁴⁴ As a signatory and not a formal party to CEDAW, the United States does not currently report to the CEDAW Committee. The United States should ratify CEDAW as soon as possible to formalize its customary law obligations and improve its own accountability on the world stage. However, regardless of its decision to ratify or not, the United States could mimic CEDAW's accountability system at the domestic level in order to monitor progress and setbacks by developing a monitoring committee to which each U.S. state could report (and to which non-profits and other advocates could also submit shadow reports for further accountability).²⁴⁵ Other monitoring recommendations from human rights advocates include: (1) the establishment of an Office of Maternal Health;²⁴⁶ (2) the local development of the ombudsmen model to encourage independent investigation into state and third party fulfillment of duties;²⁴⁷ (3) the incorporation of human rights standards into professional associations' codes of ethics and licensing mechanisms;²⁴⁸ (4) the establishment of human rights commissions at various levels of government;²⁴⁹ and (5) the development of administrative or judicial complaint and inquiry procedures to allow individuals redress for rights violations.²⁵⁰ For each new state measure that is developed to address past violations, prevent future violations, and eliminate discrimination, some accompanying form of evaluation is necessary to hold the state accountable to its rights-generated duties.

CONCLUSION

The problems with maternal care identified here are gaining notice as more and more women speak out about coercive practices, unnecessary morbidity, and discrimination during labor and birth in the United States. In Congress, Representative Lucille Roybal-Allard

²⁴⁴ See CEDAW Report, *supra* note 57.

²⁴⁵ *Id.*; Convention on the Elimination of All Forms of Discrimination against Women, *supra* note 36; Optional Protocol to the Convention on the Elimination of All Forms of Discrimination Against Women, Oct. 6, 1999, 2131 U.N.T.S. 83 (creating a system for individuals to complain about violations and an inquiry procedure to allow the Committee to investigate violations).

²⁴⁶ DEADLY DELIVERY, *supra* note 7, at 9, 100.

²⁴⁷ Cook et al., *supra* note 18, at 75.

²⁴⁸ *Id.* at 75–76.

²⁴⁹ *Id.* at 76.

²⁵⁰ *Id.* at 77.

has introduced the Maximizing Optimal Maternity Services for the 21st Century Act,²⁵¹ which “promot[es] optimal maternity outcomes by making evidence-based maternity care a national priority” and calls attention to the United States’ poor ranking in maternal and perinatal outcomes, underuse of noninvasive procedures, escalating healthcare costs, and racial and economic disparities in maternal health.²⁵² The Act calls for the promotion of optimal maternity outcomes through noninvasive evidence-based practices, better research and data collection on maternal health, and systemic reviews of care.²⁵³ While this Act and others like it have not yet garnered considerable support from lawmakers, they demonstrate the potential for progressive maternal health legislation based in human rights principles.²⁵⁴

At the administrative level, the U.S. Department of Health and Human Services has worked with the non-profit National Quality Forum to convene a National Priorities Partnership (NPP) working on systemic improvements to U.S. healthcare. In 2011, the NPP identified maternity care, “specifically, inappropriate elective deliveries and cesarean section in low-risk women” as “a major opportunity to improve care and reduce harm and costs” in the United States.²⁵⁵ The NPP also assembled a Maternity Action Team task force of public and private stakeholders to develop community, state, and national action pathways to address inappropriate maternity care and establish concrete goals to improve care, including reductions in preventable hospital-acquired harm and hospital readmissions. The task force first identified barriers to high quality maternity care as including variation in provider practice due to misaligned incentives; discomfort with practicing differently than peers; lack of aligned payment and reporting requirements and policies; gaps in provider, patient/consumer, and purchaser knowledge due to inconsistent

²⁵¹ H.R. 2286, 113th Cong. (2013) (also introduced in 2010 and 2011).

²⁵² *Id.*

²⁵³ *Id.*

²⁵⁴ *See also* Maternal Health Accountability Act of 2014, H.R. 4216, 113th Cong. (2014); Improving Access to Maternity Care Act of 2014, H.R. 4385, 113th Cong. (2014) (formally H.R. 4385: To amend the Public Health Service Act to provide for the designation of maternity care health professional shortage areas); Supporting Women’s Reproductive Health, S. Res. 60, 113th Cong. (2013) (a resolution supporting women’s reproductive health); Access to Certified Professional Midwives Act of 2011, H.R. 1054, 112th Cong. (2011); Pregnant Workers Fairness Act, H.R. 1975, 113th Cong. (2013), S. 942, 113th Cong. (2013).

²⁵⁵ NAT’L PRIORITIES P’SHP, NPP MATERNITY ACTION PATHWAY FINAL 2012 PROGRESS REPORT: IMPROVING MATERNITY CARE FOR MOTHERS AND BABIES 2 (2012).

messaging about evidence-based practices; and lack of hospital board engagement and an improvement culture.²⁵⁶ The group then agreed on three “high-leverage strategies” to address those challenges, focusing on measurement and more transparent, standardized reporting by hospitals, use of evidence-based tools and practices including staff education and “hard-stop policies and checklists to prevent non-medically indicated inductions and cesareans,” and consistent provider and consumer messaging and engagement.²⁵⁷ This overall strategy of combining problem assessment, systemic change at the provider level, empowerment of individual patients, and private and public monitoring for long-term improvement is a great example of domestic implementation of the OHCHR’s multipronged human rights-based approach.

The United States’ maternal care crisis is part of a global problem of pervasive deficiencies in maternal care. Worldwide, international human rights law can provide the starting point for remedying these deficiencies by defining both the inherent rights of childbearing women and state obligations to enforce those rights. The United States, like other states and international bodies, should act to make maternal care an explicit human right. However, recognizing that childbirth implicates other existing underlying human rights is an important threshold step to achieving evidence-based, self-determinative, and nondiscriminatory maternal care.

Once the United States recognizes the human rights of pregnant women, it can set new goals for respecting, protecting, and fulfilling those rights through various measures. The state already has many markers available by which to measure progress, stagnancy, or retrogression, including international human rights treaties, elaboration of treaties by international councils and committees, foreign law that has effected positive change in maternal health in other countries, and research and recommendations from expert NGOs and IGOs. To be a leader in the human rights arena, the United States must acknowledge the applicability of human rights to women in the United States and carry out the state’s obligations to its own citizens based on international standards of minimum conduct. That “minimum” conduct is hardly minimal in degree. The “highest attainable standard” of health is no small right, nor is the right to autonomy or the right to freedom from discrimination. Most pregnant

²⁵⁶ *Id.* at 3.

²⁵⁷ *Id.* at 5.

women in the United States have access to a hospital bed and emergency interventions during birth, but they also deserve access to midwives, education, and the right to say no to invasive procedures. Only a human rights-based approach can help women fully realize their rights to health, autonomy, freedom from discrimination, and the highest attainable standard of maternal care during pregnancy and birth.

